

THE PSYCHO-EDUCATIONAL USE OF MENTAL TOUGHNESS IN DEALING WITH
TRAUMA

by

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PROMOTER: PROF HE ROETS

OCTOBER 2014

DECLARATION

Student number: 3281-424-0

I declare that THE PSYCHO-EDUCATIONAL USE OF MENTAL TOUGHNESS IN DEALING WITH TRAUMA is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE

(Mrs AMS van Niekerk)

DATE

SUMMARY

THE PSYCHO-EDUCATIONAL USE OF MENTAL TOUGHNESS IN DEALING WITH TRAUMA

by

AMS van Niekerk

DEGREE: Doctor of Education
SUBJECT: Psychology of Education
PROMOTER: Prof. HE Roets
DATE: OCTOBER 2014

The purpose of this study was to investigate whether a psycho-educational intervention program could support traumatised people to increase their mental toughness. Mental toughness is a well proven phenomenon in sports psychology as well as in leadership in the corporate world. I wanted to apply the use of mental toughness in trauma. Literature was consulted to understand the phenomena of mental toughness and trauma respectively. The corresponding aspects of mental toughness and trauma were selected for the literature review and many similarities between mental toughness and trauma were discovered. The corresponding aspects included action taking, the importance of the “self”, facing negativity and adversity, the importance of support systems, flexibility and adjustment, dealing with guilt and self-blame, the role of self-talk, people’s perceptions, goal-setting, commitment, helplessness / learned helplessness and dealing with stress. I used the corresponding aspects to compile a psycho-educational intervention programme to support traumatised persons to develop increased mental toughness that will support them to better deal with trauma.

A valid and reliable psychometric instrument, the MTQ48 (Mental Toughness Questionnaire 48), has been successfully used to determine people’s mental toughness in sports psychology and in corporate management, but has never been tested before in supporting traumatised people. An action research design was employed, where both qualitative as well as quantitative methods were used. This is

also known as a mixed research design. Eight traumatised people took part in the research which was presented weekly, as individual sessions, over eight weeks. Data collection methods included questionnaires, observation and individual therapy.

The results of the study indicated that seven of the eight participants' overall mental toughness increased after the intervention program, and four of the eight participants' mental toughness components increased. As an additional benefit, all respondents indicated that they could better deal and cope with their trauma after the intervention program. The conclusion could be drawn that the psycho-educational intervention program was successful in supporting the traumatised participants to increase their mental toughness.

KEY WORDS

mental toughness; control, challenge, confidence, commitment; trauma; traumatised person; psycho-education; individual therapy; intervention program; action research; mixed research design.

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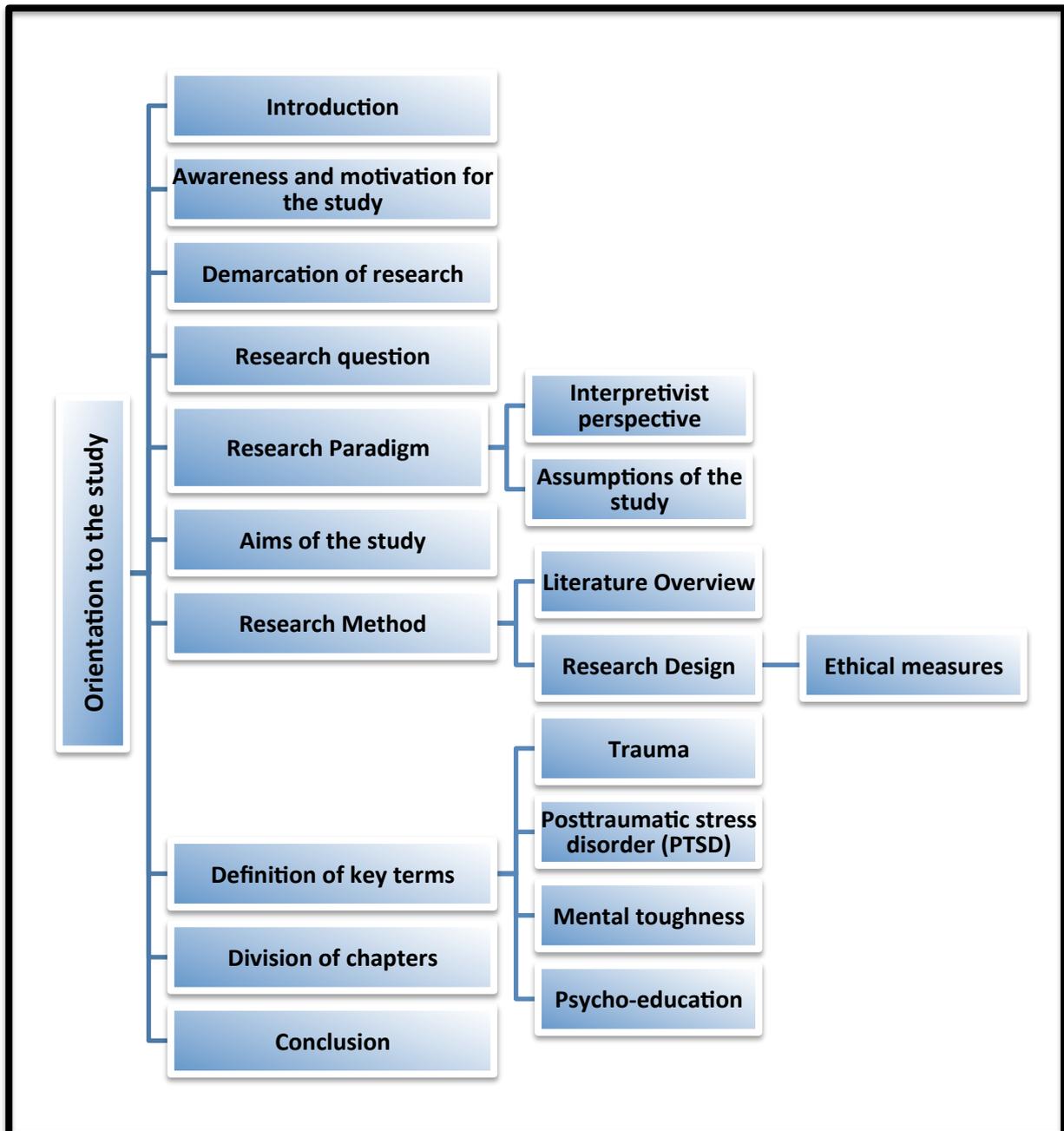
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CHAPTER 1

ORIENTATION TO THE STUDY

Figure 1.1: Chapter Outline



1.1 INTRODUCTION

The purpose of this chapter is to provide an outline of the study, which focussed on the use of mental-toughness when dealing with trauma. The background, context for the

formulation of the problem statement and the purpose of the study are provided. Thereafter the problem statement, aims of the study, research assumptions involved and the research method follows. Finally, clarification of concepts and a summary of the grouping of the chapters are presented.

1.2 AWARENESS AND MOTIVATION FOR THE STUDY

“The world breaks everyone and afterward, some grow strong at the broken places” (Hemingway 1929) (Roets & Preston 2008a: 15).

As an educational psychologist I am confronted, on a daily basis, with “broken people” and/or hurt people who experienced trauma, such as divorce, abuse, suicide, death, housebreaking, bullying and natural disasters. Trauma is part of every person’s life and as Roets and Preston (2008b: 25) state, a single traumatic event can have lasting consequences on a person as well as on the people in his surroundings, including the environment and community in which he lives. In practice I deal with many people whose unresolved experiences—in not dealing with their trauma—negatively affects their relationships with themselves, as well as with their families, friends and other people around them (Roets 2009). In this way, unresolved traumatic experiences of the past, become “unfinished business” in the future and become barriers that prevent the traumatised person from dealing with normal everyday life problems as well as with new traumatic experiences (Marshall 2007; Perschy 2004: 12; Roets 2009; James & Gilliland 2013: 150, 177).

Professionally, I have experienced that some people have the ability to recover sooner than others who on the surface, seem to have been exposed to less traumatic conditions. Noticing this, I contemplated the characteristics, personalities and skills of these people. I questioned whether it would be possible to support traumatised people to develop skills, knowledge and characteristics in order to be able to *“bend and adapt”*, like a tree in the wind, when trauma hits instead of *“snap(ping) at the gust of the wind”* of a trauma (Roets & Preston 2008a: 15). This question became the motivation for the current study.

Contemporary counselling methods consist of a variety of focus areas, for example, resilience, positive self-talk, mindfulness, stress that can motivate, positive self-esteem, flexibility, emotional intelligence, affirmations, change of thoughts, internal locus of

control, self-confidence, self-control, goal-setting, etcetera. The search to find information about the characteristics, knowledge and skills that a person requires in order to be able to “grow *strong at his broken places*”, as Hemingway stated in Roets & Preston (2008a: 15) and to be able to bounce back and deal with the challenges and stress that a traumatic experience places on the individual, led the researcher to a concept called mental toughness. Mental toughness is defined as: “*The quality which determines in large part how people deal effectively with challenge, stressors and pressure...irrespective of prevailing circumstances*” (Clough & Strycharczyk 2012: 1). I committed to examine where there is any research foundation for mental toughness.

In 2002, after more than eight years of research, Drs Peter Clough and Keith Earle developed a tool to measure a person’s mental toughness. The tool is currently known as the Mental Toughness Questionnaire 48 (MTQ48) (Clough & Strycharczyk 2012: 47; Mental toughness 2012: 2). Clough and Strycharczyk (2012: 47) describe the four pertinent reasons for developing the MTQ48:

- to learn more about the reason why some people could handle challenges and stress better than others;
- to discover whether these strengths and weaknesses of people could be measured;
- to determine whether anything could be done to increase both people’s mental toughness and their performance;
- to discover a way to assess the success of the intervention programmes that claim to be successful.

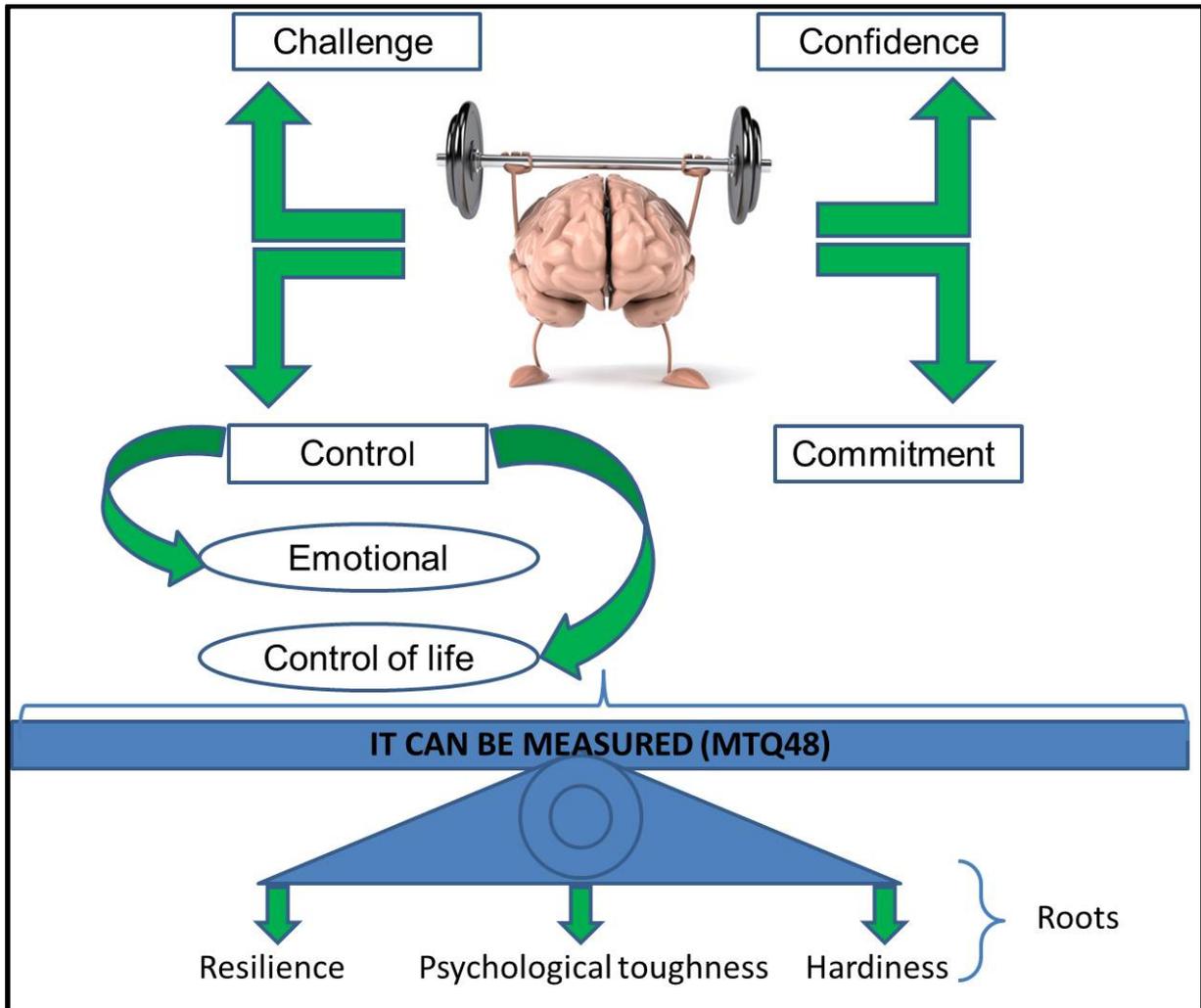
Due to mental toughness’s multiple possibilities to be used universally, today the MTQ48’s major contributions can be seen in the areas of education, social work, stress management, health, sports, career guidance and occupational areas (Clough & Strycharczyk 2012: 48; Mental toughness 2012: 4).

A research question initially formed concerning whether it would be possible to use mental-toughness to support people through their dealing of trauma. According to Preston (2011: 2) trauma is stressful and it threatens a person’s physical, social or emotional wellness. Trauma can be experienced directly, by being a witness of an event and/or by learning about an event. Every trauma survivor is unique and brings his own

perceptions and coping mechanisms to a counselling session (Preston 2011: 2; Meyer, Moore & Viljoen 2000: 344; Strydom, Roets, Wiechers & Krüger 2002: 41). Therefore part of what makes any experience traumatic or less traumatic, is the way a person interprets both the event itself and his ability to cope and gain control or remain in control of a situation. James and Gilliland (2013: 46) also indicate that although it is still controversial to determine the way in which a person's culture interacts with trauma, it is clear that it does.

What makes mental toughness more favourable in my consideration in using it to support people who deal with trauma, is that mental toughness has four vital components, namely control, challenge, commitment and confidence, as illustrated in Figure 1.2. This is known as a 4 C's model (Clough & Strycharczyk 2012: 34; Mental toughness 2012: 2). Control has two sub-aspects, namely emotional control and control over a person's life. There is a very strong link between mental toughness, stress management, performance and behaviour (Mental toughness 2012: 1). Further, the MTQ48 has its roots in three existing models, namely resilience, hardiness and psychological toughening (Clough & Strycharczyk 2012: 34-35; Horsburgh, Schermer, Veseleka & Vernon 2008: 100). According to the previous discussion mental toughness includes essential contemporary counselling concepts and furthermore, mental toughness can be measured.

Figure 1.2: Mental toughness components



Source: Researcher’s own illustration

Clough and Strycharczyk (2012: 11) emphasise that a core element of mental toughness is effectively coping with stress. Stressful experiences are triggered and can become traumatic due to a person’s inability to predict and control situations (Bethany 2007: 124). Stress has two combined aspects, namely the impact of the stressor and a person’s reaction on that stressor (Clough & Strycharczyk 2012: 18; Preston 2011: 2; Strydom *et al.* 2002: 41). A person’s response to a stressor will therefore either reaffirm the feelings of stress, or allow the person to perform at his best (Clough & Strycharczyk 2012: 18).

Bethany (2007: 124) states that a person’s ability to gain insight into his stress responses and therefore be able to change his own reactions to his responses can provide the person with a feeling of control over his responses. It is at this point in trauma, where education about the “*psychological basis for psychological phenomena*”,

such as depression, intrusive memories, mood fluctuations, aggression and memory instability, provides a traumatised person with a more realistic perspective of himself and to be able to see this “*phenomena*” as symptoms and not as weaknesses. A traumatised person then realises that he is not a victim and rather a survivor and he will be able to see himself in a more positive light, which will not damage his self-esteem. This “*psychological basis for psychological phenomena*” education is addressed by Bethany (2007: 124) as psycho-education.

According to Clough and Strycharczyk (2012: 22) a person’s mental state explains approximately 50% of the change of his performance level. Shockingly, roughly 5% of a person’s time is spent on the maximum level of his performance through the training of his mind. Clough and Strycharczyk (2012: 22) state that performance and well-being are both related to stress management. If stress could be managed, performance would improve and well-being would be optimised, and *vice versa*: if stress could be managed, well-being would improve and performance would be optimised. It appears that stress, performance and well-being are inter-related and inter-connected, and it is difficult to determine which aspect is the catalyst (Clough & Strycharczyk 2012: 271). However, for the current study, the focus remains on the development of mental toughness, and as such, the inter-correlation between mental-toughness, stress management, performance and well-being.

According to Waibel-Duncan and Yarnel (2011: 168), from as early as the end of the 20th century, Drs Steven and Sybil Wollen demonstrated concern about the nature of the psychological world that became rather one-track-minded with disease, rather than focusing on the positive characteristics of psychology prior to World War II. These positive characteristics included the curing of mental illness, the supporting of people in order for them to experience their lives as more fulfilling and helping people to discover and develop their talents (Seligman 1998:1; Miller and Harvey 2001: 313; Taylor, Kemeny, Reed, Bower and Groenewald 2000: 106). Waibel-Duncan and Yarnel (2011: 168) further states that, in their work with children of alcoholic parents, Drs Wolin and Wolin developed a model which is called the Wolins’s Challenge Model of human psychology. This model focuses on the interaction between aspects that threaten the physical and psychological well-being of children, and resilience which restricts the potential of threatening aspects in order to promote children’s physical and psychological health.

The Challenge Model conceptualises persons as their own best healers. A person's innate urge to survive as well as his protective factors (e.g. insight, initiative, independence, relationships, creativity, humour and morality) that will be developed in surviving trauma have a remarkable impact on a person's life (Weibel-Duncan & Yarnel 2011: 168; Wolin & Wolin 1993: 15). Bensimon (2012: 782) also indicates that concerning the way in which a person deals with trauma, research focuses by far on the pathological (e.g. PTSD) rather on the positive responses (e.g. resilience) that a person will gain through experiencing trauma. However, the past decade is renowned for a steadily growing number of mental health professionals who have made a shift from focusing on the destroying effects of trauma towards the strengths of a person's qualities that will recover his sense in life (Waibel-Duncan & Yarnel 2011: 168-169). The decision to rather focus on a person's abilities to prosper was also made by Bonanno (2004: 20-27) in his objections against trauma studies that focus on the pathological aspects of a person in his dealing with trauma. Bonanno (2004) states that by focusing on this negative side of a person's characteristics, the value of person's resilient abilities is sabotaged.

The available research describing the characteristics that a person requires in order to deal and better cope with trauma, are still very controversial. Psychology has made a shift away from the outdated question of whether people are a product of nature or nurture, as both have an influence. The same applies for mental toughness; as Clough & Strycharczyk (2012: 208) state, some people are born with toughness and others may develop toughness.

The opposite of mental toughness is mental sensitivity. Not all people want to change and become mentally tough (Clough & Strycharczyk 2012: 6; Egan 2014: 402), but mentally tough people seem to be more happy and fulfilled than those who are mentally sensitive – although mentally sensitive persons are also capable of living happy lives (Clough & Strycharczyk 2012: 274). Counsellors should be cautious of displaying too much enthusiasm concerning the development of mental toughness on every client, as every person is unique and not all people will be excited about the journey to gain more mental toughness and that should be respected (Clough and Strycharczyk 2012: 6).

Although there exists a great deal of controversy concerning the characteristics people require to deal with trauma, Sheikh (2008: 87) states that the most important factor to be able to cope with trauma, is the person's active engagement and his willingness to

change. Clough and Strycharczyk (2012: 269) support Sheik's statement by clarifying that before the journey of gaining mental toughness commences, a person should be committed to the journey. Commitment to change is thus an important term in both the phenomena of the development of mental toughness and coping with trauma.

The main focus of the study is to attempt to find corresponding aspects and a relationship between mental toughness and trauma. A common ground that emerges between different areas of counselling is called transition (Clough and Strycharczyk: 2012: 273). As Strydom *et al.* (2002:14) stated, the most appropriate and effective therapeutic method in order to support a client, is that there does not exist a correct or rigid supporting method, but that the method that is used by the successful therapist, is characterised by creativity and problem solving. Strydom *et al.* (2002: 41-42) further state that there are indeed a variety of techniques and methods that can be used to support and counsel clients. Some of the techniques and methods may also be better suited to certain therapists, but these can also be represented by a different school of thought, with a different therapeutic ground and even a different anthropology. Essentially, the context of supporting and counselling, where the technique is used, may differ from the original theory, but it should always be pedagogically accountable. Clough and Strycharczyk (2012: 2, 271, 273) explain transition as "*joining the dots*" of previously separated issues, not to provide a solution to a whole problem, but to move forward on the challenging and exciting "*journey that is called life*".

The literature review garnered the following results: There is useful information about methods that a therapist can use to support a client in how to develop characteristics and skills in dealing with trauma, but these sources are descriptive in nature and do not provide any scheme/(s) of how to use specific strategies and techniques. Currently, the literature merely delineates diagnostic aspects and initial techniques as self-help guidelines for persons who have lost a loved one through trauma. Limited information is provided about the expectations of a professional relationship between the therapist and the client, during continuous psychotherapy, where the focus falls on the effects of trauma on the client (Corr, Nabe & Corr 2006: 5; Lamb 1988: 561-562; James & Gilliland 2013: 3, 7). According to e-mail communication between myself and doctor Peter Clough, a developer of the MTQ48 and one of the authors of the book "Developing mental toughness: improving performance, wellbeing and positive behaviour in others", there is little evidence about the relationship between mental toughness and its applicable use in psychology. There is also a huge gap between the

theory and practice which is associated with the behaviour of mentally tough performers (Clough & Strycharczyk 2012: 263, 268; Crust 2008: 579-580). It seems that there is a dearth in the literature of practical ways where the therapist and the client are involved in continuous psycho-therapy in order to support the client, to develop characteristics and skills that will support him when he deals with trauma.

The literature overview's conclusion led me to determine the demarcation of the research for this study, as stated in 1.3.

1.3 DEMARCATION OF RESEARCH

For the purpose of this study, the following aspects are emphasized:

- The role of mental toughness in trauma.
- The therapeutic intervention in the development of mental toughness.
- The effectiveness of a psycho-educational intervention programme in enhancing mental toughness.

1.4 RESEARCH QUESTION

The problem central to this research is:

Would a psycho-educational programme that aims to improve mental toughness in a traumatised person lead to heightened mental toughness?

1.5 RESEARCH PARADIGM

1.5.1 Interpretivist perspective

A paradigm is the way in which a person sees the world. A researcher's paradigm indicates the way in which he sees the world and it includes his perspectives, assumptions and meanings (Maree & van der Westhuizen 2007: 32; Joseph 2000: 11). Included in this paradigm are my prior experiences as well as the theoretical foundation,

which is acquired through the literature review. In this research, the interpretivist perspective was employed. Inasmuch, I attempted to understand and give meaning to the phenomena of trauma and mental toughness through the meaning which the participants of the study provided. The interpretivist perspective implies the following (Nieuwenhuis 2007: 59-60; De Vos, Schulze & Patel 2006: 6):

- Every person will observe and construct reality within his own social context and therefore it is not objective.
- The focus is on a person's own experience and the subjective meaning which he allocates to it.
- Human behaviour is influenced by multiple social realities which can change over time.
- Human knowledge and understanding is limited by a person's own experiences and meaning, which influences social reality.

1.5.2 Assumptions of the study

When taking the above-mentioned interpretivist implications into consideration, it is clear that my own value system, assumptions and preconceived notions may have influenced and restricted the research (Maree & Van der Westhuizen 2007: 32; Joseph 2000: 11). Therefore it is required that I determine and analyse my own assumptions about the phenomena of trauma and mental toughness prior to the study, in order to not influence the validity of the conclusions. My personal assumptions regarding traumatised persons and their mental toughness are the following:

- Traumatized persons are unaware of the concept of mental toughness and the roles that challenge, confidence, control and commitment can play in their functioning and healing.
- Traumatized persons are unaware of their own role and inner strength in their healing process.
- An effective therapeutic intervention programme will lead to the development of mental toughness in a traumatized person.

I am aware that the above assumptions could have an influence on the way in which the data was analysed and interpreted. To counteract this my promoter Professor HE Roets

verified the analysis and if there are any queries, the analysis is open for debate and changes will be made.

1.6 AIMS OF STUDY

The overall aim of this study is to use a psycho-educational intervention programme for traumatised people to enhance their mental toughness so that by having more mental toughness, they can better deal with their trauma.

In order to reach this aim, I divided the overall aim into the following sub-aims:

- a literature review about the nature of mental toughness;
- a literature review of what trauma encompasses;
- an explanation of the research methods used in this study;
- a discussion of the sessions that were conducted to augment mental toughness in traumatised persons;
- the creation of an individual therapy intervention programme in order to support traumatised persons to increase their mental toughness;
- a description of the implementation of the sessions;
- the performance of a pre-test, post-test MTQ48 in order to determine the efficacy of the programme;
- feedback and conclusion of the results of the study.

1.7 RESEARCH METHOD

Given the aim to obtain a better insight and knowledge of the nature of trauma and the developing of mental toughness, the research method consisted of a literature overview and a research design.

An absence was identified in the literature review regarding the practical ways describing how a therapist could support the client through continuous psycho-therapy in order to develop characteristics and skills that would support him when he deals with trauma.

1.7.1 Literature Overview

The literature sources that dominated the literature review are indicated in Table 1.1 below.

Table 1.1: Overview of sources

THEME	AUTHOR(S)
Mental toughness	<ul style="list-style-type: none">• Clough, P & Strycharczyk, D. 2012• Association for Qualitative Research (AQR). 2007• Mental toughness. 2012
Trauma	<ul style="list-style-type: none">• Bonanno, GA. 2004• Corr <i>et al.</i> 2006• Kunst, MJJ. 2011• Lamb, DH. 1988• Marshall, S. 2007• Perschy, MK. 2004• Preston, LD. 2011• Roets, HE. 2009• Roets, HE. & Preston, LD. 2008• Sheikh, AI. 2008• Biermann, HH. 2005• James, RK. & Gilliland, BE. 2013.
Psycho-education	<ul style="list-style-type: none">• Bethany, J. 2007• Roets, HE. 2009• Strydom <i>et al.</i> 2002• Van den Aardweg, EM. & Van den Aardweg, ED. 1999• Meyer <i>et al.</i> 2000• Biermann, HH. 2005• Gordon, AM. & Browne, KW. 2004

- De Witt, MW. & Booyesen, MI. 1994
- Graham, A. 2004
- Jordaan, WJ. & Jordaan, JJ. 1998
- Johnson, DW. 2006
- McNiff, J. & Whitehead, J. 2011: 14

•

Research

- Holly, ML., Arhar , J.& Kasten, W. 2005: 302
- Leedy, PD. & Ormrod, JE. 2005
- McBride, DM. 2013: 52, 344-345
- Collins, KJ., Du Plooy, GM., Grobbelaar, MM., Puttergill, CG., Terre Blanche, MJ., Van Eeden, R.,Van Rensburg, GH. & Wigston, DJ. 2000
- Johnston, B. & Christensen, L. 2004
- Somekh, B. & Lewin, C. 2011: 260
- McAteer, M. 2013: 29-30
- Norton, LS. 2009: 54-55
- Welman, Kruger and Mitchell 2010: 56
- Trochim, WMK. 2006: 1
- Statistics Canada. Non-probability sampling. 2013: 1

1.7.2 Research Design

In order to investigate the research question, a mixed research design was utilised. A mixed design consists of both qualitative as well as quantitative methods (Holly, Arhar & Kasten 2005: 302). Quantitative research indicates the collection and analysis of numerical data where statistical methods are mostly used. Qualitative methods include research where information such as interviews, field notes and images are collected

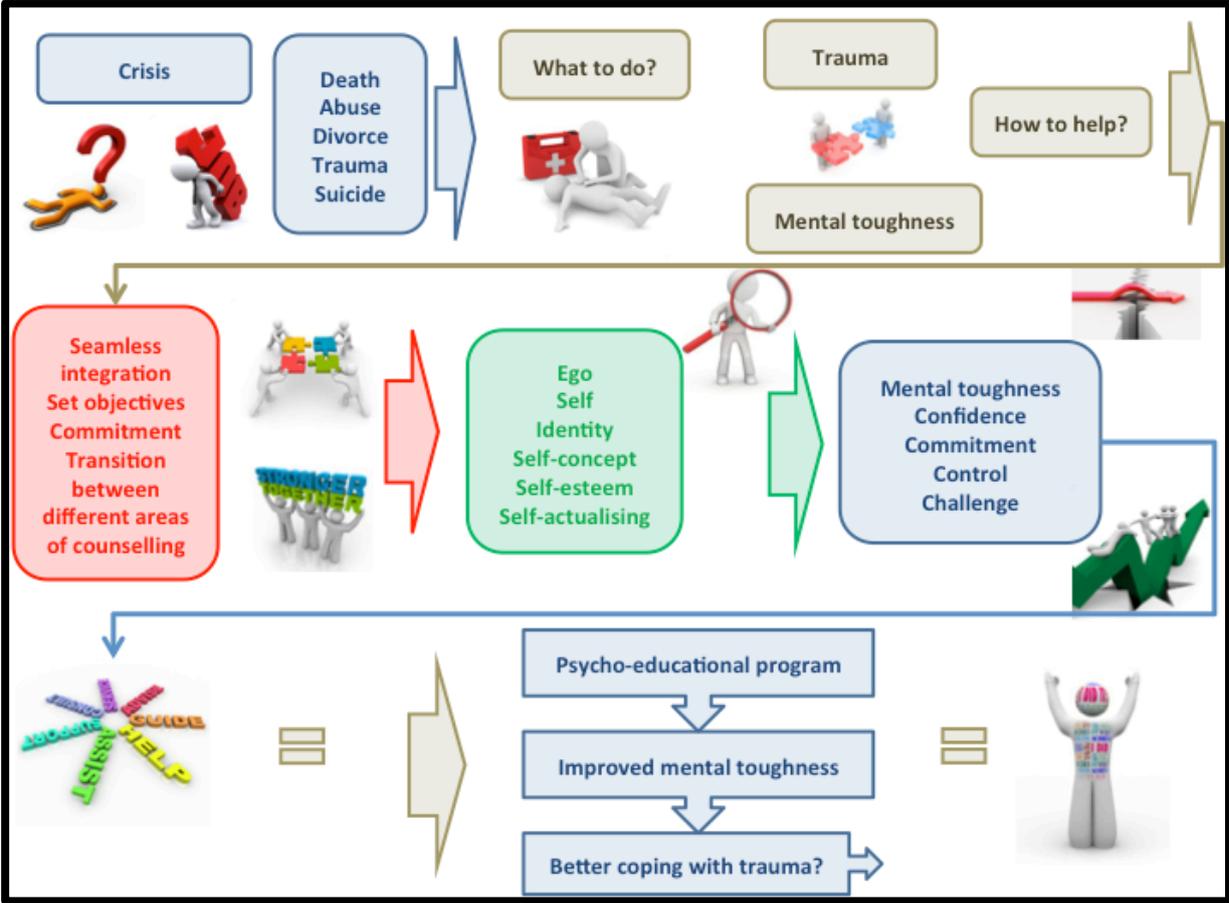
and analysed (Somekh & Lewin 2011: 260; McBride 2013: 52, 344-345). Somekh and Lewin (2011: 260) emphasise five advantages of mixed research as (a) triangulation – which focuses on correspondence between results of different methods, (b) complementarity – which uses different outlooks of different methods to support elaborated understanding of phenomena, (c) development – where the results of one method are used to implement or sample another method, (d) initiation – where new insights are established from paradoxes from different methods and (e) expansion – which enables the most appropriate methods for each focus area.

A lack of research was identified in the literature review of this study concerning practical ways in which a client can be supported by a therapist to better cope with his trauma. Very little research is available about the relationship between mental toughness and its applicable use in dealing with trauma. The empirical study aims to improve practice and investigate whether the corresponding therapeutic methods and ways of supporting a traumatised person, and to develop a person's mental toughness are meaningful in supporting traumatised persons to develop their mental toughness to better deal with their trauma. Therefore I made use of action research as action research is well known to improve and transform practice (Somekh & Lewin 2011: 13; Holly *et al.* 2005: 5; McNiff & Whitehead 2011: 14). Action research takes action and it addresses the gap between theory and practice (Somekh & Lewin 2011: 94). The researcher gains practical experience from the environment and then applies this experience in practice. Evaluation is then used to determine whether or not practice was improved. Action research is known as a spiral or cyclic activity where action is planned, action is taken, observation is done and reflection takes place. In the process, experience is gained and evaluation is done to determine whether experience and practice meet and then the spiral activity commences again (McAteer 2013: 29-30; Norton 2009: 54-55; McNiff & Whitehead 2011: 9).

I invited traumatised persons in my immediate environment to participate in the study and therefore a non-probability sample was used in the study (Welman, Kruger and Mitchell 2010: 56; Trochim 2006: 1). This decision was made due to practical implications that included the sourcing and use of a suitable venue, as well as traffic and transport constraints. This implies that not all the persons in the greater population had an opportunity to be included in the research, as in some life situations there may be circumstances where it is not possible to randomly select volunteers for a study (Statistics Canada 2013: 1; Trochim 2006: 1).

A summary of the research is presented below in Figure 1.3.

Figure 1.3: Research summary



Source: My own illustration

1.7.2.1 Ethical measures

According to Collins *et al.* (2000: 111-113), Henning, Van Rensburg and Smit (2004: 73) and Johnson and Christensen (2004: 102) the ethical prescriptions that were used in this study were to receive written consent of the participants, not to mislead them and to avoid hurting them, whether it may be physical and/or emotional in nature, for example by exposing them to emotional stress on them, humiliating them or embarrassing them. I took into account that the reliving of traumatic experiences could traumatise or upset a person again and therefore care was taken to support the participants when it was required. I clearly outlined the purpose of the study and did not mislead the participants and respected the privacy of the participants by the use of pseudonyms. In order to publish the findings of the study, I obtained the participants' permission prior to the

study. The participants were informed that they could withdraw at any time during the study. The ethical aspects are discussed comprehensively in Chapter 4.

1.8 DEFINITION OF IMPORTANT TERMS

1.8.1 Trauma

According to Reber (1995) trauma is described as a “wound” and the term is used for both physical injury (due to an external force) as well as for psychological injury (due to an extreme emotional assault). Mitchell (1983) describes trauma as a critical situation that a person has to deal with that evokes extreme strong emotional reactions which have the potential to influence that person’s normal functioning on the spot or at a later stage. Unisa (2002: 3-4) states that Freud describes trauma as a “feeling of helplessness” (Roets 2009; Unisa 2002: 3-4; Roos, Du Toit & Du Toit 2002: 90-91).

1.8.2 Post-traumatic stress disorder (PTSD)

Post-traumatic Stress Disorder (PTSD) is defined as a “reactive psychopathological response to a traumatic event” (Bensimon 2012: 782). PTSD is categorised as a class of trauma and stressor-related disorders on the DSM-5. The DSM-5 is the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (James & Gilliland 2013: 152). All the conditions included in this classification require exposure to a traumatic or stressful event as a diagnostic criterion. Although between 50% and 60% of the U.S. population are exposed to traumatic stress, only 5% develop PTSD.

The DSM-5 pays attention to the behavioural symptoms that accompany PTSD and contains four distinct diagnostic clusters. They are described as re-experiencing, avoidance, negative cognitions and mood and arousal (U.S. Department of Veteran Affairs: 2013; American Psychiatric Publishing: Post Traumatic Stress Disorder: 2013).

1.8.3 Mental Toughness

Clough and Strycharczyk (2012: 1) define mental toughness as “*The quality which determines in large part how people deal effectively with challenge, stressors and pressure...irrespective of prevailing circumstances*”. Mental toughness has four main

components, namely control, challenge, commitment and confidence which together provide an overall measure of mental toughness (Clough & Strycharczyk 2012: 2).

1.8.4 Psycho-education

The term psycho-education refers to psychological aspects of learning and behaviour in an educational environment (Van den Aardweg 1999:194). According to Van den Aardweg (1999:194) the term “psycho-pedagogical” is the study of the way a child learns and behaves in both the home and the school setting. This learning and behaviour takes place under the guidance of primary and secondary educators. Strydom *et al.* (2002:15) draws attention to Jacob’s approach of the psycho-educational theory from a perspective of educational essences. Strydom states that although Jacobs continuously refers to “the child”, the same theory is applicable to adult persons, due to the dynamic and continuous development of humans’ personalities. With scarcely any exceptions, most psychology of educational research can be termed “psycho-pedagogical” (Van den Aardweg 1999: 194).

1.9 DIVISION OF CHAPTERS

The meaningful answer of the research question implies that there are certain requirements that must be fulfilled in this study. In order to reach the aims of the research, the following chapter divisions indicate the course of the study.

- **Chapter 2**

This chapter consists of a literature review of the nature of mental toughness and its impact on people. Mental toughness’ four sub-components, namely control, challenge, commitment and confidence are explained. The context of the study, as well as the applications of mental toughness, are discussed. A detailed analysis is provided concerning the usefulness and development of mental toughness in people.

- **Chapter 3**

This second literature chapter focuses on the phenomenon of trauma and its history. Attention to both the physiological as well as the emotional reactions that people experience during and after a trauma are analysed. An intense analysis is provided regarding the way in which trauma affects relationships and a traumatised person’s

attitudes about himself and his world. The path of regaining control and recovery after a traumatic incident was investigated.

- **Chapter 4**

This chapter focuses on the elements of the research design that was used in the empirical study. The design implemented in the study is discussed according to the research problem, the aim of the empirical study, the research method, the sample selection as well as the ethical aspects relevant to this study.

- **Chapter 5**

The psycho-educational program is described in this chapter. The content and development of the programme, during the proposed eight sessions, are discussed.

- **Chapter 6**

The results of the empirical investigation are discussed. Individual participant's studies are explained in relation to interviews, background, results of pre- and post-tests and findings from the diagnostic tools. An integration of the results followed. The psycho-educational intervention programme's impact on the participants is explained.

- **Chapter 7**

This chapter concludes the study, discusses limitations and provides recommendations for future studies.

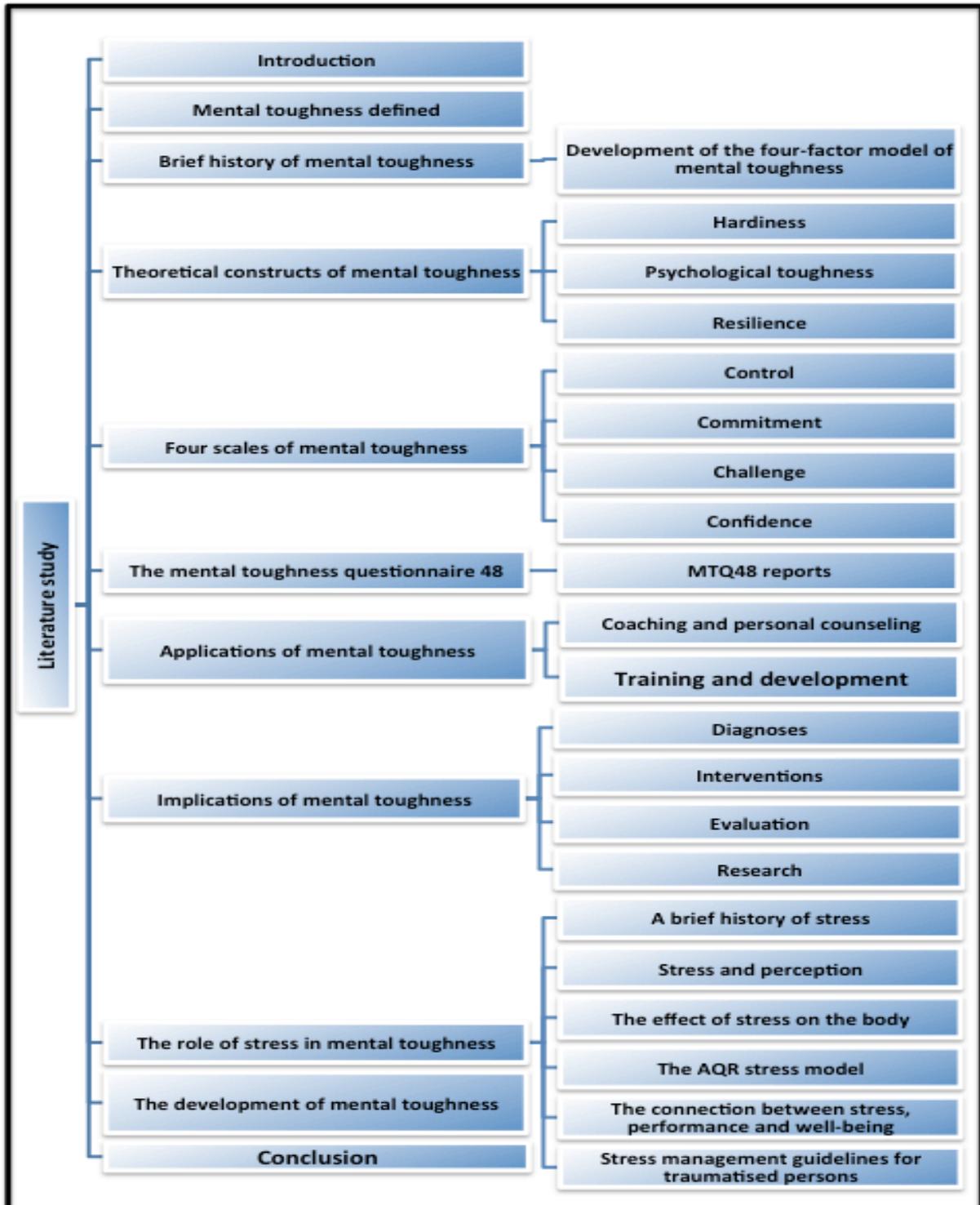
1.10 CONCLUSION

In Chapter 1, I explained how the awareness of the requirement of this study was experienced. A preliminary literature overview indicated a gap in the use of mental toughness in the psychological field and more specifically, in the counselling of a person who experienced trauma, in order to develop his mental toughness and by doing so, help him to be able to better cope with his trauma. The study has been demarcated, together with the aims and the formulation of the research problem. Concepts have been clarified. In Chapter 2 the phenomenon of mental toughness is discussed.

CHAPTER 2

LITERATURE REVIEW: THE PHENOMENON OF MENTAL TOUGHNESS

Figure 2.1: Chapter outline



2.1 INTRODUCTION

The aim of this chapter is to provide a literature overview of encompassing characteristics of mental toughness. The following objectives emanate from this aim:

- To define mental toughness;
- To explore the dynamics of mental toughness;
- To analyse the development of the Mental Toughness Questionnaire 48 (MTQ48)
- To elucidate the role that stress plays in the development of mental toughness, more specifically after trauma;
- To discover whether and how mental toughness could be developed in people.

2.2 MENTAL TOUGHNESS DEFINED

Clough and Strycharczyk (2012: 1) defines mental toughness as “The quality which determines in large part how people deal effectively with challenge, stressors and pressure...irrespective of prevailing circumstances”.

2.3 A BRIEF HISTORY OF MENTAL TOUGHNESS

During the past five years a significant increase in literature regarding the fundamental aspects of the construct mental toughness has been evident, especially in Britain and Australia (Crust 2008: 576). The term *mental toughness* was however already created in the mid-1980s by a sports psychologist named James Loehr. He emphasised the interaction between the psychological aspects of mental toughness and “*ideal performance state*” in sports performance (Clough & Strycharczyk 2012: 155). The most pertinent objection though was that Loehr’s work could not be scientifically proven (Crust & Keegan 2010: 164). Various attempts were made to pinpoint mental toughness and to describe the concept, for example “the ability to cope with intense pressure” (Williams 1988); “the ability to perform to the upper range of your talent” (Loehr 1995); and “the ability to cope better than your opponents with the demands of competitive sport” (Jones, Hanton & Connaughton 2007). According to Clough and Strycharczyk (2012: 23, 24, 30, 31, 37) the following people contributed to the body of knowledge

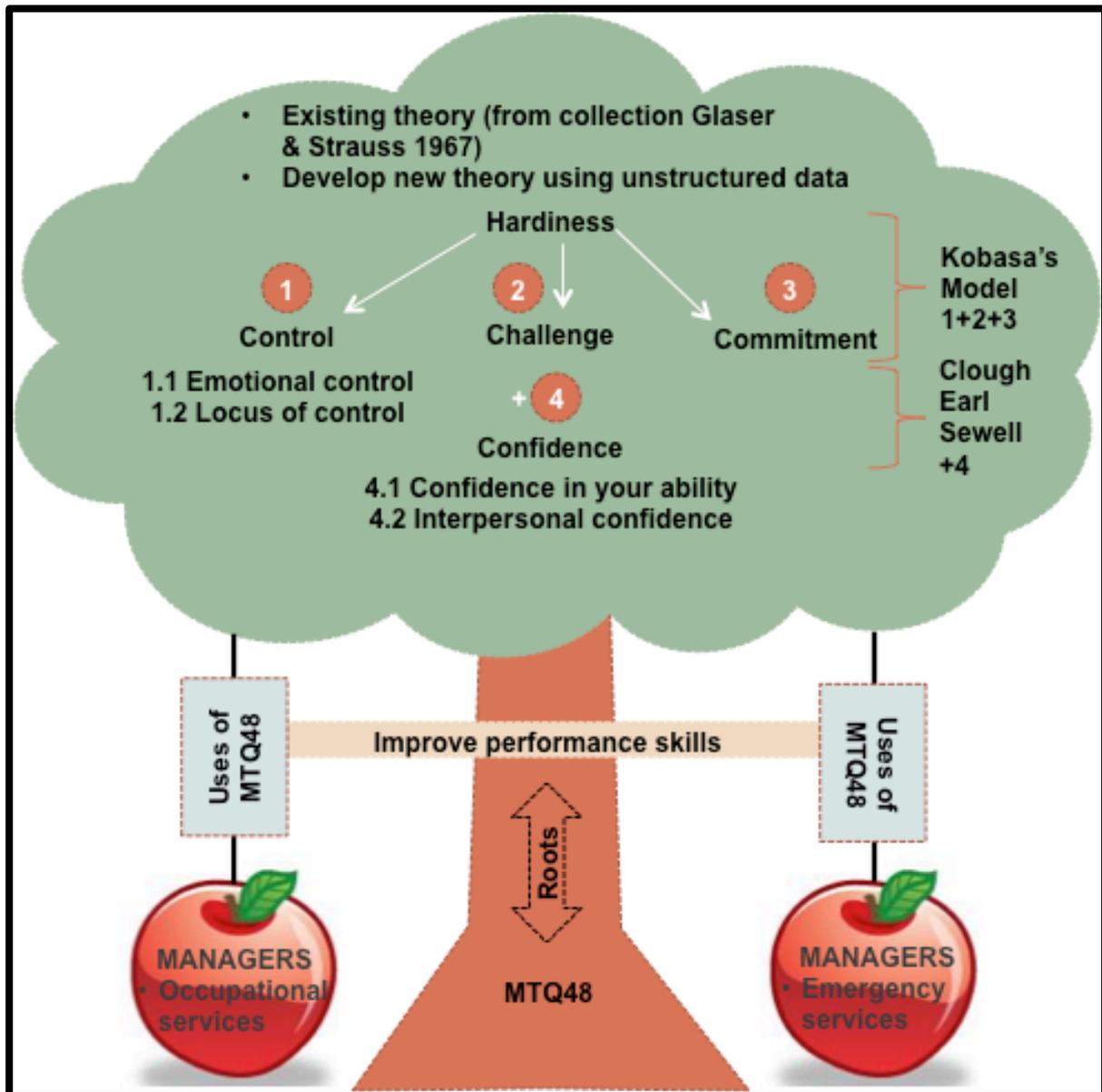
regarding the definition of mental toughness: Butler 1989; Butler and Hardy 1992; Jones 1993; Dale and Weisberg 1996; Brennan 1998; and the Curtis Management Group 1998. Mental toughness made its debut again in 2002 after the publication of a book chapter by Clough, Earle and Sewell named “Mental toughness: the concept and its measurement” (Clough & Strycharczyk 2012: 23, 30; Crust & Keegan 2010: 164).

2.3.1 Development of the four-factor model of mental toughness

Due to the restriction of data collection, Clough, Earle and Sewell commenced with a new model of mental toughness and focussed their method on both the existing theory as well as Glaser and Strauss’s (1967) method, which emphasizes the development of new theory from the collection of unstructured data (Clough & Strycharczyk 2012: 38). These studies were conducted with sports people that included people from the sports of rugby, golf, football and squash. Kobasa’s model of hardiness (1979) initially seemed to be applicable to combine almost all elements that were indicated in the study of Clough’s, Earle’s and Sewell’s (2002) literature under three headings, which are control, commitment and challenge. Hardiness (2.4.1) is similar to resilience and the term originated in health psychology. Hardiness includes three inter-correlated notions: control, challenge and commitment. Confidence was added as a fourth factor and was analysed in two parts, namely confidence in one’s ability and interpersonal confidence. Two aspects of control also emerged from the interviews, namely emotional control and locus of control (Clough & Strycharczyk 2012: 26, 27, 41; Crust & Keegan 2010: 164; Horsburgh, *et al.* 2008: 100).

In 2002 Drs Clough and Earle created a professional team that started constructing a measurement tool that could be scientifically valid and reliable when measuring a person’s mental toughness. The focus was to guide and support managers in developing performance skills in the occupational and emergency services. This measuring tool was named the Mental Toughness Questionnaire 48 (MTQ48), because it consisted of 48 items that measures a person’s mental toughness. Through the following years the MTQ48 was refined and from 2011 more than 40 countries and more than ten major languages use the model. The MTQ48 as a psychometric measure is successfully used in occupational practices, as well as in sports, health and social work (Clough & Strycharczyk 2012: 41-48; Horsburgh, *et al.* 2008: 100). The development of the four factor model of mental toughness is illustrated in Figure 2.2.

Figure 2.2: Development of four factor model of mental toughness



Source: My own illustration

2.4 THEORETICAL CONSTRUCTS AND ORIGINS OF MENTAL TOUGHNESS

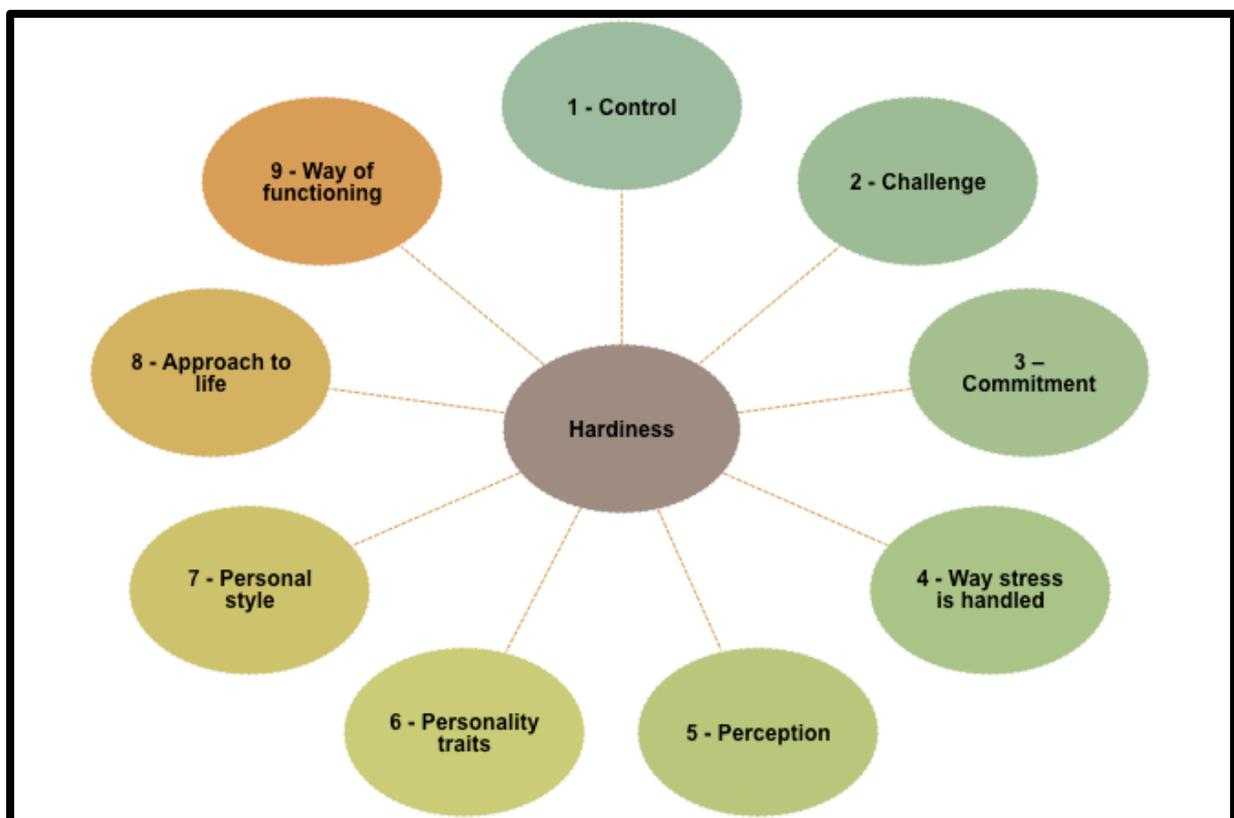
Prior to a discussion of the four scales of mental toughness, a discussion of the constructs that contributed to the development of the phenomenon mental toughness which are, hardiness (Kobasa 1979), physiological toughness (Dienstbier 1989) and resilience (Dyer and McGuinness 1996) is required. These constructs are rooted in the health psychology, but their underpinnings however play an important role in the areas of sports, educational, social and occupational psychology (Clough & Strycharczyk 2012:

24). To date, few studies have been conducted to examine the relationship between mental toughness and its applicable use in psychology (Connaughton, Wadey, Hanton & Jones 2008: 84; Clough & Strycharczyk 2012: 263, 268; Crust 2008: 579-580).

2.4.1 Hardiness

Hardiness is defined as the resistance to change when adversity beckons, and to be able to maintain resistance in similar states of adversity in the future. It is known as one of the characteristics of resilience (Bensimon 2012: 783; Bartone, Hystad, Eid & Brevik 2012: 517). Kobasa was the first person who used the concept of hardiness in 1979 and described it as personality characteristics which distinguished between executives who could handle severe work related stress and remain healthy and those who could not handle the severe work stress and fell ill. Kobasa further states that an individual's perception of a situation was an important indicator of his hardiness, which will allow him to act accordingly (Clough and Strycharczyk 2012: 26-28; Bartone *et al.* 2012: 517-518). Figure 2.3 summarises the concept of hardiness.

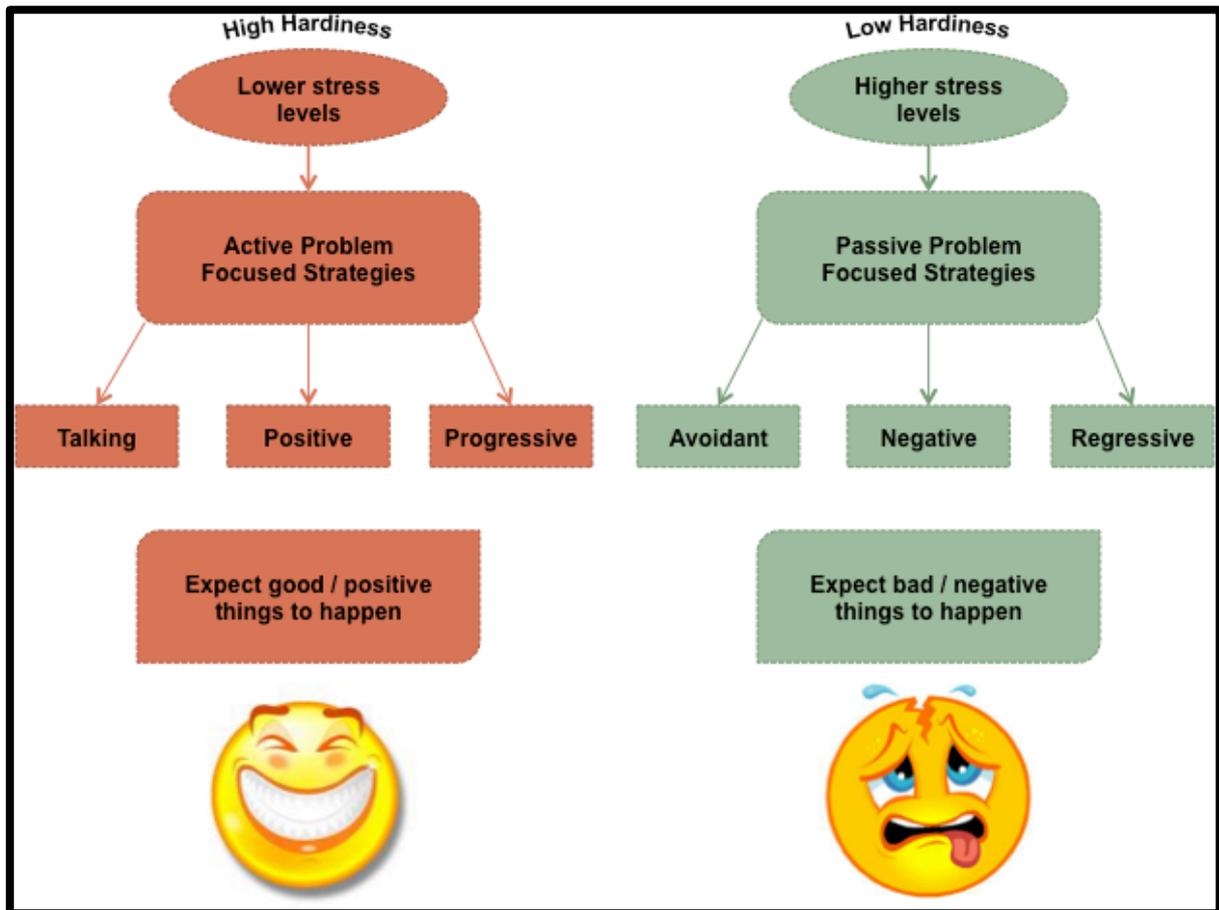
Figure 2.3: Summary of the concept hardiness



Source: My own illustration

In Figure 2.4 a comparison between low hardiness *versus* high hardiness can be seen. Kobasa's study in 1979 demonstrated that executives who need to deal with high levels of stress, but with low levels of illnesses display three kinds of hardiness in their ability to deal with stress, which are (1) an openness to change, (2) a feeling of commitment and (3) a feeling of control over their lives.

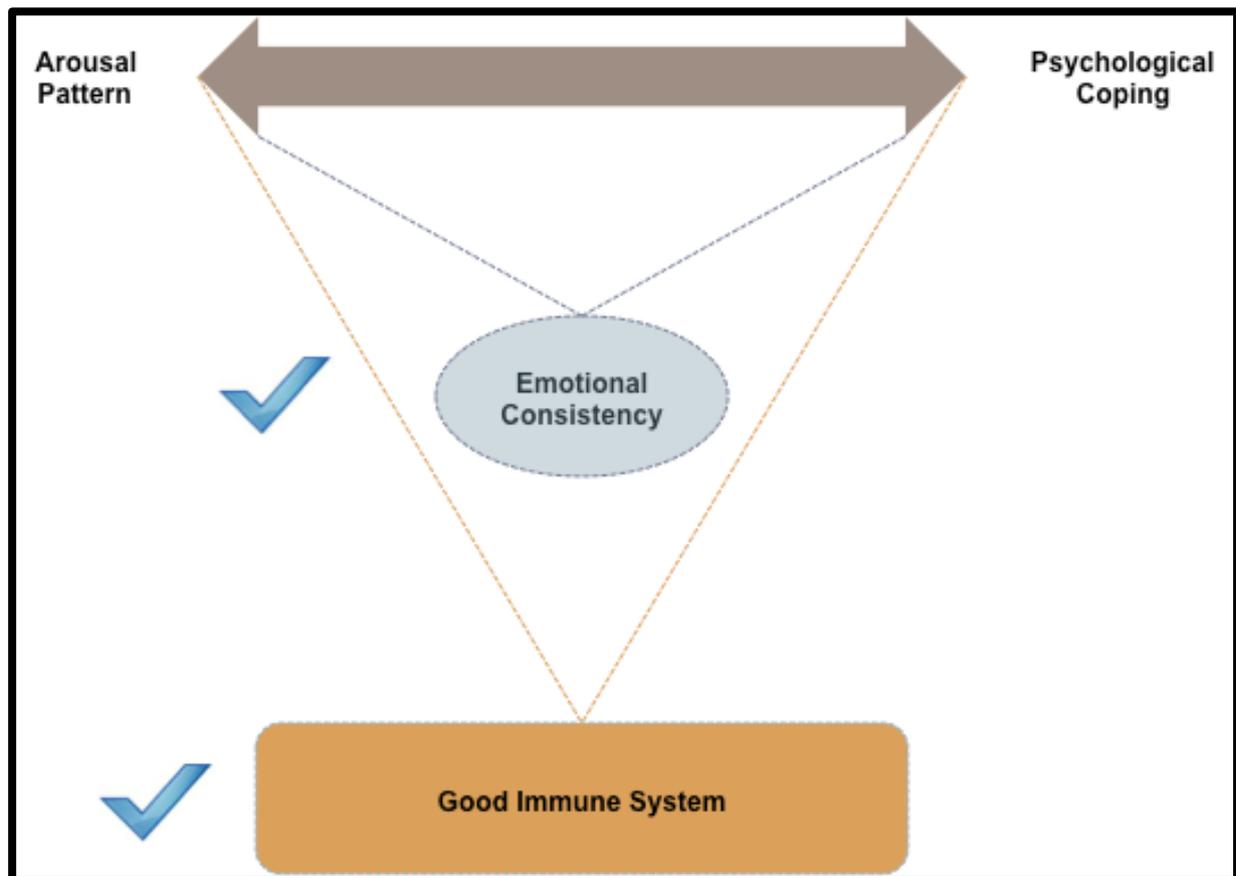
Figure 2.4: Low hardiness versus high hardiness



Source: My own illustration

2.4.2 Physiological toughness

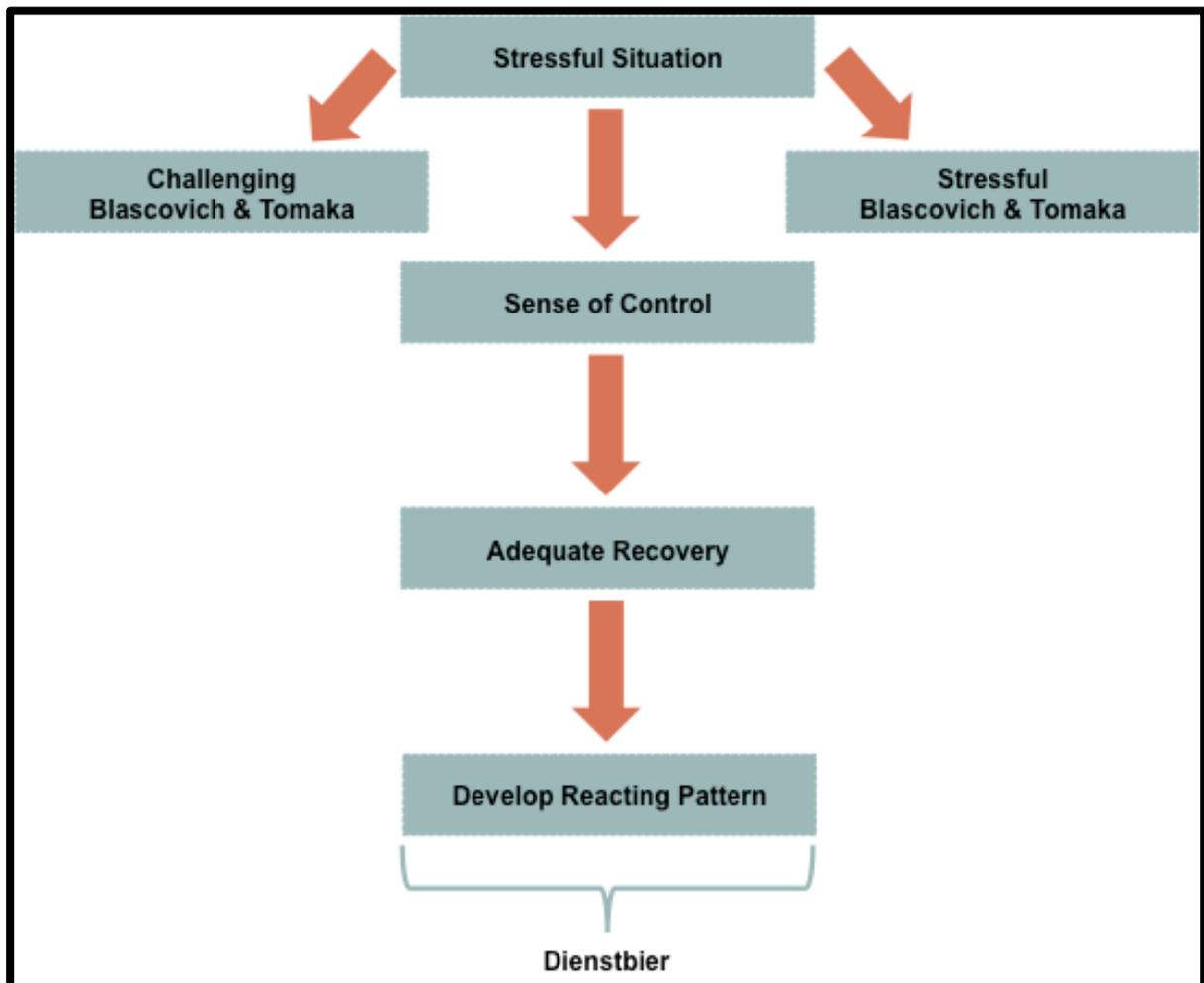
Figure 2.5: Physiological toughness definition



Source: My own illustration

Physiological toughness is defined as the interplay between arousal and psychological coping, as illustrated in Figure 2.5. The theory of physiological toughness was introduced by Dienstbier in 1989. The research implies that if a person has experienced a stressful situation, together with a sense of control over the situation as well as adequate recovery, it increases the chances that a person will develop a certain pattern in which he will react to similar stressful experiences in the future. Dienstbier concludes that stress is almost synonymous with arousal reduction.

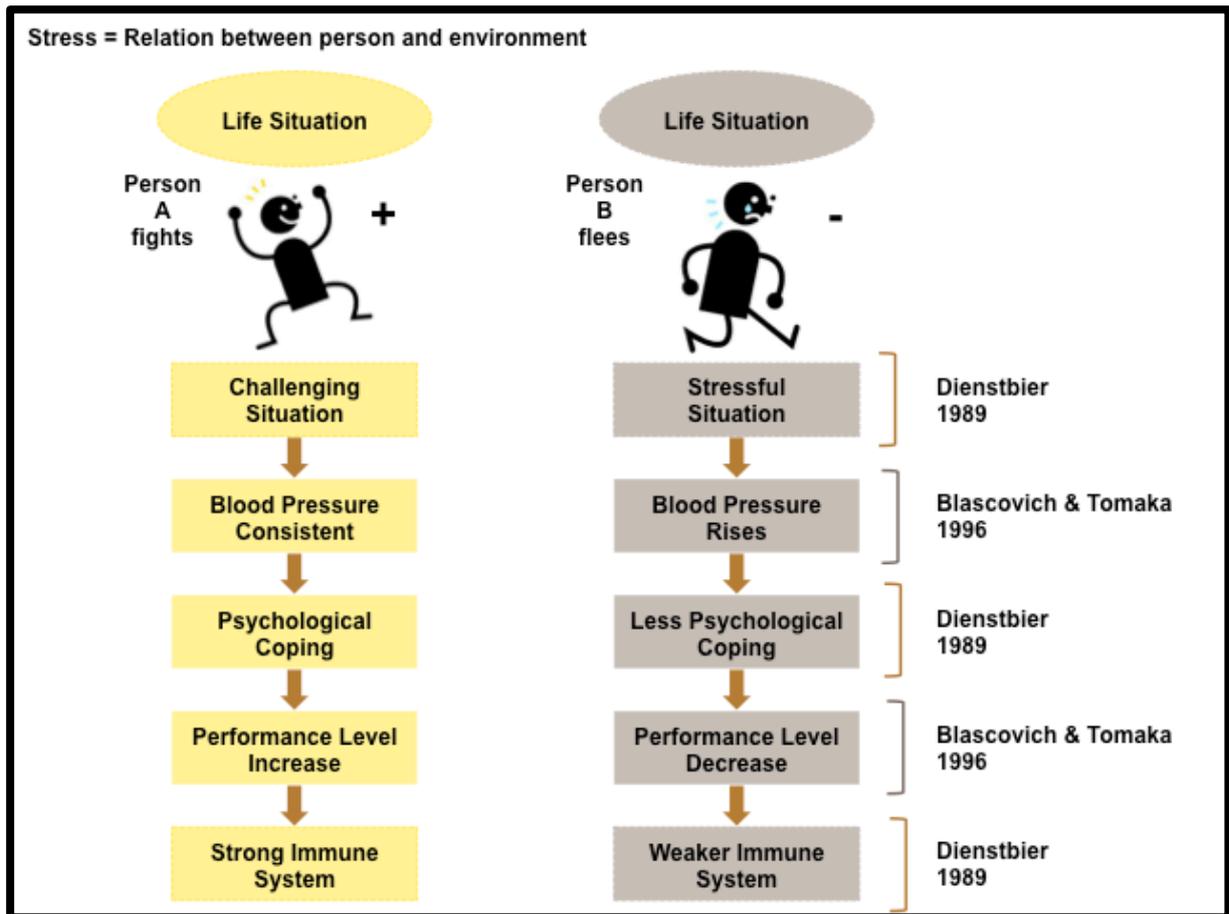
Figure 2.6: Development of physiological toughness according to Dienstbier's and Blascovich & Tomaka's biophysical model of change



Source: My own illustration

Dienstbier's theory of physiological toughness motivated Blascovich and Tomaka's biophysical model of Challenge that was developed in 1996. Figure 2.6 provides an illustration of the development of physiological toughness according to Dienstbier, Blascovich and Tomaka's biophysical model of challenge. The model of challenge states that the appraising of difficult situations by individuals is either challenging or threatening. If a situation is perceived as challenging, blood pressure does not rise and the person acts with competency. Conversely, if a situation is experienced as threatening a person's blood pressure often rises and the standard of his performance level will decrease (Clough and Strycharczyk 2012: 28-29; Dienstbier 1989: 84-91; Psychlopedia 2012: 1-3, 6; Sue, Sue & Sue 2010: 192). Figure 2.7 depicts physiological toughness.

