Youths' experience of trauma: Personal transformation though self-leadership and self-coaching

KARIEN JOOSTE[1] AND J. MARITZ[2]

[1]*School of Nursing, University of the Western Cape, Private Bag X17, Bellville, Cape Town 7535, South Africa. E-mail: kjooste@uwc.ac.za*
[2]*Department of Health Studies, University of South Africa, Pretoria, South Africa.*

Abstract

South African youth has a history of adversity and is exposed to high levels of trauma, either as victims of violence or as witnesses to these events. South Africa has a shortage of mental-health professionals and a fairly low capacity and motivation of non-specialist health workers to provide quality mental health services to youth. Evidence suggests that youth often display poor engagement in traditional primary and secondary specialist service structures. Creating a sense of responsibility and accountability may assist in providing support without creating helplessness. This may be achieved through self-leadership and self-coaching. This was a qualitative study aimed to understand how youth might use self-leadership through self-coaching to provide self-support during a traumatic event. The results indicated that youth were able to mobilise their internal resources in the form of self-leadership through self-coaching in order to deal with a traumatic experience. This, however, was a process of adaptation. They used different self-coaching strategies, namely cognitive strategies, emotional and spiritual care and social support. This culminated in a learning experience with personal transformation. Frontline health workers, such as nurses, social workers and psychologists, can serve as a network for youth and should be made aware of the value of self-leadership and self-coaching strategies that could assist youth in developing skills such as self-awareness, coping with anxiety, goal-setting, self-evaluation, and functional self-talk.

Keywords: Youth, trauma, self-leadership, self-coaching.

Introduction

Desmond Tutu named South Africa the 'rainbow nation'. The transition into post-apartheid South Africa has, however, not been smooth. South Africa remains one of the most unequal societies in the world (Lefko-Everett, 2011). Under the apartheid regime (1948-1994) various laws severely impacted on black South Africans' family lives, access to education and health care. Children and the youth have historically been the most neglected sector of the South African population (Lockhat & van Niekerk, 2000). The United Nations Educational, Scientific and Cultural Organisation (UNESCO) (2013) defines 'youth' as those persons between the ages of 15 and 24.

During the apartheid era racial discrimination dehumanised the majority of South Africans, especially children. The violation of children's rights extended beyond physical forms of violence such as torture, overt killing and severe ill treatment. People's rights were violated through the creation of squatter areas as a result of forceful removals, poor access to health and education, thus stripping children and parents of their heritage, citizenship and a sense of belonging. This caused severe emotional trauma resulting in a number of social ills (Truth and Reconciliation Commission Youth Hearings, 1997). The word trauma comes from the Latin word *wound*. With traumatic experiences the body, mind, spirit and relationships with other individuals may be wounded (Walsh, 2007). Traumatic situations may involve physical illness, harm, disability, abduction, torture, incarceration, persecution, relationship dissolution, job loss, migration/relocation, violence, and/or sexual abuse.

South African youth has a history of adversity and continues to be exposed to high levels of trauma, either as victims of violence or as witnesses to these events (Seedat et al., 2004). During a briefing by the South African Medical Research Council to the Parliamentary Monitoring Group (PMG) (2011)), an overview of the statistics on youth violence in South Africa was presented. South Africa's injury death rate was twice the global average. The death rate was driven by interpersonal and gender-based violence, followed by traffic injuries, self-inflicted injuries and injuries resulting from drowning, fire and falls. There was over 1 000 homicides involving boys and nearly 900 involving girls under the age of 14 in 2007. Furthermore, a total of 27 417 sexual offences were reported against children under the age of 18. Social factors driving the problem included poverty, unemployment, patriarchal notions of masculinity, vulnerable families and exposure to violence in childhood, access to firearms, alcohol and drug misuse.

Some individuals may be more vulnerable to the effects of trauma than others, who are more resilient; No one is, however, immune to suffering in extreme situations. If support is not provided, the results of childhood trauma could continue into adulthood. Struggling with the effects of trauma may lead to social isolation, declining school performance, behavioral problems and issues that may impact on the current and future quality of life and functioning as an individual (Eckes & Radunovich, 2007).

