AN EXPLORATORY STUDY OF THE NEEDS AND EXPERIENCES OF PERSONS DISABLED THROUGH CRIMES OF VIOLENCE

PENNY BICCARD

Submitted in partial fulfilment of the requirements for the
Degree of Master of Social Work (Clinical Practice) in the
Faculty of Community and Development Disciplines,
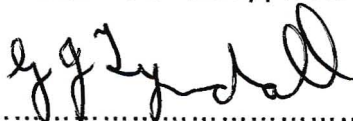Centre for Social Work, University of Natal, Durban.

June 2002

DECLARATION OF ORIGINALITY

I hereby declare that this dissertation, unless specifically indicated to the contrary in the text, is my own work.

Penny Biccard
University of Natal, Durban
June 2002

Submitted with the approval of the supervisor, Graeham Tyndall.

....

Graeham Tyndall

.21. 6. 2002.

Date

ABSTRACT

This research study aimed to explore the impact on individuals of becoming physically disabled through being victims of crimes of violence. The study begins with a literature review related to issues of disability and to victims of crime. The main focus of the research, however, was to gather information regarding the experiences and needs of persons disabled through being victims of crime and to establish the rehabilitation and trauma counselling services that they have had access to.

An exploratory, descriptive, research design guided the study. A purposive sampling procedure was used to identify twenty persons known to the Durban branch of the Association for the Physically Challenged, which provides services to physically disabled persons. Individual, face-to-face interviews were held with the respondents, using a semi-structured interview schedule. Interviewer observations were also undertaken in the process. Qualitative and quantitative methods were used in analysing the results, from which conclusions and recommendations were drawn.

The study findings indicate that the majority of persons had become severely disabled through being victims of crimes of violence. The majority of respondents were young when they became disabled, and were mostly single persons who experienced a high degree of dependence on others for various types of assistance, particularly their families and friends. The respondents also experienced a variety of unmet needs as both disabled persons and as victims of crimes of violence, through a lack of and/or inaccessibility to services. Disability, as seen within the context of the "social model", emphasises the role of a disabling environment in contributing to the meaning of disability. Resulting from the findings, it is proposed that social workers are ideally placed to foster empowerment initiatives of disabled persons and victims of crime through facilitating their active involvement in directing services that are both accessible and relevant to their needs.

ACKNOWLEDGEMENTS

I would like to extend my sincere thanks and appreciation to the following people:

To the respondents in the study who were so forthcoming and open in sharing their experiences with me.

To my supervisor, Graeham Tyndall, for his patience, guidance and encouragement throughout the research process.

To my colleagues and classmates for their assistance and interest in the study.

To my special family for their constant support and encouragement, and for not giving up that I would finish this!

Finally, a big thank you to my gem of a husband Bruce, for his motivation, patience and valued input, and for his care and understanding of me during the process.

TABLE OF CONTENTS

REFERENCES

APPENDICES

APPENDIX 1:   Interview schedule

English version

APPENDIX 2:   Uhlelo lwemibuzo

IsiZulu version

LIST OF TABLES

LIST OF FIGURES

Page

CHAPTER ONE

CONTEXT AND PURPOSE OF THE STUDY

Introduction

According to a number of authors, the experiences and rights of persons with disabilities have not received sufficient attention by social workers. They mention that social workers have done little to promote disability rights in their roles as advocates. Furthermore, they argue that few persons with disabilities enter the social work profession (Oliver, 1983; Mackelprang and Salsgiver, 1996). Investigations into disability issues following the declaration of the "National Year of Disabled Persons" in 1986 revealed an absence of disability policies in South Africa at that time (White Paper, 1997). However, since the change of government in South Africa in 1994, an implementation of policies on the rights of disabled persons has become a priority item on the agenda. The various facets of an integrated policy to address discriminatory practices linked to persons with disabilities were formalised in the "White Paper on an Integrated National Disability Strategy" of 1997. The White Paper provides a framework for integrating disability issues in all government strategies and programmes, with the goal of ensuring that persons with disabilities are able to access their rights, enabling them to participate fully in society.

There was also little concern and acknowledgement given to the plight of victims of crime in South Africa prior to 1994 (Stavrou, 1998; Holtmann, 1998). Stavrou (1998) stated that the reasons that victims of crime and political violence were low on the agenda was that South Africa mirrored the international trend of neglect of the victim; the South African governments prior to 1994 did not concern themselves to any great extent with victims of crime and power abuses; and there was a low social awareness of the impact of crimes of violence such as domestic and sexual violence. This resulted in services to victims of crime being fragmented and poorly

resourced. In addressing the problem of crime in South Africa, and the past disregard for the needs of victims, the South African government introduced the National Crime Prevention Strategy in 1996. One of the pillars of this strategy is the Victim Empowerment Programme. The aim of this Programme is to provide a victim-centred approach to service delivery, where the focus is on the empowerment of victims of crime and violence and their communities (Snyman, 1998).

Much of the literature reviewed highlights the physical and psychological effects of crime on victims (Fattah, 1989; Snyman, 1992; Morgan and Zedner, 1992; Shurink, 1993). Literature also exists regarding the psychological distress that may result from becoming disabled (Green, 1997; Livneh, 2001). However, little attention is given to the effects on victims of crime who have become permanently disabled as a result of their injuries. In the present study, one of the assumptions made is that becoming disabled as a result of a crime of violence may constitute two significantly traumatic events, namely that one is a victim of violence, and that one becomes disabled.

Social workers have an obligation to gain knowledge and understanding of the unique experiences of persons and communities in order to assist them in their interactions within society. Historically, many people in South African were not afforded the right to be heard. Today, there is a focus on the empowerment of previously disadvantaged and vulnerable persons, which involves their direct input in the delivery of services that affect them.

The researcher works in the field of disability and is employed by the Association for the Physically Challenged. This organisation provides services to persons with physical disabilities and their families. Although the researcher is a registered social worker, she is not employed in that capacity. During the course of her day-to-day activities, she noted a number of persons known to the organisation who had become disabled through crimes of violence. Disabled persons have a great number of needs. The researcher attempts to ascertain whether individuals who have

become disabled through crimes of violence have specific needs, and what these needs may be.

Context of the study

This study was undertaken at the Durban branch of the Association for the Physically Challenged, a non-profit, welfare organisation based in KwaZulu Natal for the past sixty years. The Association provides personal, family and community services to persons with physical disabilities. The respondents were all on the active caseloads of social workers employed by the Durban branch of the Association. This branch is the largest branch of the Association and provides services to various urban, peri-urban and rural communities in Durban and surrounding areas. The branch has centres in Sherwood, Umlazi and KwaMashu. Much of the work involves the provision of services to disadvantaged communities, utilising community-based venues. The branch provides services to meet a variety of needs experienced by persons with disabilities, as well as making referrals when necessary to other specialist organisations, such as the Deaf and Blind Society, Childline, etcetera. Services provided include social work counselling to individuals, families and groups affected by physical disabilities, rehabilitation services to adults and children, capacity building with community-based groups, and the facilitation of adult basic education and skills training programmes.

Rationale for the study

Crime is a major problem facing South Africa and a social concern that affects everyone from the individual, to the community, to society as a whole. Crime has many consequences. While working in the field of disability, the researcher became aware of people who had become disabled as a result of crime. For some survivors, disablement may be one of the most devastating effects of crime and raises enormous issues for individuals, families and communities. Disabled individuals and their families are forced to adapt to a new situation and an environment that may

provide barriers to accessing fundamental needs and rights. It is imperative that the country provides services and implements supports systems to meet the needs of these people and their families who may be affected, in order to empower them as participating members of society.

A study of the research literature available indicates that crime and disability are well documented, but as separate entities. There appears to be a dearth of studies which focus directly on issues that face persons who become disabled through crime. The present study was undertaken with the intention of exploring some of these issues. It was hoped that the findings might help to equip social workers in the field of disability and victim support with knowledge and understanding to be able to offer relevant services and to devise appropriate treatment plans for survivors of violence who become disabled, and their families.

Purpose of the study

The purpose of the study was to explore the impact of physical disability on victims of crimes of violence known to an organisation providing services to persons with disabilities and their families.

Objectives of the study

The objectives of this study were to:

1. Review the literature on the general topics of disability and victims of crime, particularly with reference to victims of crime who become disabled.

2. Explore the experiences of a selected number of persons who had become disabled as a result of being victims of crimes of violence.

3. Explore some of the physical, social and psychological needs of these persons.

4. Gain an understanding of the coping and support mechanisms of respondents.

5. Explore the nature and accessibility of services available to the respondents.

Research design

The study was primarily of an exploratory nature, but also used descriptive elements. According to Marlow (1998), exploratory study is undertaken when little information is available about the topic under study. "Such studies can adopt either an explanatory or a descriptive strategy" (Marlow, 1998, p. 34). This research involved descriptive elements because information obtained through the data collection was recorded and described. Both qualitative and quantitative methods of research were employed. Twenty respondents were obtained using non-probability or purposive sampling. The primary data collection tool was a face-to-face interview using a semi-structured interview schedule, which made use of close-ended and open-ended questions. This ensured that certain questions were posed to all respondents, but the interview schedule provided opportunities for exploring aspects in more detail.

The data collected was analysed using qualitative and quantitative methods of data analysis, from which conclusions and recommendations were then made. More detail is given to describing the research methodology utilised in Chapter Three.

Value of the findings

Little research appears to have been undertaken exploring the needs of persons who have become disabled through being victims of crimes of violence. It was

hoped that this study might provide insight and greater understanding into the issues that are relevant to these individuals, as well as some of the issues facing social workers and other rehabilitation practitioners in this field.

It was hoped that the respondents involved in the study would be empowered in the research process through sharing their own stories and experiences, with the hope of creating greater understanding and awareness of their needs and situations.

The Victim Empowerment Programme is a fairly recent programme in South Africa, through which victim-centred service provision is promoted (Stavrou, 1998; Holtmann, 1998). However, there appears to be little evaluation of its impact to date. It was hoped that this research might provide some insight into the services the respondents have received as victims, as well as the issues that might be relevant to a programme that places emphasis on the needs of victims of crime. There is also a growing interest in community-based rehabilitation programmes in the field of disability and a focus on co-ordinated service delivery. A further outcome of this research was to record some of the aspects relevant to persons who became disabled through crimes of violence that could be addressed in these programmes.

It was hoped that the research would benefit the Association for the Physically Challenged in contributing towards the knowledge about unique issues faced by persons who become disabled through crimes of violence. In doing so, it was hoped that the information could be used to guide the development of relevant and accessible services for these persons.

Theoretical framework guiding the research

"Social model" of disability
Detailed attention is given to the "social model" of disability in the literature review in Chapter Two. However, brief mention will be made of this model here since it presented the researcher with an understanding of disability as a product of the

society in which people live. The meaning of disability is largely determined by the social meanings that persons give to certain physical and mental impairments (Oliver, 1990). In other words, within this model, disability is regarded as a social construct. According to this model, persons with disabilities are rendered incapable through the negative, stereotypical attitudes and environmental obstacles held by society (Bickenbach, Chatterji, Badley and Üstün, 1999). The model emphasises the needs of disabled persons as defined by themselves (Oliver, 1990). A central focus of this study was to gather information and input from the experiences of persons with disabilities themselves.

Ecological systems perspective

The ecological systems perspective provides a useful framework for understanding disability and victims of crimes of violence as it is focused on a person's interaction with the environment. According to Hoffmann (1987), "ecology rests on an evolutionary, adaptive view of human beings in continuous transactions with their environment" (p. 230). When applied in the context of a helping profession such as social work, an ecological perspective presents a view that the needs and problems of humans need to be understood within the context of their environments (Hoffmann, 1987). People may affect their environments at the same time that the environment impacts on them (Hepworth and Larsen, 1986). The ecological systems perspective is particularly relevant in the field of disability where the difficulties that disabled persons experience may often be linked to the physical and attitudinal barriers that they face in their environments. As Oliver (cited in Hoffman, 1987) stated, "disability is a relationship between the impaired individual and the restrictions imposed upon him by society" (p. 231).

The role and function of social work practitioners is to improve the transactions between persons with disabilities and their environments in order to improve their quality of life and to enhance their coping capacities (Hoffmann, 1987; Hepworth and Larsen, 1986) Thus, the ecological framework provides a model conducive to

understanding the problems of disability and crime and service provision to disabled people, victims of crime and their communities.

Presentation of contents

This Chapter presented an introductory overview to the study, including the rationale, purpose, objectives, theoretical context, research design and value of the study.

Chapter Two presents a review of literature that is relevant to the study. Areas covered include models and definitions of disability, the incidence and causes of disability with special reference to injuries through violence, the demographics and needs of victims of crime, issues of crime prevention within the South African context, rehabilitation and adaptation issues of persons with disabilities, a discussion of community-based rehabilitation as a method of service delivery, the role of social work in the disability field, attitudes towards disability, and the relationship between poverty and disability.

Discussion of the research methodology used is presented in Chapter Three, which reviews the aims of the research, followed by a discussion of the research design, sampling procedures, data collection methods and data collection instrument. Aspects of validity and reliability are discussed and the methods of data analysis are explained. Finally, some consideration is given to the ethical issues and limitations of the study.

Chapter Four provides an analysis of the data collected, using both qualitative and quantitative methods, and a discussion of the findings. The results are presented in terms of the information-gathering guidelines in the interview schedule.

Conclusions and recommendations of the research are highlighted in Chapter Five. The conclusions drawn from the literature review, as well as from the research study

itself, are recorded. The Chapter concludes with suggestions and recommendations made from the study.

It was necessary for the researcher to conduct a literature review before proceeding with the data collection stage of the research, in order to gain an understanding of the relevant issues involved in the research problem, and the relevant areas to be included in the interview schedule. This review is presented in the following chapter.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The literature review examines two topics relevant to this research study, namely disability and crime. Of specific interest was the impact of disability resulting from criminal acts of violence. However, there was little literature on the latter.

"Disability occurs in every society throughout the world and has done so down through the centuries" (O'Toole and McConkey, 1995, p. 3). Disability affects the individuals concerned, their families and communities as well as the societies in which they live. The South African government has committed itself to addressing the needs of disabled people in the country through the development of the "Integrated National Disability Strategy" (1997). This strategy makes recommendations based on human rights and provision of equal opportunities for disabled persons. This is important as globally, many persons with disabilities lack access to information, resources and the fulfilment of basic needs (Cornell, 1995).

Crime is another issue affecting the society in which we live, and which has far reaching consequences for victims and their communities. Increasing crime trends in South Africa are a concern to both the South African government and the public alike (Stavrou, 1998). These trends resulted in the initiation of the National Crime Prevention Strategy in 1996, a framework of policy initiatives for addressing issues of criminal justice and crime prevention (Prozesky and Kotze, 1998; Snyman, 1998; Stavrou, 1998).

Intentional injuries caused through crimes of violence are among the leading causes of death and disability in the world (Krug, Sharma and Lozano, 2000). Thus, a link exists between disability and crime. Social workers are required to provide effective

and efficient services to clients. This involves providing a service that meets individual and environmental needs. It is hoped that some of the findings from this study might contribute towards a greater understanding of some of the pertinent issues pertaining to persons disabled through crime and hence improve service delivery to those affected.

Models of disability

Disability has been explained within the context of various models that determine how disability in a society is understood and defined. Historically, disability has been explained in terms of the "medical model". Within this model, disability is understood as a deviation from the "normal composition" and functions of an individual (Philpott and McLaren, 1997; Bickenbach, Chatterji, Badley and Üstün, 1999). As Philpott and McLaren (1997) explained, the use of the medical model results in reducing disability to a limitation or inadequacy within an individual. Within the medical model, methods of rehabilitation are aimed at improving the "pathology" of an individual, and thus assisting the person in functioning as "normally" as possible. The needs of the individual are secondary in importance to the "abnormality".

Various authors have highlighted the meaning of disability within the context of the "social model" (Bickenbach et al, 1999; Philpott and McLaren, 1997; Oliver, 1990; White Paper, 1997). In this model, disability is understood as a social construct, in which the medical condition is just one part of the problem. The problem of disability relates to the way in which society is constructed and the way in which it is focused on meeting the needs of the able-bodied members of society rather than on disabled persons (Philpott and McLaren, 1997). Environmental factors have a major impact on a disabled person's functioning and coping abilities (Üstün, Saxena, Rehm and Bickenbach, 1999). Within the context of the social model, "disability is a problem of society, difficulties resulting from a disabling environment, rather than from the defects and deficiencies of disabled people as individuals" (Pinder, 1995, p. 608). The social model of disability is succinctly summed up by Finkelstein and Stuart

(1996) who said that "the social model of disability incorporates a holistic interpretation of the situation facing disabled people. It suggests that people with physical and mental impairments can have satisfying life-styles as *disabled people* if the focus of attention is shifted towards the removal of disabling barriers rather than concentrating only on the rehabilitation of disabled individuals (overcoming the effects of personal impairments)" (p. 170). The disabling barriers mentioned refer to personal, physical and social barriers. Wendell (cited in Crisp, 2000) supported the definition of disability as socially constructed and agreed that the environment may be the source of problems as well as solutions. However, she also emphasised that the physical realities of disabled persons could be neglected if exclusive attention was given to eliminating the social barriers. She also warned against viewing persons with disabilities as one social group since this would ignore or detract from the individual differences based on gender, age, ethnicity, race and class, and would falsely generalise the social experience of disability.

