Published in final edited form as:

Palliat Support Care. 2015 April ; 13(2): 399–404. doi:10.1017/S147895151400042X.

Care and the luxury of trauma: a South African story

Leslie Swartz

Alan J Flisher Centre for Public Mental Health, Department of Psychology, Stellenbosch University

My mother died of lung cancer on 15 January 2011. For almost a year she had been living with my wife and me. She came to us after a series of falls (associated, we later discovered, not with the illness itself but with medication she was taking). She had been living for many years quite independently in a facility for old people and after falling in her apartment a few times she went into the frail care section where she could be monitored more closely. She spent two nights in frail care, and on both of these nights she fell so badly that she later required surgery, once to stitch up a deep wound on her forehead and once to repair an injury to her spine. After these two falls on consecutive nights, my wife and I decided that we could not leave my mother in the frail care unit any longer. Subsequently, after a period in hospital for the first of her surgeries, she came to live with us. We were very worried she might fall again, and so was she, and from then on we employed care workers from a local service to be with her 24 hours a day. Our lives became very different from what we had been used to. Not only was there the adjustment to living with my mother again after living apart for almost forty years, but we were living with a person who was dying. We also had an ever-changing group of care workers, 24 hours a day, whose job it was to “care” for my mother, over and above making sure that she did not fall and hurt herself seriously.

In what follows, I have changed certain details and amalgamated individual stories to hide the identities of a number of people. I shall tell the story of a care worker whom I shall name “Mary”. Mary is a woman of thirty-five who, at the time of coming to work with us, was living with her husband and her two youngest children in a council house in the greater Cape Town area. Her elder two children, aged 18 and 17, were living with relatives about 50 kilometers away. Some time into her stay with us, her neighbour’s house burned down and two of her neighbour’s children came to live with her temporarily. This was Mary’s third job as a care worker – she had been employed previously by two other agencies but she was much happier working for her current employer who, she said, treated the care workers more fairly than the previous employers had done. Unlike some of the care workers we met, she expressed a keen interest in care work and she told us that, had she not had to leave school at 17 when she was pregnant, she would have liked to have obtained her school leaving certificate and become a registered nurse. Her husband was employed on a casual basis as a security guard; her very low salary was the only marginally steady income coming into the house. She was employed on the basis that she was paid only for the days that she worked. If the agency did not have clients for her to care for, she did not earn. Two weeks prior to her

coming to work for us, the young woman for whom she had been working as a care worker for six months had died as a result of a brain tumour; Mary had not worked in the intervening two weeks.

As was the case with a number of the care workers whom we came to know, we immediately took to Mary and she to us. She especially liked the fact that while my mother was well enough we would take her out whenever we could – usually for tea and as much cake as we could get my mother to eat, as she was wasting away before our eyes. The first time Mary came with us to a shopping centre (one which caters mainly for the middle-class), she commented, “Jesus must have sent me to you – you are taking me to such a wonderful place.” Born and bred in Cape Town, Mary had never been to this shopping centre or to any shopping centre like it. Her first visit to the Waterfront (Cape Town’s major tourist destination) was also with us; she enjoyed pushing my mother in her wheelchair near the water’s edge. When she wanted to go to the toilet, I pointed out the public toilet. “No, Mr Leslie (I could not convince her to call me Leslie),” she said, “that is not for people like me.” After much remonstrance on my part, she agreed to use the public toilet. One day when my mother was not well enough to stop for tea, I took her and Mary for a short drive near our house. I drove up to Rhodes Memorial above the University of Cape Town (UCT) and explained to her how the wealthy colonialist, Cecil John Rhodes, had given a large estate to the South African nation. I pointed out UCT and Groote Schuur Hospital (the hospital where the world’s first heart transplant had taken place) and explained how the National Botanical Garden, Kirstenbosch (where we had also taken Mary for the first time in her life) was also part of a gift to the nation from Rhodes. A few days later, Mary said to me, “You know, Mr Leslie, Mr Leslie is a very generous man.” I laughed and asked her why. “Well,” she said, “Mr Leslie gave all that land to the nation.” In my telling of the story of Rhodes’s gift to the nation, Mary had thought that I had been the benefactor. To this woman, a fellow citizen of Cape Town, whose home is 20 minutes’ drive from my own, I was unimaginably wealthy. Feeling the considerable financial strain of caring for my mother, and running a house in which by choice we shared our table and our food with the care workers, and looking at the damp and the cracks of my crumbling house, I felt the irony of being seen in a league of wealth on a scale enjoyed by Rhodes. To readers of this article, I am sure, and certainly to me, there is an obvious difference between my wealth accumulated as a middle-class psychologist and an academic, and that enjoyed by Cecil John Rhodes, arch-imperialist, magnate, and entrepreneur. But not to Mary.

