PROMOTION OF ADOLESCENT MENTAL HEALTH THROUGH A SOCIAL AND EMOTIONAL LEARNING PROGRAMME IN SOUTH AFRICAN HIGH SCHOOLS

by

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DECLARATION

I declare that **PROMOTION OF ADOLESCENT MENTAL HEALTH THROUGH A SOCIAL AND EMOTIONAL LEARNING PROGRAMME IN SOUTH AFRICAN HIGH SCHOOLS** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

_____ 12 February 2016

Faniswa Honest Mfidi **Date**

PROMOTION OF ADOLESCENT MENTAL HEALTH THROUGH A SOCIAL AND EMOTIONAL LEARNING PROGRAMME IN SOUTH AFRICAN HIGH SCHOOLS

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ABSTRACT

Reports on the escalation of violence in South African schools have been a cause for concern. The Media have reported a high incidence of adolescent anger towards and fights with peers, family members and school teachers. Alcohol and drug abuse, risky sexual behaviours and gang related activities are also noted as a concern among school-going adolescents. These behaviours are precursors to mental health problems among school-going adolescents and prompted the researcher to carry out an investigation on how high schools promote the mental health of their learners.

A sequential explanatory mixed methods approach was used to explore the experiences of school-going adolescents, school teachers and school health nurses in dealing with social and emotional problems in high schools. An event history calendar was used to collect both the quantitative and qualitative data. Quantitative data was used with school going adolescents, whereas, qualitative data in the form of focus groups was used with school nurses and individual interviews was used with school teachers. Qualitative individual interviews were also used with a subset of school going adolescents to augment the quantitative results. The two sets of data were analysed independently and only at interpretation of findings were they collated and integrated. Quantitative data analysis was done using descriptive and inferential statistics whilst content analysis and thematic analysis were used with qualitative data. Major findings of the study revealed that adolescents' problems manifested themselves as inappropriate handling of emotions which resulted in drug and alcohol abuse, risky sexual behaviours and gangsterism which adversely impacted on the adolescents' social-emotional well-being and mental health. A universal prevention and promotion programme through social and emotional learning to address the social and emotional ailments of adolescents that

impede mental health promotion in high schools was proposed. The “TEAM” intervention proposes the promotion of positive peer relationships through the use of positive gangs in a safe, caring and cooperative school climate. The intervention would also capacitate adolescents with prosocial skills and values that would yield positive outcomes for greater academic and life successes generally**.** The study recommends the use of the proposed ‘TEAM’ intervention in schools for mental health promotion.

KEY WORDS

Adolescent; adolescent mental health; mental health; mental health promotion; prosocial skills; social-emotional well-being; social and emotional learning; mixed method; school violence; ‘TEAM’; universal preventive and promotive strategy.

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LIST OF ACRONYMS

CAMH	Child and Adolescent Mental Health
CASEL	Collaborative for Academic, Social and Emotional Learning
EHC	Event History Calendar
DBE	Department of Basic Education
ISHP	Integrated School Health Policy
KSD	King Sabatha Dalindyebo District
LAMIC	Low-income and Middle Income Countries
LSA	Local Service Area
NDOH	National Department of Health
PHC	Primary Health Care
SA	South Africa
SEL	Social and Emotional Learning
TEAM	Universal Intervention Programme for the Promotion of Adolescent Mental Health in High Schools
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Adolescence is a period of substantial change. It is a period between childhood and young adult life as reflected in an individual's different areas of psychosocial functioning (Shivram & Vostanis 2011:228). Pryjmachuk (2011:333) describes adolescence from a biological view. The author refers to it as a developmental phase with a set of mini stages in an individual's life that separate childhood from adulthood. Several key developmental challenges characterises adolescence, and these include development of psychological autonomy, establishing of intimate relationships, and developing a sense of identity (Petersen, Bhana & Swartz 2012:413). Under normal circumstances, an adolescent has to attain positive mastery of these key developmental challenges without any interference. Though disparities among the adolescent's cognitive, emotional, social and physical development may exist, these can be reconciled as the adolescent moves towards maturity and independence. But at times these together with heightened emotional arousal which may compromise rational decision making, can act as causes of vulnerability that predispose adolescents to a range of internalising mental disorders such as anxiety and depression and externalising behavioural disorders such as conduct disorder and aggression (Petersen et al 2012:413; Rawatlal & Petersen 2012:346; Shivram & Vostanis 2011:228). Individual capacity to deal with these adversities is dependent on the availability of support in the immediate social environment as well as on coping skills.

Besides the demands posed on the adolescents by this critical life period, a significant number of them do experience mental distress due to exposure to traumatic life events and violence, as well as harsh, inconsistent or abusive parenting factors, family breakdown, bullying and loss due to death of significant others which could weaken their emotional stability (McKenzie, Murray, Prior & Stark 2011:67; Petersen et al 2012:413).

Because adolescents are of school-going age, schools are therefore the most ideal venues for the provision of mental health promotion interventions in a cost effective manner. Schools are expected to not only offer academic support to adolescents, but also provide social and personal support (Rawatlal & Petersen 2012:346; Kimber 2011:1; Merrell & Gueldner 2010:5). Because this is the case, schools are ideal places to offer preventive support for adolescent mental health.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Mental illness which includes depression, aggressive behaviour and feeling down has been seen as the greatest health problem among adolescents. This is aggravated by risky behaviours that adolescents engage in, which serve as indicators and the basis for measuring adolescents' mental health. In South Africa adolescent risk behaviours include substance abuse, sexual behaviours as well as violent criminal behaviours (Rawatlal & Petersen 2012:346). Mental health problems are estimated to affect about 10-25% of adolescents worldwide. According to Flisher, Dawes, Kafaar, Lund, Sorsdahl, Myers, Thom and Seedat (2012:149), one in five children and adolescents suffer from some form of mental disorder. Common among adolescents (15-19 years) is depression. Depression significantly accounts for the high rates of adolescent self-harm and suicidal behaviours. According to National Youth Risk Survey, an estimated 21.4% of adolescents in South African schools have made one or more suicide attempts in a 6 months period (Mason-Jones, Crisp, Mathews & Dahnsay 2012:1; Peltzer, Kleintjies, Van Wyk, Thompson & Mashego 2008:494).

Adolescent mental health problems become both social and economic burdens and if left unattended may develop into disabling conditions later in life. Despite this serious clinical picture of adolescent mental health, it has not received the priority it deserves as evidenced by the absence or scarcity of child and adolescent mental health legislation, policies, mental health support services and programmes (Peltzer et al 2008:494). Therefore the need for mental health promotion and education strategies for adolescents has to be put in place.

Mental health can never be overemphasised. Health promotion, according to World Health Organization (WHO), is the process of enabling people to increase control over their health and its determinants and thereby improve their health (WHO 2004:16)

Mental health promotion entails promoting optimal psycho-physiological development in order to enhance positive mental health in people (Petersen et al 2012:411). Mental health promotion and prevention strategies meted early in the lifespan have shown to promote social gains in later life for both individuals and society, namely, reduced out-of-wedlock births, productive workforce and increased earnings, less reliance on social services and reduced rates of criminal behaviours (Petersen et al 2012:411). As mental health is directly related to children and adolescent learning and development, promotion and preventive interventions targeting schools may yield dual benefit that is improved academic success and social- emotional well-being (American Counselling Association 2012; Durlak, Weissberg, Dymnicki, Taylor & Schellinger 2011:405).

1.2.1 School settings

In South African school settings, prior to 1994, prevention and mental health promotion largely focused on individual coping strategies for mostly single issues such as substance abuse, HIV/AIDS and suicide with the DSM1V diagnostic system used to determine psychological support needed (Rawatlal & Petersen 2012:347). Currently, there has been a call for more broad-based contextual approaches to prevention of mental health problems and promotion of mental health. That is, move towards an ecological, systemic health promotive approach which is believed to enhance and promote resilience in adolescent mental health (Earls, Raviola & Carlson 2008:295; Delaney 2013:1). The call for extensive multi-sectoral and ecological approaches has been supported (Atkins, Hoagwood, Kutash & Seidman 2010:40). The approach will enable both the school and health professionals to work together.

Empirical evidence has shown that an inclusive ecological perspective on adolescent mental health is effective at reducing mental health problems. Its focus is not on a single mental health or behavioural issue but rather considers co-existence of deleterious influences present in the family, peer, school and community levels (Delaney 2013:1). Several contexts relevant to mental health at these levels need to be considered during mental health promotion for adolescents. Understanding the patterning of health risk factors is fundamental to the design of effective school-based intervention efforts (Thompson, Connelly, Thomas-Jones & Eggert 2013:74). Available literature on mental health problems emanates from studies done in the urban areas (Thompson et al 2013:75; Zachs 2012:155). The researcher has not found any study

done among rural school-going adolescents in South Africa. Most incidents o school violence in South Africa which were reported in newspapers happened in urban areas (Govender 2013:10). It is this lack of literature for rural adolescents that influenced the researcher's choice of conducting this study in a rural setting in addition to urban settings.

The school environment has been identified as one that offers a range of potentially protective factors against poor mental health, such as climate for attachment, commitment and aspiration to pro-social behaviours and goals (McKenzie et al 2011:68). McKenzie et al (2011:86) also claim that it is the school's social ethos and teaching environment that significantly foster resilience. In other words, protects adolescents from the development of mental health problems. It is believed that teachers together with parents and health professionals are at the forefront of being able to identify health problems in the first instance and able to offer or serve as gateways to appropriate services (Eapen & Jairam 2009:43). According to the World Health Organization (WHO 2003:5), the school is an obvious arena for mental-health promotion and an appropriate place for the introduction of life skills education which include working through social and emotional problems that might occur (South African Curriculum and Assessment Policy Statement (CAPS) for Basic Education 2011).

Education, besides fostering cognitive development of the child, should also promote total (i.e. physical, cognitive, social, emotional and moral) development of the child and address social and emotional issues which impact on school failure (Kimber 2011:3). This necessitates that teachers be conversant with the use of educational techniques, inculcated in social and emotional learning (SEL) programmes, that are based on cognitive and behavioural methods, to train students to improve self-control, social competence, empathy, motivation and self-awareness (Caldarella, Christensen, Kramer & Kronmiller 2009:52; Kimber 2011:5). Promotion of competence, self-esteem, mastery and social inclusion therefore form the foundation for both prevention and treatment of mental, emotional and behavioural disorders. Kimber (2011:35) asserts that it is possible that skills for life programs like SEL offer young people tools of a social nature to handle the real challenges and the need to cope with change during the teenage transitional period. Should that be the case, it is therefore imperative to ensure that SEL programs are pursued in schools. These programs equip the young people with life skills essential in their everyday lives and may help prevent school drop-out rate.

They also promote both contentment in school work and mental health. This study, therefore, seeks to investigate how adolescent mental health in rural schools can be promoted through social and emotional learning.

Appropriate treatment and intervention for children with emotional or behavioural difficulties has proved that it can lessen the impact of mental health problems on school achievement, and relationships with family members and peers (Eapen & Jairam 2009:43). According to Mental Health Foundation (2007) cited by McKenzie et al (2011:68), recent epidemiological research in United Kingdom has established that up to 50% of adult mental health problems have their onset in adolescence. Mental health problems have an effect on family, education and social life of the young person. Therefore a growing emphasis is on the need to find different ways of promoting improved mental health in young people using interventions ranging from health education campaigns to developing mental health services in community settings. These are more accessible to young people such as schools.

1.3 RESEARCH PROBLEM

Mental health, which amongst other connotations includes emotional and behavioural areas of health, is a critical component of child and adolescent wellbeing and impacts on their physical health, relationships and learning. Adolescents in schools experience mental distress that can negatively affect their families, education and social lives. The distress may emanate from physical and emotional abuse, family breakdown, and loss of a parent or parents. This would lead to some adolescents manifesting emotional and behavioural problems such as aggression or violence.

A high incidence of adolescent anger directed towards peers, family members and school teachers combined, has frequent coverage in the local media and press (SABC 3, 2013; The News at Six-thirty, August 2013, 18:30; Mercury 2012; Cape Argus 2012; The Star 2011). This anger is also associated with the use of alcohol and other substances. According to the *Sunday Times* newspaper of 20 October, 2013, there were numerous incidences of violence against teachers in South African schools. The newspaper has recorded two incidents in Limpopo Province, seven in Gauteng province, and four in the Western Cape. All these incidents had occurred within one month. The situation is so alarming that the teachers are even calling for armed guards

in schools (Govender 2013:10). This has been supported empirically by numerous studies done in different South African provinces on school violence (Flisher et al 2012; Norman, Matzopoulos, Groenewald & Bradshaw 2007; Van der Merwe & Dawes 2007; Van der Westhuizen & Maree 2009:54; Seedat, Van Niekerk, Jewkes, Suffla & Ratele 2009:1011). For instance, Van der Merwe and Dawes (2007:95) concurred that the rate of youth violence in South Africa is disturbingly high and constitutes one of the most significant public health crises; whilst in Van der Westhuizen's and Maree's (2009:56) study, it was reported that learners regard use of violence as the only way to resolve issues of conflict. The study further reported a high prevalence of violence among school-going girls than school-going boys. The prevalence of violence was further reported to be also high in inner city schools (Van der Westhuizen & Maree 2009:57). Flisher et al (2012:150) concurred that exposure to violence is associated with mental distress in children and adolescents. For example, suicide has been found to be on the increase in both female and male adolescents of school-going age. Peltzer et al (2008:494) report that South African national youth risk surveys in various provinces revealed that 8-29% prevalence rate for suicide attempts with more attacks from those aged 19 and older. Programmes that will empower adolescents to protect themselves and to become more aware of life-building behaviours are needed.

Although, there has been increasing recognition in recent years of the extent and implications of child and adolescent mental health problems, with the development of norms and standards for child and adolescent mental health services in South Africa, poor service coverage still exists (Lund, Boyce, Flisher, Kafaar & Dawes 2009:1122). Disparities of these services have been evident in the Eastern Cape Province, which is pre-dominantly rural and disadvantaged. The school health programmes provided by school nurses seem to be inadequate to address all the mental ill-health of adolescents. School health programmes focus mainly on drug and alcohol abuse prevention without including social and emotional behavioural disorders that are precipitating factors to drug and alcohol abuse.

Despite the introduction and inclusion of life skills as a subject into the school curricula, schools remain faced with social, emotional and behavioural disorders amongst their students (Lund et al 2009:1121). The question remains, "How do schools promote mental health of their learners?" This study will therefore explore experiences of adolescents, teachers and school health nurses in dealing with emotional and social

problems in high schools with the ultimate aim of designing a social and emotional learning programme for the promotion of adolescents' mental health in South African high schools.

1.4 STUDY PURPOSE AND OBJECTIVES

This section will discuss the overall purpose of the study and the achievable objectives and research questions to be answered by the study.

1.4.1 Research purpose

The purpose of the study is to develop a social and emotional learning programme for the promotion of school-going adolescents' mental health.

1.4.2 Research objectives

The objectives of the study are in two phases:

Phase 1: The survey

- investigate the experiences of school-going adolescents in dealing with social and emotional problems
- explore and describe the experiences of school teachers and school health nurses in dealing with social and emotional problems of adolescents
- determine approaches used by schools in handling social and emotional problems of adolescent
- explore the needs of school teachers, school-going adolescents and school health nurses in order to develop a programme for social and emotional learning

Phase 2: Programme Development

To develop a social and emotional learning programme for the promotion of school going adolescents mental health in South Africa.

1.4.3 Research questions

The study intends to answer the following questions:

- What are the experiences of high school adolescents in dealing with social and emotional problems?
- What are the experiences of high school teachers and school health nurses with regard to social and emotional problems of adolescents?
- What are the approaches used by school-going adolescents, teachers and school health nurses to promote mental health?
- What are the needs of the study populations that would inform the development of the programme for social and emotional learning?

1.5 SIGNIFICANCE OF THE STUDY

One of the standards that inform Child and Adolescent Mental Health (CAMH) services requires the Department of Health, to conduct a regular assessment of levels of service provision and needs. This study therefore will give an indication as to how school health nursing services impact on mental health promotion in high school and how the SEL programme that this study developed can be incorporated and applied to improve adolescent mental health.

This school based SEL programme is also expected to have an influence on school health policy. Its inclusion into school curriculum could be a great move to ensure that adolescent mental health resiliency is promoted early in their life span. The study findings have the potential to evoke some thoughts by policy makers on the collaboration between mental health professionals and school teachers in the promotion of mental health

1.6 DEFINITION OF TERMS

1.6.1 Adolescence

Adolescence is defined as a period of life ranging from ages 12-19 during which individuals make the developmental transition from childhood to adulthood (Marchesi &

Cook 2012:8; Setswe, Naude & Zungu 2011:279). Setswe et al (2011:279) also describe this period as characterised by marked physical, emotional and intellectual changes as well as changes in social roles, relationships and expectations all of which are important for the development of the individual and provide the foundation for functioning as an adult.

1.6.2 Adolescent:

According to the *Oxford Advanced Learner's Dictionary* (Hornby 2005:20), an adolescent is a person who is developing from childhood into adulthood. Weiten (2013:433) states that the age boundaries of adolescence are not exact but are thought to be between ages 13 and 22.

In the present study an adolescent is a young person who is still schooling in a secondary or high school in the King Sabata Dalindyebo (KSD) district and is between ages 12-19 years.

1.6.3 Social and emotional learning

This is a process of acquiring the fundamental skills and attitudes needed to recognise and manage emotions, develop feelings of caring and concern for others, making responsible decisions, establish positive relationships and handle challenging situations effectively (CASEL 2013:10). This study has adopted the CASEL's definition of social and emotional learning.

1.6.4 Social and emotional learning programme

It is a programme based on the understanding that the best learning emerges in the context of supportive relationships that make learning challenging and meaningful. It builds children's skills to recognise and manage their emotions, appreciate the perspective of others, establish positive goals, make responsible decisions and handle interpersonal situations (Merrell & Gueldner 2010:6). In this study context the mental health promotion programme to be designed for school-going adolescents will be based on the SEL.

1.6.5 Student

A student is a person attending school and other structured learning sites (Hornby 2005:66). In this study a student is a high school-going adolescent who is also taking life orientation as one of the subjects in a high school in the King Sabata Dalindyebo (KSD) district of the Eastern Cape (EC) Province.

1.6.6 Teacher

A professional teacher is a person with the educated competencies needed to engage successfully in the professional practice of teaching (South Africa 2005:6). In this study a teacher is a person who is involved in the teaching of Life Orientation (LO) subject to adolescents aged between 15 and 19 years of age in a high school in the Eastern Cape.

1.6.7 High school

A high school is an educational institution for secondary education for students from Grades 9-12 (South Africa 2005:6). In this study this relates to a secondary school in the Eastern Cape Province at the KSD district, with students aged between 15 and 19 years who are doing Life Orientation as one of their subjects.

1.6.8 School health services

This refers to a component of coordinated services that comprehensively address the health and developmental needs of school communities (South Africa 2002).

1.6.9 School health nursing

School health nursing is a specialised practice of professional nursing that advances the well-being, academic success and lifelong achievement and health of students (NASN 2011:2). In this study this will entail all essential school health services of a community health nurse practitioner in the high schools of the KSD district.

1.6.10 Mental health

According to WHO (2004:25), mental health is a state of well-being in which the individual realises his/her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (Pryjmachuk 2011:292).

1.6.11 Mental health problem

Mental health problem refers to a broad range of emotional or behavioural difficulties which cause concern or distress for the child and adolescent. If such problems persist for a long time they tend to interfere with the child's personal functioning and may require professional intervention (Pryjmachuk 2011:293). In this study, mental health problems in adolescents will include a broad range of emotional and behavioral problems categorised into internalising and externalising problems, with the former comprising depression, anxiety, shyness, social withdrawal, sadness, fear and difficulty with demands that require social assertion and the latter is acting out behaviours which include physical and verbal aggression, anger, irritability and defiance (Caldarella et al 2009:51)

1.6.12 Mental health promotion

According to WHO (2004), mental health promotion involves actions that support people to adopt and maintain healthy lifestyles, and which create supportive living conditions or environment for health. It entails interventions that aim at enhancing the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being and social inclusion and to strengthen the ability to cope with adversity (Petersen et al 2012:411; O'Connell, Boat & Warner 2009:74).

1.6.13 Life orientation (LO)

According to the Department of Basic Education Curriculum and Assessment Policy Statement (CAPS 2005), life orientation learning area entails developing skills, knowledge, values and attitudes that empower learners to make informed decisions and

take appropriate actions regarding: health promotion, social development, personal development, physical development and movement and orientation to the world of work. In this study perspective LO is the subject that aims at equipping learners with life skills necessary for social and emotional development (South Africa 2012:9).

1.6.14 Life skills

According to UNICEF (2003:1), life skills are defined as psychosocial abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. In this study these are the skills that will enable adolescents to recognise and manage their emotions, appreciate the perspective of others, establish positive goals, make responsible decisions and handle interpersonal situations.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

A paradigm is defined as a worldview, general perspective on the complexities of the world. It is a set of beliefs and practice shared by communities of researchers which regulate inquiry within disciplines (Weaver & Olson 2006:459; Polit & Beck 2012:12). These are a set of philosophical assumptions or beliefs about the nature and characteristics of reality (ontology); what counts as knowledge and how knowledge claims are justified (epistemology); the role of values in research (axiology) and the process of research (methodology) (Creswell 2013:20, Polit & Beck 2012:12; Andrew & Halcomb 2009:120).

According to Creswell (2013:25), how researchers apply these assumptions, denotes the use of a particular interpretive framework for qualitative research, such as social constructivism, and post modernism. For the current study a constructivist paradigm was followed. Since this study usede mixed methods, the qualitative aspect of the study was given priority. According to Andrew and Halcomb (2009:38), priority refers to the relative weight assigned to the qualitative and quantitative components of the study where one component with greater priority is given a dominant status and the other becomes a supplementary data source. Polit and Beck (2012:608) further argued that

the researcher's philosophical orientation or world view is inclined to lead the researcher to tackle the research problem based on the dominant approach. Therefore in this study qualitative and quantitative methods that were mixed within the study were situated within one worldview. In this instance, the constructivist paradigm (Andrew & Halcomb 2009:120). According to Polit and Beck (2012:14), constructivists emphasise the inherent complexities of humans, their ability to shape and create own experiences and the idea that truth is the composite of reality. How the four assumptions are applicable in this paradigm is described below.

- **Ontological**

This paradigm stipulates that reality is not a fixed entity but rather is a construction of the individuals participating in the research and it exists within a context and many constructions are possible (Polit & Beck 2012:12). Thus in this study, embracing multiple reality, the researcher will seeks to explore and determine the experiences of adolescent, teachers and school health nurses with regard to the social and emotional problems in high school adolescents. With intention to report multiple realities as the participants experience them, this study will collect data relating to the phenomena under study from the three research populations, which included school teachers, school health nurses and school-going adolescents.

- **Epistemological**

The Constructivist researcher gets closer to participants to gather subjective evidence about the phenomena based on individuals' views. The voices and interpretation of participants are crucial and subjective interactions are primary ways to access them (Creswell 2013:21; Polit & Beck 2012:12). In this study perspective, data collection will be conducted in the participants' natural setting (namely high school) and as the researcher interacts with them through conducting semi-structured individual interviews, their subjective experiences with regard to the social and emotional problems in high school adolescents will be elicited.

- **Axiological**

The Constructivist researcher believes that subjectivity and values are inevitable and desirable. In this study the researcher plans to make her values known by what Creswell (2013:22) describes as “positioning herself”. In reporting the study finding, the researcher will have to declare the value laden nature of the study, the information gathered, the researcher’s values and biases.

- **Methodological**

Constructivists believe in employing qualitative analysis to gain an in-depth understanding of the phenomena under study. In this study, a concurrent mixed methods approach was followed. Qualitative and quantitative methods were mixed within the study and were situated within one worldview, a constructivist paradigm (Andrew & Halcomb 2009:120).

