An Exploration of the Lived Experiences of Social Workers Dealing with Victims of Intimate Partner Violence at Ehlanzeni District, Mpumalanga

BY

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DECLARATION

I, LINDOKUHLE ANGELO MHLONGO, declare that the study titled 'An Exploration of The Lived Experiences of Social Workers Dealing with Victims of Intimate Partner Violence at Ehlanzeni District, Mpumalanga' hereby submitted to the University of Limpopo as partial fulfilment for Master of Arts Degree in Clinical Psychology has not been previously submitted by me for a degree at any other university, that it is my own work and that all the sources contained within have been accordingly acknowledged.

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MHLONGO LINDOKUHLE ANGELO **DATE**

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GLOSSARY AND ABBREVIATIONS

Abbreviation	Meaning
WHO	World Health Organisation
IPV	Intimate partner violence
STS	Secondary traumatic stress
CF	Compassion fatigue
VT	Vicarious trauma
CSDT	Constructivist self-developmental theory
VPG	Vicarious posttraumatic growth
VR	Vicarious resilience

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ABSTRACT

Intimate partner violence (IPV) poses a major challenge for social workers worldwide, as well as in South Africa. In light in the above, the present study aimed to explore the lived experiences of social workers dealing with victims of IPV at Ehlanzeni District, Mpumalanga Province. A qualitative study was conducted among social workers working with victims of IPV. The study had anticipated using 10 participants but, due to data saturation, only six participants were interviewed. Each interview took 45–60 minutes, depending on each participant's responses. A total of six participants, all females between the ages of 24 and 39 years, were selected using purposive sampling. The data were collected using semi-structured interviews, and interpretive phenomenological analysis (IPA) was applied for data analysis.

Four major themes emerged from the analysis of the data: a) emotional and psychological distress experienced by social workers; b) impact on personal and professional lives; c) coping strategies; and d) vicarious posttraumatic growth. Importantly, some themes and subthemes not included in the interview guide emerged from the data. These included subthemes such as family involvement and societal pressure. The findings of the study highlighted that it is quite rare for men to report IPV, although at times they do. There is greater IPV prevalence among females of different ages. Secondary traumatisation is one of the negative effects that social workers experience when working with cases of traumatic IPV. However, social workers have found effective ways of coping with the demands of their work. Some of the identified coping mechanisms included choosing to spend time with family, trying to forget about the day's work, travelling, being strong and resilient, consulting a psychologist, playing games, praying (spirituality) and reading the Bible, sharing their experiences with a more experienced social worker, spending time with friends, laughing, singing and remaining professional. The study found that these coping strategies helped the social workers to deal with burnout and compassion fatigue. The present study recommends that effective coping methods and support for mental health care workers are needed to assist with secondary trauma stress and the negative effects that comes with the job.

CHAPTER 1: GENERAL ORIENTATION OF THE STUDY

1.1 Background of the study

Intimate partner violence (IPV) is a public health concern that affects more than a third of all women worldwide (World Health Organisation [WHO], 2013). It also poses a major challenge for social workers globally, as well as among professionals in South Africa. Social workers are among the healthcare service providers who deal with victims of IPV and are the first contact that victims have when seeking help from professionals. They also provide mental healthcare services in hospitals, community health centres and social service organisations to provide help to those who have experienced trauma (Bercier & Maynard, 2015).

The services provided to those who have experienced trauma in the form of IPV have been linked with negative effects on the psychological wellbeing of social workers (Adams & Riggs, 2008). The predominant effect has been labelled secondary traumatic stress (STS), compassion fatigue (CF) or vicarious trauma (VT). These terms have been used interchangeably to define the phenomenon of social workers experiencing posttraumatic stress-like symptoms due to being exposed to the traumatic material narrated by their patients (Adams & Riggs, 2008). According to Bercier and Maynard (2015), approximately 5–15% of healthcare service providers experience STS.

Figley (2013) classified the effects of working with trauma survivors into three categories: psychological distress or dysfunction, cognitive shifts and relational disturbances. Psychological distress includes distressing emotions, avoiding working with traumatic material or numbing and intrusive imagery. Cognitive shifts include an increased sense of vulnerability, an extreme sense of helplessness and feelings of losing control. Relational disturbances are problems within relationships such as arguments, avoidance of intimacy and loss of interest in interacting with significant others. Moreover, STS not only affects healthcare professionals personally, but it can also negatively affect the services they provide (Kapoulitsas & Corcoran, 2015).

According to Bercier and Maynard (2015), professionals such as social workers are at a higher risk of making poor professional judgements when they are affected by STS.

Gil and Weinberg (2015) identified the following risk factors associated with STS and VT: being less experienced, having a personal history with a traumatic event and being exposed to individuals who have been traumatised. Professionals who are more experienced showed fewer STS symptoms, which may be as a result of their experience in working with many traumatised victims. However, there could also be other reasons, such as personal therapy and selfcare (Gil & Weinberg, 2015).

1.2 Research problem

The phenomenon of IPV is a serious social problem that society has not been able to deal with well because of how sensitive it is (Bober & Regehr, 2006). Many women continue to suffer from this type of violence because they fear talking about it – and this silence allows more women to be assaulted. Yet this violence not only affects the victims but also those who are witnesses to the traumatic events (Kitzmann, Gaylord, Holt & Kenny, 2003). Healthcare professionals are exposed to victims of IPV and, through their interaction, they become exposed to the traumatic events their patients have suffered. Their psychological wellbeing may be compromised due to secondary exposure to trauma. A study conducted by Rzeszutek, Partyka and Golab (2016), for instance, found that social workers working within the criminal justice system had symptoms of STS. One of the participants reported that she began suspecting every man, which caused problems in her personal life. Indeed, female helping professionals exposed to IPV through their patients experienced fear of the other gender (Rzeszutek et al., 2016). It was further reported that these professionals experienced unwelcome visual flashbacks of the incidents reported to them. Helping professionals with a higher percentage of survivors in their caseload also reported more symptoms of posttraumatic stress disorder that were not as a result of their own history of victimisation. The development of secondary stress symptoms is believed to be associated with deterioration of social support (Emery, Tracey and McLean, 2009).

Cohen and Collens (2013) argued that the interaction between victims and healthcare professionals such as social workers could have both a negative and positive impact on both parties (Cohen & Collens, 2013). While professionals might develop vicarious resilience (VR) or experience vicarious posttraumatic growth (VPG), they also might experience STS and burnout. Uncovering the lived experiences of social workers is thus crucial in understanding how their lives are impacted by their work. The understanding that is derived from their experiences could help in improving interventions that cater for both professionals and victims.

Moreover, although a large amount of research has been conducted on IPV and its impact on the victims (Seedat, Stein & Forde, 2005), little consideration has been paid to how professionals are impacted by the violence committed against the victims. The reviewed literature does not depict the lived experiences of social workers dealing with victims of IPV. Furthermore, it does not explore how exposure to the traumatic experiences of the victims may impact on social workers in their family lives and at work, nor does it examine the effectiveness of interventions being provided to victims. When working with vulnerable individuals, professionals need to ensure that the best interests of all people are upheld, and this can be ensured by determining how their lives are impacted by their professional work.

The present study seeks to address in this gap in the literature and identify how social workers deal with their stressful work conditions. Specifically, it seeks to explore the lived experiences of social workers dealing with victims of IPV in Ehlanzeni District, Mpumalanga.

1.3 Operational definition of concepts

- **Intimate partner violence:** In the context of the present study, IPV is considered to include "any behaviour within an intimate relationship that causes physical, psychological and sexual harm to those in the relationship" (WHO, 2013).
- **Secondary stress trauma:** In the context of the present study, STS is when an individual is emotionally distressed because of having to listen to the traumatic experiences of victims (Gil & Weinberg, 2015).
- **Vicarious trauma**: In the context of the current study, VT is defined as the way in which a social worker's cognitive world changes as a result of verbal exposure to the client's traumatic experience (McCann & Pearlman, 1990).

1.4 Study purpose

1.4.1 Aim of the study

The aim of the study was to explore the lived experiences of social workers dealing with victims of IPV in Ehlanzeni District, Mpumalanga Province.

1.4.2 Research objectives

- To determine the emotional and psychological distress experienced by social workers.
- To determine how the experiences of victims impact social workers' personal and professional lives.
- To examine coping strategies used by social workers when dealing with stressful work conditions.

1.4.3 Research questions

- What are the experiences of social workers dealing with victims of IPV?
- How has the trauma experienced by victims affected these social workers?

- What coping skills do social workers use to deal with the stressful situations they experience in their work?

1.5 Significance of the study

The study seeks to explore the lived experiences of social workers dealing with victims of IPV. It seeks to identify how social workers cope with the traumatic experiences that patients disclose to them in confidence. The findings of the study will help foster awareness among social workers and their managers about the importance of selfcare in stressful work conditions. Because it is important to recognise that working with victims can have positive outcomes, this study will also seek to explore these outcomes when helping victims of IPV. Because social workers also help in advocating for victims, the study will focus on how effective these interventions are in victims' lives. The findings of this study can be utilised in the review of workplace policies and the development of programmes to address the issues in question.

1.6 Outline of the dissertation

Chapter 1 provides a summary of the study, as well as the aim, objectives, research questions, operational definitions of concepts and the significance of the research. Chapter 2 provides a literature review on IPV from a global perspective, then in the South African context. The literature review will also look at the impact of IPV on social workers as well as the perspectives of these helping professionals. Chapter 3 provides a discussion on the research methodology that was used in the study. Chapter 4 outlines the research findings and analyses the data. Chapter 5 discusses the findings in relation to the literature, while Chapter 6 will summarise these findings, identify the study's limitations and offer recommendations for further research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The purpose of a literature review is to determine what is currently known about the topic of interest. The following will be addressed: global trends of IPV, IPV in South Africa, STS and IPV, VR and VPG and the perspectives of helping professionals.