The definitions and experiences of disability differ from one society to another in terms of differing social and material factors and societal attitudes (Oliver, 1990). A definition of disability developed by disabled persons themselves refers to disability as "the disadvantage or restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities" (Oliver, 1990, p. 11). The World Health Organisation defined disability as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (cited in Brandsma, Lakerveld-Heyl, Van Ravensberg and Heerkens, 1995, p. 123). The interpretation of "normal" activity may vary. As Elwan (1999) pointed out, a disabling impairment in one environment may not be considered disabling in another.

Thus, the way in which disability is defined determines the methods of rehabilitation and type of service delivery. During the apartheid era in South Africa, rehabilitation services for disabled persons were segregated and racially biased. Most services

were centrally located and institution-based, with little co-ordination and planning amongst the various disciplines involved in the field (Philpott and McLaren, 1997). In 1997, the office of the Deputy President produced the "White Paper on an Integrated National Disability Strategy". The strategy places itself within the social model. In doing so, the platform for rehabilitation services was laid out as follows: "...the reconstruction and development of our society involves a recognition of and intention to address the developmental needs of disabled people within a framework of inclusive development" (White Paper, 1997, p. 11).

Incidence and causes of disability, with special reference to violence

Many reports on the incidence of disability in the 1980's placed the world figure of the number of disabled persons at 10% (Department of Health, 1998; Cornell, 1995; Katz, Harilaou, Masoga, Phiri and Barrett, 1995). Berger and Mohan (cited in van Niekerk, Bulbulia and Seedat, 2000) quantified this in numbers by reporting that at least 78 million people in the world become disabled each year. The United Nations Development Programme estimated that the prevalence of disability ranged from 4.5% in developing countries to 7.7% in developed countries (Department of Health, 1998). Elwan (1999) noted a lack of information about disability in developing countries. In addition, certain factors might contribute to the seemingly higher rate of disability in developed countries. These may be related to differences in the definition of disability; the manner in which information about disability is collected; the fact that developed countries have an older age structure than in developing countries; and a greater capacity to diagnose some conditions in developed countries.

There appears to be a lack of reliable information regarding the nature and prevalence of disability in South Africa (White Paper, 1997). The Department of Health estimated that 12.8% of South Africa's population was disabled (Green, 1997). Contrary to this, a 1995 statistic available from the Central Statistical Service reported the prevalence of disability at 5% in South Africa (White Paper, 1997).

Various authors discuss the impact of injuries on the world's population. Krug et al (2000) stated that injuries are the leading cause of death and disability in the world. Butchart and Peden (1997) noted that violence in South Africa causes the most number of fatal injuries in the country. In 1998, 16% of the global burden of disease was caused through injury. Significantly, studies have shown that injuries most commonly affect young people, often causing long-term disability (Krug et al, 2000; Butchart and Peden, 1997; Butchart, 2000). Injuries are classified as either intentional or unintentional. Intentional injuries are those related to violence or that are self-inflicted, and unintentional injuries are those caused through motor vehicle accidents, drownings or burns, for example. This study deals with intentional injuries related to crimes of violence that resulted in permanent physical disability of the victims.

"Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (World Health Organisation, 1996, p. 3-4). Butchart and Peden (1997) identified three broad categories of violence as reported by the World Health Organisation. These categories are interpersonal violence between people, either known to each other or not at all; self-directed violence such as suicide or self-mutilation; and organised violence. In developed countries, most violence is self-directed followed by interpersonal violence and then marginal levels of organised violence. In contrast to this, in South Africa interpersonal violence is most prevalent, followed by organised violence and a smaller proportion of self-directed violence (Butchart and Peden, 1997).

There is a lack of statistical information on the causes of disability. Elwan (1999) noted that the "cause structure" of disability in developing countries differs from that of developed countries, and that the proportion of disabilities caused through injuries is higher in developing countries than in developed countries. According to Simon-Meyer (1999), the major causes of disability in South Africa are due to illness, pre

and peri-natal problems, and injuries, accidents and violence. Simon-Meyer (1999) drew attention to the fact that disability causes may vary in different regions of the country. She cited an example of this. At a hospital in Northern KwaZulu-Natal, the leading cause of disability was cerebral malaria, strokes and Mseleni Joint disease. At the same time, gunshot injuries were cited as a predominant cause of disability in Johannesburg. According to Boffard, head of Johannesburg Hospital's trauma unit (cited in Simon-Meyer, 1999), the number of admissions of victims of personal violence to Johannesburg Hospital's trauma unit in 1999, was double that of car accidents, compared with 1993 when admissions of victims of car accidents outnumbered victims of personal violence. He also maintained that the largest cause of quadriplegia in the Johannesburg area was from injuries sustained in car hijackings. While there appears to be little other literature referring to permanent disability as a result of crimes of violence, the results from this study confirm that one of the consequences for victims of crimes of violence is permanent disability.

Demographics of victims of crime

Laub (1997) discussed various key demographic dimensions of victims. According to statistics from a National Crime Victim Survey conducted in the United States of America in 1992, younger people are more likely to be victims than older people. A National Crime Prevention Survey conducted in the United States of America in the same year indicated that people experiencing victimisation through personal crimes was 20% higher for men than for women (Laub, 1997). Butchart (2000) stated that worldwide, young, economically active members of the population in the 20 to 40 year age groups are most affected by violence. He commented that males are at higher risk than females and that between 30 and 70% of total mortality in men aged 20 to 34 years is accounted for by homicide and suicide.

The needs of victims of crime

Various authors discuss the impact of crime on victims and victim needs (Fattah, 1989; Snyman, 1992; Morgan and Zedner, 1992; Schurink, 1993). As noted, one of the most evident effects of crime is physical injury. In the present research study, issues related to permanent disability as an effect of crime were investigated. Morgan and Zedner (1992) emphasised that an assessment of the extent of physical injuries to victims, the pain suffered and the subsequent disruption to a person's life are necessary to gain an understanding of the emotional impact of crimes that involve physical violence. A predominant reaction to being a victim of crime is psychological distress and trauma (Morgan and Zedner, 1992). Symptoms of distress may include fear, guilt, shock, helplessness and depression, that may take the form of insomnia, physical ailments and an inability to manage one's daily affairs (Schurink, 1993; Fattah; 1989).

A further result of crime is that of economic loss, which includes property loss, uninsured medical costs and loss of income. In addition, many victims of crime do not have access to health insurance or to public medical services (Fattah, 1989).

Fattah (1989) also noted that crime not only affects the victims, but also the family and friends of the victims. Results from a study conducted by Friedman et al (cited in Fattah, 1989) found that 80% of the supporters of victims of crime were suffering from similar psychological symptoms to the victims.

Snyman (1992) and Schurink (1993) considered some of the needs of victims of crime. The needs of victims vary and may involve the immediate and practical needs of victims; the emotional needs stemming from the psychological reactions to crime; and the need for recognition and reassurance. Victims of crime also require information related to appropriate community resources, services and legal advice; as well as the need for contact with the judicial process.

Victims of crime may require and receive various sources of social support, as researched by Denkers (1999). Results from his study showed that partners of victims were the most important support providers, followed by the social network support of family and friends and then the more distant sources of support such as churches, clubs and the authorities. He stressed that the appropriateness of any support system depends on the nature of the stressful event and how relevant the source of support is to the event (Denkers, 1999).

In the past, little attention was given to addressing the needs of victims of crime and violence in South Africa by the State and other agencies of civil society. As previously mentioned, this was similar to the trend within the international community (Stavrou, 1998; Groenhuijsen, 1998). Recently, there has been a growing awareness of the needs of victims of crime, and a realisation that there is a need for a victim-centred approach that empowers victims (Snyman, 1998). This has culminated in the Victim Empowerment Programme, a core component of the National Crime Prevention Strategy in South Africa.

Crime Prevention in South Africa

Crime affects the quality of life of all South Africans (Nel, Liebermann, Landman, Louw and Robertshaw, 2000). Efforts are needed by all role-players to combat crime and violence, thereby addressing preventive measures to decrease the incidence of injuries and disability. To this end, the Government released its National Crime Prevention Strategy in 1996 (Stavrou, 1998; Prozesky and Kotze, 1998; Schurink, 1993).

As mentioned previously, one of the pillars of this strategy is the Victim Empowerment Programme. Various authors have discussed the elements of the programme (Holtmann, 1998; Prozesky and Kotze, 1998; Snyman, 1998; Stavrou, 1998). The aim of the Victim Empowerment Programme is to provide a co-ordinated and supportive service to victims of crime in a way that empowers them. There is an

emphasis on the multi-sectoral nature of the programme where a partnership exists between national, provincial and local government departments and organisations of civil society. It is envisaged that implementing a programme that co-ordinates these structures on all levels will result in a positive impact on the victim of crime, and will ensure that the concerns of victims are taken seriously and that the incidence of crime is reduced.

As part of the National Crime Prevention Strategy, a surveillance system has been established to monitor injury and violence in South Africa. Various procedures have been put in place to obtain information about fatal injuries, non-fatal injuries and substance abuse in relation to violence and injury (Peden and Butchart, 1999). One of the central purposes of this injury surveillance system is to obtain clearer information about the extent of the problem of injuries and violence in South Africa in order to make informed decisions in developing strategies to combat the problem.

Physical disability and rehabilitation

The researcher believes that falling victim of violent crime, and becoming disabled, constitute traumatic experiences for the individuals involved, as well as for those close to them. The present study focused on persons who had become physically disabled through being victims of crime. The researcher chose to review some of the issues referred to in literature regarding the adaptation of persons to physical disability.

Keen and Shembe (1994) discussed a research process in which four general areas of intervention were undertaken. These included the physical, vocational, social and psychological areas of need. One of the first overriding problems for a person who becomes disabled is dealing with the physical changes that occur. Depending on the severity of the disability, the individual may experience a loss of mobility and independence. A disability could affect a person's ability to carry out the functions of

his or her job, to the extent that the individual might be obliged to retrain for work in a different capacity, depending on his or her physical limitations.

Coleridge (1993) and Simon-Meyer (1999) highlighted the change in identity that takes place in a person who has become disabled. Identity issues can be significant for disabled persons, whether they were born with a disability, or became disabled in adulthood. Withers (1996) explained that a person born with a disability may not experience an affirmation of his or her identity as a "whole" person, and that a person who becomes disabled later, may struggle to reconcile his or her "new self" with his or her previous identity as an able-bodied person. The process of becoming disabled may involve a sense of loss and a need for acceptance of one's new identity. Coleridge (1993) highlighted the fact that an understanding and acceptance of this new identity is required by the disabled person as well as by his or her family and community.

An important area for rehabilitation of an individual following an injury may be in dealing with the psychological effects of becoming disabled. Livneh (2001) reviewed the various components that are involved in the process of psychosocial adaptation to chronic illness and disability. She drew attention to the triggering events of the disabling condition as well as to the context in which the disability occurs. The triggering events of a condition are those events that fully or partly caused or contributed to a condition such as birth trauma, genetic dispositions or injuries. In the present study, the triggering event was injury as a result of crime or violence. The context in which the disability occurs refers to the situational conditions at the time of the event. The contextual variables may refer to the biological conditions such as health status, gender or age of a person; the psychosocial variables such as a person's personal identity and level of emotional and cognitive development; and environmental variables such as the physical, economic and social conditions in which a person lives. The context in which disability occurs enables one to better understand the impact that the onset of disability has on a person and the way in which that person is able to adapt to the disability (Livneh, 2001). Green (1997)

commented that the onset of disability often constitutes a stressful experience for individuals and their families, and may have a major effect on the disabled person's emotional functioning.

Livneh (2001) referred to some of the models that have been used to explain the nature of psychosocial adaptation to chronic disability. All share the "notion" that psychosocial reactions can be classified into the immediate short-term reactions following the trauma such as denial, shock or anxiety; intermediate reactions such as anger and grief; and the longer-term reactions such as acceptance and behavioural adaptation. It is assumed that disabled persons have suffered a significant loss, and that a grieving or mourning process is necessary for the person to be able to come to terms with the loss (Oliver, 1983; Withers, 1996; Coleridge, 1993). Oliver (1983) warned against placing too much emphasis on individualistic theories in which it is assumed that an individuals' adjustment to a disability can only take place by working through a number of phases. This may be contrary to the personal experiences of some disabled persons who may not pass through certain adjustment stages.

Theorists speak of "post disability quality of life" on an intrapersonal, interpersonal and extrapersonal level of functioning when referring to the rehabilitation of a person coming to terms with a disability (Livneh, 2001). Intrapersonal functioning refers to an individual's personal health and psychological adaptation such as one's sense of self and satisfaction with life. Interpersonal functioning relates to the family and marital relationships as well as the social relationships that a person has with others. The extrapersonal domain refers to a person's work environment, recreational and learning activities. Oliver (1983) stressed the difficulties that disabled persons may have in establishing relationships of a social or sexual nature. He noted that this might be as a result of the lack of opportunities that persons with disabilities may have to meet other people, as well as the reactions of others towards persons with disabilities. In addition, able-bodied persons may be prejudiced towards disabled

persons and their feelings of fear and ignorance may make it difficult for them to know how to relate to disabled persons.

Livneh (2001) advocated an ecological view in referring to various factors that may have an effect on an individual's adaptation to disability such as the coping strategies and the social and environmental supports that exist for a person. Green (1997) described a social support network as "a set of relationships that provides nurturance and reinforcement for coping with life on a daily basis" (p. 352), and suggested that this could consist of people from different sources such as family, friends, neighbours, work colleagues and formal helpers. Green (1997) conducted research into the social support needs of physically disabled clients. Results of this study showed that the family members in the household provided the major source of support, followed by informal sources outside of the home such as friends and neighbours and lastly, professional sources of community support. These results were similar to those of Denker's (1999) research of the sources of support available to victims of crime referred to earlier in the literature review. Another interesting finding from Green's (1997) research indicated that half of the respondents would have liked to be members of a social or recreational club. This reflected the need that disabled persons have for contact and socialisation with people outside of their household.

As mentioned, disability affects not only the disabled person, but family and friends as well. Katz et al (1995) mentioned some of the factors that affect a family's ability to adapt to a disability such as socio-economic status, religious convictions, the social support available and the coping mechanisms of the family. These authors discussed the shortage in the ratio of professionals to disabled individuals in terms of services to families dealing with disability in South Africa. They advocated the importance of a primary health care and social services approach that embodies community development, where there is equal access to services for all communities, and where communities are involved in the provision and monitoring of the services. O'Toole and McConkey (1995) noted that the global community

agreed on the importance of disabled persons being actively involved in all facets of community life where conditions promote dignity and self-reliance, as detailed in the United Nation's Convention of the Rights of the Child. This would be attained if families of disabled persons and the local communities were supported in coping with disability. Petersen, Magwaza and Pillay (1996) discussed a participatory research project facilitating a psychological rehabilitation programme for child survivors of violence in a South African community. They too stressed the importance of adopting a primary health care framework where consumers of the services are empowered through being involved in the process of service delivery. They also stressed the significance of individual coping styles and the available access to social and economic resources in relation to the way that people are able to deal with trauma. Community-based rehabilitation could present one such approach to providing support to persons with disabilities and their communities.

Community-based rehabilitation

In South Africa, much of the formal service provision available to disabled persons is closer to towns and cities where larger hospitals exist. Many physically challenged persons living in rural areas are thus at a disadvantage in terms of their accessibility to services (Rule, 1999). The importance of rehabilitation at a community level has been identified as a priority need in South Africa (Green, 2001) The South African government has committed itself to adopting a primary health care approach with the aim of bringing health care services closer to people in need. There is a focus on increasing the accessibility of rehabilitation services, as rehabilitation is an important component of the policy. The policy is guided by the principles of development, empowerment and the social integration of persons with disabilities (Department of Health, 1999).

McLaren and Philpott (1999) highlighted ways in which practitioners working in the disability sector can better address the needs and rights of disabled persons, which include working in partnership with disabled persons to better to understand their

needs; identifying those barriers that exclude disabled persons from accessing services; ensuring that all planning and service implementation is disability sensitive; and making the necessary information and resources available to ensure that the planning of services is effective. The needs of disabled persons and their families should direct the nature of the services provided, ensuring a "bottom-up" approach (O'Toole and McConkey, 1995). Research such as the present study could assist in bridging the gap between disabled persons and service providers in terms of understanding disability and developing relevant and sensitive services, through obtaining information from individuals themselves about their experiences and needs within their environments.

