A FRAMEWORK FOR THE LEADERSHIP OF YOUTH VICTIMS OF VIOLENCE TO WELLNESS

E.L. Ahanonu
School of Nursing,
University of the Western Cape, South Africa
ezihe2007@gmail.com

K. Jooste
School of Nursing,
University of the Western Cape, South Africa
kjooste@uwc.ac.za

ABSTRACT

Health care professionals have been charged to demonstrate their leadership capabilities in leading youth victims of violence to wellness. However, the manner in which health care professionals can implement this responsibility remains unknown. The purpose of this research was to develop a framework for health care professionals to apply in leading youth victims of violence towards wellness after an incidence of violence at a rural community in the Western Cape Province of South Africa. The design used for developing the framework was qualitative, exploratory, descriptive and contextual. Sampling was done through purposive sampling technique. Focus group discussions were used to collect data from 58 (23 males, 35 females) youth victims of violence while unstructured individual interviews were used among 7 health care professionals (2 professional nurses, 3 medical doctors and 2 social workers). Sample size was determined by data saturation. Field notes were taken during data collection. Open coding was used for data analysis. Trustworthiness was maintained and ethical considerations were adhered to. Research findings revealed that youth *victims of violence were concerned about the problem of violence among youth and they anticipate that* health care professionals would lead them *to wellness.* The health care professionals acknowledged the importance of leading the youth victims to wellness and also identified the challenges they were facing. Nevertheless, both

Africa Journal of Nursing and Midwifery
Volume 17 | Supplement | 2015
pp. S1–S14

Print ISSN 1682-5055

groups proposed useful strategies for leading youth victims to wellness. *These findings were triangulated to develop an original* participative leadership *framework* with information *for leading youth victims of violence towards wellness.*

Keywords: health care professionals, lead, wellness, youth, youth violence, youth victim of violence

INTRODUCTION AND BACKGROUND

Youth violence is regarded as an important public health concern in South Africa that contributes significantly to disability-adjusted life years, increases health care costs and also puts a high burden on the health care system (National Department of Health, 2012:2). For instance, among young people aged 15 to 34 years, violence has been reported to be the leading cause of unnatural death with most of these deaths resulting from firearm-related injuries, sharp object injuries, and blunt force injuries (National Injury Mortality Surveillance System, 2010:5–8). Additionally, while appraising the national trauma caseload in secondary and tertiary level health care facilities in South Africa, Matzopoulos, Prinsloo, Butchart, Peden and Lombard (2006:50) report an annual caseload of about 1.5 million trauma cases (40 per 1 000 of the population), indicating that the violence rate among youth in the country is somewhat high.

The levels of violence among the youth in many communities in the Western Cape Province of South Africa is relatively high, contributing to the burden of disease reported in the province (Govender, Matzopoulos, Makanga, & Corrigall, 2012:303). For instance, a survey on risk behaviours among youths in the province showed that within the previous six months of the conduct of the survey, about 38% of males and 8% of females had carried a weapon (Reddy, James, Sewpaul, Koopman, Funani, Sifunda & Josie, 2010). Another study that scrutinised data collected from trauma patients who reported to the emergency unit of a large Community Health Centre reported that 28% were men between the aged 19 to 35 years old and the majority (87%) of the trauma cases were caused by interpersonal violence (Govender et al, 2012:303).

Factors recognised to be linked with youth violence in South African communities including those in the Western Cape Province include alcohol abuse/dependence and drug use. Other risk factors include peer pressure, witnessing parental violence, experiencing childhood physical abuse, low educational attainment (Gass, Stein, Williams, & Seedat, 2011:2765; Govender et al, 2012:303)

The exposure of youth to an occurrence of violence has an undesirable effect on the wellbeing of the youth. For instance, it could lead to problems such as anxiety and mood disorders, depression, aggression, alcoholism, drug and substance abuse, suicidal attempts, post-traumatic stress and the practice of risky sexual behaviours

(McDonald & Richmond, 2010:833; Souverein, Ward, Visser & Burton, 2015:18). The high prevalence of these problems among the youth who have been victims of violence can be attributed to low wellness leadership programmes being implemented by health care professionals.