2.2 Global trend of intimate partner violence

The phenomenon of IPV occurs in different contexts and within different socioeconomic, religious and cultural groups (WHO, 2012). According to the WHO (2012), the devastating worldwide problem of IPV is mostly endured by women, and while women can be abusive in intimate relationships with men, it often happens in self-defence. The WHO clarifies that, "while IPV sometimes occurs in same-sex partnerships, the most common offenders of violence against women are male intimate partners or ex-partners" (WHO, 2012, p. 1).

The WHO's multi-country study on women's health and domestic violence against women (2005) is the most notable among a growing number of population-based surveys on the prevalence of IPV. The study's population-based surveys collected data on IPV from more than 24000 women from 10 countries and a variety of contexts in terms of culture, geography and urban/rural settings. The study confirmed that IPV is widespread in all countries studied. According to the WHO,

> Among women who had ever been in an intimate relationship, 13–61% reported ever having experienced physical violence by a partner, 4–49% reported having experienced severe physical violence by a partner, 6–59% reported sexual violence by a significant other at some point in their lives, and 20–75% reported experiencing one emotionally abusive act, or more, from a partner in their lifetime. (WHO, 2012, p. 2)

According to Devries et al. (2013), "this violence inflicted may be physical, sexual, or emotional." These authors explain that most research on the topic has studied the prevalence and effects of physical and sexual violence committed by partners, and explain the numerous impacts on women that IPV can have:

> The short- and long-term health impacts of women's experiences to physical and/or sexual IPV are multiple. For example, it is a foremost cause of homicide death in women globally and is associated with high levels of depression and suicidal behaviours. Prospective research from South Africa and Uganda shows that women exposed to physical and/or sexual IPV are more likely to acquire HIV infection. (Devries et al., 2013, p. 1)

2.3 Intimate partner violence in South Africa

This issue is a global one that has been affecting women for decades. Over the past 20 years, there has been evidence that violence against women has increased (Seedat et al., 2005). Moreover, the WHO's global and regional report (2013) estimates that "35% of women will experience either partner or non-partner violence." The study found that IPV is the most prevalent type of violence committed against women, affecting 30% of women across the globe. According to Bober and Regehr (2006), violence against women is a major public health problem and it is "a violation of women's human rights." Research shows that women who have been in relationships are likely to have experienced some form of violence from their intimate partner, either physical or sexual, in their lifetime (Bober & Regehr, 2006).

The South African government also has realised that IPV is a national problem (Sherman, Schmidt & Rogan, 1992). According to Shai and Sikweyiya (2015), "In South Africa, about 24.6% to 37.7% of adult women have been victims of IPV in their lifetime and 31% in their most recent marriage or cohabiting relationships." South Africa has the highest rates of IPV found by the WHO, and it is underreported in most cases (WHO, 2013). The violence has an enormous impact on the survivors, their families and their communities. Shai and Sikweyiya (2015) stated that "there is a crucial need for effective programmes on primary prevention of IPV in most parts of the country." The three identified provinces in South Africa with the highest rates of IPV are the Eastern Cape with 27%, Mpumalanga with 28% and Limpopo with 19%. These results are based on a prevalence study on IPV conducted in 1998 (Shai & Sikweyiya, 2015).

There are different forms of IPV that women may experience, such as physical abuse, sexual abuse/violence and emotional or psychological violence. These violent acts

leave women in the perpetrator's control (Cann, Withnell, Shakespeare, Doll & Thomas, 2001). Researchers have found that the women who are most likely to stay in violent relationships are those who are financially unstable, those with low self-esteem and those who have previously witnessed IPV (Werner-Wilson, Zimmerman & Whalen, 2000). The lack of social support from family, friends and the community means that victims are unable leave the abusive partner.

If these victims do seek help, social workers then usually become involved. According to Bercier and Maynard (2015), "social workers are the nation's largest group of mental healthcare service providers" (p. 81). Social workers present with posttraumatic stress-like symptoms because of being exposed to the traumatic experiences narrated by their clients, and they may experience negative psychological, emotional and cognitive effects because of secondary traumatisation (Adams & Riggs, 2008). This phenomenon has been labelled STS, CF or VT. According to Bercier and Maynard (2015), "approximately 5–15%" of healthcare service providers experience STS, CF or VT. These terms have been used to describe the phenomenon among social workers of posttraumatic stress-like symptoms as a result of their exposure to traumatic material narrated by their patients (Adams & Riggs, 2008).

2.4 Secondary traumatic stress and intimate partner violence

Secondary traumatic stress occurs when an individual becomes emotionally distressed by listening to the traumatic experiences of victims (Gil & Weinberg, 2015). Several studies have been conducted to identify the prevalence of STS among healthcare professionals. A study conducted by Bride (2007) among social workers who worked with victims of IPV and other trauma-related events found that most of those individuals experienced intrusive symptoms of STS that were related to working with their clients. Social workers who experienced STS were more likely to leave the helping profession because of the effects it had on their lives (Figley, 2013). Moreover, if left untreated, STS may impair the professional's daily function at work and their interpersonal relationships.

Compassion fatigue, VT, burnout and STS are terms that have been used to describe the psychological response that helping professionals such as social workers and therapists may experience when assisting people who have been traumatised (Figley, 2002; Maslach & Leiter, 2008). The term CF was developed by Figley (2002), and it has been used interchangeably with STS. According to Baum, Rahav and Sharon (2014), "compassion fatigued can be defined as a group of negative symptoms which are similar to posttraumatic stress disorder (PTSD)." Burnout has been described as being unproductive at the place of work and occurs in people in different professions. The effects include experiencing fatigue and being pessimistic and inefficient (Maslach & Leiter, 2008). Burnout can be caused by various factors such as being overwhelmed, loss of interest in working environment, inability to be effective in work responsibilities and personal life circumstances (Adams, Boscarino & Figley, 2006). In a study conducted by Adams et al. (2006), which explored the impact of secondary exposure to trauma on social workers, the authors found support for a two-dimensional model of CF, which consisted of STS and burnout. This model describes the reactions of professionals who had worked with individuals who were traumatised severely. Such reactions included heightened vigilance, flashbacks or intrusive memories and avoidance (Adams et al., 2006).

According to Figley (2002), when helping professionals are unable to provide clients with effective services due to their inability to engage in an empathetic and compassionate manner, this could be the result of STS and burnout. Compassion fatigue does not only have adverse effects on helping professionals, but it can also have negative outcomes for the clients as well (Figley, 2002). The services that social workers provide to victims of IPV require them to be empathetic, and any ailment that decreases this quality in those tasked with helping people recover from trauma could have far-reaching adverse effects (Feller & Cottone, 2003). If social workers and therapists are unable to show compassion and empathy, their interactions with clients may become non-therapeutic and potentially harmful. It may result in the professional experiencing burnout, which increases distress, decreases wellbeing and leads to poorer functioning (Ray, Wong, White & Heaslip, 2013).

Due to the negative impact of CF on both helping professionals and clients, researchers have identified the need to investigate factors that can decrease or increase vulnerability to this phenomenon (Cieslak, Shoji, Douglas, Melville, Luszczynska & Benight, 2014). According to a study by De Figueiredo, Yetwin, Sherer, Radzik and Iverson (2014), the cause of CF may be history of past trauma and providing services to people who had been severely traumatised. Other potential risk factors include a lack of trauma-specific training, being female, being younger in age and experiencing high levels of work-related stress (Baum et al., 2014; Kim & Stoner, 2008). Protective factors may include a perception of having enough information to assist clients and higher levels of efficacy (Adams et al., 2006). Strategies that have been shown to be effective in preventing CF include setting clear boundaries between work and home life, acquiring social support both personally and professionally, developing mindful awareness by distancing oneself from clients' traumatic experience in sessions and establishing consistent patterns of selfcare (Figley, 2002). Studies have suggested that self-compassion might be protective against CF and burnout (Beaumont, Durkin, Hollins-Martin & Carson, 2016). Recent research has indicated that resiliency-support programs – which involve helping caring professionals develop better strategies to cope with and self-awareness regarding CF – may also help protect against clinical stress (Pfaff, Freeman-Gibb, Patrick, DiBiase & Moretti, 2017).

A further factor that may be a barrier against CF is the experience of compassion satisfaction, where caring professionals' experiences positive outcomes from their work, including fulfilment, engagement and pleasure (Linley & Joseph, 2007). This adaptive phenomenon, which has been described as a form of resilience (Russell & Brickell, 2015), may offer benefits to counsellors' mental wellbeing (Bride, Radey & Figley, 2007; Craig & Sprang, 2010). Research has suggested that factors that promote compassion satisfaction may also protect against CF; these factors include positive social support, internal locus of control, years of relevant education and experience and the practice of selfcare (De Figueiredo et al., 2014).

2.5 Vicarious resilience

Vicarious resilience occurs when the therapist or social worker is exposed to a trauma survivor's resilience during the course of therapy, and explains the change that a therapist goes through due to their empathetic understanding of trauma victims and his/her ability to belief in his/her ability to cope with stressful situations (Engstrom, Hernández & Gangsei, 2008). Vicarious resilience also helps trauma therapists and social workers to learn about being resilient even after bearing witness to the narratives of trauma victims and taking part in the survivors' recovery process (Hernández, Gangsei & Engstrom, 2007). Studies that have focused on VR paradigms have based their findings on the notion that there is a reciprocal process in which the client and professional (social worker) influence each other during the therapeutic process (Hernández et al., 2007). In the same way that social workers are affected by the narratives of their trauma victims' experience (which often results in VT responses), witnessing the client's positive growth and resilience can also impact the social worker. This means that there is a positive transformation that therapists and social workers experience through their empathy and interaction with trauma survivors.

Vicarious resilience is linked with being able to recognise people's ability to heal from trauma, trusting in the effectiveness of therapy, making one's problems a priority, incorporating spirituality into treatment and developing hope and commitment. Vicarious resilience may also be achieved by participating in community work and advocating for traumatised clients (Hernández-Wolfe, Killian, Engstrom & Gangsei, 2015). Therapists can also focus on the client's resilience strategies to help them deal with their own emotionally exhausting work, which in turn can help in improving their attitudes, behaviours and emotions.