Somewhat to my dismay, I returned from work one day to find that my mother had agreed that Mary would bring her eight-year-old daughter, Jolene, to meet the family the following Saturday, when Mary was on duty. Mary said that Jolene would be no trouble, that she was very well behaved. This was true, and we had a happy few hours with Mary and Jolene at the Waterfront. My mother had not been in contact with children for a long time and she said that being with Jolene did her good. She insisted that I buy Jolene a colouring book and crayons; this I did happily. For some time after this Jolene telephoned my mother; my mother did not feel well enough to take the calls, and we heard from Mary that Jolene was disappointed. Jolene wanted to visit us again, but my mother’s health and her tolerance for distractions beyond her own immediate needs was deteriorating rapidly. We put Jolene out of our minds.

We were now about six months into our relationship with Mary. Something had shifted subtly since Jolene's visit. My mother was much more ill and in need of more focused attention, both physical and emotional. But Mary would now speak quite often of her financial difficulties. We had learned that although we were paying the care worker agency a large sum of money every month, Mary and the other care workers earned a small portion of what we were paying. Mary, who worked four twelve-hour shifts per week, was earning a fraction of what we paid our part-time domestic worker, who worked a total of twelve hours a week – a quarter of the hours worked by Mary. This meant that per hour Mary was earning, for her care work, less than a quarter of what we paid someone whose job was essentially to clean and tidy the house. For the first time, Mary asked to borrow money from us (a practice not allowed by the agency). We "lent" her small amounts of money without expectation of repayment, nor were we repaid. She told us about her abuse at the hands of her alcoholic husband, and showed us her scars. We suggested she get help at the local clinic on her day off. Mary became more withdrawn and moody.

The following week, with no explanation and no goodbye, Mary no longer came to us as a care worker and we never saw her again. We thought that this must be because she was no longer happy with us (and this might have been a factor), but later in the week we received a tearful phone call from Jolene who asked us where her mother was. Worried, we contacted the nursing agency. It turned out that, during her time with us, Mary had decided to leave her abusive husband. She gave the appearance of leaving for work as usual one day, and went to live with a friend in a town about 50 km from Cape Town where, as it happens, there was a patient whom she could care for through the agency. She walked out on her abusive husband in the only way she knew how – by walking out on her own two children and the neighbour's two children, leaving them in the care of her abusive and substance abusing husband, and by walking out on us. We never heard from Mary again. After my mother died, through other care workers at the agency, we invited Mary to a memorial tea for my mother which we held at our home. She did not come to this, and we don't know if she ever received the gift we sent her via the other care workers to thank her for the kindness she had shown my mother over a period of months.

I tell this story of Mary for a number of reasons. Some of my reasons are deeply and selfishly personal. I have been profoundly affected by my mother's illness and death, and I need to keep telling stories about the experience. But I also tell the story because it highlights the different ways in which people from different social backgrounds, with different resources, are positioned in relation to discourses about both trauma and loss, key challenges in my professional life as a psychologist, and key issues in South Africa.

One of the central ideas about trauma is that it involves a disruption or deviation from what could or should be expected in ordinary life. This applies very easily to me and my middle-class life. I am quite easily able to date the onset of the very difficult period of caring intensively for my mother. My mother lived much longer than anyone expected, but we all knew that eventually she would die, which she did. Though all the complex feelings I have about myself as a son and a man, and my mother as a mother, a woman, and a widow, will be with me for the rest of my life, I can speak of one trauma as being "over". I am no longer caring for my mother; my mother's death is in the past. In the few months after my mother's

death I struggled, uncharacteristically for me, with physical illness (I am generally very healthy), and with a range of emotions – grief, despair, regret, satisfaction, pride, and huge relief. I am now able to think of my mother's last year, and much of her life, as a wonderful legacy, a difficult but precious gift to me and my very close family.