Figure 2.7: Physiological toughness summary



Source: My own illustration

2.4.3 Resilience

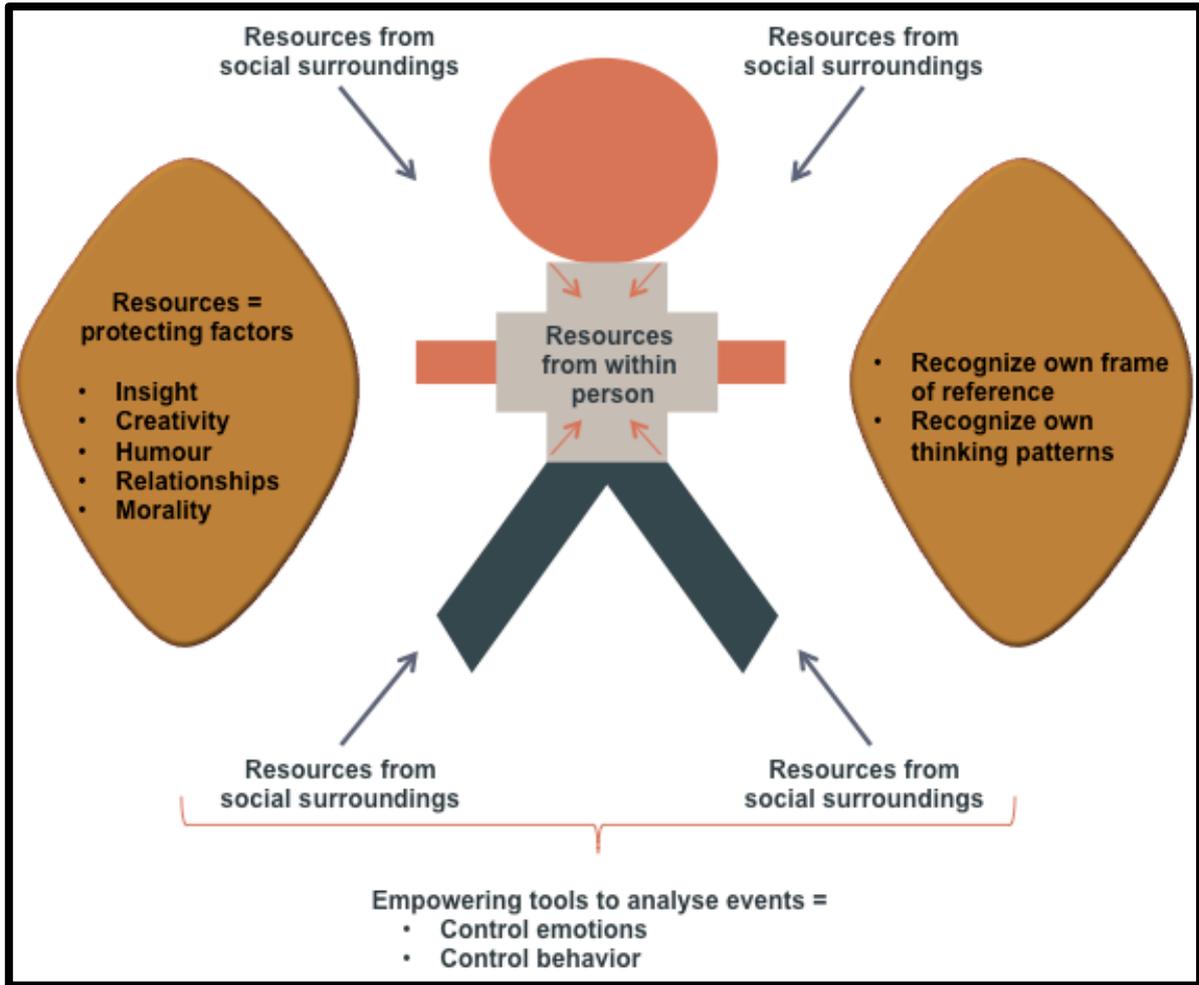
No consensus of an operational definition on resilience yet exists, but fundamentally resilience is described as a person's ability to bounce back and to adjust positively when facing adversity (Bonanno 2004: 20; Herrman, Stewart, Diaz-Granados, Berger, Jackson and Yuen 2011: 259; Karairmak 2009: 350; Miller & Harvey 2001: 318; Rutter 1999: 119; Theron & Theron 2010: 1; De Villiers & Van den Berg 2012: 93). Resilience research has its existence in the positive rather than pathological factors of adversity (Bensimon 2012: 782; Karairmak 2009: 350). Whether a person functions resiliently or not, depends on his ability to discover and exploit resilient resources within himself as well as from his social surroundings (Yeung, Arewasikporn & Zautra 2012: 595; De Villiers & Van den Berg 2012: 93). Clough and Strycharczyk (2012: 24-25), Waibel-Duncan and Whitehouse Yarnel (2011: 168) and Budde, Moesgen, Belles and Klein (2010: 23) and De Villiers & Van den Berg (2012: 93) refer to these resources as

protecting factors. These protecting factors can be linked to mental toughness due to the impact of the deed of resilience that leads to a person's psychological toughening. Examples of these protective factors include insight, initiative, creativity, humour, relationships and morality. Jackson and Watkin (2004: 14) summarise the above mentioned concepts of resilience by identifying that the fundamental objective of resilience is a person's ability to recognise his own frame of reference and thinking patterns by exploiting the power of his flexibility and accuracy of thinking. In this process a person is able to analyse events which will empower him to control his behaviour and emotions (De Villiers & Van den Berg 2012: 93, 101).

In the most recent studies, Theron and Theron (2010: 1-2) focus on resilience, specifically in a South African context, as a shift away from the listing of protecting factors to contextually and culturally specific factors that facilitate resilience. These factors include both social-cultural resources as well as personal strengths (Theron & Macalane 2010: 722; 726, 728).

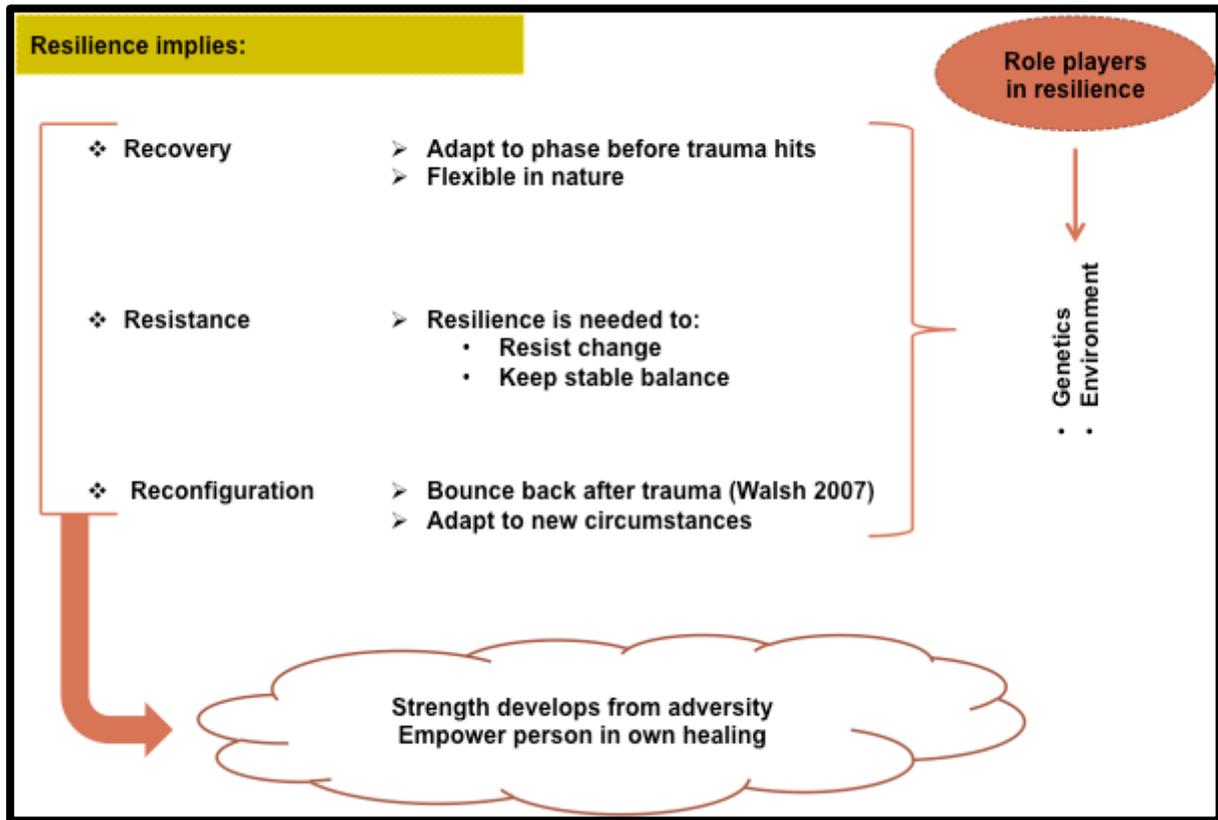
Bonanno (2004: 20-23) is renowned for the research that he conducted on loss and trauma. Bonanno (2004) emphasises resilience as a far more common phenomenon than people believed it to be and current research studies acknowledge this phenomenon as relatively common and have focused on healthy adjustment rather than on pathologic behaviour. By incorporating an awareness of resilience when dealing with loss and trauma, individuals become empowered and effective in their own healing process (Waibel-Duncan & Whitehouse Yarnel 2011: 168, 171). An illustration of the implications of resilience is provided in Figure 2.8. The relationship between trauma and resilience is demonstrated in Figure 2.9.

Figure 2.8: Definition of resilience



Source: My own illustration

Figure 2.9: The relationship between trauma and resilience



Source: My own illustration

2.5 FOUR SCALES OF MENTAL TOUGHNESS

Mental Toughness has four sub-scales that include control, commitment, challenge and confidence (Clough & Strycharczyk 2012: 51-88; Crust & Keegan 2010: 165).

2.5.1 Control

The mental toughness' control scale consists of two parts, namely life control scale and emotional control scale.

2.5.1.1 Life control

The life control scale relates to what a person believes he can generally control in his life. Egan (2014: 393) emphasises the importance of focussing on the things that a person can control. Usually a person feels that when he has control over aspects that could influence his behaviour, he can make a difference in life and that he will be able to

achieve success. People with high life control do not need constant encouragement from others as their inner strength and belief in their own abilities are powerful in their own right. In Table 2.1 possible characteristics of people with high life control *versus* people with low life control are indicated, as propounded by Clough and Strycharczyk (2012: 51-52, 54) (note that this is not an exclusive list).

Table 2.1: Characteristics of people with high life control *versus* low life control

High levels of life control	Low levels of life control
Better time managers	Less effective time managers
More effective in prioritising tasks	Less effective prioritisers
Well organised and good planners	Less organised and messy
Effective in handling more than one task at a time	More effective when handling one task at a time
See the solution, not the problem	See the problem, not the solution
More positive outlook on life	More negative outlook on life
Expect to achieve success	More prepared to fail
Less anxious in handling more tasks	More anxious in handling more tasks
Believe they can make a difference. Things just happen to them	Believe they cannot make a difference
Take responsibility for their actions and failures	Blame other people and external aspects for failures

Source: Clough and Strycharczyk (2012: 55)

2.5.1.2 Emotional control

Emotional control indicates a person's ability to control his emotions. These people have the ability to control their emotions and they are less likely to reveal their emotional state to other people. Emotional regulation and control is an important coping mechanism and it moderates stress. High emotional control does not imply that a person does not experience emotions. It does imply that a person is able to keep his emotions better in check (Clough & Strycharczyk 2012: 51-52; Mental Toughness 2012: 2). In Table 2.2 below, possible characteristics of people with high emotional control *versus* low emotional control are indicated (Clough & Strycharczyk 2012: 52) (note that this it is not an exclusive list).

Table 2.2: Characteristics of people with high emotional control *versus* low emotional control

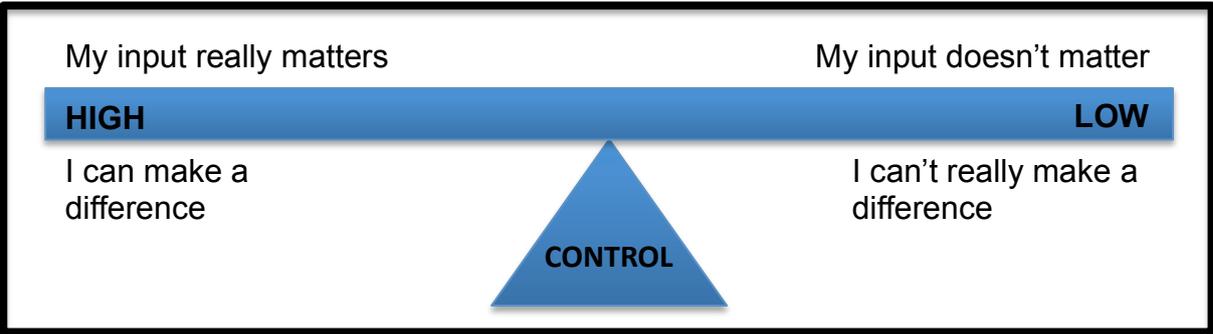
High levels of emotional control	Low levels of emotional control
Controls revealing of emotional state to others	Easily reveals emotional state to others
Has control in responding to provocation or annoyance	Responds readily to provocation or annoyance
Ability to keep emotions of anger, embarrassment and frustration in check	Shows emotions in exhibiting anger, embarrassment and frustration
Easy to move on after setbacks, criticism and negative feedback	Setbacks, criticism and negative feedback affects them negatively
Adapts if things do not go their way	Sulks if things do not go their way
Sees bullying as the bully’s problem	More likely to report bullying
As a leader, operates with sense of calmness in difficult situations	As a leader, finds it difficult to keep calm in stressful situations
Deals well with harassment	Difficulty in dealing with harassment
Takes responsibility for failure	Blames environment for failure
Good at controlling emotions	Feels guilty and blames themselves easily
Impassive about criticism of others	Shows reaction when criticized
Insensitive to remarks of people who have a “go at them”	Shows discomfort when others have a “go at them”
Stays calm in a crisis situation	Difficult to stay calm in a crisis

Source: Clough and Strycharczyk 2012: 51-54

Application of control

Control implies two sides of a scale.

Diagram 2.1: Control



Source: My own illustration

2.5.1.3 Psychological perspectives linked to control

- Learned helplessness

The concept of learned helplessness was proposed by Seligman in 1975 by using the well-known experiment of Pavlov’s dogs where sound stimuli (a bell) evoked saliva.

Learned helplessness is attributed to previous experience of failure. The expectations of a person of not being successful include that a person believes that he will not be successful, regardless of his attempts, or that whatever actions he takes will not result in changing a situation, or will not even be noticed. Though some things can indeed be outside a person's control, a matter of concern is that a person with learned helplessness has the perception that even matters that are controllable are uncontrollable issues. In this process these people decrease their levels of self-efficacy and in the process disempower themselves. Research indicates that the mental toughness's aspect of control and learned helplessness are related to one other (Brooks & Clarke 2011: 35-36; Clough & Strycharczyk 2012: 54; Sue, *et al.* 2010: 195, Egan 2014: 393).

- Attributions

According to Clough and Strycharczyk (2012: 58-59) research found that attributions are a central aspect that determine whether a person feels in control of his life or not. Rotter (1966: 2-3, 5-7, 9, 21, 25) and Heider's (1944: 358-372) research on internal and external locus of control and work on attributions significantly added value to this sub-scale of mental toughness. Rotter's research on the locus of control in 1966 illustrates people's allocation of control to internal or external aspects of their lives (Meyer, Moore & Viljoen 2003: 299-300). In 1958 Fritz Heider developed the attributions theory in order to describe how people explain (make attributions) their own as well as other people's behaviour. He divided the internal factors into ability and effort and the external factors were categorized as task difficulty and luck (Heider 1944: 361, 366, 368, 370, 372; Clough & Strycharczyk 2012: 58-59; University of Twente 2013: 1-2; Brooks and Clarke 2011: 34-35). Bernard Weiner developed on Heider's work to include an attributions model which has strong empirical support and is generally used in motivational-, social- and educational-psychology today (Weiner 2000: 1-7; Weiner 2010: 29-30 and Clough & Strycharczyk 2012: 59). Weiner included two related theories of motivation in Heider's Attribution's Theory. The one theory contains ability and effort that are within a person (intra-personal theory). The other theory is an interpersonal theory, which implies beliefs about other people's responsibility as well as emotions that are directed to other people, including anger and sympathy. Weiner (2010: 32) later added a third aspect to the attributions theory, namely control. Control indicates the extent to which a person believes he can control a situation or not.

One of the main philosophies of mental toughness is that success and failure depend on a person's perception of himself. People easily place blame on everything except on themselves. Therefore in order to become and remain mentally tough, a person should practice taking responsibility for his deeds (Clough and Strycharczyk 2012: 60)

- Luck and Superstition

The term "luck" was first used in the fifteenth century. According to Fong, Lee and Ladkin (2011: 3), Rotter (1966: 1, 3, 5), Weiner (1985: 548, 550-551, 555-566; 2000: 4-5; 2010: 30), and Heider (1994: 361) this definition corresponds with attribution's theorists' arguments that luck is a random and uncontrollable variable. Professor Richard Wiseman, a psychologist at the University of Hertfordshire is one of the most prominent researchers of "luck". Wiseman (2003: 1-5) scientifically investigated why some people are lucky and why others constantly experience ill fortune. Wiseman identified four basic principles regarding how lucky people create their own good fortune: (1) They are skilled at noticing chance opportunities; (2) They listen to their intuition and make effective decisions; (3) Lucky people have positive expectations about the future and therefore create positive self-fulfilling prophecies; (4) They turn bad luck into good by adopting a transformative resilient attitude. Superstition heralded from the perception that luck was a powerful force and it could be controlled. Superstition provides a sense of control, but according to Clough and Strycharczyk (2012: 59) and Wiseman (2003: 2) it is faulty thinking. Clough and Strycharczyk (2012: 60) further indicate that mentally tough persons have a more rational view on reality and they have a need to take responsibility for their own destiny. Wiseman (2003: 4-5) supports Clough's and Strycharczyk's findings with the findings of his research that much of the good and bad fortune that people experience is the result of their thoughts and behaviour, which in turn can influence and change their destinies.

- Neuroticism

According to Clough and Strycharczyk (2012: 60-61) and Sue *et al.* (2010: 194-195), the control component focusses on a person's ability to control his own life. There is however an important subcomponent to control, namely emotional control. Some people are emotionally more reactive than others. Researchers use the five-factor model (FFM) of personality to explain the different personality patterns. To be more reactive or less

reactive is a personality pattern which is known as neuroticism. The five personality patterns are the following:

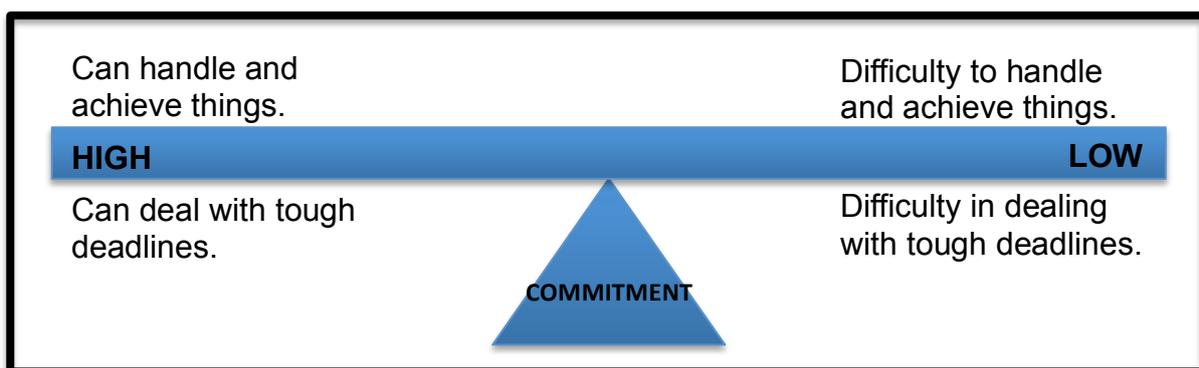
- Neuroticism: sensitive/nervous *versus* secure/confident
- Openness: inventive/curious *versus* consistent/cautious
- Conscientiousness: efficient/organised *versus* easy-going/careless
- Extraversion: outgoing/energetic *versus* shy/reserved
- Agreeableness: friendly/compassionate *versus* cold/unkind

According to Clough and Strycharczyk (2012: 60-61), research at the University of Hull has evidenced that persons with greater emotional control have lower neuroticism levels. Lower neuroticism scores are also linked to emotional stability as well as the ability to bounce back from adversity.

2.5.2 Commitment

According to Clough and Strycharczyk (2012: 64-65) commitment is defined as “*the extent to which an individual is likely to persist with a goal or work task*”. Not all people have the same degree of focus on their goals. Some people persist while others easily lose interest and focus. Diagram 2.2 provides an outline of the two sides of commitment.

Diagram 2.2: Commitment



Source: My own illustration

Sample descriptions that are often identified with high and low measures on the commitment scale are indicated by Clough and Strycharczyk (2012: 65) and have been expressed in Table 2.3 (note that this is not an exclusive list).

Table 2.3: Commitment scores

Lower scores	Higher scores
Intimidated by goals and measures	Likes goals and measures – as it describes success
Goals are overpowering	Deconstructs goals into manageable parts
Responds emotionally when given tasks	Hard working and diligent when working to finish projects
Is easily distracted	Prioritises activities and uses effort to focus
Does the absolute minimum	Will attend meetings even if they do not like the people
More likely to be late with things	Sets high standards for self and others
May sleep in at times	May overdo things and may overwork
Let others down by using excuses	Will not let others down
Blames other people and situations for not doing something	Takes ownership and responsibility
Will not easily volunteer for things, especially extreme tasks	Volunteers to do things
Feels inadequate when asked to do something	Translates goals into achievable things
More subjective about things – cannot picture a “win-lose” scenario	More objective about things

The psychological context of commitment implies the following:

- Procrastination

Procrastination is defined as a typical characteristic of a person’s behaviour to postpone responsibilities and decisions until a future date and is a “*lack of self-regulated performance*” and action (Egan 2014: 378; Johnson, Green & Kluever 2000: 270; Deniz, Tras & Aydogan 2009: 624). The formal study of procrastination only commenced in the late 1970s (Lee 2010: 6; Wilson 2012: 211, 2013; Steel 2007: 66). There are many discussions and explanations for the reasons why people procrastinate, even if they know they should not. It can, for example, be seen as a tool to cope with stress and as a passive-aggressive coping mechanism as a result of childhood experiences (Clough & Strycharczyk 2012: 65; Deniz *et al.* 2009: 628). According to Clough and Strycharczyk (2012: 65) procrastination is closely connected to learned helplessness. Knaus (2000: 163), Klassen and Kuzucu (2009: 70, 78), Johnson, Green and Kluever (2000: 270), Deniz *et al.* (2009: 623, 625, 628), Ferrari, O’ Callaghan and Newbegin (2005: 2) and Steel (2007: 65) state that action can be taken to solve the self-handicapping effect of procrastination by supporting a person to change self-doubts, low self-esteem, poor self-regulation, disorganisation, forgetfulness, low frustration levels, perfectionism, high stress levels, anxiety, behavioural rigidity and rebellion.

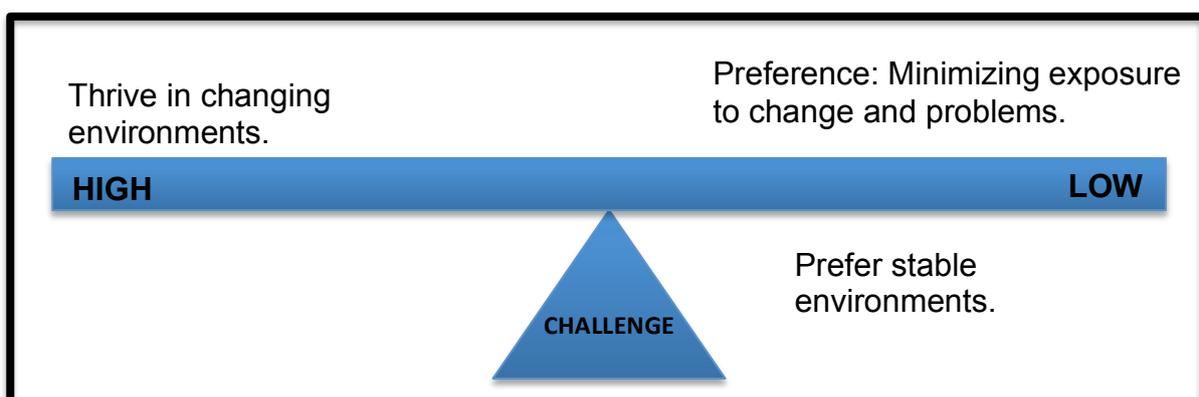
- Conscientiousness

Clough and Strycharczyk (2012: 65) also analysed procrastination as a personality trait. It is known that human beings have five predominant personality traits which are often referred to as the big “five” or the five-factor (FFM) model. Conscientiousness implies a well-organised person, who is persistent and punctual. Individuals who exhibit high levels of this trait also have high levels of thoughtfulness, good impulse control, and display goal-orientated behaviour, persistence as well as being well-organised detail-focussed (Sue, Sue & Sue. 2003: 232; McCrae and Costa 1987: 86-89 & Roberts (2013: 1-2).

2.5.3 Challenge

Clough and Strycharczyk (2012: 71-74) describe a challenge as an event or activity that a person experiences outside of the normal and ordinary life activities and it requires a person to move outside his comfort zone. Some people perceive challenges as opportunities, while others perceive challenges as threatening. After years of research of mental toughness and the MTQ48 in the business sector, Clough and Strycharczyk (2012: 71-73) indicate that the most important challenge a person needs to deal with, is change which also includes flexibility and variety in some instances. The importance of a challenge is primarily a person’s perception of the specific challenge. The situation itself can also have a negative effect, as strongly focused persons tend to place themselves as well as others in situations that are extremely difficult, or impossible to achieve and then these people often feel that they cannot cope. Subsequently, Diagram 2.3 indicates the two sides of the challenge scale for mental toughness.

Diagram 2.3: Challenge



Source: My own illustration

Challenge scores to indicate low and high scores on the challenge scale are provided in Table 2.4 below (note that this is not an exclusive list).

Table 2.4: Challenge scores

Lower Scores	Higher Scores
Do not like changes	Like changes
Prefer stable environments	Gets easily board and seeks change
Fear to fail	Cannot live without the challenge of change
Avoid effort	Like the challenge to solve problems
Intimidated by changes	Energised by changes
Want to achieve minimum standards	Want to commit and reach the best standards
Prefer routine	Want to move out of the comfort zone of routines
Concerned about other's meanings	Little regard for their impact of their activities on others

The challenge component of mental toughness and risk

Crust and Keegan (2010: 165) state that hardy persons are more willing to take risks than less hardy persons, who avoid situations that cause anxiety. Therefore Crust and Keegan (2010: 164) state that a possibility is raised that a willingness to take risks and approach challenges rather than to avoid stressful situations is important in learning to deal with stress and adversity. Llewellyn and Sanchez (2008: 413, 415, 421, 422) are consistent with prior research by Bandura (1997) in their findings that rock climbers were willing to take more risks when they perceived themselves as capable to deal and cope with these risks. Crust and Keegan (2010: 164) further state that due to Clough's *et al.* (2012) and Jones *et al.*'s (2007: 244, 250, 251) findings, mentally tough athletes are characterised by high self-confidence, as they are continuously on the look-out for challenges and have low anxiety levels. A relationship between mental toughness and risk-taking may be hypothesised, but further research should be done concerning whether this involves attitudes, behaviours or both.

2.5.4 Confidence

Confidence is defined as the way a person deals with setbacks and whether he has the self-belief to persevere and complete a difficult task that is occupied with obstacles, or not (Clough & Strycharczyk 2012: 81-83). According to Clough and Strycharczyk (2012:

81-83) confidence has two subscales which are:

- Confidence in abilities:

This confidence implies that a person believes that he has the intellectual toolkit of knowledge, skills, education and experience to take on and complete a task, even if the task is difficult, and has the possibility to have setbacks along the way. People who score high on this scale perceive themselves as persons of worth and they are known as the more optimistic people in life. To be able to see yourself as a worthy person, De Villiers and Van den Berg (2012: 97, 100) emphasise the focus on the role of personal appraisal. A client's positive appraisal of himself influences the way in which he will deal with stressors. In order to be able to appraise himself in a positive way, a client should become more aware of himself (self-awareness). Self-awareness implies becoming aware of your personal characteristics. If a person appraises himself and his skills and resources in a positive way, he will probably appraise the environment and its demands in a more positive light. Self-awareness and positive self-appraisal will support a client in having more self-belief and it will improve his confidence in his abilities.

- Interpersonal confidence:

This confidence implies dealing with criticism and unfavourable comments (oral challenges) when hindrances are experienced. It further includes a person's ability of oral confidence to state his views with authority, in spite of alternative views expressed by others. These people are known as the more assertive persons in life. In Tables 2.5 and 2.6, characteristics of people with high *versus* low confidence in abilities as well as high and low interpersonal confidence can be seen (note that this it is not exclusive lists).

Table 2.5: Characteristics of people with high confidence in ability *versus* low confidence in ability scores

Low confidence in ability scores	High confidence in ability scores
Low self-belief.	Are able to belief that they are right even when they are wrong.
Not confident that they know a subject matter – even if they do.	Confident that they know a subject matter.
Don't like it to respond in a discussion or debate.	Willing to provide responses in a discussion or a debate.
Reluctant to take part in presentations and	Willing to do presentations and oral work.

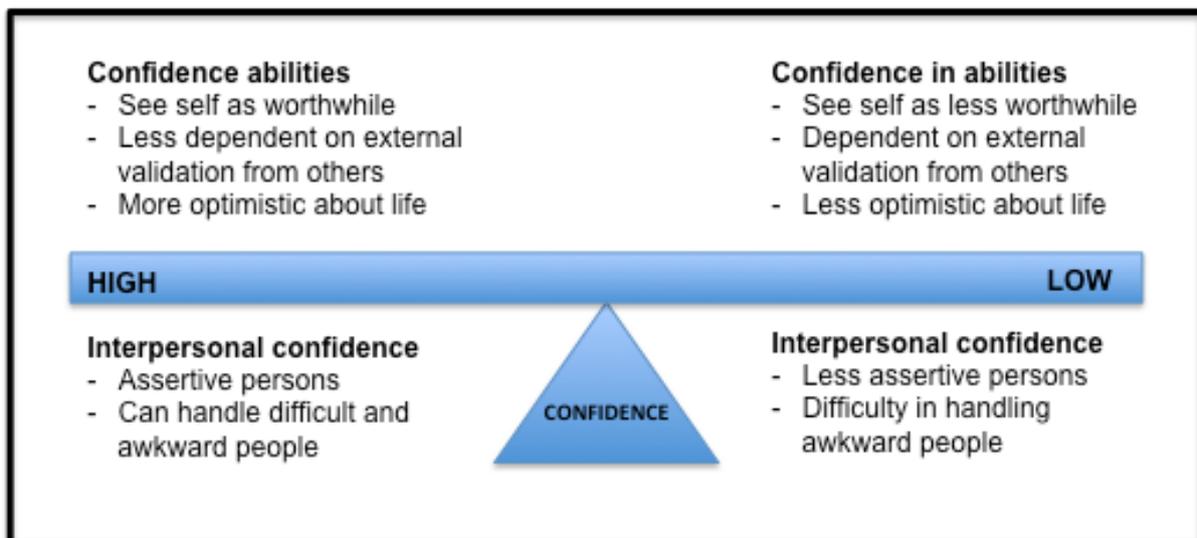
oral work.	
Easily inhibited by competence in others.	See competence in others as a personal motivator to aspire that too.
Can tend to over-talk.	Knowing better when to talk and when to keep quiet.

Table 2.6: Characteristics of people with high interpersonal confidence versus low interpersonal confidence

Low confidence scores	High confidence scores
Will not express themselves in class and/or a debate – even if they know they are right.	Are able to face criticism and they are prepared to assert themselves.
Will accept criticism, even if it is not warranted.	Can deal with negative situations and the fallout.
Are easily intimidated.	Will stand their ground.
Retreat quickly when challenged.	Willing to take more risks.
See help and support as shortcomings.	Are willing to ask for help and support.
Passive team worker.	Active team worker.
Has difficulty in dealing with assertive people.	Are willing and have the ability to deal with assertive people.

The two sides of the confidence scale is illustrated in Diagram 2.4 below.

Diagram 2.4: Confidence



Source: My own illustration

According to Clough and Strycharczyk (2012: 84-88) self-efficacy plays a vital role in the concept of confidence. They define self-efficacy as “a person’s belief in his ability to succeed in a particular situation”. The concepts self-confidence and self-efficacy are used alternately by many authors. Bandura (1977) describes self-efficacy as a belief

that a person has in his capabilities in reaching a specific level of success (Clough & Strycharczyk 2012: 85). Sue *et al.* (2010: 195) states that self-efficacy encompasses an affirmation of a person's capability as well as the strength of his belief. In defining confidence in their model of mental toughness, Clough and Strycharczyk (2012) discovered that this concept includes many characteristics of self-efficacy. Although Bandura (1977) argued that people avoid threatening situations due to the fear that they will not cope, Clough and Strycharczyk (2012) further added that the fear of not coping can be connected to a person's behaviour and cognitive processes. Although these arguments of Clough and Strycharczyk need more scientific evidence, they strongly reason that the impact of low confidence on performance could to a large extent be explained by a person's behaviour and underlying cognitive processes.

The 4 C's Model of mental toughness is summarised in Table 2.7.

Table 2.7: The 4C's Model of Mental Toughness

Component	Description	Example Developmental Strategy
Control	- Ability to handle many things at a time. - Remain influential and not controlled.	Training in the presence of distractions.
Challenge	- Perceive threats as opportunities to grow. - Thrive in environments that change constantly.	Increasing ability to deal with changes and challenges.
Commitment	Committed and intensely involved to achieve goals in spite of difficult situations.	- Set goals - Achieve goals
Confidence	- Maintain self-belief despite setbacks. - Not intimidated by opponents.	- Imagining self-facing and experiencing difficult times.

2.6 THE MENTAL TOUGHNESS QUESTIONNAIRE 48 (MTQ48)

The MTQ48 consists of 48 items and is in the format of a questionnaire. A five-point Likert scale is used to capture responses. It measures a person's mental toughness across four scales, which are control, challenge, commitment and confidence (see discussion 2.5.1 – 2.5.4). Therefore the MTQ48 is also known as the 4 C's model. The most popular way to complete it is in online format and it takes about 10 minutes. A paper and pen version is also available. In both the online and the pen and paper versions, software is used to process the data in order to generate four different reports.

The reports provide detailed outlines for the application there of (see discussion of reports 2.6.1). There are two versions of the MTQ48: The Standard Version, which will be used in this study and which creates up to five reports and is applicable for most users; and the Young Person's Version which is specifically designed to meet the language levels of younger people (Clough & Strycharczyk 2012: 1, 2, 47, 48; Mental Toughness 2012: 2-4; Crust & Keegan 2010: 165).

2.6.1 MTQ48 standard version reports

By making use of an expert software report system MTQ48 creates five reports from the client's data.

a) FOR THE INDIVIDUAL:

Development Report

This report provides feedback on the client's scores and an explanation of what the scores mean. Areas of development are indicated and actions on the improvement of performance on the different scales are suggested.

b) FOR THE COACH AND/OR MANAGER:

Assessment Report

This report focuses on recruitment and the workplace. Clear feedback is provided on the overall measure as well as for each of the four individual scores' scales. A list of between six and ten suggested questions is provided which enable managers to investigate and analyse specific scores comprehensively. In order to generate the most effective responses, the questions are open and focus on behaviour. Each manager and/or coach should adjust these questions in order to be appropriate to their specific environment.

Coaching Report

This report interprets the client's scores. Suggestions and coping and development actions are given to the user (which includes the manager and/or coach) in order for the user to consider for example a job application and to be used as a developmental guide in supporting the specific applicant.

c) FOR THE ORGANISATION:

Organisation Development Report

This report is used for groups of people in order to identify trends and patterns and takes a form of a histogram. Examples of possible groups are a year group of a school or college, a specific team or a management of an organisation.

Distance Travelled Report

After a period of mental toughness training, a new assessment will be done. The aim of this assessment is to investigate whether a client's mental toughness has increased over a period of time or not. The distance travelled report compares the current and previous assessment, and is especially valuable in return on investment (ROI) studies.

In this study, I made use of the assessment report to informally interview the clients when I provided them feedback of their test results. I used both the development and the coaching reports in order to support the traumatised persons to develop their mental toughness to better deal with their trauma. The participants received a hard copy of their development reports. The organisation development report was used to identify trends and patterns in the group. I also made use of the distance travelled report, which was completed by the participants prior to as well as after the presentation of the psycho-educational programme in order to determine whether the participants' mental toughness had increased whether it supported them to better cope with their trauma (the latter will be determined by means of a qualitative interview).

2.7 APPLICATIONS OF MENTAL TOUGHNESS

The Mental Toughness tool was particularly developed for managers in the occupational sector and the sports sector (from where it originated) who have to work in potential stressful environments (Clough & Strycharczyk 2012: 17-18; Mental Toughness 2012: 3-6). The MTQ48 has never been used in the field of educational- and clinical-psychology. In my study I used the MTQ48 tool in the field of educational-psychology in order to determine whether the development of mental toughness supported a traumatised person to better deal with his trauma.

2.7.1 The main applications for Mental Toughness in my study are the following areas:

2.7.1.1 *Coaching and Personal Counselling*

Coaching and Personal Counselling takes place either to identify and deal with adversity and problems or to support people in developing resilience. In my study individual therapy took place within a group situation by means of a psycho-educational programme which had been compiled according to the results of the literature review.

2.7.1.2 *Training and Development*

Training and development supports individuals and/or groups to develop their maximum performance levels and trains them how to better deal and cope with stress. In the psycho-educational programme of my study, I aimed to support traumatised persons, with low or satisfactory mental toughness, to increase their mental toughness in order to better cope with their traumatic events.

2.8 IMPLICATIONS OF MENTAL TOUGHNESS

The MTQ48's provide opportunities to give direction for coaches and trainers in relation to the following:

- Diagnoses are completed in order to identify a person's challenges.
- Interventions take place in order to be able to select custom-made interventions for a specific person's needs.
- Evaluations monitor a person's degree of development progress.
- Research aims to continuously evaluate which interventions are the best and to be able to make adaptations where necessary (West Midlands Coaching Pool 2010: 46).

In this study diagnoses was done by applying the MTQ48. A psycho-educational programme was compiled from the literature review and was applied through the individual therapy sessions. After each session every participant completed an evaluation form in order to determine the effectiveness of the intervention programme on their mental toughness in order to better deal with his trauma. The aim of the

research is to contribute to the field of psychology where gaps were identified regarding how to practically support a traumatised person by increasing his mental toughness.

2.9 THE ROLE OF STRESS IN MENTAL TOUGHNESS

Clough and Strycharczyk (2012: 11) state that stress and mental toughness are closely related constructs, as a core component of mental toughness is a person's ability to effectively deal with stress. As a complex context, stress has a number of definitions, but in its relationship with Mental Toughness Clough and Strycharczyk (2012: 17) define stress as *"an adaptive response, mediated by individual characteristics and/or a psychological process, that is a consequence of any external action, situation or event that places special physical and/or psychological demands on a person"*.

2.9.1 A brief history of stress

Though the concept "stress" originated in the 18th Century, research interest in stress only started in the 1950s and is still continuously growing. In the 18th Century French physiologist Claude Bernard proposed that life was determined in an organism by keeping his internal state on a constant level when the external environment changes (Johnson 2006: 300; Clough & Strycharczyk 2012: 10, 11). It was only in the twentieth century that Bernard's work was further elaborated by a Harvard physician Walter Cannon, who introduced the core aspect of stress which is known as homeostasis. Homeostasis means the ability to stay the same and it implies that our bodies' internal environment (our temperature, blood pressure, pulse rate, etc.) needs to be kept as constant as possible, regardless of changes in the outside environment, otherwise it may have consequences that include sickness and even dying.

2.9.2 Stress and perception

Sue, *et al.* (2003: 201) clearly state that a stressor is an external situation that places a physical or psychological pressure on a person and that stress is a person's internal response to a stressor. Essentially, two people will act differently in the same stress situation (Roos *et al.* 2002: 16; Clough & Strycharczyk 2012: 17; Sue, *et al.* 2010: 175). Through the years of stress research it has become clear that a person's reaction to a stressor depends on his perception of the stressor as well as on his belief system (see Figure 2.10: Stress as a personal response) (Clough & Strycharczyk 2012: 13, 14, 18;

Unisa 2002: 6; Roos *et al.* 2002: 13 – 14; Scott 1992: 8).

Figure 2.10: Stress as a personal response



Source: Roos *et al.* 2002: 16

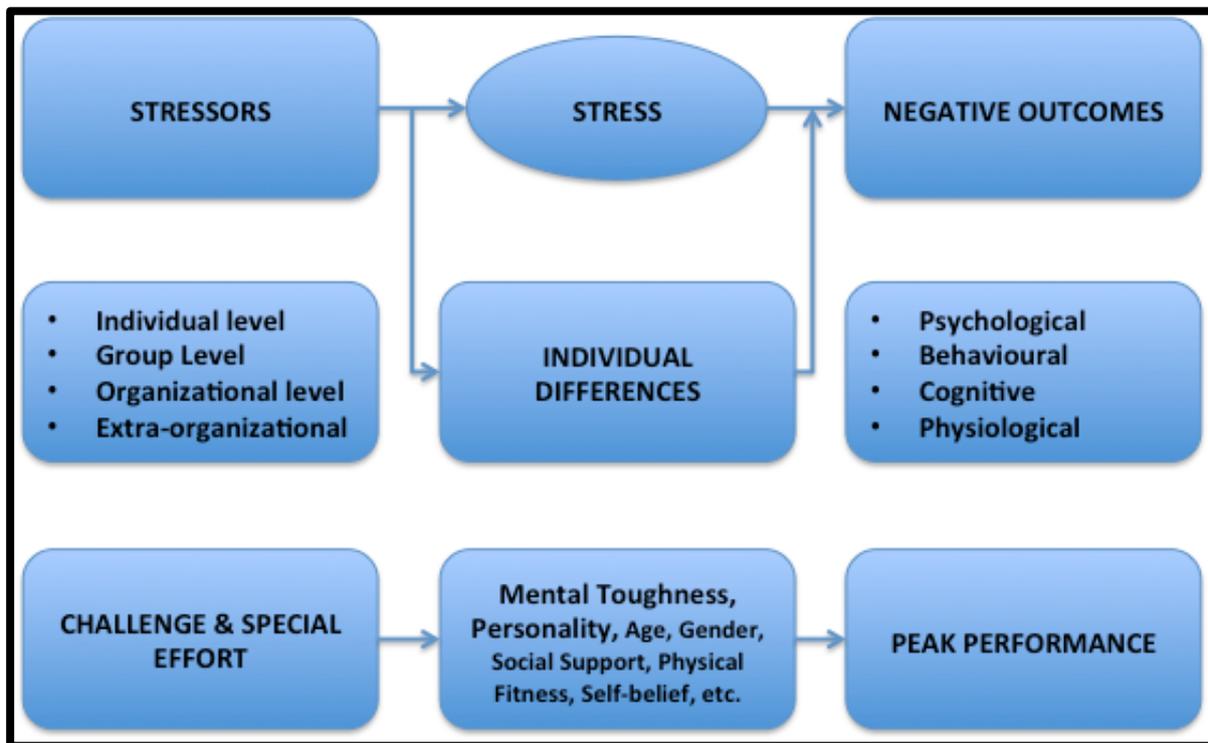
2.9.3 The effect of stress on the human body

Stress causes both physiological and psychological changes in the body. Examples of physiological changes are sweating, dry mouth and a raise in blood pressure. Stress also affects a person's heart function, hormone levels and metabolic levels. Psychological changes may include aggression, sleeping problems, change in eating habits and social withdrawal (Clough and Strycharczyk 2012: 12; Sue *et al.* 2003: 201-202; Baron, Byrne & Branscombe 2006: 520). According to Clough and Strycharczyk (2012: 12) and Roos *et al.* (2002: 14) a person can experience these symptoms and behavioural changes as independent events or these can be simultaneously occur with a person's stressful emotions that are called subjective reactions, which are both physiological and behavioural. Examples of such responses are fear, anxiety and happiness. As a person's perception and belief system determines his reaction to a stressor, there is no clear definition of stress that is measurable in an objective way and this implies that a person is stressed if he says that he is stressed (Roos *et al.* 2002: 3,16; Clough & Strycharczyk 2012: 17).

2.9.4 The AQR Stress Model

After years of research in order to support people to better deal with stress, Clough and Strycharczyk (2012: 17-18) came to the conclusion that what matters is not a definition of stress, nor an objective stress measuring instrument, but how a person deals with stress. Clough and Strycharczyk developed a stress model, which is called the Association for Qualitative Research (AQR) Stress Model, as illustrated in Diagram 2.5.

Diagram 2.5: The AQR Stress Model



Source: Clough and Strycharczyk (2012: 18)

The AQR Stress Model defines stress as follows: *“Stress is an adaptive response, mediated by individual characteristics and/or a psychological process that is a consequence of any external action, situation or event that places special physical and/or psychological demands on a person”*. The AQR’s stress definition includes the following core aspects: stress is not bad in principle and it is unavoidable, different people react differently to the same stressors and stress can cause physical and psychological harm. According to Clough and Strycharczyk (2012: 18, 20) peak performance is *“the flip side of effective stress management”* and the two are closely intertwined. When a person has reached his full potential in performing a task to the best of his abilities and receives the expected results, it is explained by the AQR Stress Model as reaching peak performance. As the mental toughness scale MTQ48 was mainly used in the occupational and sports world and not much research has been conducted in the field of psychology, I want to connect the concepts of peak performance and self-actualisation in my research. Peak performance in the occupational and sports world and self-actualising in psychology both describes a person’s full potential. Therefore in dealing with trauma, peak performance would imply the development of mental toughness, which had been absent or less-developed before, in order to enable a person to better deal with trauma in the best way he possibly could.

Clough and Strycharczyk (2012: 20) emphasise that optimising performance in order to achieve significant outcomes, will usually demand that a person deals with adversity or is challenged in ways that would otherwise prevent a less motivated person. Therefore, in dealing with trauma in the best way a person could, he needs to be motivated and have endurance, which are both aspects of mental toughness.

As indicated previously in this study, approximately 50% of the change in a person's performance level is explained by his mental state, but strangely merely 5% of his time is spent on maximising his performance level through mental training (Clough and Strycharczyk 2012: 22). According to Clough and Strycharczyk (2012: 22), it means that performance and well-being are both related to stress management. If stress could be managed, performance would improve and well-being would be optimised and *vice versa*; if stress could be managed, well-being would improve and performance would be optimised. Therefore, the authors focus on the important inter-correlation between mental-toughness, stress management, performance and well-being of people with high mental-toughness (Clough & Strycharczyk 2012: 215-216, 271).

2.9.5 The connection between stress, performance and well-being

Mental Toughness (2012: 4) states that in order to improve performance, the challenge lies in identifying the causes of stress for each person and to support the person to become aware of these causes. This awareness can lead to understanding and understanding can lead to action, which in turn can lead to improved performance. According to Clough and Strycharczyk (2012: 22) optimum performance leads to more content feelings with oneself and the world around him, which in turn leads to better performance. The common factor in these groups is stress. Characteristics of high-performing individuals are outlined in Table 2.8 and attributes which affect high performers individual's performance are summarised in Table 2.9 (Crust and Clough 2011: 23; Clough & Strycharczyk 2012: 2).

Table 2.8: Characteristics of high-performing individuals

Passion	Highly interested in a task
High self-confidence	A high level of confidence in themselves and their abilities and their ability to deal with others
Controlling the things you can	No unnecessary worries about things that they cannot control
Resilience – dealing with setbacks	They have the ability to bounce back
See the challenge, not the threat	Finding the opportunities to grow and

	develop within challenges
Focus	Can focus on important matters and clear their minds of unnecessary thoughts
Ability to relax	They can recognise when they need to take a break

Source: Clough and Strycharczyk (2012: 21)

Table 2.9: Attributes which affects performance

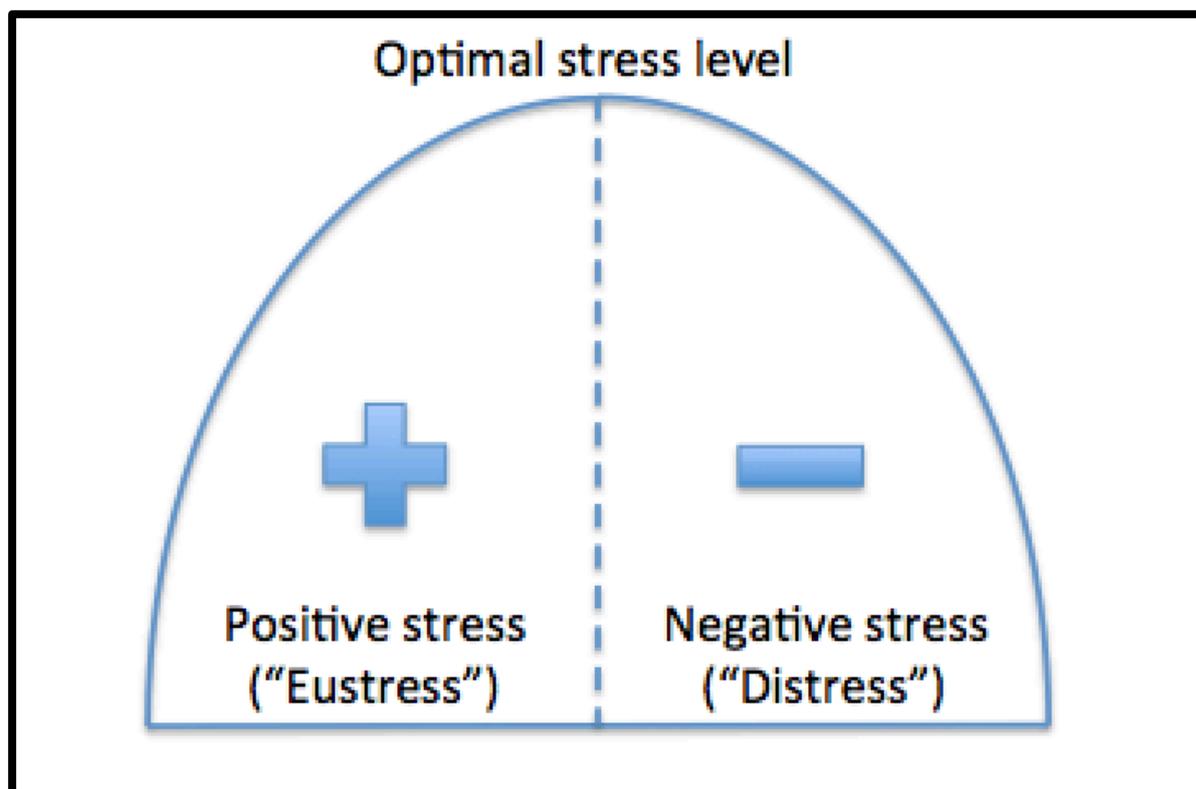
Abilities	What do you bring to a task?
Approach	How do you approach a task? What motivates you? What are your interests?
Reward	What will you gain by getting involved in a task?
Colleagues	How do you interact and communicate with the people around you?
State of mind	What are you thinking? Are you ready to rise to the challenge?

Source: Clough and Strycharczyk (2012: 21)

2.9.6 Stress management guidelines for traumatised persons

It is important to know that separately from supporting a client in dealing with a trauma, he will probably also have to face the reality of dealing with additional stresses. The reason for this is that when a person has to deal with trauma, unresolved issues of the past or aspects that have not been a problem before the trauma often come to the fore as issues. These issues should be addressed and dealt with together with the trauma. As I am using the concept of a person as a “whole”, which includes his physical, cognitive, emotional, social and moral aspects, trauma like any other human experience does not happen as an isolated experience to other aspects of a person’s life. Trauma can have negative effects on people’s relationships, self-esteem, self-image, work related issues, mental and physical health (Roos, *et al.* 2002: 21; Roets 2009; Marshall 2007: 1-2; Strydom *et al.*, 2002: 41-42; De Witt & Booysen 1994: 3; Unisa 2002: 1; Government Gazette 2001: 4). Stress is not harmful and destructive on every level and up to a certain level it can actually have a motivating effect. When stress exceeds a specific level it tends to become harmful. This level is known as the “stress curve” and is illustrated in Figure 2.11 (Roos, *et al.* 2002: 15).

Figure 2.11: The stress curve



Source: Roos, *et al.* (2002: 15)

People differ in terms of their levels and skills to deal and cope with stress as their stress thresholds differ. In developing a person's skills to cope with stress, it is however possible to increase his stress threshold (Roos, *et al.* 2002: 15). The following are good practical examples to accomplish this:

2.9.6.1 Improve your self-concept and self-esteem

People who constantly feel negative about themselves place a great deal of pressure on a person as the constant stress to maintain balance between his inner self (internal relationship) and relationships with other people (interpersonal relationships) becomes extremely stressful. It takes intensive, continuous self-discipline for a person to accept himself as a unique person, but this acceptance will empower a person to live a much more balanced and less stressful life (Roos, *et al.* 2002: 22; Van den Aardweg & Van den Aardweg 1999: 214-215; Graham 2004: 317-321; Strydom, *et al.* 2002: 21, 50; Jordaan & Jordaan 1998: 39, 617; Scott 1992: 9, 21).

2.9.6.2 Change your self-talk

Self-talk is what a person repeats to himself constantly and it can either be positive or negative (Egan 2014: 393). Most people are not conscious of their self-talk that has a powerful influence on their stress levels and actions. Negative self-talk will become self-fulfilling prophecies and a person will become what he thinks he is. Self-talk is a powerful tool to overcome stress (Scott 1992: 9; Roos, *et al.* 2002: 22). Self-talk is a well-known concept in sports coaching and there is growing evidence that self-talk influences the way in which people approach tasks and challenges (Clough & Strycharczyk 2012: 215).

2.9.6.3 Create a support system

Turning to friends and family to seek their advice, support and sympathy when one feels stressed is a very effective way to protect a person from the destruction and devastation of stress (Roos *et al.* 2002: 25; Baron *et al.* 2006: 524-525).

2.9.6.4 Take care of your health

People tend to neglect their bodies when they face stressful events. Growing research indicates that stress impairs a person's effective functioning of his immune system which can lead to colds and flu infections. High levels of stress also can take its toll on a person's cardiovascular system that can lead to heart disease, diabetes, ulcers, skin disorders, headaches, muscle tension, allergies and constipation. Examples of basic principles to take care of your health include exercising on a regular basis, sleeping enough, following a healthy diet, avoiding smoking, avoiding the abuse of alcohol and medication (Scott 1992: 9; Roos, *et al.* 2002: 14, 26; Baron, *et al.* 2006: 521-523).

2.9.6.5 Commitment to cope

As stated by Clough and Strycharczyk (2012: 64-65, 269) and Sheikh (2008: 87) the harsh reality of dealing with traumatic stress is that a person can only start to pick up the pieces of his life in order to put it back together when he is committed to doing so. Facing emotional issues can be extremely exhausting and it takes courage and energy for a person to open himself up and to adapt to the reality of the changes that trauma brought to his life. It is empowering to practically imply the following principle of Scott (1992: 42) in your life: *"Stress becomes more manageable when I concentrate on taking*

action and at least mastering the situation, if not solving it” (Roets 2009; Roos, *et al.* 2002: 14).

2.9.6.6 Use stress to motivate you

Motivation suggests a strong inner encouragement to take action towards achieving a goal. This action is called “*action with a purpose*”. Stress can be seen as either a wall or a stop on the road or as a ladder that could be used to climb up, to reach more, to conquer heights and in the process, conquer your own weaknesses (Scott 1992: 23; Corr, *et al.* 2006: 169). In this instance mental toughness can become an empowering resistance resource that can help a person buffer the effects of stress (Crust & Keegan 2010: 164).

2.10 THE DEVELOPMENT OF MENTAL TOUGHNESS

Therapists have moved beyond the nature-*versus*-nurture question as it has recently been understood that both nature (genetics) as well as nurture (environment) influence a person’s personality and behaviour. Disagreements in the research still exist on whether mental toughness is a mind-set (which can be changed) or a personality trait (which is genetically inherited) or whether mental toughness consists of different aspects in different sports. However, there is consensus that mental toughness consists of multiple components (Crust and Clough 2011: 21, 23, 24, 30).

Research indicates that people can develop mental toughness and that the MTQ48 is a valuable tool to measure the impact of stressful situations and to support people in the improvement of their performance levels (Mental Toughness and MTQ48 2013: 1; Mental Toughness 2012: 6; Clough & Strycharczyk 2012: 207; Thelwell, Such, Weston, Such & Greenless 2010: 174). Bull, Shambrook, James and Brooks (2005: 225), Clough and Strycharczyk (2012: 210) and Thelwell, *et al.* (2010: 26) indicate the that importance in supporting people to develop mental toughness is that each person should be seen as a unique being and there should be room for every person’s specific needs to develop his mental toughness. According to Clough and Strycharczyk (2012: 209) as well as Crust and Clough (2011: 24-25), mental toughness may be influenced by cognitive interventions (e.g. positive thinking and imagery). Nicholls, Polman, Levy and Backhouse (2008: 1182-1184, 1186, 1189) add to this by establishing a positive correlation between mental toughness and problem approach coping strategies such as,

mental imagery, thought control, effort cost and logical analysing; and negatively correlated mental toughness with avoidance coping strategies such as mental distraction, distancing and resignation. According to Crust and Clough (2011: 25) in a study that was conducted on elite female gymnasts, Thelwell, *et al.* (2010: 174-176, 180) also concluded that mental toughness could be developed and enhanced by visualising successful performance.

Current available research suggests that experiential learning is a key aspect in the training and development of mental toughness. In developing mental toughness it was found that athletes should rather be exposed to and not be protected against challenging situations. They should be trained to learn to cope during setbacks and turbulent times. Independent problem-solving and personal responsibility is vitally important in the development of mental toughness (Crust & Clough 2011: 21, 26, 30). Another frequently cited influence in developing mental toughness is “having goals” (Thelwell, *et al.* 2010: 174-176, 180). As young athletes become more mature they should become more involved in setting short term goals and taking responsibility regarding their development. Therefore the support of significant others (e.g. parents and coaches) is very important. Clough and Strycharczyk (2012: 210) became aware of many techniques and approaches that could support a person to increase levels of mental toughness, for example Cognitive Behavioural Therapy (CBT), Neuro-linguistic Programming (NLP) and positive psychology. Clough and Strycharczyk (2012) categorised the mental development tools and techniques into five themes that include positive thinking, visualisation, anxiety control, goal setting and attentional control.

2.11 CONCLUSION FROM LITERATURE REVIEW

In an attempt to compile a psycho-educational programme that aims to improve mental toughness in a traumatised person, it was required to undertake a literature review on mental toughness. The following findings were derived from the study:

- A person’s inner strength should never be misjudged as it can become an empowering resource in his own healing.
- Resilience and inner strength are more connected aspects than researchers and non-researchers previously believed it to be.

- The strength of an individual can be developed in order for him to become an expert and a resource in buffering the full force of hardships.
- An important buffering perspective against adversity and crisis is a person's perspective of himself as being successful. Essentially, mentally tough individuals must believe that they can persevere in spite of failure.
- People who believe in themselves and who have a good self-esteem will approach, rather than avoid or procrastinate in tasks because they believe that effort and high ability are important aspects in achieving success.
- A person who takes responsibility for his actions will believe that his success will depend on his effort and commitment and therefore he will have a better chance in achieving success.
- It is important that a person should be aware that the way he will perceive his own successes and failures as influenced by his frame of reference, which includes aspects like his norms, values, beliefs and biases.
- People with high control tend to believe that they have the choice and the power to transform the impossible into the possible. They believe that they can make the change and they do not wait for change to come along.
- People with high confidence feel proud of themselves and usually have a good self-esteem. They believe that they have good skills to contribute in order to make the world a better place.
- By changing people's thoughts and behaviour they can move from an irrational to a more rational view of life.
- Mental toughness is a multidimensional construct. The following key attributes characterises mental toughness:
 - having an unshakeable belief in yourself and your own ability;
 - coping effectively with stress and adversity;
 - recovering and rebounding from set-backs and failures;
 - persisting rather than quitting;
 - being resilient;
 - being able to push your boundaries in spite of physical and emotional pain;

- having utmost belief in yourself in controlling your own destiny;
 - thriving on pressure;
 - developing and possessing superior mental skills (Crust 2008: 577 ; Crust & Keegan 2010: 164; Connaughton *et al.* 2008: 83, 88, 91, Bull *et al.* 2005: 209, 210, 217, 226; Thelwell, *et al.* 2010: 175-178).
- Mental toughness can be developed.
 - Becoming what a person believes he is, seems to be more of a self-fulfilling prophecy than people realise.
 - In order to develop mental toughness, people should not be shielded from setbacks and trauma, but rather be supported and trained to work through it.
 - Setbacks and failures are part of life. It can form a natural part of a person's development process if he is committed to reflect upon it and to use it as growing opportunities in the developing of his mental toughness.
 - Taking responsibility is a vital factor in the development of mental toughness.
 - Social support of peers, parents, coaches, and etcetera plays an important role in supporting a person to develop his levels of mental toughness.
 - The core of the phenomenon of mental toughness consists of an intertwining of both the theoretical foundations of the aspects of personality, for example resilience, confidence and self-discipline, as well as the practical applications in connection with sport psychology, for example visualisation and focusing.
 - Stress and mental toughness are closely related to one another as a person's ability to cope with stress forms a core aspect of mental toughness. Therefore an inter-correlation exists between mental toughness, stress management, performance and well-being.

The above core aspects as derived from the literature should thus be included in the compiling of an intervention programme. The programme is discussed in Chapter 5.

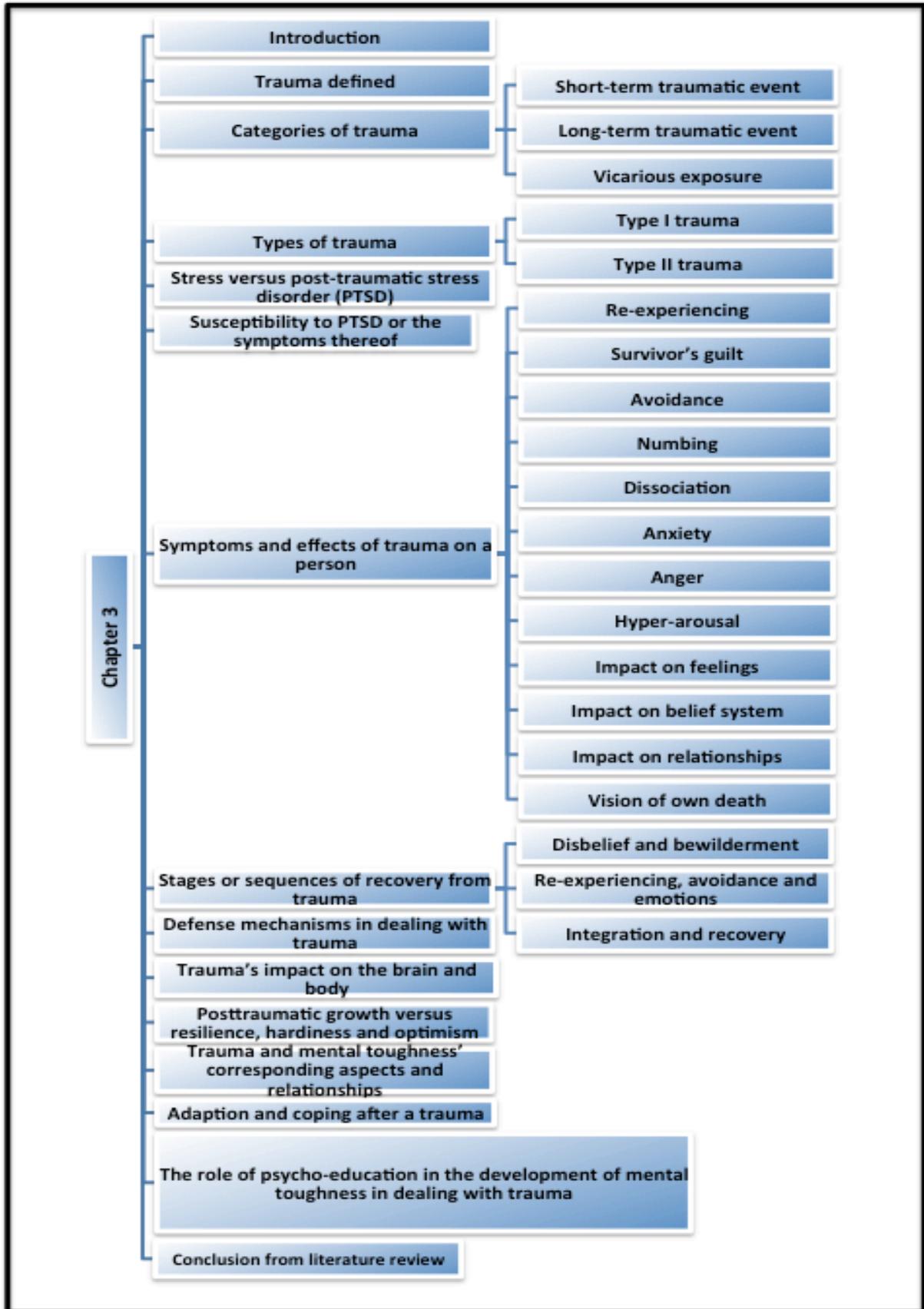
In Chapter 2 a literature review of the phenomenon of mental toughness, its history as well as its development, was completed. In Chapter 3, the nature of trauma as well as trauma's influence on a person's attitudes about himself and his life world is emphasised. The path of recovery and control from trauma is investigated. The use of

mental toughness in dealing with trauma was also researched.

CHAPTER 3

LITERATURE REVIEW: THE PHENOMENON OF TRAUMA

Figure 3.1: Chapter outline



3.1 INTRODUCTION

This chapter included a literature review on the phenomenon of trauma to gain information and insight into the following aspects of trauma:

- The definition of trauma;
- The nature of trauma;
- Trauma's effect on a person's being as a "whole";
- Symptoms and effects of trauma;
- Stages of recovery from trauma;
- Regaining control after trauma;
- Adaption and coping after trauma;
- Defence mechanisms in dealing with trauma;
- Corresponding aspects and the relationship between trauma and mental toughness;
- The role of psycho-education in the development of mental toughness to better deal with trauma.

3.2 TRAUMA DEFINED

Preston (2013: 2), Roos *et al.* (2002: 91), Unisa (2002: 8-10, 22, 30), Tedeschi and Calhoun (2004: 2) and Keeton (2009: 1) define trauma as stressful events, over which a person has no control. This stressful events cause high levels of anxiety which threatens or harms a person's emotional, physical and/or social well-being and interferes with his normal daily functioning in such a way that a re-evaluation of his actions and thoughts are needed. These strong emotional reactions have the potential to interfere with a person's ability to function either at the scene or later (Mitchel 1983).

Preston (2012: 2) states that any situation where a person experiences feelings of being overwhelmed and loneliness could be traumatic, even if there's no indication of physical harm. Keeton (2009:1) provides a good example, which support Preston's (2012: 2) statement: A child, while growing up, who had been humiliated by a parent or teacher,

may have experienced a trauma.

3.3 CATEGORIES OF TRAUMA

According to Preston (2011: 2; 2013: 2), Roos *et al.* (2002: 42, 45), Unisa (2002: 8-10, 22, 23, 30) and Tedeschi and Calhoun (2004: 2) trauma is categorised as follows:

- Short-term traumatic events

Short-term traumatic events are known as once-off traumatic events, and these include:

- Natural disasters: e.g. earthquakes, floods, severe tropical storms, hurricanes and mining disasters.
- Manmade (accidental/unintentional) disasters: e.g. airplane accidents, car accidents and fires.
- Manmade (intentional) disasters, which are deliberately caused: e.g. shooting, robbery, physical attack, sexual assault, rape, hostage taking, robbery, mugging, kidnapping and hi-jacking.

- Long-term traumatic events

Long-term traumatic events refer to prolonged exposure to trauma and consists of two sub-categories, which are:

- Natural and technological disasters: e.g. nuclear accidents, toxic spills, epidemics and chronic and/or life-threatening illness.
- Manmade (intentional) disasters: e.g. repeated sexual abuse as a child.

- Vicarious exposure

Vicarious exposure to trauma implies indirect exposure to trauma and therefore it is known as secondary traumatisation. The person is not the direct victim of the trauma, but he witnessed the event or heard about it from others and in this way distress arises in him; for example disaster, unexpected witnessing of a dead body learning about the unexpected death of a family member or friend and observation of parents with chronic stress effects. Secondary traumatisation could also be caused by exposure to closely avoided traumatic incidences (Clarke 2008: 14-16; Roos *et al.* 2002: 42, 46; Tedeschi & Calhoun 2004: 2).

3.4 TYPES OF TRAUMA

- Type I traumas

Examples of Type I traumas are hi-jackings, rape and nuclear accidents. Type I traumas are characterised in Table 3.1 (Meichenbaum 1995: 20; Roos *et al.* 2002: 43 and James & Gilliland 2013: 189).

Table 3.1: Characteristics of Type 1 Traumas

Characteristics of Type I traumas	
Single event	Sudden
Unexpectedly	Overwhelming
Rare	Dangerous
Limited duration	Quicker recovery is more likely to happen
Possibility to experience PTSD symptoms	

Sources: Roos *et al.* 2002: 43; James and Gilliland 2013: 189 and Meichenbaum 1995: 20

- Type II traumas

Examples of Type II traumas are repeated sexual abuse as child and chronic illness. Type II traumas are characterised in Table 3.2:

Table 3.2: Characteristics of Type 11 Traumas

Multiple	Repeated
Chronic	Feelings of helplessness
Limited duration	Vague memories – detachment from experience
Possibility to experience PTSD symptoms	May lead to interpersonal problems e.g. detachment from others, restricted feelings and emotions
Self-view and world view changes	Efforts to protect the self – denial, numbing, withdrawing, substance addiction
More likely to lead to complex PTSD	

Meichenbaum (1995: 20); James and Gilliland (2013: 189); Roos *et al.* (2002: 42-44)

The trauma type and impact on victims is influenced by many variables, as lists in Table 3.3 (James & Gilliland 2013: 157; Unisa 2002: 31, Hobfoll *et al.* 2009: 144 & Preston (2013: 2; Meichenbaum 1995: 340):

Table 3.3: Variables that influence the type and impact of trauma

Intensity of event	The part of the community that is affected
Degree of the threat	Chances for the trauma to repeat
Role of the person in the trauma	Loss of family and friends
Speed of onset and duration of the trauma	Degree in which the routine at home is disturbed
Availability of aid and rescue	Sociocultural circumstances (which includes both cultural norms and values as well as social support)
Unexpected/expected nature	Social support.
Level of moral conflict inherent to the situation	

3.5 **STRESS VERSUS POST-TRAUMATIC STRESS DISORDER (PTSD)**

Stress is defined and described in detail in Chapter 2. From the discussion of the perspective of stress, stress is seen in terms of a stressor (amount of pressure) which leads to a stress reaction. It is not possible to determine a person's precise breaking point, as two different persons experience the same stressor differently (Roos *et al.* 2002: 15-16, 46). If a traumatic event is not dealt with and integrated into a person's awareness system, the initiating stressor will re-emerge as stress symptoms months or years after the trauma took place and is called delayed or post-traumatic stress disorder (PTSD) (James & Gilliland 2013: 150, 160, 189; Roos *et al.* 2002: 46).

The DSM-5 pays attention to the behavioural symptoms that accompany PTSD and contains four distinct diagnostic clusters, namely re-experiencing, avoidance, negative cognitions and mood and arousal (U.S. Department of Veterans Affairs: 2013; American Psychiatric Publishing: Post Traumatic Stress Disorder: 2013; Roos *et al.* 2002: 41-42; Unisa 2002: 10). All of the conditions included in this classification as diagnostic criteria require exposure to a traumatic or stressful event (James and Gilliland 2013: 152; Unisa 2002:10). For the purpose of this study the focus was on stressors that trauma causes, and not on PTSD as such. Research carried out by Mol, Arntz, Metsemakers, Dinant, Vilters-Van Montfort and Knottnerus (2005: 494, 497) and Scott and Stradling (2006, as cited in Clarke 2008: 15) provides evidence that there is a connection between negative life events—for example divorce, chronic illness and bullying at work—and many symptoms of PTSD as caused by trauma itself. The difference between the impact of a life event and a traumatic event in terms of PTSD is that the impact of a life event decreases over years while the impact of a traumatic event is more stubborn (Mol *et al.*

2005: 498).

Another concept that should be noted when dealing with stress and PTSD is Acute Stress Disorder (ASD). The most important difference between ASD and PTSD is in onset. ASD symptoms manifest within two days to weeks weeks after a trauma, while PTSD can only be diagnosed from a period of four weeks after the event (Sue *et al.* 2003: 157-158; Bryant, Friedman, Spiegel, Ursano & Strain 2011: 335-336; Scott & Stradling 2006: 3).

3.6 SUSCEPTIBILITY TO PTSD OR THE SYMPTOMS THEREOF

Sensitivity to PTSD is determined by different personal aspects such as genetic predisposition, personal history, personality traits, self-esteem, strengths, weaknesses, state of mind, past life experiences, coping skills, social support systems, the intensity of the event, the perception of the event, conflict, stress management skills and flexibility. Some people have extremely good coping skills and they can deal with severe traumatic incidences much better than other people who might be traumatised by a less upsetting incident. A more detailed description of the personal aspects as an important determining factor, of whether a person will find an event traumatic or not, is discussed later in this chapter (A person's interpretation of the traumatic event) (Sue *et al.* 2003: 160-161; Roos *et al.* 2002: 42, 45, 55; James & Gilliland 2013: 156, 158; Unisa 2002: 16; Scott & Stradling 2006: 27).