1.7.2 Conceptual framework

A conceptual framework is a group of concepts that are broadly defined and systematically organised to provide focus, a rationale and a tool for the integration and interpretation of information (*Mosby’s Medical Dictionary* 2009). In this study, Collaborative Academic, Social and Emotional Learning (CASEL) framework on social and emotional learning guides the study. The CASEL’s Social and Emotional Learning (SEL) framework comprises five interrelated sets of cognitive, affective and behavioural competencies, which include competences in the following aspects: self-awareness, self-management, social awareness: relationship skills, and responsible decision making (CASEL 2013:12). A detailed description of the framework will be given in chapter 2.

1.8 RESEARCH DESIGN AND METHODS

In this study a concurrent mixed-method design combining qualitative and quantitative data collection and analysis was used. The purpose of the use of multiple approaches and sources of data enabled triangulation and validation of information for robust and reliable conclusions. This study proceeded in two phases:

Phase I: The exploration of experiences and needs of the study populations (school-going adolescents; school teachers and school health nurses). Quantitative and qualitative data were collected through use of event history calendar, individual interviews and focus group discussions.

Phase II: The development of a social and emotional learning programme. This was informed by the study findings from the Phase 1.
A full detailed description of this aspect will be done in chapter 3 of the study.

1.9 SCOPE AND LIMITATIONS OF THE STUDY

The study involved high schools in the KSD District and the school health services that are providing services to these high schools. Because these schools are geographically dispersed across the district use of research assistants will be sought during data gathering. An expert in qualitative research will be used to assist with data management. The fact that this study is qualitative, that a small sample is used, and that the population is from one district in the Eastern Cape, the findings do not lend themselves to wider generalisation.

1.10 STRUCTURE OF THE DISSERTATION

The structural outline for this study is organised into seven (7) chapters. Each chapter presents a brief introduction on the central theme of the chapter and ends with a conclusion namely:

Chapter 1: Orientation of the study

This chapter gives the background to the problem and the problem statement. It further describes the research purpose, objectives and significance. Concepts to be used are clarified, the theoretical foundation of the study is discussed and a brief overview of the research design, methodology and scope of the study is provided.

Chapter 2: Literature review

Chapter two discusses theoretical and empirical literature on the phenomenon of adolescent mental health and adolescent mental health promotion in order to locate and orientate what is already known about this issue. Available publications on the topic were reviewed so as to evaluate the views of other researchers on the topic and to obtain deeper meaning and understanding of the research topic. Theoretical foundation and model underpinning the study is discussed. This therefore contextualised the study and provided guides for the design of the appropriate data collection instruments.

Chapter 3: Research design and method

The chapter provides the reader with a comprehensive discussion of how the study initiative progressed. The research design and methodology, including setting, population and sampling methods as well as the data collection and analysis plan of the study have been detailed. In addition, the measures to ensure trustworthiness, validity and reliability of the study and ethical considerations are discussed.

Chapter 4: Analysis, presentation and description of the research findings

In this chapter, further details on data management and analysis are presented. Quantitative data obtained from EHC of adolescent respondents is first presented through use of frequency tables, bar graphs and descriptive statistics followed by thematic presentation of qualitative data with direct quotations from adolescents, school teachers and school health nurses. An integrated analysis of both sets of data is provided and an overview of the research findings concludes the chapter.

Chapter 5: Discussion of the findings

This chapter provides interpretation and discussion of the findings presented in Chapter 4. The discussion links literature review with study findings.

Chapter 6: Proposed Social and emotional programme for the promotion of adolescent mental health in high schools

Chapter 6 discussed the development of a universal mental health programme, based on major findings of the study, its theoretical basis and how it could be used in the promotion of adolescent mental health in schools.

Chapter 7: Summary, limitations and recommendation

The chapter contains an overall summary of the study, contributions made by the study, recommendations derived from the findings and limitations of the study.

1.11 CONCLUSION

In this chapter an overview of the proposed research is presented. The background from a preliminary literature review provided the rationale for the pursuit of this study. The research problem statement, purpose and study significance are also explained. Theoretical foundations of the study are discussed and key concepts identified and defined. Brief synopsis of the methodology to be used is given, with more detailed discussion to be found in relevant, subsequent chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Adolescent mental health, prevention and promotion, are seen as an important economic asset of the population's health, but have not fully received the priority they deserve in public health. Some mental health disorders surfacing in adult life may have their onset during adolescence. In this chapter literature review, both theoretical and empirical, has been undertaken with regard to adolescent health, adolescent mental health and the promotion of adolescent mental health. According to Creswell (2003:32), literature review acts as an orienting framework, where it shares with the researcher the results of other studies. Though some qualitative research (Streubert & Carpenter 2011:23; Polit & Beck 2010:170) do not support literature review in qualitative research, Creswell (2013:33) states that some of the qualitative studies require substantial literature orientation at the outset.

In this study relevant literature material has been searched to familiarise the researcher of the extent of the research problem, obtain background for understanding current knowledge on the topic and to illuminates the significance of this study. It further provided insight into findings of what has been done in the promotion of adolescent mental health, what is known in order to improve and what are the gaps and thereby providing focus for the current study. The following concepts guided the literature search: adolescence, adolescent health, adolescent mental health, mental health promotion, social and emotional learning, school health. An advanced EBSCOsearch online using the following databases was done: Academic search premier, Africa-wide, CINAHL, MEDLINE, PsycINFO, SocINDEX.

2.2 ADOLESCENCE − A DEVELOPMENTAL STAGE

Various authors describe adolescence as a period of significant and dramatic change spanning the physical, biological, social and psychological changes (Bower, Manion, Papadopoulos & Gauvreau 2013:165; Lawrence, Gootman & Sim 2009:1; WHO

2009:16), a vital life stage of growth and development with puberty marking its onset (Patel, Flisher, Hetrick, McGorry 2007:1302); or transition between childhood and adulthood with the notion of no longer children not yet adults (American Academy of Child and Adolescent's Facts for Families (AACAP 2008). Using age range as the basis of acknowledged stages of development, adolescence is seen as ranging from as early as 11 years up to 21 years, whilst sometimes it is extended up to 24 years of age. The term adolescent and young person has been used interchangeably. As a developmental stage, adolescence is characterised by three different spheres of development, namely, physical, cognitive and social-emotional development (AACAP 2008; Sawyer, Affifi, Bearings, Blakemore, Dick, Ezeh & Patton 2012:1632). The stages of development are chronological and under normal circumstances each one is presumed to present a differential growth level of the three spheres of development. Table 2.1 summarises the spheres in the development of the three stages.

Table 2.1: Developmental characteristics of adolescents

Early adolescence From 11-13 years – Onset of puberty		Middle adolescence From 14-18 years - Puberty almost completed		Late adolescence From 19-21 year of age - Physical development almost fully accomplished	
Cognitive functioning	**Social emotional development**	**Cognitive functioning**	**Social emotional development**	**Cognitive functioning**	**Social emotional development**
Mostly abstract thinking,	Struggles with the sense of identity	Abstract thinking continues	Intense self-involvement changing between high expectations and poor self-concept	Ability to think ideas through	Firmer sense of identity with increased emotional stability
More interest in the present than the future;	Desire for independence	greater capacity for goal setting	Continued drive for independence	examining inner experiences	Heightened sense of independence
Expansion of intellectual interest; deeper moral thinking	Increased influence of peer group Increased; tendency to test rule and limit leading to conflict with parents	Finding meaning of life.	Distancing self from parents with much reliance on friends; develop feelings of love and passion	Future oriented with continued interest in moral reasoning	self-reliance through peer relationship

(Adapted from Sawyer et al 2012:1632)

In this study, the middle adolescence has been targeted and comprised mostly those still attending high school. From the above descriptors of developmental stages, one can deduce that the adolescent period is one of increased potential but also one of vulnerability. This, WHO (2009:18) also attest to it as time of opportunity, but also of risk. As a period or window of opportunity, it sets the stage for a healthy and productive adulthood and reduces the likelihood of health problems in the years to come but also of risk to health problems which have serious immediate consequences or problem behaviours with serious adverse effects on health in the future. The study focus therefore is aimed at maximising the time of opportunity whilst at the other end minimising risk through promotion of adolescent mental health using social and emotional learning programme.

Various challenges within adolescent's control and those outside their control tend to increase adolescents' risk and vulnerability. Those within the adolescents' life control are described in Life Skills education and Continuous and Comprehensive Evaluation [South Africa] as including:

- **Building relationships**

As part of growing up, adolescents tend to redefine their relationship with parents, peer and members of the opposite sex. They extend their relationships beyond parent and family and are intensely influenced by their peers and outside world, leading to conflict with adults. It therefore becomes imperative that adolescents need social skills for building positive and healthy relationships with others including peers of opposite sex. The social skills will enable them to understand the importance of mutual respect and socially defined boundaries of every relationship.

- **Resisting peer pressure**

The adolescent finds it difficult to resist peer pressure, some of which may lead them to negative experimentation; e.g., engaging in irresponsible behaviours, aggressive self-conduct and substance abuse.

- **Developing an identity**

Inadequate information and skills prevent the adolescents from effectively discovering their potentials and developing a positive self-image and sound career perspective. Promotion of self-awareness will assist them understand themselves and therefore establish their personal identity.

- **Managing emotions**

Adolescence is described as being characterised by emotional turmoil. Mood swings ranging from feelings of anger, sadness happiness, fear, shame, guilt and love are commonly seen in adolescents. Adolescents often do not understand their situation and thus need supportive environment

- **Acquiring information, education and services on issues of adolescents**

The vast information explosion and the highly technological world adolescents find themselves in, leave them with mixed messages and many unanswered questions. With the widened communication gap between adolescents and adults, they seek information from peers who are also not well-informed and thus lead them making uninformed decisions with negative repercussions.

- **Communicating and negotiating safer life situation**

Inability to communicate and negotiate safer sexual habits and inability to resist the vulnerability to drug abuse, violence, and conflict tend to expose adolescents to greater health risks (WHO 2009:18).

Exposure to new capacities and new situations has been viewed to exacerbate the situation and exert greater risk impact. These situations include:

- Rapid urbanisation, telecommunication, travel and migration bring new possibilities and new risks to adolescents.

- Societal expectation of behaviours, roles, access to resources and prospects for development.
- Poverty, inequalities and unemployment.
- Decreasing cultural and family influence, earlier puberty and later marriage.
- Potentially harmful substances, e.g. tobacco, alcohol, other drugs.
- Violence: inflicted by and on adolescents, suicide attempts, many victims of violence including sexual abuse often perpetrated by adults (Blum, Francisco, Bastos, Kabiru, Linh & Le 2012:1567; Burns 2011:101; WHO 2009).

From the above discussion, it can be deduced that adolescents in 21st century are confronted with greater pressure than they ever had with limited resources and skills to cope with stressors. They are prone to inadequate or poor social and emotional development that can interfere with academic success, productivity and overall life satisfaction (CASEL 2013:11; Tan 2007:3). The study then seeks to explore adolescents' experiences with social and emotional problems in order to inform the development of a mental health promotion programme.

2.3 ADOLESCENT HEALTH WITHIN LIFE-COURSE

Adolescent health as described by WHO (2001) cited by Setswe et al (2011:280), is a state of optimal physical, emotional, cognitive, social and spiritual well-being in youth aged 10-24 years. A wide range of approaches are used to prevent, detect or treat adolescent health and wellbeing. According to the life course perspective, the emphasis is on the health of adolescents as affected by early childhood development (Sawyer et al 2012:1630). Social disadvantages and negative experiences in early childhood stages may interfere with normal developmental milestones in later childhood and thus cumulatively affect adolescents. In turn, much health-related behaviour that surfaces during adolescence (e.g., smoking, alcohol and drug use) contribute to contracting the epidemic of non-communicable diseases. Adoption of life-course approach therefore provides a different understanding of prevention. For instance, programmes intended for maternal, infant and child health should positively impact on the health of adolescents and prevention strategies focusing on risk processes occurring in or before adolescence to promote future health of these young people. This therefore emphasises that earlier determinants of adolescent health are the product of biological and social experiences specific to this phase of life.

It therefore remains imperative that promotion and prevention strategies in adolescent health need to focus on all the factors that impact on adolescent mental health outcomes as well as in every other sphere of health in their lives. Hence this study targets school-going adolescents.

2.4 ADOLESCENT MENTAL HEALTH

Adolescent mental health, which is also referred to as child and adolescent mental health (CAMH) is described as the capacity to achieve and maintain optimal psychological functioning and well-being and entails the ability to perceive, comprehend and interpret the surroundings, to adapt to them or change them if necessary, and to communicate with each other and have successful social interactions (Patel, Flisher, Nikapota & Malhotra 2008:313). Adolescents who spend most of their time in schools are faced with multiple adverse factors that may increase their risks to emotional and behavioural problems. Caldarella et al (2009:51) classify the common emotional and behavioural problems that adolescents often display as internalising and externalising emotional and behavioural problems. The former include depression, anxiety, shyness, social withdrawal, sadness, fear and difficulty with demands requiring social assertion whilst the latter include acting out; e.g., physical and verbal aggression, anger, irritability and defiance. Both, if left untreated may develop into mental health disorders leading to a number of negative outcomes (Ogden & Hagen 2014:31; Caldarella et al 2009:51).

Research reveals that mental health disorders affect 10-20% of children and adolescent worldwide and account for a large portion of the global burden of disease (Kieling, Baker-Henningham, Belfer, Conti, Omigbodun, Rhohde, Srinath, Ulkuer & Rahman 2011:1515; Moris Belfer, Daniels, Flisher, Villé, Lora & Saxena 2011:1239; WHO 2009:20). Kleintjies, Lund and Flisher (2010:132), further assert that approximately one in five children and adolescents suffer mental disorders. Despite their relevance as a leading cause of health-related disability in this age group, and with long-lasting effects throughout life, mental health needs of this age group are neglected especially in low-income and middle income countries. A study by Morris et al (2011:1239) on treated prevalence of and mental health services received by child and adolescents in 42 low-income and middle income countries (LAMIC) revealed that mental health services for this age group are extremely scarce and greatly limit access to appropriate care. The

study further highlighted that the presence of mental health professionals in primary and secondary schools is limited, thus a high percentage of LAMIC has no school-based mental health promotion or prevention activities. South Africa, being one of the middle-income countries, and also being a participant in this study, falls into the category. Hence, this study is undertaken with an aim to promote adolescent mental health in South African high schools.

Some of the reasons of scarcity or limited adolescent mental health services in LAMIC, stems from the fact that, there is limited or minimal training for mental health professionals in this field which leads to misidentification or over diagnosis of child and adolescent mental disorders (Morris et al 2011:1239). This in turn perpetuates the stigma about mental health disorder, with the disorders in adolescents mislabelled as discipline problems or laziness. In some countries mental health resources are concentrated in urban and affluent areas, or where they are in existence, they are mixed and provided across the lifespan (Morris et al (2011:1240).

2.4.1 Adolescent mental health in South Africa

South Africa (S.A), like some low-income and middle-income countries, is no different in being affected by the massive burden and impact of mental health disorders and challenges in prioritisation of policies and service development in mental health generally (Burns 2011:101). Findings of the study of the four African countries, SA included, identified that South African shortfalls in child and adolescent mental health (CAMH). In 2002 SA promulgated the child and adolescent mental health (CAMH) policy with guidelines for the development of age-specific services for mental disorders, substance abuse, and the sequela of trauma and violence, and highlights prevention programmes as key strategies for this group (Kleintjies, Lund & Flisher 2010:1133). Some challenging areas and barriers in CAMH were not remedied and those supported by empirical findings included:

- Lack of stand-alone mental health plan to support the implementation of current mental health policies.
- Since 2006, SA has a draft National Mental health guideline (2006) which has not been completed

- Lack of implementation plans at provincial level as recommended in the CAMH policy, due to absence of formalised mental health policy and limited capacity at provincial levels. A framework model for CAMH services was developed with norms and standards but evidence reveals that these were never implemented (Flisher et al 2012:158).
- Limited adherence to the provisions for the protection of minors as recommended by WHO; only the provision for age-specific services is stipulated in the CAMH policy. This is contrary to the fact that South Africa is a signatory to the Convention on the Rights of the Child, and had pledged to "put children first" by giving their needs the highest priority, ensuring their rights are upheld and provide them opportunities to enable them to reach their full potential (SA 2003:7).
- Limited availability of current services for CAMH: as reflected in
  - low proportion between inpatient beds for CAMH care in general and psychiatric hospitals
  - No residential services, few tertiary level CAMH inpatient units in metropolitan regions of the country provided specialist and outpatient services
  - limited or unknown number of psychiatrists specialising in CAMH and mental health professionals available in schools
  - low investment in mental health and CAMH compared to other priority public health programmes (Kleintjies et al 2010:133; Flisher et al 2012:151-158; Burns 2011:104)

2.5 MENTAL HEALTH PROMOTION AND ADOLESCENTS

Childhood and adolescence are key opportunities for the development of the foundation for mental health and prevention of mental health problems. Mental health has been accepted as an essential component of health, as clearly depicted by WHO's definition of health (WHO 2004:12). The interconnection between physical and mental health exist as they share many health determinants and aspects of promotion and prevention of health. Health promotion, according to WHO (2004:12), is intended to build people's capacity to manage their own health and work collaboratively. Considered as a preventive strategy, Ogden and Hagen (2014:14) cited by Bloom and Gullota (2003), health promotion is an inclusive perspective, and prevents predictable and interrelated

problems, protects existing states of health and healthy functioning and promotes psychosocial wellness for identified populations of people. They further argued that health promotion's focus is not on illness but emphasises the enhancement of well-being by providing people with support and supportive living conditions or environments which enable them to adopt and maintain healthy lifestyles. In this perspective health promotion is viewed as more concerned with raising competence, self-esteem, or well-being rather than prevention of psychological or social and mental disorders (Ogden & Hagen 2014:14).

Mental health promotion therefore forms an integral component of health promotion as a whole. Mental health is defined as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community. Mental health promotion therefore entails strategies to promote mental well-being of those who are not at risk, those who are at increased risk and those who are suffering or recovering from mental health problems (WHO 2004; Puolakka, Kiikkala, Haapasalo-Pesu & Paavilainen 2010:37; Weist & Murray 2011:3). Health promotion therefore in adolescent mental health should in fact target risk factors whilst maximising protective factors. Sturgeon (2007:38) also emphasised that public health approach to mental health promotion should involve efforts that support the factors that have been shown to promote mental health (protective factors) and address the factors that constitute risk factors for mental disorders. Ogden and Hagen (2014:14) highlight that epidemiological findings prompted researchers to search for an increase in the processes and variables that foster desistance from problem behaviours in children and adolescents over time. A combination of risk- and resilience-focused prevention strategies have been much advocated in order to prevent psychopathology. These are strategies that boost competence and resilience found in resilience and competence focused prevention. Competence is explained as patterns of effective pro-social adaptation whilst resilience is the manifestation of competence in the face of hardship. The former may be considered compensatory resource and the latter protective resources (Ogden & Hagen 2014:15). The compensatory and protective resources indirectly moderate the effects of risk factors by increasing the probability of social adjustment.

Despite the fact that mental health promotion positively impacts on the general health of people, it remains overlooked (Sturgeon 2007:37). This is ascribed to the poorly

resourced mental health services and stigma attached. Evidenced based mental health promotion interventions are more forthcoming from better-resourced developed countries and less marked in developing countries which are grouped under low- and middle-income countries (LAMIC). The situation is becoming worse with mental health promotion in adolescents, though seen as a substantial investment to the public health, but is given less recognition (Patel et al 2007:1309).

In every society, adolescents are faced with mental health needs. Patel et al (2007:1309) assert that adolescent mental health is an asset to be maximised through inter-sectoral mental health promotion interventions. This is because the long term consequences of the child and adolescent mental health problems can include an increased risk of a range of adverse psychosocial outcomes in later life (Vostanis, Humphrey, Fitzgerald, Deighton & Wolpert 2013:151).

2.6 MENTAL HEALTH PROMOTION IN SCHOOLS

Among the many priorities identified as important in schools, is the development of students' mental health and well- being**.** Research evidence indicates that schools will be most successful in their educational mission if they integrate efforts to promote children's academic, social and emotional learning and that strong bonds exist among student behaviour, attainment and learning and their social and emotional development (Dix, Slee, Lawson & Keeves 2012:45; Tan 2007:2).

O'Connell et al (2009) describe mental health promotion interventions as aiming at enhancing the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being and social inclusion and to strengthen the ability to cope with adversity. Since virtually all children are supposed to go to school, the school is a logical arena for mental health promotion. School as a primary setting where initial concerns arise and can be effectively remediated, has potential to reach large number of children and adolescents in a cost-effective manner (Vostanis et al 2013:151, SA 2011:17). Weare and Nind (2011:i29) also assert that schools can promote positive mental health and create resilience, providing the child or adolescent with resources to thrive and cope in adverse conditions by buffering negative stressors.

In schools, mental health promotion entails the provision of a full continuum of mental health promotion programmes and services. These include enhancing environments, broadly training and promoting social and emotional learning and life skills; preventing emotional and behavioural disorders by identifying and intervening in these problems early on and providing intervention for established problems (Weist & Murray 2011:3). Mental health promotion has risen as a very important developing area in public health services and the need is international (Puolakka et al 2010:37). For the last two decades, the school mental health promotion agenda had gained momentum especially in developed countries and Weist and Murray (2011:4) identified the following empirically proven reasons for the growth in school mental health promotion:

- Traditional and private mental health settings generally do not have special services for children and adolescents. As empirically reported, approximately 10% of children and adolescents worldwide experience mental health problems that would require assessment and interventions and if left unattended may have serious mental health consequences later in life. Three quarters of families with children and adolescents experiencing mental health problems, first approach the school in contrast to a quarter that approach their family doctors (Patel et al 2007:1310; Weare & Nind 2011:i29; Weist & Murray 2011:2). It is thus in this context that schools are seen as central site of mental health prevention and promotion of emotional well-being.
- Schools therefore are recognised as already the *de facto* deliveries of mental health services for children but yet poorly equipped and supported to handle this responsibility (Hattie & Anderman 2013:125; Weist & Murray 2011:4; Vostanis et al 2013:151; Patel et al 2007:1308). Using schools as the most universal natural setting for children to build mental health promotion and intervention effort may remove many barriers that constraint the delivery of these services in other settings. Greater outcomes and achievements of mental health promotion in schools have been valued by families, schools and communities. The educational benefits derived include improved pupils' health in both emotional and behavioural functioning, improved, academic achievement and cost saving in terms of reduced referrals (Weist & Murray 2011:4).

In spite of greater support and progress for school mental health promotion in developed countries, there are many challenges that this work confronts. For instance,

in the United States patchy progress can be seen with some communities embracing this agenda whilst others maintain *status quo* of limited school mental health programmes and services. Schools within the same community are different in terms of school mental health promotion as this is dependent on school leadership and student body's view of the concept (Weist & Murray 2011:6). Stigma also plays a role, leading to avoidance and minimisation of students' mental health issues. There tends to be marginalisation in terms of funding of school mental health promotion programmes, and there is insufficient staff and resources (Weist & Murray 2011:6; WHO 2004). The situation is worse in developing countries with wide disparities in the provision of mental health services still major challenge. This, according to Blum et al's (2012:1568) recommendation, necessitates the crucial need to enhance research capacity of investigators in low-income and middle-income countries in order to develop effective evidence-based policies and programmes to ensure the well-being of the young people in these regions.

2.6.1 Mental health promotion in South African schools

Multiple barriers to the development of SA mental health services have affected development of vitally important psychiatric services such as child and adolescent services. School mental health promotion initiatives through school health services, under primary health care (PHC), have, in the past, had very limited implementation and at times were disregarded. School health is a multidisciplinary team rendering school health services and ideally includes school health nurses, social workers, educational psychologists, specialist physicians and teachers. School health nurses form the backbone of mental health provision within primary health care.