Provision of care is important and has been recognised as necessary in providing quality health care to victims of trauma (Fredheim et al., 2011). Primary health care settings are however, severely under-resourced with reference to access and services in public health care, as well as human resources (Sharkey et al., 2011) with a large shortage of mental-health professionals and a fairly low motivation among non-specialist health workers to provide quality mental health services to

young people. Access to mental health care is especially poor for those in late adolescence and early adulthood (Patel, Flisher, Hetrik & McGorry, 2007).

Effects of trauma

Trauma may produce lasting psychological and physical effects on most people who are subjected to it. The impact of traumatic experiences on the health, well-being and development of individuals has been recognised. Typical reactions to traumatic experiences include fear and anxiety, sleep disturbances, antisocial behaviour, depression and sadness (Eckes & Radunovich, 2007). The potentially devastating effects of child abuse, rape, domestic violence, disaster, kidnapping, torture and crime victimisation have led to the recognition that there is a universal reaction to overwhelming stress (Kluft, Bloom & Kinzie, 2000).

Youth exposed to trauma often experience delayed behavioural and psychological growth (Suliman, Kaminer, Seedat & Stein, 2005). Many victims of trauma in South Africa, especially the youth, are likely to struggle with their relationships with other individuals due to shattered trust, vulnerability and feelings of grief (Hamber & Lewis, 1997). This may adversely affect daily functioning. A few surveys have described the violence and trauma exposure and its associated psychological outcomes for the youth in Africa and South Africa. A study indicated that full-symptom, post-traumatic stress disorder (PTSD) (22.2% v. 5%) and current partial-symptom PTSD (12% v. 8%) were significantly higher in the South African context than in Kenya. Apart from disability, mental distress or disorders might place a substantial burden on mortality among young people, resulting in a heightened risk of suicide (Patel et al., 2007).

There is also a dearth of [youth] specific interventions to prevent mental disorders and to promote mental health (Patel et al., 2007). As such, youth may not always have access to the necessary support they require. Support-orientated interventions run the risk of creating helplessness in the person being helped (Ylvisaker, 2006). Learned optimism, combined with a sense of responsibility and accountability, may assist in providing support without creating helplessness. This may be achieved through self-leadership and self-coaching.

Self-leadership and self-coaching

Self-leadership is the process in which people direct and motivate themselves to behave and perform in a desired way in order to take responsibility for creating the conditions that help them to achieve set goals (Georgianna, 2007). Self-coaching through constructive thoughts and sharing of ideas could enhance the perceptions of self-leadership of individuals (Neck & Milliman, 1994) after trauma. There has, however, been very little investigation into establishing and

understanding how the youth could use self-leadership through self-coaching to provide self-support.

Although many people appear to recover from trauma without intervention, many do not and as such require continual attention to their distress and dysfunction (Kluft, Bloom & Kinzie, 2000). The effects of trauma could be addressed through self-leadership and self-coaching. Van Wart (2012) mentions that there are traits related to self-leadership that include self-confidence, decisiveness, resilience, energy, need for achievement, willingness to assume responsibility, flexibility, emotional maturity and the skill of continual learning. The central insight of self-leadership theory is that the attitudes, beliefs, self-designed behavioral patterns and motivational preferences of individuals make a critical difference in both accomplishment and personal satisfaction in life. Self-leadership is thus demonstrated through how people think and how they behave according to cognitive, motivational and behavioral strategies (Yun, Cox & Sims, 2006). Self-leadership enables individuals to make the shift from reactive to proactive behaviour, and improves problem-solving and accountability in implementing actions (Neck & Houghton, 2006). A comprehensive view of self-influence considers behaviour to be a result of both internal and external factors on the individual.

Self-coaching is a positive metaphor for self-regulation and is ideally an everyday, context- sensitive intervention (Ylvisaker, 2006). Self-coaching closely resembles cognitive-behaviour therapy. Evidence suggests that the effectiveness of self-coaching can be inferred from Aronson's self-persuasion theory (Aronson, 1999). This theory postulates that self-persuasion strategies are more powerful and longer lasting than alternative sources. According to Ylvisaker (2006) the general goal of self-coaching is to improve planned goal-orientated and ultimately successful behaviour. Self-coaching interventions help the individual to construct a positive image of self (Ylvisaker, 2006), are more effective than coaching from a peer or an external coach (Sue-Chan & Latham, 2004) and provide individuals with an advantage over their un-coached peers (Sliter & Christiansen, 2012).