3.7 SYMPTOMS AND EFFECTS OF TRAUMA ON A PERSON

Stress reactions after a traumatic incident are not pathologic, but normal. To support a traumatised person, is to support a survivor as a "*normal and healthy person in an abnormal situation*" (Meichenbaum 1995: 350; Roos *et al.* 2002: 90-91; Tedeschi and Calhoun 2004: 2; Roets 2009). As mentioned before, the focus of this study is not on PTSD. It is however important to be familiar with the symptoms of PTSD in order for the therapist to be able to observe whether a traumatised client is only experiencing possible symptoms of PTSD, or whether he should be referred to a clinical psychologist. Knowledge of the symptoms of PTSD is also of importance as there is a similarity between the symptoms of PTSD and the "normal" stress that is caused by traumatic incidents (Mol *et al.* 2005: 494-498; Scott and Stradling 2006, as cited in Clarke 2008:

15; Scott & Stradling 2006: 8-13; Roos *et al.* 2002: 90; Unisa 2002: 9-14, 26-27). Kleber and Brom (1992: 4-6) focus on three important aspects for individuals who face traumatic experiences, namely powerlessness, extreme discomfort and an acute disruption of his existence. In Table 3.4 Roos *et al.* (2002: 53); James and Gilliland (2013: 152, 158, 161) and Tedeschi and Calhoun (2004: 2) categorise the symptoms and effects of PTSD:

Table 3.4: Symptoms and effects of both stress and PTSD

Symptoms of stress and PTSD			
Behavioural	Biological	Cognitive	Emotional
Mood swings	Sleeplessness	Difficulties to concentrate	Disbelief
Avoid anything related to the trauma (activities, feelings, people, places)	Nightmares	Failure of memory and forgetfulness	Shock
Alienation Anger outbursts	Fatigue: Shortness of breath and physical weakness	Decreased self-efficacy	Self-blame
Social withdrawal Isolation	Hyper arousal being on the edge, alert, nervous, being irritable, find it difficult to focus, being startled and having insomnia	Fear the re-occurrence of the trauma	Guilt feelings
Stormy relationships	Startle reaction	Flashbacks of traumatic situation	Overwhelming sadness and grief
Substance abuse Excessive smoking and drinking	Panic: palpitations, sweating	Disorientation and confusion	Feelings of helplessness and despair
Reduced work performance Staying away from work	Muscle tension	Re-experiencing (intrusive) thoughts	Anxiety and fear
Sensation seeking behaviour	Gastro-intestinal issues: stomach aches, constipation, diarrhoea, nausea	Afraid to lose control and/or feel out of control	Fear of abandonment
Sexual dysfunction	Neurological: Visual problems, nervousness, tremors	Paranoid thinking	Fear of being alone
Suicide and homicide attempts	Headaches: excessive frowning, tension headaches, migraines	Sick humour	Feels dead inside (feelings are paralysed)
Helpless	Chest pains Back aches	Hypersensitivity to criticism	Depression (severe)
Numbness	Heart burn	Poor judgement	Rage and anger
Changed eating pattern	Dry mouth	Blame	Disgust and terror
Activity level: decreases or increases	Anger outbursts		Feelings of doom and gloom
Aggressive actions	Concentration problems		Phobic anxiety: "irrational" fears
Reckless actions: gambling	Startle response is exaggerated		Feels out of control
Restlessness: continual walking, fidgeting	Feels out of control		

Roos *et al.* 2002: 53; Unisa 2002: 9-14; Preston 2013: 9-11; Tedeschi and Calhoun 2004: 2.

The approach of my study is holistic as the person is seen as a whole, which includes his physical, cognitive, emotional, social and moral aspects. It is evident from Table 3.4 (Symptoms of stress and PTSD) that trauma, like any other human experience, does not happen as an isolated experience to isolated aspects of a person's life. Trauma can have negative effects on people's relationships, self-esteem, self-image, work related issues, mental and physical health (Roos, *et al.* 2002: 21, 90; Roets 2009; Marshall 2007: 1-2; Strydom *et al.* 2002: 41-42; De Witt & Booysen 1994:3; Unisa 2002:1; Government Gazette 2001: 4; James & Gilliland 2013: 152). In order to support traumatised people to develop mental-toughness to better deal with their trauma, it is important to analyse the effects and symptoms that trauma could have on a person (Mol *et al.* 2005: 494-498; Scott and Stradling 2006, as cited in Clarke 2008: 15; Scott and Stradling 2006: 8-13; Roos *et al.* 2002: 47-52, 90; James & Gilliland 2013: 150,152, 159; 161; 189 Keeton 2009: 1; Preston 2013: 8-9).

3.7.1 The person continually re-experiences the traumatic incident

A recognisable symptom of stress and PTSD is that the traumatised person continuously re-experiences the event (e.g. flashbacks and/or nightmares) (Tedeschi & Calhoun 2004: 2; James & Gilliland 2013: 152-153, 159, 161-163, 189). Re-experiencing is triggered by sensory observations, such as sound and smells, that could be linked to the trauma (Keeton 2009: 2). The reason for having flashbacks and re-experiencing is discussed in more detail later in the chapter, in section 3.10. Re-experiencing indicates that a person has difficulty coping with the traumatic experience.

3.7.2 Survivor's guilt

Survivor's guilt is common among the survivors of trauma. In the case of death, survivors experience varying degrees of false guilt because they survived and others did not. They torment themselves for not reacting faster in order to prevent, for example, the death of another person. It is important to address guilt feelings in therapy in order for a person to be confronted with his irrational beliefs about the trauma. In a situation where a person who was drunk caused an accident and killed someone, restorative

action (e.g. meeting the parents of the deceased and apologise and/or repent) can bring some relief.

3.7.3 Avoidance

Traumatized persons tend to start avoiding all things that they can associate with the trauma. Avoidance is an automatic, unconscious reaction as the brain unconsciously starts to believe that anything that can be connected with the trauma is dangerous.

3.7.4 Numbing

Traumatized persons can become apathetic, passive, withdrawn and emotionally paralyzed in order to protect themselves from pain, fear and feelings of helplessness against the overwhelming feelings of trauma.

3.7.5 Dissociation

Dissociation implies a separation of the factors of a traumatic experience in order to reduce the impact of the traumatic event, like floating above one's own body (Burke 2008: 3).

3.7.6 Anxiety

Traumatic events may cause extreme anxiety in a person and traumatized persons are usually afraid that the trauma will recur again. This anxiety can lead to sleep disturbances, fatigue, hyper-arousal, difficulty in concentration and palpitations. De Villiers and Van den Berg (2012: 96, 101) state that in being able to control and regulate one's emotions, stress as a subjective experience and its subsequent emotions—of which anxiety can be one—are moderated through therapy (James & Gilliland 2013: 150, 160, 189; Roets 2009).

3.7.7 Anger

Traumatized people are usually angry at persons who have caused the trauma, at themselves, sometimes at a loved one who died and sometimes at God. Sometimes traumatized persons initially deny the presence of anger, but as time goes by, anger may come to the surface (Kleber and Brom 1992: 81).

3.8 Symptoms of increased nervous system arousal (hyper-arousal)

During exposure to severe stress, a person's hormones, neurotransmitters and cortical functions are activated in order to be able to handle the emergency. After being removed from the danger of a traumatic incident, the possibility exists that a person's nervous system continuously keeps functioning as if the person is still in the emergency situation, which may cause a person extreme physical and psychological distress and may cause feelings of being on the edge, alert, nervous, being irritable. As a result, the person could find it difficult to focus, be easily startled and have insomnia (James & Gilliland 2013: 154).

3.8.1 Impact on feelings

Traumatic events may cause a person to doubt his identity, his feelings of belief in his environment and his trust in other people. In the process, the trauma can cause a person to doubt his feelings of confidence in his own identity.

3.8.2 Impact on belief system

Traumatic events can destroy a person's assumptions and belief system. The traumatised person starts to question his purpose in life, his religious beliefs and his ability to control things.

3.8.3 Impact on interpersonal relationships

On the one hand, a traumatised person needs a strong support system (e.g. friends, peers and family) to help him to rebuild his life, but on the other hand he can act aggressively towards his support system and in the process, these actions push them away from him (James & Gilliland 2013: 161, 189).

3.8.4 Vision of own death

Through a traumatic experience a person may become pre-occupied with thoughts of his own and other people's death and might have many questions that need to be asked.

3.9 STAGES OR SEQUENCES OF RECOVERY FROM TRAUMA

James and Gilliland (2013: 169), Roos *et al.* (2002:54) and Kleber and Brom (1992: 74-85) and Unisa (2002: 32-36) categorised the stages of recovery from trauma, which can be seen in Table 3.5, below.

Table 3.5: Stages/Sequences of recovery from trauma

STAGES/SEQUENCES OF RECOVERY FROM TRAUMA		
	JAMES AND GILLILAND (2013)	KLEBER AND BROM (1992)
1. Emergency	<ul style="list-style-type: none"> • Fight/flight reactions (hyper-arousal) • Confusion and disorientation • Anger 	<ul style="list-style-type: none"> • Disbelief and bewilderment
2. Emotional numbing and denial phase	<ul style="list-style-type: none"> • Avoid stimuli • Deny the experience 	<ul style="list-style-type: none"> • Re-experiencing, avoidance, and emotions
3. Intrusive-repetitive phase	<ul style="list-style-type: none"> • Mood-swings • Nightmares • Intrusive thoughts and images • Isolation from others (withdraws into one's self) 	<ul style="list-style-type: none"> • Integration and recovery
4. Reflective-transition phase	<ul style="list-style-type: none"> • Perspective of the trauma elaborates • Willing to face and confront the problem • More effective coping mechanisms 	
5. Integration phase	<ul style="list-style-type: none"> • Integrate trauma with his personality • Deals with trauma as part of the past • Although the trauma is still considered a very unpleasant event, the person realises that he went through an emotional growing process. 	

Source: James and Gilliland (2013: 169), Roos *et al.* (2002:54) and Kleber and Brom (1992: 74-85) and Unisa (2002: 32-36)

The stages described by James and Gilliland (2013: 169) and also by Roos *et al.* (2002: 54), as well as the sequence of Kleber and Brom (1992: 74-85) that is also discussed by Unisa (2002: 32-36), mutually includes one another as indicated in Table 3.5. A discussion of the stages/sequences of recovery from trauma follows:

3.9.1 Disbelief and bewilderment

A traumatised person's primary reactions are disbelief and bewilderment. The individual is confused and not fully aware of reality, which implies that he is numb, but that he can act out the necessary cognitive and movement functions and he can control his emotions in order to protect himself, for example, to be safe (James & Gilliland 2013: 159-160).

3.9.2 Re-experiencing, avoidance and emotions

Life itself forces the traumatised person to return to his daily activities. This is a very confusing time as he has to deal with a variety of painful, inconsistent emotions, such as sadness and fear. During his daily life activities the traumatised person is occupied with the traumatic event, which he sometimes tries to avoid, in order to cope with the traumatic event.

3.9.3 Integration and recovery

As time passes, a traumatised person does not think and talk about the traumatic event as much anymore. He becomes more involved in the activities of his daily life again.

The first criterion for this study was that a person should be traumatised and be feeling that he cannot cope well with the traumatic event. He can be in any of the above-mentioned phases. The second criterion was that he should have low or average mental toughness, which was quantitatively confirmed by the MTQ48 as well as with a semi-structured, qualitative interview.

3.10 DEFENCE MECHANISMS IN DEALING WITH TRAUMA

The ego is the manager of the personality and forms a part of the self of a person. The ego is present in every act and thought of man and it is the driving force behind an individual's thoughts and actions. Therefore the ego is as seen as spiritual, because it can only exist in its integration with the other dimensions of a person (Strydom, *et al.* 2002:16; Van den Aardweg & Van den Aardweg 1999: 113; Roets 2009). When the ego feels threatened, defence mechanisms, which are automatic psychological coping processes, are employed to deal with the emotional inconvenience (Biermann 2005: 28-29; Roets 2009; Meyer *et al.* 2000: 71-80, 507-508; James & Gilliland 2013: 159; Unisa

2000: 35).

3.10.1 Characteristics of defence mechanisms

People usually are unaware of their defence mechanisms and most people will deny that they have defence mechanisms.

3.10.2 Examples of defence mechanisms after a traumatic event

Suppression implies that a traumatised person avoids thinking of disturbing feelings and experiences.

Denial is characterised by dis-acknowledging the painful aspects that were caused by a traumatic event and re-interpreting them in a less unpleasant way in order to feel less threatened by it.

Repression implies that a person expels any disturbing experiences and thoughts about the traumatic event from his conscious awareness.

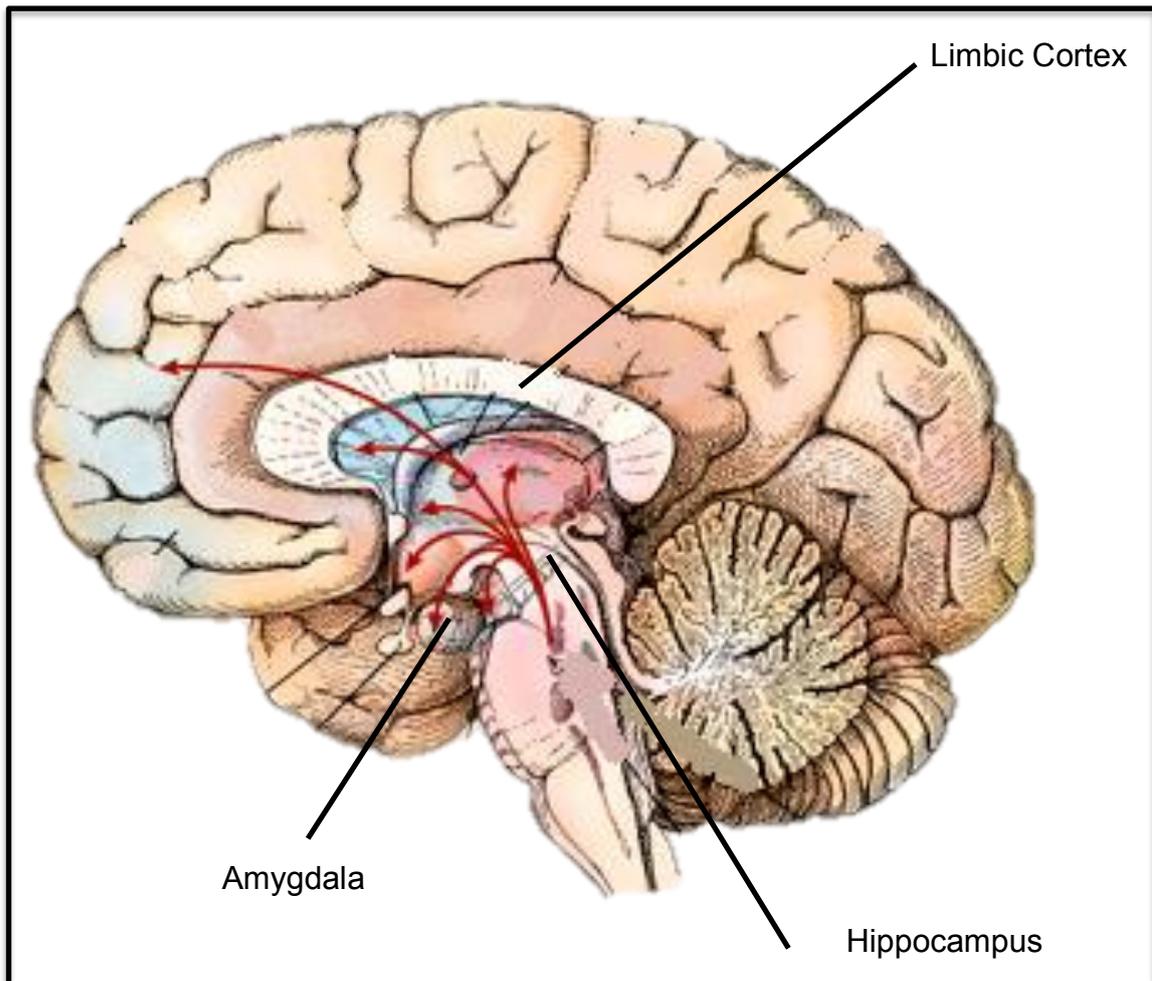
Rationalisation means that the traumatised person conceals the true reasons for his feelings, actions and thoughts by reassuring but inaccurate explanations.

3.11 TRAUMA'S IMPACT ON THE BRAIN AND BODY

3.11.1 Composition of the human brain

The brain is an extremely complicated organ. Research regarding the functions of the different parts of the brain is continuously done and there is much controversy that persists about the exact functions of each part of the brain. A discussion of the most prominent parts of the brain when dealing with trauma follows. The limbic system is a group of intertwined structures which are involved in the regulation of motivated behaviour, for example fight and flee responses, as well as the consolidation of memory indexes. The limbic structures consist of the amygdala, hippocampus, limbic cortex and septum. For the purposes of this study the focus is on the amygdala, hippocampus and the limbic cortex (Jordaan & Jordaan 1998: 157, 174-176, 180; Burke 2008: 1-5; Keeton 2009: 1-3; Preston 2013: 3-4). Figure 3.2 presents a schematic representation of the limbic system.

Figure 3.2: Schematic representation of the limbic system



Source: Jordaan and Jordaan 1998: 175

3.11.2 The body's reaction to trauma

Danger and life threat have extremely powerful consequences, and as such the brain is over-ready to quickly sense and react to dangerous situations (Preston 2013: 3). Information from the outside world reaches the brain through the five senses (smell, sight, hearing, touch and taste) (James & Gilliland 2013: 159; Keeton 2009: 2; Preston 2013: 3). The hypothalamus receives the incoming information and passes it on to either the limbic system or the cortex (Keeton 2009: 2).

During a threatening traumatic experience a person has no control of the way in which he is going to react (Preston 2013: 3). This instinctual way of responding is explained as follows: The amygdala as part of the limbic system (brainstem and midbrain) does not use any reasoning and interprets a message as either safe or unsafe (Scott & Stradling

2006: 29; Keeton 2009: 3; Burke 2008: 2). If the amygdala perceives threat it immediately takes action and communicates to the cortex (responsible for higher level thinking, logic, analysis and intellectual accomplishments); the immune and digestive systems are also cut-off. There is no time to make logical decisions. Then the amygdala activates the Autonomic Nervous System (ANS) which appeals to every part of the brain and body to react against the threat. The amygdala then decides on the best response to the threat, which includes fight, flight and freeze responses (Scott & Stradling 2006: 29; Burke 2008: 3). If perceived by the limbic system that a person has enough strength to defend himself, fight will be chosen. The sympathetic branch of the ANS responds in both the flight and fight reactions and the results are increased heart rate, respiration, the release of more oxygen in the blood and the acceleration of the blood flow to the muscles in order to be more mobile. The above-mentioned information is very important for people who blame themselves for the way in which they responded to a trauma or any environmental threat, because it is important for individuals to realise that there a person has no conscious say regarding how we will respond to a trauma (Keeton 2009: 3-4; Burke 2008: 1-4; Preston 2013: 3; Jordaan & Jordaan 1998: 160-180).

3.11.3 Coping versus not coping with a traumatic incident

- PTSD and/or Symptoms of PTSD

The hippocampus is another important part of the limbic system. The hippocampus is part of the cortex of the brain and is responsible for the encoding of new information, learning and memory. The hippocampus arranges all a person's memories in time and space (Scott & Stradling 2006: 29; Keeton 2009: 3). When a person experiences a traumatic incident, the amygdala, as the brain's "*smoke detector*" induces the body's alarm system and stress hormones adrenaline and nor-adrenaline literally flood a person's brain (Scott & Stradling 2006: 29-30; Preston 2013: 3; Burke 2008: 1, 3). Due to this heavy activity in the brainstem and midbrain (limbic system) as well as in the automatic nervous system, traumatic memories are believed to get stuck in the lower and mid-parts of the brain, which are the non-verbal, non-conscious and sub-cortical regions of the amygdala, thalamus, hippocampus, hypothalamus and brain stem. The consequences of these stuck traumatic memories are that they cannot be accessed by the frontal lobes of the neo-cortex, which is the understanding, thinking and reasoning areas of the brain (Burke 2008: 1, 3; Keeton 2009: 5). The brain's normal process to

organise and store information is disrupted and leads to confusion, forgetting, flashbacks, re-experiencing and fragmented images of the trauma. Conversely, non-traumatic memories are easily processed, integrated and stored in the conscious mental frameworks of the brain. If the ANS continues to be activated after the danger is no longer present and leaves the body actively aroused, PTSD or symptoms thereof may be the result. It implies that the traumatised person was not able to return to a homeostatic sense where he could calm down and relax after the traumatic incident (Keeton 2009: 4; James & Gilliland 2013: 154).

To be able to increase its capacity, the brain creates templates or internal representations of the outside world (Scott & Stradling 2006: 29, 31; Keeton 2009: 5). These templates are used in future events to associate and generalise events. In order to set the ANS in motion the amygdala only needs a small overlap of between 10% and 20% between a sensory hint and a template for danger. This is why a non-significant hint, such as a smell of smoke, for a person who survived a fire, is able to put the body into flight, fight or freeze mode. People may also react to hints of which they are unaware. Therefore traumatised persons have a greater chance to make false assumptions and associations and interpret danger in an environment where none exists (Keeton 2009: 5; Preston 2013: 3; James & Gilliland 2013: 160).

The brain is a flexible organ. Due to this flexibility the more the ANS is activated, the more a specific pattern becomes ingrained and the more the pattern is engrained, the more the ANS will be activated. This is what is called a PTSD cycle. Over time an incident that triggers the body's alarm system can change the sensitivity of the alarm's response. The result may be that even non-sensory cues (merely thinking of the event) can trigger the amygdala and lead to a fear response (Scott & Stradling 2006: 29; 31).

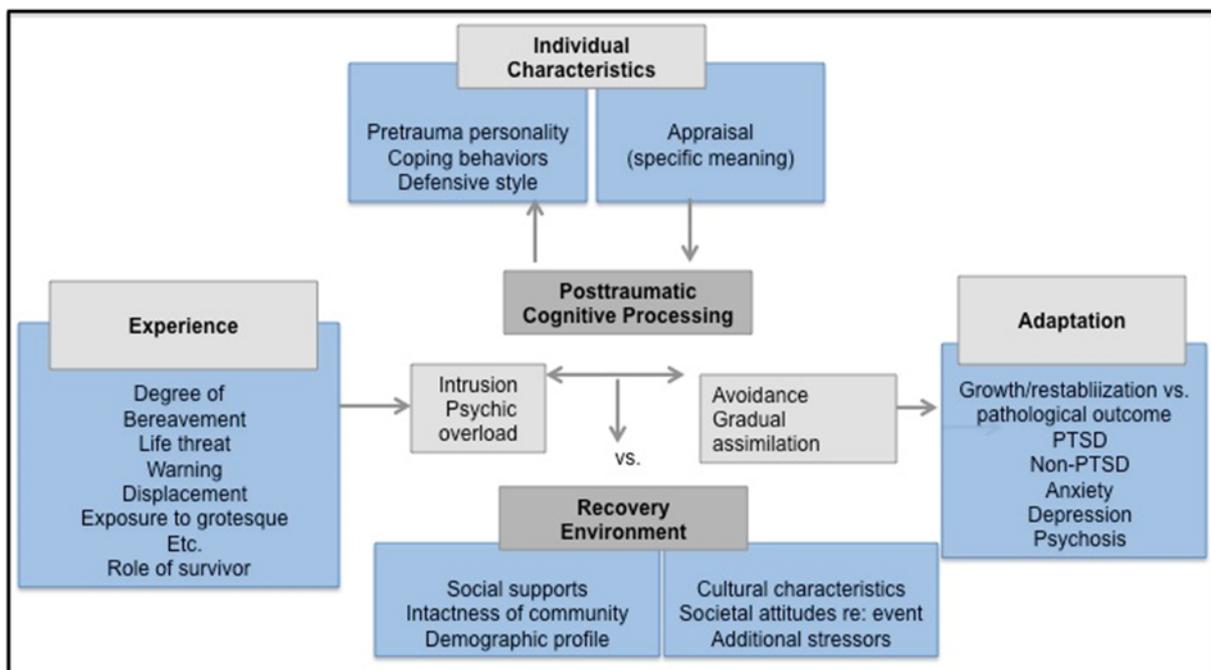
3.11.4 A person's interpretation of the traumatic event

Preston (2011: 2), Meyer, Moore and Viljoen (2000: 34) and Strydom, Roets, Wiechers and Krüger (2002: 41) state that every trauma survivor is a unique person and brings his own perceptions and coping mechanisms to a counselling session. A person's coping style and support system can also play an important role in reducing the impact of trauma. Roos *et al.* (2002: 2), Scott and Stradling (2006: 24-25), Strydom *et al.* (2002: 41) and Unisa (2002: 16) state that a person's genetic inheritance, as well as the nature of the stressful event influence the way an individual reacts to psychological difficulties.

Therefore part of what makes any experience traumatic or less traumatic is the way in which a person interprets both the event itself and his ability to cope and gain control of a situation.

As indicated in Chapter 2.5.4 (Confidence), De Villiers and Van den Berg (2012: 97, 100-101) and Roos *et al.* (2002: 42) state that self-awareness, positive self-appraisal and a high self-esteem support a client to better handle and cope with stressors. People with positive self-worth evaluate the world and its stressful demands more positively. Personal strength and positive appraisal plays an important role in resilience (which is one of the constructs that contributes to the development of mental toughness). It is therefore evident that in therapy self-awareness, positive self-appraisal and high self-esteem should be focused on as personal strengths in order to become more mentally tough and to better deal with trauma. The processing and interpretation of a catastrophic event is illustrated in Diagram 3.1 below (Sue *et al.* 2003: 160-161; Roos *et al.* 2002: 42, 45, 55; James & Gilliland 2013: 156; Unisa 2002: 16; Preston 2013: 5).

Diagram 3.1: The processing of a catastrophic event



Source: Sue *et al.* 2003: 161

3.12 THE DIFFERENCE BETWEEN POST TRAUMATIC GROWTH (PG) AND THE CONCEPTS OF RESILIENCE, HARDINESS AND OPTIMISM

Post traumatic growth implies the positive psychological change that a person experiences in his battle to deal and cope with extremely difficult life changes (Sheikh 2008: 85; Kunst 2011: 42-43; Hobfall *et al.* 2009: 139; Stockton *et al.* 2011: 85; Helgeson, Reynolds & Tomich 2006: 97; Tedeschi & Calhoun 2004: 1). Tedeschi and Calhoun (2004: 4) state that post traumatic growth and the concepts of resilience, hardiness and optimism should be clearly distinguished. Resilience, hardiness and optimism are also known as characteristics from which growth seems to benefit and it helps people to better deal with adversity (Sheikh 2008: 88; Tedeschi and Calhoun 2004: 4; Sue *et al.* 2010: 195). Bensimon (2012: 782, 783, 785) supports the latter statement by explaining that resilience is characterised as a trait rather than a state and is not characterised as a way of adjusting after trauma. In Chapter 2 hardiness is comprehensively explained (see section 2.4.1) and Bensimon (2012: 783) and Bartone *et al.* (2012: 517) categorise hardiness as one of the characteristics of resilience. A summary of hardiness is illustrated in Figure 2.4 of this study. It is indicated in Bensimon's (2012: 785) research that optimism as part of the constellation of traits can result in resilience. Bensimon (2012: 782, 786) also considers resilience as a personality characteristic. Thus hardiness, resilience and optimism, which are integral parts of mental toughness, are personal characteristics.

The focus of my study is on the psycho educational use of mental toughness in dealing with trauma. Essentially, the study analyses the development of the characteristics which a person needs in order to better deal with trauma and is **not** focussed on the changes that might occur within a person which is part of post traumatic growth. In order to be able to deal with adversity, a person should be able to make some adaptations in his life. Miller and Harvey (2001: 315, 320) explain adaptation after a loss as taking action and Sheikh (2008: 87-88) says the most important aspect in dealing with trauma is that a person should become actively engaged in the changes that the trauma will result in. From these statements it becomes evident that in order to adapt, a person should undergo some changes in his life.

3.13 TRAUMA AND MENTAL TOUGHNESS' CORRESPONDING ASPECTS AND RELATIONSHIP

As previously mentioned by Strydom, Roets, Wiechers and Krüger (2002: 14) the most appropriate and effective therapeutic method in order to support a client does not exist because there is no correct way of supporting a client. Rather, it is important the method that is used by the successful therapist, is characterised by creativity and problem-solving. Strydom *et al.* (2002: 41-42) state that the context of supporting and counselling, where the technique is used, may differ from the original theory, but it should always be pedagogically accountable. Egan (2014: x) supports Strydom *et al.*'s perspective by saying that in supporting a client in his problem-management process, the school of psychology, theories and latest trends are not important. It is about “*what works*” in therapy and that includes the ingredients, aspects and factors that are common to successful therapy. Egan combines skills, methods and themes and calls his well-proven Skilled Helper Model, of which the 10th edition has just emerged, the Standard Problem Management Model which is a contextual cognitive-behavioural-emotive approach to therapy. Clough and Strycharczyk (2012: 2, 271, 273) explain the transition between theories, schools of thought, skills and methods as “*joining the dots*” of “*previously separated issues*”. By “*joining the dots*” a whole problem may not be solved, but a step forward has been achieved in the “*journey*” of developing mental toughness.

In my attempts to “join the dots” in my study of how to support a traumatised person to develop more mental toughness in order to gain skills that will support him to better deal with trauma in the future, I selected the corresponding aspects of my literature review of both Chapter 2 on mental toughness as well as Chapter 3 on trauma. I discovered many similarities between the literature of mental toughness and trauma. These corresponding aspects are categorised in Table 3.6.

Table 3.6: Corresponding aspects between trauma and mental toughness

Mental Toughness	Trauma
<p>Taking action</p> <p>Table 2.1: People with high levels of life control take responsibility for their actions and failures.</p> <p>2.10. The development of mental toughness: Independent problem-solving and taking up personal responsibility is of vital importance in the development of mental toughness.</p>	<p>3.2 Trauma defined: Trauma requires a re-evaluation of a person's actions.</p> <p>3.7 Symptoms and effects of trauma on a person (Survivor's guilt): Restorative action can support a person to better deal with guilt feelings.</p> <p>3.13 Adaption and coping after a</p>

<p>2.5.2 Commitment (Procrastination): Action helps to save a person from procrastination; taking action will lead to the change of self-doubts, low self-esteem, anxiety, high stress levels and behavioural rigidity.</p> <p>2.6.1 MTQ48 reports (Development Report): People need to take action to improve their performance and development. These actions imply being actively involved.</p> <p>2.9 The role of stress in mental toughness (The connection between stress, performance and well-being): People who take action when facing adversity can make some changes when dealing with stress. Passive people become paralysed. Awareness of causes of stress can lead to action which can lead to improved performance.</p> <p>2.9 The role of stress in mental toughness (Commitment to cope): Taking action at least helps to master a situation, if not solve it; to get rid of stressors people need to take action; taking action will probably not solve a situation, but it will support a person to feel better and to live a better life.</p>	<p>trauma (Taking action in order to adapt) and (Goal setting): Adaption after a loss implies taking action; taking action after a traumatic event is critical; action needs to occur in a person's cognitions, emotions as well as in his behaviour. Taking action is needed to attain goals and to make changes in dealing with stress.</p>
<p>The "self"</p>	
<p>1.2 Awareness and motivation for the study: A person who is sure of himself as a person will have realistic expectations of himself and he will be able to see himself as a survivor and not as a victim when adversity arises.</p> <p>2.3 A brief history of mental toughness (Development of the four-factor model of mental toughness): People who believe in themselves can deal better with adversity.</p> <p>2.5.4 Confidence (Confidence in abilities): People who believe in themselves will have more confidence in their abilities – even if they have setbacks and adversity along their way. If a person becomes more aware of himself, it will influence his positive appraisal of himself and it will influence the way in which he will deal with stressors.</p>	<p>3.12 Trauma's impact on the brain and body (A person's interpretation of the traumatic event): Self-awareness, positive self-appraisal and a high self-esteem will support a person to better handle and cope with stress, because of his perception of himself as a worthy person.</p> <p>3.7 Susceptibility to PTSD and the symptoms thereof: A person's self-esteem contributes to his sensitivity to PTSD.</p> <p>3.8 Symptoms and effects of trauma on a person and 3.16 The role of psycho-education in the development of mental toughness in dealing with trauma: Trauma can have negative effects on a person's self-esteem and self-belief. The process that goes on inside a person is called a reciprocal process and it is influenced by a person's self-concept which in turn influences his behaviour during stress and trauma.</p> <p>1.2 Awareness and motivation for the study: A person with a positive self-esteem will have more insight to perceive intrusive memories, mood fluctuations, and</p>

	<p>aggression as symptoms caused by a traumatic incident and not as personal failings.</p> <p>3.14 The role of psycho-education in the development of mental toughness in dealing with trauma: Continuous interaction takes place between a person's self-concept and his self-actualisation as a person.</p>
<p>Face negativity and adversity</p>	
<p>Table 2.6: Characteristics of people with high interpersonal confidence versus low interpersonal confidence: People with high confidence (one of the key components of mental toughness) can face criticism and they know how to be self-assertive.</p> <p>2.9 The role of stress in mental toughness (Stress management guidelines for traumatised persons to develop their mental toughness): Trauma and stress are realities of life and every person will need to face it at some time in his life. A traumatised person will need to face the additional stresses that trauma brings, as during trauma unresolved past issues often come to the fore.</p> <p>2.10 The development of mental toughness: Facing and reflecting upon their failures creates valuable opportunities for athletes (as mentioned before, little research on mental toughness has been conducted in the psychological field).</p>	<p>3.13 Adaption and coping after trauma (Slowdown of life) and Re-entering the trauma in a controlled way and anchor yourself outside the situation: When recovering from trauma, it is important that a traumatised person should be encouraged to face the intense feelings that he would rather like to set aside. In order to resolve the emotions that destroying events bring to the surface a traumatised person should face them. In this way a traumatised person will be able to integrate the trauma into his conscious mind and make it "finished business".</p> <p>Table 3.4: Stages/sequences of recovery from trauma: In order to be able to learn to cope from a traumatic event a traumatised person should be willing to face and confront the problem.</p> <p>3.13. Adaption and coping after trauma (Taking action in order to adapt) and (Re-entering the trauma in a controlled way and anchor yourself outside the situation): The commitment to face the trauma lies at the core of a traumatised person's journey to move forward.</p> <p>3.13 Adaption and coping after trauma (Face the fear): In order to be able to learn to control his fear and emotions, a traumatised person should face his fear.</p>
<p>Support system</p>	
<p>2.9 The role of stress in mental toughness (Create a support system): A support system consisting of family and friends protects a stressed person from the destruction of stress. Parent support is a crucial component in the development of mental toughness in adolescents' lives. An effective support system and a supportive environment are emphasised in the development of mental toughness.</p>	<p>3.6 Susceptibility to PTSD and the symptoms thereof: A person's social support system plays a role in his sensitivity to PTSD or the symptoms thereof.</p> <p>3.7 Symptoms and effects of trauma on a person (Impact on interpersonal relationships): A traumatised person needs a strong support system to be able to rebuild his life.</p>

	<p>3.10 Trauma’s impact on the brain and body (A person’s interpretation of the traumatic event): A traumatised person’s support system can reduce the impact of trauma on his life.</p>
<p>Flexibility and adjustment</p>	
<p>2.4 Resilience In its relationship with trauma the process to adapt after a traumatic incident is flexible in nature. Current research studies focus on resilience as healthy adjustment and not on pathologic behaviour.</p> <p>2.9 The role of stress in mental toughness (Stress management guidelines for traumatised persons): People who are flexible to changes due to adversity realise that they are still able to make choices instead of seeing themselves as victims.</p>	<p>3.13 Adaption and coping after a trauma (Metaphors): In order to make sense of his life again, after a traumatic event, a person should be flexible. The metaphor of a river that cannot flow backwards, but should find its path again where it is blocked by rocks and debris, is given to explain what flexibility implies.</p>
<p>Self-talk</p>	
<p>2.9 The role of stress in mental toughness (Change your self-talk): Negative self-talk becomes self-fulfilling prophecies and a person becomes what he thinks he is. Self-talk empowers a person to better deal with stress. There is an important inter-correlation between mental toughness and stress management. Thus self-talk seems to enhance a person’s mental toughness.</p>	<p>3.13 Adaption and coping after trauma (Relaxation exercises): Positive self-talk and relaxation exercises support a traumatised person to face his fear and slow down his life.</p> <p>3.13. Adaption and coping after trauma (Slowdown life), self-awareness and reflection and dealing with feelings of guilt: A traumatised person experiences many conflicting emotions. Positive self-talk can help him to reframe the distorted feelings he has of himself.</p>
<p>Perceptions</p>	
<p>2.3 A brief history of mental toughness (Development of the four-factor model of mental toughness) and (2.4.1) hardiness: Hardiness includes three inter-correlated phenomena which are control, challenge and commitment. These three phenomena are three of the four components of mental toughness. The way in which a person perceives a situation is a core indicator of his hardiness and thus of his mental toughness and it influences the way in which he acts.</p> <p>2.4.1 Hardiness: Flexible people are open to change and perceive situations to have good outcomes.</p> <p>2.5.1.2 Emotional control (Learned helplessness): Learned helplessness is a person’s perception that he is not in control of things as well as about his expectation that he cannot achieve success.</p> <p>2.5.2 Commitment (Conscientiousness),</p>	<p>3.6 Susceptibility to PTSD or the symptoms: A person’s perception of a traumatic event contributes with other aspects (of both his environment and characteristics) to his sensitivity to PTSD. A traumatised person’s perceptions of stressors play a role in his recovery process.</p> <p>3.10 Trauma’s impact on the brain and body (A person’s interpretation of the traumatic event) and 3.13 Adaption and coping after a trauma (Re-entering the trauma in a controlled way and anchor yourself outside the situation): Every trauma survivor is a unique person with his own perceptions and he deals with situations according to his perceptions. A client’s perception of the trauma scene is not necessarily the true</p>

<p>2.5.3 Challenge and 2.9 The role of stress in mental toughness: The way in which a person copes with a challenge is dependent on his perception of the specific challenge. An individual thus behaves and performs according to his perception of a situation. Some people perceive challenges as opportunities while others perceive it as threatening. As previously indicated, research on mental toughness in the psychological field is still very scarce but research has been performed on mental toughness in the sports world. In a study of the relationship between perception and risk taking, it was found that rock climbers, who perceived themselves as capable of handling risks, were more willing to take risks. Although much research still needs to be done on mental toughness in the psychological field, the possibility therefore exists that the more capable people perceive themselves, the more they will be willing to move out of their comfort zones in dealing with the risks that trauma brings to the surface.</p> <p>2.9 The role of stress in mental toughness: If a person perceives that he has control over his environment and stressors, the effects of stress on that person are reduced.</p> <p>Table 2.7 and The 4 C's model of mental toughness and 2.5.3 Challenge: Challenge is one of the four concepts of mental toughness. People with high challenge perceive threats as opportunities to grow.</p>	<p>scene of the trauma.</p>
<p>Goal setting</p> <p>2.10 The development of mental toughness: Having goals is one of the vital components in developing and enhancing mental toughness.</p> <p>2.5.4 Confidence: Confidence is one of the four components of mental toughness. Confidence and self-esteem are closely linked. People with high self-esteem believe in themselves and they believe that they can make a difference in other people's lives and the world around them. Therefore they set high goals for themselves.</p> <p>Table 2.7: Commitment is one of the four components of mental toughness. Committed people set goals and are involved to achieve it in spite of difficult situations.</p>	<p>3.13.1 The importance of choices In formulating goals a traumatised person chooses to try to better deal with his trauma.</p> <p>3.13 Adaption and coping after a trauma (Goal setting): Goal setting and the feeling of accomplishment is an important aspect of the "armour" of a person who deals with trauma.</p>
<p>Commitment</p> <p>1.2 Awareness and motivation for this study: Before a person could start the "journey" of gaining mental toughness he should be committed to change; commitment is one of the four components of mental toughness</p>	<p>1.2 Awareness and motivation for this study and (Table 2.7): Commitment to change is an important term in coping with trauma.</p> <p>3.13 Adaption and coping after a trauma (Taking action in order to</p>

<p>1.8.3 Mental toughness Commitment to change is an important term in the development of mental toughness.</p> <p>2.4.1 Hardiness: Commitment is one of the characteristics of hardiness. Hardiness is known as a personal style or life approach and is a character trait of resilience (which is one of the constructs of mental toughness); In a study of executives who needed to deal with high stress levels, but who had low stress levels of illnesses, it demonstrated a feeling of commitment in their daily lives.</p> <p>2.5.2 Commitment: Commitment is defined as the extent to which a person persists with a goal or task.</p> <p>Table 10: Committed people are intensely involved to achieve goals in spite of difficult situations.</p> <p>Table 4 Commitment Scores: People who are committed take ownership and responsibility.</p>	<p>adapt): The therapist should facilitate the traumatised person to display commitment to face his pain, as it is a core aspect in the journey to move forward. This commitment implies that a traumatised person should actively get involved in the therapeutic processes. Commitment is related to the cognitive decision that a traumatised person should make to move forward.</p> <p>2.5.1.2 Emotional control (Attributions): The traumatised person should be committed to take the effort to practice new skills outside the therapy sessions.</p>
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Stress	
<p>2.9 The role of stress in mental toughness (Improve your self-concept and self-esteem): Feeling constantly negative about oneself and his abilities puts pressure and constant stress on a person.</p> <p>(Use stress to motivate you): Diagram 5: The AQR stress model: In order to explain how a person deals with stress, Clough and Strycharczyk compiled the AQR stress model in supporting people to develop more mental toughness. An inter-correlation exists between mental toughness, stress management, performance and well-being of people with high mental toughness.</p> <p>(The connection between stress, performance and well-being): In order to support a person to become more mentally tough and to improve his performance, the causes of his stress should be identified. If these causes are identified he can be supported to better understand them and start to take action to achieve better performance.</p> <p>Figure 2.11: The stress curve: In developing a person's skills to better cope with stress, his stress threshold can be expended.</p> <p>2.9 The role of stress in mental toughness (Stress management guidelines for traumatised persons), (Commitment to cope) and (Use stress to motivate you):</p>	<p>2.9 The role of stress in mental toughness (Stress management guidelines for traumatised persons), 1.2 Awareness and motivation for the study and 3.13 Adaption and coping after a trauma (Re-entering the trauma in a controlled way): It should be taken into account that in supporting a client in dealing with trauma, he also has to deal with additional stresses. The reason for this is that when dealing with trauma, unresolved issues of the past often come to the surface again.</p> <p>1.2 Awareness and motivation for the study and 3.2 Trauma defined: Trauma is a stress loaded event and it threatens a person's emotional, physical and/or social well-being.</p> <p>1.2 Awareness and motivation for the study, 3.6 Susceptibility to PTSD and the symptoms thereof (Numbing), Table 3.3 and 3.5 Stress versus PTSD: Trauma implies the facing of high levels of stress. Stress due to trauma is usually characterised by helplessness and vulnerability. Every person is a unique being and therefore people will react differently o the same stressor.</p> <p>3.6 Susceptibility to PTSD and the symptoms thereof and 3.5 Stress versus PTSD:</p>

<p>In dealing with stress, the only way to put the pieces of his life together again, is that the traumatised person should be committed to doing so. When a traumatised person takes action, he at least tries to better the situation. Maybe he will not be able to solve it on the spot, but he will be able to better deal with his stress. When a person takes purposeful action to better manage his stress, his stress becomes inner motivation to reach a goal. A strong inner motivation supports a traumatised person to keep going through stress loaded times in order to conquer his weaknesses.</p> <p>2.10 The development of mental toughness: MTQ48 is a valuable instrument to measure stress' impact on a person, to be able to support him as a unique person to better his performance.</p> <p>2.9 The role of stress in mental toughness: Coping effectively with stress is an important characteristic of mental toughness.</p>	<p>A traumatised person's appraisals regarding the intensity of the stress that was caused by the trauma plays a role in his perceptions of his recovery.</p> <p>3.13 Adaption and coping after trauma (The traumatised person's support system), (Regain control) and 3.6 Susceptibility to PTSD and the symptoms thereof: The way in which a traumatised person manages his stress influences his sensitivity to PTSD and the symptoms thereof. A therapist as well as a support system can equip a traumatised person with skills to develop a better self-esteem and personality traits to become emotionally stronger, to deal with his past life experiences, to better manage his stress to be less vulnerable and sensitive to PTSD and its symptoms in the future. The ability to gain insight in his stress responses enables him to change his reactions to these stress responses. This will provide a person with a feeling of control (one of four components of mental toughness) over his responses.</p> <p>3.8 Symptoms and effects of trauma on a person and 3.12.2 The body's reaction on trauma: Stress reactions after a traumatic incident are not pathologic, but normal, though the situation is abnormal.</p> <p>Figure 2.11: The stress curve, 2.9 The role of stress in mental toughness (Stress management guidelines for traumatised persons) and 3.10 Trauma's impact on the brain and body: Stress is not necessarily harmful and up to a certain level, it can motivate a person. The problem arises when stress exceeds a certain level; it can become destructive. When a person learns how to regulate his emotions, stress can be moderated.</p>
<p>Helplessness / Learned helplessness</p>	
<p>2.5.1.2 Emotional control (Learned helplessness): Learned helplessness is one of four psychological perspectives. Learned helplessness and control are intertwined. Learned helplessness is defined as a person's perception that things are out of his control and no matter what he attempts, he cannot change the situation - even matters that can be controlled. As mentioned before, the research on mental toughness in the psychological field</p>	<p>1.8.1 Trauma, 3.2 Trauma defined Freud describes trauma as a "<i>feeling of helplessness</i>".</p> <p>2.9 The role of stress in mental toughness and 1.2 Awareness and motivation for the study: It is important that a traumatised person sees himself as a survivor and not as a victim as a victim is helpless and has no control, but a survivor sees himself as busy doing something in his process of</p>

is still very limited, but in the academic field studies established that students with learned helplessness were less likely to set goals and they were less likely to make use of support. These students are also uninvolved in their studies and do not accept responsibility for their actions. The importance of commitment, action taking, goal setting and a support system are vital aspects of mental toughness. The mental toughness of control is closely related to learned helplessness. Thus a person who can unlearn his learned helplessness will be more mentally tough.

“standing up”.

3.7 Symptoms and effects of trauma on a person (Numbing), Table 3.2 and Table 3.3:

Stressful incidents cause psychological trauma that is characterised by helplessness amidst the overwhelming situation.

3.14 ADAPTION AND COPING AFTER A TRAUMA

Meichenbaum (1995: 349) states that the therapist initially focuses on the “*normalization*” and “*legitimization*” of the client’s reaction to a traumatic situation. As the therapy progresses there is a shift to “*symptoms as signs of recovery*”. A great deal of sensitivity and knowledge is therefore needed from a therapist.

An outline of techniques of therapy, taken from the literature, which includes both the similarities of how to support traumatised persons as well as how to support persons to increase their mental toughness follows.

3.14.1 Make a choice

James and Gilliland (2013: 10) state that “*life is a process of interrelated crises and challenges, that we confront or not, deciding to live or not*”. If trauma hits, “*not choosing is a choice*” and usually it has destroying consequences. The choice of doing something is at least a way in which a traumatised person sees the opportunity to influence decisions, rather to see himself as powerless (Preston 2013: 5; Sue *et al.* 2010: 194; Roets 2009).

3.14.2 Taking action in order to adapt

In an article from Miller and Harvey they (2001: 315, 320) explain adaption after a loss as actively taking action. Johnson, Hobfoll, Hall, Canetti-Nasim, Galea and Palmieri (2007: 428) and Sheikh 2008: (87-88) describe “taking action” after a traumatic event as critical as: “*Action is in some sense always behavioural, but action also occurs in*

cognitions and emotions” as an intrinsic motivational process. “We “work” on our thoughts, we “challenge” our emotions, we “fight” depression”.

3.14.3 Regain control

Bethany (2007: 124) states that a person’s ability to gain insight in his stress responses and therefore be able to change his own reactions to his responses can provide that person with a feeling of control over his responses.

3.14.4 Face the fear

Sheikh (2008: 85), Preston (2013: 6) and Berson and Berson (2002: 72) say that the secret is not to try to escape the negative impact of a traumatic incident, but that “*You gain strength, courage and confidence by every experience in which you really stop to look fear in the face*”. If not facing one’s fear and resolving the unbearable emotions and memories that trauma brings along, the fear-packed emotions will continuously return unexpectedly and a person will not be able to control it. Burke (2008: 5), James and Gilliland (2013: 178) and Roets (2009) focus on the importance of “completing the trauma” as a traumatised person should go through a grieving process in order to be able to put the event behind him and to make the “unfinished business” “finished business”.

3.14.5 Reduce the anxiety and physical responses associated with the trauma

James and Gilliland (2013: 172) indicate the first step towards recovering from trauma is to support the traumatised person to stabilise, which implies reducing anxiety as well as physical responses of reacting to the trauma. James and Gilliland (2013) state that relaxation and meditation are useful tools that stabilise a person.

The following relaxing exercise is a good example of how to help the traumatised person to relax and to learn more self-control (both emotional and behavioural) in dealing with stress and anxiety. The client can sit a chair or lies on a mat on his back. The therapist says the following: “*Just imagine that you are lying on the beach with that soft, warm sand, the calm breeze blowing gently over you, the gentle lapping of the cool, crystal clear water, and just easily focus your attention on that scene. Now just notice the difference in your body too. Notice the difference between how your muscles feel when they are tense and relaxed. Starting with your legs, just tense them up, feel how*

your muscles tighten up. Now relax them and just feel that tightness drop away. Notice the difference and the really pleasant feelings that occur when your muscles are just hanging loose and flaccid. Continue to picture the scene on the beach as you work your way up your body, alternating between tensing and relaxing your muscles. Notice as you continue to do this how you can change the way your body feels and what you can focus on in your mind's eye" (James & Gilliland 2013: 172-173).

3.14.6 Re-entering the trauma in a controlled way and anchor yourself outside the situation

Preston (2013: 9) focuses on the "*re-entering of the trauma in a controlled way*" and in the process, the individual unlearns the negative reactions to the brain's conditioning of the traumatic experience. An important hypothesis for treating PTSD and its symptoms is to take the traumatised person back to where psychophysiological arousal originally started. This implies to move the traumatic event to the person's conscious mind so that he could re-experience the traumatic event in the finest detail. During this process the traumatised person's suppressed feelings come to the fore and he can deal with it in order to categorise his trauma as a past event which becomes finished business (Perschy 2004: 12; Roets 2009; James & Gilliland 2013: 150, 194-195). This is accomplished when the person is deeply relaxed. The therapist instructs the traumatised person to re-experience the trauma. The assumption is that the traumatic memories can be cut so that the person can go back to the pleasant image of, for example, the beach (3.13) and anchor himself outside the situation (Preston 2013: 8).

A well-trained therapist is able to support the traumatised person to slowly "*peel away the psychological walls*" which are defence mechanisms called numbing and denial and which hinder the person to become aware of the traumatic event. The therapist constantly instructs the client to shift out of the traumatic scene to the beach scene. This happens during intense moments of fear and uncontrolled emotions experienced by the client. This process supports the client to re-enter the traumatic experience in a controlled way (Preston 2013: 9). When the client is more relaxed again and the therapist thinks he is ready, the therapist will tell the client that he will count from one to ten, and then the client will open his eyes and will be back in the here and now and he will feel refreshed. The therapist sets the images until the traumatised person experiences a maximum fear level and then shouts "*STOP*". Then he commands the client to move back to the beach scene. The alternation between the beach scene and

the trauma scene is done repeatedly until the client is able to voluntarily switch between the two scenes.

3.14.7 Grounding

James and Gilliland (2013: 266) say that grounding within trauma literally means to teach the traumatised person to put his feet on the ground when intrusive thoughts, flashbacks and overwhelming aspects of the traumatic experience are chasing him. Grounding focuses the client's attention on his immediate environment and the surroundings (Meichenbaum 1995: 368-369; Preston 2013: 14; Burke 2008: 5). Examples of the grounding technique that produce good results with traumatised persons are the keeping of a talisman that can be touched (physical grounding) to connect them with reality, writing oneself an e-mail and mental grounding by singing or reading out loud from a magazine (Preston 2013: 14 Meichenbaum 1995: 368-369; James & Gilliland 2013: 266-267).

3.14.8 Slow down life

Preston (2013: 5-6) emphasises the importance that a traumatised person should slow down his life. Slowing down his life means to be more aware of what he is feeling and experiencing in the present moment and it implies a conscious decision. The exercises that are described in section 3.13, for example cognitive behaviour tasks, breathing exercises, self-awareness and reflection, relaxation exercises, visualisation and positive self-talk and appraisal support a traumatised person to face his fear and slow down his life.

3.14.9 Cognitive-Behavioural Therapy

Cognitive-behaviour therapy helps a person to become more aware of his automatic thoughts as well as of the interdependence between his thoughts, feelings, behaviour and other people's reactions. It further helps the client to learn how to interrupt his automatic thoughts in order to change the ways in which he processes information, to alter his behaviour and to feel more in control (James & Gilliland 2013: 366; Meichenbaum 1995: 415).

Cognitive-behavioural therapy is a useful therapy technique when dealing with loss and restoration situations. Examples of cognitive therapy are relaxation training, cognitive

restructuring, thought stopping and desensitisation (switch between relaxation and presenting scenes of the trauma) (James & Gilliland 2013: 438). The client should be committed to these efforts, lest the therapy becomes a source of frustration (Scott & Stradling 2006: 44).

- The emotional wheelchair

The handout of the emotional wheelchair is a very good concrete tool of cognitive therapy and it illustrates how a person's thinking may influence his feelings (Roets 2009). The client writes his name on the wheelchair and then repeatedly visualises this process of standing up out of his emotional chair until the picture is embedded inside his mind (Roets 2009). An illustration of the emotional wheelchair can be seen in Figure 3.3 below.

Figure 3.3: The emotional wheelchair



- Metaphors

The use of a metaphor supports the client to focus on a person or a graphic image which symbolises his experience in a reasonable, non-threatening way. The metaphor of a river that cannot flow backwards, but that it should find its path again, where it is

blocked by rocks and debris, explains the importance of flexibility in dealing with trauma (Meichenbaum 1995: 458-460; Worden 2001: 70; Roets 2009; James & Gilliland 2013: 444).

- Journaling

Sheikh (2008: 87-88), Perschy (2004: 71), James and Gilliland (2013: 176-177) and Rogers (2007: 42-43) focus on the value of a journal as journaling is a safe way for a traumatised person to place his memories of the trauma at a psychological distance in order to analyse them with the therapist.

- Relaxation exercises

The compact disc “Think right now” (Brescia, 2009) contains relaxation exercises in order to support a person to relax. Relaxation exercises put a person’s brain in an alpha state, which is a relaxed state where maximum absorption of information can take place. Positive self-affirmations then follow to support a person to alter his negative thoughts and emotions. In this way he is supported to better control his emotions and to harness his actions that will lead him to more self-actualisation (Brescia 2009; Roets 2009; Burke 2008: 5).

- Visualisation

People usually tend to visualise events in their minds as quite negative. This negativity leads to destructive effects on the person as a holistic being. This process could be changed to positive visualisation which has a remarkable influence on a person’s overall performance. A person’s brain cannot distinguish between things that he sees in his mind *versus* things that happens in real life. Visualisation is applied in the sports world as a powerful skill in order to influence top sports performers’ behaviour in positive ways. An example of a guided imagery exercise is the peaceful beach scene as discussed in section 3.13 (James and Gilliland 2013: 172) or seeing mind pictures that have been put together on a poster.

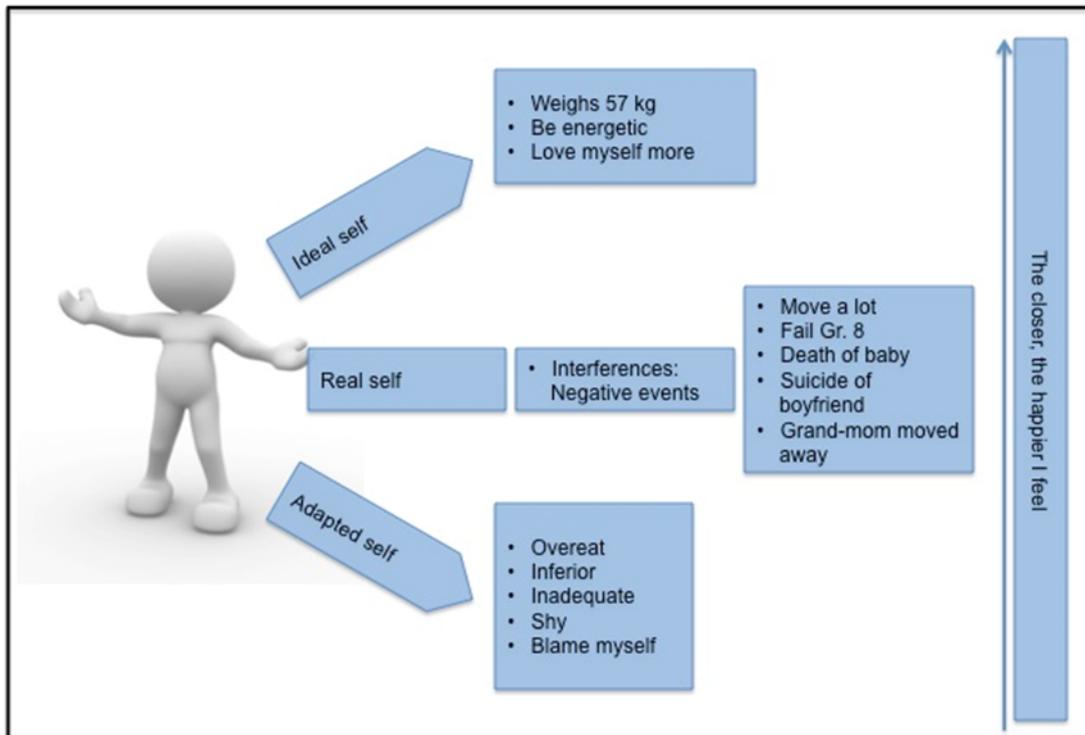
- Breathing activities

Preston (2013: 6) emphasises the importance for a traumatised person to slow down his life. Breathing activities focus on the relaxing of the body and supports a person to slow down the pace of life (Rogers 2007: 91-92; Roets 2009).

3.14.10 Self-awareness and reflection

Johnson *et al.* (2007: 430) focuses the attention on self-awareness and reflection in the continuous process of “*seeking*”, “*using*” and “*asserting*” in order to be able to cope and gain control and experience growth after a traumatic incident. Johnson (2006: 53) says that self-awareness supports a person to better understand himself and that the better a person understands himself, the better he can deal with stress. In order to support a client to become more aware of himself and to learn how to know who he is as a person, the impact that previous life events had on his self-concept and ego strength needs to be addressed in therapy. The client is supported to become aware of his real self, modified self and ideal self. The conflicting emotions of negative life events affects a person’s actual self and results in a modified self. In trying to protect the self, the modified self develops defence mechanisms. The adjusted self, shadows the positive qualities of the real self and the person's positive attributes become increasingly disguised under a haze of negative, irrational characteristics. Here, the ideal self comes to the fore. This includes characteristics that the person would like to possess, as well as the kind of person who he would like to be. The therapist should facilitate the client to be able to decrease the distance between his adapted and ideal self (Roets 2009, Sue *et al.* 2010: 54), as illustrated in Figure 3.4.

Figure 3.4: The Self, Ideal Self and Adapted Self

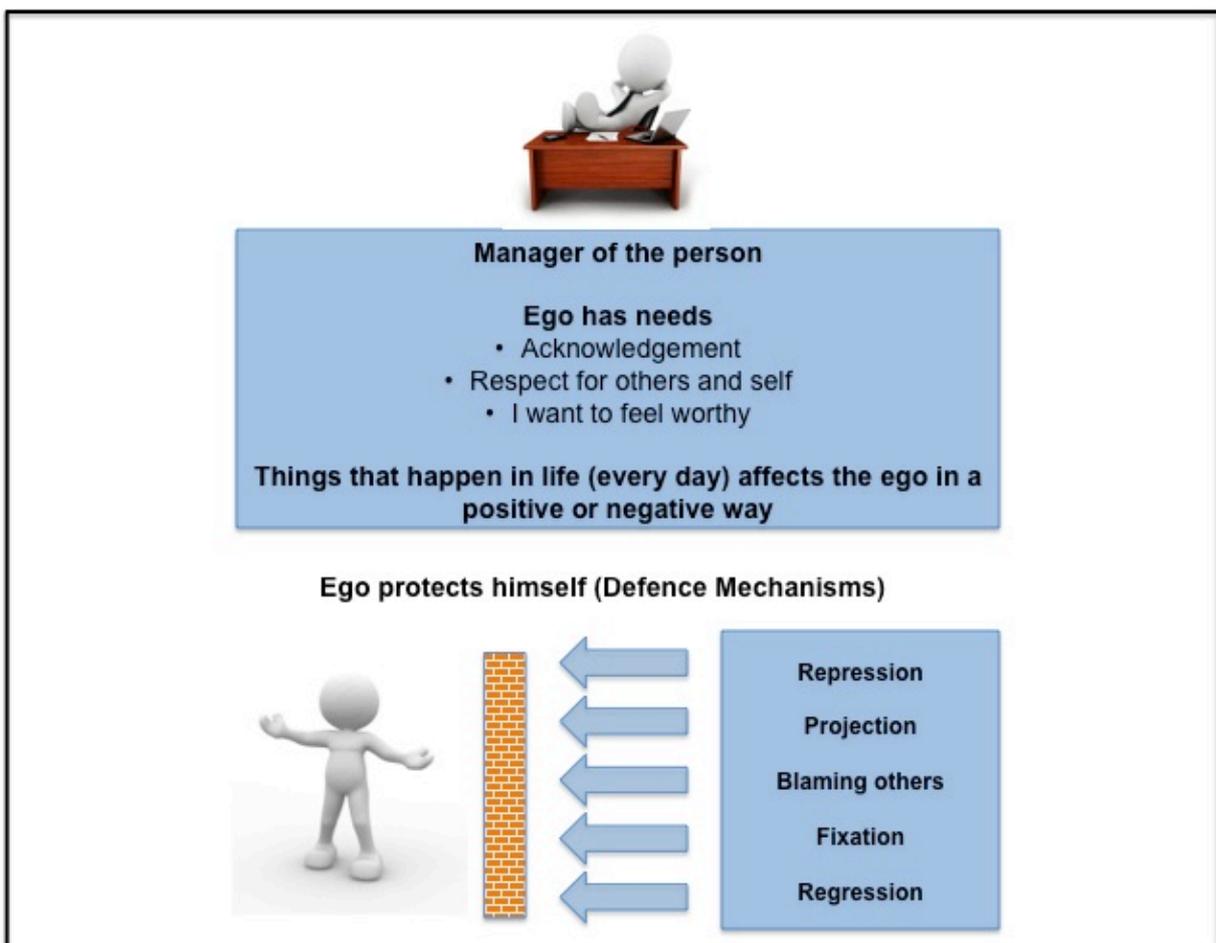


Source: Roets 2009

3.14.11 Ego strength and defence mechanisms

A person's ego is the "manager" of his personality. The ego wants recognition and feels that he has value. Everyday life events influence the ego in positive or negative ways. In order to protect his ego, a person develops defence mechanisms, demonstrated in Figure 3.5 (Meyer *et al.* 2000: 71-80, Roets 2009; Sue *et al.* 2010: 44). The traumatised person has to deal with many uncomfortable situations that effect his ego in negative ways and therefore he should be supported to restore his ego strength by cognitive therapy (James & Gilliland 2013: 438).

Figure 3.5: The ego as manager of the person



Source: Roets 2009

3.14.12 Positive self-talk and self-appraisal

People's continuous talking to themselves is known as self-talk. Self-talk can be either positive or negative. A traumatised person may, due to the emotional impact of the traumatic event, get trapped into a cycle of negative self-talk. Positive self-talk triggers

the brain to release “feeling good hormones”, while negative self-talk triggers the brain to discharge “feeling bad hormones”. Thinking causes some chemical change in the brain. When constantly telling himself that it never will go well with him again, a person programs his brain to fulfil this information. This can lead to the “shut down” of parts of the brain. When parts of the brain are shut down, it implies that parts of the neo-cortex and sometimes the whole neo-cortex become inaccessible. A person then needs to deal with a problem by using the limbic system, resulting in a less rational way of problem-solving (Neuro-Link 2010: 12; Roets 2009).

When a traumatised person constantly relives the traumatic incident, his frontal lobes can become impaired and it causes difficulty in thinking, and to put his emotions into words. This happens because a person’s left side of the brain is associated with the thinking process, while the right side is associated with pictures and images. A person’s memories are stored as pictures. Some of these pictures are so intensely embedded in the brain, that talking about the pictures does not erase it. In this way PTSD’s pictures are originated. In order to effectively deal with trauma, the creating of coherent narratives of the past is important and requires that both the left and the right hemispheres of the brain should work effectively. If these are not working effectively, a person’s narrative is either bombarded by overwhelming thoughts and feelings or it will be extremely logical and it does not consist of any emotional part. Therefore De Jager (2009) and Neuro-Link (2000: 16-18) focus on whole brain functioning. They emphasise the integration of the brain as a whole, which implies the left and the right side must be equally exercised with brain gym exercises.

3.14.13 Dealing with feelings of guilt

Guilt often goes hand-in-hand with traumatic experiences (Mol *et al.* 2005: 494-498; Scott and Stradling 2006, as cited in Clarke 2008: 15; Scott & Stradling 2006: 96; Roos *et al.* 2002: 47-52, 90; Meichenbaum 1995: 442-444; James & Gilliland 2013: 152; Keeton 2009: 1; Preston 2013: 8-9). Below is an example of how a traumatised person can manage his guilt and how to change his self-talk and affirmations to more realistic coping statements (Perschy 2004: 93):

I did the best I could do under the circumstances.

I do not control another person's life.

I am human and humans have limitations. It is unreasonable to blame myself for something that was impossible to be aware of.

3.14.14 Goal setting

In dealing with trauma James and Gilliland (2013: 157) emphasise the importance of goal setting and the feeling of accomplishment. They use the example of troops in the Vietnam War, where they felt that they were betrayed and lost motivation due to a war with no fixed goals. Sue *et al.* (2010: 195) also focuses on the important role of taking action in order to attain certain goals or to be able to make changes.

3.14.15 Play therapy

Play therapy can be used with children as well as with adults. It supports the traumatised person to integrate his trauma memories into his conscious mind. Examples of play therapy techniques include artwork, puppets, sand play, dance, poetry, writing, music, bibliotherapy, computer art, storytelling and drama. James and Gilliland 2013: (194-195, 277-278) further state that play therapy is a non-threatening technique that enables the traumatised person to learn how to emotionally regulate the reactivation of the sensory trauma stimuli. Meichenbaum (1995: 536) confirms the statement of James and Gilliland in the quote:

“Art is a process of self-healing

Art helps the chaos inside come out in a creative form”.

3.14.16 The traumatised person’s support system

According to Roos *et al.* (2002: 8), Kleber and Brom 1992: (174-176) and Preston (2013:1 3) a traumatised person’s social network and/or support system is of utmost importance during his recovery process. A good support system can help a traumatised person to better deal with stress. Social networks can be structured or unstructured. Structured support or counselling is provided by therapists, counsellors and volunteers. Unstructured support is provided by family, friends and care takers from the community. A deficient social support system can lead to unhealthy ways of coping and mental illness.

3.15 THE ROLE OF PSYCHO-EDUCATION IN THE DEVELOPMENT OF MENTAL TOUGHNESS IN DEALING WITH TRAUMA

According to Van den Aardweg (1999:194) and Strydom *et al.* (2002: 14) the term “psycho-pedagogical” is the study of the way a person learns and behaves. This behaviour takes place under the guidance of educators. As previously mentioned, Bethany (2007: 124) states that insight into a therapist’s own stress responses supports a traumatised person to be able to change his own reactions to his responses. This insight can provide that person with a feeling of control over his responses as he realises that his responses to the traumatic event is normal within an abnormal situation (James and Gilliland 2013: 266). Then it becomes possible for a traumatised person to realise that he is not a victim, but rather a survivor. Bethany (2007: 124) addresses this support of a person to gain insight into his responses as well as to gain more control over it as psycho-education. In order for a meaningful study of the relationship between the phenomena of trauma and mental toughness, it is studied and presented by means of psycho-education.

The core of a person’s intra-psychological activities (the processes that takes place within a person), include the ego, the self, the identity and the self-concept, and these are formed by meaning attribution, experience, involvement and self-actualisation (Strydom, *et al.* 2002: 41-47; Sue *et al.* 2010: 54; Roets 2009). Involvement, experience, allocation of meaning, self-actualisation and the presuppositions, namely the establishment of relationships and the life world of a person together shape the foundation of the processes that takes place within the individual (Johnson 2006: 399; Sue *et al.* 2010: 54; Strydom, *et al.* 2002: 44). The interaction of the intra-psychological activities is responsible for a person’s behaviour. This foundation hosts the “I” (ego), the self, the identity and the self-concept of a person. This behaviour determines whether and in which ways a person’s potential is developed and whether self-actualisation will take place or not. With hardly any exceptions, most psychology of educational research can be termed “psycho-pedagogical” (Van den Aardweg 1999: 194). The following often emerged throughout the literature review: a person’s self-concept, ego and relationships with other people play an important part in the development of mental toughness and in dealing with trauma.

3.16 CONCLUSION FROM LITERATURE REVIEW

In an attempt to compile a psycho-educational programme that aims to improve mental toughness in a traumatised person, it was required to undertake a literature review on trauma. The following findings were derived from the study:

- The best way to determine whether an event was traumatic is simply to analyse the impact that it had on the person.
- In order to support a traumatised person the effect and influence of the traumatic event on the person should be the primary focus, and not on the trauma event as such.
- An important part of a traumatised person's healing process is that he should see himself as a survivor and not as a victim.
- In order to regain the control that a person loses at the time of a traumatic incident, he needs to take the responsibility to become actively involved and committed in the cognitive process of therapy.
- Taking action implies that a person makes a cognitive decision to regain the control that was taken away from him when he experienced the traumatic event.
- If a person appraises himself positively, it influences the way in which he will deal with stressors in a positive way. In order to be able to appraise himself in a positive way, a person should become more aware of himself. Self-awareness implies becoming aware of his personal characteristics.
- In supporting a traumatised person to become more aware of himself and learn to know who he is as a person, the impact that previous life events had on his self-concept and ego strength needs to be addressed in therapy.
- The dealing with uncomfortable situations affects a traumatised person's ego in negative ways.
- In order to protect his ego, a traumatised person uses defence mechanisms of which he is not aware of most of the time.
- Continuous self-awareness and reflection are needed in order to gain control after a traumatic incident.

- Resilience, hardiness and optimism are characteristics that will help a traumatised person to better deal with adversity.
- Resilience, hardiness and optimism are all integral parts of mental toughness and therefore the hypothesis can be made that mental toughness will support a traumatised person to better deal with trauma.
- Trauma increases PTSD and/or its symptoms and people with high mental toughness have less chances of developing PTSD.
- A person's reactions to a trauma is influenced by aspects such as his genetic predisposition, personal history, personality traits, self-esteem, strengths, weaknesses, state of mind, past life experiences, coping skills, social support system, the intensity of the event, the perception of the event, conflict, stress management skills and flexibility.
- It takes tremendous courage to regain a person's life after a traumatic experience.
- A traumatised person's social system and family support plays a major role in his healing process.
- Traumatic events and the stress that accompanies it can lead to many negative physical and psychological implications to a person's health. In order to empower the traumatised person, he should learn about the normal symptoms due to the abnormal circumstances.
- Trauma can have long lasting and dramatic effects on a person's life, therefore learning more about the neurological processes involved supports a traumatised person to better understand why trauma impacts him the way it does, it increases his empathy for himself and others and it empowers him to believe that healing is possible and that he is a survivor.
- A traumatic event challenges a person's fundamental schemas, for example his norms, values, beliefs and his ability to deal with emotional distress.
- The primary goal of a traumatised person is to be able to cope, deal and try to make sense of his life that was shattered by the trauma.
- The traumatised person should become aware of automatic, intrusive thoughts as well as the interdependence between his thoughts, feelings and behaviour and other people's behaviour.

