"All in this together? Exploring South African social worker's experiences of shared trauma under Covid-19"

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Abstract

Covid-19 has taken a great toll on people's mental health worldwide. The present study investigates experiences of shared trauma among South African social workers in the mental health field, who were categorized as providing "essential" services during periods of lockdown. Adapting critical phenomenology as research methodology, nine in-depth, semi-structured interviews were conducted, transcribed true verbatim, and analyzed through Fairclough's socio-cultural model of critical discourse analysis. Participants were all employed at the same organisation providing mental health services around the city of Johannesburg. Sampling followed a purposive strategy while social workers were selected according to their willingness and availability. The findings of this study contribute to existing research on shared trauma by highlighting how participant's meaning-making is shaped by discourses of survival and service, as well as individual and structural failure. Possibilities of growth and change are also explored and point to pre-existing challenges that have been exacerbated by the impact of the pandemic. Here, the study sheds light on how social workers in the mental health field navigate their experiences of being exposed to similar stressors as their clients. A second-level analysis focusing on the contextual and structural aspects of participant's lived experiences further revealed the de-politicizing effect of a bio-medical and neoliberal discourse. Professionalism was identified as a potential source of hegemony and resistance if extended trough trauma-informed and culturally sensitive perspectives. Finally, recommendations are given on how social workers can realign with their commitment to social justice, while tackling structural barriers the profession and mental health care users are currently facing.

Keywords: Shared trauma; social work, Covid-19; collective trauma; South African social work; mental health

Declaration

I, the undersigned, declare that this research report is my original work. Any ideas in this report that are not my own are acknowledged through proper references and citations. This report is being submitted for a Master of Arts in the field of Critical Diversity Studies at the University of the Witwatersrand, Johannesburg, and no part of this report has been submitted in the past, or is being submitted, or will be submitted in the future for any degree or examination at any other university.

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1 Introduction

1.1 Background to the Study

Covid-19 has taken a great toll on people´s wellbeing and mental health since the outbreak of the global pandemic in late 2019. In addition to the deadly and severe physical risks of the virus, the pandemic has posed a great risk to mental health. A study conducted with more than 1200 South Africans in 2020 revealed that an estimated 56% of adults experienced increased levels of emotional and psychological distress due to the impact of the pandemic (Mlaba, 2020). As disruptions in daily routines and economic activities have created multiple stressors affecting the whole society, people with pre-existing mental health conditions have found new kinds of challenges and triggers especially difficult (Mlaba, 2020; Rasool, 2020). While seeing a rise in awareness of mental health as a national and global emergency, as well as people's increased interest in seeking related services, it must also be acknowledged that South Africa's mental health support system has nevertheless been overshadowed by the impact of decades long underinvestment (Kenny in Mlaba, 2020). This historical neglect is shaping the context of limited access to important mental health services today, along with existing cultural barriers, prolonged stigmatisation of mental health and a lack of information. Considering these structural conditions, the overall aim of this study is thus to create new insight on the impact Covid-19 has on mental health through the lens of shared trauma.

Research into the impact of the Ebola epidemic of 2014, indicated that "nearly 50% of families, survivors and those who had contact with survivors had PTSD and depression" (Neria in Owings, 2020). Similarly, professionals currently warn of a post-pandemic mental health crisis and an increased need for psycho-social support (Kenny in Mlaba, 2020). In fact, mental health professionals are already seeing an increase in mental health problems and a greater need for related services as an online survey from the South African Depression and Anxiety Group shows (SADAG, 2020). In order to face this current and future challenge, mental health professionals were deemed to be "essential" workers, what allowed and expected them to continue to provide their services under the increased risk of the pandemic. As such, social work and other related fields providing care and social relief to older people, people with mental illness or disability, as well as to children and those who are sick were defined as "essential services" under lockdown, (Chothia, 2020). Before social workers were added to the list of essential service providers, there was an outcry regarding the

misunderstood role of social work in disaster management and the failure to recognise social workers' contributions to addressing food insecurity, gender-based-violence and the psychosocial implications of Covid-19 (Rasool, 2020). As the pandemic progressed however, social workers and other mental health professionals were celebrated as the "silent warriors" (Pinheiro & Kiguwa, 2021) and heroes who were putting themselves at a disproportionate health risk while working on the frontlines. Such positive language not only overshadows a deeply exclusionary and failed health care system, but renders the vulnerability and experiences of those providing these services invisible. Thus, viewing the impact of Covid-19 in its broader socio-political context raises some interesting questions about who carries the larger burden of the pandemic and whether "we really are all in this together?". By acknowledging Covid-19 as a new form of collective trauma with tremendous effects on mental health and wellbeing, this study aims to understand and critically reflect on how South African social workers in the mental health field have experienced the impact of the pandemic. Covid-19 can be referred to as a collective form of trauma due to the fact that a set of events, directly and indirectly linked to the actual virus, have been acting as traumatic stressors in multiple ways (Boring-Bray, 2021). This trauma is collective in nature, as not only certain individuals (e.g. during a natural disaster) but rather the society at large "undergoes an extremely rapid and usually unwanted change" (Neil quoted in Plourde, 2020), characterized by its unpredictability and a large scale threat to safety. Although the extent and experiences of Covid-19 related trauma might differ significantly across countries and population groups, especially through its intersections with existing forms of traumata, it is generally agreed that the pandemic on its own is a unique and new form of trauma. Boring-Bray (2021) argues that Covid-19 "checks the boxes" that define trauma, such as: causing "loss of agency, physical and mental overwhelm, altered perception of safety, and, of course, a significant psychological response to those things" (n.p.). Social workers who live and work in the same traumatic reality as their clients are thus experiencing a phenomenon that is currently under-researched and lacking scientific attention. This research, drawing on data from nine in-depth interviews with social workers from the Gauteng province, will therefore help to create new insights relevant to the study and understanding of trauma in different contexts, as well as the profession of social work at large.

1.2 Research Problem

Although similar lockdown regulations have been adapted across various contexts, there is little in-depth information regarding how these regulations affected different professions and the impact on those providing "essential services". Gaining these insights is especially important when looking at the evidence showing that the pandemic has disproportionately affected minority and historically disadvantaged groups (Kira et al., 2021). The "racial impact" (Kamnitzer et al., 2021) of the virus, but also its intersection with other social categories like class, disability, culture, gender-identity (and so forth) must thus be seen as a consequence of existing systemic oppression and inequality. As current research has begun to shed light on the severe impact of Covid-19 on mental health and well-being in South Africa (Naik, 2021) and beyond (Kola et al., 2021), there is still a lack of focus on how mental health professionals, including social workers, experience their work and life in the context of shared trauma. Operating in an environment of multiple (historical) traumata intersecting with a new traumatic reality shared with their clients, social workers are confronted with the challenge of having to cope with this trauma on a personal and professional level. In addition the coping mechanisms that are available and suitable have been impacted by the pandemic and the political response to it. This brings into question the ways in which the qualities of mental health services and working relationships between mental health professionals have been impacted by Covid-19. Understanding how social workers in the mental health field experience and navigate such challenges is therefore at the centre of this study.

1.3 Purpose of the Study

In line with the problem stated above, this study offers the opportunity to develop important insight into an under-researched topic and current social problem. Literature on the impact of shared trauma as a unique experience that social workers and other mental health professionals share with their clients, is mainly conceptualized and studied within the context of the United States (US) and Israel (Freedman & Tuval Mashiach, 2018; Tosone, 2006; Tosone et al., 2011, 2012a). As the literature review will show, recently published research on this topic is lacking contributions from other, non-western contexts including insights from or created within the African continent and South Africa in particular. This gap does not only provide an opportunity to broaden the context of understanding shared trauma as an under-researched concept but to add nuance to pre-existing findings. Studies with similar foci but outside the conceptual framing of shared trauma could for example be found in discussions

about social work and peacebuilding in post-conflict contexts like in the example of post-genocide Rwanda (King et al., 2017) or in the broad literature on relief work after natural disasters (Connorton et al., 2012; Jordan, 2013; Lemieux et al., 2020). These studies often acknowledge the psychological impact of collective and intergenerational trauma as well as the risks related to chronic exposure to violence and insecurity but do not specifically consider its meanings for social workers or counsellors providing psycho-social support.

The main purpose of this study is thus to offer a conceptual contribution to the topic of shared trauma by exploring South African social worker's experiences of shared trauma under the current pandemic while critically exploring what these experiences can reveal about the possibilities and challenges of mental health related social work in South Africa.

1.4 Research Aims and Objectives

1.4.1 Primary aim

The primary aim of this study is to explore South African social workers' experiences of shared trauma under Covid-19 and what this can reveal about the broader challenges and possibilities of mental health related social work.

1.4.2 Secondary objectives

In line with the above, the *first objective* is to explore how social workers providing mental health services have experienced the impact of Covid-19 on their personal and professional lives, specifically with regards to the "shared traumatic nature" of the pandemic. *Secondly,* this research objective to critically evaluate what these experiences can reveal about social workers' understanding of mental health and trauma, while *lastly* examining how the structural conditions under which mental health social work is operating shape current experiences and future possibilities for the profession.

1.5 Research Questions

What can the experiences of shared trauma under Covid-19 reveal about the possibilities and challenges of mental health related social work in SA?

Specifically, the following research questions have guided this study:

1. How do social workers experience shared trauma in relation to their personal and professional lives?

2. What can the narratives of shared trauma reveal about social workers' understanding of mental health and trauma?

3. What can current experiences of shared trauma among social workers in the mental health field reveal about the structural conditions and future possibilities of the profession?

To answer these questions, this study draws on data produced from nine individual, semi-structured in-depth interviews with social workers in the mental health field. After a verbatim transcription by the researcher, critical discourse analysis was applied to understand participants meaning-making through the language they used

1.6 Key Terms

- Shared Trauma

Shared Trauma is the key term in this study and captures social workers' experiences of living and working in the same traumatic reality as their clients. The understanding of this concept has largely been shaped by Tosone's work on the impact of 9/11 on social workers and their therapeutic relationships (McTighe & Tosone, 2015; Tosone et al., 2011, 2012a). The term is defined as:

> the affective, behavioural, cognitive, spiritual, and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients. (Figley, 2012, p. 624).

To understand Covid-19 as a new form of collective trauma that creates a shared traumatic reality for the social worker and the client, we must consider its impact on various levels. As Tosone et al. (2012a) highlight, the impact of major events can occur on an intra-psychic, interpersonal and community level, potentially altering clinicians´ worldviews and mental schemata. Importantly, the term *shared* should not be misunderstood as meaning that experiences of a traumatic reality are identical among people but rather are shaped by various external and internal factors (ibid.). Explained in more detail below, shared trauma is a key theoretical concept in this study and will be expanded on through the use of additional theoretical perspectives.

- Intersectionality

Mostly associated with the feminist scholar Kimberle Crenshaw, intersectionality has emerged as a theory, practice and methodology that describes the effect of intertwining systems of oppression and thus the failure of feminist and anti-racist discourses to recognize the intersectional dimension of identities (Crenshaw, 1991). As Sloan (2018) explains, every person embodies a "multiplicity of identities" (p.97) (e.g. nationality, color, class, caste, 'race'[1], ethnicity, sexual orientation, ability status, education, religion,...) that hold historically shaped meanings associated with stereotypes, norms and specific attributes situated in layered systems of oppression and privilege. Intersectionality therefore, seeks to understand identities or identity categories not as "separate wherein one dimension can just be added onto the other" (ibid., p.98), but "as interlaced systems of oppression [that are] enmeshed and mutually reinforcing: one form of identity or inequality is not seen as separable or subordinate" (May, 2015, p. ix). In relation to the study of trauma and shared trauma, intersectionality provides an important lens in two ways. The first lies in recognizing the often neglected needs of trauma survivors in mainstream responses by considering the different axes of identity, associated with marginalisation and oppression (De La Rue & Ortega, 2019; Kira et al., 2021). On the other hand, an intersectional perspective allows us to recognize the layered and interacting dimensions of pre-existing and new forms of traumatisation while considering different vulnerabilities shaped by certain identity markers (Ezell et al., 2021; Kaminer & Eagle, 2010).

- Mental Health

Understandings of mental health and mental illness have significantly changed since the mid 20th century. Shifting from a diagnosis-focused to a person-centred understanding of mental illness and positive psychological functioning including well-being and hope, mental health is increasingly understood through a societal perspective recognizing that recognizes its intersection with both physical health and social conditions (Manderscheid et al., 2010). Mental health is thus often described using the term *wellness* which "refers to the degree to which one feels positive and enthusiastic about oneself and life, whereas illness refers to the

[1] With regards to the contested nature of 'race' as a discursively (re-)produced construct, single quotation marks are used to demonstrate an understanding of 'race' as a social, political and historical construct that is based on the ideology of white supremacy and the hierarchization of social groups according to unfounded phenotypical features.

presence of disease" (ibid., p.1). According to the World Health Organisation mental health is further defined as "a state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community"(WHO, 2001). Although this definition is seen as an important development as it departs from the "absence of illness" understanding of mental health, it has been criticized as to promoting a misconception of mental health as a "purely positive affect" (Galderisi et al., 2015, p. 231). It is also important to note that understandings of mental illness and health are rooted in Western epistemologies (Mills, 2014; Salam, 2021) including a medical, biological model and individualized understandings of personhood (Burstow et al., 2014; Diamond, 2014). In line with the above WHO definition, this study aims to critically engage with what is seen as the "normal stressors of life" while recognizing the neoliberal capitalist influence reflected by notions of individualism and productivity.

- Social Work

Although social work emerged differently across the world, the International Federation of Social Work has adopted an officially recognized definition which is describing it as

> a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. (IFSW, 2014).

However, it is important to note that authors like Schenk (2019) or Harms Smith and Nathane (2018) highlight that the historical context in which social work and its epistemological groundings are rooted are not neutral but situated in Western imperialism and a guise of philanthropy. In order to overcome the perception of social work´s role as an "extension of the government" (Schenck, 2019, p. 32) and to live up to its mandate and value of social justice the authors reflect a growing call for decolonising the theory and practice of social work. The latter implicates a break from continuous European domination within the field based on the recognition of various forms of ideology and oppression (Harms Smith & Nathane, 2018).

1.7 Summary of the Research Design

Looking at the phenomenon of shared trauma among South African social workers in the mental health field, this study has been designed using the approach of critical phenomenology. Inspired by traditional philosophical phenomenology and critical hermeneutics, the chosen design allows the researcher to analyze lived experience and subjectivity in relation to the socio-cultural, political and economic conditions of the individual (Dyring, 2020; Guenther, 2019). Situated in a critical qualitative paradigm, the research draws on qualitative data collected in nine individual, semi-structured interviews. Additionally, there were two interviews which served as a pre-test to prove the tools´ efficacy for data collection. Thus, the total number of interviews conducted was eleven. Consent forms, including the permission to audio-record the interviews, were given prior to the interviews via email or as hard copies. All of the interviews were conducted with participants from the same organisation which provides mental health care and statutory services around the city of Johannesburg in Gauteng province. Recognizing the specificity of doing research in times of a global pandemic, all necessary Covid-19 protocols and protective measures (e.g. wearing of masks, physical distancing) were realized. After verbatim transcription, critical discourse analysis in the fashion of Fairclough (1995, 2001) was applied to analyze the data.

1.8 Chapter Outline

Having given a brief summary of the research design, this research report is structured in the following manner: Chapter one introduced a short background to the study as well as its purpose and aims. The importance of generating new insights from this current novel reality has been demonstrated by highlighting a lack of research contributions on shared trauma from within the African continent, as well as the potential of these insights for the future of social work training and practice. Chapter two continues by introducing the key theoretical concepts which provide a framework for the analysis, followed by a review of the literature that speaks to the different aspects of this study. Chapter three is here divided into two major parts. The first part will provide an overview of the literature on trauma and shared trauma, while the second section offers insights into the local, socio-political context of post-apartheid South Africa and the impact of Covid-19. After highlighting the existing research gap(s), additional theoretical perspectives are introduced to broaden the conceptual understanding of shared trauma while adapting theory triangulation. At the end of this chapter, the reader should have

a good overview of the psycho-political domain in which mental health social work in South Africa is operating. Chapter four then explains the method of critical discourse analysis and the specific approach chosen for this research. The subsequent analysis in chapter five presents and discusses the themes identified, split into two main parts. The first part presents the findings in relation to social workers' experiences of shared trauma, while the second section is concerned with the broader understanding and structural conditions of mental health social work. Finally, chapter six will offer some concluding remarks and recommendations for mental health social work with respect to its local context.

2 Theoretical Framework

2.1 Introduction

Through understanding the Covid-19 pandemic as a new form of collective trauma, this study recognizes the "shared" nature of this traumatic reality. The theoretical concept describing this situation, its potential effects and differentiation is thus presented below and accompanied by an additional perspective. The concept of *intersectional trauma* serves here to broaden the theoretical understanding of trauma, by recognizing not only the trauma caused by intersecting forms of oppression and marginalized identities, but also the simultaneousness and interrelation of different forms of trauma.

2.2 Shared Trauma

Aiming to make sense of the phenomenon[2] studied, this research will draw on *shared trauma* as a key theoretical concept. Among other concepts, it is situated within the mental health literature, exploring the detrimental effects on mental health professionals working with trauma survivors who have been exposed to the same traumatic stressors. Important terms related to this "cost of caring" are burnout and compassion fatigue. Caused by the exposure to cumulative professional stress (Tosone et al., 2012a), *burnout* is described as a gradual, pathological process marked by symptoms of emotional exhaustion, while *compassion fatigue* is defined as "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient" (Figley, 2002, p. 1435).

Indirect traumatization, secondary traumatic stress or secondary trauma is further seen as a response to trauma narratives, occurring suddenly and in direct relation to the client´s experience. This concept was developed to explain the appearance of symptoms similar to post traumatic stress disorder (PTSD) (e.g. anxiety, depression, avoidance and hyper-arousal) among service providers who have not directly experienced the trauma themselves. Related to but distinct from secondary traumatic stress is the concept of *vicarious trauma* which also occurs in the context of working with trauma survivors, but describes the changes caused in the totality of the therapist´s life, including cognitive and emotional transformations

[2] South African social worker´s experiences of being directly and indirectly (through their client´s experiences) exposed to the trauma caused by Covid-19.

(Pearlman & Saakvitne, 1995). Another important concept often used to describe the conscious and unconscious affective and behavioral reactions of clinicians to their clients, is *counter-transference*. In contrast to the above terms, counter-transference is not exclusively linked to exposure to trauma narratives but is limited to the therapeutic setting (Tosone et al., 2012a). While counter-transference can be seen as a valuable tool for gaining empathetic access to the client's inner world, it is also understood as *intersubjectivity* which highlights the relational aspects of the therapist's and client's transference/s while questioning therapeutic objectivity (Berzoff & Kita, 2010).

Having said all of that, the concepts of shared trauma and shared traumatic reality capture not only the secondary, but also the simultaneously occurring primary exposure to trauma. Based on this *dual nature*, shared trauma is defined as:

> the affective, behavioral, cognitive, spiritual, and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients, (...) [having] the potential to lead to permanent alterations in the clinician's existing mental schema and worldviews. (Tosone in Figley, 2012, p. 624)

Although often used interchangeably, shared trauma and shared traumatic reality are distinct. Shared trauma describes an event-based impact on the clinician's life, while shared traumatic reality captures a broader, chronic (daily) exposure to the same traumatic stress as the affected community (ibid.). Therefore, it is suggested that the term shared traumatic reality better describes social workers' experiences during the outbreak of Covid-19, but will be used alongside the term shared trauma in this study. Tracing these terms back to their conceptual origin, it can be said that the increase of human-made catastrophes like climate change, terrorism, war and natural disasters has increased the risk of social workers having to work in traumatogenic contexts. As Tosone et al. (2012, p. 1) elaborate, working in such environments can impact people on an "intrapsychic, interpersonal and community level – leading to potential alterations of self-perceptions and worldviews". In contrast to the above concepts, the term *shared trauma* aims to capture the entirety of clinicians' experiences when living and practicing in traumatogenic contexts, thus "describing the impact on the therapeutic situation, as well as the professional and personal alterations that may result from clinician´s dual exposure to trauma" (ibid., p. 1).

It is important to note however, that living in the same traumatic reality does not imply that individuals experience and respond to shared trauma in the same way (Tosone et al., 2012a). As Tosone (in Figley, 2012) points out, there are many that may influence experiences of and abilities to cope with trauma such as: the nature, intensity, extensiveness and time frame (chronic or acute exposure) of the shared trauma, as well as the organisational and familial context. The latter is especially important in shaping the clinician's ability to cope with trauma offering social support on the professional and educational level (e.g. agency-based work settings, supervisors, and colleagues). The following chapter will further show, how structural and political factors, like the chronic underfunding of the mental health sector in South Africa as well as the imprint of apartheid policies and institutionalized oppression further shapes professional's ability to cope in an environment of continuous traumatic stress (Kaminer et al., 2018; Kaminer & Eagle, 2010).

In this light, it becomes obvious that not every practitioner is at the same risk of developing trauma-related symptoms. As the literature review will show, there are other factors that determine an individual´s vulnerability to developing these symptoms. Some of these include the clinician's actual proximity to the disaster (here for example working remotely or in-person), a high caseload, or past and current traumatic life events, as well as personal psycho-biographies (attachment style, empathy) (ibid.). Lastly, it will be shown that shared trauma can have negative, as well as positive consequences, due to the blurring of professional boundaries through increased self-disclosure and intimacy, while at the same time carrying potential for post-traumatic growth and the renewal of a professional commitment and identity including the increased need for political action and advocacy (Figley, 2012; Tosone et al., 2011, 2012a).

2.3 Intersectional Trauma

In order to broaden the conceptual understandings of current trauma concepts, this study will adopt an intersectional lens aiming to contextualize current challenges and problems with regard to their structural and historical roots. By enriching the framework in which shared trauma under Covid-19 is studied, this research aims to consider the socio-political and geographic context of this phenomenon and thereby carries the possibility of challenging "the hegemony of Western discourse [that] has impacted how trauma is conceived and researched" (Masson & Smith, 2019).

Following developments in the service provided to trauma survivors, emerging models have started to adopt practices and values rooted in intersectional feminism, aimed at addressing the unique and often neglected needs of diverse populations (Kulkarni, 2019). A study looking at survivors of intimate partner violence, for example, showed that most services available are not focused on their "economic concerns, such as housing, cash assistance/vouchers, transportation, and employment or training" (ibid., n.p.). Thus, acknowledging diverse experiences of trauma, shaped by an individual's unique intersections of identities (e.g. 'race', gender, class, ethnicity) and how they are linked to experiences of oppression including racism and poverty has important implications for service delivery and advocacy work (De La Rue & Ortega, 2019; Kulkarni, 2019).

In the South African context, Soraya Seedat, a professor of psychiatry at Stellenbosh University, highlights the cumulative impact of intergenerational and current forms of trauma. Referring to her studies on the human immunodeficiency virus (HIV) and trauma she points out the disproportionate burden on Black women, who are "double-hit" by the interplay between biological and environmental factors (ISTSS, 2020). Calls for intersectional trauma-informed approaches in the services offered by trauma clinics can thus be seen not only as a response to gaps in professional practice, but also speak directly to the underlying conceptualization of trauma. Thus, as stated above, the theoretical framework of this study must not only examine how experiences of (shared) trauma are influenced by multiple personal and structural factors, shaping diverse needs for trauma-recovery, but also how these factors might in-/de-crease the risk of multiple trauma exposures.

In short, although this study is interested in Covid-19 as a new form of collective trauma, Covid-19 is not seen as an isolated event. To capture the complex impact of the pandemic and its intersections with existing and past forms of trauma, a complementary concept of *intersectional trauma* is adopted. Described as an umbrella term in recent literature, it captures the "psychological harm and psychosocial vulnerability produced through the accumulation of cultural, political, economic and ecological stressors tied to salient identity markers such as 'race' and ethnicity" (Ezell et al., 2021). Taking into account the intersections of multiple stressors, oppressions and identity-related traumata (Kira et al., 2021), will thus not only help in understanding variations in vulnerability to trauma, but will also help to explore the different factors shaping experiences of shared trauma. Furthermore, this concept recognizes the unique impact of existing collective, inter-generational, and socio-cultural traumata created by colonialism and apartheid as discussed in the South African context

(Masson & Smith, 2019; Smith, 2014). Understanding the structural and intra-psychic impact of colonialism as a collective trauma is therefore important to interrogate the intersections of existing and current traumata. Thus, as social workers are faced with the need to "develop a deeper understanding of the mechanisms of collective and transgenerational trauma linked to colonisation and ongoing coloniality" (Masson & Smith, 2019, p. 11), current conditions require light to be shed on social workers' own experiences and what they can mean for the profession. In short, intersectional trauma recognizes the traumatizing experiences resulting from oppressive societal and structural systems like capitalism, patriarchy, colonialism and racism for the individual and groups (see above 'Intersectionality'). As a theoretical concept for the study of trauma it nevertheless allows to put into focus the overlapping dynamics of various forms of trauma and to thereby move beyond an individual or single-axis understanding of Covid-19 related trauma.

2.4 Conclusion to the Chapter

This chapter has presented the key theoretical concepts forming the framework of this study. Shared trauma was explored in relation to other terms prevalent in the trauma or mental health literature and examined through an intersectional lens. The next chapter will offer a broader contextualization of the study by discussing the impact of Covid-19 in South Africa, as well as the country´s socio-political context. Further, chapter three will offer a review of the key aspects of this study, including deeper insights into the findings of previous studies on shared trauma and understandings of trauma and mental health from different perspectives.

3 Literature Review

3.1 Introduction

This chapter provides a review of the important concepts and findings from existing literature on trauma, mental health and social work. It starts with a conceptualization of trauma and findings on shared trauma under Covid-19. The second part of this chapter then offers a broad contextualization of the impact of the pandemic in South Africa. After identifying gaps in existing literature, the chapter ends with additional theoretical perspectives that aim to sharpen the dominant understandings of trauma through a counter-hegemonic lens.