The "White Paper on the Integrated National Disability Strategy" (1997) is a policy document which provides guidelines on addressing disability in all sectors and that promotes the method of community-based rehabilitation in addressing disability needs. Rehabilitation is "a process which aims to enable people with disabilities to become as independent (physically and economically) as possible" (Rule, 1999, p. 12). "Community-based rehabilitation is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of people with disabilities" (ILO, UNESCO, WHO cited in Department of Health, 1999, p. 10). As Cornell (1995) explained, the ultimate aim of a community based rehabilitation strategy is "to promote and protect human rights and create equal opportunities" (p. 14). In this way, a person-centred approach is central to community-based rehabilitation, making rehabilitation accessible to all, and relevant to the cultural context in which it is implemented (Miles, 1996). There is a focus on the partnership between the service users and professionals involved in the disability sector.

Social work and disability

One of the central values inherent in social work is the right of the client(s) to self-determination (Tower, 1994). Tower (1994) advocated a consumer centred approach towards practice, in which those persons with direct experience of certain

life conditions (disabled persons in the case of this research study) have more knowledge than "professionals" and are able to redefine their roles as consumers of services rather than recipients. If social workers align themselves with the needs and interests of the consumers, the self-determination of individuals will result. Furthermore, social work practice that is based on the strengths of individuals provides the foundation for the empowerment of those individuals. Oliver (1983) argues that social work activities need to be broadened in understanding and accepting disability as a social problem. In doing so, the role of social workers with disabled persons is to help them to "locate the personal, social, economic and community resources to enable them to live life to the full" (Oliver, 1983, p. 31).

Oliver (1983) described how the casework, group work and community work methods of social work can be appropriate within the social model of disability. For some persons with disabilities, individual casework may focus on issues of loss and grief counselling where appropriate. Group work may provide a therapeutic medium for persons with disabilities and their families in coming to terms with disability, but may also constitute a means for sharing knowledge and empowering members with increasing confidence in their own abilities and in taking responsibility for their own lives. Oliver (1983) further discussed certain functions of community group work in mobilising persons with disabilities to focus on aspects of accessibility within the social environment and in advocating for the rights of disabled persons.

Mackelprang and Salsgiver (1996) argued that social workers are able to support the disability movement because they can offer experience and knowledge of multiple systems within society. In this way, social workers are able to assume a number of roles from counsellor, to educator, to mediator, to advocate in their work with persons with disabilities. As advocates, social workers can contribute towards challenging stereotypical attitudes towards persons with disabilities.

Attitudes and disability

When applying the context of the "social model" as discussed earlier in this chapter to understand the meaning of disability, it is the attitudes of society that disable. According to Baron and Byrne (cited in French, 1996, p. 151), "attitudes are enduring mental representations of various features of the social or physical world. They are acquired through experience and exert a directive influence on subsequent behaviour".

Coleridge (1993) and Oliver (1983) drew attention to the view of disability as a personal "tragedy", "disaster" or "loss", though Oliver (1983) emphasised that disability does not have the same meanings in all societies and that "the social structure and values of a society are also important in shaping cultural views of disability" (p. 35). Coleridge (1993) stated that it is through ignorance that able-bodied persons may fear disability and portray negative responses towards persons living with disabilities. Able-bodied persons may avoid disabled persons because of their own fear and inadequacy, and stereotypes of persons living with disabilities strengthen negative attitudes towards them (French, 1996). The discrimination and prejudice that some persons with disabilities experience serves to exacerbate their disability. Furthermore, the 'stigma' of being a disabled person may create problems that make it difficult for the individual to gain social acceptance and be afforded equal opportunities in society. This sense of exclusion and marginalisation may begin within the primary environment of the family (Hoffmann, 1987).

Various theorists have discussed ways in which negative attitudes towards persons with disabilities can be challenged and overcome (O'Toole and McConkey, 1995; Coleridge, 1993; French, 1996; Oliver, 1983). Coleridge (1993) emphasised that a first step towards challenging preconceived perceptions and attitudes is to understand the experience of disability for those persons with disabilities. O'Toole and McConkey (1995) and French (1996) emphasised that contact between able-bodied and disabled persons will facilitate the development of positive attitudes. In

addition, accurate information about disability and advocacy is also important and can be conveyed through awareness campaigns. Many persons living with disabilities believe that negative societal attitudes towards disability can only be challenged and changed if disabled persons themselves feel positive about their abilities to contribute within society (Coleridge, 1993). Coleridge (1993) further stressed the need for positive role models among disabled persons, in which the stereotype of the "helpless victim" is challenged and persons with disabilities gain acceptance of a positive identity. This cannot take place in isolation from a social environment that must become sensitive to the needs of disabled persons (Coleridge, 1993). Disabled persons need to be afforded opportunities for equal participation within society. A positive attitude towards disabled people is conducive to an enabling environment (Cornell, 1995).

Poverty and disability

In 1995, the World Health Bank categorised poor people as those individuals who consume less than one dollar (1$) per day (Cornell, 1995). It is estimated that disabled persons make up approximately 15 to 20% of poor people in developing countries (Elwan, 1999). Various authors (Cornell, 1995; Elwan, 1999; White Paper, 1997; Wilson and Ramphele, 1989) have examined and explained the link between poverty and disability. These authors noted that disabled persons have less access to services and resources, fewer educational and job opportunities, and face attitudinal and physical barriers that exclude them from contributing to their communities and being involved in the planning and decision-making that affects them. The results of a research study of a defined group of disabled persons living in the Western Cape in 1999 found that 93% of respondents were unemployed. This supports previous studies in South Africa in which many persons with disabilities were found to be economically inactive (Frieg and Hendry, 2001). Wilson and Ramphele (1989) emphasised that poverty and disability is a "mutually reinforcing dual problem" (p. 182). They noted that disabled persons are often not able to find work because of society's assumption that disabled persons are not as productive

as able-bodied persons, and because society is not structured in a way that allows persons with disabilities to reach their full potential. Furthermore, they explained that the physical and social structures of society are designed in a way that excludes disabled persons, though they noted that positive changes in this regard have been made in latter decades in terms of consideration being given to structural changes to accommodate persons with disabilities.

Elwan (1999) identified three factors that contribute to poverty that may be experienced by disabled persons and their families. These are a loss of income; the added costs that result from the disability; and the exclusion or marginalisation of disabled individuals from services and social and community activities. She expanded on the costs of disability, which may be direct costs such as those that result from items such as medical supplies and equipment; and indirect costs that result from those providing care for a disabled person who may be family members or caregivers, the disabled person him or herself, and/ or the state. In developing countries, the disabled poor often become the responsibility of their families. A study undertaken by Frieg and Hendry (2001) to establish the needs of a chosen group of persons with disabilities living in a semi-rural area of South Africa found that 66% of the respondents used caregivers to some extent.

Community-based rehabilitation, as discussed earlier in the review, is a strategy that would address the accessibility of disabled persons and their families to services and go some way towards addressing the cycle of poverty that many disabled people in developing countries face (Cornell, 1995).

Summary

This chapter began by drawing attention to the problems of disability and crime and the fact that interpersonal crimes of violence can result in permanent physical disability. The framework within which disability is understood largely determines the focus of service provision to persons with disabilities within the environmental

context, and some information was provided regarding the incidence of disability globally and within South Africa. The needs and demographics of victims of crime were discussed. In South Africa, where high crime levels give cause for concern, the National Crime Prevention Strategy aims to address this issue across all role-players, and gives more emphasis to the victims of crime. Some of the various aspects of rehabilitation of disabled persons were discussed and community-based rehabilitation was presented as an intervention strategy that promotes the empowerment of disabled persons. Attention was given to the role of social workers in the field of disability, and that, through making rehabilitation services accessible to all, societal attitudes are challenged. Finally, the link between poverty and disability was discussed.

CHAPTER THREE

METHODOLOGY

Introduction

Researchers are faced with a number of research strategies from which to choose in conducting a study. The strategy chosen depends on the nature of the problem to be addressed. This chapter presents an overview of aspects of the research methodology related to this study and the research design that was used. An outline is given of the sampling methods, data collection methods and data collection instrument used. Finally, consideration is given to the ethical issues that are raised by the study, as well as to a discussion of the study limitations.

Aims of the research

The research study aimed to:

1. Review the literature on the general topics of disability and victims of crime, particularly with reference to victims of crime who become disabled.
2. Explore the experiences of a selected number of persons who had become disabled as a result of being victims of violent crime.
3. Explore some of the physical, social and psychological needs of these persons.
4. Gain an understanding of the coping and support mechanisms of the respondents.
5. Explore the nature and accessibility of services available to the respondents.

Research design

The study was of an exploratory nature, which also incorporated descriptive elements. Bless and Higson-Smith (2000) stated that the "purpose of exploratory research is to gain a broad understanding of a situation, phenomenon, community or person" (p. 41). The purpose of this study was to obtain information relating to the lives and experiences of persons who had become physically disabled through being victims of crime, and to gain an understanding of the meanings that respondents gave to their situations. The study was exploratory since little information is available with regard to disability caused through crimes of violence and the unique feelings and experiences that these survivors might have. The research combined both qualitative and quantitative research methods.

A descriptive research design is most commonly associated with qualitative research. Denscombe (1998) stated that a qualitative research approach is concerned with "meanings and the way people understand things", as well as being concerned "with patterns of behaviour" (p. 207). Qualitative research studies have certain characteristics. They are inductive and naturalistic in nature since they aim to explore certain issues and rely on observations and interviewing of respondents. Qualitative research takes place in an open system within a dynamic reality, without controlled conditions (Padgett, 1998).

This study also made use of quantitative research methods. Bless and Higson-Smith (2000) described quantitative research as "research conducted using a range of methods which use measurement to record and investigate aspects of social reality" (p. 156). In this study, 20 respondents were interviewed and various measurements were made based on the data collected.

Sample Selection

Sampling involves selecting a number of participants for the study who comprise part of the population of persons about which the researcher wants to study (Marlow, 1998). In this case, the researcher was interested in exploring characteristics related to the "population" of persons who had become disabled through crimes of violence. Since it is not possible to access this whole population, a sample was identified through a service provider in the disability field. Respondents were approached who were on the active caseload of the social workers where the researcher is employed. The researcher used a non-probability or purposive sampling strategy, which is usually associated with qualitative research. According to Lindsey and McGuinness (1998), purposive sampling "involves the deliberate selection of respondents according to the needs of the study" (p. 1109). Using purposive sampling, respondents are chosen because of the source of rich information that they are able to provide (Marlow, 1998). Denscombe (1998) explained that non-probability sampling is justified when the process of research is to "discover" rather than to test hypotheses. Convenience or availability sampling was also used in this study, since respondents were chosen based on their availability as clients of the service-providing organisation (Padgett, 1998).

The researcher was initially provided with the names and contact details of 31 potential respondents by the social workers employed at the organisation. She was able to interview 20 of these persons, as well as two persons when she piloted the initial interview schedule. She was not able to interview the remaining nine individuals because four of them had died before the data collection stage of the research was undertaken, and she had practical difficulties in reaching five respondents. Of the 20 respondents finally interviewed, that is, excluding the two pilot interviews, three were females and 17 were males.

Method of data collection

Gaining entry and establishing rapport are two necessary processes for beginning data collection (Padgett, 1998). The researcher approached the director of the Association for the Physically Challenged about becoming involved in the study, and obtained verbal permission from her and from the social workers from whose caseloads the respondents were identified. Although the researcher is not employed as a social worker at the organisation, she has a good working relationship with her colleagues, who were most co-operative in assisting her to meet with their clients.

The primary method of data collection was individual face-to-face interviews with respondents. A second method of data collection was used, namely observation when engaging with respondents and when interviewing some of them in their homes.

Denscombe (1998) explained that interviews are appropriate to use in research when one is collecting data that is "based on emotions, experiences and feelings, ... data based on sensitive issues, ... and data based on privileged information" (p. 111). The researcher chose to use interviews as the main method of data collection since she wanted to obtain more in-depth information around her topic, particularly in view of the small number of respondents.

Interviews were conducted in respondents' home languages where possible. The researcher is not conversant in isiZulu, but was fortunate to obtain the assistance of a community worker and a final year undergraduate social work student as interpreters, where required. The researcher explained the research study and its purpose to the interpreters prior to meeting with the respondents. This was important to ensure that the research subject and method of inquiry was familiar to and understood by each interpreter. Permission was obtained from each respondent where the service of an interpreter was required.

Informed consent was obtained from respondents who were approached to take part in the study. The researcher identified herself to each respondent and explained the purpose of the research study. She also gave them information related to the practical aspects of the interviews in terms of length of time and what was involved. The importance and value of respondents sharing their experiences openly and honestly was emphasised. The researcher stressed that all information shared would be treated confidentially and that the anonymity of respondents would be ensured, namely that identifying names or details would not be used.

In some situations, the researcher covered the transport expenses for respondents who had travelled to a central point to be interviewed. She felt that this was necessary since some of the respondents struggled financially, and accessing public transport was difficult for them.

There were times when the researcher was affected by the information that respondents were sharing about their individual circumstances. In these circumstances, the researcher made a conscious decision to remain objective for the purposes of the research process, while facilitating an accepting and secure atmosphere in which the respondents felt safe to share their feelings. There were times when the researcher felt respondents were unclear as to her role, misinterpreting her role as a social worker in the process. When this occurred, the researcher explained her research role again. She nevertheless guided the respondents about where to seek assistance.

Data collection instrument

The data collection instrument was a semi-structured interview schedule (See appendices 1 and 2). The interview schedule was fairly structured in terms of the issues that the researcher wanted to address, but open-ended questions were included to allow an opportunity for respondents to be able to discuss more fully certain issues that were significant to them (Denscombe, 1998). The researcher was

also able to be more flexible in terms of asking other questions that were appropriate within the context of the interview and the information that was shared, as well as to ask for clarification of aspects discussed through probing.

Prior to conducting the interviews, the researcher obtained permission from the respondents to record their responses. She was meticulous in recording to ensure that she did not forget the details of the information that the respondents shared, and to assist her in maintaining objectivity. The asking of some close-ended questions served to minimise bias, since the researcher was able to ask certain specific questions of all of the respondents (Marlow, 1998).

The semi-structured interview schedule was initially piloted with two respondents, other than the 20 sampled. Following this process, the interview schedule was altered where particular questions did not work; for example, where questions appeared to be ambiguously interpreted by respondents, or where questions did not result in obtaining the required information.

The face-to-face interview was chosen as the primary data collection instrument since the researcher hoped to obtain rich and in-depth information related to the research questions. The researcher aimed to adopt what Patton (cited in Marlow, 1998) called "empathic neutrality", where "the researcher does not seek out to prove a particular perspective or manipulate the data to arrive at predisposed truths" (p. 159). However, as Marlow (1998) explained, various factors can influence how the interviewer's questions are answered, such as the age, sex and ethnicity of the interviewer as well as the context in which the interview occurs, to mention a few.

Limitations of the interview schedule

A limitation of the interview schedule was that, despite piloting it, individuals appeared to have differing understandings of some of the questions. This may have had an impact on the information obtained. For example, in asking a question

related to the *counselling services* that respondents had received, some respondents, where English was not their first language, had difficulty in understanding what was meant by this term. A further example was where respondents did not understand what the researcher meant in asking about the *feelings* that they had at the time of the onset of their disability. At times, this resulted in the researcher giving examples of feelings that the respondents may have had. This may have resulted in leading respondents to mention feelings that they may not have actually had at the time. Bless and Higson-Smith (2000) referred to this as respondent bias, which includes "answers based on the misunderstanding of a question or a word, and the difficulty experienced by respondents in expressing themselves" (p. 139). In these situations, the researcher made efforts to explain the questions in ways that were understood, and encouraged questions from respondents to obtain clarity about the interview questions.

In questioning respondents about their physical activities prior to and after their disability incidents, the researcher did not necessarily obtain the information that she wanted to. Respondents interpreted *physical activities* to mean sporting activities, when the researcher had expected this term to be understood as other physical activities of a day-to-day nature.

In retrospect, the researcher felt that it might have been beneficial to include an open-ended question about what other services the respondents felt could have been of assistance to them. This may have provided the researcher with useful information regarding the perceived needs and required services of respondents that may not have been raised in the study.

