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Exploring the Experience of Community Health Workers operating in Contexts where Trauma and its Exposure are Continuous

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691-045

A research dissertation submitted to the Department of Social Work,
Faculty of Humanities at the University of the Witwatersrand, Johannesburg
in fulfilment of the requirements for the Master of Arts by dissertation only.

July 2014

Declaration of Originality

I, Kirsten Jean Thomson, hereby declare that this thesis entitled “Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous” is my own original work and that all references to other sources and other author’s work have been properly cited and referenced. All interviews were conducted by me.

Furthermore, this dissertation has not been submitted previously for any other degree or examination.

Name

Date

This study is dedicated to all the Community Health Workers rendering services to patients in spite of the adversity they face in their daily lives and work. Thank you for your commitment and passion to assist the communities in which you work.

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Abstract

Violent and traumatic events are a regular occurrence in many South Africans' lives. The term 'continuous traumatic stress' was coined by South African anti-apartheid health professionals in the 1980's to explain the continuous nature of violence and trauma happening within the country. Although the political agenda may have shifted, many South Africans are still living within a context in which violent and traumatic events regularly occur. However, little is known about how health workers respond to continuous trauma within the South African setting.

The Community Health Workers - within this study - are part of the South African health model called 'Primary Health Care Re-engineering' that is currently being piloted. The research was exploratory in nature and used a mixed methods design. Twenty three Community Health Workers who participated in the study were from two sub-districts within the Ekurhuleni district, Gauteng, Johannesburg. The research included two face to face semi-structured individual interviews. The first included qualitative questions and completion of the quantitative Stressful Life Events Screening Questionnaire (1998) to explore past trauma experiences. Over a seven month period, the participants were asked to document traumatic event exposure and responses through the adapted Life Events Checklist (1995) and personal journaling. At the end of this period, participants were interviewed again to explore their current traumatic experiences.

Qualitative data were analysed through thematic content analysis and quantitative data were used to substantiate information from the interviews and checklists. Results show that Community Health Workers – within this study - have a high prevalence of exposure to traumatic events (directly experiencing, witnessing and hearing about). Prominent events included physical and sexual assault, transport accidents, fires and explosions. Media played a powerful role in exposure to events. Traumatic and unexpected losses were key experiences that need to be considered when working with trauma in the South African context. Acknowledgement of experiences (peer and external) is an essential element in developing support structures. These findings – from the context of Ekurhuleni, South Africa - contribute to exploring and understanding the experience of 'continuous traumatic stress' for Community Health Workers.

Key words: Continuous traumatic stress; Community; Trauma; Mental Health; Community Health Workers; Primary Health Care Re-engineering

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List of Acronyms

AIDS - Acquired Immune Deficiency Syndrome

CBO – Community Based Organisation

CHW – Community Health Worker

DESNOS – Disorder of Extreme Stress Not Otherwise Specified

DOH – Department of Health

DSM – Diagnostic Statistical Manual

HIV – Human Immunodeficiency Virus

NPO – Non-Profit Organisation

PHC – Primary Health Care

PTSD – Post Traumatic Stress Disorder

SASH – South African Stress and Health Study

WHO – World Health Organisation

Chapter One: Introduction

1.1. Background to the study

Violent and traumatic events are a regular occurrence in many South Africans' lives. The term 'continuous traumatic stress' was coined by South African anti-apartheid health professionals in the 1980s to explain the continuous nature of violence and trauma happening within the country at that time. The life threatening events were often linked to a political agenda. Although the political agenda may have shifted, for many South Africans they are still living within a context in which violent and traumatic events regularly occur. There is still debate as to whether 'continuous' is a useful description for the regular occurrence of events and whether 'continuous traumatic stress' is an overarching concept or whether a distinction should be made from other complicated traumatic stress conditions (Straker, 2013).

Acquiring definitions that describe these experiences are relevant for those who are working and living in communities where violence and trauma are ongoing, as it both validates their experience and assists in ways of managing the events within the broader context. Community Health Workers are one of the groups that are exposed to trauma in their own lives as well as to others' trauma in their daily work. Generally the health care service cares for the sick and weak. The role of the community health worker in this system is to care for the most vulnerable as they visit people in their homes and shacks to give them health advice and encourage them to attend the clinic when necessary. As the community gets to know the Community Health Workers better, so the community members start sharing their personal stories, which often involve descriptions of traumatic experiences.

This dissertation explores the trauma that Community Health Workers (CHWs) are exposed to in order to better describe the actual context in which they are working and living. The dissertation also reflects on these experiences in order to build on the emerging literature on 'continuous trauma'. This chapter provides an introduction to the statement and rationale for this research with CHWs as part of the Primary Health Care Re-engineering Model. It also provides a list of definitions of the key concepts that were explored and discussed in this study. The aim and

objectives of the research conducted are outlined, the methodology described, and lastly, there is a synopsis of the chapters that follow.

1.2. Statement of Problem and Rationale for the Study

The South African Stress and Health Study (SASH study) in 2007 is “the most comprehensive psychiatric epidemiological study conducted in South Africa to date and, amongst other aspects of mental health and disorder, it has noted national prevalence data on trauma exposure and PTSD” (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008, p.1589). The SASH study highlights that 75% of the sample (4351 adults) had experienced some traumatic event in their lifetime. The “findings reveal the majority of South Africans do not experience just one traumatic event. Rather, individuals in South Africa experience multiple traumas. This finding highlights the fact that “traumatic events usually do not occur in isolation” (Williams, Williams, Stein, Seedat, Jackson & Moomal, 2007, p. 852). This speaks to the continuous nature of experiencing violent and traumatic events that seem to be a normative rather than extraordinary experience (Evans & Swartz, 2000; Hamber & Lewis, 1997). These data indicates that trauma cannot be addressed as one or a series of finite events. The concept of trauma exposure (whether a single event or a multiple number of experiences) is often described as past and finite in trauma theory and practice, but there is a continued growing awareness and dialogues about the complexity and continuous nature and exposure to trauma in South Africa (Eagle & Kaminer, 2013; Straker, 2013; Benjamin, 2011; Benjamin & Crawford-Browne, 2010). In many South African community contexts, people who have experienced trauma live with a real and ongoing threat of trauma. The threat and ongoing reality of trauma affects how people live and cope, both individually and collectively. Potential continuous exposure to violence at a community level as well as individual experiences of traumatic events is the context for many of the CHWs who are caring for people with HIV/AIDS within South Africa (SA). In order to capture and respond to these experiences, it is necessary to explore the concept of ‘continuous trauma’.

1.2.1. Exposure to violence within health care settings

Interestingly, the majority of workplace violence research has been conducted within the health sector (Bowman et al., 2009). When linking in with international developments, healthcare workers are recognized to be at risk for workplace violence exposure and victimization in South

Africa (Bowman et al., 2009; Di Martino, 2002). As there is an increased movement of 'task-shifting' towards a decentralized model of care in the South African public health system, there is an increased reliance on CHWs engaging in and working within the community (Swartz, 2013). Hence, there needs to be awareness of the level of exposure to violence and victimization that CHWs may face in their workplace in order to support and train them effectively.

"Viewing CHWs as a homogenous and unchanging resources in the provision of health care, rather than as a complex and dynamic group of people with varying investments in health care practices, narrows the public health vision of CHWs and their work" (Swartz, 2013, p. 140). It is important to note that both health workers and community health workers are not a homogenous group so attention to the differences between experiences in clinics and in the community, as well as experiences, engagement and the understanding of individual health workers needs to be distinguished. Research has examined the relationship between exposure to violence, mental health and violent behaviour and suggests that high rates of exposure contribute to increased risk for mental health problems (Flannery, Singer, Jenkins, van Dulmen, Kretschmar & Belliston, 2006; Carlson & Dalenberg, 2000; Farrell & Bruce, 1997; Singer et al., 1995; Widom, 1989). This is further explored in chapter two on describing violence, especially community violence and the research linked to black women as many of the health care workers are black women.

1.2.2. Context of Primary Health Care Re-engineering Model

The community based health model called 'Primary Health Care Re-engineering' is currently being piloted in South Africa by the Department of Health (DOH). This approach proposes delivery of primary health care (PHC) services via an outreach team (of community health workers) at a household level (DOH, 2011b). This service is to be provided in close association with facility based health services, other sectors and government departments, community based organisations (CBOs) and non-profit organisations (NPOs) providing community based services (DOH, 2011c). Although health workers have worked within communities within South Africa for a number of years, a national standardized training programme for this specific cadre of workers is currently being developed within this model. CHWs' roles entail visiting homes in the community (rather than being based at clinics).

Community health workers have a hundred year long history of working in South Africa. In the period between the 1970s and 1990s the CHWs were paid by the government and afforded job security and remuneration. In 1994 (democratic South Africa) the CHWs were not initially included in the formalized national health plan (ANC, 1994). In 2004, the CHW policy framework was established and adopted but there was no stipulation for a salary for these workers, rather just a small stipend (Swartz, 2013; Schneider, Hlope, & van Rensburg, 2008; Lehmann & Sanders, 2007). “It is also imperative to recognize the marked and painful ways that health care policy, including the CHW policy, has failed to appreciate the particular difficulties and hardships associated with living and working in poverty that characterize the daily lives of CHWs working in Khayelitsha and other impoverished contexts” (Swartz, 2013, p. 146). Swartz (2013) talks specifically about a community of CHWs in Khayelitsha in Cape Town, yet her statement transcends contexts across South Africa, especially linked to the primary health care re-engineering model as this model also promotes access to people who are from the same or close by community to be community health workers. Hence, this position of CHWs serving their own community also exposes them to the same experiences as those of the patients and clients that they serve, including, scarcity of resources, employment and social & health care.

The National Department of Health’s strategic plan calls for Primary Health Care (PHC) Re-engineering (DOH, 2011b). Within this new model: counsellors, home based carers, and potentially, child and youth care worker roles within clinic settings will be integrated into the ‘community health worker’ (CHW) role. The CHW will be based within a team, within a ward within a community. The main focus of PHC Re-engineering is to strengthen district health systems and to place emphasis on community based service which includes offering psychosocial support and preventive services. The link to the concept and strategies of social development can clearly be seen in this model as it is community based and relies on inter-departmental, community and NGO interactions in order to promote social change and people’s welfare, even though the focus is health. The seven core generic roles of the CHW are: Promote health and prevent illness; conduct structured household assessments to identify health needs; provide psychosocial support to community members; conduct community assessments and mobilize around community needs; identify and manage minor health problems; support a continuum of care through service co-ordination with other relevant service providers, and support screening and health promotion programmes in schools and early childhood development centres (ECD). Each of these seven roles

is to assist with improving access and delivery of primary health care in the areas of Maternal, child, Women's' health; HIV and TB; Chronic, Communicable and non-communicable diseases and Violence and Injury.

The link to the clinic is a critical component in the success of the community health worker programme. The attitudes and the interactions of the health personnel with the CHWs create a supportive or unsupportive environment for the work (Lehmann et al. 2007). The World Health Organisation (WHO) (1990) recognizes that health professionals often perceive CHWs as lowly assistants, misunderstanding their role to promote and develop health within the community. At times this misunderstanding comes from CHWs being volunteer workers, so their significance to the system or programme is seen as less. In the report by Lehmann and Sanders (2007) it is reported that money can bring problems as money may not be enough, or workers are not paid regularly or money may be stopped altogether and there may be issues between development workers who are paid and those that are not paid. This is a contentious issue though it is important to recognize that "CHWs are poor people, living in poor communities, who require an income" (Lehmann et al., 2007, p. 24). For many CHWs, they are the breadwinners in their families.

Although the focus is on the health of people, the CHWs may be confronted with domestic violence; child abuse, and community or gang violence (Miller & Rumussen, 2010; Williams, Williams, Stein, Seedat, Jackson, & Moomal, 2007; Lehmann et al., 2007). In terms of their roles: "provide psychosocial support" is the one that is highlighted in terms of this research because as well as the exposure to violence/trauma that the CHWs may experience, they are also expected to "provide psycho-social and supportive counselling" as well as "post-trauma counselling" (DOH, 2011b, p. 6). In this capacity, CHWs are exposed to continuous and severe levels of trauma, yet there was little relevant literature on the issue. This study aimed to fill part of this gap, and hoped to inform the training programme to more accurately meet the needs of these specific workers. This research investigated the experience of continuous trauma of community health workers (what they experienced and how they coped) and provided some guiding points that may influence planning and developing of community-based programmes in South Africa.

1.2.3. Theories that facilitate understanding of the community and social context

A broader understanding of the South African context of this Department of Health model as well as the engagement of the CHWs within the community is useful from a social work perspective. Social work has a relevant and valuable focus not only on the individual but also on group and community work. This is useful when understanding the context of a national community intervention. Therefore the theoretical frameworks for this study included social work development theory, Bronfenbrenner's social ecological theory and current typologies that describe and define trauma.

1.2.3.1. What is social development?

"The social development approach transcends the debates about residual and institutional welfare by encouraging the adoption of social programmes that are primarily concerned not with providing remedial social services, but with enhancing the capacities of vulnerable/marginalized people to participate in a productive economy" (Midgley & Sherraden, 2009, p. 437). Participation is key to this approach – not only that of people, but also of government departments, community and faith-based organisations. "Inter-sectoral collaboration takes place between other government departments who are partners in promoting development such as Departments of Health, Justice, Safety and Security, Education, Labour, Public Works, Housing, and Sports and Recreation" (Patel, 2003, p.5). Social development and Social Welfare are not seen as isolated concepts but ones that link in with other areas of a person's life, for example, health and economic development. Hence social development and the PHC re-engineering community focused health model are closely aligned and linked. The focus on interdepartmental planning and service delivery ensures the prevention focus which attempt to alter the broader community issues such as poverty and dependency that contribute to the environment in which traumatic events are experienced (Miller et al., 2010; Silove et al., 2010; Patel, 1992). This collaboration also goes further, as it is not just interaction between government departments but also working together with non-governmental organisations (NGOs), informal and commercial sector organisations and businesses as well as including and encouraging community participation and involvement.

The link of state and civil society is a key theme in developmental social welfare and thereby recognizes the historical role and involvement of the voluntary sector, the non-profit sector

currently plays a pivotal role in delivering community based development programmes (Patel & Wilson, 2003; McKendrick, 1990). In 2006, there was an agreement between government and the NGO sector that critical areas for effective social service delivery include: determining norms and standards for practice; building human resource capacity; designing and maintaining a comprehensive data base for social service delivery; having a human resource plan for the sector and strengthening the partnerships between government and NGOs (Gauteng Social Welfare Summit, 2006). With the use of NGOs in service delivery for other areas, such as health, the above critical areas are also relevant and necessary to implement.

This being said, in a critical review of the White Paper of Social Welfare (1997) and its implementation, Lombard (2008) states that “the White Paper for Social Welfare (1997) did not elucidate concepts clearly enough. It omitted to define concepts like ‘developmental social services’ and ‘developmental social work’” (Lombard, 2008, p. 158). This caused confusion both in the actual implementation of service delivery and in the evaluation of such services. However, “Ten years later, it can be said that the implementation of the White Paper for Social Welfare has been effective as far as reshaping social welfare policy is concerned” (Lombard, 2008, p. 166).

1.2.3.2. Themes in developmental social welfare

Patel (2005) describes five key themes for developmental social welfare in South Africa as: the rights based approach; the inter-relations between social and economic development; democracy and participation in development; social welfare pluralism (including both the government and civil society in social development); and reconciling the micro-macro divide developmental theory and practice. In social development, there is a strong focus on social change and economic change. Any community programme – including the PHC re-engineering model - can benefit from these themes and guidelines as the beneficiary (e.g. patient/client) is the focus of the approaches and the reason for the service. It also encourages the involvement of the beneficiary in the development of the service which is central for any community model or programme. However, it is important not to dismiss the influence of exposure to and experience of traumatic events and the effect these have on achieving both social and economic change.

A rights based approach is integral to any community programme in South Africa and needs to be looked at from both the workers’ perspectives and from the perspectives of the recipients of a

service. This research will not concentrate on economic development, but it does recognize its importance and close link for any broader community intervention to be effective within a broader societal perspective. As mentioned above, the working together of government departments and civil society is of utmost importance and this is evident within the primary health care re-engineering model (which will be discussed later) and within the structure and type of work done by the CHWs and social workers. And the last aspect of bringing together the micro and macro is essential as the approach is both people-centred and participatory, including all systems, while strengthening the decision making ability of all involved. Hence this approach is inclusive and progressive in nature so that the empowerment and capacity of people can be enhanced.

1.2.3.3. Working in the community

In understanding the profession of social work, it is important to note that social work has three main avenues of service delivery: case/individual work (could be a practical, grant or therapeutic focus); group work (the focus is on working with smaller groups – could be therapeutic, educative or supportive) and community work (with a broader community change and development focus). All social workers are broadly trained in all three areas, before they specialize in an area that connects with their skill and interest, yet always holding in mind the larger context and the system connections of an individual to a group (eg. family) and to a community within the South African society (Bronfenbrenner, 2005; Payne, 2005; Hepworth & Larsen, 1990). Through this, social workers are encouraged to always challenge structural sources of poverty, inequality, oppression, discrimination and exclusion, irrespective of the intervention level (Lombard, 2008). McKendrick (2001) proposes that social workers can make an effective contribution to developmental work as he states that social workers have well developed skills in developmental group work, they have community work expertise, a proven ability to advocate on behalf of others, and they are trained in programme design and evaluation skills (McKendrick, 2001).

A crucial aspect of community work is developing and using the principles of empowerment and participation which links directly with the themes of social development as discussed above. According to Payne (2005), approaches within community work include: community development (promoting services in the interests of the community), political action (encourages disadvantaged groups to present their views), programme development and co-ordination (promoting new services and more effective co-operation of services), planning (effective planning of services) and

community liaison (promoting better links between agencies and individuals with similar interests). These approaches are useful in any community programme, whichever community or department they are delivered from and provide a useful framework when exploring the context of the community health worker's context. It again highlights the essential need for inter-departmental collaboration as each department has something to share, guide and learn from other departments. Social workers can both use and share these skills and approaches with others in the community and in other departments, organisations and programmes in order to enhance service delivery to community members.

Integral to implementing services or programmes into a community, is an understanding of the community – as best as possible - in terms of its structure, history, services available and its current needs. All too often, the political and violent history of the community and current violent context is not taken into consideration, yet this has a huge impact on peoples' current lives and thereby on service implementation and delivery. This research seeks to better understand this context of historical and present violence and trauma in which CHWs live and work. With information on current levels of trauma exposure, this may guide and develop health and social programmes implementation and delivery approaches for both the workers and the beneficiaries.

1.2.4. Typologies of trauma

The descriptions of the typologies of trauma set a context within which this research is situated. This research challenges the overarching use of terms such as 'post-traumatic stress disorder' in the South African context and explores the relevance of other descriptions to understand and respond to the experience and context, such as 'continuous traumatic stress' (APA, 2013; Straker, 2013; Higson-Smith, 2013; Kaminer & Eagle, 2010; Horowitz, Weine & Jekel, 1995; Herman, 1992). These typologies will be discussed in more detail in Chapter Two: Literature Review.

1.3. Primary Aim

To explore the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous

1.4. Research Questions

1. What is the extent of traumatic exposure experienced by Community Health Workers when working and living within the Ekurhuleni district?
2. How do the Community Health Workers respond to an experience of being directly or indirectly exposed to a traumatic event?
3. How do the Community Health Workers cope within the context of ongoing trauma?

1.5. Key Concepts

Violence: The intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (World Health Organisation, 1996).

Exposure to Violence: includes being a witness to violence, hearing about violent events or being victimized by violence (Scarpa, Hurley, Shumante & Haden, 2006; Singer, Miller, Guo, Flannery, Frierson & Slovak, 1999; Singer, Anglin, Song, & Lunghofer, 1995).

Trauma: From Greek: to wound, to pierce; 1) an injury to living issue caused by an extrinsic agent, 2) a disordered psychic or behavioural state resulting from mental or emotional stress or physical injury (Merriam Webster Dictionary, 2012).

Traumatic event: In the DSM 5, a traumatic event is described as “exposure to actual or threatened death, serious injury or sexual violation.” (APA, 2013, p. 271).

Continuous trauma: “survivors are in a situation where there is great risk of being re-traumatised” (Straker & Moosa, 1994, p. 457).

This is the term being explored in this research. To date continuous traumatic stress has been described as multiple and ongoing traumatic events. There is an experience of repeated traumatic events against a background of ongoing danger so the threat is current and real; safety is difficult

to establish; there is a lack of trust in state systems of protection and help; and there is a threat to family and community networks and systems (Healey, 2003; Murphy, 2004; Stewart, Murphy & Thomson, 2005).

Vicarious trauma: the cumulative transformative effect on the helper from working with survivors of traumatic life events (McCann & Pearlman, 1990).

Coping: For the purposes of this study, 'coping' will be described as "dealing effectively or contending successfully with a person or task, managing successfully, or dealing with a situation or problem" (Fowler& Fowler, 2011, p.254). Or it could be defined as "a process whereby a person successfully deals with a problem and life situation" (The New Dictionary of Social Work, 1995, p.15). It is recognised that 'coping' can also be described as having a negative impact and this will be further explored in chapter two in the literature review

1.6. Overview of the Chapters

1.6.1. Chapter 2: Literature chapter

Chapter Two consists of the literature review which discusses the history and current experiences of violence and trauma in South Africa, including descriptions of workplace violence. Further, the different terms that are used frequently in the trauma literature are described including, post-traumatic stress disorder (PTSD), Disorders of Extreme Stress Not Otherwise Specified and Complex PTSD. The exposure to violence and daily stressors in everyday life is explored, followed by a broad discussion about the use, description and relevance of the term 'continuous traumatic stress' both broadly and in South Africa. Theories exploring violence in the work place are considered, with a particular focus on the health care setting. Literature on coping styles, meaning making and resilience is discussed.

1.6.2. Chapter 3: Methodology chapter

Chapter Three presents the method section which considers the aim and research objectives that the study investigated and the manner in which both analysis and interpretation were conducted. It explores and describes the mixed methods design chosen so that the quantitative data supports and elucidates the detailed qualitative data. Twenty three people participated and each person

was interviewed twice (46 interviews). It also describes the tools used and the research process followed in detail. This chapter provides an overview of the ethical considerations for the research conducted and provides a discussion of the researcher's use of reflexivity especially in understanding the subjective nature of qualitative research. The strengths and limitations of the study are also described in this chapter.

1.6.3. Chapter 4: Results and discussion

Chapter Four presents the results and discussion, which provides an overview regarding the emergence of the themes and experiences (from both the quantitative and qualitative data). It is structured in line with the three research questions. It describes both the past traumatic events that participants have been exposed to as well as the current traumatic events that this group of CHWs were most exposed to at the time of the study. The description and discussion is further developed in terms of indirect exposure (witnessing and hearing about) at a community, work and media level. The responses to traumatic events are described, with a focus on experiences of safety and lack of safety. Both issues of coping (and not coping) as well as support are discussed, with a focus on the importance of acknowledgement. Although the context of Primary Health Care Re-engineering is not a specific objective of the research, it is the context in which the Community Health Workers operate so key points that emerged from the research are noted here.

1.6.4. Chapter 5: Main findings, conclusions and recommendations

Chapter Five provides an overview of the main research findings, linking the research objectives and drawing from the themes and data presented in the results and discussion chapter. The main findings are reviewed in light of the current literature in an effort to contribute to the conceptualization of "continuous trauma" in South Africa. Conclusions are then drawn. Programmatic recommendations may inform continued planning and development of the Primary Health Care Re-engineering Model.

1.7. Summary

This chapter provided the introduction to the research study that was conducted on exploring the experience of Community Health Workers operating in contexts where trauma and its exposure

are continuous. It also provided definitions of certain terminology within the research and a synopsis of the chapters that follow.

Chapter Two: Literature Review

2.1. Introduction

This chapter explores the thinking and concepts around understanding violence and trauma and their impact for Community Health Workers (CHWs) working within the Primary Health Care Re-engineering model. The Department of Health re-engineering pilot model is a community intervention utilizing CHWs. The chapter begins with the legal and theoretical framework of the overall study. Taking into account the South African context, this chapter defines violence and trauma. The chapter explores the different diagnoses and descriptions that are used to explain the impact of trauma and violence, with an emphasis on ‘continuous trauma’ and how this is currently understood in the literature. It also looks at the theory around coping and the exposure of violence within health care settings.

2.2. Theoretical and Legal Framework of the Study

As this research was based within the social work department, it is important to outline the perspective of the researcher and the study. All policies within South Africa are governed and guided by the Constitution of South Africa (1996) that affirms the rights of all people and encourages democratic values. The Constitution (1996) also locates responsibility for social welfare in the national and provincial spheres of government though services such as childcare and primary health care are local authority responsibilities (Patel, 2003). In 1997, the White Paper for Social Welfare was published. This changed the way in which social welfare was to be implemented in South Africa - and one of a few countries that has adapted to a developmental social welfare approach – which aimed to develop a system that was more just, equitable, participatory and appropriate to meeting the needs of all South Africans (Midgley & Sherradon, 2009; Lombard, 2008; Patel, 2005; Midgley, 1995; Patel, 1992).

According to the White Paper (1997), the goal of social development is to sustainably improve the well-being of the individual, family, community and society at large. Social welfare is defined as an “integrated and comprehensive system of social services, facilities, programmes and social security to promote social development, social justice and social functioning of people”. The White

Paper for Social Welfare (1997) was a progressive and radical guideline at re-structuring and re-developing the social welfare service with a social development focus which focuses more on prevention and early intervention for social problems. Understanding these overarching principles will guide the focus of the research. In this research there is an important link between social welfare, social development and health departments working together in understanding the context of continuous trauma in South Africa and how this influences both the employees and the people/communities the government structures are set up to serve. The particular structure in which this research is embedded is within health and particularly within the Primary Health Care Re-engineering (PHC) Model. This model is in a pilot phase and aims to provide and deliver health services to all who need them, especially the most vulnerable and the poor. The model is within the community so has both a health and social focus. Understanding social development principles facilitates comprehension of this context and thereby the structure and principles of the PHC Re-engineering model in which the research participants are located.

The context of this research has a community focus and social work theory and practice has valuable structures and guidelines for understanding communities. These frameworks were used to assist in exploring and understanding the exposure of violence and trauma on this cadre of workers (Patel, 2005; Payne, 2005). This understanding of social contexts is discussed throughout the dissertation. Bronfenbrenner's social ecological theory (1999, 2005) was also used to further explore and understand this context. Bronfenbrenner (1999; 2005) suggests that an individual develops and lives within a layered social system which interacts with the individual and others to shape the person's social environment and his/her personal development. This is important to understand as the research explores the CHWs context and experience of trauma within the communities in which they work and live.

Social work theory and practice also has an important role to guide this research in terms of its lens in social development, case management, community work; understanding the person in environment and general systems theory (Bronfenbrenner, 2005; Payne, 2005; Mayadas, Watts, & Elliott, 1997; Siporin, 1980). Mental health and psychosocial support is integral to this model and in understanding the influence of the exposure of violence and trauma. Social work theory and practice has useful frameworks and tools that can be used to assist in the developing and understanding of the context and role – for both patient and CHW - as well as developing and

understanding the importance of referral. Violence and injuries are recognized as the fourth burden of disease in SA, after HIV/Aids & TB; child and maternal mortality; and non-communicable diseases (high blood pressure; cardiovascular disease; diabetes; cancers and mental health) (DOH, 2011d). Therefore, for the development and expectations of what community-based health models can achieve within the South African context, it is essential to understand and explore the influence of continuous violence on health programmes within these communities.

2.3. Violence and Trauma in South Africa

To understand trauma and violence exposure in South Africa, both history and current experience will be explored within this section.

2.3.1. Exposure to violence and trauma

South Africa is not a country without a history of division, violence and conflict (Higson-Smith, 2002; Skinner, 1998). “The modern history of South Africa is a story of, more or less organized brutality and disastrous social divisions” (Higson-Smith, 2002, p. 1). From the brutality of the early European settlers; to the resentfulness of British rule and hence the South African War to the apartheid era of legislated divisions and inequalities by racial groupings of living space, social engagement and government service and delivery, and the use of violence to institute it. Although it can be explored from 18th century, the violence and trauma is not just about the set of events but is deeply ingrained in a person’s history, identity, values and traditions (Higson-Smith, 2002; Gibson, 2001). As well as the impact on identity, there is the clear evidence of structural inequality within systems and communities. South Africa is a highly complex and layered society. Apartheid has profoundly shaped social identities and maintained social divisions along racial lines. Twenty years later the structural inequalities, from years of division and violence, are still evident within the country. There are shifts and considerable changes, but the inequalities of division still need to be considered and recognized when working and living within South Africa.

From a literature search of psychological trauma post 1994, research in South Africa can be considered within twelve broad areas: nation-wide epidemiological studies; community-based prevalence studies; child and adolescent epidemiological studies; the phenomenology of trauma within South Africa; the psycho-biological aspects of trauma and pharmacological approaches to treatment; the psychotherapeutic intervention with people who have been affected by trauma;

the effects of child neglect, physical abuse and sexual abuse; the epidemiology and effects of intimate partner violence; the epidemiology and effects of sexual assault; the effects of past human rights abuse and the Truth and Reconciliation Commission; the effects of trauma on particular professional groupings (e.g. Police; journalists; emergency service personnel) and the supervision of trauma mental health workers (Benjamin, 2011; Jewkes & Abrahams, 2002; Collings, 1997). Kaminer and Eagle (2010) describe the forms of violent exposure reported in the South African Stress and Health Study (2004) as political violence, criminal violence, childhood physical abuse, non-intentional injury (road traffic and burn injuries), and indirect traumatising.

South Africa has one of the highest rates of violent crime with the national homicide rate five to eight times the global average (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). There are surveys that indicate high rates of violent crime, sexual violence and domestic abuse in post-apartheid South Africa (Le Roux, Curren, Zengele & Mukamana, 2013; Benjamin, 2011; Jewkes et al., 2009; Holtmann & Domingo-Swartz, 2008; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008). Exposure to rape, intimate partner violence, and abuse and neglect in childhood are risk factors for the country's most prevalent and serious health problems, including HIV and sexually transmitted infections, substance misuse, and common mental disorders, such as post-traumatic stress disorder, depression, and suicidality (Seedat, Van Niekerk, Jewkes, Suffla, & Ratelem, 2009). Research on high rates of violence as well as on violence exposure, prevention and trauma has been produced across various disciplines such as psychology, public health, sociology; anthropology and criminology. Each discipline provides useful explanations contributing towards the understanding of the causes of violence (Benjamin, 2011). As described in the key concepts in chapter one, 'violence' is an example of a traumatic event as it is an exposure to actual or threatened death, serious injury or sexual violation. The cumulative trauma experienced by South Africans indicates that the prevalence of violence is experienced as normative rather than extraordinary (Evans & Swartz, 2000; Hamber & Lewis, 1997). Other studies reflect that exposure to vicarious violence produces effects parallel to those observed when the violence involves direct victimization (Kaminer & Eagle, 2010; Holtmann & Domingo-Swartz, 2008; Suffla, van Niekerk & Duncan, 2004; Barbarin, Richter, & de Wet, 2001).

Violence not only impacts a person on an individual level but can also influence and exert effects at different ecological levels. Violence is complex and multi-dimensional (Benjamin, 2011; Clark et

al., 2011; Holtmann et al., 2008; Watts, Williams, & Jagers, 2003; Jenkins, 2002; Horowitz, Weine & Jekel, 1995).

Crime statistics seemed to support the surveys mentioned in the above paragraph. Although Police Minister Nathi Mthethwa states that there was a continued decline in South Africa's overall crime rate (recent crime statistics from the South African Police Service for the period 1 April 2012 to 31 March 2013), that was contact crime has decreased by 38.2% over nine years; murder rate reduced 27.2% over nine years and that rape has decreased by 3.3% in past four years, a closer look at the statistics still highlight the high rates of crime, sexual violence and domestic abuse. Africa Check's Factsheet (2013) highlighted that the violent crimes that cause the most fear and trauma amongst the public have increased. For the first time in six years, there was an increase in both the number and the rate of murders and attempted murders. In 2011/2012, the murder rate was 30.3 per 100,000 and is now 31.2 per 100000 of the population which is a 2.8% increase. Attempted murders have increased from 14859 to 16363, an increase of 10.1%. Sexual offence cases increased by 2.9% from 64514 to 66387 and the sexual offence rate per 100000 population increased from 125,1 to 127,0 an increase of 1.5%. The aggregated robbery rate increased by 196, 2 per 100 000 people to 202.6 per 100000 people which represented an increase of 3.2%. The factsheet stated that robberies are of a particular concern as they occur when armed perpetrators directly threaten or use violence against their victims in order to steal their belongings. This can result in severe trauma, injury or sometimes death to the victim/s. Street or public robberies – which the factsheet highlighted primarily affects poorer people and mainly occurred when they travel to and from work, school shopping or visiting people - increased by 4.4% to 60262 incidents which means an average of 166 cases (reported) on a daily basis. House robberies reported when people are attacked by armed gangs while in their homes increased by 7.1%, on average 49 households were attacked each day. Vehicle hijacking increased by 5.4% to 9990 incidents. Most of the vehicle hijacking cases were a result of organized crime syndicates and not random theft. The Factsheet stated that most of the murders, assaults and rapes took place between people who knew each other and lived in the same neighbourhood (Africa Check, 2013).

When exploring the exposure to violence and trauma, one cannot leave out sudden and violent deaths, usually from accidents, suicides or homicides. Most people adjust well after the loss of a loved one with the support from family and friends. However, after sudden violent loss, there may

be complicated or difficult experiences of bereavement and recovery may be slower. This complication is due to the unexpectedness of the death, the horror of the death and/or the lack of acceptance of the death, partly influenced by the fact that family and friends were not able to say goodbye (Jackson, 2013; Kristensen, Weisaeth, & Heir, 2012; Schnider, Elhai, & Gray, 2007; Green, 2000). The violent nature of death can introduce a compounded mix of grief and post-traumatic stress reactions (Levine, 2008; Figley, 1999; Herman, 1992). The trauma reactions may hinder the grief process, either due to the initial shock of the event, to the higher risk for traumatic imagery or to the different negative reactions or loss of support system and this may be referred to as 'complicated grief' or 'traumatic loss' or 'traumatic bereavement' (Kristensen et al., 2012; Wittouck, van Autreve, de Jaegere, Portzky, & van Heeringen, 2011; Green, 2000). Trauma may interfere with understanding and accepting the reality of the death. Therefore it is important to give priority to managing the trauma reactions before the process of grief (Jackson, 2013; Figley, 1999). Kristensen et al. (2012) completed a literature review that explores and summarises the different risk factors for mental health complaints for those bereaved after sudden and violent loss. These include: personal risk factors (female gender; pre-existing mental health difficulties); interpersonal risk factors (close kinship; lack of perceived social support and social isolation); and situational risk factors (blaming others or being blamed; self-blame/guilt; life threat; witnessing death or finding the deceased; waiting for death confirmation and multiple losses). When exploring issues around trauma, it is important to also include awareness of traumatic loss and other losses.

Due to the high rates of exposure to trauma and violence in South Africa, Holtman et al. (2008) state that in a society [South Africa] where victimization is as significant as ours, individual responses are subjective, emotional and fuelled by regular discussions and stories. In order to understand and explore the responses to violence and trauma, the recognition of the combination of societal problems, such as poverty and inequality between rich and poor, unemployment, a history of violence and deep rooted patriarchy should also be considered. This combination feeds into creating a society that is vulnerable to both victimization and a high incidence of offenders and this influences the way people live and make choices about their lives (Benjamin, 2011; Miller & Rasmussen, 2010; Clark et al., 2007; Ruggiero, van Wynsberghe, Stevens, & Kilpatrick, 2006; Christopher, 2004; Eitle & Turner, 2002; Rasool, Vermaak, Pharoah, Louw, & Stavrou, 2002).

It is also essential to understand the context and the influence of this context when developing community intervention programmes. Research – mainly from the States – has explored black women's experiences of violence as a witness, a victim or both. This has had negative implications for experiences of loss, grief, fear and relationships with others (Jenkins, 2002; Wolfer, 2000; Wolfer, 1999; Jenkins, Kpo & Barr, 1997; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). This research is relevant for this study as most of the CHWs are black women so their perceptions and experiences will be coloured by their role, status and experience within their communities. Understanding the impact of trauma is not just conceptualizing the event but understanding the individual's subjective understanding of the event. Many South Africans have multiple traumatic experiences and the normalization of violence as a part of daily life in South Africa – at both work and home - has contributed to a general unease and sense of insecurity (Emmet and Butchart, 2000).

2.3.2. Workplace violence

CHWs' workplace is in the community. There is paucity of research of workplace violence in South Africa (Bowman, Bhamjee, Eagle, & Crafford, 2009). Furthermore, studies outside of South Africa "present few accurate, reliable and uniform statistics available regarding violence at work" (Chappell & Di Martino, 2006, p. 21). This is mainly due to there not being a clear definition of "workplace violence". This lack of clarity is due to different work contexts. Though violence in the workplace commonly refers to actions or incidents which cause physical or psychological harm to employees or employers (Wiskow, 2003; Jenkins, 1996). The International Labour Organisation (ILO) further defines it as "incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work (ILO, 2004, p. 4). This is an important description as it recognizes that 'workplace violence' is not restricted to a particular work locale.

Bowman et al. (2009) highlight useful typologies in understanding workplace violence. They introduce a typology from the Californian Division of the Occupational Safety and Health Administration (1998) which divides workplace violence into three categories: 'Internal', 'client-initiated' and 'external' violence. This is a constructive way to explore the type and impact of violence. The 'internal' type focuses on the intra-organisational violence (perpetuated by co-workers). 'Client initiated' type is the violence by the clients/patients against the workers.

‘External’ type describes the violent events that occur outside of the actual workplace by individuals who are not linked to the organization. This last category has been studied and it is recognized that those working in areas where community violence is high, will be at higher risk to this last type which would include witnessing, hearing about or being directly involved in violence (Ronzio, Mitchell & Wang, 2011; Bowman et al., 2009; Mayhew & Chappell, 2007). Di Martino (2002) states that the World Health Organisation (WHO) considers workplace violence a form of community violence as it is not just an individual problem but a structural problem that has broader socioeconomic and cultural causes. This is constructive for our understanding the context of health workers working within communities in which they live. Also, the impact of workplace violence is felt well beyond the workplace, it also influences individual well-being and family functioning (Kennedy & Julie, 2013; Bowman et al., 2009; Du Toit, 1997; Ursano, Fullerton, & McCaughy, 1994).

As discussed above, in areas where community violence is high, there is a higher risk of exposure to witnessing, hearing about and directly experiencing traumatic events. Witnessing violence may lead to fear of future violent experiences and can have similar negative effects as being directly assaulted (Leather, Lawrence, Beale, Cox, & Dixon, 1998; Rogers & Kelloway, 1997). Therefore in such contexts, workplace violence can also link to the literature on ‘occupational stress’ and ‘occupational health and safety’ (Lethbridge, 2008; Hoel, Sparks, & Cooper, n.d.). There are many different definitions of stress and of work-related or occupational stress but the key aspect is that the demands of the job increase the sense of challenges which may put people under pressure to such an extent that they feel they are not able to cope. Moustaka and Constantinidis (2010) state that “stress is a state, not an illness, which may be experienced as a result of an exposure to a wide range of work demands and in turn can contribute to an equally wide range of outcomes, which may concern the employee’s health and be an illness or an injury, or changes in his/her behaviour or lifestyle” (p. 211). CHWs have direct contact with people in distress, so experiences of stress and of violence are common and could be considered as part of the job. As changes further develop in the delivery of public health care to focus more in the actual community in South Africa, violence and the threat of violence in itself becomes a stressor at work that needs to be recognized and considered. The actual experience of violence or the threat of violence may in itself be an antecedent of violence which could lead to perceptions of unfair treatment, tense and

stressful relationships between colleagues, lack of productivity, poor concentration, diminishing self-confidence and outbursts of frustration and anger (Brady, 1999; Hoel, Sparks & Cooper, n.d.).

Cox, Griffith and Rial-Gonzalez (2000) identify stressors at work within two groups: 'content of work' and 'context of work'. The 'content of work' refers to the work-environment and equipment, the workload and the work schedule. The 'context of work' refers to the organizational culture and function, the role in the organization, career development decision latitude and control, home-work interface and interpersonal relationships at work. It is evident that exposure to violence and trauma influences both areas. In terms of 'content of work' in this context with CHWs, the actual stories (especially those of violence, illness and suffering) shared by the patients are also stressors as they may have a negative impact on the worker's response to and delivery of service. As the workload is community-based and within a context of continued violence and trauma, the nature and experience of the workload takes on a different meaning and understanding.

'Context of work' could also include the broader social, economic and political structures, especially when the workplace is directly within the community. Trauma and violence at work (direct or indirect) can have a stressful influence on the home-work interface, especially when similar incidents are happening both in the home and work community (Cox et al., 2000). With workplace violence, one may also experience an increase of distrust or scepticism amongst colleagues at work. Community health workers' lower job-satisfaction and organizational commitment are potential outcomes of physical violence (directly experienced or witnessed) which could have a negative effect on organizational culture or service delivery (Barling, Rogers & Kelloway, 2001).