A study conducted by Hernández et al. (2007) focused on 12 counsellors who had worked with survivors of politically motivated violence and kidnapping in Colombia. The study "suggests that therapists may find their ability to reframe negative events and coping skills enhanced through work with trauma survivors if they are open to, and aware of, the possibility and utility of vicarious resilience" (Hernández et al., 2007,

p. 240). The counsellors reported that their attitudes and emotions had changed as a result of witnessing their clients' capacity for overcoming adversity. These researchers also found that, although trauma work may be harmful to the counsellors' psychological, emotional and cognitive functioning, these counsellors had often also gained insight from their clients. A study by Engstrom et al. (2008) on counsellors working with survivors of torture also found that counsellors learned from their experiences with clients. From the data gathered, the researchers were able to identify themes such as "being positively affected by the client's resilience," "alterations of perspectives on the counsellor's own life" and "valuing the therapy work performed." These findings suggest that the therapeutic work that social workers and counsellors provide to trauma survivors has a positive impact on both the client and the professional.

2.6 Vicarious posttraumatic growth and intimate partner violence

Studies have revealed that, although health workers may experience emotional distress and intrusive symptoms, they have also reported positive feelings such as improved views of themselves and changes in their personal philosophies and views on life (Ben-Porat, 2015). Like VT, VPG arises from the empathetic connection with clients that leads to disruptions of cognitive schemas (Cohen & Collens, 2013). The disruptions caused by the cognitive schemas of VT help therapists achieve VPG by changing their worldview (Calhoun & Tedeschi, 2014).

According to Calhoun and Tedeschi (2014), posttraumatic growth as well as VPG in individuals can be characterised by positive effects on a cognitive, emotional, interpersonal and spiritual level that derive from a traumatic experience. Social workers can experience positive changes such as improvements in their relationships with people, new perspectives on life, personal growth, spiritual growth and a greater appreciation for life. Growth occurs because of the realisation that, even though people go through distressing events that threaten their lives, they are able to develop resilience as well as an ability to cope (Manning-Jones, de Terte & Stephens, 2015). Such VPG occurs through listening to and hearing about the client's trauma and learning that victims can persevere in very difficult situations, confronting present

issues and spirituality, developing a greater appreciation of life, focusing on interpersonal relationships and developing compassion for others. The cause of positive change depends on the nature of a traumatic event and the individuals' resources at the time of the event.

The small number of qualitative studies on therapists and social workers dealing with female victims of IPV or trauma have shown that therapists or social workers experienced psychological challenges, but also reported positive feelings such as changes in self and increased spirituality and improvements in their general perspective and outlook on life (Arnold, Calhoun, Tedeschi & Cann, 2005). In another study conducted among therapists, physicians and nurses on the psychological impact of treating victims of politically motivated violence, a link was found between secondary traumatisation and VPG (Shiri, Wexler, Alkalay, Meiner & Kreitler, 2008). The study revealed that, even though they experienced symptoms of traumatic stress, the participants reported that therapeutic work had a positive effect and that "the secondary exposure to trauma stimulated them to find improved ways of adapting to the violent events surrounding them" (Shiri et al., 2008, p. 318).

2.7 Perspectives of helping professionals on intimate partner violence

A study conducted by Kim and Motsei (2002) in a rural community in South Africa on the experiences and attitudes of nurses to gender-based violence found that male nurses perceived physical abuse as punishment or a way of disciplining the woman. They explained that sometimes it was justifiable to beat a woman as they "don't listen," and that when a woman stands up for her rights she had to be beaten. The men believed that using physical abuse was justifiable to ensure that household chores would be done and that the women would carry out her other duties.

The female nurses indicated that a man who beats his wife is regarded as someone who "knows how to discipline" and is "keeping order in his home" (Kim & Motsei, 2002, p. 1246). They explained that a man who uses physical violence was regarded as being good (Kim & Motsei, 2002). The researchers concluded that this meant violence

against women was socially normalised, where the men's behaviour was seen to be normal and no one in the community would talk about it.

Although some women believed that violence was not the appropriate way to deal with conflict, they also stated that physical abuse is regarded as normal behaviour. They also identified certain behaviours that placed women at risk: the husband's use of alcohol, women being "disrespectful" and the wife's sexual infidelity. Punishment or physical abuse was considered a man's way of forgiving the wife after she was perceived to have transgressed. According to Kim and Motsei (2002), if a man did not beat the wife, then the woman would not be forgiven. The female nurses believed that men show their love for a woman if they beat her. This study demonstrated that not everyone shares the same beliefs about domestic violence and in different cultures it is perceived differently.

2.8 Theoretical framework

This section will discuss two theoretical frameworks that better explain an individual's subjective experiences when dealing with trauma. The theoretical frameworks are the constructivist self-developmental theory (CSDT) and the coping theory.

2.8.1 Constructivist self-developmental theory

In the present study, the researcher used McCann and Pearlman's CSDT. This theory is based on the premise that individuals are unique and complex, and their lives are shaped by their beliefs, attitudes and behaviours. In this postmodern worldview, reality can be understood as being subjective, influenced by the individual's social processes and mediated by language (McCann & Pearlman, 1990). The theory explains that, when an individual is traumatised, he or she displays disorganised behaviours or distorted thoughts. The CSDT emphasises that the irrational beliefs, distorted thoughts and behaviours are part of a unique adaptive function as the individual actively constructs meaning, thus these symptoms are not pathological (McCann & Pearlman, 1990).

The CSDT hypothesises that an individual's adaptation to a traumatic experience can be understood by the interaction between their personality, personal history, social

and cultural context and the traumatic event and its context. According to McCann and Pearlman (1990), the CSDT presents five components of the self that are impacted by psychological trauma: frame of reference, self-capabilities, ego resources, psychological needs and cognitive schemas, and memory and perception. Frame of reference is the individual's identity, worldview and sense of spirituality. Self-capabilities refer to the ability to tolerate and to manage strong feelings, the person's belief that he or she is entitled to love and the experience of a connection with others. Ego resources refer to the person's awareness of his or her relational and self-protective skills. Psychological needs and cognitive schemas are the person's feelings of safety, trust and self-esteem. Memory and perception refer to cognitive, visual, emotional and behavioural modalities. These five components of self may be affected by a traumatic event and may also be affected in a therapist experiencing VT (Pearlman & Saakvitne, 1995). The constructivist self-developmental theory was therefore found to be appropriate paradigm for the present study, which focuses the lived experiences of social workers dealing with victims of IPV.

2.8.2 Coping theory

Folkman and Lazarus (1988) proposed one of the most comprehensive theories of stress and coping in psychological literature. Their theory emphasises that coping is a process that involves appraising potential stressors and developing coping strategies that can be adaptive or maladaptive (Folkman & Lazarus, 1988). Krohne (2002, p. 3) explained that, in this theory, "stress is regarded as a *relational* concept; i.e., stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioural, or subjective reactions. Instead, stress is viewed as a relationship ('transaction') between individuals and their environment." According to Folkman, Lazarus, Gruen, and DeLongis (1986), "Psychological stress refers to a relationship with the environment that the person appraises as important for his or her well-being and in which the demands use up or exceed available coping resources."

Folkman et al. (1986) identified cognitive appraisal and coping as two important processes that mediate stressful relationships between people and their environment, and which impact their outcomes. They defined cognitive appraisal as "a process

through which the person evaluates whether a particular encounter with the environment is relevant to his or her well-being and, if so, in what way" (Folkman et al. 1986, p. 572). In the first type of cognitive appraisal, primary appraisal, the person "evaluates whether the environment is threatening, caring or protective in relation to the encounter" (Folkman et al., 1986, p. 572). In secondary appraisal, the person "evaluates whether anything can be done to prevent or withstand the encounter with the environment" (Folkman et al., 1986, p. 572). The person will evaluate his or her coping options, which include "changing the situation, accepting it, seeking more information, or holding back from acting impulsively" (Folkman et al., 1986, p. 572).

Folkman et al. (1986: p. 572) defined coping as follows:

> The person's cognitive and behavioural efforts to manage (lessen, or endure) the internal and external demands of the person-environment transaction that is appraised as demanding or over and above the person's resources. Coping has two major functions: dealing with the problem that is causing the distress and regulating emotion.

While the CSDT was found to be relevant to this study as it explains the internal experiences of social workers dealing with victims of IPV, it does not give an explicit account of various coping strategies employed by social worker. The researcher thus applied the basic tenets of the coping theory to better understand the way social workers cope with their demanding work.

2.9 Summary of chapter 2

The current chapter presented a review of the literature on IPV. The literature review focused on providing sufficient evidence on IPV from the global trend of this problem as well as in the South African context. It reviewed the concepts of STS and IPV; VR, VPG and IPV; and the perspectives of helping professionals on IPV. Furthermore, two theoretical frameworks, the CSDT and coping theory, were examined in relation to the current topic of discussion.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

In the present chapter, the methodology used in the study will be discussed. The chapter will describe the research design and the sampling, data collection and data analysis methods. The quality criteria used by the researcher will be presented and the relevant ethical considerations will be discussed.

3.2 Research approach and design

A qualitative research approach is the procedure or plan used to help understand the meaning of participants' worlds and the meaning of shared experiences between the researcher and participants in a given social context. Because the aim of the present study was to explore the lived experiences of the participants, the qualitative approach was considered suitable and most appropriate as it helps to explain how social workers make sense of their experiences. According to De Vos, Delport, Fouche and Strydom (2011), "the qualitative approach is used for the purpose of describing and understanding a phenomenon from the participants' point of view." In particular, the present study made use of the phenomenological research design to explore the lived experiences of social workers dealing with victims of IPV.