Validity and reliability of data collection instrument

The validity of a measuring instrument "reflects the extent to which you are measuring what you think you are measuring" (Marlow, 1998, p. 186). External validity refers to the extent that the research findings are able to "translate to other

comparable situations" (Denscombe, 1998, p. 214). In this research, the focus was on exploring the experiences of the respondents and gaining some depth in terms of the information shared. The findings cannot be generalised to the broader population of persons disabled through being victims of crimes of violence because of the small sample number of this population involved in the study, and the fact that they are not necessarily representative of the wider population. However, since 20 respondents were interviewed, the researcher was able to make certain general deductions based on common themes shared by the majority of respondents. Certain broad generalisations could be made with a sample number of 20. Furthermore, literature relating to existing knowledge of the topic under study was consulted to address how far the findings of this study were corroborated. This assists in checking the external validity of the study (Denscombe, 1998).

Content validity is concerned with whether the content of the measuring instrument is relevant and representative in terms of what one is trying to measure (Marlow, 1998). In addressing the issue of validity of the interview as the research instrument, the researcher was able to check that the various concepts used in the interview schedule were understood and that information shared was accurate and relevant (Denscombe, 1998). The content of the questions included in the interview schedule were derived after extensive reading around the topics involved to ensure that the questions asked in the interview schedule would be relevant.

Reliability of a measuring instrument refers to "the consistency of a measure" (Vithal and Jansen, 1997, p. 33). Denscombe (1998) explained this in terms of whether research instruments "measure the same result when used on other occasions (applied to the same 'object')" (p. 213). In using face-to-face interviews as the primary instrument of data collection, the data collected is, to a certain extent, dependent on the personal qualities of the researcher as well as the context in which the interview takes place. This may have an adverse effect on reliability (Denscombe, 1998). According to Bless and Higson-Smith (2000), data collected through face-to-face interviews is 'more or less' reliable if the source of the data is

reliable and the researcher is objective. The researcher attempted to remain as objective as possible in the interviews with respondents, and in analysing the data collected. The use of a semi-structured interview schedule also assisted in achieving optimal reliability in that the same questions were asked of each respondent. The researcher was able to ask respondents to elaborate and explain certain responses that may have been unclear. This overcomes some of the problems of reliability where variables are unclear (Marlow, 1998).

The researcher aimed to document clearly the aims and purpose of the research, the way in which the research was conducted and the reasons behind decisions. By maintaining clear records of these details, the reliability of a qualitative study could be facilitated through the researcher remaining objective about the research process and the consistency of the research instrument (Denscombe, 1998).

Data analysis

The study was guided by both qualitative and quantitative research design methods, and both methods of data analysis were used. Denscombe (1998) drew a distinction between the units of analysis used by quantitative and qualitative analyses. He stated that words are the unit of analysis most often associated with qualitative analysis and that numbers are the unit of analysis most often associated with quantitative analysis. The present research study collected data that consisted of both words and numbers.

The process of data analysis began with the researcher keeping detailed and accurate records of the interviews and observations made. This ensured that she was not dependent on her recall of events later, and thus reduced the possibility of bias during the analysis of the data. Denscombe (1998) emphasised the importance that the researcher plays in the analysis of qualitative data since much of the analysis relies on his/ her individual interpretation. He further commented that this means that the personal beliefs and values of the researcher may impact on the

analysis of the results. In light of this, the researcher tried to maintain an objective and open attitude. She also made attempts to analyse the results within the context of available literature so as to maintain an objective viewpoint.

Vithal and Jansen (1997) noted the importance of "organising" the data once it was collected into a manageable form that makes sense. The researcher did this by counting responses made by respondents; recording descriptions of significant information shared by respondents; comparing responses across respondents where applicable and identifying themes and relationships inherent in the data. The researcher kept "memos to self" during the research process as described by Denscombe (1998) so that thoughts for ideas related to the information that was being collected could be recorded. Padgett (1998) emphasised the importance of linking the study results to the knowledge base. In the present study, the researcher made an effort to place the findings within the context of existing literature and knowledge.

Kvale (1996) described ad hoc analysis as the use of different approaches in analysing the data. The researcher made use of ad hoc analysis in the study through such actions as noting patterns and themes, counting data, making contrasts and comparisons and noting possible relationships between variables.

At this point, it is appropriate for the researcher to mention some of the methods of quantitative data analysis that were used in the study. In the study, nominal data were collected. According to Denscombe (1998), this refers to the lowest level of quantitative data, in which certain information is counted and placed into categories. The researcher made sense of the nominal data through arranging the data in order, recording the frequency with which data occurred and grouping certain frequencies together where appropriate, for example, when describing the number of years that respondents had been disabled (Denscombe, 1998). Denscombe (1998) also discussed some of the ways in which quantitative data can be presented in order to

make sense. In the present study, quantitative data were presented by making use of tables, bar charts and pie charts.

Ethical considerations

As social workers involved with research focus on peoples' lives and their problems, there are important ethical issues to be considered. One of the most important ethical considerations in this study was to consider the potential harm or negative consequences to the respondents through their involvement in the study (Marlow, 1998). The participants in this study were survivors of crimes of violence that had resulted in physical disability and had experienced considerable trauma. The researcher was aware of the possible emotional distress of the respondents and did not want to cause them any secondary victimisation. She attempted to be sensitive and empathic to their feelings and experiences.

As mentioned previously, informed consent was obtained from respondents after having provided them with information about the researcher and the study. The researcher assured respondents that refusal to take part in the study would not affect the service provision from the organisation in any way, and that participation in the research was voluntary. As the researcher was not directly involved with any clients at the service-providing organisation, respondents were not personal clients. This precluded any risk of respondents feeling coerced into being a part of the research (Padgett, 1998).

The avoidance of harm to respondents can be helped through assuring anonymity and confidentiality (Marlow, 1998). The researcher assured respondents that every effort would be made to ensure that information shared would not be linked to them personally. Gaining the trust of the respondents was important to enable them to feel comfortable and to ensure honesty and openness about the information shared. The researcher assured the confidentiality of the information that respondents disclosed to her.

Limitations of the study

Unfortunately, the researcher could not conduct interviews with all of the respondents that she had hoped to because of practical difficulties. This resulted in a smaller sample number. However, the researcher focused on obtaining more in-depth information with fewer respondents. Furthermore, the sample of 20 respondents was large enough to be able to make an analysis of results using some quantitative methods.

In face-to-face interviews, the personal identity of the researcher in terms of her age, sex and racial background, could have affected the degree of honesty and the amount of information that respondents shared. The researcher made efforts to be objective, neutral and open, and began by trying to make the respondents feel as comfortable as possible in the interviews.

A limitation of the study could have been related to the ability of respondents to recall events if the incident had taken place a long time before. In this way, the reliability and depth of information recalled could have been questioned. One way in which the researcher felt she could have prevented this, was to have confined the sample to individuals who had become disabled within the last five years. This may have meant that the sample would have been a lot smaller, though perhaps the researcher could have approached other organisations for assistance in accessing their clients.

A limitation of the analysis of the results in the study may have been that further attention could have been given to obtaining quantitative data such as tabulating means and averages.

A limitation of the research was that respondents were service users of the Association for the Physically Challenged, through which the research was conducted. This implied that all the respondents had had access to some form of

service provision. The researcher emphasised the importance of honesty regarding the services that respondents received to dispel fears they may have had about sharing information about the Association. The researcher was interested in obtaining information from the respondents regarding other services that they had received, and the quality of these services.

As mentioned previously, another limitation of the study is that the findings could not be generalised to the wider population of victims of violence who became disabled, because of the small sample size and the non-random nature of the sample. However, the strength of predominantly qualitative research lies in the greater depth of information that is explored.

If it were possible, it would have been interesting to ascertain what percentage of clients on the active caseload of the Association for the Physically Challenged became disabled through being victims of crime. This was unfortunately not possible because records of the cause of disability have not been routinely kept at the organisation. A further limitation to the sampling technique of the respondents was linked to human error. The researcher relied on the information that the social workers were able to give from their files, and there may have been individuals who the social workers did not immediately identify.

Summary

This chapter described the research methods that were used in the study. The purpose and objectives of the study suggested the use of an exploratory research design, combining elements of both qualitative and quantitative research methods. The sampling and data collection methods and instrument were discussed within the framework of the chosen research design, together with a description of the analysis of data. Consideration was given to the ethical issues inherent in the research process, and to limitations of the study. In the following chapter, the results obtained in the research study are described.

CHAPTER FOUR

ANALYSIS AND DISCUSSION OF RESULTS

Introduction

This chapter presents the results of the study and some discussion of the findings. Presentation of the findings is divided into nine areas as follows:

(1) background information of the respondents;

(2) details about the disabling incident;

(3) information gathered about respondents' physical needs;

(4) psychological needs; and

(5) social needs;

(6) the attitudes of others towards the respondents;

(7) financial details of respondents;

(8) the effects of having been victims of violence; and

(9) further information gathered during the course of the study.

The results are presented in the form of tables and figures where appropriate, as well as through discussion of the qualitative results obtained.

1. Background information of respondents

1.1 Sex of respondents

Figure 1. Sex of respondents
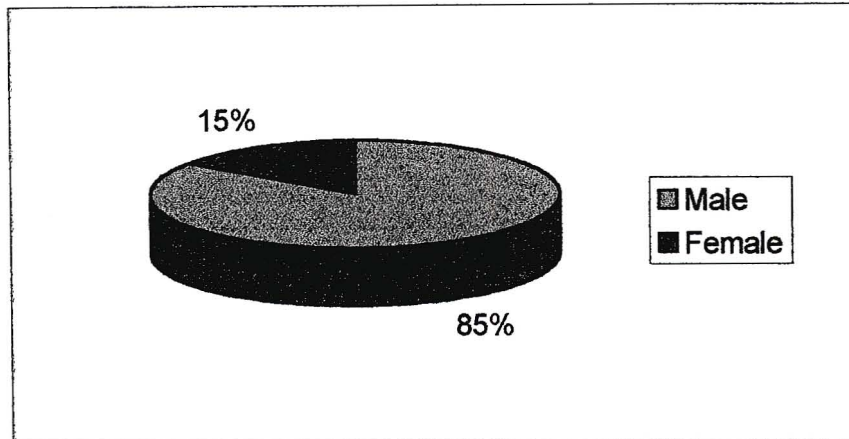
The majority of respondents were men, which is consistent with information obtained from the literature. Butchart (2000) commented that males are at higher risk of being affected by violence than women.

1.2 Racial distribution and language groupings of respondents

Table 1. Racial distribution of respondents

Race	Males		Females		Totals	
	No.	%	No.	%	No.	%
African	8	40	3	15	11	55
White	1	5	-	-	1	5
Indian	3	15	-	-	3	15
Coloured	5	25	-	-	5	25
Other	-	-	-	-	-	-
Totals	17	85	3	15	20	100

For the purposes of this research, the above categories were used as these are generally accepted in South Africa. Africans made up the highest number of respondents, followed by Coloured persons, Indians and then Whites. Information from the South African 1996 census results states that 77% of the population are African, 11% White, 9% Coloured and 3% Indian (www.statssa.gov.za). These results are fairly consistent with the general ratio of population groups in South Africa in terms of Africans making up the greatest number of respondents. However, the fact that the Association for the Physically Challenged is mainly involved with previously disadvantaged persons, particularly Africans, may skew the proportion of these groups.

The home language of ten respondents was Zulu, seven spoke English, two spoke Afrikaans and the home language of one respondent was Sotho.

1.3   Age distribution of respondents

Figure 2. Age distribution of respondents
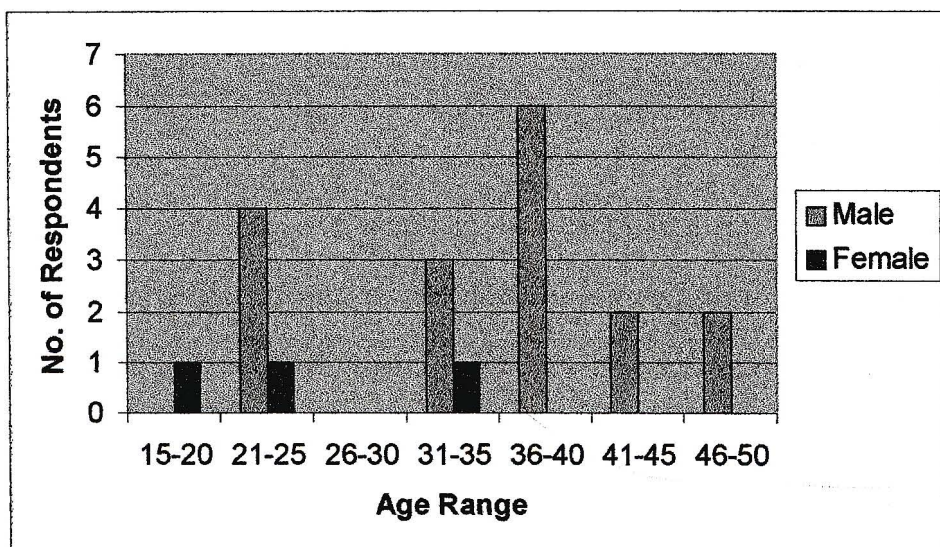
The majority of the respondents were under 40 years of age at the time of the interview. This is consistent with findings in the literature, in that young people are

most commonly affected by injuries that cause long-term disability (Krug et al, 2000).

1.4 Age at time of disabling incident

Table 2. Age at time of disabling incident

Age range (years)	Males		Females		Totals	
	No.	%	No.	%	No.	%
10– 15	-	-	1	5	1	5
16 – 20	6	30	1	5	7	35
21 – 25	5	25	-	-	5	25
26 – 30	1	5	1	5	2	10
31 – 35	3	15	-	-	3	15
36 – 40	-	-	-	-	-	-
41 – 45	2	10	-	-	2	10
Totals	17	85	3	15	20	100

It is significant that all of the respondents were under the age of 45 when the violent incident that resulted in their disability took place, and that 65% of them were between the ages of 16 and 25. Butchart (2000) stated that worldwide the young, economically active members of the population in the 20 to 40 year age group are most affected by violence.

1.5 Marital status of respondents

Table 3. Marital status of respondents

Marital status	Males		Females		Totals	
	No.	%	No.	%	No.	%
Single/ Never married	10	50	3	15	13	65
Married by Western custom	3	15	-	-	3	15
Married by Traditional custom	1	5	-	-	1	5
Divorced	1	5	-	-	1	5
Widowed	-	-	-	-	-	-
Separated	-	-	-	-	-	-
Cohabiting	2	10	-	-	2	10
Totals	17	85	3	15	20	100

The majority of respondents were single or had never been married (65%). This may be related to the young age at which respondents became disabled. One could argue that a large proportion of respondents were, at the time they became disabled, not of an age at which persons "usually" get married, and that it was subsequently difficult for them to develop long-term relationships for various reasons. These reasons may include the possibility of there being fewer opportunities for disabled persons to meet others, or because of preconceived negative ideas that people may have of persons with disabilities.

1.6   Level of education of respondents

Table 4. Level of education of respondents

Educational level obtained	Males		Females		Totals	
	No.	%	No.	%	No.	%
No formal education	-	-	-	-	-	-
Primary School: Grade 1 to 7	-	-	2	10	2	10
Grade 8 to 11	12	60	1	5	13	65
Matric	4	20	-	-	4	20
Certificate	-	-	-	-	-	-
Diploma	1	5	-	-	1	5
Degree	-	-	-	-	-	-
Postgraduate	-	-	-	-	-	-
Totals	17	85	3	15	20	100

Fifteen of the respondents (75%) had not reached a matric level of education. This educational pattern of respondents could be indicative of the fact that the service provider, from whom the sample of respondents was drawn, targeted previously disadvantaged communities. Historically, in South Africa, many people from these communities were not given equal access to educational opportunities. These results could also reflect the fact that six respondents were at school at the time of the disabling incident. Three of these respondents subsequently did not return to school. This information is further discussed at a later stage in the chapter.

1.7   Respondents and children

Fourteen respondents had children. This is significant because of the responsibilities attached to being a parent, particularly as most were single people. A number of respondents mentioned their children and the effects that having children had on them as disabled persons. One respondent explained how his daughter had felt frightened of him when he became disabled, and had not been able to understand

what had happened to him. Two respondents cited the financial difficulties associated with the extra financial obligations of providing for children. Two respondents spoke of their frustration at not being able to be as physically active with their children as they would have liked. One respondent expressed the joy that he had felt in having conceived a child after having become disabled. He had not realised that this was possible, and this had reaffirmed his sense of sexuality and physical abilities.

Reliable information regarding respondents' abilities to have children after they had become disabled was not obtained. This was a limitation of the study since this has implications for disabled persons and their partners, and may affect a person's sense of self-worth.