The CHW's role is a good example of one is influenced by both context and content of work. Even though the health workers' focus is health, they often find themselves listening to or supporting people through traumatic situations. At times, this has been overwhelming and difficult for the worker, either because they feel that they are not equipped to know how to manage such situations; or because the situations are something that they can identify due to their own experience; or the traumatic situation links to their fears of the violence that they may face within

the community in which they live and/or work (MacRichie & Leibowitz, 2010; Miller & Rumussen, 2010; Di Martino, 2002).

Hence, it is essential when focusing on health workers - whose work is based within the community in which they live – to acknowledge the broader inter-dependent systems (of family, individuals, organisations and communities) and to recognise the risk and protective factors that challenge or support people after a violent event (Bowman et al., 2009; Krug, Dahlberg, Mercy, Zwi, & Losano, 2002). It is difficult to separate work context from personal context when they are so closely linked. With the awareness of the violent context in which people work, it is necessary to conceptualise more sustainable models of intervention that are relevant to the organization and to the community violence risk and impact for the workers in the field.

2.4. Trauma Symptoms

In exploring and understanding trauma, it is necessary to expand on reactions to and symptoms of trauma. This will be further discussed in this section. Days and weeks after a traumatic event, most people experience trauma and stress reactions which are part of the normal and adaptive response to a life threatening event. According to the literature, key elements of a traumatic experience include: it is unexpected, the person is not prepared and it is about the individual's response to the event (Robinson, Smith & Segal, 2014). Although this is not always the best description in contexts of continuous trauma, there is always an element of unexpectedness (even in the fear of something happening) and the influence of the event is evident on the individual's meaning and response to it. Common symptoms of trauma include: intrusive symptoms (re-experiencing the event in thoughts, images, recollections; upset or anxious when reminded of the event); avoidance symptoms (avoiding places, thoughts and people associated with the event; problems with recalling some aspects of the event; feeling 'removed' from other people); intrusive symptoms (being alert for danger; being jumpy and easily startled; experiencing sleep disturbances; difficulty concentrating); physical symptoms (eating disturbances, sexual dysfunction, low energy, chronic and unexplained pain); emotional symptoms (anxiety, fearfulness, feeling out of control, irritable, angry, emotional numbness, withdrawal from usual routines and relationships); psychological symptoms/response (shock; feel confused, feel suspicious; feel depressed, exhausted but unable to rest; grieving for loss of safety and security in

the less and potentially grieving if someone has died in the event); behavioural symptoms/effects (substance abuse; uncontrollable reactive thoughts; feeling damaged; self-destructive or impulsive behaviour) and spiritual symptoms (altered worldview; troubling existential questions; a loss of a sense of meaning in life; a loss of hope and sense of connection) (Robinson et al., 2014; Bosch & McKay, 2013; Levine, 2008; Ross & Levine, 2005; Christopher, 2004). Levine (2008) explores the bodily reaction in a life threatening situation which includes both mind and body in a fight, flight and freeze response and he works with the bodily response to the event before managing the emotional impact of trauma. There has also been much research to study how trauma changes the structure and function of the brain and therefore impacts how the traumatic event is processed (Robinson et al., 2014; van der Kolk, 2007; van der Kolk, McFarlane, & Weisaeth, 2007; Vasterling & Brewin, 2005; Christopher, 2004; Fisher, 2003).

Janoff-Bulman (1985) described the effect of trauma as that which shatters individuals' basic assumptions about life and the person has to come to terms with the fact that the world can be an unsafe, unjust and unpredictable place. Assumptions are cognitive schemas that relate to the beliefs and perception a person has of the world – often quite conservative so they are a protective structure but are resistant to change (Affleck & Tennen, 1996; Janoff-Bulman & Schwartzberg, 1991). Herman (1992) added that the most central basic human assumption is one's need for basic relationships. Relationships can be considered safe or after a trauma event, human relationships get called into question and victims may withdraw or disconnect from others and from the world, resulting in isolation and lack of social support (Goldenberg, Pyszczynski, Greenberg, & Solomon, 2000; Herman, 1992).

More severe trauma symptoms – which can show up, even years later - include: severe dissociation (feelings of enduring disconnection from body, surroundings or self); repeated intrusive 're-experiencing' of the event (may include flashbacks or auditory/olfactory triggers); extreme withdrawal (from social networks); extreme hyperarousal (experiencing panic attacks; unable to concentrate); debilitating anxiety (severe phobias or obsessions); severe depression (feeling a constant lack of happiness and pleasure in life) and problematic substance use (prolonged and excessive use of alcohol or drugs to numb distress and aid coping) (Bosch & McKay, 2013; Levine, 2008). It would be important for the person to be referred to a mental health professional if any of these symptoms are present.

The American Red Cross states that disaster or front line workers may also become direct or secondary victims within the contexts in which they are working. Secondary victims could be linked to survivor guilt or just managing the cumulative trauma symptoms of the people they are working with, they may experience similar symptoms, even if they have not had the direct experience (Baldwin, 2013). This reaction is also known as ‘vicarious trauma’, ‘secondary trauma’ or ‘compassion fatigue’ (Palm, Polusny, & Follette, 2004; Turner, 2000; Figley, 1995; McCann & Pearlman, 1990). The symptoms include: intrusive imagery and thoughts, avoidance and emotional numbing, hyper-arousal symptoms, somatization and a disruption of beliefs about safety and the benevolence of the world (Palm et al., 2004; Herman, 1992; McCann & Pearlman, 1990; Janoff-Bulman, 1985). At times CHWs may be “overwhelmed by their own personal responses to disaster [and other trauma events]” (Palm et al., 2004, p. 75). If there is little distance to trauma of others or if CHWs are at risk themselves, they could experience the same or similar trauma symptoms and this could influence their ability to manage and deal with experiences in the workplace or community. The following sections explore the explanations that are used to describe experiences of and responses to trauma and violence.

2.5. Post-Traumatic Stress Disorder (PTSD)

Much of the literature around trauma, violence and its impact is defined and understood by the term Post Traumatic Stress Disorder (PTSD). In 1980, PTSD was finally formally recognised within the mental health professions when it was included in the third edition of the Diagnostic Statistical Manual as a distinct disorder. The Diagnostic Statistical Manual IV-TR (APA, 2000) defines PTSD as the response after a traumatic event which causes intense fear and/or helplessness in an individual and that it should evoke significant symptoms of distress in most people. It also lists a set of observable symptoms that include persistent and distressing re-experiencing of the event, dreams, numbing, avoidance of situations, and hypervigilance. Instead of changing the diagnostic criteria for PTSD, the DSM IV-TR added information within the “associated descriptive features” by describing symptoms that were associated with the exposure to a severe interpersonal stressor (Ebert & Dyck, 2004; Smyth, 2001; APA, 2000).

Subsequently the definition of PTSD has changed with the introduction of the Diagnostic Statistical Manual Five (DSM 5) in June 2013 (APA, 2013). Post-traumatic Stress Disorder (PTSD) is included in

a new chapter in DSM 5 on Trauma and Stressor-Related Disorders. This is among several changes approved for this condition compared to the description in DSM IV-TR (APA, 2000), which addressed PTSD as an anxiety disorder. The key changes also include the definition of PTSD and there are now four categories of symptom identification rather than the previous three. The new diagnostic criteria for the manual's next edition identify the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). (APA, 2013, p.271)

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

DSM 5 (APA, 2013) pays more attention to the behavioural symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three, as in the previous edition. The four main categories of symptoms are:

- 1. Intrusion symptoms** include: nightmares; intrusive daydreams; for children - play games that repeatedly re-enact the trauma- this is isolated play and doesn't engage others; flashbacks; gets very upset if something happens that reminds them of the trauma; bodies get worked up with the reminders, including sweating, shaking, and fast heart rate.
- 2. Avoidance symptoms** include: avoids places or things that remind them of the trauma; withdraws from other people
- 3. Negative alterations in cognitions and moods** include: look less happy and are less loving; children play less than before; difficulty concentrating; alcohol abuse; persistent and distorted blame of self or others; persistent negative emotional state

4. Alterations in arousal and reactivity include: difficulty sleeping; difficulty concentrating or focusing; irritable, for children this is increased temper tantrums; increased aggression; jumpy and scared; very concerned about safety; reckless or destructive behaviour.

Although the development of the PTSD diagnosis is developing and growing with knowledge about trauma, there is still contention about PTSD being used as the main descriptor of the impact of trauma. PTSD is a framework that was developed to deal with the reactions of soldiers who had been in combat and then had been removed from the war zone back home. It is noted that not all those exposed to traumatic stressors develop PTSD (Kaminer et al., 2008; Ebert & Dyck, 2004; Kaysen, Resick & Wise, 2003; Carlson & Dalenberg, 2000; Horowitz et al., 1995). Wilson (1994) adds that it is the interaction between the event and the individual that is critical to understanding the impact of what are considered traumatic stressors. Carlson and Dalenberg (2000) outline that there are three defining features of traumatic events: a lack of control over what is happening; the perception that the event is a highly negative experience and the suddenness of the experience. They also state that the factors that influence the response to trauma are: biological factors; developmental level at the time of trauma; the severity of the trauma; the social context; and prior and subsequent life events. Despite the high levels of trauma and violence exposure within South Africa, the SASH study found that only 2.3% of South Africans had a lifetime experience of PTSD (Stein, Seedat, Herman, Moomal, Heeringa, & Kessler, 2008). With the level of crime and violence reported – and not reported – it would be expected that the PTSD rate would be higher. Therefore it seems that PTSD may not be the only description to use when understanding and explaining the impact of trauma and violence within communities.

2.6. Disorders of Extreme Stress Not Otherwise Specified (DESNOS) and Complex PTSD

In 2005, a committee met to review the research on trauma and has 'organised the most frequently studied symptoms under the rubric of *disorders of extreme stress not otherwise specified (DESNOS)* (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The criteria of DESNOS have developed from Judith Herman's work (1992) and have been substantiated by other researchers, theorists and practitioners in the field. The term 'Disorders of Extreme Stress Not Otherwise Specified (DESNOS)' was presented as a construct to capture the psychological disturbances expressed by those who are victims of prolonged interpersonal trauma as the PTSD diagnosis did not seem to capture some of the issues. It emphasized the multi-dimensional nature

of posttraumatic stress including: regulation of affect and impulses, memory and attention, self-perception, interpersonal relations, somatization and systems of meaning. Some key findings through exploring the description of DESNOS is that the most pervasive impact of trauma is in the first decade of life and increased number of traumatic experiences have an impact on increased suffering (van der Kolk et al., 2005).

Complex PTSD was proposed by Herman (1992) to describe a syndrome observed in survivors of prolonged and repeated trauma. It looked particularly at interpersonal relationships and the symptom clusters extended beyond PTSD to include: alterations in affect regulation; consciousness; self-perception; perception of the perpetrator (often known); relations with others and systems of meaning (Eagle & Kaminer, 2013; Resick et al., 2012; Ebert et al., 2004). Ebert and Dyck (2004) explore a concept of “mental death” that they would consider the core feature of Complex PTSD. The essence of “mental death” is the loss of identity. They describe this loss under four identity domains: Firstly, it causes a person to act and live in ways that are inconsistent with the person’s core beliefs, assumptions and values which may lead to experiences of shame and guilt. Secondly, it causes a person to perceive others differently from how they were previously perceived, especially in terms of diminishing capacity to trust and attach to other people. Thirdly, it causes major changes to a person’s view of the world, including beliefs related to social order, justice and safety. Fourthly, it causes a change in a person’s behaviour in that there is a loss of continuity between pre-trauma and post-trauma patterns of behaviour and perception of self. The extent of the loss may differ for each person and may vary over time though it is a useful way to make sense of and explore the impact of different losses after a traumatic event.

The status of Complex PTSD is controversial and there was much debate currently about whether it should or could be included within the DSM-V and it was not. It is felt that there is not enough scientific evidence to substantiate it to be described as a disorder. However, whether it is included or not, this debate is further evidence that many feel unhappy about the straight forward PTSD diagnosis and are exploring other options to further describe the reality that many people experience on the ground.

2.7. Exposure to Violence and Daily Stressors

Other commentators recognise PTSD as the core model in understanding the impact of trauma experience and exposure, yet, have encouraged a broadening of this model to include the effect of social conditions specifically in environments and communities of post-conflict (Stevens, Eagle, Kaminer & Higson-Smith, 2013; Bell, Mendez, Martinez, Palma, & Bosch, 2012; Diamond, Lipsitz, Fajerman, & Rozenblat, 2010; Silove, Brooks, Bateman, Steel, Fonseca, Amaral, Rodger, & Soosay, 2010; Miller, Kulharni & Kushnar, 2006; van Ommeren, Saxena, & Saraceno, 2005).

There have been other studies that look at ongoing traumatic stress due to living in war zones. These studies recognise that civilians are exposed to a range of stressful experiences (including the threat of death or serious injury; witnessing others killed or hurt; the sound of explosions and gunfire; losing one's home; forced relocation and separation from family and friends) and have shown that there is an increase in psychological distress. Some of these residents display typical symptoms and signs of PTSD. However, there is another group of people that do not report these discrete symptoms. Rather, there seems to be a cumulative impact of repeated and ongoing stress and conflict that goes beyond the direct effects of violence and results in increased anxiety and hyperarousal, less re-experiencing of the event and the fears are linked to day to day events (e.g. food shopping; collecting children from school) rather than the traumatic events. Keeping oneself and others safe is a core concern around which everything else is organized (Bell et al., 2012; Diamond et al., 2010; Jenkins, 2002).

Miller and Rasmussen (2010) further contribute to helping develop a framework in thinking about the complexity between direct and indirect exposure to traumatic events as well as including the daily stressors experienced by people within settings of organized violence. They argue that the negative impact of life experience on mental health and functioning of people is not just the direct impact of exposure to violence. They note that "daily stressors also have powerful effects on mental health outcomes" as well as playing a role in "mediating the relationship between exposure and psychological distress" (Miller et al., 2010, p. 8). The authors explain that "the effects of direct exposure to physical violence were seen against the backdrop of the structural violence that formed the stressful context of everyday life (poverty, discrimination; and marginalization)" (Miller et al., 2010, p. 9). This is a useful framework to think about the context in which the CHWs find themselves (personally and with their clients) as they are dealing with daily

stressors that are largely beyond people's control; that are pervasive and include a wide range of phenomena from low intensity stressors (i.e. overcrowding; unemployment, social isolation) to quite traumatic experiences (i.e. child abuse; intimate partner violence) (Bell et al., 2013; Miller & Rasmussen, 2010; Eitle et al., 2002). Chronic life stressors (such as poverty and/or living in an unsafe environment) may also result in over-identification with patients and colleagues who have experienced trauma events.

2.8. Exploring the Definition of 'Continuous Traumatic Stress'

2.8.1. Defining trauma impact in South Africa

Bell et al. (2012) state that research conducted into trauma and its impact has had a strong focus on war veterans and not so much on the civilian population that has also been impacted by the fighting. In the South African context, people continue to experience traumatic events – both as direct and indirect victims. As explained in Chapter One, the term 'continuous traumatic stress' was initially used by Gillian Straker and her team in the 1980s when describing the political unrest and community evidence that was experienced during apartheid (Straker, 1987; 1994). It seemed a useful description to explore the consistent nature of institutionalised violence at that time. Although the political framework of South Africa has changed, the experience of ongoing violence still pervades individuals' and communities' lives. Hence the PTSD description described above is useful for some people however it does not fully describe or reflect the experiences and reactions of people living within South Africa. While much of the presenting symptomology is common to all traumatic experience, the context within which trauma occurs is not. Trauma impact is highly *context specific*, and practitioner responses must take cognizance of this.

"The founding four organisations (i.e. Survivors of Violence, KwaZulu Natal; The Trauma Centre for Survivors of Violence and Torture, Cape Town; Centre for Study of Violence, Johannesburg and The National Peace Accord Trust, Johannesburg) of a national trauma network (Themba Lesizwe) in South Africa identified 'continuous trauma' as a distinct dynamic of practice across the country" (Benjamin, 2011, p. 6). The concept of "continuous traumatic stress" could be helpful in understanding the complexity of South Africa as it allows exploration of the context in which we are living when making sense of the impact of trauma on an individual or collective level. Here,

social work theory and experience can also be useful in guiding understanding and intervention within community contexts.

A theoretical framework that guides thinking about community interaction and community intervention in South Africa – and generally - is Bronfenbrenner's social ecological theory (1999, 2005) that suggests that an individual develops and lives within a layered social system which interacts with the individual and others to shape the person's social environment and their personal development. The four systems are micro (immediate social system around the individual such as family, work and friends), meso (linkages between the micro systems), exo (influences in the environment in which the individual does not have direct involvement) and macro (large scale societal factors such as policies, ideologies, belief systems and socioeconomic and cultural influences). Systems theory helps social workers understand how systems both determine and are determined by those who make up the system (Payne 2005). This is useful not just for social workers but for any project that is community based. It is particularly useful framework in exploring ongoing traumatic experiences and the meaning that this has both for individuals, their work and the communities in which they live. When working in the community, many layers need to be acknowledged and recognized and worked with in different ways. This is a constructive framework to explore the interdependent and shared interactions between the individual, the traumatic event and the environment (Harvey, 1996).

2.8.2. Discussion about the definition of the term 'continuous traumatic stress' and other related descriptions

The lack of clarity of a standardized definition of the term 'continuous traumatic stress', makes understanding and documenting this description difficult. This is further compounded by psychological and psychiatric fields not recognizing 'continuous traumatic stress' as an actual disorder – whether it should be or not is part of the continued exploration and debate. Generally, there is a lack of clarity with regard to definitions and terminology to describe responses to trauma within contexts which are not safe. These include: "chronic traumatisation" (Kaysen, Resick, & Wise, 2003; Herman, 1992); "continuous traumatic stress" (Straker, 1987); "compounded community trauma" (Horowitz et al., 1995) and "ongoing traumatic stress response" (Diamond, Lipsitz & Hoffman, 2013). "Chronic traumatisation" is characterized by repeated exposures to traumatic stressors within the same overall context over time" (Kaysen et

al., 2003). Baum, O'Keefe and Davidson (1990) highlight the fact that chronic traumatising is not just damaging due to the specific incidents that happen but because of the effects of living in a state of constant danger. When trying to understand reactions within a traumatic context, Herman (1992) explains that these occur when action is of no avail and when no defence, no escape from or resistance to the event is felt possible. Herman further expounds that the impact of the traumatic event and reaction breach the attachment of family, friends, love and community and "undermines the belief systems that give meaning to human experience" (Pomeroy, 1995, p. 90).

"Compounded community trauma" includes both familial and community trauma experiences and how they affect interpersonal relationships and development of identity. Histories include severe disruptions in a person's experience of caring and meaningful interpersonal experiences that have left them with an inability to trust others (Horowitz et al., 1995, p. 1359). In recognizing the many individuals who do not develop PTSD but seem to experience high anxiety and distress when living in ongoing trauma situations, the term 'ongoing traumatic stress response' has been proposed as an alternative way to describe their experience. Key elements to this description include: anxiety not attributed to a discrete event/s in the past; no evidence of re-experiencing; avoidance behaviours are to do the current context of traumatic stress and protecting oneself from current or real danger; anxiety is more about potential future danger and anxiety symptoms resolve once the individual is out of danger (Diamond et al., 2013, p. 104-105). A key element of continuous traumatic stress is that survivors are in a situation where there is great risk of being re-traumatised (Straker & Moosa, 1994).

2.8.3. Description and effect of 'continuous traumatic stress'

There is much debate as to whether 'continuous traumatic stress' is a descriptor or a specific construct in the mental health field (Eagle & Kaminer, 2013; Stevens, et al., 2013; Straker, 2013). The term 'continuous trauma' or 'continuous traumatic stress' has been used by South African and Northern Ireland practitioners to describe a mental health presentation arising from a context with a mixture of acute, current, traumatic and violent incidents within a backdrop of a divided society with a history of violence and traumatic experiences. There is a co-existence of acute and continuous traumatic stress events (such as community and criminal violence) that are either witnessed or repeatedly experienced and where recovery occurs within an environment of ongoing fear and threat (Stewart, Murphy & Thomson, 2005). So even after a discrete or specific

traumatic event, there is a persistent threat of violence that is part of the experience of the community. There is a debate as to whether the threat and actual experience of another event could be explained as 'continuous' and that maybe terms such as 'ongoing' and/or 'chronic' are better descriptors. The definition of continuous is "continuing without stopping; happening or existing without a break or interruption" (Merriam Webster Dictionary, 2012). Therefore, by using the word 'continuous', it seems that the understanding would be that the traumatic events continue without stopping. It is known that this is not the case. However, the value of the term 'continuous traumatic stress' is not so much the description of how quickly the events happen one after each other but rather the experience that the individual has of the events. The experience is that the traumatic events are continuous in nature as the events crosscut all areas of and individual's life and it pervades their consciousness all the time. It also is not just the direct events that happen to a person that is the concern, but all the events that a person may hear about, both locally, nationally and internationally and the perception that these events could possibly happen to an individual and their loved ones. The potential for the event to happen at work, home or within the surrounding community is possible and can be experienced as eventual i.e. waiting for it to happen. The eventuality of the experience builds into the 'continuous' experience of traumatic events.

Crawford-Browne and Benjamin (2002) describe a response to continuous traumatic events as a generalized sense of fear and people feeling unsafe. This is further supported by Diamond et al. (2010) who says the "preoccupation with safety is likely to be most prominent" (p. 91). Continuous traumatic stress consists of multiple events and is ongoing; the threat is current and real; there is less concern with the past in general in an environment that contains current danger; safety is difficult to establish; there is a lack of trust in state systems of protection and help; there is a threat to family and community networks and systems (Straker, 2013; Benjamin & Crawford-Browne, 2010; Hamber & Lewis, 2007; Stewart, Murphy & Thomson, 2005; Murphy, 2004; Healey, 2003).

Roach (2013) adds that in responses to experiences of continuous trauma, anger replaces fear; emotions are 'muted' or 'shallow' and approach to danger replaces avoidance. People are living with 'an expectation that something traumatic is about to happen' (Crawford-Brown & Benjamin, 2002). Nitchke, Heller & Miller (2000) concur when they state that there is a "preoccupation with

threat and an anxious apprehension of the next danger accompanied by muscle tension, restlessness and fatigue” (Roach, 2013, p. 154). An important aspect here is that the experiences of continuous trauma denotes that the individual is currently in danger and their emergency reactions are avoidance and hyperarousal (Diamond, Lipsitz & Hoffman, 2013). The individual impact of continuous traumatic stress could look like: disconnection, inability to regulate emotion; aggression; fearlessness, impulsivity; reduced capacity for empathy; effect on memory; somatization; minimizing the impact of trauma, disassociation, effect of self-perception and identity; victim could become the perpetrator, and a negative impact on relationships (Eagle and Kaminer, 2013; Benjamin, 2011).

For this reason, when exploring a context where there has been a history of violence and where there is current trauma and conflict, it is also necessary to recognise “that the emotional consequences of living in a conflictual society are not adequately represented through reference to psychiatric symptomatology. Instead they exist in their profound form in ways that are harder to measure and code. They exist in people’s ideas about themselves, their country and their future” (Gibson, 2001, p. 70). These ideas of self, others and the country have a profound effect on the development of personal and social identity; behavioural impacts (i.e. hyperactivity; anxiety; impulsiveness; attention problems; aggression; alcohol and substance abuse) and the lack of basic trust in the world and in relationships (Bell et al., 2012; Matzopoulos et al., 2010; Gibson, 2001; Herman, 1992). Higson-Smith (2013) notes that the impact of trauma “changes survivors’ capacities to control their own lives and influence the world around them” (p. 178). Although Higson-Smith’s (2013) current work mainly explores the impact of torture on victims, this is a description that is also evident and relevant to how continued violence in communities influence the sense of control and capacities that people have of managing their own lives. Eagle and Kaminer (2013) further explore that CTS occurs in contexts where “danger and threat are largely faceless and unpredictable, yet pervasive and substantive” (p. 89). Hence there is a sense of continuous danger, lack of trusted external protection and it is difficult to discriminate between real and perceived or imagined threats.

Weingarten (2003) had previously described how the meaning given by a person to an experience frames their interpretation of the event, their response and hence its impact. This is a concern when these “individuals are surrounded by mainly emotional and psychic violence, but also at

times, physical violence inflicted on those who they live beside” (Straker, 2013, p. 214). Hence the experience and meaning of trauma influences their experience of life. Jansen (2012) delves further into this idea when he talks about the bearing witness to events and situations and how this shaping of people and context is held in the “knowledge in the blood”. He also states that this “‘bearing’ suggests heaviness, a burden on your back” (Jansen, 2012, p. 22). The tangibility of the everyday threat (direct or indirect) impacts the physiological response of the body which directly impacts the emotional experience and interaction of the person with individuals and the community.

Interestingly, individuals who hear relatively high amounts of news and information about violent events - so are exposed to but not directly affected – were found to be more likely to report depression, PTSD symptoms, aggressive behaviour and interpersonal problems in a study by Scarpa et al. (2006). Hence measuring people’s perceptions of chronic danger rather than focusing on specific incidents may be a means of understanding and measuring the traumatic context. (Kaysen et al., 2003). The socioecological model re-emphasises this thinking that events within their overall environmental and social context is important in understanding various forms of psychopathology and cultural and community worldviews (Bronfenbrenner, 2005).

“Anxiety” is recognized as a central emotional state that promotes hypervigilance which is supposed to protect the body (and the person) in danger but in contexts of continuous danger and/or violence a person pays a price for maintaining this forced physical alertness (Diamond, et al., 2013; Higson-Smith, 2013; Crawford-Browne & Benjamin, 2002). Diamond et al. (2013) highlight that these reactions are normal and natural to the extreme conditions in which people are living within and should not be seen as psychopathology. According to Straker (2013), “there is less concern with the past in general in an environment that contains current danger” (p. 211) reiterating the idea that one is preoccupied with current survival (Diamond et al., 2013; Eagle & Kaminer, 2013; Higson-Smith, 2013) which directly links to the vulnerability of the body and the reminder of death.

Injuries and violence don’t only have an effect on human development and mental health but they also undermine social cohesion and the nation’s social and economic development. They are, therefore, a substantial burden of preventable mortality and physical and emotional disability.

Developing prevention and intervention programmes that address forms of violence and injuries is a social, public health and mental health issue (Seedat et al., 2009; Kaminer et al., 2008). Therefore, service planners and providers need to challenge purely individualistic trauma accounts and include the socio-political context of traumatic experience in their treatment strategies and interventions (Stewart, Murphy & Thomson, 2005).

2.9. Coping with Experiences of Trauma

2.9.1. Coping styles

Folkman and Lazarus (1985) are two authors who have contributed greatly to the initial literature on stress and coping. They would define coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person” (Lazarus & Folkman, as cited in Green, Choi & Kane, 2010, p. 733). Many definitions of coping since 1980 continue to include descriptions that include internal and external mechanisms utilized to change psychological and structural aspects of stress or distress and some descriptions have gone further to include managing the negative emotions associated with the challenges (Scarpa & Haden, 2006; Davison, Neale, & Kring, 2004; Skinner, Edge, Altmann, & Sherwood, 2003; Fleishman, 1984).

The transactional model of stress developed by Lazarus and Folkman (1985) is a useful process to understand how one processes threat. The primary appraisal determines the level of danger, the potential pain, loss or discomfort and the amount of effort that will be needed to manage the situation. If no threat is perceived, no stress or trauma is experienced. However, if a threat is perceived, a person will go through the secondary appraisal process in which he/she examines his/her perceived available resources to cope with the problem. These processes are not always conscious, but the appraisal of the situation is often based on past experience and perceived ability to cope. A perceived sense of the inability to cope will increase the stress and overwhelming experience of the situation. (Duhachek & Kelting, 2009; Lazarus & Folkman, 1985)

Lazarus (1999) stated that one of the factors that assists in mitigating the relationship between life stress and physical and psychological functioning is coping style. However, these descriptions of different styles are not always agreed upon. It is difficult to identify ‘coping’ as it is more of an

organizational construct that is used to describe a number of actions engaged in by an individual, rather than a once off behaviour (Skinner et al., 2003). What is key to note is that there are individual differences in the way people react to and cope with highly aversive events from chronic distress, intrusive memories and great sadness to short lived reactions and back to previous levels of functioning (Bonanno, 2004; Bonanno & Kaltmann, 1999). Coping literature often focusses on understandings of the impact of threat, loss and uncontrollability which highlights that either ones values, beliefs or body are challenged or have been compromised or damaged (Park, 2010). A person's capacity to adapt to life after a traumatic event guides us in understanding their coping ability (Benight, 2011).

The most widely accepted categories or styles of coping- which were first formulated by Folkman and Lazarus – are the problem-focused and emotion-focused coping styles (Folkman, 1997; Fleishman, 1984). These are useful constructs that either focus on the tasks of doing or the process of support that the person may need – with or without support from others. In terms of emotion-focused coping, there is an attempt to regulate emotions and this could be active or avoidant. Active emotional coping (i.e. venting emotional distress and cognitively reframing the situation) is seen as an adaptive response (Folkman & Lazarus, 1985). Avoidant emotional coping is viewed as maladaptive as the person may use denial or self-distraction to avoid the source of the stress (Holahan & Moos, 1987). However, it is noted that people may use both styles, depending on the situation or the stressor and “problem-focused coping in the absence of active emotional coping may be problematic” (Schneider et al., 2007, p. 345).

Pearlin and Schooler's (1978) categories of coping are also useful. These are responses that change the situation; responses that alter the meaning or appraisal of the stress; and responses intended to control distressful feelings. Rice (1999) further describes coping by identifying the different aspects of coping: coping resources, strategies and efforts. “Coping resources refer to (a) personal traits (i.e. self-efficacy, optimism, perception of control and self-esteem); (b) social resources (i.e. family, friends, workplace and extended networks) and lastly (c) physical resources (i.e. good health, adequate physical energy, functional housing and minimum financial stability” (Rice, 1999, p. 290). The resources can mediate or buffer the negative impact of stress or trauma. The different aspects of coping assist in understanding a person's abilities and the context's influences so as to strengthen or support a person or community better. Weisman (1986) suggests

coping strategies include: seeking information; getting guidance; sharing concern; finding consolation; laughing it off; changing emotional tone; forgetting what happened; putting it out of your mind; keeping busy; distracting yourself; confronting the issue; acting accordingly; redefining; resigning yourself to this is what it is; examining consequences; finding an escape somehow; blaming or shaming someone else or denying as much as possible. Not all these coping strategies are useful or helpful in the long term, especially when managing trauma and loss, but these strategies link with the emotion-focused and problem-focused styles of coping and can assist with assessing what strategy a person has chosen, so can assist them in managing differently, if necessary.

The researcher prefers the description of 'managing a response' rather than 'coping', especially within the context of ongoing trauma and violence, as it seems to give permission to manage well or not well. It is recognizing where the person is at in dealing with the difficult or traumatic situation. 'Coping' gives the impression that the person is doing well and more than just surviving the situation when this may not be the case. "Not all coping strategies are likely to reduce distress" (Schonfeld, 1990, p. 142). Hence, literature has developed to include unhelpful coping strategies that could include: "dysfunctional coping" (i.e. less useful coping techniques such as venting of emotions and behavioural and/or mental disengagement, which may be identified as helplessness); 'denial' and use of substances (Carver et al., 1989). Mancini and Bonanno (2006) also observe that some people may endure horrific events without experiencing significant disruptions in functioning.

Folkman and Moskowitz (2004) consider that coping is a process and should be analysed as such – including the environment/context, a person's interactions; cognitive appraisal processes and biopsychosocial outcomes. This links to Bronfenbrenner's (1999) 'person in environment' description and including all aspects in understanding the response of the person. Park (2010) describes coping as positive reinterpretation, religious coping, emotional social support, acceptance and emotional processing coping. Social support is recognized as a significant and important form of external support which guides how a person can respond. Even perceived social support can have a helpful and protective factor to the person's experience (Cluver, Fincham, & Seedat, 2009). This support is usually accessed from family or friends and even co-workers (Salston & Figley, 2003; Hattingh, 2001; Rice, 1999). This support is sought for seeking advice or

information or sought for emotional reasons, getting sympathy and understanding. “Workers who are unable to communicate with co-workers about their reactions to various difficult situations [at work] may have more difficulty seeking support, and therefore, be at increased risk of experiencing feelings of isolation” (Palm et al., 2004, p. 76).

Lifton (as cited in Pomeroy, 1995, p. 100) explores three ways in which trauma can impact a person: transformation; rigid fundamentalism and fragmentation. A transformative process allows for healing of damages that trauma can inflict on a person: physically and mentally. A person may establish boundaries to protect themselves but continue to always feel under attack – a rigid fundamentalism is then how the person interacts with the world around them, which feels very unsafe. In the fragmented response, a person has lost boundaries, trust and connection. A person with this response often has reactions that could reflect rage, terror and/or numbness. On the other hand, Wolfer (2000) describes three coping methods of black women of community violence which include: getting away; getting along and getting through. ‘Getting away’ included staying indoors or leaving the neighbourhood for a night or a day. ‘Getting along’ included learning ways of interacting with community members in spite of fear or uncertainty. This included recognizing and minimizing interaction with dangerous people or situations. ‘Getting through’ recognized that not all violent events could be prevented, thus other ways of coping were developed including using drugs and alcohol or praying or listening to gospel music to manage distress (Jenkins, 2002; Wolfer, 2000). Brady (1999) adds to this discussion by highlighting that victims of violence may also be more sceptical of any help offered which may make treatment and recovery more difficult, hence ‘getting through’ ways of coping are more linked to self-management and self-medication.

Tummers, Bekkers, Vink and Musheno (2013) look at ‘coping’ as a response to job stress, especially in community or front line work. They define it in three main ways: worker modifies the client/patient demand (use available resources to manage service delivery); or modifies their objectives of the job (focusing their job or choose to not manage certain cases) or they modify their perception of their clients/patients (this may be favour over some groups than others, but will treat this group in a way that they feel is ideal). In a study on workplace violence, in the Western Cape, the avoidant coping style (especially when an individual does not think that they have support from their organization or community where the event happened) was noted and this was reflected in the participants’ lives as an increase in displaced aggression (which spilled

over both at work and at home); increased fear of the community in which they lived and/or worked; and a sense of constantly feeling traumatised, 'on-edge' and anxious (Bowman et al., 2009). Soon after a crisis, avoidant coping can help manage day to day activities, but a reliance on this coping style over time can lead to mental health difficulties and worse overall mental health outcomes (Holahan & Moos, 1987). Trauma experiences at work may become difficult to separate from home experiences and descriptions of everyday living as well as descriptions of violence.

In understanding coping behaviours at work, it is useful to assess the behaviour independently of the stressors at work and yet should be linked to the job context (Schonfeld, 1990). This links to the importance of understanding context and defining what structure or strategies would be useful to have in place to support a person with the challenges they face in the work context.

2.9.2. Making meaning

The trauma impact, response and ways of coping could also be linked to the literature on 'making meaning' and the effects that meaning making has on stressful life events. Meaning making can reframe the meaning or significance of a stressful event in an attempt to reduce the emotional impact. Although 'meaning' is a concept that is quite difficult to define and describe, it is a central notion when exploring the impact of events on individuals and communities (Park, 2010). Park et al. (2010) summarizes the tenets that make up the meaning-making model. The two key components include global meaning and situational meaning. Global meaning refers to a "framework through which people perceive and understand themselves and their environment and direct their behaviour" (Park & Gutierrez, 2012, p. 9). It includes beliefs, goals and subjective feelings of purpose which include views of justice, fairness, control, luck and predictability. This then forms the core schema through which people interpret their experiences (Park & Gutierrez, 2012; Park, 2010). Situational meaning describes the specific assessments that individuals have of particular experiences and occurrences in their lives (Park & Gutierrez, 2012; Park, 2010). Hence the meaning is not always linked directly to the actual event, but rather, it relates to how the event violated the global meaning. Janoff-Bulman and Schwartzberg (1991) emphasise that the appraisals of uncontrollability (often described as part of the experience of traumatic events) imply violations of the global beliefs of the individual in their ability to master themselves or their surroundings or situations. Therefore it is important not to just focus on the event and the immediate understanding given to it but to also note the subsequent event meaning.

Making meaning continually evolves and changes throughout time as it reflects the cultural variations of values and beliefs reinforced through the social discourse (Ungar, 2013; Ungar, 2012). “Global and situational meanings share a symbiotic relationship that shapes the present and future goals of a person as well as their overarching worldviews – analysis of one kind of meaning without the other would be incomplete” (Park et al., 2012, p. 22). The understanding of these two types of meanings can help with exploring ways that people see the world and how they manage or cope with the events in their lives. “Meaning-making coping” is understood as creating ways to change either the appraised meaning- often termed ‘assimilation’ – or change the global beliefs or goals – often termed ‘accommodation’ (Park, 2010). Folkman (1997) describes meaning-making coping as using positive appraisal; revising goals and planning goal-directed, problem-focused coping and activating spiritual beliefs and experiences. This last description can also be termed ‘religious coping’ or ‘spirituality’. Activating spiritual beliefs is used regularly in global and situational meaning making (Park, 2010; Simpson & Starkey, 2006; Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001).

“Spirituality refers to the belief in a power apart from one’s own existence and implies a connection with a universal force transcending everyday sense-bound reality” (Connor, Davidson, & Lee, 2003, p. 487). Hence this links well with meaning-making and it gives a broader purpose, source of hope and meaning for the context in which the person is working or living. Religious persons use their faith to give meaning and purpose to negative events that happen to them. This explanatory framework helps them to make sense of these events – which aids in the integration and processing of the event into their lives (Harrison et al., 2001; Pearlman & Saakvitne, 1995). Ano and Vasconcelles (2005) concur with this idea when they conducted a meta-analysis on religious coping and found that positive religious appraisals and acceptance related to better adjustments in stressful situations.

2.9.3. Resilience

‘Resilience’ is another term used when looking at coping with trauma and loss. Bonanno (2004) describes resilience as the ability to maintain a stable equilibrium while Ungar (2012) defined it as the capacity of both the individuals and their environments to interact in ways that optimize developmental processes. Ungar’s definition encourages personal agency of the individual yet, with the ecological perspective, it does not blame the person for not successfully negotiating an

adverse event, especially when there is limited access to support and resources. Therefore social contexts are seen as complex and dynamic that will create an environment in which a person is more or less vulnerable to harm (Harvey, 2007). Resilience is recognized to be multidimensional and Harvey (2007) suggests that at times it is possible to see survivors of traumatic situations as both suffering and surviving – in the initial stages, it is not an either/or response. In many studies it is noted, that there is greater coping and/or resilience when there is a social support system for the person (Bell et al., 2012; Benight, 2011; Harvey, 2007; Mancini et al., 2006; Galea, Ahern, Resnick, Kilpatrick, Bucuvulas, & Gold, 2002) and personality and coping style also plays a role (Mancini et al., 2006). Harvey (2007) emphasizes being aware of the influence and role that cultural and contextual mediators play a role in impacting traumatic response and thereby resilience. Diamond et al. (2010) suggest that another resilience factor includes the nature and quality of the local, community leadership which is important when working within community.

Ungar (2013) explains that through the different studies of resilience, it has helped recognize that resilience is a set of processes that are linked to mental health and positive psychological functioning. He also noted that even when there is lack of safety in the neighbourhood and many trauma events, if the community is cohesive, this could mediate the effect and negative impact of the traumatic experience. Again, this links the importance of social support in mitigating and managing adverse circumstances.

Kobasa complements this thinking when he describes adaptive behaviours of resilient individuals as “cognitive hardiness” (Beasley, Thompson & Davidson, 2003). A further description of this is that cognitively hardy individuals believe they can control or influence events, have a commitment to activities and their interpersonal relationships and do not see life as a threat, but rather a challenge (Beasley et al., 2003). Again the importance of connection with others is highlighted as well as the view that they have some influence over events, even if it is just over their own reaction.

2.9.4. Physical health

There are descriptions which people would define as ‘coping but it has become more of a hindrance than a help over time. An example of this is that trying to keep oneself and others safe becomes the core concern around which everything else is organized. This ends up being a sapping

energy exercise rather than a helpful one (Jenkins, 2002). Also, although people may say that they are 'coping', the physical health often tells a different story. Physical health deteriorates when coping with chronic threat and frequent loss (Jenkins, 2002).

2.9.5. Debriefing and/or supervision

'Debriefing' is a term that is broadly used to refer to a form of support and defusing of feelings and reactions after an event. This could be any type of event - one that is organized and/or one that is unexpected, like a trauma event. However, Raphael and Wood (2004) state that "debriefing is contra-indicated for those who are recently and traumatically bereaved (Kristensen et al., 2012, p. 86). In latest research and literature, this is especially relevant to the victim. However, as a method of support and guidance for workers in the field, this style or method of coping is useful to verbalise feelings and concerns, and through the social support, provides an experiences in which to reframe and gain perspective on difficult or traumatic situations. It reduces isolation and allows for participants to learn from each other about what is useful, what is expected and how to manage these situations.