3.3 Sampling and setting

The participants in the present study were selected using the purposive sampling method. The researcher chose purposive sampling, which is a type of non-probability sampling (Bless & Higson-Smith, 2000). It involves choosing participants who share similar characteristics and who are likely to give relevant, significant and rich data that will help answer the research questions. The sample of the study comprised six social workers dealing with victims of IPV. The inclusion criteria for the study was any social worker between the ages of 24 and 39 years, male or female, dealing with victims of IPV within the Mbombela area. The participants must have had more than two years' working experience in dealing with victims of IPV. The race and cultural background of the social workers was not a determining factor. The research was conducted in

Mbombela, which is the capital city of Mpumalanga Province. The city is predominantly occupied by SiSwati-speaking people. Although a sample of 10 participants was initially envisioned, the researcher collected the data until saturation was reached (Fusch & Ness, 2015). Data saturation occurs when enough quality data is collected to support the study and meet its aims.

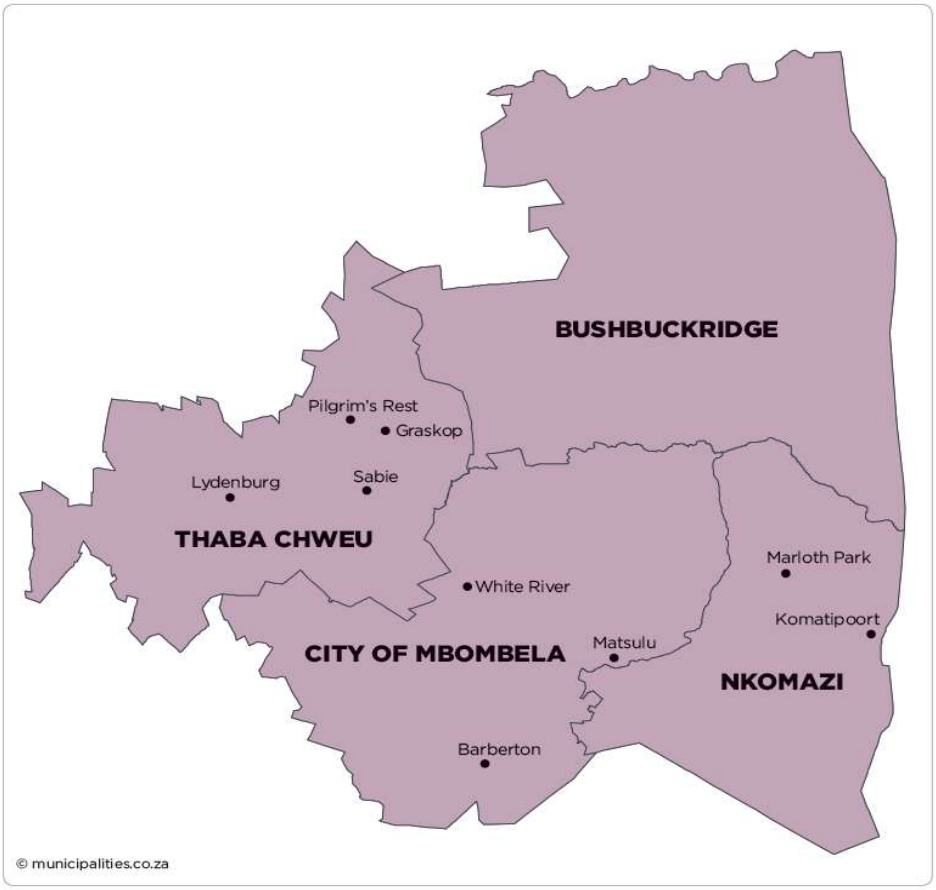

Figure 1. A map showing the approximate geographical area of Ehlanzeni District

3.4 Data collection

The researcher used semi-structured interviews as an instrument for data collection (see Appendix 1). Semi-structured interviews help the researcher to explore and probe the topic being researched (Wagner, Kawulich & Garner, 2012). Through the use of open-ended questions, the researcher guided the conversation to ensure that she gathered detailed information that covered the subject of inquiry while still allowing the

participants freedom to answer in their own way and from their own perspective (Patton, 2002). The participants were allowed to use English and siSwati when the interviews were conducted. Each interview was conducted at the participant's place of work (GRIP), situated in Mbombela, and the duration for each interview was 45–60 minutes. The data collected were recorded and stored using two digital audio recorders (used as a precautionary measure in case one audio recorder has technical problems) with the permission of the study participants.

3.5 Data analysis

Interpretive phenomenological analysis (IPA) was applied to analyse the data based on the transcribed individual interviews. This strategy is centred on exploring how participants give meaning to their personal and social world, particularly their experiences (Smith, 2011). The approach is phenomenological in that it attempts to give pre-eminence to the personal experiences of the participants and the perceptions they have about a specific phenomenon (Larkin & Thompson, 2012) – in this case, the experiences of social workers who work with victims of IPV. The theoretical underpinnings of IPA coincide well with phenomenological research design.

Step 1: Looking for themes in the first case

This first step involved making notes of major themes identified from the data. The right-hand margin was used to document emerging theme titles. The notes were then transformed to yield phrases that capture the essential quality of that theme. During this phase, the text had to be read several times in order to gain an understanding of the language of the participants as well as to make meaning of the whole interview.

Step 2: Connecting the themes

The next step required analytical or theoretical ordering. The researcher made meaning of the connections among emerging themes. Some of the themes clustered together while others emerged as superordinate concepts. The researcher then reflected on the emerging themes and identified and categorised them into psychological themes.

Step 3: Developing a table of themes

This step required the researcher to identify clusters of themes that captured the respondents' understandings of the topic. The themes that emerged were the emotional and psychological distress experienced by social workers, the impact on personal and professional lives, coping strategies, and VPG. From the main themes, subthemes were developed.

Step 4: Continuing the analysis with other cases

The researcher then analysed the interviews with the other respondents. The researcher could either use the themes from the first transcript or start from the beginning again with the second respondent. In this study, the researcher began with the emerging themes that were identified from the first transcript. Similar themes emerged from the subsequent transcripts, which were then categorised into psychological subthemes.

Step 5: Writing up

In the final stage, the themes were used to give meaning to the participants' experiences. This stage was concerned with translating the themes into a narrative account. The themes were used to explain the participants' experiences and are supported by verbatim extracts from the transcripts of the interviews.

3.6 Quality criteria

3.6.1 Credibility

Credibility in qualitative research is concerned with whether the research is conducted in a manner that ensures the subject is accurately identified and described (De Vos, Strydom, Fouche & Delport, 2011) and is the alternative to internal validity in quantitative research. The study ensured that credibility in the research was maintained through triangulation. Triangulation is based on the premise that no single method can be used to explain a phenomenon (Patton, 1999). Because multiple methods reveal empirical evidence or reality, the use of multiple data collection methods or analyses provides for richness of the research findings (Merriam & Tisdell,

2015). In this study, triangulation was achieved by observing the participants, using the interview data and using documents related to the research topic to ensure consistency of the findings.

3.6.2 Transferability

Transferability is the qualitative alternative to external validity in quantitative research. It is the degree to which the findings of a study can be applied to different contexts (De Vos et al., 2011). The researcher ensured that transferability was maintained by giving a detailed description of the setting and the participants and a detailed account of the findings, supported by the quotes from the participants' interviews, the researcher's field notes and other documents.

3.6.3 Dependability

Dependability is the stability of research data in terms of its ability to be replicated over time. It is the alternative to reliability in quantitative research (Merriam & Tisdell, 2015). The researcher looks into changes in the phenomenon of the study as well as changes in the design created by refined understanding of the setting (De Vos et al., 2011). In this study, the researcher observed and interviewed the participants in their natural setting – their workplace. Doing so helped in making the captured data most congruent with the reality understood by the participants (Merriam & Tisdell, 2015).

3.6.4 Confirmability

Confirmability emphasises the importance of objectivity. It is based on the need to replicate findings of a study by new and more refined research (Merriam & Tisdell, 2015). Confirmability requires verifying that the participants' responses are not in any way influenced by the researcher. The researcher maintained confirmability by keeping a detailed record (an audit trail) of how data were collected, how categories or themes were derived and the decision-making process throughout the research process.

3.7 Ethical considerations

3.7.1 Permission for the study

The researcher obtained ethical clearance from the University of Limpopo's Research and Ethics Committee before the study was conducted (see Appendix 1: Ethical clearance letter). The researcher also obtained gatekeeper permission to interview social workers dealing with victims of IPV from the Greater Rape Intervention Project (see Appendix 2: Letter of permission from Greater Rape Intervention Project).

3.7.2 Informed consent

Informed consent means that the research participants are given enough information about the study to help them make an informed decision about whether to participate in the study or not (Bryman, 2016). Before the interviews were conducted, the researcher obtained informed consent from the participants. Participants were told that participation was voluntary, and that they could stop participating at any time of their own free will, without penalty (see Appendix 3).

3.7.3 Confidentiality, privacy and anonymity

Anonymity and confidentiality mean that none of the information provided by the participants that could possibly lead to their identification will be disclosed to anyone (Saunders, Kitzinger & Kitzinger, 2015). The participants in the research study were assured confidentiality. The consent form also explained confidentiality and its limits. Privacy and anonymity were maintained during the proceedings of the research study by ensuring that the participants' identities were not revealed. The researcher conducted each interview in a secure and private venue. The questions that were asked avoided invading the participants' privacy unless doing so was necessary to meet the study objectives. Audio recordings and transcriptions of the interviews were locked in the departmental research unit. Participants were given pseudonyms, which were used in the recorded audio interviews, transcriptions and on reports on the research.

3.7.4 Avoidance of harm to participants

Due to the nature of the topic that was investigated, the study may have posed a risk to the participants because the nature of their work includes dealing with trauma. The researcher ensured that the psychological welfare of participants was maintained by referring participants who showed emotional distress to clinical psychologists and registered counsellors.