- Play therapy (e.g. artwork, clay work, storytelling, bibliotherapy) and cognitive therapy (e.g. relaxation training, thought stopping, cognitive restructuring) enable the traumatised person to learn how to emotionally deal with sensorial trauma stimuli.
- Corresponding aspects between both the literature review of mental toughness and trauma are:

Table 3.7: Corresponding aspects between both the literature review of mental toughness and trauma (summarised)

action taking	the importance of the “self”
facing negativity and adversity	the importance of support systems
flexibility and adjustment	people’s perceptions
the role of self-talk	commitment
goal setting	dealing with stress
helplessness / learned helplessness	

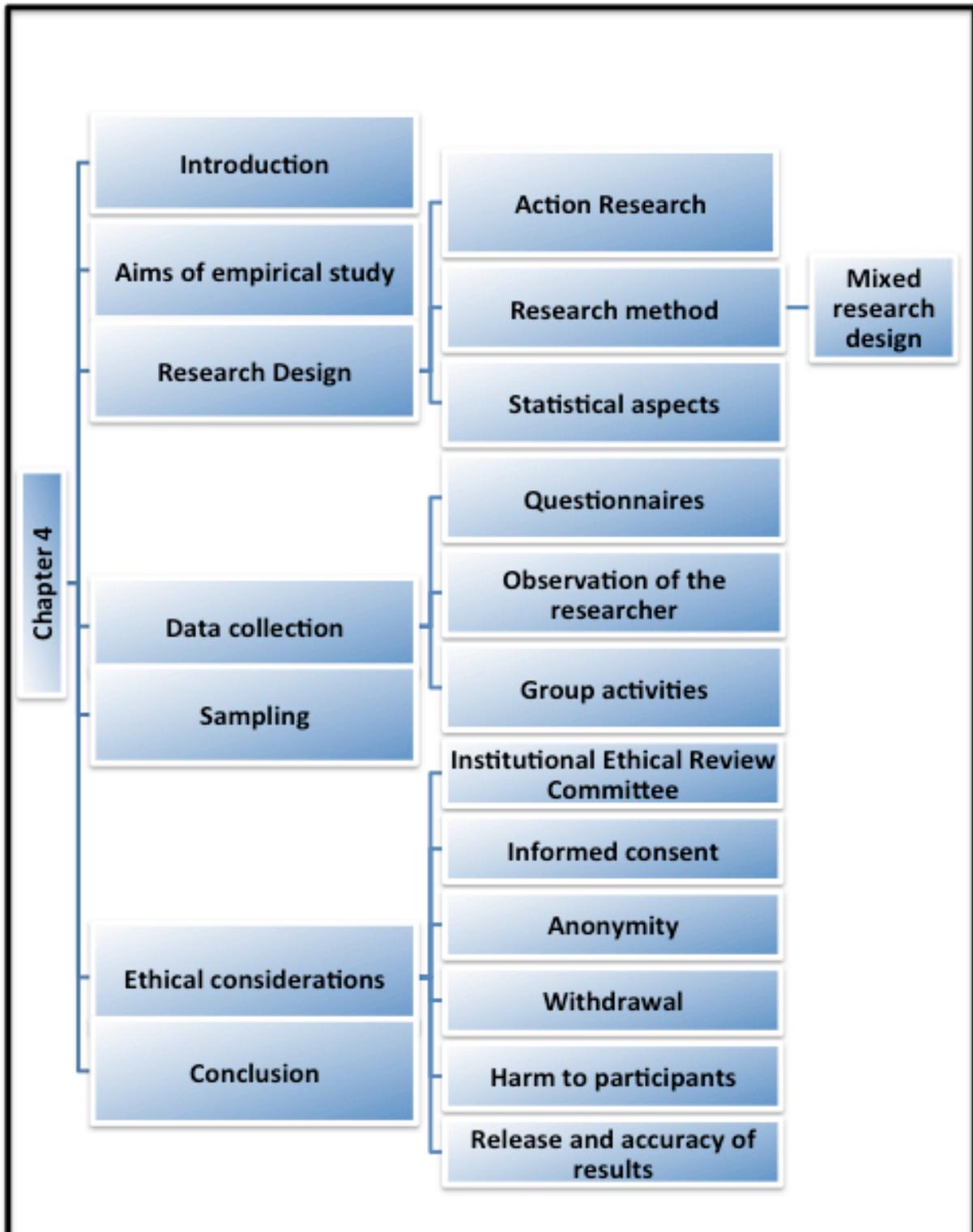
In Chapter 3 a literature review of trauma was undertaken. Both the psychological as well as the physical symptoms and the impact of trauma as experienced by individuals were discussed. Obstacles in the way of recovery and the regaining of control after a traumatic incident were explained. Corresponding aspects between trauma and mental toughness were delineated. The psycho-educational benefits of supporting a traumatised person were explained.

In Chapter 4, the study’s research design is discussed. It includes information about the research method, research aim, participants, ethical aspects as well as the research results.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

Figure 4.1: Chapter outline



4.1 INTRODUCTION

The aim of this chapter was to provide an outline of the empirical methodology of this study to discover whether the use of a psycho-educational intervention programme can support traumatised persons to develop more mental toughness in order to better deal with their trauma. A literature review was done concerning mental toughness and trauma in order to find the corresponding aspects between these two phenomena. The corresponding aspects (theoretical part) were used to compile a psycho-educational intervention programme (empirical part) for my study to investigate the effectiveness of the intervention programme. The data collection process was explained as well as the way in which the data collection helped me to reach the aims of my study.

4.2 AIMS OF THE EMPIRICAL STUDY

The main aim of my study is outlined in Chapter 1:

Would a psycho-educational programme that aims to improve mental toughness in a traumatised person, lead to higher mental toughness?

The aim was divided into sub-aims, namely:

- To analyse traumatised people's coping mechanisms.
- To investigate the ways in which trauma affects people.
- To determine the most effective ways of supporting a traumatised person.
- To investigate what mental toughness implies.
- To compile a list of the corresponding aspects between trauma and mental toughness.
- To investigate how mental toughness can be used in supporting a person to better cope with his trauma.
- To discover the role of individual therapy in the development of mental toughness in dealing with trauma.

These sub-aims of my study provided the needed empirical information to answer the main aim or the research question of my study.

4.3 RESEARCH DESIGN

4.3.1 Action research

As indicated in Chapter 1 of this study, a gap was identified in the practical application of theory in supporting a client to better cope with his trauma. Very little research on the application of mental toughness in the psychological field exists. My aim through the empirical study was to improve practice by compiling a psycho-educational intervention programme to support traumatised persons to increase their mental toughness to better cope with their trauma. Due to the practical application of the theoretical knowledge, I identified action research as the design for my study as action research contributes to both theory and practice and therefore it narrows the gap between theory and practice as neither of the two is considered to be more important (Holly *et al.* 2005: 31; Somekh & Lewin 2011: 94; Norton 2009: 55).

Holly *et al.* (2005: 30-31) and Somekh and Lewin (2011: 13) identify three general types of research: pure or basic research, applied and action research. Pure research implies theoretical development and practical implications may or may not be present. Applied research makes use of theories and principles and enhances these with informal methods in order to solve specific problems. Action research combines both basic and applied research as knowledge; practice and development are not separated. Action research is action oriented and it focuses on a problem-solving approach to improve a “*person’s living in the real world*” (McNiff & Whitehead 2011: 15). Holly *et al.* (2005: 5, 31) states that action research is about creatively taking action as well as the commitment “*to bring ones practice in line with one’s values and aspirations*”. Therefore action research implies improvement and transformation (Somekh & Lewin 2011: 8-9; Holly *et al.* 2005: 5). The purpose of research is to create new knowledge and the purpose of action research, more specifically, is to create a special type of knowledge. Action, with regards to action research, implies improving practice, while the term research denotes explanations and descriptions of what the researcher is doing and when practice is improving. Explanations and descriptions are also known as “theory”. The purpose of action research is thus (1) to create new knowledge, which (2) feeds into new theory. Typically, the action researcher wants to make the following claims:

- I have improved my practice and I can explain and describe what I did and why I did it.

- I have improved as a manager, as I have studied what I am doing and I can explain and describe how and why I have improved (McNiff & Whitehead 2011: 14).

Action research is known as research “*from inside*” a setting and not as research “*on a social setting*” and is performed by researchers working in collaboration with participants in order to generate knowledge (Somekh 2006: 7; Somekh & Lewin 2011: 94; McAteer 2013: 11, 15-16). Action research impacts practice immediately because of integral connections to day-to-day work. Action research takes place through a cyclic process and is known as a cycle or a spiral of steps, which includes planning, action, observation and reflecting, and each series of cycles informs the development of the next as a repetitive process (McAteer 2013: 29-30; Somekh & Lewin 2011: 94; Holly *et al.* 2005: 44; Somekh 2006: 11). The action research cycle is provided in Figure 4.2 and is analysed as described by McNiff and Whitehead (2011: 9) and Norton (2009: 70) in more detail:

Planning:

- Evaluate what is happening.
- Identify an issue.
- Think of possibilities of how to go forward.

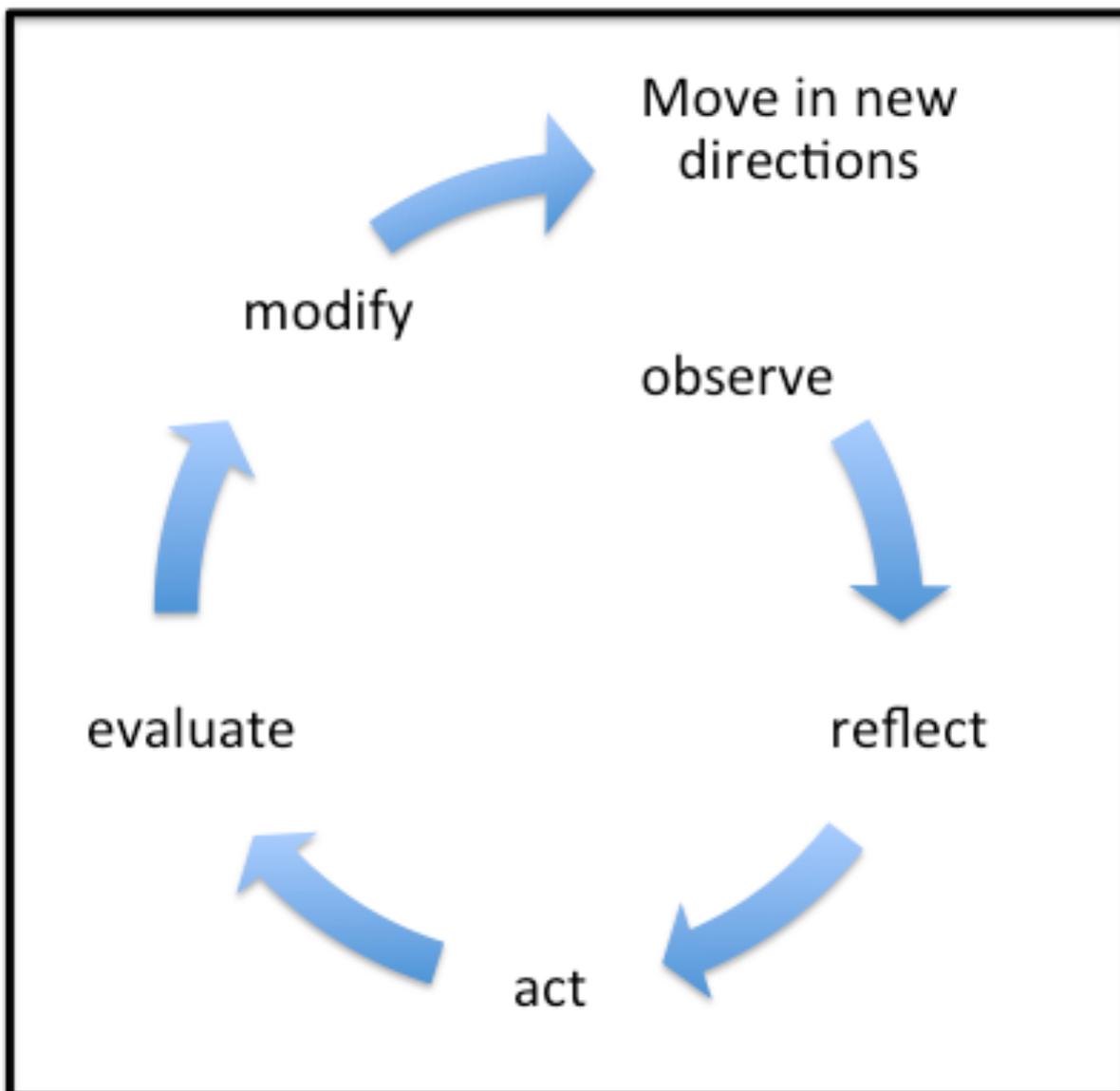
Action:

- Test the possibilities.

Observation and reflection:

- Monitor the action by collecting data about what is happening.
- Test the information’s validity to knowledge.
- Modify practice.

Figure 4.2: An action-reflection cycle



Source: McNiff and Whitehead (2011: 9)

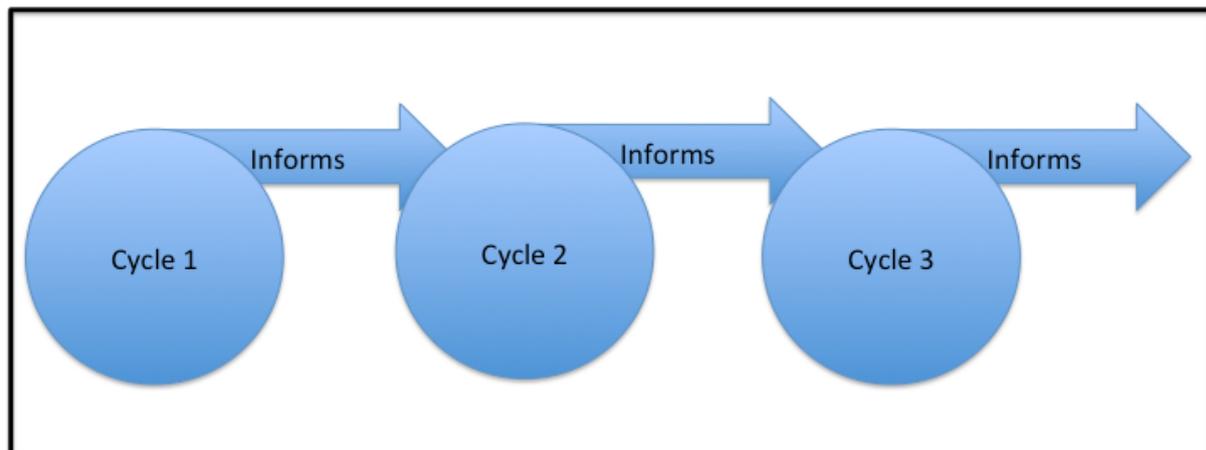
McAteer (2013: 30) describes the process of action research as “*messy*” and McNiff and Whitehead (2011: 9) capture the messiness of action research by illustrating it as a spiral that spawns other spirals along the way, while increasing in diameter. This is illustrated in Figure 4.3 (McAteer 2013: 30).

Action research as a powerful tool for transforming includes the following:

- It is a lifelong learning and development process.
- It is a critically reflective process that can become a natural part of learning.
- It enables conscious and intentional learning from experience.

- It enables programme development.
- It empowers a person to focus on what he values most, supports him to prioritise and to achieve his goals.
- It leads to more effective learning (Norton 2009: 54-56; Holly *et al.* 2005: 5; Somekh & Lewin 2011: 8-9).

Figure 4.3: The cyclic nature of action research



Source: McAteer (2013: 11)

4.3.2 Research method

4.3.2.1 Mixed research design

My empirical study is a mixed method research design that utilises both qualitative and quantitative methods in an action research format. Somekh and Lewin (2011: 97) indicate that action research often involves sources of qualitative data on the basis of analysis, but it often involves quantitative data as well. The aim of my study was not to influence policy as such, but to share and observe in-depth understanding of the details of practice. Holly *et al.* (2005: 248) state that mixed methods is the most creative way in which a researcher can present his work, as artistic, literary and scientific meaning can be combined in order to break down the walls between qualitative and quantitative research. Quantitative data deals with methods and techniques that acquire the most appropriate data to explore the research aims. Alternately, qualitative data has its roots in people's verbal expressions, metaphors and other symbols as the researcher attempts to gain knowledge and understand the participant's life-world and the way he

experiences phenomena (Welman, Kruger and Mitchell 2010: 207; Norton 2009: 220, 224).

4.3.2.1.1 *Quantitative instruments*

MTQ48

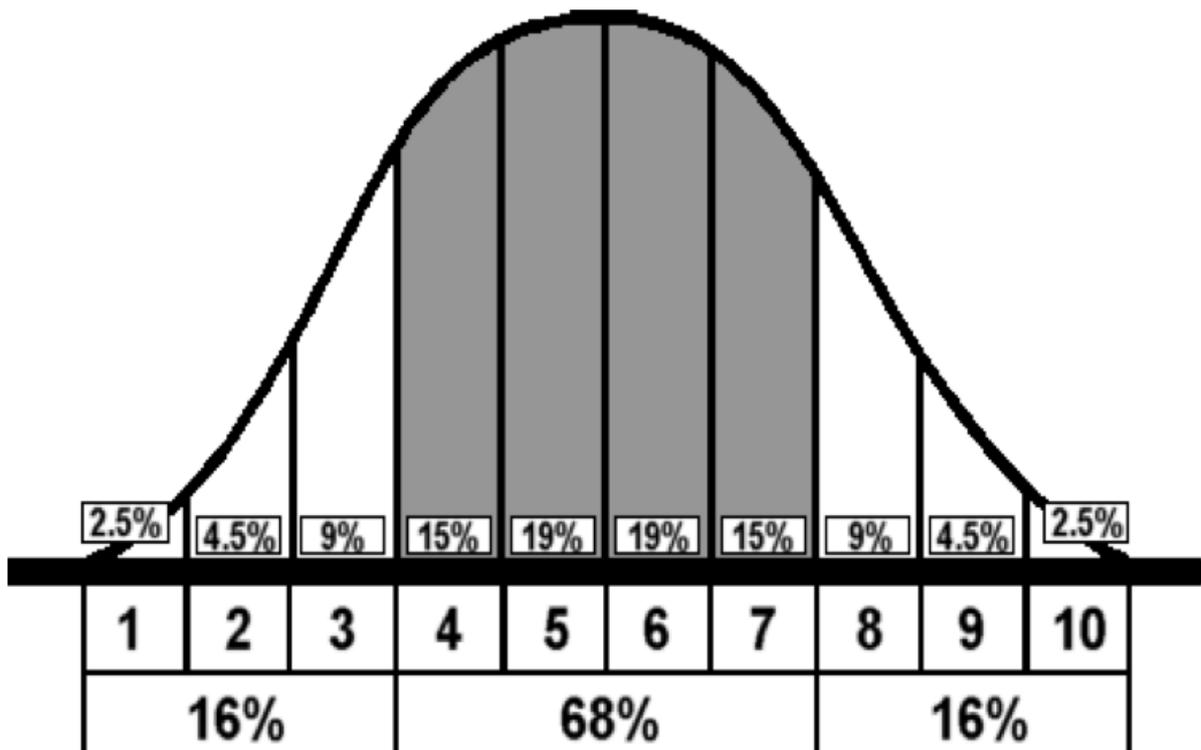
In this study quantitative research was used to determine traumatised individuals' levels of mental toughness. This was done by means of a standardised questionnaire which is known as the Mental Toughness Questionnaire 48 (MTQ 48) (standard version) of the United Kingdom (Clough & Strycharczyk 2012: 47; Mental toughness 2012: 2). The MTQ48 consists of 48 items which are in the format of a questionnaire. Responses are captured by a five-point Likert scale. It measures a person's mental toughness across four scales, which are control, challenge; commitment and confidence (see discussion 2.5.1 – 2.5.4). The usability of a measuring tool depends on its characteristics. This implies that a measuring tool should be valid and reliable. The concept of reliability is complex and the most simple definition is that reliability is the extent to which a scale delivers consistent results or scores. Consistency does not imply that the results remain the same when circumstances change; it has to be indicated by the measuring tool. The overall consistency of the MTQ48 is 0,9 or above. It means that the reliability score of the MTQ48 is a high or acceptable score. The requirement for validity is described as whether a scale measures what it is supposed to measure. The validity score for the MTQ48 ranges from 0,25 to 0,42 which indicates a high or acceptable score. The MTQ48 is thus a valid and reliable measuring instrument (Collins *et al.* 2000: 195-197; Clough & Strycharczyk 2012: 3, 48; Crust & Swann 2011: 217-219; Association for Qualitative Research (AQR) 2010a: 9).

The MTQ48 was completed by the participants in online format within approximately ten minutes. I attended skype training with the Association for Qualitative Research in Chester UK and received a certificate which declares that I am a licensed user (see Addendum Z) of MTQ48, in accordance with their requirements. The MTQ48 data was processed by software to generate four different reports which include an organisation development report, a coaching report, an assessment report and a development report (2.6.1). In this study the MTQ48 was used as a pre-test to test participants' mental toughness and to select qualifying participants for the study. To qualify as a participant for my study, a person's mental toughness should have been low or average (see below: MTQ48 Interpretive Information). I included "around average person's" as well because

according to the criteria for overall mental toughness of the Mental Toughness Questionnaire User Guide (AQR 2010a: 47-48) “*These individuals are able to cope with most of life’s challenges, although, when **facing some difficult circumstances** they may **feel nervous** and a little **threatened**....their **self-belief** may be **affected by others’ criticism**. When **opportunities for development** present themselves, they are likely to **accept the challenge**, although the **potential for failure** may concern them....they may become **distracted** when facing difficult circumstances...they may **occasionally** feel that **events overtake** them....they may, on **occasions**, feel **anxious and worried**”.* These criteria have room for improvement.

The MTQ48 was used again as a post-test after the psycho-educational programme concluded to determine whether the participants’ mental toughness increased or remained the same. This report is called a distance travelled report. In order to identify patterns and trends in the voluntary traumatised group of my study, I made use of an organisation development report, which takes the form of a histogram, as like most psychometric data the MTQ48 is analysed by a sten scale (Association for Qualitative Research (AQR) 2010b: 19). The normal distribution or the histogram’s bell curve is displayed in Figure 4.4.

Figure 4.4: Normal distribution of the MTQ48 group histogram



STEN									
1	2	3	4	5	6	7	8	9	10
PERCENTILE									
2.5%	4.5%	9%	15%	19%	19%	15%	9%	4.5%	2.5%
CUMULATIVE PERCENTILE									
2.5%	7%	16%	31%	50%	69%	84%	93%	97.5%	100%

Percentiles

A percentile score compares an individual's score to a percentage score of a population. For example, if someone's score comes at the 70th percentile then 70% of the members of a group (population) score below this point. The 50th percentile is called the average or median. Percentiles are easy to understand, but they have a disadvantage in that they are not equal units of measurement. The purpose of percentiles is to provide a rank order. The bell curve with the percentile scores beneath it can be seen in Figure 4.4 (Association for Qualitative Research (AQR) 2010b: 20).

Stens

The MTQ48 uses sten scales to report scores as stens, which is a standardised psychometric method of scoring. Stens divide the area under the bell curve, which is called the normal distribution, in 10 equal parts. Thus there is a relationship between the stens and the percentile scores.

MTQ48 Interpretive Information

In Table 4.1 below the MTQ48's legend of the different stens is presented.

Table 4.1: Legend of the MTQ48's stens

Stens	Interpretation	Percentage of adult working population
1-2-3	below average	16%
4-5-6-7	around the average	68%
8-9-10	above average	16%

The following descriptions are provided for guidance only (see: Addendum A)

4.3.2.1.2 Qualitative instruments

In qualitative research it is important to view the person in light of his relationships with himself and his life world; fundamentally viewing the individual against the background of his totality as human being (Nieuwenhuis 2007: 51; Collins *et al.* 2000: 91). This research cannot be measured on a scale. Qualitative research in this study was used to observe the traumatised person's life world and the change in his behaviour and actions during the participation in the psycho-educational programme. Qualitative research in this study included interviews (both structured and unstructured, see Addendums B, C and D) which were conducted with participants prior to, during and after the psycho-educational programme. Further qualitative media that were used included metaphors and play therapy (e.g. artwork, writing, poetry, music, bibliotherapy, drawing and storytelling), as described in section 3.13).

4.3.3 Statistical aspects

The MTQ 48 was scored according to the psychometric test specifications and interpreted quantitatively. The qualitative interpretation was discussed with my supervisor, Prof. H.E Roets, who is a practising educational psychologist.

4.4 DATA COLLECTION

In order to focus on the corresponding results of different research methods to establish new insights in understanding the phenomenon of the relationship between trauma and mental toughness, triangulation employed during my study (Somekh & Lewin 2011: 260). The methods of data collection in this study were the following:

4.4.1.1 Questionnaires

- The MTQ 48 was used as both pre-data collection and post-data collection.
- Evaluation questionnaire for participants, as part of action research, was used after each session in order to determine the effects that the programme had on the traumatised persons (see Addendum D).

4.4.1.2 Observation of the researcher

Holly *et al.* (2005: 142-143) focus on observation as the foundation of good research as the researcher has to know “what” to look for and “how” to search for it. Intensive observing and intuition are some important capabilities and capacities required during this process, because qualitative research is not strictly a procedure. In order to perform research “from the inside” I became a participant-observer in this study rather than a distant observer (Holly *et al.* 2005: 142; Somekh 2006: 7; Somekh & Lewin 2011: 94; McAteer 2013: 11, 15-16). My observations were unstructured because unstructured research is a holistic approach, which formed an important construct of my study (Holly *et al.* 2005: 14-15; Nieuwenhuis 2007: 51; Collins *et al.* 2000: 91).

Observation took place throughout the therapy process of the eight sessions, as I wanted to gain insight in both the traumatised individuals’ life worlds which included their behaviour and activities, as well as in the cyclic process of improving their mental toughness to better cope with their trauma (Somekh & Lewin 2011: 133; Norton 2009:

220). I summarised each session using process notes.

4.4.1.3 Individual therapy

My role during the therapy was that of facilitator. This implied that I had to make a conscious effort to stand back and let each person develop at his own pace. According to the Department of Educational Studies (UNISA 2008: 7-9) this role was required by the participants to observe and reflect on their own skills, as stated by Hornby (1990: 191): *“If I can create a relationship characterized on my part by a genuineness and transparency, in which I am my real feelings; by a warm acceptance of and prizing of the other person as a separate individual; by a sensitive ability to see his world and himself as he sees them; then the other individual in the relationship: will experience and understand aspects of himself which previously he has repressed; will find himself becoming better integrated, more able to function effectively; will become more similar to the person he would like to be; will be more self-directing and self-confident; will become more of a person, more unique and more self-expressive; will be more understanding, more acceptant of others; will be able to cope with the problems of life more adequately and more comfortably”*. Therefore each session of my study was followed up by reflection and observation on the information, skills, knowledge and change that the traumatised persons gained and/or lost through the therapy in order for me to compile an effective and relevant programme which will enable therapists and psychologists to use in the future.

4.5 SAMPLING

Samples can be distinguished either as probability or non-probability samples (Welman *et al.* 2010: 56; Trochim 2006). I made use of a non-probability sample in my study. This implies that not all the persons in the greater population had a chance to be included in my research. This reflects other real life situations there may be circumstances where it is not possible to randomly select volunteers for a study (Statistics Canada 2013: 1; Trochim 2006). According to Welman *et al.* (2010: 52-53) a population includes all the people about whom the researcher wants to make specific conclusions. I invited traumatised persons in my immediate environment to participate in the study. This decision was taken under consideration of practical implications, such as securing a meeting venue, as well as traffic, transport and time constraints that often impact on

face-to-face interaction. The trauma centre situated at the police station in Wapadrant, together with the Reformed Church in Wapadrant enabled me to find voluntary participants (Statistics Canada 2013: 1; Welman *et al.* 2010: 69) (Addendum AA).

The consequences of a non-randomised sample is that the researcher cannot control all nuisance variables, which could lead to low generalisation and causal explanations (Mouton 2001: 151; Welman *et al.* 2010: 88; Statistics Canada 2013: 2). Through a pre-test it was confirmed that the participants were at least similar in terms of the dependant variable, which in this study is their mental toughness levels. I made use of the organisation development report (pre-test) in order to identify trends and patterns of similarity in the group, which are discussed in Chapter 6. A post-test was performed after the completion of the psycho-educational programme, and differences in respect of the dependant variable (mental toughness) were used to deduce whether it was the result of the psycho-educational programme as the independent variable (psycho-educational programme) (Welman 2010: 94-95). The results are discussed in Chapter 6.

4.6 ETHICAL CONSIDERATIONS

Ethics are principles of conduct about what constitutes right and wrong. Ethics can be a complex issue in research, as what is right for one person may not be right for another one, and similarly what is right for a researcher may not be right for the participant and researchers are not always able to be objective (McBride 2013: 98; Thomas 2011: 68-69). The researcher must analyse the nature of his actions in the improvement of his knowledge, as some researchers may think that volunteers would not mind to take part in their research. The fact is however that volunteers *do* mind: *“They may be embarrassed; they may, if they are children, not want to lose respect among their peers; they may, if they are professionals, not want to be seen taking part in the project that has the endorsement of management. They may feel under pressure, just being asked”* (Holly *et al.* 2005: 176). Ethics is also crucial in the accuracy of the research and although modifications are made along the way, planning for the research journey is very important. Ethical considerations played a paramount role in my study and I adhered to the following strict guidelines throughout my study:

4.6.1 Institutional Ethical Review Committee

An Institutional Review Board (IRB) is a committee with experience that is sufficient to oversee the ethics of research conducted by the researchers affiliated with that institution (McBride 2013: 110; Welman *et al.* 2010: 181). My research proposal was submitted to the Research Ethics Committee (REC) of the University of South Africa and the study obtained ethical approval to continue with the conduct of the research (see Appendix Y).

4.6.2 Informed consent

Informed consent implies that the participants have been informed about the nature of their participation, the goals of the study, the process of the research, risks and benefits of the study, duration of the study, their right to withdraw from the study at any time, ethical rules about confidentiality, opportunities to ask questions before the commencing of the study, my credibility and my contact details (McBride 2013: 107; Norton 2009: 181; Holly *et al.* 2005: 106, 177; Thomas 2011: 69; McNiff & Whitehead 2011: 95).

In this research all participants gave consent after they were informed of the purpose, goal, process, risks and benefits, and confidentiality (Addendum AB). The participants received a written copy of my credibility as a researcher, as well as my professional contact details.

4.6.3 Anonymity

Anonymity is the protection of a participant's privacy and is usually preserved through the use of pseudonyms or the exclusion of names from documents (Holly *et al.* 2005: 177; McNiff & Whitehead 2011: 96; Norton 2009: 181, 185).

In this research the participants' anonymity was protected by using pseudonyms. It was clearly outlined to the participants that they were participating in a research study and would report all information.

4.6.4 Withdrawal

Participants need to know that they can withdraw from the study at any time and they do not need to fear any negative consequences (Holly *et al.* 2005: 177) of their actions.

In this research the withdrawal of participants was discussed with them before the study started. They were assured that they could withdraw from the study, even after they had provided written consent to take part in the study.

4.6.5 Harm to participants

The risk of harm to the participants should be reduced as far as possible. Therefore a “*risk-benefit analysis*” should be conducted to ensure that the benefits outweigh the risks to the participants (Norton 2009: 181, 187; Welman *et al.* 2010: 182; McBride 2013: 107-108).

In this research there was a possibility that traumatised persons may be re-traumatised when talking about, thinking of and re-living their traumatic experiences. Possible harm and benefits were outlined in the letter of consent that was provided to each participant (Addendum AB). The benefits outweighed the risks as more personal growth than re-traumatising took place, and in being re-traumatised the opportunity was created for the participant to be able to work through the traumatic incident to be able to face his trauma and to better deal with it.

The termination of each session was handled with sensitivity and participants who needed debriefing were counselled at the completion of the intervention session. In my capacity as a registered and practising educational psychologist, I could control the potential harm.

4.6.6 Release and accuracy of results

Results that are obtained through research should be characterised by objectivity, accuracy and unambiguity. The limitations of the study must be noted. Any plagiarism or bias should be avoided (McBride 2013: 89, 112, 117, 183; McNiff & Whitehead 2011: 93, 103; Welman *et al.* 2010: 182).

In this research all results were evaluated by my supervisor. The limitations of my study are noted in Chapter 7.

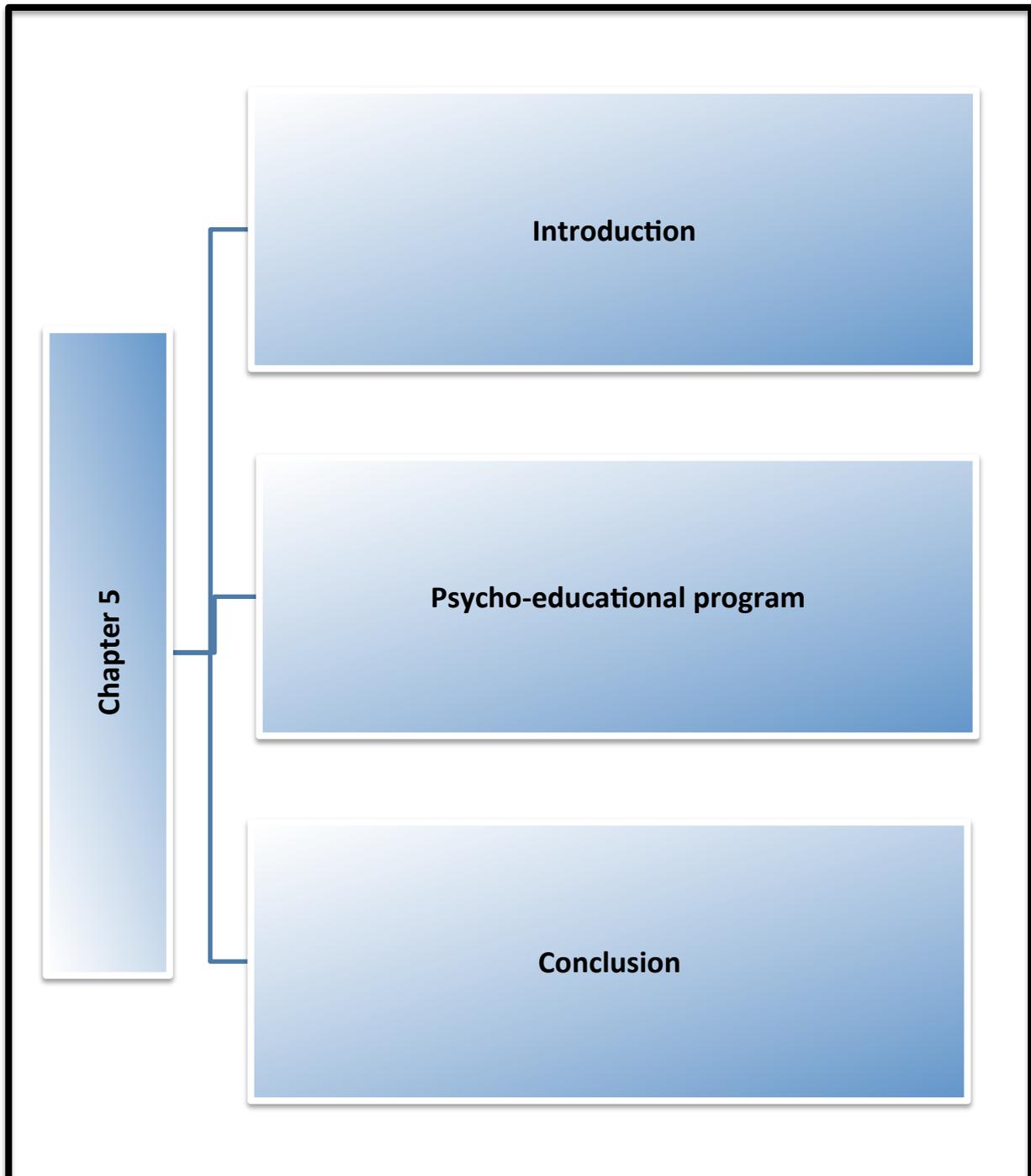
4.7 CONCLUSION

This chapter outlined the research design of my study. The research method, sampling,

data collection process and instruments and ethical issues were explained. The psycho-educational programme is comprehensively discussed in Chapter 5.

CHAPTER 5
PSYCHO-EDUCATIONAL PROGRAMME

Figure 5.1: Chapter outline



5.1 INTRODUCTION

In a therapy study that sought to determine how to support survivors of interpersonal trauma, Payne, Liebling-Kalifani and Joseph (2007: 100-101) indicate that a supportive environment encourages a client to become intrinsically motivated. This aids the client in integrating his self and his experience in a way that positively reconstructs his self-structure. The implication of a reconstructed self-structure is personal growth beyond the level prior to the traumatic incident.

As indicated in Chapter 3 I selected the corresponding aspects of my literature review of of mental toughness (Chapter 2) as well as trauma (Chapter 3) to compile a psycho-educational programme to support traumatised persons to develop more mental toughness that will support them to better deal with trauma in the future. It is important to remember that the psycho-educational programme that was presented through the therapeutic sessions, was not a generalised programme, but that individual's needs were accommodated (West Midlands Coaching Pool 2010: 46). No programme will completely fit each individual participant's needs. Therefore general activities were included in the programme and it had been be adapted to each traumatised person's specific needs.

5.2 PSYCHO-EDUCATIONAL PROGRAMME

The programme was presented in eight sessions. Sessions were held weekly for one hour and fifteen minutes per session. At outline of each session follows:

SESSION 1: Participant A. Semi-structured interview (qualitative) when receiving feedback of MTQ48.

Aims

- To introduction the participant to the therapist.
- The therapist explained the format of the study.
- To provide understanding of what mental toughness implies.
- Participants are explained what trauma implies and whether it is short term and/or long term in nature.

- Participants receive feedback and discuss the levels of their own mental toughness.
- Participants make the choice to face the trauma.
- Participants understand the concepts of taking action and being a survivor.

Content

- Each participant receives a hard copy of his report of his current mental toughness.
- Explanation of the first step of participant in trying to gain back his life within his trauma is to face the trauma and to realise that he is a survivor, as well as that he has taken action by taking part in this study.
- Hand-out and discussion of mental toughness' four components and what it practically implies in the participant's experience of trauma in his everyday life.

Hand-out

- Hand-out of mental toughness' four components (Addendums E and F).

Homework for participants

- Requested to bring a memory stick or CD for the next session.
- Requested to read through mental toughness report at home.
- Requested to read through mental toughness' four components.
- Requested to complete the semi-structured questionnaire at home (Addendum B).

SESSION 2: Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started.

Aims

- Participant is supported to relax and to learn to know himself better.
- To gain insight into the feelings, emotions, thoughts and behaviour which he experiences after the trauma.

- To realise that his emotions are normal in an abnormal situation.
- Debrief with stress balls.

Content

- Participants chose a metaphor that represents him and creates it out of play-dough.
- Therapist and participants discuss the semi-structured questionnaire that the participant completed for homework.
- Participants receive a bright coloured stress ball with an attached note: *I am a survivor and not a victim.*

Hand-out

- None.

Homework

- There are certain parts of trauma that can be controlled: The participant needs to focus more on the things that he/she can control than wasting time on the things that she cannot control (Addendum G).

SESSION 3: Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions.

Aims

- Discuss trauma's effect and/or symptoms on participant as a "whole" person: physical, emotional, behaviour and thoughts.
- To see the different emotions in a concrete way inside your body.
- Participant realises that his brain's protecting instincts decided what he needed to do during the traumatic incident/s.
- Understand trauma's effect on participant's brain and body.
- To discover both lost and new identities due to traumatic events.

Content

- Therapist draws outline of participant's body on a large poster against the wall.
- Different colours are allocated to different emotions, for example blue represents sadness, red represents anger, black represents fear, etc.
- Different coloured emotion-flowers are arranged in a flower pot (which will be used again in Session 6).
- Participant indicates place in his body where different emotions are experienced (by an applicable coloured flower), followed by a discussion that includes questions like: "What are you scared of?" "What do you do when you are angry?"
- Therapist discusses hormonal actions and reactions inside participant's brain during a trauma and when trauma gets "stuck".
- Analysing of the self: True self, Adapted self and Ideal self (Addendum H).

Hand-out:

- Conquering trauma: From victim to survivor.

Homework

- Completing the hand-out about the process from being a victim to becoming a survivor.

SESSION 4: I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)

Aims

- Participant realises: "I don't have any control of what will happen to me, but I have the control of what I will think and do about the things that happened to me".
- Participant identifies personal healing strengths.
- Participant learns to anchor outside the trauma.
- Participant learns to re-enter trauma in a controlled way.
- He accomplishes the relaxation through breathing exercises
- He realises the power of visualisation in conquering trauma and reaching goals.
- He involves all his senses in visualisation in order to better attain goals.

Content

- Participant focuses on the metaphor: “I choose to take myself out from under the car’s tires and to put myself behind the steering wheel of my car”.
- Participant gains inner perspective and identifies his personal protecting characteristic shield.
- Participant identifies anchors outside the traumatic situation where he feels safe and still feels safe and like his old self again (before the trauma) “outside the trauma”.
- Re-entering the trauma in a controlled way by using the relaxation exercises.
- Listen to the Prosper CD (Brescia 2009).
- Follows the visualisation exercises.

Hand-out

- Not to choose is also a choice and it usually has destroying consequences (Addendum J).
- Protecting shield (Addendum K).
- Anchor outside trauma (Addendum L).

Homework

- Participant has to compile a poster using magazines, to visualise and represent his goals. The participant should listen to the *Prosper CD* while looking at the final product (poster).
- Participant must gather at least nine objects from home and put it in a “Name of person” box. These objects should tell the participant more about who he is, e.g. a cd, his favourite perfume, book, etcetera.

SESSION 5: Grounding myself by understanding my ego and defence mechanisms. See myself as a unique person and appreciate myself.

Aims

- Participant must clearly see and discuss goals on the poster that was made during homework.
- Learn some grounding aids for when trauma tends to overwhelm participant.
- Discover the effectiveness of the relaxation exercises.
- Investigate the ego and defence mechanisms.
- Identify personal defence mechanisms.
- Discover the power of goal setting.
- “Taking responsibility” for his life by using the principle of the “*slight edge*”.
- Re-discover himself as a unique person.
- Learns to know how to be good to him.

Content

- Discuss the participant’s poster which was given as homework.
- Explain how to literally put his feet back on the ground if anxiousness tends to overwhelm participant. Practical guidelines are discussed and custom-made for each individual person.
- Hand-out of a picture of the ego, the discussion of the ego as manager of the person and what his needs imply.
- Allow participant to write down his defence mechanisms and discuss how he uses it.
- The “*slight edge*” of goal setting and examples from participant’s own life.
- Sharing the objects that participant brought to explain himself and to rediscover and appreciate himself as a unique and special person.
- Explain how to “pack” personal first-aid kit of “priceless tools” of how to be good to himself.

Hand-out

- The ego’s needs (Addendum N).
- The walls (defence mechanisms) that the ego builds around it (Addendum O).

- Grounding (Addendum M).
- The “*slight edge*” (Addendum P).

Homework

- Participant must reflect on all sessions and visualise how he is becoming empowered to gain control of himself.
- Use the first-aid kit to be good to himself, and participant must use it at least once a day.

SESSION 6: How to fill up my “empty bucket” although I am a broken person

Have you filled a bucket today? A guide to daily happiness for kids (McCloud: 2014)

Aims

- Realise that he has a choice to stand up from his emotional wheelchair.
- The value of positive self-talk.
- The importance of knowing himself well in order to realise his unique personality and to appreciate and love himself more.
- Participant understands brokenness: How he can have a fulfilled life and add value to other people’s lives although he is similar to a cracked pot.
- Participant must first attend to his own needs before he will be able to add value to the world around him as well as to other person’s lives.
- Participant refrains from focusing on himself, as it makes his world a very small and unhappy place.
- Have an action-plan for when he faces setbacks and obstacles.

Content

- Participant: “I choose to stand up from my emotional wheelchair by crossing out my name from my wheelchair”.
- Participant: “I am broken. What do I do when I think that I’m not good enough?”
“In our weakness, we find our strength” (Addendum R).

- Read the story entitled “Giraffes can’t dance” (Andreaes & Parker-Rees 2013). Participant needs to find his own “song” in life; otherwise he will always feel that he isn’t good enough.
- Describe what positive self-talk means and how it helps the neurons in participant’s brain to multiply.
- Explain ways in which positive self-talk and self-affirmations will support participant to become the best version of himself that he was created to be.
- Help to compile participant’s own self-affirmation card.
- Participant needs to ask whether he’s filled his bucket each day

Each member will “*fill a bucket*” with the skills that he is equipped with to be a survivor and not a victim in his journey to better deal with his trauma. In the process he is also equipped to fill other people’s buckets. Filling one’s own bucket is like using an oxygen mask in case of an emergency in an aeroplane. The participant needs to attend to himself first before he will be able to attend to any other person. By the participant filling his own bucket, he will develop and have the following aids:

- love herself (represented by a gift box with a coloured heart inside - to remind the participant that this is the greatest give that he could ever give. It is difficult to love anybody else if one does not love yourself).
- know his positive characteristics which are part of his protective shield (represented by a jewelry box with six dividers - in each divider a positive characteristic is written down in order to constantly remind the participant of the treasures and gifts he owns in order for him to use it every day)
- humour (represented by a funny, colourful bird - to remind participant to laugh at himself and to be able to make other people laugh)
- be able to make the world a better place (first for the participant, then to others - represented by a stress ball with the world map on it).
- friendliness and love (represented by a small teddy bear - to remind participant to be friendly with him in the first place and be good to him before he can be friendly with other people and be good to them).
- bravery (represented by a small mouse - to remind participant that his negative emotions like fear/despondency/anxiety/loneliness, etcetera will resurface

from time to time, but that he will need to act like a brave mouse, although he may feel scared/ tired/ shivering and force himself to move from the comfort “hole”/zone and face the world and force himself to continue with his everyday life).

- The participant must realise that he first needs to fill his own bucket. As a traumatised person, his bucket is full of more negative feelings. He is equipped and has the knowledge to fill his bucket now because now he is aware of:
 - his positive characteristics.
 - his ego and his needs.
 - his defence mechanisms.
 - what to affirm and say to himself on a daily basis.
 - how to use his first-aid kit.
 - He has already stood up from the emotional wheelchair.
 - what makes him “tick” and “dance”.
 - the power of the slight edge.
 - that he has to go on in life, although he will sometimes feel as small and as scared as a tiny mouse.

Hand-out

- The neurons and negative self-talk (Addendum V).
- Emotional wheelchair (Addendum Q).
- “In our weakness, we find our strength” The cracked pot (Author unknown) (Addendum R).

Homework

- Participant to complete: Transactional Analysis questionnaire (ego states) (Addendum W).

SESSION 7: My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.

Aims

- Identifying participant's ego states and their role in the development of his mental toughness and in dealing with his trauma.
- To learn to better handle his concerns about the future.
- To have a detailed look at the past, to review the present and see and plan for the future.
- To realise that he does not have any choice about what will happen in the future, but that he has a choice of how to handle whatever will happens.
- To be reminded and supported in his choice to persist in the process of empowering himself.

Content

- His ego states: parent (nurturing or critical), adult, child (free or adapted). Which one does participant need to pay more attention to?
- Sand therapy: Participant's past, present and future.
- To realise that persisting in the process to keep on moving forward, does not mean that he will be fearless, but that the secret lies in forcing himself to go on in spite of anger, anxiety, tiredness and feelings of powerlessness.
- He constantly needs to talk to the little "monsters" in everyday life.

Hand-out

- The ego states and transactional analysis (Addendums S and T).
- On facing and understanding one's limitations (The cracked pot) (Addendum: R).

Homework

- Complete the MTQ48 again.
- Addendum C: Semi structured questionnaire (to be completed after the therapy sessions).

SESSION 8: Feedback on post-test MTQ48 and semi-structured questionnaire

Aims

- To complete the feedback form after the psycho-educational programme's past two months' seven sessions.
- Taking part in the semi-structured interview after completing the feedback form of the therapy programme.
- To receive feedback and a hard copy of his mental toughness score.
- To realise his role in taking responsibility, for every day, for the rest of his life.

Content

- Completion and discussion of the semi-structured interview questionnaire.
- Discussion of mental toughness report and a comparison of scores before and after the intervention programme.
- To be mindful enough to see and to know the pitfalls in his life and character traits and not to "fall in", but to walk around the holes in his road and to choose a new road.

Handout:

- Taking responsibility (I walk down the street) (Addendum U)
- Distance travelled report MTQ48

Homework

- To apply the new skills that he has accomplished for the rest of his life and to extend it so that he can become more of the person that he could be.

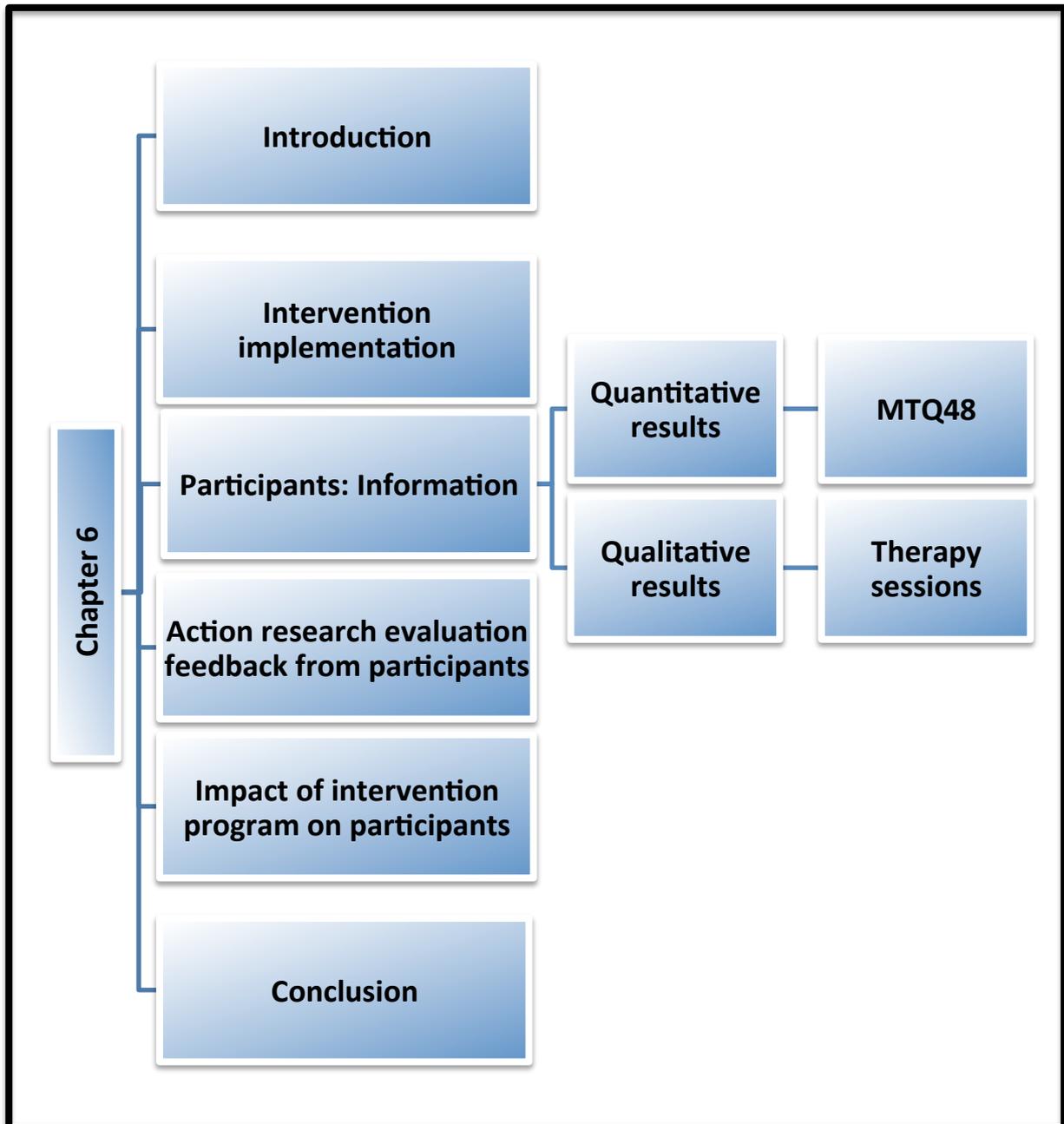
5.3 CONCLUSION

In this chapter I outlined the eight sessions of the psycho-educational intervention programme. In Chapter 6 the practical application and the results of the intervention programme are discussed.

CHAPTER 6

RESULTS OF THE EMPIRICAL RESEARCH

Figure 6.1: Chapter outline



6.1 INTRODUCTION

The aim of this chapter is to provide feedback on the psycho-educational intervention therapy sessions and to discuss the findings of the study. Eight participants who

displayed low-to-average mental toughness were identified to take part in the therapy sessions. Eight individual therapy sessions of 75 minutes each took place with each participant.

6.2 INTERVENTION IMPLEMENTATION

The detail of the eight sessions of the intervention programme is described in Section 5.2. Significant aspects of each session are discussed below. It is important to note that as indicated in 5.1, no programme will completely fit each person's needs. The same intervention programme was followed with all the participants, but the sequence and duration of the activities differed according to the participants' individual needs.

6.3 PARTICIPANTS: INFORMATION, QUANTITATIVE RESULTS (MTQ48) AND QUALITATIVE RESULTS (THERAPY SESSIONS)

6.3.1 PARTICIPANT A

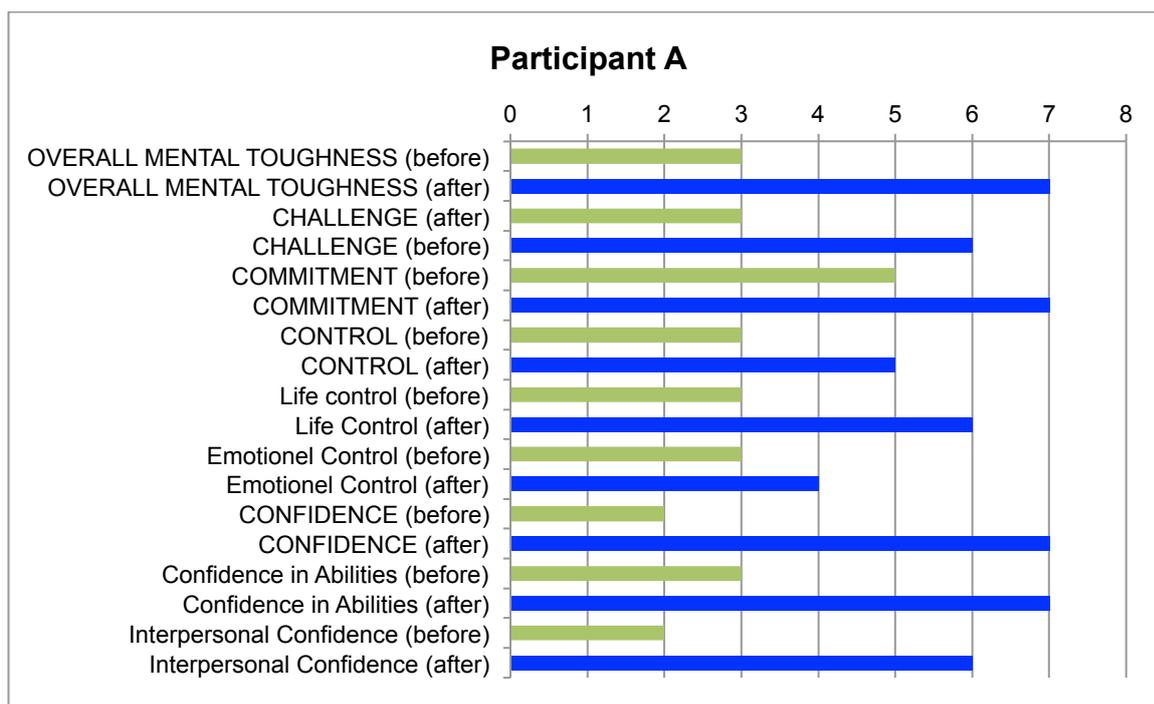
Age: 43

Gender: Female

Occupation: Homeopath with a PhD.

Trauma: Emotional abuse by narcissistic husband. One child of her pair of twins suffers from Down Syndrome.

Graph 6.1: Participant A . Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant A. Semi-structured interview (qualitative) when receiving feedback of MTQ48

The participant said she expected to have low mental toughness, but started crying. Her overall mental toughness indicates a score of three (low mental toughness). Participant A was referred to me by a trauma centre at a police station as she went there twice to complete incident reports against her husband. An attorney advised her to report these incidences to create a record, in order to file for divorce in the future. She has been married to her husband for 18 years and has been verbally and emotionally abused during her complete married life. She desires a divorce, but she is fearful because her husband constantly threatens that he will take away her children.

Table 6.1: Participant A's qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Confidence in abilities (score 3: under average)	- Abusive relationship - Narcissistic husband - Gave up thriving practice as homeopath due to move
Interpersonal confidence (score 2: under average)	- Withdrawal from family and friends due to humiliating relationship - Emotionally drained - No more interaction with colleagues at work
Challenge (score 3: under average)	- Procrastinates in challenging situations as she does not believe in herself - Does not want to face challenges
Life control (score 3: under average)	- Victim of verbal abuse

under average)	- Alcoholic husband
Emotional control	- Finds it difficult to relax - Feels guilty towards twins if she exercises or if she works to build up a new practice.
What are her highest scores	How she confirmed these scores
- Commitment (sten 5: average)	- Strong personal characteristic - If she decides to commit, she will stick to it, e.g. in her work and studies - Takes good care of twins, especially Down Syndrome child

SESSION 2: Participant A. *Metaphor and further semi-structured interviews from questionnaire that was completed before therapy started*

METAPHOR: The participant chose a conveyer belt because it is very strong on outside but inside it is soft. She explained that her husband and other people see and use her as a doormat, and that she sees herself like this too (hence the use of the metaphor). She commented that even conveyer belts can break.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What kind of trauma have you experienced?

Participant A: Verbal abuse in marriage.

What makes you feel that you are not coping with your trauma?

Participant A: Depressed feelings; panic.

How did trauma change your life?

Participant A: Less trust in men and relationships; withdrew from family and friends and recently realised I need them.

How do you cope with trauma?

Participant A: Avoidance; living under the radar until I can establish myself financially and then escape.

How do you see yourself?

Participant A: Broken; deceived; disillusioned.

What are your negative characteristics?

Participant A: Procrastination; despondency; oversensitivity.

What are your positive characteristics?

Participant A: Perseverance; sensitivity to the needs of others.

Do you have a support system?

Participant A: Family: dad, mom, in-laws.

What is the best thing that you've ever accomplished?

Participant A: Raising kids to best of my ability. Always bouncing back from bad experiences (however slowly). Having qualified as a doctor in homeopathy. Being a successful homeopath as a doctor.

What expectations do you have about this individual therapy programme?

Participant A: Get to know myself better; find the stronger person that I used to be; get on with life.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION:

Positive experiences: The participant felt that the session helped her to put thoughts into words and she was thankful to have someone who patiently listened.

SESSION 3: Participant A. *Trauma's effect on body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Sadness (represented by colour blue) in eyes and mouth; Participant A remembers having a strict upbringing, with an authoritative father. Her parents had an unstable marriage with fighting and have since divorced. Her family is isolated. She still withdraws. She was scared of father, because she had no say in matters they discussed. She experiences a knot on stomach.

Ashamed (orange) in head; Participant A confesses to being a rebel due to her strict upbringing. She attended parties at university, had pre-marital sex with men, and feels very guilty for her behaviour. She admitted that she always blamed her husband for affairs, but now I she felt ashamed. A discussion followed about the consequences of

growing up with an authoritative father and how her rebellious behaviour was an attempt to break away and take revenge on men. The discussion moved onto her mother's extra marital affair, her parents' divorce and the feelings of insecurity, disappointment as well as dealing with the new identities of her divorced parents and the hurt she experienced from it, and she described how she dealt with it.

Conclusions: Participant A grew up in fear (represented by the colour black), which became way of living and comfort zone. She then married a man who aroused the feelings of her comfort zone; a man who expects women to submit under his authority. She needs to forgive her father, herself as well as her mother for their negative choices of the past. She explained that she often feels sorry for herself and that her dad has the same tendencies.

Lonely (brown) in head; Participant A's abusive husband is not her companion and she often feels like a single parent.

Angry (red) all over body; Participant A is angry at her husband who controls her emotionally and scares her by saying things like he'll take away the children.

Pride (pink) in head and shoulders; Participant A is proud of her studies, of being a doctor and of work success.

SELF ASSERTIVENESS

Participant A wants to become more self-assertive. She has started a new practice. Practical ways in which she can apply assertiveness is to walk/sit/stand up straight; pull her shoulders back; look the world in the eyes; act as if she has self-confidence although she may not feel that way; tell herself that she "can do this" and that she is getting better and better every day.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION:

Positive experiences: Participant A explained that the positive experiences included standing still and clearly seeing the emotions inside her body. It gave her insight into how she really feels.

SESSION 4: Participant A. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

FEEDBACK ON SELF ASSERTIVENESS: Participant A stated that she had been practicing the skills (discussed the previous week) and although she is still unsure of herself, it feels better to walk up straight, pull her shoulders back and look the world in the eyes.

PROTECTING SHIELD

Participant A's negative characteristics include introversion, withdrawal, over-analytical concerning herself, life situations, husband's comings and goings, over sensitiveness about what other people say and think of her, drives herself too hard, relies too much on herself, does not accept help from others to sometimes take care of her children. Her positive characteristics which can become a protective shield include empathy, friendliness, drive, introversion, honesty and analytical nature (good in work situation).

ANCHOR OUTSIDE TRAUMA

Participant A anchors where she feels safe: at work, with family (albeit that she has only experienced this recently), when children are at school and she has time to read devotions. The aim of the anchors are to use them when panic and depression tend to overwhelm her.

PROSPER

Listening, practicing and visualising her goals (at least three times a week) should help Participant A to anchor herself outside the verbally abusive situation and re-enter it in more controlled ways. Re-entering in Participant A's situation implies that she cannot remove the verbal abuse, but rather start to focus on things that she can control, which are her thoughts and behaviour.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION:

Positive experiences: Participant A shared that she believed that the future is in her hands and hard work is the only way that she can find herself and strengthen herself.

SESSION 5: Participant A. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

VISUALISATION POSTER

Feedback: Participant A started attending hip-hop dance classes with her son previous week and she reported that she feels energetic when exercising, as kids are old enough to join her. Her poster included a picture of confident lady, and she had placed quotes on the poster with applicable pictures: “A happy person is a healthy person”; “time to stop and smell the flowers”; “mission accomplished”; “discover your future”; “quality family time”. She realised that one of her sons takes life as seriously as she does and she wants to show him to have more fun and how to grow with dignity while growing older. Although she was sceptical about the *Prosper* CD, she was surprised at the calming effect that it had on her.

DEFENCE MECHANISMS

Participant A exudes inferiority (unsure of who she is, does not like herself) withdrawal (feels inferior, withdraws inside herself), fixation (wants to stay in the previous phase of her life where it went better between her and her husband and she does not want to face reality and realise that he currently has an extra marital affair and she needs to decide to stay or to file for a divorce), regression (tends to return to an earlier stage in life and procrastinate on the confrontation of the current situation and blames others, especially her husband for verbally abusing and humiliating her, but she has never put her foot down to stop him).

PARTICIPANT A’S “BAG” OF WHO I AM

Participant A admitted that it was difficult to decide what to bring. In the bag were oil pastels (she’s creative), a medication book (creative book where she describes homeopathic medicine); CSI story book on how crimes are resolved; favourite green blouse (green symbolises life, reminds her to live a full life, and to be less serious); Dove soap (to remind her to allow self to fly); a CD that she received for Mothers’ Day from Down Syndrome boy’s (it thanked the moms for their diligence and love in having a special needs child), a bracelet that includes symbols describing the armour of God.

FIRST-AID KIT

Participant A added the following aids of how to be good to herself in her first-aid kit: exercising; dancing; eating healthy; breathing exercises (prosper cd), hair-cut, taking more short-cuts, complimenting another person once a day and/or doing something nice for another person once a day, as well as laughing more.

ACTION RESEARCH EVALUATION QUESTIONS:

Negative experiences: Participant A felt that there was too much homework, and that visualisation might not be the best approach for every person. Even though Participant A agreed that visualisation works a certain extent, she found it difficult to visualise the outcome of her divorce.

Negative experiences that became positive experiences: The participant admitted that it was difficult to hear that she has a tendency to sorry for herself.

SESSION 6: Participant A. *How to fill up my “empty bucket” although I’m a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket which was filled with a gift box, a jewelry case, and a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant A was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its’ needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant A believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her “tick” and “dance”, she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. The positive characteristics in her jewelry box include caring for others, perseverance, sensitivity to the needs of others, analytical nature, as well as her dynamism and creativity.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Positive experiences: Participant A affirmed that she understood that loving herself is

an important step, not a “guilt-purchase”.

SESSION 7: Participant A. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant A’s ego states switch back and forth between parent (nurturing) and adult. She explicitly saw that her free child needs to be developed. She feels less neglected and sorry for herself when she allocates time to herself. She also realised that by being too much of a nurturing parent she can tend to “suffocate” her children. She has started allowing her parents and in-laws to sometimes look after the twins, freeing both herself and her children to enjoy other facets of their lives.

TRANSACTIONAL ANALYSIS

Participant A recognised herself in the “I am ok” and “you are not ok” category, as she is judgemental and continuously finds fault with her husband. She realised during course of sessions that she is too sensitive can be judgemental and she has to share responsibility for the negative events in her life and marriage.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant A’s sand picture represented her life as follows: the closed shells represented part of her past) and the open shells in her future reflected that she has started opening up. A bird that stretches its wings indicates she needs to proverbially stretch her wings and fly, essentially to realise her potential. Food indicates she does not need to do everything perfectly, but rather that she enjoy her everyday tasks (like preparing food and helping children with their homework). These changes were possible as she started to multi-task and to take short-cuts. Stepping stones indicated her route through life. Rats and foxes symbolise negative events like her abusive relationship (which she still experiences), her parents’ bad marriage and divorce, sexual relationships at university as well as the birth of her Down Syndrome child. She does not want to be like the crab, as crabs walk sideways and ignore things and crabs do not face realities. The free child and funny characters are reminders to take life less seriously. The angel represents Participant A growing wings when she helps other people (in her practice as a homeopath), thereby achieving her potential.

ACTION RESEARCH EVALUATION QUESTIONS:

Positive experiences: Participant A confirmed that the sand therapy helped her to see that there was progression in her life, as well as in the therapy sessions.

SESSION 8: Participant A. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

As seen on the Distant Travelled Report above, Participant A's overall mental toughness improved from being scored a two (below average) to being scored a seven (highest score on average). Participant A's lowest score is a four (average) for Emotional Control, which was initially marked as a three (below average) before the commencement of the therapy sessions. Through the semi-structured questionnaire below, it is qualitatively indicated why Participant A's mental toughness increased.

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant A: Yes, I'm more confident in my abilities.

What have you learned about yourself?

Participant A: Feeling sorry for myself is non-productive.

What do you do differently in your everyday life?

Participant A: Less procrastination. Get more things done. Move forward.

What have you learned about your trauma?

Participant A: I am not responsible for other people's mistakes or mistaken opinions about me.

Do you think that you are coping better with your trauma?

Participant A: Yes, albeit difficult.

Participant A still lives with her husband and needs to face the difficult situation of his abusive words and the extra-marital affair daily.

What makes you feel that you are coping better now?

Participant A: I find it less difficult to get over wrongs done to me.

Have any of your relationships changed? How have they changed?

Participant A: Yes. More open and relaxed around other people at work. More patient with my kids.

Did your feelings change? Can you explain how these changed?

Yes, I feel less anxious at times.

What did you gain from these intervention sessions?

Participant A: Finding myself again. Not feeling guilty when I do not get to everything, facing life.

Do you have a support system?

Participant A: Yes. Dad, mom and in-laws.

How do you see yourself?

Participant A: More self-confident and less apologetic.

How do you see the road ahead?

Participant A: Still difficult but will get there.

Would you recommend these intervention sessions for other people? Why or why not?

Participant A: Yes, life is so hectic and nasty. A trauma can easily make you lose yourself, especially if it is a longstanding trauma.

Do you have any recommendations for the presenting of this programme in the

future?

Participant A: Voluntary group sessions can work, because it can extend your support system.

6.3.2 PARTICIPANT B

Age: 44

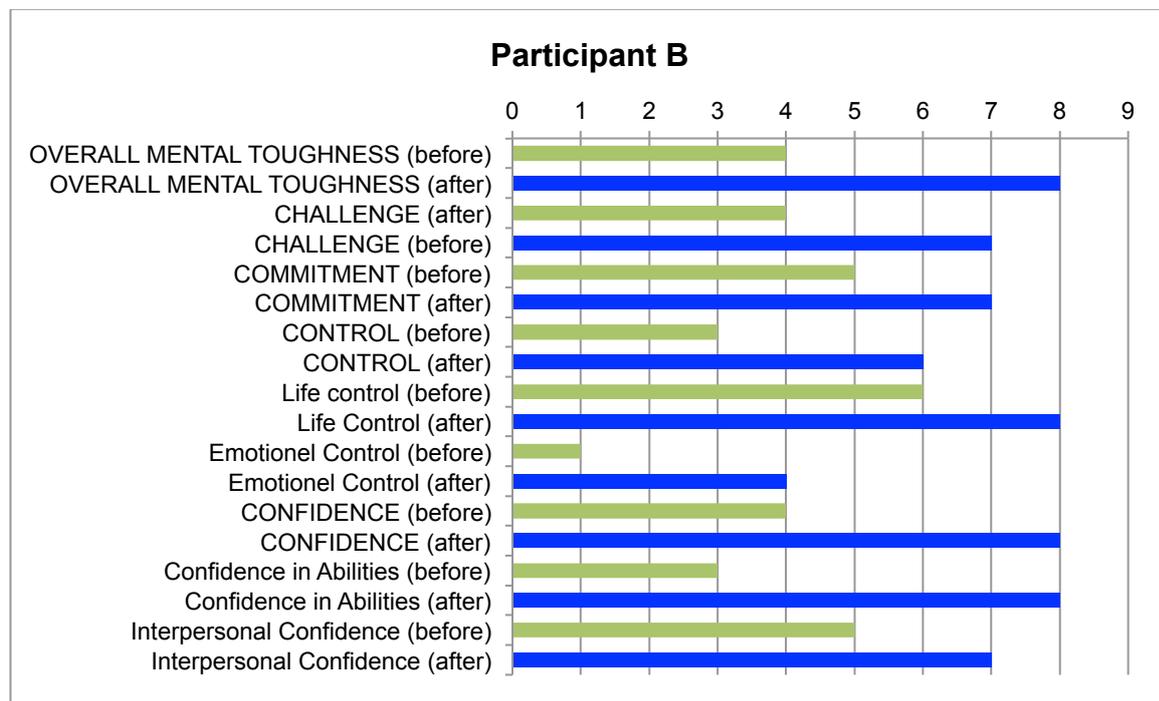
Gender: Female

Occupation: Executive personal assistant

Trauma: Parents' divorce. She has been married and divorced twice and her second husband physically abused her.

QUANTITATIVE RESULTS (MTQ48)

Graph 6.2: Participant B. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant B. *Semi-structured interview (qualitative) when receiving feedback of MTQ48*

Participant B was shocked to see how low her emotional control was (sten one lowest end of MTQ48 scale). Her confidence in her abilities (sten three under average) also

came as a surprise, as she thought that other people see her as more confident. She explained that she tries to maintain an image of high self-confidence, but she knows deep down inside of her that she is very unsure of herself.