Leadership has been identified as an essential role of health care professionals because they have an ethical responsibility in practice to attend to the needs and concerns of their clients. Jooste (2014:284) describes leadership as the process of influencing the conduct or behaviour of individuals (e.g. through role modelling) in order to maximise their potential and to realise collective goals. As leaders, health care professionals are in a position of authority and they have the capability of influencing and leading individuals, including youth victims of violence towards wellness (Human Resources Institute, 2011:3). Health care professionals; such as nurses, doctors and social workers are called upon to demonstrate their leadership capabilities by leading youth victims of violence towards wellness (Snider & Lee, 2007:167–168). Nonetheless, the way in which health care professionals can carry out the responsibility of leading youth victims of violence towards wellness after an incidence of violence remains unclear. Therefore, there is a need to develop a framework that can be implemented by health care professionals with to create new leadership support, evaluate their current contributions and improve or modify existing platforms to enhance wellness of youth victims of violence.

Statement of the research problem

Stipulated in the *Provincial Nursing Strategy of the Western Cape* is the need for the leadership capability of health care professionals to be demonstrated in practice (National Department of Health, 2009:16). While health care professionals provide treatment for youth who have experienced varying degrees of violence, *it was not clear* how they lead them towards wellness after an incidence of violence. Furthermore, limited literature outlines the manner in which health care professionals can lead youth victims of violence towards wellness in their community. From the research problem, the following research questions were posed:

- What are the expectations of the youth victims of violence with regard to health care professionals who are leading youth victims of violence towards wellness?
- What are the experiences of health care professionals while they are leading youth victims of violence towards wellness?
- What framework can enable health care professionals to lead the youth victims of violence towards wellness?

Purpose of the study

The purpose of this research study was to develop a framework for health care professionals to lead youth victims of violence towards wellness at a selected community in the Western Cape Province of South Africa.

DEFINITION OF KEYWORDS

Health care professionals *in this study* refer **to professional nurses, medical doctors and social workers.**

Lead refers to guiding or directing a course; 'to lead' in the context of this study referred to leadership that can be defined as the process of influencing the conduct or behaviour of individuals (e.g. through role modelling) in order to maximise their potential and to realise collective goals (Jooste, 2014:284).

Wellness *in this study* refers to *'a way of life oriented [sic] toward optimal health and well-being in which the body, mind and spirit are integrated by the individual to live life more fully within the human and natural community'* (Myers, Sweeney & Witmer, 2000:252).

Youth in this study refers to individuals who are between the ages of 15 and 19 years of age.

Youth violence refers to the involvement of young people, as victims, in incidents that involve the threat or use of physical force in the context of interpersonal, inter-communal, other conflict, or crime. This violence may be perpetrated with or without a weapon and could result in physical injuries or death (Graham, Bruce, & Perold, 2010:38).

Youth victim of violence in the context of this study refer to a youth who had been a prey of violence in the community of study and had been involved in one or more random acts of violent behaviour such as physical combat, sexual abuse and rape caused by a person or persons who may be known or unknown to the youth.

RESEARCH METHODS USED FOR FRAMEWORK DEVELOPMENT

A qualitative, exploratory, descriptive and contextual research design was utilised to achieve the objective of developing the framework. In this study, the Theory of Health Promotion in Nursing (University of Johannesburg, 2009:4–6) was the point of departure of the meta-theoretical assumptions while the principles from Contextual Constructs Model (CCM) of Knight and Cross (2012) were followed in identifying research constructs and contexts. The steps of Jabareen (2009:54–62) were adapted

for the development of the framework; these are: **Step 1:** *Identifying data sources and conducting comprehensive data collection;* **Step 2:** *Identifying and naming themes and categories;* **Step 3:** *Deconstructing the findings and categorising concepts;* **Step 4:** *Integrating concepts;* **Step 5:** *Synthesis, re-synthesis and* clarification of concepts*; and* **Step 6:** *Validating the conceptual framework.*

Concepts derived were organised and described as a framework according to the survey list of the Practice Orientated Theory of Dickoff, James and Wiedenbach (1968:423) by asking the following six questions:1. Who or what performs the activity (agent)? 2. Who or what is the recipient of the activity (recipient)? 3. In what context is the activity performed (framework)? 4. What is the endpoint of the activity (terminus)? 5. What is the guiding procedure, technique or protocol (procedure)? 6. What is the energy source for the activity (dynamics)?

Step 1: Identifying data sources and conducting comprehensive data collection

The research setting was a selected rural community in the Overberg district of the Western Cape Province of South Africa. The community is faced with high levels of violence, drug and substance abuse among its youth. In addition, there is a high level of unemployment among those residing in the community and the majority have a low level of education.

