

# THE EXPERIENCE OF YOUTH VICTIMS OF PHYSICAL VIOLENCE ATTENDING A COMMUNITY HEALTH CENTRE: A PHENOMENOLOGICAL STUDY

## **M. Selenga**

School of Nursing,  
University of the Western Cape, Cape Town  
mselenga@uwc.ac.za

## **K. Jooste**

School of Nursing,  
University of the Western Cape, Cape Town  
kjooste@uwc.ac.za

## ABSTRACT

The Western Cape Province of South Africa has the worst multifactorial crime problem in the country. It has the fastest growing crime rate in many crime categories, such as rape and gun-related incidents. The experiences of the youth after a violent physical incident are unclear. The purpose of this article is to describe the experiences of youth victims attending a community health centre in the Cape Flats. A phenomenological, exploratory, descriptive, and contextual design was followed in this study. This study explored and described the lived experiences of youth victims of physical violence in terms of the support they received in a natural setting at a community health centre in the Cape Flats. Purposive sampling was used for the study, and data saturation determined the size of the sample. Eight participants who visited a health care centre for follow-up treatment were selected. Data was analysed using Creswell's six steps of open coding. Main themes that emerged from the data analysis included: (1) violent incidents that had a negative impact on the participant; (2) participants applied defence mechanisms to deal with their trauma; (3) and participants

experienced care and support either negatively or positively. A recommendation of this article is the implementation of an in-service training programme to the nurses who care for the youth after violent physical incidents.

**Keywords:** community health centre, physical violence, traumatic events, victims, youth.

## INTRODUCTION

Adolescents who are exposed to violence are inclined to be violent themselves and at a higher risk of psychopathology (Hertweck, Ziegler & Logsdon, 2010:202). This is of great concern to the mental health services in the Western Cape, especially in the Cape Flats, where the burden of mental illness is already at an alarming rate due to illicit use of drugs and head injuries (Shields, Nadasen & Pierce, 2008:590). These mental health disorders become chronic and continue into adulthood, thus decreasing the productivity and influencing quality of life of the youth (Hertweck et al., 2010:202).

Violence is a well-known problem in South Africa, particularly in Cape Town. The violent crime statistics in Cape Town were higher (118 per 100 000) than the national average (114 per 100 000) between 2005 and 2006 (Gie & Haskins, 2007:7). Unfortunately, violent incidents have negative consequences on individuals; such as loss of limbs, head injuries, as well as deformity of the face and other body parts. This has a negative impact on the person's self-image and self-esteem. This could also impact on the stretched resources of the health service and its triage system.

The South African youth aged between 15 and 34 constituted 37% of the population in 2008 and this figure increased to 42% in 2014 (United Nations Population Fund South Africa (UNPFA SA), 2014). The South African youth are faced with many challenges; such as unemployment, drug abuse, crime, and violence. Not all youths are able to transcend these challenges on their own.

According to Norman, Matzopoulos, Groenewald and Bradshaw (2007:700), in the Western Cape alone, violence accounts for 12.9% of premature mortality, second to HIV/AIDS that accounts for 14.1%. These rates are higher than the national average of 129 versus 115 for males, and 25 versus 21 for females per hundred thousand people.

Violence has detrimental effects on the youth (Shields et al, 2008:58). It does not only affect the youth, but the community in general because the youth is the future generation of this country. According to a study undertaken by Shields et al. (2008:593) in Cape Town, 93% of youth in the sample had seen someone being hit and 83% had seen someone being kicked and shoved. Several studies have also concurred that the exposure to violent incidents is associated with poor mental

health outcomes (Hanson et al., 2006:1992; Shields et al., 2008:599; Hertweck et al., 2010:208).

## STATEMENT OF RESEARCH PROBLEM

The youth in the Cape Flats are faced with various challenges in an environment of violence. Violent incidents cause traumatic experiences and could have detrimental effects on their psychological and physical health (Shields et al., 2008:58).

At the community health centre, the researcher observed that professional nurses were uncertain about the support victims of physical violence needed. In order to address this problem, the experiences of the youth as victims of physical violence should be known.

## PURPOSE OF THE STUDY AND THE RESEARCH QUESTION

The purpose of this study was to explore and describe the experiences of youth victims of physical violence attending a community health centre.

The research question was: What are the lived experiences of the youth victims of physical violence at a community health centre in the Cape Flats?

## DEFINITION OF KEY CONCEPTS

**Physical violence** refers to the intentional use of physical force or power – threatened or actual – against oneself, against another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (WHO, 2011).