1.8   Area of residence

Asherville	1
Bonella	1
Cato Manor	3
Durban Central	1
KwaMashu	5
Newlands East	2
Overport	2
Sherwood/ Mayville	1
Residential facility	4
Total	20

All of the respondents interviewed in the study lived in urban areas and peri-urban township areas such as KwaMashu. One of the respondents lived in an informal settlement within one of the urban areas. The areas in which respondents lived differed in terms of socio-economic levels. Of the areas in which respondents lived, KwaMashu is furthest from the centre of Durban, followed by Newlands East.

Information obtained from the Urban Strategy Unit of the Durban Metropolitan Council indicated that KwaMashu has a lower per capita income compared with the areas more central to Durban (http://www.commprofile.urbstrat.org.za). This corresponded with lower educational levels, higher levels of unemployment and fewer community resources. This could be significant for persons with disabilities in terms of their accessibility to transport, health and other services. Those respondents living in lower socio-economic areas appeared to have less access to services and seemed to feel more isolated in their communities.

1.9   Place of abode

Table 5. Place of abode

Abode type	Males		Females		Totals	
	No.	%	No.	%	No.	%
Own home *	2	10	-	-	2	10
Lives in family home	9	45	1	5	10	50
Rented home/ flat **	4	20	-	-	4	20
Institutional facility	2	10	2	10	4	20
Total	17	85	3	15	20	100

*   "Own home" refers to a home that is owned by the respondent.

**   "Rented home" refers to a home or flat that is rented by the respondent or his family.

Only one of the 20 respondents lived alone. This may be indicative of the fact that disabled people find it difficult to live independently. Half of the respondents lived with their families. This may suggest that the support of families for persons living with disabilities is very common, and highlights the fact that families are also affected when a family member becomes disabled.

1.10 Type of disability

Table 6. Type of disability

Disability	Males		Females		Totals	
	No.	%	No.	%	No.	%
Paraplegic	11	55	3	15	14	70
Quadriplegic	2	10	-	-	2	10
Hemiplegic	3	15	-	-	3	15
Amputee	1	5	-	-	1	5
Totals	17	85	3	15	20	100

The majority of the respondents had fairly severe forms of disability. They were paraplegics, quadriplegics and there was also one amputee, all of whom relied on the use of wheelchairs for their mobility. Fourteen of the respondents were paraplegics. This could reflect the fact that the Association for the Physically Challenged provides a service to a large number of paraplegics. For example, quadriplegics constitute a smaller proportion as they may use other service providers with more focus on persons with these needs.

1.11 Causes of disability

Table 7. Cause of disability

Cause	Males		Females		Totals	
	No.	%	No.	%	No.	%
Gunshot	8	40	3	15	11	55
Stabbing	7	35	-	-	7	35
Assault	2	10	-	-	2	10
Total	17	85	3	15	20	100

Eleven of the 20 respondents (55%) were victims of gunshot attacks, one of the most violent crimes. Burrows, Butchart and Peden (2000) recorded some of the

statistics available regarding the extent of firearm injuries in South Africa, which showed that the number of gunshot victims at King Edward VIII Hospital in Durban had increased by 873% between 1983 and 1993. The researchers noted that gunshot injuries were often more severe than other forms of injury and often resulted in multiple injuries. Furthermore, studies showed that males are more at risk of firearm injuries than females. This is similar to the results of the present research study in terms of the higher number of males in the sample than females.

Interestingly, provisional data collected in a study to look at the type of weapon most commonly used in violent incidents in Durban, indicated that firearms caused the majority of violence-related fatalities, compared with lower percentages in Johannesburg and Cape Town (Butchart and Peden, 1997).

1.12   Number of years as a disabled person at time of interview

Table 8. Number of years as a disabled person at time of interview

Year number	Males	Females	Totals
Less than 5 years	5	2	7
5 – 10 years	7	1	8
11 –20 years	4	-	4
Twenty years +	1	-	1
Total	17	3	20

Five respondents had become disabled more than 11 years previously. This could have presented a limitation in terms of the reliability of respondents' answers to certain questions, as noted in the previous chapter. If respondents had become disabled some years previously, they may have forgotten the details of their experiences at the time of the incidents. As the majority of respondents were disabled at a young age, they have spent a large part of their young and middle adulthood as disabled persons.

2. <u>Details about the disabling event</u>

2.1 Number of respondents knowing their perpetrator

Five of the 20 respondents in the present study knew their perpetrators. Previous studies in Cape Town and Johannesburg showed that a large proportion of victims of violent crime knew their offenders by sight or by name, with a higher proportion of victims in Cape Town knowing their perpetrators than in Johannesburg (Camerer, Louw, Shaw, Artz and Scharf, 1998; Louw, Shaw, Camerer and Robertshaw, 1998).

2.2 Involvement of police

The researcher asked about the involvement of the police in the criminal incidents. By this, she meant the involvement of the police in terms of attending the crime scene, taking a statement or following up with an investigation. In 16 of the 20 cases, the police were involved. In eight of these cases, a statement was taken from the victim but no arrests were made. In four cases, the police arrested the alleged perpetrator. In three of the cases, the police arrived at the scene of the crime and assisted with calling an ambulance and taking statements, but no arrests were made. In one of the cases, the police were themselves perpetrators in accidentally shooting the respondent. It is of concern that the alleged perpetrators were only arrested in four instances. No information was gathered in this research as to whether the alleged perpetrators were convicted for the crimes or not. It is thus not clear whether any of the alleged perpetrators in these four incidents were convicted. This appears to support the general opinion of the South African public that not enough is being done to apprehend and punish offenders. It is also significant in this research study, since few of the respondents who became disabled through crime felt that justice had been done in apprehending those who had been responsible.

2.3 Source of initial support

All but two respondents said that they received their initial support following the incident from their family and friends. This is supported by the results of previous studies as detailed in the literature review (Green, 1997; Denkers, 1999). The other two respondents said that they had received most of their initial support from hospital staff. The kind of support that family and friends were reported to have given included financial, practical and emotional support. The two respondents who felt they did not have the initial support of family and friends appeared to have had difficulty in accepting their disability and life circumstances, and were fairly depressed at the time of the interview. The absence of initial support of family and friends might well have affected how these two respondents adapted to their disability.

2.4 Details of hospitalisation

All the respondents were hospitalised following the incident that caused their disability. Seventeen respondents were hospitalised initially at provincial public hospitals and three at private hospitals. Eleven respondents were then transferred to a convalescent hospital. The shortest total stay in hospital was a period of a week and the longest total stay in hospital was three and a half years. Two respondents explained that they had spent a substantial time in hospital because there had been difficulties in finding suitable and safe accommodation after their discharge. The average length of stay in hospital for respondents was just over six months. This result was obtained after having excluded the shortest and longest hospital stays. The longest stay was substantially longer than other hospitalisation periods of respondents, and it was felt that inclusion of this number would skew the results. Many respondents spent substantial amounts of time away from their homes and their communities following the disabling incident.

While in hospital, all but one of the respondents received physiotherapy services. He was only in hospital for a week and was told of outpatient physiotherapy services.

Thirteen of the respondents received occupational therapy in combination with physiotherapy services. One of the respondents had one session with a psychiatrist, and four of the respondents were referred to a social worker for a varied number of sessions. One of these three respondents, who had suffered considerable trauma, was also referred to a psychologist while in hospital. Further information regarding the counselling services received by respondents is discussed at a later stage in the chapter.

2.5 Sharing of information about the disability with respondents

The researcher was interested to establish how the respondents had been given details of their disability after the incidents had taken place in terms of what had happened to their bodies, how they had been affected and what they could expect in the future. Six were initially not given any information regarding their disability at the hospital. One of these read his own chart, and another overheard doctors and hospital staff talking about his condition among themselves. Of the respondents who were informed, doctors were the informants in twelve cases, physiotherapists were involved in imparting information in the case of two respondents, and one respondent had been given information from a nurse on asking for it. One respondent complained that the information given by a doctor was too "high tech" for him to understand. One respondent felt that he had been treated insensitively when all he was told was that "you know you can't walk again".

Two respondents felt that they had been given incorrect information. One was told that he would be able to walk in five to six years time following the incident, but this had not happened. A doctor told another respondent that he would be "O.K". As a result, this respondent had never thought that he wouldn't be able to "get up and walk out of the hospital".

The way in which respondents were given information about their disabilities and prognoses was significant. The level of information, empathy and understanding that

respondents received at this initial phase could have been very important to aid their understanding of, and feelings about their traumatic experiences. It is therefore significant that six of the respondents (30%) did not receive any information from professionals at the hospital, and of those who were given some information, it appears that not all were treated with empathy and understanding, or given the correct information.

2.6 Information given about services on discharge

Eight of the 20 respondents were not given any information regarding available community services at the time of hospital discharge. Five respondents were told of the outpatient physiotherapy facilities at the hospitals from which they were discharged. However, most of these respondents lived far from the hospitals where they had been admitted, rendering outpatient facilities practically inaccessible. Two of the respondents were discharged to institutional care facilities. Six respondents were given information about local service providers and clinics in the areas where they lived. Eight respondents were not given any information about community-based services. Ongoing rehabilitation for persons with disabilities is necessary to aid in their progress physically, as well as emotionally and socially since many disabled people suffer from a feeling of isolation within their communities because of problems with mobility. As mentioned in the literature, community-based rehabilitation is a means to address the problems in South Africa of disabled persons living in areas away from the larger centres where most traditional service provision is based (Green, 2001; Department of Health, 1999).

2.7 Respondents' perceptions of their treatment in hospital

Question 30 in the interview schedule (See appendices 1 and 2) attempted to establish whether respondents felt they had been treated any differently in hospital, having become disabled through crimes of violence as opposed to if their disability had been caused through a non-violent incident such as a motor vehicle accident.

Two of the respondents felt that they had been treated badly by hospital staff and that the staff had initially assumed that they were responsible for the incident. This may suggest an element of prejudice against victims of violence.

3. Physical needs

3.1 Influence of disability on physical activities of respondents

In response to questions 34 and 35, respondents interpreted *physical activities* to mean sporting activities. All the respondents, apart from one, were actively involved in various sports prior to the incidents that caused their disabilities. One respondent said that he had not been particularly active prior to the disabling incident apart from enjoying a pastime of fishing, which he continued to do. Of the other 19 respondents, only five respondents had become involved in physical activities since the incident that caused their disability, such as wheelchair basketball, table tennis, volleyball and a home exercise routine. Involvement in physical activities and sports benefits one's health as well as the development of a positive self-esteem. A large number of respondents was not experiencing these positive benefits. This could have added to the sense of loss that respondents may have felt since they had all engaged in physical activities prior to becoming disabled.

Of those respondents who were not actively involved in physical activities or sports, the majority felt unable to take part in physical sports. This may have indicated a low motivation to become involved in sports, or a lack of confidence in their own abilities. It might also have been due to their lack of information about what is available in terms of sporting facilities and resources for disabled persons in their communities.

3.2 Use of assistive devices

All of the respondents, apart from one, relied on assistive devices to aid them in their mobility. Thirteen of the 20 respondents relied completely on the use of

wheelchairs. Six respondents were able to use crutches or callipers occasionally, as well as wheelchairs at certain times. Only one respondent did not require a wheelchair and was able to walk with the aid of a calliper or walking stick.

One of the limitations of the study was that there was not a specific question exploring respondents' use of urinary catheters. Adjusting to one's changed body functions is one of the crucial adaptations for disabled persons. Some respondents shared the fact that they were reliant on the use of catheters. For some, this had been a source of embarrassment and frustration. One respondent expressed that one of the greatest challenges for him had been to dispense with a catheter and to use the toilet "like a normal person". As a practising Moslem, he explained that it was particularly important in his religion to be clean so that one could be given a good burial when one died.

This highlights the reliance of disabled persons on assistive devices that may create feelings of dependence and also add to the financial burden that people with disabilities face.

3.3   Caregiver information

Five respondents were fairly dependent on caregivers for their tasks of daily living. For three of these respondents, their wives were the main caregivers; a fourth respondent employed a private fulltime caregiver; and the fifth respondent stated that her sister was her main caregiver. For these respondents, assistance was required for tasks such as bathing, cleaning, cooking, and, in three instances, dressing. A sixth respondent required fulltime care for the first two years following the incident. His wife had had to give up her job to care for him. At the time of the interview, he was self-sufficient in terms of his daily care tasks.

Four respondents lived in institutions. While they were able to be self-sufficient in terms of tasks such as dressing and bathing themselves, they had their meals cooked for them and were able to receive care should they require it.

Seven respondents were able to complete most tasks of daily living on their own, but these respondents were all living with family members who assisted them with tasks such as cooking and being mobile. In one case, a respondent lived with his elderly father and two young children, and in this situation the father also assisted with caring for the children. Two respondents explained that they were able to care for themselves in terms of their tasks of daily living, but they both lived with family members. Only one respondent lived alone and was therefore able to care for himself completely independently.

Many people living with disabilities rely on the assistance of others and are not often able to live independently. This may affect a disabled person's confidence in his or her own abilities and sense of self-worth.

4. <u>Psychological needs</u>

4.1 Perceptions of respondents of changes in their personalities

Twelve respondents did not feel that they had intrinsically changed as people since they had become disabled. Of those respondents who felt they had changed, two said they were "sadder" people now, one of whom expressed feeling ashamed of his situation and inability to be independent. One person said that he had difficulty in controlling his temper since the disabling incident, and that he felt it was linked to his feelings of frustration regarding his disability. Two respondents said that they felt they were "better people" since becoming disabled. This seemed to be a reaction to the feeling they had been given a "second chance" at life. One respondent said he believed he was meant to become disabled because of the "bad" things he had

been involved in before the incident. He felt that becoming disabled had been the start of a "long process towards becoming a better person".

There was not a specific question addressing the effect that respondents felt the disability had had on their relationships and friendships with other people in their lives, but some respondents raised this aspect within the context of the interview. Seven respondents spoke of their loss of friends following the disabling incident. Respondents expressed feeling that their friends felt the respondents no longer had "anything to offer" them and that they were a "burden". One respondent felt that his friends were uncomfortable with him in a wheelchair. Two respondents felt that their lack of mobility had affected their independence and therefore their ability to socialise and see friends. Five of the respondents shared some of the difficulties that becoming disabled had placed on their relationships with their partners or other family members as family members struggled to come to terms with the respondents' disability and ensuing dependence on care. One respondent spoke of the confusion and fear his young daughter of three years had felt when her father became disabled. One respondent shared how his siblings had called him a "cripple", and that his becoming disabled appeared to "break up his family" since no one seemed able to deal with it. One respondent believed that his divorce from his wife was as a consequence of his becoming disabled. Two respondents living in an institution expressed their sadness at no longer living with their family members and within their communities. Some respondents expressed the importance of their immediate families in providing them with ongoing support. One respondent felt that he had developed a stronger sense of relationship values since being disabled because of the appreciation he now has for the supportive people in his life.

These comments highlighted the effects of disability on relationships and significant others in the life of a disabled person, and is an area that could be further explored through research.

4.2   Feelings of respondents following disabling incident

Some of the common feelings that respondents felt immediately after the disabling incident were those of disbelief and denial, depression, anger and feelings of helplessness. One respondent expressed having felt suicidal following the realisation that he was disabled. Another said that he had felt a sense of loss in that he could no longer see his future as he had planned. Three respondents shared their feelings of racial hatred that they had towards their perpetrators, and three respondents said that they had felt overwhelming feelings of revenge towards their perpetrators for what had happened. The discussion of psychosocial reactions in adapting to chronic disability by Livneh (2001) supports the range of feelings that respondents reported.

Prior to the interviews, the researcher had hypothesised that persons who become disabled through interpersonal violence may experience differing feelings about their disability and situation from persons who become disabled through non-violent acts such as motor vehicle accidents. When asked about this in question 43 of the interview schedule, 11 respondents replied that they thought their feelings would have been different if their disabilities had not been as a result of interpersonal violence. Seven respondents said they would not have had the same feelings of hatred or revenge, and two felt that they would have felt differently because of the fact that a non-violent act may have been unintentional. One respondent, who knew his perpetrator, felt it was helpful to have been able to confront this person, and that this may not have been possible had his disability been caused through an event where a second or third party had not been involved. Another respondent felt that he might have received more financial support had he become disabled through a motor vehicle accident and been able to claim from the "Road Accident Fund".

The researcher was aware that this question was based on personal assumptions as to the feelings the respondents may have had under other circumstances, but felt that it was useful to gain some insight into what might have been unique feelings

associated with the trauma of violence by another person that resulted in permanent disability.

4.3   Respondents' experiences of counselling

Eight respondents had not received counselling at any time since the disabling incident, either regarding their disabilities, or the trauma of having been victims of interpersonal violence. Four respondents had been referred to a social worker at the hospital initially, though for one respondent this had involved only one session. One of these respondents said he had not found intervention by a social worker helpful and that the social worker had not understood how he had felt. He admitted that he had not been ready to listen at the time. For these respondents, the intervention by social workers had appeared to involve aspects of trauma counselling.