3.2 Conceptualizing Trauma

3.2.1 Trauma and PTSD

Before introducing the respective findings on the study of shared trauma, this section discusses the different conceptual meaning(s) of trauma by tracing the concept back through its scholarly development. Giving a historiography of trauma, Leese et al. (2021) speak about three waves of trauma studies, ranging from (1) a medicalized definition of trauma, (2) to a broader understanding of PTSD that moves beyond a cluster of symptoms, and finally to (3) an interdisciplinary approach with a scholarly call for the decolonization of trauma studies. The first wave emerged from the discipline of psychiatry and is focused on a biological, medical conception of trauma which is understood as "a frightening event outside of ordinary experience" (Van der Kolk & Van der Hart, 1991, p. 172) and "central (...) in the social and cultural history of modern western societies" (Micale & Lerner in Leese et al., 2021, p. 9). The clinical diagnosis of Post-Traumatic Stress Disorder (PTSD) which is mostly associated with trauma gained its momentum after the Vietnam War when the impact of war trauma was assessed in terms of its symptomology among returnees. Although contested and questioned by scholars like Summerfield (1995) and Young (1995) who criticize the de-politicizing effect of this clinical concept, the latter is still very important in shaping popular understandings of trauma.

Following its roots, PTSD was fist defined in the third edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association in

1980. This marked the beginning of defining trauma in terms of its symptoms and thus as an anxiety disorder composed of four criteria (Goozee, 2021). In short these criteria are linked to four symptom clusters which include: the exposure to a *traumatic event* (1), *re-experiencing* the traumatic event (2) through for example thoughts or disturbing dreams, a numbing and *avoiding effect* (3), as well as miscellaneous symptoms and feelings of *increased, persistent arousal* (4) visible in for example sleep disturbance, memory impairment or hyper-alertness for more than one month (Goozee, 2021, p. 3; Kaminer & Eagle, 2010, p. 30). The main critique of this medicalized definition lies in its effect of de-contextualizing trauma which turns traumatic experiences into a de-politicized private event (Goozee, 2021). Understanding trauma through PTSD is thus built on the assumption that the essence of the human experience of violence, war and catastrophic events can be summarized and known through its negative psychological effects. Rooted in the biomedical, western understanding of mental health and observable behavior, trauma is thus not only measured through a combination of pathologized features of human responses but centred on the individual being in a state of passive victimhood. In short, this model cannot account for the complexity of human experience, as features of PTSD, although prevalent around the world, might not mean the same thing in different settings (Summerfield, 1995). Ignoring a socialized view of trauma and mental health, the medical model and discourse therefore does not only impose a universal understanding of trauma and its effects on everyone, thereby overlooking cultural variations and influences, but produces a certain kind of subject in the need of a particular (medical) kind of treatment. According to Summerfield "traumatic experiences need to be conceptualized in terms of the dynamic interactions between the victimized individual and the surrounding society, evolving over time, and not only as relatively static, confined entity to be located within the individual" (Kleber et al., 1995a, p. 13).

Recognising the shortcomings of this model is thus not only of particular importance to the study of trauma from a critical (diversity) perspective but also highlights how the popularity of medical terminology sets a framework of meaning-making that "emphasizes a victim position and potentially fails to give due attention to the expression of agency" (Traverso & Broderick, 2010, p. 7). The medical model therefore, leads to those exposed to trauma being put into a specific passive position while shaping how they themselves make sense of their experience. As Kaminer and Eagle (2010) point out, many people with PTSD tend to internalize the medical diagnosis which can translate into shame and blaming themselves for being ill, weak, or incompetent. Adopting such perceptions of self can thus be seen to align with the so-called "internalized stigma of mental illness" (Heller & Gitterman, 2011).

Described as combining features of perceived and self-stigma, Ritsher and Phelan (2004 in Heller & Gitterman, 2011, p. 26) argue that the internalized stigma of mental illness is rooted in and can be measured along five dimensions: alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance.

Moving away from a solely medical conceptualization of mental health and trauma, a second wave of trauma scholarship has emerged through considering new sources and types of traumatisation. This conceptualization of trauma includes experiences of "vicarious" or "secondary" trauma as well as experiences of oppression or other life stressors that do not necessarily fit into the categorization of PTSD. Literature on "insidious trauma", for example, examines the effects of objectification and gender-based discrimination (Miles-McLean et al., 2015), and the repetitive demonization of emotionality (Cates, 2014), as well as 'race'-based discrimination as sources of traumatization (Thyer & Lankton in Figley, 2012, p. 523; Miller, 2009). Interdisciplinary perspectives coming from the social and political sciences have thus challenged the a-political conceptualization of trauma rooted in the "eventalization" of experience by calling to attention the fact that "the majority of trauma victims tend to be politically oppressed and/or economically impoverished", thereby highlighting that "trauma and its effects are symptoms of power imbalances in society, not of individual disorder" (Summerfield in Kaminer & Eagle, 2010, p. 41). Acknowledging the need to broaden the context in which trauma is understood and studied, namely in the socio-political context it occurs, thus implies the need to put conceptualizations of trauma into conversation with other theoretical and counter-hegemonic perspectives (see 3.5). By doing so, this study aims to contribute to a "third wave" of trauma studies which is still to be spearheaded (Leese et al., 2021) but could be seen as a collective and interdisciplinary approach to broaden the concept of trauma beyond PTSD. Scholars who reject a redefining of trauma and rather call for a total decolonization of trauma studies and psychiatry (Andermahr, 2015; Goozee, 2021) could be said to form part of this endeavour.

3.2.2 Sharing a new traumatic reality under Covid-19

3.2.2.1 Shared Trauma.

Looking at Covid-19 as having caused a new traumatic reality that practitioners and their clients share, this study aims to explore the experiences of social workers while asking "are we all in this together"? – meaning, are we all experiencing the impact of Covid-19 in the

same way. As argued above, this is presumably not the case and thus more questions are raised around what shapes different experiences of the crisis. Having introduced the dominant understandings of trauma, researchers have suggested that the uncertainty, invisibility, global dimension and ongoing continuum of the pandemic render it a unique phenomenon that is likely to challenge current trauma paradigms and concepts (Catrone, 2021; Kira et al., 2021). In this sense, the concept of *shared trauma* not only offers a suitable framework with which to create new insights, but will also be adopted carefully by critically looking at existing research gaps and introducing other theoretical perspectives.

Shared trauma is conceptually rooted in research on the impact of shared experiences of collective trauma among mental health professionals and social workers in the aftermath of 9/11, as well as conflict in Israel (Sderot) (Tosone et al., 2011), and is used to describe the transformative changes clinicians experience as a result of the dual exposure to trauma (Tosone et al., 2012a). In comparison to other related concepts such as vicarious trauma, compassion fatigue (Figley, 2002) and secondary trauma, trauma symptoms are not (only) caused by the indirect exposure (witnessing, hearing) to trauma in the therapeutic setting, but have a multilevel and multimodal dimension as practitioners are directly and indirectly exposed to the same trauma as their clients. Studies focusing on social workers' responses after 9/11 show that their experiences of shared trauma are not identical and neither are the experiences of clients and clinicians similarly impacted by the same events or circumstances (Bauwens & Tosone, 2010; Tosone et al., 2011, 2012a). Examining the relationship between shared traumatic stress and various factors related to secondary trauma and Post-traumatic stress disorder (PTSD) Tosone et al. (2011) found that social workers with more secure attachment styles were more resilient. Further, researchers have found no significant impact of enduring distress, but linked former potentially traumatic life events to social workers' increased ability to cope (resilience). These findings are in contrast to studies focusing on the experiences of Holocaust survivors who reported higher levels of PTSD symptoms following 9/11 (Lamet et al. 2009 in Tosone et al., 2011), which points to other research that has highlighted the impact of past and multiple exposures to trauma (Kaminer et al., 2008; Kaminer & Eagle, 2010; Van der Veer, 1995).

Recognizing the limitations of existing research on shared trauma it must be acknowledged that leading studies in this field were conducted among *white*[3], female, married, women

[3] In this paper, *white* – in lower case italic writing is used to demonstrate the constructiveness of how difference is produced and marked considering that *white* remains generally unmarked. This is on contrast to

within the same age group and location, Manhattan. This highlights the need for attention to more socio-demographic factors in the conceptualisation of shared trauma as well as the need for more nuanced insights into the experiences of shared trauma through qualitative research. Studying the long-term impact of shared trauma on social workers' professional and personal lives, Bauwens and Tosone (2010) found alterations in participants' perceptions of self, outlooks on the world and professional practices, as well as sustained feelings of vulnerability, hyper-vigilance and traumatic memories (ibid.). They also found that a lack of social and organizational support was correlated with the changing of professional boundaries and blurring of roles. While some clinicians made a conscious decision to change their professional practice and experienced post-traumatic growth, others experienced the blurring of professional boundaries as having a challenging impact on practice and identity. This positive outcome was reportedly linked to factors such as: increased political activism, connectedness, personal and professional intimacy, as well as self-care and skill development (Bauwens & Tosone, 2010; Figley, 2012). Other studies not directly falling under the literature on shared trauma, but concerned with the impact of traumatisation after major "population-based collective traumas" like 9/11, earthquakes or hurricanes, highlight interesting differences in the impact of traumatisation among different racial groups. Focusing largely on minority groups in the US, reports suggest that "causes of higher PTSD rates in minorities are largely attributed to disadvantaged cultural and socioeconomic experiences in certain groups", while "cumulative experiences with repeated trauma add to many individuals' PTSD, [as] 'minorities' are disproportionately exposed to environments featuring poverty and violence" (Ai in Figley, 2012, p. 521). Although focusing on specific racial groups described as "minority" in a majority (*white*) population, these findings highlight the importance of pre-disaster (dis-)advantages in shaping experiences of shared trauma and consequential risk of PTSD. While this research was in line with the findings on patterns of trauma exposure and violence in South Africa (Kaminer & Eagle, 2010), it nevertheless seems difficult to establish a clear differentiation between pre-traumatic and trauma/event-related stressors in causing symptoms of PTSD. Coming back to the study on resilience and post-traumatic growth (PTG), research further suggests that there are also racial variations in positive outcomes after traumatisation. Large and small-sample studies have found that being categorized as part of a "minority race was associated with greater PTG directly and indirectly through both positive pathways of spiritual and social support, as well as through a negative

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the capital B in Black which refers to the self-determination of Black as a political identity as well as the self-empowerment inherent to this marking of difference.

pathway of spiritual struggle" (Ai in Figley, 2012, p. 251). Interestingly, these findings create a potential paradox by associating a higher risk for PTSD with greater potential for PTG among 'racial minorities' or marginalized populations, which must still be considered with caution and in comparison with data on negative posttraumatic consequences. Before coming to the Covid-19 related insights on shared trauma, it can nevertheless be said that 'racial' variation in traumatisation is a new and valuable research area that is crucial to this study as it calls for a culturally sensitive assessment of trauma, coping and intervention (ibid).

3.2.2.2 Experiences of shared trauma under Covid-19.

Having introduced the context in which shared trauma emerged as a concept recently published research has captured the experiences of shared trauma and shared resilience among social workers and their clients in different therapeutic and educational settings. While many of these insights mirror previous findings, Covid-19 has brought about new challenges, traumatic stressors and coping mechanisms. This section will examine how the impact of shared trauma on social workers and clinicians/therapists is currently understood and interpreted.

As mentioned earlier, shared trauma can have a severe impact on one's personal and professional life. Sharing the loss of connection, fear of death and illness, anxieties about the future and experiences of self-quarantining, social workers reported immense challenges to the structure and process of treatment relationships (Catrone, 2021). From the context of psychotherapy, feelings of counter-transference (Zalayet, 2021), compassion fatigue (Edwards, 2021) and increasing self-disclosure have challenged the professional role of mental health professionals and thus the power-relation between them and their clients (Sapiro, 2021; Tosone et al., 2021; Tucker, 2021). As a result, increased levels of intimacy were reported to have an altering effect on the therapeutic environment by blurring roles and professional boundaries (Bloomberg, 2021; Wilking, 2021). While some practitioners experienced this blurring of boundaries as a source of innovation and as opening up opportunities, others described a loss of intimacy and shared embodiment through remote working as a "therapeutic rupture" (Tucker, 2021). An observed negative effect was that even long-term working relationships could not be sustained but came to an end due to rising tension and power disparities (Catrone, 2021; Edwards, 2021). The negative consequences on social workers' personal and professional selves were further reflected by feelings of loss,

fear, pain, sorrow, grief and helplessness, as well as symptoms of direct or vicarious trauma (e.g. concentration difficulties, memory problems, dissociation, numbing or avoidance) (Bell & Robinson, 2013 in Sapiro, 2021). Professionals were also reported to have questioned their competence, life choices, and commitment to continued work as a result of the pandemic (Catrone, 2021; Nathanson, 2021). These experiences highlight how the unravelling of (pre)existing power differentials across the material, physical, and bodily dimension, as well as the intra- and inter-psychic space (mental health conditions, intimacy and trust-building) exposed the importance of supervision, reflexive practice and social justice activism (Tosone et al., 2021). Looking at the positive effects of the pandemic, Sapiro (2021, p. 324) points out how difficult it is to justify and keep emotional distance in a shared traumatic environment. This can lead to more symmetrical client-clinician relationships and thus can bolster the sense of connection while increasing the appreciation for the inter-subjectivity of therapy. The term "shared resilience in a traumatic reality", as coined by Nuttman-Shwartz (2015), can thus be used to describe the ways in which social workers and their clients experience the possibility for mutual learning and post-traumatic growth. The opportunity for such positive outcome is nevertheless reported to be shaped by contextual factors including the ripeness/willingness to adapt to a changing holding environment on both sides.

Looking at all the above information, it becomes clear that Covid-19 has posed a unique challenge to mental health professionals. Further, it was also shown that different factors play a crucial role in how we navigate traumatic experiences, as well as the impact shared trauma has on social workers' professional and personal lives. These factors are related to a practitioner's personal and internal world (closest social networks, socialization, as well as unique psycho-biography), as well as the institutional/ organisational space such as support from supervision and working relations, and lastly the wider socio-political context in which the pandemic was handled. Acknowledging the complexity and multi-layered dimension of shared trauma thus asks for a critical and contextual assessment of this experience. In order to transfer and apply this concept to the South African context, any analysis must take into account a potentially influential cultural meaning of trauma and consequential intervention. The next section therefore, aims to develop a culturally informed understanding of trauma.

3.2.3 Cultural meanings of Trauma

As there are many perspectives in the literature challenging the Eurocentric epistemology underlying dominant understandings of trauma, resilience and mental health (Andermahr, 2015; Burstow, 2019; Goozee, 2021; Mills, 2014; Tummala-Narra, 2007), this section offers insights from intercultural research that highlight the role of community, cultural belief systems and meanings from an intercultural perspective.

Having introduced the dominant meanings of and discourses on trauma, it is also important to take into account the internal and external forces helping people to make meaning of traumatic experiences. As Nevhutalu and Mudhovozi (2012) highlight, it is the social context and thus socio-cultural background that directly and indirectly shapes individual and collective meaning-making of trauma-inducing events. They argue, that every social environment tends to respond to acute trauma with generosity and has specific "social and religious structures that aim at helping the acutely distressed people until they resume self-care" (p.181). In order to prevent the development of PTSD, these responses need to include external validation of the lived traumatic experience as well as support, as a lack thereof might sustain traumatic memories which "will likely be expressed as anger, withdrawal or disruptive behaviour" (ibid.). The impact of *cultural belief systems* that shape conceptions of the self in relation to the external world (Tummala-Narra, 2007, p. 37), is thus important for understanding resources for resilience and coping, but also (conflicting) meanings of trauma and recovery. In societies with a collectivist orientation, like South Africa, social relations and networks are seen as a major source of self-worth, control, sense of self, security and belonging (in a physical and spiritual sense) (Bollaert, 2019; Mkhize, 2014; Motsi & Masango, 2012; Tummala-Narra, 2007). The importance of interdependence makes communal life including rituals and traditions a valuable "source of resilience", as well as a potential source of additional distress as a crisis might have the power to disrupt existing networks. As Tummala-Narra (2007, p. 37) puts it, "traumatic events and the ways in which the larger community understands and responds to these events can actually undermine an individual's access to and reliance upon traditional support networks". Acknowledging culture as a mediator of traumatic experience is thus the key to understanding cultural variations of shared trauma under Covid-19 therefore brings attention to how unquestioned universal ideas of trauma can lead to misdiagnosis and stigmatisation. Assessing how trauma is understood and experienced in a context where life and worldview are defined in communal ways, one must consider local knowledge and culturally sensitive approaches to dealing with

trauma, which are often pushed to the margins. Further, it is inevitable to gain an understanding of how stress and pain are perceived - namely, "as a problem affecting the community and not just the individual (...) especially if society fails to provide answers and support to the people who are helpless and desperate" (Motsi & Masango, 2012, p. 5). Taking into account the impact of more insidious forms of trauma caused by intersecting experiences of oppression, which are often shared across generations (Fanon, 2008; Tummala-Narra, 2007), it must be acknowledged that Covid-19 is not the "first" shared trauma to be encountered, but rather is interacting with a long history of shared, intergenerational and individual traumata. In the South African context, the wounds and enduring effects of colonialism and apartheid, evident in current forms of violence and inequality, must thus be seen as forms of pre-existing collective trauma (Masson & Smith, 2019). Looking at the sources of trauma from the perspective of an African belief system, a study conducted with 75 participants in rural communities of the Limpopo province, found that participants attributed trauma to cultural causes such as witchcraft, demonic possession and ancestral spirits[4], as well as other sources including substance abuse, intimate partner violence, rape, robbery, road accidents, and murder (Nevhutalu & Mudhovozi, 2012). Although this study was conducted exclusively with Venda-speaking participants, it can be said that African concepts of suffering, misfortune and illness are based on a holistic and context specific understanding of trauma. The belief in witchcraft and the ancestral system mentioned above, present key aspects shaping African perspectives on trauma and wellbeing. A failure to act in accordance with cultural rituals or to cooperate with other members of the community is, for example, seen as a potential cause of mental illness and misfortune (Nevhutalu & Mudhovozi, 2012, p. 192). According to Mkhize (2014) this stems from the overall teleological orientation of explaining the cause of things and manipulation of life forces. Supporting the notion that "people's understanding of trauma and its causes anchors on their macro-system, the cultural 'blueprint' that partially determines social structures and activities that occur" (Eamon, 2010 in Nevhutalu & Mudhovozi, 2012, p. 190), the study cited above also shows that a diversity of worldviews and meanings of trauma exists in South Africa. It can thus be concluded from this section that neither narrowly defined conceptions of trauma, nor the western model of PTSD can account for the pluralistic experience of trauma.

[4]Here especially the influence of the meso-system, an intermediate universe also called "the 'structured collective imaginary', a system that is highly respected for giving rise to all good and bad fortune, as well as giving of form to people's desires, fears, anxieties and hope for success" and is "also believed to regulate the day-to-day psychological fate of individual human beings in Africa (van Dyk, 2001 in Nevhutalu&Mudhovozi, 2012, p. 191).

3.3 Contextualizing the impact of Covid-19

3.3.1 Bridging South Africa´s Past and Present

Before reviewing some of the literature focusing on patterns of trauma exposure prevalent in South Africa, both today and prior to the current pandemic, this section wants to give a first contextualization of trauma exposure by recognizing the impact of South Africa´s socio-political landscape. As the country´s political transition from a *white* supremacist regime to a representative democracy is nowadays dominated by discourses of "broken promises" and an "unfinished transformation", it is important to consider the relationship between today´s socio-economic issues, rendering South Africa one of the most unequal countries in the world, and past decades of institutionalised 'racial' segregation, state violence and oppression (Battersby in Kobayashi, 2020, p. 174). Looking at the continuities that characterize the post-apartheid state today, Battersby highlights a combination of factors visible on multiple levels. On a macro-level the state is reflects the impact of economic policies prioritizing market de-regulation and trade liberalization over redistribution, factors that drive different forms of (service delivery) protests, as well as the rise of a new radical party, the Economic Freedom Fighters. The spatial legacy of 'racial' segregation under apartheid is dominant on both a macro and meso-level and is mirrored in the slow change of land ownership, redistribution and the peripheralization of poor households (ibid., pp. 173-174). It is also reflected in a historical underfunding of education and public services which leaves traditionally Black schools and universities, and thereby Black South Africans, at a huge structural disadvantage. In light of these intersecting political, economic and social determinants, a lack or impossibility of 'racial' de-segregation, which continues to mirror the spatial impact of apartheid policies, becomes central when looking at the unequal and 'racial' distribution of wealth, property, housing and population across provinces and an urban-rural divide (Brankovic et al., 2020; Kobayashi, 2020). Looking at the statistics, this means that 64.2 % of Black South Africans, compared to just 1% of *white* South Africans, are currently living in poverty, (Statistics South Africa, 2017), intersecting with high rates of rural unemployment driving processes of urbanization. That women and the youth are carrying a disproportionate burden of these structural conditions became especially evident during the time of hard lockdown. Research investigating dynamics of unemployment under Covid-19 found

> that job losses were not uniformly distributed amongst the different groups. In particular, groups who have always been more vulnerable – such as women,

> African/Blacks, youth, and less educated groups – have been disproportionately negatively affected (Ranchhod & Daniels, 2020, n.p.)

by the pandemic. With much evidence, it can thus be said that the main continuity of the apartheid-legacy is the racialised inequality rooted in the historic "institutionalisation of *white* privilege" (Brankovic et al., 2020, p.29) which continues to drive unequal access to life opportunities today. According to research with different members of the Khulumani group, this inequality is seen as one of the main driving forces behind violence (Brankovic et al., 2020). South Africa has one of the highest rates of violence globally, is one of the top five countries with the highest rates of femicides (12.1 in 100,000 victims per year) (Head, 2019), has the fifth highest murder rate globally (34.1 per 100,000 people), has twice the global average rates of child homicide, and rates of youth violence that are at nine-times the global average (Langa & Bowman, 2017). Following the reports of apartheid-survivors whose activism is bridging past and present experiences, it is very difficult to isolate certain drivers of violence as they interlink and influence each other. In this sense, marginalisation and violence perpetuate each other, caught in a cycle of intergenerational transmission of poverty and socio-economic exclusion (Brankovic et al., 2020). Findings from the Centre for the Study of Violence and Reconciliation (CSVR) further also suggest that high rates of urban violence can be traced back to a "normalisation of extreme violence as a legitimate conflict resolution tactic under apartheid [which] has continued to an ongoing 'culture of violence' in the country"(CSVR, 2007 in Brankovic et al., 2020, p. 13). Aiming to understand the increased violence in post-apartheid South Africa in the form of service delivery protests and particularly Black male-on-male violence under the label of xenophobia, Richards and Langa (2018), as well as Langa and Kiguwa (2013, 2016) unpack how changing identities among young Black males, as well as notions of citizenships and belonging are shaped by a shift in socio-economic and cultural conditions after 1994. As Richards and Langa (2018) explain, past and inherited notions of masculinity are strongly linked to pre-1994 political resistance that "found a home in militarised subcultures that provided a sense of mastery, recognition and freedom (...) entwined with the idea of violence and social discord as an expression of manhood" (p.4). Different forms of violence must thus be seen as a reflection of the broader socio-, gender-, class- and 'race' politics in today´s post-apartheid South Africa and men´s struggle to reclaim and re-imagine masculinity (Langa & Kiguwa, 2016; Richards & Langa, 2018). Today´s male violence against women and other men can thus, along with other explanations, be seen as a tool used to compete over and access positions of power through subordination of others (Langa & Kiguwa, 2013). A major take-away from this section is thus

the importance of linking micro with macro explanations of violence. Part of this is considering the psychological and psycho-social impact of colonisation and apartheid and how it interacts with the current socio-political realities of South Africa (Langa & Kiguwa, 2016).

3.3.1.1 Social work in a Context of Injustices.

The above provides a first insight into the context in which social work emerged as a profession responding to social problems in South Africa. Looking at the role and development of social work across time, Smith (2014) discusses how the professionalization of social work in South Africa was shaped by Afrikaner nationalism, segregationist state policies and racist discourses from the late 19th century onwards. With the goal of reducing the *white* poverty and "Afrikaner proletarianization" that occurred in the aftermath of the South African War (1899-1902), welfare and social work services were mostly directed towards this group, creating a segregated and exclusionary service delivery system (ibid.). Essentialist understandings of 'racial' categories alongside individualized perspectives on poverty and class thereby informed practices aimed at policing "bad" or "immoral" behavior under the banner of charity and philanthropy(Harms Smith & Nathane, 2018; Smith, 2014). Rooted in a context of social engineering, social work in South Africa was thus born into an "ideology of white supremacy and racist capitalism" (Harms Smith & Nathane, 2018, p. 2) and was aimed at maintaining the status quo and increasing state control. From the 1920s onwards social work became more formalized and first entered historically *white* universities while the state took charge of the professions' future structuring. Historically social work was thus born into a system of injustices (Schenck, 2019) and a psychopolitical reality shaped by the violence of colonisation and apartheid (Harms Smith & Nathane, 2018; Hook, 2004). The content of training and education has thus been rooted in British and American models of social work linked to western individualism and understandings of personhood, leading to the call for a "decolonial turn" today (Harms Smith & Nathane, 2018; Schenck, 2019). Within an ideological context of liberalism and racialized capitalism, social work became an instrument of social and 'racial' control by embracing "status quo maintenance activities" (Smith, 2014, p. 314). Criticizing the lack of appropriate responses from within the profession, Smith states:

> The complicity and collaboration by social work with racist segregationist and "protectionist" policies linked well with liberal ideologies of the time(Smith, 2014, p. 315)

Similar observations have been made in the realm of psychology which "rather than playing any meaningful role in addressing issues of institutionalised racism (...) – played a pivotal role in the perpetuation, elaboration and reproduction of racism" (Duncan et al., 2014, p. 363). The emergence of student associations and social movements embracing radical and transformative agendas nevertheless became an important force against the oppressive apartheid government and its social welfare system in the 1980s (Patel, 2005). Although situated at the margins of popular discourse, the Black consciousness, as well as worker´s and women´s movements and strikes became important sites of resistance. The transition process, ushered in by South Africa´s first democratic election in 1994 and the work of the Truth and Reconciliation Commission, was further seen as a new commitment to social justice and human rights (Smith, 2014). However, with the subsequent adoption of a neoliberal agenda for growth and the country´s integration into the global capitalist market economy, social work was infiltrated by a neoliberal agenda, merging discourses of social and economic development with those of "business" and capitalist marketization. It can thus be argued that besides the voices of resistance and innovation

> social work generally remained true to those who held hegemonic discursive power in society, namely a "new right", neoliberal and managerialist South African social welfare system operating on discourses of modernity (Sewpaul & Hölscher, 2004, p. 94)

From the above it can thus be concluded that social work in South Africa has developed and operated in a context of competing hegemonic discourses, those supporting the maintenance of an oppressive status quo – and those creating and shaping practices of resistance (Carey & Foster, 2013; Smith, 2014).