A **victim** of crime is defined as a person who has suffered harm – including physical hurt – through acts that are in violation of our criminal law. In this study, violence refers to any kind of physical attack inflicted by someone else.

The National Youth Policy (South Africa, 2014) defines **youth** as any person between the ages of 14 and 35 years. For the purpose of this study, participants were male and female individuals between 18 and 27 years who were traumatised in informal settlements in the Cape Flats.

## RESEARCH METHODOLOGY

In qualitative research, a researcher aims at producing research results that are derived from a participant's subjective experience of reality. A phenomenological,

exploratory, descriptive, and contextual design was used to explore the lived experience or participants' subjective view of their world. The study was exploratory in an attempt to gain insight into the hardly explored phenomenon of youth victims and physical violence. The descriptive design enabled the researcher to gather rich descriptions about participants' specific experiences. A contextual design was followed, since the study was conducted in the natural setting of an emergency unit at the Mitchells Plain Community Health Centre, Mitchells Plain, Cape Flats in Cape Town. Purposive sampling was used to select youth victims of physical violence and who paid follow-up visits to a community health centre. Saturation of data determined the sample size of eight participants. The managers at the institution were approached in writing to explain the aim and objectives of the research project. Participants gave written informed consent. Individual unstructured in-depth interviews (in a private room to maintain confidentiality) and field notes were used to gather the data.

The interviews lasted between 30 and 45 minutes. Interviews were conducted in English; the data of participants who expressed themselves in their own language was translated to English. Interviews were audio recorded, and field and reflective notes were kept. Data was collected during May–June 2013. A pilot interview was conducted with one participant before the main study commenced; the data answered the research question adequately. Therefore, that interview was included in the main study. Demographic details of the participants in the study: eight interviews were conducted, including the pilot interview. Their ages ranged between 18 and 27 years and they were males of which the majority was unemployed with grade 11 as the highest level of education.

## DATA ANALYSIS

The researcher conducted the data collection and analysis concurrently and followed the steps of open coding (Creswell, 2009:159): transcribing interviews verbatim, becoming immersed in the data, developing categories and themes from statements, and describing the phenomena. Those experiences are presented as results of the study.

The researcher used criteria spelled out by Creswell (2009:159) to ensure trustworthiness and qualitative rigour of this study. The researcher used direct quotations from the participants' interviews to ensure credibility. An expert in qualitative research, the researcher's supervisor, and an independent coder conducted an audit to confirm the findings. To enhance authenticity, the researcher kept a reflective journal to record personal thoughts and feelings related to the study to augment the data analysis, since she had personal experience of violence as a nurse. It was necessary to write and reflect about those experiences in order to bracket her own experiences from those of the participants (Burns & Grove, 2009:545–546).

Due to the nature of this study, findings cannot be generalised to other settings or groups.

## DISCUSSION OF RESEARCH RESULTS

The data analysis yielded three themes that were sub-categorised.

**Table 1:** Themes and categories

Theme	Category	Sub-category
Violent incidents where negative experiences that impacted the on the whole of the participant	Physical injuries	
	Psychological strain	Negative emotions such as sadness, anger, anger and worry
	Social strain	Lonely Isolated
	Occupational concerns	Ability to lead a productive work-life
Applied defensive coping strategies to deal with the trauma	Denial Rationalisation Blame	
Diverse experiences of care and support	Positive experience	Care
		Holistic support
	Negative experience	Lack of attentive care
		Lack of information that lead to participants feeling vulnerable
		Lack of psycho-social support

Theme 1: Participants experienced violent incidents in an extensively negative way

The impact of a violent attack affects individuals on all levels of their being and interferes with their well-being. Haan (2008:31) defines violence as a behaviour involving physical violence intended to hurt, damage, or kill. His definition also includes the emotional and psychological impact of violence. The participants in this study confirmed their experiences as an interruption of their complete state of well-being.

Theme 1 comprised four categories, namely, physical injuries, psychological strain, social strain, and occupational concerns.

Physical injuries

Exposure to community violence resulted in physical injuries. The participants reported injuries that had a direct impact on their physiological functioning. Participants reported physical ailments due to a violent attack.

... they started stabbing me ... and I was bleeding a lot ... (P3)

A participant suffered blood loss due to the injury that decreased the heart rate, caused sleep disturbance, might lead to death or disability, reduced quality of life, as well as major physical consequences; such as brain injuries, bruises, and chronic pain (WHO, 2007:7).