Implementation of school health services has been slow in many provinces, with low coverage at sub-district, school and learner levels (SA 2012:8). In an effort to strengthen school health services under PHC re-engineering, National Department of Health (NDOH) and National Department of Basic Education (DBE) launch an Integrated School Health Policy (ISHP) (SA 2012:9). In the policy the school health vision has been spelt out as that of promotion of optimal health and development of school-going children and the communities in which they live and learn (SA 2012:9). This collaborative work agrees with the WHO-AIMS (WHO 2007:22) report on the mental health system in SA that formal collaborations between the government's

department responsible for mental health and other departments/sectors/agencies exist. Despite all such developments, service gaps within and between provinces remain, with rural areas like in Eastern Cape particularly underserved (Petersen et al 2012:42; Flisher et al 2012:158; WHO 2007:23).

In terms of support for child and adolescent health, the percentage of primary and secondary schools with either part-time or full-time mental health professionals is unknown. Few provinces have been reported to have school-based activities to promote mental health and prevent mental disorder, for instance, Gauteng, Free State and North West reported 1-20% of their schools, whilst Western Cape had the most 51-80% of schools with school-based activities (WHO 2007:23). These figures leave much to be desired for adolescent mental health in schools.

Flisher et al (2012:158) highlighted an urgent need to restore the balance between "curative and promotive/preventive interventions" and reiterated that strategies to strengthen individuals, families and strengthen communities and systems will not only remove societal barriers to mental health and improve mental health but contribute to the social and economic progress of the country by improving educational outcomes and social functioning in adulthood. School mental health programs should be made available to all students including those in general and special education, in diverse educational settings.

2.6.2 School-based programmes and promotion of mental health

According to Weist and Murray (2011:4), school-based programmes that promote mental health are effective, particularly if developed and implemented using approaches common to health-promoting schools' approach such as involvement of the whole school, changing the school psychosocial environment, developing personal skills, involvement of parents and wider community, and over a long time implementation period. According to Dowdy, Quirk and Chin (2013:125), school-based mental health services involve the delivery of any type of mental health services in a school setting either within classroom, entire school or through external programmes linked to the school, by a variety of personnel providing services; e,g., psychologist, social worker, psychiatric nurse, therapists or counsellors. Children and adolescents in schools are faced with mental health difficulties especially those transitioning from elementary to

middle or high school. Studies in the US and England reveal that transitions from these educational settings affect students' achievement and motivation to learn (Dowdy et al 2013:126). The situation may further be aggravated as it coincides with the onset of adolescents' physical, cognitive and psychological development. Empirical findings therefore revealed that use of school based mental health programmes to address children's mental health needs in schools bear positive educational outcomes. Increased drive by evidence highlighted by Dowdy et al (2013:126) showed relations between children's social and emotional well-being and academic achievement. Therefore an inverse relation between academic achievement and mental health problems appear to be pervasive across nations.

Many developed countries prioritise the school mental health agenda. With schools faced with the challenge of preparing students to participate in a complex, global community and workforce, the need for systemic educational reform becomes an increasing priority. As a result, many of the developed countries like England, US, Canada, New Zealand, Australia and Ireland are taking a more active role in improving educational outcomes for all students (Weist & Murray (2011:5). Based on the strong scientific evidence about the impact of SEL factors on students' academic learning and school success, most of these countries supported and adopted implementation SEL programmes. Few empirical reports on school-based mental health initiatives were found in developing countries, and none were found on the social and emotional learning programme implementation in developing countries especially LAMIC. Hence the researcher undertook this study to develop adolescent mental health promotion programme based on SEL.

2.7 SOCIAL AND EMOTIONAL LEARNING AND THE PROMOTION OF MENTAL HEALTH IN SCHOOLS

Durlak et al (2011:406) describe SEL as an approach that integrates competence promotion and youth development frameworks for reducing risk factors and fostering protective mechanism for positive adjustment. SEL is defined as a process of acquiring core competencies across cognitive, affective and behavioural domains and include aspect of self-awareness, self-management, social awareness, relationship skill and responsible decision making (Davies 2013:1; Hoffman 2009:535; CASEL 2013:9) (see Figure 2.1). It is believed that when these core competencies are learnt and applied,

they can assist individuals to handle interpersonal situations more constructively. Humphrey (2013:42) described the key driver to the introduction and growth of SEL as the increased number of adolescents who experience crisis in their lives. This view is common to many contemporary media portrayals of young people and academic discourse, in which they are characterised as fragile, stressed, and/or depressed.

An increasing number of positive outcomes of SEL continues to create high levels of interest in it today with states and school districts in European countries adopting requirements for teaching SEL. Extensive research demonstrates that SEL has been associated with positive results such as improved attitudes about self and others, increased pro-social behaviours, lower level of problem behaviours and emotional distress, students' connection to school and improved academic performance (CASEL 2013:10; Humphrey 2013:2; Davies 2013:4; Hoffman 2009:535).

That all children might benefit from SEL instruction, including those who are at risk, those beginning to engage in negative behaviours and those already displaying significant problems, depicts the focus of SEL as universal prevention and promotion program (Zins & Elias 2007:235). Ogden and Hagen (2014:13) differentiate between universal prevention and promotion with target prevention and promotion. Universal prevention entails the level of prevention that benefits the entire population; e.g., adolescents and seeks to prevent or delay the occurrence of a disorder. Individuals need not be screened but just provided with information and/or skills needed to prevent the problem. Targeted or indicated prevention requires that individuals undergo screening process and targets those exhibiting signs of a particular disorder. Known risk factors are used to identify the targets (Ogden & Hagen 2014:13).

SEL has been the programme through which individual social skills can be developed. Social skills generally considered subset of SEL, are socially acceptable behaviours that enable an individual to interact effectively with others and to avoid or escape negative social interactions with other. According to Elliot and Gresham (2007:1), these social skills include the following categories: communication, cooperation, assertion, responsibility, empathy, engagement and self-control. All these categories are what CASEL's (2013:9) model of five core competencies in SEL encompasses. That is *self-awareness and self-management* is aligned with self-control; *social awareness* with

empathy and engagement; *relationship management* with communication, cooperation and assertion and *responsible decision making* with responsibility (Davies 2013).

The necessity of these skills and competencies of SEL is crucial for young children and youth to function effectively in our society as they facilitate development of mutually supportive relationships with others and ultimately enable academic skills and positive emotion growth (CASEL 2013:10; Davies 2013:1). As significant predictors of school achievement, problem behaviours and school attendance, social skills are critical building blocks necessary for learning to be directed, motivated and facilitated by positive relationships with teachers, peers and parents. Students' ability to recognise and regulate emotions is essential as unmanaged emotional stress can detract from engagement in learning opportunities and hinder academic progress over time (Zmuda & Bradshaw 2013:173).

The SEL competencies have been described as the skills that underlie mental health. Failure to meet developmental milestones in the different domains of intra- and interpersonal competence can lead to an increased risk of psychopathology. Empirical evidence supports that empathy, self-awareness, self-regulation, and social skills have each been highlighted to be protective factors for mental health disorders. This protective role of social and emotional competencies may be in moderating relationship between chronic stressors and mental health outcomes (Humphrey 2013:29). Linking SEL to mental health is depicted in the operationalised definition of mental health by Humphrey (2013:30) as comprising:

- Emotional health − being happy and confident, not depressed and anxious
- Psychological health – being resilient and autonomous
- Social/relational health – having good relationships with others, and not behaving in a way that can cause harm, such as bullying

Durlak et al (2011:417) in their current meta-analysis, reveal that SEL programmes are successful at all educational levels (i.e elementary, middle and high school) and in urban, suburban and rural schools although they have been studied least often in high schools and in rural area. Hence, this study focuses on high school in the rural Eastern Cape.

2.8 THEORETICAL BASIS OF THE STUDY

In this study, CASEL's (2013) framework on social and emotional learning provided the theoretical basis. CASEL's Social and Emotional Learning (SEL) model in Figure 2.1 comprises five interrelated sets of cognitive, affective and behavioural competencies, which are categorised into competences in the following aspects: self-awareness, self-management, social awareness: relationship skills, and responsible decision making as described in Figure 2.1.

Figure 2.1: Five social and emotional learning core competencies

(CASEL 2013:7)

The Table 2.2 provides definitions of the five competence clusters of the SEL model.

Table 2.2: Description of the five core competencies of SEL Model

Self-Awareness:- Ability to accurately recognise one's emotions and thoughts and their influence on behaviour. This includes accurately assessing one's strengths and limitations and possessing a well-grounded sense of confidence and optimism.
Self-Management:- Ability to regulate one's emotions, thoughts and behaviours effectively in different situations. This includes managing stress, controlling impulses, motivating oneself, and setting and working toward achieving personal and academic goals
Social Awareness:- The ability to take the perspective of and empathise with others from diverse backgrounds and cultures, to understand social and ethical norms for behaviour, and to recognise family, school and community resources and support.
Relationship skills:-The ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups. This includes communicating clearly, listening actively, cooperating, resisting inappropriate social pressure, negotiating conflict constructively, and seeking and offering help when needed.
Responsible decision making:-The ability to make constructive and respectful choices about personal behaviour and social interactions based on consideration of ethical standards, safety concerns, social norms, the realistic evaluation of consequences of various actions, and the well-being of self and others.

(CASEL 2015:6)

The above mentioned five clusters can be further categorised into intrapersonal and interpersonal domains. *Self-awareness* and *self-management* are consistent with the intrapersonal domain whereas *social awareness* and *relationship skills* represent dimensions within the interpersonal domain. *Responsible decision-making* is both an individual and social process and therefore overlaps both domains (Marchesi & Cook 2012:8; CASEL 2015:6).

Using these competences assisted the researcher to contextualise the entire study. Based on the scientific evidence and notion that emotional intelligence is not static, it can be developed over the course of one's life, the researcher sought to determine the level of social and emotional development of school-going adolescents in high schools.

The SEL model therefore provided theoretical foundation from the initial processes of designing and developing constructs to be included in the Event History Calendar (EHC) grid that was used to collect quantitative data of the study; up to the data analysis and interpretation and the development of the proposed mental health promotion programme.

2.10 CONCLUSION

The literature survey focused on the “adolescence” phase and the mental health risks that occur as a result of one being a school-going adolescent. Previous strategies used in schools for the promotion of adolescent mental health were also reviewed. Previous studies were also reviewed in order to explore realistic findings that have been general. These findings were practical in guiding the current study in the development of a “programme of adolescent mental health promotion”. Chapter 3 will discuss the methodology in detail.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter provides detailed discussion of the research design and methods used in the study. The following aspects are covered: research design, research paradigm, population and sampling, data collection, data collection tools and procedures, ethical consideration related to data collection and data analysis. The chapter also presents the discussion on reliability and validity measures for both quantitative and qualitative aspects of the study.

3.2 RESEARCH DESIGN

Research design is described as an overall approach to a study that encompasses the aim, methods and the anticipated outcomes (Andrew & Halcomb 2009:11). The research design serves as a logical blueprint, a framework and a strategy that will enable the researcher to systematically answer the research questions. The research design therefore provides a useful guide for the decisions that the researcher makes about the methods to be used and the logic followed in making interpretations at the end of the study (Yin 2010:76; Andrew & Halcomb 2009:11; Creswell & Plano Clark 2011:53). According to Creswell (2009:3), the decision to choose a research design is informed by the researcher's worldview or paradigmatic assumptions, procedures of inquiry and specific methods of data collection, analysis and interpretation. The design must be appropriate for the study and the resources available.

Research paradigm or philosophical worldview is a term used to explain the researcher's set of generalisations, beliefs and values she/he espouses with regard to the world and nature of research (Creswell & Plano Clark 2011:39). These, according to Creswell (2009:6), depict the researcher's general orientation about research and provide the foundation for the proposed study. Research paradigms have strong implications for the research methods to be used to develop evidence and thus determine whether the researcher embraces quantitative, qualitative or mixed methods

(Polit & Beck 2010:16). In this study a pragmatic worldview provided a philosophical foundation by using different strategies for data collection and analysis.

A number of authors of research methods (Creswell 2014:10; Creswell & Plano Clark 2011:39; Polit & Beck 2012:251; Andrew & Halcomb 2009:11) have identified pragmatic worldview as a research paradigm informing mixed methods. It has been seen as worldview possibilities arising out of actions, situations and consequences and concerned with what works, using diverse approaches to arrive at solutions to the problems (Creswell & Plano Clark 2011:40). In this study perspective, the researcher is focused on using all available approaches to understand the research problem. Best practical approaches that will provide answers and solutions as to what approaches schools use to promote adolescent mental health and how teachers, school nurses and adolescents deal with social and emotional disorders affecting school-going adolescents in high schools in the Eastern Cape. This study used mixed method approach where the researcher drew from both quantitative and qualitative approaches when engaging in the research (Creswell 2009:10).

Pragmatic researchers believe in pluralistic approaches to derive knowledge about the problem. Hence this study combined qualitative and quantitative data collection and analysis procedures to answer the research questions and for substantiation of information that would lead to reliable conclusions. Mixed methods as an approach of inquiry involves planned mixing of qualitative and quantitative methods at a predetermined stage of the research process in order to provide better answers to the research question with both approaches giving a more complete picture of the research problem (Andrew & Halcomb 2009:3; Creswell 2009:4).

Mixing qualitative and quantitative methods according to Bryman (2006) cited in Creswell and Plano Clark (2011:62), suggests that the two approaches are believed to be associated with strengths and weaknesses and therefore combining them allows the researcher to offset their weaknesses and draw on the strengths of both. Depending on factors such as the nature of the study, the availability of study participants and financial and other resources, a mixed methods approach is deemed the best choice for understanding a phenomenon in some studies.

According to Leech and Onwuegbuzie (2011:175), mixed methods can allow for the study of multiple perspectives, conditions, contexts and factors as they interact. Though mixed methods are viewed as expensive and time consuming because the researcher seeks to solicit views from many sources, Creswell (2014:218) highlights it as a valuable strategy in neutralising biases and weaknesses of mixed approaches and triangulating data sources in search of convergence and integration across qualitative and quantitative databases. Empirical literature further endorses the value of the mixed design as that of obtaining confirmation, complementarity, initiation, development, expansion and enhancement of significant findings from mixing qualitative and quantitative databases (Andrew & Halcomb 2009:54; Creswell 2014:218; Leech & Onwuegbuzie 2011:177; Teddie & Tashakkori 2009:143; Gray 2009:214).

A stage in the research process where both quantitative and qualitative data collected are integrated has to be predetermined by the researcher. Creswell (2009:4) further argues that it is not only about mixing qualitative and quantitative data, but also ensuring that both approaches work hand in hand to ensure overall strength of the study. Yin (2010:88) also asserts that for a study to be valid, properly planned collection and interpretation of its data are essential so that conclusions made accurately reflect and represent the real world that was studied.

A mixed methods research approach was employed because the research questions sought answers to real-life experiences, multi-level perspectives, including some contextual influences, and values of the population under study. The experiences of school-going adolescents, teachers and school health nurses with regards to dealing with social and emotional problems in high school were explored. Trends, patterns and relationships in social, emotional and behavioural disorders were determined. As mixed methods research is believed to provide answers that work in practice (Teddie & Tashakkori 2009:154), it is in this study's interest to develop a universal intervention programme that would effectively promote adolescent mental health in schools. According to Gray (2009:214), mixing two approaches can be done for complementarity to increase the meaningfulness and validity of the study findings through capitalising on inherent method strengths to counteract another method's biases. In this study quantitative and qualitative data will be integrated during interpretation phase, with the qualitative findings used to explain and contextualise the results from the quantitative data. This will result in significance enhancement which Leech and Onwuegbuzie

(2011:177) describe as expanding interpretation of results from one approach by another, seeking elaboration, illustration, enhancement and clarification of the findings from one method with the results from the other.

According to Polit and Beck (2012:608), several dimensions in designing a mixed methods study, include concerns about: a) time orientation for data collection, that is, whether concurrent (data collected at the same point in time using the two methods or sequential (data collected at different times; and b) prioritisation, that is whether the two approaches have equal weighting or equal emphasis or status without dominating the other. This research used a sequential data collection with the two approaches, qualitative and quantitative, having an equal status. Teddie and Tashakkori (2009:143) describe sequential mixed methods as a design in which the phases of the study occur in chronological order, with one strand emerging from or following the other. Mixing seeks to answer exploratory and confirmatory questions chronologically in a pre-specified order. In this study, a sequential explanatory design was used where the quantitative and qualitative strands were mixed at a predetermined point of interface.

Creswell and Plano (Clark 2011:71) describe mixed methods as having two distinct interactive phases (Figure 3.1) which starts with collection and analysis of quantitative data followed by collection and analysis of qualitative data. Data may be analysed independently, inferences drawn and based on themes obtained in qualitative results, comparison may be made with quantitative results and thus make the two forms of data remain separate but connected (Creswell 2014:221; Polit & Beck 2012:634; Creswell & Piano Clark 2011:71; Andrew & Halcomb 2009:68; Teddie & Tashakkori 2009:154). The first phase in this study, of quantitative data collection from the participants, was done using an Event History Calendar (EHC), followed by collection of qualitative data using semi-structured interviews with the same participants. Focus group discussions, field notes and observations were also used.

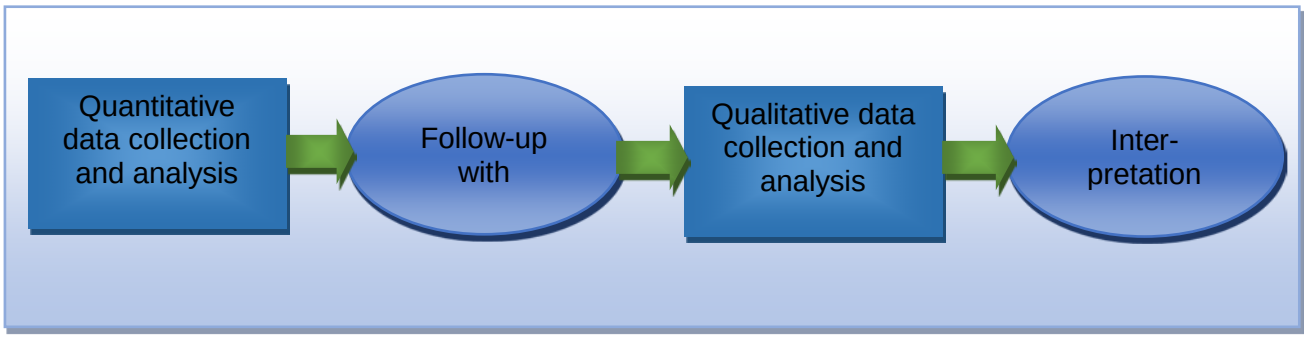

Figure 3.1: Diagrammatic presentation of sequential explanatory mixed method

(Adapted from Creswell 2014:221)

3.2.1 Quantitative strand of sequential explanatory mixed method

According to Creswell (2009:4), quantitative research is a means for testing objective theories or hypotheses by examining relationships among variables and in turn measuring these variables to produce numerical data that is statistically analysed. Predictions generated in quantitative research are tested in the real world. Compared to qualitative research, quantitative research may also be viewed as exploratory because it entails measurement of variables and statistical. Quantitative research deals with numerical description of trends. As envisaged in this study, the quantitative strand of sequential explanatory mixed method was used to determine and measure behavioural trends and patterns of high school adolescents for risk or protective factors.

A descriptive, cross-sectional survey was conducted with school-going adolescents in rural and urban high schools of the Eastern Cape Province. Polit and Beck (2012:264) describe a survey design as a flexible design with a broad scope to obtain information about prevalence, distribution and interrelationship of phenomena within a population under study, whereas, cross-sectional entails collecting retrospective data at one point in time. Gray (2009:219) further asserts that descriptive surveys are used to identify the scale and nature of social problems. This study therefore sought to determine and describe social, emotional and behavioural patterns of school-going adolescents over time in the context of adolescents' life events, relationships and other risk factors. Using a self-designed Event History Calendar (EHC) retrospective data on social, emotional and behavioural patterns were collected over a period of three years from the school-going adolescents using autobiographical memory cues. The domains or history categories to be used in the EHC were based on the five competencies in CASEL's social and emotional learning model.

3.2.1.1 Sampling for quantitative strand

Quantitative approaches are described as making use of large sample sizes in order to strive for representativeness. Representativeness is the ability of the sample to accurately represent the entire population (Polit & Beck 2010:317, Creswell & Plano Clark 2011:174; Teddie &Tashakkori 2009:178). In this study a representative sample for the quantitative strands was selected from school-going adolescents using a systematic sampling technique. Probability sampling, using random sampling techniques are mostly used to achieve this objective. Through randomly choosing individuals based on a systematic procedure the researcher selected a large number of cases, necessary tor generalise the findings (Creswell & Plano Clark 2011:174; Teddie & Tashakkori 2009:178). Polit and Beck (2012:614) assert that researcher's sample size decision for the quantitative component should be guided by the use of power analysis so as to diminish type II errors in the statistical analyses.

3.2.2 Qualitative strands of sequential explanatory mixed methods

Qualitative research has been viewed as a powerful source for analysis because of its high contextual nature, conducted through intense contact within natural 'real life' settings and its ability to depict how and why things happen (Gray 2009:166). The author further asserts that it is through qualitative inquiry that the researcher gains the holistic or integrated view of the phenomena under study including perceptions or experiences of the participants. This is the design, according to Streubert and Carpenter (2011:20), that values participants' viewpoints with limited disruption to natural context of the phenomenon. Participants are selected based on the fact that they possess first-hand experiences about the phenomenon. In this study, the qualitative research strand enabled exploration of the experiences of school-going adolescents, teachers and school health nurses with regard to the social emotional and behaviour problems of adolescents in high schools. As the main focus of qualitative research is to understand the ways in which people act and account for their actions, the interaction of the researcher with the three groups of research participants of the study was aimed at exploring the issues of social and emotional problems, and how they were dealt with in the school context.

With a wide variety of data gathering instruments, which can be flexibly used, a qualitative approach strives to achieve a rich, deep sense of the participants views and meaning in order to construct a kind of 'thick descriptions' of the phenomena under study (Creswell 2014:186; Gray 2009:177). These include in-depth interviews, observations and focus groups. This study used individual structured and semi-structured interviews, focus group discussions, field notes and observations. Individual interviews were used with school-going adolescents and school teachers whereas focus group discussions were used with school health nurses. Field notes and observations were used with all groups of participants.

3.2.2.1 Sampling for qualitative strand

Unlike quantitative approaches, qualitative research uses small samples**.** This is because of the nature of its concern which is not aimed at generalising but at discovering meanings and uncovering multiple realities (Polit & Beck 2010:318; Creswell 2014:186). The main focus and interest in qualitative sampling is who could provide a rich information reservoir in order to gain insight and understanding of the phenomenon (Creswell 2014:189). People who are knowledgeable, can articulate, be reflective and willing to talk are suitable participants to be recruited to the study. The determining factor of the sample size is based on the informational needs of the study guided by the principle of data saturation and the type of qualitative design. For instance ethnographic and case designs may use a sample of 2-4 participants whilst in phenomenological design 6-10 participants are deemed sufficient. The effect of data saturation too, which is collection of data to the point where no new information is obtained or fresh data no longer sparks new insights or reveal new properties (Creswell 2014:189; Polit & Beck 2010:321) is the most often used principle to make decisions about when sampling can stop.

In mixed method designs the type of sample to be used is determined and based on the study's time orientation, that is, whether concurrent or sequential and the relationship of the two strands that are mixed, that is embedded or nested type (Polit & Beck (2012:615). In this sequential mixed method, a nested type of sample will be used. This is the sample where the participants in the qualitative strands are the subset of the quantitative strands (Polit & Beck 2012:615; Leech & Onwuegbuzie 2011:175). The study therefore used a random sampling to select 200 school-going adolescents and

purposive sampling to select school teachers and school health nurses. According to Teddie and Tashakkori (2009:187), purposive sampling is aimed at selection of small sample that will yield the most information about the particular phenomenon whilst random selection aims at representativeness of the population under study. Teddie and Tashakkori (2009:187) believe randomly selecting subjects from a larger population adds credibility to the results. The qualitative strand of this study used three types of participants namely; school-going adolescents, teachers and school health nurses. The sample selection of school teachers and school health nurses was through purposive sampling. Based on the researcher's knowledge that teachers and school health nurses interact with school-going adolescents in one way or another, the researcher purposefully selected them as good informants to reflect on and articulate the phenomenon under study (Polit & Beck 2012:516).