3.3.2 Trauma, violence and mental health in South Africa

Having started by giving a brief overview of the structural characteristics and enduring effects of historical inequality today, this section aims to establish and retrace the existing links between trauma, various forms of violence and mental health found in previous literature.

One of the first quantitative studies focusing on trauma and mental health in post-apartheid South Africa was conducted by Hirschowitz and Orkin (1997). The study aimed to assess the impact of large-scale political violence on South Africa´s population. Interested in the correlation between experiences of traumatic events, the development of PTSD and overall mental health, they conducted a nationwide survey including 3870 participants between the ages of 16 and 64 from 4000 different households. Although their findings exposed a high level of PTSD across all sectors of society, they indicated some structural variation in the extent of trauma exposure and reaction to trauma. Finding that informal housing, poverty and illness related unemployment was related to poor states of emotional wellbeing, they also identified major differences in peoples reported mental wellbeing across regions. People living in former "Bantustans" or "homelands", like the North West province where 24 % reported their mental state to be fair or poor, showed poorer states of mental health compared to an average of 11% (Hirschowitz & Orkin, 1997, p. 178). Overall, the study found that approximately five million adults (almost a quarter of the population aged 16-64) had been exposed to one or more traumatic events leading to a large proportion of South Africans suffering from (one or more) symptoms of PTSD as well as other effects[5]. From this early study it can be argued that the experience of trauma and violence follows structural patterns (as supported by more recent research), and that apartheid´s political violence left the majority of the population suffering from symptoms of PTSD and mental ill-health. Lastly, the study not only challenges the individualized conception of PTSD as a psychological illness, but also highlights the prevalence of challenging mental health conditions that do not fall under the clinical definition of PTSD.

Later research aimed at developing an epidemiology of trauma and posttraumatic stress disorder in the South African general population, additionally found that 70% of the population is being or has been exposed to at least one potentially traumatic event and that the most prevalent types of traumatic events (also shaping the conditional risk of developing PTSD) were related to the unexpected death of loved ones and the witnessing of death and injury (Atwoli et al., 2013, p. 8). Not only do these findings counter other studies that suggest intimate partner violence is the dominant type of trauma exposure, but they also didn´t find a significant correlation between socio-demographic factors (like sex, age and education) and the risk of developing PTSD (ibid.). Although this counters international evidence, it is in line with Kaminer and Eagle (2010) who argue that knowledge-production about the impact of

[5] Besides the official symptoms of PTSD, this study included symptoms/ feelings of powerlessness, bewilderment, anxiety and depression to measure the state of mental health among South Africans.

protective and risk factors in developing PTSD is still in its early stages. Trauma studies largely distinguish between variables that pre-date the traumatic event or experience (e.g. gender, genetic vulnerability, personality features, cognitive schemas), factors linked to the traumatic event itself (type of traumatic event), and post-traumatic variables including social support or other life stressors (Kaminer & Eagle, 2010, p. 40). As discussed above, PTSD has become the main form in which trauma is understood and researched. Criticizing the way it has developed into a diagnostic category thus constructing traumatic stress as "an 'illness' rather than as a normal and appropriate response to abnormal experiences" (Young and Summerfield in Kaminer & Eagle, 2010, p. 41), this study wants to question the dominant (medicalized and depoliticized) understandings of trauma by putting these understandings into conversation with other perspectives (see 3.5). By contextualizing the study/experiences of shared trauma, this research aims to acknowledge the "dynamic interaction between the victimized individual and the surrounding society" while adopting a more socialized view of mental health (Kleber et al., 1995b, p. 13). Establishing links between individual experiences and the context in which they appear will not only help us in understanding potential differences in responses to trauma but also in understanding the context in which mental health related social work in South Africa takes place.

3.3.2.1 Patterns of Violence and Trauma Exposure.

As mentioned above, there are different forms and drivers of violence in South Africa that are associated with the risk of (in-) direct traumatisation. Although the scope of this study does not allow for a holistic review of the complex nature of the latter, some nuances in trauma exposure should be highlighted. In line with the above discussion, it must be acknowledged that the impact of colonialism and apartheid is a "chronic trauma" (Simpson, 1995) shared across generations within the post-colonial /post-apartheid context of South Africa. According to Simpson this is important as it has led to

> a uniquely high degree of social pathology, with higher rates of divorce, rape, intra- and extra familial abuse, suicide, *white*-collar and violent crime, motor vehicle accidents, and murder than in most other countries. The usual societal traumas are increased as an indirect result of the extent to which political trauma weakens the body politic and the capacity of a social system to defend and heal itself (1995, p. 189).

Having said this, it becomes apparent that there are very few South Africans whose lives have been entirely untouched by trauma. The simultaneousness and intersecting dimensions of different forms of violence thereby show that "traumatic experiences [are] an inescapable part of daily life" in South Africa (Kaminer & Eagle, 2010, p. 9). Although this means that no form of violence or traumatic event can be understood in a supposed "singularity", the current Covid-19 pandemic has demonstrated that not everyone is at the same risk of being exposed to trauma or its effects. Research indicates that exposure to specific forms of violence is closely linked to the experience of distress, traumatic events and the development of PTSD. Drawing on the conclusions of a study conducted by Kaminer and Eagle (2010), it can further be seen how the most common forms of violence (political, criminal and gender-based violence, as well as childhood physical abuse), non-intentional injuries (road traffic injuries and burn injuries), and indirect forms of traumatisation (witnessing or hearing about trauma) have affected certain parts of the society disproportionately throughout the past.

Considering the large-scale effect of political violence as mentioned earlier, evidence from the truth and Reconciliation Commission shows that the majority of those who suffered severe ill-treatment, detention, and torture during Apartheid were Black South Africans and male youth. While this can largely be explained through their role in the anti-apartheid struggle, it must also be acknowledged that the anti-apartheid struggle was a nationwide, community-based movement that also included women who were also affected by state violence. It is therefore safe to assume that "there are few, if any, segments of the current adult Black South African population that have not been directly exposed to the political violence of the apartheid years" (Kaminer & Eagle, 2010, p. 13).

Looking at the incidents of criminal violence (murder and armed robbery), South Africa has shown to have one of the highest rates in the world. Recognizing the gendered dimension of violence, evidence (although confronted with under-reporting) shows that women in South Africa are at a disproportionate risk of experiencing physical and intimate partner violence. A number of different studies indicate that rates of sexual violence (especially rape and other forms of sexual assault) in South Africa are exceptionally high when compared to other countries and that women with specific socio-demographic characteristics are at much higher risk of sexual victimization (Africa Health Organisation, 2021; Gould, 2020; Head, 2019). Recent statistics are in line with this, showing that about 21% of partnered women experience interpersonal violence in their relationship while the risk for physical and/or sexual violence is higher among women with a low socio-economic status, a lower level of education and

among those who are divorced or separated (Statistics South Africa, 2018). Previous research findings support this by demonstrating substantial differences across provinces and age, suggesting that young women living in peripheral (e.g. townships) and rural areas are especially vulnerable to sexual violence (Kaminer & Eagle, 2010). Findings published in 2021 further show that about „51% of women in SA say they've experienced GBV, with 76% of men saying they've perpetrated GBV at one stage in their lives (2010 Gauteng sample)" (Africa Health Organisation, 2021).

The South African Stress and Health survey (SASH), which was conducted among 4,351 adult South Africans in 2002 and 2004, was the largest national representative study on the prevalence of PTSD and trauma exposure (Kaminer et al., 2008). Finding that over a third of South Africa´s population has been exposed to violence, the report shows that men who developed PTSD are more likely to have experienced criminal assault and childhood physical abuse, whereas women with PTSD are more likely to have experienced intimate partner violence (ibid., p. 1594). Looking at the exposure to multiple forms of trauma, William et al. (2007) further demonstrate the cumulative effect of trauma in relation to distress while finding no significant variation in risk according to socio-demographics other than gender and marital status. Although this kind of large-scale study has not been replicated in recent times, it shows the importance of considering new forms of trauma within the context of other traumas in South Africa (ibid.).

Information on crime and violence during the Covid-19 pandemic has been rather confusing. On an international level South Africa still ranks high when it comes to crime. Statistics from the Global Crime Index of 2021[6], as well as the Global Index of Organized Crime, covering people, environment and trade related crimes[7] demonstrate this trend. On a national level however, data from Statistics South Africa (2022) suggests that experiences of crime have dropped in 2020/2021, while research on the prevalence of intimate and domestic violence during lockdown call for a critical reading of this information. Recognizing that South Africa did not experience the predicted rise in incidents of domestic violence as reported from China and some European countries at the beginning of the pandemic (Vetten, 2021), current research is still in search of nuanced explanations for this. The Institute for Security Studies published an article considering the impact of South Africa´s ban on alcohol, which did not occur in other countries, on incident of domestic violence. According to current estimations

[6]Numbeo Global Crime Index Country ranking estimating overall levels of crime across countries. See https://www.numbeo.com/crime/rankings_current.jsp
[7]See: https://ocindex.net/country/south_africa

the ban on alcohol could have helped to reduce the severity of violent incidents, while the effects of misinformation, isolation and risk of infection might also have led to changes in help-seeking behavior (Gould, 2020). Overall there has been a high awareness of gender-based violence throughout the pandemic, rendering crisis centres and help-hotlines "essential" in the early period of lockdown (Vetten, 2021).

The above information points to important differences shaping experiences of and exposure to violence and trauma. Whether at home, in the community or wider society, it can be said that trauma remains a deeply political topic in post-apartheid South Africa – one that is "rooted in historical dynamics of power and inequality" (Kaminer & Eagle, 2010, p. 26). Having highlighted that the majority of South Africans have in some way experienced one or more traumata in the past , it will be argued that Covid-19 is not the only or first trauma shared among large parts of the population, but rather is intersecting with existing and diverse histories (or continuing forms) of trauma.

3.3.2.2 Mental health and social work in South Africa.

Having now shed a light on the different forms of violence-induced traumatisation and life stressors Covid-19 is intersecting with, the above also provides the context in which mental health related social work is operating in South Africa. As this study will be based on social workers experiences of shared trauma in this field, a short contextualization will be given of the conditions under which they are operating. While acknowledging the detrimental effect of Covid-19 on the mental health of many South Africans (Naik, 2021), it is worth considering the legal context shaping access to and the provision of mental health related services. As demonstrated by a number of different scholars, the Mental Health Care Act of 2002 (MHCA) (implemented since 2004), as well as the signing of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2007 were major milestones in improving mental health services in South Africa as they led to the adoption of a more human rights-driven ethos and "patient centred" approach to mental health care (Burns, 2011; Lund & Docrat, 2019; Szabo & Kaliski, 2017). As Szabo and Kaliski (2017) highlight, these changes, although intended to deliver a more "humane" and "egalitarian" kind of care, came with tremendous shortcomings due to an increased administrative burden and resource dependency (inadequate funding as major barrier). Retrospectively, these changes helped to create a major "mental health gap" by imprinting chronic problems into an already inadequate system

(Burns, 2011). In spite of attempts to reform the National Mental Health Care Act and the development of a National Health Policy Framework and Strategic Plan (2013-2020) aimed at creating more comprehensive and decentralised care, numbers show that systemic failure comes with devastating consequences. One example leading to a public outcry in 2017 was the Life Esidimeni tragedy which caused the death of nearly 150 psychiatric patients who were moved to underfunded and unlicensed facilities as part of a poorly planned de-institutionalisation project implemented by the Gauteng Department of Health (GDoH) (Lund & Docrat, 2019; van Rensburg, 2017). The latter can be seen in light of the critique by Schwartz et al. (2008), who have called out the legacy of a segregationist and underfunded health care system shaping dynamics of marginalization today through unequal access to care, the lack of skilled personnel and specialized care. This tension between a well-intended approach towards more accessible and less stigmatizing care and the systematic failure in place can then be seen in the context of a broader theoretical polarization of mental health (discourses) in post-conflict societies. According to Swartz and MacGregor (2002, p. 168) this polarization is fed by arguments against an "over-pathologizing" of mental health conditions and those framing the effects of violence, inequality and trauma as inevitable part of the human condition. But looking at the material(ized) impact of this dilemma today, a nationally representative study evaluating the expenditures for mental health across all nine provinces for 2016/2017 shows that only 5% of the total national health budget is spent on mental health services. The study also reveals an alarmingly high treatment gap which is estimated to be at about 92% (less than 1 in 10 people living with mental health conditions are receiving appropriate care) (Docrat, Crick Lund, et al., 2019; Lund & Docrat, 2019). Interestingly, findings also suggest large disparities between provinces[8] as well as between the types of spending (86% on inpatient care, compared to 7.9% on primary level care) which indicates a rather reactive mental health care system focused on treating the most severe conditions (Docrat, Crick Lund, et al., 2019). In all, the information provided calls for "stronger service delivery at community and primary health care level" and "better referral pathways" (Lund & Docrat, 2019) which could help to meet the goals of South Africa´s legislative and policy aspirations.

All this being said it is not only the mental health service users and those who are neglected that suffer due to an under-resourced system, but also social workers and other mental health professionals working in this environment. In addition to major financial constraints, the lack

[8]"For example, in Mpumalanga, spending on mental health per uninsured South African was R58.50 while in the Western Cape it was R307.40" (Lund &Docrat, 2019).

of access to mental health services is also shaped by insufficient available information (education and awareness) , as well as continuing stigmatization of mental health driven by our closest networks (family and friends), society at large, and in some cases by mental health professionals themselves (Kakuma et al., 2010; Mavundla et al., 2009; Schwartz et al., 2008; Seedat et al., 2002). This it is to say that social workers not only play a crucial role in providing adequate mental health services in a context where mental health and wellbeing are still structurally neglected, but that they can be a driving force in the de-stigmatization of mental health conditions (Kakuma et al., 2010). Social workers have become primary providers of mental health services, not only in South Africa but around the world, operating with a needs-based, as well as systemic approach informed by the profession's values and ethical standards (Golightley, 2008). As these ethical standards include social work's commitment to social justice, diversity and social change (Heller & Gitterman, 2011), it also requires a critical, anti-discriminatory stance towards issues of mental health. Unique to the South African context, social workers have adopted a practice theory called developmental social work. Rooted in the broader political (and professional) transition of South Africa after apartheid, the White Paper for Social Welfare of 1997 marked a shift towards a developmental approach to welfare[9] aimed at eradicating the "final" imprints of apartheid. Based on this and a decolonization of social work practice and theory, it is now argued that social work "can no longer afford to sustain a practice model based on helping clients cope or adjust to unjust circumstances" (Schenck, 2019, p. 33), but rather must focus on ameliorating suffering, doing advocacy work and policy improvement aimed at removing the barriers which hinder its mandate to address social injustices.

3.3.3 The trajectory of Covid-19 and lockdown in South Africa

The previous sections were aimed at examining the broader context in which the impact of Covid-19 as a new experience of shared trauma must be understood (Ellberger, 2021). Although this study is mainly interested in how this new shared traumatic reality is experienced by mental health care providers (social workers), the following section will highlight some critical insights into the overall impact of and response to the pandemic in South Africa. It will consider how lockdown regulations and the militarized response to the

[9]Summarized as "a process of planned social change designed to promote the well-being of the population as a whole within the context of a dynamic multifaceted development process" (Midgley, 1995 in Ncube &Noyoo, 2020, p. 342)

Covid-19 outbreak inflicted violence and trauma on a population whose (mental) health has already been compromised (Baldwin-Ragaven, 2020).

3.3.3.1 Policing the every-day: inflicting violence and trauma under Covid-19.

In their monographic analysis, Pinheiro and Kiguwa (2021) unpack how the framing of and response to Covid-19 in South Africa has been (and still is) heavily reliant on war-metaphors, as well as the discourse of a "shadow-pandemic" caused by the increase of sexual and gender based violence (GBV). This narrative of "a pandemic within a pandemic" can be seen as a rising global phenomenon used to highlight the intersections of Covid-19 with existing inequities in different contexts (e.g. anti-Black racism as a pre-existing pandemic in Audate, 2021; Canham, 2021). In the case of South Africa, Pinheiro and Kiguwa (2021) argue that the outbreak of the pandemic was initially framed and responded to as a "war against the virus" established through government addresses to the nation and speeches from key political actors. In reference to other scholars (Enloe, 2020; Foucault, 1978; Posel, 2005) they show how in the early phase of the Covid-19 outbreak, militaristic, wartime language and ideology shaped the rhetoric and the following material, physical response which must be seen in a historical context of colonial violence that has been used to police and discipline bodies "according to racist, androcentric and heterosexist gendered matrices" (p.14). These ideologies have not simply emerged through the rise of Covid-19 but rather shape the performance of hegemonic masculinity and gender identities within South Africa in general. As such, Covid-19 related responses should be understood in their intersection with every-day manifestations of heteropatriarchy, coloniality, and capitalism, and thus the broader context of gendered, raced, classed (etc.) power relations.

After the pandemic was declared a national disaster on March 15 2020, resources and collective action were mobilized to defend the country against the virus. Knowledge was organized and spread by specific authorized actors, including former Health Minister Zweli Mhkize, the Ministerial Advisory Committee, the National Command Council, and Minister of Police Bheki Cele. Highlighting existing contradictions within the overall discourse of the pandemic, the authors describe president Cyril Ramaphosas' role as establishing a politics of leadership that departs from authoritarianism and militaristic frames (generally associated with warring discourses), building on metaphors of "shared citizenship" ("My fellow South African´s") and "joint battle" (Pinheiro & Kiguwa, 2021, p. 81). This deviation from the

overall war-frame has primarily served a narrative of South Africans being united and "equal" in the fight against a shared enemy. But alongside these "tones of unity, community and nationalism" (p.83), which rendered invisible the different positions from which people entered the “fight”, a clear distinction emerged between those who were given space to speak and those who were supposed to "lock down" and follow instructions. This hierarchy arguably followed the existing power relations prevalent in a heteropatriarchal system, thus silencing the voices, concerns and needs of those who lacked relative agency prior to the pandemic (ibid.). Mandated to oversee and ensure the implementation of lockdown regulations (social distancing, staying at home, alcohol ban, etc.), 70 000 troops of the South African Police service (SAPS) and military (SANDF) were deployed in late April 2020 (BBC, 2020). Mainly positioned in under-resourced areas such as townships and inner-city areas, state interventions turned into a repressive, violent and fear-instilling force, that mirrored the racist and classist assumptions underpinning societal relations in post-apartheid South Africa, as well as the conception and localization of "potential troublemakers" (Pinheiro &Kiguwa, 2021, p.97). As different sources have reported, “in the first seven days of lockdown alone, more than 2 000 people had been arrested for quarantine related infractions and allegations had surfaced that police and army officials were murdering and raping people” (ibid., p. 96). Considering that no military was deployed in wealthy, middle-class, majority *white* suburbs it becomes clear how the violent policing of bodies under the enforcement of lockdown regulations was not only gendered, but also racialized, classed and spaced.

The violence and trauma inflicted on different bodies has thus disproportionately affected women and members of the LGBTQIA+ community as crisis like the current pandemic often exacerbate pre-existing risks posed by oppressive structures that shape unequal access to health care and safety while increasing the risk of interpersonal violence (Pinheiro & Kiguwa, 2021, p. 104). How one experiences and copes with a new form of shared trauma is therefore not generalizable but dependent on pre-existing life stressors, histories of violence and trauma exposure, which do not only determine a person´s bodily strength to deal with a potential infection, but pose a threat to overall health, safety and wellbeing (Baldwin-Ragaven, 2020). Explaining the link between increased GBV and a state of crisis (for more detail see Pinheiro & Kiguwa, 2021), Pinheiro and Kiguwa (2021) unpack how the framing of GBV in its current form has been de-contextualized and rendered as something “recent” and “spectacular” (p.110).

Lastly, it must be noted that the prevalent war metaphors have not only impacted how notions of victim-targets have been gendered and raced under militaristic responses, but how the construction of so called “essential” or “frontline” workers, emerged as a new, also gendered, category during the pandemic. Reading their role within this discursive context, Kiguwa and Pinheiro (2021) argue that both in South Africa and globally, essential workers have mostly been found to be women operating in the background while being spoken for by male health experts and politicians. Framed as the silent “war heroes”, public appreciation disguised the structural dimension of existing service gaps, further helping to place them as scapegoats for a failing, poorly managed and under-resourced health system (Maphumulo & Bhengu, 2019). Beyond that, “female community workers (in SA and in other African countries) were largely constructed as second-class “soldiers” who were fighting against COVID-19 but remaining invisible" and in the background (Pinheiro & Kiguwa, 2021, p. 84).

3.3.3.2 (Un-)Grievability and mourning under Covid-19: a matter of life.

Looking at the devastating impact of Covid-19 related policing on the every-day, the physical body and the mind, it must be asked whose bodies were being targeted, de-humanized and left to die. As Canham (2021b) argues in his transcontinental exploration of Black death, Black bodies have historically died and continue to die at a disproportionate rate, being caught in a condition marked by the proximity to death. Having to “sit with dying” and the ever-present possibility of death, whether through the spread of a virus, other diseases, lack of resources, or systemic anti-Black racism, makes the “black condition one of mourning and memorialization” (Rankine, 2015 in Canham, 2021b, p. 2). Seeing the current condition of traumatisation and dying in this light, one needs to consider how the pandemic affected those whose lives are deemed “ungrievable” as well as how it affected those who have been deprived of their right to mourn and bury their loved ones according to cultural rituals and customs.

In order to understand the impact of lockdown regulations prohibiting cultural practices of memorialization and funerals which historically “provided a collective space for assembling black affect of grief and rage” (Canham, 2017 in Canham, 2021b, p. 3), these practices must be understood in their political and performative dimensions. Seeing funerals as spaces of collective mourning, where people insist “on the value of the dead, the importance of cultural practices, and its calls for the disruption of business as usual”, public grievability becomes a

political act of community resistance (ibid, p.2). As such collective mourning challenges not only individualized and privatized notions of suffering and loss, but strengthen solidarity, empathy, and mutual understanding. On a micro-level, it might further function as a reminder of our interconnectedness, showing how our relationships and human bonds are part of how we constitute our sense of self (Butler, 2004; Canham, 2021b). Being deprived of these practices, which have political, cultural, personal and spiritual importance, has thus not only led to a disruption of "the ancestral ecosystem", as many people could not be buried in their ancestral lands or with the necessary rituals, but added to existing wounds caused by an epoch of massacres (e.g. Marikana, Bisho, Sharpville, Langa, Mpondo) and murder (Canham, 2021b). As history and the present show, the question of whose life matters, whose life is (publicly) grievable, is not just a question of 'race', but one of gender, socio-economic position, sexual orientation, (Dis-)ability, and age. Covid-19 has thus not only affected people of colour disproportionately but also women, older people, Trans- and Queer- bodies and all of those whose health conditions were already compromised. The following question, therefore, is: who has been and continues to be rendered "ungrievable" in this pandemic?

Butler offers an important perspective in the discussion of the connections between violence, mourning and politics (2004). Starting from the perspective of a "common human vulnerability, a condition of primary vulnerability that emerges with life itself" it is necessary to see how this vulnerability "is exploited and exploitable", creating lives, that "are supported and maintained differently" through the unequal distribution of human physical vulnerability across the globe (pp.31-32). Thus, those lives that are not seen as worthy of protection and support do not equally qualify as "grievable". According to Butler this is linked to the question of "what is real?" and "whose lives are real?", as those rendered "unreal" have already suffered the violence of derealization, living lives that are not even considered lives but positioned outside any frame of what it means to be human. How this de-realization then enables physical violence and silent death is linked to its de-humanizing effect. Although the enactment of violence is mainly enabled through de-humanizing discourses, it is the de-humanization that occurs at a previous level (at the limits of discourse) that renders certain lives "unmarkable". And lives that are unmarkable – are publicly ungrievable, vanishing in a discourse of silence where "there have been no lives, and no losses" (Butler, 2004, p. 36). Connecting this back to the political dimension of mourning as an act of resistance, it is then valid to ask whether "the prohibition on grieving [is] the continuation of violence itself?", as "the derealization of loss-the insensitivity to human suffering and death-becomes the mechanism through which dehumanization is accomplished" (Butler, 2004, p. 148).