Population and sampling

Data was collected from purposefully selected youth and health care professionals (professional nurses, social workers and medical doctors) in the community. Purposive sampling was used to select respondents, which will generate the necessary data to meet the objective of a study (Polit & Beck, 2012:517). The selected youth were high school *learners* living in the community and between the ages of 15 and 19 years. Also, they had been victims of violence for not longer than six months prior to participating in the study. *The health care professionals* who were eligible for this study had to have a minimum of two years of experience and were working in a health care setting in the community at the time of the study.

Method of data collection

Focus group discussion (FGD) was used for data collection among the youth in this study since it allows a researcher to acquire a broad range of opinions from participants in a non-threatening way and lets the participants to easily express themselves and to clarify their own views (Hennink, Hutter & Bailey, 2011:136–137). The discussions were conducted in a private and comfortable room involved about six to eight participants per group and lasted for a period not more than 60 minutes.

The youth participants were allowed to freely describe their expectations regarding health care professionals leading youth victims of violence to wellness in their community. Likewise, unstructured individual interviews were conducted among the health care professionals at a scheduled time and place that was convenient for them. Interviews lasted for an average of 90 minutes. An open-ended question which was followed by appropriate probing questions was asked to elicit information on the experiences of the participants. The following questions were posed to each category of participants:

Youth: *'What are your expectations with regard to health care professionals acting as leaders in addressing the problem of violence occurring among youth?'*

Health care professionals*: 'Can you tell me about experiences in guiding and leading youth victims of violence towards their wellness?'*

Field notes were also taken during the discussions and interviews. An audiotape recorder was also used to record the discussions and interviews.

A total of nine focus group discussions were conducted among the fifty-eight youth participants and seven unstructured individual interviews were done among the health care professionals (two professional nurses, three medical doctors and two social workers). The number of respondents who participated in this study was determined by data saturation, which is the point when no new information is generated (Burns & Grove, 2011:317). Data was collected during the months of September to October 2013. Diverse communication techniques and skills such as active listening, minimal verbal response, clarifying, silence, paraphrasing and summarising were employed to ensure effective communication (Kadushin & Kadushin, 2013:168). At the outset, four pilot interviews (two focus group discussions and two unstructured individual interviews) were conducted to assess whether the issues raised with the participants elicited the required information for the purposes of the study. Since the data from these interviews yielded the necessary information, it formed part of the findings of the study.

Data analysis

Data analysis involved verbatim transcription of the voice recordings of the interviews and writing up of field notes. The steps of the Tesch (2003) coding technique (cited in Creswell, 2009:186) were used for analysis of the data. Two independent coders analysed the data after which an inter-coder consensus meeting was done to reach an agreement about the coding.

Trustworthiness

Guba and Lincoln's (1994) strategies of credibility, transferability, dependability, confirmability and authenticity were applied in this study.

Ethical considerations

Research participants received information sheets encompassing the study objectives. Participants who were 18 years and older signed a consent form while those under the age of 18 were given forms requesting permission from their parents or guardians and also signed an assent form. Ethical approval to conduct this study was obtained from the Higher Degrees Committee of the Faculty of Community and Health Sciences, University of the Western Cape, South Africa (registration number 13/9/39). Permission was received from the relevant authorities and the Governing Board of the school provided permission for the study. The ethical principles proposed by Terre Blanche, Durrheim and Painter (2006:67–68) were adopted in this study. For instance, respect for persons evidenced by the participants providing written informed consent, thus demonstrating voluntary participation, upholding privacy by way of the participants being unidentifiable and respect for persons being that they were treated fairly and could withdraw from the study at any stage.

Research findings of step 1

The main theme that emerged from the data analysis of the findings from the youth victims of violence showed that youth had huge expectations of the health care professionals working in their community in leading them towards wellness. Health care professionals were mindful of the challenges faced by youth in attaining wellness in their community. This central theme was clearly supported by the following four categories (i) Dimensions of wellness related to healthy body, mind, spirit and positive interactions; (ii) Building a sound and trusting relationship; (iii) Common problems and issues of concern among youth in the community; and (iv) Guidance of youth to wellness.