Lehmann and Sanders (2007) document the importance of supervision for the success of a CHW programme, yet highlights that this is usually the weakest link in such a programme. It is recognized that supervision is a cost but it develops experience, reduces isolation and increases interest and motivation in the work. In the context of lay health workers, government expects NGOs to supervise the work that they do – even if the work is linked directly to the clinic and not the NGO's mandate (Daniels, Clarke, & Ringsberg, 2012). Hence, an important element of coping seems to be building capacity in order to cope with the challenges and trauma events to which people may be exposed to.

2.10. Summary

This chapter discussed the literature review conducted to gain insight into understanding trauma and violence within the South African context and the importance of this knowledge in exploring the environment in which the community health workers work. It explored the different concepts and definitions used to understand and explain trauma, violence (including violence within the workplace) and daily stressors, with a specific focus on continuous traumatic stress. It also

discussed the literature on coping and meaning making and how this is used or not used within this setting.

Chapter Three: Methodology

3.1. Introduction

This section presents the methodological framework used to carry out this study. It begins with an overview which is further elaborated on throughout the rest of the chapter. This includes a description of the design, an explanation of the population and sampling procedure, a discussion on the tools and process of data collection and analysis and finally an account of the ethical and reflexivity issues. Strengths and weaknesses of the study are described in detail at the end of this chapter and are highlighted where relevant in this chapter.

3.2. Overview of the Research

Table 1. *Overview of the Research Study*

Research Study Element	Description
<i>Study type:</i>	Mixed methods
<i>Study length:</i>	9 - 12 month period
<i>Study locations:</i>	2 sites in Ekurhuleni, Gauteng – peri-urban: Tsakane & Thokoza
<i>Study participants:</i>	Community Health Workers within the Primary Healthcare Re-engineering directorate
<i>Inclusion criteria for participants:</i>	Participant must have worked within communities for at least 2 years and reside in the same/close by community in which they are working
<i>Actual number of participants:</i>	23
<i>Participant recruitment strategy:</i>	Purposive and Availability sampling. Working with Department of Health. The PHC re-engineering is only at pilot stage at the moment, so research was explained at two of the pilot sites and community health workers could volunteer for the study, if interested
<i>Research analysis:</i>	Qualitative data (interviews and journals) was analysed using Thematic Content Analysis Descriptive Statistics were used to analyse the quantitative data
<i>Methods of data collection:</i>	Face to face in-depth interviews Questionnaires (stressful life events screening tool used as part of the interview; Life Events Checklist (1995) used as monthly self-report tool over a 6 month period) Journaling
<i>Research instruments:</i>	Semi-structured interview schedule Stressful life events screening questionnaire (1998) Monthly: Adapted Life Events Checklist (1995) Monthly: Outline for the weekly journal

Research Study Element	Description
<i>Primary Aim</i>	To explore the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous
<i>Secondary Objectives</i>	<ol style="list-style-type: none"> 1. To explore and document the traumatic events (as measured by the Stressful Life Events Screening tool (1998) and the Life Events Checklist (1995)) that Community Health Workers could be exposed to when working and living in Ekurhuleni district 2. To describe the specific set of responses experienced by Community Health Workers directly or indirectly exposed to a traumatic event in Ekurhuleni communities in which the experience of trauma is continuous 3. To identify coping methods that the Community Health Workers working and living in Ekurhuleni have used in managing contexts in which trauma is continuous

3.3. Research Design

The research design used in this study was mixed methods so as to incorporate both quantitative and qualitative methodology. Qualitative methodology uses a wide range of strategies of enquiry to gain a better understanding and description of the phenomenon being studied. It is explorative and descriptive in nature (Bless, Higson-Smith & Kagee, 2006; de Vos, Strydom, Fouché, & Delport, 2005). Quantitative methodology relies on measurements to compare and analyse data (Bless et al, 2006; de Vos et al., 2005). The mixed methods approach is when the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts, collection and analysis in a single study (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004). Maxwell and Loomis (2003) highlight that the research questions are essential to mixed methods research as they inform and are informed by other components of the research design (Tashakkori & Teddlie, 2010, p. 283). As the research questions and objectives were finalised, this informed the need of the mixed method approach. Although the main component was qualitative - to get the experiences and responses felt by the participants – it was decided that a quantitative element would further assist in describing the actual experience by documenting the exposure to specific types of events.

Cresswell and Zhang (2009) explained three essential characteristics of the design of mixed methods research: Firstly, the collection and analysis of both quantitative and qualitative data; secondly, the collection and analysis must be rigorous and follow procedures for good research designs, and thirdly, the integrating and combining the two sets of data by either merging; connecting or embedding the data. In deciding on what and how data will be collected and analysed in terms of timing, weighting and mixing (data merge) will impact the typology of the mixed methods design chosen for a research project (Nastasi, Hitchcock, & Brown, 2010). Creswell and Plano Clark (2007) proposed four major design types based on the timing, weighting and mixing. The weighting is depicted in writing by putting the dominant design in capitals, if both designs have equal weighting then both designs would be in capitals. The four major design types include: triangulation (depicted as equal weighting of QUAN and QUAL); embedded (depicted as QUAN [qual] or QUAL [quan]; explanatory (QUAN → qual) and exploratory (QUAL → quan). Leech and Onwuegbuzie (2009) further breakdown the three dimensional typology as *Mixing*: fully or partially; *time orientation*: concurrent or sequential and *emphasis*: equal or dominance which yields eight design types with an accompanying notational system eg. A partially mixed concurrent equal status design would be depicted as QUAN + QUAL; a partially mixed concurrent dominant status design could be depicted as QUAN + qual or QUAL + quan (Nastasi, Hitchcock, & Brown, 2010).

The typology of this study was a partially mixed concurrent dominant status design: Quan + QUAL (Nastasi, Hitchcock, & Brown, 2010). A concurrent design is one in which the “investigator collects both quantitative and qualitative data simultaneously (i.e. at roughly the same period in a single phase) in the study” (Creswell & Zhang, 2009, p. 613). The data were collected over a time period of eight months as this time fitted with the time scale of the master’s project and allowed for pre- and post-interviews to be conducted. The researcher collected seven months of trauma exposure data per participant – staggered over the eight month collection period - in order to get an understanding of the community health workers’ context. The collection of checklists over period of time was chosen as it was expected to increase the dependability of the data i.e. the stability of the findings over time and the confirmability to the internal coherence of data in relation to the findings, interpretations and recommendations (Denzin & Lincoln, 1994). The study was partially mixed as the qualitative data obtained were more dominant (as the interviews asked questions that covered both exposure and coping) with the quantitative data supporting the trauma exposure information obtained through the interviews and the self-report journals (see figure 1 to illustrate the overall design).

“Qualitative research uses qualifying words or descriptions to record aspects of the world” (Bless, Higson-Smith & Kagee, 2006, p.43). Qualitative research assisted as this study aimed to explore participants’ experiences within the community in which they work and live. The experience and understanding of trauma impact was personal, thus an individual’s thoughts and feelings needed to be explored in a subjective manner in depth. The qualitative aspect of the study explored and documented the types of traumatic experiences that the community health workers had experienced in the past and present. It also questioned how the participants managed or coped with these experience. This was facilitated through semi-structured interviews and the stressful life events questionnaire.

“Quantitative research relies on measurement to compare and analyse different variables” (Bless et al., 2006, p.43). The quantitative aspect of the study included a monthly self-report checklist to record the exposure to community violence. In understanding trauma, perception and time of events may not be accurate due to shock reaction and the impact it has on memory (van der Kolk, 2007), hence the checklist and journals were used to document day to day experiences so that the researcher gained a better description of what the CHWs were exposed to within the communities in which they work. The use of a comprehensive, highly structured, and behaviourally detailed multiple-item assessment for potential traumatic events versus a structured clinical interview has been advocated by experts in the assessment of trauma for years (Elhai, Gray, Kashdin, & Franklin, 2005), hence, mixed method design increased the comprehensiveness of the study.

The majority of the information was obtained through the interviews at the beginning and end of the study and the checklists backed up the verbal information about event exposure. The intent of this mixed methods design was to understand a construct from the perspective of two different types of evidence (Nastasi, Hitchcock, & Brown, 2010; Creswell, 2007). This worked well for the aim of this study as it was to explore a concept as well as peoples’ experiences of trauma. The data collected from the interviews, checklists and journal entries were merged to examine the links and to substantiate what was recorded verbally and written down. “The emphasis is on quality rather than quantity, the objective is not to maximize numbers but to become “saturated” with information on the topic” (Padgett, 1998, p. 52).

3.4. Population and Sampling

A combination of purposive and availability sampling was chosen for this study (Bless et al., 2006; de Vos et al., 2005; WHO, 2004). Purposive sampling is based on the judgement of the researcher in that the sample was composed of elements that contain the typical attributes or characteristics of a representative sample (Bless et al., 2006; de Vos et al., 2005). There are several strategies within this form of sampling and in this case convenience sampling is relevant as it was a method that used the study units that happened to be available at the time of data collection (WHO, 2004). The rationale for purposive sampling was that the sample would be selected from a group of CHWs who were part of the pilot for the Primary Healthcare (PHC) Re-engineering Model. The population of CHWs in Gauteng in 2011 was 6388. The CHWs were directly or indirectly (through NPOs) employed by the Department of Health (DOH). Existing CHWs have been prioritized for recruitment, selection and appointment to the ward based PHC re-engineering outreach teams for the pilot phase of the project. Criteria for selection into a PHC team as a CHW included:

- Persons who are functionally literate and numerate (tested through applicant completing the application form in their own writing without assistance)
- Have at least 1 year experience as a community based health worker (2 years desirable)
- Have a positive testimonial from a previous employer (NPO or DOH)
- Resided in the area that they will be serving (in areas where there is a shortage of CHWS the “area” could be more broadly defined)
- Prepared to undergo orientation and training and sign a performance agreement
- Passed a basic competence assessment

From the Progress on PHC Re-engineering: Report to the NHC (DOH, 2011a, p.7)

The Primary Health Care Re-engineering Model was being piloted in a few provinces in South Africa. For the purpose of this study, a sample was extracted from the larger population of community health workers within the Ekurhuleni district. This district was chosen as it was part of the pilot of the PHC Re-engineering Model and was accessible due to previous work agreements.

Strydom (2005) argues that the sample is based on choosing the participants who meet the criteria for the goal and focus of the study. The criteria for the study included CHWs who were currently working in the PHC Re-engineering Model pilot and participants who had worked within community work (in any capacity) for at least two years; were from the same/nearby area in which

they were working and that the participant volunteered to be involved (Guest, Bunce, & Johnson, 2006; Babbie & Mouton, 2001). In some cases the CHW may live and work in the same area and thereby community. For most of the participants, they lived within the same broader area of Ekurhuleni though their home and work communities were different. In many cases the work community was a poorer community and would be described as an informal settlement or shack communities whereas the CHW lived in low cost or formal housing areas.

Each district has implemented the Primary Health Care Re-engineering Model slightly differently depending on the needs and resources of their districts. In the Ekurhuleni district at present there are three clinics in which primary health care is being implemented. Each clinic represents a sub district of Ekurhuleni. Each clinic has one or two teams of community health workers of eight people per team. The majority of the workers are female. Each team was linked to a specific clinic/hospital and works in the communities around the hospital, which supports 10-20% of the population of the clinic/hospital. In this study, two of the clinics were chosen for recruitment of participants by the Department of Health, mainly due to the accessibility of the clinics in terms of distance. Both clinics were based in informal settlements in Ekurhuleni: Tsakane and Thokoza. Ekurhuleni Metropolitan Municipality is a metropolitan municipality that forms the local government of the East Rand region of Gauteng, South Africa. The name *Ekurhuleni* means '*place of peace*'. Tsakane has a population of 135,994, with cultural percentage Zulu 57% Sotho 11%. The area of Tsakane is 29.74km². Thokoza has a population of 105,827, with cultural percentage, Zulu 39% Sotho 27% Xhosa 20%. The area of Thokoza is 8.65km². (Citypopulation, 2013). Both areas have a history of past political violence (especially Thokoza). For both communities the areas around them include a variety of accommodation variations including: formal housing, low cost housing, hostels and shack communities (informal home built dwellings). The shack communities are a mixture of South Africans and non-South Africans with a high level of unemployment. Therefore the community health workers are exposed to clients living in abject poverty in addition to being traumatised by violence and diseases such as HIV/Aids and cancer.

Once ethics clearance and DOH authorization for the research was granted, the district coordinator for Primary Health Care Re-engineering was then sent a letter explaining and detailing the research. Availability sampling "consists of taking all cases on hand until the sample reaches the desired size" (Bless et al., 2006, p.105). The description of how availability sampling was used

in this study: the researcher met with the group of community health workers – working with PHC re-engineering - who were based in the two identified clinics to explain the aim of the research and answered any questions from the CHWs. The CHWs then self-selected if they wanted to be involved in the study. If the CHW volunteered, the researcher confirmed that they fulfilled the above mentioned criteria (linking with the purposive sampling). The limitation of convenience and availability sampling is that it could be biased as participants self-select on interest and availability, so others may be under-selected or missed altogether (de Vos et al., 2005). To counter this, the criteria were used to provide a basis for experience and when the preliminary results were shared with participants and team leaders, it was explored whether the non-participants of the CHW teams reported similar experiences to their colleagues. The team leaders confirmed the experiences were similar across their teams – whether the person had participated in the study or not.

The sample size was initially twenty participants. Twenty Three (23) community health workers volunteered to be part of the study. All met the criteria and the researcher decided that a few extra interviews could be useful in case there was any attrition from the research project. However, no one dropped out and everyone filled out the checklists diligently so it was decided to use all the data obtained.

3.5. Data Collection

A good way to see the flow of data collection within this research process is through a diagram (see Figure 2 for a summary of the overall methodology description). Although sampling is not a data collection method, it is noted in this diagram to show where it fits into the broader methodology of the research and the importance in preparing the participants for the data collection process.

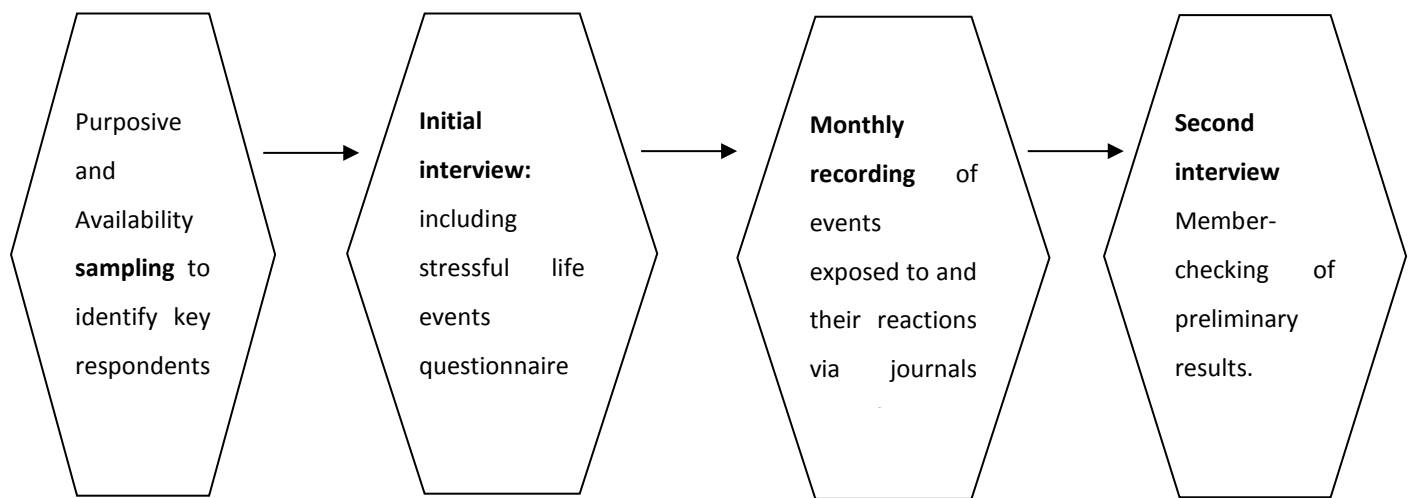


Figure 2. *Diagrammatic Representation of the Research Process*

3.5.1. Data collection process

3.5.1.1. Initial interview

In-depth interviews can be defined as face-to-face encounters between the researcher and informants. The focus of the interview was directed toward understanding participants' perspectives on their lives, experiences or situations as expressed in their own words, which was useful as a particular issue was being explored in depth (Law et al., 1998; Minichiello, Aroni, Timewell, & Alexander, 1990). Face to face, individual semi-structured interviews were conducted at the beginning and end of the study period with each of the participants. "Semi-structured interviews are very helpful in exploratory research... it helps to clarify concepts and problems and allows for the establishment of a list of possible answers and solutions" (Bless et al., 2006, p. 119). Each interview lasted for about an hour and a half. The participants were again informed of the purpose of the study as well as the support structures that they could access, if needed, during the course of the study. There were seven participants to whom support was offered at the end of the first interview as the interviewer was concerned about their current situation. All participants signed the participant consent form (see Appendix B) and the participant consent form for audio taping of the interview (see Appendix C) before the interview commenced. It was explained to participants that they could withdraw from the research process at any time. It is recognised that interviews are time consuming and therefore are more expensive to facilitate. However, the in-depth focus

required for this research could only be obtained through interviews and assisted in accessing detailed information which improved the transferability of the data obtained (Denzin & Lincoln, 1994).

The first interview explored the participants' trauma experiences and exposures to date; how they understood safety, and the ways they have coped. The researcher used a semi-structured interview schedule - which included the Stressful Life Events Screening Questionnaire - to access this information (see Appendix E). The questionnaire was used to access information from the interview in terms of what events the participants had experienced in the communities in which they live and work. The Life Events Checklist was filled out with the participant at the end of the interview so that initial data were captured and to confirm that the participant understood how to fill this out on a monthly basis.

It is important to note that English was used as the language for conducting the interviews. Interviews were conducted in English as the researcher conducted all the interviews, though it is recognised that this could be a limitation. Interviews in the first language of the participant are considered the best option of gathering data from interviews, especially when personal and emotional stories are talked about. However, all participants have been trained for their position in English and are expected to write reports in English so they all had an understanding of the language. As the researcher has worked in the field of trauma for sixteen years, this was considered an advantage as she would be able to recognise or gauge any concerns that talking about trauma could bring up for participants. The participant would be referred for counselling, if necessary. With the researcher facilitating the interviews, this assisted with identifying themes and experiences which assisted with analysis later. There were three interviews that initially seemed difficult in terms of language. In order to check out participant's understanding, the researcher either changed the structure of the questions into simpler English; or went through the checklist per event and asked the participant to repeat what they needed to do. Through these mechanisms, the researcher was comfortable that important and relevant information was not being lost in translation.

3.5.1.2. Monthly recording

Each participant was requested to fill out the Life Events Checklist (see Appendix F) on a monthly basis and a bi-weekly journal. These items documented the traumatic and violent experiences that they were exposed to within the community in which they are working during the time of the study. It was expected that the journaling would assist with documenting actual exposure rates as well as provide a process for the participants to manage their reactions to the increased awareness of events happening around them. It was emphasised that the journal was to record and process their experiences. The journal was for the participants' use, and they chose whether they wanted to fill them in, or wanted to hand them in monthly, with the checklist. The recording of the monthly checklist began in the first interview and ended at the second interview. Within the first interview, the researcher filled out the checklist with the participant, in order to get a baseline from them but also to explain the process and confirm they understood how to fill out the form.

3.5.1.3. Second Interview

The second interview occurred seven months after the initial interview. It had some of the same questions as the first interview but the focus was to access the description of the context, the experiences of trauma and of the actual research experience that the CHWs had had (see Appendix D). Preliminary results were also shared about some of the general responses and trends that had initially been identified in the data and therefore this interview was also used for member-checking and validation of data and to assist with the confirmability of the study (Shenton, 2004). By accessing both past and current experiences, this improved the credibility of the data and thereby assisted with accessing information for further understanding and exploring the concept of 'continuous trauma'. The second interview was also an opportunity to clarify and confirm any missing data from the first interview and clarifying the monthly checklist experience to confirm that the participants understood and used the process as described. If not, then participants' information would have been removed from the analysis. All participants understood the process and therefore all checklists were used. At the end of the second interview, the participants were offered a debriefing with a professional (external to the research project) about their experience in the research. No one took this offer up as they had felt that the checklists and research experience had been helpful to them in aiding them to cope with work and their personal experiences.

3.5.2. Research instruments

Each tool was pre-tested, with some changes made. Below are the descriptions of the tools.

3.5.2.1. Semi-structured interview schedule (see Appendix D)

An in-depth semi-structured interview was used with an interview schedule, with topics relating to: expectations, hopes and fears about working within the community; their own sense of safety (home/community/work); the impact of trauma on relationships with self and others; how have they coped; how have they been supported at work. It is recognised that interviews can produce vast amounts of data and that they are time consuming and labour intensive (Pope, Ziebland, & Mays, 2000). This instrument was chosen for this research as detailed information needed to be obtained for exploring and explaining a concept.

3.5.2.2. Stressful Life Events Screening Questionnaire (1998) – revised (see Appendix E)

This questionnaire “places less emphasis on disasters and more emphasis on behaviourally specific assessment of traumatic events of an interpersonal nature...[and] elicit information about some important details for each endorsed event” (Goodman et al., 1998, p. 524-525). It has also been subjected to multiple forms of validation and has excellent specificity, test-retest reliability and good concurrent and convergent validity, with the validation test being with a group of USA college students (Goodman et al., 1998, p. 536). The Stressful Life Events Screening Questionnaire (SLESQ) was evaluated in 2006 for validity with disadvantaged populations. The authors assessed the cultural validity and reliability with low-income African American women with positive results (Green, Chung, Daroowalla, Kaltman & DeBenedictis, 2006). The Stressful Life Events Screening Questionnaire was recommended for research and general screening purposes (Goodman, et al., 1998). To the researcher’s knowledge, this questionnaire has not been used in previous studies with CHWs in South Africa. This instrument was also developed to screen for exposure to trauma which is an important aspect in this research: explore and document trauma exposure.

The types and frequency of past events (which were mainly personal experiences) were explored by the Stressful life events screening questionnaire (1998). This questionnaire has thirteen items which included: life threatening illness; life threatening accident; robbery/mugging; traumatic death; sexual assault; child abuse; intimate partner violence; witnessing of traumatic event; and

war zone. The questionnaire asked closed questions about whether the participant has experienced the event (requiring a yes or no answer); and if yes, requested further information in terms of their age at the time, when it happened and the duration. This descriptive information was important as it “enables researchers to learn some of the details of the event” (Goodman et al., 1998, p. 525). This questionnaire is part of the interview schedule. It is asked as the third question so when the researcher asks about reactions and coping, specific events can be referred to if the participant struggles to think about specific scenarios or experiences.

3.5.2.3. Life Events Checklist (1995) (see Appendix F)

This checklist was developed to measure exposure to potentially traumatic events. The Life Events Checklist (LEC) has “demonstrated adequate psychometric properties as a stand-alone assessment in traumatic exposure, particularly when evaluating consistency of events that actually happened to a respondent. It has also demonstrated convergent validity with measures assessing varying levels of exposure to potentially traumatic events and psychopathology known to relate to traumatic exposure” (Gray, Litz, Hsu, & Lombardo, 2004, p. 331). The studies reported here describe the testing of the LEC with college undergraduates and combat veterans. The LEC exhibited adequate temporal stability, good convergence in associations with variables known to be correlated with traumatic exposure in a sample of undergraduates. With the sample of combat veterans, the LEC was significantly correlated with measures of psychological distress (Gray et al., 2004). To the researcher’s knowledge, this checklist has been successfully used in a study in SA with HIV positive patients in a township in Cape Town (Smit et al., 2006).

The format and structure of the checklist was user friendly and clearly differentiated between different levels of exposure which was useful to ascertain in this research. This was a self-report tool which consisted of 17 items which represented different forms/types of traumatic experiences. Events linked with the Stressful life events screening questionnaire (1998) and it had extra events which included: natural disaster; fire/explosion; exposure to toxic substances; captivity; severe human suffering and an option for any other very stressful event.

The participant filled out the checklist on a monthly basis for a seven month period. For each item, the respondent ticked whether the event (a) happened to them personally, (b) whether they had witnessed the event, (c) whether they had learned about the event, (d) if they were not sure if the

item applied to them, or (e) if the event did not apply to them at all. The participant indicated whether or not he or she experienced one or more of these events. This checklist was used to complement the interviews and assisted with the documenting of actual events experienced. This helped differentiate the direct and indirect experiences that participants were exposed to and assisted with the triangulation of emerging themes and experiences.

Participants were asked – in the second interview - to give a description of the events they were reporting so that there was a sense of what and how they understood the event. The three events that were most open to interpretation were “toxic substances”; “severe human suffering” and “any other stressful life event”.

“Toxic substances” in the actual questionnaire refers to toxic spillages and natural disasters related to toxic substances. Participants used it to describe substance abuse either in their own families or within the community.

“Severe human suffering” included families not having food; seeing people getting sicker and sicker; grief – losing close people, especially parents; no grants; no real place to stay and no water or toilets; seeing shacks burn and the person losing everything that they owned; and people living in poverty.

“any other stressful event” included young girls being impregnated (not by choice) and having to have abortions and choosing backstreet/cheap abortion; people being evicted by the red ants; people not working; men leaving their wives for their girlfriends and not supporting their children; neighbours taking justice into their own hands; children not going to school; not being able to access identity documents for patients, and seeing children left behind with no one when their mother dies. When referred directly related to CHW’s situation, it included: not being paid for work; having to deal with own stress plus the patients’ situation and that they are at high risk for getting tuberculosis (TB).

3.5.2.4. Journaling (see Appendix G)

Participants were given a journal outline that could be used to guide the participants to record actual trauma events and process their response to the event. This was a voluntary tool so not all participants used it to its full potential. Most participants used the journal structure to fill out the “life events checklist” in order to assist with the accurate recording of events and experiences. The journal was also used as a space for reflection and management of emotion (Harvard Health

Publications, 2013; Baikie & Wilhelm, 2005; Pennebaker & Beall, 1986). It was hoped that it would assist the participants in managing the increased awareness of what they are exposed to as well as develop the description of living within a context of continuous violent exposure and what coping skills were developed. The researcher also used a journal to write down and reflect on emotions and reactions after the interviews in order to “be aware of the multiple influences they have on research processes and on how research processes affect them” (Gilgun, 2010, p.1). This increased awareness was used to develop and assist with the analysis process (see Appendix H for an example).

3.5.2.5. Pre-testing of Tools

It is recognized that by using checklists, especially those that are self-administered, reliability was reduced and reporting of events was susceptible to recall biases (Dohrenwend, 2006). Dohrenwend (2006) also highlights three ways to reduce the intra-category variability by involving subjective appraisals; by giving participants the definitions of terms and by facilitating interviews. In this research, a variety of tools were requesting similar information in different ways so it was expected that by using the journals and interviews as well as the checklists, that this assisted in increasing the validity and reliability of the data obtained.

By using all four of these instruments it was hoped that the reliability of events reported and experiences shared would assist with data triangulation and therefore in accessing the information that was needed to answer the research questions. All four of these instruments were pre-tested. “This step is essential in ensuring that the measuring instrument is going to measure or provide the data the researcher is seeking” (Strydom, 2005, p.206). Four community health workers - not from the teams who were interviewed for the research - were interviewed and given the questionnaires and journaling outline. Changes were made to some of the questions in the semi-structured interview (see Appendix D). The checklist and screening questionnaire are standardised tools, but feedback from the CHWs assisted in better explaining their use and clarifying concerns that participants may have in using them. Some words of the tools were adapted to suit the South African context by clarifying or explaining terms/words used within them e.g. in the checklist, giving examples of exposure to toxic substances and in the screening questionnaire, instead of using the word ‘mugging’ used ‘attack’. The Life Events Checklist was also further modified to identify where the participant had experienced, or witnessed or heard about the traumatic event

i.e. P= happened to you or to someone close to you; W= happened at work (this included both the clinic and community in which the CHW worked. So the event would happen during working hours); C= happened in the community (this described the community in which the CHW lived) (may/may not know person); M = media (local; national; international). The modification of the tool could influence validity and reliability of the tool.

Generally interviewees reported that although some of the questions were quite personal and at times difficult to answer, they felt the process was helpful as it helped them to recognise what they had experienced but also assisted them in identifying how they had managed the event. This was a consistent response that the participants shared with the researcher.

Summary of Research Interviews - Researchers reflections

An outline was drawn up to capture key information for each interview (see Appendix H). This made it easier for the researcher to go back to the interviews at a later stage. Included in each interview summary sheet was a space for the researcher's reflections (see Appendix H). This made it easier to analyse reflexivity both during data collection and in the analysis of the research.

Padgett (2004; 1988) emphasizes the importance of employing various methods of data collection and tapping various sources of data. By using standardized tests to support the data coming from the interviews, it was expected that this assisted with *triangulation* of data and therefore improved the *rigor* and the *credibility* of the research. Triangulation was a means of corroboration, which allowed the researcher to be more confident of the study conclusions (Bowen, 2005). As the research methodology accessed information from the participants' pasts (though the first interview); from their present experiences (7 month documentation and second interview) and explored how they had coped (both in the interviews and in journaling), this increased different descriptions of their experiences and therefore increased the credibility of the study. It helped to better understand the relationship of the participants within their context, understand the effect of the context on the CHW and therefore assisted in the exploration the concept of 'continuous traumatic stress'.

3.6. Data Analysis

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data (De Vos et al., 2005). The initial qualitative thematic content analysis highlighted themes, concepts, interactions and structures relevant to the research focus and questions. The quantitative data from the checklist and screening questionnaire documented and provided further evidence and thereby assisted in the description of the themes identified.

3.6.1. Qualitative data analysis

“Qualitative research uses analytical categories to describe and explain social phenomena” (Pope, Ziebland, & Mays, 2000, p. 114). Data obtained in qualitative research was analysed through objectively extracting categories, themes and patterns in the data collected, in order to create meaning in the study (Fereday & Muir-Cochrane, 2006; De Vos, 2005; Babbie & Mouton, 2001). In qualitative component of the research, it was recognised that the “analytical process begins during data collection as the data gathered are analysed and shape the ongoing data collection” (Pope, Ziebland, & Mays, 2005, p.114). This highlighted the importance of the researcher facilitating the interviews, as themes and experiences of the interviews guided the whole research process and analysis. Reflexivity is essential for this process so that the researcher was not overwhelmed by the volume of information (both emotion and content). Therefore, the organising and analysing of the data, themes and experiences were able to be identified and learned from the interviews and checklists (Watt, 2007; Mauthner & Doucet, 2003).

The analysis of interview transcripts and field notes was based on an inductive approach geared to identifying patterns in the data by means of thematic codes. The steps are clearly written out so that other researchers are aware of the process and to increase the trustworthiness of the research process (Fereday et al., 2006; Golafshani, 2003). The process of analysis contained the following steps:

Step 1: listened to the recording of an interview, transcribed it and then read and re-read the transcript as well as read and re-read the journal entries.

Step 2: recognised and developed emergent themes within what each participant has said in both the interviews and journal. “Some researchers have found that the use of more than one analyst can improve the consistency or reliability of analyses” (Pope et al., 2000, p115). The themes were

then put into Nvivo as “tree nodes” and each interview was coded by the same themes. A colleague of the researcher coded some of the interviews so inter-rater reliability was used to check consistency and reliability of themes and codes that were identified by the primary researcher from the interviews.

Step 3: read and documented types and number of events each participant was exposed to over the seven months as stated in the interviews and this was linked and compared to what was recorded in the monthly Life Events Checklists (presented on an excel spread sheet).

Step 4: explored the previously identified themes for connections and patterns between them. Triangulated emerging themes with the data collected about the type and number of events exposed to. Recorded links between themes and experiences.

Step 5: involved repeating the process for each participant interview.

Step 6: brought the themes and patterns of each participant together and identified themes and experiences which existed across all of the participants.

Step 7: brought together the themes and linked them to the types and levels of exposure - recorded in the quantitative scales. The participants were informed of what had come up generally in the research analysis in the second interview and this respondent validation assisted with analysis and confirmability of the data obtained.

Step 8: findings were documented and written up in the results and discussion chapters.

3.6.2. Quantitative data analysis

The data collected from the stressful life events questionnaire and the life event checklists were used to validate the information from the interviews and journals. This data described and ascertained the types of traumatic events participants were most often exposed to, how many months it had happened over the research period and in what way they were exposed (directly or indirectly). The data for each tool was put into an excel sheet which linked the different variables of each community health worker. The two sheets were then put into Statistical Package for the Social Sciences (SPSS) so that the researcher could calculate descriptive statistics and demographic information. Frequencies were aggregated to differentiate prevalence of different types of events and differentiate direct and indirect experience. This was done for each experience: direct (personal) and indirect (work, community and media). To investigate which type of events were experienced in which areas, cross tabulation was used. The information from this analysis is presented in a later chapter (results and discussion) in a table format so the types and numbers of

exposure can be easily read. This information was used to triangulate with the emerging themes of the qualitative data (see step 7 above). In terms of hermeneutic content analysis, the aim was to represent the meaning content of non-numerical data with some numbers of statistics (Tashakkori & Teddlie, 2010). Berelson (1952) states that “by definition, content analysis must be objective” (Tashakkori & Teddlie, 2010, p. 387). Hence, applying numbers to some of the information collected, increased the objectivity of the data and hence the validity of the data and the analysis.

3.6.3. Merging and interpretation of data

As per figure 2: Data Collection Process, the final part of the analysis was to bring both the quantitative and qualitative aspects together with identified patterns, themes and convergences. The quantitative results supported and added additional insights and meaning to the qualitative data (Bergman, 2010) which enhanced the credibility, reliability and dependability of the data and therefore trustworthiness within the research process which is discussed in more detail below.

3.6.4. Trustworthiness and rigor

“Establishing trustworthiness ensures the quality of the findings” (Law, Stewart, Letts, Bosch & Westmorland, 1998, p. 8) and attaining rigor is about incorporating and maintaining reliability and validity as part of the qualitative research process (design and methods) and analysis (Lietz, Langer, & Furman, 2006; Shenton, 2004; Golafshani, 2003; Morse, Barrett, Mayan, Olsen, & Spiers, 2002).

This section has been written to summarise the key strategies for this research process. Lincoln and Guba (1985) describe the four aspects of trustworthiness (and therefore rigor) as credibility, transferability, dependability and confirmability. The strategies and processes to manage these four aspects are discussed below.

3.6.4.1. Credibility

Credibility is about “internal validity...how congruent are the findings with reality?” (Shenton, 2004, p. 64). Thinking about credibility was key for both developing the design and methods for the research process. In order to strengthen the validity of information given, both interviews and standardized checklists were used to access information. Participants were also given their own

journal sheets to write about their responses to events. This helped them both reflect and manage the emotion that developed from the increased awareness of trauma exposure as well as assisted in documenting traumatic experiences that they have. Information from the different methods of collection assisted with data triangulation. Strategies used included: reflexivity; interview technique; establishing the authority of the researcher (Krefting, 1990, p. 217).

3.6.4.2. Transferability

Transferability is about “demonstrating that the results of the work at hand can be applied to a wider population” (Shenton, 2004, p. 69). The study was small but by using different sub-districts it is hoped that this has assisted in identifying similarities and differences and seeing how transferable the same research could be in different contexts in South Africa. Strategies used included: purposive sample; comparison of data; dense description (though in-depth interviews) (Krefting, 1990, p. 217).

3.6.4.3. Dependability

Dependability is about the issue of reliability – if the work were to be repeated, would similar results be obtained (Shenton, 2004). One of the ways this has been addressed was that the processes of the study have been reported in detail so that another researcher knows what was done. Also inter-rater reliability was done i.e. another researcher was given the same transcripts and asked to code them and similar codes were identified. Strategies used included: triangulation; code-recode procedure (Krefting, 1990, p. 217).

3.6.4.4. Confirmability

Confirmability is about “confirming real objectivity” (Shenton, 2004, p.72). A key aspect of this was for the researcher to remain as objective as possible. This was done through a “reflective commentary” in which the research reflected on the stories and actions she received from the interviews, checklists and journals in order to keep some distance to the information and to not get caught up in the emotion. The quality of transcripts was also an important component of rigor for qualitative research. To minimise errors in transcribing, an assessment of transcripts was routine practice (Poland, 1995). The interviews were transcribed. The researcher chose random interviews from the transcriptions and went through the tape and transcribed material to

compare whether the same detail and description was the same in both written transcripts. Transcriptions were of a high quality. The researcher then read through all transcripts to initially pick up themes and then read through the interviews again to do the coding. Reading through the transcripts was essential for accessing the themes so clear and direct transcription was essential. Member checking of the information was used in the second interviews as the researcher shared the key themes that had come through the initial interviews and checklists and confirmed with participants if the preliminary findings described their experience. Strategies used included: double checking transcription; triangulation; member-checking; reflexivity (Krefting, 1990, p. 217).

3.7. Ethical Considerations

Proposals for this research were conducted in accordance with the protocols and procedures specified by both the research and ethic committees of the district and the university. The Wits Ethics Committee granted ethics in November 2012 (see Appendix I) and the Department of Health (Ekurhuleni) authorized the research in March 2013 (see Appendix J) and the district coordinator for Primary Health care Re-engineering was sent a letter explaining and detailing the research.

There are the eight ethical considerations- collated by Strydom (2005, p. 58-66) - that need to be taken into consideration in a research context: avoidance of harm; informed consent; deception of participants; confidentiality; actions and competence of researcher; cooperation with contributors; release or publication of findings and debriefing of participants. Each of these will be further explored below:

3.7.1. Avoidance of harm

The participants were working within environments that may be unsafe as this was part of what the study wanted to clarify and document. As part of the initial discussion and signing of consent forms, safety plans for the participants within their work and home contexts were discussed and agreed. In the individual interviews, the life experiences were, at times, quite difficult to talk about and the researcher used her skills to manage potential disclosure and heightened emotional response and suggested referral when necessary. Participants were given a counselling organisation's name and number when they signed the consent form. Therefore, if difficult

emotions or reactions came up for the participant during the research process, they could access further support or counselling free of charge.

3.7.2. Informed consent

For the participants to be involved, they were asked to sign a consent form. All involvement in this study was voluntary and a participant could leave at any time, if they so decided. Participants signed consent forms both to be part of the study and for the interviews to be recorded. Audio tapes and transcripts were securely saved in a password folder and transcripts that were printed had no identifying details on them (other than the code number given) and were kept in a locked filing cabinet. As the work was done within the context of health care, the employees were from the Department of Health hence approval from the district department was also obtained (see Appendix J).

3.7.3. Deception of participants

Strydom (2005) defines deception as the deliberate withholding of information or facts resulting in the participants not being fully informed. The research had a clearly defined goal and research questions. This was explained to all participants during their pre-interview briefing and when obtaining consent at the first interview. It is hoped that this would protect participants from deception. Participants were given a verbal explanation of the research (as a group and individually). Each person was given an information sheet that detailed the purpose and process of the research. Each person was promised confidentiality and anonymity as they were given a number and their names would not be used in the final report. Also, participants were given the assurance that they were free to discontinue their participation at any time without being required to offer an explanation. Participants were also given the preliminary results and further explanation of how quotes would be used in the report so they could decide (after participating) whether they were comfortable with having their stories written and shared anonymously. All participants agreed to their quotes being used in the report and other publications.

3.7.4. Confidentiality

Sharing experiences of violence and trauma are personal and often difficult to talk about to others. Confidentiality was discussed with each participant so that they were aware that their

stories would not be directly shared with others in the research or in the research report as general themes from participants' experiences were identified and not personal detailed stories. Anonymity was discussed with the participants with the assurance that any quotes or information quoted in the final research report would not be directly traced back to them.

3.7.5. Actions and competence of researcher

The researcher has been working in the field of trauma for seventeen years. She is a social worker by training. Due to this experience, the researcher is aware of the need for sensitivity as well as questioning skills in exploring experiences of trauma and violence in people's lives. The research project that the researcher did for her honours degree looked at the experiences of asylum seeker and refugee children and adapting an adolescent group programme to the needs and experiences of the children from 8-12 years.

3.7.6. Co-operation with contributors

Strydom (2005) recommends that all expectations be formalised prior to the research being undertaken to avoid any later dissatisfaction or misunderstanding. Agreements were finalised between Department of Health and Wits Reproductive Health and HIV Institute in terms of the expectations of the actual research process (how, who and where) as well as agreements in terms of reporting back on the findings and recommendations.