3.4 Research Gaps

As existing research shows, the concept of shared trauma provides viable ground on which to explore the experiences and challenges social workers encounter while having to live and work in the same traumatic reality as their clients. However, due to the newness and uniqueness of this global pandemic and its effects in South Africa, it is imperative that one interprets recent research findings with caution. The historical and socio-political context in which the concept shared trauma has evolved and been studied, namely in the western American experiences, means it has major limitations when transferring existing findings to other contexts. Although past and current studies are considering a variety of possible factors that may shape one's response to shared trauma, there are several shortcomings that need to be mentioned. Firstly, current findings give little account to the specific social and geographic location of research participants, including the socio-political factors shaping their experiences. Secondly, while trauma histories are included in past studies on the impact of shared trauma (Bauwens & Tosone, 2010; Tosone et al., 2011), there is little insight into the nature of these traumatic experiences or the possible intersection of different traumata. While more recent research can be seen as taking a more innovative approach by relying greatly on self-reflective insights from practitioners during Covid-19, they do not give the coherent picture necessary to complement cross-country quantitative research on Covid-19 related mental health challenges. Therefore, it can be said that exploring the experiences of shared trauma among South African social workers will offer important insights to counterbalance the dominance of Western-based research in the field as well as the medicalized understanding of trauma by adding a socio-political perspective. This socio-political perspective includes: a consideration of South Africa's unique historical, political and cultural context, the prevalence of collective/intergenerational trauma, structural inequalities, and the historiography of social work. Unpacking these context-specific factors that shape experiences of shared trauma (e.g. spirituality, communal values, diversity of worldviews and cultures) will thus contribute to the (theoretical) conceptualization of "shared trauma", while giving insights into the structural conditions under which social workers are providing essential mental health services. These insights may be useful in informing future policy making as well as social work practice and training.

3.5 Putting Shared Trauma in Conversation with:

In order to address the aforementioned gaps and conceptual limitations, additional theoretical perspectives will help to enrich current discourses on trauma and mental health.

3.5.1 A Socio-Political Perspective

This section starts with a socio-political lens by introducing Fanon's concept of "psychopolitics" (Hook, 2004, p. 115) and explaining why it is a valuable tool for bridging the identified research gaps. Famous for his leading role as a postcolonial scholar, political activist and psychiatrist, Fanon offers a critical contribution to this study by locating the psychological, as well as lived experience within the political. As shown by Hook (2014), Fanon looks at the lived experience of the Black subject not in its everyday meaning, but as "a domain of experience that is deeply enmeshed in the world of which it is part of" (p.92). He thus calls to attention how the broader historical and socio-political context shapes lived experiences, as well as how an analysis of the latter can be used to change the world. This political dimension to analyzing the psychological is not unidirectional but rather aims to blur the lines between the political and the psychological by unpacking how they both influence each other. This critical awareness of how political factors (especially relations of power) impact the psychological, but might also become internalized and embodied individually, is called "psychopolitics". In addition to the above, Fanon's concept enables one to understand something framed as a private and individualized experience (trauma) in its broader context. Locating this study in Fanon´s call for politicizing the psychological can thus be seen as part of "a critical process by which we employ psychological concepts, explanations and even modes of experience to describe and illustrate the workings of power" (Hook, 2014, p. 85). Acknowledging that socio-political factors shape how identities are formed and limited as well as how lived experiences are made sense of therefore calls for a critical awareness of diverse human subjectivities and their enmeshment within power relations. In this sense, Fanon insists on a socio-political specificity and historical groundedness in the domain of analysis (Hook, 2014). Gooze (2021) takes on Fanon´s ideas in her call to decolonize psychiatry and trauma studies, showing how his standpoints provide an important "bridge between psychiatry and the political" by "linking society, health, and power" (p.6). In short, this perspective promotes a "sociogenic psychiatry" which calls for a more social and political understanding of trauma by highlighting the current understandings' epistemological

limitations and complicity in oppressive practices. For Gooze, Fanon´s relevance to the study of trauma lies in the "sociogenic theory" which "recognizes the significance of the relationship between the individual and their environment" (2021, p. 5). Recognizing and activating the political potential of trauma, suffering, and lived experience speaks to the very aim of this study and thus to the critical phenomenological approach adopted. Interrogating current conceptions of shared trauma with this perspective will therefore help in understanding and critiquing the existing power-relations that shape different experiences of shared trauma under Covid-19, as well as in re-politicizing lived experience. And although decolonial theory or decoloniality is not an outspoken anchor of this study, it has the potential to contribute to a trauma scholarship in the quest for decolonization.

3.5.2 A counter-hegemonic Perspective

Drawing links between the political and the psychological has a specific counter-hegemonic potential and mandate. As Gooze (2021) challenges the Eurocentric roots of psychiatry by demonstrating how it continues to de-politicize the oppression and violence that underpins trauma and suffering, Burstow et al. (2014) offer an additional collection of counter-hegemonic perspectives by highlighting how "biological psychiatry" and medicalized discourses specifically target marginalized population groups. Giving rise to the voices of different psychiatry survivors, the authors of this book unpack how people´s perceived dangerousness and criminalization renders them necessary targets of psychiatry, as well as how the effects of state-violence, experiences of colonialism, racism, civil war, genocide and occupation are obscured by psychiatry´s complicity in their oppression. In other words, they

> all remain targets for psychiatric oppression – in particular by psychiatry's tactic of individualizing and reframing the distress resulting from state-related violence as biogenetic and bio-chemical induced "mental illness." In this way, psychiatry remains the handmaiden of the state (...) redirecting attention away from those who ultimately should be made accountable for the distress of so many people. (p.13)

By locating psychiatry within a web of power and powerful institutions, Diamond (2014) further highlights how marginalized people are "particularly vulnerable to psychiatrization", and are thus "labelled and subjected to different types of psychiatric intervention" (p. 194). From a feminist perspective it can be argued that some groups of women are at a higher risk

of being psychiatrized. While women's experiences (emotional, behavioural etc.) are generally judged depending on existing gender expectations and in proximity to symptoms of mental health conditions, it is the "elderly women, girls, racialized women, disabled women, women in prison, trans women, and women living in poverty" who are at a disproportionate risk of being coerced into a relationship with psychiatry (ibid., p. 196). Drawing on this insight, it is part of the aim of this study to critically examine how dominant discourses about mental health/illness are internalized, reproduced or resisted which can help to unpack how the pathologizing of experiences (while naturalizing, normalizing a certain mental health condition) functions to sustain a hegemonic order. This calls for an intersectional perspective, as one needs to understand the specificity of lived experiences, in this case shared trauma, to formulate recommendations for needs-based activism, advocacy and intervention. The above thus lays the ground for an analysis that considers how meanings and experiences of trauma are intersecting with the oppressive effects of colonialism, capitalism, heterosexism, transphobia, adultism, ableism, sexism, ageism and patriarchy.

3.5.3 An Intersectional Perspective

As one can see, the critical psychiatry as well as the critical psychology movement (e.g. Fanon) is inclusive of the theory and practice of intersectionality. Already adapted to the framework of trauma (see 2.2), intersectional theory or intersectionality offers an important lens through which to understand trauma by interrogating "the interplay of multiple social dynamics and power relations" that place "constitute subjects in particular socio-political formations" (Cho et al., 2013, p. 807). Having emerged in the 1980s as a critique of the uni-dimensional, single-axis thinking underpinning legal and other discriminatory practices, intersectionality developed from its roots in Black feminism and Critical Race Theory into a widely adopted concept, method, and paradigm (Carbado et al., 2013; Cho et al., 2013). Without engaging in the various debates underpinning the usefulness of cross-disciplinary adaptation, as well as conceptual and methodological matters concerning intersectionality, this paper sees it as a valuable analytical tool with which to consider contextual dynamics of power and how they produce and re-enforce particular identity categories which in turn create certain types of subjects and vulnerabilities. In short, intersectionality is not seen as a static meta-theory, but rather "as a nodal point (...)—a gathering place for open-ended investigations of the overlapping and conflicting dynamics of 'race', gender, class, sexuality, nation, and other inequalities" (Lykke, 2011 in Cho et al., 2013, p. 788).

Conceptualizing the relationship between identity categories and the structures of power and oppression in such a dynamic and multi-layered way asks for a multi-level analysis. Including an intersectional lens within the research on shared trauma (and other topics) will thus offer the possibility of filling research gaps left by studies with an one-dimensional approach (Hancock, 2007). In order to do so it might be valuable to draw on the structural and political definition of intersectionality. Cho et al. (2013) point out that *structural intersectionality* captures the "multilayered and routinized forms of domination" (Crenshaw, 1991 in Cho et al., 2013, p. 797) and asks for an "analysis of the overlapping structures of subordination", while *political intersectionality* is found in processes of "resisting the systemic forces that significantly shape the differential life chances of intersectionality's subjects and for reshaping modes of resistance" (ibid., p.800). The latter is thus a reflection of the practical potential of intersectionality and demonstrates how an intersectional analysis can inform social and political struggles. In line with what has been discussed so far, it is not the aim of intersectionality to see subjects only as (structural) positions but rather to be attentive to how the broader context, including time and space, shapes experiences of shared trauma. Having said this, it is imperative that one considers the different subject positions and broader socio-political context of inequalities in shaping how social workers make meaning of the impact of Covid-19. Lastly, intersectionality helps to conceptualize shared trauma under Covid-19, by recognizing how the pandemic is intersecting with (pre-) existing forms of collective and individual trauma (see 2.2).

3.6 Conclusion to the Chapter

This chapter has offered deeper insights into the study of trauma as well as different theoretical perspectives that will help in reading the findings of this particular study in a critical and contextualized manner. In discussing existing research on shared trauma, the link between violence and trauma in South Africa, as well as the role of social work, this chapter has laid important groundwork from which the experiences of participants can be understood. But before coming to the analysis of this research, the next chapter will shed light on the research design, ethical considerations and strategies for assuring rigor.

4 Research Design and Methodology

4.1 Introduction

This chapter will discuss the chosen research design and methodology. At the beginning of any research project some important decisions need to be made regarding the interpretative and theoretical framework, including the paradigm and methodological choices which shape the content of each study (Creswell, 2007). In order to construct a critical research design that is not based on a "cafeteria approach" (Holstein & Gubrium, 2012 in Pasque & Pérez, 2015), i.e. the selection of research methods based on personal preferences, the next section will explain why critical phenomenology forms the fundamentals on which this project is built. The ways in which the chosen research design shaped decisions regarding the data collection technique, the research instrument and the method of analysis are further explored below. The need to be sensitive to existing power imbalances throughout the research process is then recognized by reflecting on the role of the researchers' positionality.

4.2 Research methodology and paradigm

As this research aims to understand how social workers make meaning of their experiences of shared trauma under a global pandemic, as well as the factors that shape these experiences it was decided a phenomenological approach provides the most appropriate methodology to underpin the design of this study. Recognizing that personal experiences do not occur in a vacuum but are shaped by culture, ideologies, discourses, social constructions, historical context and thus unequal relations of power, critical phenomenology appears to offer the most suitable framework for this study (Guenther, 2019). Adopting a critical lens through which to examine the research topic situates the study in a critical qualitative paradigm and builds on the work of Lincoln and Cannella (2015) who state that critical research can be understood as, "any research that recognizes power—that seeks in its analyses to plumb the archaeology of taken-for-granted perspectives to understand how unjust and oppressive social conditions came to be reified as historical givens" (p.244).This decision is further inspired by Denzin (2015), who argues that "as global citizens we are no longer called to just interpret the world, which was the mandate of traditional qualitative inquiry"(p.33) but rather to focus on research that makes a difference in the lives of socially oppressed persons by resisting and naming

existing injustices. A phenomenological design opens the possibility of gaining a deep understanding of everyday experiences as it is concerned with human perceptions of lived experience and how individuals or groups construct meaning of these experiences (Creswell, 2007; Patton, 2002). The main advantages of this approach are thus the possibility of retrieving rich and detailed information and thereby extracting the essence of the participants' meanings (Miles et al., 2014). However, phenomenology does have limitations in the form of potential researcher bias and the difficulty of "bracketing" out the researcher´s own experience. Taking an interpretative approach to s the data collected must therefore include researcher reflexivity at any stage of the research process. The generalizability of results is further limited to the specific context and sample although new insights can always inform future research questions and agendas. Lastly, Patton (2002) argues that phenomenological research is always retrospective as individuals "cannot reflect on lived experience while living through the experience" (p. 104). This perspective highlights another possible limitation to this research as the Covid-19 pandemic has been ongoing throughout the data collection and analysis process. Therefore, the participants' ability to reflect on their experience might have been impacted or impaired. Although it has been argued that in traditional phenomenology peoples´ reflections on their experience mirror what they can "consciously" access (Creswell, 2007; Groenewald, 2004), a critical interpretative lens allows us to broaden this understanding. Adopting insights from discourse theory and a critical discourse analysis of the data will therefore allow us to also uncover the hidden meaning of participants´ experiences expressed through their choice of language.

4.3 Data sources

As stated earlier, the topic and questions guiding this research aim to explore a phenomenon about which little is currently known. To address these questions, new in-depth information is required that is based on the "inside" perspectives of people´s lived experiences. Therefore, in-depth interviews (IDI) appeared to provide the most adequate tool to gain the qualitative data needed to study a complex social process like the meaning-making of shared traumatic experiences. Thus it was decided that the preliminary data that had been collected in the form of interview recordings, would be transcribed (true) verbatim, making interview transcripts the main source for analysis and interpretation. Using interviews as discursive data, as discussed by Nikander (in Gubrium, 2012), is of special relevance for this research endeavour because it offers insights into

> the ways in which people make sense of themselves and of each other—that is, how they negotiate various cultural meanings, categories, and identities of "us and them" or "me and others" to build versions and social order into their worlds in collaboration with the interviewer. (p. 404)

Using a critical discourse analysis model to make sense of the interview transcripts therefore not only fits into the critical paradigm but will enable us to understand shared traumatic experiences through the use of discursive formations.

4.4 Data Collection and Research Participants

4.4.1 Data Collection Technique

In order to collect the data needed, nine individual in-depth, semi-structured interviews were conducted. According to Johnson and Rowlands (2012), in-depth interviews are a unique social form of interaction that is built on interviewer-interviewee intimacy and seeks to gather information that generally goes deeper than and beyond the kind of information accessed through surveys or focus groups. The chosen technique is thus designed to allow the researcher to access very personal and sensitive information, including the "lived experience, values and decisions, occupational ideology, cultural knowledge, or perspective" of the interviewee (ibid. p.100). Gaining such deep and contextualized insights provides the best foundation from which "to interpret the meaning of the described phenomena" (Brinkmann & Kvale, 2015, p. 6). A major advantage of this strategy is that is allows the interviewee to unfold and recognize their own knowledge-producing potential by letting the issues seen as important by the participant shape the interviews' dynamic (Brinkmann in Denzin & Lincoln, 2018, p. 1002). These kinds of individual interviews must be well prepared in advance and can challenge the researcher in various ways. Besides organisational tasks (e.g. time-management and schedule), these interviews require a private setting in which trust can be built and anonymity assured (Padgett, 2017). In order to avoid reproducing unequal power relations or creating a one-sided conversation, the researcher must be able to accept and handle pauses, as well as be able to ask follow-up questions and encourage participants to further explore topics while avoiding becoming all "knowing" (ibid., p.173) or informal.

In order to ascertain whether the questions were clear enough and would lead to the information needed, a pre-test with the first two participants was conducted. Following this,

minor adjustments were made for clarification, including the addition of two more questions, one of them proposed by one of the participants of the pre-test. The data gathered from the first two interviews was not part of the actual study and analysis what was communicated to the participants beforehand. Due to the global pandemic, with the aim of minimizing potential risks to the participants and the interviewer, online and in-person interviewing was offered. In all cases, the latter version was preferred. This made it necessary to follow official health protocols (social distancing, mask wearing and sanitizing) but also enabled the interviewer and interviewees to benefit from the "embodied presence" which can help to build rapport and trust, as well as develop context sensitivity and conversational flexibility (Brinkmann in Denzin & Lincoln, 2018). All eleven interviews took place in the surrounding area of Johannesburg and lasted for 30-60 minutes. In line with the standards for ethical research, informed consent was given before every interview, which was held in English and audio-recorded. All interviews took place between October and November 2021.

4.4.2 Research Instrument

A semi-structured interview schedule, developed by the researcher and approved by the university ethics committee, was used to frame and guide the interviews. In the context of qualitative research, interviews go "beyond a spontaneous exchange of views" and follow a "clear purpose and structure" (Adams, 2010, p. 18). In this regard, a semi-structured schedule can help to fulfil the purpose of gaining "participant-centred insights" by framing the "set topic" of this research, while on the other hand leaving space for the participants to guide the interview by exploring their experiences (ibid, p.21). As mentioned above, this choice of tool comes with certain challenges. According to Adams (2010), challenges may come in the form of researcher empathy and skills, the researcher's knowledge about the subject and context and the ability of the researcher to manage silence as well as emotionally challenging situations and professional boundaries. Lastly, ethical responsibility forms part of adhering to professional boundaries and was taken up by the researcher by adhering to the administrative requirements (e.g. getting ethics clearance and informed consent), as well as by protecting the rights, safety, dignity and wellbeing of the participants throughout the research process. Within the interview setting, this meant being non-judgemental, open and engaging, while practicing emotional control in challenging situations and offering free external counselling. While face-to-face interviewing had many advantages, the need to wear masks as a protective measure might have impacted the flow of conversation and understanding because non-verbal

expressions became difficult to read. In order to counter the limitations explained above, extensive reflexive journaling, as well as peer debriefing was practiced. A training in research ethics organized through the university was completed by the researcher in advance.

4.4.3 Population and Sampling

The population for this study consisted of twelve social workers employed at a local organization offering mental health services in the Gauteng province. The organization was chosen based on its presumed expertise and monopoly within the area, operating in major townships such as Soweto, Tembisa and Katlehong, as well as in the city of Johannesburg. After initial contact was established with the head of the organization and official permission to conduct the research given, participants were selected based on their availability and willingness (Padgett, 2017, p. 116). This was mainly based on the condition that all the social workers participating met the given criteria defined for a purposive strategy. These criteria were: (a) being employed as a social worker; (b) providing mental health services; (c) during the ongoing Covid-19 pandemic; and (d) participants were over the age of 21 years, as becoming a social worker requires a four-year degree. All participants were spread over four different offices in the locations mentioned above and were firstly informed through the local manager who was given all information including consent forms and participant information sheets via mail. The majority of participants reached out to me personally (sent their consent form upfront via mail) in order to schedule an appointment for the interview or I received their contact details through the manager to contact them. Only in one case the manager invited me for two days to first go there, introduce myself and the project while then inviting the participants personally (consent forms were individually signed before each interview on site). In this specific case the manager was on site, in his own office, during the interview process which might have impacted participants' overall ability to feel safe and to open up. Although this is reflected on in the 'reflexivity' part, there is no ethical concern based on the followed procedure described above.

In line with a phenomenological approach the anticipated sample size was kept rather small (Beitin, 2012; Padgett, 2017) and initially comprised ten participants excluding two participants for the pre-test. However, due to organizational matter and delays caused by health concerns, the actual sample size for this study ended up comprising nine social workers all of whom were Black South Africans between the age of 25 and 50. To give some

demographic details (see 5.2): the majority of participants, (seven out of nine) were female and originally came from outside the Gauteng province. The amount of time the social workers had been working at the target organization for also differed, ranging from six years to two months. Six out of the nine participants were hired after the Covid-19 pandemic had started, meaning after January 2020. Five out of the nine participants identified as operating in the statutory social work field, as their clients were mainly under the age of 18 and diagnosed with a mental illness. The other four participants shared tasks with the aforementioned including awareness campaigns and family counselling but presented their work as more focused on group work and outpatient care for both adults and children.

4.5 Data Analysis

4.5.1 A Critical Approach to Language and Discourse

Using interview data as discourse data comes with specific considerations. As there are a variety of approaches to discursively analyse forms of interactions, often through texts, it is the critical strand of method(ologies) that are of interest for this study. Although there are approaches to discourse analysis (DA) that are interested in and based on the consideration of power and the socio-political (e.g. Foucauldian DA), there are also other reasons to chose critical discourse analysis.

Rooted in the theory of critical linguistics, and thus in critical theory itself, critical discourse analysis (CDA) understands "language as social practice" (Fairclough & Wodak, 1997 in Wodak, 2001, p. 1) that is not only conditioned by social and historical factors but can produce, sustain and resist existing power relations. In this sense CDA is anchored in the concept of power, history and ideology, as it is

> fundamentally concerned with analysing opaque as well as transparent structural relationships of dominance, discrimination, power and control as manifested in language. In other words, CDA aims to investigate critically social inequality as it is expressed, signalled, constituted, legitimized and so on by language use (or in discourse). (Wodak, 2001, p. 2)

Language is thus seen not only as a powerful and productive form of interaction, but as a social phenomenon and "medium of domination and social force" (ibid.). Structures of dominance that are produced through the effects of power (powerful groups) and ideology are

therefore of great interest as they shape ways of meaning making, subject positionings and taken-for-granted assumptions or conventions. Thus, as part of our dominant structures, discourses are understood as "a moment of social practices" (Fairclough, 2001) that carry several (semiotic) elements, while interacting with other aspects of our social order. Seeing language as a tool to express, maintain and challenge power therefore asks one to understand discourses in their historical-spatial context and through their linkages to other discourses (interdiscursivity). A major analytical focus of CDA is to examine the "dialectic relationships between semiosis (including language) and other elements of social practices" (ibid, p.122). Critical discourse analysis might also be seen as a theoretical orientation or methodology, rather than a fixed method or tool, because it calls for a trans-disciplinary orientation and does not impose strict sequential procedure (Fairclough, 2013; Wodak, 2001). At this point it might be helpful to highlight the overall aims of and similarities between various CDA approaches. Originated in the tradition of critical theory, CDA aims to produce "enlightenment and emancipation" and thus to "root out a particular kind of delusion" (Wodak, 2001, p. 11). By choosing the perspective of those who are suffering, oppressed or marginalized, CDA approaches embrace a particular political commitment through being concerned with the conditioning role of power in our social and material lives. The practical aim is then to analyse "who is responsible for the existence of inequalities and who (...) have the means and opportunity to improve conditions" (ibid, p.10).

Adapting the analytical framework of Norman Fairclough (1995, 2001, 2009), as described below, CDA can be said to employ a focus on structure and activity. Through the entry point of semiotics, it considers the symbolic meaning (semiosis) of different activities that produce social life (social activity, genres); the representations of self and others (representations); as well as the performance of positions and styles (identities, ways of being). It is thus not only individuals who express values and meaning through the specific use of language, but also social groupings, organizations and institutions. Having said this, CDA is also concerned with questions like "how discourses are constructed in and constructive of social institutions"; "how ideology functions in social institutions"; or "how people obtain and maintain power within a given community" (Wodak, 2001, pp. 11–12).

With regard to this study, a primary concern is then the ethical issue of discursively analyzing sensitive information given by participants with the assumption of the researcher having a genuine interest in their lived experience (Willig, 2004 in Willig, 2014). This ethical issue can arguably be countered by adapting a Foucauldian perspective that sees research participants

not as strategic users of discourses, but as "historical subjects who are themselves constructed through and positioned within discourse" (Foucault, 1982, p. 208). Considering the content, linguistic structure and broader context of the interactions, CDA requires one to be aware of how the interviewer contributes to the conversation and takes an active part in constructing the discursive context of the information gathered (Willig, 2014). In doing so, CDA offers a critical and flexible approach to making sense of the complexity of lived experiences and social life. As a tool for analysis it can thus help us identify the mechanisms and power relations that shape social worker´s experiences of shared trauma, while at the same time dismantling how discourse(s) can produce (assumed) legitimacy, consensus and acceptance of dominance (Herman & Chomsky, 1988 in van Dijk, 1993, p. 255). On the other hand, it can help reveal social workers' role in society and how the profession views/ challenges the conditions in which it operates. Taking a critical stance therefore, does not deny the individual´s agency, experience or meaning making, but rather aims to highlight that these do not take place in a vacuum.

4.5.2 Critical Discourse Analysis – A Socio-Cultural Approach

As mentioned above, this study adopts the CDA-approach proposed by Norman Fairclough (Fairclough, 1995, 2001, 2009, 2013). Offering a stage-wise procedure, Fairclough understands discourse as a form or moment of social practice that is situated within a specific historical context and expresses existing social relationships by either reproducing or contesting these relationships. Discourses therefore produce and reflect certain positionings within power relations and function to serve or negate specific interests at play. A critical analysis of discourse, and thereby social practices, thus includes multiple layers that help us to read texts (or visuals, interaction, etc.) through the lens of engagement and estrangement (Janks, 1997). For Fairclough, CDA is the analysis of the "dialectic relationship between semiosis (including language) and other elements of social practices" with particular attention being paid to the (radical) changes taking place in social life (Fairclough, 2001, p. 123). Giving a shortcut to his socio-cultural approach, Janks (1997) demonstrates a three-layer analysis following the three proposed dimensions of discourse. These comprise of: the object of analysis (visual and or verbal texts e.g.), the processes that produce the object and those by which it is received (e.g. writing, reading, listening), as well as the broader socio-historical conditions that shape the above. In line with these three dimensions, the analysis of the collected data includes three separate but interconnected steps. Based on the work of Janks

(1997) and Postigo et al. (2006), the first analytical step can but does not have to be a *textual analysis* directed at the specific linguistic selections, sequencing (etc.) and signifiers, that are determined by "conditions of possibility" (Janks, 1997, p. 329). Working from a text further requires some specific attention to aspects such as: lexicalisation or vocabulary, patterns of transitivity (for a summary see Janks, 2017, p. 336) including processes of nominalisation and the question of agency, as well as the choice of mood, topicality (information focus), the structure of the text, presuppositions, cohesion and ambiguity. As proposed by different authors, it is useful to follow the checklist of Halliday adapted by Fairclough (1989, pp. 110-111) when analyzing patterns and their linguistic functions among the grammatical resources provided.