3.8 Summary of chapter 3

In summary, the current chapter focused on research methodology. The chapter offered a breakdown of the following: research approach and design, sampling and setting, data collection, data analysis, quality criteria and ethical considerations. The present study made use of the phenomenological research design. The purposive sampling method was used and the current study was conducted in Mbombela, which is the capital city of Mpumalanga. Furthermore, data were collected using semi-structured interviews and analysed using IPA. Lastly, the quality criteria and relevant ethical considerations were discussed.

CHAPTER 4: RESULTS ANALYSIS

4.1 Introduction

The present chapter presents the findings of this study. The chapter will start by describing the demographic profiles of the participants, which will be followed by a table of the themes and subthemes that emerged from the study. The rest of the chapter will present the detailed findings from the interviews.

4.2 Demographic profiles of participants

Table 4. 1: Demographic details

Participant no.	Age	Gender	District	Municipality	Years' experience
1	30	Female	Ehlanzeni	Mbombela	3
2	39	Female	Ehlanzeni	Mbombela	5
3	35	Female	Ehlanzeni	Mbombela	3
4	24	Female	Ehlanzeni	Mbombela	2
5	25	Female	Ehlanzeni	Mbombela	2
6	32	Female	Ehlanzeni	Mbombela	1

Table 4.1 shows the demographic profiles of participants. The interviews were conducted in Mbombela Municipality in Ehlanzeni District, Mpumalanga. The results show that all the participants were females between the ages of 24 and 39 years. The amount of experience of each social worker in dealing with IPV ranged from 1 year to a maximum of 5 years. The participants were invited to use either SiSwati or English.

4.3 Emerging themes

Four themes emerged from the data analysis, each with several subthemes. The themes that emerged are as follows: a) emotional and psychological distress experienced by social workers, b) impact on personal and professional lives, c) coping strategies, and d) VPG. These themes, together with their subthemes, will be described below with extracts from the interviews provided as support.

Table 4.2: Themes and subthemes

Themes	Subthemes
Emotional and psychological distress experienced by social workers	Experiences derived from dealing with IPV survivors
	Types of distress experienced by social workers
	Effects of the distress on social workers' evaluation of their profession
Impact on personal and professional lives	Effect on social workers
	Effect on professional work
	Impact on daily life
Coping strategies	Coping skills developed by social workers to deal with the stressful situations
	Effectiveness of the coping skills
VPG	Benefits derived from interaction with IPV survivors

4.4 Emotional and psychological distress experienced by social workers

4.4.1 Experiences derived from dealing with IPV survivors

What emerged from the data is that IPV cuts across all genders, social statuses and professions. However, most of the participants reported most cases of IPV are reported by women. Although males can also be victims, the highest prevalence is among females of all age groups. The worst experience reported by the participants involves cases where the survivors withdraw charges, which makes it difficult to end cases of IPV, as the same people then come back to report the same issues. One of the participants had this to say:

> *"Even so those women tend to say 'I'm going to report this person but I don't want my person or my husband, my partner to be arrested, I just want a protection order to say okay, I just want him to stop abusing me either [sic] than saying let's break up.'"* ***(Participant 1)***

Another participant echoed the same sentiments when she said*:*

> *"Uhm, I've seen cases of intimate partner violence, and uhm, even though it's only women, it's mostly women that come to the offices to report, but what I've noticed is that men are also abused, but their reporting, it's very low than [sic] women."* ***(Participant 5)***

In addition, another participant mentioned that:

> *"You know, I've realised that intimate partner violence cut across all ages and gender. It doesn't matter of [sic] your social status or your financial status, all those kinds of things. We have survivors from poor backgrounds, middle class and the high class."* ***(Participant 2)***

It emerged that family has a major role in promoting IPV. Most participants reported that most of their clients complain that their family members always protect the perpetrator. In most cases, the family does not support the survivor. Instead, they try force the survivor to drop the charges, if there are any, or force social workers not to document anything. It was also found that sometimes the family members, especially

mothers, advise their daughters to bear with the situation as they also went through the same. In support of the above, other participants had this to say:

> *"And they will be like, 'why did you leave your house, to come to the police station? Can't you see that you are embarrassing us?'"* ***(Participant 4)***

Another participant mentioned that

> *"…I meet my friend and try to explain, my friend will be like: 'Hey you, where have you seen that? You know that you need that person. You know that person is the one that provides for you, so whatever they told you in the office what [sic] it's gonna mess things up for you.'"* ***(Participant 5)***

It emerged that social pressure is one factor that perpetuates IPV. Based on the participants' experiences, they all felt that society has normalised IPV. Hence, whenever an incident happens, local society usually prefers to brush it aside and discourage the survivors from seeking help from social workers or from opening a case or obtaining a protection order from the police. One of the most striking points that emerged was that some survivors end up not reporting IPV issues. Hence, based on what emerged from the study, the prevalence of IPV might be much higher than what is currently known. One of the participants had this to say:

> *"Society has influence over us, because if you are 30 and you staying at home and you don't have a husband or if you 30 what-ever age you are you come out of [sic] your marriage, how could you, how could you leave such a beautiful house, you've struggled so much to have the car…"* ***(Participant 2)***

Another issue noted by participants was that the survivors end up experiencing worst cases of IPV, such as sexual, physical and emotional abuse, because they are afraid that if they leave their partners and become single, society will stigmatise them.

In addition to the above-mentioned points, Participant 2 also added the following:

> *"Like, it has been a culture and it has been allowed, so it makes it difficult for you to actually come out and stand up against it, because as soon as you come*

out and stand you're actually taken as someone who's not respectful." ***(Participant 2)***

4.4.2 Type of distress experienced by social workers

Most of the participants reported that they usually experience STS and VT because of what they hear from their clients. It drains them emotionally to understand that someone is going through such horrible experiences. However, most participants also reported that what depresses them more than this is realising that someone is going through what they also once experienced. Others reported that sometimes they felt stress concerning their feelings that the police do not really discipline the perpetrators, whom they say are usually given bail and abuse the survivors again:

> *"Ey, what can I say? Yah, emotionally I do get hurt cause you see sometimes like you have to counsel the victim that's here before they can go to the other side…"* ***(Participant 3)***

To elaborate on the distress she experiences as a social worker, Participant 4 mentioned that

> *"You, you will carry all of them. You get this one [who] is being beaten, this one is being assaulted, this one [says] 'my husband doesn't want me to see my children.' This one [says] 'my house it's burnt down.' This one [says] 'he chased me out.' You see all those things… you, you carry them."* ***(Participant 4)***

Other types of stress emerged from the realisation that the survivor has worse problems, but still reports that she is fine and does not need any help:

> *"…other stressors is [sic] whereby you see that this person needs help but this person doesn't acknowledge that like he or she needs help, she's like 'no, no, no.' I don't know 'cause I've never been biased, as like I'm not allowed to judge... ."* ***(Participant 6)***

4.4.3 Effects of the distress on social workers' evaluation of their profession

Because of the trauma experienced by social workers from listening to the IPV experienced by their clients, the participants indicated that they regard social work negatively as a profession. The participants further indicated that they found the social work profession stressful because the social worker is made to experience and live with whatever the survivors go through. Furthermore, the participants explained that it was difficult to forget about those negative experiences, which made them negatively evaluate the social work profession. One participant had this to say:

> *"Uhm… let me think about this. UH-UH. But I wouldn't advise anyone to do social work (chuckles). Every time I speak to my daughter, I always say you can't be a social worker. Anything that has to do with humans, supporting humans, no, no, no, it's too much, don't go there."* ***(Participant 2)***

4.5 Impact on personal and professional lives

4.5.1 Effect on social workers

Most of the participants indicated that the secondary trauma they experienced has affected their personal lives. For example, some participants indicated that the negative experiences and trauma they suffered made them develop trust issues, particularly when the survivors report to them that they have been sexually abused by partners who are respected figures in the country, such as policemen or pastors. These revelations of abuse have caused most of the interviewed social workers to adopt defensive behaviours that sometimes affect their personal lives. A noteworthy point that emerged was that most of the social workers interviewed now have developed a hatred for men, as the experiences of their clients have left them feeling as though men are the perpetrators in most instances. The above points are supported by the following extracts:

> *"I don't trust men, hey. You can't! (Both laugh). My stepdaughter is 21 now and I always tell her men are just… they not dogs but you can't trust them. There are those maybe who are actually good partners, but they are not as many as those who are abusers."* ***(Participant 2)***

The above-mentioned statement is supported by another participant's response:

> *"As a person I feel like I don't have a heart for men anymore. And as a mother – I'm a mother I… I had someone in my life – the father of my kids, he has been abusing me emotionally – it wasn't physical but abusers abuse regardless of whatsoever [sic] whether it was… ."* ***(Participant 6)***

Another participant noted the following:

> *"…it also affects my view of the next sex or the next gender – it's so hard for me sometimes to believe a male – although I must not be judgmental as a professional one [as a professional person], but I tend to say when I look at a particular male I would say, this one seems to be abusive, that one seems to be controlling just by that… ."* ***(Participant 1)***

4.5.2 Effect on professional work

It emerged that the trauma involved in their work affects social workers in diverse ways. Burnout and CF were common among the participants. Sometimes it is difficult for them to compile their reports as their mind is focussed on different survivors' issues. Sometimes, the social worker has to postpone compiling the report, which negatively affects her chances of meeting deadlines. In most cases, the participants reported that it affects their workflow or routine. For example, one participant had this to say:

> *"Uhm, because you cannot pour from an empty cup, it affect my work in a way that, if somebody gonna come again with a case, with me still being stressful, stressed about the previous case, I don't think I I'm able to offer, my… my everything in the case… ."* ***(Participant 5)***

In confirmation of the above, another participant indicated that,

> *"If I can… attend uhm, three people, two, okay two, with very traumatic stories… trust me I won't be able to function after that. That's why sometimes I ask for an early day or… because… you won't take anything anymore."* ***(Participant 4)***

Another participant reported the following:

> *"You just burst and cry like in the middle of the session and now the survivor's wondering, 'And then why?' (laughs). It does affect you, hey, even if you see when you have your own issues when you come with them to work it affects [you] a lot. That is why it is very much important for you to have selfcare. To just take care of yourself." (**Participant 2)***

4.5.3 Impact on daily life

The trauma experienced by social workers has negatively impacted upon their daily life. Some of the participants indicated that it has caused a lot of changes in their lives. For example, some social workers reported that the stress at work has affected their life routines and the way they relate to other people. Others indicated that the trauma and stress from work have negatively affected some other activities they used to do after work, such as studying. Such plans can be affected because the social worker cannot focus on anything after work as a result of stress and recalling what the survivors shared with her. In addition, most of the social workers reported that they now experience cognitive shifts because of stress, which affects their daily life, such as family time. One participant explained that,

> *"Oh I worry but I… okay there is one, you see that one it was the one case that worried me a lot that day because I couldn't sleep, yoh it worried me. The child was… she 12 years… she was raped by her brother, [her] brother from his [sic] uncle's side because her father had died." **(Participant 3)***

In addition, participant 4 had the following to say:

> *"Then even if you don't rest, dealing with all those issues, it creates a [sic] burnout. Sometimes you just need like, I want to sleep. I want to sleep but… not think about work, not think about other people's problems, not think about everything – you just want to sleep." **(Participant 4)***

In corroboration of the above, Participant 1 had the this to say:

> *"Hmmm ja neh. When I go home at the end of the day I would reflect on what I have done and that takes my time with my family either than [sic] spending time with people that I love, I would say okay what Nolwazi has went through, joh, it's horrible, I would reflect on it and say okay but what if, what if she has done that, it does affect one…"* ***(Participant 1)***

4.6 Coping strategies

4.6.1 Coping skills developed by social workers to deal with the stressful situations

In an effort to try to survive in such a stressful profession, the participants indicated that they have developed several coping skills. Some of the common ones included opting to spend time with family, trying to forget about the day's work, travelling, being strong and resilient, consulting a psychologist, playing games, praying (spirituality) and reading the Bible, sharing their experiences with a more experienced social worker, socialising with friends, laughing, singing and remaining professional. Some of the participants said,

> *"It's okay… I debrief, debriefing with my manager and then we have debriefing sessions now and again, although she can be busy, but ja we do that. My coping mechanism is also be [sic] singing, hey, singing to my loudest voice – it helps. It helps a lot."* ***(Participant 1)***

> *"I think my distraction, neh, it's Candy Crush (laughs); it's funny, but is it a skill? It's not okay to me [sic] 'cause it helps, I feel like playing the game on my phone like Candy Crush helps, and what else? I think as a person I read the Bible that helps a lot – I pray."* ***(Participant 6)***

> *"Wooooh, I go out! I have fun. I enjoy spending time with the family. I go out. I travel a lot with my family because they are the people who actually makes [sic] me laugh."* ***(Participant 2)***

4.6.2 Effectiveness of the coping skills

Most of the participants agreed that the coping skills they developed were greatly effective in assisting them to cope with the trauma and stress from their work. Most of the participants indicated that coping skills such as debriefing, laughing and singing gave them the encouragement to carry on with their work. Some of the participants had this to say:

> *"You know when you out with your family you just laughing, you actually forget about everything. Like I said, you do everything like you go down ushaye idibala, you see, yeah (chuckles)."* ***(Participant 2)***

> *"…those skills have helped me to refrain from judgement and not judge people and accept them for who they are and understand them for who they are; I think it has been very much effective."* ***(Participant 6)***

> *"Okay it has 'cause when I have had a good laugh when I have relaxed or debriefed with my manager and when I prayed about certain issues I get this strength to say, 'let me continue providing the help that people need out there.'"* ***(Participant 1)***

In terms of the usefulness of resilience, the majority of the participants agreed that resilience is very important in the social work profession. They reported that social work is stressful, hence resilience helps them to carry on with their work and help their clients:

> *"Yes, speaking of resilience, I am a very resilient person. It helps a lot 'cause it kept me going every day, every day, every day cause you know if you not resilient as a person you will end up hating what you doing, you understand?"* ***(Participant 6)***

> *"Yes, it helps 'cause you will have to, you will have to do that when a person has shared their particular experience with you – it doesn't end with them, there's a line of people that are still looking for your attention – there is people [sic] who want your help, so…"* ***(Participant 1)***

4.7 Vicarious posttraumatic growth

4.7.1 Benefits derived from interaction with intimate partner violence survivors

The findings showed that some of the participants had gained something from their profession. For example, some of the participants indicated that STS has boosted their spirituality through praying. Below are some of the relevant extracts:

> *"I pray for us, I pray for myself as a professional, I also pray for the person that I'm helping – I don't normally focus on myself, I usually pray for the victims or I would like to see myself being that person who usually prays for the victims."* ***(Participant 1)***

> *"Prayer helped in a lot of situations – I am able to overcome many issues – I know that… I remember the father of my kids, he [said] to me that 'you are busy praying' and I wasn't working, he would say 'you suppose [sic] to pray for work', and another thing funny he said, 'you suppose [sic] to pray for me to be the right husband for you'… ."* ***(Participant 6)***

Other participants also felt that they have benefited from hearing the experiences of their clients. For example, one participant had this to say:

> *"…working with this intimate partner violence cases… they actually open up your mind. You get open to different things. You get open-minded, let me put it that way."* ***(Participant 2)***

4.8 Summary of the findings

This chapter presented the findings of this study. The demographic information showed that all the participants were females between the ages of 24 and 39 years. The had 2–5 years' experience in dealing with IPV. Four major themes emerged from this study: emotional and psychological distress experienced by social workers, impact on personal and professional lives, coping strategies and VPG. It was found that IPV is prevalent among women of all ages in South Africa. Women are exposed to IPV in the form of emotional abuse, rape and brutality, and are often stigmatised. Analysis of

the themes showed that social workers experience STS and VT from dealing with IPV victims.

These experiences affect their personal lives and their professional work. Due to the trauma, it was found that most social workers interviewed now mistrust men, as they identify them as the perpetrators of most IPV cases. The findings also revealed that social workers usually develop coping skills to effectively cope with STS, such as choosing to spend time with family, trying to forget about the day's work, travelling, being strong and resilient, consulting a psychologist, playing games, praying (spirituality) and reading the Bible, sharing their experiences with a more experienced social worker, socialising with friends, laughing, singing and remaining professional. They all agreed that these coping skills were effective in helping them cope with stress. Other participants also reported that besides being exposed to STS, dealing with IPV issues helped them in many ways, such as becoming more open-minded and being spiritual.

4.9 Summary of chapter 4

The current chapter focused on presenting the results. It gave a clear description of the participant demographics and emerging themes and subthemes. Each theme and subtheme was described and extracts from participants interviews were provided.

CHAPTER 5: DISCUSSION OF RESULTS

5.1 Introduction

This chapter will discuss the study findings in relation to the literature review according to the emerging themes identified in the previous chapter. The findings are also discussed in terms of the theoretical framework chosen.

5.2 Emotional and psychological distress experienced by social workers

What emerged from data is that IPV affects people from all genders, social statuses and professions. However, most of the participants reported that the majority of those who regularly report cases of IPV are women. Though males can be also victims, the highest prevalence is among females of all age groups. The worst experience reported by the participants is that sometimes the survivors withdraw charges, which makes it difficult to end cases of IPV, as the same people come back to report the same issues to the social workers. The findings of this study are confirmed by other existing findings that reported that IPV cases are relatively high in South Africa. The South African government has realised that IPV is a national problem (Sherman et al., 1992). A study by the WHO (2013) found that IPV is the most prevalent type of violence committed against women, affecting 30% of all women. In South Africa, about “24.6% to 37.7% of adult women have experienced IPV in their lifetime and 31% in their most recent marriage or cohabiting relationship” (Shai & Sikweyiya, 2015). The findings of this study also confirm the findings of Shai and Sikweyiya (2015), which identified Mpumalanga Province as one of the provinces with a high prevalence of IPV.

It also emerged that family has an important role in promoting IPV. Most participants reported that the majority of their clients complain that their family members protect the perpetrator. In most cases, the family does not support the survivor. They often force the survivor to drop the charges, if there are any, or force social workers not to document anything. It was also found that family members, especially mothers, sometimes advise their daughters to bear with the situation as they had gone through the same.

Furthermore, it was found that social pressure also perpetuates IPV. All the participants, as a result of their experiences, felt that society has normalised IPV.

Hence, whenever an incident happens, local society usually prefers to brush it aside and discourage the survivors from seeking help from social workers, opening a case or applying for a protection order. Another element noted by participants was that the survivors end up having to live with some of the worst forms of IPV, such as sexual, physical and emotional abuse from their partners, because they are afraid that if they leave them and become single, society will stigmatise them. It emerged that some survivors end up not reporting IPV issues at all. Hence, the prevalence of IPV might be much higher than what is currently believed. This finding is supported by existing studies. According to Bober and Regehr (2006), IPV is a serious social problem that people have not been able to deal with effectively because of how sensitive it is. Many women suffer from this type of violence because they fear talking about it, and this silence increases the number of women being assaulted.

5.3 Types of distress experienced by social workers

Most of the participants reported that they usually experience STS and VT because of what they hear from their clients. It drains them emotionally to work to understand someone who is going through these traumatic experiences. Most participants also reported feeling depressed when seeing someone going through situations that they also once experienced. Other types of stress that emerged from the data concerned survivors refusing help or denying problems that the social worker notices. Others also reported stress from the police's inability to deter perpetrators, who are usually given bail and return to abuse the survivors. The results of this study agree with similar findings from other studies that have shown that social workers experience posttraumatic stress-like symptoms by being exposed to the traumatic experiences narrated by their clients (Bride, 2007). According to Adams and Riggs (2008), social workers may experience negative psychological, emotional and cognitive effects because of secondary traumatisation. Other studies such as Bercier and Maynard (2015) approximate that the prevalence of STS among social workers is 5–15%.