I don't know anything for sure about Mary and how she is now. I hope she is well. But it will be very clear from the story I have told that, unlike my own experience, there is no easy beginning to Mary's trauma, and probably no clear end. Her life, simply put, is, was, and probably will be, hard. Her difficulties have implications for Jolene's life as well – when did Jolene's traumatic experiences begin (probably before the day her mother walked out without explanation), and when will they end? What, in the context of lives like these, and the lives of the majority of people in the world who do not enjoy the predictability of life that I enjoy, who live, as Butler (2006) would have it, precarious lives, does it mean to speak of trauma as something unusual, something which can begin and end? To what extent is the concept of trauma something of a luxury in itself?

As a psychologist who has been active in dealing with and thinking about issues of violence and exclusion in South Africa for many years, these issues have concerned me for some time (Swartz & Levett, 1989; Swartz, 1991, 2012a; Claassens, Swartz & Hansen, 2013; Kleintjes, Lund & Swartz, 2013). It is not by chance that recent research which poses serious questions about the applicability of conventional trauma models in contexts of ongoing violence and oppression was conducted by South Africans (Kaminer & Eagle, 2010; Stevens, Eagle, Kaminer & Higson-Smith, 2013).

But there is something more fundamental at stake here than the question of whether, in order to understand trauma globally, we should move to models which can take account of ongoing oppression, victimization and social exclusion. By buying care from Mary and people like her, my family and I were in the process of buying a very important form of treatment for our own experiences of traumatization during my mother's illness. My mother did not have to worry about being left alone and falling. She did not have to deal with being alone (which she found increasingly difficult as the illness progressed). We did not have to engage with something I would have found exceptionally difficult – the sheer viscosity of caring for the sick, the uncovering of the body of my mother, the close engagement with it, the dealing with vomit, urine and faeces. I cannot be sure of this, but I have a reasonable idea that had I dealt with all of these things – had I been the one to watch my mother throughout the night, month after month, washing her and cleaning up her mess, I would have found the adjustment to her death much more difficult. Something happened in the relationship between us and the care workers, a small story in a more universal story about the dynamics of care, infused as this story is with ongoing divisions along lines of privilege, gender, race, class, and even along lines of space – the implicit but powerful boundaries which determine who may be where and at what times. The story is banal but difficult to tell. By buying care, as wealthy people do from poorer people all over the world (Kittay, Jennings & Wasunna, 2005; Kittay, 2009; Tronto, 2013) we were doing everything to alleviate our own traumatization. We were doing nothing (at best) to alleviate the ongoing traumatization of the care workers – and even in cases, like that of Mary, where we had a good relationship with them, we may have been complicit in a host of ways of making

things worse for them – perpetuating their poverty, thus helping to narrow their options for agency in their lives.

How do I understand and live with my complicity in enacting the very processes which render the lives of care workers less predictable and more difficult? I believe that I treated Mary and the other care workers (all of whom have their own stories, but all of whom know what it means to live an unpredictable life and to be abused in a variety of ways) well. I don't want to pretend to be a worse person than I think I am. But I was kind on my own terms. I decided what to give and what not to give, and when. I decided the extent to which I wanted to listen to (and get involved in) the difficult stories I heard about their hard lives. I decided to continue paying the care worker agency a large amount of money every month to employ people in my home at a wage I regarded as appalling. I did not want to take on all the difficulties of being a direct employer to care workers, though had I done so I could have paid care workers far more than they earned through the agency (and my bills would have been smaller too). Most centrally, encapsulated as I was in my concern for my mother and myself, and encapsulated as I was, also, in my own class and cultural position, I would not and could not engage in the most basic act of imagination which would have enabled me to explain to Mary and to others what I saw as the limits and possibilities of our relationship. I did not have to think about these things partly because I called the shots – if I did not like a care worker I could arrange for her to be replaced (as I did on occasion). And though Mary was able to choose to stop working in our home (a choice for which she failed to offer explanation, which hurt me initially), I suspect it was a desperate choice, and one of many which did not materially change the circumstances of her life. Mary had to watch patients die and then move on to the next patient without any real recognition of her feelings about these dramatic changes; she had, or so it seemed to her, little or no choice about her frantic and in part destructive decision to get away from a worse evil in her life – the evil of direct abuse of her body by her husband. So with the field of engagement the trauma of the dying body and the person of my mother, Mary and I were engaged in a macabre drama of enactment of all that is good, but also all that is destructive and capricious and unfair about the exercise of power. These dramas intersect centrally with the dynamics of therapy and care.