3.3 RESEARCH METHOD

3.3.1 Sampling

3.3.1.1 The population

Burns and Grove (2009:343) describe a population as particular individuals or elements who are the focus of the research and could form target and accessible populations of the study. The target population is a group of potential participants who meet sampling criteria to whom one wants to generalise the study findings. A portion of target population which is available to the researcher forms an accessible population (Polit & Beck 2012:274).

The study populations consisted of the following:

- School-going adolescents: These are all high school learners or students who are in grades 10, 11 and 12 in the King Sabata Dalindyebo (KSD) district schools of the Eastern Cape Province. For those high school learners below 18 years of age an assent (Annexure D) was developed and parents consented before data collection. Whereas, high school learners aged 18 years and above consented for themselves (Annexure D)

- Teachers: These are all teachers in the same KSD district that teach Life Orientation subject in the three high school grades 10, 11 and 12 and who consent to participate in the study.
- School health nurses: Nurses who provide school health services in the KSD district schools and who volunteered to participate in the study.

3.3.1.2 Sampling and sampling procedure

Burns and Grove (2009:343) describe sampling as involving the selection of a group of people, events, behaviours or other elements with which to conduct a study. A sample is a subset of the population elements and forms the basic unit used for data collection and generalisation.

The research setting for this study comprised high schools in the KSD municipal district of the Eastern Cape Province. To obtain a sample of the schools a list of the high schools in the district were accessed from the KSD district offices for education and this was used as a sampling frame. A random sample of the high schools to be recruited into the study was selected. The KSD district has been selected because of its convenience and accessibility to the researcher and it is predominantly rural. Empirical evidence reveals that most studies on school-going adolescents mental health have been concentrated on schools in urban areas both developed and developing countries and limited evidence of those done in rural areas (Poulakka et al 2015:37; Weist & Murray 2011:6). The sample of the research settings was representative for the purpose and the objectives of the study for it covered a variety of contexts where high school adolescents, teachers and school health nurses operate. The sample was a mix of high schools in rural and urban areas so as to enable the researcher broader exploration of the phenomenon. This is also believed to provide a comprehensive picture of how school-going adolescents in these contexts thrive, with regard to the social, emotional and behavioural problems. A sample size of 4 high schools in KSD District was used for their nearness and easy accessibility to the researcher.

3.3.1.2.1 Sampling and sampling criteria for school-going adolescents

Within the selected high schools, three grades (10, 11 and 12) of each school were targeted for inclusion in the study. As schools differ in their students' enrolment, a

representative sample was selected in each grade using systematic sampling. According to Salkind (2014:187), systematic sampling involves selecting every '*k*th' name on the list, with the *k*th being the number between 0 and the size of the sample. Class lists of students in each grade were used as a sample frame. To obtain a systematic interval *(k*), the researcher divided the population size by the desired sample size and thus *k* becomes the size of gap between elements selected from the list (Burns & Grove 2009:353). For instance in a class of 40 students, with the desired sample size of 20, the sampling interval will be 2 which means every 2nd student in the class list was selected. As probability sampling yields a large sample, the researcher aimed at reaching a wide range of student participants from both rural and urban schools in order to get views of students with diverse experiences. This sample size also meets statistical test requirements of a quantitative study and thus provides a good estimate for the parameters of the population.

A representative sample was drawn based on the sampling criteria. Burns and Grove (2009:344) describe sampling criteria as a list of characteristics essential for membership to the target population. As these criteria denote who the target population is, the sample is selected from the accessible population within the target group. In the study this sample will be drawn from those participants who happened to be at school on that particular day and time.

Inclusion criteria

The participants to be included in this research have to comply with the following sampling criteria:

- Currently registered students in the selected high schools in the KSD district of the EC.
- Doing grades 10, 11 and 12 with life orientation as one of the subjects of study.
- Willingness to participate voluntarily in the research.
- Ability to read and understand the consent letter to facilitate informed consent or be granted permission through parental assent.
- Able to speak and understand English.
- Ability to write responses in the EHC tool.

- Could either be male or female.
- Be between the ages 15-19 years and of any racial group.

A total of 200 participants from the three grades in each school were selected and from the 4 selected high schools used in this study.

3.3.1.2.2 Sampling school teachers and school health nurses

Purposive sampling was used to select the second group of participants which were teachers and school health nurses. Burns and Grove (2009:355) describe purposive or purposeful sampling as conscious selection of certain participants by the researcher based on his/her judgement that they are information-rich cases for the phenomenon under study. Though much criticism has been levelled against this sampling technique and its limitations, it is imperative that the researcher clearly indicate the characteristics of the participants desired and the rationale thereof. As qualitative research is conducted to gain in-depth understanding of a complex experience or event, using purposive sampling whose focus is more on the experience, event and incident than people, is highly recommendable (Burns & Grove 2009:355; Creswell & Plano Clark 2011:173).

In this study, teachers and school health nurses who interacted with school-going adolescents were selected based on the assumption that they could provide extensive information about the experience or event being studied. Teachers were also selected on the basis of their involvement in teaching Life orientation (LO) as a subject. This is the subject that aims at equipping learners with life skills. During the teaching of life skills it is believed that the teachers would have observed the adolescents for any social, emotional and behavioural problems. Because of their restricted number (maximum of two in each school) all those available and consented to participate were recruited.

School health nurses during their school visits for school health services are believed to have interactions with school adolescents, thus were purposively recruited through the offices of the nursing service manager of the local health service area, under which they serve. The offices were the meeting points for health nurses on a weekly basis.

Eligibility criteria

- Teachers should be currently involved in teaching Life orientation subject in any of the three grades used in the study for a period of 2-3 years and above.
- School health nurse should be a professional nurse who has 2-3 years of experience in primary health and school health care services.

Table 3.1 summarises the description of the study coverage and sample.

Table 3.1: Description of the study coverage and sample

Research setting		Samples			Data collection methods
Locality	**High schools**	**Survey sample**	**Interview sample**	**FGD sample**	
Rural	**School A:** Adolescents Teachers	56	8 1	- -	Questionnaire(EHC); and interviews Semi-structured interviews
	School B: Adolescents Teachers	59	- 2	- -	Questionnaire EHC); Semi-structured interviews
Urban	**School A:** Adolescents Teachers	32	- 2	- -	Questionnaire(EHC); Semi-structured interviews
	School B: Adolescents Teachers	53	8 2	- -	Questionnaire(EHC); Interviews and Semi-structured interviews
LSA (Local health service area)	School health nurse		-	8	2 focus group discussions
Total		**200**	**23**	**8**	**Mixed methods**

3.3.2 Data collection

3.3.2.1 Data collection approach and method

Data collection is a series of interconnected steps used to gather information that addresses the research questions of the study (Creswell & Plano Clark 2009:171). In a mixed method design, data collection proceeds along the two strands, that is, quantitative and qualitative strands with each strand fully conducted following its persuasive and rigorous approaches (Creswell 2014:189).

3.3.2.1.1 Quantitative data collection method

Quantitative approaches often use structured self-reports as data collection instruments. These are as Polit and Beck (2012:312) describe versatile and wide ranging data collection methods that yield information that can be easily analysed. Their structured format assists in maintaining consistency and objectivity and reduction of bias. Quantitative tools may be administered orally in a face-to-face encounter or be self-administered questionnaires (Polit & Beck 2012:293). In the study, an Event History Calendar adapted and modified by the researcher from Fisher and Lee's (2014:782) sexual health history calendar for assessment of adolescents' sexual risks, was used. The EHC has been used to elicit contextually linked information in the school-going adolescents' lives with regard to risk and protective social, emotional and behavioural patterns.

3.3.2.1.2 Event history calendar (EHC) as data collection instrument

Martyn in Belli, Stafford and Alwin (2009:71) describes the EHC as a structured but flexible tool to collection of retrospective data which enhances recall of past events through use of past experiences as memory cues. Adolescent EHC elicits temporally linked information on adolescent life context, showing interrelationships, patterns and risk behaviour trends. The EHC provides visual and concrete picture of the integrated adolescent health risk behaviours which can be used as a common frame of reference for adolescent-interviewer communications. Step by step instructions used to complete the EHC and use of autobiographical memory cues and retrieval cues to increase recall, encourage reflection on the time-linked integrated risk history graph and enable them to

discuss actual and potential risk behaviour history with interviewer (Martyn 2009:71). As a data collection instrument used in clinical assessments of adolescent risk behaviours, EHC takes into consideration that risk and protective factors in the context of an adolescent's life are determinants of risk behaviours. Enormous empirical evidence reveals wide use of EHC mostly by studies on the assessment of sexual risk behaviour patterns of adolescents (Martyn 2009:69; Martyn, Saftner, Darling-Fisher & Schell 2012:461; Fisher & Lee 2014:777). It is on these grounds that the researcher chose to use EHC in the study to obtain information on social emotional problems of school-going adolescents with some modifications of the domains to be assessed.

An EHC exemplar grid comprises of standard set of timing cues in columns labelled by time unit (years), age and grade in school and a set of substantive cues in rows labelled by domains e.g (significant events, family, friends etc) (Martyn et al 2012:461). It is designed to first elicit and focus at the onset with sensitive data and proceed downwards to more sensitive and risk behaviour data (Martyn 2009:71). In the study the same EHC grid was modified and adapted to accommodate the aspects of social and emotional competencies. .

3.3.2.1.2.1 Developing and application of the EHC

Several modifications on Fisher and Lee's (2014:782) sexual health history calendar (SHHC) were made to include domains in the grid that are relevant to social and emotional competencies, and to align the instrument to the study objectives and questions. The grid contained five vertical time columns labelled with five sequential years across the top of the page. Down the left side of the page horizontally history categories followed chronologically and these pertain to:

a) Biographic information that include age, grade level, gender and race
b) Life context includes personal goals, important events within oneself, family and school
c) The five core competencies of CASEL's social and emotional learning model, as described in the previous chapter, that is, personal and social competencies

The EHC document was printed on A3 paper size, with a landscape orientation, with colour-coded sections to delineate the instructions, questions with example answers,

and data entry areas. Instructions for instrument completion were embedded in the EHC in a step-by-step fashion and each question included example responses (Annexure E). Like traditional EHC, this instrument format included in the upper sections less sensitive questions about events in the individual's life. These included any important personal, family and school event that would serve as contextual cues for subsequently assessed personal and social competencies. Thus each individual was required to first record any important personal, family and school event that took place in each year cohort. Below this, a second section provides for assessment of personal and social competencies with rows for documenting responses. Several aspects of these competencies extracted from CASEL's model were listed along the left margin with brief definition of what each entails and example responses. Respondents were asked to report on occurrence of each of these competencies in the specified years. At the end of the column additional space was provided for respondent's additional information which would not have been covered but deemed significant to the respondent. The designed EHC was first tested in a pilot study of 5 participants before use with study participants.

Through their principal and class teachers students were gathered in a big class hall and after the researchers' introduction, thorough explanation of the purpose of the study and research process as a whole to the students, individual students were requested to consent to participate by signing a consent forms.

Thereafter school-going adolescents who consented to participate were divided into three groups according to grades. Each respondent was provided with a blank copy of EHC instrument to be completed. The researcher provided a brief verbal review of the instrument completion instructions step by step and questions from respondents if any were invited. With the help of research assistants three classes/grades completed the EHC concurrently and were invigilated to ensure that completion was done through individual effort.

3.3.2.2 Measures to ensure validity and reliability for the quantitative strands (event history calendar)

- **Validity**

Andrew and Halcomb (2009:124) describe the goal of measurement validity as ensuring that the instrument accurately measures what it is supposed to measure. Polit and Beck (2012:336) refer to this as soundness of the study evidence. To enhance validity, the EHC would be subjected to scrutiny by the supervisor to judge whether items used meet certain criteria and are related and relevant to the phenomena being studied. Member checking will be done to validate the correctness of the information. The researcher will ensure that she is in context at all times during the completion of the EHC and allow only discussions about the phenomena studied.

- **Reliability**

Polit and Beck 2012:331 describe reliability as the instrument's consistency in measuring the target attribute. The event history calendar as a widely used instrument in clinical research with adolescent lends itself to a measure of reliability and validity. A wide empirical review undertaken on the EHC and its use mainly with adolescents has proven it a better tool for producing quality retrospective data (Belli et al 2009:5; Martyn et al 2012:461; Fisher & Lee 2014:778; Tshweneagae 2012:3). Based on these premises the researcher decided to use EHC to assess the social, emotional and behavioural problems amongst school-going adolescents.

To ensure reliability of the data gathering tool (EHC), pre-testing it on a small group similar in characteristics to the intended respondents was done. The pretesting gauged whether respondents understood the domains in the EHC, determined the understanding of the language, the length and relevance. This is believed to enhance its reliability. Revision on some aspects of the tool in the light of experiences from the pretesting were done and finalised for use in the field. Before carrying out fieldwork, standardisation of practice, process and approach was discussed and established with the supervisor and research assistants. After each fieldwork day, the researcher and assistants met to review the data collected. These end of the day reviews enabled

taking note and correcting anomalies so as to avert problems at the earliest stages. EHCs were checked for accuracy and completeness during these review sessions.

3.3.2.1.4 Qualitative data collection method

The qualitative strand of the mixed method design involves a much more extensive method of data collection than the quantitative strand. The researcher being the key instrument in the data collection process undertakes thorough steps for ensuring accuracy of the process. These include setting boundaries; collecting data through unstructured/semi-structured interviews, observations, and documents; and establishing protocols for recording information. The researcher is expected to also explicitly and reflexively identify her own biases, values and personal background and indicate how these biases could influence the study process. The researcher put aside her personal thoughts on how other students turn to use alcohol and substances, became deliquents and bully others at school. As a mental health practitioner it was easy for the researcher to free out these thoughts and concentrate on the research process. In this study, the researcher kept observational/field notes during data collection process and provided reflective notes throughout the research process. With a qualitative approach**,** the initial plan cannot be tightly prescribed as change is inevitable when the researcher enters the field. According to Polit and Beck (2012:532), this calls for creativity on the part of the researcher to design workable solutions and strategies in such instances. The main focus of qualitative research is to obtain and learn meanings participants hold about the phenomenon or problem understudy, through making use of tacit knowledge (intuitive and felt knowledge) to understand the participants' multiple realities (Creswell 2014:206). The ultimate aim is to gain a holistic account that will provide a complex picture of the phenomenon under study. In this study qualitative data collection was done through individual interviews and focus group interviews. School-going adolescents after completion of the EHC were invited to volunteer for individual interviews using the completed EHC as guide. Semi-structured interviews with school teachers were conducted whilst school health nurses were involved in focus group discussions.

- **Individual interviews with school-going adolescents**

After completion of EHC, volunteers were invited for the sequential phase of the study, that is, individual interviews in a private office with the researcher. Each participant had to bring along his/her EHC that was used to guide the interviews. The A3 paper sized EHC spread out in front of the participants, emulated timelines that provided a focal point for the interviews. The EHC was spread out in front of the participant and the researcher and using domains and responses supplied in the event history calendar, the researcher probed deeper to gain clarity on individual EHC responses on adolescent's experiences with social, emotional and behavioural problems in high schools.

- **Semi-structured interviews with school teachers**

Burns and Grove (2009:510) described semi-structured interviews as self-report data collection techniques with specific sets of the topic aspects to be covered in the qualitative interviews. In the study, using the same statement *"Tell me your experiences of encountering social and emotional problems in schools and how you dealt with them"* individual interviews with school teachers were conducted. Follow up questioning, probing and clarification was used to elicit needed information from the participants. Privacy of these interviews was maintained by making use of the small private, quiet office (e.g. library and laboratory rooms) far from the classroom and staff rooms in the respective school premises, that is, urban and rural high schools. From these interviews the researcher hoped to identify adolescents' social and emotional problems in schools and the approaches that schools used to promote adolescent mental health. Compared with the CASEL's model of social and emotional learning, these form the basis of the SEL programme that will be proposed for introduction to South African high schools.

- **Focus group discussions (FGD) with school health nurses**

Focus groups interviews are described as group interviews or discussions of 5 to 10 people to simultaneously solicit their opinions and experiences about the phenomenon (Polit & Beck 2014:290). In this study FGD were used with school health nurses. The group of school health nurses were mobilised though their local service area (LSA).

Use of a group format is believed to be efficient to generate a lot of dialogue. Discussions were held in the boardroom of the LSA offices. The participants were part of the school health team servicing urban and rural high school in the KSD municipal district. After full explanation of the research process using the study information leaflets, the nurses were requested to sign consent form voluntarily. From a group of twelve (12), eight nurses volunteered to avail themselves for the FGDs. Two audio-taped FGDs were conducted and were held on the 23rd and 27th of March 2015 The FGD guide solicited information on the participants' experiences with social and emotional problems of school-going adolescents. The opening statement or question was::

1. **What are your experiences with social, emotional and behavioural problems of school-going adolescents in high schools?**

    1.1 How did you deal with these problems?
    1.2 What mechanisms are in place to deal or prevent these social, emotional and behavioural problems?
    1.3 What would you like be done to promote mental health in high school adolescents?

During discussions, the researcher and research assistants kept observational notes of the process and reflections were made by each thereafter.

- **Field notes**

Greef in De Vos, Strydom, Fouché and Delport (2011:359) describes field notes as written accounts of things the researcher hears, sees, experiences and thinks about in the course of interviewing. These also entail noting both empirical observations and the interpretations thereof. In this study, full and vital notes of what went on during interviews and impressions immediately after, were recorded as memos. A logbook for the recorded notes and observations during the interviews with adolescents, school teachers and in FGD with nurses were used throughout fieldwork. During data analyses the researcher made reflective notes on the impressions made by EHC responses of adolescents, and narratives from the interviews and focus group discussions. Greef

(2011:359) suggests that the researcher's emotions, preconceptions, expectations and prejudices ought to be written down so that they could be developed in the final product.

3.3.2.2.2 Measures to ensure trustworthiness during qualitative data collection

According to Streubert and Carpenter (2011:49), trustworthiness refers to the rigour in qualitative research that accurately represents the participants' experiences. Lincoln and Guba's framework as described in Polit and Beck (2012:584) was used in this research to ensure trustworthiness of the study findings. The framework identifies the following criteria in assessing trustworthiness: credibility, transferability, dependability, confirmability and authenticity. Table 3.2 indicates the strategies, activities and application of trustworthiness as envisaged to be used in the study.

Table 3.2: Measures of trustworthiness

Strategies	Activities	Application
Credibility	Prolonged engagement with the field	- Time spent with participants during interviews until data saturation level is attained - Building rapport and creating context of trust with participants - Formal and informal discussion of the findings with participants
	Member checking	- Deliberate probing during interviews and clarifying meanings of participants' comments - Taking back for clarity and verification of some specific descriptions in the EHC entries or thematic summaries.
	Peer debriefing	- Discussions with independent colleague or supervisor - Consensus discussion with independent coder - Presenting research design and findings at research forum and doctoral seminars,
	Reflexivity	- Field notes during interviews reflecting researcher's feelings, thoughts,

Strategies	Activities	Application
		experiences and observations - Analysis of reflective notes in personal journal or memo
	Data and method triangulation	- Mixing quantitative and qualitative strand in the study through EHC, individual interviews and focus group discussions. - Using three different data sources (students, teachers and school health nurses as participants)
Dependability	Dense description of methodology	- In-depth and detailed description of research design and methods
	Data and method triangulation	- As discussed
	Code recode procedure	- Independent coder with consensus discussion
	Dependability audit	- All material and documentation used in the field, detailed log of decisions - Scrutiny of data and supporting documents by an external reviewer/moderator
	Peer debriefing	- As discussed
	Reflexivity	- As discussed
Transferability	Realisation of the sample	- Purposive sampling - Selection criteria
	Dense description of study context, participants and findings	- Rich, thorough and vivid descriptions of fieldwork , verbatim quotes of participants, and detailed log of decisions
Confirmability	Confirmability audit	- Safekeeping of raw data: audio tapes of interviews, completed EHC and field notes for a period of two years after publication of the thesis

Strategies	Activities	Application
	Peer debriefing	- As discussed
Authenticity	Bracketing and reflexivity	- Keeping reflective journal of the researcher's personal biases, values and thoughts
	Thick and contextualised descriptions	- Lucid and textured descriptions including verbatim quotes from study participants

3.3.3 Ethical considerations

Ethical consideration entails adherence to the rules and standards of ethical conduct during any research that involves human beings as study subjects/participants. Various authors of research design and methods delineate the important ethical principles to be adhered to by the researchers throughout the research process (Burns & Grove 2009:185; Polit & Beck 2012:152; Streubert &Carpenter 2011:62). These include the three ethical principles identified in the Belmont Report as principle of beneficence; respect for human dignity and principle of justice.

Upholding these principles is a moral endeavour to generally safeguard participants' rights by doing no harm (non-maleficence), and doing good (beneficence); maintaining confidentiality (protection of information) and autonomy (freedom of choice) and justice (fair treatment and equality) to preserve people's dignity and respect (Bless, Higson-Smith & Kagee 2006:142; Polit & Beck 2012:152).

3.3.4 Permission to conduct research

The approval to conduct the study was sought from several Ethics committees before commencement of data collection. The University of South Africa (UNISA) Research ethics Committee reviewed the study proposal and granted ethical clearance (Annexure A). Thereafter, the proposal was sent to the Provincial Department of Health and Education research committees respectively, which reviewed it and approved its compliance with ethical standards before granting permission to conduct the study (Annexure C). Permission and approval was also sought with the district authorities for

health and those of basic education, the nursing manager of the participating LSA and school principals (Annexure B1 & B2).

3.3.2 Voluntary participation (autonomy)

People should make a choice on whether or not they should participate in a study. Any form of coercion should be avoided and individuals should enroll out of choice. Where payment or other incentives are offered, there should be strict procedures ensuring that participation is by individuals who qualify according to the study protocol. In all cases participation should be voluntary. If participation is confined to a particular group of people this may reduce generalisability of findings.

Voluntary participation is linked to disclosure of adequate factual information to potential participants on details of the study including the risks and benefits. It is expected that people are able to make informed decision regarding their participation when sufficient information has been provided to them. In this study all participants were allowed to voluntarily choose to participate or not to. They were at liberty to withdraw at any point from the study without any sanction, should they wish to do so. Participation was purely through participants' free will without any form of coercion or bribe.

To ensure autonomy, a written statement explaining the purpose of the study and procedure for data collection was developed and given to each participant to read before consenting to participation (Annexure D). This was done to ensure consistency in information provided to all potential participants.

3.3.3 Informed consent

For participants to make decisions to participate in a study, sufficient information is required. According to Polit and Beck (2012:157), informed consent means participants have adequate information about the study, understand that information clearly and are able to consent to or decline participation voluntarily. In this study information leaflets detailing purpose and objectives of the study, the process of data collection, benefits and risk were prepared for all the participants (adolescents, teachers and school nurses) to read before they sign the consent (Annexure D). For those learners below 18 years, these were accompanied by a request for parental assent to consent to

participation and were handed in to the school principals for distribution to learners who were to take them to their parents prior the date of data collection. On the actual day of data collection the information leaflet was again read out and copies given to the participants prior to their enrolment in the study. Each individual was given the opportunity to ask questions or seek clarity and then requested to sign the consent document as proof that the researcher's explanation was clearly understood and participation was voluntary. Those with parental assent to participation were also requested to sign the consent too. As this study used mixed method approaches with adolescents, an ongoing consent was renegotiated at the second qualitative phases of data collection. This, Polit and Beck (2012:157) describe as allowing participants to play a collaborative role in deciding on an ongoing participation.