Patel et al. (2007) state that youths often display poor engagement in traditional primary and secondary specialist service structures and that measures such as self-help strategies and education, especially in non-clinical settings, could be more effective to address their traumatic events. A greater sense of self-leadership after trauma could be created among youth by healthcare professionals in the work environment (Neck & Milliman, 1994) of Primary Health Care clinics, for example. Neck and Milliman (1994) state that coaching of the process of self-leadership to traumatised youth, could clarify their individual goals and tasks to drive performance. It also enables individuals to move from a more reactive position to a greater proactive stance. This, in turn,

could improve problem-solving abilities and accountability in implementing actions (Neck & Houghston, 2006). However, it is unclear how youths who experienced a traumatic event were supported by coaching of self-leadership. This study was guided by the following research questions:

- How do youths experience a traumatic event?
- Which self-coaching strategies do they employ to support themselves?
- How could traumatised youths be supported through self-coaching to guide themselves after a traumatic event?

The theoretical framework of Reed (2007:25) was supported in this study, that states that Appreciative Inquiry is based on the principles and assumptions that in every society, group or individual, something works. It was believed that with parents, self-coaching and self-leadership (the something) is already practised. Furthermore, reality is created in the moment and there are multiple realities. Our reality on self-leadership is created when we practise self-coaching and self-leadership. The act of asking questions of individuals influences them in some way. The researcher asked questions about self-coaching and self-leadership and influenced youths in some way.

People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known). Youths would have more confidence with their own actions in their future practices when they carry parts of their past practices forward.

Methodology

Participants

A total of 22 youth participated in the study. Their ages ranged from 18-23, with a mean age of 20. Of the 22 participants, 19 were female and 3 were male visitors to the clinic. Four participants were enrolled for tertiary education. The other 18 participants were either unemployed or in the process of looking for employment.

Research design

Appreciative inquiry (AI), located in social constructionism, formed the paradigmatic foundation for this qualitative research. AI concentrates on exploring ideas that people have about what is valuable in what they do and then tries to work out ways on which this can be built (Reed, 2007). The emphasis is on appreciating activities and the responses of people rather than concentrating on the problems. An emerging qualitative design was used (Creswell, 2013) to explore and describe the phenomenon under study (youths' experience of

trauma) in its natural setting. Qualitative studies are useful for learning about the meaning that participants hold about the phenomenon or issue as they aim to provide a holistic account of the issue under study.

Measures of trustworthiness

Strategies employed to ensure the quality of data included measures of trustworthiness (Guba, 1981). Credibility was ensured by triangulation of data of interviews and field notes. Rich descriptions and purposeful sampling contributed to applicability of the findings. An independent coder used recode procedures for ensuring the dependability of the findings. Confirmability was addressed through reflectivity of the researcher on the process (Onwuegbuzie, Leech & Collins, 2008).

Data collection procedures

In July 2012, data were collected through in-depth individual interviews (Creswell, 2013) and focus group discussions (Krueger & Casey, 2009). The interviews lasted 45 minutes on average. A pilot individual interview served as preparation for the study and detected no flaws in the data collection method. This allowed for flexibility and assisted in building rapport with the youth. The focus groups allowed for frank discussions between the youth but at the same time provided a sense of universalism, in that they did not feel alone in their experiences. Data were collected in Primary Health Care Clinics in Region B of Johannesburg. In addition, a field diary was kept in order to jot down insights as they occurred, as well as personal responses of the researchers to the events and experiences of the youth (Burns & Grove, 2009). Data were collected through purposive sampling until saturation occurred, meaning that no new information came forth. The questions were formulated by means of appreciative guidelines. The GEM Initiative's Four-D Model was used, consisting of Discovery, Dream, Design and Deliver (Watkins & Mohr, 2001). The questions posed to the participants were as follows:

- What were your best experiences after being traumatised?
- What would you like to include in the support of the traumatised youth?
- How would you like to lead yourself?

Data analysis

Data were analysed using NVivo 10 software. The computerised programme proved useful for storing and organising interviews and notes, as well as quantifying the number of sources, references and coverage of codes. The software also served as an audit trail. As computers do not think on one's behalf, we used the data analysis spiral as described in Creswell (2013).

After the data were organised into computer files and files were converted into text units, transcripts were read in their entirety several times to establish a sense of the whole before breaking it into parts. Memos (short phrases or ideas) were written in the margins. Initial codes and categories were formed and later refined. Multiple forms of evidence were identified to support each code and category and subsequently aggregated major themes formed.