Table 6.2: Participant B's qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Emotional control	<ul style="list-style-type: none"> - Parents' divorce - Forced separation from mom in high school (mom lived in London and she, dad and step-mom moved to South Africa). - Bad relationship with step-mom - Never allowed to say how she feels - Never allowed to voice her own opinions
Confidence in abilities	<ul style="list-style-type: none"> - Parents made decisions for her. Never acknowledged her as individual person - Dad and step-mom constantly told her how bad she is, what a stinking attitude she had and how troublesome she made life for them - Feels guilty about rebelliousness as teenager and hatred against step-mom
What's her highest scores	How she confirmed these scores
Life control	<ul style="list-style-type: none"> - To feel in control she has learned to be perfectionistic. - She manipulates the people at work as well as her teenage daughter by losing her temper regularly in such a way that they have become scared of her and rather back off.
Commitment	<ul style="list-style-type: none"> - She believes and has proved over the years that no matter what happens and how difficult it is, she will not give up, but will show others that she can deal with the situation.
Interpersonal confidence	<ul style="list-style-type: none"> - She usually gets along well with other people (she started to rethink this as she realised that she can emotionally manipulate people and gets along with others less well than she thinks).

SESSION 2: Participant B. *Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started*

METAPHOR: The participant chose to describe a small box with a lid on it with a golden crown inside. Participant B felt that people do not realise her value and potential and she is actually full of surprises, but she does not allow many people to come close to her as she is scared of getting hurt.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What kind of trauma have you experienced?

Participant B: Parents' divorce. Two marriages and divorce myself and second husband physically abused me.

What makes you feel that you are not coping with your trauma?

Participant B: “My tendency to fly off the handle and lose my cool badly when things don’t go the way I expect”.

How did trauma change your life?

Participant B: Undermined my self-confidence and I have feelings of inner rage and anger.

How do you cope with trauma?

Participant B: Rage, shout, cry, eat, sleep.

How did your trauma change your relationships?

Participant B: I tend to scare people into submitting to my requests.

How do you see yourself?

Participant B: Sometimes small, sometimes confident, sometimes moody, sometimes in control, sometimes fun, sometimes serious.

What are your negative characteristics?

Participant B: Quick temper, sometimes negative outlook.

What are your positive characteristics?

Participant B: Sense of humour.

Do you have a support system?

Participant B: Yes. Friends, parents, boyfriend.

What is the best thing that you’ve ever accomplished?

Participant B: “Bringing up my daughter, who at 13 is far more mature and confident than I was at an older age”.

What expectations do you have about this individual therapy programme?

Participant B: “I want to discover why I feel the way I do so that I can make positive

changes in my life”.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Negative experiences that changed into positive experiences: Participant B explained that moulding a clay representative of myself made me feel uncomfortable. She did not enjoy the realisation that she was not as mentally tough as she initially thought. However, her realisation during this painful activity that she has value was a cherished discovery, because deep down inside Participant B feels worthless.

SESSION 3: Participant B. *Trauma’s effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Anger (red) in throat, heart and at back of head (burning sensation as if skin is on fire), which occur when Participant B is humiliated at work.

Frightened (black) under breasts, as Participant B feels defenceless, and these feelings started when her second husband physically abused her.

Jealous (green) in breath (holds breath); Participant B explained that when she feels insecure or when she is scared that her boyfriend and daughter will reject her, she becomes jealous.

Happy (yellow) in head and chest; Participant B feels happy when there are moments that she is financially stable. She also feels happy when she is on holiday and can relax (felt in her head and chest). Participant B doesn’t often relax, as she has been a single parent for almost 11 years, which is a huge responsibility and heavy load.

Excited (purple) in chest; Participant B bought concert tickets for the teen-sensation “One direction”, which her and her daughter will attend in 2015.

Proud (pink/white) in chest; Participant B is proud of her daughter who is 13 years old, because she has confidence and performs well at school. She is also proud of herself as single parent and in what she has achieved professionally, which is design and manage companies’ websites and often she receives very good feedback.

Conclusions: Participant B experiences most of her feelings situated in the chest and

stomach areas. She has struggled for most of her life with a problematic digestive system, including an ulcer. A possible reason for these health challenges may be suppressed emotions and constant conflict between her, her dad and her step-mom.

When we discussed what happened in her brain during the trauma of her physical abuse, Participant B explained that she always believed that she was pathetic to just close her eyes when her husband sat on top of her and started hitting her the first time. During the discussion, we concluded that she could not fight him, as he was physically too strong, and she also could not flee, as he locked her up inside the room. She froze by closing her eyes and it served as a protective mechanism. Participant B experienced tremendous relief by realising that closing her eyes was her brain's way to try to protect her and that she was not pathetic as she has punished herself for believing for all these years.

THE "SELF"

Interferences and/or negative events in Participant B's life are and were her parents' divorce, the move to England and subsequent re-location back to South Africa, her mom and dad's extra-marital affairs, her bad relationship with her dad and step-mom, her own failed marriages, as well as the physical abuse endured from second husband, and being a single mom. These interferences led to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person). Participant B's adapted self often displays aggression and rage and uses overeating, suppression of emotions and the struggle to control emotions, as well as anxiousness, perfectionism, and negative feelings like "I am not ok" to survive. Her **ideal self** would like to be more relaxed, less serious and to better control her negative emotions.

ACTION RESEARCH EVALUATION QUESTIONS

Negative Experiences: Participant B did not like experiencing old emotions which she thought she had gotten over. These emotions were brought back and she realised that she had not dealt with them properly.

Positive experiences: She is relieved that she finally understands why she overreacts in certain situations; it's due to her my low emotional control. In learning that Participant B could not have done anything to change or prevent the abuse from her ex-husband, she understands that freezing during the abuse was her brain's protection strategy, and

she now feels empowered instead of pathetic.

SESSION 4: Participant B. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

PROTECTING SHIELD

Participant B identified her positive characteristics which become part of her protecting shield; she identified her sense of humour. Her negative characteristics are her quick temper and her sometimes negative outlook on life.

ANCHOR OUTSIDE TRAUMA

Participant B's anchors where she feels safe include the bushveld, reading, "googling", drinking tea, playing around and laughing (like children) with her daughter and/or boyfriend, to look at and touch her potato peeler (this is something she and her mom have as a common denominator; they are both good cooks and often make jokes about it to decrease their emotional distance).

PROSPER

Participant B easily becomes emotionally upset if things do not transpire according to her expectations. She has a tendency to become very low and she does not know how to get out of it. Listening, practicing and visualisation of her goals will help to anchor herself outside the emotional situations where she throws tantrums, feels sorry for herself and acts like a small child to gain control over other people by scaring them. Re-entering emotional situations in Participant B's situation implies that if she differs in opinion from her boss or people at work/or her child at home, it is important that she literally walks out of the situation and does the breathing exercises and looks at the photo of her prosper poster, which she programme as her mobile phone/computer's screensaver. Participant B will also start to focus on things that she can control, which are her thoughts and behaviour and when she starts to feel sorry for herself, she can stop "feeding" her negative feelings by rather focusing and replacing these self-pity feeling with her energising visualisation pictures.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Positive experiences: Participant B realised that becoming very low, feeling sorry for herself and thinking others do not understand her has been a way to deal with trauma

which happened in my past, both as a child and as an adult, but in the process she just became more depressed. Now, she has practical ways to “get out of my hole”.

SESSION 5: Participant B. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

VISUALISATION POSTER

Participant B researched her favourite places on the internet (bushveld, nature, mountains, sea, sunsets, personal photographs, etc.) and made a collage with a very relaxed ambience. She seems to be well aware of her senses, as she explained: “*When listening to the prosper CD, bushveld silence vibrates in my body, I smelled the wet ground, it was like touching the horse’s hair and mane with my hands*”. Instead of pulling herself down and feeling sorry for herself when she gets emotional, frustrated, irritable and tearful she invested time to listen to prosper, which helped her to calm down and she fell asleep. She explained that looking at her poster makes her feel free. She realised that she had not included a photo of her dad, but she decided that while she loves her dad, she never feels safe with him.

DEFENCE MECHANISMS

Participant B experienced feelings of inferiority (she does not have university qualifications), withdrawal (when emotionally overloaded), regression (tends to return to an earlier stage in life by throwing tantrums like a child and manipulates people to gain control; probably because she was never allowed to show emotions and voice feelings during her upbringing). She felt controlled by her dad and step-mom and at last she can now control them as well as other people. Repression is the repressed feelings of rejection from her mom (her mom forced her to move back to South Africa with dad and step-mom), dad and stepmom (she was a rebel and they always told her how difficult she made their lives) by escaping into story books. Participant B has realised that her self-confidence is not as good as she thought because she readily manipulates people. She also has tendencies towards binge eating.

PARTICIPANT B’S “BAG” OF WHO I AM

In the bag, Participant B has a bunny-skin jacket (this appears to be a foundation as belonged to great grandmother and grandmother), a potato peeler (explained in paragraph “anchor outside trauma”), a pottery hedgehog which she made in primary

school when her step-mom took her along to a pottery class (she has realised that there was one thing that she enjoyed doing with her step-mom), a photo of her daughter (she is very proud of her daughter, as well as of being a single mother), her dog's vet certificate (the dog snores like pig, which makes her laugh), cards and letters from her daughter over the past years (which Participant B read to me – and it is clear that her daughter must indeed love her), marketing certificate from USB (she continues to feel disadvantaged and inferior because she does not hold a degree, but she has realised and acknowledged her excellent computer skills and feedback from clients in her role as a personal assistant), her cellular telephone (she loves technology, computers and webpage writing in her job), second husband's engagement ring (huge and beautiful diamond, although he abused her, she never thinks of it, she really likes the ring very much).

FIRST-AID KIT

Participant B put the following aids of how to be good to herself in her first-aid kit: read, go to the gym, play with dogs, draw, cook, prosper, play and joke around with her daughter and/or boyfriend.

ACTION RESEARCH EVALUATION QUESTIONNAIRE

Positive experiences: Participant B felt relief when she learned to react in a different way and to change her behaviour. She has also realised that the truth is a blessing and it opens up doors, and that she can control her negative thoughts.

SESSION 6: Participant B. *How to fill up my “empty bucket” although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case, a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description).

Participant B wrote down her positive characteristics again (it was done in Session 4, see “protective shield”) and put it in her jewelry box to be constantly reminded of her

valuable gifts and to make sure that she would use them. She added the following characteristics, and said that she hasn't been able to do this three weeks ago, loyal, caring, analytical, good mom. She realised the value of knowing her positive characteristics and the role it plays in her well-being.

ACTION RESEARCH FEEDBACK

Positive experiences: Participant B explained that she understood the contributing power that focusing on her positive characteristics has on her well-being. She can improve her energy through self-affirmations. Realising that taking the responsibility and making small daily changes can have a large impact over time – it's easy to do, but also easy not to do.

SESSION 7: Participant B. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant B's dominant ego states are the parent and then the adult. If emotionally upset, she becomes the critical parent. She has become much more nurturing and less critical parent since she started to understand her repression and regression as defence mechanisms and learned why it is difficult for her to control her emotions and how to better control them. She has realised that she needs to spend less time working (even during evenings and weekends) and to develop the free child, to teach her 13 old year daughter (who also has tendencies to exhibit stress) how to be a free child as well, because previously Participant B could also have been classified as an adapted child (a character that moans, whines, feels sorry for self, and perceives herself to be the black sheep).

TRANSACTIONAL ANALYSIS

Participant B recognised herself in the "I am ok" and "you are not ok" category, as she is judgemental and finds fault with her boss and colleagues at work, as well as with her daughter. She crusades against her daughter who is less organised and perfect than she is.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant B's sand picture represented her **past** life as follows: she lived happily in England with her mom, step-dad, two brothers and dog. Her dad forced her to move back with him and her step-mom to South Africa. She had no choice and still cannot understand why her mom gave her no choice; her mom never talked about it. She was very sad and unhappy in South Africa, and she lived on a plot, had no friends, felt sorry

for herself and read to escape. On the plot there were many of snakes, scorpions, locusts, and she hated it. She never got along with her dad and step-mom. They had a baby together, and she had to baby-sit when they went out. Her dad and step-mom always told her about her bad attitude and her difficult behaviour and she did not dare to say something. There was no relationship and caring between her and her parents. She always had a knot in her stomach, and felt depressed. She liked swimming and walking on the plot. (When she retold the story in the session, Participant B became very emotional). Her dad and step-mom encouraged her at age of 18 to move in with her boyfriend, and their readiness to get rid of her shocked her. She could never understand why her own mom did not “rescue” her. Her mom had an extra-marital affair. Participant B realised during the session that her mom could never face her own emotions and, until today, cannot talk about emotions (she suppresses it). Participant B’s **present** consists of herself, her boyfriend and daughter. They are happy together, have fun, feel free and give each other space; they like to be outside. In the **future** she sees her and boyfriend together as retired and financially free. She sees her daughter as a strong woman with a strong partner who loves her and maybe there will be a little baby one day.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant B explained that she is more at peace because she now better understands herself, due to her mom’s own negative childhood years. Her mother’s way to deal with her hurt was not to face her emotions, but rather to avoid it. This is possibly why her mother never came to her rescue from her terrible step-mother.

SESSION 8: Participant B. Feedback on post-test MTQ48 and semi-structured questionnaire

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant B’s overall mental toughness improved from a sten of four (average) to an eight (above average). Her emotional control increased from a score of one (lowest score on sten scale) to a score of four (average score).

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant B: I realise that if I change my attitude, it can also change situations around me. I have started to consciously remind myself to relax.

What have you learned about yourself?

Participant B: I'm over-anxious and have a low level of emotional control. This ties up with incidents that have happened in my life. Learning why I am reacting the way that I do gave me relief, as I'm very hard on myself. I can undo this negative behaviour and it brings relief.

What do you do differently in your everyday life?

Participant B: Using my coping techniques for times when I'm anxious. Learning to relax more and enjoy life, try to bring out my inner child and have fun.

What have you learned about your trauma?

Participant B: I could not control what happened to me. Biggest eye-opener: learning that the body has three ways of coping with trauma. My body froze during the abuse.

Do you think that you are coping better with your trauma?

Participant B: Yes. I also believe that it will take quite a while to settle in my mind, but I'm willing to be patient; know that the result will be positive.

What makes you feel that you are coping better now?

Participant B: Huge sense of relief. I'm more patient with myself and happier within myself.

Have any of your relationships changed? How did it change?

Participant B: Relationship with my daughter and partner moved to higher levels due to my increased patience with myself and more positive outlook on life. It's reflected in the way that I speak to them and how I handle conflict with them.

Did your feelings change? Can you explain how it changed?

Participant B: Yes, I feel happier and more positive because I now know that I can do something positive about myself and become less negative.

What did you gain from these intervention sessions?

Participant B: Extremely insightful. I'm analytical, so I took everything that I learnt to heart, no matter how hard it was. I examine the information given to me and use it to my best advantage.

Do you have a support system?

Participant B: Yes. My partner, parents and friends.

How do you see yourself?

Participant B: Serious, loyal, good sense of humour, loving, hard-working, never gives up!

How do you see the road ahead?

Participant B: On my way to more positivity and fun in life. Hopefully a less stressful one as I learn to relax more.

Would you recommend these intervention sessions for other people? Why or why not?

Participant B: Absolutely. The value I gained from them is so positive. I am grateful to Marisa for the opportunity. I never thought that it would be this helpful. I think that if a person is willing to have a hard look at themselves and willing to make changes that this intervention will be immensely successful, but they have to be willing to change.

Do you have any recommendations for the presenting of this programme in the future?

Participant B: Not really as I'm certainly no expert in this field. I am very much guided by Marisa's expertise.

6.3.3 PARTICIPANT C

Age: 62

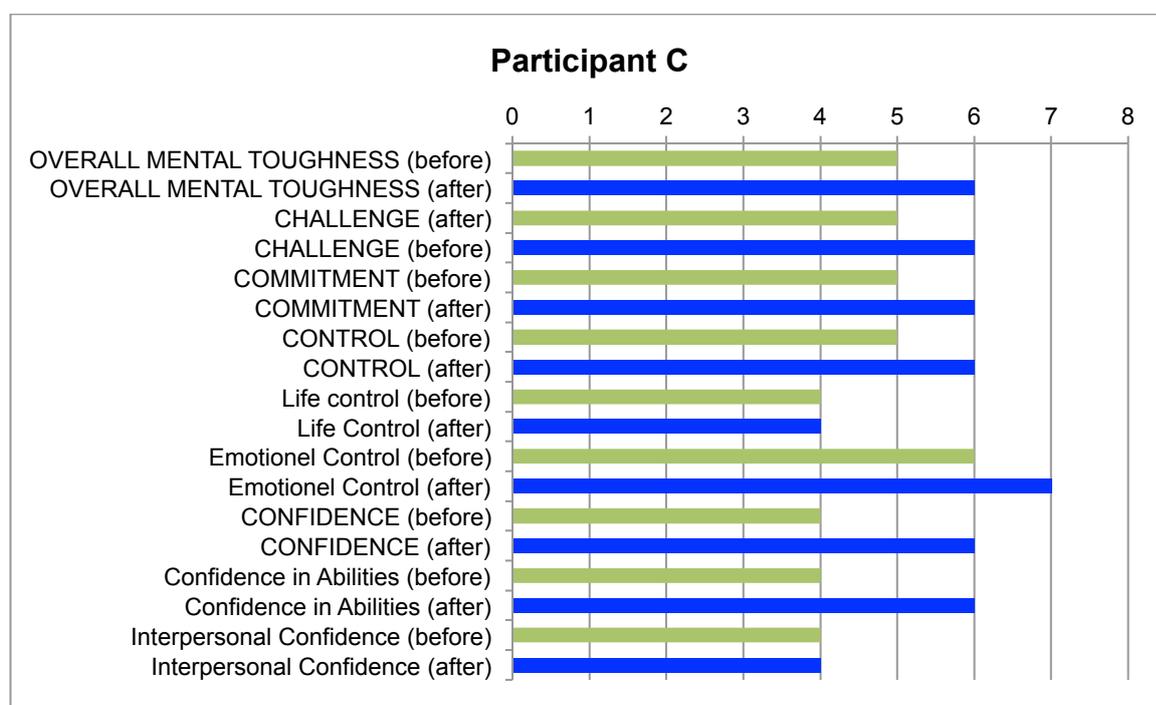
Gender: Female

Occupation: Housewife with care centre for pre-schoolers at home.

Trauma: Husband’s death due to prostate cancer (8 months ago, Sept 2013) and youngest daughter lost a baby at 25 weeks (July 2012) and also had another miscarriage after that.

QUANTITATIVE RESULTS FROM MTQ48

Graph 6.3: Participant C. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant C. Semi-structured interview (qualitative) when receiving feedback of MTQ48 (quantitative)

Participant C’s overall mental toughness has a score of five which is average. She did not know what to expect from the MTQ48. After 8 months she’s still very emotional.

Table 6.3: Participant C’s qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Life control (score 4)	- Husband’s death 8 months ago; saw how he deteriorated in past three years (he was brave and positive). - Alcoholic son in law. Scared that daughter and grandchildren may

	get hurt, e.g. in a car accident due to drinking. Husband had always talked to and dealt with son-in-law.
Confidence in abilities (sten 4)	<ul style="list-style-type: none"> - Husband was there to make decisions - Could always lean on his support when she made decisions - Grew up in generation where men were “decision makers” and women the “submitters”. - Doesn't belief enough in herself as person.
What's her highest scores	How she confirmed these scores
Emotional control (sten 6)	- She usually is a cool, calm and collected person and can control her emotions.

SESSION 2: Participant C. Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started

METAPHOR: Flower who loves the garden and birds. It needs attention, nurturing and water. The protector (big plant) has been taken away. Now lack of care as big plant protected her. Her dream is to bring other people joy and wants to stay beautiful for long time.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

Myself: What kind of trauma have you experienced?

Participant C: Husband's death 8 months ago due to prostate cancer.

Myself: What makes you feel that you are not coping with your trauma?

Participant C: It's difficult for me to be alone at night. I'm scared to go home after an outing (due to safety issues in our country). Certain days it just feels as if everything goes wrong.

Myself: How did trauma change your life?

Participant C: Husband was handy man and could fix everything. Difficult to count on others now.

Myself: How do you cope with trauma?

Participant C: Go on with my after care centre.

Myself: How did your trauma changed your relationships?

Participant C: It had no influence.

How do you see yourself?

Participant C: Good mother and grandmother.

What are your negative characteristics?

Participant C: Impatience. Can talk before I think.

What are your positive characteristics?

Participant C: Love children. Get along well with other people.

Do you have a support system?

Participant C: Yes. My three children, friends, neighbours.

What is the best thing that you've ever accomplished?

Participant C: To walk a 21 km race.

What expectations do you have about this individual therapy programme?

Participant C: I hope it will help me to better cope with my husband's death.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant C enjoyed the clay exercise she was quite nervous about what to expect. It made her feel more at ease - as she did not sleep well the previous night in anticipation of the session.

SESSION 3: Participant C. *Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Sadness (blue) in eyes, heart, chest and head, as she is saddened by memories of her husband when she sees happy couples together.

Scared (black) in head, because Participant C is scared to enter the house on her own, as she is aware of the high crime rate.

Jealous (green) in head, because she feels jealous when she sees other couples

together.

Happy (yellow) all over body, as Participant C experiences happiness when she's with her children and grand-children, as well as when she thinks of the beautiful memories of her husband.

Excited (purple) all over body; she loves sunshine, her children and grand-children.

Proud (pink/white) in head and heart; Participant C is proud of her children and grand-children. She is proud of herself for surviving the past eight months. She has had to make decisions to sell three vehicles in the past few months, and it was difficult as she felt that she tore away a part of herself (good camping memories with husband and the "bakkie"- a type of Light Delivery Vehicle in South Africa).

THE "SELF"

Interferences and/or negative events in Participant C's life is and was her husband's death, her daughter's miscarriages, her son-in-law's drinking problem, the decisions about the daily management of her business (while her daughter does the admin, she still needs to make decisions which have a direct influence on her future finances), hearing how a car hit her dad in front of their house as a small girl, her own dad's death in 1993 due to prostate cancer and her mother's colon cancer during same time (her mom is now 83 years old). These interferences have led to an **adapted self** (in order for the ego to still feel good about itself and for her to be able to cope as a person). Participant C's adapted self includes worrying excessively, experiencing self-doubt and struggling to make decisions. Her **ideal self** would like to be more relaxed, less dependent on her children to make decisions, and to have the confidence to talk to her son-in-law about his drinking problem.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant C explained that it was quite interesting to categorically "see" the different emotions in her body, and now she's aware that those emotions are really there. She is now aware of the way her husband's death has changed her feelings, behaviour, emotions as well as physical parts of herself. She has sometimes wondered if there was something wrong with her, as she tends to forget things easily. She constantly feels very emotional and her appetite has changed - although it's getting better.

SESSION 4: Participant C. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

PROTECTING SHIELD

Participant C found it difficult to identify her positive characteristics and became nervous. Her negative characteristics include impatience and irritability in traffic and sometimes with the children of her day-care centre and forgetfulness (especially after husband's death). She needed encouragement and support to identify her positive characteristics, which becomes part of her protecting shield. These include loyalty, kind-heartedness, getting along well with people, loving people, and reliability (and I added courage to her lists to achieve what she did the past eight months and to keep on going). From participant C's background and generation, it has generally been unacceptable to dare to mention or focus on positive characteristics, as it indicates arrogance. After a long discussion, Participant C realised the importance of positive self-talk and appreciating herself.

ANCHOR OUTSIDE TRAUMA

Participant C's anchors where she feels safe is with God (she said that she felt slightly forced by her conscience to put Him first), at home, with her children and grand-children, with friends, when she welcomes the children in the morning at her day-care centre, working in her garden and her mother. She actually admitted that her relationship with God has changed, which was quite difficult for her, in that she's angry with God for taking away her husband. She feels guilty about her anger towards God and again, for someone from her generation it is unacceptable to be angry with God. After our discussion she felt relieved that it is normal for her as a traumatised person to be angry at God. She was even more relieved to realise that she can tell God about her anger and completely open her heart to him and that He will not be angry at her. She also realised that she has new identities (e.g. widow, single woman, and single mother) after her husband's death, which explains why her relationship with God has changed.

PROSPER

Listening, practicing and visualising her goals (at least three times a week) will help to anchor Participant C outside the intense sadness, after her husband's death, which overwhelms her at times, and then she can gradually re-enter it in more controlled ways.

Re-entering in Participant C's situation implies that even though she cannot take away the sadness, she can start to focus on things that she can do to make herself feel better. Her homework was to compile a visualisation poster of positive ways she sees herself and how she will achieve goals.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant C admitted that it was the first time that she had the courage to say that she was angry at God for taking away her husband and that she feels guilty about her feelings. She explained that it's a relief to know that it is normal to experience these angry feelings and that she can share it with God. She also became aware of her feelings of irritability and why she sometimes gets more impatient than she did in the past with the children in her day-care centre.

SESSION 5: Participant C. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

VISUALISATION POSTER

Participant C made a very creative collage and/or poster and said it felt like it soothed her pain when she did it. Her poster consisted of the following: A dark corner marker 2013 indicates her husband's death, her daughter's miscarriages and her aunt's death, while it has a little light on the horizon as she knows it will come through again. Family, friends, camping, hiking, seaside and beach followed. Then the words "two are better than one" as life was easier and better when her husband was still alive, BUT then she added the words "I am responsible for my own happiness" (she explained it as a hard reality but true nonetheless). She also added phrases like "get out in nature", "happiness", "eat healthy", "fun", "gardening", "friendliness", "love" and "sunshine". She also added to the poster an image of her GPS, which gives her direction. It symbolises her friends, the Bible as well as her prosper poster.

DEFENCE MECHANISMS

Participant C has the following defence mechanisms: pretends that it is going well with her, while it often it not the case, as well as withdrawing. She explained that she and a friend had a small argument as friend says she withdraws. Participant C tried to explain to her friend that it is difficult feeling like a third wheel on the wagon without her husband. Participant C realises that her friends (she has very close life-long friends) still care and

want to mean something to her, and that she has to allow them to feel that they are valuable. Sometimes it is necessary to force herself to accept an invitation from a friend and to tell herself that feeling like the third wheel on the wagon is not true and she is not going to allow herself to feel that way.

PARTICIPANT C'S "BAG" OF WHO I AM

In Participant C's bag, she has the following: a walking trophy that she received when she completed the Namaqualand Ultra Echo Marathon, her camera as she is sentimental and likes to take photos, her perfume (Flowers of Kenzo), she loves flowers and gardening and her metaphor is a flower (flowers energise her), photos on her husband's bedside table of their children (they were and remain a close family who love camping and nature), a fine crochet handbag which her mother made her (before she got Parkinson's Disease), her favourite story books from Irma Joubert and Deon Meyer, her husband's funeral letter and beautiful photos which her children compiled, her favourite CD (Jak de Priester) and her husband's Bible (she said he read it through many times and it comforts her to know he's with God).

FIRST-AID KIT

Participant C put the following aids of how to be good to herself in her first-aid kit: gardening, going for walk, phoning a friend, reading a book, eating a fruit, listening to music, visiting a neighbour, doing something for a person who cannot do it for him/herself (e.g. shopping for a friend who recently had an operation).

ACTION RESEARCH EVALUATION QUESTIONNAIRE

Negative experiences that changed into positive experiences: Participant C discovered her defending mechanisms were an emotional experience. She learned that she used to pretend that things were fine, although they sometimes are not, had been a defence mechanism since she was a young girl ("used to hide my true feelings and uncertainties"). **Positive experiences** included that she found it encouraging and affirmative to know that her strong support system (life-long friends and children) love her and they want to be there on this painful road to support her. She just has to allow them to do it.

Her mother had a hip replacement the previous week and Participant C did not feel like visiting her that night as she felt emotionally drained, but when she looked at her first-

aid kit, she realised that she had no choice and went to visit her mom, because she had been waiting for Participant C the whole day and she could light up her mother's life.

SESSION 6: Participant C. *How to fill up my "empty bucket" although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case, a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant C was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant C believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her "tick" and "dance", she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. Participant C had to write down her positive characteristics again (it was done in Session 4, see "protective shield") and put these in her jewelry box to be constantly reminded of her valuable gifts and to make sure that she would use it. It was still challenging for her to write down her positive characteristics, but it went better this time.

ACTION RESEARCH FEEDBACK

Positive experiences: The practical skills that Participant C uses, helps her tremendously. She gave an example when she drove to meet up with me, the traffic was heavy and she was running late and she started to work myself up. It struck her like thunder about what we had discussed about breathing deeply and laughing when she blows out her breath. Then she realised there is no use in getting worked up, as it will only influence her attitude to be bad for the rest of the day and she wants to be the best for her day-care kids.

She mentioned that she's really tired at night and does not have energy to read too much or to do needlework, but looking at and unpacking her bucket with all the aids

helps her to better deal with her lonely nights.

SESSION 7: Participant C. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant C's dominant ego states switches between the parent (nurturing) and the child (adapted) child.

In her role as "teacher" at the day-care centre at school, she is a lovable, caring, nurturing parent. In her role at home she becomes the child who feels sorry for herself, she whines and thinks she's the black sheep. We focused her attention on the aspect that too much of the nurturing parent can become suffocating. She wants somebody to love and who can love her in return, and therefore she needs to be aware of not becoming desperate and suffocating. She needs to develop more of her free child and therefore she will make use of her first-aid kit to laugh and have more fun.

TRANSACTIONAL ANALYSIS

Candidate C recognised herself in the "I am ok" and "you are ok" category. She is sometimes judgemental and finds fault with others, but she is aware of it and attempts to appreciate others for who they are.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant C's sand picture represented her past life as follows: her husband and three children. They often visited the National Parks; they liked camping and nature, they were a close family, and they laughed a great deal. Her husband was a nice man, a wonderful handy man and had a fighting, optimistic spirit until the end. Her **present** is represented by her and her three children. It is quite an empty world as the main focus is on adapting without their dad. The previous Sunday they had been together and missed him tremendously; they spoke about him, laughed much and also cried about him. Her **future** is represented by all her children and grand-children (who are already born now but not in her present, most probably as the main focus for her is still to gain new identities and to try to adapt). They enjoy it to be together, they spend a lot of time outside, laugh a great deal and are a happy family. Participant C sees herself in the role of the head of her family in the future and now, at present.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: After a busy day with her day-care group, Participant C enjoyed working with the sand.

SESSION 8: Participant C. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant C's overall mental toughness improved from a sten of five (average) to a six (average). Her confidence in her abilities improved from a sten of four (average) to a sten of six (average). Her Life Control still has a sten of four.

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant C: I feel that I can go on with life again and I am going to put in an effort to be positive.

What have you learned about yourself?

Participant C: Gained knowledge about trauma's effect on my body. It influences me physically, emotionally and affected my behaviour. I better understand myself and my reactions and realise that I am not crazy (e.g. by forgetting things easily), but it is my brain's way of shutting down the systems that are not crucial for survival. I feel that I can go on with my life again and I want to do it.

What do you do differently in your everyday life?

Participant C: I've put up my visualisation poster against my wall and look at it every day, I read through my self-talk at least once a day. I've put my bucket where I can see it and take it out when I am alone at night to keep my mind focused on uplifting things.

What have you learned about your trauma?

Participant C: I cannot take away my trauma, but I can use practical things, like anchors and my first-aid kit if things tend to get too much and overwhelm me.

Do you think that you are coping better with your trauma?

Participant C: Yes. I have all these practical aids to support me and I understand myself much better.

What makes you feel that you are coping better now?

Participant C: It is easier to drive at night and I am less scared. I ensure that a friend, or my children know when I will be on the road at night and how late I will be home. We “check in” with one another then.

Have any of your relationships changed? How did it change?

Participant C: Yes, my one friend who told me that I am withdrawing from her and other people, now know that I sometimes feel like a third wheel on the wagon. I can share it with her and she can support me to not feel sorry for myself, but to force myself to go out.

Did your feelings change? Can you explain how it changed?

Participant C: No, I still mourn my husband’s death.

What did you gain from these intervention sessions?

Participant C: I’ve learned to feel good about myself again. One aspect was that I was forced to find my positive characteristics and to appreciate myself more. I feel more capable to face the future.

Do you have a support system?

Participant C: Yes, a very good one. Children, family, friends.

How do you see yourself?

A good mother, grandmother and head of my family.

How do you see the road ahead?

Participant C: I really miss my husband a lot. I know there will be difficult times in the future, but I look ahead with much more positivity and new practical skills to use.

Would you recommend this intervention sessions for other people? Why or why

not?

Participant C: Yes. It helped me to better understand myself and my emotions in my traumatic situation and it feels as if I'm coping better.

Do you have any recommendations for the presenting of this programme in the future?

Participant C: No.

6.3.4 PARTICIPANT D

Age: 34

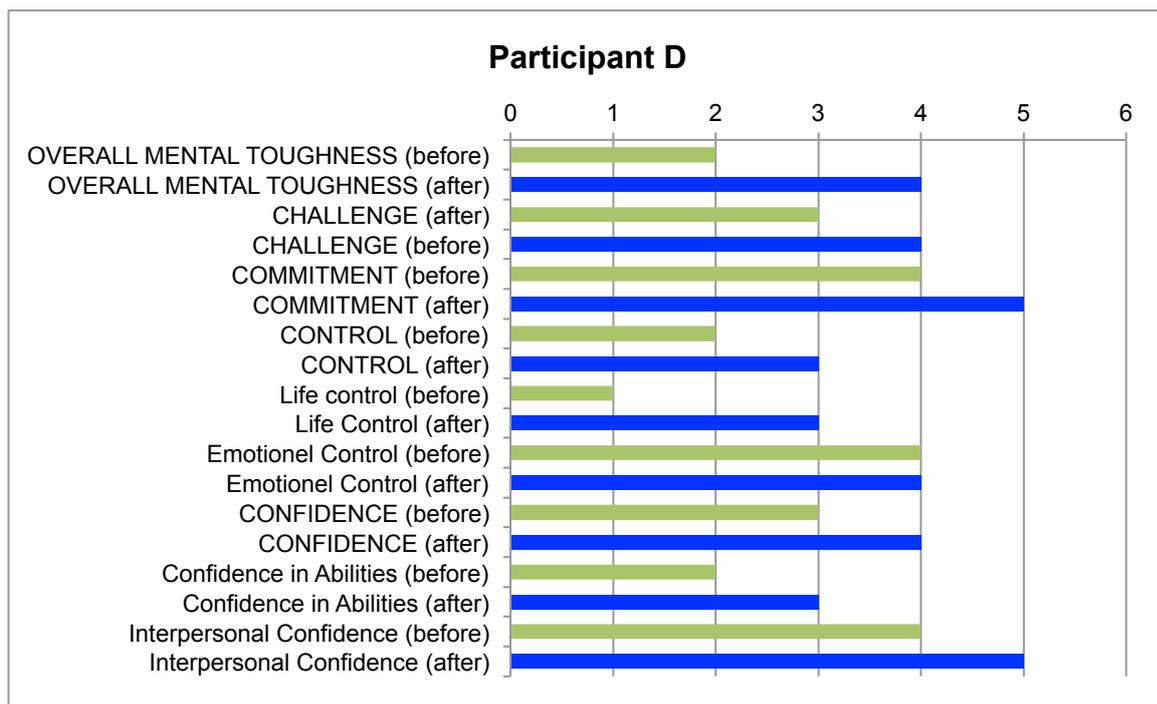
Gender: Female

Occupation: Radiographer (busy with PhD).

Trauma: Post-natal depression (her son is two years old, and suffered from bad reflux issues and underwent operations).

Re-traumatised: At time of therapy, her son was scheduled for another operation within two weeks' time, and she was terrified.

Graph 6.4: Participant D. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant D. Semi-structured interview (qualitative) when receiving feedback of MTQ48 (quantitative)

She expected to have low mental toughness scores (overall score sten two) as she feels extremely low emotionally and she is physically tired as she has not slept through the night for two years.

Table 6.4: Participant D’s qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Life control (sten 1 below average)	<ul style="list-style-type: none"> - Son is two years old, premature birth, born with reflux, several operations, tonsils removed, ear infection, asthma; she has never slept through for 2 years. - Traumatic birth, son in ICU first 24 hours, she had high blood pressure, could not breathe properly, during epidural her intestines were accidentally punctured by the doctor. - She has gained weight, feels negative about body, does not want husband close to her. - Does not find enough time for studies.
Confidence in abilities (sten 2 below average)	<ul style="list-style-type: none"> - One of twins, sister academically stronger, parents and teachers always compared them, she felt inferior and rebelled, parents experienced her as difficult child, sister was the good one. - Sister finished with doctorate and she’s still busy. Dad also has doctorate. She wants to show them she can. - <i>Always felt I need to prove myself.</i> - <i>Think I’m not good mother, other moms look happy and confident.</i> - No physically intimate relationship with husband for two years

	<i>I'm too fat and ugly now.</i>
What's her highest scores	How she confirmed these scores
Commitment (sten 4 average)	- Commitment is one of her strongest characteristics. Once committed, she will not let people down; strong perseverance. - Achieved good success in work and studies. Studied and worked for three years in England (again, felt pressure to prove herself).
Interpersonal confidence	- Gets along well with other people, wants to add value to others' lives.

ACTION RESEARCH EVALUATION QUESTIONS

Participant D has realised that she is re-experiencing the trauma of my son's birth again as his coming operation triggered those intense feelings and that she is not becoming crazy.

SESSION 2: Participant D. *Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started*

METAPHOR: Participant D used a house as a metaphor for her life. The house is strong and wants to be a safe haven and protect loved ones against rain and bad weather. The house's walls are and were shaken by the birth of Participant D's son, and the house no longer looks good; the walls are cracked, and it needs reparations.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What motivated you to take part in this research?

Participant D: The advertisement – I realise I have a problem.

What kind of trauma have you experienced?

Participant D: Post-natal depression.

What makes you feel that you are not coping with your trauma?

Participant D: Sleeplessness, stressed, tension in body.

How do you try to cope with your trauma?

Participant D: Anti-depression medication, try to organise life.

How did the trauma change you/your life?

Participant D: I feel guilty about what happened and that I am not a strong and good

enough mother. I feel emotionally numb.

How did the trauma change your relationships?

Participant D: No physical intimacy with husband since son's birth.

What kind of feelings do you experience?

Participant D: Lack of self-confidence, sadness.

What expectations do you have about this individual therapy programme?

Participant D: To gain more self-confidence and to realise I cannot change the past.

Do you have a support system at the moment? Who are these people?

Participant D: Yes. Husband, family (mom, dad, sister and brother).

How do you see yourself?

Participant D: Wife, mother and professional woman.

What are your negative characteristics?

Judging myself and negativity.

What are your best characteristics?

Participant D: Goal focused, self-disciplined, hard-working, friendly, creative, committed, caring.

What is the best thing that you have accomplished?

Participant D: To be able to expand my knowledge and qualifications in my career and to establish work-life balance.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant D realised that she has been through tough times and that she is only human and needs to be less hard on herself.

SESSION 3: Participant D. *Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Sadness (blue) in stomach (has ulcer), and heart, as she longs to have back her old life before son's birth, her and her husband have lost one another.

Shy (orange) in mouth and stomach. She wants to lower her long hair over her face to hide emotions, she does not want outside world to see that she cannot cope with son. She has a fat and ugly stomach after the birth of the baby.

Scared (black) in arms and heart, because she is scared her husband will leave her due to the lack of a sexual relationship between them. Her arms are empty, but she feels threatened when he comes too close (her body hurts and she is fat and shy of it).

Jealous (green) in head, stomach and eyes, as she is jealous when she sees moms and children who look happy together; moms seem to cope well and enjoy children and she does not enjoy it and neither copes with it.

Excited (purple) in whole body; her husband bought her a beautiful mother's day ring from him and her son, and wrote a special card, like the years before the baby's birth.

Proud (pink/white) in upper body and shoulders; she is proud of work and what she has achieved in her studies and when she worked in England. Because of these achievements, she can lift her shoulders and walk up straight.

Anger (red) in brain, hands, heart, as she wants to hit something, she has anxiousness, and she is out of breath.

Due to participant D's traumatic experience with her son's birth as well as not sleeping well and having postnatal-depression, her ANS seems to be continuously activated, even now that the danger of life risks are no longer present. It leaves her body actively aroused, and that may result in PTSD or symptoms thereof. It seems that participant D was not able to return to a homeostatic sense where she could calm down and relax after the traumatic birth (Keeton 2009: 4; James & Gilliland 2013: 154). The more the ANS is activated, the more the pattern is engrained and the ANS will continue to be activated (which is known as the PTSD cycle) (Scott & Stradling 2006: 29; 31). Participant D has received anti-depression medication from her GP for more than one

year.

THE “SELF”

Interferences and/or negative events in participant D's life are and were: her son's birth, her son's subsequent operation within two weeks, no good communication or sexual relationship with her husband after baby's birth, lived in shadow of twin sister, did not do well in school, grandmother said she's fat (she was not supposed to hear it); her sister used to diet because of Participant D being overweight, her parents experienced her as a rebel and problem child, she did not want to live anymore, teachers compared her to her sister, her dad lost job (she was in high school) and her twin sister moved away one week prior to this session (Participant D's twin sister has been a strong form of support in helping Participant D's with son). These interferences lead to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person): She says that she is fat and ugly, she is dumb, she experiences anxiety, she feels pressure to prove myself, she withdraws from husband, she says she is not good enough, she has depressed feelings and reactions, she is angry at her son, she is angry with her husband (fat body, emotional suffering), she feels guilty because of anger. Her **ideal self** would be to be more relaxed, to have life control, to be close to her husband again (emotionally and physically), to be happy and to lose weight and look good again.

Participant D is exhausted, and has black circles around eyes. We compiled a list of immediate things to get in place to support her: her parents (both work during week) would take care of her son the ensuing Friday night, she would buy her contraceptive pill immediately (as it probably adds to her hormone imbalances because she does not take it regularly), she will send her husband a list to buy needed groceries in week, she will play baroque music in bedroom to feel more at peace, she would need to put her son in his own bed as she has bought him a new bed (he was still sleeping in their room). My advice was to rather walk out of room and get fresh air when her son constantly cries, than having urge to hit him, scream into the pillow, or hit the pillow, or squeeze and feel clay dough; she also had to learn to say no at work for extra short notice work but Participant D has difficulty in saying no because she always wants to please others.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant D explained that it was time to attend to herself first

(like in an emergency situation in an aeroplane) and then she would be able to attend to others. She felt that she needed to start putting herself first and taking care of herself.

SESSION 4: Participant D. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

Participant D provided feedback on the previous week's implementation of immediate things to get in place. She allowed parents to take son, and he was happy and peaceful. For the first time in two years she and her husband relaxed at home, prepared food together and she told him about her physical issues and fears. It was decided between her and her husband that from that point onwards, their son would spend at least one night of the weekend at her parents' house for a sleepover.

PROTECTING SHIELD

Participant D identified her positive characteristics, which becomes part of her protecting shield as: hard working, perfectionistic, dependable, caring. Her negative characteristics include dwelling on past negative memories (see "the self"), feeling sorry for herself.

ANCHOR OUTSIDE TRAUMA

Participant D's anchors where she feels safe: taking a bath, cooking, applying make-up, hair care, string beads, go to favourite creative arts shop, decorating house and bedrooms, bicycling around block (she had not done that since her son's birth, so they bought a child carrier and would try together with husband) and walking around the block with husband.

PROSPER

Participant D felt that she lost all control in her life after the trauma around the birth of her son. As her brain's alarm system constantly tends to be in overdrive, she should be supported to learn how to calm down and relax again. Listening, practicing and visualising her goals (at least three times a week) will help to anchor herself outside situations where she constantly experiences emotional overdrive as well as hypersensitivity. Re-entering emotional situations in Participant D's situation implies that she needs to find a comforting place in her house where she can do the breathing exercises and visualise, smell, taste and feel her success in feeling more peaceful, and

having more self-confidence.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant D realised that she has to be more self-assertive at work and she has to start saying no for unplanned overtime working.

SESSION 5: Participant D. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

VISUALISATION POSTER

Participant D's poster included a confident working woman with the heading "the good wife", which implies balance between being a mom, wife and working woman. Her study leader for her Doctorate studies is her role model and Participant D wants to be like her. She believes patients share their life-stories with radiographers and she can make a huge difference to them. Her metaphor, the house, also appeared on the poster with stronger walls and was newly painted. Her son's third birthday party with cupcakes and treats she prepared were part of the poster, as was a woman relaxing at the seaside. This is a reminder of not being too busy to enjoy life. An image of wedding rings symbolise her desire to solidify ties with her husband again. A Velcro mat for her son's bedroom also appeared on poster, to prepare him and herself to eventually move him to his own bedroom.

Homework this week: Participant D has to ask her husband just to hold her tight at night (no sex); and they were to give one another a nice foot and/or body massage.

DEFENCE MECHANISMS

Participant D feels sorry for herself (feels that people don't appreciate her value), keeps on dwelling on negative things of past, displacement (takes out work frustration on husband at home), pretends to be in control (wants to show outside world I'm "ok", to get approval that she's fine), inferiority (against twin sister who had been the "model child"). A discussion followed and the outcomes were that Participant D need to learn how to be "ok" with herself, to love herself more, accept herself as unique person and give the "I'm ok" ticks herself.

PARTICIPANT D'S "BAG" OF WHO I AM

In Participant D's bag, she had a hair straightener (likes to take good care of hair and make-up), a little travel bag from Paris (she and her husband loved travelling and did loads before son's birth; they plan to go away in December if all goes well with son's operation), Ivoria perfume (she and her husband like it; it gives her confidence), a picture of a Christmas tree and lights (it's her favourite time of year), jewelry (tries to look after herself well), roll-on deodorant (always wants to feel and smell fresh), base coat of nail polish and lip ice (*"you'll never find me anywhere without it"*), a note pad (always busy to take notes), diary (she is an organiser). She discussed her constant organising, and it became apparent that it is one reason why she needs to feel like she has gained control of her life.

FIRST-AID KIT

Participant D put the following aids of how to be good to herself in her first-aid kit: coffee with friend (she does not do it that often and needs it), read (kindle), watch TV (record favourite programmes and watch in the morning when she works the 11:00 am shift), take a bath, beading, skype with sister (who moved away to other province), contact with mom, play, run around and laugh with husband and son. She needs to force herself to use her first-aid kit at least once a day (for the rest of her life); she'll add more first-aid items as time progresses, as she currently finds it difficult to be good to herself.

ACTION RESEARCH EVALUATION QUESTIONNAIRE

Positive experiences: Participant D really has difficulties sleeping and relaxing and she needs to put in real action with the prosper CD, in order to try to relax and to put her brain in an *alpha* state in order to be more receptive to the visualisation exercises.

Participant D had arrived at the realisation that small things in her life make her happy and she needs it to survive and enjoy life; for example, to have tea with a friend.

SESSION 6: Participant D. *How to fill up my "empty bucket" although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs. Many were unsure about how to do it.

The session commenced with revision of what was experienced and achieved during

the past five weeks. This was physically represented with an empty bucket together with either a gift box, a jewelry case, or a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant D was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant D believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her “tick” and “dance”, she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. Participant D had to write down her positive characteristics again (it was done in session 4 see “protective shield”) and put it in her jewelry box to be constantly reminded of her valuable gifts and to make sure that she would use it: caring, loveable, friendly, diligent, purposeful.

ACTION RESEARCH FEEDBACK

Positive experiences: Participant D shared that went to have tea with her friend the previous week, as she never makes time, and it made her feel positive and good.

She also did beading when her son went for his sleepover at her parents' house over the weekend. Her husband at last had time for some woodwork again. It felt a bit like they were back in the old days. She explained that they relaxed and had time to enjoy one another's company in a tidied house (no toys were laying around).

SESSION 7: Participant D. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant D's dominant ego state is the parent (nurturing). As indicated in her metaphor (house), she wants to protect and nurture her family. We discussed the possibility that too much nurturing can be suffocating. It is important that she should focus on learning to be good to herself and to focus more on her interests as well.

TRANSACTIONAL ANALYSIS

Participant D recognised herself in the “I am not ok” and “you are ok” category, as she

was always compared with her twin sister by her parents, teachers and friends.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant D's sand picture represented her **past** life as follows: happy childhood with dad, mom, sister and brother at the seaside. Brightly coloured flowers symbolise her parents' support and love. They always supported her, and as a family they loved to go and have ice-cream at Milky Lane. They had two dogs. Participant D loves dogs, but is allergic to them, and still is today; it's a frustration for her. **Present:** Participant D and her husband often enjoyed sushi before her son was born, and she misses it. Steekbossies on the road indicates unhappy things like the trauma and post-natal depression around her son's birth, the comparison between her and sister as twins, when her dad lost his job, her grand-mother's harsh remarks that Participant D was fat. The donkey represents Participant D - sometimes she feels like Shrek's donkey (stupid), but in the film, Donkey says wise things and so does she. An eagle flies high above the sky and looks out for prey. Participant D is aware of the negative things, like the eagle and Steekbossies on her road. We discussed it and she is disillusioned by the negative things that have happened to her. **Future:** Participant D, her husband and her son will be able to do more things together as son is gets older (e.g. touring overseas, riding bicycle and motor cycles, having picnics together, braais and spending time outside). Participant D has a need to be good to herself. She just wants to sit, be peaceful and think, and take time to take care of herself. The pebbles around her symbolises calmness and good things that will happen to her, e.g. her son will get better and she will sleep more, have more time for her studies, and she will once more have time to chat in the bath at night with her husband, she will have time to exercise again, and she will have another baby (although she feels under pressure, but has realised that she puts the pressure on herself and she has to give herself time to get better and feel better herself before she commits to another child).

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: I need to make myself happy and positive and don't wait for others to do it. It's my responsibility.

SESSION 8: Participant D. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant D's overall mental toughness improved from a sten of two (below average) to a four (average). Her life emotional control increased from a sten of one (lowest score on sten scale) to a sten of three (average score). Confidence in her abilities improved from sten of two (below average) to a sten of three (still below average, but moved up one sten). Emotional Control stayed the same, at a sten of four (average score).

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant D: Yes, my whole perception of life. I have to attend to myself first. I need to give myself the acknowledgement that I expect from others and love myself more.

What have you learned about yourself?

Participant D: That I am a good enough person and that I must believe more in myself.

What do you do differently in your everyday life?

Participant D: I try to tell myself (self-talk) to be more positive.

What have you learned about your trauma?

Participant D: That it is not the end of the world. I am going to survive. I must not be so hard on myself.

Do you think that you are coping better with your trauma?

Participant D: Yes, I feel more in control of my totally out-of-control world. There are a few things that I could change which makes a difference, like my self-talk, using my first-aid kit, to focus on my positive characteristics and to appreciate myself more.

What makes you feel that you are coping better now?

Participant D: Better understand the way in which my body reacts to the trauma.

Have any of your relationships changed? How did it change?

Participant D: Yes, my husband and I can at least talk to one another again.

Did your feelings change? Can you explain how it changed?

Participant D: Yes, I feel a bit happier. My self-talk about my body changed. I look at myself through less critical and more merciful eyes.

What did you gain from these intervention sessions?

Participant D: Hope.

Do you have a support system?

Participant D: Yes, my dad, mom, sister.

How do you see yourself?

Participant D: I am a good wife and I try my best to be a good mother. I am a professional career woman.

Myself: How do you see the road ahead?

Participant D: Better than the one behind, but I realise I have to work very hard to apply what I've learned in the sessions.

Myself: Would you recommend this intervention sessions for other people? Why or why not?

Participant D: Yes, very good interactive sessions.

Myself: Do you have any recommendations for the presenting of this programme in the future?

Participant D: Yes, I will certainly recommend it. It was very practical.

6.3.5 PARTICIPANT E

Age: 32

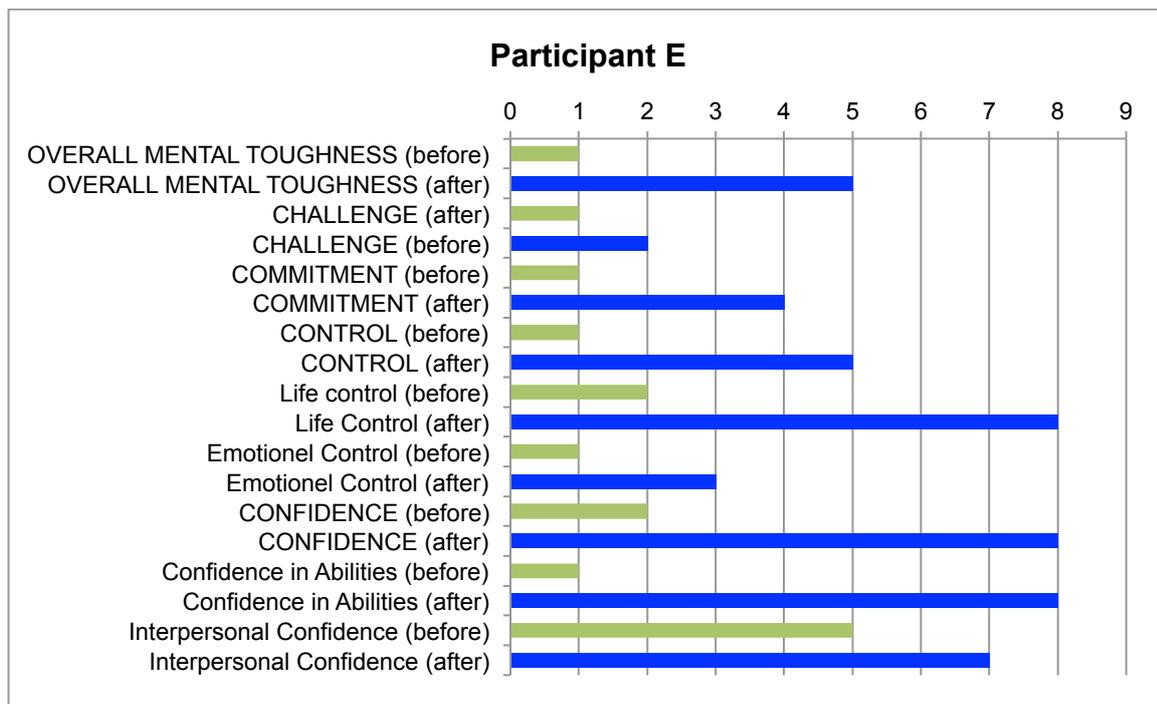
Gender: Female

Occupation: Not able to work due to bipolar disorder.

Trauma: Participant E suffers from bipolar disorder. Her father’s death a decade ago was traumatic. She also suffered from a cancer tumour in her brain, and experienced epilepsy. She underwent brain surgery when she was in Grade 8. From that point onwards, she was unable to cope academically. She then attended the New Hope School (for children with cerebral palsy). She said that the school is for dumb children. She was also a victim of bullying.

SESSION 1: Participant E. Semi-structured interviews (qualitative) when receiving feedback of MTQ48

Graph 6.5: Participant E. Quantitative results (MTQ48): Pre- and post-test



Participant E’s overall mental toughness score received a score of one, which is under average (lowest end of mental toughness score scale). It was expected that she would have low mental toughness because of her bipolar disorder, and because she was medically boarded.

Table 6.5: Participant E’s qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores

Challenge (sten1: under average)	- No challenges - Lives with mom (“unsure if I can live on my own”) - Cannot accept challenges, too scared and insecure
Commitment (sten 1: under average)	- Cannot commit due to bipolar. - When feeling very low, cannot work.
Emotional control (sten 1: under average)	- Cannot control her emotions well.
Life control (sten 2: under average)	- “Life controls me: cancerous tumour; epileptic seizures, dad’s depression, dad’s death, my bipolar”
Confidence in abilities (sten 1: under average)	- I do not have confidence in my abilities as I was a volunteer at the after care centre for children. They could never count on me – when I feel very down in the mornings I could not go there. - Worked as admin officer at church. The same happened: I could not go to work every day and they eventually asked me to resign.
What are her highest scores	How she confirmed these scores
Interpersonal confidence (sten 5: average)	- Likes other people - Gets along well with people (in individual set-up, does not like groups)

SESSION 2: Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started

METAPHOR: Beautiful building with a high tower. The buildings roof can open, and the participant is inside. There are walls between her and other people. Participant E believes that she is too different, due to her bipolar disorder, to be accepted by other people. There are doors to get out of the building and start climbing to the summit of the tower. It is difficult for her to get to the summit as she complicates the road for herself. The participant is aware of a voice inside her head that tells her that she is a bad person and that she does not deserve anything good. Even so, she wants to get to the summit.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What motivated you to take part in this research?

Participant E: I hope to be able to process the trauma I’ve experienced and am still experiencing, especially my dad’s death. I hope to learn to live better with bipolar and to get the negative voice inside me to quiet down.

What makes you feel that you are not coping with your trauma?

Participant E: I still cannot talk about my dad’s death without crying (it’s already been 10 years).

How did trauma change your life?

Participant E: I lost everything with my dad's death: direction, friend, comfort zone; bipolar was triggered by his death. I don't think I needed to go to school for special needs.

How do you cope with trauma?

Participant E: I tell myself to "shut up". I have this voice in my head that constantly tells me how bad I am.

How do you see yourself?

Participant E: As a fat pre-schooler without friends.

What are your negative characteristics?

Participant E: I am impatient, too hard on myself, I worry, I criticize, and nobody can rely on me.

What are your positive characteristics?

Participant E: Lots of love to give (especially for children).

Do you have a support system?

Participant E: Yes, my mom.

What is the best thing that you've ever accomplished?

Participant E: Nothing. (After the first session was completed, she could write down that she had lost 15 kg in the past year).

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant E felt that I had treated her like she was normal - which was quite a surprise. She was very appreciative and said that she felt like she have value. The clay dough was a winning activity for Participant E.

Negative experiences: The participant explained that before the session, she was aware that she was "a mess". However, after the session, she realised just was a "bad mess" she was.

Future recommendations: Participant E recommended that more colours of clay be made available for the metaphor.

SESSION 3: Participant E. *Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY

Sadness (blue): in eyes symbolised that she had witnessed traumatic incidents.

Jealous (green): in heart, if she sees happy couples. She wishes that she could have someone special to love me. Her younger cousin got married month ago.

Bored (grey): in head and heart; Participant E does not work and is often bored, but she is unable to commit to work due to bipolar disorder.

Lonely (brown): in whole body, as Participant E misses having someone special in her life. A friend who she met in Denmar Psychiatric Hospital, died.

Proud (pink): in head, mouth, stomach. The participant lost 15kg in the past year, but she remains hard on herself and states that it does not because she subsequently gained 3kg. However, she believes she is a very good baker.

Excited (purple): in whole body when she experiences a "high" (manic bipolar episode).

Happy (yellow): in arms; she is aware that her mom loves her when her mom hugs her.

THE "SELF"

Interferences and/or negative events in participant E's life are and were: her dad's depression/bipolar disorder (was treated for depression, although she thinks he was bipolar), her dad's moods fluctuated and he emotionally abused her mom; her cancer, New Hope School, no friends (children referred to her as the crazy one). These interferences led to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person): she says she is crazy and she has acted crazy, she wants attention and gets it by whining or over-eating. She has made herself unreachable (she has built wall around self). Her **ideal self** would like to know the real person she is, to be more stable (not controlled by unpredictable ups and downs), to be constructive and busier, and to be calm.

A discussion followed where Participant E voiced that her biggest issue (as secretary at church and “teacher” at after care centre at school) is to get up each morning and have the courage to leave the house. Once she’s there, she is fine and is able to function at work. She explained that her mom has a bad self-concept and no self-confidence, and that her mom had never learned how to live – that her mom is scared. She has a challenge ahead: her uncle and aunt are going on holiday for two weeks. Participant E offered to take care of their house and dogs. It will be her first time that she has ever stayed alone. She is excited, but also scared.

TIME TABLE

Participant E had experienced difficulties in completing her day-to-day tasks at home, for example to feed the dog, to water the garden and to clean the house. As she was medically boarded and is not allowed to work, she thinks she has unlimited time to do her tasks at home. She therefore procrastinates instead of completing tasks. By the end of the day she realises that she has not done anything useful. We set up a time table for her. I was surprised that she actually started using the time table, and it worked well for her. She seemed to be undeniably committed to be helped.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: She explained that she is a visual person and by portraying her emotions in colour, it was valuable and helped her to better understand herself.

Negative experiences: She has to “face” her problems, and she does not usually do that.

SESSION 4: Participant E. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

PROTECTING SHIELD

Participant E identified her positive characteristics which become part of her protecting shield as wisdom and able to give good advice (from bipolar viewpoint), sympathetic, like to be of help to others, and can express love. Her negative characteristics that draw her down include worry, manipulative streak, impatience, her quickness to judge, and her poor self-control.

ANCHOR OUTSIDE TRAUMA

Participant E's anchors where she feels safe: reading (fiction), be with family (mom, brother), coffee shop (reading) or coffee with friend (in coffee shop), baking (favourite activity) and Jesus Christ (although she admits that it is difficult to be a Christian). Participant E explained that when she gets depressed, it helps if she goes out to a coffee shop, but it's difficult to "take the step" out of her comfort zone and go out. We made an agreement that she is going to force herself to go by telling herself that "I can do it", "I am going to be ok", should she feel herself becoming depressed and getting "low" in the future.

PROSPER

Listening, practicing and visualising her goals (at least three times a week) will help to anchor Participant E outside the situation where she constantly tells herself (self-talk) that she is a bad person and does not deserve anything good. Re-entering in Participant E's situation implies that even though she cannot take away the bipolar, she can start to focus on things that she can control, which are her thoughts and behaviour. Her homework included compiling a visualisation poster of the positive ways in which she sees herself and achieves goals.

Participant E said she had started to realise that her dad was less perfect that she thought he was. She realised he had bad childhood years and never wanted to talk about it. He criticised people harshly.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: She was happy to receive practical "anchors" as well as ways in which she can be more grounded, to support her to get out of/through a depressed "state".

SESSION 5: Participant E. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

Participant E provided feedback that she had felt very depressed four days prior to the counselling session, and despite the depression she had upheld her commitment to our agreement. She forced herself to take a book and went out to a coffee shop. She was surprised that she could get out of her "low". She realised that she will be fine on her

own at her uncle and aunt's house, although she is eating more than normal. We discussed a plan of how try to eat less in the subsequent weeks.

VISUALISATION POSTER

The heading of Participant E's poster was "Why not me? (Because it can be me!)". She put icing sugar on her head (the white sugar which symbolises good, sweet, memories and fighting against the voice that constantly tells her she is useless). This is important, because she realised that she has to make choice about which voice to listen to. She added ENOs powder (antacid) to icing sugar, because these two ingredients react and spread out (her good thoughts and memories will increase). There were also children on the poster (she would like to work at the after-care centre again, she likes children and gets along very well with them).

A discussion followed concerning the problems of her past. She realised that there is no challenge for her in working at the after-care centre. The challenge is having the courage to go out of the house, as she is scared to move out of her comfort zone. In the future Participant E will commit to use self-talk to talk herself out of the house, into the car and off to "applicable place".

After the discussion, the Prosper poster description continued: Participant E wants to write book to inspire people and/or fiction (she has already started to collect information). She also wants to start her own baking business from home, as she has already baked biscuits and cookies a few times and it went well. She also had an image of computers, because she enjoyed admin work at the church in the past, and she would like do it again in the future if an opportunity comes her way.

DEFENCE MECHANISMS

Participant E blames her shortcomings on the bipolar disorder, and uses it as an excuse not to achieve any goals; she is fixated on the stage of her life when her dad was alive and she does not want to go on; she experiences withdrawal and believes that she cannot cope; she hurts people (including her mom and brother, because she is/was hurt by the contradictory behaviour of her dad, as he was simultaneously a nice guy and emotionally abused her mom), she is manipulative because she wants love and pity. A discussion followed concerning her manipulative streak as a defence mechanism. She admitted that "I'm scared if I get things right that people will expect me to get it right

again". She realised that it became a comfort zone and a way of living to limit and destroy herself.

PARTICIPANT E 'S "BAG" OF WHO I AM

In the bag, Participant E included a book that was meaningful to her (Redeeming love, Francine Rivers); a photo album to of family pictures and especially her dad; biscuits and cookies that she baked; a star necklace from Weight-Watchers after she lost 15kg; a note book with words from the poem *footprints in the sand*, which used to motivate her to go out in the past; her dad's key chain with "s" on ("s" always meant "dad is special" to her); through the therapy sessions she added the following "s" words when she touched the key chain) to describe herself: super, self-assertive, self-confidence, self-talk; she included her own note book, where she writes down her favourite recipes and inspiring quotes.

FIRST-AID KIT

Participant E put the following aids of how to be good to herself in her first aid kit: read in a coffee shop, take a nice bath, bake something and hand it out to the neighbours, sing aloud with her favourite music, listen to prosper CD, draw pictures or colour in.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant E explained that it was useful and freeing to learn more about her defence mechanisms. She had never before told anybody and never thought that she purposefully did not want to succeed, because then people might have certain expectations of her and she was afraid that she would no longer receive special attention.

SESSION 6: Participant E. *How to fill up my "empty bucket" although I am a broken person*

Participant E provided feedback that she was still coping while staying on her own. Her mom joined her over the weekend. However, she continued to eat more than she knew was necessary.

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs. Many were unsure about how to do it.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case and a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant E was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant E believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her "tick" and "dance", she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. Participant E added positive character traits as valuables to her jewelry box that included sympathy, wisdom, a sense of humour, a willingness to serve others (she had started to take part in hospital visits again two weeks prior to the session).

Participant E provided feedback on incident that occurred at home: The geyser started leaking in the roof above her bed. She explained that in the past she would typically have started to panic, but instead she remained calm and supported her mom to also stay calm. She telephoned the landlord to ask for help in the matter.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Positive experiences: Participant E explained that the lessons and motivation from the stories were exceptional and meaningful to her.

Negative experiences: She was unsure about whether the positive self-talk and affirmations would work for her, but she was willing to attempt the exercises..

Future recommendations: She suggested that a hand-out be provided of the content of the bucket as she could not remember what it all means.

SESSION 7: Participant E. My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.

EGO STATES

According to the Transactional Analysis Questionnaire, Participant E's dominant ego states switches between the parent (nurturing) and the (adapted) child.

In her role as “teacher” at the after-care centre at school she is a lovable, caring, nurturing parent. In her role at home she becomes the child who exudes self-pity, she whines and thinks she is the black sheep of the family. We focused her attention on the aspect that too much of the nurturing parent role can become suffocating. She wants somebody to love and who can love her and therefore she needs to be aware not to become desperate and suffocating. She needs to develop more of her free child and therefore she must use her first-aid kit to laugh and have more fun.

TRANSACTIONAL ANALYSIS

Participant E recognised herself in the “I am not ok” and “you are ok” category. She is sometimes judgemental and finds fault with others in order to protect herself) and then moves into the “I am ok” and “you are not ok” category.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant E’s sand picture represented her life as follows: **Past** – included a black bat (dark past), a black bucket (dad could be very demanding), a dwarf (dad could sometimes be sweet) and an elephant (she had been overweight). **Present** - included a child who was unaware of what goes on around her; “bling” that symbolised hope for the future, as well as the hope to have her own baking business from home; there was a dog, as she would love to have her own dog and receive unconditional love from pet. **Future** - included a lady who exuded confidence, as she is already more comfortable in own skin and more self-assertive); as well as laughter. All these improvements will make Participant A feel less like a child and more independent.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: She gained the insight that her dad was not perfect as she always thought he was. She has a more balanced picture of him now – he has both positive and negative characteristics.

SESSION 8: Participant E. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant E’s overall mental toughness improved from a sten of one (below average)

to a sten of five (average). Her challenge sten improved from one (below average) to a sten of two (still below average) as her greatest challenge is finding the courage to get moving and leave the house. As soon as she leaves the house, she is fine. Her commitment's sten of one (below average) moved up to a sten of four (average). Participant E realised that in the past she sometimes purposefully did not "get things right" to receive attention from others. She realised that she used her bipolar disorder as a defence mechanism to be non-committal. Her Life control's sten increased from a two (below average) to an eight (above average). The relief and experience that she could practically achieve through controlling a large part of her thoughts and behaviour led to a great increase in her life control as well as her emotional control. Her emotional control increased from a sten of one (below average) to a sten of three (below average). Confidence in her abilities increased from a sten of one (below average) to a sten of eight (above average) as she started to realise why certain behaviour was triggered in her life, what her defence mechanisms became and what her comfort zone is. Interpersonal confidence as her strongest mental toughness aspect also increased from a sten of five (lowest end of average scale) to a sten of seven (highest end of average scale) as she realised that she can influence other people's lives.

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant E: Yes, I feel much more optimistic than pessimistic.

What have you learned about yourself?

Participant E: I am a survivor. I've started dreaming again, but not only dreaming, I also started to put words into action, e.g. my baking, I forced myself to go out when I felt down, I committed to go through with the therapy sessions, I'm working hard to change my self-talk. I use the visualisation exercises as I want to achieve my goals.

What do you do differently in your everyday life?

Participant E: I dwell less on things. I've believed in the past that I am totally caught up in the claws of bipolar disorder. Now I know that there are things that I can control, e.g. to go out to a coffee shop if I get too down, to force myself to go out of the house to

attend the therapy sessions and to deliver my baking products.

Do you think that you are coping better with your trauma?

Participant E: Yes, I see things more in perspective. The **mole heaps** are mole heaps and not mountains any more.

What makes you feel that you are coping better now?

Participant E: I do not have such destroying thoughts anymore.

Have any of your relationships changed? How did it change?

Participant E: Yes. Relationship with my mom is more difficult as I can cope independently of her for the first time in 32 years. She is still used to the dependant me.

Did your feelings change? Can you explain how it changed?

Participant E: Yes, I've learned a lot about who I am. I am growing more into the person who I want to be.

What did you gain from these intervention sessions?

Participant E: Before the sessions I just existed. Now it feels as if I started to live life.

Do you have a support system?

Participant E: Yes; mom, brother, some friends.

How do you see yourself?

Participant E: I have value. I am good enough. I am on the same level as others and they are not better than me.

How do you see the road ahead?

Participant E: Realistically. I know I will need to work hard to stay positive and to keep up with the changes that I have started.

Would you recommend these intervention sessions for other people? Why or why not?

Participant E: Yes. It changed my life and it would be wonderful if other people can experience the same.

Do you have any recommendations for the presenting of this programme in the future?

Participant E: Each session was valuable; I cannot think that it could have been better.

6.3.6 PARTICIPANT F

Age: 31

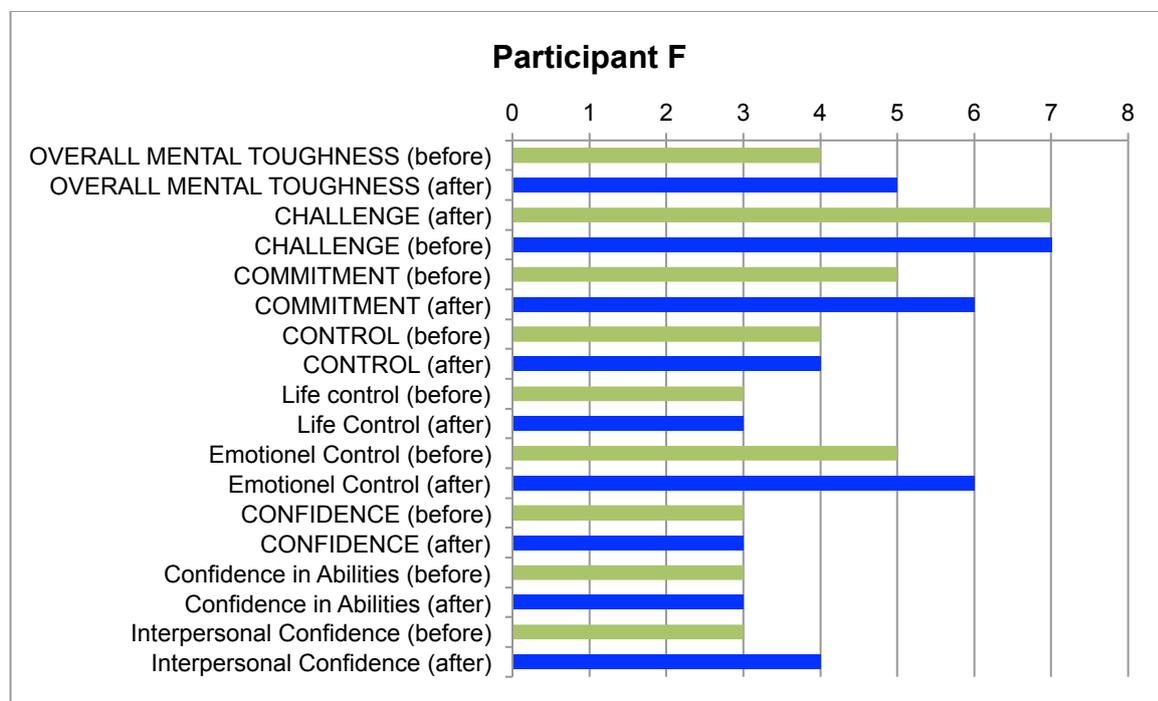
Gender: Female

Occupation: Graphic designer

Trauma: Her dad’s cancer and his subsequent death a year ago.