3.3.4 Confidentiality (non-maleficence)

Confidentiality is concerned with respecting people's privacy by not revealing the individual's identity to anyone other than the researchers and all involved in the study such as supervisors. This also pertains to any information participants share with the researcher (Polit & Beck 2012:162). In this study all participants were assured that all confidential information and protection of invasion of privacy would be prioritised throughout. For instance, documents such as consent forms with participants' names were separately filed from the completed EHC and defined codes instead of names were used to identify the completed EHC. Only the researcher and the research assistants handled the completed EHC documents which were thereafter kept in a locked drawer to ensure limited access to information. A number system in coding EHC responses was used to enter and record different files of SPSS and all information was accessed through a password.

Interviews were conducted in private rooms in the school premises with only the researcher and the potential participants. Audiotapes and field notes were also kept under lock and key. Data collected was shared among researchers and was kept without identifiers where identification was not required for further follow up research.

Participants were informed that study findings would be disseminated in professional journals and presented in seminars and conferences. But reporting would not identify who was interviewed.

3.4 CONCLUSION

This chapter described the methodological underpinnings of the study which is sequential mixed method research. Both quantitative and qualitative strands were discussed with emphasis on how they were used to answer the research questions.

The sampling procedures and selection criteria for participants, data collection instruments used and critical ethical issues observed in data collection and analysis were also discussed. The discussion also centred on how the study rigour and measures of trustworthiness were ensured in order to maintain the research integrity.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents data management, analysis and the research findings in details. Data for this study were derived from completed event history calendars, focus group discussions and individual interviews. Quantitative and qualitative data were analysed separately in order to protect possible data loss through distortion. Data were categorised into that of rural and urban participants. The chapter begins with the description of the analytical process which includes data cleaning, coding, organisation and reduction and the description of demographic profile of the target population. Research findings are then presented in thematic areas or categories. The study aimed at developing a social and emotional learning programme for the promotion of school-going adolescents' mental health. In order to realise this goal the following objectives spelt out in Section 4.1.1 were proposed and the research answered the questions outlined in Section 4.1.2

4.1.1 Research objectives

The study aimed at meeting the following objectives:

- Investigate the experiences of school-going adolescents in dealing with social and emotional problems.
- Explore and describe the experiences of school teachers and school health nurses in dealing with social and emotional problems of adolescents.
- Determine approaches used by schools in handling social and emotional problems of adolescent.
- Explore the needs of school teachers, school-going adolescents and school health nurses in order to develop a programme for social and emotional learning.

4.1.2 Research questions

The research questions listed in this section followed from the objectives of the study in order to enable the researcher to develop a social and emotional learning programme for the promotion of adolescent's mental health. These research questions are as follows:

- What are the experiences of high school adolescents in dealing with social and emotional problems?
- What are the experiences of high school teachers and school health nurses with regard to social and emotional problems of adolescents?
- What are the approaches used by school-going adolescents, teachers and school health nurses to promote mental health
- What are the needs of the study populations that would inform the development of the programme for social and emotional learning?

4.2 DATA MANAGEMENT AND ANALYSIS

Data management and analysis were done in two ways. Firstly, quantitative data from completed event history calendar were collated in several ways and at different stages to facilitate multi-method analysis of the whole adolescents' life trajectories. Entries of information on individual life history were input into a Microsoft Excel file and manually counted as individual responses towards each domain in the EHC. Each response category was given a numerical code to ease identification in the data template.

The Statistical Package for Social Sciences (SPSS) IBM version 23 was used to analyse the data from completed EHC. Responses on the EHC on the various concepts of the grids were used as response codes which were used for data entry and description in the SPSS data template. Corbin and Strauss (2008:160) assert that quantitative information goes through transformation to numerical values which are known as codes. The data were firstly presented in the form of descriptive statistics using frequencies and proportions. The chi-square goodness of fit test was used to test if the aspects were equally likely to occur, that is, they follow a uniform distribution. This was motivated by the fact that the researcher wanted to find whether experiences of adolescents were the same. The chi-square test of independence was also done to

determine the association between the variables. The Cramer's V was used to determine the strength of the association and where differences existed, the chi-square post-hoc test was done using standardised residuals.

Secondly, qualitative data were prepared for exploration and data analysis in detail**.** Polit and Beck (2014:304) describe qualitative analysis as reductionist in nature as large masses of data have to be converted into small, more manageable segments. This process, according to Creswell (2014:196), involves steps from the specific to the general with multiple level of analysis as shown in the Figure 4.1.

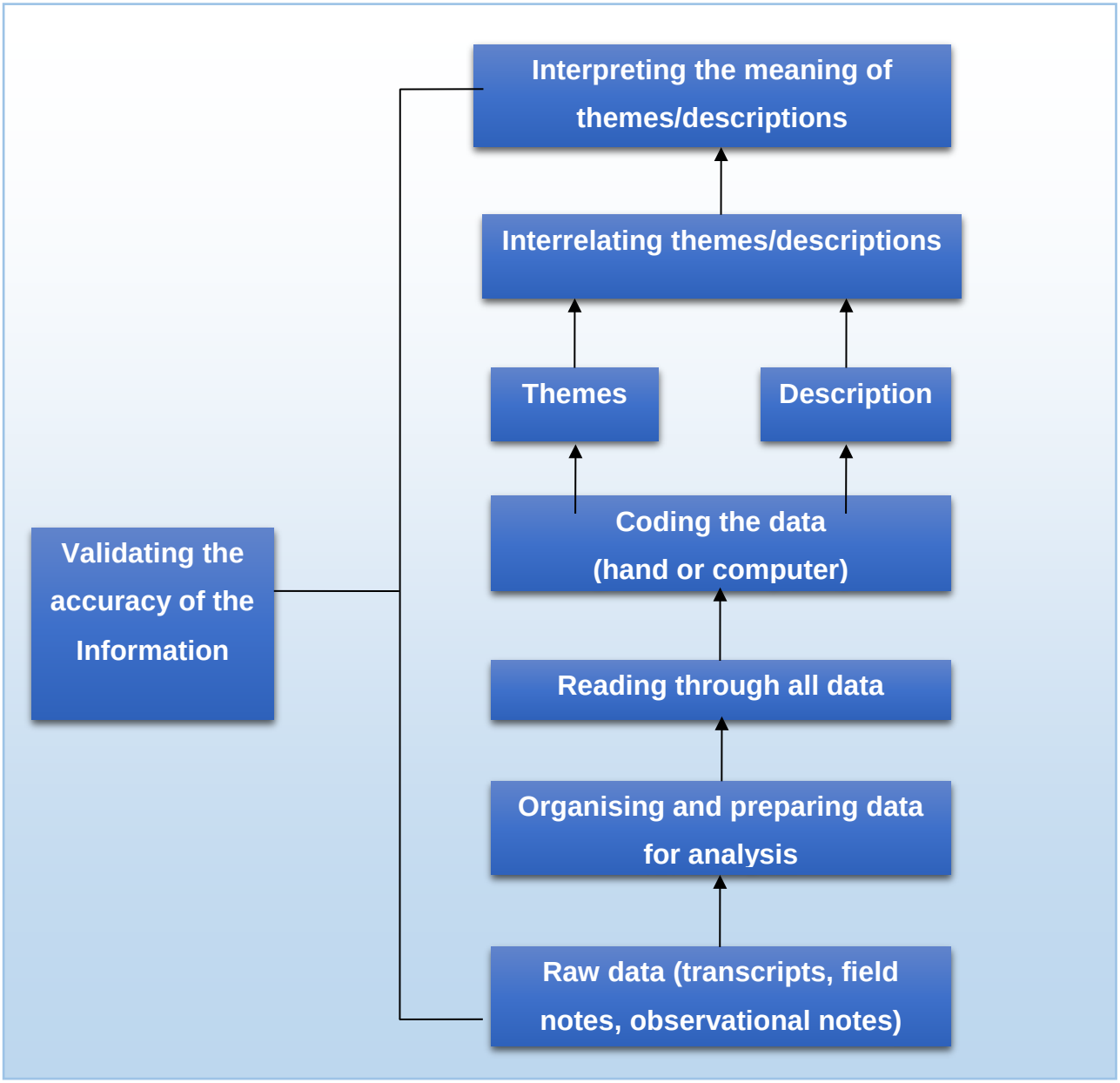

Figure 4.1: Qualitative data analysis process

(Creswell 2014:197)

The process of qualitative data analysis presented above should not be presumed to be linear, with steps following each other chronologically as shown in the diagram. But rather it is interactive in practice and steps can occur simultaneously or interchangeably. This experience was evident during data analysis for this research.

Qualitative data generated from individual interviews with school-going adolescents, and school teachers, and that from transcripts of focus group discussions with school health nurses were transcribed verbatim. In some instances, the data from adolescent interviews were stratified according to urban and rural settings. Data cleaning and editing were done to prepare data for coding and subsequent analysis of content. Polit and Beck (2014:306) describe qualitative content analysis as the breaking down of narrative data into smaller units, coding and naming the units according to the content they represent and grouping coded material based on shared concepts. In the study the end product is the emerging central themes and categories that are used as headings of the research findings' sections. Creswell (2014:2003) describes themes as the ones that appear as major findings displaying multiple perspectives from participants supported by diverse quotations and specific evidences.

The section that follows presents separate findings of the two data strands in detail and thereafter provides a combined interpretation and integration of the two findings.
Polit and Beck (2012:618) describe the integration of different strands at a point of integration rather than during analysis as merging. The merging enables the drawing together of the findings of the two separate analyses in order to synthesize the results and develop an overall interpretation. Descriptive statistics, frequency distributions and content analyses, were used to summarise and present data. Neale (2009:278) advises against a tendency to emphasise one set of findings over another in mixed research methods. Therefore the integration of findings from both methods will be utilised optimally.

4.2.1 Demographic profile of the population

The target population of this study comprised school-going adolescents, school teachers and school health nurses.

4.2.1.1 Adolescents

Selected school-going adolescents' demographic data include age, gender, school grades and school settings. A total of 200 respondents was recruited and completed the event history calendar questionnaire. Table 4.1 shows the demographic characteristics of adolescents who participated in the study.

Table 4.1: Characteristics of the participants (n=200)

Variable	Category	Frequency	Percent (%)
Gender	Male	88	44.0
	Female	112	56.0
	Total	**200**	**100.0**
School setting	Urban	85	42.5
	Rural	115	57.5
	Total	**200**	**100.0**
Age	15	29	14.5
	16	29	14.5
	17	55	27.5
	18	33	16.5
	19	54	27.0
	Total	**200**	**100.0**
Grade	10	67	33.5
	11	56	28.0
	12	77	38.5
	Total	**200**	**100.0**

The majority of the respondents were females, making up 56% (n=112) whilst 44% (n=88) were males. The probable reason is that females tend to volunteer more readily than males. In terms of school setting, about 57.5% (n=115) were in the rural whilst 42.5% (n=85) were in the urban. Three school grades (10, 11 and 12) in each setting were adequately represented with respondents' age group ranging from 15-19 years.

After completion of EHC questionnaire, a subset of the sample of adolescents was, on a voluntary basis, recruited to participate in individual interviews. These were recruited from one urban high school and one in rural setting. A sample of 16 adolescents was interviewed.

4.2.1.2 School teachers

A total of seven teachers both females (n=5) and males (n=2) were interviewed. All of them were involved in teaching the Life Orientation (LO) subject amongst other subjects in grades 10-12. Fifty-seven percent (n=4) of them were from urban high schools and 43% (n=3) from rural high schools. All of them have teaching experiences of more than 3 years. Figure 4.2 shows their age group distributions.

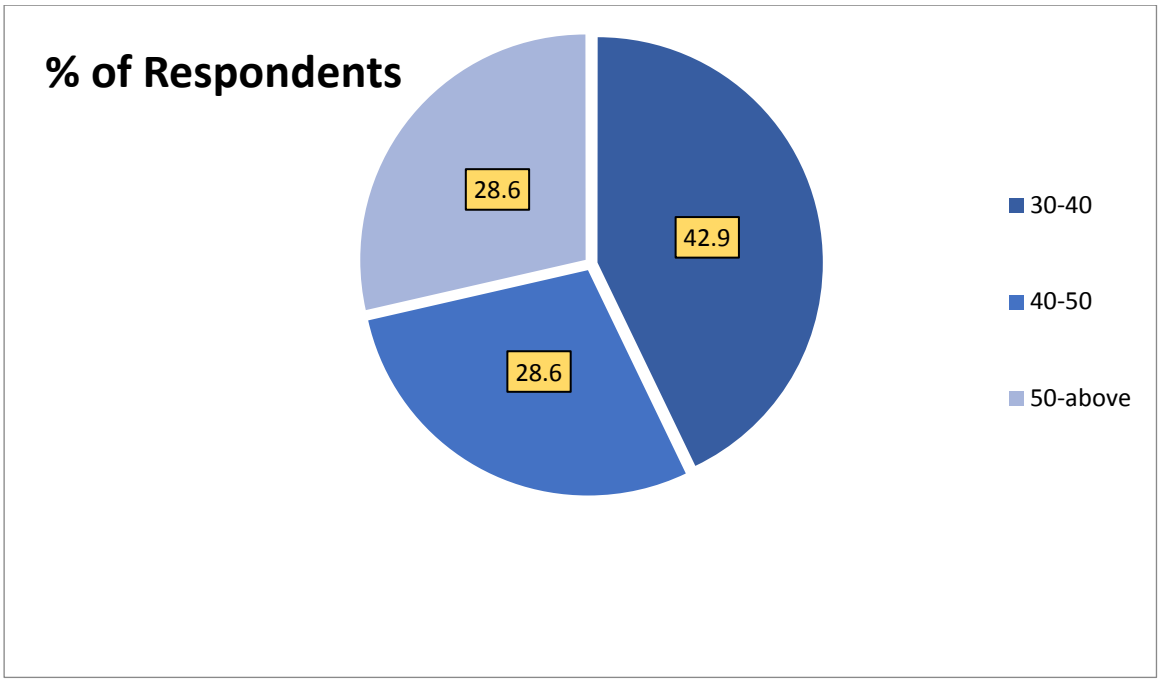

Figure 4.2: Age distribution of school teachers (n=7)

The majority of the school teachers (43%) were between ages 30-40. This age group, according to the researcher, is believed to be young enough to interact and understand the language and behaviours of the adolescents well. Whereas those older than these, are also regarded as well experienced in dealing with social and emotional problems of the school-going adolescents.

4.2.1.3 School health nurses

These were professional nurses of the local health service area (LSA) responsible for school health services in the district and were rendering health services to the participating high schools. Two to three participants in the FGD worked with high schools in the selected district and organisational context in a rotational basis. This homogeneity, according to Ekornes, Hauge and Lund (2012:289), is likely to facilitate sharing of opinions and make it easier to explore the phenomenon under study. There

were seven (7) female and one (1) male participant. All of them had more than 5 years' experience in the nursing profession. Fifty percent (50%) of them were on contract and permanent posts respectively. About 38% of participants were already retired whilst 63% forming the school health reengineering team is ages ranging between 35-45 years. All participants had community health nursing sciences amongst their qualifications. Only two were trained psychiatric nurses. The Table 4.2 depicts the demographics of the school health nurses.

Table 4.2: Demographic characteristics of school health nurses (n=8)

Demographic characteristics	Frequency	Percent (%)
Gender		
Male	1	12.5
Female	7	87.5
Age groups		
35-45	5	62.5
46-55	1	12.5
60 and above	2	25.0
Professional qualifications		
Community health nursing and others	6	75.0
Psychiatric nursing and others	2	25.0

4.2.2 Quantitative data results

Quantitative data from the EHC was used to test the following hypotheses as shown in Table 4.3.

Table 4.3: Research hypothesis

Hypothesis 1	H_0:	There is no relationship between geographic location and handling difficult situations
	H_1:	There is a relationship between geographic location and handling difficult situations
Hypothesis 2	H_0:	There is no relationship between gender and goal setting
	H_1:	There is a relationship between gender and goal setting
Hypothesis 3	H_0:	There is a relationship between school grade and life events
	H_1:	There is no relationship between school grade and life events
Hypothesis 4	H_0:	There is a relationship between age and dealing with significant events
	H_1:	There is no relationship between age and dealing with significant events

The responses from EHC items were not all answered by all respondents. The following shows the number that responded to each item:

- Life events exposure: n=200
- Events at school: n=120
- Personal awareness: n=167
- Goal setting and motivation: n=191
- Dealing with significant events: n=149
- Handling of emotions: n=200
- Handling difficult situation/Stress management: n=200
- Relationship management: n=194
- Decision making: n=181
- Reflection on decisions n=130

The patterns and trends of these variables will be discussed in details.

4.2.2.1 Life events exposure

The respondents were asked to indicate the life events they had once been exposed to in their lifetime. The mostly highlighted events are listed in Table 4.4. Bereavement,

family situations (like parental separations, divorces, one parent absence) and bullying were highly ranked as events the majority of respondents tend to be exposed to.

Bereavement was the one with the largest proportion of 36.5% as shown in Table 4.4.

Table 4.4: Life events exposed to (n=200)

Events	Frequency	Percent (%)	Rank
Bereavement	73	36.5	1
Family situation	58	29.0	2
Bullied	47	23.5	3
Arrest and gangsterism	12	6.0	4
Pregnant/impregnated	10	5.0	5
Total	**200**	**100.0**	

While fewer respondents (6%) reported being arrested and/or involved with gangsters, only 5% reported being pregnant or impregnated someone.

4.2.2.2 Events at school

Respondents were required to state events, good or bad that they were involved in at school. Table 4.5 shows aspects reported about.

Table 4.5: Events at school (n=120)

Aspect	Frequency	Percent (%)	Rank
Award winning/good grades	52	43.3	1
Failed/poor grades	30	25.0	2
Truancy/suspension	21	17.5	3
Leadership role	17	14.2	4
Total	**120**	**100.0**	

Most respondents (43%) reported obtaining school awards and/or good grades whilst 25% were those who failed or had poor grades. Eighteen percent (18%) were those

who played truancy or were suspended. Lowest proportion of 14% of the respondents had leadership role.

4.2.2.3 Personal awareness

Respondents were asked to indicate personal attributes (strengths and/or weaknesses) to demonstrate personal awareness. Table 4.6 shows these results. Out of 167 responses of participants who responded to a statement on personal awareness 53% indicated self-confidence, 38.3% indicated shyness and 9% (n=167) indicated self-centeredness. Self-confidence is deemed an essential trait for adolescents to withstand peer temptations and influence and thus enable them to self-regulate themselves.

Table 4.6: Personal awareness (n=167)

Personal attributes	Frequency	Percent (%)	Rank
Confident	88	52.7	1
Shy	64	38.3	2
Self-centred	15	9.0	3
Total	**167**	**100.0**	

4.2.2.4 Goal setting and motivation

In this aspects respondents were to describe their personal goals in life and role models that provide motivation to them. Goals were classified as either professional or social in nature and role models being distinguished adults models and celebrities. Majority of respondents indicated having professional goals and distinguished adult role models in their lives as motivators at 74% and 76% scores respectively. This leaves a good impression of well-motivated and goal directed school-going adolescents. Table 4.5 shows the proportions of these results.

Table 4.7: Goal setting (n=191) and motivation (n=164)

Goal Setting and Motivation		Frequency	Percent (%)	Rank
Goals	Professional	141	73.8	1
	Social	50	26.2	2
Total		**191**	**100.0**	
Role models	Adult	124	75.6	1
	Celebrity	40	24.4	2
Total		**164**	**100.0**	

4.2.2.5 Dealing with significant events

Figure 4.3 shows how the school adolescents deal with significant events. The respondents tend to participate in alcohol and drug abuse and succumb to peer pressure. However, only 15% of adolescent participants indicated that they never succumb to or resist peer pressure. Suicidal tendencies were also reported at 9%. An insignificant number of participants sought help and this is a cause for concern. Figure 4.3 summaries these findings.

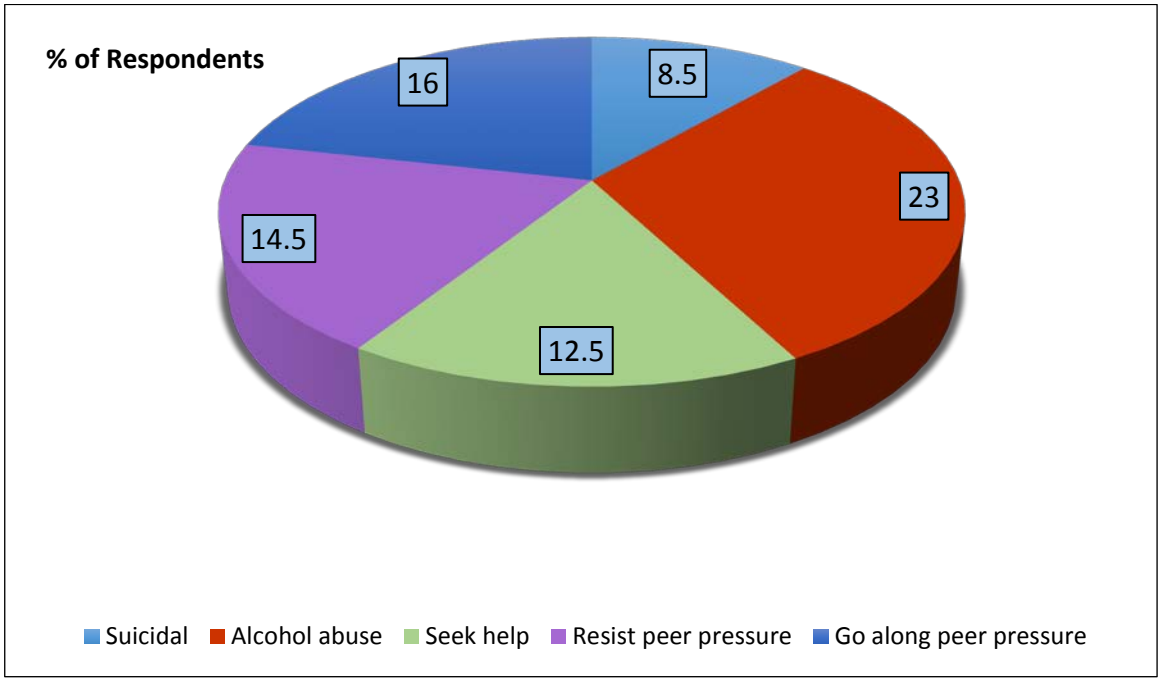

Figure 4.3: Dealing with significant events by participants (n=149)

4.2.2.6 Handling of emotions

Handling of emotions is inappropriately done by some of the studets. For instance, almost 48% (n=96) of the adolescents reported being withdrawn, or get depressed and hide their feelings and that may be the reason why adolescents then get involved in negative behaviours including alcohol and drug abuse or even commit suicide (Sawyer et al 2012:1640). Anger outbursts followed in frequency at 30% (n=60). Table 4.8 shows these proportions.

Table 4.8: Handling of emotions (n=200)

Emotion	Frequency	Percent (%)	Rank
Withdrawn from others/depressed	86	43.0	1
Anger outburst	60	30.0	2
Talk about their feelings	44	22.0	3
Hide feelings	10	5.0	4
Total	**200**	**100.0**	

4.2.2.7 Handling difficult situations

The aspects alcohol/drug/dagga (cannabis) abuse, extramural activities and fighting/blaming seem to be having almost equal proportions when it comes to handling difficult situations as shown in Table 4.9. Alcohol and/or substance abuse and fighting are seen as risk behaviours in handling difficult situations whereas involvement in extramural activities such as sports, athletics and music could be seen as a more positive way of dealing with these situations and thus provide a protective factor against involvement into risks (Ogden & Hagen Tobler). Risk and protective factors are, according to Weist and Murray (2011:3), the focal areas to be targeted by mental health promotion interventions.