Ethical considerations

The ethical considerations suggested by de Vos, Strydom, Fouché and Delport (2011) were taken into account. Consent to conduct research was granted by the University of Johannesburg and the Department of Health in Gauteng. Informed consent was obtained from all participants by means of a letter communicating the necessary information pertaining to the project. Confidentiality was maintained through the anonymity of responses. Participation was voluntary and participants were informed that they could withdraw at any stage of the data collection process.

Results

The youth expressed their experience of the traumatic events as life changing and as a catalyst for profound awakening and personal transformation. Participants were not obliged to share the nature of their trauma. Those that did volunteer revealed the nature of their trauma as including rape, sexual abuse, miscarriage, abortion, loss of parents at a young age and unemployment. Two participants shared that they were forced to relocate to Gauteng, away from family support, in order to look for work or further their education. They experienced this relocation as traumatic. Although the experience was negative for most, two participants related positive outcomes. The most significant finding was that self-support manifested through self-leadership and self-coaching. This was, however, a process of adaptation. Participants used four main self-coaching strategies, namely cognitive strategies, emotional and spiritual care and social support. Each of these strategies will now be discussed with verbatim quotes in italics.

A process of adaptation

Self-leadership and coaching are not once-off events but emerged as a '*process*' (YN4). The process required '*being patient with* [yourself] *because it might take time… there's bigger things ahead of us so we really need to be positive and be patient*' (YI4). Participants who coped positively with the trauma seemed to have resigned themselves to their loss and accepted that situations can change. '*What happened... accept the situation*' (YFG5). '*I accepted that I lost the baby* (YI5). They seemed to realise that this was a necessary process in order to move

forward. '*Nowadays I am really coping because I have realised that dwelling on the past will not take me anywhere. I need to let go that is when I will be able to let go that's when I will be able to move on*' (YN2).

Walsh (2007) remarks that recovery is a gradual process over time. It is a time of adaptation to new ways of being and doing. Ylvisaker (2006) agrees that life is a series of adjustments. Survivors of trauma realise that there are tasks associated with and responses to loss. These include accepting the loss, feeling deeply but also acquiring new skills and reinvesting energy (Maurice, 2013). Resilience involves 'mastering the possible', coming to accept what is lost and what cannot be changed while directing opportunities to what one has control over and seizing opportunities to move forward (Walsh, 2007).

Participants harnessed the following cognitive strategies in order to alleviate anxiety: positive self-talk, personal mindfulness and reading. This ultimately culminated in learning from the experience.

Cognitive strategies

A cognitive strategy is a mental process or procedure for accomplishing a particular cognitive goal (Clark & Chinn, 2009). Self-talk or inner speech is a cognitive strategy that refers to aspects of subjective experience and self-regulation, the development of internalised thought and the socialisation of communicative speech (Depape et al., 2006). Participants initiated the self-coaching process through positive self-talk. '*I told myself to have a positive attitude. I change myself, my attitude. I talk positive to myself*' (YFG1). They seemed to have experienced self-talk as '*safe*' (YFG3). '*Well I always encourage myself, that I'm gonna go through this positively. I'm not alone so I always talk to myself actually, when I'm in those situations*' (YI4). Positive self-talk may also have been a strategy to reduce anxiety.

Various studies have found that strategies associated with self-leadership include behavior-focused and constructive thought strategies (Houghton & Yoho, 2005; Pearce & Manz, 2005; Carmeli, Meitar & Weisberg, 2006). Depape et al. (2006) claim that self-talk is a predictor of emotional intelligence and is associated with emotional intelligence in a positive direction.

In addition to the self-regulatory function of self-coaching, participants mentioned the importance of being mindful and focused: '*to manage yourself, there must be results, you must keep focus* (YN2). Siegel (2007) refers to this self-regulatory function as attunement. It is a form of focusing attention on the internal world and on the here-and-now. According to Siegel (2007), this mindfulness promotes resilience and enables flexibility and self-understanding. '*Knowing yourself will make you stronger, know your goals. Because there are*

people who are negative influences and if you don't know what you want in life you will go with anything that comes along your way. So knowing your grounds will keep you strong' (YN4).

Davidson (2003) believes that setting goals and pursuing pathways towards goals activates the reward circuitry of the pre-frontal cortex, setting in motion a complex chemical interplay between the pre-frontal cortex and the amygdala. This has the effect of dampening fear and stimulating hope.