5.4 Effects of the distress on social workers' evaluation of their profession

Because of the trauma experienced by social workers from listening to the IPV stories of their clients, the participants indicated that they regard social work negatively as a profession. The participants further indicated that they find social work as a profession to be stressful because the social worker is made to experience and live with whatever the survivors go through. Furthermore, the participants explained that it was difficult to forget about those negative experiences. This finding is supported by Figley (2013), who noted that social workers who experienced STS were more likely to leave the helping profession because of the effects it had on their lives.

5.5 Impact on personal and professional lives

5.5.1 Effect on social workers

Most of the participants indicated that the secondary trauma they experienced has affected their personal lives. For example, participants indicated that the negative experiences and trauma they suffered made it difficult for them to trust anyone. The most striking theme that emerged was that most of the social workers interviewed have developed a hatred for men, as the experiences of their clients have told them that men are perpetrators of IPV in most instances. This knowledge has made them develop defensive personalities, which negatively affects their relationships. This finding is supported by the CSDT (McCann & Pearlman, 1990). This theory explains that, when an individual is traumatised, they display irrational behaviours or distorted thoughts. The CSDT emphasises that the irrational beliefs, distorted thoughts and behaviours are part of a unique adaptive function as the individual actively constructs meaning. The social workers' psychological needs such as trust and feelings of safety are negatively affected by STS, as explained by the CSDT (McCann & Pearlman, 1990).

5.5.2 Effect on professional work

It emerged that the trauma affects social workers in diverse ways, and may result in burnout and CF. These made it difficult for the participants to compile their reports, as their mind is focussed on what they have heard. Under certain circumstances, the social worker has to postpone compiling the report, which negatively affects her chances of meeting deadlines. In most cases, the participants reported that it affects their workflow or routine and how they handle clients. Maslach and Leiter (2008) described burnout as a state of workplace dysfunction involving feelings of tiredness, hopelessness and inadequacy. Burnout may be "the result of a combination of factors, including a feeling of being overwhelmed, frustration with the work environment, a perceived inability to be effective, and personal stressors" (Adams et al., 2006, in Hopwood, Schutte & Loi, 2019). According to Figley (2002), CF, including STS and burnout, may affect caring professionals' empathy and compassion towards clients. According to Kapoulitsas and Corcoran (2015), STS negatively affect the services provided by the healthcare professional.

5.5.3 Impact on daily life

The trauma experienced by social workers has negatively impacted their daily lives. For example, some social workers reported that the stress at work has affected their life routines and the way they relate with other people. Others indicated that the trauma and stress from work have negatively affected some activities they used to do after work, such as studying. Such plans are affected as the social worker cannot focus on anything after work because of stress and recollections of what the survivors shared with them. Also, most of the social workers reported that they now experience cognitive changes because of stress, which affects their daily life. According to Figley (2013), cognitive shifts include "a heightened sense of vulnerability, an extreme sense of helplessness and loss of personal control."

According to Bercier and Maynard (2015), "approximately 5–15%" of healthcare service providers experience STS, CF, and VT. These terms have been used to describe the phenomenon among social workers of posttraumatic stress-like

symptoms as a result of their exposure to traumatic material narrated by their patients (Adams & Riggs, 2008).

5.6 Coping strategies

5.6.1 Coping skills developed by social workers to deal with the stressful situations

The participants indicated that, in an effort to try to survive in such a stressful profession, they have developed several coping skills, such as opting to spend time with family, trying to forget about the day's work, travelling, being strong and resilient, consulting a psychologist, playing games, praying (spirituality) and reading the Bible, sharing their experiences with a more experienced social worker, socialising with friends, laughing, singing and remaining professional. The findings in this study support the phenomenon of VR, which is the positive transformation that a therapist goes through due to the empathetic understanding of trauma victims and the ability of the therapist to believe in his or her ability to cope with adverse situations (Engstrom et al., 2008). Vicarious resilience encourages recognition of people's ability to heal from trauma, trust in the effectiveness of therapy, making one's problems a priority, incorporation of spirituality into treatment and development of hope and commitment. Vicarious resilience may also be achieved by participating in community work and advocating for traumatised clients (Hernández-Wolfe et al., 2015).

The coping theory accentuates that coping is a process that involves appraising potential stressors and developing coping strategies that can be adaptive or maladaptive (Folkman & Lazarus, 1988). Krohne (2002, p. 3) explains that, in this theory, "stress is regarded as a *relational* concept; i.e., stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioural, or subjective reactions. Instead, stress is viewed as a relationship ('transaction') between individuals and their environment." The present study has identified that social workers have adopted different ways of coping with their work. It was noted that some have opted to seek help from other professionals, to travel and to rely on family support. These coping mechanisms support the theory's basic tenet that each individual copes with stress in adaptive and maladaptive ways. Stress is viewed in

terms of the individual and their environment and the ways in which he or she can use coping resources to deal with the demands.

5.6.2 Effectiveness of the coping skills

Most of the participants agreed that the coping skills they developed were greatly effective in assisting them to deal with the trauma and stress from their work. Most of the participants indicated that coping skills such as debriefing, laughing, singing and being resilient gave them what they needed to carry on with their work. These findings further support VR, as trauma therapists and social workers learn about being resilient after bearing witness to the narratives of trauma victims and taking part in the survivors' recovery process (Hernández et al., 2007).

Professional selfcare is the use of skills and strategies by workers to maintain their own personal, familial, emotional and spiritual needs while attending to the needs and demands of their clients (Figley, 2002). Suggested individual selfcare strategies may include setting realistic goals with regard to workload and client care. There is substantial evidence suggesting that support from professional colleagues and supervisors may also serve to decrease the effects of professional burnout. Social support from professional colleagues can include concrete support, such as assisting with taking on a particularly difficult client, or emotional support, such as comfort, insight, comparative feedback, personal feedback and humour. The practice of selfcare and development of individual coping strategies and coping skills are also useful for workers experiencing STS or VT (Newell & MacNeil, 2010).

Furthermore, physical health, balanced nutrition, adequate sleep and exercise or recreation serve to reduce the effects of these conditions. Maintaining spiritual connections through church, meditation and self-revitalisation all enhance general selfcare. For individuals experiencing secondary traumatic stress, psychotherapy may be a reasonable treatment option, particularly for those with past trauma history (Nelson-Gardell & Harris, 2003). Finally, the use of emotional and social support from close family and friends has been indicated as a useful defence against the symptoms of STS.

5.7 Vicarious posttraumatic growth

5.7.1 Benefits derived from interaction with intimate partner violence survivors

Other participants also felt they have also benefited from hearing the experiences of their clients. This view is supported by other existing studies. Cohen and Collens (2013) argued that the interaction between victims and health professionals such as social workers could have a negative and positive impact on both parties. Studies have revealed that, although health workers may experience emotional distress and intrusive symptoms, they have also reported improved views of themselves and changes in their existential stance on life (Ben-Porat, 2015). According to Calhoun and Tedeschi (2014), posttraumatic growth (as well as VPG) in individuals can be characterised by positive cognitive, emotional, interpersonal and spiritual consequences that are developed from the experience of a traumatic event.

5.8 Implications of theory

5.8.1 The constructivist self-developmental theory

The CSDT is based on the premise that individuals are unique and complex and their lives are shaped by their beliefs, attitudes and behaviours. In this postmodern worldview, reality can be understood as being subjective, influenced by the individual's social processes and mediated by language (McCann & Pearlman, 1990). The CSDT explains that, when an individual is traumatised, he or she displays irrational behaviours or distorted thoughts. CSDT emphasises that the irrational beliefs, distorted thoughts and behaviours, rather than being pathological, are part of a unique adaptive function as the individual actively constructs meaning.

The findings of the current study are in line with the rationale of the CSDT. The study revealed that secondary traumatisation can be interpreted from an individual's subjective meaning of the event as it occurs. The study also revealed that people's adaptation to a traumatic event is based on their personal, cultural and professional context. For example, the study revealed that culture influences how IPV is viewed within families. In some cultures, IPV is dealt with within the family context and the incident is not reported because it is felt that the family can deal with it. Professionally, social workers provide counselling and allow survivors to make informed decisions

based on their current situations. The traumatic event experienced by victims of IPV can have an impact on the professional, such as changes in his or her personal attitudes towards men (such as beliefs that men cannot be trusted or that men are dangerous), his or her view of society (such as beliefs that IPV has been normalised by society) and his or her own psychological and cognitive schemas. These finding are corroborated by the theory's explanation of the five components of self that are impacted by psychological trauma: frame of reference, self-capabilities, ego resources, psychological needs and cognitive schemas, and memory and perception.

5.9 Summary of Chapter 5

In summary, chapter 5 provided an extensive discussion of the finding from the current study. These findings were discussed in terms of the themes that emerged from the data collected and in terms of previous literature. Lastly, the CSDT was used to better explain the findings of the current study.

CHAPTER 6: SUMMARY, RECOMMENDATIONS AND CONCLUDING REMARKS

6.1 Summary of the major findings

Firstly, it is of paramount importance to note that it emerged that IPV is very common in South Africa; it is regarded as one of the greatest challenges the government still has to face. The study revealed that social workers have different experiences when dealing with victims of IPV. Intimate partner violence affects people from all genders, social statuses and professions. Although males can also be victims, the study revealed that the people who regularly report cases of IPV are women of all ages. It also emerged that family has a large role in promoting IPV.

Secondly, the study identified that the social workers experience different types of distress. They usually experience STS and VT from hearing clients telling their stories. According to Adams and Riggs (2008), social workers may experience negative psychological, emotional and cognitive effects because of secondary traumatisation. It was also found that the distress experienced by social workers also impacts their evaluation of their profession. They reported that social work is stressful because they are made to re-experience and relive the survivors' traumatic experiences. They may also experience emotional distress due to the inability of survivors to understand the importance of receiving help.