Table 4.9: Handling difficult situations (n=200)

Aspect	Frequency	Percent (%)	Rank
Alcohol/drug/dagga abuse	50	25.0	1
Extramural activities (sport, athletics and music)	48	24.0	2
Fighting/blaming	40	20.0	3
Sexual activities	38	19.0	4
Withdrawn from friends or family	24	12.0	5
Total	**200**	**100.0**	

Withdrawal from friends and/or family and indulging in sexual activities were also identified as coping strategies with difficult situations.

4.2.2.8 Relationship management

Adolescent responses indicated how they related with teachers, parents and peers. Most of the respondents were respectful with a limited proportion reported being disrespectful. Figure 4.4 depicts these results.

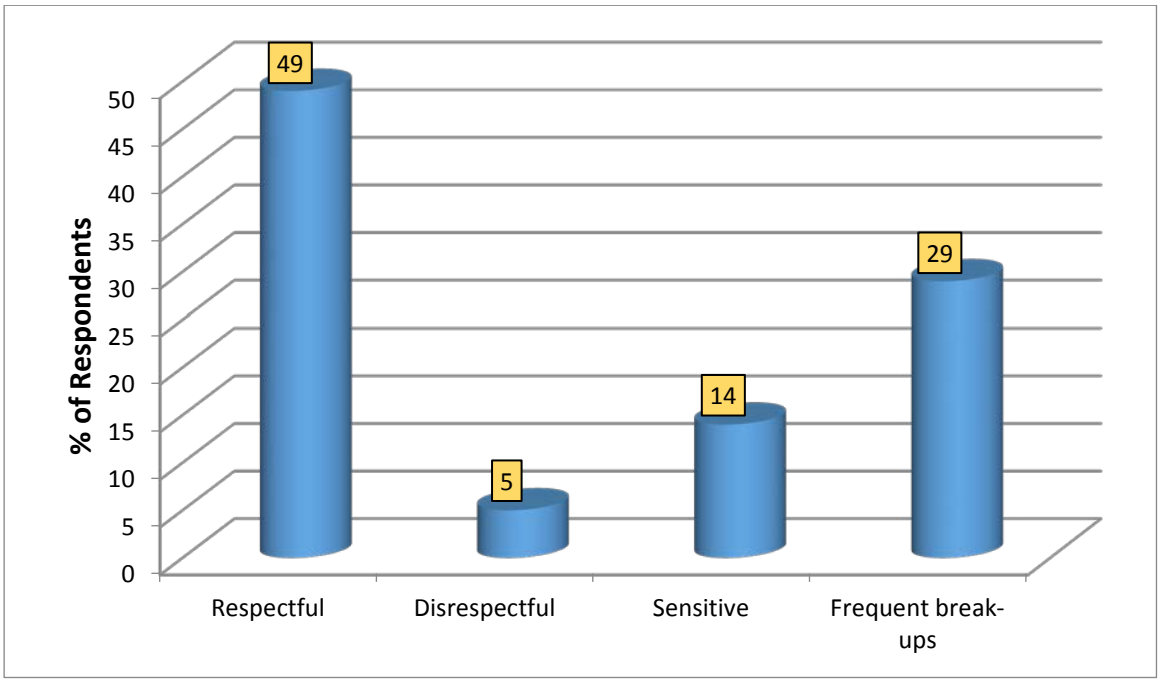

Figure 4.4: Relationship management by participants (n=194)

Although a larger proportion of responses (51%, n=98) demonstrated being respectful, there was a small number of respondents who reported being sensitive towards others. Whereas close to 30% (n=58) respondents indicated that they do not have lasting relations or they had frequent break ups.

4.2.2.9 Decision making and reflection on decisions

Only 181 out of the 200 respondents completed this section. Seventy seven (43%-n==77) indicated that they make their own decisions and 35% (n=63) of respondents consulted peers...

Aspects on reflections about decisions taken that were reported most frequently were acceptance and blaming/scapegoating with proportions of 46.2% (n=60) and 41.5% (n=54) respectively

4.2.3 Socio-demographic determinants of experiences of adolescents in dealing with social and emotional problems

The chi-square test of independence was used to determine whether there was any difference between socio-demographic and experiences of school-going adolescents in dealing with social and emotional problems. The socio-demographic variables used were gender, school setting, age and grade. The test was done at the 5% level of significance and a p-value of less than .05 would lead to the rejection of the null hypothesis.

The hypothesis to be tested was:

- H_o: Social and emotional problems are independent or have no association with gender, school setting, age and grade
- H_1: Social and emotional problems are not independent or there is an association between gender, school setting, age and grade and the social and emotional problems

The chi-square is valid if not more than 20% of the cells has expected count of less than 5 and that all expected values should be at least one. If a chi-square is not valid then

results are not conclusive and should not be interpreted or considered. Only valid test of the study results are presented.

The chi-square test of independence post-hoc analysis was done using standardised residuals. The residual, that is, the difference between the observed frequency and the expected frequency is a more reliable indicator when it is converted to the z-score and compared to a critical value. In this case since the 5% level of significance was used, the critical value used was ±1.96. Positive standardised residuals meant that the cell was over-represented in the actual sample compared to the expected frequency. Similarly the negative standardised residuals meant that the cell was under-represented in the actual sample as compared to the expected frequency.

4.2.3.1 Impact of gender on the experiences by adolescents of social and emotional problems

The chi-square tests of independence show that there was an association between gender and all the other aspects except life events exposed to (Appendix G). These were highly significant at p-value ranging from .000-.004 (less than .05).

- ***Gender and dealing with significant events***

In this aspect results indicate that males and females differed when dealing with significant events as shown in Figure 4.5.

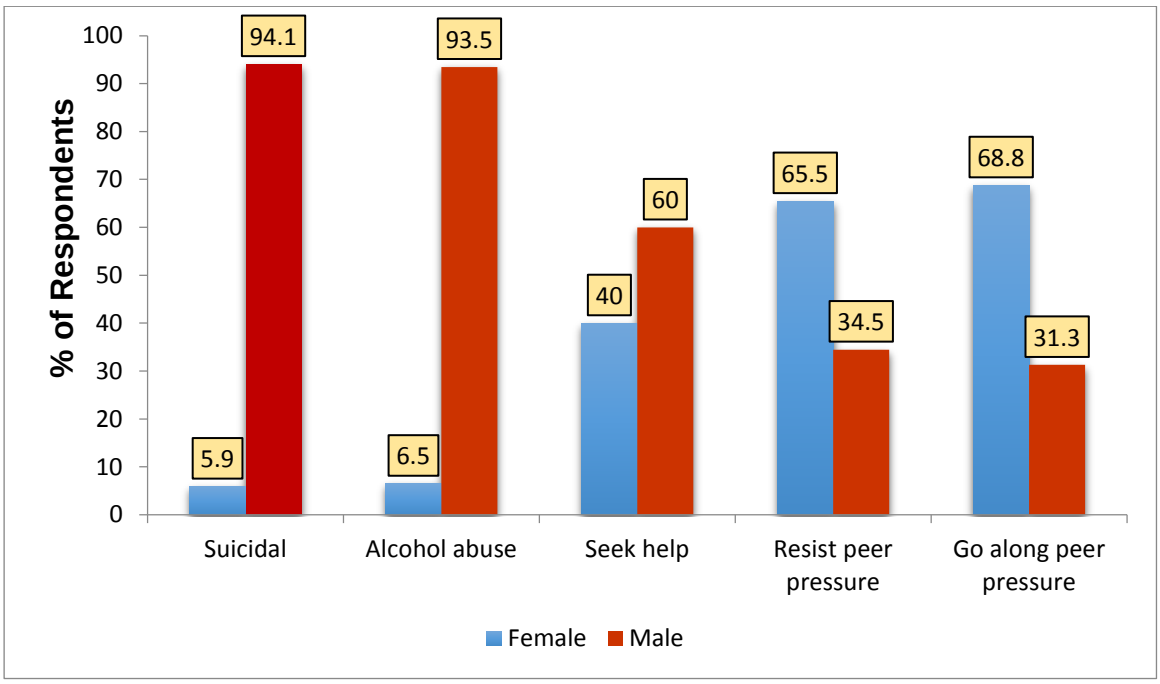

Figure 4.5: Dealing with significant events by gender (n=149)

Alcohol abuse and suicidal attempts/ideations were revealed as more common among males compared to females. Females were reflected with equal proportions of both resistant to peer pressure and going along with peer pressure.

- **Gender and handling of emotions**

A high level of significance has been indicated between handling of emotions and gender. Figure 4.6 shows the different proportions of these results.

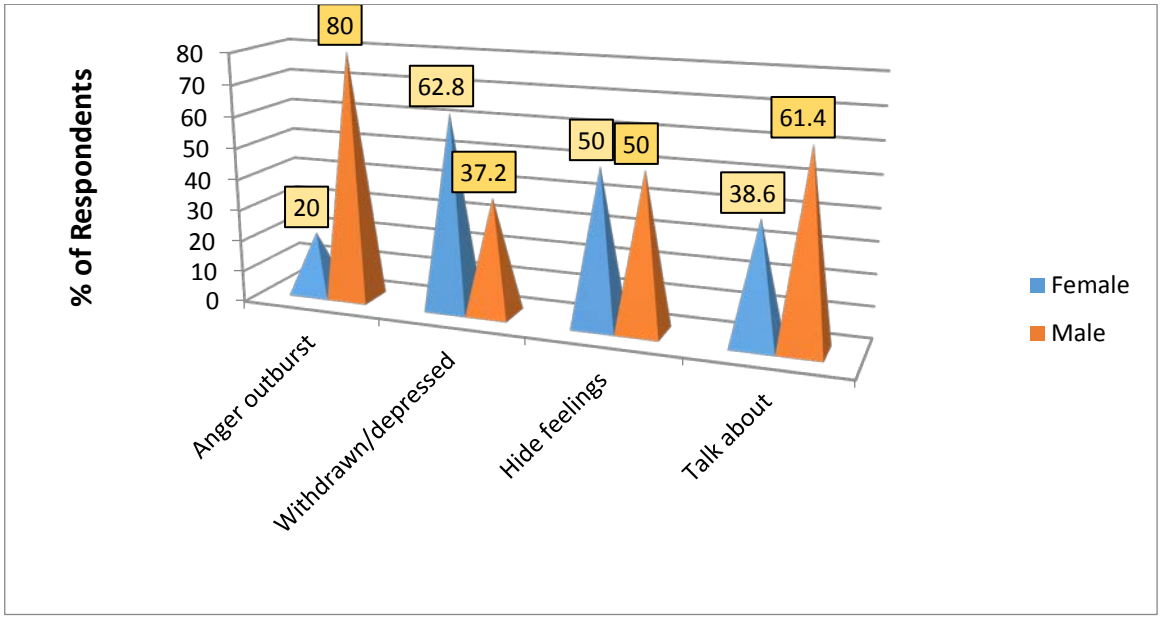

Figure 4.6: Handling of emotions by gender (n=200)

Anger outbursts and *talking about* situations that anger one, were reported more by males whilst *withdrawn/depressed* emotions were reported by females. *Hiding feelings* were experienced by both sexes equally.

4.2.3.2 The impact of school setting on experiences with social and emotional problems

A total of two hundred (200) responses from the two school settings, rural and urban were obtained.. The chi-square test of independence showed that there was no association between school setting and *life events exposed to, dealing with significant events, dealing with difficult situations, decision making* and *personal awareness.* All the p-values of the aspects were above .05. The aspects *handling of emotions, relationship management, reflections on decisions* and *events at school* had p-values less than .05 and it can be concluded that school settings had an impact on the aspects (Appendix G).

- **Setting and handling emotions**

Differences in responses on the aspect of handling emotions in the two school settings revealed significant differences. Figure 4.7 shows the results.

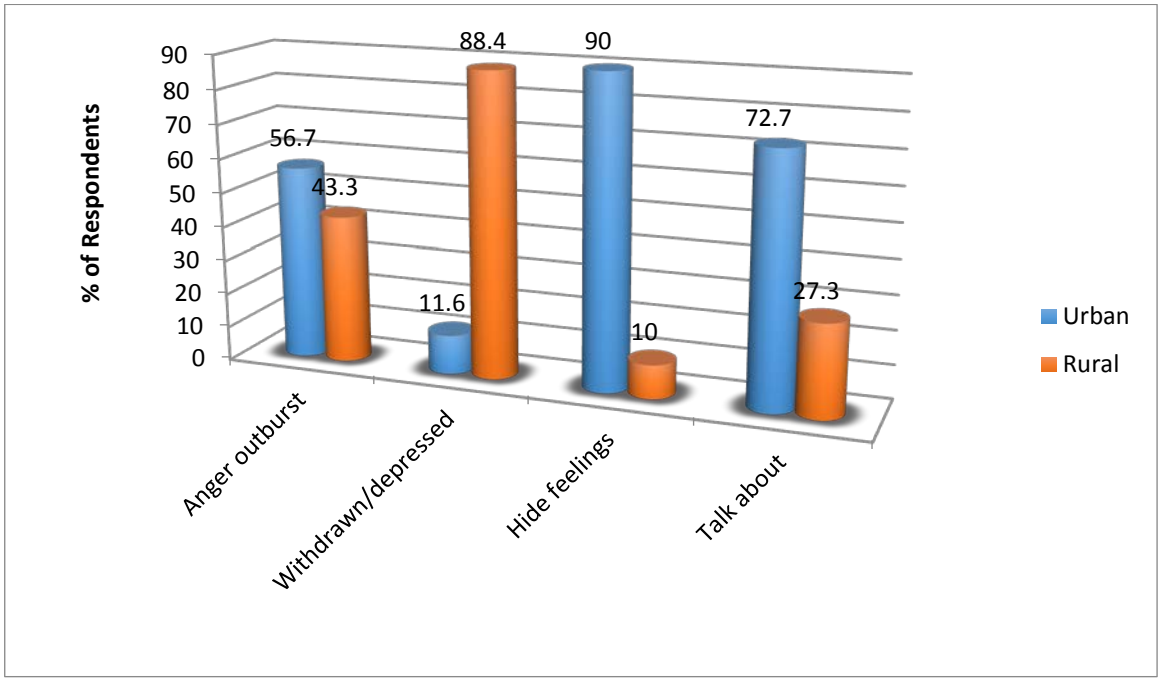

Figure 4.7: Handling of emotions in school setting (n=200)

The results reflect that *withdrawal/depressed* at almost 89% (n=178), is more prevalent amongst respondents from rural high schools. *Anger outbursts and talking about* situations that anger one have probably been reported in all high schools but reported more in the urban high school.

- **School setting and reflection on decisions**

Responses on reflections made on decision making have a moderately strong relationship with the type of setting as shown in Figure 4.8.

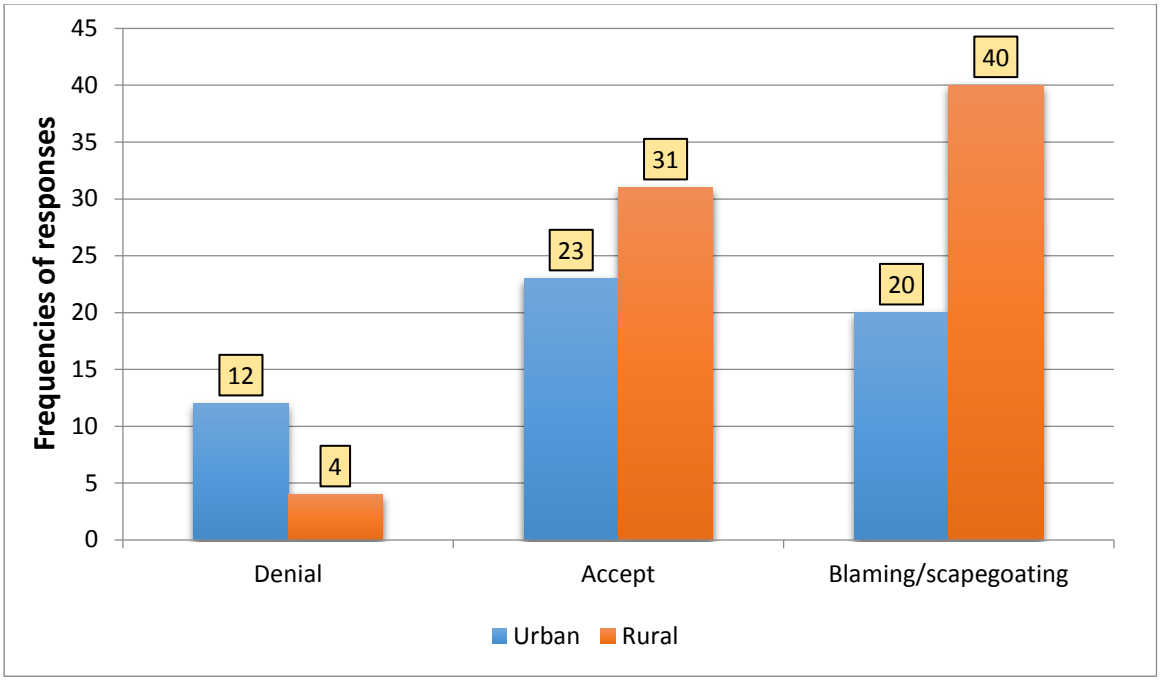

Figure 4.8: Reflection on decisions in school setting (n=130)

Looking at the bar chart it can be noted that rural adolescents seem to show *acceptance* of consequences of their decisions and at the same time *blaming and/or scapegoating* is also depicted in their reflections. For urban adolescents these have been in low proportions.

- **School setting and events at school**

Failing grades and truancy or being suspended has been reported mostly by rural high schools. On a similar note both school settings depicted good grades and award winning amongst their adolescents but mostly in urban high schools. Leadership roles

were more pronounced in urban high schools. Respondents reported that winning an award was a motivator for mental well-being. Figure 4.9 summarises of the results.

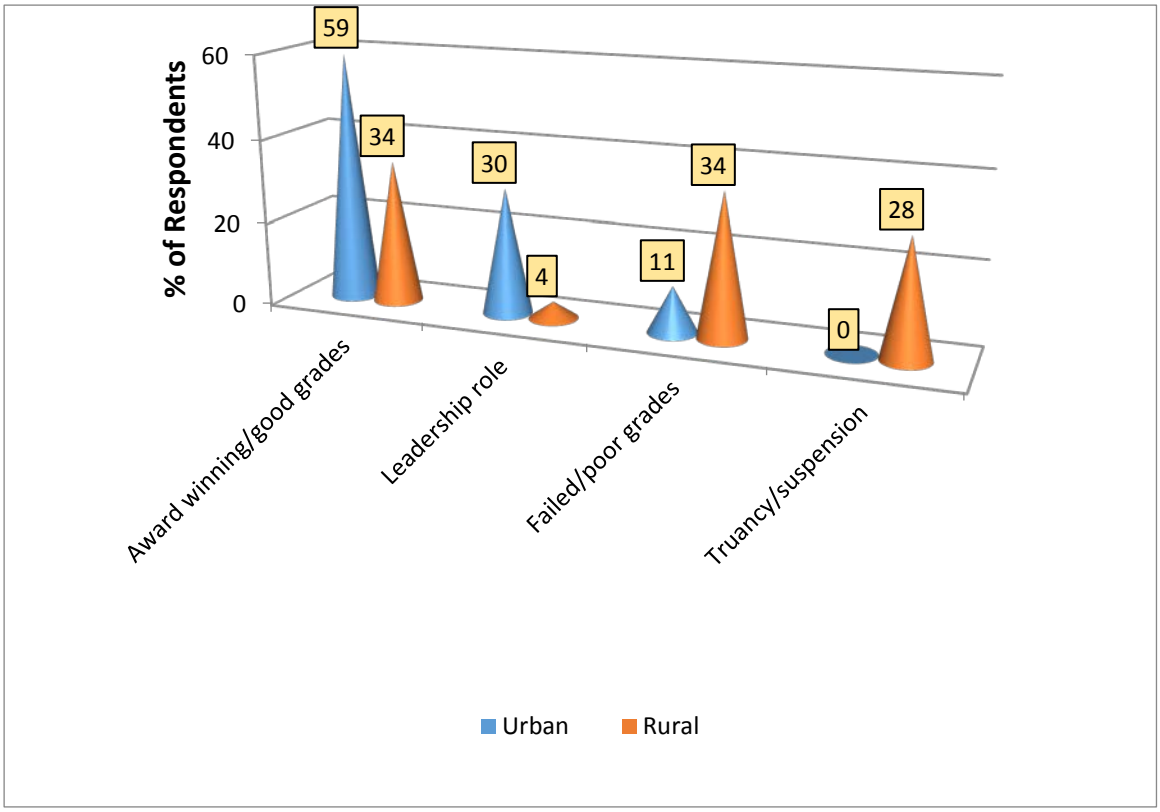

Figure 4.9: Events at school in different settings (n=120)

4.2.3.3 The impact of age on adolescents' experiences OF social and emotional problems

The age group was divided into three categories which were 15–16 years, 17–18 years and 19 years. The chi-square test of independence showed that all aspects were significant except for *"life events exposure to", "handling of emotions"* and *"relationship management"* with 33.3%, 25% and 25% of the cells with expected values less than 5 respectively. Thus the results were not used. The remaining tests that were significant and valid are shown in (Appendix G).

- **Age and dealing with significant events**

One hundred and forty nine (149) of the respondents answered an item on dealing with significant events. The chi-square test of independence showed that there were

differences in responses due to age. The Cramer's gave a value of .406 signifying that the two variables might be measuring the same concept. The clustered bar chart is shown in Figure 4.10.

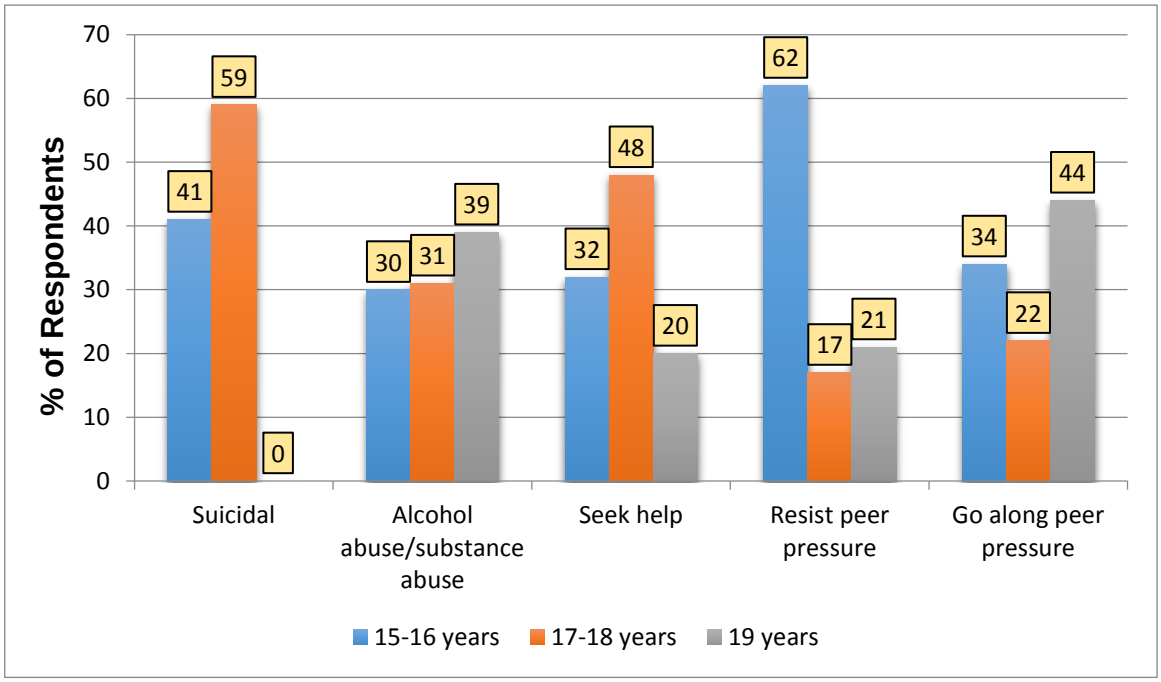

Figure 4.10: Age and dealing with significant events (n=149)

The bar chart suggests that ways of dealing with significant events seem to be age-specific. Those aged 15–16 years were the most likely to resist peer pressure. This could imply that this age group is still in early adolescence and still respecting parental authority as compared to peer pressure. Those aged 17–18 years showed the greatest tendency to be suicidal and on the other end willing to seek help. Alcohol abuse was evident in the most senior age group (aged 19 years), which tends to go along with peer pressure. Peer influence has, in most instances, led to alcohol and drug abuse.