In addition to setting goals, participants realised that self-awareness as a process needed time and space for one's self, but also having support nearby in case it was needed. '*After the trauma, it is important to have space and time to be alone, but have someone nearby*' (YN4).

The final cognitive strategy was reading. Although the first two strategies focused more on the internal word, reading seemed to be a cognitive strategy that helped the participants to connect with others through reading their experiences. Reading is a complex cognitive process in which the reader, through interaction with the text, constructs appropriate meanings (Kim & Goetz, 1995). Participants found meaning in reading about other individuals' experiences of trauma as it provided a sense of universalism (psychological processes are common to all). '*Reading other people's narratives, it makes me feel better*' (YI3). '*I just live to read*' (YI5).

Reading might be viewed as a form of bibliotherapy (using reading materials to help solve personal problems). Reading is both a cognitive and affective experience (Jack & Ronan, 2008). McCann (2013) highlighted the benefits of bibliotherapy in helping to reduce psychological distress in people with moderate depression.

These cognitive strategies amalgamated into a form of experiential learning in which new knowledge and ways of knowing emerged. This learning became an internalised strategy to possibly avoid future distress and as a way of supporting others.

'*I have learnt from experience. From school, from my everyday life, from being the elder sister as well I have to be the leader. I have people, brothers looking up to me to be their role model. I don't have to do mistakes also my mother being a single parent so I have to be there for her as well*' (YI6).

This kind of learning is about the determination to direct energy to forge some good out of tragedy and endeavour to prevent future violence or trauma with renewed purpose (Walsh, 2007).

Emotional care

The process of adaptation also involved an aspect of emotional care and self-regulation which comprised the participants expressing their emotions in different ways. This was done through crying and writing of personal diaries '*well I do cry, that makes me feel better*' (YI3).

'*Like if I'm feeling like how I'm feeling now, I just take a book and write what I feel, what I'm going through and how I can help myself to overcome it*' (YI2).

Jacobson, Marrocco, Kleinman and Gould (2011) warn that restrictive emotionality is highly associated with elevated depressive symptoms and suicidal thoughts and behaviours among high school students. The skills of expressing one's emotions, either verbally or through another medium such as writing, are critical for emotional self-regulation.

The emotional and physical health benefits of expressive writing after a traumatic or stressful event have been well documented (Baikie & Wilhelm, 2005). Writing may provide a safe avenue for emotional expression. Writing may be cathartic or confrontational and has the potential to bring about cognitive and emotive changes, both with long and short terms.

Spiritual care

In times of great stress people often turn to spiritual practices as a means of coping. Spirituality is broader than religion and includes a relationship with self, others and a higher being. Spiritual care may include prayer, meditation and reading devotional scriptures (Hartwick & Kang, 2013). Frankl (1984) mentions that one can withstand, and even thrive in difficult situations if one has commitment to the cause and an understanding of how the situation is tied to the larger mission.

One participant said '*It takes a lot of courage and faith to get through* (YFG9). Another mentioned that without this spiritual aspect, coping or recovery would be much harder and could hinder transformational growth: '*That is when my faith moved to the next level because I realised without God life will be hard. I started praying each and every day asking for his protection, guidance and for him to help me to be strong no matter how hard it is*' (YN2).

Shaw, Joseph and Linley (2005) concluded that religion and spirituality are typically associated with post-traumatic growth in positive ways. Gottlieb (2003) warns that '*we can open our hearts to full acceptance of the world, but not by telling others or ourselves that there is some cosmic meaning for all of this pain. Instead, we find that the only way to fully take in what surrounds us, to be fully*

at peace, is to resist'. Resistance in this context means that we resist what is unjust in order to realise what is just. Resisting unfair conditions sustains a practice of reasonable hope (Weingarten, 2010).

Hill and Pargament (2003) note that religion and spirituality are not a set of beliefs and practices divorced from everyday life, to be applied at special times or only on special occasions, but should be fostered and sustained constantly. One way participants' practised spirituality was to give back to others through volunteering. '*I volunteer at a crèche at home. Just stuff that I see every day it's not right so if I can just start making a difference in the community. I just wanna help the young people even if it's not gonna do any good at least I tried'* (YI5). Another wanted to '*go to school and talk to them'* (YI2).