QUANTITATIVE RESULTS (MTQ48)

Graph 6.6: Participant F. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant F. Participants semi-structured interviews (qualitative) when receiving feedback of MTQ48 (quantitative)

Participant F did not know what results to expect from MTQ48.

Table 6.6: Participant F's qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Life control (sten 3 under average)	<ul style="list-style-type: none"> - Dad's cancer and death. - Tough schedule at work. - Already 31 and does not have a boyfriend. Friends pressure her. - Constantly worries about things e.g. at work and in personal life
Confidence in abilities (sten 3 under average)	<ul style="list-style-type: none"> - More like my dad than my mom (her dad was shy, introverted, did not communicate feelings; her mom is more extroverted and says how she feels). - Questions absence of a boyfriend? - Sees herself as sister and good friend.
Interpersonal confidence (sten 3 under average)	<ul style="list-style-type: none"> - Actually shy, pretends to be happy-go-lucky and joker. - Worry about what other's think of her.
What are her highest scores	How she confirmed these scores
Challenge (sten 7 high average)	<ul style="list-style-type: none"> - She likes challenges and changes (but not challenge of crazy, non-stop work pressure). - Worked in London for two years and still travels regularly.
Commitment (sten 5 average)	<ul style="list-style-type: none"> - Friends and colleagues can always count on her.
Emotional control (sten 5 average)	<ul style="list-style-type: none"> - Good control of emotions. Rather walk away than explode. - She realises that it is difficult for her to deal with conflict and she would rather walk away, than to face it and may explode later (heap up).

ACTION RESEARCH EVALUATION QUESTIONS:

Positive experiences: She seldom shares her emotions. She explained that I (therapist) created an atmosphere where she felt comfortable to share her emotions (*create a safe, non-threatening atmosphere for the client*).

SESSION 2: Participant F. *Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started*

Metaphor: Participant F used a Labrador (dog), running and returning ball, as her metaphor. The dog is enthusiastic, tries his best, becomes tired, has no chance to take break, and often it seems that life goes too fast. The dog might want to stop and enjoy the flowers on the way, and simply enjoy being in nature. The dog needs a great deal of attention and care. The dog's friends pressurise him as they expect him to be in a relationship, and the friends often make him feel like there is something wrong with him.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What makes you feel that you are not coping with your trauma?

Participant F: Feeling of helplessness, I could not do anything to help him.

How did trauma change your life?

Participant F: Realise importance of people like my mom and not to allow “petty” things to spoil relationships.

How do you cope with trauma?

Participant F: Pray, talk with family and friends who have experienced death.

What kind of feelings do you experience?

Participant F: I am confused, helpless, negative. My dad was a strong big guy, but after he became sick he became frail and small.

How do you see yourself?

Participant F: 50/50; sometimes ok and sometimes I stress and worry about things - like not having a boyfriend, what people think of me, feel stressed-out at work.

What are your negative characteristics?

Participant F: I worry too much about what others think, dwell on things. I don't accept compliments easily.

What are your positive characteristics?

Participant F: Loyal, flexible, friendly, try to see good in others.

Do you have a support system?

Participant F: Yes. Friends, mom, brother, sister, special friend (X), small group at church.

What is the best thing that you have ever accomplished?

Participant F: I lived and worked in London (two years), travel and see world.

What expectations do you have about this individual therapy programme?

Participant F: To better face uncomfortable situations, to better deal with my feelings

around others' expectations of me (to be in a relationship), to worry less.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Positive experiences: She explained that it is important to work through traumatic feelings, as in stressful times these emotions (if not dealt with) can surface again.

SESSION 3: PARTICIPANT F. *Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Sadness (blue) in eyes; she misses having someone special in her life.

Frightened (black) in stomach and heart; she has been scared of the dark since being a little girl (not aware of specific reason).

Anger (red) in cheeks; it is difficult for her to explain how she feels, because she does not like conflict, and instead she stores and nurtures her emotions.

Shyness (orange) in stomach; she believes she is too fat and criticises her hollow back like her granny.

Lonely (brown) in whole body; she wants to have someone special in her life.

Jealous (green) in heart; she is unsure of where she stands with her special friend (X). At times there is more between them than friendship, and at other times he takes another girl friend to a function, which is confusing.

Excited (purple) in whole body; she is excitable about small things, like eating ice-cream and chocolate.

Proud (pink/white): It was initially difficult to find something, but through some discussion she admitted that she was proud of having lived in London, and proud of her creativity at work and her studies.

Participant F expects bad things to happen because her past shows her this reality with her dad's death, her inability to secure a boyfriend, and her relentless work schedule. She is scared that she will become as quiet and depressed as her dad was. A discussion followed, where she explained that her dad never shared his emotions. He

had been the black sheep of his family. The difference between them is that she talks about her emotions easily and she has close friends and likes to spend time with them. It does not mean that she will not get depressed, but she is at least aware of these tendencies and she will remain attentive and seek help if needed.

THE “SELF”

Interferences and/or negative events in Participant F’s life is and were her dad’s death, his depression (after he was diagnosed with cancer), not having a boyfriend, and pressure from friends about when she is going to get married. These interferences led to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person). Participant F’s adapted self is “worrying about worries”, concerned about what other’s think of her, seeing herself in her role of sister and friend and not “girlfriend” (to protect herself from not getting hurt). Her **ideal self** wants to be the warrior, not the “worrier”, to be less of a people-pleaser, to love herself more, to accept herself, and to be able to accept compliments.

SELF ASSERTIVENESS

Participant F wants to become more self-assertive. Practical ways in which she can apply this is to walk/sit/stand up straight; pull her shoulders back; look the world in the eyes; act as if she has self-confidence, even though she may not feel that way; tell herself that she “can do this” and that she is “getting better and better every day” (although it may feel unnatural at the start, it will become a way of living).

ACTION RESEARCH EVALUATION QUESTIONS:

Positive experiences: Emotions that were represented by colour provided her with a tangible visual picture, which she found very effective and practical. She realised the importance of acknowledging her emotions in order to work through her dad’s death.

SESSION 4: Participant F. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

PROTECTING SHIELD

Participant F identified her positive characteristics which become part of her protecting shield as: a sense of humour, laughter, loyalty, diligence and being a pillar of strength to others. Her negative characteristics include procrastination, hiding emotions and not

expressing her thoughts and feelings.

ANCHOR OUTSIDE TRAUMA

Participant F's anchors where she feels safe include camping, reading outdoor magazines, making "potjiekos", having a "snoek" barbeque, spoiling other people and making others laugh.

PROSPER

Participant F tends to worry about unnecessary things, like what people think of her. She realised that she focus on herself as a friend and a "sister", rather than focussing on her womanhood and being a girlfriend. Listening, practicing and visualising her goals (at least three times a week) will help her learn to expect good things to happen in life, to start to talk to her worries in order to chase them away and to focus on her womanhood (which she has a need for, but she does not know how to do it). She will start to focus on things that she can control, which are her thoughts and behaviour and when she starts to worry she will not continue "feeding" her worries by focusing on them, but instead re-enter and replace the emotions with her positive visualisation pictures. Soon, she will start to see herself as a woman (in relationship with a man) and not as a sister and a friend.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: She affirmed that she can only start changing her perceptions if she learns more about who she is.

SESSION 5: Participant F. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself.*

VISUALISATION POSTER

Participant F's poster consists of the following: women with confidence who are smiling; her favourite perfume, jewelry and accessories; people who are sharing their feelings and opinions with others; the words "cut out" to diminish the worries from her life; a quote that says that "difficult circumstances build character". She lists one of her strong points on the poster – which is to get along well with other people, she added some important insight in herself – that it's fine to sometimes show emotions in a relationship, as she never shows her emotions and pretend to be happy-go-lucky most of the time.

Participant F also included a bucket list of things she wants to do and places to travel to.

DEFENCE MECHANISMS

Participant F pretends to be happy-go-lucky, she avoids conflict, suppresses her emotions, and plays the roles of sister and/or friend. She also flees instead of fighting.

PARTICIPANT F'S "BAG" OF WHO I AM

In Participant F's bag are the following: photos from London, where she proudly lived and worked for two years; photos of other countries; an image of U2 (favourite music band); a camp-food recipe book, as she likes to cook for and spoil others; Terry Pratchett books (she enjoys his excellent sense of humour); a picture of a Labrador, as she loves animals; a camera, as she travels often and likes to capture memories; coffee, because she loves drinking coffee with friends; a shooter glass, which she collects from all over the world; slippers, because she enjoys being comfortable after work.

FIRST-AID KIT

Participant F put the following aids of how to be good to herself in her first-aid kit: movies, Terry Pratchett books, facials, massages, coffee shop visits, visit fresh fruit markets, go for walks with dog, laugh out loud.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: The visual images forced her to confront (and not to ignore, which is what she often does) her emotions and how she deals with emotions when she is trying to cope.

SESSION 6: Participant F. *How to fill up my "empty bucket" although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case, a teddy bear, etcetera (see Chapter 5 Session 6 for a more

detailed description). Participant F was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant F believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her "tick" and "dance", she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. Participant F wrote down her positive characteristics again (it was done in Session 4 - see "protective shield") and put these in her jewelry box to be constantly reminded of her valuable gifts and to make sure that uses it. These characteristics are loyalty, excellent sense of humour, caring, friendly, committed, and living life to the fullest.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Participant F realised that it is acceptable to love herself and that she actually needs to do. This allowed her to feel free. She mentioned that society never talks about loving ourselves more.

SESSION 7: Participant F. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant F's dominant ego states are the parent (nurturing) and then the adult. She realises that her need to have someone special (boyfriend) in her life, can sometimes mean that she nurtures people too much while attempting to fulfil her own needs, which can be suffocating for others. Her attention needs to be focussed on her free child, who needs more development. She purposefully needs to have more fun.

TRANSACTIONAL ANALYSIS

Participant F recognised herself in the "I'm not ok" and "you are ok" category, as she is critical of herself and by comparing herself to others; she feels that she is not good enough.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant F's sand picture represented her **past** life as follows: she lived on farm with her mom, dad, brother and sister. The growth in her life was represented with small pieces of grass that became strong bushes. During her travels on that road there had been some people who hurt her (friends in school, boyfriend in school, special friend (X)) as well as difficult situations to deal with (dad's depression and withdrawal). They always had dogs, and the family liked to be together and to eat together. In her **present life, she's** extremely busy at work. Sometimes she makes plans to go out with friends for sushi. Some days are dull, some are colourful. She loves animals for their unconditional love. There are some lizards on the road (represents her dad's death, and the disappointment of the special friend (X)), as well as difficult clients to deal with at work. The image of Shrek symbolises herself, as she is sometimes impulsive and stubborn. Shrek married a dragon and it all worked out, so maybe she will get married as well in the future. A fairy indicates her dreams of a good future, as well as the dreamer inside her (although she is realistic most of the time). The tree represents caring people around her (sometimes she needs to remind herself of that), and the gems remind her that "every cloud has a silver lining". The **future** is represented by a water turtle who keeps on swimming in life, an eagle to keep rising and a mirror to remember to look back and reflect on the good things of the past. She would like to have a less unpredictable job in the future, like having a guest house. If she gets married, her current working hours would be too much of a burden. She would love flexible working hours.

ACTION RESEARCH EVALUATION QUESTIONS

Participant F explained that the sand play therapy was very relaxing and that it calmed her down. It helped her to visualise her life; after a hard day at work it was soothing for her soul.

SESSION 8: Participant F. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant F's overall mental toughness improved from a score of four (average) to a

sten of five (average). Both her commitment and emotional control increased from a sten of five (average) to a sten of six (average). Her interpersonal confidence increased from a sten of three (average) to a sten of four (average).

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant F: Yes, for the first time I had the bravery to face my emotions (which I tended to ignore).

What have you learned about yourself?

Participant F: I have much more worth and good characteristics than I realised as I mainly focused on my negative aspects.

What do you do differently in your everyday life?

Participant F: I purposely start every day with a happy thought and positive self-affirmations.

What have you learned about your trauma?

Participant F: Some bad emotions are normal. In order to heal you need to work through them and cannot skip them.

Do you think that you are coping better with your trauma?

Participant F: Yes, I understand myself better and I have learned some practical skills of how to handle setbacks and worries as well as how to maintain better feelings.

What makes you feel that you are coping better now?

Participant F: I have started to talk about my deepest feelings and fears and experienced relief when I started to share it.

Have any of your relationships changed? How did it change?

Participant F: I started to stand up for myself at work by started to say what I think and

what I do not feel like, and I do not allow people to emotionally walk over me anymore.

Did your feelings change? Can you explain how it changed?

Participant F: Yes, I used to be very pessimistic and now I feel a bit more optimistic and try to focus on the more positive side.

What did you gain from these intervention sessions?

Participant F: I have learned that I can control the way I react to situations, but that I need to constantly fill my emotional tank.

Do you have a support system?

Participant F: Yes, good friends and family and a care group at church.

How do you see the road ahead?

Participant F: I have learned some skills to better cope with emotional situations and I have also learned to trust my gut feelings.

Would you recommend these intervention sessions for other people? Why or why not?

Participant F: Yes, in my situation I have learned practical, non-threatening ways to explore my feelings and that as a unique person I will have different feelings than other people might have.

Do you have any recommendations for the presenting of this programme in the future?

Participant F: Yes, for sure and I will have follow up sessions, if needed, with Marisa in the future.

6.3.7 PARTICIPANT G

Age: 44

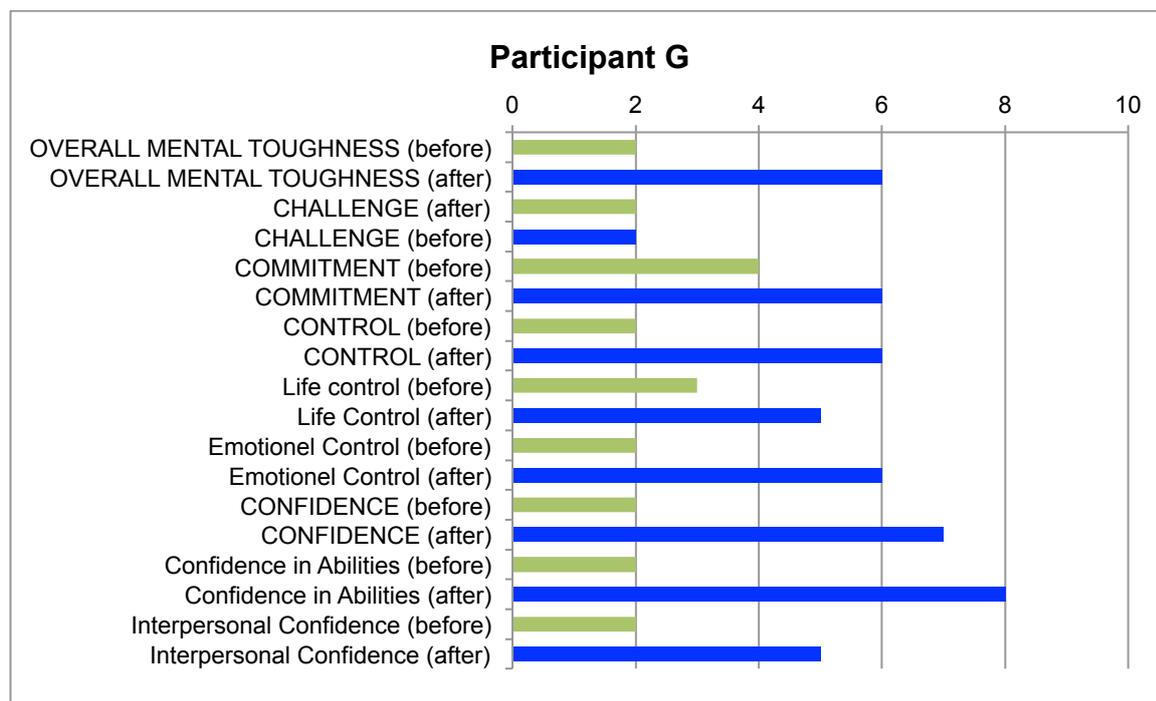
Gender: Female

Occupation: Police Officer

Trauma: Son's death 9 months ago. He was 18 years old and shocked by an electrical wire. She had been admitted to the Vista Clinic (a private psychiatric hospital) for three weeks and uses psychiatric medication, but at the time that therapy commenced, she had shown no signs of improvement. She is an emotional mess and her manager at work is concerned about her. Her pistol was taken away from her and she has been transferred to an administrative job because she cannot deal with any stressful situations.

QUANTITATIVE RESULTS FROM MTQ48

Graph 6.7: Participant G. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant G. Participant's semi-structured interviews (qualitative) when receiving feedback of MTQ48 (quantitative)

Participant G expected a low mental toughness score as she described herself as broken and dead on the inside as a part of her had died with her son. She explained that she does her job like a robot every day. Overall, her mental toughness score is a sten of two (below average).

Table 6.7: Participant G's qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Challenge (sten 2 below average)	<ul style="list-style-type: none"> - Total life changed when son died. Normal activities became challenging: to get out of bed, get dressed, to greet and talk to others, etc. - No energy to deal with challenges at work or to deal with teenager son of 16 years. They fight continuously.
Life control (sten 3 below average)	<ul style="list-style-type: none"> - She lost all control, her son's death and emotional pain controls her life. - Her dad's suicide (she was six years old) resurfaced again. She has no meaning in life.
Emotional control (sten 2 below average)	<ul style="list-style-type: none"> - Emotional outbursts. She cannot control emotions. - Touchy, very sensitive, snaps easily, cries intensely, screams, aggressive (wants to hit someone).
Confidence in abilities (sten 2 below)	<ul style="list-style-type: none"> - Lost herself totally, does not know who she is anymore, self-doubt, no self-confidence at home and at work, cannot take initiative like in

average)	the past. - Believes she is deemed to make a mess of everything (fights with son).
Interpersonal confidence (sten 2 below average)	- Withdraws from people, does not want them close to her, no energy to even greet them, wants to hide, touchy.
What are her highest scores	How she confirmed these scores
Commitment (sten 4 average)	- One of her strong characteristics, never lets people down, you can always count on her.

SESSION 2: *Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started*

METAPHOR: Participant G chose a flower as a metaphor for her life. Her two boys are also flowers and they grow next to her. She cannot live without them. She connected the three of them with a small bracelet. She is a very fair mother as all three of the flowers have two leaves each. She needs care and other people around her to grow. Her boyfriend (of the past four months) gives her, as a flower, a great deal of much security, love and care.

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What motivated you to take part in this research?

Participant G: My son's death eight months ago. I want to help others who go through the same hurt.

What makes you feel that you are not coping with your trauma?

Participant G: I am very emotional, some days I do not want to live any more, I am very tired and I also have difficulty in sitting still.

How did trauma change your life?

Participant G: My whole life changed. The old me died with my son on the railway road. I withdrew from other people.

How do you try to cope with trauma?

Participant G: I am working myself to death, not to be confronted with my thoughts about him, but I still think of him.

How do you see yourself?

Participant G: I just go on like a robot.

What kind of feelings do you experience?

Participant G: Anger, hatred, bitterness, sadness, sometimes I do not have any emotions at all (I just feel nothing).

Myself: What are your negative characteristics?

Participant G: I don't want to be friendly with anybody else. I want to be left alone.

Myself: What are your positive characteristics?

Participant G: At this stage there's nothing. I always liked people, but at the moment I don't.

Myself: Do you have a support system?

Participant G: Yes, my boyfriend.

Myself: What is the best thing that you've ever accomplished?

Participant G: I have survived eight months without my child.

ACTION RESEARCH EVALUATION QUESTIONS

Negative experience that becomes positive experience: Participant G confirmed that the clay dough work was strange, but in the end she enjoyed it and it calmed her down as she did not know what to expect from the session.

SESSION 3: Participant G. *Trauma's effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Sadness (blue) in whole body (her whole body is broken); She wants to vomit if she thinks about what happened with her son's dead body under the ground.

Anger (red) in head, brain, heart, arms; she wants to hold her son. She is struggling with the question "Why did he need to die?"

Frightened (black) in whole body; she is scared to be alone, and that her son of 16

years of age and her boyfriend will reject her as she is not herself anymore. She admitted to being depressed and that she “just wants to die”. She also mentioned that she was date raped by a previous boyfriend and that she is scared of men. Her husband cheated on her and they divorced in 2007. Her dad committed suicide when she was 6.

Lonely (brown) in whole body after son’s death, even when her younger son and boyfriend are with her.

Proud (white) in heart; she is very proud of her sons and their achievements. **Happy (yellow)** in heart; her youngest son makes her happy as her children are her life. Participant G reached an important insight during the discussion of her happy feelings as she said that she doesn’t allow herself to get better, as she feels guilty towards her deceased son when she feels happy and has fun.

This was a very important turning point in her life, as I could explain to her that she’s busy losing her second son while he is “alive” as they were constantly fighting and screaming at one another and he kept on telling her that he cannot stand it any longer, as she acts like she had only one child - her deceased child - and nobody else counts anymore.

She admitted that she is always depressed, and that she lacks energy energy to have fun, like she had with her son in the past. A long discussion followed where we practically planned how she could deal with both her dead and living sides. She realised that she is taking away her second son’s life and she cannot do it to him anymore. He cannot handle it to see her crying. Therefore she will cry in her bedroom, but not in front of him.

We compiled a list of things they did together in the past which they are going to start doing again during the week. Most importantly, we discussed the fact that she will need to force herself, “on purpose” to do these activities as she has a lack of physical and emotional energy. She cried so loud that I was unsure about whether she would be able to stop and she appeared to be so broken, but she was committed not to lose her second son as well. The list consisted of playing board games and cards, listening to their favourite songs (music night), having a tickle fight (same as in the past), going out for a milkshake, going out to a shopping mall, watching her son’s favourite TV program with him (he always wants her to do that) and to have coffee time (she, boyfriend and

son) every night at 7:00pm.

SELF AFFIRMATION CARD

We wrote down the following sentences which she needed to read out loud twice a day:

- I am not allowed to take away my son's life. He is alive and therefore I have to have fun with him.
- I am not going to lose my child who is alive.
- I do my best and I am having more and more success every day.
- I do not feel guilty when I am having fun, as I am still alive.
- It is my responsibility to live a life with my son.

THE "SELF"

Interferences and/or negative events in Participant G's life is and were her son's death, her dad's suicide (she and her brothers found his body hanging from a beam when her mom had been in hospital with the birth of her youngest brother), she failed Grade 1 that year and needed to move to live with her grandparents. Her mom remarried again after one year, to an alcoholic and started drinking with him. Her mother was constantly manipulated and threatened the children by saying she would commit suicide as well and she remembers many nights when they went to bed hungry. In 2007 she was divorced and was date raped by a boyfriend. These interferences led to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person). Participant G's adapted self is: I am not allowed to be happy and enjoy anything, I do not deserve anything good, I am always busy – I cannot sit still (try to forget my pain), I am aggressive, depressed, I have no self-confidence and I am anxious. Her **ideal self** would like to feel more whole again, have a good relationship with her second son like before, be more relaxed, and have more energy (physical and emotional).

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: For the first time she understood what happened inside her brain and body and why even my digestive system functions differently (ulcer and

stomach aches). She realised that she has to make the choice and commit herself if she wants to heal. She admitted that my (therapist) patience and calm attitude allows her to feel secure and comfortable, and she felt that I really listened to her.

SESSION 4: Participant G. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

It was the first session where it literally looked as if she was lifted up. She looked and felt better for the first time in eight months. She could not believe how her son's attitude and her overall mood and the atmosphere at home changed since she started to use the "nice things list". She said it was really difficult, but she forced herself to do her homework. Both she and her son can laugh again and she enjoyed knowing that she can have fun. She says that her deceased son will always be in her heart and she does not feel like she is "dropping" him anymore when she is having fun.

PROTECTING SHIELD

Participant G identified her positive characteristics which become part of her protecting shield as her commitment, and in the past she got along well with people and wanted to help them. Her negative characteristics are to focus on her negativity, like her bad relationship with her second son and the fact that she failed Grade 1. In retrospect, she realised that she failed Grade 1 due to the trauma and disruption around her dad's suicide, not because she had inferior abilities.

ANCHOR OUTSIDE TRAUMA

Participant G's anchors where she feels safe: taking a hot bath, drawing, beading, going for walk with her boyfriend, drinking coffee with her boyfriend, listening to her favourite "happy" music and dancing to its rhythm.

PROSPER

Participant G explained that she would start to focus on things that she can control, which are her thoughts and behaviour, especially when she starts to drown in her sea of sorrow. She has to compile a poster of her dreams for her future.

ACTION RESEARCH EVALUATION QUESTIONS AFTER

Positive experiences: The value of strengthening her self-concept and learning to love

herself plays an important role in her healing. Her son can see the difference in her and their relationship is becoming what it had been in the past (“we laugh a lot”). The nature of the sessions was very practical and she said that she used the hand-outs and aids at home, showing and sharing it with her son and boyfriend.

SESSION 5: Participant G. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciate myself.*

The relationship between her and her son is still flourishing. Although she still mourns a great deal, she and her son seem to have found one another again.

VISUALISATION POSTER

Participant G’s poster mostly consists of activities with her son, like laughing and having fun together, playing games, eating out, watching TV, making a nice fire together, spending time at the seaside and exercising. It is an energising, “active” poster and it has a happy feeling.

DEFENCE MECHANISMS

Participant G experiences the following defence mechanisms: Guilt (she cannot have fun and enjoy life), withdrawal (from family and friends), fixation (wants to stay in the previous phase of her life when her eldest son was still alive), aggression (wants to hit someone, snapped in front of son’s girlfriend and warned her not to hurt her son).

She has resolved to take “time out” if she becomes aggressive again, she will rather hit her pillow and/or scream into her pillow, and/or install her son’s boxing bag in garage and use it.

PARTICIPANT G’S “BAG” OF WHO I AM

In Participant G’s bag were photos of her sons, a sport trophy belonging to her second son, her deceased son’s cigarettes, his necklace and a ring, his jacket which she wears, a “snow world” gift from him, a toy car of him, his ID book and the last packet of sweets that she found in his pocket. She realises that she only has items of her sons in her bag and especially items of her deceased son and nothing about who she is. This is acceptable, because it indicates that she is very focused on her son and treasures his memories. Her homework was to go and collect nine items to tell herself who she is and bring it with for the next session.

FIRST-AID KIT

Participant G put the following aids of how to be good to herself in her first-aid kit: taking a hot bath, drawing, reading, playing with clay dough, working in her small garden and going for a walk with her boyfriend.

ACTION RESEARCH EVALUATION QUESTIONNAIRE

Positive experiences: She explained that she had never worked through the pain of her past. She realised that she cannot fully put it behind her because it still hurts and influences her behaviour. She needs to address it in therapy. She did not know about her defence mechanisms and it is shocking to her that she did not allow herself to heal and get better. She was thankful that I acted professionally, and it made her feel comfortable to open up and share her pain.

SESSION 6: Participant G. *How to fill up my “empty bucket” although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case, a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant G was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant G believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her “tick” and “dance”, she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse. Participant G had to write down her positive characteristics again (it was done in Session 4 - see “protective shield”) and put it in her jewelry box to be constantly reminded of her valuable gifts and to make sure that she uses it: empathy, relatability, good listener, friendly, caring and likes to give hugs to people in need. She was surprised to realise how many good characteristics she has.

Participant G expressed feedback; that her colleagues at work and boyfriend say that

they can see a remarkable change in her emotions and attitude and that they are proud of her.

ACTION RESEARCH FEEDBACK

Positive experiences: She explained that she was really committed (although some days it is difficult) to do what she practically learns and it really helps her tremendously. The challenge is to remain committed.

SESSION 7: Participant G. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

PARTICIPANT G'S "BAG" OF WHO I AM (SECOND BAG)

It was challenging to find objects that describe her, as she has never focused on herself. In the second bag, Participant G included high-heeled shoes, as she recently started wearing high heels as she had previously been a tomboy; she enjoys her feminine side and included her favourite perfume that makes her feel special; her police knife, as a police officer she needs to protect herself; large sea shell because she loves the sea, her bathroom's theme represents the seaside and she feels safe there; sunglasses because she spoiled herself with a good pair; a necklace (with photos of her son inside), from a friend who supported her through son's death; jeans, because she loves them; cellular phone, because it contains photo memories of her sons and special events. She realise the value of appreciating herself as a unique and special person.

She is proud that she was handed back her pistol and attended a shooting day during the weekend (she did very well). She still has difficult times, but she does not want to try to commit suicide again.

EGO STATES

According to the Transactional Analysis Questionnaire, Participant G's dominant ego states are the critical parent and then the adapted child as she can moan, whine and feel sorry for herself. She became much more of a nurturing parent since she started to understand how to better deal with her emotions and put in an effort to spend quality time with her son.

TRANSACTIONAL ANALYSIS

Participant G recognised herself in the “I am not ok” and “you are ok” category, as she tends to feel inferior when she compares herself to other people. She realised the importance of the positive self-talk, the first-aid kit and visualisation.

Participant G provided feedback of a conflict situation at work during the week and concluded that she could stand up for herself again - which she could not do the past eight months. Usually, she would just start crying.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant G’s sand picture represented her **past** life as follows: bugs and insects, which symbolised her dad’s suicide, the emotional disruption she experienced as a child, her mom’s re-marriage, her mom and stepdad’s drinking, her divorce and date raping, and her son’s death. Her **present** subsists of her and her son busy barbequing, eating hotdogs together and playing with their dog. The **future** is represented by her sitting underneath the palms at the beach; she loves the seaside and wants to go there more. In the future, she is surrounded by dolphins and fish, which makes her feels peaceful.

ACTION RESEARCH EVALUATION QUESTIONS

Negative experience that changed into positive experience: At first it was difficult for her to gather the things that represented herself, but she realised at the end that there’s a “me” in her life as well and she needs to love “me” (herself)!

SESSION 8: Participant G. Feedback on post-test MTQ48 and semi-structured questionnaire

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant G’s overall mental toughness improved from a sten of one (below average) to a sten of six (average). Her challenge had the same sten of two (below average), and this was discussed with her. One possible reason for the static sten is because life still have many challenges, and she has lost some of her old identities and has gained new identities and she still experiences a great amount of emotional pain and challenges while trying to cope with life. Her commitment sten increased from a sten of four (average) to a sten of six (average). Her life control increased from a sten of three

(under average) to a five (average) and emotional control from a sten of two (under average) to a sten of six (average). Her confidence in her abilities moved up from a sten of two to a sten of eight and her interpersonal confidence increased from a sten of two (below average) to a sten of five (average).

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED)

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant G: Yes, my look out on life changed. My youngest son is still alive and I am not going to "loose him alive". I am alive as well and I am going to live life to the fullest with him.

What have you learned about yourself?

Participant G: I am alive! I do not need to feel guilty when I have fun with my son!

What do you do differently in your everyday life?

Participant G: I try to take one day at a time. I am not allowed to take away my son's life – he is still alive!

What have you learned about your trauma?

Participant G: My son's death was busy destroying me. I started living again with the support of the therapy sessions.

Do you think that you are coping better with your trauma?

Participant G: Yes. I have learned to better deal with my emotions and that there are other ways to deal with it than suicide.

What makes you feel that you are coping better now?

Participant G: I am equipped with tools and skills to cope better, e.g. I know my defending mechanisms, I realise the effect that a fun list has on my family as I have started to do the activities with my son and boyfriend two weeks ago. I have learned the importance of being good to myself (first-aid kit). The positive self-talk makes me feel

better and I have realised that I do not need to feel guilty towards my son if I have fun (he'll be always in my heart). Prosper helps me to calm down at night and I am forced to lay down.

Have any of your relationships changed? How did it change?

Participant G: Yes, my relationship with my son is much better (we had lots of conflict before). Even my colleagues at work said my whole attitude has changed.

Did your feelings change? Can you explain how it changed?

Participant G: I still feel sad and broken about my son's death, but I believe and experienced that with the knowledge that I gained through the therapy sessions, I can better deal with difficult situations.

What did you gain from these intervention sessions?

Participant G: I had been like a dead person. I started to focus on "life" again as I realised that I am still alive.

Do you have a support system?

Participant G: Yes, my boyfriend and friends.

How do you see yourself?

Participant G: I see myself as a mom with two lives: the one is for my dead son – I can still cry, but rather behind a closed door as otherwise it overflows my total relationship with my other son who is a teenager and who hates it to see me crying. The other part is allowed to and has to have fun with my son.

How do you see the road ahead?

Participant G: I am still fighting to get back my life, but I cannot allow the trauma of my son's death to make me take away my other son's life.

Would you recommend these intervention sessions for other people? Why or why not?

Participant G: Yes, definitely. It took me from considering suicide back to realising that I am alive and that I want to be alive. I believe that in the future I will support other people

who lost their children as I enrolled in a counselling course at my church.

Do you have any recommendations for the presenting of this programme in the future?

Participant G: No, Marisa handled my pain with utmost respect which I indeed appreciate.

6.3.8 PARTICIPANT H

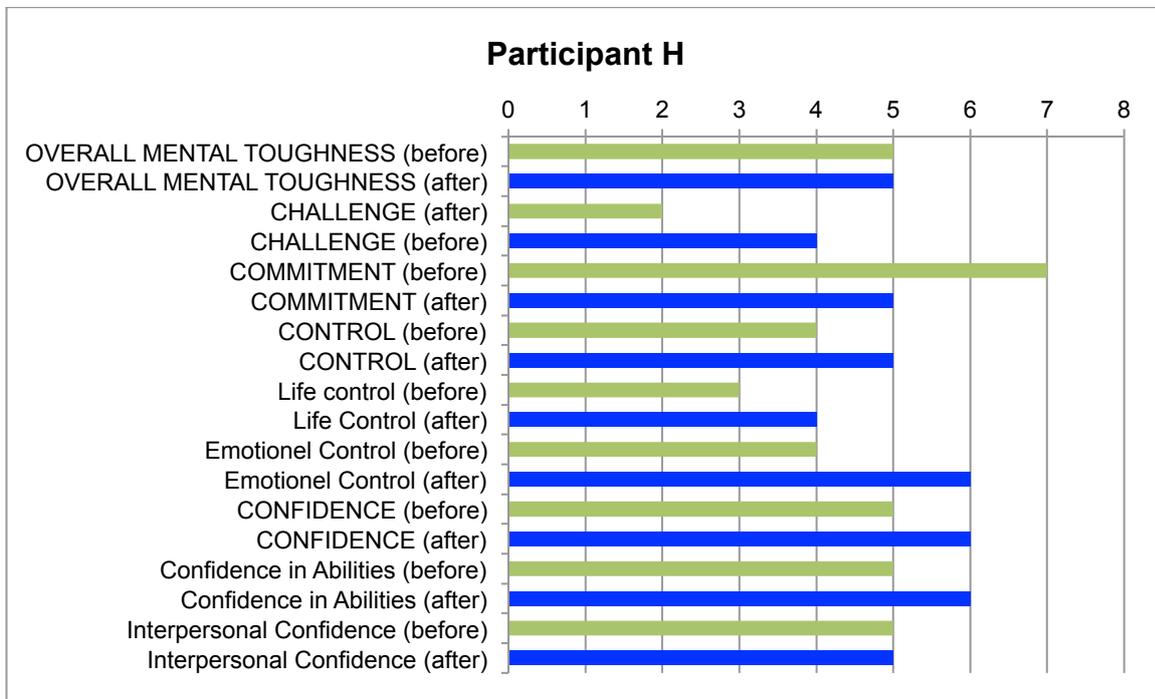
Age: 59

Gender: Female

Occupation: Office Manager

Trauma: Husband's death a year ago. He had cancer and suffered extensively during the last two months of his life. He had been very depressed since 1999, up until his death.

Graph 6.8: Participant H. Quantitative results (MTQ48): Pre- and post-test



SESSION 1: Participant H semi-structured interview (qualitative) when receiving feedback of MTQ48 (quantitative)

Participant H did not really know what to expect from her mental toughness scores. Her overall mental toughness score was a sten of five (average). She said that her principal challenge (for which she scored an under-average sten of two) after her husband's death was the difficulty that she experienced in dealing with everyday challenges like the maintenance of the household.

Table 6.8: Participant H's qualitative confirmation of MTQ48 scores

What are her low scores?	How she confirmed these low scores
Challenge (sten 2 below average)	- Needs to make decisions alone concerning the household and finances. - Has difficulty in sleeping.
Life control (sten 3 below average)	- Life feels out of control after husband died. She feels heavy load of responsibilities on her shoulders. Drains her emotionally.
Emotional control (sten 4 average)	- Feels more vulnerable than before husband's death.
What are her highest scores	How she confirmed these scores
Commitment (sten 7 average)	- One of her strong characteristics is that she never lets people down, she can always be counted on.
Confidence in abilities (sten 5 average)	- Although she has an average score, she says that she sometimes doubts herself and her abilities, especially when making decisions.

SESSION 2: Participant H. *Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started*

METAPHOR: The sea and the outside world is a metaphor for her life. She feels free when outside; and nature energises her. She spends as much time outside as she can every week. The uphill make her realise she can cope and finish things (one cannot turn around halfway – she always presses through).

SEMI-STRUCTURED INTERVIEW BEFORE THERAPY STARTED (SUMMARISED)

What motivated you to take part in this research?

Participant H: I wanted to make sure that I am fine after my husband's death.

What makes you feel that you are not coping with your trauma?

Participant H: Sometimes I feel a heavy load of responsibilities on my shoulders.

How did trauma change your life?

Participant H: I have more responsibilities in terms of my household and decisions.

How do you try to cope with trauma?

Participant H: I am always busy with work, I try to socialise with friends and with projects at home.

How do you see yourself?

Participant H: Positive and as a child of God.

What kind of feelings do you experience?

Participant H: The “blank” when I need to ask my husband his opinion of things and he is not there to answer me anymore.

What are your negative characteristics?

Participant H: Self-doubt when I need to make decisions.

What are your positive characteristics?

Participant H: Diligence, loyalty.

Do you have a support system?

Participant H: Yes. Friends, colleagues, family.

What is the best thing that you’ve ever accomplished?

Participant H: To have walked 101 kilometres in five days, on six different occasions (over a few years!)

Action research evaluation questions after session:

Participant H: I did not know what to expect, but Marisa made me feel comfortable and I could relax.

SESSION 3: Participant H. *Trauma’s effect on my body, behaviour, feelings, thoughts, brain and emotions*

FEELINGS INSIDE HER BODY:

Lonely (brown) in whole body; husband is no longer there.

Frightened (black) in whole body; she does not like to be alone, even though her daughter of 31 years of age still lives with her, she fears for the day when her daughter will leave.

Sad (blue) in eyes and heart, because of her husband's death.

Uncertainty: (no colour assigned to uncertainty - we used green) in stomach, as she experiences a knot in her stomach. She is also uncertain about how to make decisions about building an outside fence and selling a broken vehicle.

Proud (pink) in heart and feet, as she completed many walking routes with a group of friends.

Happy (yellow) in heart and head, as she still has much to be thankful for in spite of her circumstances: good old friends, colleagues, children).

Excited (purple) in heart, mouth, eyes, arms; when she sees that plans fall into place, e.g. buying of new car, successfully booked a holiday for December at the seaside.

THE "SELF"

Interferences and/or negative events in Participant H's life are and were her dad's death when she was 20 months old; she could not study teaching as she applied too late so she completed a secretarial course instead; her own mom's death a few months before her husband's death; her husband's depression that he struggled with for nine years and made her question whether he still cared about her). These interferences led to an **adapted self** (in order for the ego to still feel good about itself and to be able to cope as a person). Participant H's adapted self is: restlessness (she cannot sit still, always busy), self-doubt, struggles to sleep (uses sleeping tablets). Her **ideal self** would like to be able to live life fully until the end, to calm down and recharge her batteries (not to be so busy) and to do the things on her bucket list, e.g. Rowing on the Orange River rowing and completing the Rietvlei Granny Walk.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experiences: Guilt can be added as feeling and colour as she feels guilty for putting her husband in a care centre and did not take care of him at home for the last four weeks of his life. We discussed this issue and she realised that she neither had the facilities and physical strength nor the emotional strength to take care of her husband at

home. It was responsible of her to place him in a care centre.

She was forced to be confronted with her emotions, but it was non-threatening (“play-play”). She realised the value of categorically “seeing” the emotions in my body. She learned that she has more and different emotions than she thought she would have. She would recommend a professional person to support a traumatised person to take an in depth look at his emotions.

SESSION 4: Participant H. *I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation)*

PROTECTING SHIELD

It was moderately challenging for Participant H to identify her positive characteristics as she grew up in a generation where it was considered bad to boost yourself and even to acknowledge your good characteristics and/or talents was unacceptable. At the end she listed her positive characteristics which become part of her protecting shield: positivity, diligence, conscientiousness, friendliness, good organising skills and compassion. Her negative characteristics (which were easy for her to identify) is to doubt her decision-making and to be concerned about other’s opinions of her.

ANCHOR OUTSIDE TRAUMA

Participant H’s anchors where she feels safe: going for a walk, reading her devotions, reading stories and magazines, visiting her neighbours (old friends) and to spending time with her three adult children.

PROSPER

It is difficult for Participant H not to be busy and to simply relax. She will start to focus on things that she can control, which are her thoughts and behaviour and she will make an effort to at least try to calm down at night time to try to sleep better. Her homework was to compile a poster, of calming down and relaxing as well as her future dreams.

ACTION RESEARCH EVALUATION QUESTIONS

Positive experience of the session: She realised the importance of talking to a professional person (even if you think you are fine), like she did. She is being equipped with many new skills (and things that she learned about herself) which empowers her to

be stronger.

SESSION 5: Participant H. *Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself*

VISUALISATION POSTER

Participant H fell asleep before she could finish listening to the prosper CD - which is good news as she struggles to calm down at night. Her visualisation poster consists of the following: the sea, where she often goes to and a sentence “don’t live down, live up and be happy”; her first walking route on her 50th birthday; the words “make time and just do it”; importance to take good care of her health and to eat healthy; the words “never stop dreaming”; gardening - she loves it and it calms her down; the words “repeat” - implies to repeat the nice things in life; camera (to capture memories and to make time to slow down life); and walking with her friend to keep fit.

DEFENCE MECHANISMS

Participant H explained that she was always busy and that it was challenging to slow down, as well as that she cannot be alone and she always wants people around her.

PARTICIPANT H’S “BAG” OF WHO I AM

In Participant H’s bag were photos of her walking trails, walking shoes, as she reminds herself constantly to take up the responsibility and exercise; her favourite perfume; recipe book because she loves cooking; a blanket which she is crocheting; her touring hat with the words “just do it”; biscuits because she bakes biscuits on a monthly basis to collect money for her walking routes every year and a photo of her family as she often spends time with her three children. The topic of being proud of herself and to acknowledge her good qualities again came to the surface as she is a remarkable woman but does not give herself that acknowledgement.

FIRST-AID KIT

Participant H put the following aids of how to be good to herself in her first aid kit: work in the garden; enjoy a facial; bake something special; needle work; be creative (makes things e.g. collages by using stones, wood and old food tins); knitting scarves in winter; visit her friends; read “blessings for sleep time” book.

ACTION RESEARCH EVALUATION QUESTIONNAIRE

Negative experiences which changed into positive experiences: She did not know that always being busy can sometimes be a defence mechanism. She did not know anything about defence mechanisms.

The prosper CD and her first-aid kit are practical ways to help her to stop and to relax as it is difficult for her to do that.

Negative experiences of the session:

The homework had been substantial. As she was tasked with compiling a visualisation poster, listening to the prosper cd as well as collecting items, which describe themselves, and put it in a box/bag.

SESSION 6: Participant H. *How to fill up my “empty bucket” although I am a broken person*

This session emphasised that the participants are required to choose to stand up from their emotional wheelchairs.

The session commenced with revision of what was experienced and achieved during the past five weeks. This was physically represented with an empty bucket together with a gift box, a jewelry case, a teddy bear, etcetera (see Chapter 5 Session 6 for a more detailed description). Participant H was empowered by realising the following skills and knowledge: discovering her positive characteristics, understanding her ego and its' needs, realising her defence mechanisms, knowing what to affirm and say to herself on a daily basis, how to use her own first-aid kit. Participant H believed that she had already stood up from my emotional wheelchair, because she is aware of what makes her “tick” and “dance”, she understands the power of the slight edge and that she just has to go on in life, although she admits that she will sometimes feel as small and as scared as a tiny mouse.

Participant H had to write down her positive characteristics again (it was done in session 4 see “protecting shield”) and put it in her jewelry box to be constantly reminded of her valuable gifts and to make sure that she uses them: positive attitude, loyal, laughs often, helpful, tolerant (a new skill discovered and gained through therapy). She reminded me today that she has many special characteristics and qualities and that she

may and must and should be proud of it and that is an important thing that she learned in the therapy sessions.

ACTION RESEARCH FEEDBACK AFTER SESSION

Positive experience of the session: She really enjoyed the bucket and the objects inside, as it is practical.

SESSION 7: Participant H. *My ego states and the way it influences my relationships with myself and other people. My past, my present and my future.*

EGO STATES

According to the Transactional Analysis Questionnaire, Participant H's dominant ego state is the parent. She moves between being a nurturing and a critical parent. She realises that her daughter (who lives with her) is much more of a passive person than she is and that it is not wrong to be like that, as she used to compare her "busy body" self to her laid-back daughter and often criticized her daughter for it.

TRANSACTIONAL ANALYSIS

Participant H recognised herself in the "I am not ok" and "you are ok" category, as she tends to wonder what other people think of her and sometimes doubts her own abilities. She realised the importance of how to purposely acknowledge her good qualities and positive characteristics in order to move to the "I am ok" and "You are ok" category.

SAND THERAPY: MY PAST, MY PRESENT AND MY FUTURE

Participant H's sand picture represented her **past** life as follows: living on the farm with her husband and three children, and they spent much time outside in nature, among many animals on farm. They lived a happy, care-free life before husband became depressed in 1999. Her **present** exists of her and her three grown-up children. They eat out, camp, go to the seaside together (none of them are married yet). In the **future** she would like to have grandchildren and to be an active granny who will share her love with her children and grandchildren, who spends time with family and good friends. She always take her camera with her to capture the good times that they spend together.

ACTION RESEARCH EVALUATION QUESTIONS AFTER SESSION

Positive experiences: She explained that she enjoyed the sand therapy after her day at work. It was relaxing.

SESSION 8: Participant H. *Feedback on post-test MTQ48 and semi-structured questionnaire*

MTQ48 DISTANCE TRAVELLED REPORT AFTER THERAPY SESSIONS (QUANTITATIVE RESULTS)

Participant H's overall mental toughness remained on a sten of five (average). The following mental toughness components increased: Challenge sten increased from two to sten four; Life control increased from sten three to sten four; emotional control increased from sten four to sten six; and her confidence in abilities increased from sten five to sten six.

Interpersonal confidence stayed on the same sten of five and commitment decreased from a sten of seven to a sten of five. We discussed the decrease in commitment and one of the possibilities may be that the different components of mental toughness came more into balance during the therapy sessions as all her scores are between stens of four and six, which are all average scores.

SEMI-STRUCTURED QUESTIONNAIRE AND INTERVIEW AFTER THERAPY SESSIONS (SUMMARISED):

Has anything changed during the past two months' sessions? If yes, what has changed?

Participant H: More at peace that I've put him in a care centre during last four weeks.

What have you learned about yourself?

Participant H: Need to think more of myself, acknowledge my good characteristics and often think of it.

What do you do differently in your everyday life?

Participant H: Read positive self-talk every morning before work. I also gave it to people who work in office with me to read it every morning and they do!

What have you learned about your trauma?

Participant H: To accept it, although it will be difficult at times. To fully live my life, as I want to do and always did, as I still have life.

What makes you feel that you are coping better now?

Participant H: I feel calmer, and I can calm down better as I listen to prosper at night. If I experience a problem I talk to myself and calm myself down, take a breath and then try to handle it to the best of my ability.

Have any of your relationships changed? How did it change?

Participant H: Yes, my one friend who told me that I withdrew from her better understands my actions and realise that it is normal for grieving people to want to withdraw.

Did your feelings change? Can you explain how it changed?

Yes, I can support other grieving people.

What did you gain from these intervention sessions?

Participant H: Confirmation that I am on the right way, that I have the right attitude in life (positive) and that I have a future.

Do you have a support system?

Participant H: Yes. My children, friends, colleagues.

How do you see yourself?

Participant H: Positive and a go-getter.

How do you see the road ahead?

Participant H: To live life to its fullest as I did since I had been a little girl – that is what I have learned from my mom who had been a single, “seize-the-day”, parent.

Would you recommend these intervention sessions for other people? Why or why not?

Participant H: Definitely. The practical applications are excellent.

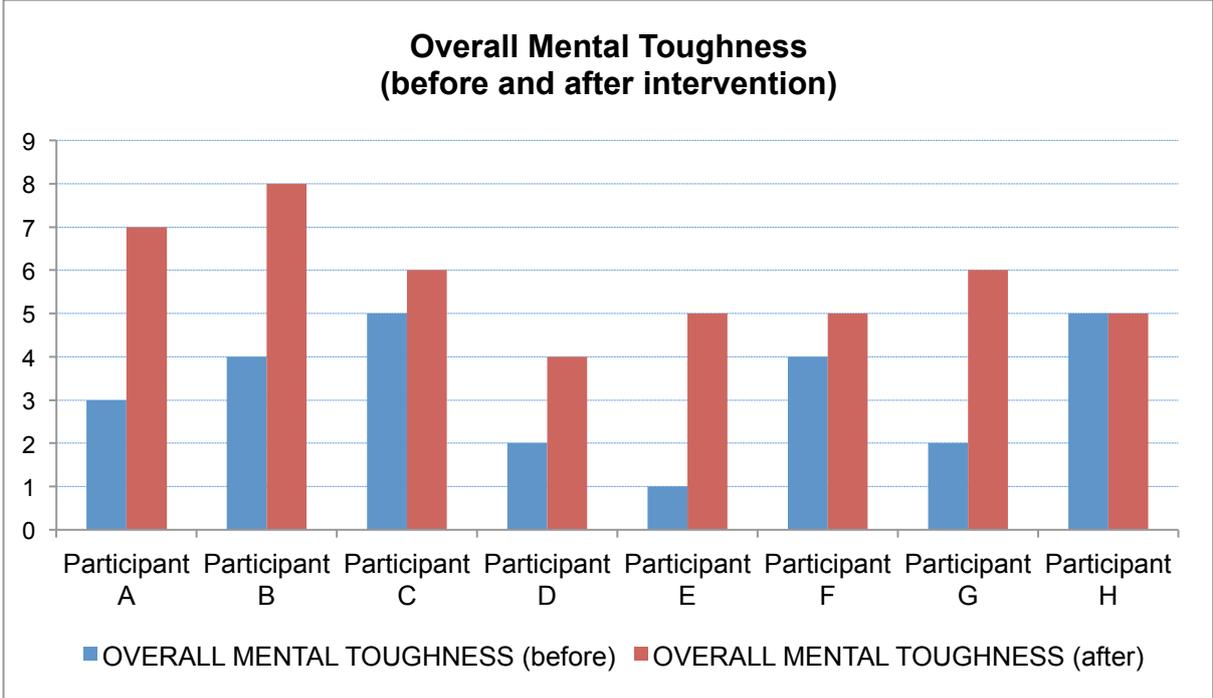
Do you have any recommendations for the presenting of this programme in the future?

Participant H: Just go ahead with this wonderful work.

6.4 IMPACT OF INTERVENTION PROGRAMME ON PARTICIPANTS

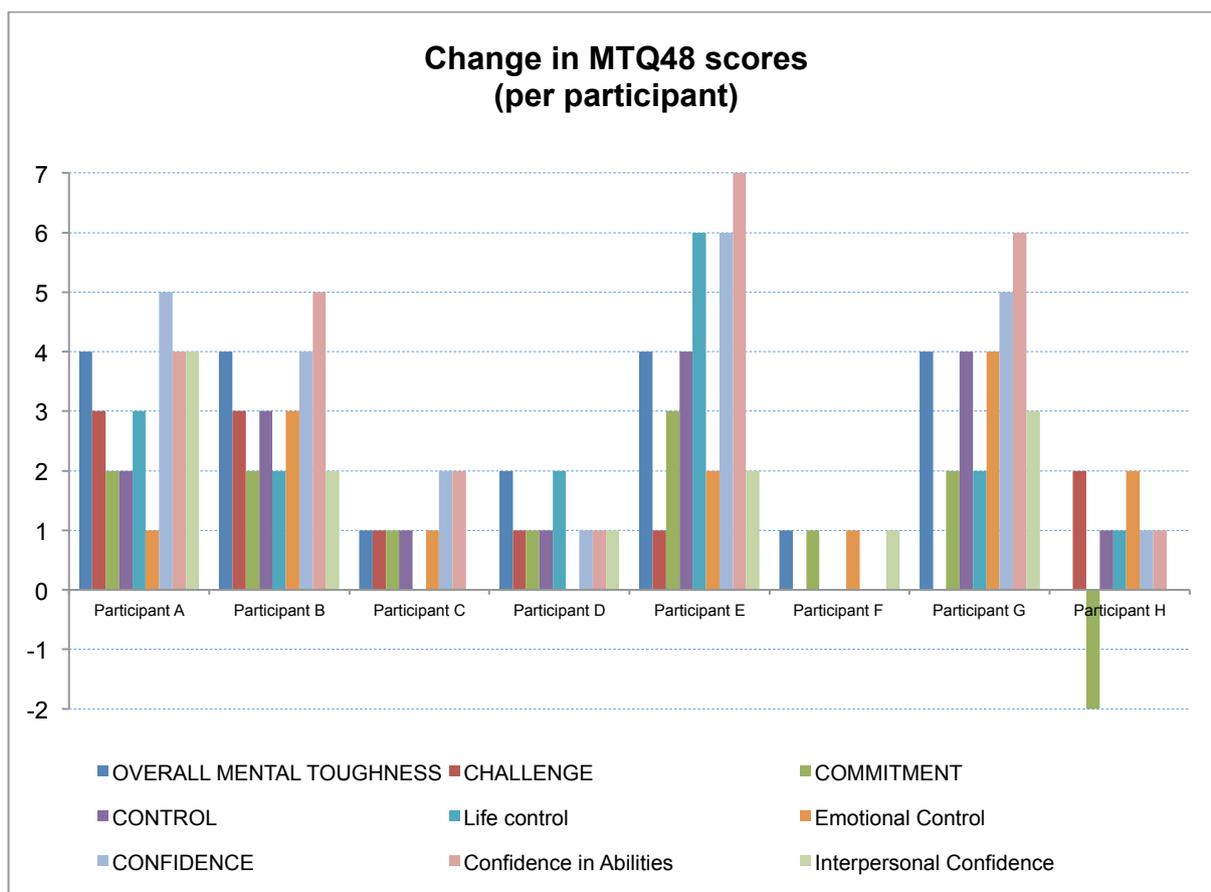
The impact of the intervention was determined by pre-tests and post-tests as well as semi-structured interviews. In section 6.3 the climaxes of each participant's results of the MTQ48 as well as the semi-structured interviews were indicated and briefly discussed. All the participants' overall mental toughness increased after a post-test was done on completion of the eight therapy sessions, except for participant H who's overall mental toughness sten of five remained the same (see Graphs 6.1 to 6.8). Participant H though showed increases in challenge where her sten of two increased to a sten of four, life control's sten of three increased to a sten of four, emotional control moved up from a sten of four to a sten of six and her confidence in her abilities changed from a sten of five to a sten of six. Progress is shown in both participant H's MTQ48 results as well as in her semi-structured questionnaire after the therapeutic intervention, where she indicated that she feels calmer and deals better with decision-making in her everyday life (one of her crucial issues after her husband's death). She also indicated during the sessions as well as in the action research evaluation questions after the sessions, that she realised that she needs to recognise her positive characteristics and qualities more and that she does her positive affirmations and self-talk every morning before work.

Graph 6.9: Overall Mental Toughness (before and after intervention)



Four participants' overall mental toughness scores increased with four stens each, two participants scores increased with two stens per participant, one participant moved up one sten score and one participant's overall mental toughness did not increase with a full sten score.

Graph 6.10: Change in MTQ48 scores (per participant)



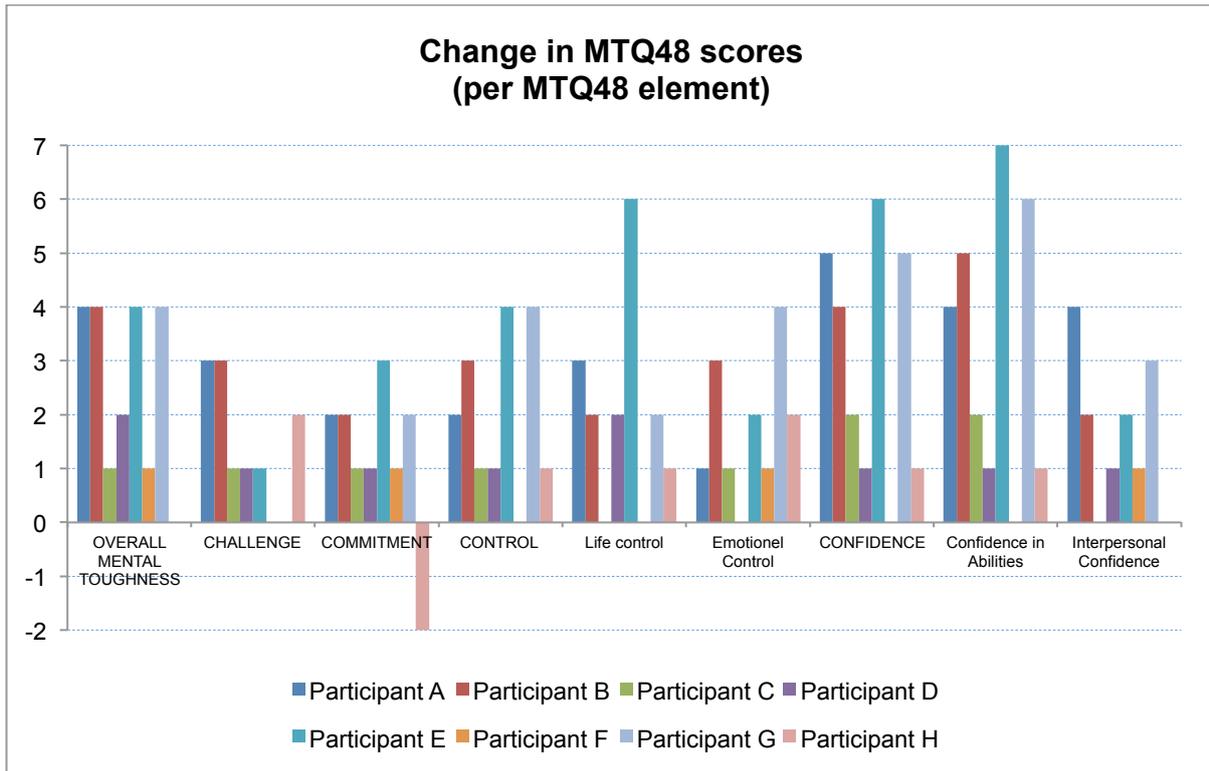
According to Graph 6.10, the participants who seem to have benefited the most from the intervention sessions are participants A, B, E and G. Participant F seems to have benefited the least, as only four of the nine components of her mental toughness increased. Both participants D and F experienced difficulties in saying “no” at work, as they seemed to be people-pleasers. Both participants were in continuous conflict about people at work who just expected from them to do more work and to work late, even on very short notice. Although they realised it, it seems clear that they still have a “way to travel” in order to be more self-assertive at work and to sometimes say no for their own self-preservation. Both participants are unsure of themselves and they take others’ comments too much to heart, and both of them will often rely on others to help them to maintain and enhance their self-belief. Both of them scored a score of three for their life control (after the intervention). Although participant D’s life control increased with two points, it is still below average. Both of them often experienced that their work controls them. Therefore it seems that self-assertiveness plays an important role in whether a person’s score increased or not. Future research is required to prove this. Both participants D and F experienced depressed feelings (D has post-natal depression) and

F sometimes just feels down and depressed and is scared that she might develop depression like her dad did. Although their mental toughness increased, neither one of these participants' mental toughness increased as much as participants' A, B, E and G's. The possibility exists that the mental toughness of people with symptoms of depression and/or people who have depression, will increase less than people who do not have depression and/or the symptoms thereof. It will also be interesting to investigate, whether a relationship between self-assertiveness and depression exists as both of these participants experience issues with self-assertiveness and depression.

Participants C and H were the oldest participants in the study. They were respectively 59 and 62 years of age. As discussed earlier, Participant H's overall mental toughness stayed the same, although the rest of her scores (except for one score) increased (and one of her scores moved down). Both Participants C's and H's scored increased, but not as much as those of participants A, B, G and E. These specific participants grew up in conservative homes where self-acknowledgement was seen as arrogance. This had been their perceptions when they started with the intervention programme. It will be interesting to do further research in the future to determine whether older people's mental toughness in general increases less or not and/or whether it has to do with their perceptions of life.

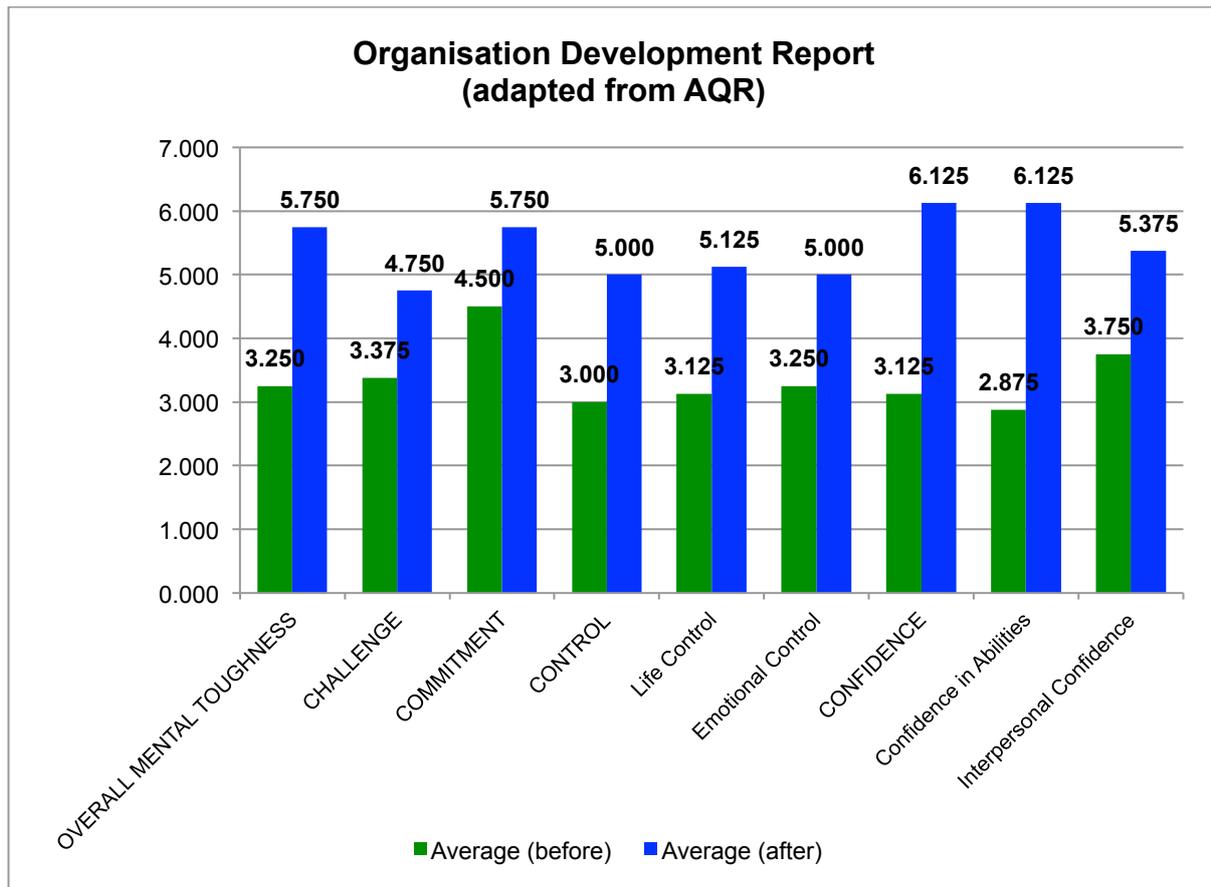
Participant H was the only person who had a sten that decreased after the intervention programme as her commitment sten decreased from a sten of seven (highest average sten) to a sten of five (average). The explanation for this is probably that her stens are more evenly distributed after the intervention as the stens are all between four and six (which are both average scores).

Graph 6.11: Change in MTQ48 scores (per element)



The mental toughness components that increased most after the intervention were confidence and confidence in abilities, which increased with an average score of 3 and 3.25 respectively. Five participants (A, D, E, F, G) had below average scores for confidence before the therapy started and three participants (B, C, H) had average scores for confidence in the pre-tests. It was obvious through the intervention sessions (through the qualitative observation and feedback from participants) that all participants struggled to have confidence in themselves and their abilities and self-doubt was the rule and not the exception. In the post-test, six of the participants (A, C, D, F, G, H) gained average scores for confidence and two participants (B and E) had above average scores for confidence. In the pre-test for confidence in abilities six of the eight participants (A, B, D, E, F, G) scored below average and two participants (C and H) obtained average scores. In the post-test of confidence in abilities, three participants (B, E, G) scored above average, three participants (A, C, H) gained average scores and two participants (D, F) scored below average.

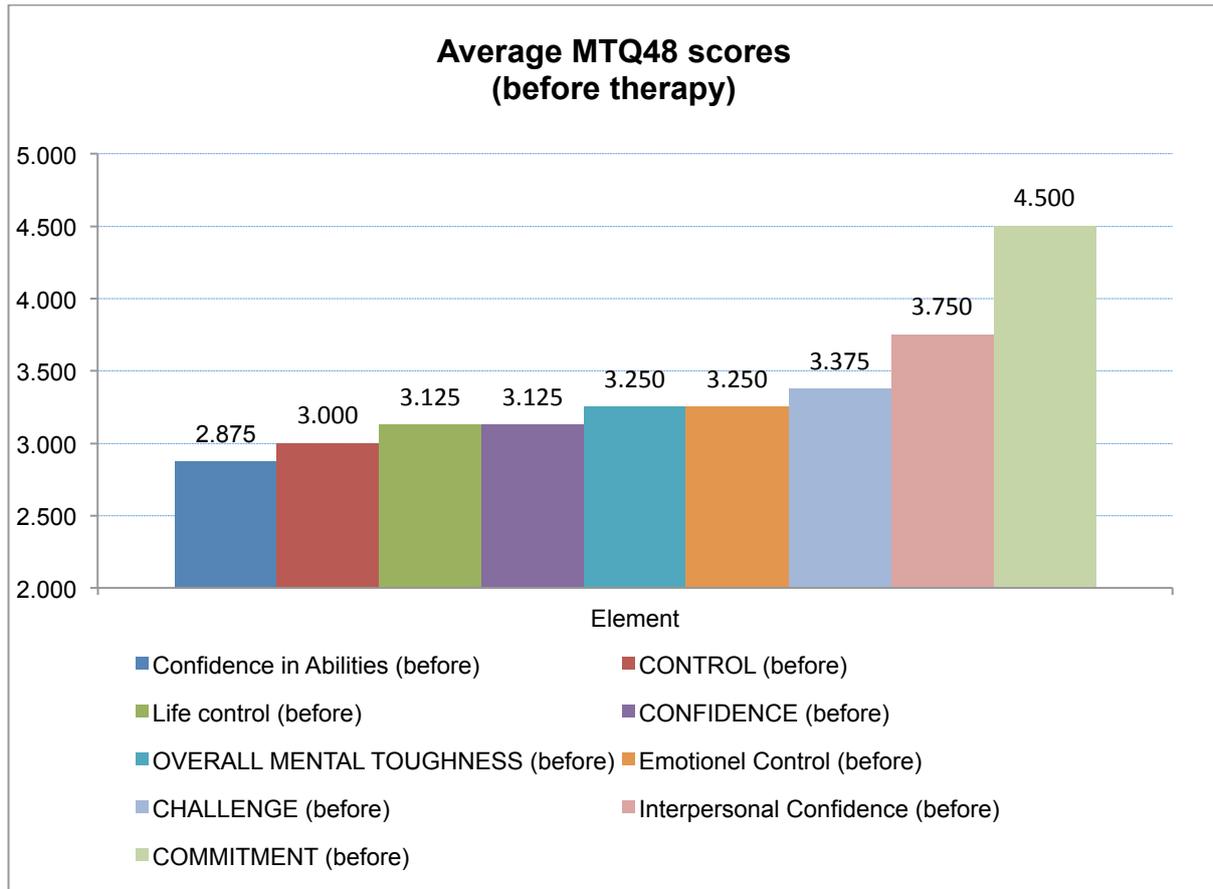
Graph 6.12: Organisation Development Report (adapted from AQR)



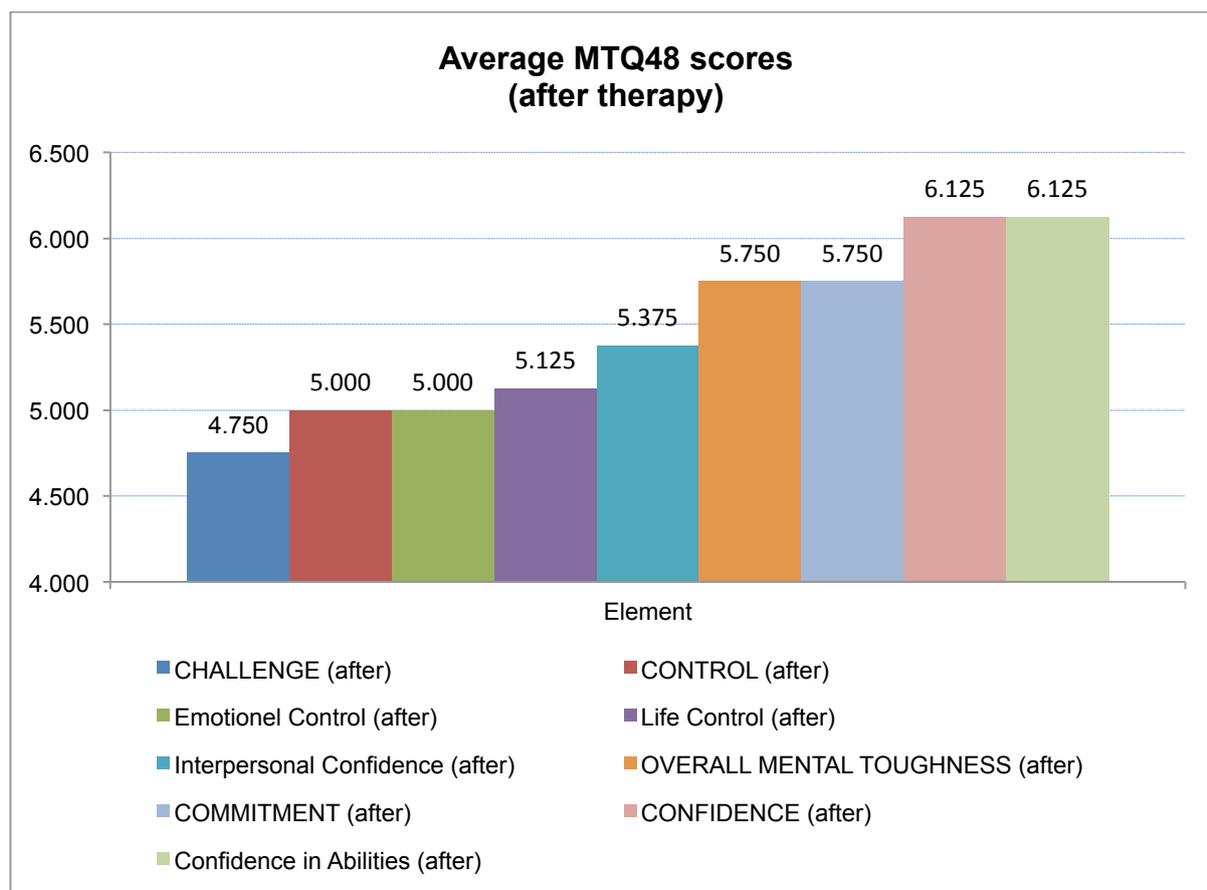
An organisation development report of the eight participants of the study was created to see the results for each scale of the MTQ48 before as well as after the intervention therapy sessions. The difference between the means of the pre- and post-tests indicates the average point with which a score increased. From Graph 6.12 it is evident that all components of mental toughness increased during the intervention sessions. The average score of the overall mental toughness of the eight participants together increased with a score of 2.5. Challenge increased with an average score of 1.375, commitment increased with 1.25, control increased with 2, life control increased with 2, emotional control increased with 1.75, confidence increased with 3, confidence in abilities increased with 3.25 and interpersonal confidence increased with 1.625.