From the data analysis of the individual interviews, the main theme that emerged was that the health care professions recognised the fact that wellness was very important. However, they felt that guiding youth victims of violence towards wellness was a challenging process. This central theme was reinforced by three categories: (i) points of view about wellness, (ii) barriers to leading youth victims of violence towards wellness, and (iii) guidance to leading youth victims to wellness.

Step 2: Identifying and naming themes and categories

This step entailed a comprehensive and separate examination of the data (interviews and field notes), which were from the youth and health care professionals. Emergent themes and categories from the collected data were identified and described.

Step 3: Deconstructing the findings and categorising concepts

This step involved a review of the themes and categories, followed by construction of concluding statements to identify characteristics and roles with respect to the survey list of the Practice Orientated Theory of Dickoff *et al.* (1968) in order to identify important concepts that would form part of the conceptual framework.

STEP 4: INTEGRATING CONCEPTS

The key concepts from the findings were triangulated and integrated into one framework. The Practice Oriented Theory of Dickoff *et al.* (1968) was applied to organise the concepts. Figure 1 below shows the findings from the youth victims of violence and the health care professionals that were integrated together using the survey list of the Practice Orientated Theory of Dickoff *et al.* (1968).

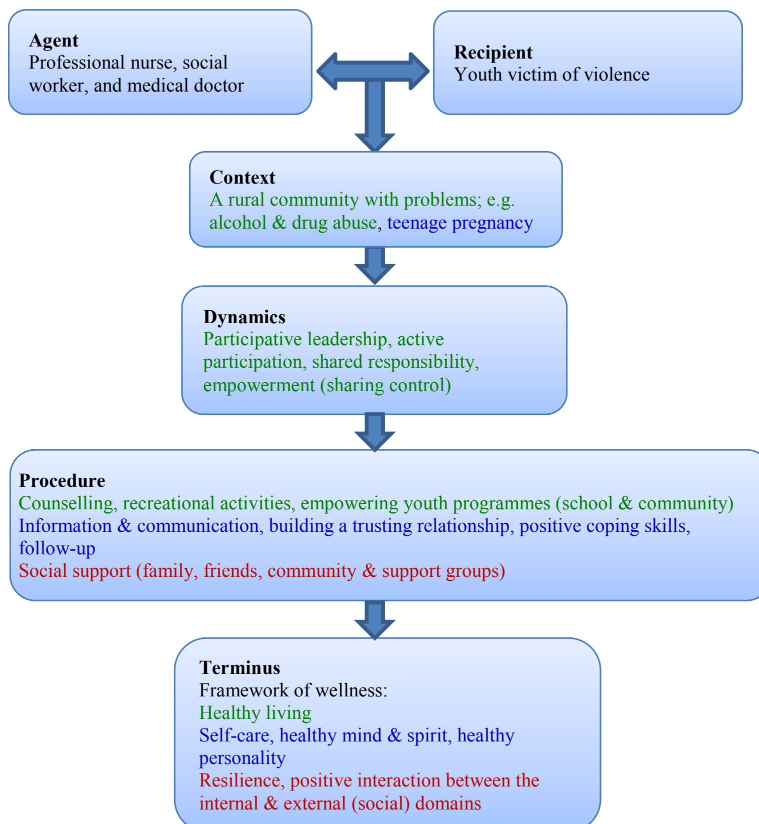

Figure 1: Integrated findings from the youth and health care professional participants using

Step 5: Synthesis, re-synthesis and clarification of concepts

This step involved the description of the framework with the purpose of *allowing it all to make sense* and providing a comprehensive understanding how health care professionals lead youth victims of violence to wellness.

Step 6: Validating the conceptual framework

As a final point in this study, the developed framework was validated by the participants to make certain that the findings and impressions were in line with the opinions of the participants. The comments they provided showed that they approved the developed framework.

DESCRIPTION OF THE FRAMEWORK

This study showed that youth who have been victims of violence experience substantial amounts of psychological trauma or distress as a result of the violent incident, which impinges on their overall wellness. The *term wellness* was described by the participants to comprise a healthy mind (psychological, emotional) and spirit, healthy living, self-care, resilience, healthy personality and positive interaction between the internal and external (social) domains. It was revealed in this study that the *procedure that can* be used by health care professionals in leading youth victims of violence towards wellness includes the provision of counselling services, building a sound and trusting relationship (which was described as health care professionals showing passion, enthusiasm and willingness to serve), information sharing and communication, developing and encouraging positive coping skills, recreational activities, using social support (family, friends and community support groups), follow-up (tracking) and implementation of empowering youth programmes in the school and the community in general.