3.7.7. Release and publication of findings

Strydom (2005) proposes that findings of research need to be presented in such a way that the reader will be clearly informed as to the research findings. Research reports need to include strengths and limitations as well as future recommendations for the research. "Participants also need to be informed of the research findings" (Strydom, 2005, p. 66). The participants, Department of Health and Wits Reproductive Health Institute (Wits RHI) will be informed of the results. The research findings will be released through the submission of an academic report to the University of Witwatersrand. Copies of this report will be provided to the Department of Health and Wits RHI. Additionally the researcher intends submitting a journal article in order to share the findings with the wider research and practice community and has been requested to present the findings at the annual Department of Health Gauteng Research Conference.

3.7.8. Debriefing of participants

At the signing of the consent form, participants were given a counsellor's name if they felt they required counselling support and then at the end of the second interview, the participant were offered a debriefing session with a professional (external to the research project) about their experience in the research. The journaling structure was also a way for participants to reflect and debrief about their work and the research process (see Appendix G). How to use the journal outline was explained to each participant at the beginning of the interview process. Some participants submitted the journal each month, so if a concern arose from these descriptions, an appropriate referral for support could be made. At the end of the research process, the participants had shared about how helpful they found the research process and no one took up the offer for debriefing.

3.8. Reflexivity

South Africa constitutes a highly complex and layered society where Apartheid and violence have shaped social identities and maintained social divisions within a wide range of racial, linguistic, class and life experiences. The nature of this research converges with the social divisions and the nature of asking about traumatic experiences was also potentially emotive for both the participants and the researcher (Schmid, 2010; Dickson-Swift, James, Kippen, & Liamputtong, 2009).

"Since the researcher is the primary 'instrument' of data collection and analysis, reflexivity is deemed essential" (Watt, 2003, p. 82). As the researcher facilitated the interviews, and read the journals and inputted the data from the checklists, it was also important that the researcher kept a reflective space. This space was used to reflect on the information that was shared and her own responses and reactions were identified both within the actual interviews as well as how this related to the greater complexity of interaction of roles, position and race. At the end of every interview the researcher wrote down her general comments about the experience; any questions or comments she was left with as well as noted her emotional response to the participant and the content of the interview (see Appendix H for two examples).

By engaging in an ongoing dialogue through the journal writing (keeping note of recording reflections: observational note, methodological note, theoretical note and analytic memo), it assisted the researcher in coding and in identifying patterns and recurrent themes as well as processed any emotion that was linked to the content of the interviews (Gilgun, 2010; Watt, 2007; Mansfield, 2006; Mauthner & Doucet, 2003). The process and experience of reflexivity will be commented on throughout the findings and discussion chapter.

3.9. Strengths and Limitations of the Research

3.9.1. Strengths of the research

3.9.1.1. Mixed methods research

Mixed methods research offered a methodology that allowed one to describe and develop techniques that are closer to what researchers actually use in practice (Johnson & Onwuegbuzie, 2004). This methodology of the research allowed for the researcher to extract aspects of peoples' experiences (personal and work) in a naturalistic manner to access interesting and useful information in understanding their context which contributes to the concept of 'continuous traumatic stress' and will hopefully assist in training and support of this cadre of worker. The ability to be able to triangulate results between the quantitative and qualitative data gave a broader view of the experiences of the participants, both what they had been exposed to as well as detailed descriptions about these experiences for them.

3.9.1.2. Longitudinal study

Longitudinal studies spread data collection over a period of time. In most cases it involves evaluating the same group of people over time or a specific phenomenon (e.g. unemployment) over time at the same period of each year (Bless et al., 2006). Although this is not a longitudinal study that spans years, it does span a period of eight months and includes an interview at the beginning and the end of the study which expands the amount and type of data that can be collected and further supports the exploration and understanding of the number of times that people experience traumatic events.

Over the research period, the researcher collected the monthly checklists which seemed to be interpreted by participants as an investment of the researcher in the research. There was a monthly visual and verbal connection and acknowledgement of collecting forms which the researcher supposes aided the consistent checklist completion. The researcher valued the participation and commitment of participants.

3.9.1.3. Process of the research

Conducting the second interviews was important for the researcher who was able to find out how the participants coped generally with the increased awareness of trauma events as well as what they had valued about the research. It was not an expectation of the researcher but the participants spontaneously shared how the first interviews and sharing of past trauma stories was a relief for them. The researcher was aware that performance in interviews to be a “good participant” could be part of the eagerness and investment of the participants. Some participants talked about feeling that they had been “healed” by talking about the traumatic experience in the first interview. The researcher is aware that “healing” cannot happen in one interview but recognized the relief that was felt and shared by participants because of their story being heard. Being heard and having one’s story witnessed was a powerful and important consequence to the interview process.

Rice (1999) emphasizes the importance of social support and therefore acknowledgement of one’s experiences. Having past experiences acknowledged and validated seemed to increase the interest and engagement in the research as there were no major difficulties in participants fulfilling the requirements of the research. Also the expressed appreciation of the checklists and journals was an unexpected consequence of the research process. The researcher expected it to increase vulnerability (Rogers & Kelloway, 1997), instead, it had a positive impact in helping people understand their current situations which assisted both with thinking about how to respond in the present as well as to how to respond or plan for the month ahead.

3.9.2. Limitations of the research

3.9.2.1. Generalizability

Although it was a mixed methods design, the sample size of twenty three participants was relatively small so the results are treated conservatively and quantitative findings had a limited *generalizability* (Shenton, 2004). The generalizability was affected by the sample size and the non-probability nature of the sample. It was however hoped that by exploring two different clinics that this assisted in increasing the *relevance and the validity* of the findings for understanding the context in which community health workers are working within South Africa, particularly in Gauteng.

3.9.2.2. Credibility of interviews

The other limitation of the interviews that could affect the *credibility* (and therefore trustworthiness) of the study was that they were facilitated in English. It is recognised that when talking about personal and emotional stories (of which trauma is such), it is easier to talk about it in your first language. Some nuances and explanations may have been lost. However, the researcher has been working in the trauma field for seventeen years and through counselling, training and research, has worked both with translators and with second language speakers. As this was a sensitive topic and questionnaires asked specifically around trauma events, it was important that the researcher had the skill to manage the responses and potential emotion that the questions triggered. It was felt that the researcher had experience in this, and therefore would be best to facilitate the interviews. By the researcher facilitating the interviews, this also assisted with the analysis at a later stage.

3.9.2.3. Reliability and validity of questionnaires

Goodman et al. (1998) describe the challenges of assessing traumatic exposure hence both interviews and questionnaires are used to increase the *reporting consistency* and the *incident validation*. As discussed earlier under the tools, both the Stressful Life Events Screening Questionnaire (1998) and the Life Events Checklist (1995) have been standardized and their *reliability and validity* has been tested (Green et al., 2006; Gray et al., 2004; Goodman 1998). As mentioned previously in pre-testing of tools, the modification of the LEC could influence validity and reliability of the tool.

As the Life Events Checklist and the journal are self-report tools, disclosure of information may not be accurately reported due to the private and sensitive nature of the topic. Yet, it was anticipated that over an extended period of time (seven months) and in conjunction with interviews, this has improved the *rigor* and *dependability* of the data that was provided.

Although exploring 'coping' was part of the secondary objectives, this was not specifically measured by a tool. 'Coping' descriptions were based on anecdotal and interview discussions. It may have been interesting to measure how the participants were coping, as opposed to just recording their own experiences of it. This may be a rich area for further research or exploration.

3.9.2.4. Researcher bias

Although the researcher's experience and interest in trauma may have been useful (her sensitivity, questioning skills in exploring experiences of trauma and in containing emotional arousal), this experience also brings a bias to the researcher's focus and interest in the data obtained. "By engaging in ongoing dialogue with themselves through journal writing, researchers may be able to better determine what they know and how they think they came to know it" (Watt, 2007, p.84). The use of different methods of accessing data, and having the researcher reflect on the process through her own journaling and the respondent validation in the second interview, has hopefully helped to reduce this bias.

3.10. Summary

This chapter has discussed the research design and methodology in detail. It also included the research instruments, the method of distributing and collecting the questionnaires to ensure a research process that was valid, reliable and met the ethical considerations. It explained the practice of reflexivity and the importance for this to be part of this research process.

Chapter Four: Results and Discussion

4.1. Introduction

This chapter offers an overview of both the quantitative and qualitative results. It begins with a description of the participants' demographic details. The data are organised according to the research questions, and are presented separately in tables or diagrams or themes as well as interwoven together with quotes, as appropriate. As the results and discussion are both in the same chapter, theory is incorporated throughout. Results are initially presented and at the end of each section there is a specific discussion linking the findings with relevant theory. The researcher's own experience and reflections are also incorporated into some of the discussion and results throughout this chapter.

The key themes that emerged from the qualitative interviews are described below in Table 2. All findings will be discussed under the three research questions: Traumatic events to which community health care workers are exposed; Responses to trauma and Coping and support.

Table 2. *Broad themes from the Thematic Analysis*

Themes	Description of theme	Page no.
Most difficult trauma experience	Participant describes their most difficult traumatic experience	78
Responses to traumatic events		108
- Own responses to the event	- Personal reactions to trauma	109
- Responses to others who experience event	- Description of participants' reactions towards others who have had traumatic experiences	113
- Others responses to participants after an event	- Descriptions of others' reactions to the participants trauma experiences	115
Safety	Exploring the topic and experience of safety	117
Lack of safety	Exploring the understanding and experience of lack of safety	121
Coping and support	Ways that participants coped and the support they accessed	128

4.2. Research Participants' Demographic Details

Twenty two of the participants were women and one was male. The majority of community health workers within Ekurhuleni are women. They had all been working within their communities for a number of years in different roles, including volunteering in schools or for community projects, but mainly home based carers. The minimum that a participant had worked in community type work had been two years and the maximum was thirteen years. There was a lot of different work and community work experiences within the group. The participants had been part of the primary health care (PHC) re-engineering pilot model for the past 1-2 years. When initially interviewed, some had only been part of the PHC re-engineering pilot model for six months, though they had been involved with working in their community for a number of years. One of the minimum requirements was the interviewee was to have worked for at least two years in the community. There was quite an age range within the group from the youngest being 23 years and the oldest being 59 years. Due to the age differences, this also accounted for the varied lengths of time working in the community and the vast experiences of both community work and trauma experiences. The below table describes the participants when first interviewed in March/April 2013 (see Table 3 for descriptive statistics for the Community Health worker participants).

Table 3. *Descriptive Statistics for Community Health Worker Participants (N=23)*

Statistic	Age (years)	Years in Community Work	Years in Primary Health Care Re-engineering
Mean (SD*)	38 (8.87)	6.74 (2.96)	1.6 (0.56)
Median	37	6	2
Minimum	23	2	0.6
Maximum	59	13	2

*SD = standard deviation

4.3. Traumatic Events to which Community Health Workers are Exposed

To understand exposure to traumatic events, this study looked at both the participants' traumatic life histories and current trauma in all areas of their life experience. Traumatic life history was documented by using the Stressful Life Events Questionnaire, and current traumatic situations were recorded by the adapted Life Events Checklist (LEC). There was a concern of bias in the data collection due to self-selection. It was agreed that preliminary feedback of results would be given to the participants and their team leaders. The team leaders stated that the experiences expressed by the self-selected participants were similar to the challenges and experiences shared by the other CHWs that they support. There were no noteworthy differences between the two clinics.

4.3.1. Exposure to events: Traumatic life history experiences

To understand the types of direct and indirect events people have endured, participants were asked about their traumatic histories. Table 4 is the summary of the results of the Stressful Life Events questionnaire which states past direct and indirect experiences that CHWs had had at the time of the first interview. The experiences were mainly related to personal life events rather than events that had happened in a work context. This is important to note as this adds to the continual nature of traumatic events. It also helps understand that even home or their own community in which they live is not considered to a safe place in which to manage and process the stresses and challenges of their work context. The table below has the types of events in the order of frequency. In some cases, a particular past event may have happened more than once to a person yet this was not reflected below. As the age range of the group was vast, it was difficult to look at the pattern at different ages. The median age of when the event occurred is recorded in the table. The percentage of participants who experienced the event is recorded in the table below to the second decimal point.. However, in the discussion the percentages have been rounded off to assist with flow of reading the material.

Table 4. Summary of Stressful Life Events Checklist (N=23)

Type of Event	Number of participants that experienced it (N=23)	Percentage of participants	Median Age when event experienced
Physical force or weapon used against you in a robbery or mugging	14	60.87%	28
Been present when someone killed? Seriously injured? Sexually or physically assaulted?	14	60.87%	28
Someone died because of an accident, homicide or suicide	13	56.52%	30
When a child, did caregiver slap repeatedly/beat/attack/harm you	12	52.17%	9
Been in any situation where you were seriously injured or life was in danger	12	52.17%	27
As an adult, have you been kicked, beaten, slapped or physically harmed by someone	10	43.48%	24
Life threatening illness	9	39.13%	25
Someone repeatedly ridiculed you, put you down, or told you that you were no good	9	39.13%	26
Someone physically forced you to have intercourse; oral/anal sex against your wishes or when helpless/ asleep/ intoxicated	7	30.43%	14
Been in any situation that was extremely frightening or horrifying or helpless (not reported)	6	26.08%	34
Life threatening accident	5	21.74%	27
Have you had a miscarriage	4	17.39%	22
Touched private parts of your body	4	17.39%	10
Threatened with a knife/gun	2	8.70%	33

The level of direct traumatic experience and exposure in this research group's life histories was high. Table 4 highlights the impact of indirect experiences: fourteen (61%) of the participants had been present when someone has been seriously injured or killed. Of the events shared, three of them happened within a family context and eleven of the experiences were linked to community violence that was witnessed. Thirteen (57%) had had someone close to them die because of an accident, homicide or suicide. These included seven transport accidents, five fatal gun shootings, a stabbing, a person burnt and four people who committed suicide. Although the question asked specifically about accident, homicide or accident, two participants shared experiences of family members who died because of sickness (a headache and the other unknown), as they felt this had been very traumatic for them. These were examples of how traumatic life histories are a reminder that traumatic death for themselves and others is a possibility and a reality in the present and future to more than half of the CHWs in this study.

The direct traumatic experiences are defined as those in which the participant was physically harmed or their life had been threatened. Fourteen participants (61%) had had physical force or threat used against them in a robbery and in every event the perpetrator was a stranger. Twelve (52%) of the group have perceived their life to be in danger; ten of these experiences were linked to community incidents and two of the experiences were within their own family. Also 52% of the group (n=12) stated that they had been hit as a child. In all cases it was a caregiver (mother, father, aunt, stepfather, 'gogo', or uncle). However most described these as discipline experiences in which they recognized what they had done wrong.

Ten (43%) participants had been physically attacked or harmed by someone – three of these experiences were committed by strangers and the other seven were known partners (husband or boyfriend). Ten (43%) participants admitted to currently being in a domestic violent relationship. During the course of this research study, three of these women left their violent relationship. Seven (30%) participants of the sample have been raped. For the majority of this group, it was their first sexual experience and occurred when they were between the ages of 6 and 17 years when the rape occurred. In all rape experiences the perpetrator had been known: a father, uncle, neighbour, boyfriend or husband. Similarly the two incidents of 'private parts touched' were done to the participants when they were children (8-10 years) by a father and an uncle. When participants talked about being ridiculed, it was by someone in the family who had put them down

or told them that they were no good. In the frightening or horrifying situations, all those recorded were community situations, often watching someone else being killed or burnt alive. This happened when participants were over 18 years and linked to some of the current experiences that people talked about.

Literature describes the high levels of trauma and societal problems in South Africa (SA) and the influence that this has had on a person's identity, their responses to events and the choices they make about their lives (Miller & Rasmussen, 2010; Holtman et al., 2008; Patel, 2005; Rasool et al., 2002; Gibson, 2001; Higson-Smith, 2001). The results from the questionnaire highlighted the life history traumatic experiences. These findings supported the literature to date both in terms high levels of trauma as well as the different forms of trauma that are common in SA i.e. intimate partner violence; physical and sexual assault; and child abuse (Kaminer & Eagle, 2013; Suffla, van Niekerk & Duncan, 2004; Jewkes & Abrahams, 2002; Collings, 1997).

The **most difficult traumatic event experienced** was asked about in the first interview. Some of the most difficult experiences were those that the person had directly experienced, and others were experiences that they had heard about in the community. Some of the participants reported still thinking about and experiencing flashbacks about past events. Therefore some participants may have had unresolved trauma issues which could be activated by hearing similar trauma from patients (Figley, 1999). In the first interview, participants shared what for them was their most difficult experience – which was generally linked to an experience in their childhood or the recent past. The results below concur with what has been documented in reports and literature as common forms of traumatisation in South Africa (Kaminer et al., 2013; Norman et al., 2007; Suffla et al., 2004).

- **Vehicle accidents**

The most difficult experience talked about was transport accidents that ended in death. Seven people talked about these experiences of losing close family members in car accidents, sometimes being in the taxi/car as well and sometimes witnessing the explosion of the vehicle.

We came out to help the guy, it was an explosion and the guy burn inside the car, on the side of the highway [pause] so I feel that we were too slow to help the guy and I find myself guilty. (CHW 3)

Some spoke about how they still experience and see the accident.

It's coming always when I'm thinking about that accident but pictures come in. (CHW 21)

Two of the incidents talked about were hit and run experiences, with no resolution of the case to date. No resolution caused distress to the participants who continued to worry about the experience, especially when it had happened to a family member.

We both crossed the road. We didn't see the cars, fast cars, so I hear the, the sound, BOOM! When I check on my left-hand side, I see my sister lying down there and the shoes were not there. (CHW 6)

- **Community violence**

Community violence was mentioned by six participants and this included both current and past violent experiences that had been witnessed and experienced, mainly within their personal lives and in the communities in which they have lived or currently live. The memory of the event included both the visual and auditory memory for some of the participants.

Eish! There were a lot of sounds of guns and the other people, when you walk in the street, you find them. People lies down, they were dead, you must jump over them. And when the night, you'll see the guns, they light gun, you see? You see the light that they cause to that direction. (CHW 6)

In terms of the history of both of the areas in which the research was conducted, there has been a lot of community violence related to political groups fighting against each other, especially in the 1980s and early 1990s. For some of the participants the past violence still feels as real as if it was in the 90s as they still dream and can see pictures of these events.

That made it difficult because I saw lots of people die in front of me, you see? Between the children when I saw children died in front of me because they are kids and [pause] adults, you see? (CHW 10)

The description of the current violence in the community is often associated with alcohol or drug usage and linked closely with weekends or public holidays. This will be further discussed – with theory - under current exposure: physical assault.

- **Threatened by weapons**

Another six participants talked about themselves or a family member being stabbed or held up by a gun as the toughest experience. One participant shared an experience that she heard shooting when her husband was out and did not know what had happened to him – thankfully he had not been killed but the “waiting and unknown” had a powerful impact on her.

And then, I hear the gunshot, I was like – the stomach was like that [physically showing a larger stomach], I was pregnant at that moment, maybe six, seven months, but scary as I hear the gunshot being fired, and I did not know what had happened next [pause] I was shaking, and it happened so fast. (CHW 20)

For another participant, a stabbing experience ended his boxing career. He was stabbed in the eye on the same day as a friend of his was killed. Both incidents happened when they unexpectedly came across a group of men who were ready to fight in their area. This experience was linked with the community violence of the time,

Sections were fighting. We were fighting against the other areas, so it happened...I was at the gym and on our way back, we find these guys in our area. So we did try to run away, they clash with us and that is when I was stabbed. (CHW 3)

- **Violent domestic relationships**

Five participants highlighted that the most difficult experience for them was staying in and being in a relationship where there was and is domestic violence. For example, several women described getting abused and/or forced to have sex when their husbands demanded it. Their worry and fear about the impact the violence was having and had had on their children is often immense. A participant would explain that it would happen on different occasions, though at times it feels like there is a pattern for the abuse,

Maybe we are going somewhere, or I will talk something that he doesn't like, then he beats me. Uh. It happens like this. Every weekend it's a fight, every weekend. (CHW 8)

The participants also associate the beatings with alcohol use,

My husband, if he is drinking, he beats me. (CHW14)

Four participants also talked openly about domestic violence but not in their own lives (even though three people were in or had been in such relationships). For these women, the main concern or worry was about their sisters and not themselves,

Because it's my sister. If he fights her, he beats her [pause] yoh, I feel painful. (CHW14)

Linked to the above experiences, the participants felt they could handle their own violent relationships. Their concern for their sisters was that the partner used an item (e.g. spade or bottle) to beat the woman. Participants described this as leaving them helpless as they could not control when these fights would happen and they were concerned that their sisters' risk of being killed was high. One participant, although concerned for her sister, added that her sister cannot leave this marriage as he had paid lobola and it is what it is.

Three participants talked about their rape experiences as being their worst or most difficult experience. One participant talked about remembering her rape experience with her boyfriend annually on the anniversary of the event,

Rape is a difficult violence ...my boyfriend raped me on 5 May and now always on 5 May I will think about it. So 5 May I am raped forever. (CHW 11)

One participant was twelve when she was raped and she feels that this has impacted negatively on any relationship with a man that she tries to have.

Because of what my aunt's husband did to me [pause] I am not good in relationships. I can't keep relationships. (CHW 4)

Similar to research in other settings, it was clear that for these women, sexual violence profoundly changed their sense of selves and their self-perceived worth in relationships (Perilloux, Duntley & Buss, 2012).

- **Other difficult traumatic experiences**

Participants also shared another five specific experiences which included: an attempted suicide of a nephew, witnessing a shack burn down (with an alleged perpetrator in it), a son being addicted to drugs (this linked to general community fears of most of the participants as they shared their concerns about boys taking dagga [marijuana] and not knowing what was going to happen next), a

tenant doing something that brought the police to her home and the final example of the most difficult experience for a participant was watching tragedies in the world on the television (e.g. about child rape or about a natural disaster) and it felt like one could not do anything about it yet increased her fear about her own children.

The line between what happens in the residential and work community and what happens in one's own family feels very permeable and unsafe – something that the participants could not protect or control. All the participants reported having a great fear of what they have heard and experienced, and that it could and would happen to their own child/children/family – this highlights the continuous nature of traumatic experiences. All participants had had previous traumatic events (measuring at least five life history trauma events per participant). This supports the literature explaining that the violence in South Africa is normative rather than extraordinary (Evans & Swartz, 2000; Hamber & Lewis, 1997). Yet the participants' main concerns were not about historical events and how they had managed them but they were rather concerned about their and their family's current safety. This concurs with the literature on continuous traumatic stress in that the preoccupation with safety is a main concern (Eagle & Kaminer, 2013; Diamond et al., 2010).

4.3.2. Exposure to events: Current traumatic events in 2013

In order to document and understand the types of direct and indirect experiences that the CHWs were exposed to, the adapted Life Events Checklist (1995) (LEC) was used. Below, the results of the checklist are documented in a Table 5. The participant noted on the monthly LEC whether the experience had happened at least once in that month. Individually, it can be calculated how many months the participant experienced an event over the seven month period. The below table explains how many participants experienced the event at least once over the research period. Some of the events are discussed in more detail below and the number of times in which participants experienced the event over past 7 months is described in these sections. Further information on number of times the participant experienced the event over a seven month period is recorded in Appendix K. These results were shared with the CHWs in the second interview so that discussions about these experiences and how the CHWs understood and constructed the experiences could be further explored.

Table 5. Overall Summary of the Results of the 17 items from Life Events Checklist (N=23)

Item	Personal	Witness	Heard about
Natural Disaster	2 (8.70%)	8 (34.78%)	18 (78.26%)
Fire and Explosion	3 (13.04%)	20 (86.96%)	21 (91.30%)
Transportation accident	5 (21.74%)	21 (91.30%)	23 (100%)
Serious Accident	2 (8.70%)	14 (60.87%)	18 (78.26%)
Toxic substances	2 (8.70%)	10 (43.48%)	17 (73.91%)
Physical Assault	10 (43.48%)	21 (91.30%)	23 (100%)
Assault with a weapon	8 (34.78%)	18 (78.26%)	21 (91.30%)
Sexual Assault	1 (4.35%)	14 (60.87%)	23 (100%)
Unwanted Sex experience	4 (17.39%)	12 (52.17%)	17 (73.91%)
War Zone community experience	-	8 (34.78%)	15 (65.22%)
Captivity	-	15 (65.22%)	18 (78.26%)
Life Threatening Illness	11 (47.83%)	21 (91.30%)	19 (82.61%)
Severe Human Suffering	6 (26.09%)	21 (91.30%)	18 (78.26%)
Sudden Violent Death	2 (8.70%)	12 (52.17%)	18 (78.26%)
Sudden unexpected death (someone close to you)	21 (91.30%)	14 (60.87%)	12 (52.17%)
Injury you caused someone	2 (8.70%)	-	-
Other Stressful life events	20 (86.96%)	18 (78.26%)	17 (73.91%)

Trauma exposure recognizes the realness and current presence of violence in everyday life – linking the continuous nature of violence and threats and the ever present reminder and risk of damage to one’s self, or to the risk of losing one’s life (Murphy, 2011; Murphy, 2004). Trauma was experienced as being part of life, part of the every day. It was described as happening all the time and at times, felt like it was too much,

Trauma goes on and on and on. Yes, every day. (CHW 11)

I have many trauma, uh, trauma things I come across with, in the community. It’s too much. (CHW 16)

Exposure: Hearing about traumatic events

Hearing about trauma was a common occurrence for every CHW in our study. This finding was similar to studies such as Scarpa et al. (2006) who explored lifetime prevalence of hearing about violence and found that their entire sample of 518 young adults had reported hearing about community violence. In this case all participants had heard about community violence through different events. Transportation accidents, physical and sexual assault events had been heard by all. And then at least half had heard of other events, other than 'injury you caused someone else'.

But I hear, and I see all about the [events] but that thing that I hear too much is sexual harassment. I just heard the news of some people when they are talking about this sexual harassment and the car accidents, they are killing people every day, all the TV they are keeping that news on the highways, the car accidents. Ja, I hear about that all the time.
(CHW 21)

Often, hearing about traumatic events at work is because CHWs have regular access to people, developing relationships in the community. In the discussions with the CHWs, all had at least one transportation accident to talk about; sexual assaults were mainly linked to children (mainly girls but also boys) and women in the community and the unwanted sexual experience was linked to conversations about young girls, "sugar daddies" and inappropriate touching of young children. In some cases, the sexual experience was still unwanted, but was seen as a means to access money or food – transactional sex was not always seen as a choice within the community, especially with young girls.

The indirect experiences heard about were often within ones' own community. This finding concurs with previous research that reported that traumatic events were reported near to home or within the community in which people lived (Clark et al., 2011; Scarpa et al., 2006).

Exposure: Witnessing traumatic events

There were four events that were witnessed by twenty one participants (91%) and these were physical assault, transportation accident, life threatening illness and severe human suffering. This was mostly experienced in the communities that they live in, rather than the ones that they work in.

Life threatening illness was spoken about more in their work than home context. HIV is not considered by this group as a “life threatening illness” as they recognize that it can be managed. Fire and explosion (87%) is also what they have seen a lot of, mainly in the communities in which they live, but they also hear about and see the after effects in the communities in which they work.

Recent research has shown that witnessing violence may lead to fear of future violence events and may have similar negative effects as being personally assaulted or attacked (Ronzio et al., 2011; Clark et al., 2007; Eitle & Turner, 2002; Leather et al., 1998; Rogers & Kelloway, 1997). This was evident for this group of participants as the above Table 5 shows the number of participants that were exposed to events and they regularly spoke about their fear of traumatic events happening directly to them or their families (Crawford-Browne et al., 2002). There have been other studies that have shown that in relation to the witnessing of community violence in residential neighbourhoods among adults, the higher prevalence is among women in urban settings (Ronzio et al., 2011; Clark et al., 2002; Resnick et al., 1993). As all, but one, of the participants were women, this could not be compared with males but the witnessing of traumatic events was particular high for this group of CHWs.

Participants initially described trauma as what was ‘witnessed’. This description was challenged as the outcome of the research highlighted how much people hear about trauma and how this has overwhelmed them as well. When the preliminary results were shared with the participants, they all agreed that the hearing about events happened to them the most and they realised that external stories were indirect and not direct experiences of trauma. Many participants had not realised this before being part of the research. This was further supported by Palm et al. (2004) who suggested that the physical proximity to an event may relate to a greater experience of trauma symptoms – this could include witnessing – though they do acknowledge that indirect experience can also impact stress reactions. It was interesting to witness in a short time period (research time) how socially constructed narratives of trauma could change. An example is the realisation that although it felt like all direct and indirect experiences (heard about or witnessed in their work and residential community or the media) were directly happening to the participants, this was not the reality of the situation. When the narrative of the experience changed, the response to the events changed too.

Exposure: Direct experience

Twenty one (91%) of the participants had someone close to them die of an unexpected death – though all participants had experienced at least one death over the past seven months. Managing death and loss is a powerful and consistent theme for this group. Some of the deaths were due to illness, others were to do with transportation accidents, suicide and fighting. Although the item was “death of someone close to you”, some of the CHWs included patients or neighbours that lived in the street, as although they are not friends, they saw them almost on a daily basis so considered them “close, like family”. As discussed in the literature chapter, the unexpectedness or shock with a traumatic death can lead to a complicated process of bereavement (Jackson, 2013; Kristensen et al., 2012; Schneider et al., 2007; Green, 2000). These deaths are a strong reminder and realization of the risk of danger or death to the participants and their loved ones. Although many of these deaths happened in their personal life contexts, the experiences influenced how they engaged and experienced the stories and situations that they heard in the work community contexts.

Exposure: Within Community, Work and Media

This research builds on other research and aims to document the different types of exposure in terms of direct experience, witnessing and hearing about trauma events (Ronzio et al., 2011; Scarpa et al., 2006). These results are further described by analysing the experience at work, in the community in which participants’ live and in the media (see Figure 3). Figure 3 depicts the seventeen different variables measured by the scale. The bar chart below includes direct and indirect (an amalgamation of both witnessed and learned about events) experiences.

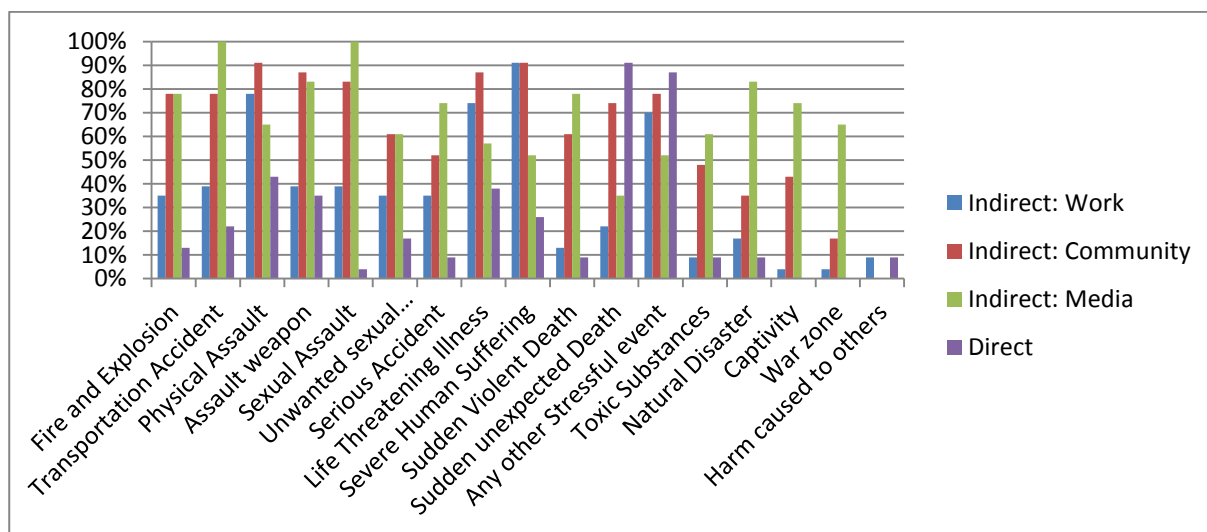


Figure 3. *Prevalence of Direct and Indirect Exposure to Traumatic Events (N=23)*

The percentages above relate to the number of participants who experienced the event and do not relate to how often the event actually happened. Although it would be interesting to talk about all seventeen events (listed in Figure 3), seven of the above events are discussed in more detail due to the high percentage of participants affected by the event. Each of these events will be discussed in terms of the results of the study and then a theoretical discussion of the findings is incorporated at the end of each section. The presentation of results focuses on the number of times participants recorded having experienced the event over the seven month recording of checklists and then more detail about where the event was most often experienced (witnessed or learned about) in the media; in the residential community or at work (clinic or work community). Although only seven events are highlighted in this discussion, all events have been further broken down into tables and bar charts. Please see Appendix K for the number of times in which each of the events were recorded over the past 7 months and Appendix L for the bar charts which outline how often the events were experienced and recorded as witnessed or learned about in work, community and media.

Kaminer and Eagle (2013) state that South Africans are “traumatised by accidental injuries such as traffic accidents and burns” (p. 148). This concurred with the results as the first two events discussed were experienced in the participants’ own community and heard a lot about in the media. Fire and explosion was an event that every participant talked about in the interviews and was rated highly on the exposure list.

4.3.2.1. Transport accident

Only five (23%) participants had been in a transport accident themselves. Twenty one (91%) participants had witnessed an accident (average of witnessing 4.23 events over a seven month time period) either while travelling themselves or from their homes (as some explained that they lived on busy roads, where accidents happened quite regularly). All participants had heard about an accident happening (average of hearing about 4.47 events) either because it was a family member, or linked to a colleague or heard about from work or the media. This links to the above description by participants as transport accidents being one of the most difficult traumatic experiences. Twenty participants had heard of more than one experience over the seven month period that they were recording events.

And transportation accident, it is strong one. Maybe your taxi it's, maybe fire and the people maybe die. Maybe five or ten die. It is a trauma. (CHW 11)

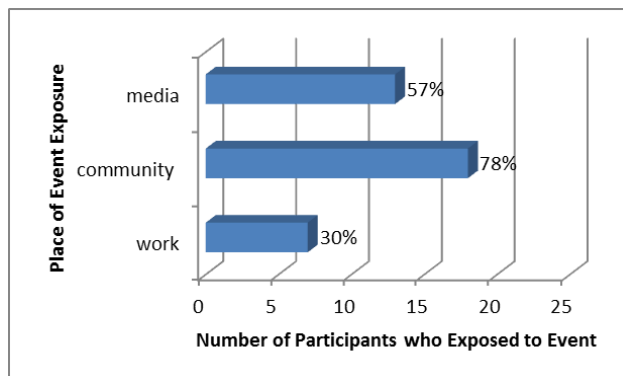


Figure 4. *Witnessing Transportation Accident (N=23)*

The majority of the transport accidents witnessed were in the participants' own community – 18 (78%). The highest number of times this incident was reported witnessed over the 7 month period was five times by four of the participants within the community. Thirteen (57%) of participants witnessed accidents on the television, usually on the news.

Because I saw an accident, not for me, for the other people. So I was so shocked, I saw an accident like this...But the accident I was seeing last, I think it's two weeks back, it was so horrible. I think there are three people on a X5 you see, and a truck. All the people has already died. So, that's why I was so shocked. But I experienced a lot. (CHW10)

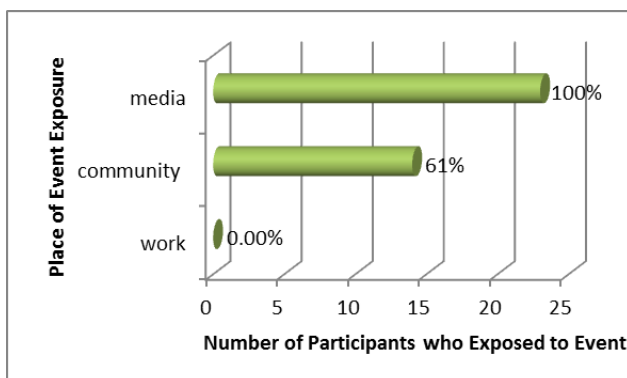


Figure 5. *Learned about Transportation Accident (N=23)*

Every participant (100%) heard about a transport accident in the media, with an average of 4.57 events. In South Africa, holiday periods such as Easter and summer holidays are often associated with high death tolls on the road. This research period covered the Easter holiday so this may have

contributed to some of the accidents heard on the media. Fourteen participants (61%) also talked about hearing about accidents in their own communities, often linking to deaths of family members or neighbours. Media gives an added dimension to access to information about traumatic events around the world and although they may not have happened in South Africa, the effect and concern about the accident was described as being in the person's thoughts and increased their fear it could happen to them.

We saw them a lot on TV and in the newspapers... also transportation accidents, there was on time with the train moving out of rails and killed a lot of people, I think it was in China... it was stressful for me even today I'm not right, still have images. (CHW 5)

4.3.2.2 Fire and explosion

This event did not happen to that many participants directly. Only 13% (n=3) had directly experienced a fire or explosion but 87% (n=20) had witnessed one and 91% (n=21) had heard about one. Though they did witness and hear about it on a relatively frequent basis. Two participants had quite a few events recorded: one participant witnessed thirteen different events, and this included witnessing at work, in her own community and on the media. Another participant heard about fourteen different events - the majority of these were linked to work or media.

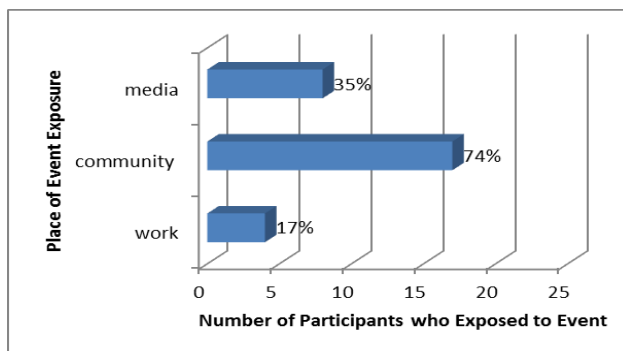


Figure 6. Witnessing Fire and Explosion (N=23)

Witnessing actual fires and explosions was seen more often in the participants' own communities (n=17), with an average of 3.4 events. Many of the fire and explosion events were described as a gas cooker exploding or a candle setting things on fire. There was a sense of helplessness expressed about this experience.

Like my neighbour last week, she was cooking inside the house, doesn't know what happened, we just heard them screaming, when we go out we find that the house was in fire. Lost everything. Even the house was falling down after that. We don't know. You can say house sometimes, when it's explode, ja. It's doing like that. (CHW 10)

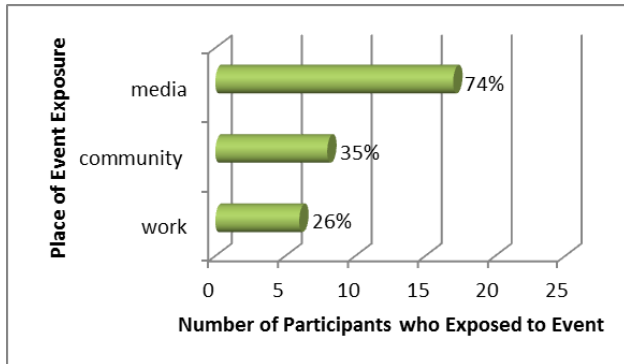


Figure 7. *Learned about Fire and Explosion (N=23)*

Hearing about fire and explosion events were mainly heard about in the media (n=17), with an average of 3.52 events. Although not many events were recorded as being heard about at work, when work experiences were recorded, they were intense and often involved known provocation by a person towards another person e.g. burning down a person's house due to anger; or burning a person (in or out of their house) if they were an alleged perpetrator.

In the community they like to kill each other, a lot. I don't know why, but they like to do that, so the other friend of mine he told me about there is somebody, he came to his house, and when he came, he found the girlfriend is not there. Was a kid inside. When he came there he did not found the mother. He go to the garage and buy the petrol and what he did, he burn the house, they are still in, the kid is inside... And then after, the mother came of the kid, the mother came he found the kid dead and then the other one is not dead yet, but he is burnt, he is burnt... So because she was cheating the kids got burnt and died. And then [the other] kid he died when, he died last – last of last week he died. (CHW 7)

4.3.2.3. Physical assault

When CHWs were asked about what they understood about the word “violence” the description given was linked to physical assault, usually linked with a person or people being high on some substance, whether it was drugs or alcohol.

It is something physical and involves beating. (CHW 11)

Table 6. *Physical Assault – number of times in which participants experienced this as was recorded over past 7 months (N=23)*

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	13 (56.52%)	2 (8.70%)	-
1	4 (17.39%)	-	5 (21.74%)
2	4 (17.39%)	5 (21.74%)	3 (13.04%)
3	2 (8.70%)	4 (17.39%)	2 (8.70%)
4	-	5 (21.74%)	3 (13.04%)
5	-	2 (8.70%)	3 (13.04%)
6	-	1 (4.35%)	1 (4.35%)
7	-	1 (4.35%)	1 (4.35%)
8	-	1 (4.35%)	1 (4.35%)
9	-	-	1 (4.35%)
10	-	-	2 (8.70%)
11	-	1 (4.35%)	-
12	-	1 (4.35%)	1 (4.35%)
Average no of events experienced	1.8	4.57	4.61

As mentioned previously, ten participants (43%) had had direct personal experience of physical assault. Twenty one (91%) of participants witnessed physical assault and everyone (100%) heard about at least one experience. Some people hearing more than ten experiences at work, on the media and within the community. At times physical assault seemed pervasive in all areas of life.