Finally, participants mentioned that their spiritual well-being was enhanced with a renewed appreciation of life. '*It is about appreciating life and being alive no matter the circumstances'* (YN4). Andrykowski et al. (2005: 600) reported that survivors often report that the: '... experience has improved interpersonal relationships, enhanced appreciation for life, reordered life priorities, increased empathy and self-esteem, or deepened spirituality'. Spiritual coping strategies may enhance self-empowerment, which safeguards the wholeness and integrity of the person (Baldacchino & Daper, 2001).

Social support

Social support may be from kinship networks such as family, or professional networks such as teachers, nurses or social workers. Social care was provided to the youth through positive role models (who in some cases were deceased). An additional layer of social care was interestingly provided by being aware of or avoiding certain peers.

A role model is someone who inspires others with positive thoughts, their character, values and goals. This influence could be positive or negative. Participants made specific reference to the positive role models in their lives. These included their parents (often their mothers), family or community members. The youth seemed to have internalised what they have learnt or observed form their role models and have taken this learning as a guide as to how to live their lives.

'*I use to look up to my mother. When things went wrong, I think about her'* (YFG6).
'*Well I actually learnt this from other people. I love looking at how other people live and learning from their experiences. I don't want to repeat the same mistakes they have made. My family and other people around me have made mistakes and I don't want to do the same'* (YN4).

Our field diaries note a great amount of mixed emotions on the role of peers as a social support system. Youth are very susceptible to peer norms (Patel et al., 2007). Some participants felt that '*you can't trust them*'. A reference was made, girls who cannot be trusted to share information with or act as a supportive care because '*girls skinner*' [gossip]. When using peers as social support, a warning was given '*You must trust the person*' (FG7). Weingarten (2010) affirms that not all relationships give rise to support or hope.

Youth used their moral and value systems to provide a guide as to '*know what's good for me so other things I really do ignore them* '(YI4). '*They do things that are so different and I just push myself away from that. My friends are so really different from me*' (YI2).

Peer relationships represent an important component of youth's supportive context. Peer relationships are situated within a complex context with varying aspects influencing these relationships. As such they may be supportive or disruptive (Li et al., 2011).

Conclusion

The results indicated that youth were able to mobilise their internal resources in the form of self-leadership through self-coaching in order to deal with traumatic experiences. This was, however, a process of adaptation. They adapted by using different self-coaching strategies, namely cognitive strategies, emotional and spiritual care and social support. Self-leadership through self-coaching is a life-long personal journey, one in which an individual develops his or her strong qualities and addresses their weaknesses. The results support a statement by Levine (2008) that traumatic experiences can be a jump-off point for relational, psychological, emotional, spiritual and physical transformation.

Frontline health workers, such as nurses, social workers and psychologists, should be made aware of the value of self-leadership and self-coaching strategies that could assist youth in developing skills such as self-awareness, coping with anxiety, goal setting, self-evaluation and functional self-talk. Youth can also be assisted in identifying motivating associations, motivating images, people or other symbols of strength and success (Ylvisaker, 2006) on which they may model themselves or bring to mind in times of distress. With the ever increasing non-verbally mediated exchanges such as Facebook, text messaging, and e-mailing, youths may be in greater need of assistance in identifying and expressing emotions. Therefore, the interaction via social media alone may also inhibit the emotional expression and connection to others as a form of support. Although trauma and stress may have a negative impact on youth, social support may play a protective role.

Youth often understand the components of mental health but need structured support to translate this understanding into lifestyle activities as well as in implementing and monitoring self-coaching. Bibliotherapy is another approach to use as an adjunct to standard care and treatment.

Helping youth perceive themselves as resilient creates hope. However, the future may be uncertain and not completely within our control. Seeking pathways toward something better in our lives helps to sustain hope.

A limitation of this study is the small sample size. Results may therefore not be generalised. The literature control, however, assisted in the transferability of the results. Self;-reported data, such as interviews and focus groups, rely on individuals' perceptions and cannot be independently verified. Future research could focus on evaluating intervention strategies of self-leadership and coaching for traumatised youth.

References

Andrykowski, M.A., Bishop, M.M., Hahn, E. A., Cella, D. F., Baumont, J.L., Brady, M. J. & Wingard, J.R. (2005). Long-term health-related quality of life, growth, and spiritual well-being after hematopoietic stem-cell transplantation. *Journal of Clinical Oncology,* 23(3), 599-608.