In the developed framework, it was clear that both health care professionals and youth victims of violence have important roles to play in the leadership process. On the one hand, the roles of health care professionals, in addition to providing physical treatment for observable wounds or injuries, are as follows: empowerment, engendering support, role-modelling and collaboration. To fulfil their empowerment role, health care professionals should be able to share relevant, accurate and adequate information with the youth victims to assist them cope with the psychological trauma experienced. Also, they should be taught how to live a healthy lifestyle. Their supportive role could be achieved by way of providing emotional support and substantial helpful services such as counselling services to prevent victim-blaming behaviour, use of support groups and giving practical assistance to victims and their family members. The role modelling role can be evident by the demonstration of a behavioural patterns that are worthy of emulation. For instance, the exact words of

some of the youth victims of violence describe role modelling in terms of a healthy life style: 'to lead us by example' and 'to show that they are also doing the things that they want us to do'. In addressing the needs of the youth victims of violence in their community, another crucial role to be played by health care professionals is to collaborate and establish meaningful partnerships with other professionals and organisations. For example, they can partner with stakeholders such as other members of the health care team, community members and leaders, community-based organisations, religious organisations, funding agencies, international organisations, as well as governmental and non-governmental organisations in their immediate and external environment. Furthermore, partnership can be with international organisations, including multilateral and bilateral agencies. Their community responsibilities include providing the youth victims with non-judgmental supportive counselling services, general screening of persons in the community, keeping record of injuries and trauma cases, protecting the privacy of the victims and ensuring confidentiality as well as referring or linking the victims to useful resources. Also important is the need for health care professionals to display positive attitudes to the youth victims by respecting them, maintaining confidentiality and building trust. To do this, they must demonstrate the following characteristics: competence, having a vision, empathy, perception, change agency, courage, emotional intelligence, professionalism and being synergistic.

On the other hand, the crucial roles of the youth victims of violence in their leadership journey to wellness are self-management and shared responsibility. Their self-management role needs to be demonstrated by them taking responsibility for their own wellness after being empowered and supported by the health care professionals. This active role is important because it will enable them, first of all, to view wellness as being conceivable and also to ensure independence and a sustainable wellness way of life. For example, after being counselled and empowered by a health care professional who shares relevant information and skills on coping with trauma or stress experience and ways of achieving and maintaining a healthy lifestyle, the youth victims should be able to apply these skills and knowledge to his or her own life. In other words, the onus still rests with the youth victim of violence to strive towards wellness by being actively involved in the participative leadership process. The youth victim could actively practise self-management by carrying out self-care, eating nutritious meals, exercising regularly and maintaining social ties with family members, friends and support groups. The role of shared responsibility should be depicted by the youth victim of violence being a proactive follower who shares responsibility with the health care professional functioning as the leader. For this relationship to be impactful, the youth victim of violence ought to respect the authority and value the competence of the health care professional. Hence, for the youth victim to execute the self-management and shared responsibility role and to be successfully led towards wellness, he or she needs to acquire certain important