Ja sometimes it is hard, especially dealing with a community and wanting to intervene...

For an example if maybe community is beating up somebody, you want to intervene there.

Or maybe there is a house where they are evicting the people of which you don't know. It becomes very hard to go there and find out sometimes. I think sometimes we're not sure, how to go about and where to start if you want to intervene. (CHW9)

Fear of foreigners was also highlighted when talking about violence. The many descriptions were of foreigners hurting South Africans but more of a concern was foreigners hurting foreigners and South Africans hurting foreigners. The police would do nothing to intervene. The non-South African women and children would not report assault or violence as they feared the police.

The foreigners can't go to the police, they just scared. You talk to them, 'no, go to the police', unless I can take that foreigner go to the police and talk to the police, say 'no, there's not South Africans and this and this'. (CHW 10)

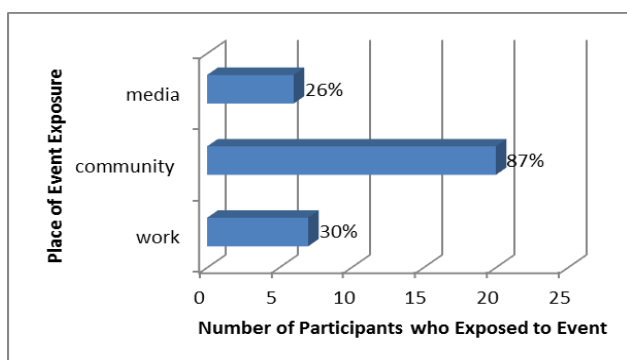


Figure 8. *Witnessing Physical Assault (N=23)*

For twenty (87%) of the participants, their experience of physical assault was in their own community. Participants had many stories about witnessing both child and relationship physical beatings.

Child abuse is too much. I stay next to the hostel. There's a child there that is beaten every day. Because the man get a child with another lady and now he married another lady. The second one [woman] does not want that child. They beat him every day. Every day. Night and day. Day and night. I call the police. The parents run away when the police come. They beat that child, he's bleeding. The neighbour took him to the hospital. (CHW 10)

That guy will come into that house and beat that lady and then that lady was screaming and then we go and see what's happened and that guy took the gun and shoot him, shoot the lady and the child, even him, you see? (CHW 12)

Other physical assault experiences witnessed were usually linked with substance abuse (participants gave examples of fights in the shebeens or on the way home from the shebeens).

When people are drunk, some they are fighting one another, in the night when – ja, they are fighting another, some they are shooting each other, you see. They drink till after they are drunk, ja, they cause violence. (CHW 13)

This increases the fear and concern of safety about being able to walk home, especially at night time.

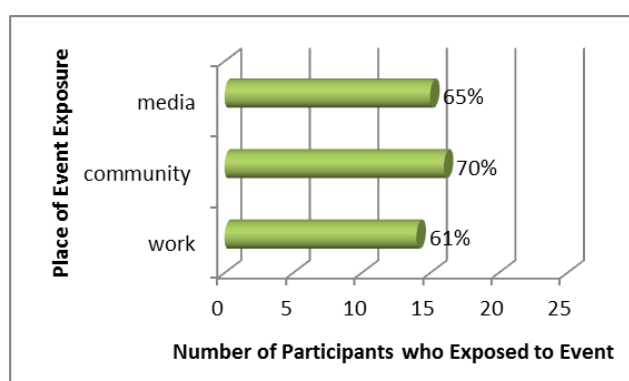


Figure 9. *Learned about Physical Assault (N=23)*

Although only 16 participants (70%) recorded events that they heard about in their community, it was talked about a lot in the interviews. Hearing about physical assault at work was recorded by fifteen (65%) of the CHWs.

And the other one, you find that I can say like that, maybe there's a father in the house, but that father is a bully, you see... Lots of our houses you find that there are bully fathers in the house. If the father's a bully, he hurts the other people. (CHW 10)

4.3.2.4. Sexual assault

Direct experience of sexual assault in the last seven months was only recorded by one participant. Fourteen (61%) of the participants had witnessed people being sexually assaulted or attempted sexual assaulted. All participants (100%) had heard about a sexual assault case over this period, with an average of 5.30 events. Only two people (9%) had heard of one experience, otherwise participants had heard about more than one experience. There was a great concern expressed by the participants about the rape and abuse of children in the community – both in their own community as well as in the community in which they work. Also the abuse of children who were

suffering, and forced to have sex with older men for food came up as a great concern among the group of CHWs.

The young mother died so the other men, they rape her [the child] so it is traumatised because when we go to the police, this man said, she is not the first one, go to the school, say this is not the first one to rape this child. Some people rape her before, you see. (CHW 13)

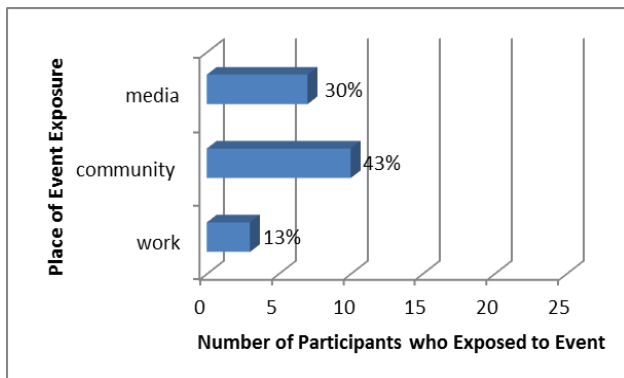


Figure 10. *Witnessing Sexual Assault (N=23)*

Most of the witnessing of events occurred in one's own community with an overall average of 2.93 events witnessed. It was recorded by ten participants (43%) as having witnessed sexual assault in the community – this would usually mean that the participant had seen the person soon after the event and they were still in shock about the experience. Witnessing it through the media would include the news or on “soapies” (TV programmes). Though the seven participants (30%) that recorded witnessing this event, usually described the actual assaults presented on the news - seeing the impact or consequence of the event.

You see, those who see people or children who have been raped. Yes the last one, eish it's too difficult, and there's a comment between this one because there's a lot of things, like in the newspaper last week I saw that two children [had been raped]. (CHW 18)

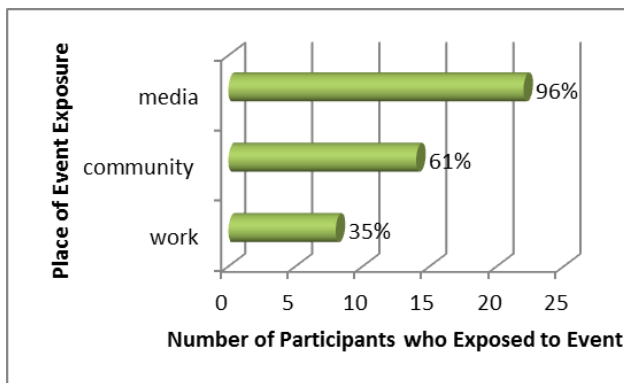


Figure 11. *Learned about Sexual Assault (N=23)*

The majority of the participants (n=22) reported that sexual assault was mostly heard about through the media (television). The stories in the media were sometimes linked to their own community 61% (14) but were usually from other communities around South Africa. Not many people (35%) reported hearing about sexual assault at work, but it was noticed that as the CHWs have gotten to know the community members better, people were sharing more stories with them. However, the stories that were heard were intense and overwhelming. For example, the one quote below does not just relate to rape but also to mutilation and death of a young lady in an area in which some of the CHWs were working. It's a story that increased fear and shocked people in terms of the brutality of the act. All CHWs that worked in this area mentioned this event and how shocked, helpless and angry it made them.

Like a girl has been raped to the community, our same community, but the rapist was not staying that side, but the girl was, they just take the girl when is eighteen or twenty, say "I found a job for you", [then] rape that girl, the last one he rape, he just, do the worst thing, he take the eyes out, then he pulls out, after she leave that girl lying there. She's go to the coma after it, is dead now, she's passed away now, and that make me feel like why, why she rape after it she take the eyes out and then he pulls out, what's happening if he isn't in prison that boy now. (CHW 15)

The raping of children is a big concern in the community, especially when it is noted that most rapists are known to the child and family and are not strangers. Transactional sex for basics, like food, was also prevalent within the communities in which CHWs work and live.

The other lady we meet, she said, she leaves her kid – she is a 3 year old girl - with her boyfriend so that she can go to the shops in the mall. When she comes back her boyfriend has raped the kid. (CHW 7)

Maybe some of them suffering, human suffering, some of them, before that they get food in the night, they're suppose to give, have sex, to get the money to buy the food. And it's not right, because that one is the old man. But she's suppose to sleep with that old man, and is like his father, but you have no choice. (CHW 15)

Physical and sexual assaults were experiences that all participants heard about and every participant had an experience to share. There was also a strong association with violent events and substance abuse (Carlson & Dalenberg, 2000). This increased the uncontrollability and insecurity around these experiences and increased the risk of death for the CHWs – both at home and in the workplace. Xenophobic violence was intense within the communities as well as within the social and protective structures such as the police, health and social services (Higson-Smith, 2013; Jackson, 2013). Foreigners were a particularly vulnerable group, especially within the communities in which these CHWs were placed.

When exploring events such as physical and sexual assault, one needs to understand broader contexts in which “mutually reinforcing patterns such that physical violence establishes social dominance and ideological violence legitimizes and normalizes oppressive social relationships and material inequality” (Watts et al., 2003, p. 186). This was evident within the CHWs context both in their own personal relationships (struggling with their own voice in their intimate partner and family relationships) as well as what they were exposed to in terms of witnessing and hearing about domestic violence, child abuse and sexual assault cases both in the communities in which they worked and lived (Jewkes et al., 2009; Eitle & Turner, 2002).

These results displayed a pervasiveness of violence, a depth of trauma and a multiplicity of problems which complicated the context in which CHWs found themselves. The results concur with the experience of living and working within an environment that is one of ongoing fear and threat. There was a co-existence of acute and continuous traumatic stress events that was

pervasive in the descriptions of the participants' own and broader contexts (Straker, 2013; Benjamin et al., 2010; Stewart et al. 2005; Crawford-Browne et al., 2002)

4.3.2.5. Life threatening illness

This event has been described as it links strongly with the CHWs job role. However, as mentioned above, HIV/Aids was not seen as a life threatening illness. What the CHWs defined as a life threatening illness was if people were HIV positive and not taking their medication or diseases such as cancer or last stages of diabetes. It was an event that was witnessed (91%) and heard about (83%) a lot at work but this would make sense in terms of the CHWs job role as they are working in health. There was an average of 5.76 events witnessed and 4.26 events heard about. Eleven (48%) participants were also supporting friends and/or family members with a life threatening illness physically, financially and emotionally. So their work and home lives both include assisting and managing illness. However, some participants shared the increased expectation family or themselves had on them to be able to help or cure the person – even though this is not their job as they are more a link, rather than the 'healer'.

The main area that participants reported witnessing life threatening illness was in their own community though all three areas (work, community and media) were important. Twenty participants (87%) witnessed in their own community; fourteen (61%) witnessed in their workplaces and ten (43%) noted that they had seen it in the media.

In hearing about illness, fifteen participants heard it most within their workplace (65%) and the home community and media influence was similar at 52% (n=12). They would also hear about people within the community who have died due to illness, either their own patients or people would share about other deaths within the community.

Because we can, we can hear from other people when they talk their stories and you know it's not nice... some other things you sleep with your heart that is paining, you know. It's not nice things are happening. (CHW 22)

4.3.2.6. Sudden unexpected and sudden violent death

Twenty one (91%) of participants had experienced a sudden unexpected death of a loved one, 61% (n=14) had witnessed one (average 2.57 events) and 52% (n=12) had heard about one (average 1.5 events). If someone died unexpectedly but through violent means (by another human being), then it was recorded under 'sudden violent death'. If there is a death due to accident or illness or unexplained, it was recorded under this event. All – but one - participant experienced the unexpected loss of at least one person that they had known. Participants also witnessed and heard about unexpected deaths about people within the community (some known, some not) and within their work contexts. Loss is a strong theme that pervades the participants' experiences and needs to be noted when exploring issues of trauma.

They must – it was my aunt there – going, he came from Joburg to Eastern Cape. When he came there, just feel the headache and then go to the doctor. When he went there to the doctor get the tablets and go home. When he come home, feel sleep, and sleeping after – never wake up again. (CHW 7)

Although 'sudden violent death' is a separate event in the checklist, it has been included in this section as it links to death and loss. Only two participants (9 %) had experienced a direct sudden violent death but twelve (52%) had witnessed one (average of 3 events) and eighteen (78%) had heard about one (average of 3.72 events). Important to note for this event is the intensity of the stories shared, as they were experienced as overwhelming. The fear from these violent deaths seemed to permeate peoples' engagement with their own community as well as with other people (known or unknown) in their work setting (clinic and/or community) – an example of continuous traumatic stress (Eagle & Kaminer, 2013; Levine, 2008; Crawford-Browne et al., 2002). The sudden deaths may link to family members (either living close by or in other provinces) or deaths they see within the community in which they work, usually related to alcohol induced or targeted (gang-like) fights. When the participants talked about the experiences of death they had in the research interviews, there was not a separation of deaths that were personal versus work related. As the researcher I needed to ask clarifying questions to find out more about who had died and the reason for the death.

[There is] lots of other killings is because people end up in fights and then, and then someone dies they trying to hi-jack them and do it, they want to take the other things or for more money or something... No one knows who killed him, but he is killed. (CHW 7)

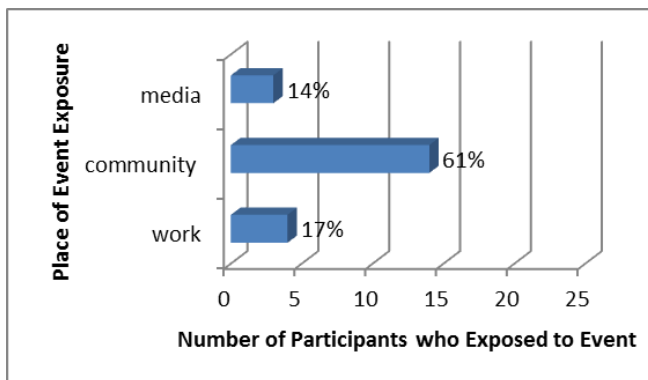


Figure 12. *Witnessing Sudden Unexpected Death (N=23)*

Most witnessing of sudden unexpected deaths happened within the participants' own communities in which they lived. Examples given by participants included deaths from community fights, or deaths of neighbours through domestic violence or fires. One participant noted seven times that she had witnessed unexpected deaths in this period.

Again, the percentages were not high, but the types of experiences witnessed have had a powerful impact on participants, either described as images being 'stuck in their head' or fearful of what happens in the community, could happen to his/her own family.

It was something that I saw on the TV even now from the other one from last week that small boy in Cape Town cut the head it was stressful for me even today I'm not right... still have images. (CHW 5)

Is only one that I see there, two boys was fighting on the street...It was so hard for me to see that thing... I don't know if the other one is killed because the ambulance arrived immediately and take him...I was so scared because I just think to see that thing I don't want to happen to my son because I have a big boy, 25 years. And then the boys they like to fight too much. (CHW 21)

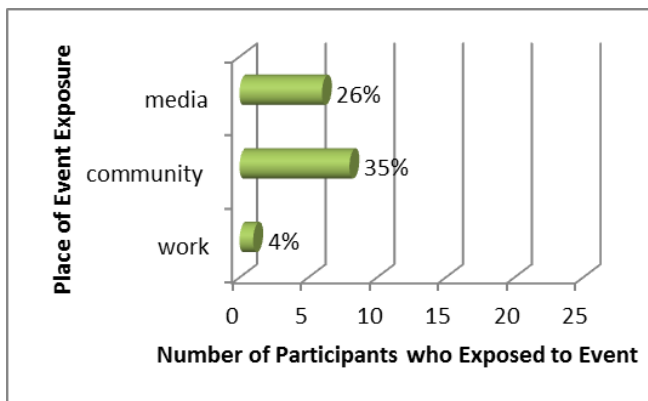


Figure 13. *Learned about Sudden Unexpected Death (N=23)*

The percentages in hearing about sudden unexpected deaths were not extremely high. Again, it is noted because the impact of a loss of someone has a powerful impact on the person, especially when there was no warning for it. The majority (35%) of the learned about events that were reported by participants happened in their own community.

Seventeen participants (74%) reported that hearing about sudden violent deaths mainly came from reports in the media. These were from local newspapers or the national news. So even if violent deaths were happening in a different province, this affected how a person felt about their own community – either worrying that it may happen where they worked or relieved that the event happened elsewhere.

As the CHWs got to know the communities they worked in better, people started sharing with them about the different events that happened in the evenings or over the weekends. Of the few stories shared, some were quite intense. See the quote below that describes a boyfriend killing his girlfriend and was then caught by other community members who were coming home from shift work. There were questions about why it happened, mixed with potential cultural beliefs and practices. Without the questions answered, fear became pervasive in the community.

The boyfriend he took the girl, cut the neck, took her down there in the street. Unfortunately, these other men come from the work at about four o'clock in the morning. They saw that man. There's something here on his shoulder. They ask that man, "What is that?" That man took the body of that lady down and ran. No one knows where she come from. How can you kill the people who stay with you? Why do you kill? [The community]

they're afraid of that man. When he comes out of that jail, who's next? We don't know.
(CHW 16)

As described above in both unexpected and sudden violent deaths, loss is a major theme that permeated the research. All participants had lost at least one person they had known (patient or family member) during the research, either expected (due to illness) or unexpected (due to illness, accident, homicide, or suicide) – See Table 7.

Table 7. *Losses that CHWs experienced during Research (N=23)*

CHW	Losses
CHW1	2 relatives – one relative died of an illness Good friend/neighbour A patient – illness
CHW2	Son – illness – unclear but think it was TB Family member - illness Member of the church congregation - illness
CHW3	Grandmother – illness Uncle – illness Neighbour (was close to) - illness
CHW4	Unknown death
CHW5	Friend – illness (did not know that she was so sick) Patient – illness
CHW6	Aunt – illness Cousin – disappeared for over a month (had been robbed and thrown off the train on the way to Joburg). He was found.
CHW7	Aunt - illness
CHW8	Neighbour (close to her) – short illness Uncle – heart attack
CHW9	Brother in law - illness Neighbour - Unknown death Neighbour - illness

CHW	Losses
CHW10	Patient - illness Cousin's friend - Unknown death Neighbour – car accident
CHW11	Unknown death
CHW12	Daughter's friend (14 years) – sudden illness Cousin – Unknown death CHW now look after cousin's 1 month old baby
CHW13	Niece - Unknown death Neighbour – killed by her husband Child - killed by stepfather (in community) Neighbour – childbirth to triplets (now all died)
CHW14	Patient - illness
CHW15	Brother in law - Unknown death Boyfriend (new relationship) – suicide Close neighbour (like sister) – Unknown death Uncle's girlfriend – committed suicide by drinking poison (as uncle broke up with her) Lady –fighting with neighbour, killed herself
CHW16	Girl in community killed – racism 4 ladies over 2 months were raped and killed in the community Man in community killed his girlfriend Neighbour - Unknown death Cousin – someone attempted to kill, not successful
CHW17	Cousin - stabbed by gangsters (in CT) Grandfather - Unknown death Family member - Unknown death Neighbour - taxi accident
CHW18	Grandmother – gall stone problem
CHW19	Friend – illness Patient – illness

CHW	Losses
CHW20	Brother – work accident Niece – hit and run Uncle – beaten up (by girlfriend’s friends) and died New patient - illness Patient – illness
CHW21	Patient - illness
CHW22	Cousin - Unknown death
CHW23	Friend from school - Unknown death Cousin - Unknown death Uncle - Unknown death Aunt - Unknown death Family friend - Unknown death Patient - Unknown death

Whenever one works with people and families in communities, there will always be loss. The unexpectedness of death can lead to complications, especially when there is shock and horror within the story of the death. The deaths above are a mixture of unexpected violent deaths or accidents and those that were expected due to illness. As participants talked about the loss experiences, some had good support from family and friends which assisted in the grieving. However, for many of the participants, they took off a couple of weeks of work to assist with the management of the funeral and then have just “carried on with life”. There was a sense that they were carrying a great sadness with them, losing a sense of purpose in work and attempting to manage the loss alone (Kristensen, Weisaeth & Heir, 2012; Schneider, Elhai & Gray, 2007). The violent nature of death can introduce a compounded mix of grief and post-traumatic stress reactions. In most cases, participants were not present at the times of death so there were traumatic intrusions that filled their mind as they tried to make sense of what happened (Levine, 2008; Figley, 1999; Herman, 1992). For some, they were still managing the trauma reactions and all were still in the early stages of grief (with regard to the above table), so the reminders of places and people were still overwhelming. (Kristensen et al., 2012; Wittouck et al., 2011).

There was also sadness about patients who had passed away as participants had worked with them for two or more years so there had been a relationship that had developed between them. Until participants had been part of this research process, there did not seem to be a conscious awareness that one may go through a similar grief process for patients as well as family, friends and community members. There was an increased awareness to be gentle with themselves when managing death both at work and in their own home and community.

4.3.2.7. Any other stressful events

The below table illustrates the number of times in which participants experience other stressful events over the research period.

Table 8. Other Stressful Life Events – number of times in which participants experienced this as was recorded over past 7 months (N=23)

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	3 (13.04%)	5 (21.74%)	6 (26.09%)
1	4 (17.39%)	2 (8.70%)	1 (4.35%)
2	5 (21.74%)	3 (13.04%)	3 (13.04%)
3	6 (26.09%)	3 (13.04%)	7 (30.43%)
4	1 (4.35%)	1 (4.35%)	4 (17.39%)
5	2 (8.70%)	2 (8.70%)	1 (4.35%)
6	1 (4.35%)	2 (8.70%)	-
7	1 (4.35%)	-	-
8	-	1 (4.35%)	1 (4.35%)
11	-	1 (4.35%)	-
12	-	2 (8.70%)	-
13	-	1 (4.35%)	-
Average no of events experienced	2.95	5.5	3.35

One of the most stressful events shared by participants was not getting paid for three months within the research period. In many cases, participants were the main bread winners. This had a negative impact on their work as they were stressed about how they were managing their own basic needs so at times it was difficult to support other people also struggling with basic needs and traumatic experiences.

Ja, you're expecting something to find that there's nothing at the end of the month and that, it made you very stressful. Even now, we don't know when we are going to get that statement. (CHW 18)

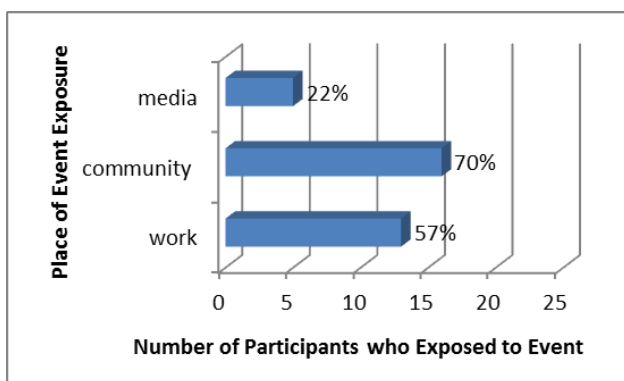


Figure 14. *Witnessing Any Other Stressful Event (N=23)*

“Witnessing of violence may tend to occur in contexts characterised by exposure to diverse other stressors, it is important to evaluate the effects of witnessed violence taking full account of other dimensions of social stress” (Eitle et al., 2002). Witnessing stressful events happened both at work (n=13) and in their own community (n=16). The CHWs were working and living within communities in which there was high unemployment and general life stresses in terms of lack of the basics of food and housing. Even if the families in the work community did not talk about their circumstances, the CHWs could see the difficulties that they were experiencing. Seeing the stressful events challenged some of the CHWs in terms of how involved they should get with the issues of the community e.g. current fights, evictions or issues relating to orphan and vulnerable children. The feelings the CHWs experienced were quite overwhelming and depressing, feeling helpless at times as not sure how to help.

Some people when you enter, you see people they haven't got food. Sometimes it stresses you and you haven't got money to give, just like you see people got two months child, other one is two years, when you enter their house, there's nothing. No food, children are

crying, you see it makes you, there's nothing in the house, and you, I've got nothing to give to him, then it make you, it's depressing. I can't help these people. I haven't got nothing. (CHW 13)

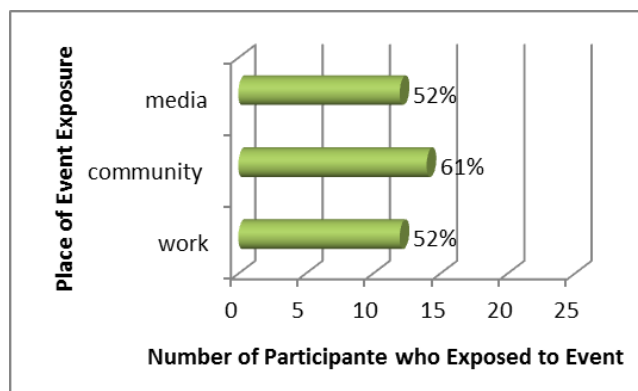


Figure 15. *Learned about Any Other Stressful Event (N=23)*

Over half the group (52%), talked about hearing about stressful events both from the patients and their colleagues. Fourteen participants (61%) talked about hearing about stressful events in their own families and neighbourhoods. Media (52%) also played a role in hearing about stressful events that were happening within South Africa and the world. When the CHWs entered homes to assess health issues, they were often confronted with the lack of basic needs in the household. They recognised that they could refer people for support or access to grants. However, they had not had positive feedback about the relevant referral organisations or departments assisting the people that they had sent. .

Ja, no adults. Their mother was maybe a year, passed on and so the children were left alone...The authorities finally evicted the children from the house. [There were three children]. It was bad you know. I felt helpless and especially those people, they are just near me, nearby where I stay. I am caught up in the middle and do not know what to do. You see. (CHW9)

'Any other stressful event' assisted in highlighting the need to broaden trauma context understanding to include social conditions that both contributed to and/or were influenced by traumatic experiences (Stevens et al., 2013; Bell et al., 2012; Diamond et al., 2010; Silove et al., 2010; Miller, Kulharni & Kushnar, 2006; van Ommeren et al., 2005). The stressful contexts of everyday life in which the CHWs worked included poverty, deprivation, overcrowding,

unemployment, intimate partner violence, rape, attacks, illness, marginalisation and discrimination. These elements complicated situations of both health and social needs in terms of supporting the patient as well as the helplessness that it instilled in the worker as the needs felt too overwhelming to do anything about or the needs linked directly to the worker's own lived experience and resulted in over-identification with the patient (Bell et al., 2013; Miller & Rasmussen, 2010).

Exposure: Influence of Media

The media had been a regular experience of witnessing and hearing about traumatic experiences. Majority of the participants referred to the television (TV) when talking about media. Eight participants informed the researcher that since being part of this research, they actually started watching the news more often. They had realised that bad things happen everywhere and to know what was happening elsewhere helped them feel they could cope better with the events that they experienced. Watching the media connected many external life events to the participants' own personal experience whether they had experienced it or not.

Ja, then you finish watching TV, you sit and say, sjoe, if it was me, eish. (CHW 19)

I just watching TV sometimes, but ja, I didn't like to watch TV too much... I don't need any more pictures in your head... You can afraid. (CHW 21)

In the initial interviews, participants related "trauma experiences" to those that they directly experienced or those that they witnessed. After doing the checklists, it was evident that many of the trauma experiences within the community and work and media were things heard about and not just witnessed. When this was shared with participants in the second interview, they said it was the first time they recognised the influence of hearing events on their own perceptions of what was happening in the community and how they were responding both to traumatic and stressful life experiences.

It's the newspaper, because I saw lots of things in newspaper, you see... So I was so shocked to see this, now what is this, other people want to kill people... Yes, it was in the paper, in the newspaper. (CHW10)

Because we can, we can hear from other people when they talk their stories. Even the TV, we watch the TV, we see all those things are happening each and every day. (CHW 22)

It was recognised that the violence and trauma does not only have a negative impact on an individual but also on the systems and organisations that were designed to minimise harm to community members (Straker & Moosa, 1994). The CHWs described the systems in which they worked and lived (e.g. health, social development and police) as overstretched and overwhelmed by the type and number of events that were happening to individuals and communities.

This quantitative data supports previous studies that state when community violence is high there was greater risk for CHWs to experience traumatic events. Within the workplace violence literature, this would fit into the 'external type' of events of that occur in the work and home community (Bowman et al., 2009; Mayhew & Chappel, 2007). The above data evidence concurred with the experience that daily exposure to violence and trauma – both direct and indirect - is common for individuals and communities in South Africa (Eagle & Kaminer, 2013; Benjamin, 2011).

4.4. Responses to Traumatic Events

Christopher (2004) talks about the mismatch of “the biology of the self and the sociology of the self” (p.77). As humans we have both conscious and unconscious response patterns to manage stressful or threatening situations. Most of these response patterns are linked with physical, emotional and cognitive processes of the brain, body and memory. Every experience is a sensory experience and is often unconscious and becomes conscious when the person is no longer in survival mode but can start to process and try to make sense of what happened. If intense sensory experiences are happening too frequently, the consciousness of the experience may not emerge and the person remains in a reactive state (Levine, 2008; van der Kolk et al., 2007; van der Kolk et al., 2005; Christopher, 2004).

To explore these responses in more detail, this section is divided into three different sections, each with a table summarising the key responses, with quotes from the participants to support and further describe the experience. The three sections are: Participants' own responses to a

traumatic experience; Participants' responses to others' traumatic experiences and Others' responses to the Participants' traumatic experiences.

4.4.1 Participants' own responses to a traumatic experience

Participants were open to sharing about their responses to traumatic situations with the researcher. The researcher felt privileged with the level of openness of sharing, while bearing in the mind the perceptions and expectations that the participants may have had of the researcher as she was a social worker. For many it was the first time they had shared their trauma stories, so it was also the first time they talked about some of their responses– both from that time and those symptoms that they were still managing.

Participants described several types of responses to experiencing traumatic events (see Table 9). Many had physical and emotional reactions, such as pain, sleeplessness, and tearfulness, and anger. However, others spoke of cognitive reactions such as reflecting on one's own mortality and asking difficult questions about society.

Table 9. *Participants' Own Responses to a Traumatic Experience (N=23)*

Own response to a traumatic experience		Quotes to describe this
Personal Responses	Physical responses experienced	<p>Your whole physical body, your whole body is tightening, the breath, the whole shock, it is a very physical response.(CHW 1)</p> <p>You don't walk faster, you just check, you check and watch, you keep on watching and watching. The heartbeat, the heart beats more. (CHW 13)</p> <p>Your body feels fear. (CHW19)</p>
	Sleeplessness	<p>Because I was always thinking about everything, and then even when I'm sleeping, sometimes I couldn't sleep well. I was thinking the whole night and then the end of day I will cry, you see, I am not coping. Sometimes I will feel so tired because I couldn't sleep. (CHW 12)</p>

Own response to a traumatic experience		Quotes to describe this
Personal Responses	Sleeplessness	It was too much in the head. You can't sleep well, you just think. (CHW 13)
	Emotional responses experienced soon after the event	<p>I just crying all the time when I just think of that thing. I can't even manage to deal... everything just come back. (CHW 15)</p> <p>I was afraid even to look at him. I'm always scared, scared, scared and I don't want to see him. I was scared. (CHW 5)</p>
	Emotional responses experienced after a period of time	<p>Always when I think of her, I'm still crying. I cry. I cry. Three years and I'm still crying. (CHW 16)</p> <p>It is still difficult for me, It was difficult because they have taken from me, forcefully you see. I blame myself of not defending myself enough. (CHW 3)</p>
	Cognitive responses experienced – thoughts and questions	You ask where is your God? (CHW 11)
	Cognitive responses experienced – thoughts and questions continued	There were so many people they are died that at home because, it started with my younger brother. He just sick and die. And my sister just sick and die. And my younger sister again, she just sick and die. I was so very scared to say, it's only me, anytime I can die. (CHW 21)
	Cognitive responses experienced - Flashbacks or images of the traumatic event	It comes back. On that date every time it just keeps coming back. Yes, sometimes there people, you still sit alone in rape. (CHW 11)
Relational and Social Responses	Praying about the situation	<p>First I am shocked, I am shocked what is happening now you know but I pray, pray, pray. (CHW 11)</p> <p>You get hurt, always, when you saw sometime, you cry and this time you are alone, you say God help me. (CHW 18)</p>

	Own response to a traumatic experience	Quotes to describe this
	Practical Action	<p>I'm going to the hospital and stitch there. (CHW 17)</p> <p>I scream after. So it was then, I go to the police station and report the matter. (CHW 8)</p>
	Using substance to manage the feelings and reactions	<p>Even now, I think maybe drinking is fine. I just want to drink all Saturday. So I thought maybe I'm healing myself when I'm doing that, because I forgot then, when I'm drinking I've forgot everything... it's not taking it away because when it's finished in the morning I cannot, in the morning I still remember those things. So it's not healing, it's making things worse. (CHW 15)</p>
	Talking to others	<p>I speak to one of my sisters. (CHW 14)</p> <p>I spoke to a friend. Just the friend. (CHW 15)</p> <p>I told my pastor. I didn't talk to anyone because it was, I don't know, because I was small or not something you talk to the old people. (CHW 5)</p>

The physical and emotional aspects of the responses are consistent with usual trauma responses reported in theory (Levine, 2008; Robinson et al., 2014; Ross & Levine, 2004; Carlson et al., 2000; Herman, 1992; Janoff-Bulman, 1985). The participants talked about the physical impact both at the time of the trauma but also after the experience. They talked about how the body reminded them of what happened, either from the actual injury or just from the stress and tension that the body continued to hold. Roach (2013) also discusses the response of exposure to traumatic events in the form of physical symptoms including gastric upset, insomnia and headaches. These descriptions are supported by research into understanding the impact of trauma on the body (Levine, 2008; van der Kolk, et al., 2007). Direct exposure to physical violence was likely to

manifest in stress-responses e.g. not sleeping; flashbacks; holding stress in the body that could possibly lead to an impairment in health.

The participants also talked about the overwhelming nature of their emotions and struggling to manage them and at times finding it difficult to support the people that they needed to work with due to not having capacity to deal with more stressors and trauma. The “shock” element of trauma was decreased as it was described that the event occurred within a context of ‘expecting it may happen to me one day’, rather than something that was completely unexpected. This was supported by the quantitative data, as many participants had heard about many traumatic events, so it seemed to become a realistic expectation that one day the event may happen to them or to a loved one. This expectation that something that has not happened to me, will happen to me is a key element in understanding and differentiating ‘continuous trauma’ to other experiences or forms of trauma (Straker, 2013; Benjamin & Crawford-Browne, 2010; Stewart, Murphy & Thomson, 2005; Healey, 2003; Crawford-Brown & Benjamin, 2002).

Pearlman and Saakvitne (1995) recognise that an individual’s experience of trauma is mediated by his/her context. There were mixed reactions about accessing social support. Herman (1992) emphasizes that a person’s social milieu will frame the meaning of the event and that relationships that may have been considered safe initially, after a trauma event, they get called into question and victims may withdraw or disconnect from others and from the world, resulting in isolation and lack of social support. A person’s world view has been shattered and it has a negative impact on relationships (Bell et al., 2012; Benjamin, 2011; Janoff-Bulman, 1985). Use of substances to manage difficult emotions and experiences assisted in forgetting as well as in ‘having a good time’ as described by participants about their own lives as well as their family and friends – this linked to the literature on behavioural impact of trauma on individuals’ responses (Bell et al., 2012; Carlson et al., 2000). These responses were relevant in all post traumatic experiences yet in a context of ongoing trauma, the adaptation to cope is a focus on how to manage the future rather than deal with the past. Trauma reactions and symptoms (especially intense fear and suspicion) of the participants needs to be understood within the context of realistic on-going threat and not as maladaptive or inappropriate current reactions to past events but rather protective measures to attempt to secure safety in the present (Eagle & Kaminer, 2013; Straker, 2013).

4.4.2. Participants' responses to others' traumatic experiences

Participants were concerned about the people they worked with and they wanted to be able to help. At times the participants seemed overwhelmed by the trauma that they heard about and they felt by sharing their own trauma stories was a way of supporting people. However, some of the participants did refer others to social workers and counsellors even though they did not use counselling themselves. After hearing the different stories from patients or community members, the participants explained that they then began to wait and expect for a similar event to happen to them.

It is hard to carry your own and others, it becomes big. It is a big load. It is too much you can't carry it anymore. (CHW 13)

Table 10. *Participants' Responses to Others' Traumatic Experiences (N=23)*

Responses to others' traumatic experiences		Quote to describe this response
Emotional Responses	Feelings of being overwhelmed	I listen and then I try to make counsel and then when I get out, I leave the house, because you can't have all the stories on your shoulder... it's their story. And then when you go out, leave their story and then go. (CHW 2)
	Feelings of being overwhelmed	I hear someone telling me a bad story, I don't react badly at that moment. At that time I am strong because I'm trying to help you as much as I can, but once I'm alone, it all comes back. Eish, I feel bad, so bad. (CHW 4)
	Helplessness	It was difficult because when you go home, in your home, you feel tired, sit...it's just headache sometimes, its headache because you think a lot. You want solution, you think a solution but you not get a solution... if you can't help them you are going to get depressed, when you sleep you think of them, when you wake up in the morning, you think of them... eish, life is tough. (CHW 19)

	Responses to others' traumatic experiences	Quote to describe this response
	Guilt	So you sometimes feel guilty that you, you couldn't be there to stop this bad thing happening. You'd like to stop it. (CHW 5)
Emotional Responses	Shame	I feel like I am going to cry and they feel shame to me [what does it mean to feel 'shame to you?'] you hurted in the heart... when you feel shame to somebody, you hurt here [point to heart] inside. (CHW 21)
	Internalization of others' trauma	It's not easy, like it is my story when someone just tell us hey something like this happened... you say oooh, it's not me, but I feel like they just pulled a knife on me and I feel like when it's me what I'm gonna do? (CHW 15)
Cognitive Responses	Internalization of others' trauma continued	Ja, I will cry because, uh, some of the things I did experience. But I wouldn't want her to see that I, um, I'm the same experience with her. I will say it will be ok. (CHW 8) I start hating men and sometimes become quite scared of them, because of what happened. (CHW 4)
	Ask for help	I listening to them. If it's something very big that I cannot even handle sometimes, I ask for help for that person because some other problems are very big. (CHW 22)
	Increase the fear of their own safety	Ja, you feel like you can run, like you are seeing the people, what the people are going to say. I'm jumpy and they going to chase me, you step hard, go fast and try to make them to don't think you are running for them. Why you are running from them. You are always, when you are going, you are checking around, just like that. You are scared, ja. (CHW 7)

Hearing about traumatic events happening to others around them increased participants' concern and fear relating to their own trauma experiences and future fears (Benjamin & Crawford-Browne, 2010; Stewart, Murphy & Thomson, 2005). All events heard about or witnessed became those that could become part of their story and their responses were sometimes as if it had happened to them, even though it had not. Again, relationships get called into question and people do not want to share with others as it did not feel safe and there was a description of managing life alone (Bell et al., 2012; Matzopoulos et al., 2010; Herman, 1992).

There was a lot of comparison and reflection about one's own traumatic experiences when hearing of others' trauma events. This reflection was not only a comparison about how challenging the experience was but rather emphasized the potential of other events that could happen to them. The focus was not about the past but about what may potentially happen in the future (Eagle & Kaminer, 2013). At times it was difficult to distinguish between real and perceived threat as future prospects felt as if they had already happened (Eagle & Kaminer, 2013; Diamond, et al., 2013; Higson-Smith, 2013).

4.4.3. Others' responses to the participants' traumatic experiences

In most cases, the CHWs themselves were the main support people within their families and friends. They were the people who are used to giving support to others yet rarely received it. A quote that seemed to summarise many participants' experiences – yet also made the researcher feel sad that people did not feel that they received the support that they needed - is this one:

Interviewer: Has someone ever reacted in a way that has been helpful. Like something they've said or something that they've done that you liked and you could say thank you for doing that, that was helpful?

Interviewee: No. (CHW 31)

However, when probed further, some of the participants talked about feeling appreciated and were supported by family and friends and this helped them manage and cope both their own and their work worries and experiences.