The second step of the analysis focuses on the processes of production and reception, and thereby on *discourse practices and the orders of discourses* also framed as "interpretation" (Janks, 1997). Here, it is not only the situation (time and place) and intertextual context that is of interest but also the textual hybridity and the different (hidden) interests that are at play. Looking at the variety of discourses available in a specific context thus aims to investigate patterns of dominance, marginalisation, and conversationalization (also known as colonization) of discourses and whose interests are served by this (interdiscoursive analysis). Lastly, the third step is a *social analysis* and explanation that links discourse practices to the broader context of socio-cultural practices by paying attention to how textual signifiers have been shifting over time and what this can reveal about the functioning of ideology. As Cervera et al. (2006) point out, Fairclough's method or approach sees each text as being embedded in "the immediate situation involving participants in a particular setting; the wider institution or organization, and the level of society" (p.15).

Following the model of explanatory critique (Roy Bhaskar), these analytical steps form part of a broader five-stages approach, which according to Fairclough (2001, p. 125) starts by:

(1) focusing upon or identifying a social problem ("social wrong") and its semiotic aspect.
(2) Following that, the identification of obstacles that need to be tackled is revealed through the three-step analysis described above.

At this stage, a linear process of analysis is not recommended but instead a movement and interconnection of the steps above. Most important, and particular to this approach, is the combination of a *linguistic* (relevant semiotic forms) and *interdiscursive* (articulation and intertwining of genres, styles and discourses) analysis (Fairclough, 2001, 2013), that aims to

identify the different (semiotic) elements and their dialectic relationship as well as how they impose, enable or naturalize specific meanings and knowledge.

(3) The third stage is concerned with the question of whether the social order "needs" the identified social problem, or in other words whether the social wrong is "inherent" to the social order (Fairclough, 2013, p. 238). Of interest are her misrepresentations and (ideological) constructions that function to sustain unequal power relations.
(4) Following that, the next step induces a shift from negative to positive critique by looking for possibilities within the social process to overcome the identified obstacle(s). The latter might include discourses or acts that test, resist and challenge dominant discourses, representations and taken-for-granted assumptions.
(5) Lastly, the analysis takes a reflexive turn to the forgoing steps with the focus on evaluating the supposed effectiveness of its critique in relation to an emancipatory aim.

Situating the analytical steps described at the beginning of this section within this broader framework of analysis and critique thus allows the researcher to meet the aims of this study by first, acknowledging the complexity of social life and the phenomenon under study, and secondly by producing findings with a practical implication.

4.6 Limitations

The research design presented does come with some important challenges and limitations. Concerning the data collection method, Roller and Lavrakas (2015) have highlighted two specific considerations - one being the interviewer-interviewee relationship and the "power dynamics" within the interview context. Linked to this is the potential danger for interviewer-bias (own positionality, unquestioned assumptions, beliefs and values) to negatively affect the interviewee´s response, as well as the accuracy of the data gathered. To limit this potential impact, reflexive journaling and peer debriefing (see below) was adapted. The fact that the researcher is *white* and not from South Africa must be considered here, as it creates a unique entry point to the data while at the same time presenting a limitation that cannot to be ignored. The second limitation derives from the fact that the interviewer is mainly in charge of the questions stated even in a semi-structured mode, creating an asymmetrical relationship. In order to remain conscious of and reflexive regarding existing power dynamics, potential assumptions and prejudices, the importance of strategies such as: critical reflexivity,

awareness, and positive engagement techniques as suggested by Roller and Lavrakas (2015) were recognized. These strategies can help to build rapport, trust and a safe and engaging environment. In order to handle potential interruptions and emotional issues that may arise from the sensitive nature of the topic, the interviewer tried to be prepared to be an empathetic, non-judgmental listener who "can show concern and then gently steers respondent to a calmer state" (Weiss, 1994 in Padgett, 2017, p. 193).

Having already mentioned an ethical challenge involved with analyzing the interview data discursively, the proposed interpretation technique also presents some limitations. According to Morgan (2010 in Mogashoa, 2014, p. 111)critical discourse analysis suffers from a general lack of explicit techniques which can lead to confusion and questions about its scientific rigor. Instead of seeing this as potential barrier, having a variety of options can be seen as an opportunity for the researcher to find the most adequate model for the data collected and purpose of this study. In order to prevent confusion for the researcher and reader, concepts and decisions regarding analytical tools and steps will be described in detail, as with the chosen approach presented above. Furthermore, the researcher takes the stance that "meaning is never fixed and everything is always open to interpretation and negotiation" (Mogashoa, 2014, p. 111). In this regard, discourse analysis does not aim to give definite answers, but rather to provide insights based on an ongoing argumentation and debate. As critical discourse analysis aims to name and challenge taken-for granted assumptions and unequal relations of power, it can also cause disturbing disruptions of the notions of selfhood, gender, autonomy, identity, choice and so forth (ibid.). Handled with the necessary awareness, empathy and debriefing, these disruptions might also carry the power to unfold new creative energy and innovation by offering space for mutual growth and exchange.

4.7 Researcher Reflexivity

Following the limitations discussed above, the researcher wants to carefully reflect on how situational power-imbalances as well as the positionality of researcher and participants influenced the research project and data collection. As research is a "shared space" in which truths, experiences and knowledge is produced(Bourke, 2014), I hereby aim to share and further develop a critical consciousness and awareness about the impact of identity and power within this study.

Managing situational power-imbalances

Although I tried to establish a connection to the participants early on by highlighting our shared commitment to and identification with the social work profession, as well as their expert status to counter situational power-imbalances, multiple factors shaped our disconnectivity. One of them was, at least in some locations, the direct influence of managerial personnel which helped to organize the data collection process by scheduling my visit involving the introduction of myself and the project followed by the individual interviews. In comparison to the other locations, there was thus little room for personal connection to or exchange with the participants upfront. Although the voluntary nature in each case was highlighted and all guidelines for ethical research followed, I felt that there was an underlying institutional pressure to participate. The latter and the fact that all interviews happened in the organisation´s office might have influenced the way in which participants felt safe enough to share also negative experiences. As the interviews happened during normal working hours, there was further an underlying pressure or rush of going back to work. In offices where the manager was not present, interviews were longer and felt more natural. In reference to the broader context, it can be said that all offices visited by the researcher where located in densely populated townships surrounding the broader Johannesburg-area.

Positional reflectivity

As part of reflecting on situational power-imbalances, I further want to consider how my own positionality impacted the data collection process. While some of the participants shared their academic experience with me and showed empathy for my position as a student, there were multiple factors shaping our interaction. Being a *white*, female, heterosexual, cis-gender foreign researcher seeking to understand Black South African social workers experiences under the pandemic brings a few important considerations. Although I have prepared myself in becoming more self-conscious about the impact of embodying certain hegemonic identities by writing up a former essay on the same topic (as contribution to the forgoing Research Methods course), I need to state that even this section is not enough to reflect on and uncover the whole impact of unconscious bias, dynamics of ‘race’ relations etc., that are at play.

But reflecting on how my *situatedness* within the specific context influenced the process of data collection, I can say that being an outsider to the community and cultural context in which participants work and often form part of, I experienced a higher reluctance among the

female participants to share in-depth personal information. Although cooperation was great among all, I felt that especially male participants as well as older female participants spoke more openly about their personal and emotional experience under Covid-19. In most cases participants verbally indicated and made sure that I would understand what they mean and asked (in-) directly whether I can follow. Being an outsider in this regard thus might have impacted that specific topics and nuances did not come up in the interviews, but also allowed some participants to share in-depth personal insights as it gave me a presumably neutral role. Besides 'race', cultural background and nationality, age and gender thus played a crucial role as it seemed that male and older female participants felt more comfortable in sharing personal details with me. Explaining these dynamics is a difficult undertaking as this observation was not discussed with the participants. Leaning towards literature on interracial relationships (Childs, 2005; Fanon, 2008), 'racial' identity and inequality (Casey, 2016; Gumede, 2014), one could nevertheless argue that the *white* body is not only a key marker and signifier of inequality and power (Casey, 2016), but reflects the "intractability" of *white* privilege and domination in Post-Apartheid South Africa (Matthews, 2012). Research on interracial relationships and Black women´s attitudes towards them is further impacted by the overall de-valuation of Black beauty and culture, viewing *white* women as endangering Black women´s worth (Childs, 2005). In this regard women who were closer to the researcher's age might have perceived me as a threat. As Frye (in Matthews, 2012, p. 176) argues, "*white* people, even reflective, well-intentioned ones, are always 'caught in a web that connects them inexorably to sources in *white* privilege and to consequences oppressive to people of color". Considering the patriarchal structure in South African family and gender relations it was further surprising that men opened up so much about their private life and mental health. This could point to the possibility that they felt more comfortable talking to a stranger and foreigner, while at the same time picturing an interesting and under-recognised position within the mental health field.

The power-imbalance created by academic language or long formulations within the questions further played out to be a hampering factor. Although feedback from the pre-tests was reflected on and adapted, some questions seemed to overwhelm the participant´s reflective capacity in this setting (mostly one question relating to the impact of their identity). Further, it was notable that the body-language of many participants was nervous and tense at the beginning what made it necessary to find easier and calmer ways of communication. In these cases I tried to speak with a calming voice, having an open and reassuring body language, as well as using humour to ease tensions. Considering the impact of broader societal power

imbalances and how they shape the perception of individuals and their bodies, it is further notable that issues like 'race' and racism, as well as inequality and poverty rarely came up although they shape the environment in which social workers are providing services. As a *white*, female foreigner I did not feel comfortable to initiate these conversational aspects as I felt it would be a means of projecting a certain picture about the subjects I study. Letting these topics come up naturally, where they did come up, was for me an attempt to not reproduce stereotypes and show `respect` by careful and active listening. Lastly, the fact that all participants, as well as the researcher have no (obvious or communicated) physical or mental disability must be considered when analysing and reflecting on how both can understand and at the same time speak about the lived realities of the organisation´s service users.

In line with the aim of critical research and the reflection above, the researcher committed to use the specific insights gained to not only analyze the collected data from a hermeneutics of suspicion, but also from a hermeneutics of faith (Josselson, 2004). Reading the transcripts through a lens of engagement and estrangement (Janks, 1997) helps to take a critical stance towards the texts while aiming to produce useful practical recommendations.

4.8 Ensuring Quality and Accountability

Linked to the challenges discussed earlier, this section presents the strategies adapted to ensure the quality and thus "trustworthiness" of this qualitative study. As introduced by Guba and Lincoln (1985 in Lietz et al., 2006; Morse, 2015) the concept supposes that "a trustworthy study [is] one that is carried out fairly and ethically and whose findings represent as closely as possible the experiences of the participants" (Steinmetz, 1991 in Padgett, 2017, p. 296). The different criteria constituting the concept of trustworthiness are: credibility, transferability, dependability and confirmability. Credibility can here be understood as the extent to which findings are internally valid (accurate), while transferability reflects on the extent to which users of the research can determine the study´s design or/and findings to be applicable to other contexts. Dependability "is the degree to which an independent "auditor" can look at the qualitative research process and determine its "acceptability" and, in so doing, create an audit trail of the process" (Roller & Lavrakas, 2015, p. 21). And lastly, confirmability is seen as using the same dependability audit to investigate the findings, interpretations and conclusion (ibid.). Building on the concept of trustworthiness to judge the rigor of qualitative research, Roller and Lavrakas (2015) have developed "The Total Quality Framework". Consisting of

four interrelated components: credibility, analyzability, transparency, and usefulness, this concept provides a viable framework to ensure quality and accountability in every part of the research process.

4.8.1 Credibility

At the stage of the data collection Roller and Lavrakas (2015) define the scope and data gathering as key in determining how complete and accurate the data collected will be. To ensure that credibility is not threatened, this study has a clear definition of the target population, identified an adequate sample design and scope, as well as strategies for recruitment. In order to gain the cooperation of the selected sample, techniques facilitating rapport (active listening, follow up-questions) were adapted to gain the participants trust. The assurance of complete confidentiality and avoidance of any costs further helped to overcome reluctance or refusal throughout the recruitment process. Concerning the data gathering process, credibility was assured by having a detailed understanding of the construct(s) under study, as demonstrated in the literature review/theoretical framework covering the current conceptualization of shared trauma and related concepts. Further, pre-tests were conducted to assure internal consistency and clarity of leading questions. Potential researcher bias is openly communicated and considered through the nature of the IDI framework (how the researcher is part of co-constructing the meaning and context of the interview). Part of this critical reflexivity includes being aware of how my own positionality as a *white*, able-bodied, middle-class, young, non-South African student might impact the data collection by making me an outsider, while also highlighting potentially shared interests. Introducing myself as a social worker, the researcher tried to highlight her interest in and commitment to the social work profession, its values and mandate. Sharing a potentially similar understanding of what it means to be a social worker could be seen as a uniting or connecting factor. Further, reflexive journaling and peer debriefing were be adapted to stay mindful and to navigate these aspects. Especially when the research topic is close to the researchers' own experience, what is the case under Covid-19, debriefing can help to work through and share observations, experiences and their emotional impact (Padgett, 2017). Reflexive journaling and debriefing thereby become a tool to stay mindful of boundaries and emotional or interpersonal dynamics that are not outspoken. It can prevent the researcher from becoming "emotionally enmeshed" (Padgett, 2017, p. 148) or "knowing" (ibid., p.173) when moving forward in the process of interviewing.

4.8.2 Analyzability

In order to ensure the quality of the analysis of the collected data, two processes deserve separate attention: processing and verification (Roller & Lavrakas, 2015). At the stage of processing the "preliminary data" through transcription, potential errors must be avoided. Being familiar with the terminology and context of social work in South Africa as well as the subject under study, helped to overcome or avoid problems in transcribing interview sections difficult to understand. Further, past experiences in interviewing within intercultural contexts as well as in transcription, as part of the researcher´s social work training, provided a good foundation to produce high quality transcripts. At this stage, potential errors in the preliminary data were identified and corrected if necessary through the researcher´s attention to internally inconsistent data elements and (true) verbatim description (e.g. contradictory statements).

At the verification stage of the "The Total Quality Framework" (Roller & Lavrakas, 2015) the accuracy of and confidence in the analysis and interpretation of the data is assured. In doing so, verification techniques were adapted in the form of theory triangulation (using different theories to make sense of the data), peer debriefing (discussing the impact of my subjectivity with my supervisor, colleagues, or the academic consultant for this study), as well as reflexive journaling or/and memos (written form or as short audio recordings after every interview). Rather informal and flexible in form, the latter can help to defend the study at a later point by providing enough details about what happened at each stage. During the analysis, reflexive journaling provided a basis to review the soundness of interpretation. "Theory triangulation" (Padgett, 2017, p. 301) can further help to validate research findings by not relying on one specific theoretical framework but using a multiplicity of perspectives to make sense of the data. The role of peer debriefing is to eliminate/ prevent the influence of possible biases producing faulty/weak preliminary interpretations (Roller & Lavrakas, 2015, p. 40).

4.8.3 Transparency

According to the adapted quality framework, transparency captures the completeness and disclosure of the final research report. To accomplish transparency in regard to findings and recommendations, but also to every other aspect mentioned so far, the report is written using "thick description" (Padgett, 2017; Roller & Lavrakas, 2015), the rich details of the phenomena and context of the study allowing other users to determine the study´s *transferability* to other contexts.

4.8.4 Usefulness

Lastly, the overall "usefulness" of the study can be describes as the extent to which other users of the research derive value from the findings, interpretation, design and recommendations (Roller & Lavrakas, 2015, p. 45). In order to address this aspect, this research report has a separate section reflecting on important knowledge gaps identified, recommendations for action or other potential steps. In consultation with the organisation targeted in this research, the above could be achieved in collaboration after presenting my final results to the organisation. Potential follow-up actions could take the form of co-creative solution finding, new networking opportunities or institutional routines, as well as educational and practical activities. At the time of this write up there is no such thing planned but the handing back of a shorter research report to the organisation. Having said this, the recommendations will consider their practical applicability and local context.

4.9 Ethical considerations

4.9.1 Autonomy

Recognizing the autonomy of every potential participant in this study is based on the ethical principle of respect for every person. Adhering to this principle means to acknowledge their right to make a free and informed decision about their voluntary participation in this study, as well as their withdrawal from it at any time during the process (Orb et al., 2000). In doing so, participants were informed about the terms of participation as soon as the recruitment process started, in form of the PIS, and were asked to give their *informed consent*. The latter did not only include the disclosure of important information about the study (the aim, purpose, risks, benefits, costs), but, also participants consent to audio-record the interview. Although this step is often misunderstood as a one-time bureaucratic step, it must rather be seen as an ongoing negotiation of trust (ibid.). Therefore, the use of simple language, was aimed to "avoid [any] wording or illustrations that could be interpreted as being patronising or humiliating" (Horn & Ndebele, 2014, p. 88). All participants were further informed that they have the right to withdraw from or not participate in the study without facing any negative consequences.

4.9.2 Beneficence / Anonymity/ Confidentiality

Linked to the principle of beneficence in research ethics is the moral obligation of doing good and prevent harm and do no harm (Orb et al., 2000). Translated into ethical research practice this principle was followed by minimizing potential risks (see below), while ensuring complete confidentiality and anonymity (ibid.). *Anonymity* is hereby understood as the non-disclosure of any personal information concerning the participants, the organisation or locations in any processed data. This will be ensured through the use of pseudonyms when using direct quotes in the research report (as far as agreed in informed consent). In line with the new legal requirements stated in the Protection of Personal Information Act (POPIA), *confidentiality* will be and is ensured at any stage of the data collection, processing, and storage. As the intimate context of IDI cannot ensure the non-disclosure of identities, the research setting (location and time) will be held highly confidential. Participants´ privacy is further be protected by eradicating any personal information in the processed data, while storing the processed and preliminary data safely in a password protected computer for six years.

4.9.3 Justice

Adhering to the principle of justice which refers to "equal share and fairness", as well as the avoidance of "exploitation and abuse of participants" (Orb et al., 2000, p. 95), this study recognized the situational *vulnerability* of potential participants, which can be caused by potential physical, psychological, and economic *risks*(Chi et al., 2014). As this research does not include formal categories of vulnerable persons/groups, such as minors (all participants must be above 18 years), people with mental health disorders or population in an institutionalized context (Bracken-Roche et al., 2017), contextual sources of vulnerability can be in the sensitive nature of the research topic and questions asked, as well as the physical risks related to Covid-19. In order to minimize and navigate the potential harm of emotional discomfort or distress (psychological risk), the researcher was all-time alert to emotional reactions by the participants and offered a break or cut if necessary. I further engaged in some mutual support and positive words were appropriate. Further, free counselling was organized and offered by an external social worker in private practice (contact details were shared on the PIS, and participants reminded individually of the available counselling support).

Potential bodily harm caused by the current context the global pandemic was minimized by first letting the participant decide between in-person and remote interviewing, secondly by the adherence to the current Covid-19 safety protocol (mask wearing, keeping social distance of min. 1,5 m, choosing a ventilated room) and the university‘s guidelines for non-medical research during Covid-19. The latter implied the avoidance of paper work (gaining informed consent prior to the interview via mail), as well as the provision of sanitizer, additional masks or a protective shield. By any means, the potential physical and/or social reputation or risk aligned with the transmission of Covid-19 for the researcher, participant, and the University was aimed to be minimized with great alertness to changing contextual factors.

4.10 Conclusion to the Chapter

Moving forward, this chapter has explained the research design of this study including methodological choices. The benefits and limitations of each aspect have been highlighted as well as the role of researcher positionality and reflexivity. To follow up on the impact and role of the researcher’s own social location especially in regards to the participants, the data and findings, the following analysis in chapter five highlights important observations. Having discussed the importance of debriefing and reflexive journaling in the context of managing limitations and ethical considerations, excerpts of the researcher’s journal are attached in the appendix.

5 Analysis and Discussion

5.1 Introduction

Examining the ways in which social workers have made sense of their experiences under Covid-19 offers a novel perspective on what it means to belong to an "essential" profession providing mental health and statutory services during a state of emergency. The participant's discourses surrounding their experience of shared trauma on a professional and personal level reveal ambivalences and conflicts arising from current struggles, loss, fear and uncertainty, as well as their intersections with a previously challenging working environment. Enacted discourses will thus further shed light on the broader understanding of current problems in mental health related social work and its context. A prevalence of neo-liberalist (managerialism, lack of resources, outcome measurement, etc.) and individualist discourses alongside a socialist-collectivist perspective (here in the moral obligation and duty of care) and cultural values rooted in Ubuntu present possible points of resistance and counter-hegemony. Gaining deeper insight into the understandings surrounding and context of mental health social work, the dominance of medical and technological language raises important questions around how social workers understand their role, function and relationships within the community and wider society. A focus on professionalism and problem-discourses will help to uncover ideologies that are (un-) consciously reproduced in social workers' views and everyday interactions. While this analysis aims to understand processes of meaning-making and the mechanisms enabling ideological hegemony, it more so aims to produce useful and practical recommendations as part of its 'critique'. In this regard, this chapter provides a basis for recommendations developed from the following discussion and the literature referred to. Starting with some demographic information of the participants, this chapter will proceed by presenting the themes and discourses concerning social workers' experiences of shared trauma (5.3), followed by an exploration of their understandings of mental health and the structural context of social workers' service provision (5.4).

5.2 Participants´ Demographics

In order to contextualize the analysis below, it is important to recall that the data used was generated through nine in-depth, semi-structured interviews with nine Black, multi-lingual

South African social workers, seven of whom were female and two of whom were male. The male participants were both between the ages of 35 and 45 years old. Both were married and were parents. Four of the female participants were in the age range of 25-35 and thereby were very close to the researcher's age. Two of the participants were between the ages of 35 and 45 and the oldest participant was in the age range of 40-50. The organization is known for its work in the mental health field and five out of the nine social workers identified themselves as statutory social workers because of their focus on children under the age of 18 diagnosed with a mental illness. Overall, the tasks of the social workers were reported to range from organizing foster care and transferral writing to individual and family counselling services including access to grants and other institutions. Difficulties in finding foster care placements during Covid-19, was reported to be one of the big challenges shared by those specifically working with minors. Beyond these tasks, awareness campaigns form an important part of the organization´s work and they are integrated into the organization's yearly planning. The other four participants did not exclusively focus on minors. Their duties included group work and educational events as part of their extended focus on outpatient care and prevention of mental illness. As mentioned earlier in this study, working experience within the target organization ranged from five years to two months and six out of the nine participants were hired during the pandemic.

5.3 Social worker´s experiences of Shared Trauma

5.3.1 The Ambivalence of being "essential": between Survival and Service

Navigating the experiences of shared trauma under Covid-19, the participants of this study draw especially on discourses of survival and duty of care. While social workers are seen as playing a crucial role in the field of mental health generally (Golightley, 2008) and in the response to the psycho-social impact of the pandemic in particular (Piccolino, 2021), it is important to understand how the dual exposure to trauma, suffering, loss and anxiety impacted their coping mechanisms and opportunities. Facing the worsening crisis of unemployment, health and lack of social cohesion combined with a militaristic policing of Covid-19 regulations (Pinheiro & Kiguwa, 2021), the pandemic has exposed the "intersectional stressors of living with inequality, racism, classism, marginalisation or being `othered´" (Baldwin-Ragaven, 2020, p. 34). After being added to the list of essential workers in March 2020 (Chothia, 2020), social workers in the mental health field and elsewhere saw

an increase in recruitment (Mahlati, 2020) and rising a awareness about of professions contribution to society. This trend is mirrored in the demographics of the participants, as six out of nine social workers interviewed had joined their current position during the pandemic. How they experienced their work and personal life under the national crisis response and pre-existing challenges is discussed alongside the main topics identified through analysis.

5.3.1.1 Surviving the Uncertain.

Recalling their memories of the beginning of the pandemic, the majority of participants shared an overall increase in psychological distress caused by uncertainty, rising levels of anxiety and the fear of being infected by and infecting others. Concerns for family and friends, as well as the trauma, caused by the personal loss of loved ones and the constant witnessing of death and pain stood out as main contributions to this distress. The presence of an existential threat central to the discourse of survival is clearly expressed in a statement of participant five:

> *"Eh, the information was not as clear as it is now that we are speaking... during that time when you just hear that somebody is affected* ***we were all running for our lives****. No one wanted to sit with you ...you don´t want to be affected. So imagine I´m sitting in the office, a client coming in here you don´t know where the client is coming from. (..)So* ***obviously that creates that anxiety****, (...) working with people coming from outside that might affect me. And if they´re affecting me it might mean I will leave my family behind"P5*

They further went on to describe the shared experience of being more vulnerable to mental ill-health:

> *"peoples are still losing jobs and so forth, all those stressors (...) people who have a history of mental illness, and those who never had, they are all falling into one basked, now that we are speaking. Even me, like I said, I mentioned that the anxiety, that we are having, even we didn´t manage to at least resist it. I might have maybe been falling into this (laughs)."P5*

Although the shared vulnerability in a shared traumatic reality might be seen as potentially uniting factor that facilitates intimacy in professional relationships (Tosone, 2006), this example depicts the unique impact of Covid-19 in creating separation and distance through

"fear of the other" as potential danger. Being exposed to similar stressors and challenges to their mental health (e.g. personal loss or anxiety), social workers reported empathy towards but also suspicion of their clients. The discourse of survival shaped by ideas of individualism, self-reliance and responsibility strengthens this observation and is mirrored by participants here:

> *"(...) it was not life as normal, but we were just trying to live through each day. It was just a matter of living through each day and surviving and doing the best you can."P8*

Participant seven highlights the ambivalent feeling of being scared for her own life and family members while experiencing the loss of clients due to Covid-19:

> *"I was also scared that I would lose another family member due to this Covid (...) and I might as well get that Covid through interviews. Cause it was a scary moment. One minute this person is here and the next you just hear that person has passed on because of Covid, you know. So it was very stressful and very fearful at the same time. And at times I just thought whether it is better if I stop going to work because* ***my life comes first****." P7*

The above examples demonstrate how a discourse of survival shifts social workers' focus and attention to the immediate and short-term while decentring the broader social and political context. In effect, a focus on individual survival can disable social critique of the status quo and the militaristic responses enacted in "a war against the virus" further compromising the lives of those most vulnerable (Baldwin-Ragaven, 2020; Pinheiro & Kiguwa, 2021). Another discourse countering the described fear and anxiety accompanying the continuation of work was the discourse of **service**. Being an expression of the continued commitment to social work values during a state of emergency, service reflected "a genuine desire to help others" (Kamnitzer et al., 2021) and to stay connected and supportive, although this was challenged by structural factors as discussed in the next section. Participant two expressed this commitment while facing their own personal struggles (insomnia):

> *"You enjoy what you are doing, you love what you are doing, so I feel like no man I have to go... and* ***serve*** *the people. I have to go and provide service to the people because people are in need of* ***service****; they are in need of service. If I sit and see someone who is in need of my s****ervice****, why should I not give my time and provide* ***service****"P2*

The last example highlights how being seen as an "essential worker" comes with ambivalent feelings and reactions. While the discourse of survival became a dominant response to the fear and uncertainty caused by the pandemic and broader societal issues, the discourse of service shows how professional identity can provide a point of resilience and resistance (see 5.4.2). Participant seven further highlights how drawing on professional values helped her to uphold boundaries in a situation where her stressful personal experiences were similar to those of her clients.