The exposure to an attack left permanent scars to a participant:

I now have this 4cm scar in my face (P8)

One participant mentioned his concern of permanent brain damage due to a violent incident:

I was very concerned because, I thought of the [brain] damage that could have happened to me. (P6)

Traumatic brain injury is one of the most devastating injuries an individual could sustain, whether it is caused by an accident or an intentional act (Butcher, McHugh, Lu, Steyenberg, Hernandez, Mushkudiani, Maas, Marmarou & Murray, 2007:281).

## Psychological strain

Strains are an individual's response to stressors; in this study, it was the violent act perpetrated against an individual. According to Tromp, Van Rheede and Blomme (2010:120), strain is experienced when individuals perceive environmental demands or constraints to exceed their capabilities. The participants recalled the experience to be psychologically exhausting:

I was scared at first ... (P3)

I was just scared when they [perpetrators] approached me. (P4)

Grant, McCormick, Poindexter, Simpkins, Janda, Thomas, Campbell, Carleton and Taylor (2005:515) are of the opinion that youth who are exposed to violence may have more internalised symptoms, such as anxiety and depression.

Another participant described the feelings and experiences of anxiety that resulted from being exposed to a violent attack.

I think of what happened sometimes .... I get flashbacks, and it is quite difficult for me. (P6)

Exposure to violence is associated with a range of emotional reactions (Ho, Cheung, You, Kam, Zhang & Kliewer, 2013:1), such as stress disorders, anxiety disorders, as well as feelings of hopelessness and helplessness.

A violent experience also exacerbated the feelings of aggression and anger for this participant.

I felt aggressive, it made me feel aggressive, and the fact that it wasn't meant for me. (P3)

The feelings of this participant correspond to the research done by Kelly (2010:62) about exposure to community violence that is associated with aggressive behaviour.

## Occupational concerns

The participants explained how a violent attack resulted in social strain. They could not go to work for a certain period of time during their recovery, since they were unable to function well after the incident. Most of the participants were casual workers and they were unable to earn an income for the days they did not work.

The trauma had a financial implication on their social lives and their ability to provide for their families and for themselves:

... and I do not have a lot of leave days, so I will have to take unpaid leave until I feel better  
... .(P1)

Himmelstein, Warren, Thorne and Woolhandler (2005:66) conducted a study about the impact of injury on the economic status of individuals. They discovered that people who had been injured had increased medical costs.

## Theme 2: Applied defensive coping strategies to deal with the trauma

The psychological categories included denial, rationalisation and blame. Defence mechanisms protect individuals against anxiety, and the consciousness of the inner dangers and stressors. Through the coping process, an individual endeavours to handle conditions that evoke hostile emotions by managing those emotions on their own (Riolfi & Savicki, 2010:97).

When participants were faced with a violent ordeal, they projected certain feelings towards the perpetrators and also towards the nursing staff who cared for them.

## Denial as a coping mechanism

Zimmerman (2007:297) defines denial as a natural defence to repress an unpleasant reality, both on an individual and on a societal level. Denial is avoiding the awareness of some painful reality or existence of a severe problem. Individuals try to escape the reality of adversity they had experienced.

Participants shared how they blocked their feelings of fear and stopped feeling the pain that was inflicted on them during the victimisation, for example:

I was scared at first, but I stopped feeling fearful because after the first knock, it's painful but the second time, you can't feel anything. (P1)

Participants came to grips with the pain that they felt during the attack. This was the psychophysiological response to the trauma that they experienced. They described their experiences as the pain disappearing while they were being assaulted. That was how their psyche and bodies dealt with the victimisation at the time it occurred. During extreme stress, the brain tries to avoid conscious awareness of acute stress and facilitate denial by repressing traumatic memories. However, the memory, while not in conscious awareness, remains retrievable.

## Rationalisation as a coping mechanism

Rationalisation is a defence mechanism that a person uses to attempt justifying the reasons for behaviour or attitude logically. Palmer (2009:1) suggests that when individuals become fearful during an inescapable traumatic event, their feelings of helplessness and total loss of power and control form a script that becomes engraved in the neurological pathway of the central nervous system. A participant stated:

I was scared at first but I stopped feeling fearful because after the first knock. It's painful, but the second time, you can't feel anything (P1)

The participant rationalised the pain because after the first hit, his justification enabled him to tolerate the inflicted pain. When something transpires that a victim finds challenging to accept, that person would usually concoct a logical reason why it has happened.