Aronson, E. (1999). The power of self-persuasion. *American Psychologist,* 54, 875-884.

Baikie, K. A. & Wilhelm, K. (2005). Emotional and physical health benefits of expressive writing. *Advances in Psychiatric Treatment, 11*, 338-346.

Baldacchino, D. & Draper, P. (2001). Spiritual coping strategies: A review of the nursing research literature. *Journal of Advanced Nursing, 34(6)*, 833-841.

Burns, N. & Grove, S. K. (2009). *The Practice of Nursing Research* (6th ed.). St. Louis: Elsevier.

Carmeli, A, Meitar, R. & Weisberg, J. (2006). Self-leadership skills and innovative behaviour at work. *International Journal of Manpower*, 27(1), 75 – 90.

Clark, C. & Chinn, L. (2009). *Cognitive Stategies*, at http://www. education. com/ reference/ article/cognitive-strategies/. November 2013.

Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing Amongst the Five Approaches (3rd ed.).* Los Angeles: SAGE.

Davidson, R. J. (2003). Affective neuroscience and psychophysiology: Toward a synthesis. *Psychophysiology, 40*, 655-665.

De Vos, A. S., Strydom, H., Fouche, C. B. & Delport, C. S. (Eds.) (2011). *Research at Grass Roots* (4th ed.). Pretoria: Van Schaik.

Depape, A., Hakim-Larson, J., Voelker, S., Page, S. & Jackson, D. L. (2006). Self-talk and emotional intelligegence in university students. *Canadian Journal of Behavioural Science, 38(3)*, 250-260.

Eckes, A. & Radunovich, H. L. (2007). *Trauma and Adolescents*. University of Florida. IFAS Extension.

Frankl, V. (1984). *Man's Search for Meaning*. New York: Washington Square Books.

Fredheim, T., Danbolt, L. J., Haavet, O. R., Kjønsberg, K. & Lien, L. (2011). Collaboration between general practitioners and mental health care professionals: A qualitative study. *International Journal of Mental Health Systems,* 5, 13.

Georgianna, S. (2007). Self-leadership: A cross-cultural perspective, *Journal of Managerial Psychology*, 22(6), 569 – 589.

Gottlieb, R. S. (2003). *A spiritual Resistance: Finding a Peaceful Heart and Protecting the Earth.* Maryland, MD: Lanham.

Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review,* 29, 75-91.

Hamber, B. & Lewis, S. (1997). *An Overview of the Consequences of Violence and Trauma in South Africa*. Research Report. Centre for the Study of Violence and Reconciliation, South Africa.

Houghton, J.D. & Yoho, S.K. (2005). Toward a contingency model of leadership and psychological empowerment: When should self-leadership be encouraged?' *Journal of Leadership & Organizational Studies,* 11 (4), 65–83.

Hartwick, J.M. & Kang, S. J. (2013). Spiritual practices as a means of coping with and meliorating stress to reduce teacher attrition. *Journal of Research on Christian Education,* 22, 165-188.

Hill, P. & Pargament, K.I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health. *American Psychologist,* 58(1), 64-74.

Jack, S.J. & Ronan, K.R. (2008). Bibliotherapy: Practice and research. *School Psychology International,* 29(2), 161-182.

Jacobson, C. M., Marrocco, F., Kleinman, M. & Gould, M. S. (2011). Restrictive emotionality, depressive symptoms, and suicidal thoughts and behaviors among high school students. *Journal of Youth Adolescence,* 40, 656-665.

Kim, Y.H. & Goetz, E.T. (1995). Children's use of orthographic and contextual information in word recognition and comprehension. In V. W. Berninger (Ed.), *The Varieties of Orthographic Knowledge: Relationships to Phonology, Reading, and Writing* (pp. 205-249). Dortrecht, The Netherlands: Kluwer Academic publishers.

Kluft, R. P., Bloom, S. L. & Kinzie, J. D. (2000). Treating traumatized patients and victims of violence. In C.C. Bell (Ed.), *Psychiatric Aspects of Violence: Issues in Prevention and Treatment. New Directions in Mental Health Services,* 86, 79-102.

Krueger, R. A. & Casey, M A. (2009). *Focus Groups* (4th ed.). Thousand Oaks: Sage.

Lefko-Everett, K. (2011). *Inequality: South Africa's greatest devide.* Retrieved October 10, 2013, at http://reconciliationbarometer.org/volume-eight-2010/inequality-south-africa%E2%80%99s-greatest-divide/. November 2013.