The mean of the lowest score in the pre-test, of the eight participants, was confidence in abilities, with a score of 2.875 and the mean of the highest score in the pre-test was commitment with a score of 4.5. The mean with the lowest score in the pre-test, of all eight participants, was challenge with a score of 4.75 and the mean of the highest score in the pre-test was confidence in abilities with a score of 6.125.

Graph 6.13: Average MTQ48 scores before intervention



Graph 6.14: Average MTQ48 scores after intervention



In Graphs 6.13 (before therapy) and Graph 6.14 (after therapy) the scores of both the pre- and post-tests are indicated from the highest to the lowest mean.

From above-mentioned discussion of both the quantitative as well as the qualitative results of the study, the conclusion is thus drawn that the traumatised persons' mental toughness (persons A, B, C, D, E, F, G), or at least aspects thereof (participant H) increased through the intervention programme.

An important **further question** is, whether the participants found that they can **better handle** their various **traumas** and better deal with it. This was determined through my observation as well as through the therapy sessions and feedback of the participants. What follows is a summary of the participants' comments after the intervention sessions.

Participant A: I'm more confident in my abilities. I'm aware that I can feel sorry for myself and purposefully not try to do it anymore. It's still difficult to live with my husband, but therefore I force myself to reach out more to others. I'm busy finding myself.

Participant B: I have learned why I emotionally tend to overact easily. This knowledge

empowers me. I'm committed to change and I have already started to harvest from the seeds that I started sowing. I'm less anxious and I experience a huge sense of relief. My relationships with both my daughter and boyfriend are more relaxed and on a better level and I like myself more.

Participant C: I feel I can go on with my life again and I feel better about myself. I have practical aids and I know what to do when I get overwhelmed, like my anchors, my bucket and my first aid kit. I'm less scared at home at night.

Participant D: I feel more in control of my world which felt totally out of control. I understand why and how my body reacted on my trauma. I now have a weekend support system in place. My husband and I can at least talk again of things that really matters, like our relationship.

Participant E: It was freeing to realise that I'm a survivor and not a victim of my bipolar disorder. My thoughts are more positive and not so destroying anymore. My life changed from just existing to living again. I know I have to work hard to keep it this way.

Participant F: I can face my emotions for the first time in my life. I talk to my worry monsters and try to I chase them away. I know that I have to do it on purpose. I try to see myself not only as a sister and a good friend to men, but also in the role of a woman.

Participant G: I went from suicidal thoughts back to life. I've realised that I have another son who is still alive and that I can't take life away from him. Sometimes it's difficult, but I really force myself to do what I've learned during the therapy sessions.

Participant H: I don't feel guilty anymore for putting my husband in a care centre. I read my positive self-talk every morning before work and try to appreciate my positive characteristics more. I'm overall calmer and I calm down at night if I listen to my prosper cd.

6.5 ACTION RESEARCH EVALUATION FEEDBACK FROM PARTICIPANTS

As discussed in Chapter 4 (4.3) evaluation is an important part of the cyclic process of action research. An example of the action research questionnaire is attached as Addendum D. The participants' overall evaluation of the sessions was positive and can

be summarised as follows:

Positive experiences of the therapy sessions:

- The importance that the therapist should create an atmosphere where participants feel safe enough to open up and share their deepest emotions.
- The precise representation of the participants' emotions (with different colours) inside their bodies.
- Sand play therapy was very popular and relaxing.
- They experienced empowerment in being able to gain insight in how they acted and reacted.
- Explicit reminders and enhancers of being mentally tough were very effective (e.g. the bucket with its content (Session 6 of Chapter 5).
- Except for two participants, the participants found the clay work relaxing. One of them realised later in the session that the clay metaphor actually helped her to gain more profound insight of herself.
- The realisation of having a good support system, as they sometimes felt lonely in their traumas.
- To realise that they are "normal" in an "abnormal" traumatic situation.
- To learn to love and appreciate themselves more and that they actually should love themselves.

Negative experiences of the therapy sessions that became positive experiences:

- The discovering of defence mechanisms (which later on helped them to understand the ways in which they adapted to cope with the challenges in their lives).
- To face hurting emotions which they thought they had resolved.

Negative experiences of the therapy sessions:

- Two of the participants said that they received too much homework after Session 5. They had to compile a visualisation collage, to listen to the prosper CD as well as collected eight items in a box/bag to describe who they are.

Participants' recommendations for the therapy sessions:

Guilt, which is represented by the colour *white* was added as an “emotion flower” as traumatised persons usually experience a great deal of guilt.

All participants said that they cope better with their traumas, although it sometimes is more difficult than other times. The conclusion is thus drawn that a psycho- educational intervention programme, which was aimed to support traumatised persons, lead to increased mental toughness and better dealing with trauma.

6.6 CONCLUSION

As previously mentioned, no programme will completely fit each person's needs as each person is a unique individual. Each traumatised person is at a different stage of their trauma and brings his own perceptions to an intervention session. The same intervention programme was used with all eight participants, but the detail, sequence and duration of the activities were adapted according to their personal needs.

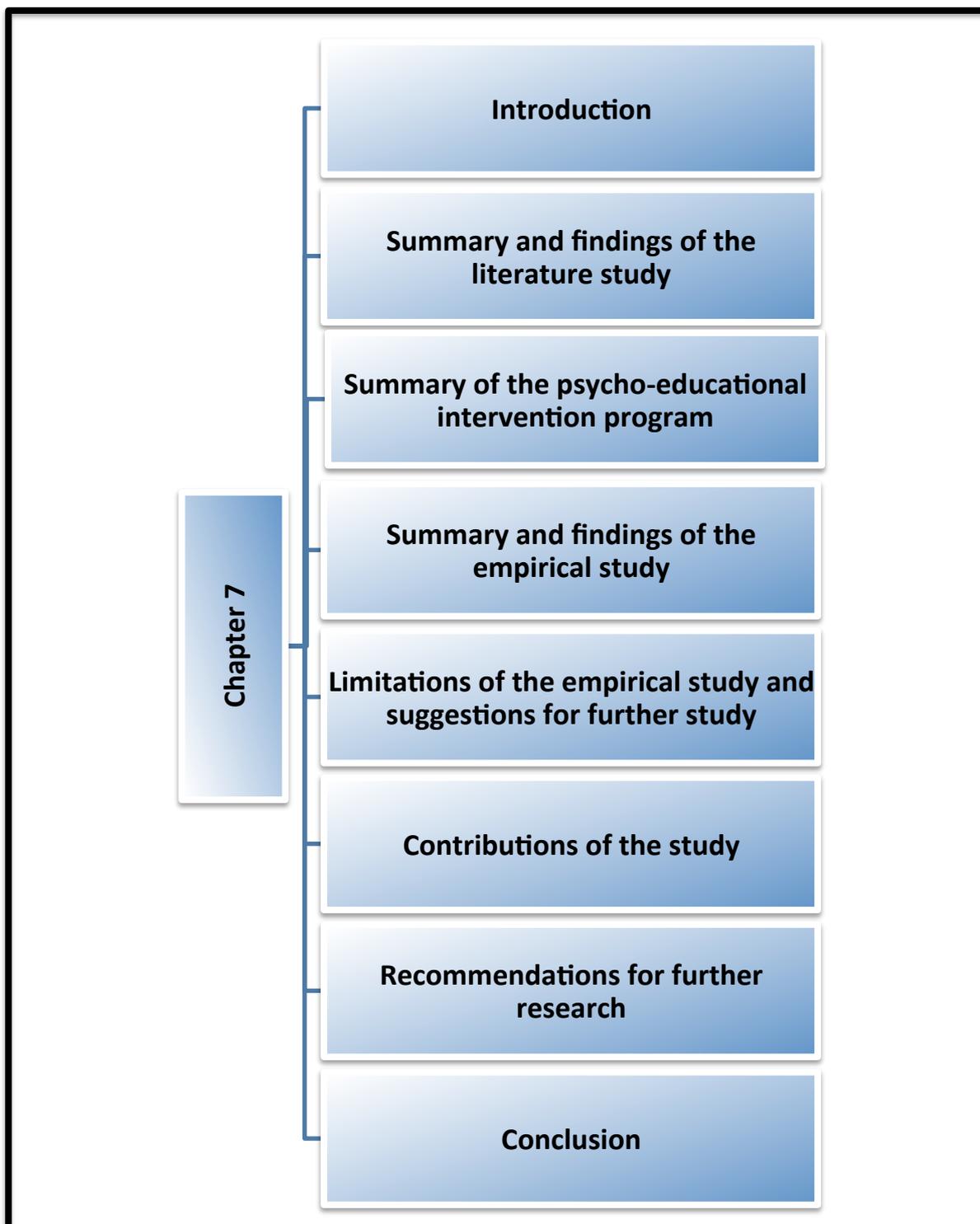
The evaluation of the data indicates the intervention programme as being successful in increasing a traumatised persons' mental toughness in order to better deal with their trauma.

In Chapter 7 the study is summarised.

CHAPTER 7

SUMMARY, CONCLUSION AND RECOMMENDATIONS OF STUDY

Figure 7.1: Chapter outline



7.1 INTRODUCTION

The aim of this chapter is to provide a summary of my study. The purpose of this study was to investigate the effects of a psycho-educational intervention programme on the mental toughness of traumatised people. In this chapter, a summary of the study as well as the findings of the literature review, the empirical study, the intervention programme and the conclusions from the results are discussed. The limitations and recommendations for further research are also explained. The contributions of the study are also delineated.

7.2 SUMMARY AND FINDINGS OF THE LITERATURE REVIEW

As an educational psychologist, I am confronted by traumatised people on a daily basis. These people have to deal with both their traumas as well as with unresolved past experiences, which tend to be triggered over again by the trauma (Roets 2009; Perschy 2004:12; James & Gilliland 2013: 150, 177; Marshall 2007: 1-2). In my desire to support these people, I undertook a literature review and discovered that limited information exists regarding how a therapist should practically support a traumatised person (1.2).

In **Chapter 2**, I investigated the phenomenon of mental toughness. Most resources focus on diagnostic aspects and are descriptive, without any specific guidelines about how to use the strategies and techniques. The literature further indicated that a person can become his “own best healer” if he is empowered with skills and characteristics to do so (1.2). I agree with both Bethany (2007: 124) and Van den Aardweg (1999: 194) that by supporting a person through psycho-education, the individual can gain insight into his responses and learn to change his reactions to his stressors. During this process he learns to better control aspects like his thoughts and behaviour.

Mental toughness has its roots in three well-known psychological phenomena which are resilience, psychological toughness and hardiness, and has four fundamental aspects, namely control, challenge, commitment and confidence. Therefore mental toughness seemed to have a strong base to be able to support traumatised people in a psycho-educational intervention programme (discussed in Section 2.5). Mental toughness was found to be considerably more favourable because it can be measured with the MTQ48 (discussed in Section 2.3). The MTQ48 had proven successful in the world of sport

psychology and corporate management as a valuable and reliable measuring instrument (2.10).

7.2.1 Conclusions were established from Chapter 2:

Mental toughness is defined as: *“The quality which determines in large part how people deal effectively with challenge, stressors and pressure...irrespective of prevailing circumstances”* (Clough & Strycharczyk 2012: 1). Mental toughness can be developed. Clough and Strycharczyk (2012) state that mental toughness intertwines both theoretical foundations, like confidence and resilience, and practical applications, for example visualisation and focusing. This intertwining of theory and practice provides a detailed analysis of the literature about the prominent aspects in the development of mental toughness (discussed in Section 2.10).

The first important aspect is that a person should be willing to develop more mental toughness, implying that he therefore should be willing to take action (Mentioned in Section 1.2). In a person's willingness to increase mental toughness, the individual should be willing and committed (one of the four components of mental toughness) to take responsibility for his own life and to face his setbacks and failures (refer to Section 2.5.1.2 & 2.5.2 for more explanation). Setbacks and failures are part of life and people should rather be supported to “face it” and work through it than to be shielded or protected from it (discussed in Section 2.9).

Self-belief is an important buffer against adversity and crisis and a strong sense of self-belief is an important characteristic of mental toughness. In order for persons to learn to believe in themselves, they should learn about who they are and start focusing on their positive characteristics and skills (as explained in Section 2.5.4). A client should be guided by the therapist to become aware that his perceptions of his own success and failures are influenced by his frame of reference, which includes his norms and values (discussed in Section 2.5.2). In supporting a person to gain insight into himself and the way he adapted, due to stressful experiences in his life, will empower him to discover his inner strengths. In this process he can play the core role in his own healing process (3.1.3).

An inter-correlation exists between mental toughness, stress management, performance and well-being. Characteristics of mental toughness include *inter alia* the ability to effectively cope with stress and to recover from adversity and failures.

Therefore in supporting a client to increase his mental toughness he should be supported in how to better deal with his stress and how to manage it. Positive self-talk is a further aspect to support a person in dealing with stress, as it plays an important role in the development of a person's positive self-concept (discussed in Section 2.9).

A flexible person will be better able to cope with negative emotions than a rigid person, as he will realise that he is still able to make choices and is not completely trapped inside his adversity. The therapist should support the client about how he can start to push his own boundaries, in spite of physical and emotional pain (Description of MTQ48 Scales & Stens; Stens 1-2-3, Addendum E).

Learned helplessness and the control component of mental toughness are closely intertwined. Learned helplessness implies a person's perception that things are out of his control – even things that he can control. If a person can unlearn his learned helplessness he can become more mentally tough (described in Section 2.5.1.2).

Another core aspect in developing mental toughness is goal setting. James and Gililand (2013: 157) focus on the value of accomplishment for a traumatised person. Sue *et al.* (2010: 195) also focuses on the importance of taking action, which implies making changes in order to attain certain goals (2.10; 2.5.4 & Table 10).

Support systems, for example, peers, parents and coaches play an important role in the development of mental toughness and the client should be supported to realise whether he has a support system/s and how to put his support systems in place. This will allow him to become stronger to increase his mental toughness characteristics, like resilience and persistence (2.9).

In **Chapter 3** I investigated the phenomenon of trauma. Trauma is defined as stressful events, over which a person has no control. These stressful events cause high levels of anxiety and threaten or harm a person's emotional, physical and/or social well-being and interfere with his normal daily functioning in such a way that a re-evaluation of his actions and thoughts are needed. These strong emotional reactions have the potential to interfere with a person's ability to function either at the scene (of the trauma) or later (Mitchel 1983) (Preston 2013: 2, Roos *et al.* 2002: 91, Unisa 2002: 8-10, 22, 30, Tedeschi & Calhoun 2004: 2 and Keeton 2009: 1).

The following conclusions were made from Chapter 3:

Trauma can cause feelings of helplessness and although what may be traumatic for one person, it might not necessarily be traumatic for another person. To determine whether an event was traumatic or not, one can assess the impact that it had on a person. A person's reaction to a trauma is influenced by aspects such as genetic predisposition, personal history, personality traits, self-esteem, strengths, weaknesses, state of mind, past life experiences, coping skills, social support system, the intensity of the event, the perception of the event, conflict, stress management skills and flexibility. Therefore a therapist should know that every traumatised person brings his own perceptions to a therapy session. In supporting a traumatised person, the main focus should therefore be on the effect of the trauma on the person and not on the trauma as such (3.7 and 3.10).

In "facing" and dealing with trauma, a traumatised person should be committed and willing to take action which implies he should get actively involved in his healing journey. By "facing" trauma, an individual attempts to regain the control that had been taken away from him through the traumatic event, a traumatised person should make a deliberate and active cognitive decision. A traumatised person should know that it takes tremendous courage to regain his life after a traumatic experience and that traumatic events challenge a person's fundamental ground, for example, his values, norms and ability to deal with stress (3.2; 3.7 and 3.13).

An empowering tool in a traumatised person's life is to see himself as a survivor and not as a victim. In order to properly support a traumatised person through therapy, it is important to address the impact of negative previous life events on his self-concept and ego strength. Flexibility allows a traumatised person to start to make sense of his life again, as rigidity complicates life and make it difficult for a traumatised person to try to adapt with the changes in his life. Both self-awareness and positive self-appraisal will support a person to better deal with his trauma. A traumatised person should be supported by the therapist to discover his defence mechanisms. People use defence mechanisms (e.g. withdrawal and fixation) to protect themselves (discussed in Section 1.2 and Section 3.13).

It is important that a traumatised person should be supported to become aware of intrusive thoughts as well as the interdependence between his and other peoples' thoughts, feelings and behaviour. Some traumatised people deal better with trauma than others do. Characteristics which help a traumatised person to better deal with

trauma are resilience, hardiness and optimism. Resilience, hardiness and optimism are integral parts of mental toughness and therefore the hypothesis can be made that mental toughness will support a traumatised person to better handle his trauma (2.4 & 3.11).

Trauma and the accompanied stress can have negative physical and psychological implications on a person’s health. In order to empower the traumatised person, he should learn about the **normal** symptoms, as well as the neurological processes that take place in his brain, due to the **abnormal** circumstances. In this process the traumatised person will better understand why trauma impacts him the way it does and it will empower him to believe that healing is possible. Play therapy (e.g. artwork, clay work, storytelling, bibliotherapy) and cognitive therapy (e.g. relaxation training, thought stopping, cognitive restructuring) are powerful aids that support a traumatised person to learn how to emotionally deal with sensorial trauma stimuli. A support system of family and friends protects a stressed person from the destruction of stress (discussed in Sections 3.6; 3.7 and 3.10).

7.2.2 Corresponding aspects between the literature review of mental toughness (Chapter 2) and trauma (Chapter 3):

In my study of how to support a traumatised person to develop more mental toughness in order to gain skills that will support him to better deal with trauma, I selected the corresponding aspects of my literature review from Chapter 2 (mental toughness) and Chapter 3 (trauma). I discovered many similarities between the literature of mental toughness and trauma. These corresponding aspects are the following:

Table 7.1 Corresponding aspects between trauma and mental toughness (summarised)

action taking	the importance of the “self”
facing negativity and adversity	the importance of support systems
flexibility and adjustment	dealing with guilt and self-blame
the role of self-talk	people’s perceptions
goal setting	commitment
helplessness/learned helplessness	dealing with stress

These above mentioned corresponding aspects (theoretical part) were used to compile a psycho-educational intervention programme (empirical part) for my study. The intervention programme is discussed comprehensively in Chapter 5.

7.3 SUMMARY OF THE PSYCHO-EDUCATIONAL INTERVENTION PROGRAMME

The intervention programme was discussed in Chapter 5 and consisted of eight individual sessions per participant of approximately 75 minutes each. There were eight participants. I invited traumatised people in my immediate environment to participate in the study. A trauma centre, situated at a police station, as well as a local church helped me to find participants. I made use of a non-probability sample as not all the persons in the greater population had a chance to be included in my research. The choice of a non-probability sample was due to practical arrangements of a venue, traffic and transport issues. Sessions took place on a weekly basis. The aim of the sessions was to support traumatised participants with low or average mental toughness scores to increase their mental toughness. I made use of action research, where both quantitative as well as qualitative methods were used, as I wanted to improve practice and take action to address the gap between theory and practice (Somekh & Lewin 2011: 13; Holly *et al.* 2005: 5; McNiff & Whitehead 2011: 14). Evaluation after the sessions was an important part of the cyclic activity of action research. Therefore each participant completed an evaluation form after each session in order to improve practice. The participants' positive and negative experiences of the sessions were summarised in Section 6.5. The session content is outlined below:

- Session 1: Semi-structured interview (qualitative) before the start of the intervention programme when participant received feedback of MTQ48:
 - MTQ48 (Development Report).
- Session 2: Metaphor and further semi-structured interviews of questionnaire that was completed before therapy started:
 - Clay metaphor.
- Session 3: Trauma's effect on participant's body, behaviour, feelings, thoughts, brain and emotions:
 - Body's outline (life size) with emotions represented by different colours of flowers.
 - Hormonal actions and reactions inside the brain.
 - The self: true self, adapted self, ideal self.

- Session 4: I cannot control everything that happens to me but I can control my behaviour and thoughts (Visualisation):
 - Breathing exercises.
 - Anchor outside trauma.
 - Re-enter trauma in a controlled way.
 - Visualisation poster.
- Session 5: Grounding myself by understanding my ego and defence mechanisms. Seeing myself as a unique person and appreciating myself:
 - Visualisation poster.
 - Defending mechanisms.
 - “Bag” of who I am.
 - First-aid kit.
- Session 6: How to fill up my “empty bucket” although I am a broken person:
 - The cracked pot (“In our weakness we find our strength”).
 - Giraffes can’t dance (Andreae & Parker-Rees 2013) (I need to find my own “song/music” in life).
 - Self-talk and affirmations.
 - How to fill my own bucket (first) and then those of others.
- Session 7: My ego states and the way it influences my relationships with myself and other people. My past, my present and my future:
 - Ego states.
 - Transactional analysis: Parent, adult, child.
 - Sand therapy: My past, present and future.
- Session 8: Feedback on post-test MTQ48 and semi-structured questionnaire:
 - MTQ48 (Distance Travelled Report).
 - I walk down the street (taking responsibility).
 - Semi-structured interview (after intervention programme).

7.4 SUMMARY AND FINDINGS OF THE EMPIRICAL STUDY

7.4.1 Quantitative instruments

MTQ48

The action research of my study consisted of the MTQ48 psychometric measuring instrument as a quantitative research method. A prerequisite to take part in the study was that a person should have low or average mental toughness. Both a pre- as well as a post-test was completed by each participant, before starting the therapy and after the completion of the intervention programme, respectively. The MTQ48 has proved itself over the past 12 years as a valid and reliable measuring instrument (2.10). The MTQ48 takes about 10 minutes to complete and consists of 48 items which measures a person's mental toughness across four scales which are control, challenge, commitment and confidence. The different scores are indicated with stens between one and ten, where a score of between one and three indicates below average, a sten of between four and seven indicates an average score, and scores of between eight and 10 indicates a high average score (2.3 and 2.10).

All components of mental toughness increased during the intervention sessions (see Graph 6.12). The average score of the Overall Mental Toughness of the eight participants together increased with a score of 2.5. The challenge component increased with an average score of 1.375, while the commitment element increased with 1.25. Similarly, the control component was elevated by 2 stens, and the life control sub-set increased by 2 while the emotional control component increased with 1.75. The confidence element increased with 3, and the confidence in abilities element was elevated with 3.25, while the interpersonal confidence increased with 1.625. Four participants' Overall Mental Toughness scores increased with 4 stens each, two participants' scores increased with 2 stens per participant, one participant moved up one sten score and one participant's (participant H) overall mental toughness did not increase with a full sten score. Participant H though showed increases in the challenge component, where her sten of 2 increased to a sten of 4, her life control's sten of 3 increased to a sten of 4, her emotional control moved up from a sten of 4 to a sten of 6 and her confidence in abilities changed from a sten of 5 to a sten of 6.

7.4.2 Qualitative instruments

An important further question was whether the participants experienced that they can better deal with their traumas. This was determined through the following qualitative instruments that were used in this study: **semi-structured questionnaires** (before and after the intervention programme), **observation of the researcher** and **action research assessment questions** after each session. All eight participants indicated that they better deal with their trauma and that they will recommend the intervention programme for traumatised people.

From the above-mentioned discussion of both the quantitative as well as the qualitative results of the study, the conclusion is thus drawn that the traumatised persons' mental toughness (persons A, B, C, D, E, F, G), or at least aspects thereof (participant H) increased through the intervention programme. The intervention programme is considered as being effective in increasing a traumatised person's mental toughness in order to better deal with his trauma (Section 6.4).

7.4.3 Summary of the participants' assessments as part of the cyclic process of action research:

Positive experiences of the sessions included the safe atmosphere that was created in the therapy sessions, the effectiveness of the concrete and practical aids, learning that not loving themselves is not an option, to learn that they are not alone in their traumas, but that they have strong support systems and have realised their normality in abnormal traumatic situations. **Negative experiences** of the therapy sessions were that they had too much homework after Session 5 and that they had to face negative emotions through the intervention programme, which they thought they had dealt with. **Negative experiences** that **changed** into **positive experiences** were the difficulty of facing their defence mechanisms. The participants later realised that these insights into their defence mechanisms actually helped them to understand the ways in which they adapted to deal with challenges in their lives.

The participants' positive experiences explained in their action research assessments of the intervention programme seemed to outweigh their negative experiences of the intervention by far (6.5).

7.5 LIMITATIONS OF THE EMPIRICAL STUDY AND SUGGESTIONS FOR FURTHER STUDIES

Although the psycho-educational intervention programme is seen as being successful in supporting traumatised people, the study had the following limitations:

- It was a once-off study that was conducted over a short period of eight weeks. Therefore no conclusions can be made about the long-term effects of the intervention programme.
- Only a limited number of the population took part in the study and therefore the study cannot be generalised to the larger population. The results are only applicable for the population of this study.
- A non-probability sample was used in the study and therefore not all the people in the greater population had a chance to be included in the research. The results are thus only valid for the population of this study.
- All participants came from an economically affluent area. Therefore the results cannot be generalised to disadvantaged areas as it only applies for a specific area.
- In this study only English and Afrikaans speaking people were represented. A larger sample which includes other racial groups of South Africa is required to represent the population of South Africa.
- All the participants were women. Therefore the results cannot be generalised to men as it applies only to the women who took part in this study.
- All the participants were white. South Africa is known as the rainbow nation and a larger sample of the nation is required to accurately represent the different cultural groups. James and Gilliland (2013: 46) state that culture interacts with trauma (although the way in which it does is still controversial). In this regard, the study of a white South African ladies group was useful.
- Traumatized people are unique individuals in different stages of their traumas and they have to deal with different emotions. An intervention programme that addresses all the participants' issues at the same time therefore is not being practically feasible. In the future, such a study could be limited to people who experienced the same kind of trauma, for example the death of a child.

7.6 CONTRIBUTIONS OF THE STUDY

My study makes the following contributions:

- According to my literature research as well as communication with Dr Peter Clough, who is one of the editors of the book “Developing mental toughness” (published in 2012) and a developer of the MTQ48, my study is the first to research the phenomenon of mental toughness in the trauma field. Therefore my study contributes to the pool of knowledge of psychology and trauma (both theoretically and practically).
- The literature review and intervention programme provides a sound basis for the understanding and development of mental toughness in traumatised people (Chapters 2, 3 and 5).
- A psycho-educational intervention therapy programme has been compiled for the practical use in supporting traumatised persons. In this way the “gap” between theory and practice has been narrowed through the study (Chapter 5).
- Therapists are equipped with a ready-made intervention programme of which the sequence and duration of the sessions can easily be adapted to suit different traumatised peoples’ needs who are at different stages of their trauma.
- The psycho-educational intervention programme may be used by therapists as a departure point to design their own intervention programmes for their traumatised clients.
- The intervention programme is practical and hands-on in nature, which is needed in practice as the literature review indicated that ways in which a therapist can support a client most of the time are descriptive and focus on diagnostic aspects.
- The literature review offers a well-researched resource of knowledge on trauma as well as mental toughness. This knowledge can be used by practitioners to extend their knowledge in these areas (Chapters 2 and 3).
- The findings in the pre- and post-tests indicated that the mental toughness components that increased most after the intervention were confidence and confidence in abilities. It was obvious through the intervention sessions (through the qualitative observation and feedback from participants) that all participants struggled in having confidence in themselves and their abilities and that they did

not believe enough in themselves. This finding might suggest that therapists need to focus their psychological support to traumatised persons more regarding these two components of mental toughness (Chapter 6).

- The study provides hope, as a glimpse into the lives of traumatised persons indicated that although it is a painful and tough journey, the “light of hope” will shine through in their lives again.

7.7 RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations can be made for future research:

- A similar study to research the long-term effects of the study on the participants.
- A duplication of the research with a larger sample.
- Similar research with other cultural groups.
- A duplication of the research with male participants.
- The study can be adopted for traumatised people from disadvantaged areas.
- A similar study, which is limited to people who experienced the same kind of trauma, for example the death of a child.
- Research to investigate whether people with depression or symptoms thereof will have the ability to increase their mental toughness as much as people who do not display depression or symptoms thereof. As most traumatised persons experience at least some symptoms of depression, a questionnaire to determine whether a person experiences enough symptoms of depression to qualify to take part in the study might be developed.
- Research to determine whether the relationship between self-assertiveness and depression exists as two of the participants of this study both experienced challenges with self-assertiveness and depression.
- It will be interesting to do further research in the future to determine whether older people’s mental toughness in general increase to a lesser degree or not, and/or whether it has to do with their perceptions of life or maybe both of these factors.

- The study can be adopted for traumatised children of different age groups as a mental toughness youth version already exists. It is suitable for children from the age of 11.
- A mental toughness test (which may include pictures) could be developed for very young children.

7.8 CONCLUSION

From the above-mentioned discussion the conclusion could be drawn that the psycho-educational programme was successful in supporting the traumatised participants to increase their mental toughness. In this process the participants also learned to better deal and cope with their traumas (Chapter 6).

I think the essence of mental toughness in dealing with trauma, is well summarised in the words of Berson and Berson (2002: 76) where they state that when supporting clients who face the shock, fear, panic and horror of trauma, it doesn't mean that their fears are allayed. It however means that in facing their fears and insecurities they can go on and pursue hope.

From the literature review and empirical research it became clear that mental toughness is about getting up in the morning, although you do not feel like doing it, and facing the day, facing your fear, facing your challenges and most of all, facing yourself. Mental toughness is about going forward although with trembling legs and maybe sweating hands, and a heart that pound in your throat, although you do not feel like it. Mental toughness is about going on and never giving up. Mental toughness is like Meichenbaum's (1995: 458) metaphor of a river which describes crisis: *"The river flows relentlessly to the sea. When it reaches a point where it is blocked by rocks and debris it struggles to find ways to continue its path. Would the alternative be to flow backwards? That is what a person in crises craves, to go back in time. But life doesn't provide a reverse gear and the struggle must go forward, like the river, with occasional pauses to tread water and check out where we are heading"* (Kfir, 1989, p. 31)...*Water adapts itself to the configuration of the land.*

One must be "flexible" and as Berson and Berson (2002: 73) note: *"You gain strength, courage and confidence by every experience in which you really stop to look fear in the face"*. Then you learn to *"deal effectively with challenge, stressors and*

pressure...irrespective of prevailing circumstances” and then you become more and more mentally tough (Clough & Strycharczyk 2012: 1).

BIBLIOGRAPHY

- American Psychiatric Publishing. 2013 *Post Traumatic Stress Disorder*.
<http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf> (accessed on 2013/07/20).
- Andreae, G. & Parker-Rees, G. 2013. *Giraffes can't dance*. New York: Cartwheel Books.
- Association for Qualitative Research (AQR). 2007. *The MTQ48 Handbook*.
www.mtq48.co.uk and www.aqr.co.uk (accessed on 2012/02/09).
- Association for Qualitative Research (AQR). 2010a. *Mental toughness Questionnaire: A user guide*. United Kingdom : AQR Ltd.
- Association for Qualitative Research (AQR). 2010b. *Organisation development report: Sample report*. AQR Ltd.
- Baron, RA., Byrne, D. & Branscombe, NR. 2006. *Social Psychology*. 11th edition. United States of America: Pearson Education, Inc.
- Bartone, PT., Hystad, SW., Eid, J. & Brevik, JI. 2012. Psychological hardiness and coping style as risk/resilience factors for alcohol abuse. *Military Medicine*, 177 (5): 517-524.
- Bensimon, M. 2012. Elaboration on the association between trauma, PTSD and posttraumatic growth: The role of trait resilience. *Personality and Individual Differences* 52: 782-787.
- Berson, MJ., & Berson, IR. 2002.: Children's responses to trauma. *Kappa Delta Pi Record*, September 38 (2): 73-76.
- Bethany, J. 2007. Psychoeducation for survivors of trauma. *Perspectives in Psychiatric Care*, July 43 (3): 123-31.
- Biermann, HH. 2005. Shattered dreams: pastoral care with parents following the death of a child. Unpublished MEd-dissertation. Pretoria: University of South Africa.

- Bonanno, GA. 2004. Loss, trauma and human resilience: have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59 (1): 20-28.
- Brescia. 2009. *Think right now*. Unreleased Labrock records.
- Brooks, A. & Clarke, L. 2011. Combining client-centered therapy with attribution theory. *Mental Health Practice*, 14 (9): 34-37.
- Bryant, RA., Friedman, MJ., Spiegel, D., Ursano, R. & Strain, J. 2011. A review of acute stress disorder in DSM-5. *Focus: The Journal of Lifelong Learning In Psychiatry*, Volume IX (3): 335-350.
- Burke, T. 2008. How trauma impacts the brain.
<http://www.rachelsvineyard.org/Downloads/Canada%20Conference%2008/TextOfBrainPP.pdf> (accessed on 2013/08/09).
- Budde, A., Moesgen, D., Belles, S. & Klein, M. 2010. The effects of parental problem drinking on children: A review of current research findings and their relevance for practice. *Socialinis Darbas. Patirtis Ir Metodai*, 5 (1): 17-30.
- Bull, SJ., Shambrook, CJ., James, W. & Brooks, JE. 2005. Towards an understanding of mental toughness in elite English cricketers. *Journal of Applied Sport Psychology*, 17 : 209-227.
- Clarke, W. 2008. Working with survivors of trauma. *Mental Health Practice*, 11 (7): 14-17.
- Clough, P. & Strycharczyk, D. 2012. *Developing mental toughness: improving performance, wellbeing and positive behaviour in others*. United States: Kogan Page Limited.
- Collins, KJ., Du Plooy, GM., Grobbelaar, MM., Puttergill, CG., Terre Blanche, MJ., Van Eeden, R., Van Rensburg, GH. & Wigston, DJ. 2000. *Navorsing in die sosiale wetenskappe: Fakulteit Lettere en Wysbegeerte. Enigste studiegids vir RSC201-H*. Pretoria: Unisa.
- Connaughton, D., Wadey, R., Hanton, S. & Jones, G. 2008. The development and maintenance of mental toughness: Perceptions of elite performers. *Journal of Sports Sciences*, 26 (1): 83-95.

- Corr, CA., Nabe, CM. & Corr, DM. 2006. *Death and dying, life and living*. 5th edition. United States of America: Thomson Wadsworth.
- Crust, L. 2008. A review and conceptual re-examination of mental toughness: Implications for future researchers. *Personality and Individual Differences*, 45: 576-583.
- Crust, L. & Clough, PJ. 2011. Developing mental toughness: from research to practice. *Journal of Sport Psychology in Action*, 2: 21-32.
- Crust, L. & Keegan, R. 2010. Mental toughness and attitudes of risk taking. *Personality and Individual Differences*, 49: 164-168.
- Crust, L. & Swann, C. 2011. Comparing two measures of mental toughness. *Personality and Individual Differences*, 50 (2): 217-221.
- De Jager, M. 2009. Linkerbrein, regterbrein of heelbrein. <http://www.mindmoves.co.za> (accessed on 2013/07/26).
- Deniz, ME., Tras, Z. & Aydogan. 2009. An investigation of academic procrastination, locus of control and emotional intelligence. *Educational Sciences: Theory and Practice*, 9 (2): 623-632.
- De Vos, AS., Schulze, S. & Patel, L. 2006. The science and the professions, *Research at grass roots for the social sciences and human service professions*, edited by De Vos, AS., Strydom, H., Fouche, CB. & Delpont, CSL. Pretoria: Van Schaik: 3-26.
- De Witt, MW. & Booyesen, MI. 1994. *Die klein kind in fokus: 'n Sielkundig-opvoedkundige perspektief*. Pretoria: Acacia.
- De Villiers, M. & Van den Berg, H. 2012. The implementation and evaluation of a resiliency programme for children. *South African Journal of Psychology*, 42 (1): 93-102.
- Dienstbier, RA. 1989. Arousal and Physiological toughness: implications for mental and physical health. Faculty publications, Department Psychology. Paper 216. Nebraska-Lincoln: University of Nebraska-Lincoln.
- Egan, G. 2014. *The skilled helper: A problem-management and opportunity-development approach to helping*. 10th edition. United States of America: Brooks/Cole Cengage Learning.

- Ferrari, JR., O'Callaghan, J., & Newbegin, I. 2005. Prevalence of procrastination in the United States, United Kingdom and Australia: arousal and avoidance delays among adults. *North American Journal of Psychology*, 7 (1): 1-6.
- Fong, L., Lee, A. & Ladkin, A. 2011. Decomposition of perception of luck: Gamblers in Macao casino hotels. *In: 9th APacCHRIE Conference, Hong Kong 2-5 June 2011. Proceedings*. ApacCHRIE.
- Gordon, AM. & Browne, KW. 2004. *Beginnings and beyond: foundations in early childhood education*. 6th edition. USA: Thomson Delmar Learning.
- Government Gazette. 2001. National Education Policy Act, 1996 (ACT NO 27 of 1996): National Policy: *Education White Paper Five (5) on Early Childhood Development*. Gazette no 22756.
- Graham, A. 2004. Life is like the seasons. *Childhood Education*, 80 (6): 317-321.
- Heider, F. 1944. Social perception and phenomenal causality. *Psychological Review*, 51: 358-374.
- Helgeson, VS., Reynolds, KA. & Tomich, PL. 2006. A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology*, 74 (5): 797-816.
- Henning, E., Van Rensburg, W. & Smit, B. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik.
- Herrman, HH., Stewart, DE., Diaz-Granados., Berger EL., Jackson, B. & Yuen, T. 2011. In review: What is resilience? *The Canadian Journal of Psychiatry*, 56 (5): 258-265.
- Hobfoll, SE., Johnson, RJ., Hall, BJ., Palmieri, PA., Canetti-Nisim, D. & Galea, S. 2009. Trajectories of resilience, resistance, and distress during ongoing terrorism: The case of Jews and Arabs in Israel. *Journal of Consulting and Clinical Psychology*, 77 (1): 138-148.
- Holly, ML., Arhar, J., & Kasten, W. 2005. *Action research for teachers: Travelling the yellow brick road*. 2nd edition. Upper Saddle River, New Jersey: Pearson, Merrill Prentice Hall.
- Hornby, G. 1990. A humanistic developmental model of counselling: a psycho-educational approach. *Counselling Psychology Quarterly*, 3 (2): 191-203.

- Horsburgh, VA., Schermer, JA., Veselka, L. & Vernon, PA. 2008. A behavioural genetic study of mental toughness and personality. *Personality and Individual Differences*, 46: 100-105.
- Jackson, R. & Watkin, C. 2004. The resilience inventory: Seven essential skills for overcoming life's obstacles and determining happiness. *Selection & Development Review*, 20 (6): 13-17.
- James, RK. & Gilliland, BE. 2013. *Crisis intervention strategies*. 7th edition. United States of America, Belmont: Brooks/Cole Cengage Learning.
- Johnson, DW. 2006. *Reaching out: interpersonal effectiveness and self-actualisation*. 9th edition. United States of America: Pearson Education, Inc.
- Johnson, B. & Christensen, L. 2004. *Educational Research – Quantitative, Qualitative and Mixed Approaches*. Boston, New York, San Francisco, Mexico City: Pearson.
- Johnson, EM., Green KE. & Kluever, RC. 2000. Psychometric characteristics of the revised procrastination Inventory. *Research in Higher Education*, 41 (2): 269-279.
- Johnson, RJ., Hobfoll, SE., Hall, BJ., Canetti-Nasim, D., Galea S. & Palmieri, PA. 2007. Posttraumatic growth: Action and reaction. *Applied Psychology: An International Review*, 56 (3): 428-436.
- Jones, G., Hanton, S. & Connaughton, D. 2007. A Framework of mental toughness in the world's best performers. *The Sport Psychologist*, (21): 243-264.
- Jordaan, WJ. & Jordaan, JJ. 1998. Mense in konteks. 3de uitgawe. Johannesburg: Heinemann Voortgesette Onderwys (Edms) Bpk.
- Joseph, R. 2000. *Stress free teaching: A practical guide to tackling stress in teaching, lecturing and tutoring*. Oxford: Routledge.
- Karairmak, O. 2009. Establishing the psychometric qualities of the Connor-Davidson Resilience Scale (CD-RISC) using exploratory and confirmatory factor analysis in a trauma survivor sample. *Psychiatry Research*, 179: 350-356.
- Kfir, N. 1989. Crisis intervention verbatim, in Meichenbaum, D. (ed). 1995. A Clinical Handbook/Practical Therapist Manual for assessing and treating adults with

- Post-Traumatic Stress Disorder. Canada. Institute Press). New York: Hemisphere Pub. Corp.
- Keeton, M. 2009. How trauma affects the brain. <http://karunacounseling.wordpress.com/2009/03/03/how-trauma-affects-the-brain/> (accessed on 2013/08/09).
- Klassen, RM. & Kuzucu, E. 2009. Academic procrastination and motivation of adolescents in Turkey. *Educational Psychology*, 29 (1): 69-81.
- Kleber, RJ. & Brom, D. 1992. *Coping with trauma*. Amsterdam/Lisse: Swets & Zeitlinger.
- Knaus, WJ. 2000. Procrastination, blame and change, in *Procrastination: current issues and new directions*, edited by Ferrari, JR. & Pychyl, TA. *Journal of social behaviour and personality*, 15 (5): 153-166.
- Kunst, MJJ. 2011. Affective personality type, post-traumatic stress disorder symptom severity and post-traumatic growth in victims of violence. *Stress and health*, 27: 42-51.
- Lamb, DH. 1988. Loss and grief: psychotherapy strategies and interventions. *Psychotherapy*, 25 (4): 561 – 569.
- Lee, E. 2010. The relationship of motivation and flow experience to academic procrastination in university students. *The Journal of Genetic Psychology*, 166 (1): 5-14.
- Leedy, PD. & Ormrod, JE. 2005. *Practical Research: Planning and Design*. 8th Edition. New Jersey: Merrill Prentice Hall.
- Llewellyn, DJ. & Sanchez, X. 2008. Individual differences and risk taking in rock climbing. *Psychology of Sport and Exercise*, 9: 413-426.
- Maree, K. & Van der Westhuizen, C. 2007. Planning a research proposal, in *First steps in research*, edited by Maree, K.. Pretoria: Van Schaik. p. 24-46.
- Marshall, S. 2007. Bereavement counselling – is it viable? *Therapy Today*, 18 (5). Internet: <http://www.therapytoday.net/article/15/25/categories> (accessed on 2012/10/23).
- Mental Toughness Questionnaire User Guide. 2010. AQR. p. 47-55.

- McAteer, M. 2013. *Action research in education*. London; Sage.
- McBride, DM. 2013. *The process of research in psychology*. 2nd edition. United States of America: Sage Publications, Inc.
- McCloud, C. 2014. *Have you filled a bucket today?: A guide to daily happiness for kids*. Canada: Ferne Press.
- McCrae, RR. & Costa, PT (Jr). 1987. Validation of the five-factor model of personality across instruments and observers. *Journal of Personality and Social Psychology*, 52 (1): 81 – 90.
- McNiff, J. & Whitehead, J. 2011. *All you need to know about action research*. 2nd edition. London: Sage.
- Meichenbaum, D. 1995. *A Clinical Handbook/Practical Therapist Manual for assessing and treating adults with Post-Traumatic Stress Disorder*. Canada. Institute Press.
- Mental Toughness. 2012. *Mental Toughness MTQ48*.
<http://www.mentaltoughness.co.nz/> (accessed on 2012/02/08).
- Mental Toughness and MTQ48: explanatory note doc.
<http://ebookbrowse.com/mental-toughness-and-mtq48-explanatory-note-doc-d120048682> (accessed on 2013/04/18).
- Meyer, WF., Moore, E. & Viljoen, HG. 2000. *Personologie: van individu tot ekosistiem*. Johannesburg: Heinemann.
- Meyer, WF., Moore, E. & Viljoen, HG. 2003. *Personology: From individual to ecosystem*. 3rd Edition. Sandown: Heinemann Publishers (Pty) Ltd.
- Miller, ED. & Harvey, JH. 2001. The interface of positive psychology with a psychology of loss: A brave new world? *American Journal of Psychotherapy*, 55 (3): 313-322.
- Mitchell, JT. 1983. When disaster strikes...The critical incident stress debriefing process. *Journal of Emergency Services*, 8: 36-39. (In Roos, V., Du Toit, R. & Du Toit, M. (eds). 2002. *A counsellor's guide in dealing with trauma, death and bereavement*. Pretoria: University of Pretoria).

- Mol, SSL., Arntz, A., Metsemakers, JFM., Dinant, G., Vilters-Van Montfort, PAP. & Knottnerus, JA. 2005. Symptoms of post-traumatic stress disorder after non-traumatic events: evidence from an open population study. *British Journal of Psychiatry*, 186: 494-499.
- Neuro-Link. 2000. *Onderwyser-opleiding: 'n Brein gebaseerde benadering tot leer en ontwikkeling*. Pretoria: Neuro-Link.
- Neuro-Link. 2010. *Neuro-Link: Learning receptiveness profile*. 1st edition. Pretoria: Neuro-Link.
- Nicholls, AR., Polman, RCJ., Levy, AR. & Backhouse, SH. 2008. Mental toughness, optimism, pessimism and coping among athletes. *Personality and Individual Differences*, 44: 1182-1192.
- Nieuwenhuis, J. 2007. Introducing qualitative research, in *First steps in research. 1st edition*, edited by Maree, K.. Pretoria: Van Schaik. p. 47-69.
- Norton, LS. 2009. *Action research in teaching and learning: A practical guide to conducting pedagogical research in universities*. London and New York: Routledge Taylor & Francis Group.
- Payne, A., Liebling-Kalifani, H. & Joseph, S. 2007. Client-centred group therapy for survivors of interpersonal trauma: A pilot investigation. *Counselling and Psychotherapy Research*, 7 (2): 100 -105.
- Perschy, MK. 2004. *Helping teens work through grief*. 2nd edition. New York: Brunner-Routledge.
- Preston, LD. 2011. *Supervisor notes for Intern Educational Psychologist student*. Pretoria: Unitas Hospital.
- Preston, LD. 2013. *Conquering trauma: From victim to survivor*. Pretoria: Unisa.
- Psychlopedia. 2012. *Physiological toughness*. Internet: <http://www.psychlopedia.com.au/Psychlopedia/article.asp?id=230> (accessed on 2012/11/23).
- Reber, AS. 1995. Dictionary of psychology. 2nd edition. London: Penguin Books. (In Roos, V., Du Toit, R. & Du Toit, M. (eds). 2002. A counsellor's guide in dealing with trauma, death and bereavement. Pretoria: University of Pretoria).

Roberts, BW. Conscientiousness.

<http://faculty.las.illinois.edu/bwroberts/conscientiousness/index.html> (accessed on 2013/05/11).

Roets, HE. 2009. *Class notes for MEd-Guidance students*. Pretoria: University of South Africa.

Roets, HE. & Preston, LD. 2008a. *Using the phenomena of human resilience in the impact phase of trauma intervention*. Pretoria: University of South Africa.

Roets, HE. & Preston, LD. 2008b. *Using ego strengths for initial diagnostic criteria: A Psycho-educational Perspective*. Pretoria: University of South Africa.

Rogers, JE. 2007. *The art of grief: the use of expressive arts in a grief support group*. United States of America: Taylor & Francis Group, LLC.

Roos, V., Du Toit, R. & Du Toit, M. 2002. *A counsellor's guide in dealing with trauma, death and bereavement*. Pretoria: University of Pretoria.

Rotter, JB. 1966. General expectancies for internal versus external control of reinforcement. *Psychological Monographs: General and applied*, 80 (1): 1-28.

Rutter, M. 1999. Resilience concepts and findings: Implications for family therapy. *Journal of Family Therapy*, 1999 (21): 119-144.

Scott, D. 1992. *Stress that motivates: Self-talk secrets of success*. United States of America: Bawden Printing Company.

Scott, M & Stradling, SG. 2006. *Counselling for Post-Traumatic Stress Disorder*. 3rd edition. London: Sage (In Clarke, W. 2008. Working with survivors of trauma. *Mental Health Practice*, 11 (7): 14-17).

Scott, M & Stradling, SG. 2006. *Counselling for Post-Traumatic Stress Disorder*. 3rd edition. London: Sage

Seligman, MEP. 1998. *Building human strength: Psychology's forgotten mission*. online.missouri.edu/exec/public/filedownload.aspx?f=/exec/... (accessed on 2012/11/30).

Selye, H. 1936. A syndrome produced by diverse agents. *Nature*, 138 (32): 112-131. (In Clough, P. & Strycharczyk, D. 2012. *Developing mental toughness*:

- improving performance, wellbeing and positive behaviour in others*. United States: Kogan Page Limited).
- Sheikh, AI. 2008. Theory and practice posttraumatic growth in trauma survivors: implications for practice. *Counselling Psychology Quarterly*, 21 (1): 85-97.
- Somekh, B. & Lewin, C. 2011. Theory and methods in social research. 2nd edition. London: Sage.
- Somekh, B. 2006. Action research: A methodology for change and development. USA: Open University Press.
- Spielberger, CD. 1983. *Manual for the state trait anxiety inventory*. Consulting Psychologists Press: Palo Alto, CA. (In Clough, P. & Strycharczyk, D. 2012. *Developing mental toughness: improving performance, wellbeing and positive behaviour in others*. United States: Kogan Page Limited).
- Statistics Canada. Non-probability sampling. Internet: <http://www.statcan.gc.ca/edu/power-pouvoir/ch13/nonprob/5214898-eng.htm> (accessed on 2014/03/05).
- Steel, P. 2007. The nature of procrastination: a meta-analytic and theoretical review of quintessential self-regulatory failure. *Psychological Bulletin*, 133 (1): 65-94.
- Stockton, H., Hunt, N. & Joseph, S. 2011. Cognitive processing, rumination, and posttraumatic growth. *Journal of Traumatic Stress*, 24 (1): 85-92.
- Strydom, I., Roets, E., Wiechers, E. & Krüger, D. 2002. Inleidende oriëntering: voorligting in opvoedkundige kontekste met spesialisering in skoolvoorligting (Hons Bed). Enigste studiegids vir OSV 451 – 3 / OSV 411 – R. Pretoria: Universiteit van Suid-Afrika.
- Sue, D., Sue, DW. & Sue, S. 2003. *Understanding abnormal behaviour*. 7th edition. New York, Boston: Houghton Mifflin Company.
- Sue, D., Sue, DW. & Sue, S. 2010. *Understanding abnormal behaviour*. 9th edition. New York, Boston: Houghton Mifflin Company.
- Taylor, SE., Kemeny, M., Reed, GM., Bower, JE. & Gruenewald, TL. 2000. Psychological resources, positive illusions and health. *American Psychologist*, 55 (1): 99-109.

- Tedeschi, RG. & Calhoun, LG. 2004. Posttraumatic Growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15 (1): 1-18.
- Thelwell, RC., Such, BA., Weston, NJV., Such, JD. & Greenlees, IA. 2010. Developing mental toughness: Perceptions of elite female gymnasts. *International Journal of Sport and Exercise Psychology*, 8: 170-188.
- Theron, LC & Theron, AMC. 2010. A critical review of studies of South African youth resilience, 1990-2008. *South African Journal of Science*, 106 (7/8): 2-8.
- Theron, LC. & Macalane, JM. 2010. Resilient street youth: A qualitative South African study. *Journal of youth studies*, 16 (6): 717-736.
- Thomas, G. 2011. *How to do your case study: A guide for students and researchers*. London: Sage.
- Trochim, WMK. 2006. *Non-probability sampling*. *Research Methods Knowledge Base*. <http://www.socialresearchmethods.net/kb/sampron.php> (accessed on 2014/03/07).
- Unisa. 2002. *Short course in crisis debriefing and trauma counselling*. Pretoria: Centre for Community Training and Development, University of South-Africa.
- University of Twente. 2013. Attribution theory. Internet: http://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/Public%20Relations,%20Advertising,%20Marketing%20and%20Consumer%20Behavior/attribution_theory.doc/ (accessed on 2013/03/27).
- U.S. Department of Veterans Affairs. 2013. *DSM-5 Criteria for PTSD*. Washington DC. Internet: http://www.ptsd.va.gov/professional/pages/dsm5_criteria_ptsd.asp (accessed on 2013/12/18).
- Van den Aardweg, EM. & Van den Aardweg, ED. 1999. *Psychology of education: a dictionary for students*. Second edition. Pretoria: E & E Enterprises.
- Waibel-Duncan, MK. & Whitehouse Yarnell, J. 2011. The challenge model: Examining resilience in Pelzer's a child called "It". *Journal of Child and Adolescent Psychiatric Nursing*, 24: 168-174.
- Weiner, B. 1985. An attributional theory of achievement motivation and emotion. *Psychological Review*, 92 (6): 548-573.

- Weiner, B. 2000. Intrapersonal and interpersonal theories of motivation from an attributional perspective. *Educational Psychology Review*, 12 (1): 1-14.
- Weiner, B. 2010. The development of an Attribution-Based Theory of Motivation: A history of ideas. *Educational Psychologist*, 45 (1): 28-36.
- Welman, C., Kruger, F. & Mitchell, B. 2010. *Research methodology*. 2010. 3rd edition (9 th impression). Cape Town: Oxford Press.
- West Midlands Coaching Pool: Conference 2010. www.wmcounsils.org.uk/media/upload/People%20and%20Leadership%20Team/Coaching%20Pool/Conf2010/Slides/Mental_Toughness.pdf Internet: (accessed on 2013/11/30).
- Wilson, BA. 2012. Belonging to tomorrow: an overview of procrastination. *International Journal of Psychological Studies*, 4 (1): 211-217.
- Wiseman, R. 2003. The luck factor. *The Skeptical Inquirer*, May/June: 1-5.
- Wolin, SJ., & Wolin, S. 1993. The resilient self: how survivors of troubled families rise above adversity. (In Waibel-Duncan, MK. & Whitehouse Yarnell, J. 2011. The challenge model: Examining resilience in Pelzer's a child called "It". *Journal of Child and Adolescent Psychiatric Nursing*, 24: 168-174).
- Worden, JW. 2001. *Grief counselling and grief therapy: a handbook for the mental health practitioner*. 3rd edition. New York: Brunner-Routledge.
- Yeung, EW., Arewasikporn, A. & Zautra, AJ. 2012. Resilience and chronic pain. *Journal of Social and Clinical Psychology*, 31 (6): 593-617.

ADDENDUM A: DESCRIPTION OF MTQ48 SCALES & STENS

It is important that users not solely rely on the MTQ48's results but on an appraisal of different relevant sources. The different sources of my study will be the MTQ48, semi-structured interviews (before and after the attendance of the psycho-educational programme), participation in the group work activities, feedback and inputs from the other group members as well as different therapeutic methods, techniques and activities (described in Chapter 5).

Description of MTQ48 Scales & Stens (quoted from the Mental Toughness Questionnaire User Guide (AQR) 2010: 47-55)

Overall Mental Toughness

Stens 8-9-10

This individual has the capability to withstand a significant amount of pressure. They have confidence in their abilities and are often willing to take on demanding tasks, believing they will succeed. They can usually shrug off criticism and not take others' comments to heart. They are likely to speak their mind when working in groups and are usually comfortable in many different social and work contexts.

They are normally committed to the task in hand. They tend to be tenacious and resolute and likely to complete what they start. They can deal with unforeseen circumstances without undue stress. When problems arise, they are unlikely to give up and, typically, view such events as challenges and opportunities for personal development, rather than threats to their security.

They believe that they are in control of their life. They feel that they are responsible for their own destiny and that they are influential in their own environment. They tend to be in control of their emotions and can cope with difficult events. They are usually calm and stable under pressure.

Stens 4-5-6-7

These individuals are able to cope with most of life's challenges, although, when facing some difficult circumstances they may feel nervous and a little threatened.

They are quite confident in their abilities, but their self-belief may be affected by others' criticism. When opportunities for development present themselves, they are likely to accept the challenge, although the potential for failure may concern them. They are likely to be comfortable in most social situations and will usually contribute to group activities.

They will usually achieve their goals, although they may become distracted when facing difficult circumstances. They are likely to feel in control in most situations and feel they have some power to influence what goes on around them. However, they may occasionally feel that events overtake them.

Under normal circumstances, they are in control of their emotions. They tend to be fairly calm and stable but they may, on occasions, feel anxious and worried.

Stens 1-2-3

These individuals may find it difficult to cope with stressful and really demanding environments and, on some occasions, suffer from a lack of self-belief. They may find it hard to deal with criticisms and will probably take others' comments too much to heart. In addition, they may be overly self-critical at times. They may not be willing to push themselves forward enough, possibly as a result of worrying that they will not succeed.

On occasions, they may not speak their mind, even when they feel strongly about a particular issue. They may be slightly uncomfortable in groups and they may be a little apprehensive in social settings.

When facing problems and difficult circumstances, they may feel nervous and threatened. They may avoid some challenging situations for fear of failure, and hence may not take all their opportunities for personal development. They may worry about things unduly, sometimes getting problems out of perspective. Unexpected events may completely throw them on occasions.

Challenge

Stens 8-9-10

These individuals will tend to see a challenge as an opportunity rather than a threat, often using it as a way to achieve personal development.

They are not intimidated by changes in their routine and may be actively drawn to fast moving, challenging environments. They will tend to be “quick on their feet”, having an ability to quickly deal with unexpected events.

They may become quickly bored by repetitive tasks, becoming frustrated by what they see as mundane. They will probably appreciate an unstructured environment that allows them scope to be flexible.

Examples in the workplace might include taking on too many tasks or projects – because each one seems interesting. In turn this might mean that some work is not completed properly or is forgotten.

Sten 4-5-6-7

These individuals will be able to cope effectively with most of life’s challenges, and may use these as a way on enhancing their personal development. They may at times seek “change for change’s sake”, but are reasonably accepting of a degree of routine.

They will be most comfortable in an environment that provides them with a balance of predictability and flexibility, but they will usually be able to react quickly to the unexpected when necessary.

Occasionally, these individuals may take on more challenges than they can handle, which might mean that they struggle to complete tasks assigned to them.

Sten 1-2-3

These individuals may feel a little daunted when facing challenging situations. They will tend to be uncomfortable in unstable environments and are likely to try to minimise their exposure to change.

They may prefer to work with established routines and they will probably perform best in this type of environment. They have quite a strong preference for the predictable over the unpredictable, and may be quite slow to react to unexpected

changes.

Typically, in the workplace, this might mean that the individual is reluctant to take on new work or challenges – particularly where it upsets the “status quo”. This response can be seen as obstructive.

Control

Sten 8-9-10

These individuals will tend to feel in overall control of their lives and believe that they can make things happen. Their overall control orientation has two distinct areas: Life Control and Emotional Control.

In the workplace, they may typically be seen as unflappable and believe that they can always make a difference. However, there are occasionally situations where the organisation or events do not allow this to happen. Often, these individuals will not recognise this is occurring and will become frustrated – “knocking their heads against a brick wall” or they will simply react negatively to the obstruction.

Sten 4-5-6-7

These individuals are likely to feel in control in most situations, although they may occasionally feel that events are overtaking them. Their control orientation can be split into two distinct areas: Life Control and Emotional Control.

Typically, in the workplace, these are people who might work steadily for long periods of time with significant success but who will occasionally appear to reach an impasse. For the most part they can cope with work and with life but can be worn down. The solution often lies in rebuilding their feeling of control.

Sten 1-2-3

These individuals may feel they are not really in control of their destiny, but are more at the mercy of the things and the people around them. Their control orientation can be split into two distinct areas: Life Control and Emotional Control.

Typically, in the workplace, these individuals will be tense and anxious – and may

demonstrate that to others. They may unsettle others around them if their anxiety takes over. They may often undervalue their contribution to the organisation and dismiss their achievements.

Life Control

Sten 8-9-10

They will normally feel that they can have a major influence on their environment. They rarely feel that they are just 'going through the motions', believing that what they do makes a real difference.

Sten 4-5-6-7

They believe that what they do will normally make a difference, but may, on occasions, see themselves as "going through the motions".

Sten 1-2-3

They may not believe what they do really make a difference, sometimes feeling that they are simply 'going through the motions'

Emotional Control

Sten 8-9-10

They are not prone to undue worrying, and tend to be able to control their anxieties. They tend to be poised and are unlikely to "lose their cool", even in stressful situations. They may not show their true feelings to other people.

Sten 4-5-6-7

Whilst they may worry about important aspects of their lives, they do not usually get this out of proportion. They will normally remain cool, calm and collected but from time to time they may have difficulty in controlling their emotions.

Sten 1-2-3

They are quite anxious individuals and may worry unduly. They may often find it quite hard to relax. They may find it a little difficult to control their feelings and will reveal

their emotional states to other people. They tend to be anxious and more easily upset than others.

Commitment

Sten 8-9-10

These individuals will usually complete their tasks even under difficult conditions, finding different ways to motivate themselves. They will have high levels of internal resources, which allow them to sustain high levels of effort.

They are resilient and tenacious. Once these people have begun a task, they will usually see it through to the end, tending to deal with obstacles that are blocking the achievement of their end goal.

Typically, in the workplace, These are the kinds of people to whom you would be likely to entrust a key project. There may be occasions where the high degree of focus may mean that others may be bruised by these individuals' commitment to achieve – particularly where weaknesses are ruthlessly criticised and strengths and achievements taken for granted.

Whilst this behaviour may be acceptable for the “crisis” assignment, sometimes these individuals do this for all assignments – and may acquire a reputation for being “hard”. In this circumstance, others will increasingly seek to avoid working with this individual because the experience is unpleasant.

Sten 4-5-6-7

Whilst these individuals will normally stick to their task, they may, on occasions, become distracted. This may mean that they, occasionally, do not achieve their goals in the most efficient way, or fail to reach the end point. They are relatively resilient and will normally be enthusiastic and motivated, but under extreme pressure their enthusiasm for a particular task may wax and wane. They are usually quite optimistic in outlook, believing that they will succeed.

Sten 1-2-3

These individuals may become easily diverted from the task at hand. They may find it

difficult to complete tasks when facing significant adverse circumstances and may consequently give up too easily. They may become unwilling to sustain effort if they believe that they cannot overcome the obstacles in their way. In general, they may find it hard to summon up enthusiasm for some tasks.

In the workplace, this may manifest itself in uncompleted tasks and increasing levels of stress where individuals become more and more de-motivated - particularly when the unexpected happens. They may “stop in their tracks” and may not seek help or support.

These individuals may offer apparently plausible excuses for why things don't happen – they will overemphasise the negatives of a situation. They can convince themselves that something is not achievable – when it is achievable.

Confidence

Sten 8-9-10

These individuals have high levels of self-confidence and are self-assured. Typically, in the workplace, these are seen as high achievers and will often succeed where others will give up or fail - but they may “go for it” when this is not really warranted. They can be determined to try to succeed even when the task is unachievable.

Sten 4-5-6-7

These individuals are reasonably self-assured, having moderate levels of self-confidence. Typically, these are people who can be relied upon to deliver satisfactorily most of the time. However, if subjected to a run of setbacks, their confidence and inner belief will diminish – and they may underperform even though they clearly still possess ability.

Sten 1-2-3

These individuals are not particularly confident and may lack a degree of self-belief. Often, in the workplace, these will be people with skills and qualities who underachieve and will avoid putting themselves forward for tasks and responsibility.

They may blindly carry out work – to the issued instruction – but will not always

communicate problems along the way, which might mean that the work will not be completed satisfactorily. They may wait to be told what to do next.

Confidence in Abilities

Sten 8-9-10

These individuals will typically have the self-belief to attempt tasks that may be considered too difficult by individuals with similar abilities but lower confidence. They have a genuine feeling that they are a worthwhile person. They will tend to accept new and difficult assignments, and will expect to be successful. They have a generally positive view about life and don't allow mistakes to get them down.

Sten 4-5-6-7

These individuals will usually have the self-belief to attempt most tasks but may, on occasions, fail to tackle challenges they are in reality capable of handling. They will normally believe that things come right in the end, but they may become overly self-critical at times, allowing mistakes to prey on their mind.

Sten 1-2-3

These individuals lack a degree of confidence in their own abilities. They may often expect things to go wrong and this may lead them to avoid difficult tasks. They may get mistakes out of proportion, worrying about them for a considerable period of time. They may have a tendency to be overly self-critical, allowing negative self-talk to dominate their thoughts.

Interpersonal Confidence

Sten 8-9-10

These individuals are likely to speak out in groups, and feel sufficiently confident to argue with others when they feel they are in the right. In general, they will speak their mind and will be willing to take charge of the situation if they feel this is appropriate. They will tend to make their presence felt.

Sten 4-5-6-7

These individuals will tend to feel comfortable in groups, but may not always speak their mind when they have something to say. They will sometimes be willing to take charge of a situation, but on some occasions they may fail to behave proactively. Normally, they will play a significant role when working with other people.

Sten 1-2-3

These individuals may be slightly intimidated when working in groups and will sometimes back down in arguments, even when they believe strongly in something. They will not seek to take the lead, preferring a more “back-seat” role. This may mean that their skills and ideas are not fully appreciated by others.

ADDENDUM B: SEMI-STRUCTURED QUESTIONNAIRE

To be completed before the individual therapy program

Name: _____ **Date:** _____

1) What motivated you to take part in this research?

2) What kind of trauma have you experienced?

3) What makes you feel that you are not coping with your trauma?

4) How do you try to cope with your trauma?

5) How did the trauma change you/your life?

6) How did the trauma change your relationships?

7) What kind of feelings do you experience?

8) What expectations do you have about this individual therapy programme?

9) Have you ever received some support from a professional person after your trauma?

10) Do you have a support system at the moment? Who are these people?

11) How do you see yourself?

12) What are your negative characteristics?

13) What are your best characteristics?

14) What is the best thing that you've accomplished?

ADDENDUM C: SEMI-STRUCTURED QUESTIONNAIRE

To be completed after the individual therapy programme

Name: _____ **Date:** _____

1) Do you think that you are coping better with your trauma?

2) What makes you feel that you are coping better now?

3) How do you try to cope with your trauma?

4) How did it change your life?

5) Have any of your relationships changed? How did it change?

6) Did your feelings change? Can you explain how it changed?

7) What did you gain from this intervention?

8) Do you have a support system?

9) How do you see yourself?

10) What are your negative characteristics?

11) What are your best characteristics?

12) How do you see the road ahead?

ADDENDUM D: ACTION RESEARCH EVALUATION QUESTIONS
AFTER EACH SESSION

Name: _____ Date: _____

Session: _____

My positive experiences of this session are

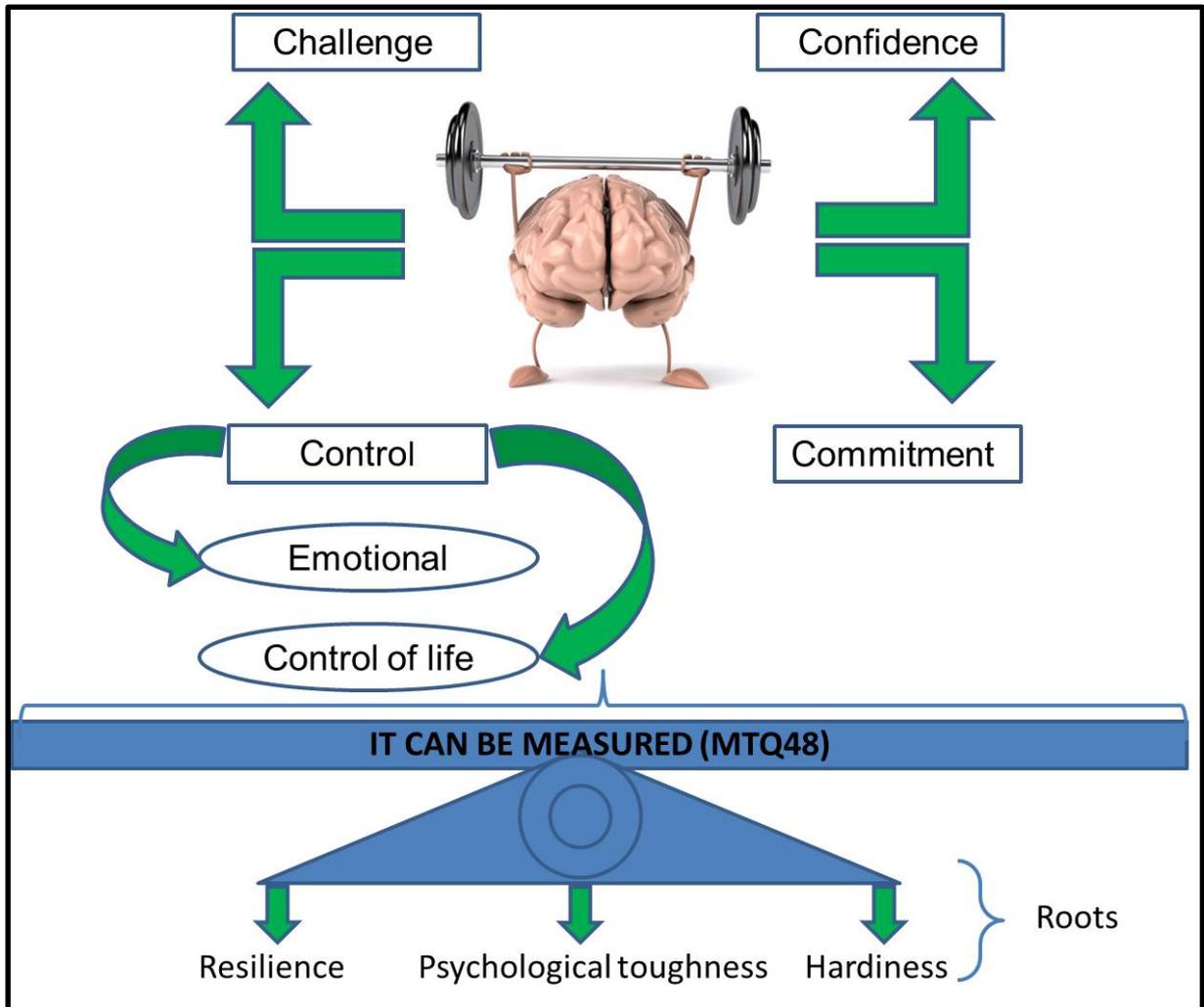
What I didn't like about this session is

I can relate the content to my own situation, because

What I would recommend for the future is

Thank you very much.