Some of these dramas related to care occur, as I have suggested, at the level of the body at its most visceral. In her now classic work on the anthropology of nursing, Jenny Littlewood (1991) points out that it is not by chance that there has been an association of the idea of nursing with the idea of bedpans. Historically, as Littlewood shows, it was the gendered role of nurses as women to deal with the smelly and unmanageable bodily fluids and products of the sick, while (male) doctors could have an altogether more distant relationship with these bodily products. Within nursing itself, closeness to the unsavoury aspects of the body was determined in part by the position of the nurse in the hierarchy, itself affected very fundamentally by race and class, as Shula Marks (1994) in her history of nursing in South Africa has shown. As nursing has professionalized as a discipline, and with greater emphasis on making nursing a profession on a par with medicine, it is hardly surprising (though there are other reasons for this) that we have seen the emergence of lower-level non-professionals and paraprofessionals who increasingly take over the dirtier and more unsavoury side of nursing – such as cleaning wards, emptying bedpans, and even talking with patients (Smith,

Swartz, Kilian & Chiliza, 2013). Julia Twigg (2000), writing in the context of care for the elderly in Britain, makes the cogent case that we need to view care work as a form of bodywork, to recognize the dirty and disgusting nature of what many care workers are called on to do. We may protest that the work is noble or dignified. We may use the language of morality and faith to suggest that care work is a calling and therefore cannot be disgusting or dirty. As Twigg (2000) shows, however, many care workers do experience the work as both dirty and disgusting, but not only as dirty and disgusting.

There is a strange paradox in the way we think and talk about care work. On the one hand, there is valorization of care work – people who tend to the sick and needy are commonly viewed as having a “calling”, and we speak about them in hushed tones, commenting (truthfully enough) that we cannot imagine that we could do that kind of work. This valorization, though, masks the common reality of the exploitation or neglect of people loaded with heavy burdens and neither rewarded nor properly recognized for their work. There is an obvious gender dimension here, with caring commonly being seen as “naturally” female. If we look at the epidemiology of mental disorder (including trauma-related pathology) in South Africa (Williams et al., 2008), and we compare it with low rates of formally qualified mental health care personnel in the public sector in particular (Lund, Kleintjes, Kakuma & Flisher, 2010), it follows that most of the care work for people affected emotionally by trauma is happening in relatively informal contexts and by people with little or no training. It is on this informal care sector that the biggest burden of trying to provide hope after trauma lies, assuming that hope after trauma is a common goal. The fact that things are this way though, is not simply a consequence of “nature” – it has to do with broader factors which shape our society and, to add insult to injury, which ensure that the risks for experiencing trauma are not equally or randomly distributed through society.

Introducing their article on care work in the context of globalization, Kittay and colleagues note:

People do not spring up from the soil like mushrooms. People produce people. People need to be cared for and nurtured throughout their lives by other people, at some times more urgently and more completely than at other times. Who is available to do the labor of care and who gets the care they require is contingent on political and social organization. Similarly, norms surrounding both the giving and receiving of care, while dictated in part by the nature of human need, is also conditioned by cultural and ethical understandings and by economic and political circumstances. The distribution of care therefore is a question of justice and the interactions between carer, cared for, and the larger community an appropriate matter of ethical inquiry. Demographic alterations due to birth and mortality rates, migration, and employment opportunities (and expectations) can have a profound impact on the availability and quality of care, and on the distributive questions of who does the caring and who gets care. Furthermore these demographic shifts affect the provision of care on a global level, when those who can pay for care buy the services of careworkers in other parts of the world. Care and dependency, particularly in the form of dependency care have been, are, or are likely to be features of all our lives.

(Kittay et al., 2005, p. 443).

Kittay (2001, 2009) suggests that the notion of independence as a goal of life or indeed of psychotherapy is highly ideologized. Striving towards independence may be a cultural value and a norm in the West, but what is obscured in this striving is the fact of interdependence as a feature of life. Put more strongly, it is possible to say that some may achieve ideals of independence and individuation not despite the ubiquitous nature of care and dependency but precisely because there are those who, like Mary in the case of my family, are there doing care labour (Kittay et al., 2005). And as Kittay further notes, this often hidden economy of care, an economy which I would argue is absolutely crucial to understand if we are to think sensibly about how to help people to survive trauma, has gone global. Poor women from lower-income countries are abandoning their own children and families to get care work in higher-income countries. The independence of the middle-class elites in these wealthier countries, including their ability to go on realizing their individual dreams and goals after experiencing traumatic events and processes, depends centrally on the care work provided often invisibly, often illegally, by women (and some men) from poorer countries. While providing what may be termed the hidden work of independence, these same migrants, though they may love their families deeply, are complicit in setting up conditions in their families which make them vulnerable to emotional difficulties later in their lives.