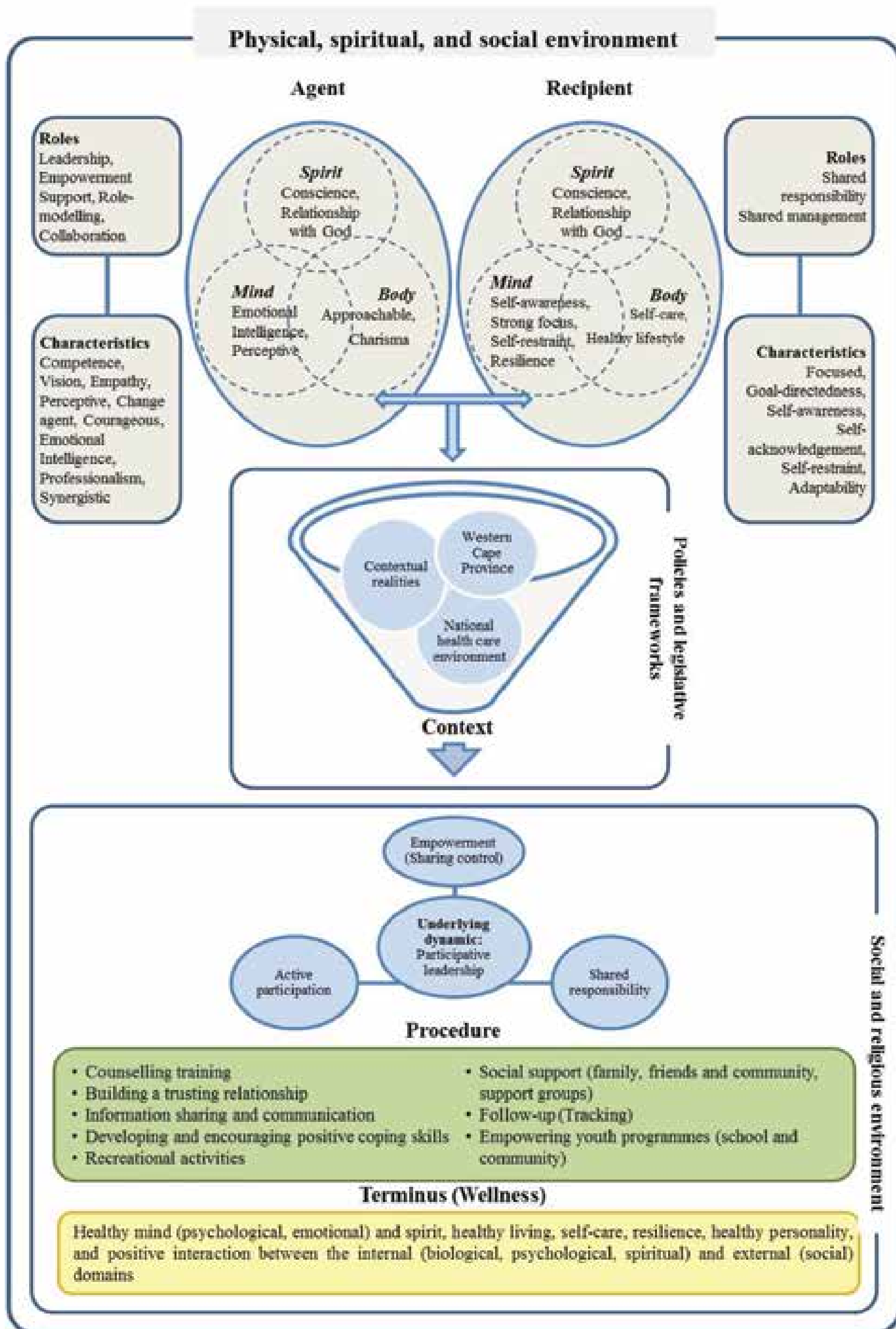

Figure 2: Framework for leading youth victims of violence towards wellness

characteristics. These characteristics are being focused, goal-directed, self-aware, self-acknowledgement, self-restraint and adaptability.

The underlying dynamic in this framework is *participatory leadership*. Through a participatory leadership style, health care professionals can address the expectations of the youth victims of violence to long-lasting holistic wellness. Participatory leadership involves the facilitation of empowerment (sharing of control), active participation and shared responsibility between the agent and the recipient who create an enabling environment to achieve a common goal of wellness for the youth victims. The ideal situation would be for the youth victim to receive ample counselling from the health care professional, starting at their first contact to enhance the immediate reactions and subsequently to address long-term crisis reactions.

Finally, it is crucial that health care professionals bear in mind that the leadership of the youth victims to wellness is a process that could take a long period of time. Therefore, it is necessary that continual counselling support is provided to the youth victim of violence in order for him or her to attain wellness. Figure 2 below shows the diagram of the developed framework.

CONCLUSION

Health care professionals are regarded as leaders by youth victims of violence in the community who likewise anticipate that they will be good role models and demonstrate their leadership competences in leading youth victims of violence to wellness in their community. The developed framework will be of immense assistance to ensure that they fulfil this responsibility.

RECOMMENDATIONS

The framework presented in this article offers an important approach that can be utilised by health care professionals working communities to provide leadership for youths who have been victims of violence in order to guarantee their total wellness. The authors recommend that the framework should be applied in similar contexts and feedback should be provided to enhance further refinement of the framework.

LIMITATIONS OF THE STUDY

The framework offered in this article was developed using information acquired from interviews conducted among youth victims of violence and health care professionals at a selected rural community of the Western Cape Province, South Africa, which may not be representative of other environments. Hence, it is necessary that the proposed framework should be verified in diverse settings before it is extensively operationalised.