> *"I knew what they were going through and I always put myself into their situation that this might also happen to me, or what might happen to me might happen to the very same person. (...) in instances [feel closer to client], especially those who lost their loved ones* ***cause I know the feeling of losing someone close to you.*** *You end up, sometimes having a good working relationships, checking out on the regularly. (...) But it didn´t really change, I was just using my* ***professional values*** *when working with them. So I knew I should not be (...) we shouldn´t form more than a working relationship with them."P7*

5.3.1.2 Failing and being Failed.

In line with the above, many social workers expressed their gratitude for finding employment or staying employed during times of rising unemployment and the fear of poverty. Participants seven and six stated:

> *"When the pandemic started I got a job at mental (...) so you gain an* ***opportunity****, yeah to, you know, to get something a job yes, to also feed my family" P7*

> *"I realized that we had* ***opportunities*** *that we had opportunities, especially us as social workers in mental health. Because there are many social workers that have been hired"P6*

However, participants also shared the negative impact of the pandemic on their professional and personal lives, causing feelings of personal failure, frustration and self-doubt. The distress caused by an increasing workload, lack of resources and the ineffectiveness of protective measures like working from home, in rotation or switching to telephonic-counselling is reflected in a statement by participant two:

*"You find yourself to **fail the client´s needs**...yeah, cause you don't have enough time. You don´t have enough resources to, to assist that particular person (...) when we [with wife] are sitting, I will still remember, I have this case, I have to assist this person – I have **failed to assist** this person, I´m looking for this document, finalizing everything –**I´m failing** to get them (..) something...I, I, I failed to leave work at work" P2*

In spite of the work-related stress reported, social workers participating in this study remained employed or gained new job opportunities during the pandemic. This stands in contrast to the increased job losses during the first moths of lockdown in which about 2.2 million South Africans lost their jobs (Smit, 2021). As research shows, the rise in unemployment and economic uncertainty had affected certain social groups disproportionately (Ranchhod & Daniels, 2020) and has a significant impact on people´s wellbeing and mental health (Posel et al., 2021). Work and unemployment related stressors are thus something that social workers and their clients experience differently within this shared traumatic reality created through Covid-19.

Moving on, participants one and five showed how the (partial) closing of offices and implementation of Covid-19 regulations also impacted client´s perceptions of their services:

*"Because of Covid it becomes a very challenging issue, cause sometimes clients presume you just don´t want to assist them – or you are failing to assist them. So sometimes it affects us to a point where **you think you are failing the client**, you are **failing yourself**" P1*

*"I think social worker is not treated as it was supposed to be. (...) when this thing of Covid started our offices were closed. Once this thing of lockdown started, social work offices were closed. (...)**When they close your office the client will think, oh that office is not essential**. It's not essential for me to go to the social work office. So, that's wrong. You do take care of physically, eh, only – but we have also to take care for mental service"*

These examples highlight what Pinheiro and Kiguwa (2021) describe as the scapegoat effect in which the construction of essential or frontline workers as "war heroes" disguises the fact that South Africa's healthcare system functions "in ways that are stressful, under-resourced and poorly managed" (p.83). The ability to provide quality service under a state of emergency depends on the structures and conditions already in place which are inadequate. As recent

studies show, the field of mental health is one of the most under-resourced in South Africa receiving only 5% of the total public health budget with 86% of this going into in-patient care (Docrat, Besada, et al., 2019). The ways in which these structural conditions impacted social workers' experiences can be seen in mixed statements regarding the support they received from the organization itself. Although participants mentioned the positive effects of additional trainings, the provision of personal protection equipment and possibility of working in rotation, they also shared feelings of "being failed". Participants seven and eight for example show that being seen as an "essential worker" can also mean being expected to compromise your own mental health:

> *"They were expecting us, because we are social workers to provide, you know, counselling for the other colleagues (...) we are not receiving counsellings for us, noo, maybe they know...the* ***social workers they know how to deal with this****." P7*

> *"No, honestly, I would say the focus was mostly on what can we do for the clients,* ***it wasn´t about us that much****. But when we came back to work we were given hand sanitizer, masks and they were trying to fumigate"P8*

Participant two further shares the feeling of not being taken seriously when sharing personal difficulties:

> *"In some situation,* ***I feel that the organisation fails me****. Because sometimes you (...) I'm someone who used to laugh much, I´m someone who laughs much.. so when you say, if a person says I´m not feeling well, I think the crew doesn't take it seriously, they take it as a (...), as a joke. (...) I ended up doing a sick leave of which that was when I went to consult and that´s when I got the medication [for insomnia]. So the organisation would provide support, but still not...****I feel to be failed****" P2*

Lastly, participant four mirrored this disconnection between the management and social workers stating that:

> *"I don't think we have that much support. Cause I can feel that, yo the cases here, you have to move up and down. You know it´s, like* ***you´re not recognized for the hard work and everything****. (..) Don´t always look for challenges (speaks with higher voice) eh there´s a case here, you have to push, you have to push, and all*

these kind of things, you understand. (..) So I don´t think they do understand what the staff is going through" P4

While these examples only highlight a perceived lack of support by the organization, they do point to the increased risk to social workers' mental health during the pandemic as also viewed in other "essential work" professions (Höller & Forkmann, 2022). The psychological burden carried by social workers is further overshadowed by discursive constructions of the "duty to care" which are not only inherently gendered but depict a "universal capacity" and "moral duty" to the community they serve (Pinheiro & Kiguwa, 2021, p. 85). Although this duty in the context of shared trauma can be seen as a source of intimacy, purpose and connection (Siegel, 2020; Tosone et al., 2012b) as participant seven pointed out:

"When clients come I make sure that when they go home their problem is being solved, you know,(...) especially in the black communities we believe, eh, when I approach a social worker I meet ah, you know I want to solve the problem. Yes, so I try all my best"P7

it can also become a factor that legitimizes the lack of reciprocity and absence of a meaningful conversation about the limits of the "duty to care" (Cox, 2020). These limits could include the impact of working in an under-resourced sector that offers no medical aid for essential workers in the face of increased risks to health (participant four). In addition to this, the presence of a neo-liberalist agenda and discourse within social work helps to transfer responsibility of care to the individual (Mearns, 2014) and leads to forms of "subjective coping" (Carey & Foster, 2013) that promotes the acceptance of uncomfortable truths, situations and actions (ibid.). Linguistically, this moral obligation and lack of choice is perpetrated in the de-personalisation of powerful agents, here the management and government (e.g. "they closed our office"), as well as passive constructions (e.g. "we were told") and a dominance of declarative and imperative statements ("we need to"; "you have to"). Considering the immediate and wider context of the argument made above, it is also important to note that most of the social workers interviewed identified themselves as statutory social workers, thus being further bound to the legal framework they are mandated by and the discourse associated with it. The adoption of a legal discourse can here function as a source of professional legitimacy and resilience, as participant three showed:

"You know, someone can provoke you and just what to, to bring you out of your way, and then go and report your job...so you must just think. (...) most of the time

you must just use your... ***you must stick on the act the mental health act, children´s act****. If the parents say what I know, when my child doesn't have...I will say, according to the children´s act, we do this. I don´t want to kid you. That´s how you perceive...according to mental health act we do this we do that, you see." P3*

But at the same time, it can become a challenge for social workers as the statutory and legal discourse can disguise the responsibility of the state to implement and build the structures necessary to make existing laws practicable. Participant four highlighted how being mandated by the law can become an ethical dilemma as existing institutions are often not appropriately equipped:

"It's just the thing of 24h,(...) they say the children´s act specifies if you conduct placement and you notice that the child is in danger you have to remove the child immediately. So that 'immediately', it becomes a challenge. Where are you gonna take the child? As for many that come to you I can see that you are a 30 year old unit placement and I can see that if I can leave you in that environment, its either you will, they will do more maybe you can lose your life or anything, you will be in danger. So I have to remove you ...where am I taking you? ***It becomes a burden of the social workers*** *and we did nothing". P4*

Being positioned between the legal and institutional space by helping people to practice their individual rights protected by law can thus give us a unique insight into the systemic (mal-) functioning of the welfare sector. In the context of past experiences like the Life Esidimeni tragedy, the state needs to listen to practitioners on the ground, as both the state and practitioners carry responsibility and should be made accountable for their actions. Having these insights should then be seen as a potential point of resistance as it brings an opportunity to expose the (mis-) use of state power through financial prioritizing and to advocate for systemic change.

5.3.1.3 Risk and Resilience.

As the above has shown, social workers have experienced an increased risk to their own mental health due to Covid-19. In addition to heightening levels of distress, anxiety and fear

participants also reported a negative impact on their physical health, as described in the comments below:

> *"Including health wise, (...) since last year and this year, ahh my health, I can feel sometimes it has been disturbed (...) I was sharing that with a friend of mine who I´m working with. Ahh, you must buying vitamin tablets, then I´m not someone who like to drink pills"P9*

Participant two mentioned the onset of insomnia and the need for medical treatment as his levels of stress wouldn't decline (see statement above), while participant eight shared her experience of giving birth earlier than expected:

> *"Oh my God, that time we had a lot of work so I was always driving around. You won´t believe that I gave birth, I came to, (..) it was a Wednesday I was still at work (...) so* ***I feel like that even the stress, it was contributing cause I gave like three weeks earlier****." P8*

Although this study does not explicitly investigate risk factors, the given examples highlight that risk and thereby vulnerability is shaped by different personal and structural aspects. Considering the situational context, it is interesting to note that the male participants (two out of nine) opened up more easily and shared more intimate details about their personal life and mental struggle. The majority of the women remained on a rather generalized level when giving personal information. This could have been influenced by a number of factors. Firstly, the different positionalities of the researcher and participants might have played a role in the participants holding back detailed personal information. The fear of any negative information being disclosed to management could also have been a factor. Furthermore, the gendered dimension of the construction of "frontline workers", who tend to be women, (Pinheiro & Kiguwa, 2021, p. 85) could have had an impact on the women centeringand valuing attitudes of strength, resilience above showing vulnerability. Putting this into the wider socio-cultural context this can be attributed to a broader gendered experience of "madness" where symptoms of mental illness, psychiatric labelling and thus interventions are historically judged according to dominant gender roles and expectations (Diamond, 2014). This not only has a negative impact on women through associating certain characteristics to femininity, but as shown above, might become a barrier to men being heard and supported in their experience of mental distress. The reason that male participants, as well as older women opened up more about their mental state might also be related to the researcher's perceived "neutral" role as an

outsider to the cultural and institutional context. As argued in the previous chapter, the intersections of age, gender and 'race' can have an important impact on how attitudes towards the other might impact the interactions between researcher and participant

Gaining a further understanding of Covid-19 as a new collective and shared trauma, participants highlighted that the trauma caused by the pandemic is not an individual but shared experience, demonstrated by statements of participants eight, one, and seven:

> *"no one was ready for, for whatever was happening, all this pandemic, no one was ready we all just had to find ways to to cope with lots..ah, a lot of people lost family members, a lot of people lost ah friends, family, so it was not easy. I think for* ***everyone, everyone was affected somehow****. It was traumatic for everyone actually." P8*

That social workers and clients share the same potentially traumatic experiences of personal loss was also demonstrated by participant one:

> ***"****Since I lost my mother in 2008. I don't forget. I still believe that when you're still young... need the support and love. But then, unfortunately you have to move on. So, dealing with pain – I lost my grandmother also..I lost my grandfather [due to Covid-19] also, it still hurts. But, you know life needs to go on. (..)I had to stand up and look for something- that's when I applied for a job in Joburg, here. So I had to leave my brother at home..."P1*

Another social worker explained:

> *"it is collective because* ***it doesn't matter whether you are white, black or what cultural...Covid is Covid****. It affects us ah in the same way. So what we are all experiencing is either...or you have a family member who passed on and the family got infected and you also get affected. So everyone ehm, is affected". P7*

As the topic of collective/shared trauma was initiated through the questions asked in the semi-structured interview schedule, it presented a pre-established lens through which social workers could describe their experiences. That all participants agreed on the framing of Covid-19 as a new form of shared trauma could thus be read as approval of the chosen framework, or as being influenced by the desire to avoid the discomfort of disagreement (path of least resistance). Having said this, the social workers expressed their empathy, collective

responsibility and understanding through concern for others, while at the same time trying to uphold their professional boundaries and focusing on their own safety as discussed in 5.3.1.1.

On the other hand, the generalization of traumatic experience eclipses the varying levels of vulnerability shaped by social determinants of health (Baldwin-Ragaven, 2020), including the role of colonialism and apartheid (Czyzewski, 2011). How different live circumstances shape varying experiences of shared trauma under Covid-19 was not reflected on by the participants. The absence of this critical aspect of the study could have been due to the dissimilarities between the researcher and the participants or a general lack of critical reflection on the different factors shaping experiences of shared trauma[10]. The latter could then be seen as a form of oppression-blindness (Current & Tillotson, 2018; Ferber, 2012) because it ignores the structural factors shaping risk and vulnerability.

5.3.1.4 Family, Spirituality and Professional Skills.

Turning to the aspects that helped participants cope with the challenges experienced in their personal and professional lives, factors such as **family** and **spirituality**/ religion stood out while also carrying an ambivalent meaning.

Especially in the early months of lockdown, social workers spent more time than at home and with family. As work-related migration to the urban space is a very common and increasing phenomenon in South Africa (Mlambo, 2018), many of the participants were used to staying apart from their families for long periods of time. This is shown in the demographics of the participants of whom only one was from the Gauteng province. The majority of the participants reported to have moved to Johannesburg in order to find work, but originally come from different provinces. While the social support provided by the immediate and extended family network was a dominant source of resilience, participants also experienced it as a source of distress. As participant six stated: *"I can say the support, the support is from family members. Just talking…staying strong",* she also shared that Covid-19 created fear and distance within the family, saying:

[10] Most participants struggled with the question related to „the different factors shaping their unique experience".

"So even at home, we were very scared to visit our family, we were always stuck at home. When we visit home we were scared, my family was scared about us coming from Joburg. ***They were always complaining****, yo that side, that side eh the number of Covid is very high, so don´t come to infect us. ..." P6*

On the other hand, participant five shared how challenging it was to stay with family for a long time and how it impacted intimate relationships:

"(..)it [staying at home] was challenging at some point, because ***we end up seeing things that we never saw from our partners and family members*** *(laughs). With things you never saw it before, now I´m realizing, oh, when I´m spending so much time with this person, she get irritated, uh, we we we we bore each other fast and so far... it was overwhelming sometimes". P5*

The latter presents another "shared" experience among clients and social workers, as participant seven reports:

"the clients came to counselling after Covid because they lost their jobs (...) and having to ***stay at home permanently with their partners****. That caused also disputes with their partner, which* ***ended up in divorce or separation****. Because now they are fighting with their spouse, the finances and you know when they are always at home and have nothing to do, they just end up picking fights." P7*

These examples highlight that the intimate space of "home" and family became an ambivalent one with the onset of the pandemic. This finding is echoed by Tosone et al. (2021) who found that "home held [a]special meaning, whether as a haven for some or as a place no longer safe" (p.349). The loss of safety can here be attributed to the ever-present threat of being infected through human contact or touch, as well as the increased risk of domestic violence and abuse (Bloomberg, 2021). Additionally, family ties were called into question due to differing perspectives on Covid-19 regulations and their impact on cultural rituals and traditions. Here, social workers did not only report the negative psychological impact on families who were not allowed to bury their loved ones according to important rituals, but also a negative impact on their ability to deal with loss on a personal level. Participant nine for example stated:

"I´ve got limits. (...) even though in the families, because I can remember my aunt was, ***my aunt passed away but I couldn´t even got*** *to the, (...) to the, I was at the funeral but I couldn't get the chance to get inside at the graveyard. I´ve grown up*

in a traditional way. So if someone died, you´ll see that person for the last time, you understand to me every day is like she is still alive. (...) so my sister was telling me no, maybe it´s because you didn´t see her, so you didn´t make peace" P9

When referring to her clients, participant seven recalled similar experiences. She reported that a mother was brought to her office because she developed depression after having to bury her daughter who died due to Covid-19:

*"There was this other lady she was grieving when **her daughter passed on and she did not perform these rituals**. And after, **after the funeral she started acting strangely**. Yes, because she did not have the time to perform whatever they needed. And now they believe that her spirit is still haunting." P7*

The impact of Covid-19 on people´s ability to cope with loss and trauma must thus also be seen in its cultural context. The questions Canham (2021a) asks concerning how to mourn and grief in times of mass dying - how to support and acknowledge each other´s pain in times of social distancing and isolation, are therefore of the utmost relevance. Especially in the South African context he argues, "memorials and funerals provided a collective space for assembling Black affect of grief and rage in the anti-apartheid movement" (Canham, 2017 in Canham, 2021b, p. 3), and therefore carry a political meaning. As a space in which the Black community historically strengthened its ties of kinship and social bonds through practices of mourning, rituals and action, sitting with the body before its burial and the funeral itself became a place of resistance against state oppression (ibid.). Taking away and policing this space through Covid-19 regulations thus has a huge impact on people's ability to cope with trauma and loss. Psycho-social support and other forms of help needed to deal with the long-term impact of the pandemic must thus not only include a trauma-sensitive, but also a culturally informed approach.

A second theme concerning potential coping-mechanisms and support was the turn to spirituality and religion. Three of nine participants explicitly stated the importance of the church as source of community, counselling, and encouragement in their lives (Participant 6, 7, 9). The impact of this support structure not being available due to Covid-19 regulations thus had a tremendous impact for some of them, as participant nine states:

*"It has affected me a lot. I really, because **I can´t go to church**. And when you are alone, even when you know that you can pray, that you can pray alone, but*

sometimes when you have people, you you you get encouraged. But when you are alone, even though you pray and believe that God will listen, but just ***because you are alone you feel like, (...) ah I´m doing nothing****. (...) it's not like the way it used to be, (...) mhmh (shaking head) this pandemic has created, like I´m an enemy to you". P9*

Although this example shows that faith and religion could not be sustained as a potential factor supporting post-traumatic growth or enhance coping (Tosone, 2021), participant six reported different experiences from an awareness campaign in Tembisa:

"they interviewed community members, and some of them they said it didn´t brought lot of trauma because of our supporting system...yes we go to the church, so we know, we knew that everything that what´s happening, its written in the bible, so we are not scared"P6

Being equipped with the **knowledge, skills and resources** around mental health was also reported by the participants as having a positive impact on their abilities to cope and thus could be seen as a factor shaping resilience. That professional identity and training can become a protective factor in regards to mental health and wellbeing is demonstrated by the two following abstracts:

"I think as a professional, sometimes, some of these things when we were learning, we thought maybe we are doing it for, for the sake of clients (..) so by somewhere, somehow ***you realize, what I always tell clients, it can also works for me."*** *P5*

"I would do research, my own research how to deal with this, this and this. You know when you are, ... equipped with information, you can also do it yourself" P4

This finding does not only point to the importance of building resilience within social work training, but to the potential positive effects of working with trauma victims (Abur, 2020; Nuttman-Shwartz, 2015), as well as previous professional experience (Tosone et al., 2012b). The increased impetus to improve selfcare and skill-development can also be seen as having a positive impact on social workers' experiences as demonstrated by existing findings (Bauwens & Tosone, 2010). This also shows that social workers and their clients share ways of coping with the impact of the pandemic, which is an important finding in regards to the shared nature of pandemic related trauma. Even group events held by the organization were

reported as having a positive effect on social workers ability to process their own experience by connecting to their clients as participant nine shared:

> *"we had an event of mental health which I did. It was about how Covid impact mental health, so I did the dialogue where I was asking them questions, so they can share their experiences. (...)* ***It helped me, to somewhere somehow accept that I am not 100% healed****. But sharing that experience that my mother died (...).Yeah, and then* ***there were the same experiences like me, so it helped me a lot to know I´m not alone in this journey****"P9*

5.3.2 The Possibility of Change and Growth

Globally, Covid-19 has had and is still having a dramatic impact on peoples´ livelihoods. Disruptions across global and local food systems, the labour market and public health have left those marginalized and most vulnerable population groups at a disproportionate risk (Chriscaden, 2020). It has brought major changes to every aspect of our lives and as Piccolino (2021) argues "changed everything about what we knew our life to be" while calling into question not only our understandings of life, our but perceptions of suffering in the search for professional and personal hope. The need for and presence of change was also acknowledged by the participants of this study:

> *"so it´s just, we needed to adapt to a lot of changes (...), I would say ah Covid came at a time where no one was expecting that things are gonna change, so in that time we had to sit down and see, so how can we change our, the way we render our services to accommodate our clients in this time that there is Covid. Can we maybe try to make telephonic counselling, but then* ***that was also not possible****, because (..) lack of resources, so (laughing) we, we actually had meetings with the general manager to see how can we change. (..) So it was a time for us to change a way of doing things. So you also need to think fast and, not to use the same way all the time (..) try to, change your way of doing things I would say." P8*

Despite the changing environment and acknowledged need to adopt new professional practices, all of the three examples (above and below) show that the implementation was not

successful and was even potentially harmful as they helped widen the already existing service gap.

> *"we were trying to do phone counselling and so forth, but it was **not effective** as such. Because some they don´t even know where to find us when we are not in the office.(...) it was very difficult, because when you are sitting at home the only people that you reach out is those are knowing your office" P5*

> *"there were times when people were not allowed to come, into the office and we had to do the telephonic counselling, (..) and it is **not effective**. (..) Cause sometimes it´s good when conducting interviews to ah, to check [the] non verbal, especially with kids. (...) And also some people don´t have ...especially our clients, mental, mental (...) they don't have phones."P7*

In contrast to other studies highlighting the positive impact of online counselling as a possible alternative to face to face therapy (O'Shea Brown, 2021; Tosone et al., 2021), this option was shown not conducive to the participant´s situation. As participants highlighted, the lack of resources and preparedness made it impossible for them to keep up with their standards and provide quality service. Participant four expressed this in a metaphor saying *"(...) you cannot cook without your ingredients. That means that you have to try to make something so that you can eat."* The lack of resources within the organization as well as among clients, who were mainly situated in townships at the outskirts of Johannesburg, made it very difficult for social workers to reach existing and potential service users. This shows that telephonic-therapy or telephonic-counselling is "a privilege reserved only for those who can afford a phone, stable internet connection, and/or a laptop" (O'Shea Brown, 2021, p. 237), as well as a safe place where confidentiality and privacy can be assured. Considering the living situations of the clients served by the participants, most of the factors mentioned would not apply. This calls for a socio-political analysis of the determinants shaping clients access to appropriate care.

Looking at the opportunities for personal and professional growth presented by the pandemic, six out of nine participants expressed their gratitude for and the positive impact of additional trainings. Being able to take part in online-trauma counselling workshops, trainings on Covid-19 in relation to personal safety, prevention and its intersection with other diseases, social workers shared a great impetus to learn and push professional boundaries.

Reflecting the findings of other studies on shared trauma, participants also reported the blurring of professional boundaries due to telephonic-counselling and the expectation that

they use their personal phones. While participant three formulated availability as part of the "duty to care" and professional identity, participant two felt its negative impact through not being able to uphold healthy boundaries:

> *"Even if we were at home, late, any time they were calling, you must give them counselling....**to be a social worker** there is not time to go to work, **there is no time to knock off.** You work every time, wherever you go. You must always be available for your clients as a social worker" P3*

> *"we used to communicate with our clients through whatsapp. Yeah, we used our personal, our personal stuff to communicate with clients. (..). I used to receive some calls from clients, I received a call some other time, I can´t , I remember it was around eh eh 11 at night, 11, yeah, or 11 to 12, I can´t stop myself. (..)That day I received this and this and this, and sooo, it's also bad for us to communicate with clients. **It´s bad for my side because I can´t rest**."P2*

The latter example can thus be read in the context of a missing discussion about the limits of "the duty of care" (Cox, 2020), where the agency and management itself carries a responsibility to ensure that additional risks to the mental and physical health of their employees are minimized. Although participants identified the lack of resources as the main problem experienced and barrier to a fulfilling and satisfying practice, they also engaged in a discourse justifying the limited support they received. Participant four for example, although being vocal about the lack of support stated:

> *"when you work for an NGO, you know we don´t have resources, we don´t have medical aid, we don´t have whatsoever, we don´t .... so some things are hard for the, ah, organisation to show support or to render support to the staff" P4*

Talking about the trouble with transport, participant eight further said:

> *"it is stressful, mostly because I think it´s because it is an NGO, like for instance right now we are six social workers and four auxiliary social workers (..) we are sharing like one or two cars, so we struggle" P8*

While participant three in continuation of the above comment stated:

> *"(...) If you are in this field for money you won´t call it, yeah. But if you are here with your heart, you will manage" P3*

Engaging in a discourse that defines altruistic behavior as part of what it means to be a social worker, although unconsciously, can have the effect of justifying the chronic underfunding and lack of recognition of the profession itself. Understanding such "altruistic ideological veneer" (Carey & Foster, 2013, p. 261) within a neo-liberal discourse that promotes the marketization of welfare services, both can become a linguistic devise to legitimize market-led pressure while masking existing structural causes of exclusion, inequality and poverty (ibid.)