## Blame as a coping mechanism

According to O'Connor, Kotze and Wright (2011:115), a phase of blame is a common phenomenon that arises after an initial state of shock once individuals grasp the magnitude of the incident and feel that the universe is no longer a rational and orderly system.

The participants blamed the nurses for their bad experience at the day hospital for their 'non-caring' attitude. That was a psychological response that allowed the patients to shift the adverse feelings caused by the perpetrator to feeling that the nurses made it worse by not attending to them immediately. Their personal experiences eclipsed the fact that the trauma unit was inundated with many patients who were either injured or had medical emergencies.

The feelings of neglect led the participants to project their anger and disappointment to the nursing staff at the day hospital:

... and I felt neglected somehow ... (P3)

... the staff ... I got no support, I was sitting here ... I could have bled to death because they let you wait the whole time ... (P4)



According to O'Connor *et al.* (2011:115), blaming provides an early, simple and irrational solution to multifaceted inter-personal or situational problems. It is a process of identifying the problem that results from another person's actions. In a trauma setting, this generates fear, and it destroys trust in the medical and nursing team.

### Theme 3: Diverse experiences of care and support

According to McAlpine and Amundsen (2011:173), diversity of experiences means the way different clients would understand the care and support; this includes openness to differences among people, values, cultures and perspectives.

In most cases, the trauma unit is the first point of contact after patients have experienced a violent attack in a community. The participants articulated that they experienced a lack of either interpersonal or external support, or both. However, some of the participants had positive experiences with the care and holistic support they had received at the community health centre.

#### Positive experiences

Some patients reported positive experiences in respect of the treatment they had received from staff members. They reported that the support assisted them in coping better with the trauma that they experienced and restored their positive outlook on life.

Participants felt cared for and emotionally supported when they were probed about what had happened to them. One participant experienced the support as a sign of concern that the nurses displayed:

I can say I was emotional[ly] supported by the sister that did my dressing, she was very helpful and supportive, it was just the doctor that didn't seem to care, he just told the sister to do all the work, he just gave me pain tablets. ...it felt like she wanted to know what was wrong with me and was interested in knowing what had happened. For me, it was a sign of showing concern so that made me feel better ... . (P3)

A participant indicated that information provided left them feeling more confident:

The sister told me it was going to be okay, I was alright after that. I felt better ... . (P4)

Another patient pointed out that psychosocial care provided was essential to him:

... they gave me emotional support, they told me to be strong. I felt better afterwards because of the support that I got from them. (P7)

According to the participants' recollection, they received support from the nurses in the form of asking what had happened, giving advice about recovering sooner, giving health education with regard to their injuries, and caring for the wounds.

## Negative experiences

Participants experienced that they were not supported emotionally when they approached the health services for treatment. Some described their experience as painful and viewed the nursing staff as uncompassionate.

One participant described that the lack of communication had left him feeling neglected:

... that day, the lady doctor was just consulting with the other doctor but had minimal conversations with me, and I felt neglected somehow. This is my first time being injured, but its hurtful and a painful experience ... . (P1)

Another participant felt that the long waiting hours would have caused his death if he had sustained the wound elsewhere:

It's like the people here are not interested, because if I had a wound somewhere else, I could have bled to death because they let you wait the whole time ... . (P2)

The participant felt that the information requested from him was insufficient:

... they just asked me with what was I stabbed and asked me to show him the wound. (P2)

According to Dinkins (2011:2), empathy is one of the basic building blocks of ethics and ethical conduct towards fellow human beings. Without empathy, it is challenging for any of us to recognise the needs and wants of other people to enable us with knowledge about treating them kindly and generously, or to practise nursing effectively in our day-to-day interaction with them.

One of the participants felt that the nurses ignored her and no nurse was there for her:

The nurse that stitched me just cut my weave [hair extension] off ... she did not listen to me when I asked her not to cut it off and to try be careful. She ignored me ... I was so sad. She had no empathy at all ... . (P7)

A participant reported that he was not supported in terms of proper communication.

Pytel, Fielden, Meyer and Albert (2009:406) are confident that communication among nurses, patients, and patients' family members plays an important role in the recovery of patients after a medical intervention. Their quantitative study was conducted with patients in an emergency department about their satisfaction with the communication between them and the emergency department personnel. The youth patients of this study assisted the researcher in identifying three main communication needs, which were explanation of the procedures done on them, education about their injuries or illness, and circumstances that may require them to return to the emergency unit.