ACKOWLEDGEMENT

The authors would like to thank all the research participants for sharing their experiences.

REFERENCES

Burns, N. & Grove, S. 2011. *Understanding nursing research: building an evidence-based practice* (5th ed.). Maryland Heights: Elsevier Saunders.

Creswell, J. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). California: Sage Publications Inc.

Dickoff, J., James, P. & Wiedenbach, E. 1968. Theory in a practice discipline: part 1. Practice oriented discipline. *Nursing Research*, 17(5):415–435.

Gass, J., Stein, D., Williams, D. & Seedat, S. 2011. Gender differences in risk for intimate partner violence among South African adults. *Journal of Interpersonal Violence*, 26(14):2764–2789.

Govender, I., Matzopoulos, R., Makanga, P. & Corrigall, J. 2012. Piloting a trauma surveillance tool for primary healthcare emergency centres. *South African Medical Journal*, 102(5):303–306. doi:10.7196/samj.5293.

Graham, L., Bruce, D. & Perold, H. 2010. *Youth violence and civic engagement in SADC region*. Midrand: Southern Africa Trust.

Guba, E. & Lincoln, Y. 1994. Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research*, 105–117. Thousand Oaks, CA: Sage Publications Inc.

Hennink, M., Hutter, I. & Bailey, A. 2011. *Qualitative research methods*. London: Sage Publications Ltd.

Human Resources Institute. 2011. Wellness leadership: Part of the wellness coaching white paper series. Retrieved from http://www.healthyculture.com/Articles/Wellness Leadership White Paper.pdf (Accessed 10 March 2014).

Jabareen, Y. 2009. Building a conceptual framework: Philosophy, definitions, and procedure. *International Journal of Qualitative Methods*, 8:49–62.

Jooste, K. 2014. Leadership. In S. Booyens & M. Bezuidenhout (Eds.), *Dimensions of healthcare management* (3rd ed.). Cape Town: Juta & Company Ltd.

Kadushin, A. & Kadushin, G. 2013. *The social work interview* (5th ed.). New York: Columbia University Press.

Knight, S. & Cross, D. 2012. Using contextual constructs model to frame doctoral research methodology. *International Journal of Doctoral Studies*, 7:39–62.

Matzopoulos, R., Prinsloo, M., Butchart, A., Peden, M. & Lombard, C. 2006. Estimating the South African trauma caseload. *International Journal of Injury Control and Safety Promotion*, 13(1):49–51. doi:10.1080/15660970500036382

McDonald, C. & Richmond, T. 2010. NIH Public Access. *Journal of Psychiatry Mental Health Nursing*, 15(10):833–849. doi:10.1111/j.1365-2850.2008.01321.x.The

Myers, J., Sweeney, T. & Witmer, J. 2000. The wheel of wellness counselling for wellness: A holistic model for treatment and planning. *Journal of Counseling and Development*, 78:251–266.

National Department of Health. 2009. *Provincial nursing strategy*. Cape Town: Provincial Government of the Western Cape.

National Department of Health. 2012. *Strategic plan for nursing education, training and practice 2012/2013–2016/2017*. Pretoria: Government Printers.

National Injury Mortality Surveillance System. 2010. *A profile of fatal injuries in South Africa: 10th annual report 2008*. Cape Town: Medical Research Council.

Polit, D. & Beck, C. 2012. *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.

Reddy, S., James, S., Sewpaul, R., Koopman, F., Funani, N., Sifunda, S. & Josie, J. 2010. *Umthente Uhlaba Usamila – the South African youth risk behaviour survey 2008*. Cape Town: South African Medical Research Council.

Snider, C. & Lee, J. 2007. Emergency department dispositions among 4100 youth injured by violence : A population-based study. *Canadian Journal of Emergency Medicine*, 9(3):164–169.

Souverein, F., Ward, C., Visser, I. & Burton, P. 2015. Serious, violent young offenders in South Africa: Are they life-course persistent offenders? *Journal of Interpersonal Violence*, 1–24. doi:10.1177/0886260515570748

Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in practice: Applied methods for the social sciences* (2nd ed.). Cape Town: UCT Press.

University of Johannesburg. 2009. *Theory of health promotion in nursing: dDepartment of nursing science paradigm*. Auckland Park: University of Johannesburg.