Seven respondents had received counselling services from community-based service providers. For four of these respondents, social work intervention involved assistance with practical help such as accommodation and did not cover issues related to assisting them to cope with the emotional trauma of the event. One of the respondents interviewed still has regular contact with a psychiatrist and had been prescribed anti-depressants following the disabling incident.

It was significant that eight respondents (40%) had not received any counselling services since the literature highlights the importance of dealing with the psychological effects of disability in rehabilitation (Livneh, 2001). The level of psychological support that an individual receives could affect how that person adapts to his or her disability.

5.   <u>Social needs</u>

The respondents' understanding of social activities was subjective and varied from playing in a music group, fishing with a friend, doing homework with classmates to

being involved in gang activities. Only two respondents were not involved in social activities prior to their disabling incident. It is possible that they were engaged in social activities, yet did not perceive them as such. The other 18 respondents gave examples of various social activities that they had engaged in prior to the incident, 12 of whose social activities were linked to physical sports.

At the time of the interview, seven of the respondents were not involved in any social activities, and did not receive services to meet their social needs. Of these, one said that though he does not get out of the house, some friends do visit him at home. Five respondents stated that they attended social support groups or rehabilitative facilities provided by service providers in the community. All of these respondents, apart from one, felt that these services were useful for various reasons. They provided an opportunity for meeting and interacting with other people; for the sharing of common ideas and difficulties; learning from others' experiences; and a feeling of empowerment through contributing within the group. The respondent who did not find these activities useful felt that it he would benefit from a more structured and active group.

Of the respondents receiving services to meet their social needs, one was informed of the service by the hospital he attended, four respondents were told of services by members or friends of their local communities, and two respondents were referred to these services by social workers. Eight respondents were involved in their own social activities with friends and family.

The social activities that respondents had engaged in prior to being disabled had involved their friends. The fact that seven respondents were no longer involved in social activities, corresponds to the personal experiences of many who felt they had lost friends since being disabled. Furthermore, the social activities of many respondents had been linked to their physical and sporting activities. Many disabled persons feel unable to or do not take part in any physical activities, and this affects their contact with other people, resulting in diminished social interaction.

It is significant that, of those seven respondents who were not involved in any social activities, three live in areas that have few services for disabled persons, and were further from the centre of Durban. Three of these respondents lived in homes that were not easy to access in their wheelchairs, making moving from their homes difficult. The seventh respondent was largely confined to his bed and this impacted on his ability to leave the house and have contact with other people.

6. Attitudes of others

Questions 51 and 52 of the interview schedule attempted to establish respondents' perceptions of the attitude of others towards them.

Twelve respondents said that they felt people treated them differently from able-bodied people, five respondents did not feel that they were treated differently and three respondents were not sure. Of those respondents who did feel that they are differently treated, six felt that able-bodied people feel pity for them. A common feeling of respondents was that people think that they are not capable of doing certain things and view them as "nothings". One respondent said that he thought people regarded disabled persons as "always begging". Two respondents felt that they are treated with a lack of respect and are looked down on by others, while one respondent felt that people are not sensitive to his feelings. One respondent said he had been robbed twice while in his wheelchair. He felt that this was linked to people looking down at him as a disabled person. One respondent felt that other people did not see him as a "normal person". He felt that some people did not think "he was right intellectually" and that sometimes people spoke loudly to him.

These comments highlighted the social attitudes that many people have towards disabled persons as "dependent and in need of care" (White Paper, 1997). The perceptions that respondents had of other peoples' attitudes towards them also exacerbated their feelings of isolation and discrimination. While members of society

continue to label disabled persons, their access to their basic rights and inclusion in mainstream society will be hindered.

7.   Financial circumstances

7.1   Vocation/ employment of respondents at time of disabling incident

Table 9. Vocation/ employment of respondents at time of disabling incident

Employment and vocational activities	Males		Females		Totals	
	No.	%	No.	%	No.	%
School	3	15	2	10	5	25
Tertiary study	1	5	-	-	1	5
Formal employment	6	30	-	-	6	30
Contract/ Casual employment	2	10	-	-	2	10
Self-employed	1	5	-	-	1	5
Housewife	-	-	-	-	-	-
Unemployed	3	15	1	5	4	20
Other	1	5	-	-	1	5
Totals	17	85	3	15	20	100

Table 9 indicates that 45% of respondents were employed in formal, casual or contract employment; 30% were involved in school or tertiary study; and 20% were unemployed at the time that they became disabled. The respondent recorded under "other" was a fulltime paid volunteer for a political organisation. Six respondents were at school or studying when the incident took place. Three of these respondents did not return to school, and two managed to complete their schooling. The sixth respondent was attending school at the time of the interview, having been out of school for approximately two years.

Ten respondents were not financially independent at the time they became disabled, with eight having been financially supported by family members (and in one case by

a grandmother). One respondent was financially supported by a political party and another engaged in illegal activities to obtain an income.

Two respondents had disability insurance at the time of the incident and one respondent had received workmen's compensation after the incident. The other six respondents, who were employed in some capacity at the time of their incidents, had no disability insurance cover. At the time of the interview, 16 respondents were in receipt of disability grants. Apart from the two respondents who were in receipt of disability insurance monies and thus did not receive disability grants, two were waiting for their disability grant applications to be processed. Neither of these two respondents had any other form of income. One was living in a residential facility and the other was being supported by his mother, while their disability grants were being processed.

Of the 18 other respondents, 11 had no other form of income apart from their disability grant or insurance payout. Two respondents had spouses who were employed, while the remaining five were engaged in their own income-generating activities or occasional contract work. One of these respondents attended the sheltered employment workshop of a service provider.

In summary, two respondents received an income from disability insurance and the remainder were in receipt of disability grants, apart from the two respondents who were waiting for their disability grants to be processed at the time of the interview. Since becoming disabled, only five respondents had other forms of income through their own income-generating opportunities, compared with ten who earned an income before their disability. This suggests that disability has a marked effect on people's ability to find employment and earn their own income.

7.2   Monthly income of respondents at time of interview

Table 10. Monthly income of respondents at time of interview

Income range (Rands)	Males		Females		Totals	
	No.	%	No.	%	No.	%
No personal monthly income	2	10	-	-	2	10
Below R500	-	-	-	-	-	-
R500 – R999	10	50	3	15	13	65
R1000 – R1 999	1	5	-	-	1	5
R2000 – R3 999	3	15	-	-	3	15
R4000 – R6000	1	5	-	-	1	5
Above R6000	-	-	-	-	-	-
Totals	17	85	3	15	20	100

Fifteen respondents (75%) had a monthly income of below R1000. The amount of a disability grant at the time of the completion of the interviews was R620. Seventeen of the respondents (85%) said that their financial circumstances were a lot worse since they had become disabled. One of the most common reasons given was the additional expense incurred from the purchase of various supplies and equipment that they required such as catheter bags, crutches, wheelchairs etcetera, as well as increased medical expenses. Six of these respondents appeared to be the sole breadwinners for their families, four of whom relied solely on their disability grants for an income. The White Paper (1997) recorded that approximately 30% of disabled persons in receipt of their disability grants in South Africa in 1993 were supporting their entire families with the grant, and that the maximum allowance for a disability grant was below the household subsistence level. One of the respondents in the present study mentioned that his immediate family had had to rely on the financial support of extended family members.

Interestingly, three respondents said they were financially "better off" since they had become disabled. Two of these respondents said that they had not had their own

income before they received a disability grant. One respondent said that he and his family were content and that, financially, they managed as well as they had before he was disabled.

These results emphasised the financial implications of disability, and the added financial pressure that disabled persons and their families experience.

8.   The effects of being victims of violent incidents

Three respondents said they had not been affected in any way from being victims of violent incidents. The researcher wondered whether these respondents might not have understood the question or were unable to express how they had been affected. Of those respondents who answered in the affirmative, six said they felt vulnerable and unable to protect or defend themselves because of their disability. As mentioned previously, one respondent had been robbed twice while in his wheelchair. Five respondents expressed their feelings of distrust of other people and some verbalised this through saying that they only liked to spend time with people whom they knew and felt they could trust. One respondent said that he had felt fearful in the initial stages after the incident, and four said that they still experience fear. One of these respondents expanded on his feelings of fear of fast cars because this was related to the violent incident. Three respondents said that they experienced nightmares about their incidents and two of the respondents said that they experienced racist feelings towards the racial groups of their perpetrators.

Three respondents mentioned how being victims of crime had made them feel towards the government of the country and it's responsibilities. One person was bitter towards the government because of the high crime levels in the country. A second respondent said South African society is violent, and that the laws are not strict enough on offenders and that not enough support was given to victims of crime. The third person said that he felt more attention should be given to the issue of accessibility of disabled persons in society in terms of buildings etcetera. One

respondent said that he thought people assumed that he was a criminal because he had become disabled through a crime of violence. Four respondents spoke of the feelings of sadness, anger and, in one instance, the need to take revenge that they now feel. These may be common feelings to survivors of victimisation, according to the literature (Roberts, 1990).

9.   Further information

Towards the end of the interview, he researcher provided an opportunity for each respondent to share his or her thoughts or information about aspects they wanted to raise that were not covered in the interview. Four respondents spoke of the difficulties they had in coping with being dependent on other people. Two of these respondents said that they felt they were a "burden" on others. Two respondents mentioned chronic health conditions that they had developed as a result of their disability. Six respondents felt that they had been given a "second chance" and that they no longer took things and the people in their lives "for granted". Five respondents emphasised their difficulties with getting around. This resulted in respondents feeling isolated without many opportunities to interact with other people. Five respondents spoke of feeling sad and depressed and the researcher observed that they seemed depressed and sad during their interviews.

Summary

This chapter has presented the findings of the study, relying on both qualitative and quantitative methods of analysis. Information was gathered through one to one interviews and observations by the researcher. The findings of the study have been consistent with certain findings of other studies involving victims of violence and crime and the experiences of disabled persons. Further conclusions of the findings and recommendations by the researcher will be highlighted in Chapter Five.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Introduction

Disabled persons have often been excluded from participating fully in society. Disability has historically been understood within a medical framework, implying that disabled persons are "ill" and reliant on others for care (White Paper, 1997). Furthermore, disability is exacerbated by poverty, and conversely, poverty makes disadvantaged communities vulnerable to disability (Elwan, 1999). Many of those affected have been unable to access fundamental rights, such as an individual's right to education, social equality and employment opportunities. South Africa has adopted the international vision of addressing the past inequalities of disabled persons. This involves promoting the human rights of disabled persons to facilitate their becoming fully integrated and participating members of society. This vision falls within the understanding of disability within a "social model" in which the environment is required to change to accommodate persons with disabilities (White Paper, 1997).

Another neglected group of persons has been the victims of crime and violence. Until the 1970's, criminal justice systems worldwide placed more focus on the offender than the victim (Groenhuijsen, 1998). Apart from the emotional needs that victims might require following an incident of violent crime, it is necessary to provide a victim-friendly environment for victims to access practical assistance and information about the services available to them. The South African government has also adopted the directions of many in the global community by developing a policy that prioritises the needs of the victim within society (Stavrou, 1998).

This research aimed to explore the experiences of persons who had become disabled through crimes of violence. In meeting the purpose of the study, the following took place:

- A review of literature was undertaken to gain an understanding of the issues involved. This included a review of relevant literature pertaining to disability, crime and its victims, as well as a discussion of appropriate frameworks within which to address the needs of disabled persons and victims of crime.

- The experiences of 20 persons who had become physically disabled through crimes of violence were explored in one-to-one interviews. This involved examining the needs of respondents, including the sources of their support, and the nature and accessibility of services they had received.

This chapter presents the conclusions drawn from the literature review and results of this study. Recommendations made from the study are also suggested.

Conclusions from the literature study

Little literature could be obtained that deals directly with persons who have become physically disabled as a result of crimes of violence. As a result, the researcher explored literature pertaining firstly to disability and secondly to crime and its victims.

The literature highlighted the importance of defining disability within the social model of disability, as opposed to the traditional medical model. The social model has had positive implications in drawing attention to the fundamental human rights issues of disabled persons and the way in which they are able to access resources. The recognition that it is not the disabled person, but rather the structure of the environment that is the problem, has also had a positive impact on the directions that the mode of service delivery in the field of disability is taking. For example, there is a growing interest in community-based rehabilitation as a method of service

delivery, in which disabled persons are empowered through being involved in the planning and implementation of services that are relevant, accessible and effective for them. In addition, social workers may promote the self-determination of individuals through involving disabled persons in directing service delivery and accessing resources within their environment. This results in improvement towards a society that is less disabling.

The literature review emphasised the way in which societal attitudes towards disability contribute towards negative stereotypes of disabled persons. These attitudes can be overcome through the integration of able-bodied and disabled persons within a society that affords disabled persons equal opportunities. This would result in disabled persons as positive role models.

The literature review further highlighted the link between poverty and disability. Poverty may result in disability through inadequate medical facilities and environmental infrastructure, while disability may result in poverty through a number of mechanisms, some of which will be discussed.

While statistics related to the incidence and causes of disability globally, and in South Africa in particular, appear to vary, there is agreement that injuries (including those secondary to violence) are a leading cause of disability (Krug et al, 2000; Butchart and Peden, 1997; Butchart, 2000).

A review of the literature relating to the impact of disability on disabled persons on the one hand, and the impact of crime on victims on the other, highlights similar areas of need for both groups of persons. These include the psychological impact of the experience, economic loss, the importance of support systems, the effects on family and friends, and the adaptation required by those affected. However, there is little work exploring the impact of being a victim of a crime of violence that has resulted in permanent disability.

The literature drew attention to the historical neglect of the needs of victims of crime both internationally and in South Africa, and highlighted the changing focus to delivering services to them.

Conclusions from the research study

Various conclusions emerged from the interviews with respondents who had become disabled through crimes of violence. These included the following:

- The majority of the respondents in the study were men, but what was interesting to note is that most of them were young. Most of the respondents were under the age of 40 years at the time of the interview, and 65% were under the age of 25 years when they became disabled. The age trends are supported by the literature (Butchart, 2000; Krug et al, 2000).

- The majority of the respondents were single or had never been married. This may suggest that persons who become disabled at a younger age than the "usual" age at which people marry, are less likely to get married. This may be because disabled persons have fewer opportunities for meeting other people and/ or potential life partners. It may be more difficult for disabled persons to marry because of negative societal perceptions towards them.

- The respondents experienced a high degree of interpersonal dependence. Of those respondents who were not living with their partners, all but one were living with other people, mostly family members, and four respondents were living in residential institutions. All respondents, apart from the one living alone, relied to differing extents on other persons for assistance. For some respondents this involved assistance with most tasks of daily living, while for others it involved assistance with being mobility. This is a clear example of the disabling effect of the environment on these respondents and thus their dependence on others.

- The majority of respondents had not reached their educational potential. Only five respondents had reached an educational level of matric, while one respondent was still attending school at the time of the research interview. This has implications for the financial independence and the social development of respondents.

- Fourteen respondents had children, though the research was not able to indicate clearly whether respondents had borne children since being disabled.

- The respondents lived in areas serviced by the Association for the Physically Challenged. These included predominantly urban and peri-urban areas, some of which had fewer resources and which differed in the degree of poverty that residents experienced. Those respondents who lived in those areas further from the centre of Durban had less access to services and resources, including social work and rehabilitation services. Within the social model of disability, these individuals were further disabled by their environment.

- The researcher visited 14 of the 20 respondents at their places of abode for the interview. Of these, five respondents were living in homes that were not suitable for them, given their disabilities, and all of these relied on the assistance of other persons to get in or out of their homes. This observation highlights the problems of accessibility faced by many persons with physically disabilities, and the problems of isolation that many disabled persons experience.

- Disability through crimes of violence was found to be fairly severe, for example quadriplegia and paraplegia. These respondents require access to a comprehensive range of resources.

- Although the research did not gather information pertaining to the convictions of the perpetrators, the results highlight the probable high number of violent criminal acts for which perpetrators are not apprehended. Although there had been some form of police involvement in the criminal events that caused the disabilities of 16 respondents, the alleged perpetrator was only arrested in four cases. The initiation of the National Crime Prevention Strategy in 1996 aimed to implement policies that addressed the high levels of crime, and should result in a more efficient criminal justice system with increased apprehension of offenders. These results suggest that this might not be happening.

- It appears, from this research, that the majority of emotional, practical and financial support for these victims came from their families and friends. This is corroborated by other studies (Green, 1997; Denkers, 1999). Although the study did not directly address the impact that disability had on the relationships of respondents with other people, some respondents reported that they had lost many of their friends after they had been disabled. This may further isolate disabled persons in terms of there being fewer persons to provide them with support.