Emergency unit triage is the process of filtering patients based on their medical urgencies; its main aim is to determine patients' need for urgent care in order to facilitate care before their condition worsens. This information is displayed in the waiting area of trauma units. Although this system is implemented, patients still wait longer than what the triage score suggests. This is usually due to the high turnover of patients in the emergency unit.

The participants were scared to ask the nurses how long they would wait and the reasons why they had to wait for such a long time. They also witnessed how some of the other patients who asked were told to 'just' wait:

We were just sitting there waiting for my name to be next, but it didn't seem to happen ... . (P5)

... after the looong [emphasis] wait, I was called in, by that time I had even lost hope that they had my folder or while I was in toilet. I wanted to ask but I observed how people that were asking were just told to wait. (P7)

A participant felt that if she could afford private care, she would not have waited such a long time to get treatment:

I arrived here at the hospital at around 7:30 pm on a Friday night and I was only seen on Saturday at 4:00 am. So, it was a nine hours wait. It must have been the longest wait of my life. I never thought that I a person [sic] can wait this long for medical assistance. I felt like if I had money or medical aid, I would have received better and quicker medical care ... . (P7)

In the study conducted by Pich, Hazelton, Sundin and Kable (2010:270), they found that the long waiting hours frustrated patients. According to the triage score, the patients who had to be treated within an hour also had to wait for three to four hours. In the same study, they found that patients perceived emergency departments as a public entitlement, thus having unrealistically high expectations of the nurses.

The participants felt discouraged as a result of the long waiting hours and lack of communication. The trauma units at community health centres – due to the increase in community violence and gang-related injuries in the communities – were usually under pressure to provide emergency medical treatment to the injured people.

## CONCLUSIONS

Violent incidences affect the whole being. This means that every dimension of the patient as a person should be explored and where needed, health education and advice should be provided to patients. During a violent encounter, participants experienced a range of physical injuries caused by an attack. Some of those injuries had long-term effects on the individual that might affect their quality of life. The effects of community violence also had psychologically exhausting repercussions for the

participants. Some of the participants were able to cope with those effects due to the support they had, while some experienced symptoms of psychological discomfort, such as aggression, anxiety, and depressive symptoms. Youth who are exposed to these symptoms are likely to participate in gangs and gang activities.

## RECOMMENDATIONS

A patient-centred communication style by nurses could have a positive effect on the patient-nurse relationship.

A need exists for regular information sessions for nurses on the triage score for patients to understand how the scoring works and why they would wait longer than the time reflected on a triage score chart.

A need exists for continuing skills development, especially with regard to the health problems in that community. It remains the duty and responsibility of the hospital staff to be equipped and able to deal with these increasing incidents of caring for victims of physical violence.

Further research will establish the prevalence rate in relation to victims of physical violence who seek medical assistance at the trauma unit of the community health centre. This will assist in quantifying the problem and effectively implementing measures to support these victims of physical violence.

Future studies should concentrate on the patients in the waiting areas of an emergency unit to identify whether they do understand the triage system and their experiences thereof. Also, the experiences of nurses who care for patients who are victims of physical violence in a trauma unit should be explored.

## LIMITATIONS OF THE STUDY

The results of this study were limited to the experiences of youth patients who had been victims of physical violence and who attended the emergency unit of a community health centre where the research interviews took place. Therefore, these findings cannot be generalised to an emergency unit at another community health centre.

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## LIST OF REFERENCES

Burns, N. & Grove, S.K. 2009. *The practice of nursing research*. St. Louis MO: Elsevier.