Having discussed participants' perspectives on ways of adapting to the pandemic and the realistic possibility of implementing these within the professional domain, it is interesting to share the reported impact on their personal lives. As Tosone has argued in different publications, shared trauma "can lead to permanent alterations in the clinicians mental schema and worldview" (Tosone in Figley, 2012, p. 624). Although this impact might also be shaped by various factors pre-dating the onset of the pandemic, as well as the level of exposure and other contextual aspects, the following abstracts will highlight some experiences:

While participant one for example recalled her increased appreciation for small things in life and empathy for others,

> *"**Covid changed my perception on life** in general and in appreciating things. Like appreciate the little, but appreciate each moment because the moment we are spending now could be our final moment. So we just need to appreciating every moment, and also to be nice to the next person. You don't know what they are going through." P1*

participant nine shared her altered relationship to material/monetary things, as well as to members of her community who have also changed in her perspective:

> *"It has affected me a lot. I don´t sometimes even see the value of money, because you get it today and tomorrow it´s finished. You try to look all around, what have I done with this money, just finished, because most of the things have increased in prices. Taxis, food, medication, everything." P9*

> *"Covid-19 has impacted a lot. People have changed a lot, people have, (..) I, I don´t know how can I say that, **they have understood the world in another way** around them. It´s like people´s life has stopped. People are not, most of the people they are not even interested to listen to whatever you want to say. I don´t know, is*

it about unemployment, is it about, eh, I , I don't know but people don´t seem as interested as they were before.(...)"P9

However, besides the increased chances for employment, participants struggled to identify positive changes or opportunities for the future of social work. For four out of nine social workers it was very difficult to answer the question about future opportunities. Participant eight even said *"I don't see any...can't think of any- just lots of challenges"P8.* An increased sense of purpose or (re-)commitment to social justice and advocacy as found in existing studies (Tosone et al., 2021) was absent or not given priority in all interviews. The invisibility of these topics as well as the personal and organizational self-care routines brings questions about the applicability and commitment to social work values within a state of continued crisis and trauma (Kamnitzer et al., 2021). Acknowledging that access to certain forms of self-care presents in itself a privilege and is shaped by the same structural factors defining risk and vulnerability, mindfulness and peer-support, as well as other creative, spiritual and advocacy practices offer great opportunities to develop collective and individual routines of self-care. As Tosone mentioned in an interview with Siegel (2020), "practice what you preach" in regards to selfcare, mindfulness and resilience. This advice given to mental health professionals seems especially important as participants in this study prioritized physical health care measures themselves.

5.3.3 New Trauma, additional Burden: between New and 'Normal'

Moving on to the last section of this part of the analysis, it is interesting to take a deeper look at the temporal change reported by participants, including the meaning it carries, and considerations regarding the intersection of different forms of trauma.

Throughout the continuous state of emergency which brought with it emergency laws, new surveillance techniques and the governments´ increased impact on peoples´ personal lives, discussions about the "new normal" have been taking place. Although there is, as of yet little academic debate about the concept itself, it might be argued that the impact of Covid-19 has cast the "pre-pandemic normality" in a very attractive light (Lewis, 2020). Having discussed the impossibility of sustainable change and the participants´ difficulty in identifying future opportunities for their profession as well as personal lives, social workers also reported a desire for or an already existent (partial) return to "normal".

"All in all, I think, we are coping – we are coping. Although Covid-19 isn't, that now we don't have anxiety as we were having before when Covid-19 was still new.(..) now we are used to it, received our vaccine, we can even go to work (...) ***we don't have this anxiety anymore*** *to see, what if a client comes with Covid-19.* ***Now we have a better understanding of Covid-19****. Now, compared to back then. That's life, yeah" P1*

"Sometimes I would feel like there is no Covid. There is no Covid, aiih, we we can see the numbers are rising but we are always in the taxi, there is nothing that is happening. (..)So you will always go back to, yo, my uncle passed away but not, I´m no longer scared. Covid is Covid, so yeah"P6

On the other hand, there were concerns about the ongoing nature of the pandemic and its long-term impact as participants nine and five show:

"It´s a trauma, it´s a trauma. Because if it was a crisis, we cannot say it is a crisis. A crisis is something that will end, you know that you can handle it, it will end. But ***a trauma is ongoing****. Remember they were saying, wave four is coming. You see, you don´t know how will it come, how is it going to affect, who are you going to lose, do you understand." P9*

"So that [restrictions in movement] was ahh, ***another trauma*** *that, to be honest, (...) others, others this time we are speaking, they are not living at the stage of a trauma right now, but when time goes on those things are still coming to hit them very well. Cause* ***now people are still dealing with themselves.****" P5*

What is perceived as new or "normal", is further reflected in the intersectional nature of existing trauma in South Africa. The high prevalence of previous and intergenerational trauma caused by political violence under colonisation and apartheid as well as continuing inequality, crime and gender based, sexual violence (Brankovic et al., 2020; Kaminer & Eagle, 2010; Kulkarni, 2019) must thus be seen as part of the "old" and undesirable "normal". Participant one for example states:

"Covid-19 is not something that we knew growing up. ***Growing up, you know there is rape, there is abuse, there is this.*** *But Covid-19 came just out of the blue. So everyone was not expecting it..it was like an accident. You don´t learn that when I go to Maponya (Maponya Mall) I will come across an accident, right." P1*

As this comment shows, awareness and experiences of previous trauma also carry the dangerous potential of normalizing existing forms of violence and oppression by comparing them to new forms of traumatisation under Covid-19. A major mechanism at play in this is the overall de-politicization of trauma, as the pandemic as well as other traumatizing events are not happening in a vacuum but embedded within "human decision-making" (Lewis, 2020). Linguistically, this de-politicization is reinforced through a personalization of Covid-19 ("this Covid") presenting the virus as an active agent engaged in material processes (transitivity analysis). In contrast to the above, participant five explained that some people do not even see a difference between now and them because the presence and "excess" of black death (Canham, 2021b) is not new to them:

> *"We are still busy trying to convince them, go and get your jab. Because they still believe that, ahh, there was death before Covid-19. So* ***when people are dying what´s new?*** *You understand, they don´t see it the way others see it, you understand." P5*

This comment depicts the unsettling reality of many people whose lives were compromised before the start of the pandemic (Baldwin-Ragaven, 2020; Butler, 2004). It reflects what Canham describes in the abstract below

> This moment has continuities with other mass dyings like the devastation of malaria in sub-Saharan Africa, floods that leave bloated bodies in the reeds of Mozambique, draughts that stalk our drying subcontinent, and the massacres that are part of the fabric of our history—from Bisho to Boipatong. If COVID-19 leads to overwhelmed lungs, how different is this from death through being submerged and drowned in floods or in the deathly Mediterranean crossings by Africans reaching for Europe? (Canham, 2021b, p. 8)

and points to the much broader role of social work, namely to critique and strive to change the oppressive structures and socio-political conditions rendering peoples' lives "precarious" (Butler, 2004). The danger and threat posed by Covid-19 can thus be seen as causing one or many traumatizing events which present a new dimension to a continuum of death and trauma. In the South African context current research has established the concept of "continuous traumatic stress" (CTS) which is rooted in studies on mental health conditions and challenges under apartheid (Stevens et al., 2013). Case studies on the exposure to continuous traumatic stress in South Africa show that the concept is valuable in explaining

traumatic stress responses in post-conflict societies as they "relate to violence being a condition of living, rather than a finite past event, for many residents" (Kaminer et al., 2018, p. 3). Along with similar symptoms to PTSD, CTS is characterized by the exposure to multiple violent events across different contexts from multiple perpetrators, while an objective source of danger or future harm continues to exist in the present (Kaminer et al., 2018). In this light, the above excerpts show that pre-existing threats and stressors must be recognized when aiming to understand the traumatic impact of Covid-19 in South Africa. Normalizing the continuous exposure to traumatic stress in the field of mental health endangers professionals' ability to provide adequate trauma-sensitive and context-specific services. Expanding our understanding of traumatic stress "survival" in times of mass dying thus carries the possibility of a shift from an individual to a collective perspective that leaves no other option but to take responsibility for social justice and structural change.

5.4 Unmasking the Functioning of Ideological Hegemony

5.4.1 Making Meaning of ´Problems´ in Mental Health Social Work

In order to uncover how ideology is entrenched in our everyday lives and thus also in social work practice and theory, I want to start this second part of the analysis with social workers' conceptualizations of 'problems' within the field of community mental health care in South Africa. As Fook explains

> The ways in which we assess problems, and the ways we describe and define them are of course integrally connected with the ways in which we construct knowledge of our world. Therefore our understanding of subjectivity and identity, of the nature of knowledge and constructions of power are bound up with how we conceptualise and assess the 'problems' with which we work (Fook, 2012, p. 132).

How social workers understand and construct the problems they encounter, here in the interaction between researcher and participant, thus not only shapes possible treatments or interventions but also gives insight into professional relationships and subject positions (Keddell, 2016). They might also help us to understand how social workers define their role in society, their own identity in relation to their clientele, as well as the context in which they operate.

5.4.1.1 Cultural Beliefs as a Barrier to Care and Understanding.

In four of the nine interviews, participants articulated their views on how cultural understandings of mental health and illness prevent people from getting appropriate help. The importance of the African belief system is in understanding causes of mental illness and trauma is also demonstrated by a study conducted in Limpopo province, South Africa. Nevhutalu and Mudhovozi (2012) show that the culture of a particular society not only governs norms and explanations for mental illness but also defines preferred treatment options and help seeking behaviour. Most Africans, they argue, believe in "supernatural or spiritual causation of illness" and therefore in traditional healing methods, often combined with a dissatisfaction with western medicine that can be seen as undermining "religious and ancestral aspects of the problem" (p. 182).

Concerning the impact of the pandemic and how it is perceived trough a cultural lens, participant five stated:

> *"...culturally, when the virus was said is upon us, we, we, we heard a lot. People are saying you can use this, you can use that and so forth, go get some herbs and so forth that can make you feel better and so forth. The majority died on that treatment, trying to to to think that is the way to deal with Covid. As we are speaking now, culturally again there are still people who think vaccine is not a solution" P5*

Concerning help-seeking behavior of families and clients, the same participant further mentioned:

> *"now when the person is mentally ill... the family is busy trying to look for help in a wrong, what, in a **wrong direction** (...)I´m saying the people are not coming to us who give them **scientific**, what, help. Them, they will be ... going to sangoma, sangoma is the one who will assist on this. And then the person is deteriorating or the situation is worsening in the process of...the person is no longer taking **medication** and so forth (..)They [African people] don´t believe that if you are a mental ill it can be caused of stress or depression, they don´t believe that. Their understanding is that somebody out there doesn't like you" P5*

Similarly, participants one and nine argued:

"because culture it plays a part. You´ll find a person that has schizophrenia is not under ***medication*** *because people believe that the person is not sick but rather the person was bewitched...and that this person will be fine, instead of understanding what is mental health, what is schizophrenia. And that the person has to take* ***medications*** *like that they can be better and* ***do like any other person****.* ***They won´t understand it****, but they would resort to their cultural views (...)" P1*

"Though unemployment can impact, but when you look inside the person´s experience, you get it´s more deeper because most of mental illness, it runs from the ***genes****. (...) [but] somebody would say, noo (higher voice) they have witchcraft, her or him. And then they will take her or him to the sangomas. Then the illness is not cured, but 99% when they take them to the hospitals and they get* ***medication****, they become* ***right, and can join us in the community and work together****"P9*

As one can see from the above examples, culture and cultural understandings of mental health and trauma play an important role in clients' perception of mental health services and help-seeking behavior. The way that social workers made meaning of the impact of culture in this study was heavily related to a "problem-construction", linked with narratives of a lack of understanding or knowledge of mental health. Educational events and awareness campaigns thus appear as an important focus of the organizations' work as they reportedly aim to change peoples' attitudes through the sharing of information. The language used to distinguish between traditional methods ("wrong direction"; "become right") and "scientific" medicine or knowledge demonstrated the existence of dominant discourses. Here, the dominance of a scientific, medical discourse representing a bio-medical model of understanding mental illness (Baltrusaityte, 2010; Waitzkin, 1989), with the de-valuation of cultural, traditional knowledge and treatment, forms a colonial discourse that re-enforces the dialectic of western science and indigenous knowledge. This is not to say that the participants consciously perpetuate a colonial discourse, but rather that they are a reflection of dominant discourses within the professional and institutional space of mental health care. Thus, it can be argued that institutional knowledge and practices are shaped by the dominance of a medical paradigm which, along with other macro-systemic components, determine the available and preferred treatment options (Nevhutalu & Mudhovozi, 2012). As Habermas (cited in Waitzkin, 1989, p. 224) argued, "science is ideology par excellence precisely because it claims to be above ideology, that is objective ad value neutral", thereby de-politicizing social issues by defining them in technical terms in need of technical solutions. In this regard, medicine and its

dominance in other professional fields can become a form of social control if not balanced with other, socio-political perspectives (Diamond, 2014; Waitzkin, 1989). As the psychiatric discourse and conception of mental illness is historically rooted within a medical model (Baltrusaityte, 2010), one critique concerning the medicalization of distress is that professionals within the field "often believe that they are extending the caring function of the medical role" (Waitzkin, 1989, p. 225). In this case, social workers in the field of mental health have a unique role in countering the individualization of mental illness as proposed within a medical understanding. In practice this implies the need to challenge and stretch understandings of mental illness through a critical analysis of the social, cultural and political environment. In addition to the above argument, it is important to notice that the enacted discourses do not exist within a vacuum but can be and are challenged on several occasions as discussed in the following sections.

5.4.1.2 Relapse and the Non-adhering 'Patient'.

A second problem-conceptualization that stood out among the participants working in the outpatient care of adults was the construction of the "non-adhering" or "misbehaving" client (Baltrusaityte, 2010) in relation to increasing numbers of relapsed clients.

> *"While we refer the people to the clinic to take medication, next time **he is using substances again**, so its ...kind of difficult for us to help them. ... the medication is not even working. We can send them to to to psychiatric hospital, after medication, after two weeks the family is coming here again, please help – the person is relapsed again. So we are stuck with the clients and it is very tiring because next time, next week, same person is coming to the office, next month same person." P6*

> *"if we stay in the office, not going to them, they just relapse. The family, when they tell them please take your medication, **they don´t take them serious**. So that´s why it affected us." P6*

> *"most people, most of our clients relapsed because **they don´t want to accept their condition, they don´t want to take their medication**. So most of the clients who come here, it´s like okay our, this person was on medication now it´s no*

longer taking medication (...) there is no one to monitor. Whether these people are taking their medication and then some end up not taking their medication." P7

From the above it can be argued that the subject position of the "non-adhering patient" is discursively constructed through a position of agency, depicting non-adhering behavior as a conscious choice to sabotage treatment goals (Baltrusaityte, 2010), as well as a result of poor insight which is seen as integral part of treatment compliance and positive outcomes (Baltrusaityte, 2010; McGorry & McConville, 1999; C. C. Williams, 2008). The term insight in relation to mental illness is understood here as recognizing that one is mentally ill, the ability to label mental events as pathological, and recognizing the need for or adhering to treatment (Baltrusaityte, 2010, p. 17). In line with the previous discussion, Williams (2008) argues that "judgements of insight are always based on the extent to which patients endorse a biomedical explanation for illness" (p.247). Professionals' perceptions of insight thus often ignore the social experiences shaping the ways in which clients deal with their diagnosis, while carrying the belief that a "lack of insight reflects the absence of complex, reflective thought" (ibid.). In regard to the examples given, the construction of the "non-adhering patient" can be used to obscure the inappropriateness of available treatment options (e.g. lack of choice), structural and socio-political factors shaping the impact and context of diagnosis (e.g. stigma, public attitude, substance abuse as coping mechanism for trauma, institutional underfunding) as well as the responsibility of professionals for inadequate service. On the other hand, understandings of "poor insight" should not only be seen as cause of relapse, but also as justification for paternalistic behavior within therapeutic relationships, thereby undermining autonomy and self-determination which are at the heart of treatment compliance and an emancipatory social work practice. Linguistically this can be observed in the prevalence of active verbs and distribution of agency. In contrast to the arguments made above, that clients are active agents in relapse and not taking medication, it is mostly the social workers themselves and family members who facilitate the processes of diagnosis and treatment with clients as passive recipients.

5.4.2 Professionalism as Source of Hegemony and Resistance

Having shed light on the different ways in which social workers make meaning of the ´problems´ they encounter and how this can influence their practice, this section aims to highlight how a discourse of professionalism (Carey & Foster, 2013) can help maintain and

reinforce unequal power relations, as well as challenge dominant norms and beliefs within the practice of mental health social work.

5.4.2.1 Social Justice in the shadow of De-politicization and Neo-liberalism.

As mentioned above, the medicalization of experiences of mental illness and trauma, can be seen as one mechanism of de-politicization (Goozee, 2021; Waitzkin, 1989), because it understands illness and trauma symptoms as pathological aberrations located within the individual. Scholars from within critical scholarship therefore argue for a re-contextualization and decolonization of mental health and trauma studies (Andermahr, 2015; Goozee, 2021; Mills, 2014). Although participants shared their awareness of contextual issues like unemployment, housing insecurity, poverty and forms of violence, there was little linkage made between the social environment and causes or treatment of mental illness. Participant eight for example mentioned how she observes rising numbers in abandoned children and admitted adults, but could not find any explanation:

> *"Recently we´ve had a lot of ah cases of abandoned babies, firstly.* ***I don´t know what is contributing*** *to that. We also have a lot of parents who have been admitted in mental institutions. (...) so our workload has really, it´s gone up, it´s just paling up." P5*

The statement from participant nine as mentioned earlier also shows that social explanations are de-centerd when aiming to understand the causes of mental illness:

> *"Most of the people they will tell you that, ohh (higher voice) I had the but I was not aware, I thought it was a headache. I thought it was I´m growing up, I think it was because unemployment.* ***Though unemployment can impact****, but when you look inside the person´s experience, you get it´s more deeper because most of mental illness,* ***it runs from the genes****" P9*

Along with the aforementioned reliance on a scientific discourse and treatment methods, it can be argued that medicalization and pathologization are direct hegemonic practices as they serve the purpose of psychiatry, namely "the rehabilitation and reintegration of individuals back into the environment from which they came" (Goozee, 2021, p. 8). In her exploration of why and how to adapt a perspective of decoloniality within social work, Schenk (2019) argues that social work has historically been an "extension of the government" and thus "handmaiden

of the state" (p.32) in both Europe and South Africa. Focusing on the struggle of gaining recognition and status among other professions has led social work to neglect its value and its ethics concerning social justice. As it will be argued, the restructuring of social work according to neoliberal values and the impact of global capitalist macro-economic policies has contributed to this (Lombard, 2019). Therefore, social workers more than ever have a responsibility to question the injustices perpetrated by the status quo and to stop "mediating between the state and the oppressed" by "helping clients cope or adjust to unjust circumstances" (Schenck, 2019, p. 33). As part of a developmental social work approach, which is indigenous to South Africa (Lombard, 2019), this could mean overcoming the historically grown but false dichotomy between micro- and macro practice in social work. Adapting a "dual approach" which focuses on the interconnectedness of social justice and micro-interventions (e.g. counselling, employment measures, empowerment) (ibid., p. 58) could thus be one way to re-politicize social work within the field of mental health. Additionally, this could involve asking question like *why* rates of relapse are increasing and medical treatment isn´t successful. Seeing clients´ "non-adherence" as a form of resistance instead of stolidity or a lack of understanding could also offer much deeper insight into their experiences and needs.

Having said this, it must be acknowledged that Covid-19 has had a huge impact on possible treatment options, especially in regard to social events and support groups. As participant nine stated:

> *"Due to Covid, they don´t allow [holding support groups], so it´s difficult for our people, he, it´s very difficult. (...) I managed to do one event, last month,(..) about mental health, and they were crying a lot, complaining that we are relapsing, because they don´t see each other. And even though I can go and do home visits, I cannot cover all of them, you understand. And then, and they they keep on sharing that it was better that time when there was, they were having support groups" P9*

Shutting down options for psycho-social support due to Covid-19 restrictions thus had a devastating impact as the same participant goes on

> *"So that is why I know that there is Covid, we understand that it kills, but somewhere somehow* ***the closing of those support groups*** *peoples to meet, share their experiences,* ***it kills a lot****." P9*

This perspective was further shared by participant five who observed that:

> *"Many people ended up doing things that they were not supposed to do. We, we understand that majority died by Covid but other ended up committing* ***suicide*** *themselves" P5*

The deadly impact of the pandemic on mental health is a new and important observation that can be seen as a potential point of resistance as it can inform future advocacy and awareness work. Additionally, participant five expressed the structural impact of prioritizing physical health within the national emergency planning. He stated:

> *"You know hospital during the time of hard lockdown, (Pfff breathes out), some of them* ***converted the ward for psychiatry*** *to make it for medical because they were not having space. (..) they convert a ward for psychiatric to make it a what, for emergency and so forth. Us, they didn´t regard us as such, you understand." P5*

With these insights and a constructive critique of the response enacted by the government and hospitals, social workers in the mental health field have a unique position of being able to use their experiences to impact future policy-making and advocacy. Acknowledging the structural dimensions of what causes increased distress, risk and relapse during the pandemic can thus serve as a catalyst for renewed political action and commitment.

One major barrier to pursuing a "dual approach" that links micro- interventions with social justice can be seen in the neo-liberal agenda undermining the ethics and values of social work. As Carey and Foster (2013) argue, the effect of neo-liberalism in social work has led to a shift from a collective state provision of welfare services to individual and family-centred responsibilities. It has also allowed for the growing influence of a private sector including the changing of managerial styles and increased organizational control by output measures and performance indicators (p. 258). Within the context of such reforms, attitudes towards and within the social work profession have altered in ways that increasingly value concepts such as "partnership, competition, a purchaser/provider split, the quasi-market and choice of empowerment" (Carey & Foster, 2013, p. 258), thus defining the role of social workers in terms of efficiency, choice, opportunities and competition. How this effects the quality and context of the welfare services provided is highlighted by Foucault who argues that the power-relations

> in health and welfare institutions contribute towards a market-led 'discursive device' that empowers professionals, not as promoters of needs or advocates of anti-oppression, but instead as eligibility or risk assessors (with new powers of

> surveillance) whilst also placing new responsibilities upon older [and mentally ill] people as self-regulating 'service users'. (Foucault in Carey & Foster, 2013, p. 260)

How such a neoliberal agenda has impacted the participants of this study was evident in their choice of language and topicality. Participant two for example stated:

> *"(...) you know you are working for someone who is supposed to impress someone (...) so to can get funding. As it is so... there is a lot of pressure, a lot of work that we are expected to do. I can feel that there is a lot of work and then Covid blast" P2*

In addition to participant two, participants six, seven and nine also mentioned the existing pressure in regard to meeting their target, which under Covid-19 led to an increasing fear of unemployment:

> *"(...) the case is we working into the NGO, there´ll be, they want stats. Maybe they expect you to have maybe 300 people..you know. (...)And it's difficult to reach our target." P7*

> *"(...) now, I cannot reach as much as I can, as much as I wish. I can have information that I like to share in relevant places with relevant people, but no, no awarenesses, you understand. But at, at the end of the month I have to submit what, stats to the department. My stats, that´s very low. (..) they never said that, but you, you judge yourself, (higher voice) ah with this letter that I´m submitting to these people, they are paying me every month only to see necessary that, (higher voice again) ohh let´s close two offices, you always think." P9*

From these abstracts, it can be read that the pressure social workers articulated is also shaped by the neo-liberal influence within the sector and the control that the management has over their employees. Participant two further demonstrates this:

> *"So if you are failing to get a placement, (..) they they report the case. The department report the case to the general manager of the organisation to say, you guys we referred the case to you, what are you doing, how far are you? You are not doing anything. When the pressure comes to us, us as social workers, it will come via the, the, the protocol just to say the head manager to the service manager to the manager" P2*

Pressure and powerlessness thus put social workers in a position where they are "forced to compete against each other for jobs and scarce resources" which fuels separation and fear by leaving "little room for feelings of human solidarity or collective interest" (Ferguson, 2004, p. 302). Additionally, such strategies "ensure that the worker's skills and knowledge [are] subordinated to the authority of the employer" (ibid., p. 303) causing feelings of diminished control and appreciation among social workers.

5.4.2.2 Powerlessness and Alienation: a potential Point of Resistance.

Another broader impact of the de-contextualization or de-politicization of mental illness and trauma is its alienating effect on social workers and their clients. This alienation can be observed through social workers perceived loss or lack of control of institutional processes and outcomes, as well as in the contradictions underpinning the reality of social workers' practice.