She tries to make me cool done and move on. Always put the present in front of my eyes to see this is not an end of the life. We have to do, always be present, be positive and move on in life. (CHW 7)

Table 11. Others' Responses to the Participants' Traumatic Experiences (N=23)

Others' responses to participants' traumatic experiences		Quotes to describe this response
Supportive Responses and	Support through listening	She listens to me... she is so brave, because she will try and give you the courage, you see. She is my pillar of strength. (CHW 3)
	Encouragement to 'carry on'	She's advising me. There are a lot of challenges in our world and there is coming to us to deal with this, so when we face the challenge, you can't just jump, you have to face and see the solution and move on. (CHW 7)
	Comfort through prayer	Some they will just quote on the bible to comfort you so sometimes you get relieved, ja. And you also pray. You just put all the burden to God. (CHW 18)
Unhelpful Responses	Second guessing CHW responses	You see, my boyfriend said, why didn't you blow the whistle, I said why? You can do that, it's in your nature that someone come here, you can, you will still remember the phone [or whistle] or you can run. (CHW 1)
	Blame	After that, sometimes you are afraid to go to the police station because they will blame you and for me to go to the police station and report about my husband raping me, it's another story, they will laugh at me. (CHW 7)
	Ignoring hurt	My friend is maybe he's the same problem with me, but he's just sitting there, don't do nothing. So he said to me, aai go back to your husband, don't leave him, it's gonna be fine... He said haai he's a man, a man is, you know you're not gonna change the man. Men are the same you see. (CHW 15)
	Comparison of stories	They say 'okay its okay' Now I am alright because I know your story. Mine is bad, but better than yours, you see? (CHW 10)

“An individual’s social context exerts an influence on his or her responses to trauma both before and after the event... [and] can strengthen or weaken his or her ability to cope with a traumatic stressor” (Carlson et al., 2000, p. 19). The importance of listening and having their experience recognised was emphasised (Park, 2010; Street et al., 2001). Supportive social contexts created a way for a person to regulate their fear of perceived or actual harm and the community cohesiveness could mediate the long term negative impact of traumatic events (Ungar, 2013; Benight, 2011; Harvey, 2007; Galea et al., 2006; Beasley et al., 2003). Key responses included blaming and/or a comparison of stories which lead to a lack of acknowledgement of the participants’ experiences and had a negative impact on them, hence was not considered supportive (Harvey, 2007). The expression that “it is life” was described by the participants as helpful at times, however the researcher struggled to accept this resignation of that it is just life and one moves on. From a class and work role perspective, it seems these contexts should be challenged and changed and not just accepted.

Carlson and Dalenberg (2000) describe three defining features of traumatic events: a lack of control over what is happening; the perception that the event is a highly negative experience and the suddenness of the experience. The above descriptions of responses, either personally or on behalf of others, have been overwhelming and, at times, difficult for the CHW. This is because they felt that they were not equipped to know how to manage such situations; or because the situations were something that they could identify with due to their own experiences and were seen as negative or dangerous; or the traumatic situation linked to their fears of the violence that they may face within the community in which they live and/or work (Di Martino, 2002; MacRichie & Leibowitz, 2010; Miller & Rumussen, 2010). This was particularly evident for community health care workers as they are working in the communities in which they live or which were close by.

4.4.4. Safety

Safety encompasses ‘self-safety’ – in which one needs to feel safe and out of harm’s way – and other-safety – which is the need to keep others safe from harm (Rosenbloom, Pratt & Pearlman, 1999). Participants were asked about safety – what places felt safe and how they felt when they were safe. Places of safety were their own home and church. Safety was also explored in the work context: both in the clinic and in the community. A key feature of safety was daylight. It was felt

that in the daylight fewer bad things happened and there was a greater awareness of what was happening around people so people could protect themselves better.

Yes, even here in the daylight sometimes you feel safe, sometimes you are not feeling safe because like if you see many people come in front of you some guys even if it is daylight, but there is no one at the back it's you alone and these many guys, so you feel unsafe in that space in that little space until you pass them. (CHW 5)

Night seemed to have a direct association with danger and fear. The primary preoccupation in contexts of continuous traumatic stress is with peoples' sense of their current and future safety (Eagle & Kaminer, 2013) rather than the impact of particular events on themselves or their relationships. The priority in life is about survival and Diamond et al (2010) also highlight that the preoccupation of safety is most prominent in peoples' thoughts and planning. When thinking about safety and vulnerability within this context, it can be noted that "both expectation of safety and attempts to render daily life comprehensible are damaged or destroyed" (Eagle & Kaminer, 2013, p. 94). At times this can elicit a sense of hopelessness and a sense of being overwhelmed that is both evident in body and in mind. At another level, this fear of not feeling safe, increased peoples' arousal and awareness and their responses to people and life events is one of survival.

4.4.4.1. Safety at home and their own community

Twenty participants highlighted that being home, with family, was what they would consider their 'safest place'.

If I at home, I feel safe (CHW 14)

Because I stay inside. When it's five o'clock, I call all my children to inside. We stay inside and watching tv. I feel safe when I sit with all of them. (CHW 31)

I was safe because I will be staying with my mother and my family. My family will be next to me. (CHW 12)

Six participants highlighted that they were only safe at home when the doors were locked. The researcher would question whether this was a description of 'safety' but for the participants, they

felt calm when they were locked in their house, especially when all their family members were home, so they could relax. Being able to relax was considered a good explanation of safety.

Because I close my door and my gate, then I think I'm safe, it's home. (CHW 20)

Aspects of safety in the community included there being a sense of community support. Five participants talked about having access to the police who came in times of trouble. For this group of people, they felt confident that the police would assist them. One person talked about the community policing forum that was established – with the police – during the time of the research. She felt this had a huge influence for her, her friends and family about experiencing a sense of safety in their community, especially at night time.

Yes, coz, there are lots of police in my sight, you see? They do not live in my area but they are patrolling and that makes it feel safe. (CHW 10)

We got a community police forum there. And the community, the rest of them, they want peace, they don't want crime in that place. They work together. (CHW 6)

Five participants shared the experience that the rural places that they grew up in, were places that they considered safe and peaceful. It also reminded them of the relaxed and fun-filled childhood that they had had. For those that shared about the rural communities, talked fondly of a grandmother or grandfather who they saw as supportive and loving towards them.

I think in the rural areas it's much better, when you go home, that feeling like 'phew' you can feel like, feels like a safe place. (CHW 4)

4.4.4.2. Safety at church

Ten participants emphasised church as a safe place. The key reasons were being with people with whom they could talk and it was a community in which they were known. Church was considered a place of healing and prayer which was a significant part of making it a safe place. For many participants their sense of faith was what helped them manage and make sense of difficult situations. This faith was sustained and developed within church.

Church is safe. You see you are healing – then you heal spiritually, and physically, obviously. (CHW 12)

4.4.4.3. Safety at the clinic

The two things about safety in the clinic were that there was security and that there were many people around. It was also felt that the clinic was seen as a support for the community so the community appreciated and relied on the clinic. There was also a sense of hope that if something bad happened at the clinic, and if the police were called they would respond quickly.

I think it's a safe place for me because when something's happened the security they can maybe call fast and the, they, I don't know how to say it. I will say it the police maybe if something's wrong happening they will come fast if they see what's happening here so in my thinking it's safe. (CHW 18)

It's just safer because there is a lot of people moving around and you are only here during day time. (CHW 4)

4.4.4.4. Safety in the work community

Initially feeling safe in the work community had not been participants' experiences. They reported that they felt quite fearful of the communities they were told to work in as they did not know much about the community. At this point, working in pairs and having some form of identity (e.g. bags) was essential to give an expectation of safety. Twelve participants emphasised the importance of the partners – without being directly asked – in assisting in the work and in the creation of feeling confident and safe in the work, as it highlighted that they were not alone.

It helps having a partner because the first go into the community was very unsafe because you did not know you did not know. (CHW 11)

If a person wants to do something to you, and there's another person here, the other person can go and call for help. (CHW 4)

Having a specific role and purpose in entering the community, in spite of the fear and danger of unknown people, was seen as important. This title and role of "CHW" was reported to protect them and help them avoid harm as people are generally grateful that they are there to assist. A title seemed to decrease fear and vulnerability.

In my community people would know when there is a person who is sick and they will come to me and tell me that at that house there is a problem, they would come to me and report that person to me and they knew that I would give help. (CHW 9)

You feel not safe when you first go to the registration, First house you enter, you don't know how people are there in their house, what you are going to find, you see. But when I do follow ups it is better, you get to know the people. (CHW 13)

However, as they have got to know the community, the sense of safety within the community has increased. This was a key theme in the second interviews with the participants, as they knew the community better and the community members were clearer about their role, there was an experience of increased safety and it was described that everyone looking out for one another.

So people getting to know you and they also looking out for you. (CHW 10)

When they accept you, when your role's clear, then, ja, that's good you can see that space and see that change. (CHW 6)

Safety was an important concept and experience for the CHWs to manage daily life, yet it was also a fragile concept, as it could be easily damaged (Eagle & Kaminer, 2013). Feeling a sense of safety, allowed participants to feel they could think about and engage in life, rather than looking over their shoulder and just surviving life. However, due to the continuous experience of traumatic events, this space that safety created was often threatened. The importance of being able to create a sense of safety assisted in creating ideas and thinking to manage an unpredictable context (Diamond et al., 2013; Straker, 2013).

4.4.5. Lack of safety

A key element of continuous traumatic stress is "struggling to recognize the difference between a real and perceived threat as most things feel unsafe and a potential life challenge" (Eagle & Kaminer, 2013, p. 89). After a direct traumatic experience, a normal response to the trauma is to fear the event happening again. In a context of ongoing violence, there is a possibility that the event can happen again, hence the difficulty in differentiating between a real or perceived threat. This difficulty was further compounded by the impact of hearing about or witnessing events that

have not directly happened to them as it became a possibility that it could actually happen to them, hence their context was experienced as unsafe.

And then I came out-, they didn't see me, then if they saw me, then they, because I saw them and I saw their faces, then it will make me unsafe because they saw me and then I will say to the police, uh, describe them, so they will come for me and kill me. (CHW8)

Lack of safety was discussed by the participants in terms of their homes and communities; the experience of known and unknown people (both in the work and their own community) and within the context of the clinic.

4.4.5.1. Known vs. unknown people

Although most people described home as a safe place, some participants highlighted that this was not the situation as things can happen within the home or people could attack the home. The fear of home and fear of bad things happening in the community was usually associated with night time and therefore darkness. This was partly because of the bad things that people have experienced during this time of day or because of the stories people had heard.

Ja, these days we are not safe anymore. We are always unsafe when go home, you see. It's not safe, you can't stay at home and open your door and say you resting. When you get to the house, you must lock the doors. Because there are some, these days when you enter your gate, someone is entering too, you must then to lock doors, everything. It is not right to live like that. We don't live safety today anymore. I don't know whether it's this unemployment [pause] it's not safe anymore. People say they don't work, but they don't work, they want to rob us. It's not safe anymore... Everybody haven't got nothing these days. Because everybody today...can't say this one and this one to help me, because everybody got his needs and wants. (CHW 13)

Initially all participants talked about the fear of the 'unknown' in the community in which they were required to work. There was a lot of uncertainty and fear as participants did not know the communities in which they were required to work – even though they were relatively close to the area in which they lived,

The main thing is that you don't know what people are going to do. It's the unknown, ja. The unknown is not safe. (CHW 15)

The above descriptions about the people were about those in their own community as well as those within the community in which they work. When walking around a community in their own capacity (either not as a CHW or people not recognising them as such), the person realised their vulnerability and therefore their fear increased as their awareness of a potential threat to their life was perceived. The 'sense of vulnerability' was context specific and it increased during the night time period.

At night time I know there is a lot of theft, yoh. Ja, at night I stay in at home. I don't like to walk around at night. (CHW 14)

With the increase of fear or uncertainty about other people, a sense of 'othering' or 'dehumanizing' between people was apparent in that there was not acknowledgement or connection to the humanness of another (Watts et al., 2003; Goldenberg et al., 2000). To be able to cognitively distance oneself from others, this assisted in the derogation of others and therefore being able to manage to cope within uncomfortable situations. This was further highlighted in the community space in which a stranger was perceived as "dangerous" before anything was known about him/her, a more strongly linked association made towards men, though this was also shifting in the examples and stories that people shared.

You come across scary people you don't know, you don't know how, when you speak to them, you don't know how they are going to react to you. But you come scary see. But you go there... But you don't show that you are scary, you speak to them, you express yourself. I am coming from so and so, so I'm going doing this and this and this. Some they allow you, some they chase you out. So when they chase you, you go, you don't stay. (CHW13)

In other houses, when we come inside, we find sometimes there are men only. So we can't get safe. (CHW 10)

People may start carrying a perception and fear and start expecting that something bad is going to happen to them (Crawford-Browne & Benjamin, 2002). Usually the 'something bad' was linked to something or someone being unknown.

Because when you are on the street, we fear, because sometimes when you enter the house, you think before that sjoe, when you knock, you start question yourself for who, who is, who I am going to find there in the house. When it's a man, sjoe, you are scared,

you feel safe when you talk to him, you sit outside, not said, come in, you are scared when he says, 'come in'. (CHW 19)

There was also great fear of being raped. This is a good example of CHWs struggling to differentiate between a real or perceived threat (Eagle & Kaminer 2013). Although there is no record of a CHW being raped during his/her working hours or within the work community, due to all participants hearing about this event happening to others around them, it was a fear that most of the participants carried with them when working in the community.

That makes you feel unsafe because you thinking of rape, maybe they can put you inside then just close the door, you see. Ai, Bad things come to mind. (CHW 18)

Many of the fears talked above were linked with the unknown. However, participants also mentioned that just because someone is 'known' does not make them safe. People that are known to the participants are sometimes the ones that hurt them – whether that was in their personal relationships or within the community.

Ja, because sometimes you are going to say in my community I feel safe, but sometimes that people know you, can send other people to hurt you. Example, I am not at house now, I am here, when I get home I'm told the criminal get into my house, get in, when I ask a neighbor, she said, I did not see it. When they come, the truth come out, she said sjoe, I saw them, but I'm scared to tell you that I saw them. [interviewer: Why is she scared to tell you that?] They are going to kill him or her. Some of them, they do [threaten], in our community, when you saw the criminals and they saw you, that you saw them, when the police tell them, when they go out. (CHW 19)

However, in spite of fear and danger of known and unknown people, all participants talked about how they directly talked to people they came across in the community and did not show their fear.

4.4.5.2. Lack of safety at clinics

Despite reporting feeling safe at the clinic, CHWs discussed concerns over the ability of the security guards to ensure safety,

Yes, at the clinic you cannot say my clinic can be safe, but you can see our security they put a woman as security at the clinic so a woman cannot do anything if we have a mentally

disturbed patient who can be dangerous to the community at the clinic and in our clinic we are using like this one, we are using one door... anything can happen anytime. You can also know that the people are here just to take their tablets, maybe something has disturbed him he can just come in here and stab or do whatever to the small children so I believe our clinic should have been put in different rooms and the security at the clinic should be tight. (CHW 3)

Participants shared concern that in other areas in South Africa, when people had been frustrated with lack of services, the clinics have been set on fire. The fear that this could happen to them was evident although this had not happened in either of the areas as protests around service delivery had been peaceful to date. One such time was when the researcher was there to conduct interviews. Nurses were concerned about the researcher's safety as the crowd was walking up the road. The nurses expressed their main concern as the researcher being white and made the assumption that she would not have experienced such a protest before and were worried she would be scared of the black protesters. The researcher had to assure them that this was not the first time she had witnessed a group gathering and protest. The researcher was surprised that the nurses were so open to talk about their concerns about the racial divide as usually this is not something openly expressed in South Africa. Subsequently, the nurses, themselves, were fearful of the protesters and drove their cars away as they were concerned that their vehicles would be damaged. Instead of a racial divide being emphasised, a class divide was accentuated. The CHWs were more intrigued and left the clinic premises to stand on the side of the road and encourage the protesters as they walked and sang.

Because the clinic is for the community, but whenever if maybe there is a nurse that you do not like at the clinic, they feel that – they take that anger out of the clinic and they would break open the clinic because I see in other areas they burn the clinics and they have to walk a long distance to collect their medication so these are some of the things. It can be safe, but if only it can upgrade the security staff. (CHW 3)

When the CHWs' sense of vulnerability increased – either due to their own traumatic experience or after hearing/witnessing an event - their behavior became difficult to regulate as their expectation of the fear of danger and death kept their bodies in a hyper-aroused state. As

described above in 'responses to events', the CHWs described how their bodies held the fear and trauma that they had or that they might experience.

The four key responses highlighted by Martin-Baro (1989) in the literature review for people living under conditions of extreme fear were evident in this group of participants, especially when they described their experiences of lack of safety. These responses were a sense of vulnerability (especially in the dark and being around people or communities that are unknown; fear of being raped), exacerbated alertness (distrust of people, not knowing who can hurt one, body holding the stress and tension of being on constant alert), a sense of the loss of control over one's own life (home and neighbours not considered safe and trustworthy) and an altered sense of reality (distrust of unknown and known people, difficult to know and trust people).

The above quantitative and qualitative data on the events and experiences of the CHWs give credence and examples to descriptions of continuous traumatic stress by Eagle and Kaminer (2013) who state "the kinds of stressors to which community members are exposed in the context of CTS are extreme and involve the kinds of threat to life and bodily integrity that are generally understood to constitute traumatic rather than chronic stressors" (p. 86). It was important to recognise that the social constructed narrative was powerful because it was so personal.

A key aspect to 'continuous trauma' is recognising that context has a more powerful impact than the individual reaction. The context standards shift and change, challenging previously held expectations and how people view themselves as people as in relation to the community or country in which they are living and working (Benjamin, 2011; Crawford-Brown & Benjamin, 2002; Gibson, 2001). Therefore specific events were understood within the social construct and expectation that trauma is part of life as opposed to an 'unexpected' event. This changed making meaning of the event as well as responding to the event as it is within the realm of experience (Diamond et al., 2013; Weingarten, 2003). This was well understood within Brofenbrenner's (1999) socio-ecological structure as the social and cultural events and developed beliefs about people and community were influenced by broader daily events and experiences, hence a person was understood through their context and not just their individualised traumatic experience. "The 'woundedness' is carried by the group and may produce powerful, shared narrative, affects and practices" (Eagle & Kaminer, 2013, p. 89). Although participants were reluctant to share their

personal stories with others – especially work colleagues – this did not take away from the similar and shared narratives and affects and practices of the participants. The traumatic events recorded across work settings; residential community and media show the continuity of trauma across contexts. As events were cross cutting, this added to the experience of traumatic events being continuous.

Another feature of continuous traumatic stress suggested by Eagle and Kaminer (2013) is the 'realistic appraisal of future threat' (p. 92). Sharing concerns about safety is seen as a positive response to manage risk, rather than a maladaptive response to a specific event (Diamond et al., 2010; Palm et al., 2004). Participants held a comparison of their known experiences within the unknown encounters that they have within their work context. The world was seen in a different way - it was no longer a safe and good place but one in which bad things happened, often (Herman, 1992; Janoff-Bulman et al., 1991; Janoff-Bulman, 1985). The level of trauma exposure that people experienced gave them a new lens to view the world that focused on the 'trauma narrative' as safety of themselves and those that they care about (both at work and in their own homes and communities) was paramount (Gibson, 2001). Poverty also influences this lens as imagination and hope for something different was curtailed by the lack, not only of money and basics, but the lack in education and critical thinking (Miller & Ramussen, 2010). Creating an awareness of where trauma takes place and which events were direct or indirect, generated a space to think differently about their context. This change of thinking allowed for choice and management both of some events (e.g. choosing whether to watch the news or not) and choosing to access relevant support when needed.

Some important and useful comments and suggestions about the practical experience of Primary Health Care Re-engineering were brought up by the participants as they shared about their trauma and loss experiences. These have been recorded but as they were not directly linked to the research objectives, and due to limited space for the dissertation, they are briefly discussed here. There is still a need to better understand and integrate the primary health care concept within the broader medical hierarchy.

It is recognized that the CHW role is part of a broader labour context within South Africa where the blur of boundaries of employment and volunteerism is politicized. This context is broader than

the daily functioning of the clinic and the primary health care re-engineering model. The connection between volunteerism and lack of recognition is significant as often the individual feels that their status as a 'volunteer' negates their knowledge and competence (Swart et al., 2004). Although specific recommendations will not be offered for this as it is out of the scope of the research data, it does fit into the broader structure of the literature review which both discusses the legitimization of the role of the CHW both in policy and service delivery development (Daniels, et al., 2010; Lehmann, et al., 2007) .

4.5. Coping and Support

This section explores the participants' experiences of coping and the events and/or actions that gave them support in witnessing; hearing about and directly experiencing traumatic events. The discussion moves from a description of not being able cope with all they are managing – at home and at work – to examples of coping and support that were useful.

4.5.1. Not coping

Participants did not differentiate between positive and negative coping. Rather, the experiences of coping were described as useful or as 'not coping'. The participants' did not recognise ways they had developed negative coping tools, rather they recognised when they were managing and were able to admit that at times they did not feel that they managed or coped with their work and/or life experiences.

- **Acknowledgment of not being able to cope**

Before exploring in detail about how CHWs managed traumatic experiences and what support they wanted in order to continue to do their work, this section starts with a quote questioning the assumption of "*coping?*" as some participants were clear that at times they were not coping.

Initially you can cope with it and then it gets to a point so that the trauma that you are not coping. (CHW 11)

I have never found support, I just make myself say, 'Ja, I'm fine' but I can see that I'm not fine. (CHW 15)

'Coping' is a word that is used quickly and liberally when working within communities but not often understood or fully explored. At times we may be too quick to look at how people are managing and not recognising when they feel they are not, so they do not feel they have a platform or space to acknowledge the 'not coping'. The quote below elicits this feeling of initial desperation, but then ends in a sense of acceptance of 'what is, is what is'. There was a link to a higher power – in this case, God – who ultimately would look after them, even though this had not been their lived experience in the past year. The participant prayed as a way to cope and manage the situation. At the time of trauma and shock, she questioned, 'Where is your God?' (CHW 11) – God becomes depersonalised and separated. It is no longer 'her' God but 'your' God.

God punishing me this year, he wants something to me, that's what I always told myself. [Why would he punish you?] I do not know, maybe he want me to come to him, even to pray you see. So I can't pray when I've got problems, I do not want to lie, I can't. I tried, but I see that I can't. And I try even to say Our Father only. I do not know, but I always put my trust to him you see...Because he knows everything. (CHW 12)

For some people it was difficult to describe or identify the feeling they have felt as they had had many different experiences and have just had to keep going.

Because, for me I don't know, because, uh, I've been through a lot myself. The way I handle things, sometimes I think that it's okay. It's easy for me to take, to take them and let them go but not knowing that somehow, inside, there are a lot of problems. (CHW 4)

- **Acknowledgement of the influence of hearing and witnessing difficult stories**

The influence of the work and hearing the difficult stories had an uncomfortable and overwhelming impact on the CHWs and they recognised how this experience had had a negative impact on how they cope.

So, they make us see these things, it make you stress. You can't every day hear bad things. You must hear things that will make you happy. It's not right for a human being to hear always bad things. They affect you physically and spiritually. They affect you both. (CHW 13)

At times the impact of hearing the 'scary and bad things' was not displayed only in "us and them" differentiation between themselves and the people they work with but also in a lack of trust in friendships and colleagues.

- **Acknowledgement of not being able to talk to other people about the scary experiences**

Nine participants specifically talked about not talking to other CHWs as they were not sure if they could trust them and worried about what their colleagues would think of them. Participants were also concerned that their colleagues would tell others or they would laugh at them. It was important for this group to show that they were coping and did not need support from their colleagues. Most of the CHWs stated that they did not have many friends and struggled to trust people, including the people they worked with daily.

Ai, so many things I don't like to tell my colleagues... coz you don't always know what they're going to do with the information and that they'll tell someone else. (CHW 14)

Other participants did not want their colleagues to know what they were dealing with at home, so they shared issues around work stress but would not talk about difficult situations in their home and community life.

Because when I go, when I wake up and come to work, I leave that stress at the gate. And then I'll come to work, okay, you can't see me even there is something was happened to me when I'm here at work. Even if I've got the problem at home, I will be there [at work], you can't see me. (CHW 10)

This linked to research that emphasized that workers who find it difficult to share with co-workers seemed to struggle with seeking other forms of support and therefore were at risk of feeling or being isolated (Palm et al., 2004; Salston & Figley, 2003). This was consistent with the participants' views in finding it difficult to share with co-workers and also in not choosing to access counselling services – though they would refer others for such services.

- **Acknowledgement of the practice of 'trying to forget'**

Although participants talked about 'trying to forget' as a 'way to cope', it was acknowledged that this has not been the most useful way of coping, as they had not been able to 'just forget' or their methods of forgetting have not had the desired long term impact. The one example of forgetting

was using alcohol. Initially it did have the desired effect of not having to remember but the long term impact was negative and the issue did not just disappear. Part of 'forgetting' is also about not trying to think too much as if there was less thinking about situations, then less emotion was linked with it.

I just wanted to drink. So I thought maybe I'm healing myself when I'm doing that because I forgot then, when I'm drinking I've forgot everything. It's helping as I'm not thinking too much. It's not taking it away because when it's finished in the morning, I cannot, in the morning I still remember those things. Why I drink like that, it's coming back. So it's not healing, it's making things worse. (CHW 15)

Others were not always sure how they wanted to forget, though they knew they wanted to do this. At times it was surrendering the situation to God (and waiting on God's time to take it away) and at other times they tried to seek a solution as then they could forget.

I think about it and then I just, I forget. Only God knows when. Ja, I can be forget but not clearly. I tell myself, ah, just leave it. But I try to solve that problem. I don't forget when I didn't solve the problem. (CHW 16)

4.5.2. Coping

This section explores the strategies of coping that have been implemented by these participants.

- **Acknowledgement of the importance of sharing/talking**

In terms of coping, some CHWs have learnt that sharing with colleagues could be helpful, especially sharing with their partner. Others still felt they could not talk to colleagues but they found other people they did feel comfortable with and found that talking was useful.

When I'm in the work there are many of us, just we are talking and we are sharing. Some of them they are sharing the same story as mine, I say mos, it's not only me this thing is happening to. When we are talking we are sharing. Ja, that makes me feel [like I'm] coping. (CHW 15)

Although nine participants said they struggled to talk to anybody, at the end of all interviews, each participant shared the experience of talking about certain (even if not all) events to at least one person. It needed to be somebody that they trusted.

I like sharing with someone and I'll become healed by talking. I'm coping when I'm sharing with someone. (CHW 1)

It's better when I talk... it relieve you, to talk with your heart. You can feel better. (CHW 31)

Five participants shared that they went for formal counselling support – either to a counsellor or a social worker. Some of the counselling experiences were helpful and others not as helpful. Three participants explained that they did not think it helped them. However, they would still encourage others to go for counselling. For some, their counselling and support in this regard came from the pastor or prophet at their church or from a traditional healer. This was generally described as supportive.

And there was a social worker. I tried to go and tell them that “yes, I’m got a trauma for my brother”. So they try to talk to me. Ja, just forget, tell yourself that your brother was dead. I was try but now it’s better. (CHW 10)

I talk to the pastor at the church, he help. Ja, he helps me a lot. (CHW 13)

- **Sharing with friends and family**

Although many participants talked about not having friends that they could trust and share things with, six participants highlighted the importance of having a friend to communicate with, sharing both tough and good stories. Their friends were seen as a key support and helped them in coping with life and work situations

It's my friends that I trust, it is my big thing on how I cope. (CHW 19)

For twelve participants, family were seen as a key support. In most cases, this support was sisters but also included niece, mother, mother-in-laws and brothers. It was discussed that the family knew them better and were always there for them, no matter what. Family were trusted.

As I've said before, that most of time, after I've spoken to my sister, she will counsel me and then I will open everything to her and then I will feel as if it didn't happen per say. (CHW 3)

A key aspect of getting support from the family was knowing that the family loved them.

Interviewer: what support do you get?

Interviewee: They love me. (CHW 17)

- **Work role as a clarifying purpose**

“This definition of vulnerability in humans is often associated with violence but it could also be vulnerable to care and nurture... The realization of vulnerability may surely inspire care, love and generosity, but it may equally inspire abuse, intimidation and violence” (Murphy, 2011, p. 578). This was useful to explore when looking at personal and community relationships as someone who could be loving and good, could also be the person that could hurt and violate. This was evident in participants’ personal lives as over half the research participants (52%) reported to be in or have been in a violent domestic relationship. Their personal experience linked with a negative experience of vulnerability. Yet, as they talked about helping others in their vulnerability, so they were strengthened in their sense of purpose and in the management of their personal lives. Because of the challenges and threat to life the CHWs have had in their own lives, this has given them compassion and focus to want to assist and build the community they work in.

Everything when they keep, talk to them, they are telling me, so she is going to make this and this and this and this. I’m their friend, that help me a lot. It gave me strength to, ja, to go on. (CHW13)

- **Crying and expressing emotion**

Eight of the participants talked about crying as a way of expressing emotion and of coping. To deal with the stories they heard at work and at home, they described crying as a release and relief. However, the participants did not like their children or other people to see them cry.

I was crying and crying and crying after that. I’ll be better. Be alright. (CHW 1)

To manage, sometimes when I am alone, when I am alone at home, I cry. When I think about all the things. (CHW 19)

- **Acknowledgement of a higher power to assist**

The CHWs did not always recognize some of the behaviours or fears they were living with, in their own lives, but they were still able to support and find energy to give to others, to make a change and see a difference in their community. This was also evident with CHWs responses, focusing

away from the physical impact of their life experience towards their spiritual faith, trusting that God would guide and sustain them in managing the violent events they experienced and heard about. This symbolic reality seemed to be crucial for CHWs to keep a world view in which they could continue to support others and manage their work (Goldenberg et al., 2000; Pearlman & Saakvitne, 1995). Twenty two of the participants talked about how they prayed for protection, or for guidance, or for help both in the work they did as well as for their family and community situations. They also appreciated it when others prayed for them as it helped them cope. One aspect of praying is that this was a coping technique that could be incorporated into a routine work day:

I maybe go to the toilet, you know, to pray to God. I pray for that person and me. (CHW 1)

Praying also felt like it could provide a solution to problems,

And ask God, "Dear, Dear Lord help me with this situation. (CHW 4)

For some the praying assisted with the 'forgetting',

Anyway, from church, at home, I put my life to God, everything, I'm just praying and after I'm praying I forget. Praying helps me forget a lot a lot. (CHW 5)

Praying and listening to gospel music were responses that the participants used regularly to access global meaning of spiritual support and guidance to assist them in 'getting through' living and working within a context where they are fearful of something happening (Park et al., 2012; Harrison, et al., 2001; Wolfer, 2000).

At times participants established a clear spiritual link in terms of finding a reason for what had happened. At other times there was a belief expressed in trusting a higher power that all things happen for a reason, whether you fully understood that reason or not.

Ja, that is life for. Have to move on, not hold the life. Ja, you have to move on. Anything happened, happened for a reason. It's not for fun. For a reason, Ja. Because we are not going, we are not going to have all answers that is happening on the outside. You have to say, this happened for a reason. No matter I don't what the reason is, but I have to move on, ja. (CHW 7)

- **Acknowledging how watching media gives local perspective**

The influence of media has been mentioned above. However, it was important to make mention of it here, as it was expressed by many participants as a way of managing and learning about different solutions that could be tried in their own area. By being involved in this research, eight participants started watching the news to assist them in accessing a bigger perspective in order to help them respond to their local challenges in their own communities and in the ones in which they work.

It is important because you see the difficulties come across with other people in other areas and then you compare to us here. Maybe South Africa is better than other places or other places is better than South Africa. You compare the things that happened to other people, yes. [interviewer: Right and that helps you cope?]. Yes, and you get the solution how to help that person because when you something in the media, there is a solution there, yes and discussions. (CHW 16)

- **Research as a coping strategy**

For some, talking about the traumatic experiences in the research process was the first time they had shared it with someone.

I never told anyone because my aunt told me to keep quiet about it. Just keep quiet about it... I think she had a reason because that husband of hers was very abusive to her. (CHW 4)

Participants found it was not as bad to talk about the past and current traumatic events as expected. Participants also reported experiencing relief from doing so, so found other people that they trusted to talk about difficult situations. Five people (who had not spoken to their colleagues before) talked about how through the research process, they started talking to their colleagues about the challenges within the work situation. They found this helpful as they could all support each other, especially realising that they are dealing with similar experiences and therefore felt less alone.

As described above, the CHWs themselves would not often describe that they were 'coping' so this challenged quite a bit of the theory in this section. The word 'coping' seems to carry with it an assumption that everything is and will be okay. This was not the case within the contexts in which these CHWs live and work. From the responses that the participants shared, their strategy seemed

to be one of survival, rather than one of coping. When exploring the different coping styles of the participants, it seemed that most verbally talked about being problem-focused but were often overwhelmed by feelings and concerned about not being able to be safe or to protect their family. The emotion-focused coping style that was most used was the avoidant style, not in terms of denial but because of the increased fear of the possibility of something bad happening, avoidance was recognised as an adaptive response (Diamond et al., 2013; Folkman, 1997; Fleishman, 1984).

Rather than a focus on 'coping', the researcher would suggest a focus on 'managing a response' to the challenging circumstances in which people live and work. Pearlin and Schooler's (1978) description is useful here. Firstly, responses that change a situation were used more regularly as the CHW's response to assist others but not as a response for themselves. Secondly, responses that alter meaning were represented in two ways: at times the meaning was overwhelming and became generalised fears, for example, 'all men are bad or dangerous'. The other representation was focusing on the global meaning (Park et al., 2012) of belief, trusting a spiritual meaning to the situations i.e. even though it did not make sense, to trust that there was a symbolic spiritual meaning that God was still in control even though the situation did not make sense. Thirdly, responses that intended to control distressing feelings, in many cases this was shown through not trusting others and focusing on what needed to be done. However, these feelings usually came back at night time or when they were alone.

Although participants talked about not talking to colleagues, this support is recognised as being important in coping with trauma (Salston & Figley, 2003; Hattingh, 2001). An example in this context was that there was a good relationship of trust and respect with both of the team leaders therefore participants were able to share difficult work and life situations with them. Support and recognition played a significant role in reinforcing the CHW's sense of competence and increased motivation in the workplace (Street & Blackford, 2001).

In terms of the transactional model of stress (Lazarus & Folkman, 1987), at the first interview the CHWs seemed to be stuck at the 'primary appraisal level' in which they determined the level of danger and threat as they talked about events yet found it difficult to access available resources at a secondary appraisal level to manage the response to the traumatic event. At the second interview, the use of the checklists and journals seemed to help people develop some boundaries

and capacity to separate other's situations from theirs. The participants, therefore, seemed to have extra emotional capacity to recognise both their stressors and resources. The researcher was not naïve that this experience 'healed' people (as some participants described the impact of the research process) but it definitely gave the participants more capacity to cope with challenges as they talked about their responses and actions completely differently from the first interviews. This was an unexpected outcome of the research. The researcher had been concerned that the research process could increase vulnerability and fear for participants but it had had the opposite effect. This was not only reported by the CHWs but also noted by the team leaders who compared them to other people on their team. The team leaders identified the positive shift and change in those that had been part of the research.

4.5.3. Support

This section explores the forms of support that they participants described as useful.

- **Support from family and friends**

Part of coping was getting support from others. However participants struggled to talk about this. In many cases they were the support structures for their family and friends. It was difficult for them to accept help from others and challenging for them to give examples of support that they had received. The few examples that were given were not always considered useful by the participant, but they recognized that the other person was trying to be helpful. Examples included: giving options rather than advice; giving advice (rarely seen as helpful); giving practical support (e.g. driving a person to court); and joking and singing.

Because she's done lots, like sometimes driving you to the court, listened to you, helped you think. (CHW 12)

Ja, they, they tell me so many people tell me that is part of life. It's the way we deal with our problems, ja. I feel accepted because they give me hope that it's not happened to me, only. It's helped me so much if they say 'it's part of life.' (CHW 14)

Or when you there, we are together, there we are joking, we are talking, we are joking, we are singing, is right, you forget all the fucking stress you have. (CHW 16)

Schat and Kelloway (2003) recognize that support from family and friends is effective in reducing the negative impact of trauma but they highlight that this has no effect on the fear of future workplace violence. Generally family – and a few friends – support was seen as very important. Participants had a person in their family that they trusted and would share with that person. However, they would usually be sharing things that related to them directly and not necessarily what happened at work. Participants experienced joking and singing as good support as it allowed for release of the stress and trauma that they were carrying in their thoughts and emotions.

- **Support from debriefing**

In previous work situations, many of the participants had experienced debriefing and found it valuable. In talking about support with the CHWs, the process of debriefing kept coming up as they felt it would help them think through and problem solve the challenging situations they hear at work. They would like it to be used for work situations. It was suggested that this support may be relevant from the NGO or someone external to the clinic, and someone who understands working in a community and has access to links with other department and organisations.

She used to come and she was just, you know, given us support and ask the problems that we are facing from the field, we talk, if you have a problem, she take you and help. Sometimes we miss that because some other problems here in the field we face them, it's very difficult. It's a good thing because some other problems, you know, you carry some people's problems. (CHW 22)

Lehmann et al. (2007) did a literature search which emphasized that for CHW programmes to be successful the workers needed access to regular and reliable support and supervision. All CHWs appreciated and acknowledged the support that they received from their team leaders. And the team leaders highlighted the support that they received from the Primary Health Care Re-engineering manager, the EPWP manager, the facility managers and clinic staff and the community councillors for the practical and structural implementation of the programme in these two areas. This feeds into the literature on resilience as it is noted that where there was a greater sense of social support (within the team or community), the CHW would experience a greater sense of managing traumatic and challenging situations (Bell et al., 2012; Benight, 2011; Harvey, 2007; Galea et al., 2002).

Both CHWs and team leaders spontaneously expressed an interest in a more formal debriefing process to assist with the emotional and social complications that come up with some cases. It was hoped that someone who had an understanding of working in a community could assist in building capacity and skill as well as provide support for the emotional impact of the work. This would assist with emotional support and better management of cases. It could also be a time to develop problem-solving skills and ways to think about challenges that might be encountered in the future. The checklists that were used in this research could be used as a tool to discuss and explore the context of each month in which cases and experiences were contained.

- **Support from training**

The participants also talked about the importance of initial and ongoing training. They felt it would be a way to continue to develop their skills as well as increase their knowledge and understanding of the work that they are doing. It was noted that the training that they do to become a CHW was not acknowledged as they had not received a certificate for it.

Yes, yes, it will help us a lot, because now you are doing this, after that we are just left alone, but you see, and going to use our mind again. But now we know that if we have a trauma, you're suppose to tell the person. We are suppose to calm, calm. (CHW 15)

CHWs felt that they had received a good introduction in counselling and first aid, but that they needed further support, guidance and training especially in these two areas. In terms of counselling, they felt they needed to know more about trauma and grief counselling and how to approach and manage difficult people so that they could do the work they need to do. They added that they would appreciate learning more about community structures and ways of engagement and facilitating educational support groups.

About training I think I need it. Say maybe basic counselling. When you get to the situation there, maybe some people they need to be counselled. I think that will help us. If you can get more. If we can get deeper, ja and maybe the first aid. We do have first aid but maybe we need more experience. Like when we find someone is in labour pains we just get confused. I think those will help us in the community. (CHW 18)

A big issue that CHWs were expected to manage was dealing with disasters – whether this be natural disasters, or fire or loss of home. The CHWs were often the first people at a site or they

were asked to support. Therefore a request for basic guidance on what needed to be done in the first stages of a disaster would be helpful for them.

So when you go you come across some difficult things that you must help somebody, training in safety in how to protect ourselves, how to help other people when they come to families that are traumatized and learn about safety. When there's a fire, help them how to deal with fire...When you approach there you find that the shacks are burning. So, we must have training... We need the debriefing because we come across many things. (CHW 13)

Both initial and continuing training is seen as ideal (Lehmann et al., 2007). Initial training was usually quite broad and was good as an introduction, but when people were in the workplace, they realized that they needed further development in certain areas. Palm et al. (2004) also support the importance and continuation of training in order to improve the work environment and to limit the potential of indirect trauma reactions. The CHWs – supported by the team leaders – identified areas of further training. This is listed in the recommendations.

The broader inter-dependent systems (of family, individuals, organisations and communities) needs to be acknowledged and the risk and protective factors that challenge or support people after a violent event recognized for the context in which the CHWs work and live (Krug et al., 2002; Bowman et al., 2009). This support section highlighted the practical suggestions that can assist in both debriefing and training support. The CHWs expressed interest and passion about helping people but also wanted to learn more for themselves. Many participants wanted to develop more in their professional lives to become a nursing sister or a social worker.

- **Support through the research experience**

The researcher was concerned that the experience of the research would increase the CHWs' awareness of trauma they were experiencing and thereby raise their sense of vulnerability. Within the qualitative framework, the researcher recognised the value of second interviews to encourage the participants to engage with the research data but also to reflect on the findings of the research. By following this process, the researcher discovered that the checklists, the writing of the journals and the whole research experience seemed to have the opposite effect for the workers. The relief participants found in participating in the research was powerful as they felt

that they had been given a voice about their past and current life and circumstances. An essential element in feeling supported and therefore considered to be 'coping' better is 'acknowledgement' (Street et al., 2001). From their stories being acknowledged in the first interview, this seemed to engage participants both in the research process and they also considered and responded to their work circumstances differently.