- Butcher, I.M., McHugh, G., Lu, J. and Steyenberg, E.N., Hernandez, A.V., Mushkudiani, N., Maas, A. R., Marmarou, A. & Murray, G.D. 2007. Prognostic value of cause of injury in traumatic injury: Results from IMPACT study. *Journal of Neurotrauma*, 24(2):281–286.
- Creswell, J.W. 2009. *Research design: Qualitative, quantitative, and mixed methods*. Thousand Oaks: Sage.
- Dinkins, C.S. 2011. Ethics: Beyond patient care: Practising empathy in the workplace. *Online Journal of Issues in Nursing*, 16(2):1–3.
- Gie, J. & Haskins, C. 2007. *Crime in Cape Town: 2001–2006. A brief analysis of reported violence, property, and drug-related crime in Cape Town. Strategic Development Information and GIS Department*. Cape Town: City of Cape Town.
- Grant, K.E., Mc Cormick, A., Poindexter, L., Simpkins, T., Janda, J.M., Thomas, K.J., Campbell, A., Carleton, R. & Taylor, J. 2005. Exposure to violence and parenting as mediators between poverty and psychological symptoms in urban African American adolescents. *Journal of Adolescence*, 28:507–521.
- Haan, W. 2008. *Violence as essentially contested concept*. Groningen: University of Groningen, Department of Criminal law and Criminology. Springer.
- Hanson, R., Self-Brown, S., Fricker-Elhai, A., Kilpatrick, D., Saunders, B. and Resnick, H. 2006. Relations among parental substance abuse, violence, and mental health: The survey of adolescents. *Journal of Addictive Behavior*, 31:1988–2001.
- Hertweck, S.P., Ziegler, C.H. & Logsdon, M.C. 2010. Original study: Outcome of exposure to community violence in female adolescents. *Journal of Paediatric and Adolescent Gynaecology*, 23:202–208.
- Himmelstein, D., Warren, E., Thorne, D. & Woolhadler, S. 2005. Illness and injury as contributors to bankruptcy. *Market watch*: 63–74.
- Ho, M.Y., Cheung, F.M., You, J., Kam, C., Zhang, X. & Kliewer, W. 2013. The moderating role of emotional stability in the relationship between exposure to violence and anxiety and depression. *Journal of Personality and Individual Differences*, 1–6.
- Kelly, S. 2010. The psychological consequences to adolescents of exposure to gang violence in the community: An integrated review of literature. *Journal of Child and Adolescent Psychiatric Nursing*, 23(2):61–73.
- McAlpine, L. & Amundsen, C. 2011. Making meaning of diverse experiences: Constructing an identity through time. In L. McAlpine & C. Amundsen (eds.), *Doctoral education: Research-based strategies for doctoral students, supervisors, and administrators*, 173–183. Amsterdam: Springer.
- Norman, R., Matzopoulos, R., Groenewald, P. & Bradshaw, D. 2007. High burden of injuries in South Africa. *Popul Health Metr*, 85(9):695–702.
- O'Connor, N., Kotze, B. & Wright, M. 2011. Blame and accountability: Understanding blame and blame pathologies. *The Royal Australian and New Zealand College of Psychiatrists*, 19(2):113–118.
- Palmer, T.J. 2009. Fear and destructive forces. Available at <http://www.transpersonalpsychologist.net/Reseach.html> (Accessed 18 February 2014).
- Pich, J., Hazelton, M., Sundin, D. & Kable, A. 2010. Patient-related violence against emergency department nurses. *Nursing and Health Sciences*, 12:268–274.

- Pytel, C., Fielden, M.N., Meyer, K.H., & Albert, N. 2009. Nurse-patient/visitor communication in the emergency department. *Journal of Emergency Nursing*, 35(5):406–411.
- Rioli, L. & Savicki, V. 2010. Coping effectiveness and coping diversity under traumatic stress. *International Journal of Stress Management*, 17(2):97–113.
- Shields, N., Nadasen, K. & Pierce, L. 2008. The effects of community violence on children in Cape Town. *Journal of Child Abuse and Neglect*, 32:589–601.
- South Africa. 2014. *National Health Policy 2014–2019*. Pretoria: Government Printers.
- Tromp, D., Van Rheede, A. & Blomme, R. 2010. The relationships between psychological strain, organisational support affective commitment, and turnover intentions of highly educated hospitality employees. *Advances in Hospitality and Leisure*, 6:117–134.
- United Nations Population Fund (UNFPA) South Africa. 2014. Young people fact sheet. Available at [http://countryoffice.unfpa.org/filemanager/files/southafrica/young\\_people\\_march\\_2013\\_fact\\_sheet.pdf](http://countryoffice.unfpa.org/filemanager/files/southafrica/young_people_march_2013_fact_sheet.pdf) (Accessed 15 September 2014).
- World Health Organization (WHO). 2007. *Third milestones in a Global campaign for violence prevention report, scaling up*. Geneva: World Health Organisation.
- World Health Organization (WHO). 2011. Global campaign for violence prevention. Definition and typology of violence. Available at <http://www.who.int/violenceprevention/approach/definition/en/index.html> (Accessed 15 January 2013).
- Zimmerman, C. 2007. Death denial: Obstacle or instrument for palliative care? An analysis of clinical literature. *Sociology of Health and Illness*, 29(2):297–314.