When I first read Kittay's work on the globalization of care, I was immediately reminded of the marketing slogan once used by the South African Tourist Board: "A world in one country". The fact is that we do not have to go transnational to experience the global phenomenon of care being sold on to those who can pay by those who have no choice (though, of course, with increased migration it is true that we have many traumatized migrants providing care in South Africa now). We experience the buying and selling of care close up. Mary lives twenty minutes away from my home by car, and in coming to my house every day there was a real sense in which she was travelling the world. This reality (and it is a reality which goes beyond issues of care work) must have implications for everyone. As we are all too aware at present, for example, the issue of policing the boundaries of Europe in the face of the possibility of thousands of migrants fleeing violence and civil unrest is a huge political issue. In South Africa, similarly, we have our own issues of xenophobia and fear that the other will take what we have (Adjai & Lazaridis, 2013). More fundamentally though, we are daily our own border police, thinking as individuals of ways to block out the beggar on the street; the person whose body we step over hoping that they really are just drunk and not ill; the physical and public fight we keep out of for fear of getting hurt ourselves.

South Africa has been a democracy for twenty years. I cannot help but feel a wry but regretful knowingness when South Africa is called a "postconflict society" (O'Mahony, Doak & Clamp, 2012). With our levels of crime, violence and brutality, we are not "post" anything (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009). In one sense, this observation is banal: there is never a break between the past and the present. As Richard Armstrong (2005) says of psychoanalytic theories of development: "The past will not play dead for us: there is no 'over' over there" (p.135). But there is another sense in which the observation is important. We know that there are, or have been, societies in which levels of

traumatization and violence have decreased, where gaps between rich and poor have narrowed, where overall levels of health have improved. Democratic South Africa is, unfortunately, not one of those countries. And lest I be accused of the common problem of South African exceptionalism, it needs to be said, in fairness, that inequality is growing globally both within and between countries (Kim, Millen, Irwin & Gershmann, 2002; Lyon & Farmer, 2013). Inequality breeds traumatized lives, and what has been termed “slow violence” (Nixon, 2011).

Without giving up the privileged life I lead (and this is a sacrifice I am not prepared to make), I cannot but be complicit in some ways in the oppression of others – including the oppression of people who make my life and those of the people I love, more bearable – people who enable me to appear independent, and not in need of care. I participate in the effacement of people on whom I depend a great deal. In this I am not unique. My own academic and professional work focuses partly on issues of empowerment and participation, on trying to create situations of social justice (Swartz, 2009, 2013), and in giving voice to care workers (Wilson & Swartz, 2013). I do not apologize for this work; I am proud of much of it. But as my difficult and ultimately failed relationship with Mary, and with others (Swartz, 2012b), showed me in a visceral way, I need to take responsibility for my complicity in oppression and to act in my everyday life to try to make things better. This is a responsibility I share with other privileged people world-wide.

References

- Adjai C, Lazaridis G. Migration, xenophobia and new racism in post-apartheid South Africa. *International Journal of Social Science Studies*. 2013; 1(1):192–205.10.11114/ijsss.v1i1.102
- Armstrong, RH. A compulsion for antiquity: Freud and the ancient world. Ithaca: Cornell University Press; 2005.
- Butler, J. Precarious lives: The power of mourning and violence. New York: Verso; 2006.
- Claassens, J.; Swartz, L.; Hansen, LD., editors. Searching for dignity: Conversations on human dignity, theology and disability. Stellenbosch: SUNMedia; 2013.
- Kaminer, D.; Eagle, G. Traumatic stress in South Africa. Johannesburg: Wits University Press; 2010.
- Kim, JY.; Millen, JV.; Irwin, A.; Gershman, J., editors. Dying for growth: Global inequality and the health of the poor. New York: Common Courage Press; 2002.
- Kittay EF. A feminist public ethic of care meets the new communitarian family policy. *Ethics*. 2001; 111:523–547.
- Kittay EF. The personal is philosophical is political: A philosopher and mother of a cognitively disabled person sends notes from the battlefield. *Metaphilosophy*. 2009; 40(3–4):606–626.
- Kittay EF, Jennings B, Wasunna AA. Dependency, difference and the global ethic of longterm care. *Journal of Political Philosophy*. 2005; 13(4):443–469.
- Kleintjes S, Lund C, Swartz L. Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: a qualitative study of perspectives of policy makers, professionals, religious leaders and academics. *BMC International Health and Human Rights*. 2013; 13:17. Retrieved from <http://www.biomedcentral.com/1472-698X/13/17>. [PubMed: 23497079]
- Littlewood, J. Care and ambiguity: Toward a concept of nursing. In: Holden, P.; Littlewood, J., editors. *Anthropology and nursing*. London: Routledge; 1991. p. 168–178.
- Lund C, Kleintjes S, Kakuma R, Flisher AJ. Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology*. 2010; 45:393–404.10.1007/s00127-009-0078-5 [PubMed: 19506789]