The participants explained that they felt that the research helped them cope better with the events happening in their lives as it gave them a picture of what they were directly dealing with in their own lives and then what they were dealing with at work and in the community and the media.

It was eye opening. I've learned too much, I'm reading these things how to deal with problems. I learn too much, I like... Ja, good experience for me. I learned a lot. It was great for me. (CHW 13)

By being able to separate the three of these areas both by using checklists and journaling, they were able to recognise what they needed to deal with directly, what they needed to deal with in the community and what was work information. This supports research that shows that writing allows people to express and manage emotion and it fosters an intellectual process which assists in creating a different story of the traumatic event and limits the typical rumination (Baikie & Wilhelm, 2002; Pennebaker et al., 1986). The change in the description of coping and in the participants' interaction was significant – between the two interviews - as participants recognised how they were managing and realised that they could cope with difficult situations.

I will start to say it was helpful, because that time when I've just, that thing, I was just crying all the time, but since you are here now, we give that paper, when I see something, I just like see, it's happened, but now I don't cry anymore... You are helping me now. (CHW 15)

Previously participants had experienced all events - heard about or witnessed – as if it had happened to them. Therefore they felt overwhelmed with what they had to manage. After the research experience, participants could differentiate between direct and indirect events, and some indirect events therefore had a lessor effect. It was not always easy to record the events that

had happened but the sense of containment and management that participants experienced was more positive and powerful than the difficulty in noting the reality of the events.

So now I can write and see what was there, what was happening in last month, and what is happening this month... Because sometimes it can feel, when all the stuff's happening in the community, it feels like it's happening to us, even though we know it's not, but this helps you say – okay that's something else, this is what happened to me, this is what I had to deal with. (CHW 6)

Research, it's helpful because when you write and tick, it helps manage stuff you're dealing with. (CHW 20)

For some participants sharing traumatic events for the first time allowed them to feel a sense of relief in being able to talk about such experiences. It felt like they could “let go” and no longer needed to continue to carry the experience with them. This was an unintended consequence of the research interviews.

And also that thing that I shared with you that thing about rape for my uncle it makes me relieved because there are sometimes when I sleep at night I don't have the sleepless at night I always thought of that, but after sharing with you oh I am relieved. (CHW 1)

Some participants explained that the research helped them to better identify problems that people were dealing with, and this assisted with referral to correct channels e.g. to social workers or to Home Affairs. They felt that they were more empowered being able to identify and issues and this gave them energy and different focus in assisting the patient with connecting them to relevant referrals.

It was very good for me because I did experience and get experience the problems of people and referring to social workers and finding help for people that was very good for me. (CHW 2)

There was also a sense of understanding the patients and community members better. At times, connecting with their humanness and similarities, rather than getting stuck in the problems that people shared or the problems that were witnessed. Being part of the research seemed to encourage the CHWs to engage differently with their patients and work.

Okay, it make me to go further and search, ja, how other women are to my experiences, ja. How they feel, how they take things further, what they are doing. So it make me go search for – make own research, ja... There are people who are, there are women who were like me, I was afraid to talk, to tell other people how I live my life... So I found that there are women who were like me, so to those women I speak to them and say it's helpful, it make you to be open to talk about your problems, your rape, your abuse. It makes life easy when you speak out. (CHW 8)

All participants reported back in the second interview that by being able to better identify others' problems, they found that they had more emotional capacity and thinking ability to deal with the issues that came up. Participants explained that they were managing their own difficult situations better and found that they also had more energy, emotion and time to be able to give to friends or family when difficult things happened to them.

It made me to be more positive about the events surrounding me... Just like in August when my neighbour lost her husband in an accident I was so supportive of her and I even surprised myself... I realized I can deal with them [the tough and hard events]... Maybe I was afraid of facing tough situations but now I can face them and be of help if somebody. (CHW 4)

4.6. Summary

The above quantitative and qualitative data supported and explicitly showed the continual exposure of traumatic events that CHWs experienced in their daily personal and work lives. These descriptions add to the debate that the term 'continuous traumatic stress' is a useful descriptor in understanding a context in which people live and work, where violence is seen as normative rather than extraordinary (Straker, 2013; Stevens et al., 2013; Evans & Swartz, 2000; Hamber et al., 1997).

The line between what happens in the community and what happens in one's own family felt very permeable and unsafe for the participants. Therefore issues of safety and lack of safety were

explored as these concepts are central to the description of continuous traumatic stress (Eagle & Kaminer, 2013; Diamond et al., 2010).

Coping and support was explored for this group, with a key focus on assisting in managing expected, yet unpredictable, circumstances. The experience of the research was included due to the unexpected support it gave participants to differentiate traumatic events. The context of Primary Health Care Re-engineering was highlighted.

Chapter 5: Main Findings, Recommendations and Conclusions

5.1. Introduction

Due to both the current and historical challenges within the South African context, community workers – including community health workers - are at a heightened risk of exposure to traumatic events in their own lives and their patients' lives (Benjamin, 2011; Seedat et al., 2009; Holtman et al., 2008; Kaminer et al., 2008). The high levels of personal exposure, alongside witnessing the high levels of trauma among patients and the community, require that traditional definitions and interventions for trauma need to be reviewed to assist in the training and support of this cadre of worker. This is particularly true as the health care workers live within or nearby the same communities as their patients, reducing protective emotional boundaries. This section will outline the main findings, the conclusions and finally the recommendations of this study.

5.2. Main Findings

Research on workplace violence in South Africa has been limited, (Bowman et al, 2009) with no discussion of the risk of exposure to violence of South African CHWs. This study aimed to document the exposure to traumatic events of CHWs both within their past and present, in all areas of their life experience. The research focused on exploring the experience of CTS by assessing the types of traumatic exposure, the CHWs' responses to this exposure, and their coping skills. The main findings are organised under the study's objectives.

5.2.1. Objective One: To explore and document the traumatic events that community health care workers have been exposed to when working and living in Ekurhuleni district

In the first interviews participants described trauma as an experience that was witnessed or directly experienced. However, the most common form of traumatic exposure among the participants was hearing about traumatic events, most frequently transportation accidents, physical and sexual assault; fire and explosions; assault with weapons and life threatening illness. Participants had been surprised about this finding, yet after preliminary results were shared with them, they all agreed that they had heard many stories from their families, communities and workplaces. The stories from the residential communities or workplace had not been considered

as directly impacting them, as their concern and focus had been dealing with their own direct challenges and traumatic events and about the safety for themselves and their loved ones. However, due to the monthly checklists, and in the second interviews, the participants acknowledged the preliminary results and recognised the influence that the traumatic stories they had heard had had on them. Participants explained that they had come to realise that the traumatic events that they had heard about, they had been actually been responding to as if the event had directly happened to them. They realised that hearing these stories had increased the fear that they had about certain areas or people. The recognition of the impact of 'hearing about' traumatic stories did not negate the impact of those witnessed or directly experienced but was further evidence for the description of the continuous experience of traumatic events that CHWs had had. The participants had not separated work and personal experiences before doing so with the Life Events Checklist. This supported literature on the psychological impact of the social conditions of a conflictual society (Stevens et al., 2013; Diamond et al., 2010, Miller et al, 2006) and the literature on continuous traumatic stress in that there was a pre-occupation with safety, fear and anger that replaced the awareness of past trauma or differentiating trauma experiences (Diamond et al., 2010; Crawford-Browne & Benjamin, 2002).

Traumatic events most frequently witnessed by the participants included: transportation accidents; physical assault; severe human suffering; life threatening illness; and fire and explosion. And those most directly experienced were sudden unexpected death and other stressful life events. Many of the witnessed traumatic events were related to violence, which was similar to previous studies by Ronzio et al. (2011) and Clark et al. (2002). This is significant as violence is an extreme form of trauma as it undermines trust in other people, making the world feel unjust and unsafe (Bell et al., 2012; Herman, 2000). This was evident in the next section of responses to traumatic events.

Media played a key role in exposure to traumatic events. Many participants had not realised that the stories of traumatic events in the news had exerted an influence on them. A number of events discussed within the media had happened in their own communities or clinics e.g. rape of young girls; or transport accidents. As these experiences in the media were similar to their own experience, they related to these events as if they had happened to them. Through the monthly reporting of events, the participants reported that they had not been consciously aware of how

the traumatic events that they witnessed and heard about in their work context had affected them. This affect was both personal and had influenced their view of the context. All participants experienced a number of traumatic and loss events over the course of the research – with the average of each event experienced documented in the results chapter. These results substantiate literature that critiques the use of the theory of “post” traumatic stress when the danger is ongoing (Stewart et al., 2005; Crawford-Browne et al., 2002). The experience of lack of safety due to current threat was accentuated as traumatic events happen regularly and consistently which supported what is currently written about ‘continuous traumatic stress’ (Eagle & Kaminer, 2013; Roach, 2013; Diamond et al., 2010). It is important to note that when the preliminary results were given as feedback to the participants and the team leaders, the team leaders said that the experiences described by the self-selected group were similar to the other community health workers that they support.

5.2.2. Objective Two: To describe the specific set of responses experienced by Community Health Workers in Ekurhuleni communities in which the experience of trauma is continuous

Exposure to traumatic events amongst this group of community health workers was high, and their personal responses reflect this. Trauma is understood in terms of the individual response within their context. The meaning given to the event – due to community and individual beliefs and norms – will influence the initial response and ways to manage the experience (Park et al., 2010). Three areas of responses were explored: the personal response of the CHW, the CHW’s response to seeing or hearing about other people’s traumas and other people’s responses to hearing about the CHWs’ traumatic experiences. The important thread throughout the responses was breakdown of trust in relationships. This supports the literature that was reviewed in Chapter two (Levine, 2008; Robinson et al., 2005; Ross & Levine, 2004; Carlson et al., 2000; Herman, 1992; Janoff-Bulman, 1985).

The participants’ own responses to traumatic events were divided into personal (physical response; emotions soon after and delayed; thoughts experienced; flashbacks and images), social and relational responses (praying about the situation; practical action; using substances; talking and not talking to others). The CHW’s responses to others’ traumatic events were described as affecting them personally as if they had had the experience directly. Feelings experienced were

that of being overwhelmed, of helplessness, of guilt and of shame. Thoughts experienced were linked to their own experiences, and there was a need to help and to resolve the situation.

Others' responses to CHW's traumatic events were summarized into supportive (support shown through listening, linking it to 'it's part of life', through prayer) and unhelpful responses (responding with own fears, blaming the participant, and not following through on services). Generally the participants found it difficult to access support from others.

Personal reactions to their own and others' traumatic events link to theory and practice that has been reviewed for this study (Diamond et al., 2010; Ross & Levine, 2004; Herman, 1992; Janoff-Bulman, 1985). A fundamental outcome of the study highlights the strong connection between trauma and loss which supports the literature (Kristensen et al., 2012; Wittouck, et al., 2011; Green, 2000; Figley, 1999). Sudden violent death and unexpected death were two traumatic events that had an impact on many of the participants. The deaths were either linked to chronic illness or violence. When exploring the context of trauma, it is important to take into consideration experiences of loss and grief processes when working to reduce trauma symptoms. In many cases participants had not dealt with the trauma responses or their loss experiences but rather accepted it as a 'norm' and kept doing what needed to be done, with a survival focus. This focus dulled participants' emotional responses and the effect of the events were not managed or processed so people continued to carry the experiences with them in everyday life. Managing trauma reactions before processing grief is documented as helpful in managing traumatic bereavements (Jackson, 2013; Figley, 1999). Further support and understanding of death and grieving may be necessary to consider when working within community programmes in South Africa.

However, personal reactions and responses cannot be understood out of the context in which people are based. The continuous nature of trauma across contexts had a blurring and overwhelming effect as indirect and direct experiences had a similar impact on the individual. In the initial interviews there was a sense of participants being overwhelmed by their exposure to traumatic events. Events that directly impacted participants and indirectly influenced them were blurred with few effectual or relational boundaries, so everything felt like it was directly happening to them, all of the time. There was no break or space from dealing with trauma and loss in their lives offering limited scope for recovery. The participants were experiencing high levels of exposure

to traumatic events, within their work, homes and communities leading to limited experiences of safety. Each participant in the study had experienced at least five direct traumatic events in their life history. However, unlike experiences of PTSD (Kaminer et al, 2008; Carlson et al., 2000; Horowitz et al., 1995), participants did not focus on their past trauma but rather on the worries and concerns about the lack of safety and fear of traumatic events happening currently and in the future.

A key finding was that the participants were unable to differentiate the effect of indirect experiences from their direct ones, e.g. the traumatic event that they heard about on TV in Japan felt like it was something that had directly happened to them. This emotional response increased the feeling of fear and threat. The emotions blurred the reality of differentiating the context of Japan from South Africa and the participant was unable to identify the actual possibility and reality of the threat. This emotional blurring is more complicated when traumatic events happen closer to home, and this influences the cognitive ability to identify actual threats. Theory discussed in chapter two supports the above description as living within a context of ongoing danger, there is difficulty in identifying real and perceived threats and the influence this has on both personal and social identity (Eagle & Kaminer; 2013; Bell et al., 2012; Gibson, 2001). An outcome of the research is that when participants could differentiate between their own and others' experiences, they found they were less overwhelmed as it helped them identify and manage the stress, trauma and/or loss.

5.2.3. Objective Three: To identify coping methods that the Community Health Workers working and living in Ekurhuleni have used in managing contexts in which trauma is continuous

This research challenged some of the theory of "coping" as many participants would have described themselves as 'not coping' yet they still managed to be at work and fulfil these requirements each day. Acknowledgement or recognition of a person's traumatic experience by an external person (e.g. family, friends, colleagues, line managers) seemed to play an important role in giving a person legitimacy to advocate for what they need to manage challenging circumstances and continue to undertake effective work (Street et al. 2001). The need to increase personal skills to facilitate and manage the traumatic events within a complex and ever-changing situation was recognised.

As supported by current literature (Park, 2010; Connor et al., 2003; Harrison et al., 2001), a higher power – mostly referred to as God - was considered essential to assist in the management of dealing with traumatic and unforeseen events. Every participant talked about something “happening for a reason” and it usually linked into a spiritual perspective. This perspective explained that a higher power had a greater understanding of the situation that they were in and they trusted that this power would also serve justice in the situation, even if not evident in this present physical one. This explanatory framework supports the integration and processing of traumatic events (Harrison et al., 2001).

An unexpected outcome of the research was that an increased awareness of traumatic events happening in the participants’ lives did not increase vulnerability but had the opposite effect of assisting with managing with the challenges of these life events. The checklist used to document the events to which the participants had been exposed to for the research became a tool that assisted participants to differentiate between direct and indirect experiences. This created a sense of relief (as opposed to being overwhelmed) and assisted in working out what could be directly managed and what support they needed. This had an impact for both their personal and professional lives as before it had blurred into one. Simple support measures (e.g. filling out a checklist or having a structured journal to write in) seemed to create space for thinking through and managing difficult and traumatic situations. Journal writing was considered a safer and useful way to process information and feelings than talking about it. Talking about things to trusted people was important but if that was not possible, this was a practical and useful structure and way to process and ‘take the experience out of one’s head’. This supported research that shows that writing allows people to express and manage emotion and it fosters an intellectual process which assists in creating a different story of the traumatic event (Pennebaker et al., 1986; Bailie & Wilhelm, 2002).

Previous experiences of debriefings were acknowledged as useful and helpful. This was supported in other research for the work of this cadre of worker (Lehmann & Sanders, 2007). Requests for regular debriefing about the work experience and context were made by all participants.

5.3. Conclusions

In summary, the purpose of this study was to explore the experience of CHWs working and living in a context in which trauma and its exposure were continuous. There was an emphasis about the CHWs within the PHC Re-engineering Model as this gave a specified context in terms of the district and the role and type of work of the CHWs – as opposed to the broad description of ‘community health worker’ that has been used within the South African context. The qualitative and quantitative data supported and explicitly showed the high prevalence and continuous nature of traumatic events that CHWs in this study experienced in their daily personal and work lives. The level of exposure in the research supported the development of thinking and theory around ‘continuous trauma’. This information added to the debate that the term ‘continuous traumatic stress’ could be a useful descriptor in understanding a context in which people live and work, and where violence was seen as normative rather than extraordinary (Straker, 2013; Stevens et al., 2013; Evans & Swartz, 2000; Hamber et al., 1997). The majority of the events that were experienced were heard about, with some being witnessed and directly experienced. The study therefore contributed to current debates on the concept of ‘continuous trauma’ and how understanding this unpredictable context has implications for community service delivery.

This research added to the debate on ‘expanding the lexicon of traumatic stress’ (Straker, 2013) as it concurred with current literature on both the continuous nature of traumatic events – across contexts - as well as the responses to manage these events. Eagle and Kaminer (2013) state that in contexts of CTS, there could be a denial or minimisation of danger that would not be helpful for people living in such contexts as it may increase re-victimisation. Within this research, the concern for lack of safety or the perceived lack of safety was prominent in the groups’ conscious mind. At times it may have felt like an exaggerated description, but after the documentation of events experienced monthly, this description was a realistic experience of the participants and raised an awareness of potential traumatic events that might be faced (Diamond et al., 2013; Crawford-Brown & Benjamin, 2002). Continued support for understanding and experiencing the responses was needed for participants to manage their work and life experiences. Supervisory support was requested by Community Health Workers in order to provide a framework to help them to contextualise and think about the work issues and the affect generated by the work.

The CHW plays a valuable role in promoting both health care and social support in the communities in which they work and indirectly in the communities in which they live. By connecting and communicating with the community members, the ability to access and provide support through this cadre of worker should not be underestimated. These systems in which CHWs work were experienced as overstretched and overwhelmed by the type and number of events that were happening to individuals and communities. This supports the theory that any service or programme (health, social, economic) should be encouraged to take the socio (including traumatic experiences) -political context into consideration in planning and implementation (Seedat et al., 2009; Kaminer et al., 2008; Stewart, Murphy & Thomson, 2005).

Working with community health workers is not a 'cheap option' in providing access to health care to all. The initial effort and input to make the structure credible needs to include understanding about the social, political and economic community context (including trauma exposure) as well as developing the skills of the worker to meet the needs. All levels of the structure including the CHW, the Team Leader, the Clinic Manager, the NGO manager, the EPWP coordinator and the Primary Health Care Manager need to have the skill and support to manage both health and social structures and the emotional impact of the direct stories – especially the trauma stories - from patients and staff.

5.4. Recommendations

Due to the relatively small sample of twenty three participants, it is recognised that not all results and recommendations can be generalised. The research has given an indication of the level of trauma exposure in the Ekurhuleni communities in which the Community Health Workers were working and it should prompt further research in other districts and assist in planning and structuring the Primary Health Care Re-engineering Model as it is in the pilot phase.

5.4.1. Recommendations for practice: training and support

In exploring the traumatic exposure experienced by CHWs, it seems this information about context and continuous traumatic stress should form a central part of the education, training and management of the CHW. This could include understanding the broader context and how this

affects the CHW in their role. Simple processes (e.g. the use of checklists) could also be taught as this could assist in the management of trauma exposure.

Acknowledgement of the Community Health Workers as people as well as in the work they do should be part of daily meetings. Currently, the team leaders do this well in their teams. It would be good for this to be evident within the broader clinic space and for the CHWs themselves to acknowledge each other as well as the nurses and other people they work with in the community. Aspects of the debriefing process (specific questions) can be taught to the team leaders who can then facilitate it as part of the regular meetings. In terms of personal issues, there could be encouragement to receive counselling when there are issues that are overwhelming. Not all community counselling centres have high quality counselling but it is important to explore further as in the Thokoza area there are counselling services that offer quality counselling.

Other support suggestions include monthly debriefing of the actual community health workers. This could be facilitated by an external person that may be linked with the NGO or another organisation in the area. This person should have an understanding of trauma, community work/development, health and social issues. Checklists (from the research) could be used to give a context for each CHW for each month of work and to discuss cases and situations that will be influenced by the context. Monthly or bi-monthly debriefing of the team leaders should be undertaken. This could be facilitated by an external person or someone within the health structure. This would be useful to help process the actual emotional impact of the work as well as strengthen links and structures to support the need and response of the work.

Training course suggestions:

Three areas of training that were highlighted by both the team leaders and the community health workers themselves were:

1. First Aid – as they are often asked by community members to assist and at times are the first at the scene of crisis/trauma (e.g. shack burnt down) and would like to know some basic first aid.
2. Understanding working in a community: community dynamics; working with different cultures; working with difficult people as this understanding would help them management

situations differently and should also include the social and trauma history of South Africa and the community in which they work.

3. Continued development of counselling skills, especially trauma counselling. As community health workers get to know community members better, more information is shared and it would be useful to continue to develop advanced counselling and problem-solving skills and to be able to assist in the initial management of trauma cases that are shared with them or those that they come across in order to contain and appropriately refer. This is particularly so as traumatic material feels overwhelming and improved skills will enhance the CHW's capacity to cope with the experiences to which they are exposed.

Due to space, other training course suggestions are in Appendix M. Many participants stated that they would appreciate a certificate as a Community Health Worker to recognise the training and work that they have done to date.

From the experiences shared by the CHWs in terms of joint management of NGOs and DOH, it seems that being clearly governed by DOH would be helpful in terms of management and increased legitimacy of their role. Relevant NGOs could still be active in the support of working in the community or the support of CHWs.

This research emphasised the importance of different government departments working together with community organisations and leaders. The implementation of these partnerships is particularly important on the ground, i.e. the services directly supporting community members. Further collaboration that could be considered includes an on-the-ground connection between the Department of Social Development and Department of Health by having a social auxiliary worker work alongside the community health worker so that both health and social issues can be dealt with, as the workers meet the needs and questions that are asked by the members of the community.

5.4.2. Recommendations for future research

This research focused on identifying different forms of traumatic exposure and their prevalence. Further research into the relationship between violence exposure and socio-emotional problems of health workers would be useful to assist in developing effective community health services.

Therefore sensitive, yet rigorous, exploration of the complexity of the experience of violence in this work context and consideration for the broader dynamics of the context in which the workplace violence occurs is recommended.

Practical research to test the longer term use of the Life Events Checklist and journal structure as tools that could continue to assist community health workers to manage, understand and respond to their social and work contexts in South Africa in the long term.

Further research into other PHC Re-engineering pilot areas about the CHWs exposure to traumatic events would be interesting in order to compare and contrast the Ekurhuleni results. This would assist with the generalizability of this study to other Primary Health Care Re-engineering districts.

5.5. Concluding Comment

As Straker (2013) states there is currently a debate as to whether the concept of ‘continuous traumatic stress’ is an overarching concept to explain a context or whether the presentation of responses are different to other complicated trauma disorders to explain a separate condition. This research has provided a rich picture of the experiences of trauma exposure of Community Health Workers working in Ekurhuleni district, Gauteng. The findings add to the argument that there are different presentations of responses by those living with high exposure to traumatic incidents.

Acute traumatic events happen within a context of continual traumatic and violent incidents – across residential and work contexts - and therefore recovery occurs within an environment of ongoing fear and threat with minimal time or safety to facilitate reflection. This research identified the different presentations and the need for psychological support for people working and living in such contexts. This support should include training on how to manage the appropriate concerns and fears of ongoing threat. This research supported the view of understanding ‘continuous trauma’ to describe a context as this reflects the meaning people give to their environment and affected how they experienced individual traumatic events and managed the consequences of such experiences. As participants understood their context better through the research process, they were able to start differentiating between direct, indirect and perceived threat and therefore manage life events differently. Community Health Workers experience high levels of exposure to

traumatic events and this is essential to understand and recognise in order to develop effective macro service delivery and relevant training and support structures.

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Appendices

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Appendix A: Information sheet for participants

Information sheet for participation in the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

My name is Kirsten Thomson and I am a social worker and a post-graduate student registered for the Degree Master of Arts in Social Work at the University of the Witwatersrand. For the requirement for the degree, I am conducting research into exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

Continuous exposure to violence at a community level as well as individual experiences of traumatic events is the context for many of the community based healthcare workers within South Africa. Documenting your patterns and experiences will contribute to theory, definition and conceptualization of “continuous trauma”. This research project will explore the exposure and experience of trauma and violence of community health care workers within the structure of primary health care re-engineering and enable the practical strengthening and development of frameworks that are useful to guide and support effective service delivery within communities. It will occur within Ekurhuleni, and City of Johannesburg districts in Gauteng.

I wish to invite you to participate in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. If you agree to take part, there are three parts to the research process:

1. I will arrange to interview you at a time and place that is suitable for you. The interview will last approximately 2 hours.
2. Over a six month period you will be requested to document your experience of or exposure to traumatic events and the feelings towards these experiences. This will be done by filling out a Life Events Checklist once a month and every second week, filling out a journal entry which records your feelings and perceptions. You will be given both the monthly checklist and journal outline and I will go through them with you in case you have any questions about them.
3. Six months later, I will again arrange to interview you at a time and place that is suitable for you. In this interview, I will be sharing some of the information I have found out and checking in with you about it. I will also be asking you what you have learnt from the experience of being part of the research.

You may withdraw from the study at any time and you may refuse to answer any questions that you feel uncomfortable with answering. At the end of the research process, you will have an option of a debriefing session by a member of the Counselling and Prevention Team from Wits Reproductive Health and HIV Institute.

With your permission, the interview will be tape recorded (there is another form to be signed for this permission). I will be listening to the tapes to record the interview in a written format. The tapes and interview schedules will be kept for two years following any publication or for six years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying details will be included in the final research report.

As the interview will include sensitive issues around trauma and your reactions, there is a possibility that you may experience some feelings of emotional distress. Should you feel the need for supportive counselling following the interview, I have arranged for this service to be provided free of charge by the Centre of the Study of Violence and Reconciliation in City of Johannesburg and Khanya Family Centre in Ekurhuleni. CSVr's contact number is: 011 403 5650. Ask for Monica Bandeira. Khanya Family Centre's contact number is: 011 905 0915. Ask for Eunice Potsane. If you would like to talk to someone when the organisation may be closed (ie. at night or on the weekend), then you will be able to phone Lifeline who are available 24hours to talk through difficult situations. Lifeline's 24 hour crisis number is 011 422 42 42 or 0861 322 322.

Please feel free to ask any questions regarding the study. I shall answer them to the best of my ability. I may be contacted on 011 348 5517 or 082 618 1867. If you would like to check with my research supervisor at Witwatersrand University, her name is Francine Masson and her contact details are 011 717 4480. Should you wish to receive a summary of the results of the study, this will be made available to you on request.

Thank you for taking the time to consider participating in the study

Yours sincerely,
Kirsten Thomson

Appendix B: Participant consent form

Participant consent form for participation in the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

I have read the information sheet for participation in the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care Workers within the Primary Health Care Re-engineering Model.

I have understood what this research involves and what is expected of me.

I understand that:

- I may refuse to answer any questions that I feel uncomfortable answering.
- I may withdraw from the study at any time and it will not be held against me in any way.
- Participation for this interview is entirely voluntary and no information that may identify me will be included in the research or any other report.
- I also understand that the researcher can make use of direct quotes

I hereby consent to participate in this research project. I also give Kirsten Thomson permission for my results to be used in the write up of this study towards her Master's Degree in Social Work at Witwatersrand University. And permission for the information and results to be used in writing up of further reports and publications for disseminating information on the work of Community Health Care Workers within Primary Health Care Re-engineering.

Name: _____

Date: _____

Signature: _____

Appendix C: Participant consent form for audio taping of the interview

Participant consent form for audio taping of the interview for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

I hereby consent to the tape-recording of the interview and for verbatim quotations to be used. I understand that Kirsten will be listening to and recording the interview in a written format. I understand that my confidentiality will be maintained at all times and that the tapes will be destroyed two years after any publication arising from the study or six years after completion of the study if there are no publications. I understand that my confidentiality will also be maintained in the verbatim quotations used in the research report as although actual statements will be used, the person linked to the statement will not be identifiable.

Name: _____

Date: _____

Signature: _____

Appendix D: Semi-structured in-depth interview schedules

In-depth interview schedules for first and second interviews for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

(The questions in brackets and italics in the first interview schedule were the initial questions that were changed after pre-testing; the questions in bold are the ones that were added after pre-testing of the tools)

In-depth interview Schedule: First Interview

1. Identifying details:

- 1.1. Age:
- 1.2. Male/Female:
- 1.3. District:
- 1.4. How long have you been working in community work?
 - 1.4.1. Can you briefly describe the roles/activities you have been involved in?
- 1.5. How long have you been involved with community health care?
- 1.6. **How long have you been involved in Primary Health Care Re-engineering Model? What have you enjoyed about the work?**
- 1.7. Do you live in the same community in which you work?
- 1.8. Who else lives in the family home? (extended family, friends?)

2. Exploring understanding of trauma and violence:

- 2.1. What do you understand by the word “trauma”? (*How would you describe trauma?*)
- 2.2. What do you understand by the word “violence”? (*How would you describe violence?*)
- 2.3. How would you describe violence in the community in which you work/ live?
- 2.4. How would you describe trauma in the community in which you work/live?

3. Complete Stressful Life Events Questionnaire

4. Number of trauma experiences and symptoms (links with above questionnaire)

- 4.1. What have been your most difficult trauma experiences (this could be direct or indirect)?
- 4.2. What reactions after a traumatic event, did you feel most difficult to manage?

5. Exploring reactions to traumatic event experiences:

- 5.1. **Who have you spoken to about the traumatic events that you have experienced (probe: family; friends; colleagues)?** What were their reactions to your experience of a traumatic event?
 - 5.1.1. What was useful/helpful?
 - 5.1.2. What was not useful/helpful?

5.2. What are your reactions when you hear someone else talk about their experiences of a traumatic event/s?

6. Exploring safety:

6.1. Can you describe a context or environment where you feel safe? (e.g. Any place at home? At work?)

6.2. If yes, what makes it safe? (*If yes, what makes you feel safe in this environment?*)

6.3. Would you describe the community you live in as safe or unsafe? In which ways it is safe or unsafe (or what makes you feel safe or unsafe there)?

6.4. Would you describe your workplace as safe or unsafe? In which ways it is safe or unsafe (or what makes you feel safe or unsafe there)?

6.5. Can you describe a context or environment where you feel unsafe?

6.6. If yes, what makes you feel unsafe in this environment?

6.7. Could you describe ways in which being in unsafe spaces changes how you behave?

6.8. Could you describe ways in which being in unsafe spaces changes how you feel?

6.9. Do you feel a difference when you move from a safe space to an unsafe one? If yes, what are those differences?

7. Exploring ways of coping:

7.1. In managing traumatic experiences in your life, how have you coped?

7.1.1. What have you done?

7.1.2. What have you thought/said?

7.1.3. How have you felt?

7.2. What has been the most useful support someone has given you?

8. Exploring changes in world view:

8.1. What are your views/reactions when you come across people that you do not know?

8.2. How safe do you feel walking around your community?

8.3. How has working and living in your community changed the way you see your community and people in general? (probe: beliefs they are carrying about people, violence, trauma).
(*What beliefs do you carry about your community and people in general?*)

In-depth interview Schedule: Second Interview

- How did you find the research experience?
 - What was it like filling out the checklist?
 - How would they describe “severe human suffering”; “other stressful life event”
 - What did you put down as ‘c’ or ‘w’ or ‘m’
 - Did you talk/share with colleagues?
 - What was most difficult?
 - What did you like about the experience?
 - How did you cope with it?
- Did you write in the journal?
 - What made you chose to write about the ones you did?
- Feedback of the results
 - LEC feedback
 - Overall: personal exposure
 - Overall: witness results
 - Overall: learned about results
 - SLEQ feedback
 - Confirm losses they have experienced in their life
 - What does it mean to you when “own life is in danger”?
 - Good friend/family member who has passed away because sick (not as Q)
 - Qualitative results
 - What do you think of the preliminary results [explained: results so far]?
 - Do you think this seems to describe what you and others experience?
- In doing the work that you do, what support would you like?
 - From NGO? From clinic?
- What do you like most about the community you work and live in?
- What do you not like about the community you work and live in?
- Follow up on any questions that I need still need feedback on ie. The outstanding information about them
- Do a final checklist with participant (this was used to confirm that the researcher understood how they had been filling out the checklists and whether all checklists can be used for the research)
- Kirsten’s Next steps: writing and handing in on 14 February.
 - Can send the summary at the same time
 - Should be marked about 2 months later, then will give them feedback about it

Thank you for your involvement in the study

Appendix E: Stressful life events screening questionnaire (1998) – Revised

Stressful life events screening questionnaire (1998) to be used in the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

STRESSFUL LIFE EVENTS SCREENING QUESTIONNAIRE - REVISED

The items listed below refer to events that may have taken place at any point in your entire life, including early childhood. **If an event or ongoing situation occurred more than once, please record all pertinent information about additional events on the last page of this questionnaire.** (Please print or write neatly).

1. Have you ever had a life-threatening illness?

No _____ Yes _____

If yes, at what age? _____

Duration of Illness _____

Describe specific illness _____

2. Were you ever in a life-threatening accident?

No _____ Yes _____

If yes, at what age? _____

Describe accident _____

Did anyone die? _____ Who? (Relationship to you) _____

What physical injuries did you receive? _____

Were you hospitalized overnight? No _____ Yes _____

3. Was physical force or a weapon ever used against you in a robbery or mugging?

No _____ Yes _____

If yes, at what age? _____

How many perpetrators? _____

Describe physical force (e.g., restrained, shoved) or weapon used against you.

Did anyone die? _____

Who? _____

What injuries did you receive? _____

Was your life in danger? _____

4. Has an immediate family member, romantic partner, or very close friend died because of accident, homicide, or suicide?

No _____ Yes _____

If yes, how old were you? _____

How did this person die? _____

Relationship to person lost _____

In the year before this person died, how often did you see/have contact with him/her? _____

Have you had a miscarriage? No _____ Yes _____ If yes, at what age? _____

5. At any time, has anyone (parent, other family member, romantic partner, stranger or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?

No _____ Yes _____

If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.-2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Who did this? (Specify stranger, parent, etc.) _____

Has anyone **else** ever done this to you? No _____ Yes _____

6. Other than experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you to have sex against your wishes?

No _____ Yes _____

If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.-2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Who did this? (Specify sibling, date, etc.) _____

What age was this person? _____

Has anyone **else** ever done this to you? No _____ Yes _____

7. When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?

No _____ Yes _____ If yes, at what age _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.- 2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Describe force used against you (e.g., fist, belt) _____

Were you ever injured? _____ If yes, describe _____

Who did this? (Relationship to you) _____

Has anyone **else** ever done this to you? No _____ Yes _____

8. As an adult, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.- 2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Describe force used against you (e.g., fist, belt) _____

Were you ever injured? _____ If yes, describe _____

Who did this? (Relationship to you) _____

If sibling, what age was he/she _____

Has anyone **else** ever done this to you? No _____ Yes _____

9. Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you were no good?

No _____ **Yes** _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.- 2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Who did this? (Relationship to you) _____

If sibling, what age was he/she _____

Has anyone **else** ever done this to you? No _____ Yes _____

10. Other than the experiences already covered, has anyone ever threatened you with a weapon like a knife or gun?

No _____ **Yes** _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____, more than 10 _____

If repeated, over what period? 6 mo. or less _____, 7 mos.- 2 yrs. _____, more than 2 yrs. but less than 5 yrs. _____, 5 yrs. or more _____.

Describe nature of threat _____

Who did this? (Relationship to you) _____

Has anyone **else** ever done this to you? No _____ Yes _____

11. Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?

No _____ Yes _____ If yes, at what age? _____

Please describe what you witnessed _____

Was your own life in danger? _____

12. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)?

No _____ Yes _____

If yes, at what age? _____ Please describe. _____

13. Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported?

No _____ Yes _____

If yes, at what age? _____ Please describe. _____

The interviewer should determine if the respondent is reporting the same incident in multiple questions, and should record it in the most appropriate category.

Appendix F: Life events checklist (1995) - adapted

Life Events Checklist to be used in the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

LIFE EVENTS CHECKLIST (LEC)

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995, Adapted by K Thomson, 2013

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you. Fill out this checklist for each month

P	= happened to you or to someone close to you
W	= happened at work
C	= happened in the community (may/may not know person)

<i>Event</i>	<i>Happened to me</i>	<i>Witnessed it</i>	<i>Learned about it</i>	<i>Doesn't apply</i>
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)				
2. Fire or explosion				
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)				
4. Serious accident at work, home, or during recreational activity				
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)				
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)				
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)				
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)				
9. Other unwanted or uncomfortable sexual experience				
10. Combat or exposure to a war-zone (in the military or as a civilian)				
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)				
12. Life-threatening illness or injury				
13. Severe human suffering				
14. Sudden, violent death (for example, homicide, suicide)				
15. Sudden, unexpected death of someone close to you				
16. Serious injury, harm, or death you caused to someone else				
17. Any other very stressful event or experience				

Appendix G: Participant journal schedule

Participant Journal Schedule for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

District:

Date:

Key traumatic experiences or events that I have experienced over the past two weeks:

How I reacted to what has happened:

How I have coped with what has happened: (what has been useful or not useful)

My thoughts and feelings about what has happened and about my reactions to it:

Appendix H: Summary structure used after each Interview

Summary structure used after each interview for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]

It was used to write down key points from the interview, initial themes that came out of each interview, the general experience of the interview and at the end there are questions that guide reflexivity of the researcher which includes: general comments, questions or thoughts that the researcher is left with and the researcher's emotional response.

There are two examples - one of a first and one of a second interview of a participant. All identifying details and codes have been removed for anonymity.

Summary of Masters Research First Interview

Name/code and age: CHW Xx

Xxyears

Date of Interview: Xxxx

Place and time of interview: Xxxx

Length of interview: 1 hour and 45 min

Interview process (interrupted or not; interviewee talkative/shy/...):

Interviewee was open and engaged. Interview space was my car – as clinic rooms were all being used. No interruptions though at one point a generator type noise started but hoping the tape did not pick this up.

How long been working in the community: 5 years – started as a volunteer in HBC

How long been involved with PHC re-engineering: 6 months

Key points from interview:

- Open and engaged
- Trauma involves bottling up and trying to keep going
- Best support is practical support
- Don't really trust other people
- Worse situation: way her stepmother treated her; and realising that she is not her real mother
- Teenage pregnancy
- Can help others
- Knows she is a strong woman and can deal with difficult situations

Main themes:

- Coping : prayer; not talking to others; trust her pastor; talk to sister (who is now dead)
- Support: practical support is key; suggest others go for counselling
- Safety: home with her children; clinic
- Unsafety: cannot be open in a group; shebeens; alcohol and substance abuse; forest: fear of unknown animals; community in which work and live (know about the stories)
- CHW status in the community is helpful and protective
- Death – not really dealt with

Comments that stood out:

none

Interviewer's general comments:

Interviewee was open. She seemed to struggle with the last question...she could see her value as a CHW, but could not talk about what she has learnt about the community.

At the end she wanted assistance with how to manage her daughter – yet at the beginning she talked about what a great relationship she had with her children

Hard to ask about life threatening illness as feels like breaking confidentiality

Questions or thoughts that the researcher is left with:

Concerned she has managed a lot of life by herself

Hard to remain researcher, and not be counsellor

Researcher's emotional response:

Felt protective of her

Felt somewhat stuck about her situation – her description of her daughter living with her husband (sister and mother) was a bit confusing.

Any other comments:

Gave her number of the organization that agreed to assist research participants, if needed.

Summary of Masters Research Second Interviews

Name/code and age: CHW Yy

Date of Interview: Xxx

Place and time of interview: Xxxx

Length of interview: one hour

Interview process (interrupted or not; interviewee talkative/shy/...):

Interview in car as no elec in clinic and toyi toyi-ing outside re service delivery

Key points from interview:

- Found the research process helpful – by doing the first interview she found how important and useful it was to share and realised that she was no longer scared in her life, that she could make choices for herself
- Not as overwhelmed by the community violence. By being able to tick off the events and the types of events, it made it more manageable
- Not as nervous of groups of boys, she know says “hello” and they say hello back. She realises she is no longer carrying the fear that she has had
- She will go into the streets after 8pm, if she wants to visit someone, no longer feels the fear
- Community has started a street committee in August, so the good guys and women are helping patrol the streets. She enjoyed being part of the meetings that developed this. She was able to attend the meetings, even though they were often at night time
- Feel more comfortable in the community that she works in, so much so, if her partner is not around, she would feel ok going herself
- Although lost a close friend – she has a renewed sense of God and God’s timing that has helped her to make sense of the situation
- Enjoyed writing the journal: learnt a lot about herself; realised where she needed to forgive in her own life; after writing, helped her to speak to people and to deal with things

Main themes:

Coping: seemed to be doing better.

Training and Support: in separate document

Losses: in a separate document

Comments that stood out:

Quote about PHC re-engineering: something about when the community sees we are there to help them, the attitude to CHW changes

Hectic e.g. – but a good e.g. of a rape and mutilation that happened to a women in the community this past month.

Interviewer's general comments:

A good interview. Good to see participant in a better and stronger place. Can even be in same room as her ex-husband. Even though she had a death of a guy that she liked – she seems to be managing well.

Seemed to benefit from the process

Questions or thoughts that the researcher is left with:

A positive response to the checklists is not what I had expected.