Thirdly, the study found that the social workers' personal and professional lives are impacted. They reported experiencing secondary trauma, which affects their personal lives. Others reported that the negative experiences and trauma suffered resulted in them developing trust issues within their intimate relationships. Their professional work is impacted because they experience burnout and CF. They have difficulties compiling reports due to their inability to separate themselves from the survivor's traumatic experience. Maslach and Leiter (2008) described burnout as a state of workplace dysfunction, involving experiences of fatigue, pessimism and inefficacy. An individual may experience burnout as the "the result of a combination of factors, including a feeling of being overwhelmed, frustration with the work environment, a perceived

inability to be effective, and personal stressors" (Adams et al., 2006, in Hopwood et al., 2019).

It was found in the present study that social workers use different coping skills, which is consistent with previous findings (Manning-Jones, de Terte & Stephens, 2016). Popular skills included opting to spend time with family, trying to forget about the day's work, travelling, being strong and resilient, consulting a psychologist, playing games, praying (spirituality) and reading the Bible, sharing the experiences with a more experienced social worker, socialising with friends, laughing, singing and remaining professional. The study revealed that some participants also experience posttraumatic growth when they interact with survivors. This view is supported by other existing studies. Cohen and Collens (2013) argued that the interaction between victims and health professionals such as social workers could have a negative and positive impact on both parties.

6.2 Implications for research

Research on the experiences of mental health practitioners is generally in its early stage. As such,

- Further research is needed to explore both male and female social workers and interpret their lived experiences dealing with victims of IPV.
- Future research can further explore the use of mixed methods to gain a better understanding of the experience of social workers. This can assist in obtaining rich qualitative and quantitative data from a large population.
- Future research is needed to focus on cultural factors such as race and different ethnic and socioeconomic groups. Doing so will assist in gaining more insight on how other cultural factors influence social workers' experience when dealing with victims of IPV.
- The present study did not consider victims' lived experiences of IPV in order to evaluate the effectiveness of treatment interventions. Hence, further research could focus on such areas in future.

6.3 Recommendations of the study

Base on the findings of the current study, it is recommended that:

- Support systems within NGOs and government departments be established for mental healthcare workers. Doing so will foster effective coping methods, thereby reducing secondary trauma and its negative impact on carers.
- An accurate representation from provincial level of victims of intimate partner violence is needed to give an informed conclusion on the statistics of IPV survivors.
- There needs to be collaboration of mental healthcare workers, families and community leaders in dealing with IPV. This can encourage community and family psychoeducation on IPV and the impact on the victims' mental health.

6.4 Reflections

In the following section I as the researcher share my own personal journey in conducting this study. I will first provide personal reflections on my experiences throughout the research process. Thereafter, I will share my reflections as a professional.

6.4.1 Personal reflections

The research process has had a large impact on different aspects of my life. Firstly, it was an insightful process working with all six social workers in the study. They were able to share and willing to narrate some of their personal experiences working with victims of IPV. The topic of study was one I felt as a researcher I was quite passionate about. I came to the realisation that I became concerned about the kind of traumatic incidents women are facing. This shifted my objectivity because I think, in some way, I viewed men as being the ones who inflict harm and did not consider that it happens to everyone, regardless of who you are. After this realisation, I had to remove myself from the situation and reflect on my own countertransference issues regarding the topic. Doing so helped me to be objective and not allow my own bias to taint the study.

6.4.2 Professional reflections

The study facilitated better understanding as a professional of the topic under discussion. I was challenged to think beyond my own limitations in terms of what I was comfortable with as a clinical psychologist in training. I developed a better understanding of how other professionals deal with the traumatic experiences that come with their jobs. As I professional, I had the opportunity to understand the need for selfcare in ensuring better provision of services to survivors.

6.5 Limitations of the study

Several limitations of this study were considered when interpreting findings. Firstly, some of the interviews were done in siSwati. The translation of the interview data from siSwati to English might have led to omissions or inappropriate substitutions of the original material provided by participants.

Secondly, the study did not consider male social workers. The results could only be supported by female social workers, and it cannot be said that male social workers experience their work in the same way.

Thirdly, the study had six participants, who were all females working with victims of IPV. The results of the study can therefore not be generalisable to all professionals within the caring profession. The study was able to interpret the experiences of only these six participants, although enough data were collected to support the study and meet its aim. Further research can be done with a larger sample size to determine whether these results can be replicated.

Lastly, they study only relied on social workers working within the Ehlanzeni region in the Mbombela District in Mpumalanga. Hence, other people were not interviewed to get richer data from different regions in order to obtain different perspectives.

6.5 Concluding remarks

The study aimed to explore the lived experiences of social workers dealing with victims of IPV through the use of IPA. A thorough exploration of the experiences of social workers was undertaken by attempting to answer the following research questions: What are the experiences of social workers dealing with victims of IPV? How has the trauma experienced by victims affected these social workers? What coping skills do they use to deal with the stressful situations that their work presents? The IPA approach was used because it best suited the research method in addressing the aim of the study, which focused on lived experiences.

The following themes were found: the emotional and psychological distress experienced by social workers, impact on personal and professional lives, coping strategies and VPG. It was found that all participants had different experiences when working with victims of IPV. The participants were able to develop coping strategies despite the secondary trauma they experience daily. There were protective factors mentioned by participants, which helped with dealing with burnout and CF. These protective factors included family support, religion and debriefing sessions. The study has revealed that, although dealing with IPV survivors is strenuous, there is some satisfaction gained by the helping professionals.

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Appendix 1: Ethical clearance letter

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: **06 March 2019**

PROJECT NUMBER: **TREC/31/2019: PG**

PROJECT:

Title:	An Exploration of the lived Experiences of Social Workers dealing with Victims of Intimate Partner Violence at Ehlanzeni District, Mpumalanga
Researcher:	LA Mhlongo
Supervisor:	Dr JP Mokwena
Co-Supervisor/s:	Dr S Moripe
	Prof JC Makhubele
School:	Social Sciences
Degree:	Master of Arts Clinical Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

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Appendix 2: Gatekeeper's permission letter

GRIP
Siyakuphakamisa

Department of Welfare Ref No: 008-771

VAT Reg No: 4660187925

Established March 2000

BBBEE No: 6589101

17 Ehmke Street, Nelspruit

P O Box 26122, Nelspruit, 1200

Tel: +27 13 752 4404

Tel/Fax: +27 13 752 4407

E-mail: info@grip.org.za

Website: www.grip.org.za

GBV and Rape Intervention Programme

7th May 2019

To: Miss L .A Mhlongo

Re: confirmation of research data collection at Grip Nelspruit

This letter serves to confirm that Miss Mhlongo LA with the topic: An exploration of the lived experiences of Social Workers dealing with victims of intimate partner violence at Ehlanzeni District, Mpumalanga; has been given clearance to collect her research data at GRIP.

Yours Sincerely

Licky B Thusi (DCEO)

Appendix 3: Participant consent letter

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date_____

Dear Participant,

Thank you for showing interest in this study, which focuses on the exploration of the lived experiences of social workers dealing with the victims of intimate partner violence in Mbombela Local Municipality at Ehlanzeni District. The responses you will provide during the interview process will remain strictly confidential. The researcher will not disclose your identity or give out information that will identify you as a participant in the study. Please note that your participation in the study is voluntary, and as a participant you are allowed to withdraw from participating any time you wish to do so.

Kindly answer all the questions as honestly as possible. Your participation in this study is very important. Thank you for your time and cooperation.

Kind regards

…… …….

Mhlongo LA Date

Master Arts (Clinical Psychology) Student

Appendix 4: Participant consent form

I_____ hereby give my permission to participate in the MA Clinical Psychology research project that focuses on the exploration of the lived experiences of social workers dealing with victims of intimate partner violence at Ehlanzeni District, Mpumalanga Province.

The purpose of this study has been fully explained to me. Furthermore, I understand that I am participating voluntarily and without being coerced in any way to do so. I also understand that I can terminate my participation in this study at any point should I wish to do so, and that this decision will not affect me negatively in any way.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be disclosed to anyone and that my participation in the study will remain confidential.

Signature: _____

Date: _____

Appendix 5: Demographic information for participants

Title: An Exploration of the lived Experiences of Social Workers dealing with Victims of Intimate Partner Violence at Ehlanzeni District, Mpumalanga.

Thank you for showing interest in this study, which focuses on the exploration of the lived experiences of social workers dealing with the victims of intimate partner violence in Mbombela Local Municipality at Ehlanzeni District.

Below is demographical information required for participants of the study.

Please fill in the required information in the blank space provided.

Name and surname: _____

Age of participant: _____

Gender: _____

Year(s) of experience: _____

District: _____

Municipality: _____

Signature: _____

Date: _____

Appendix 6: Interview guide

Objectives	Interview questions
To determine the emotional and psychological distress experienced by social workers	What are your experiences as a social worker dealing with victims of intimate partner violence?
To determine how the experiences of victims impact their personal and professional lives	How has the trauma experienced by victims affected you as a social worker?
To examine coping strategies used by social workers when dealing with stressful work conditions	What coping skills do you use to deal with the stressful situations that your work comes with?

Appendix 7: Turnitin Report

An Exploration of the Lived Experiences of Social Workers Dealing with Victims of Intimate Partner Violence at Ehlanzeni District, Mpumalanga

By Lindokuhle Mhlongo

Submission date: 16-Mar-2020 05:43PM (UTC+0200)
Submission ID: 1276517952
File name: Lindokuhle_Turnitin.docx (146.01K)
Word count: 14395
Character count: 78105

Appendix 8: Editorial Letter

To whom it may concern,

This letter serves to confirm that the attached document, ‘An exploration of the lived experiences of social workers dealing with victims of intimate partner violence at Ehlanzeni District, Mpumalanga,’ has been edited by a qualified language practitioner. For further verification, I may be contacted by email: kellygilbertson@gmail.com or by phone: 0616150292.

Kind regards,

Kelly-Anne Gilbertson