To start with the lack of control, previous examples have shown that participants see themselves as mainly controlled by the acting management, funding-dependency and expected outcome measures as part of a neoliberal agenda in welfare services. As Ferguson argues,

> social workers find they have less freedom and control over their contact and work with clients; they are subject to speed-up, bureaucratic control and regulation; their work activities increasingly confront them and their clients as a set of 'alien' practices. (2004, p. 304)

Participant two expressed these feelings of powerlessness and being 'caught up' in work while explaining how work has created a distance between his partner and himself:

> *"... I used to, to, to talk to my partner, to say (..) this work is is (voice fading) it is creating a distance between yourself and myself. Because I can´t, I can´t say I can just go and I said, by this gate – when I get out of this gate I can feel like I'm a* ***free man****, I'm a* ***free bird****, I'm just moving without any problem. Well, when we are sitting, I will still remember, I have this case, I have to assist this person (...)".P2*

The metaphor of a 'free bird' here describes his feeling in of being caught up and unable to change anything about the current situation. Awareness of the lack of necessary resources provided by the organization and the strong focus on outcome measures (targets, statistics) mentioned earlier can, therefore, be seen as one contradiction navigated by social workers in their everyday practice. Furthermore, the aforementioned dialectic of culture and medicine can be viewed as potential sources of alienation and contradiction. Participant seven for example mentioned how important the support from her own church is and that the closing of church and inability to perform certain rituals affected her, as well as other community members:

> *"(...) for example **our church**, I go to ZCC (Zionist Christian Church) (..)so we no longer, they have large number of people, so we couldn't go there.(..) it is a cultural, traditional church and then we believe that sometimes when we go there we get some we get some holy water for protections"P7*

> *"in **our culture** there must, if the person passed on, the person must, yo, ahh, the body must be prepared and taken to the (..), to be buried at the family grave, but then with this, people did not experience that. They have to go from the mortuary straight to the graveyard.(...) they they believe that they the, they did not burry their loved ones with dignity, how they are supposed to be buried and that they can, I can see it is stressful, it causes more pains and you know discomfort" P7*

As these abstracts show, spirituality and culture form an important part of the meaning making of social workers' experiences. Participant nine acknowledges the influence of performing rituals and thus culture on peoples' wellbeing, while at the same time seeing culture as a major barrier to help (see 5.4.1.1). This shows that "culture can be a double-edged sword [and] because human beings depend on it, its loss becomes a traumatic experience" (Motsi & Masango, 2012, p. 5). From the arguments made above, it can be concluded that culture in the field of mental health can be a risk, as well as a protective factor. This contradiction is a tension social workers have to navigate in their daily practice while balancing their own beliefs and professional identities. Participant nine further expressed this in her confusion about professional values, saying:

> *"(...) it [Covid-19] was affecting a lot a lot a lot. And (..) some of our clients we normally, ehm, forget our profession of social worker, we put ourselves **ubu ubuntu bo**, I give them my phone number, before Covid. (...) If I see someone cry,*

*instead of empathize with her I sometimes sympathize, I **forget my skill of a social worker** and then I go home with the same pain, and work through it at home (...)" P9*

*"I´m somebody, I don´t know, sometimes I feel like (..) **I don´t understand my values**, or whatever as a social worker. (...) this morning I was asking myself, maybe social work was **not my profession**. In the morning today, I felt like maybe the profession is not for me (laughs) **I don´t belong** to the profession" P9*

Her alienation from professional values becomes even more evident in her struggle to adhere to the dominant social work ethics that define parameters of "appropriate" and "professional" help:

*"(...) if I see a client here, Kathrin, who is hungry, very hungry. I have food in my bag, I have food at home, I´m just making an example, this person I can see that she or he is very hungry, I give him or her my food. **To social work it´s not right**, because if that person gets sick out of this food they normal say you´d be held accountability of this sickness. But you see, it is difficult if you see someone is hungry. (...)you´re just doing it with mercy that you understand the pain of being hungry. Then, let me give, because I went though that hunger-, **I understand the the poverty. I´m coming from it**. I understand when someone say let me give a, cause I went through that hunger-, I understand the the poverty, I´m coming from it (...)so when I offer that person food, it causes some, ah in **social work they say it´s wrong**."P9*

What participant nine expresses here is her alienation from the dominant understanding of social work and what professionalism means. She feels alienated in her professional and cultural values that seem to obviate each other, saying: – *"it becomes an overload for you as a human being, unu ubuntu inside you".* Drawing on Ubuntu as another lens through which to understand and question professionalism can thus be seen as a point of resistance, as well as the shared experience of poverty which might forge mutual understanding and connection. On the other hand, alienation and the (perceived) lack of control might become an impediment towards "mutual understanding and unity in the fight against oppression", because "the system places barriers between social worker and client" (Ferguson, 2004, p. 304). To understand this better, this abstract from the same interview also shows that clients feel alienated by the practice or the perceived role of social worker within the community. In the

following situation participant nine reported being rejected when doing door-to-door awareness campaigns:

> *"Because everytime you speak it like, ahhh (higher voice), go, ah go and tell Ramaphosa, aii, ANC. They were not interested in whatever I´ve, we´ve come to share with them. They were interested in the politics (...) I think those elections have affected people, the government elections. I don´t know. P9*

She continues:

> *(...) [so] I keep on moving, there are good days and bad days.* ***There is nothing that I can do*** *and I cannot change their mindset. I cannot even judge them, because I don´t understand,* ***I cannot understand their situation.*** *They´re understanding their situation and circumstances better than me." P9*

Here, it becomes clear that the de-politicization of social work also has an impact on how it is perceived among (potential) clients. Although the interviewee demonstrated her shared experience of having to live in poverty, the topic of politics and its impact on living conditions and wellbeing seems to be a dividing factor, causing clients to feel alienated from the services social work has to offer. An empowerment approach as embraced by many participants, then "implies an individualistic conception of power, which (...) obscures the real power relationships in society, (...) while the state, the real seat of power in society, appears powerless" (Ferguson, 2004, p. 306). Through "measures of support or counselling; coping and surviving [become] the ultimate objective" (ibid.), which render social work complicit with the status quo. In order to realign itself with the values of social change and social justice within the context of South Africa, social work needs to re-think current practices, beliefs and structures. One starting point could be a critical evaluation of the appropriateness of the dominant theories and approaches practiced within the organization and beyond. Understanding the problems and challenges social workers face from a socio-political perspective might open opportunities for (re-)gaining control over their work (and private) lives. At a basic level, this could involve "groups of workers coming together, within agencies or across agencies, to discuss how they would like to work and how they can overcome the constraints imposed by lack of resources and managerialist approaches" (Ferguson, 2004, p. 309). On a theoretical level, it could mean reconstructing and redefining professional values in alignment with cultural values and knowledge, as well as coming to

"understand [how] our own oppression and/or privileges [might] influence our behaviour personally and professionally" (Lombard, 2019, p. 62).

5.5 Conclusion to the Chapter

This chapter was organized into two main sections. The first section discusses the findings concerning social workers' experiences of shared trauma under Covid-19. Dominant discourses of survival and service, but also narratives of risk, vulnerability and the possibilities of change were identified as important themes in understanding the participants' meaning making. In addition to difficulties in adapting to the new circumstances of the pandemic and sustaining quality service, the analysis revealed how institutional limitations have been exaggerated by the impact of the pandemic. The existence of shared stressors and coping mechanisms, but also differences in the experiences of social workers and their clients, further underpin the importance of a critical analysis of shared trauma. The second section focuses on the structural issues that shape social workers' experience in the mental health field and discusses problem constructions, as well as the ambivalence of professionalism. Identifying opposing discourses and the alienating impact of a neoliberal and the medical paradigm defined points of potential resistance while helping to develop recommendations presented in chapter six.

6 Conclusion

6.1 Introduction

This chapter will present a summary of the main findings regarding social worker´s experience of shared trauma under Covid-19. Highlighting the contribution to the field of trauma studies, but also mental health social work, concluding remarks present a basis from where recommendations are developed. Aiming to keep the latter practicable, they will provide important ideas for mental health social work in the context of South Africa and beyond.

6.2 Main Findings

Starting with the first objective of this study which was to:

> *explore how social workers providing mental health services experience the impact of Covid-19 on their personal and professional lives - with regards to the "shared nature" of the pandemic (objective 1),*

the study revealed interesting insights. Applying a method of critical discourse analysis, social workers' meaning making was dominated by the ambivalence of discourses of *service* and *survival*. Recognizing the unique impact and defining features of the pandemic, participants shared increased levels of anxiety and fear for self and others caused by the continuous threat of loss and ill-health. In their professional lives and institutional context, pre-existing and often structural limitations were exacerbated what negatively impacted their overall ability to provide quality service. The decline in quality was hereby reported through the lack of contact with clients (continued or new), caused by an ill-prepared switch to telephonic-counselling as well as the lack of awareness campaigns and support groups. Rotational working and the explained measures further led to an increase in stress levels which impacted participants´ mental and physical health. The analysis further revealed that feelings of personal and professional failure were internalized and individualized, causing some to question their professional choice and identity. For others, professionalism provided a valuable source to keep up boundaries in working relationships, while also offering a potential source of resisting the impact of a neoliberal and Eurocentric agenda in social work practice and theory.

With regards to strategies of coping, the pandemic has challenged existing mechanisms known as having a positive and healing potential. Spiritual practice as well as the space of home and family was identified as carrying an ambivalent meaning. The inability of going to church and be part of the spiritual community left some participants in feelings of loneliness, hopelessness and without the needed counselling previously received. Others experienced the space of home as source of distress and conflict, while family relationships were put under pressure by the impact of Covid-19 regulations (e.g. travel bans and funeral restrictions). Here, the role of cultural and traditional rituals which could not be performed due to government restrictions was reported as having a negative impact on social workers', as well as clients' ability to cope with personal loss. Additional trainings provided by the organisation, as well as the knowledge and skills associated with mental health social work nevertheless helped participants to deal with experiences of distress and loss. With regards to the shared nature of the trauma caused by Covid-19, social workers and clients thus relied on similar coping mechanisms, while being exposed to similar stressors (e.g. isolation, personal loss, fear and anxiety). But besides these similarities, participants experienced a rise in job opportunities stabilizing their economic situation. This presents a major difference, as many South Africans were hit by a wave of unemployment affecting their mental health. Professionalism and empathy were reported as helping social workers to deal with this shared nature of experiences, while (individual) survival remained a main discourse.

Looking at the second objective which was to:

> *critically evaluate what these experiences can reveal about social workers understanding of mental health and trauma (objective 2),*

the analysis has critically discussed problem constructions in social workers' meaning making, as well as the role of professionalism as source of resistance and hegemony. The main focus was here on understandings of mental health, although perspectives on trauma were also shared by participants. Concerning the first, cultural beliefs, as well as the construction of the "non-adhering clients" were identified as important features of social workers´ meaning making. Both were found to be expressions of the impact of a western, bio-medical model dominating ideas about mental health and illness. The broader impact of a neoliberal agenda and de-politicization of trauma and mental health within the field was further found as causing alienation and powerlessness among participants and clients. Having said this, social justice appeared as a silenced or marginalized discourse which has important implications for social work as a profession and theory-based practice.

The third objective of this study, focused on

> *How the structural conditions of mental health social work shape current experiences and future possibilities for the profession (objective 3).*

This aim was here linked to the second part of the analysis and revealed the impact of a neoliberal agenda on social workers' experiences. The chronic underfunding of the sector and a rather reactive mental health care was shown as causing high levels of workload and stress in under-resourced institutions. Especially in the statutory sector, social workers are carrying the burden of disparities between law and institutional capacity for alternative or in-patient care. The dependency on government funds has further created an environment in which a social worker´s impact is measured in statistics and targets. This can not only have a negative impact on the quality of services provided but also undermine the values of the profession, thereby cause alienation and powerlessness visible in high employee fluctuation and low job-satisfaction. Future possibilities are reflected in the recommendations suggested below.

6.3 Conclusions

Drawing conclusions from the above findings and the analysis must highlight similarities to previous research, as well as new insights for the study of shared trauma. Living and working in the same traumatic reality as their clients, participants did not only portray the "ambivalence" of what it means to be an "essential worker", but highlighted how the impact of Covid-19 cannot be understood without putting it into context with (pre-)existing challenges, traumata and life stressors. In contrast to previous studied on shared trauma, mainly conducted in the Global North, the analysis revealed that the constraints caused by a chronic underfunding of the sector has challenged social workers ability to live up to social works' core values under a time of crisis. The ineffectiveness of protective measures and adjustments such as working from home or switching to telephone-counselling can thus be seen as having increased a pre-existing service gap and further compromised people´s mental health. In light of this it is alarming that social workers remain to suffer under the pressure of outcome and budget control, becoming the scapegoat for a structural neglect of the country´s mental health needs. Another contrast lies in the potential for post-traumatic growth and innovation, as well as rising levels of intimacy between social worker and clients. Coping mechanisms like recreational activities, increased political activism, spirituality or social support systems (e.g. family and friends) (Tosone, 2021) further carried a different and more

ambivalent meaning compared to past studies on shared trauma. Recognizing that the impact of Covid-19 intersects with previous and other forms of trauma thus highlights the need for a critical analysis and (re-)politicization of trauma studies in general, and the concept of shared trauma in particular. For social workers in the mental health field this would not only mean to adopt trauma-informed and culturally-sensitive approaches, but to be aware of the multiple stressors and traumas their clients but also they themselves are exposed to. Although professionalism has presented itself as a double-edged sword by functioning as source of hegemony or/and resistance (5.4.2) it could also develop into a source of resilience and healing when involving an institutional culture of selfcare, mutual support and open communication. As shown, social workers experienced similar forms of distress as their clients but felt expected to compromise on their own mental and physical health through their duty and commitment to care. Together with the structural limitation that were in place before the pandemic, the experiences of social workers demonstrated how important it is for mental health to be included in a national emergency response to a global health crisis, while receiving more attention and budget in the national/provincial health planning. Recognizing the increased risk and burden (mental) health professionals had to carry throughout the pandemic would thus include to have a meaningful discussion about the risks, responsibilities and forms of reciprocity that are associated with "being essential". Lastly, this study concludes that social workers are an underestimated resource for state interventions and planning in South Africa. Being situated in the overlapping space of legal and institutional frameworks their every-day experiences offer a special insight into the structural disparities and problems. Especially in South Africa, where the de-institutionalization process of care has been overshadowed by tragedies like the Life Esidimeni project (van Rensburg, 2017), governmental and non-governmental institutions are called to work better together and value the voices and experiences from experts on the ground. Possibilities for future research lie especially in the advancement of intersectional approaches towards the study of shared trauma. Gaining more insights on the different identity- and context-related factors that shape experiences of shared trauma, coping and the development of PTSD, are seen as inevitable for a better understanding of geographic and cultural variations in experiences of shared trauma. Finally, it should not only be an academic endeavour to (re) politicize the concept of trauma but to simultaneously politicize and contextualize pathways for healing.

6.4 Recommendations

In line with the third objective of this study, future possibilities for mental health social work are assessed. The following recommendations are based on the findings of this research and offer suggestions concerning the practice, education, and theory of social work.

For social work practice

As social workers already reported the availability of trauma-counselling trainings, this study recommends the structural implementation of a trauma-informed approach into social workers everyday practice. With regards to the problems identified, such approach would help "to avoid over-pathologizing behaviour and to appreciate the complex nexus between poverty, oppression, and trauma", thus to take a person-in-environment perspective (Levenson, 2017, p. 105). Principles guiding this approach are safety, trust, choice, collaboration, and empowerment. "When infused into practice, this can help to minimize the likelihood of repeating dysfunctional dynamics in the helping relationship and capitalize on the opportunity to create a corrective experience for consumers of services" (ibid, 107). On the other hand, the main findings have pointed to the importance of developing an institutional context and culture in which selfcare, mutual support and open communication about mental health issues are reflected. It is thus recommended to adapt evaluation mechanisms that measure social workers job satisfaction, as this would help to improve the working environment and prevent employee fluctuation.

For social work education

With regards to social work education the study has revealed that it is important to enhance and strengthen students´ analytical skills and critical reflexivity. Taking a look at the problem-constructions social workers have drawn on, issues of power, difference and stigma are very important for adopting an anti-oppressive practice (Dominelli, 2002) oriented towards social justice and change. Part of the latter is thus to advance the decolonization of social work curricula and theory (Schenck, 2019), thereby creating space for students to develop a professional identity and practice rooted in the local context and values. In doing so, social work can redefine its identity and perception as the "handmaiden of the state" (Schenck, 2019, p. 32). Lastly, social work education should include a clear focus on building resilience

skills and resources in students. As Abur (2020, p. 23) argues, it "is very important in order for students to be well-prepared and manage complex issues of their clients in the field of social work such as emotional reaction of clients and work pressures". In a post-conflict society like South Africa, where levels of continuous traumatic stress and intergenerational trauma are affecting a huge part of the population, the latter could include to help students work through own traumatic experiences and advance post-traumatic growth and resilience.

For social work theory

Although the above recommendations have already pointed to the importance of decolonial theory and trauma-informed perspectives, this study wants to recommend the adoption of a "health-inequality approach" in the field of mental health social work.

This is mainly because social workers inhibit a unique position by offering "a social perspective that complements and supports the stated need to address health inequalities and promotes positive mental health within an approach grounded in social justice and human rights" (Karban, 2016, p. 5). Health inequalities are here understood as those inequalities that arise from an unequal distribution of the social determinants of health (SDoH), and are, like other inequalities, presumably avoidable (Kawachi et al., in Karban, 2016, p. 6). Social determinants of health (SDoH) can further be described as "the causes of the causes" which shape a social distribution of common mental disorders, as well as access and treatment options. They thus depict a " higher susceptibility to illness and disease as a product of particular socio-economic and physical environments" (Czyzewski, 2011, p. 1), while recognizing the importance of the social location of individuals and groups. Social workers can thus play unique role in challenging individualized discourses on mental health, treatment and recovery by critically analyzing and highlighting the social, structural determinants of mental health.

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Appendix A: Participant Information Sheet

To whom it may concern,

My name is Kathrin Maier and I am a Masters student in Critical Diversity Studies at the University of the Witwatersrand, Johannesburg. As part of the requirements for my studies I am conducting research on the experiences of South African Social Workers during Covid-19, supervised by Dr. Francine Masson. The aim of this research project is to find out how social workers are experiencing the impact of living and working in the same (shared) traumatic reality as their clients. Gaining a better understanding of the context in which essential services are provided and what challenges/opportunities mental health professionals face, aims to fill a current research gap that can help inform future policy, practice, activism or education.

As part of this project, I would therefore like to invite you to take part in an interview. This one-off activity will take around one hour (60 - max.90 min.) and involve me asking some demographic questions, as well as those concerning your personal experiences under Covid-19. The time and place of the interview will be chosen according to your preference and with strict adherence to all Covid-19 safety protocols. In line with current developments and lockdown restrictions, I will also offer you to conduct this interview online, using a platform you are familiar with. With your permission, I would also like to audio record the interview using a digital device. This recording will be stored in a password protected computer and only accessible for researcher. It will be deleted after 6 years if no publications arise from this work or two years after if a publication is written.

I further want you to know that there will be no personal costs to you if you decide to participate in this project. There will also be no direct benefits or disadvantages if you choose not to participate or to withdraw from the study. If the interview will take place online, I will

nevertheless provide you with a R50 data voucher to compensate for potential costs and to prevent complications due to data availability. Your participation is entirely voluntary and you may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential as I will not be asking for your name or any identifying information, and the information you give to me will be held securely in a password protected computer and not disclosed to anyone else. No one other than myself and my supervisor will have access to these recordings. When representing your participation in my final research report I will be using a pseudonym (false name). In case you experience any psychological distress or discomfort at any point in this process, we will stop the interview or resume another time. If you need some support or counseling services following the interview, these will be available free of charge counseling service provided by an external social worker in private practice, Ms Adelaide Mangena and she can be contacted on 0828414638.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you. The data collected from this research project will be stored in a password protected computer and will be kept for six years. With your permission the data collected from this research project may be used by other researchers. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0)11 717 1408, email hrecnon-medical@wits.ac.za

Yours sincerely,

Kathrin Maier

Student:

Kathrin Maier

Email: 2441135@students.wits.ac.za

Phone: 0633034282

Supervisor:

Dr. Francine Masson

Email: Francine.Masson@wits.ac.za

Phone: 0117174480

Free Counseling Service:

Ms. Adelaide Mangena

Phone: 0828414638

Appendix B: Consent Form

Consent form for Participation in the Research Project:

"All in this together? Exploring South African social worker´s experiences of shared trauma under Covid-19"

Researcher: Ms Kathrin Maier **Email:** 2441135@students.wits.ac.za

I,…….., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
I agree that the researcher may use anonymous quotes in his/her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO

Name of Participant:…….

Signature:……..

Date:……..

Appendix C: Interview Schedule

Self-developed Research Interview Schedule/ Guide_Version2:

"All in this together? Exploring South African social worker´s experiences of shared trauma under Covid-19"

I. OPENING

Welcome. Go through PIS and get signed consent (if not sent via mail). Start recording.

II. DEMOGRAPHIC QUESTIONS (establishing rapport)

a) For how long have you been working as a Social Worker? *(probe working experience)*

b) What kind of work are you doing in the organisation – how does your day look like? *(probe position, type of tasks & clients, workload)*

c) What do you like about being a Social Worker? (probe how she/he/they view the role of social work, professional identity)

III. GUIDING QUESTIONS

a) As I am very interested in how you experienced your work as a Social Worker under the pandemic, I would like to ask you how Covid-19 has impacted your professional life and identity? *(probe changes in working environment, relationships, and identity)*

b) How did you experience the support and safety provided by the organisation? (probe working condition/ support from organisation during Covid-19 in particular)

c) And how would you describe the impact Covid-19 had on your personal life? *(probe changes in personal life, identity and interconnection to the above)*

d) Would you agree with the framing of Covid-19 as being a new form of collective trauma? *(probe understanding of the broader impact of Covid-19 and of traumal)*

e) If you think about the diverse factors that shape(d) how you experience(d) the impact of the pandemic, what are they? – here I am referring to for example age, gender, your living or economic situation. *(probe factors like age, 'race', location, spirituality, family, economic situation, etc.)*

f) And how did you navigate or cope with these changes? (probe coping strategies, support system and stumbling blocks)

g) Lastly, what challenges and opportunities would you say has the pandemic brought to the forefront concerning the status and future of the profession (Social Work)? *(probe structural challenges, need for change, lessons to learn, role of Social Work, future vision)*

h) Are there any other comments or information that you would like to share with me?

IV. CLOSING

Thank Interviewee – remind of free counselling service and contact on PIS – offer sharing of RR. Stop Recording.

Researcher/Student: Kathrin Maier

Phone: 0633034282

Email: 2441135@students.wits.ac.za

Appendix D: Ethical Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Maier

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H21/08/16**
PROJECT TITLE	All in this together? Exploring South African social worker's experiences of shared trauma under Covid-19
INVESTIGATOR(S)	Ms K Maier
SCHOOL/DEPARTMENT	Centre for Diversity Studies/
DATE CONSIDERED	20 August 2021
DECISION OF THE COMMITTEE	Approved Risk Level: Low
EXPIRY DATE	27 September 2024

DATE 28 September 2021 **CHAIRPERSON** (Professor J Knight)

cc: Supervisor : Dr F Masson

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to submit an amendment of the protocol to the Committee. **I agree to completion of a regular progress report. For Minimal and Low studies, this is due annually on 31 December. For Medium and High Risk studies, this is due twice annually on 30 June and 31 December.**

Kathrin Maier
Signature

08 / 10 / 21
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix E: Ethics Training Certificate

CERTIFICATE OF COMPETENCE IN RESEARCH ETHICS

Name: Kathrin Maier

Student/Staff No: 2441135

Date of Certification: 02 June 2021 - 01 June 2024 (This certificate is valid for a period of three years)

TRAINED BY:

PROFESSOR JASPER KNIGHT
(RESEARCH ETHICS)

SIGNATURE

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

ISSUED BY:

DR ROBIN DRENNAN
(DIRECTOR: RESEARCH
OFFICE)

SIGNATURE

This certificate is confirmation of successful completion of a training course in Research Ethics for Non-Medical human research, based upon achieving a minimum level of competence in different assessment tasks.

Appendix F: Reflexive Journal Excerpt

Day 3 21-10-2021

Today felt like another step forward – yesterday afternoon I managed to contact all potential participants and fixed the time. My Bf and me woke up early and met the social workers at the XYZ already around 8.30 (he drove me, as Uber wouldn´t go into the area they told me). It was a warm welcome and both were dressed nicely. The first participant was really talkative, honest and open – I was glad that topics like GBV and traditional understandings of MH came up – this interview actually took almost an hour and at the end he even started to ask me about my experience what was quite nice and I let it happen because I felt it helps to make it become a rather mutual activity, thereby strengthening my interest etc. As the second interview therefore took only about half an hour - I really have to say that I think men are somehow more comfortable and open with me than women. It feels like they open up more and are not as nervous as the female participants. In the second interview it was rather challenging to get any personal information and sometimes my question seem to be "inappropriate" or too deep, making me feel like crossing a boundary or so. It actually makes me uncomfortable asking the questions in the name of researcher consistency – knowing that I have to explain them (one specific question) again or reframe them in some more understandable way. I literally think that the best information came from me asking and reframing some of the questions, because everyone has a different level of concentration, focus, nervousness and capacity to reflect. I assumed it would be good to have questions that make participants think and reflect – but being nervous nevertheless gives them the pressure to answer quickly what sometimes creates tense and weird situations. I then try to spread some calmness and warmth – telling them to take time if they want. I also felt that follow up questions sometimes let them think I have problems understanding what they mean, so often they simply repeat what they said. Some of the participants actually asked me to give them the questions beforehand so they could prepare – or pointing out that it would have been nice (after the interview). I think they don´t want to say something "wrong" – although there is no wrong or right. This kinda shows how difficult it is for some to answer spontaneously. Nevertheless, the third interview for that day was also really interesting!! Although the woman only started recently she was very honest about her gain in finding a job as mental health professional during the pandemic – on the other hand it became also very emotional when she told me about all the loss and fear, as her husband was very sick with Covid. Interestingly the topic of grieving and funerals/customs/traditions came up what made me

really happy ...as it reflects what I covered in the literature review. It showed me how theory and practice are connected and that my understanding or preparation is not totally distant from what social workers actually experience(d). All in all I had to think a lot about the VERY DOMINANT meaning and importance of medicine/diagnosis and a medical discourse!!!! Especially because social workers are somehow the link between medical institutions and the families/ people involved. The traditional understandings are seen as a lack of education and barrier to MH services, thus as something backwards ....that can be overcome by awareness &education campaigns.