- **Age and dealing with difficult situations**

Various ways of *handling difficult* situations showed a very strong relationship with age as depicted in the clustered bar chart shown in Figure 4.11.

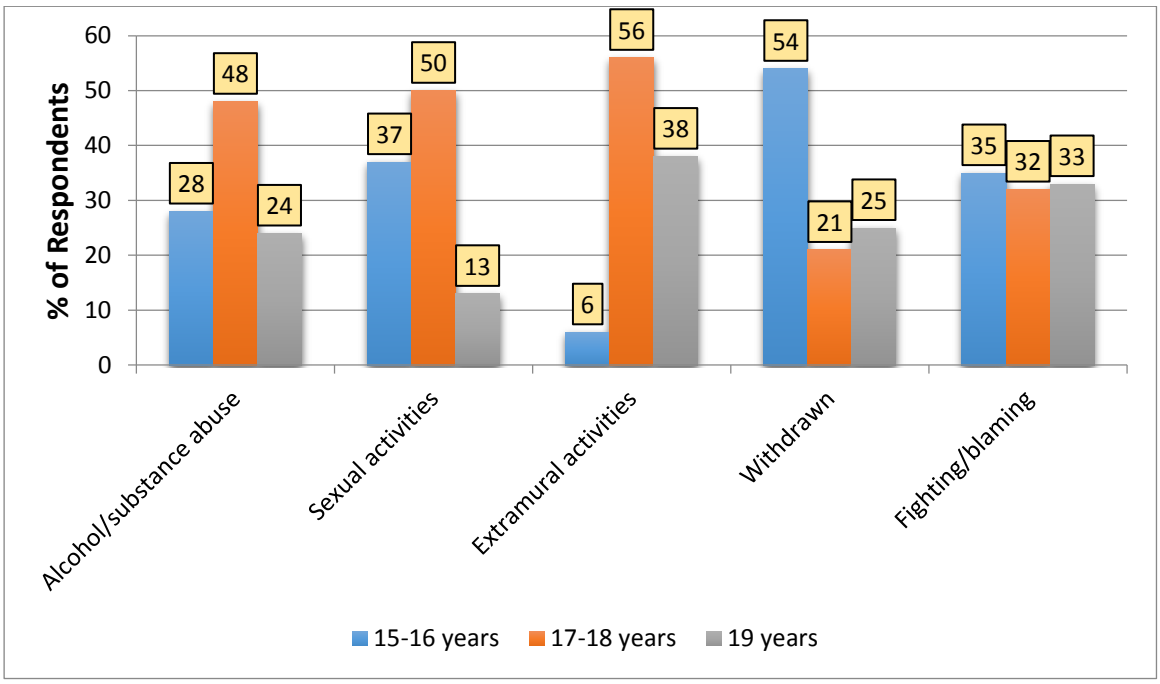

Figure 4.11: Age and handling difficult situations (n=200)

The clustered bar chart showed that the category "*fighting/blaming*" was equally distributed among the three age groups. The age group 17−18 years had high proportions than the others in involvement in alcohol and drug abuse, indulging in unsafe sexual activities and engaging in extramural activities such as sports, athletics and music.

- **Age and decision-making**

In terms of the aspect *"decision making"* the Cramer's V was .246 indicating that there is a moderate relationship between the variables. The clustered bar chart is shown in Figure 4.12.

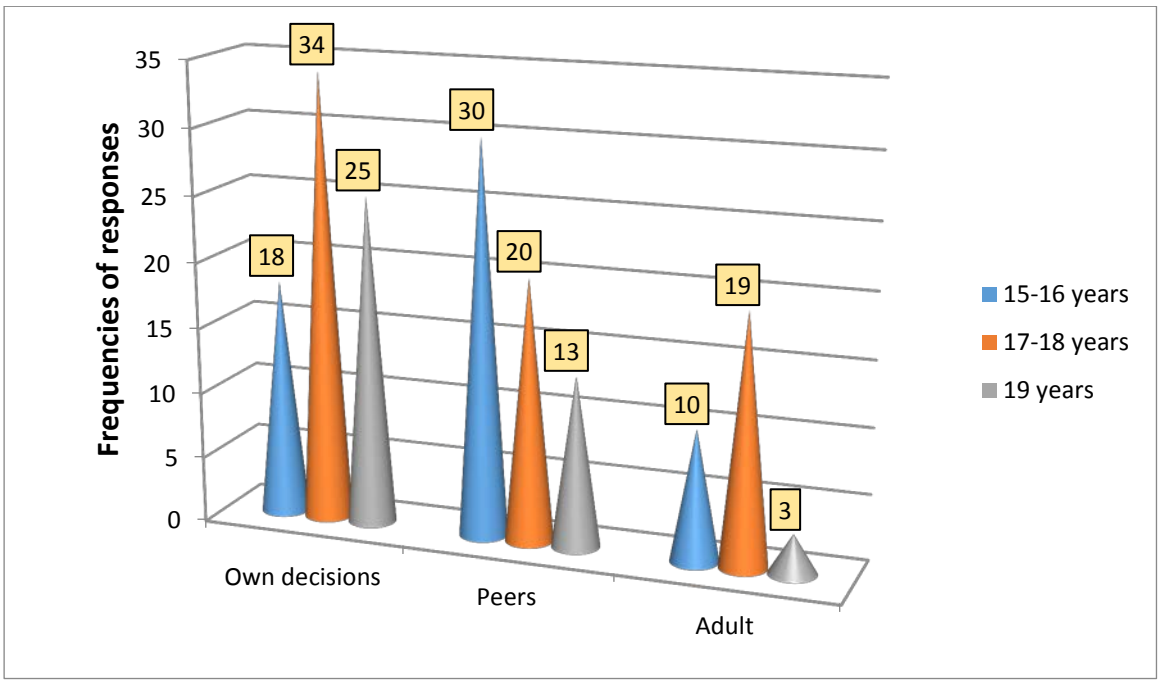

Figure 4.12: Age and decision making by age (n=181)

It can be observed that those who are 15–16 years old tend to turn to their peers for decision making whilst those 17–18 years tend to make their own decisions.

4.2.3.4 The impact of grade on adolescents' experiences of social and emotional problems

The chi-square test of independence was administered to determine whether there was any association between grade and experiences of the school-going adolescents in dealing with social and emotional problems. The aspects "reflections on decision" and "personal awareness" had p-values of .258 and .367 respectively. Thus the null hypothesis of no association was not rejected. The aspects "dealing with significant events", "dealing with difficult situation", "decision making" were significant and the chi-square valid (Appendix G). The significant chi-square results are discussed in the following sections.

- **Grade and dealing with significant events**

In terms of the aspect *"dealing with significant events"* the Cramer's V was .366 indicating that there was a strong relationship. The clustered bar chart is shown in Figure 4.13.

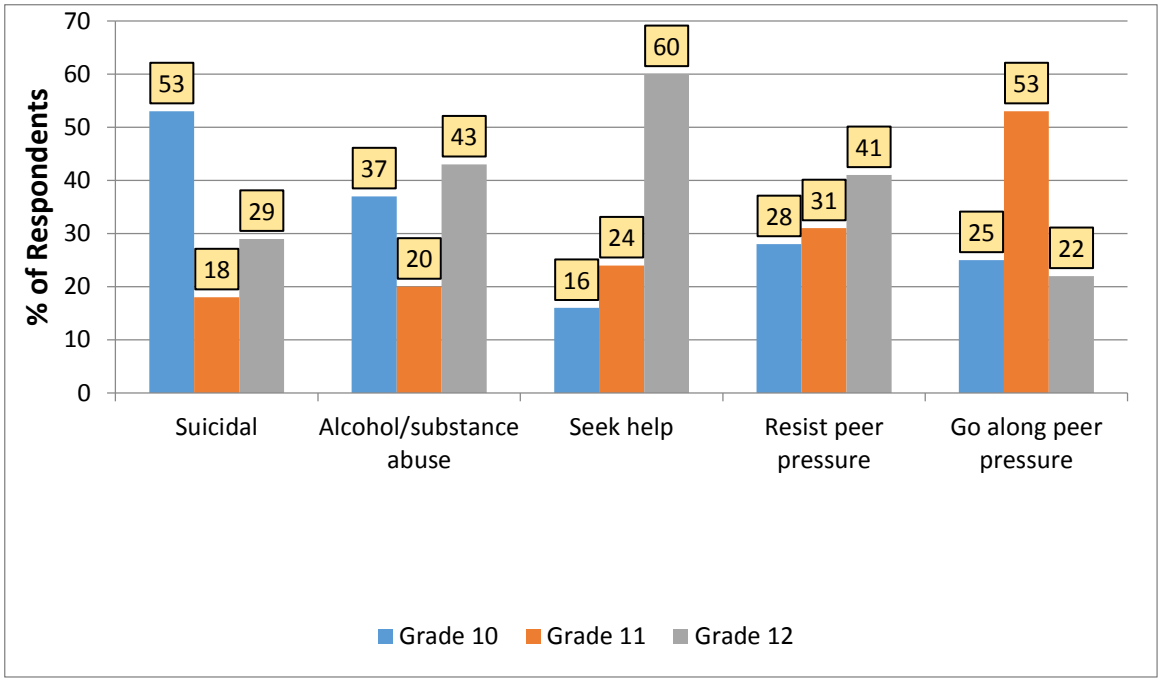

Figure 4.13: Dealing with significant events by grade (n=149)

Looking at the bar chart it can be observed that students in Grade 12 tend to abuse alcohol, seek help and resist peer pressure. On the other hand the Grade10 students tend to be suicidal and also to abuse alcohol while those in Grade 11 go along with peer pressure.

- **Grade and handling difficult situation/**

The aspect of *"handling difficult situation"* showed that the adolescents handled better difficult situations as they grow older as seen in the ability to do so in higher grades. Figure 4.14 summarises how school going adolescents handles difficult situations.

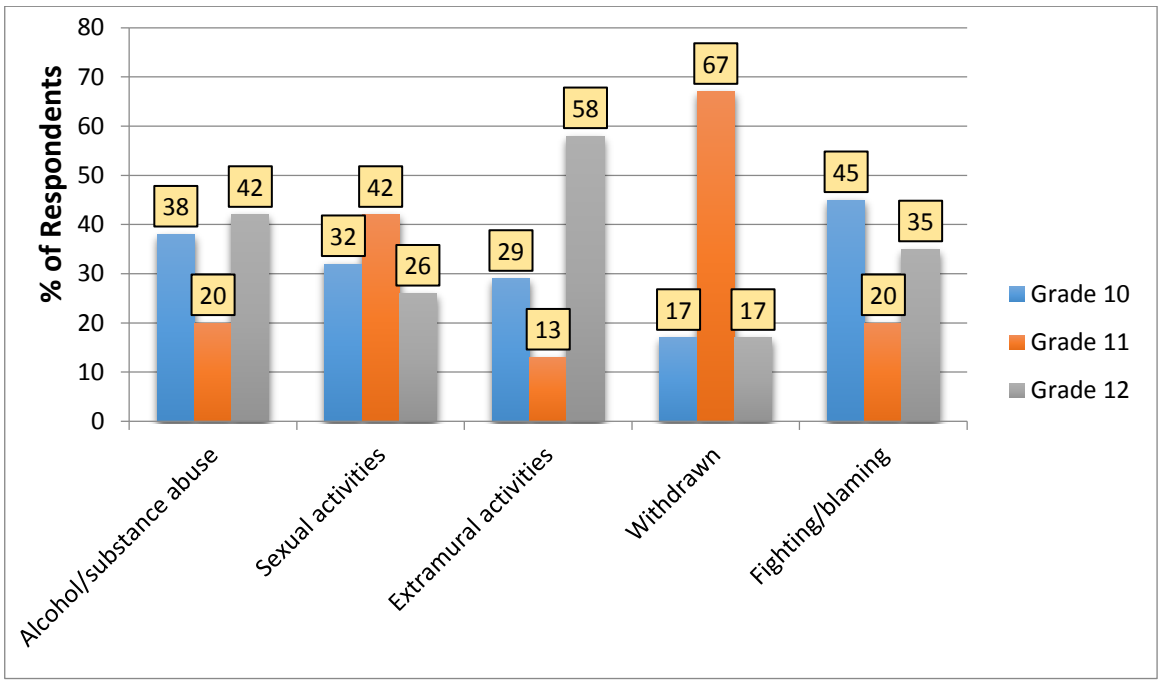

Figure 4.14: Grade and handling of difficult situations (n=200)

The bar chart shows that there are certain events that are normally experienced by a specific grade. Grade 12 students tend to relieve stress by engaging in "extramural activities" whilst Grade 11 students indulge in sexual activities and tend to be withdrawn. Grade 10 students are more into fighting/blaming.

- **Grade and decision-making**

In terms of the aspect *"decision making"*, the chi-square value was 12.584 with a p-value of .013. Thus there was an association of decision making by grade. The Cramer's V was .264 indicating a moderately strong relationship. The clustered bar chart is shown in Figure 4.15.

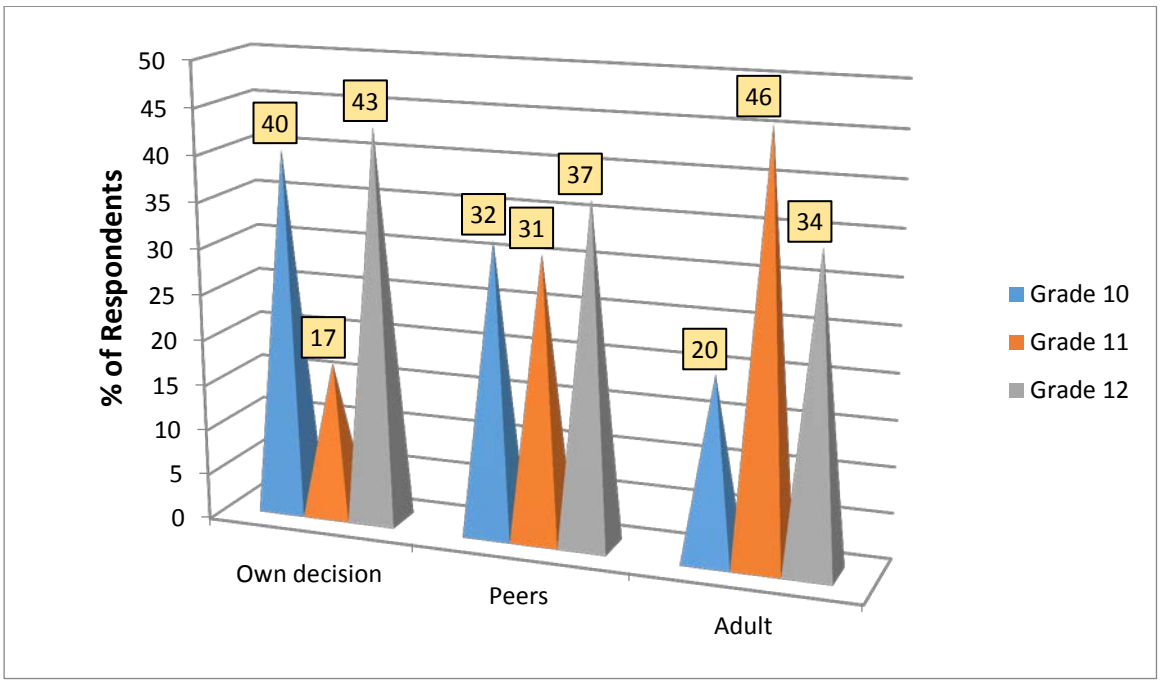

Figure 4.15: Decision-making by grade (n=181)

Grades 10 and 12 tend to make their own decisions whilst seeking decision advice from peers was similar across the grades.

- **Grade and events at school**

In terms of the aspect *"events at school"* the Cramer's V was .4826. These values indicate that the grade and events at school might be probably measuring the same concept. The clustered bar chart is shown in Figure 4.16.

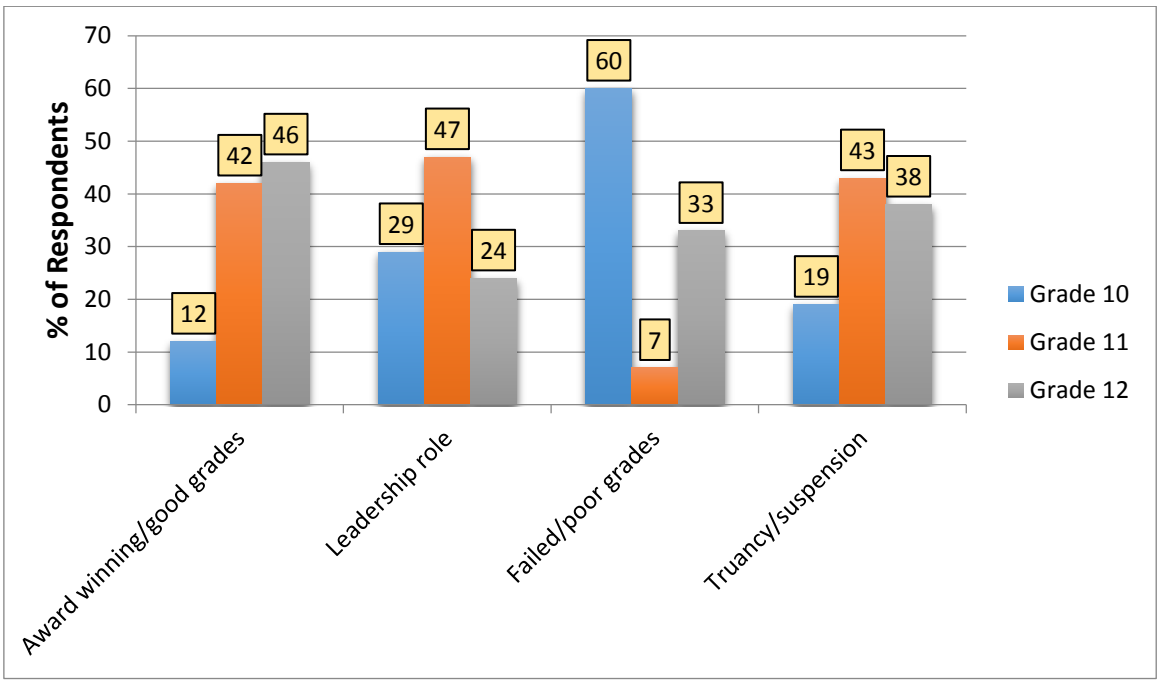

Figure 4.16: Grade and events at school by grade (n=120)

The results show that events taking place at school were differently experienced by certain grades. Respondents in senior grades (11 and 12) reported winning awards in schools more than those in lower grades, whereas failing/poor grades was mostly experienced by grades 10. A small proportion of respondents especially in Grade 11 and 12 also reported marked involvement in truancy/suspension.

4.2.3.5 Impact of gender by school setting on adolescents' experiences of social and emotional problems

The chi-square test of independence was done to determine whether there was an association between gender by school setting on experiences of school going adolescents in dealing with social and emotional problems. Most of the aspects were significant. The aspects that were valid and with p-values less than .05 were "dealing with significant events", "dealing with difficult situation" and "decision making" (Appendix G). The significant results are shown in Figure 4.17.

- **Dealing with significant events by gender and school setting**

Rural and urban schools were compared by gender on dealing with significant events as shown in Figure 4.17.

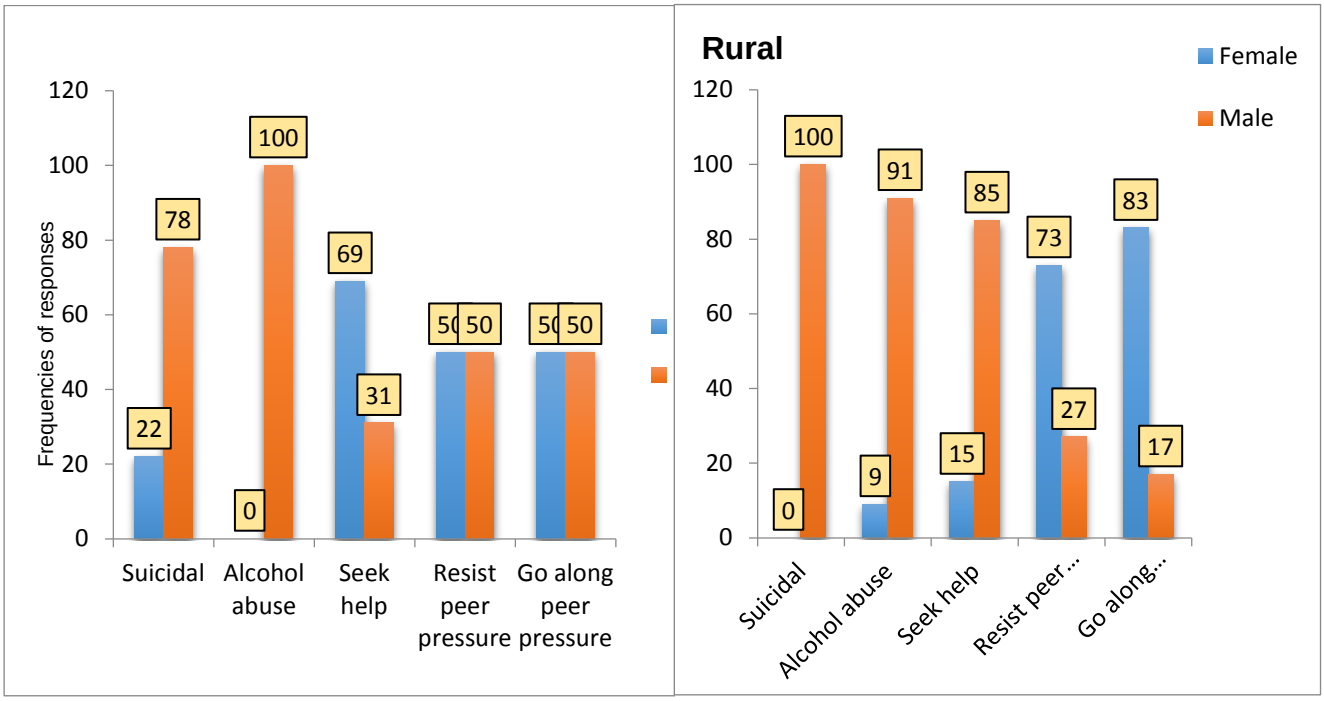

Figure 4.17: Dealing with significant events by gender and school setting (n=155)

The above comparative bar graphs indicate high proportions of males in both settings as inclined to abuse alcohol or substances and have suicidal tendencies (100%, n=155). Males in rural setting tend to mostly seek help compared to their urban counter parts.

- **Handling difficult situations by gender and school setting**

Males and females from the two setting showed some differences in other aspects of handling difficult situations. Figure 4:18 summarises the results.