Levine, P.A. (2008). *Healing Trauma. Restoring the Wisdom of your Body (Audiorecording*). Boulder, CO: Sounds True, Inc.

Li, Y., Lynch, A. D., Kalvin, C., Liu, J. & Lerne, R. M. (2011). Peer relationships as a context for the development of school engagement during early adolescence. *International Journal of Behavioral Development,* 35(4), 329-342.

Lockhat, R. & Van Niekerk, A. (2000). South African children: A history of adversity, violence and trauma. *Ethnicity and Health,* 5 (3/4), 291-302.

Maurice, J. M. (2013). Chilean miners' experience and parallels to surviving the foster care system. *Canadian Family Physician,* 59 (June), 658-659.

Neck, C.P. & Houghton, J.D. (2006). Two decades of self-leadership theory and research: Past developments, present trends, and future possibilities, *Journal of Managerial Psychology*, 21(4), 270-295.

Neck, C. P. & Milliman, J. F. (1994). Thought Self-leadership: Finding Spiritual Fulfillment in Organizational Life. *Journal of Managerial Psychology*, 9(6), 9-16.

Onwuegbuzie, A. J., Leech, N. L. & Collins, K.M. (2008). Interviewing the interpretative researcher: A method for addressing the crisis of representation, legitimisations and praxis. *International Journal of Qualitative Methods,* 7(4), 1-15.

Parliamentary Monitoring Group (PMG) (2011). At http://www.pmg.org.za/report/20110601-medical-research-council-provincial-overview-issues-pertaining-violen). October 2013.

Patel, V., Flisher, A. J., Hetrick, S. & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *Lancet, 369*, 1302–13.

Pearce, C.L. & Manz, C.C. (2005). The new silver bullets of leadership: the importance of self and shared leadership in knowledge work. *Organizational Dynamics,* 34(2), 130-40.

Reed, J. (2007). *Appreciative Inquiry.* Thousand Oaks: Sage.

Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B. & Stein D.J. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools. *British Journal of Psychiatry,* 184, 169-175.

Sharkey, A., Chopra, M., Jackson, D., Winch, P. J. & Minkovitz, C. S. (2011). Influences on health care-seeking during final llnesses of infants in under-resourced South African settings. *Journal of Health, Population and Nutrition,* 29(4), 379-387.

Shaw, A., Joseph, S. & Linley, P. (2005). Religion, spirituality, and post-traumatic growth: A systematic review. *Mental Health, Religion & Culture,* 8(1), 1-11.

Siegel, D. J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-being.* New York: W W Norton & Co.

Sliter, K. A. & Christiansen, N.D. (2012). Effects of targeted self-coaching on applicant distortion of personality measures. *Journal of Personnel Psychology, 11(4)*, 169-175.

Sue-Chan, C. & Latham, G. P. (2004). The Relative Effectiveness of External, Peer, and Self-Coaches. *Applied Psychology: An International Review,* 53(2), 260-278.

Suliman, S., Kaminer, D., Seedat, S. & Stein, D.J. (2005). Assessing post-traumatic stress disorder in South African adolescents: using the child and adolescent trauma survey (CATS) as a screening tool. *Ann Gen Psychiatry,* 4, 2.

Truth and Reconciliation Commission Youth Hearings (1997). At http://www.justice.gov.za/trc/special%5Cchildren/claassen.htm. October 2013.

United Nations Educational, Scientific and Cultural Organization (UNESCO), (2013). At http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/. November 2013.

Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process, 46(2)*, 207-227.

Van Wart, M. (2012). *Leadership in Public Organisations: An Introduction*. USA: M.E. Sharpe Inc.

Watkins, J. M. & Mohr, B. J. (2001). *Appreciative Inquiry: Change at the Speed of Imagination*. CA: San Francisco.

Weingarten, K. (2010). Reasonable hope: Constructs, clinical applications, and supports. *Family Process,* 49(1), 5-25.

Ylvisaker, M. (2006). Self-Coaching: A Context-sensitive, person-centred approach to social communication after traumatic brain injury. *Brain Impairment,* 7(3), 246-258.

Yun, S., Cox, J. & Sims, H.P. (2006). The forgotten follower: A contingency model of leadership and follower self-leadership. *Journal of Nursing Psychology,* 21(4), 374-388.