- Lyon E, Farmer P. Inequality, Infections, and Community-Based Health Care. *Yale Journal of Health Policy, Law, and Ethics*. 2013; 5(18):465–473. Retrieved from <http://digitalcommons.law.yale.edu/yjhple/vol5/iss1/18>.
- Marks, S. *Divided sisterhood: Race, class and gender in the South African nursing profession*. London: Palgrave Macmillan; 1994.
- Nixon, R. *Slow violence and the environmentalism of the poor*. Cambridge, Mass: Harvard University Press; 2011.
- O'Mahony D, Doak J, Clamp K. The politics of youth justice reform in post-conflict societies: mainstreaming restorative justice in Northern Ireland and South Africa. *Northern Ireland Legal Quarterly*. 2012; 63(2):267–290.
- Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: prioritising an agenda for prevention. *The Lancet*. 2009; 374(9694):1011–1022.10.1016/S0140-6736(09)61664-0
- Smith J, Swartz L, Kilian S, Chiliza B. Mediating words, mediating worlds: Interpreting as hidden care work in a South African psychiatric institution. *Transcultural Psychiatry*. 2013; 50:493–514.10.1177/1363461513494993 [PubMed: 23833246]
- Stevens G, Eagle G, Kaminer D, Higson-Smith C. Continuous traumatic stress: Conceptual conversations in contexts of global conflict, violence and trauma. *Peace and Conflict: Journal of Peace Psychology*. 2013; 19:75–84.10.1037/a0032484
- Swartz L. The reproduction of racism in South African mental health care. *South African Journal of Psychology*. 1991; 21:240–246.
- Swartz, L. Building disability research capacity in low-income contexts: Possibilities and challenges. In: MacLachlan, M.; Swartz, L., editors. *Disability and international development: Towards inclusive global health*. New York: Springer; 2009. p. 91-103.
- Swartz, L. Disability and equity in South Africa. In: Kometsi, K.; Jacobs, CL., editors. *South African Human Rights Commission Equality Report: Commentaries on equality: Race, gender, disability and LGBTI issues*. Braamfontein: SAHRC; 2012a. p. 33-42.
- Swartz L. Race, gender, and the impossibilities of care. *Medical Humanities*. 2012b; 38:34–37.10.1136/medhum-2011-010073 [PubMed: 22108630]
- Swartz, L. Between faith and doubt: Training members of disabled people's organisations in southern Africa in basic research skills. In: Claassens, J.; Swartz, L.; Hansen, LD., editors. *Searching for dignity: Conversations on human dignity, theology and disability*. Stellenbosch: SUNMedia; 2013. p. 81-90.
- Swartz L, Levett A. Political repression and children in South Africa: the social construction of damaging effects. *Social Science and Medicine*. 1989; 28:741–750. [PubMed: 2652325]
- Tronto, JC. *Caring democracy: Markets, equality and justice*. New York: NYU Press; 2013.
- Twigg J. Carework as a form of bodywork. *Ageing and Society*. 2000; 20:389–411.
- Williams DR, Herman A, Stein DJ, Heeringa SG, Jackson PB, Moomal H, Kessler RC. Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine*. 2008; 38:211–220.10.1017/S0033291707001420 [PubMed: 17903333]
- Wilson A, Swartz L. Paid carers talk about emotionally charged experiences in caring for dying people: A South African study. *Journal of Palliative Care*. 2013; 29(4):246–252. [PubMed: 24601077]