ADDENDUM E: HANDOUT SESSION 1, THE FOUR COMPONENTS OF MENTAL TOUGHNESS



**ADDENDUM F: HANDOUT SESSION 2, THE FOUR C'S – A
SUMMARY**



The Four C's – a summary

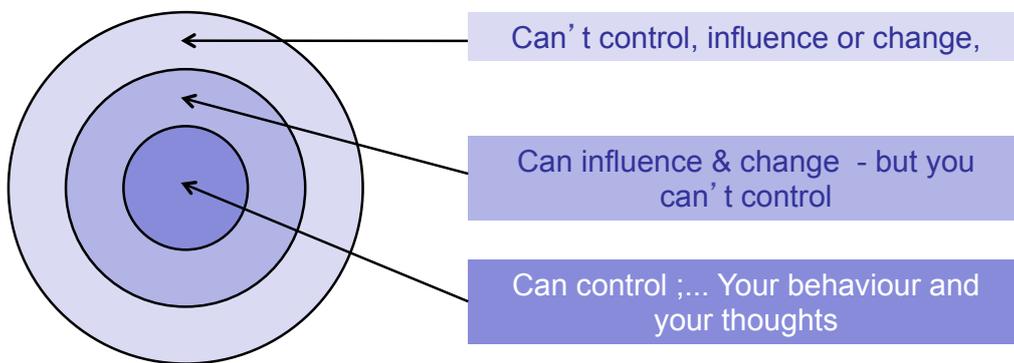
Scale	What this means
Control	I really believe I <i>can do it</i>
	I can <i>keep my emotions in check</i> when doing it
Commitment	I <i>promise</i> to do it – I'll set a goal
	I'll <i>do what it takes</i> to deliver it (hard work)
Challenge	I am <i>driven</i> to do it – I will take a chance
	<i>Setbacks make me stronger</i>
Confidence	I <i>believe</i> I have the ability to do it
	I can <i>stand my ground</i> if I need to

Together these give rise to **Mental Toughness**

ADDENDUM G: HANDOUT SESSION 2, MENTAL TOUGHNESS –
CIRCLES OF CONCERN, INFLUENCE AND CONTROL



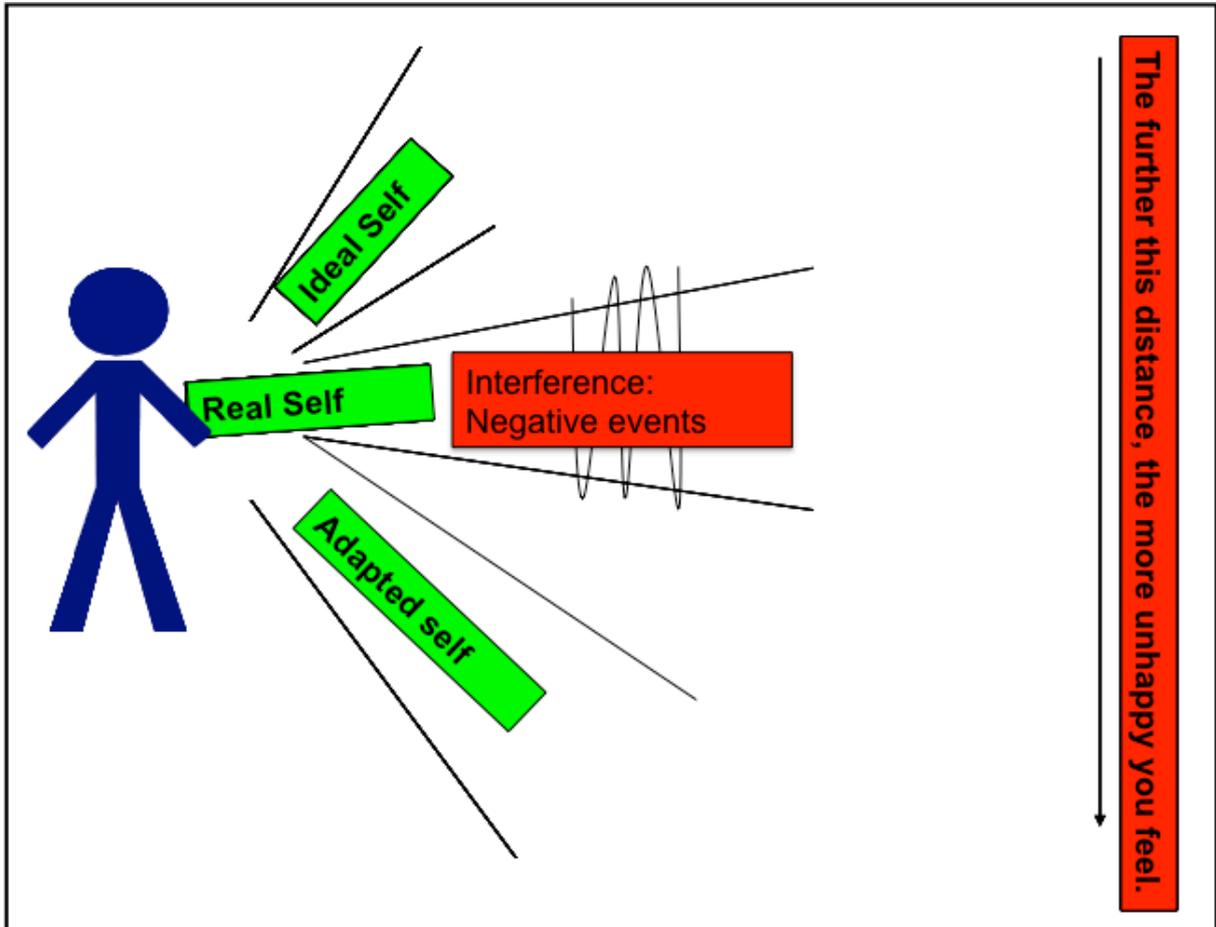
Mental Toughness
– Circles of Concern, Influence & Control



It is more effective to spend time and energy on what you can control.
The challenge is to stretch yourself to widen your circle of control.



ADDENDUM H: HANDOUT SESSION 3, THE SELF



ADDENDUM I: HAND-OUT SESSION 3, CONQUERING TRAUMA: FROM VICTIM TO SURVIVOR



WHAT IS TRAUMA?

Trauma is **stressful** events, over which a person has **no control**. These stressful events cause high levels of **anxiety** which threaten or harm a person's **emotional, physical** and/or **social well-being** and **interfere** with his normal daily **functioning** in such a way that a re-evaluation of his actions and thoughts are needed. These strong emotional reactions have the potential to interfere with a person's ability to function **either** at the scene or **later** on.

Any **situation** where a person experiences feelings of being overwhelmed and being lonely could be traumatic, **even** if there is **no** indication of **physical harm**; for

example a child, while growing up, who had been humiliated by a parent or teacher, may have experienced a trauma (Handout: Dr LD Preston).

Hand-out: Session 3

1. UNDERSTANDING TRAUMA

Trauma is categorised as follows:

- **Short-term traumatic events**

Short-term traumatic events are known as once-off traumatic events. These events include:

- **Natural disasters:** e.g. earthquakes, floods, severe tropical storms, hurricanes and mining disasters.
- **Man-made (accidental/unintentional) disasters:** e.g. airplane accidents, car accidents and fires.
- **Man-made (intentional) disasters** which are deliberately caused: e.g. shooting, robbery, physical attack, sexual assault, rape, hostage taking, robbery, mugging, kidnapping and hi-jacking.

- **Long-term traumatic events**

Long-term traumatic events refers to prolonged exposure to trauma and consists of two sub-categories which are:

- **Natural and technological disasters:** e.g. nuclear accidents, toxic spills, epidemics and chronic and/or life-threatening illness.
- **Manmade (intentional) disasters:** e.g. repeated sexual abuse as a child.

- **Vicarious exposure**

Vicarious exposure to trauma implies **indirect exposure** to trauma. This person is not the direct victim of the trauma, but he **saw** the event or **heard** about it from others

and in this way distress arises in him, for example **disaster**, learning about the unexpected **death** of a family member or friend and observation of **parents** with chronic **stress effects**. Traumatization can also be caused by **exposure to closely avoided** traumatic incidences.

2. TRAUMA'S IMPACT ON THE BRAIN AND BODY

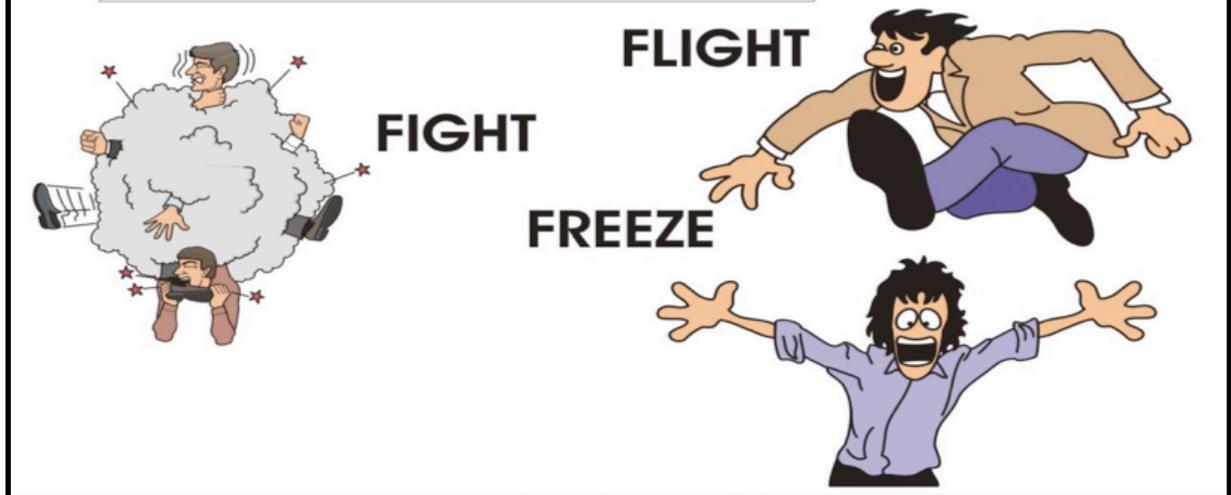
Danger and life threat have extremely **powerful** consequences. Due to this, the **brain** is **over ready** to quickly sense and **react** to dangerous situations (Preston 2013: 3). **Information** from the **outside** world reaches the brain by the five **senses** which are **smell, sight, hearing, touch and taste**.

During a threatening **traumatic experience** a person has **no control** over the way in which he is going to **react**. This **instinctual** way of responding is explained as follows:

- the brain perceives **threat**
- it immediately takes **action**
- there is **no** time to make **logical decisions**
- communication to the parts of the brain which are responsible for the **higher** levels of **thinking** as well as the **immune** and **digestive** systems are **cut off**
- the Autonomic Nervous System (ANS) appeals to **every part** of the **brain** and **body** to **react against** the **threat**
- the brain decides what the best response for the threat will be, which includes **fight, flight** and **freeze** responses
- the ANS responds in both the flight and fight reactions and the results are increased **heart rate, respiration**, the **release** of more **oxygen** in the blood and the acceleration of the **blood flow** to the **muscles** in order to be more **mobile**.

WHY DID I REACT LIKE I DID.....?

In response to a any cue for danger three specific survival strategies become evident. This response is an "unlearned" "unplanned" reaction which...*just happens...*"



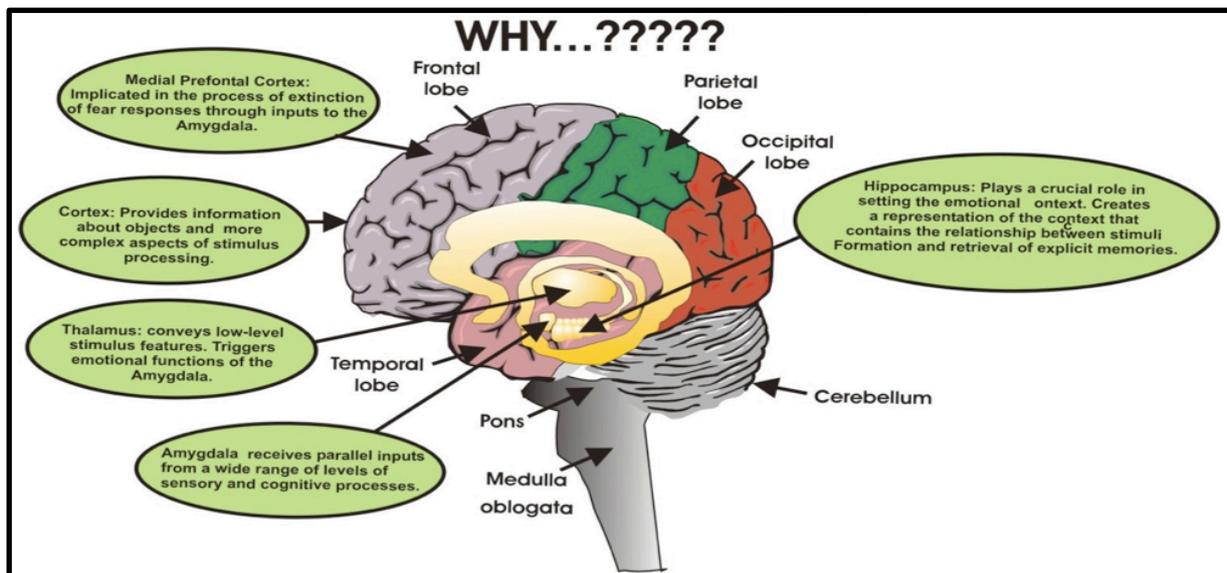
Above mentioned information is very **important** for people who **blame themselves** for the **way** in which they **responded** to a trauma or any environmental **threat** as we **do not** have any **conscious say** on how we will **respond** to a trauma.

3. COPING VERSUS NOT COPING WITH A TRAUMATIC INCIDENT

When a person experiences a traumatic incident:

- the amygdala (the **brain's "smoke detector"**) sets off the body's **alarm system** and **stress hormones** of adrenaline and nor-adrenaline literally **flood** a person's **brain**
- this heavy activity in the brain causes traumatic memories to get stuck in the nonverbal and non-conscious parts of the brain
- these stuck traumatic **memories cannot** be **accessed** by the frontal lobes which is the **understanding, thinking** and **reasoning areas** of the brain
- the brain's **normal process** to organise and store **information** is **disrupted** and leads to **confusion, forgetting, flashbacks, re-experiencing** and fragmented **images** of the trauma.

(On the other hand non-traumatic memories are easily processed, integrated and stored in the conscious mental frameworks of the brain).



- If the ANS continues to be activated after the danger is no longer present and leaves the body actively aroused, PTSD or symptoms thereof may be the result
- It implies that the **traumatised** person **was not able to return** to a state where he could **calm down** and **relax** after the traumatic incident.

To be able to increase its capacity, the brain creates **templates** or internal representations of the outside **world**. These templates are used in **future** events to **associate** and generalise **events**. In order to set the **ANS** in motion, the brain only needs a **small overlap** of 10% to 20% between a **sensory** hint and a template for **danger**:

- a **non-significant** hint, such as a **smell** of **smoke**, for a person who **survived** a **fire**, is able to put the **body** into **flight, fight** or **freeze** mode
- people may also **react** to **hints** that they are **not aware** of
- **traumatised** persons have a **greater chance** of making **false assumptions** and associations and **interpreting danger** in an environment where none exists.

- the **more** the **ANS** is activated, the more a specific **pattern** becomes **ingrained** and the more the pattern is ingrained, the **more** the **ANS** will be activated
- this is what is called a **PTSD cycle**
- over time an incident that triggers and sets off the body's alarm system can change the sensitivity of the alarm's response.
- the **result** may be that even **non-sensory** cues (just **thinking** of the event) can **trigger** the **brain** and lead to a **fear** response
- the **stress alarm** system is on **overdrive**.

4. REMEMBER

Trauma is not normal stress, it involves facing an overwhelming threat or danger.

- There is no **RIGHT OR WRONG** way to respond. You did what you could with what you had.
- There are no "**SHOULD**S" (should have) or "**COULD**S" (could have) "**IF**S" (If I had...).
- You are the "**HERO**". You have "survived" the situation and are alive to resume your life.
- How you coped and what you did was **RIGHT** – You are here to "*tell the tale*". This very fact may be the **heroic act**, as relating **your story** may be the answer someone needs. In a criminal situation you may be the one to identify the perpetrators or by just relating your story it may help some other victim to become a survivor
- Remember "**Superman**" is in comic books, you did what you could with what you had in an **ABNORMAL SITUATION**.
- How you presently feel and what you experienced is **RIGHT** for you!

- The reactions and responses you are presently feeling are very real and completely **NORMAL** (Hand-out: Dr LD Preston).

Part of **what makes** any **experience traumatic** is how you **interpret** both the **event** itself and your **ability** to **cope** and **remain** in **control** of the situation. **Trauma** is specific and **unique** to every **person**. Every trauma **survivor** brings his/her **own meaning** and **way** of **coping**. Coping and regaining one's life is based on **personal history, personality, strengths, weaknesses, skills** and **relationships**. We call this the person's **RESILIENCE** (which is an important root of mental toughness).

Therefore the following **three realities** are **essential** to acknowledge:

- **Reality One:** You are **no** longer a **victim**, you are now a **survivor**.
- **Reality Two:** **Living** your **life everyday** **heals** you after trauma and gives you a **greater** sense of **accomplishment**.
- **Reality Three:** **Healing** after trauma is your **birth right**. You **only** have **one** **life** and you are **now going** to **live** it (Hand-out: Dr LD Preston).

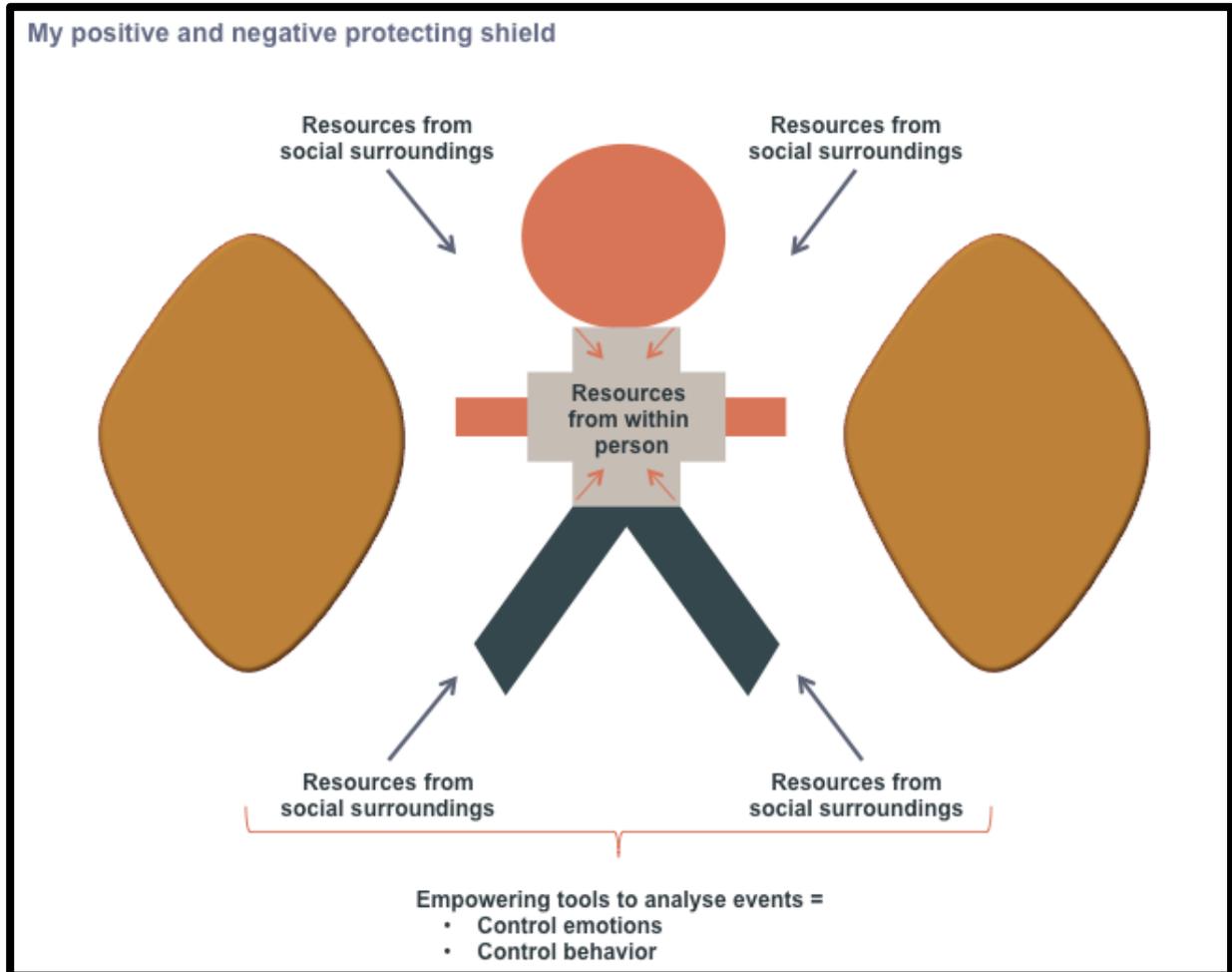
ADDENDUM J: HAND-OUT SESSION 4, TAKE CONTROL

Neem beheer / Take control



Not to choose is a choice and it usually has destroying consequences.

ADDENDUM K: HAND-OUT SESSION 4, PROTECTING SHIELD



**ADDENDUM L: HAND-OUT SESSION 4, ANCHOR OUTSIDE
TRAUMA**



ADDENDUM M: HAND-OUT SESSION 5, GROUNDING

Grounding within trauma **literally** means to learn **how** to **put** your **feet** on the **ground** when **intrusive thoughts**, **flashbacks** and **overwhelming** aspects of the **traumatic** experience are **chasing** you.

How to put my feet on the ground?

- Find a safe spot.
- Focus on my immediate environment and its surroundings:
 - I am right here in my room/in the elevator/at the shopping mall. I am not back in the (mention traumatic incident/traumatic circumstances) 20 years ago.
 - Who is with me?
 - What is in the room?
 - What does the room look like?
 - Realise how safe it is.
- Touch a cold wall.
- Feel the floor underneath your feet.
- Feel your own cold/warm hands.
- Breathe deeply.
- Keep a talisman that can be touched (physical grounding).
- Write yourself an e-mail.
- Sing out loud (mental grounding).
- Read out loud from a magazine / story book.



ADDENDUM N: HAND-OUT SESSION 5, EGO AS MANAGER OF THE PERSON



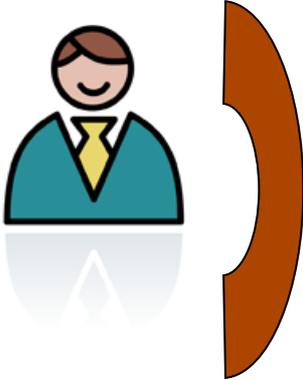
I - EGO

Ego has needs

- acknowledgement
- respect of others and self
- wants to feel worthy

Things that happen in life (every day) affect the ego in a positive or negative way.

Ego protects himself

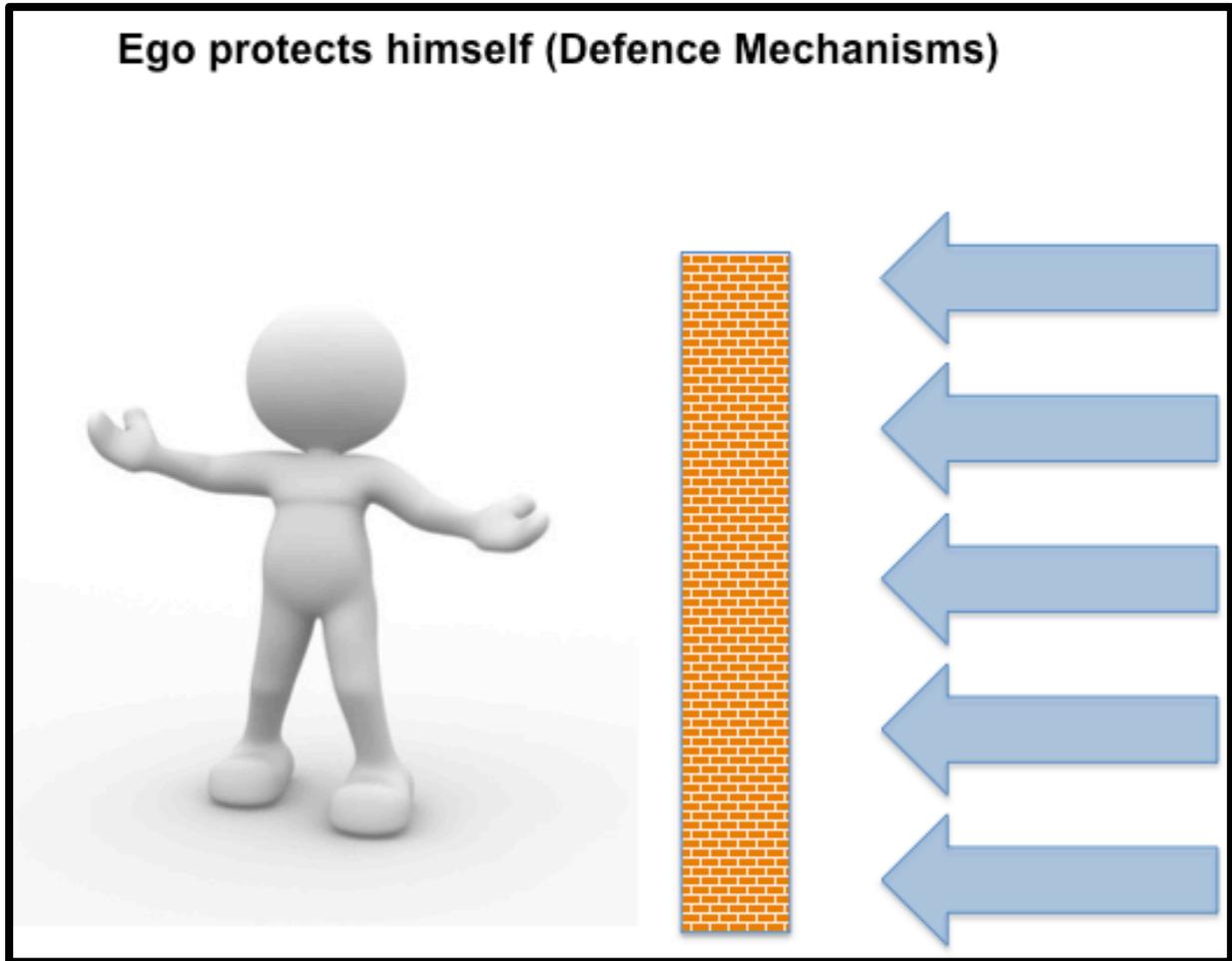


- Repression**
- Projection**
- Blaming others**
- Fixation**
- Regression**

**ADDENDUM O (a): HAND-OUT SESSION 5, DEFENDING
MECHANISMS**

1. **Repression:** ignore thoughts / feelings.
2. **Projection:** accuse other persons of something, for example desires that is my own and now I see it as something that others do.
3. **Blame others:** for my failures in life.
4. **Regression:** return to behaviour of an earlier stage in my life.
5. **Fixation:** stay in the previous phase of my life and refuse to go to the next stage.
6. **Withdraw:** out of life into myself.
7. **Displacement:** angry to boss/teacher and take it out on my wife/husband/friends/children.
8. **Inferiority:** react with opposite, threatening others/hurt others.

ADDENDUM O (b): EGO'S DEFENCE MECHANISMS



ADDENDUM P: HAND-OUT SESSION 5, THE SLIGHT EDGE

5% people successful

95% people not successful

WHY

BECAUSE:
THEY ARE NOT WILLING TO
MOVE OUT OF THEIR COMFORT
ZONES

Slight Edge

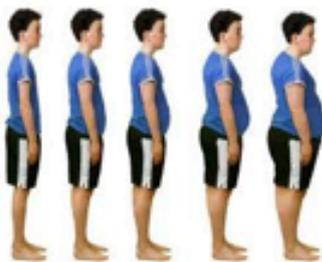
(Very small decisions I make every day)

-Read 10 pages a day



= 3 650 per year

-Gain 1 kg per year



- *2
- *3
- *4
- *5
- *6
- *7
- *8
- *9
- *10

63 kg

66 kg

69 kg

60 kg

Size 12

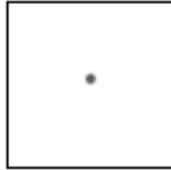
Size 14

Size 16

Size 18

3 years = new
size clothes

-Make one dot on a page every day for a year. In 365 days = 365 dots



-To walk / run 30 mins every day (5 days per week)
-In a week = 2:30. In a year = +- 125 hours!



Rocket to the moon:

97% of the time not on track to reach moon

3% of the time on track

BUT WILL reach the moon



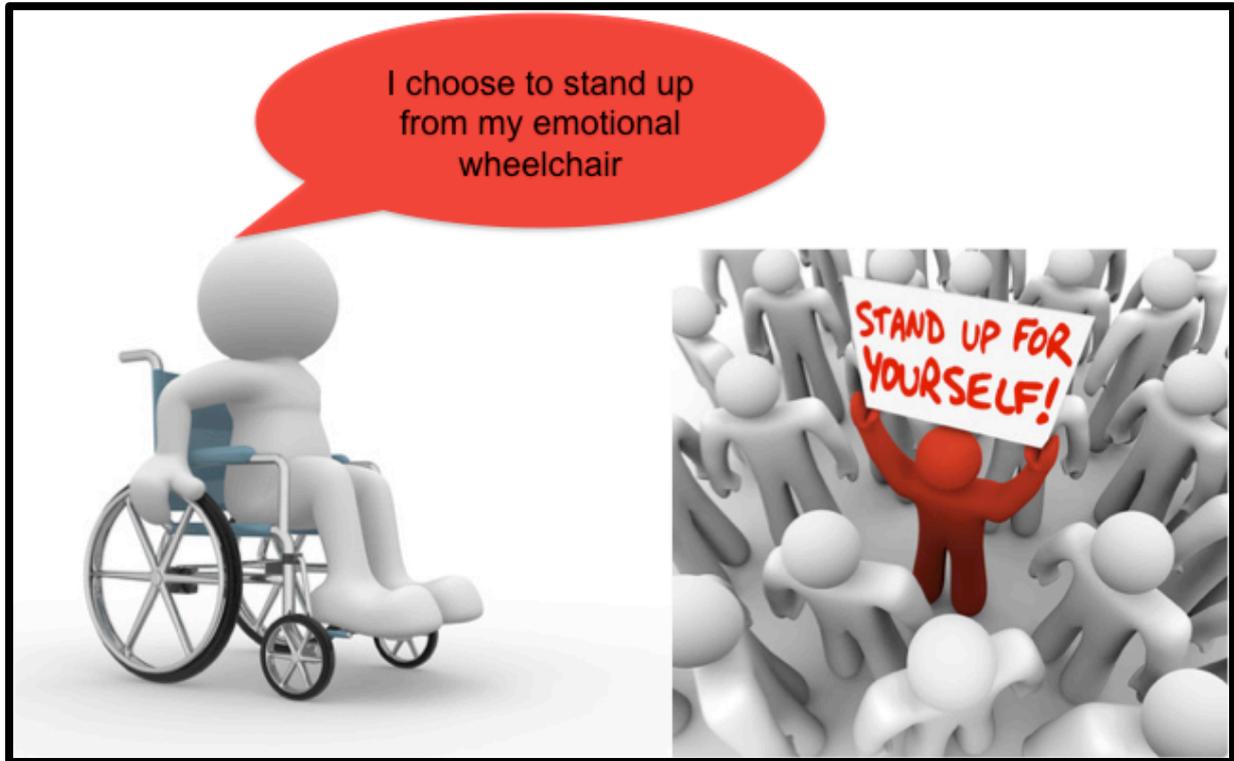
Slight Edge

-Easy to do but also

-Easy not to do!

Darryn Hardy (The Compound Effect)

**ADDENDUM Q: HAND-OUT, SESSION 6 THE EMOTIONAL
WHEELCHAIR**



ADDENDUM R: HANDOUT SESSION 6, THE CRACKED POT

The cracked pot

A water bearer in India had two large pots, each hung on the end of a pole which he carried across his neck. One of the pots was perfectly made and never leaked. The other pot had a crack in it and by the time the water bearer reached his master's house it had leaked much of its water and was only half full.

For a full two years this went on daily, with the bearer delivering only one and a half pots full of water to his master's house. Of course, the perfect pot was proud of its accomplishments. But the poor cracked pot was ashamed of its own imperfection, and miserable that it was able to accomplish only half of what it had been made to do.



After two years of what it perceived to be a bitter failure, it spoke to the water bearer one day by the stream. "I am ashamed of myself, and I want to apologize to you." "Why?" asked the bearer. "What are you ashamed of?" "I have been able, for these past two years, to deliver only half my load because this crack in my side causes water to leak out all the way back to your master's house. Because of my flaws, you have to do all of this work, and you don't get full value from your efforts," the pot said.

The water bearer felt sorry for the old cracked pot, and in his compassion he said, "As we return to the master's house, I want you to notice the beautiful flowers along the path."

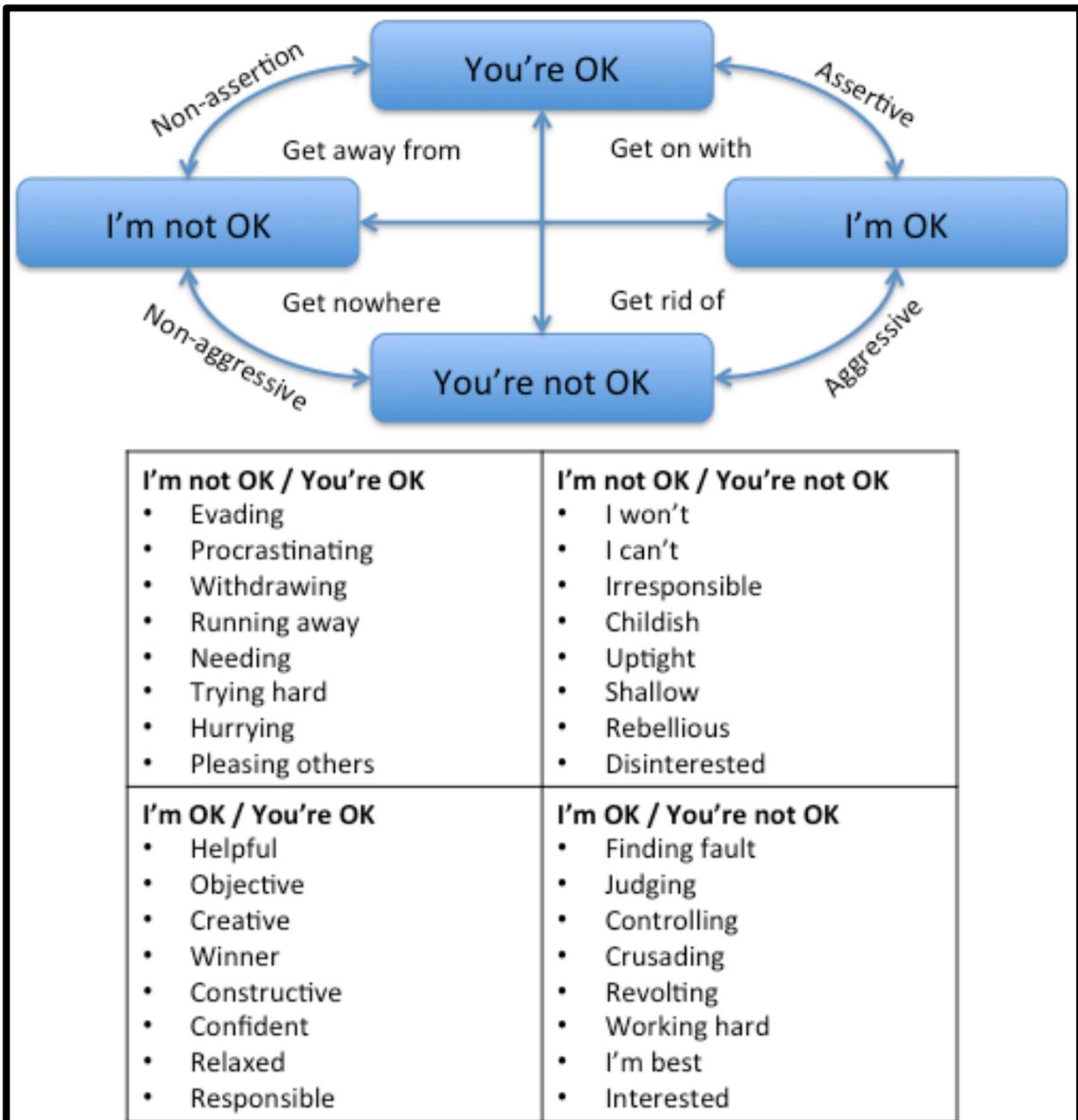
Indeed, as they went up the hill, the old cracked pot took notice of the sun warming the beautiful wild flowers on the side of the path, and this cheered it some. But at the end of the trail, it still felt sad because it had leaked out half of its load, and so the pot apologized to the bearer for its failure.

The bearer said to the pot, "Did you notice that there were flowers only on your side of the path, but not on the other pot's side? That's because I have always known about your flaw, and I took advantage of it. I planted flower seeds on your side of the path, and every day while we walk back from the stream, you've watered them. For two years I have been able to pick these beautiful flowers to decorate my master's table. Without you being just the way you are, he would not have this beauty to grace his house."

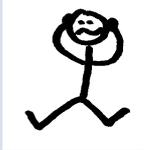
Each of us has our own unique flaws. We're all cracked pots. But if we will allow it, God will use our flaws to grace his table. In God's great economy, nothing goes to waste. Don't be afraid of your flaws. Acknowledge them, and you too can be the cause of beauty. Know that in our weakness we find our strength.

Author unknown

**ADDENDUM S: HAND-OUT SESSION 6, TRANSACTIONAL
ANALYSIS**



ADDENDUM T: HAND-OUT SESSION 7, EGO STATES

Level 1	Characteristics	Out of control	Words	Voice	Gestures
Parent Nurturing parent (NP) 	<ul style="list-style-type: none"> • Empathy • Caring • Concerned • Consideration • Protect • Help • Love 	Too much = suffocating	<ul style="list-style-type: none"> • Care • Good • Tender • Splendid 	<ul style="list-style-type: none"> • Comforting • Concerned • Caring • Supportive • Understanding 	<ul style="list-style-type: none"> • Accepting • Smiling • Reaching towards • Open
Critical parent (CP) 	<ul style="list-style-type: none"> • Rigid • Punish • Evaluative • Judgmental • Criticize • Make rules 	Too much = dictator	<ul style="list-style-type: none"> • Should • Ought • Must • Always • Bad 	<ul style="list-style-type: none"> • Curt • Critical • Condescending • Disgusted • Disapproving • Unpleasant 	<ul style="list-style-type: none"> • Points • Angry • Frowns • Looks down
Adult (A) 	<ul style="list-style-type: none"> • Analytical • Control • Objective • Facts • Actions • Not emotional • Unconditional 	Too much = boring	<ul style="list-style-type: none"> • What? • How? • When? • Practical • Data 	<ul style="list-style-type: none"> • Even • Unemotional 	<ul style="list-style-type: none"> • Thoughtful • Alert • Bright
Child Free child (FC) 	<ul style="list-style-type: none"> • Impulsive • Laugh • Cry • Shout • Important! Human 	Too much = out of control	<ul style="list-style-type: none"> • Woe • Fun • Like • Want • Won't 	<ul style="list-style-type: none"> • Free • Loud • Energetic 	<ul style="list-style-type: none"> • Uninhibited • Spontaneous
Adapted child (AC) 	<ul style="list-style-type: none"> • Whiny • Poor me • Complaint • Rebel • Black sheep • Feels hurt 	Too much = depression, guilt, anger - out of control	<ul style="list-style-type: none"> • Can't • Wish • Try • Hope • Please 	<ul style="list-style-type: none"> • Whiny • Defiant • Complacent 	<ul style="list-style-type: none"> • Pouting • Sad • Innocent
Little professor (LP) 	<ul style="list-style-type: none"> • Manipulate • Egoistic • Creative • Unschooled wisdom 	Too much = loss of his credibility			

ADDENDUM U: HAND-OUT SESSION 8, I WALK DOWN THE STREET

I walk down the street

"I walk down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost... I am helpless.
It isn't my fault.
It takes forever to find a way out.

I walk down the same street.
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I am in the same place.
But, it isn't my fault.
It still takes me a long time to get out.



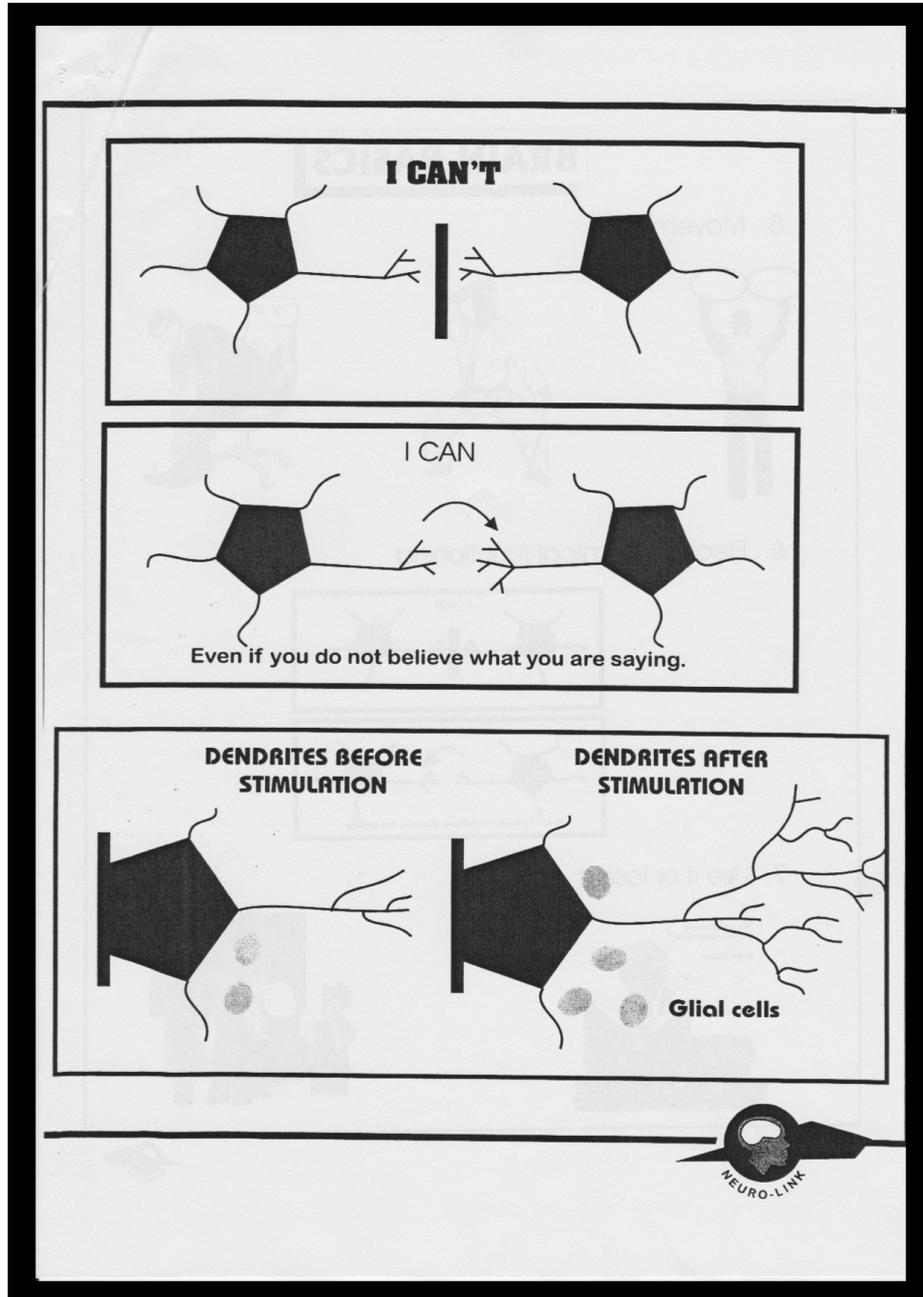
I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I still fall in. It's a habit.
My eyes are open.
I know where I am.
It is my fault. I get out immediately.

I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

I walk down another street."

Portia Nelson

**ADDENDUM V: HAND-OUT SESSION 6, THE NEURONS AND
NEGATIVE SELF-TALK**



ADDENDUM W: HAND-OUT SESSION 6, TRANSACTIONAL ANALYSIS QUESTIONNAIRE

TRANSACTIONAL ANALYSIS QUESTIONNAIRE

There is no time limit to this questionnaire. It will probably take around ten minutes to complete. The more spontaneous and honest you can be, the more accurate the results probably will be.

**If you agree more than you disagree with a statement, mark a plus (+) in the box.
If you disagree more than you agree, mark a minus (-) in the box.**

1. Teenagers would be better off if they tried harder to understand and utilise the experiences of older people.
2. I enjoy fast driving.
3. Generally I manage to keep a calm appearance even when I am all upset inside.
4. There are too few people nowadays with enough courage to stand up for what is right.
5. People who tend to be "Bossy" actually lack self-confidence although they may not realise this.
6. I do not like it when people are not clear about what I say and ask me to repeat.
7. Effective leadership means to enable people to give the best of themselves rather than seek the best for themselves.
8. There is too much sex and violence on TV nowadays.
9. In my opinion, it is healthy to freely discuss sex, bodily functions, intimacy, etc.
10. I find it difficult to stick to a diet, to quit smoking, etc.
11. In my opinion, speed limits should be strongly enforced.

12. Parents tend to be too permissive nowadays.
13. I believe that absolute openness and honesty with others is possible.
14. In my opinion, 95% of the important life decisions are based on feelings.
15. Too many people nowadays allow others to push them around too much.
16. Although most people are not, I seem to be quite comfortable with a long period of silence.
17. I can recall situations where, as a child, other people made me feel ashamed.
18. Sometimes children need to be slapped on the buttocks for their own good.
19. We need more rather than less censorship in the movies, TV, magazines, etc.
20. Even with strangers, I seldom feel bored, impatient or lonely.
21. I know that sometimes I ought to eat and drink less than I do.
22. The good opinion of others is important.
23. My parents encouraged me to explore and learn things for myself.
24. I get uncomfortable when something unexpected happens.
25. Even when one feels life is not worth living, no one is justified in committing suicide.
26. I try and attend many courses, seminars, lectures, etc.

27. Sometimes I tell myself, "Shut up - you are talking too much".
28. A remedy for divorce would be to make the conditions more stringent so that marriage would be considered more seriously.
29. I seldom, if ever blush.
30. Most mistakes result from misunderstanding rather than carelessness.
31. Tense situations make me feel uncomfortable enough that I must do something about it.
32. Most youngsters will benefit from obligatory military service.
33. Many times I have had to change my strong convictions as a result of new information.
34. Humility is one of the virtues, perhaps the greatest one.
35. Expressive hair styles seem to have to compensate for small brains nowadays.
36. Experience is useful but in most instances, it probably needs to be modified by new facts and information.
37. Marriage between people from different races or countries are heading for trouble.
38. All work and no play add up to a dull life and that is not the way I want to live.
39. Sometimes I hear myself say "I do not make the rules, I just follow them".
40. You can not change human nature.
41. I do not believe that there has to be a natural and un-resolvable conflict between organisations and individuals.

42. Sometimes I get so discouraged that I want to run away.
43. Capital punishment should never be completely done away with.
44. People should attend church more often.
45. Most decisions carry some consequences and I like to evaluate those consequences before making a decision.
46. I am concerned about the approval of others.
47. I like to run things, be boss of the situation, take charge.
48. Even at social gatherings I find myself discussing business or gathering data from magazines and books.
49. Being a subordinate is not that easy but is better than being the boss.
50. I quickly become bored with a situation.
51. I believe that society would be better off if the laws were more rigorously enforced.
52. I am not ashamed of my tears when I am sad enough to cry, even when others are around.
53. When I think people are wrong or stupid, I say so.
54. I envy people who quit their career in order to start a new life style.
55. I just cannot trust people like many seem to do.
56. Even though there may be a standard approach to a situation, I like to figure out new ways.

- 57. I put things off until they can't be put off any longer.
- 58. I am inclined to challenge others, enquiring and become aggressive.
- 59. Most people are capable of sustained self-direction and control.
- 60. Things like working in the garden, swimming, sex and other forms of physical activities make me feel good all over.
- 61. I get angry or disgusted with someone I think is submissive, compromising, etc.

SELF SCORING AND PROFILES

INSTRUCTIONS

You score one point for each item you have answered with a +.

Answers with a - or questions not answered do not score.

1.	<input type="checkbox"/>	32.	<input type="checkbox"/>	3.	<input type="checkbox"/>	2.	<input type="checkbox"/>
4.	<input type="checkbox"/>	35.	<input type="checkbox"/>	7.	<input type="checkbox"/>	6.	<input type="checkbox"/>
5.	<input type="checkbox"/>	37.	<input type="checkbox"/>	9.	<input type="checkbox"/>	10.	<input type="checkbox"/>
8.	<input type="checkbox"/>	40.	<input type="checkbox"/>	13.	<input type="checkbox"/>	14.	<input type="checkbox"/>
11.	<input type="checkbox"/>	43.	<input type="checkbox"/>	16.	<input type="checkbox"/>	17.	<input type="checkbox"/>
12.	<input type="checkbox"/>	44.	<input type="checkbox"/>	20.	<input type="checkbox"/>	21.	<input type="checkbox"/>
15.	<input type="checkbox"/>	47.	<input type="checkbox"/>	23.	<input type="checkbox"/>	24.	<input type="checkbox"/>
18.	<input type="checkbox"/>	50.	<input type="checkbox"/>	26.	<input type="checkbox"/>	27.	<input type="checkbox"/>
19.	<input type="checkbox"/>	51.	<input type="checkbox"/>	29.	<input type="checkbox"/>	31.	<input type="checkbox"/>
22.	<input type="checkbox"/>	53.	<input type="checkbox"/>	30.	<input type="checkbox"/>	34.	<input type="checkbox"/>
25.	<input type="checkbox"/>	55.	<input type="checkbox"/>	33.	<input type="checkbox"/>	39.	<input type="checkbox"/>
28.	<input type="checkbox"/>	58.	<input type="checkbox"/>	36.	<input type="checkbox"/>	42.	<input type="checkbox"/>
		61.	<input type="checkbox"/>	38.	<input type="checkbox"/>	46.	<input type="checkbox"/>
				41.	<input type="checkbox"/>	49.	<input type="checkbox"/>
				45.	<input type="checkbox"/>	54.	<input type="checkbox"/>
				48.	<input type="checkbox"/>	57.	<input type="checkbox"/>
				52.	<input type="checkbox"/>	60.	<input type="checkbox"/>
				56.	<input type="checkbox"/>		
				59.	<input type="checkbox"/>		

PARENT SUBTOTAL Nurturing, Caring Indulgent	PARENT SUBTOTAL Controlling, Organising Critical		
<div style="border: 1px solid black; width: 60px; height: 40px; margin: 0 auto;"></div> PARENT		<div style="border: 1px solid black; width: 60px; height: 40px; margin: 0 auto;"></div> ADULT	<div style="border: 1px solid black; width: 60px; height: 40px; margin: 0 auto;"></div> CHILD

P.A.C. PROFILE

	PARENT	ADULT	CHILD
100%	16	16	12
90%	14		
80%		14	10
70%	12		
60%		12	
50%			8
40%	10		
30%			
20%	8	10	6
10%	6	8	5
0%	4	6	3

Interpretation of your P.A.C. Profiles

The highest percentage score of the three scores indicates the particular Ego State mostly used by you. If there is a difference of **twenty** or more percentage points between the highest and the second highest score, this means that the highest scoring Ego State is your dominant ego state.

If there is less than **twenty** percentage points difference, there is a likelihood that you switch back and forth between Ego States without being consciously aware of this switch.

ADDENDUM X: PHOTOGRAPHS OF SESSIONS



Participant F: Metaphor



Participant G: Metaphor



Participant B: Metaphor

	Gym	Stap	Hosp besoek	Skattei goed	8 Water	Kos	Tuin	Self sorg	Punte	Na- skool	Kg
Donderdag	✓	✓		✓	✓			✓			
Vrydag		✓		✓	✓	✓	✓	✓	30%		
Saterdag	✓			✓	✓			✓	23		
Sondag	~~~~~										
Maandag				✓	✓	✓	✓				
Dinsdag		✓		✓	✓						
Woensdag				✓	✓			✓			

Participant E: Daily time table



Participant E: Emotions in body



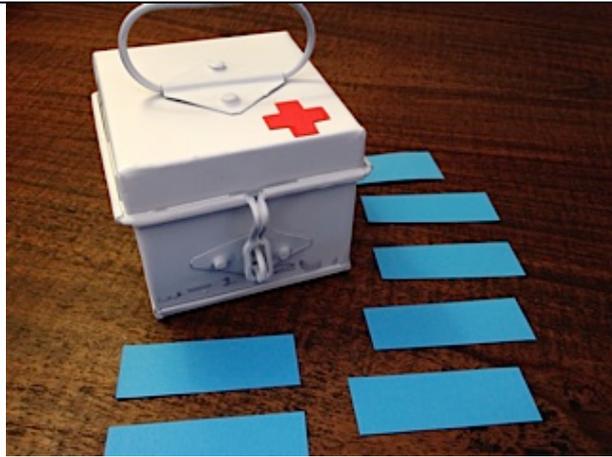
Participant E: Emotion flowers



Participant D: Emotions in body



Participant D: Emotion flowers



First aid kit



How to fill my bucket and others'



Participant F: Sand tray



Participant C: Sand tray



Participant A: Sand tray



I am not a victim, I am a survivor!

ADDENDUM Y: RESEARCH ETHICS CLEARANCE CERTIFICATE



Research Ethics Clearance Certificate

This is to certify that the application for ethical clearance submitted by

Ms AMS van Niekerk (32814240)

for a D Ed study entitled

Psycho-educational use of mental toughness in dealing with trauma

has met the ethical requirements as specified by the University of South Africa College of Education Research Ethics Committee. This certificate is valid for two years from the date of issue.

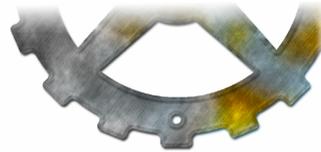
Prof CS le Roux
CEDU REC (Chairperson)
lrouxcs@unisa.ac.za

2 October 2012

Reference number: 2012 SEPT/ 32814240/CSLR

ADDENDUM Z: MENTAL TOUGHNESS LICENSED USER
CERTIFICATE

AQR



This is to certify that

Marisa van Niekerk

has completed training in the use and interpretation of MTQ48
and is now licensed to use:

MTQ48

Awarded on 11th March, 2014

The License Number

MTQ123728

has been assigned to you

Please quote this number when ordering meters

Signed:

Doug Strycharczyk – Managing Director
AQR

ADDENDUM AA: LETTER OF CONSENT FOR INSTITUTION

Marisa van Niekerk

Educational Psychologist

HED Pre-Primary; HED Junior-Primary, B.Ed Hons (Early Childhood Development)
M.Ed (Educational Psychology)

HPCSA Reg. Number PS 0122432
0523240

Practice No.



Cell: 074 041 0081
E-mail: marisavniekerk@gmail.com

Consulting room:
170 Old Kent Drive
Midstream Estate
1692

Consultation hours:
Mon – Fri: 9:00 – 18:00

18 March 2014

Dear Dr Vermeulen

I am a doctoral student in Educational Psychology at the University of South Africa (Unisa). I am planning to conduct research to determine whether a psycho-educational programme aimed at augmenting the mental toughness (emotional resilience) of a traumatised person will indeed lead to increased mental toughness and improved skills for dealing with such trauma. Examples of traumatic events are divorce, abuse, suicide, death, robbery and natural disasters. Mitchell (1983) describes trauma as a critical situation with which a person is faced and that may lead to extreme emotional reactions. These extreme reactions have the potential to affect a person's normal functioning, either directly after a trauma or at a later stage. Clough and Strycharczyk (2012) define mental toughness as the quality that largely determines how someone deals with challenges, stressors and pressure, regardless of the circumstances that prevail in his/her life.

A Mental Toughness Questionnaire (MTQ48) was developed in 2002 and has proved itself a reliable and valid assessment instrument for determining a person's ability to deal with pressure in the workplace and on the sports field. However, no research has been done as yet to determine the relationship between mental toughness and its appropriate use in trauma (Association for Qualitative Research (AQR) 2007; Clough & Strycharczyk 2012). Hence the aim of this study is to obtain more practical information of the ways in which psychologists may support traumatised clients.

I am herewith requesting your permission to conduct this research at the support centre of the Reformed Church Wapadrant.

The proposed research project comprises two phases:

1. The first phase is the assessment phase of the study and includes the identification of traumatised persons (adults 18 years and older) who display a low level of mental toughness.
2. The second phase of the research project – the intervention phase – will attempt to support these identified persons in individual therapy sessions as part of a psycho-educational programme. More information pertaining to the programme will be made available to the identified persons at a later stage.

Consent form

Whenever researchers study people, the study is explained to them and they are requested to give their permission for voluntary participation in the study. Once the voluntary participant has been given more information on the study, he/she will be asked to complete the consent form. An example of this letter of consent will also be submitted to you for your information.

Please note: This particular consent form only requests the voluntary person's permission for the first part of the study, namely the assessment phase. A second letter of consent – for participation in the psycho-educational programme – will be handed only to the first 10 persons complying with the criteria of low mental toughness.

My proposed research procedure

The support centre of the Reformed Church Wapadrant as well as the trauma centre at Garsfontein Police Station will be contacted and I will share with all its members my proposed study by means of an information document. A certificate of consent issued by Unisa regarding my research will also be included in this letter. I will ask the potential participants to e-mail me their completed consent forms for participation in the research

within one week. Before anyone will be assessed, I undertake to double check that he/she in fact completed and signed this letter of consent.

I will also keep a list of the sequence in which I received the e-mails. Before a person may take part in the study, his/her mental toughness will be determined, since both low mental toughness and having experienced trauma constitute a prerequisite for the study. Ten persons will be designated for the second phase (psycho-educational programme).

An individual interview will be conducted with each client. This semi-structured interview will focus on determining whether and to what extent the client considers his/her mental toughness to be low. During the interview the client will complete a standardised questionnaire, known as the Mental Toughness Questionnaire (MTQ 48). This test instrument has been registered in the United Kingdom. The MTQ48 consists of 48 items and can be completed in approximately 10 minutes. A psychometric matrix and user-friendly report will be provided to the client in a follow-up session.

Confidentiality

All information obtained by means of the interview and the MTQ48 will be treated confidentially. The only other person who will have access to the confidential information is my study leader, Professor H.E. Roets, from the University of South Africa. No information regarding a client will be disclosed without his/her permission. However, in exceptional cases, I may be obliged by legal or professional rules to disclose information on a client. These include the following:

Emergency situations

The client has to take note that should a situation arise where I believe that there is a real risk that he/she may injure him-/herself, any other person, or me, I am obliged to take the necessary steps to prevent such injury from occurring, even though it may compel my disclosure of confidential information relating to the client.

Statutory duty

A legal prescription may force me to disclose confidential information about a client.

Court orders

A court may instruct me to disclose confidential information. However, in terms of my professional rules, I must do all I can to prevent the disclosure of a client's personal information.

I will discuss the assessment results with the client, provided that this information does not pose any risk of harm to the client him-/herself or any other person. In the event of suspected potential harm, I will inform the client beforehand of my obligation to disclose such information.

Duration of the study

The study will be conducted over a period of eight to nine weeks at the Reformed Church Wapadrant (eight to nine sessions). One session will last approximately 75 minutes.

PART II: CERTIFICATE OF CONSENT

This form has been revised and approved by Professor H.E. Roets, who is mentoring me, Anna Maria Susanna van Niekerk, in my studies and who has to ensure that all ethical procedures are complied with during this research.

I (name and surname) _____ herewith give consent that Anna Maria Susanna van Niekerk may conduct her studies at the Support Centre of the Reformed Church Wapadrant, Pretoria.

I have read carefully through the information above. I was given the opportunity to ask questions about it and the questions that I asked were answered adequately.

Signature: _____ Date (day / month / year): _____

Name and surname of researcher: _____

Signature of researcher: _____

Date (day / month / year): _____

Thank you very much. I appreciate your support in this regard.

Kind regards



Marisa van Niekerk



Prof. H.E. Roets

Promoter

ADDENDUM AB: LETTER OF CONSENT FOR PARTICIPANTS,
PART 1

Marisa van Niekerk

Educational Psychologist

HED Pre-Primary; HED Junior-Primary, B.Ed Hons (Early Childhood Development)
M.Ed (Educational Psychology)

HPCSA Reg. Number PS 0122432
0523240

Practice No.



Cell: 074 041 0081
E-mail: marisavniekerk@gmail.com

Consulting room:
170 Old Kent Drive
Midstream Estate
1692

Consultation hours:
Mon – Fri: 9:00 – 18:00

18 March 2014

Letter of Consent for (name and surname): _____

This letter of consent is meant for persons from the Sunrise Trauma Centre at the Garsfontein Police Station and members of the Reformed Church Wapadrant's Support Centre, Pretoria.

Name of researcher: Anna Maria Susanna van Niekerk (Marisa)

Name of university: University of South Africa (UNISA)

Promoter: Professor H.E. Roets

This letter of consent consists of two parts:

- Information sheet (to share with you information pertaining to the study)
- Consent form (requiring your signature should you agree to the assessment of your mental toughness)

You will receive a copy of the complete letter of consent once all the necessary signatures have been obtained.

PART 1: INFORMATION SHEET

Introduction

I am a registered Educational Psychologist and doctoral student in Educational Psychology at the University of South Africa (Unisa). I plan to conduct research to determine whether a psycho-educational programme aimed at augmenting the mental toughness (emotional resilience) of a traumatised person will indeed lead to increased mental toughness and improved skills to deal with such trauma. Examples of traumatic events are divorce, abuse, suicide, death, robbery and natural disasters. Mitchell (1983) describes trauma as a critical situation facing a person that may lead to extreme emotional reactions. These extreme reactions have the potential to affect a person's normal functioning, either directly after a trauma or at a later stage. Clough and Strycharczyk (2012) define mental toughness as the quality that largely determines how someone deals with challenges, stressors and pressure, regardless of the circumstances that prevail in his/her life.

A Mental Toughness Questionnaire (MTQ48) was developed in 2002 and has proved itself a reliable and valid assessment instrument for determining a person's ability to deal with pressures in the workplace and on the sports field. However, no research has been done as yet to determine the relationship between mental toughness and its appropriate use in clinical and educational psychology (Association for Qualitative Research (AQR) 2007; Clough & Strycharczyk 2012). Hence, the aim of this study is to obtain more practical information on the ways in which psychologists may support traumatised clients.

The proposed research project comprises two phases:

1. The first phase is the assessment phase and includes the identification of traumatised persons (adults 18 years and older) who display a low level of mental toughness.
2. The second phase of the research project – the intervention phase – will attempt to support these identified persons in individual therapy sessions as part of a psycho-educational programme. More information pertaining to the programme will be made available to the identified persons at a later stage.

Consent form

Whenever researchers study people, the study is explained to them and they are requested to give their permission for voluntary participation in such study. Once you as a voluntary participant have been given more information on the study, I will ask you to complete and sign the consent form.

Please note: This particular letter of consent **only** asks for your permission as volunteer for the **first part of the study, namely the assessment phase**. A second letter of consent – for participation in the psycho-educational programme – will be handed only to the first 10 persons who comply with the criteria of low to satisfactory mental toughness.

Aim

The aim of this section of the research project is to identify potential participants for the therapeutic phase of the study.

My proposed research procedure

The support centre of the Reformed Church Wapadrant, as well as the trauma centre at Garsfontein Police Station, will be contacted and I will share with its members my proposed study by means of an information document. A certificate of consent issued by Unisa regarding my research will also be included in this letter. I will ask the persons who are interested in participating in the research to e-mail me their completed consent forms within one week. Before anyone will be assessed, I will double check that he/she in fact completed and signed this consent form.

I will also keep a list of the sequence in which I received the e-mails. Before a person may take part in the study, his/her mental toughness will be determined, since low mental toughness and having experienced trauma constitute a prerequisite for the study. Ten persons will be designated for the second phase (psycho-educational programme).

An individual interview will be conducted with each client. This semi-structured interview will focus on determining whether and to what extent the client considers his/her mental

toughness to be low. During the interview the client will complete a standardised questionnaire, known as the Mental Toughness Questionnaire (MTQ48). This test instrument has been registered in the United Kingdom. The MTQ48 consists of 48 items and can be completed in approximately 10 minutes. A psychometric matrix and user-friendly report will be provided to the client in a follow-up session.

Voluntary participation

Participation in this study occurs on a voluntary basis and you may choose whether you would like to take part in this research study or not.

Risks and discomfort

The possibility exists that when you share with me personal and confidential information, you may feel uncomfortable and/or that feelings of re-traumatisation may be elicited. It is important to know that you only need to share with me information with which you feel comfortable. As an educational psychologist I shall be able to support you in releasing and dealing with threatening emotions.

Benefits

Your participation in the study may lead to a situation where we (you and I) can support you to identify areas in your life on which you wish and are able to work. During this process you will gain better insight into yourself.

Confidentiality

All information obtained by means of the interview and the MTQ48 will be treated confidentially. The only other person who will have access to the confidential information is my study leader, Professor H.E. Roets, from the University of South Africa. No information regarding a client will be disclosed without the client's permission. However, in exceptional cases, legal or professional rules may oblige me to disclose information regarding a client. These exceptions include the following:

Emergency situations

The client has to take note that should a situation arise where I believe that there is a real risk that he/she may injure him-/herself, any other person, or me, I am obliged to take the necessary steps to prevent such injury from occurring, even though it may compel my disclosure of confidential information relating to the client.

Statutory duty

A legal prescription may force me to disclose confidential information about a client.

Court orders

A court may instruct me to disclose confidential information. However, in terms of my professional rules, I must do all I can to prevent the disclosure of a client's personal information.

I will discuss the assessment results with the client, provided that this information does not pose any risk of harm to the client him-/herself or to any other person. In the event of suspected potential harm, I will inform the client beforehand of my obligation to disclose such information.

Voluntary consent to participation

Should you agree to take part in the study, you remain free to withdraw from it at any time, whether during assessment, therapy sessions and/or interviews. You need not give any explanations.

Duration of the study

The study will be conducted over a period of eight to nine weeks at the Reformed Church Wapadrant (eight to nine sessions). One session will last approximately 75 minutes.

Who to contact

If you have any questions, you are welcome to contact me.

Contact details: Marisa van Niekerk

Cell no: 074 041 0081

E-mail: marisavniekerk@gmail.com

PART II: CERTIFICATE OF CONSENT

This form has been revised and approved by Professor H.E. Roets, who is mentoring me, Anna Maria Susanna van Niekerk, in my studies and who has to ensure that all ethical procedures are complied with during this research.

I (name and surname) _____ herewith give consent for my participation in the first part (assessment phase) of this study. This means that I will complete one questionnaire and attend one informal interview.

I have read carefully through the information above. I was given the opportunity to ask questions about it and the questions that I asked were answered adequately.

I herewith give my consent as voluntary participant:

Name and surname (participant): _____

Signature of participant: _____

Contact number: _____

E-mail: _____

Date: _____ day/month/year

OR

I herewith REFUSE my consent to act as voluntary participant:

Name and surname (participant): _____

Signature of participant: _____

Contact number: _____

E-mail: _____

Date: _____ day/month/year

For completion by researcher

Confirmation by researcher in respect of consent

I confirm that the voluntary participant was given the opportunity to contact me should he/she have any enquiries with regard to the study. I answered all his/her questions to the best of my ability. I confirm that the participant was not forced to take part in the study and that his/her consent was voluntary.

A copy of the letter of consent was made available to the voluntary participant.

Name and surname (researcher): _____

Signature of researcher: _____

THANK YOU VERY MUCH.



Marisa van Niekerk



Prof. H.E. Roets

Promoter

ADDENDUM AC: LETTER OF CONSENT FOR PARTICIPANTS,
PART 2 OF STUDY

Marisa van Niekerk

Educational Psychologist

HED Pre-Primary; HED Junior-Primary, B.Ed Hons (Early
Childhood Development)

M.Ed (Educational Psychology)



HPCSA Reg. Number PS 0122432
0523240

Practice No.

Cell: 074 041 0081
E-mail: marisavniekerk@gmail.com

Consulting room:
170 Old Kent Drive
Midstream Estate
1692

Consultation hours:
Mon – Fri: 9:00 – 18:00

10 April 2014

Letter of Consent for (name and surname): _____

This letter of consent pertains to the second phase of the research study, namely the psycho-educational individual therapy programme.

Name of researcher: Anna Maria Susanna van Niekerk (Marisa)

Name of university: University of South Africa (UNISA)

Promoter: Professor H.E. Roets

Title of research study: The psycho-educational use of mental toughness in dealing with trauma.

This letter of consent consists of two parts:

- Information sheet (to share with you information pertaining to the study)
- Consent form (requiring your signature should you agree to take part in the psycho-educational individual therapy programme).

You will receive a copy of the complete letter of consent once all the necessary signatures have been obtained.

PART 1: INFORMATION SHEET

Introduction

I am a registered Educational Psychologist and doctoral student in Educational Psychology at the University of South Africa (Unisa). I am conducting research to determine whether a psycho-educational programme aimed at augmenting the mental toughness (emotional resilience) of a traumatised person will indeed lead to increased mental toughness and improved skills to deal with such trauma. Examples of traumatic events are divorce, abuse, suicide, death, robbery and natural disasters. Mitchell (1983) describes trauma as a critical situation facing a person that may lead to extreme emotional reactions. These extreme reactions have the potential to affect a person's normal functioning, either directly after a trauma or at a later stage. Clough and Strycharczyk (2012) define mental toughness as the quality that largely determines how someone deals with challenges, stressors and pressure, regardless of the circumstances that prevail in his/her life.

A Mental Toughness Questionnaire (MTQ48) was developed in 2002 and has proved itself a reliable and valid assessment instrument for determining a person's ability to deal with pressures in the workplace and on the sports field. However, no research has been done as yet to determine the relationship between mental toughness and its appropriate use in clinical and educational psychology (Association for Qualitative Research (AQR) 2007; Clough & Strycharczyk 2012). Hence the aim of this study is to obtain more practical information on the ways in which psychologists may support traumatised clients.

The proposed research project comprises two phases:

1. The first phase is the assessment phase and includes the identification of traumatised persons (adults 18 years and older) who display a low level of mental toughness.
2. The second phase of the research project - the intervention phase – will attempt to support these identified persons in individual therapy sessions as part of a psycho-educational programme. More information pertaining to the programme will be made available to the identified persons at a later stage.

Consent form

Whenever researchers study people, the study is explained to them and they are requested to give their permission for voluntary participation in such study. Once you as a voluntary participant have been given more information on the study, I will ask you to complete and sign the consent form.

Please note: This particular letter of consent requests your consent as volunteer for the second part of the study, namely the psycho-educational individual therapy programme.

Aim

You have been identified as a potential participant in the psycho-educational individual therapy programme of this study.

Voluntary participation

Participation in this study occurs on a voluntary basis and you may choose whether you would like to take part in this research study or not.

Risks and Discomfort

The possibility exists that when you share with me personal and confidential information, you may feel uncomfortable and/or that feelings of re-traumatisation may be elicited. It is important to know that you only need to share with me information with which you feel comfortable. As an educational psychologist I shall be able to support you in releasing and dealing with threatening emotions.

Benefits

Your participation in the study may lead to a situation where I can support you to identify areas in your life on which you wish and are able to work. During this process you will gain better insight into yourself.

Confidentiality

All information obtained by means of the interview and the MTQ48 will be treated confidentially. The only other person who will have access to the confidential information is my study leader, Professor H.E. Roets, from the University of South Africa. No information regarding a client will be disclosed without the client's permission. However, in exceptional cases, legal or professional rules may oblige me to disclose information regarding a client. These exceptions include the following:

Emergency situations

The client has to take note that should a situation arise where I believe that there is a real risk that he/she may injure him-/herself, any other person, or me, I am obliged to take the necessary steps to prevent such injury from occurring, even though it may compel my disclosure of confidential information relating to the client.

Statutory duty

A legal prescription may force me to disclose confidential information about a client.

Court orders

A court may instruct me to disclose confidential information. However, in terms of my professional rules, I must do all I can to prevent the disclosure of a client's personal information.

I will discuss the assessment results with the client, provided that this information does not pose any risk of harm to the client him-/herself or to any other person. In the event of

suspected potential harm, I will inform the client beforehand of my obligation to disclose such information.

Voluntary consent to participation

Should you agree to take part in the study, you remain free to withdraw from it at any time, whether during assessment, therapy sessions and/or interviews. You need not give any explanations.

Duration of the study

The study will be conducted over a period of eight to nine weeks at the Reformed Church Wapadrant (eight to nine sessions). One session will last approximately 75 minutes. The sessions are free of charge.

Who to contact

If you have any questions, you are welcome to contact me.

Contact details:

Marisa van Niekerk

Cell no: 074 041 0081

E-mail: marisavniekerk@gmail.com

PART II: CERTIFICATE OF CONSENT

This form has been revised and approved by Professor H.E. Roets, who is mentoring me, Anna Maria Susanna van Niekerk, in my studies and who has to ensure that all ethical procedures are complied with during this research.

I (name and surname) _____ herewith give consent for my participation in the second part of this study. This part involves the psycho-educational therapy programme.

I have read carefully through the information above. I was given the opportunity to ask questions about it and the questions that I asked were answered adequately.

PART II: CERTIFICATE OF CONSENT

I herewith give my consent as voluntary participant:

Name and surname (participant): _____

Signature of participant: _____

Contact number: _____

E-mail: _____

Date: _____ day/month/year

OR

I herewith REFUSE my consent to act as voluntary participant:

Name and surname (participant): _____

Signature of participant: _____

Contact number: _____

E-mail: _____

Date: _____ day/month/year

For completion by researcher

Confirmation by researcher in respect of consent

I confirm that the voluntary participant was given the opportunity to contact me should he/she have any enquiries with regard to the study. I answered all his/her questions to the best of

my ability. I confirm that the participant was not forced to take part in the study and that his/her consent was voluntary.

A copy of the letter of consent was made available to the voluntary participant.

Name and surname (researcher): _____

Signature of researcher: _____

THANK YOU VERY MUCH.



Marisa van Niekerk



Prof. H.E. Roets

Promoter