- All of the respondents were hospitalised following the incidents that resulted in their disabilities. The average length of stay in hospital was just over six months. This was significant since it suggests that the disabling incidents resulted in many respondents' spending substantial amounts of time away from their homes and families, which would have resulted in a disruption in their own and their families' lives.

- Disclosure of disability to individuals appeared to be inadequate and inappropriate. All of the respondents first realised that they were disabled while in hospital. The results indicate that six respondents were not given any explanation about their disability while in hospital, and that some respondents

were told about their disability in a manner that did not convey empathy. The way in which information is shared has an impact on victims of crime as well as on persons who become disabled. These are traumatic events and empathetic understanding of the immediate reactions and needs of survivors, as well as the sharing of relevant information, is very important in providing an adequate and effective service to those affected.

- It appeared that the psychological needs of respondents were poorly addressed, while services to meet their physical needs, such as physiotherapy, especially initially, appeared to be available. All of the respondents, apart from one, received varying degrees of services while in hospital, which included physiotherapy and occupational therapy, while substantially fewer respondents received psychiatric, psychological or social work services while in hospital. Importantly, few received information related to accessing community-based services at the point of their discharge from hospital. This was significant since longer-term rehabilitation is often essential for persons with disabilities if they are to develop to their fullest individual potential.

- The results suggest that little attention is given to helping victims disabled through crimes of violence in dealing with the traumatic effects of their experiences. It was significant that eight respondents had not received any counselling services following their experiences, and of those that did receive counselling services, this only involved issues related to trauma counselling in four cases.

- The majority of respondents were physically inactive. The results indicate that from having been physically active, only five respondents engaged in sporting activities after they had become disabled. This may result in considerable lack of mobility, which in turn affects an individual's sense of independence

and feelings of positive self-esteem. It was previously mentioned that all but one respondent were dependent on caregivers for differing levels of care.

- The incident resulting in persons becoming disabled through crimes of violence has an emotional effect on the victims as well as their family and friends. The research highlighted some of the emotional reactions that respondents experienced following the disabling incidents, which was corroborated by the literature regarding the psychosocial reactions to the onset of disability and crime (Livneh, 2001; Morgan and Zedner, 1992; Schurink, 1993; Fattah, 1989). Seventeen respondents expressed how they had been affected through being victims of violent incidents; from prejudices towards other people engendered by their experiences, feelings of vulnerability, psychosomatic repercussions such as nightmares and opinions about the government and its policies relating to crime. Three respondents felt their experience of becoming disabled had had a positive outcome in that they felt they were "better people" since the incident. The research also highlighted some of the reactions experienced by respondents' families and friends to disability which confirmed that family and friends of disabled persons and victims of crime are also affected (Fattah, 1989; Katz et al, 1995).

- The results of the study indicate that many persons with physical disabilities suffer from social isolation. Financial difficulties and difficulties with accessing transport may have affected the opportunities that respondents had to be involved in social activities. Furthermore, many social links appeared to be linked to sporting activities. Thus, for persons with physical disabilities, who may feel unable to take part in sporting activities, the onset of their disability may also have negative consequences on their social interaction and relationships with others. The provision of social and recreational support services went some way towards meeting the social needs of those persons who were involved.

- The majority of respondents felt that able-bodied persons treated them differently because of their disabilities, and that some able-bodied persons held negative attitudes towards them. The impact of negative and stereotypical attitudes of society and persons towards persons with disabilities is discussed in literature, and the ways in which these attitudes can be challenged (Coleridge, 1993; Oliver, 1983; French, 1996; O'Toole and McConkey, 1995). Two respondents also felt they had been treated badly by hospital staff, and that hospital staff had wrongly assumed that they were responsible for the incidents they were involved in. This may also suggest an element of prejudice against victims of violence.

- In highlighting the young age of respondents in the study, it is significant that individuals of this age are regarded as economically active. However, the results of the study suggested that disability affected the opportunities for respondents to be engaged in their own income-generating or formal employment activities. This trend is noted in the literature (White Paper, 1997). Results also indicated that 75% of the respondents had a monthly income of below R1000, and that most of the respondents were the sole breadwinners in their families, some of whom were supporting their entire families on their disability grants. These results support references to the link between disability and poverty (Elwan, 1999; Cornell, 1995; White paper, 1997; Wilson and Ramphele, 1989). A further subjective observation of the researcher was that those respondents who had access to more financial resources were able to make certain adaptations to their disability, such as having a ramp built within the home, and employing a fulltime caregiver. This highlights the role the individual can play in making improvements to a disabling environment, if he or she has means and resources available.

Suggestions and recommendations

A number of suggestions and recommendations can be made following a review of the study and its findings.

- Since the findings of this study suggest that relationships are affected by the onset of disability, an area for further research could be an exploratory study into the impact of physical disability on relationships between disabled persons and their partners or friends.

- Although much of the discussion on community-based rehabilitation as a service delivery strategy in the field of disability is directed at health workers, it is suggested that social workers have an important role to play in the implementation of this strategy. The social work profession is ideally placed through its involvement in improving the interactions between persons and their environments to provide a service that is relevant and directed by the needs of disabled persons themselves. The social worker's role in community-based rehabilitation should be expanded and improved.

- Service providers should address means of involving disabled users of services more fully in the planning, delivery and evaluation of services, perhaps through service providers holding educational and consultation workshops. This would empower service users as well as create a foundation for a more integrated model of service delivery that is "owned" by disabled persons. Victims of violence should also be central in contributing to the development of relevant services to meet their needs, as advocated through the implementation of the Victim Empowerment Programme referred to earlier in the text.

- Further education of medical staff such as doctors and nurses would be useful in sensitising them to the issues involved for persons who are admitted

to hospital with injuries that will result in permanent disability, and in providing guidelines on how to inform their patients of their disability and to provide them with immediate relevant information. Furthermore, attention could be given to educating medical staff about the reactions that victims of violence may experience, and the psychological needs these particular patients may have in addition to their medical needs as newly disabled persons. Given a sufficient human resource capacity within the health department, persons becoming disabled through violence would benefit from multi-disciplinary intervention in which different health professionals could provide a sensitive and holistic service to such patients on their first admission to hospital.

- The Victim Empowerment Programme places emphasis on building and maintaining partnerships between the State, non-government organisations and civil society, where a co-ordinated approach to service delivery for victims of crimes of violence is envisaged (Prozesky and Kotze, 1998). Service providers in the disability field could be included within the organisations that are involved in the programme because of their contact with persons disabled through crimes of violence. In forming partnerships with other organisations involved in the field of crime prevention, organisations in the disability sector could be valuable in contributing to a co-ordinated delivery of services where the needs of the victim are central.

- Training courses could be offered to caregivers of disabled victims in order to build their capacity and to offer them support and guidance in their roles as carers. This could result in ensuring a more efficient service to disabled persons in their home environments and communities. Such training could involve elements related to victim support, utilising the expertise of such organisations as the National Institute for Crime Prevention and the Rehabilitation of Offenders (NICRO), for example.

Conclusion

This final chapter identified the main findings of the study, discussed their implications, and recommendations were made in light of these findings.

Through seeking information from disabled persons and victims of crime themselves, an understanding and sensitisation of their needs may be acquired. This study offers insights into the perceptions and realities of persons who had become disabled through violence. It is hoped that these findings will sensitise social workers and others working in the field of disability and in victim support programmes to the needs of those affected. Furthermore, it is hoped that the findings should inform social workers on how best to address the challenges faced by those affected. It is envisaged that this study could be a starting point for further exploration of the link between crimes of violence and resultant disability, and in the development of appropriate and co-ordinated services to meet the needs of those persons who become disabled in this way.

REFERENCES

Bickenbach, J.E., Chatterji, S., Badley, E.M. and Üstün, T.B. (1999). Models of disablement, universalism and the international classification of impairments, disabilities and handicaps. Social Science and Medicine, 48, 1173-1187.

Bless, C. and Higson-Smith, C. (2000). Fundamentals of social research methods. An African perspective (Third edition). South Africa: Creda Communications.

Brandsma, J.W., Lakerveld-Heyl, K., Van Ravensberg, C.D. and Heerkens, Y.F. (1995). Reflection on the definition of impairment and disability as defined by the World Health Organization. Disability and Rehabilitation, 17(3/4), 119-127.

Burrows, S. (2000). Fatal Injury surveillance in South Africa. Monograph Series. Violence and the Cost of Injury, 1(4), 58-78.

Burrows, S., Butchart, A. and Peden, M. (2000). The extent of firearm deaths and injuries in South Africa. In Chetty, R. (Ed.) The firearm factbook. Pretoria: Directorate of Safety and Security.

Butchart, A. (2000). On the costs and Costing of Violence and Injuries due to Violence. Monograph Series, 1(4), 130-163.

Butchart, A. and Peden, M. (1997). Injury and Trauma. In Barron, P. (Ed). South African Health Review. Durban: Health Systems Trust.

Camerer, L., Louw, A., Shaw, M., Artz, L and Scharf, W. (1998). Crime in Cape Town. Results of a victim survey. ISS Monograph Series, No.23. South Africa: Institute for Security Studies.

Census National Results. (1996). http://www.statssa.gov.za.

Coleridge, P. (1993). Disability, liberation and development. London: Oxfam.

Cornell, J. (1995). Poverty and disability: a position paper. Swedish International Development Authority.

Crisp, R. (2000). A qualitative study of the perceptions of individuals with disabilities concerning health and rehabilitation professionals. Disability and Society, 15(2), 355-367.

Denkers, A. (1999). Factors Affecting Support After Criminal Victimization: Needed and Received Support From the Partner, the Social Network, and Distant Support Providers. Journal of Social Psychology, 139(2), 191-202.

Denscombe, M. (1998). The good research guide. Buckingham: Oxford University Press.

Department of Health. (1998). Policy guidelines on the Prevention of Conditions leading to disability. Draft 5.

Department of Health. (1999) Rehabilitation for all! National Rehabilitation policy. Final draft.

Durban Urban Strategy Unit. (2002). http://www.commprofile.urbstrat.org.za

Elwan, A. (1999). Poverty and disability. A survey of the literature. Study done by the World Bank.

Fattah, E.A. (Ed). (1989). The Plight of Crime Victims in Modern Society. United Kingdom: The Macmillan Press Ltd.

Finkelstein, V. and Stuart, O. (1996). Developing new services. In Hales, G. (Ed). Beyond disability. Towards an enabling society. London: Sage Publications Ltd.

French, S. (1996). The attitudes of health professionals towards disabled people. In Hales, G. (Ed). Beyond disability. Towards an enabling society. London: Sage Publications Ltd.

Frieg, A. and Hendry, J.A. (2001). Perceived needs of disability grant recipients in a semi-rural South African area. Social Work/ Maatskaplike Werk, 37(4), 357-364.

Green, S. (1997). Assessment of psycho-social needs of clients with physical disabilities. Social Work./ Maatskaplike Werk, 33(4), 343-359.

Groenhuijsen, M. (1998). Objectives of victim assistance: the professionalzation of service providing organisations. A comparison between European experiences and recent developments in South Africa. Social Work Practice, 1(4), 15-24.

Hepworth, D.H. and Larsen, J.A. (1986). Direct social work practice. Theory and skills. United States of America: The Dorsey Press.

Hoffman,W. (1987). An ecological perspective in social service provision to persons with physical disabilities. Social Work/ Maatskaplike Werk, 23(4), 230-237.

Holtmann, B. (1998). Victim Empowerment. Social Work Practice, 1(4), 8-14.

Katz, B., Harilaou, M., Masoga, B., Phiri, V. and Barrett, A. (1995). Disability and the Family: Community Based Intervention. Social Work Practice, 1(4), 15-23.

Keen, A.W. and Shembe, A.Z. (1994). Improving the self-esteem of a patient who has been disabled in the workplace: Can social work be effective? Social Work Practice, 1(3), 6-8.

Krug, E.G., Sharma, G.K. and Lozano, R. (2000). The Global Burden of Injuries. American Journal of Public Health, 90(4), 523-527.

Kvale, S. (1996). Interviews: an introduction to qualitative research interviewing. Thousand Oaks: Sage Publications Inc.

Laub, J.H. (1997). Patterns of Criminal Victimization in the United States. In Davies, R.C., Lurigio, A.J. and Skogan, W.G. (Eds). Victims of Crime (Second edition). U.S.A: Sage Publications.

Lindsey, E. and McGuinness, L. (1998). Significant elements of community involvement in participatory action research: evidence from a community project. Journal of Advanced Nursing, 28(5), 1106-1114.

Livneh, H. (2001). Psychosocial Adaptation to Chronic Illness and Disability: A Conceptual Framework. Rehabilitation Counseling Bulletin, 44(3), 151-161.

Louw, A., Shaw, M., Camerer, L. and Robertshaw, R. (1998). Crime in Johannesburg. Results of a city victim survey. ISS Monograph Series, No.18. South Africa: Institute for Security Studies.

Mackelprang, R.W., and Salsgiver, R.O. (1996). People with disabilities and social work: Historical and contemporary issues. Social Work, 41(1), 7-15.

Marlow, C. (1998). Research methods for generalist social work. (second edition). United States of America: Brooks/ Cole Publishing Company.

McLaren, P. and Philpott, S. (1999). HST update. Issue no.41. Durban: Health Systems Trust.

Miles, S. (1996). Engaging with the disability rights movement: the experience of community-based rehabilitation in Southern Africa. Disability and Society, 11(4), 501– 517.

Morgan, J. and Zedner, L. (1992). Child victims. Crime, impact and criminal justice. Oxford: Clarendon Press.

Nel, P., Liebermann, S., Landman, K., Louw, A. and Robertshaw, R. (2000). Making South Africa safe. A manual for community crime prevention. Pretoria: CSIR.

Oliver, M. (1983). Social work with disabled people. London: The Macmillan Press Ltd.

Oliver, M. (1990). The politics of disablement. A sociological approach. New York: St. Martin's Press.

O'Toole, B. and McConkey, R. (1995). Innovations in developing countries for people with disabilities. Lancarshire: Lisieux Hall Publications.

Padgett, D.K. (1998). Qualitative methods in Social Work Research. Challenges and Rewards. Thousand Oaks: Sage Publications.

Peden, M. and Butchart, A. (1999). Trauma and Injury. In Crisp, R. (Ed). South African Health Review. Durban: Health Systems Trust.

Petersen, I., Magwaza, A.S. and Pillay, Y.G. (1996). The Use of Participatory Research to facilitate a Psychological Rehabilitation Programme for Child Survivors of Violence in a South African Community. Social Work, 32(1), 67-74.

Philpott, S. and McLaren, P. (1997). Disability. In Barron, P. (Ed). South African Health Review. Durban: Health Systems Trust.

Pinder, R. (1995). Bringing back the body without the blame?: the experience of ill and disabled people at work. Sociology of Health & Illness, 17(5), 605-631.

Prozesky, J. and Kotze, S. (1998). Crime Prevention through Development and Restorative Justice. Social Work Practice, 1(4), 4-7.

Roberts, A.R. (1990). Crisis Intervention handbook. Assessment, treatment and research. United States of America: Wadsworth Publishing Company.

Rule, S. (1999). Community-based rehabilitation. HST Update. Issue no.41. Durban: Health Systems Trust.

Schurink, E. (1993). Victimline. The development and evaluation of a support service for crime victims. Pretoria: Human Sciences Research Council.

Simon-Meyer, J. (1999). Causes of disability. HST Update. Issue no.41. Durban: Health Systems Trust

Snyman, H.F. (1998). Victim Empowerment in South Africa. Social Work Practice, 1(4), 43-46.

Snyman, R. (1992) Victim support schemes and a proposed model for rendering services to victims of crime in South Africa. In Schurink, W.J., Snyman, I., Krugel, W.F., and Slabbert, L. (Eds). Victimization: Nature and Trends. Pretoria: HSRC Publishers.

Stavrou, P. (1998). The South African Government's Victim Empowerment Programme. Social Work Practice, 1(4), 25-30.

Stavrou, P. (1998). Caring for Survivors of Violence. A Community Mental Health Care Model: The South Coast Hospice Trauma Counselling Network. Social Work Practice, 1(4), 31-42.

Tower, K. (1994). Consumer-centred social work practice: Restoring client self-determination. Social Work, 39(2), 191-197.

Üstün, T.B., Saxena, S., Rehm, J. and Bickenbach, J. (1999). Are disability weights universal? The Lancet, 354(9186), 1306.

Van Niekerk, A., Bulbulia, S. and Seedat, M. (2000). An Epidemiological Investigation of Injury in a Western Cape Neighbourhood Study. In Suffla, S., Stevens, G. and van der Walt, C. (Eds). Monograph Series. Violence and the Cost of Injury, 1(4), 79-129.

Vithal, R. and Jansen, J. (1997). Designing your first research proposal. Kenwyn: Juta & Co. Ltd.