Researcher's emotional response:

Glad it was a positive experience for the participant

Bit horrified with the example of the girl that was raped and her nipples were cut out... when alive and then she went into a coma – hectic stories that are the in community in which the CHW work

Any other comments:

Appendix I: Ethics clearance from Human Research Ethics Committee

Ethics clearance from the Human Research Ethics Committee (non-medical) for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]



Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)

H121006 Thomson

CLEARANCE CERTIFICATE

PROTOCOL NUMBER H121006

PROJECT TITLE

Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model

INVESTIGATOR(S)

Ms K Thomson

SCHOOL/DEPARTMENT

Humanities

DATE CONSIDERED

19 October 2012

DECISION OF THE COMMITTEE

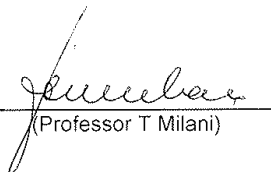
Approved Unconditionally

EXPIRY DATE

31 October 2014

DATE 29 October 2012

CHAIRPERSON


(Professor T Milani)

cc: Ms. F Masson

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

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 resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**


Signature

01 / 11 / 2012
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix J: Ekurhuleni Department of Health research ethics clearance certificate

Research Ethics Clearance Certificate from the Ekurhuleni district, Department of Health for the research entitled: Exploring the concept of continuous trauma through the experience of Community Health Care workers within the Primary Health Care Re-engineering Model.

[After examination process, Examiners suggested a change in title. New title is now: Exploring the experience of Community Health Workers operating in contexts where trauma and its exposure are continuous]



RESEARCH ETHICS CLEARANCE CERTIFICATE

Research Project Title: Exploring the concept of continuous trauma through the experience of Community Health Care workers within Primary Health Care Re-engineering

Research Project Number: 08-02-2013-01

Name of Researcher(s): Mr Kirsten Thomson

Division/Institution/Company: Wits University

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT ETHICS PANEL (EHDEP)

- THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT HAS BEEN FULLY APPROVED BY THE EHDEP. THE RESEARCHER(S) MAY THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT.
- NOTE THAT THE RESEARCHER WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT AT THE ANNUAL EKURHULENI RESEARCH CONFERENCE HELD IN JULY/AUGUST.
- THE ETHICS PANEL WISHES THE RESEARCHER(S) THE BEST OF SUCCESS.

MR VUKILE MLUNGWANA
RESEARCH COORDINATOR: EKURHULENI METROPOLITAN MUNICIPALITY
Dated: 26/02/2013

DR JOSEPH SEPUYA
DEPUTY CHAIRPERSON: EKURHULENI METROPOLITAN MUNICIPALITY
Dated: 26/02/2013

Dr R. K. Khehuma
CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI REGION)
Dated: 26/02/2013

Appendix K: Tables of all seventeen events analyzed: directly experienced, witnessed and heard about (N=23)

Natural Disaster – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	21 (91.30%)	15 (65.22%)	5 (21.74%)
1	2 (8.70%)	2 (8.70%)	3 (13.04%)
2	-	3 (13.04%)	4 (17.39%)
3	-	1 (4.35%)	4 (17.39%)
4	-	1 (4.35%)	1 (4.35%)
5	-	-	3 (13.04%)
6	-	-	2 (8.70%)
7	-	1 (4.35%)	1 (4.35%)
Average no of events experienced	1	2.75	3.39

Fire and Explosion – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	20 (86.97%)	3 (13.04%)	2 (8.70%)
1	3 (13.04%)	5 (21.74%)	4 (17.39%)
2	-	3 (13.04%)	5 (21.74%)
3	-	4 (17.39%)	5 (21.74%)
4	-	4 (17.39%)	2 (8.70%)
5	-	2 (8.70%)	2 (8.70%)
6	-	1 (4.35%)	1 (4.35%)
7	-	-	1 (4.35%)
13	-	1 (4.35%)	-
14	-	-	1 (4.35%)
Average no of events experienced	1	3.40	3.52

Transportation Accident – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	18 (78.26%)	2 (8.70%)	-
1	3 (13.04%)	2 (8.70%)	3 (13.04%)
2	2 (8.70%)	3 (13.04%)	3 (13.04%)
3	-	3 (13.04%)	3 (13.04%)
4	-	4 (17.39%)	4 (17.39%)
5	-	5 (21.74%)	3 (13.04%)
6	-	1 (4.35%)	1 (4.35%)
7	-	2 (8.70%)	2 (8.70%)
8	-	-	1 (4.35%)
9	-	-	2 (8.70%)
10	-	-	1 (4.35%)
11	-	1 (4.35%)	-
Average no of events experienced	1.4	4.23	4.57

Serious Accident – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	21 (91.30%)	9 (38.70%)	7 (30%)
1	1 (4.35%)	4 (17.39%)	5 (21.74%)
2	1 (4.35%)	4 (17.39%)	4 (17.39%)
3	-	5 (21.74%)	1 (4.35%)
4	-	-	1 (4.35%)
5	-	-	1 (4.35%)
6	-	-	2 (8.70%)
7	-	1 (4.35%)	1 (4.35%)
21	-	-	1 (4.35%)
Average no of events experienced	1.5	2.43	4.06

Toxic Substances – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	21 (91.30%)	13 (56.52%)	6 (26.09%)
1	-	5 (21.74%)	6 (26.09%)
2	1 (4.35%)	3 (13.04%)	4 (17.39%)
3	1 (4.35%)	-	-
4	-	-	3 (13.04%)
5	-	-	2 (8.70%)
6	-	-	-
7	-	1 (4.35%)	2 (8.70%)
9	-	1 (4.35%)	-
Average no of events experienced	2.5	2.7	2.94

Physical Assault – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	13 (56.52%)	2 (8.70%)	-
1	4 (17.39%)	-	5 (21.74%)
2	4 (17.39%)	5 (21.74%)	3 (13.04%)
3	2 (8.70%)	4 (17.39%)	2 (8.70%)
4	-	5 (21.74%)	3 (13.04%)
5	-	2 (8.70%)	3 (13.04%)
6	-	1 (4.35%)	1 (4.35%)
7	-	1 (4.35%)	1 (4.35%)
8	-	1 (4.35%)	1 (4.35%)
9	-	-	1 (4.35%)
10	-	-	2 (8.70%)
11	-	1 (4.35%)	-
12	-	1 (4.35%)	1 (4.35%)
Average no of events experienced	1.8	4.57	4.61

Assault with Weapon - number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	15 (65.22%)	5 (21.74%)	2 (8.70%)
1	5 (21.74%)	4 (17.39%)	4 (17.39%)
2	2 (8.70%)	2 (8.70%)	1 (4.35%)
3	1 (4.35%)	5 (21.74%)	4 (17.39%)
4	-	3 (13.04%)	3 (13.04%)
5	-	1 (4.35%)	3 (13.04%)
6	-	-	-
7	-	1 (4.35%)	2 (8.70%)
8	-	1 (4.35%)	1 (4.35%)
9	-	-	1 (4.35%)
12	-	1 (4.35%)	2 (8.70%)
Average no of events experienced	1.5	3.72	4.76

Sexual Assault - number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	22 (95.65%)	9 (38.70%)	-
1	1 (4.35%)	4 (17.39%)	2 (8.70%)
2	-	3 (13.04%)	3 (13.04%)
3	-	3 (13.04%)	2 (8.70%)
4	-	1 (4.34%)	3 (13.04%)
5	-	1 (4.34%)	3 (13.04%)
6	-	1 (4.34%)	5 (21.74%)
7	-	1 (4.35%)	2 (8.70%)
9	-	-	1 (4.35%)
11	-	-	1 (4.35%)
17	-	-	1 (4.35%)
Average no of events experienced	1	2.93	5.30

Unwanted Sexual Experience – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	19 (82.61%)	11 (47.83%)	6 (26.09%)
1	2 (8.70%)	3 (13.04%)	1 (4.35%)
2	1 (4.35%)	6 (26.09%)	6 (26.09%)
3	1 (4.35%)	-	2 (8.70%)
4	-	3 (13.04%)	2 (8.70%)
5	-	-	3 (13.04%)
6	-	-	2 (8.70%)
7	-	-	-
17	-	-	1 (4.35%)
Average no of events experienced	1.75	2.25	4.18

Warzone Community Experience – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	23 (100%)	15 (65.22%)	8 (34.78%)
1	-	4 (17.39%)	5 (21.74%)
2	-	3 (13.04%)	4 (17.39%)
3	-	-	-
4	-	-	1 (4.35%)
5	-	-	1 (4.35%)
6	-	1 (4.35%)	1 (4.35%)
7	-	-	3 (13.04%)
Average no of events experienced	0	2	3.27

Captivity – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	23 (100%)	8 (34.78%)	5 (21.74%)
1	-	7 (30.43%)	5 (21.74%)
2	-	4 (17.39%)	3 (13.04%)
3	-	3 (13.04%)	4 (17.39%)
4	-	-	1 (4.34%)
5	-	-	1 (4.35%)
6	-	1 (4.35%)	1 (4.35%)
7	-	-	2 (8.70%)
8	-	-	1 (4.35%)
Average no of events experienced	0	2	3.33

Life Threatening Illness – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	12 (52%)	2 (8.70%)	4 (17.39%)
1	7 (30.43%)	2 (8.70%)	4 (17.39%)
2	2 (8.70%)	3 (13.04%)	3 (13.04%)
3	1 (4.35%)	2 (8.70%)	2 (8.70%)
4	1 (4.35%)	3 (13.04%)	1 (4.35%)
5	-	2 (8.70%)	4 (4.35%)
6	-	3 (13.04%)	1 (4.35%)
7	-	-	-
8	-	-	2 (8.70%)
9	-	2 (8.70%)	-
10	-	1 (4.35%)	-
12	-	1 (4.35%)	-
13	-	1 (4.35%)	-
14	-	1 (4.35%)	-
19	-	-	1 (4.35%)
Average no of events experienced	1.64	5.76	4.26

Severe Human Suffering – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	17 (74.35%)	2 (8.70%)	5 (21.74%)
1	5 (21.74%)	-	4 (17.39%)
2	-	4 (17.39%)	-
3	1 (4.35%)	-	1 (4.35%)
4	-	1 (4.35%)	1 (4.35%)
5	-	2 (8.70%)	3 (13.04%)
6	-	3 (13.04%)	2 (8.70%)
7	-	-	1 (4.35%)
8	-	3 (13.04%)	-
9	-	3 (13.04%)	4 (17.39%)
10	-	3 (13.04%)	-
12	-	1 (4.35%)	-
13	-	1 (4.35%)	-
14	-	-	1 (4.35%)
Average no of events experienced	1.33	6.95	5.28

Sudden Violent Death – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	21 (91.30%)	11 (47.83%)	5 (21.74%)
1	2 (8.70%)	5 (21.74%)	2 (8.70%)
2	-	3 (13.04%)	1 (4.35%)
3	-	1 (4.35%)	5 (21.74%)
4	-	2 (8.70%)	4 (17.39%)
5	-	-	1 (4.35%)
6	-	1 (4.35%)	1 (4.35%)
7	-	-	3 (13.04%)
8	-	1 (4.35%)	-
Average no of events experienced	1	3	3.72

Sudden Unexpected Death – number of times in which participants experienced this as was recorded over past 7 months

Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	2 (8.70%)	9 (38.70%)	11 (47.83%)
1	7 (30.43%)	6 (26.09%)	7 (30%)
2	6 (26.09%)	3 (13.04%)	4 (17.39%)
3	4 (17.39%)	1 (4.35%)	1 (4.35%)
4	1 (4.35%)	2 (8.70%)	-
5	2 (8.70%)	-	-
6	1 (4.35%)	1 (4.35%)	-
7	-	1 (4.35%)	-
Average no of events experienced	2.43	2.57	1.5

Injury You Caused Someone Else – number of times in which participants experienced this as was recorded over past 7 months

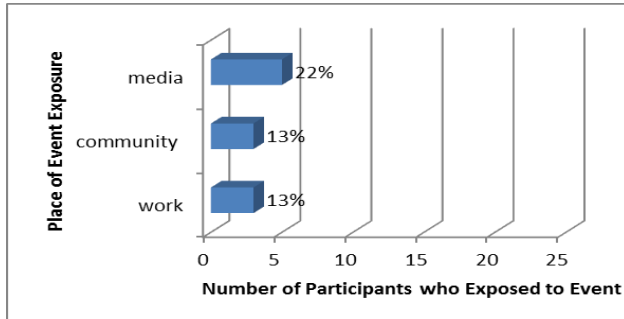
Number of times	No. of participants Direct experience	No. of participants Witness	No. of participants Learned about
Never	21 (91.30%)	23 (100%)	23 (100%)
1	1 (4.35%)	-	-
2	-	-	-
3	1 (4.35%)	-	-
4	-	--	-
5	-	-	-
6	-	-	-
7	-	-	-
Average no of events experienced	1	0	0

Other Stressful Life Events – *number of times in which participants experienced this as was recorded over past 7 months*

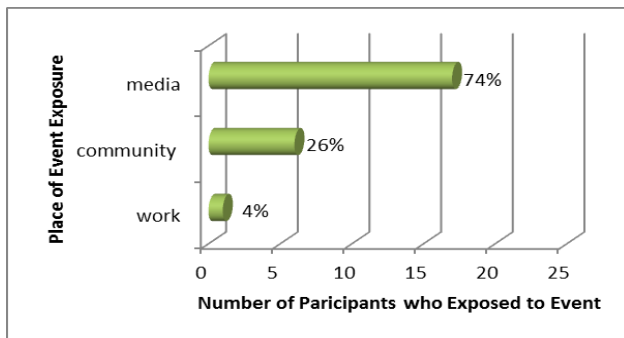
Number of times	No. of participants Direct experience	No. of participants Witnessed	No. of participants Learned about
Never	3 (13.04%)	5 (21.74%)	6 (26.09%)
1	4 (17.39%)	2 (8.70%)	1 (4.35%)
2	5 (21.74%)	3 (13.04%)	3 (13.04%)
3	6 (26.09%)	3 (13.04%)	7 (30.43%)
4	1 (4.35%)	1 (4.35%)	4 (17.39%)
5	2 (8.70%)	2 (8.70%)	1 (4.35%)
6	1 (4.35%)	2 (8.70%)	-
7	1 (4.35%)	-	-
8	-	1 (4.35%)	1 (4.35%)
11	-	1 (4.35%)	-
12	-	2 (8.70%)	-
13	-	1 (4.35%)	-
Average no of events experienced	2.95	5.5	3.35

Appendix L: Figures of all seventeen events analyzed: witnessed and heard about at work, in the media and within ones' own community (N=23)

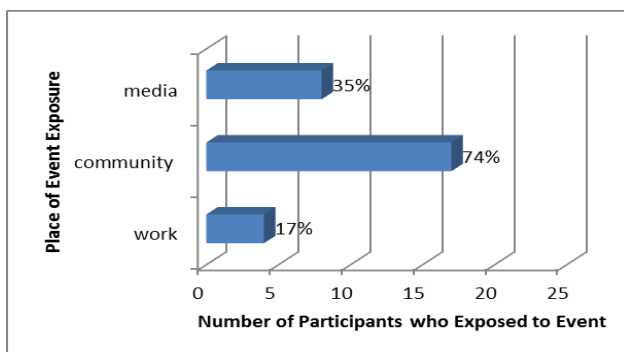
Natural Disaster Witnessed:



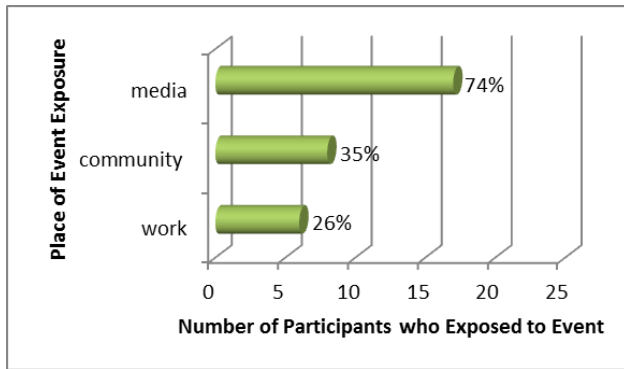
Natural Disaster Learned about:



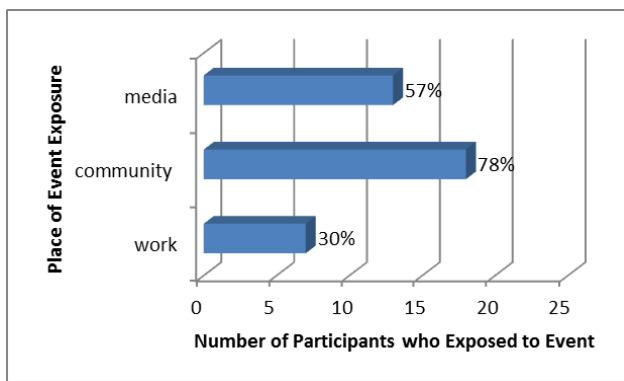
Fire and Explosion Witnessed:



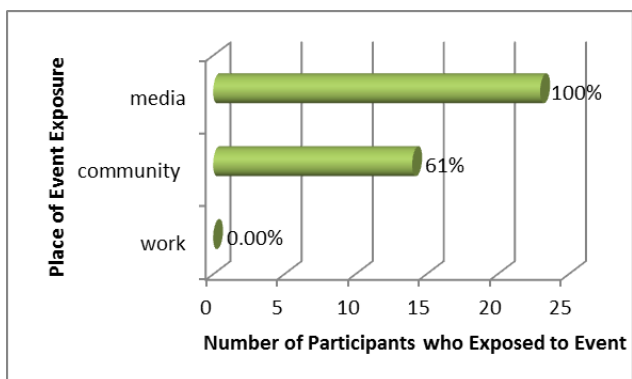
Fire and Explosion Learned about:



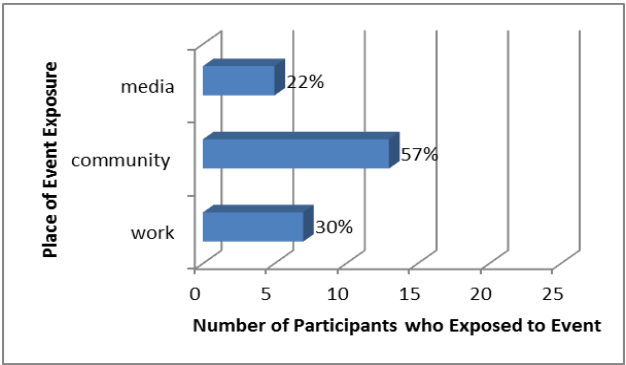
Transportation Accident Witnessed:



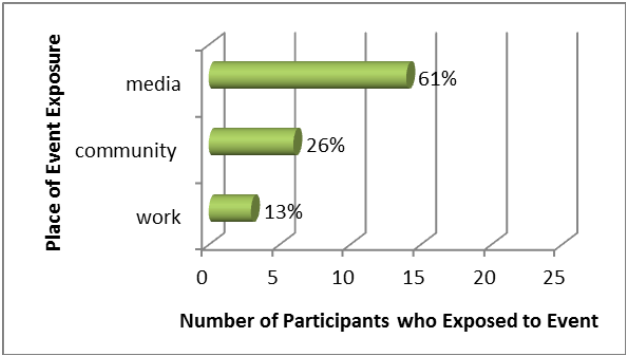
Transportation Accident Learned about:



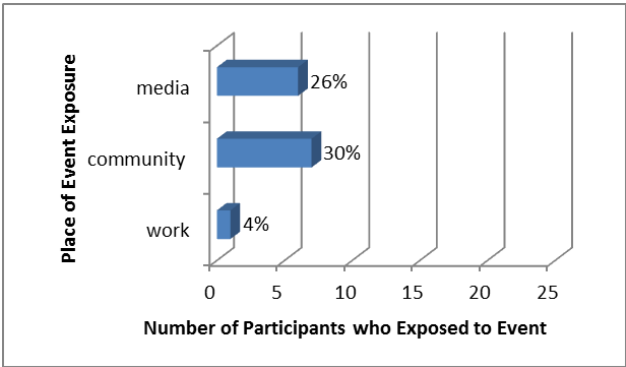
Serious Accident Witnessed:



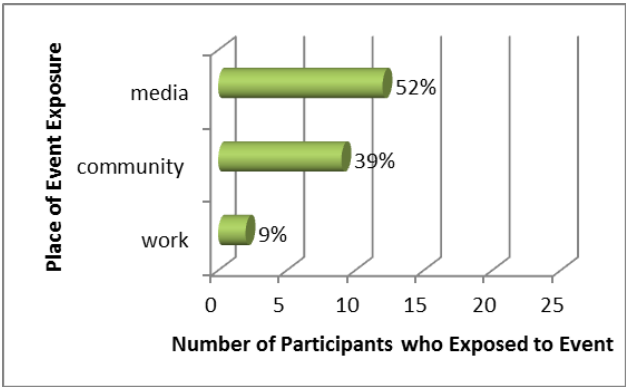
Serious Accident Learned about:



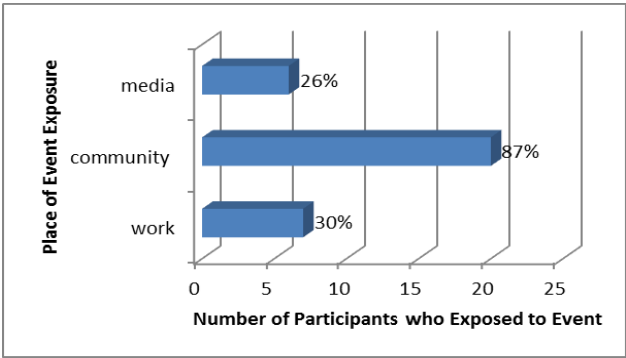
Toxic Substances Witnessed:



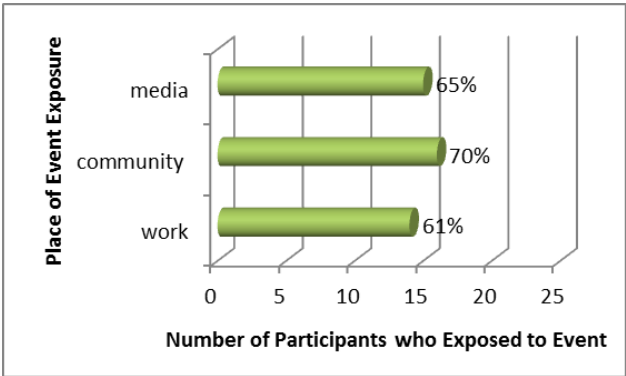
Toxic Substances Learned about:



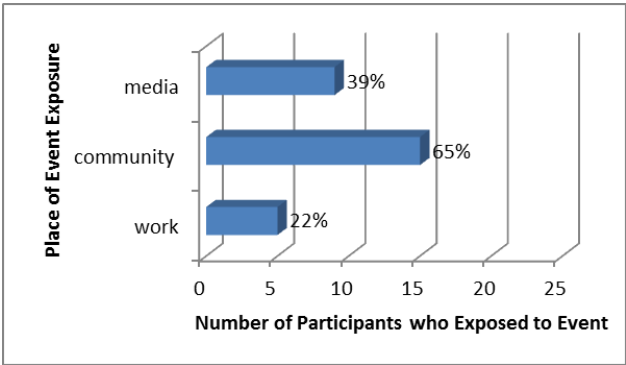
Physical Assault Witnessed:



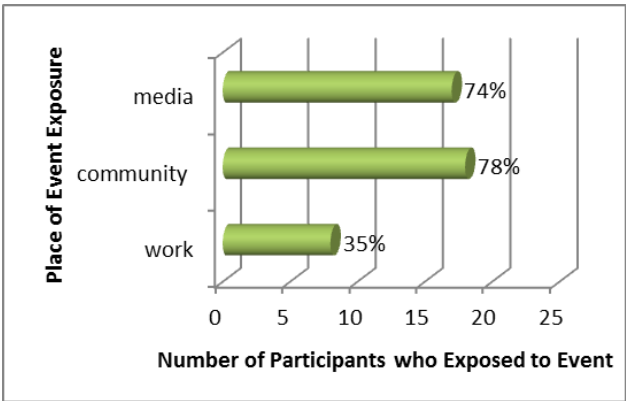
Physical Assault Learned about:



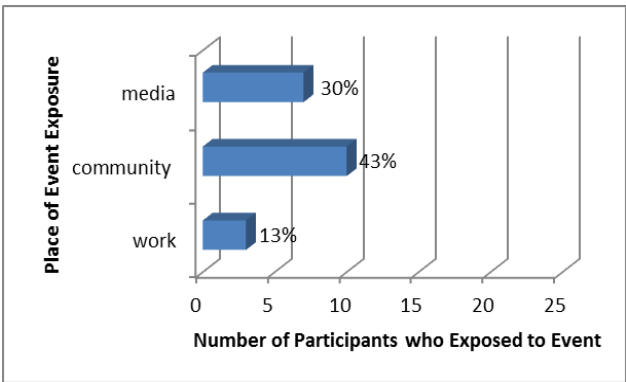
Assault with Weapon Witnessed:



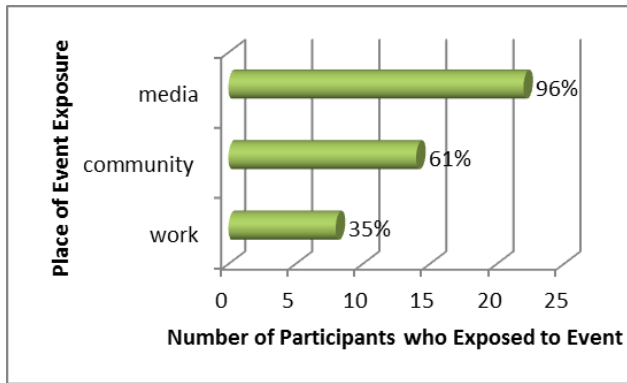
Assault with Weapon Learned about:



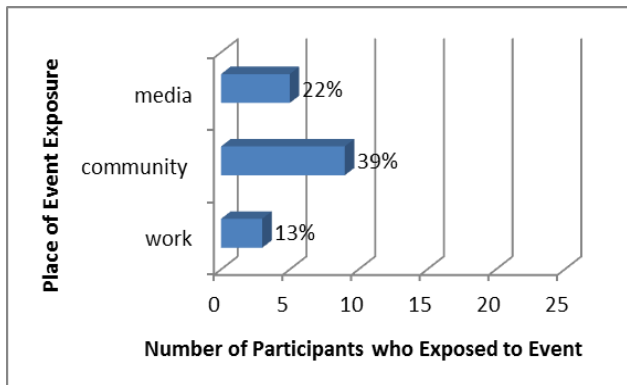
Sexual Assault Witnessed:



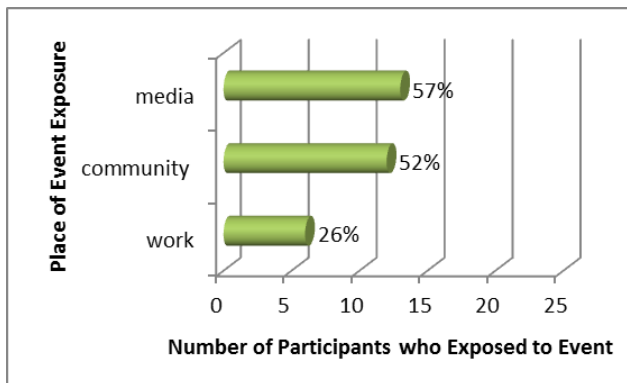
Sexual Assault Learned about:



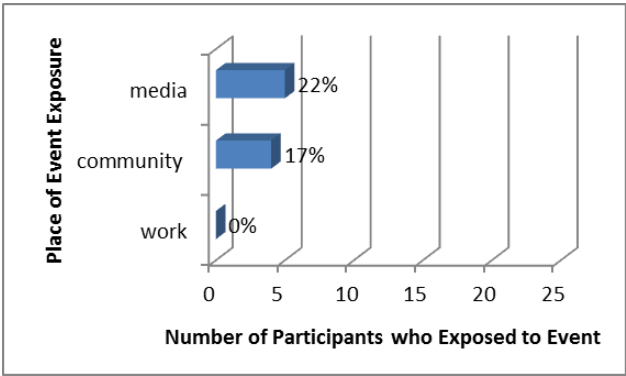
Unwanted Sexual Experience Witnessed:



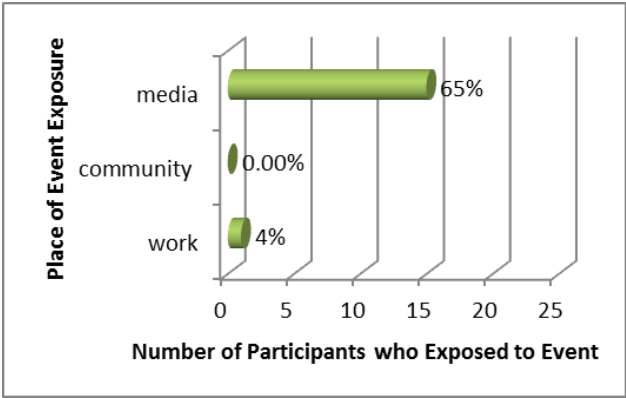
Unwanted Sexual Experience Learned about:



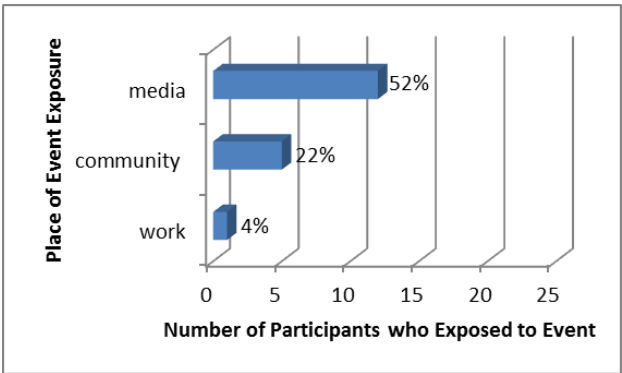
War zone Community Experience Witnessed:



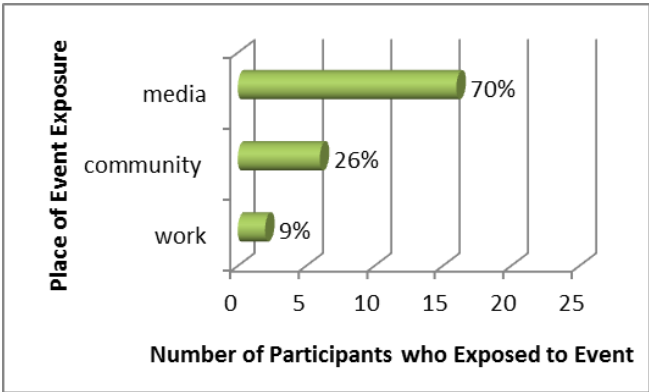
War zone Community Experience Learned about:



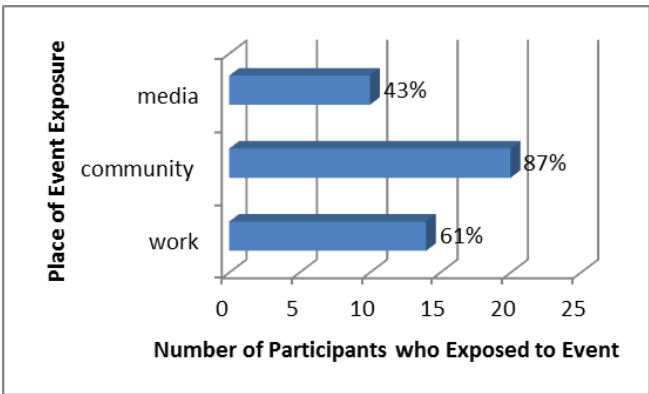
Captivity Witnessed:



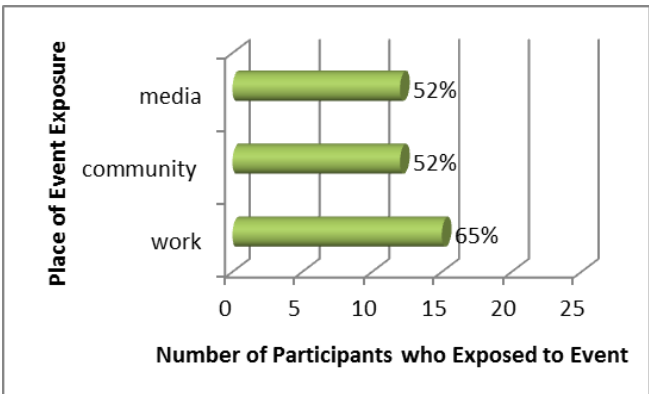
Captivity Learned about:



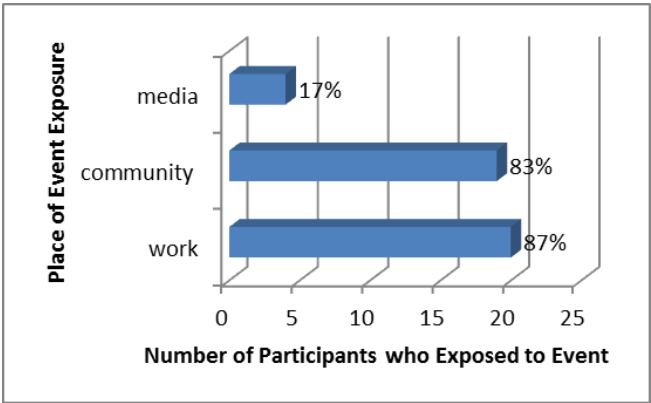
Life Threatening Illness Witnessed:



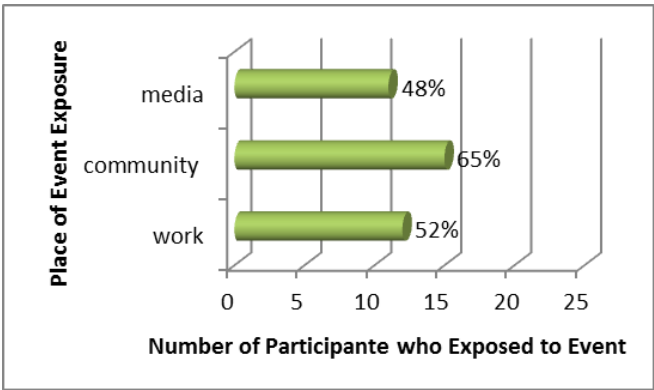
Life Threatening Illness Learned about:



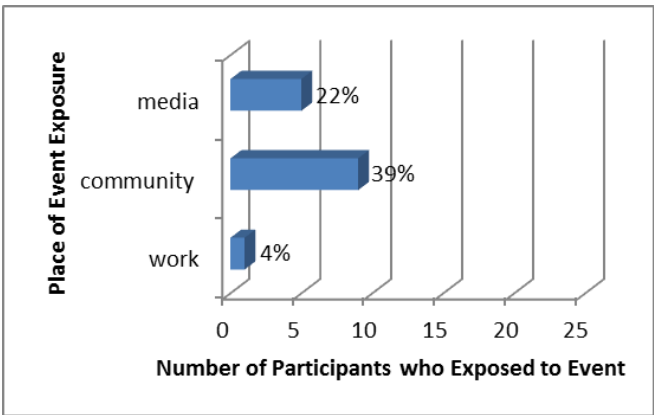
Severe Human Suffering Witnessed:



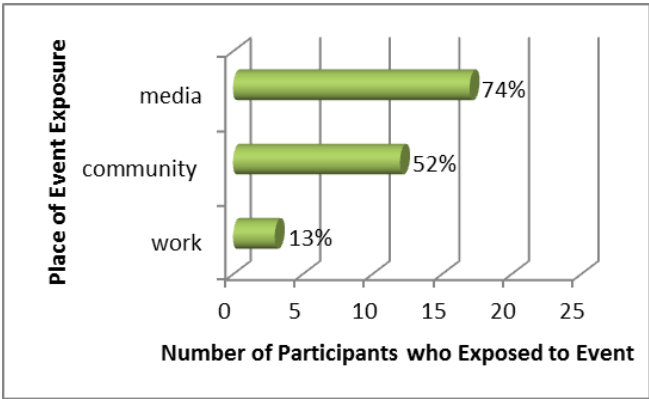
Severe Human Suffering Learned about:



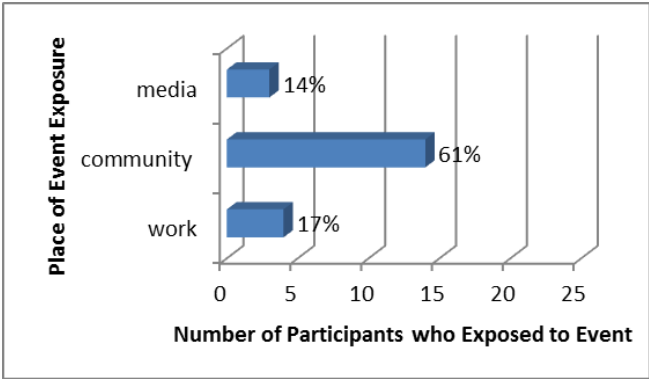
Sudden Violent Death Witnessed:



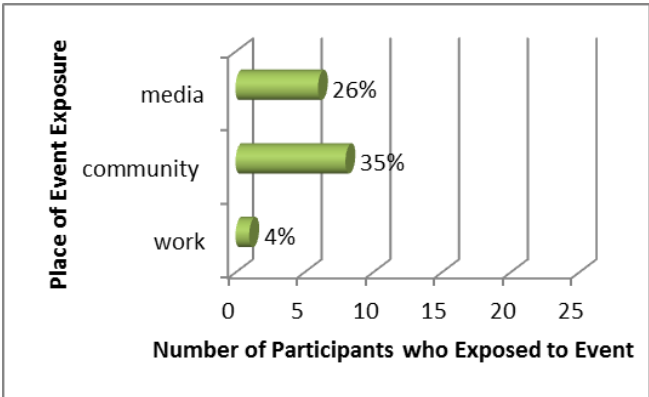
Sudden Violent Death Learned about:



Sudden Unexpected Death Witnessed:



Sudden Unexpected Death Learned about:



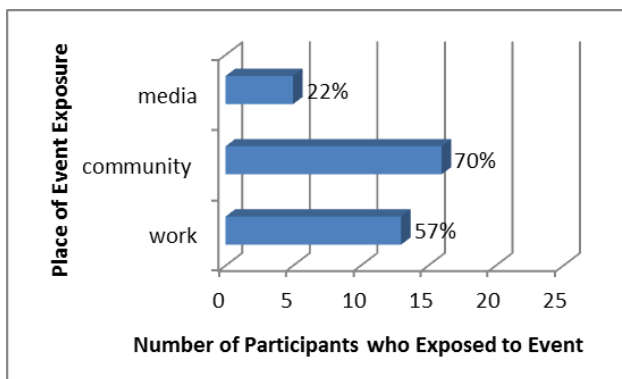
Injury you caused someone else Witnessed:

0% for work, community and media

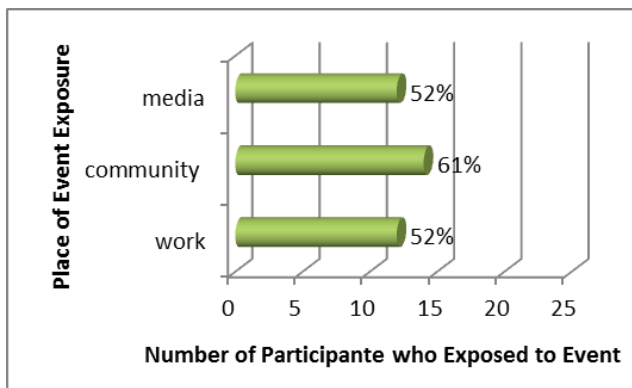
Injury you caused someone else Learned about:

0% for work, community and media

Other stressful life events Witnessed:



Other stressful life events Learned about:



Appendix M: Training Course Suggestions for Community Health Workers

Other areas of training that community health workers have identified, as they have been working in the community, include:

- Self-defence course
- Adherence counselling
- Basic HIV/Aids – how to do a HIV test
- How to work with kids – knowledge and practical things that they can do
- Although have basics in general health, would like more information – need to know more and need to know updates of diabetes, TB etc.
- Also be good to be able to do basic things like giving an injection as people often expect us to be able to do this (as the community see us as nurses)
- Information on family planning
- Like training on “speaking skills”: how to approach people; how to deal with difficult people or situations e.g. How to deal with drunk or angry people; what to do when a person cries uncontrollably
- Training on disaster management would be good (e.g. There are shack fires and it would be good to know how to support and help the community after a disaster like this)
- Training in being able to facilitate support groups so can run them in the community
- Training on how to help people manage and deal with emotions and relationships and how to develop and build up relationships
- More information on cleaning and hygiene so can assist patients better
- Would be good to understand social services and how to refer so can help people better
- Would like to help people to do more with their lives e.g. Income projects
- Once a month class: continued training and development (e.g. Help manage trauma situations – need to learn more; how to improve counselling)