White Paper on an Integrated National Disability Strategy. (1997). Western Cape: Rustica Press.

Wilson, F. and Ramphele, M. (1989). Uprooting poverty. The South African challenge. Cape Town: David Philip.

Withers, S. (1996). The experience of counselling. In Hales, G. (Ed). Beyond disability. Towards an enabling society. London: Sage Publications Ltd.

World Health Organisation. (1996). Violence: A public health priority. Report of WHO global consultation on violence and health. Geneva: WHO.

APPENDIX 1
INTERVIEW SCHEDULE
ENGLISH VERSION

INTERVIEW SCHEDULE

Date of interview_____

Name of respondent (to remain confidential)   _____

Medical diagnosis (from case files) _____

A. PERSONAL DETAILS OF RESPONDENT

1. Sex   1. Male _____ 2. Female _____

2. Age   _____

3. Home language

1. Zulu

2. English

3. Afrikaans

4. Other. Specify

4. Race (to note, not to ask)

1. African

2. White

3. Coloured

4. Asian

5. Other. Specify

5. Marital status

1. Single

2. Married by Western custom

3. Married by traditional custom

4. Divorced

5. Widowed

6. Separated

7. Cohabiting

6. What standard of education have you obtained?

1. No formal education
2. Primary School: grade 1 to 7
3. Grade 8 to 11
4. Matric: grade 12
5. Certificate
6. Diploma
7. Degree
8. Postgraduate
Specify.

7. Do you have any children?   Yes ☐   No ☐

8. If yes to question 7, how many children do you have?

Sons _____ Daughters _____

9. Where do you live? (Probe)

10. Whose home do you live in?

11. How many people live in this dwelling?

12. Could you explain your disability to me?

B. DETAILS ABOUT THE DISABLING EVENT

13. How did you become disabled?
    Please could you describe this incident to me?
    Did you know your perpetrator?

14. When did this happen? (Attempt to get exact date)

15. How old were you at the time?

16. Were you living with anybody at that time?   Yes ☐   No ☐

17. If yes to question 16, please elaborate.

18. Can you tell me what happened to you immediately after the incident? (Probe)

19. Were the police involved when the incident took place?

Yes ☐   No ☐

20. If so, in how were they involved?

21. Where did you receive your initial support from following the incident that left you disabled?
    1. Family
    2. Friends
    3. Community organisation (eg, church, social activity group etc)
    4. Professional assistance (eg.social work, psychologist etc.)
    5. Other. Specify.

    Please elaborate on what kind of support this involved?

22. Were you hospitalised because of the incident?   Yes ☐   No ☐

23. If yes to question 22, which hospital did you go to?
    (If no, proceed to question 31).

24. If yes to question 22, for how long were you in hospital?

25. If yes to question 22, what kind of help or services did you receive at the hospital? (Probe)

26. Were you given any information about your disability at the hospital?

Yes ☐   No ☐

27. If yes to question 26, what information were you given?

28. If yes to question 26, who gave you this information?

29. If you were admitted to hospital, were you given any information at the hospital about where to go for help when you were discharged? Please elaborate.

30. Do you think the hospital staff would have treated you any differently if your disability had been caused by a non-violent act?

31. If you did not go to hospital, did you know where to receive assistance after the incident?

Yes ☐ No ☐

32. If yes to question 31, what services and/ or organisations were you told about?

33. If yes, who told you about these services?

C. PHYSICAL NEEDS

34. What kinds of activities or sports did you take part in before you became disabled?

35. How has the incident affected you in terms of your physical activities? Please elaborate.

36. Since the incident, have you needed any devices to assist you physically?

Yes ☐ No ☐

Please explain.

37. Since the incident, do you need someone to care for you? Yes ☐ No ☐

38. If yes to question 37, who is your caregiver?

39. If yes to question 37, how does your caregiver assist you?

D. PSYCHOLOGICAL NEEDS

40. Prior to the incident, how do you think your friends would have described you as a person?

41. How do you think they describe you now?

42. What were your feelings immediately after the incident? Please elaborate.

43. Do you think your feelings would have been different if your disability had not been caused through a violent act?

    Yes ☐   No ☐

44. If yes to question 43, please explain in your own words.

45. Did you receive any counselling services following the incident?

    Yes ☐   No ☐

46. If yes to question 45, from where or from whom did you receive these services?

47. If yes to question 45, who told you about these services?

48. If yes to question 45, please tell me about this counselling in your own words? (Probe)

E. SOCIAL NEEDS

49. Prior to the incident, what kinds of social activities were you involved in?

50. At the present time, what social activities are you involved in?

51. Do you find that people treat you differently as a disabled person from able-bodied people?

Yes ☐   No ☐   Not sure ☐

52. If yes to question 51, how do you feel that people treat you?

53. Do you receive any services that meet your social needs?   Yes ☐   No ☐

(Prompt if necessary)

54. If yes to question 53, from whom or from what organisation do you receive these services?

55. If yes to question 53, how did you hear about these services?

56. If yes to question 53, do you find these services useful? Please explain in your own words.

F. FINANCIAL CIRCUMSTANCES

57. What were you doing in your life at the time that you became disabled?
    1. School
    2. Study
    3. Formal employment
    4. Contract/ Casual employment
    5. Self-employed
    6. Housewife
    7. Unemployed
    8. Other.
    Please elaborate on the above.

58. If you were working at the time, what kind of work were you doing?

59. If you were working at the time, did you have disability insurance?

Yes ☐   No ☐

60. If you were not employed, how were you being financially supported?

61. Do you receive a disability grant? Yes ☐   No ☐

62. Do you have any other form of income? Yes ☐   No ☐

63. If yes to question 62, what is the source of this income?

64. Could you please tell me what your gross monthly income is?

1. No monthly income
2. Below R500
3. R500 – R999
4. R1 000 – R1 999
5. R2 000 – R3 999
6. R4 000 – R6 000
7. R6 000 – R11 999
8. R12 000 and above

65. Please describe your financial circumstances now compared to the time before you became disabled?

66. Are there any other comments or information you feel you would like to give me about your experiences of being disabled and how this happened to you?

67. How do you think being involved in a violent incident has affected you?

APPENDIX 2

UHLELO LWEMIBUZO

ISIZULU VERSION

UHLELO LWEMIBUZO

Usuku lwemibuzo _____

Igama lomphenduli wemibuzo (alizikudalulwa) _____

Imiphumela yokuhlolwa udokotela (ethathelwa emabhukwini) _____

A. IMININGWANE NGOMPHENDULI WEMIBUZO

1. Ubulili   1. Owesilisa _____   2. Owesifazane _____

2. Iminyaka   _____

3. Ulimi olukhuma ekhaya

    1. IsiZulu
    2. IsiNgisi
    3. IsiBhunu
    4. Ezinye. Cacisa

4. Uhlanga
    (qaphela, loku ungakubuzi)

    1. Umuntu omnyama
    2. Umlungu
    3. Ikhaladi
    4. OwaseNdiya
    5. Ezinye. Cacisa

5. Isimo mayelana nokugana

    1. Awuganile
    2. Ushade ngokwesiko laseNtshonalanga
    3. Ushade ngokwesiko lesintu
    4. Sewashada naphinde nehlukana ngokomthetho
    5. Washonelwa wumyeni/yinkosikazi
    6. Sewashada nehlukana, hhayi ngokomthetho
    7. Umasihlalisane

6. Ufunde wagcina kuphi?

1. Awuzange ufunde nhlobo

2. Emabangeni aphansi: wagcina ebangeni lesihlanu

3. Wagcina phakathi kwebanga lesithupha nebanga lesishiyagalolunye

4. Unomatikuletsheni: ibanga leshumi

5. Unesitifiketi

6. I-diploma

7. Uneziqu

8. Uneziqu ezingaphezulu kwesisodwa

Cacisa.

7. Unazo yini izingane?   Yebo ☐   Cha ☐

8. Uma uthe yebo kulombuzo ongenhla, unezingane ezingaki?
   Amadodana _____ Amadodakazi _____

9. Uhlala kuphi? (Uthi ukubuzisisa kahle)

10. Umuzi kabani ohlala kuwo?

11. Bangaki abantu abahlala kulendlu ohlala kuyo?

12. Ungakwazi ukungichazela ngokukhubazeka kwakho?

B. IMININGWANE NGESEHLAKALO SOKUKHUBAZEKA

13. Kwenzeka kanjani ukuthi uze ukhubazeke?
    Ngicela ungichazele lesisigameko sokukhubazeka kwakho.
    Uyamazi umuntu owenza lesisenzo?

14. Isehlakalo senzeka nini? (Zama ukuthola usuku oluqondile)

15. Wawuneminyaka emingaki ngalesosikhathi?

16. Ukhona umuntu owawuhlala naye ngalesosikhathi? Yebo ☐ Cha ☐

17. Uma uthe yebo kulombuzo ongenhla ku-16, ngicela uke uchaze kabanzi.

18. Awungichazele ukuthi yini eyenzeka kuwena sisanda kwenzeka lesisehlakalo? (Zama ukubuzisisa kahle)

19. Ngabe kukhona okwenziwa amaphoyisa emva kwalesisehlakalo?

Yebo ☐ Cha ☐

20. Uma uthe yebo ngenhla, yini eyenziwa ngamaphoyisa?

21. Waya kuphi ukuze uthole ukusizo lokuqala emveni kwesehlakalo esakwenza ukuba ukhubazeke?
    1. Emndenini
    2. Kubangani
    3. Inhlangano yomphakathi (izibonelo: ebandleni, iqembu elithize, nokunye)
    4. Usizo lochwepheshe (izibonelo: njengosonhlalakahle, udokotela wengqondo, nokunye)
    5. Okunye. Cacisa.

    Ngicela uchaze kabanzi ukuthi wathola luhloboluni losizo?

22. Walaliswa esibhedlela emva kwesehlakalo Yebo ☐ Cha ☐

23. Uma uthe yebo kulombuzo ongenhla ku-22, waya kusiphi isibhedlela? (Uma uthe cha, qhubekela kumbuzo okunombolo 31).

24. Uma uthe yebo kumbuzo ongunombolo 22, wahlala isikhathi esingakanani esibhedlela?

25. Uma uthe yebo kumbuzo ongunombolo 22, wathola nhloboni yosizo esibhedlela? (Buzisisa)

26. Lukhona ulwazi owalunikezwa esibhedlela ngokukhubazeka kwakho?

Yebo ☐ Cha ☐

27. Uma uthe yebo kumbuzo ongunombolo 26, wanikezwa luphi ulwazi?

28. Uma uthe yebo kumbuzo ongunombolo 26, ubani owakunikeza lolulwazi?

29. Uma wangeniswa esibhedlela, lukhona yini ulwazi owalunikezwa mayelana nezindawo zosizo ongaya kuzo lapho usuphumile esibhedlela? Ngicela uchaze kabanzi.

30. Ngokucabanga kwakho, ngabe abasebenzi basesibhedlela bakuphatha ngendlela ehlukile ukuba ukukhubazeka kwakho kwakungadalekanga ngendlela enendluzula phakathi?

31. Uma wawungazange uye esibhedlela, wawazi lapho owawungathola khona usizo emva kwalesisehlakalo?   Yebo ☐   Cha ☐

32. Uma uthe yebo kumbuzo ongunombolo 31, yiziphi izinhlangano zosizo noma uhlobo losizo owawutshelwe ngalo?

33. Uma uthe yebo kumbuzo ongunombolo 31, ngubani owakutshela ngalolusizo?

C. IZIDINGO NGOKOMZIMBA

34. Yimiphi imidlalo owawuyidlala ngaphambi kokuba ukhubazeke?

35. Lesisigameko sikuthikameze kanjani ekwenzeni izinto ezisebenzisa umzimba? Ngicela uchaze.

36. Seloku kwenzeka lesisehlakalo, zikhona yini izinsiza osuke wazidinga ukulekelela umzimba wakho?   Yebo ☐   Cha ☐

Ngicela uchaze.

37. Seloku kwenzeka lesisehlakalo, uyamdinga yini umuntu ozokunakekela?

Yebo ☐   Cha ☐

38. Uma uthe yebo kumbuzo ongunombolo 37, ngubani umnakekeli wakho?

39. Uma uthe yebo kumbuzo ongunombolo 37, ukusiza kanjani umnakekeli wakho?

D. IZIDINGO NGOKWENGQONDO

40. Ngaphambi kwalesehlakalo, ngokucabanga kwakho abangani bakho babengakuchaza kanjani njengomuntu abamaziyo?

41. Njengamanje ucabanga ukuthi bakuchaza kanjani?

42. Wazizwa uphatheke kanjani kusanda kwenzeka lesisehlakalo? Ngicela uchaze.

43. Uma ucabanga, ngabe imizwa yakho yaba ngehlukile kunalokhu ukuba ukukhubazeka kwakho akudalekanga ngenxa yokuhlukunyezwa?

Yebo ☐   Cha ☐

44. Uma uthe yebo kumbuzo ongunombolo 43, ngicela uchaze ngamazwi akho.

45. Kukhona ukunakekelwa ngosizo lwezengqondo owaluthola emva kwalesisehlakalo?   Yebo ☐   Cha ☐

46. Uma uthe yebo kumbuzo ongunombolo 45, waluthola kuphi futhi kubani lolusizo na?

47. Uma uthe yebo kumbuzo ongunombolo 45, ngubani owukutshela ngalolusizo?

48. Uma uthe yebo kumbuzo ongunombolo 45, ngicela ungichazele ngosizo owaluthola usebenzisa amazwi akho? (Buzisisa)

E. IZIDINGO ZOKUHLANGANYELA NABANYE ABANTU

49. Ngaphambi kwalesehlakalo, yiziphi izinto owawuzenza ukuze uthole ithuba lokuhlanganyela nabanye?

50. Njengamanje, yiziphi izinto ozenzayo ezikwenza uhlanganyele nabanye?

51. Kuyenzeka yini ukuthi uthole abantu bekuphatha ngendlela ehlukile ngoba ungumuntu okhubazekile kunabantu abangakhubazekile ngokomzimba?

Yebo ☐   Cha ☐   Anginaso isiqiniseko ☐

52. Uma uthe yebo kumbuzo ongunombolo 51, ngokubona kwakho abantu bakuphatha kanjani?

53. Ngabe uyaluthola usizo oluhlangabezana nezidingo zakho zokuhlanganyela nabanye abantu?   Yebo ☐   Cha ☐

(Uma kufanele, yigubhe impendulo)

54. Uma uthe yebo kumbuzo ongunombolo 53, uluthola kubani noma kuziphi izinhlangano lolusizo?

55. Uma uthe yebo kumbuzo ongunombolo 53, wezwa kanjani ngalolusizo?

56. Uma uthe yebo kumbuzo ongunombolo 53, uyasizakala yini ngalolusizo? Ngicela uchaze ngamazwi akho.

F. ISIMO SEZEZIMALI

57. Wawenzani empilweni yakho ngesikhathi ukhubazeka?

   1. Isikole
   2. Izifundo
   3. Uqashwe emsebenzini ngokugcwele
   4. Ubambe itoho
   5. Uzisebenza
   6. Wawungunkosikazi wesekhaya ongasebenzi
   7. Ungasebenzi
   8. Okunye.

   Ngicela uchaze kuloku okungenhla.

58. Uma wawusebenza ngalesosikhathi, wawenza msebenzi muni?

59. Uma wawusebenza ngalesosikhathi, ngabe wawunawo yini umshwalense obhekene nokukhubazeka?

   Yebo ☐   Cha ☐

60. Uma wawungasebenzi ngalesosikhathi, usizo lwemali wawuluthola kuphi?

61. Uyasithola isondlo sabakhubazekile na?   Yebo ☐   Cha ☐

62. Ikhona enye imali oyithola njalo?   Yebo ☐   Cha ☐

63. Uma uthe yebo kumbuzo ongunombolo 62, ivela kuphi lemali oyitholayo?

64. Ungakwazi ukusho ukuthi isiyonke ingakanani imali oyitholayo ngenyanga?

    1. Ayikho nhlobo

    2. Ayeqi ku-R500

    3. Iphakathi kuka R500 no R999

    4. Iphakathi kuka R1 000 no R1 999

    5. Iphakathi kuka R2 000 no R3 999

    6. Iphakathi kuka R4 000 no R6 000

    7. Iphakathi kuka R6 000 no R11 999

    8. Iphakathi kuka R12 000 kwenyuke

65. Awuchaze isimo sakho sezimali njengamanje usiqhathanise nangesikhathi ungakakhubazeki.

66. Kukhona yini okunye ofuna ukukusho mayelana nezinto ozifundile njengomuntu okhubazekile kanye nokuthi lokhu kwenzeka kanjani kuwe?

67. Uma ucabanga, ukuzithola uhlukunyezwa kukuthikameze kanjani wena empilweni yakho?