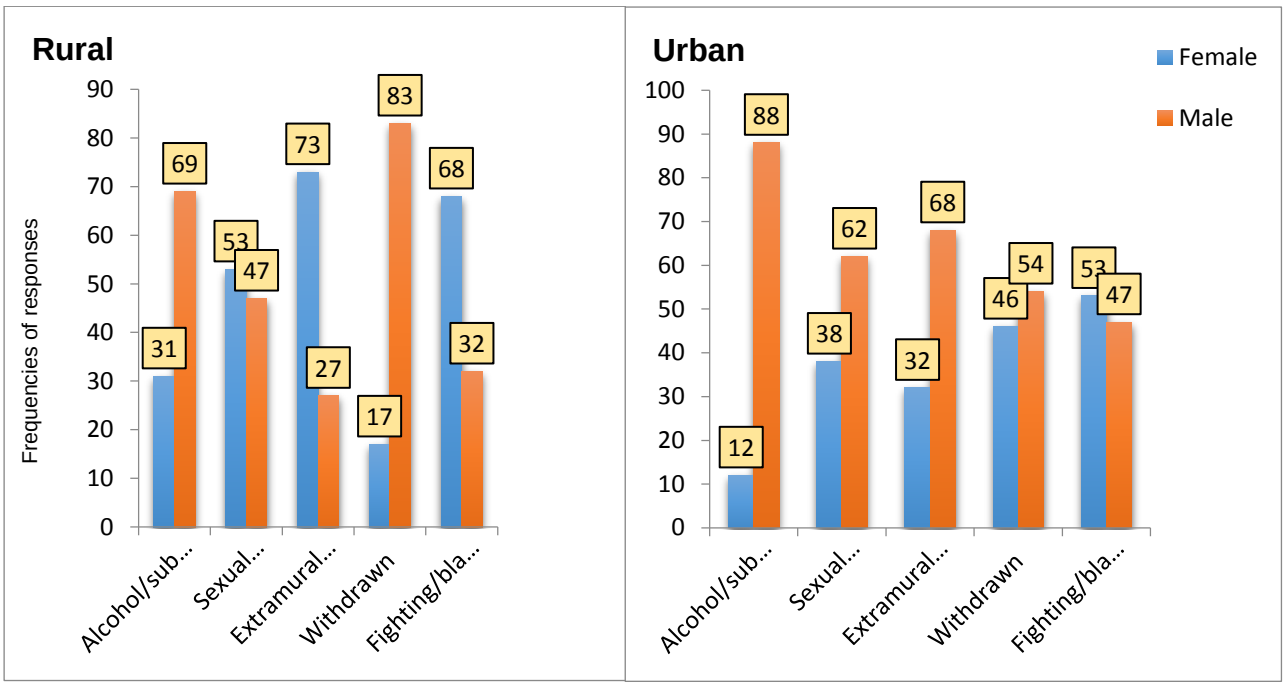

Figure 4.18: Handling difficult situations by gender and school setting (n=200)

Alcohol/substance abuse when dealing with significant events is more frequently reported by males than females of both settings. Rural males indicated high proportions of being withdrawn/depressed than their counterparts in urban settings. Rural females too showed higher proportions responses in the involvement in extramural activities (73%) than urban females; a positive sign in dealing with stressful events. Compared to their counterparts in the urban setting, more females in rural setting indulged in sexual activities and fights (53% and 68% respectively).

- **Decision making by gender and school setting**

The results from the two settings comparing by gender regard to adolescent decision making indicate the biggest differences in own decision making and those influenced by peers and adults as seen in Figure 4.19.

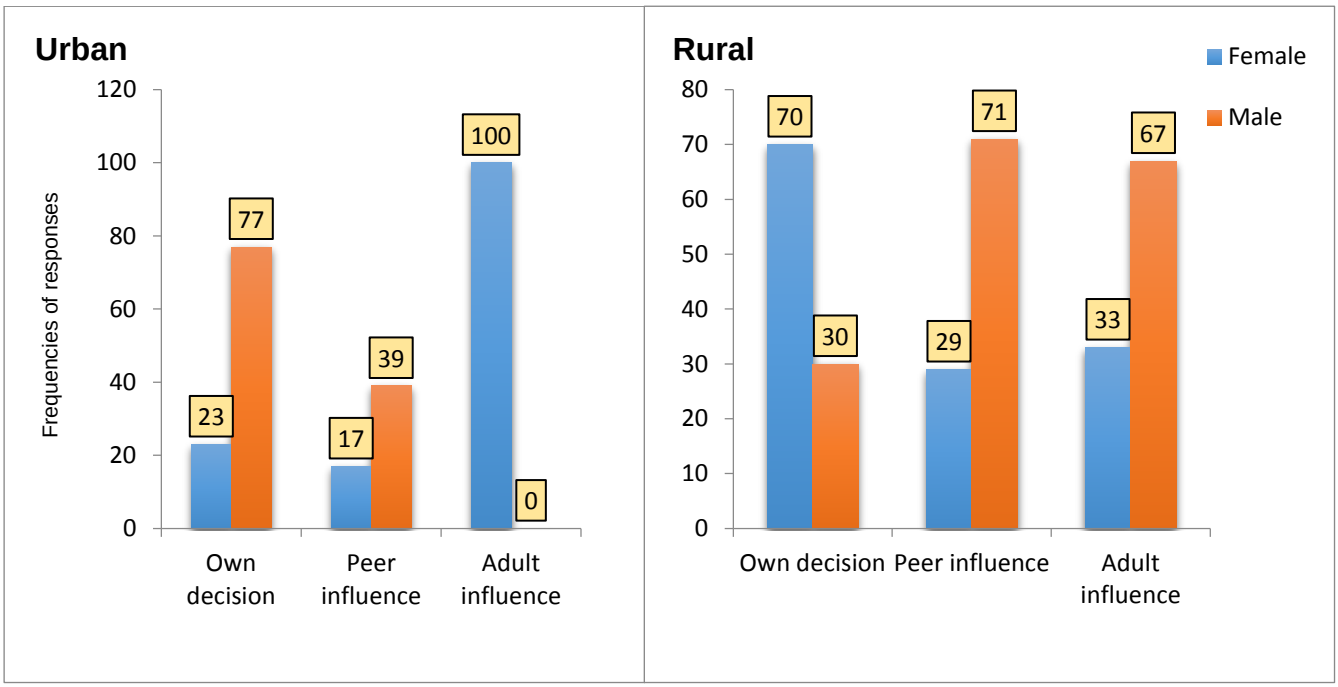

Figure 4.19: Decision making by gender and school setting (n=177)

Females in both setting differed in the influences of their decisions, with more urban adolescents being influenced by adults compared to rural adolescents who report a greater reliance on their own decisions. Rural males show more influence by peers in decision making. These results are in contrast to Table 4.17 which indicates that more rural females go along with peer pressure than rural males.

4.3 QUALITATIVE RESULTS

Individual interviews were conducted with a representative sample of adolescents. The individual interviews followed the same style as the survey and used the EHC grid. The researcher used probes and unlike the survey, the participants were able to talk at length about issues that they encounter at school and even made suggestions on how problematic issues can be improved. A total of sixteen (16) adolescents volunteered to be interviewed. Though data saturation was met on the 10th participant, interviews were continued up until the 16th participant.

4.3.1 Themes, subthemes and categories

The following findings emerged as shown in Table 4.10.

Table 4.10: Themes, subthemes and categories from individual interviews with adolescents

Theme	Subtheme	Categories
1 Handling emotions	1.1 Anger - Being bullied - Relationship problems - Parental rejection - Failing a grade	1.1.1 Handled by: - Fighting - Drinking alcohol - Smoking dagga (Cannabis) - Engaging in sexual intercourse
	1.2 Sadness - Loss of loved one - Disappointment from relationships - Failing a grade	1.2.1 Reacted By - Suicidal attempts - Suicidal ideations - Sleep a lot and eat less - Withdrawn
	1.3 Happiness - Obtaining an award - Reward from parent/guardian - Obtaining good grades	1.3.1 Demonstrated by - Laugh and shared joy with friends - Indulging in sex - Drinking alcohol
2 Handling difficult situations	2.1 Identified difficult situations - Bereavement - Abuse - Family disorganisation: Parental separation/divorce; parent working away from home; changing living environment (from rural to urban and vice versa); alcoholic parent - Social deviance (arrest, gangsterism	2.1.1 Handle through: - Drinking alcohol - Smoking (Cannabis) - Fighting - Suicidal attempts - Talking about their problems
3 Dealing with stressful situation	3.1 Perceived stressful situations - Pregnancy - Failing a grade - Illness in the family - Absence of one or both parents - Death of a parent or close relative	3.1.1 Dealt with by: - Drinking alcohol and drug abuse - Eating less/sleeping a lot/ cry about - Isolate oneself - Suicidal ideation - Talking about their problems - Playing music or sports
4 Relationship management	4.1 Relationship with - Teachers - Parents	4.1.1 Managed by being - Respectful - Disrespectful to

Theme	Subtheme	Categories
	- Peers	teachers parents/peers - Frequent break-ups with friends - Fights
5 Motivation and goal setting	5.1 Role models - Adults	5.1.1 Motivated by: - Family member either parent/sibling/close relative - Teacher - Important political figure
	- Celebrity	- Idolised famous persons(Actors, singers/sports figures)r - Wealthy business person
	- Goals	- Professional (doctors, nurses, teachers/ engineers) - Social (art, business)
6 Decision-making/ choices	6.1 Decision-making - Influences	6.1.1 Influenced by - Adults - Peers - Self - Internet

4.3.1.1 Handling emotions

Participants were asked to identify different emotions that they had experienced in their lifetimes and situations that had triggered them and how they managed those emotions. Identification and recognition of one's own emotions and their influence on behavior is in accordance to CASEL's SEL framework one of the reflections of the competencies in "self-awareness".

From the recordings in the EHC, participants had just listed these emotions as anger/short tempered, sad/cry, happiness/laughing. With further probing and clarity seeking questions on these emotions, the participants explained each emotion as experienced. More elaboration on this section of the results will include discussion of each emotion and its management by participants.

- **Anger**

Participants highlighted some of the circumstances that brought about anger which included verbal bullying by peers and parents (e.g., teased or embarrassed in front of others, unfairly punished); loss of a loved one and physical and emotional abuse (due to family fights and deprived of personal and school needs) by parent, or guardian. The following excerpts from the interviews indicate this:

> "… because of my Zulu accent, some girls use to tease and call me with negative names and I bit them."
>
> "When I failed my June exams, I was stressed and lost my temper often."
>
> "When my mother shouted at me, I will conceal my anger and just locked myself in the room."
>
> "When my uncle died in an accident, I was not happy but angry because we were close to each other."

From the above excerpts the participants also indicated their ways of handling situations that anger them.

- **Sadness**

Sadness was mostly due to bereavement, failing grades and/or disappointments from relationships.

> "My mother's drinking habits … (started crying) depress me as I feel sometimes this is unfair to my sick father."
>
> "Death of my uncle and my cousin in the same year depressed me a lot and led to me failing a grade."
>
> "Lost a sibling, and having my elder brother arrested affected me badly."

- **Happiness**

Happiness was brought about by good grades, award winning and rewards from parents.

> "I was so excited when I was awarded best maths student in the whole school."
>
> "Was very happy after my mother won a Lamborghini car in a competition."
>
> "A year after my elder sister died, my little sister was born, I was so happy."

Handling of emotions

A variety of behaviors used to handle these emotions was identified and described by adolescents. Both risky and positive behaviors were indicated amongst the ways of handling emotions. Risky behaviors included fighting, drinking alcohol, sexual activities, and suicidal ideations whilst positive behaviors were talking about the situation that angered/frustrated, avoiding the situation or involvement in extramural activities.

The handling of emotions is evident in the following excerpts:

> "Whenever I get angry I fight the person who angers me."
>
> "When excited I like having casual unsafe sex."
>
> "Sleeping when angry helps and relieves me."
>
> "Talking to my teacher when frustrated changed my mind about always thinking of taking my life."

4.3.1.2 Handling difficult situations

Situations identified included loss of a loved one/bereavement, one parent being not available or working away from home, being bullied, family disorganisation, abusive parent or guardian, being involved in gang fighting or being an accomplice in a murder

case. Drinking, smoking, fighting and suicidal ideas were identified as ways to handle these situations as described in the following extract:

One respondent stated:

> "When my mother married another man besides my father, I was angry at her and started drinking and smoking weed."

Whilst one respondent, verbalized that:

> "When I lost my grandfather who was my source of support and role model, I felt lonely and thought about taking my life too".

> "When I was involved into gang fights, I use to drink and smoke dagga a lot and then not go to school for about 2 weeks."

To deal with being bullied, one respondent stated:

> "I fight back peer pressure."

4.3.1.3 Dealing with stressful situation

Stressful situations identified by the adolescents included death of a parent or close relative, peer pressure, failing a grade, being pregnant, illness in the family, and absence of one of the parents. School adolescents' responses denoted both positive and negative ways of dealing with stress. Negative ways included drinking a lot, altered appetite, sleeping a lot or crying, withdrawal, and suicidal ideation. One respondent stated:

> "When my father died, I lost everything, could not deal with it; stayed alone and had anger. Would not look at my mother."

> "After my grandfather's death, there were fights in the family over his wealth (hesitantly holding tears). I did not want anyone connected to me, started drinking alcohol excessively and not going to school."

> "When my uncle and cousin whom I was very close to died, I wanted to be alone and even thought of committing suicide. And again when I failed my grade I thought of committing suicide."

Positive ways of dealing with stress included playing music or sports and talking about the situation to someone. The following extracts of responses depict these:

One respondent stated:

> "When parents were fighting and ended up separated I consulted my friend who advised me to see/talk to someone and get counselled."

Whilst the other respondent reported:

> "When stressed I listen to music on my phone or go jogging."

4.3.1.4 Relationship Management

Most participants cited positive relationships with parents, teachers and friends. A few reported managing disagreements with parents and teachers by being disrespectful and breaking relationships with peers and involvement in fights. The following statements from the participants attest to that:

> "When staying with my mother we fight and I can't cope with staying with her".

Whilst other one states:

> "My closest relative was abusive to me not giving me food and things I needed for school."

One participant on reasons to be disrespectful claims that:

> "Teachers make our life difficult and are overly strict."

> "My sister's husband… too loud and stresses me."

"My mother and I don't see eye to eye, we are not living together because we fight with each other. I break up with my friends because they sometimes advise me to do wrong things like missing school or drinking alcohol"

4.3.1.5 Motivation and goal setting

Participants were mostly motivated by adults in their lives that they perceived as role models. Such adults included parents, siblings', teachers and some political leaders. Some participants were motivated by celebrities such as singers and actresses especially those coming from humble beginnings. This was best espoused by participants who said:

"One day I will be a renowned singer just like Zahara."

"My mother is my role model, she is a hard worker, rearing us all by herself."

4.3.1.6 Decision-making/choices

Decision making among adolescents was in part influenced by adults and family members, especially parents and siblings. However, some participants noted that friends and the internet had an influence on them particularly concerning what to wear and which games to play.

One participant verbalised:

"I prefer to go along with my friends' advices especially on sexual matters.

4.3.2 Qualitative results from school teachers

Individual interviews were conducted with seven school teachers who were teaching Life Orientation (LO) as a subject. Three were in rural high schools and four in urban high schools. Responses to the following questions with intermittent probing, and clarity seeking questions were sought:

- Tell me your experiences with social and emotional problems of school-going adolescents.

The following were follow-up questions:

- What mechanisms are in place to deal with these problems in your schools?
- What do you think can be done best to deal with these problems?

The narratives yielded the following findings which are presented in themes and subthemes in Table 4.1.

Table 4.11: Social and emotional problems as perceived by school teachers

Theme		**Sub-theme**	
1	Teenage pregnancy	1.1	Risky sexual behaviors
		1.2	Lack of parental monitoring
2	Substance abuse	2.1	Bullying
		2.2	Stealing
		2.3	Vandalism
3	Disruptive behaviours	3.1	School drop-out
		3.2	Identity crisis
		3.3	Gangsterism
4	Poor interpersonal relationships with either parents, boy/girlfriends and/or teachers	4.1	Poor academic performance
		4.2	Absenteeism
		4.3	Inattentiveness
5	Suggested mechanisms in dealing with SE problems	5.1	Interdisciplinary involvement
		5.2	Reinforcement of peer education programme

4.3.2.1 Teenage pregnancy

Pregnancy in girls has been identified by many school teachers as most prevalent problem in their schools and adolescents display various behavioral symptoms during pregnancy. One teacher highlighted:

> "When pregnant you will observe them to be cheeky with spells of irritability."

One commented:

> "Despite the availability of family planning, they are not adhering and do not fear HIV/AIDS infections."

> "Parents have reported that their children misbehave "sleeping out" without parental permission."

> "Boys miss many classes if the girls' parents have reported that they had impregnated a girl in school."

> "An interesting episode occurred when one boy came to class and shouted to a classmate (girl) that he is not the one who impregnated her."

> "Pregnant girls are always moody, sleepy or absent minded."

4.3.2.2 Substance abuse

Many teachers reported some social and emotional problems that emanated from the use of alcohol and substance abuse by school-going adolescents. This is highlighted in the following responses:

> "After short/lunch breaks during school periods, you will observe that they are not behaving as in the morning."

> "Most bullies have been found to be indulging in substance use. These are stealing from others in order to get the money for the fix."

> "Many a times, boys have been caught smoking dagga in the toilets."

> "Obscene language and nasty, violence-depicting cartoon drawings on the walls and doors in the toilets, when they are high."

4.3.2.3 Disruptive behaviours

These are behaviors mostly evident from those adolescents who use alcohol or drugs. These, amongst others, include deviant behavior like involvement in theft and/or gangsterism. Poverty and psychological problems of identity crisis are also associated with behaviours such as alcohol and drug use or theft/gangsterisms. The outcome is increased rate of drop outs due to poor academic performance. One teacher reported that some adolescents displaying anger and irritability in class have been found to have psychological problems that include family disorganisation and financial instability.

4.3.2.4 Poor interpersonal relationships with either parents, boy/girlfriends and/or teachers

Most school teachers reported relationship problems of school-going adolescents with parents, teachers and peers (boy and girlfriends). The noticeable behaviors were moodiness, inattentiveness and poor performance in classwork

4.3.2.5 Suggested mechanism

To respond to the two follow-up sub-questions of the interview guide:

- What mechanisms are in place to deal with these problems in your schools?
- What do you think can be done best to deal with these problems?

Most teachers indicated that there are no mechanisms in place to deal with these social and emotional problems. Teachers reported that even if they have identified a student who is emotionally challenged, if he/she does not open up it becomes difficult for them to interact with. Interactions are possible only with those who opened up. Reactive strategies are sometimes used to deal with a particular incident as it occurs. This is confirmed by the following statements from the participants:

> "We only deal with that particular incident … like for instance when one Grade 12 pupil was found drunk and violent, we called the police."

> "When one child reported fearing for his life from the gang he belonged to, we called the parents who solved it, (we are told) through buying her child out of the gang."

> "We sometimes find dagga and nasty, offensive writings in the walls of the toilets, but we can't do anything as we did not catch anyone."

> "Peer education programme undertaken by the provincial department is not regularly done, but it does help."

> "I may have studied psychology, but at times we are not skilled to deal with some of these social, emotional and behavioural problems. We just have to refer them."

The school teachers suggested that peer education programmes in schools should be strengthened. The participants further suggested that all schools should have a teacher responsible for ensuring peer education programs and the same teacher must work with peer leaders in each class. Interdisciplinary collaboration in schools for the promotion of mental health was also deemed essential. One teacher commented:

> "I think it could greatly help, that we periodically be in-serviced on these social and emotional problems… what to look-out for, as sometimes we may mistakenly label the adolescent as ill-disciplined or moody whereas it may be signs of an emotional problem…school nurses can be of assistance."

4.3.3 Qualitative results from school health nurses

Two focus group discussions were conducted with a group of school health nurses with 8 participants. The following questions with intermittent probing, clarity seeking questions were used:

- What are your experiences with social, emotional and behavioural problems of school-going adolescents in high schools?
- How did you deal with these problems?
- What mechanisms are in place to deal with or prevent these social, emotional and behavioural problems?

- What would you like be done to promote mental health in high school adolescents

The following themes emerged.

Table 4.12: Social and emotional problems as perceived by school nurses

Theme	Sub-theme
1 Emotional challenges due to:	1.1 Pregnancy
	1.2 Rape
	1.3 Bullying
	1.4 Abject poverty
	1.5 Orphaned
2 Risky behaviours	2.1 Alcohol abuse
	2.2 Unsafe sex
3 Disruptive behaviours	3.1 Lack of respect
	3.2 Inattentiveness
	3.3 Poor academic progress
4 Recommended strategies	4.1 Interdisciplinary collaboration 4.2 Mental health promotion programme in schools 4.3 Human and material resources

School health nurses reported that most of their clients were students referred by teachers hence there were similarities in the identified and emerging themes above. In the absence of the social worker in schools, the nurses were to deal with most of the social problems including lack of social grant and/or foster care to orphaned school children

4.3.3.1 Emotional challenges

All the 8 nurses interviewed reported seeing adolescents with emotional challenges. The emotions displayed included anger, withdrawal or depression in some adolescents. Amongst those referred to the school health nurses included:

> "A child reported being raped by mother's boyfriend."

> "One pregnant student was always sleepy and cheeky in class."

"One case of orphaned adolescents with no financial support as they did not have birth certificates, reported to be very withdrawn and unkempt."

4.3.3.2 Risky behaviours

The following were reported to be due to alcohol abuse and unsafe sexual activities.

"In one school, I was called to intervene with a violent child who was drunk. We could not handle him as he was so violent and abusive."

"Whilst interviewing one student about condom use, the answer was 'mom, we cannot eat sweet with its cover.' Some reported that their boyfriends do not want condoms and had to agree fearing being left out."

"Judging from the questions they ask during sexual education, most of the school adolescents are sexually active even from the earliest age of 15 years."

"We also found out some students are already on antiretroviral drugs."

4.3.3.3 Disruptive behaviours

Lack of respect and inattentiveness in class leading to poor academic progress has been noted as contributing to disruptiveness in classroom**.** Adolescents' untoward behavior against teachers and adults at large were a cause of concern from school health nurses. One school health nurse commented:

"Whilst visiting one of the schools, I observed that students are not taking heed of teachers' commands, they answer back; and this was found to be more common among girls."

One also commented that:

"Even when they talk to us as nurses about sexuality, they express their feelings in the slang language used with peers. This shows disrespect for adults. ."

> "Some students were found short messaging and reading sexual illicit magazines not allowed in class. These were generally those students who repeated grades.

4.3.3.4 Recommended strategies

To answer to the following sub-questions:

- What mechanisms are in place to deal or prevent these social, emotional and behavioural problems?
- What would you like be done to promote mental health in high school adolescents?

School health nurses, in the focus groups cited the following challenges that hinder service provision to schools:

- Lack of follow up of referred cases due to lack of resources e.g transport and school health team members.
- A need for an interdisciplinary team in schools.

The following excerpts describe this:

> "I had a raped child referred to me who I further referred to the social worker. I do not know what happened with the case as I could not be able to go to that school due to transport problem."

> "The violent child that was apprehended by police on the day we were in that school, could not be followed up because we could not go back to that school, transport was a major problem."

> "We use to go together with health promoters when we are busy with physical examinations they give health education. But now the transport we use cannot accommodate them in."

"The presence of a social worker in the team can fast track attending to the some social problems (such as lack of social support grant to orphans, rape cases etc.)"

4.3.4 Combined analysis

Whilst SPSS analyses portrayed quantitative findings of the study, qualitative content analyses provided supportive in-depth clarification and understanding on the findings of the phenomena under study. Findings of both data strands from the school-going adolescents were merged after separate data analyses. Both study findings incorporated use of frequencies and percentages to reveal proportions that denote the extent and scope of the phenomena under study, together with the thematic findings that provided complementary findings about the central phenomena under study. The researcher compared and contrasted the findings to gain an overall picture of the social and emotional difficulties facing school-going adolescents. Thus convergent description of the experiences of school-going adolescents with social and emotional problems was provided. A full detailed interpretive integration of the findings will be given in Chapter 5.

4.3.4.1 Findings on social and emotional problems of school-going adolescents

Both analyses yielded findings that highlighted existence of social and emotional problems of school-going adolescents related to and including the following:

- Handling emotions
- Dealing with significant and difficult situations
- Decision making and reflection on the decisions
- Relationship management

The above aspects from the study findings negatively impact on the development of aspects of personal and social competencies expected from adolescents as described in CASEL's SEL framework discussed in Chapter 2 of the study. A summary and comparison of the study findings to the SEL competencies is provided in Figure 4.20.

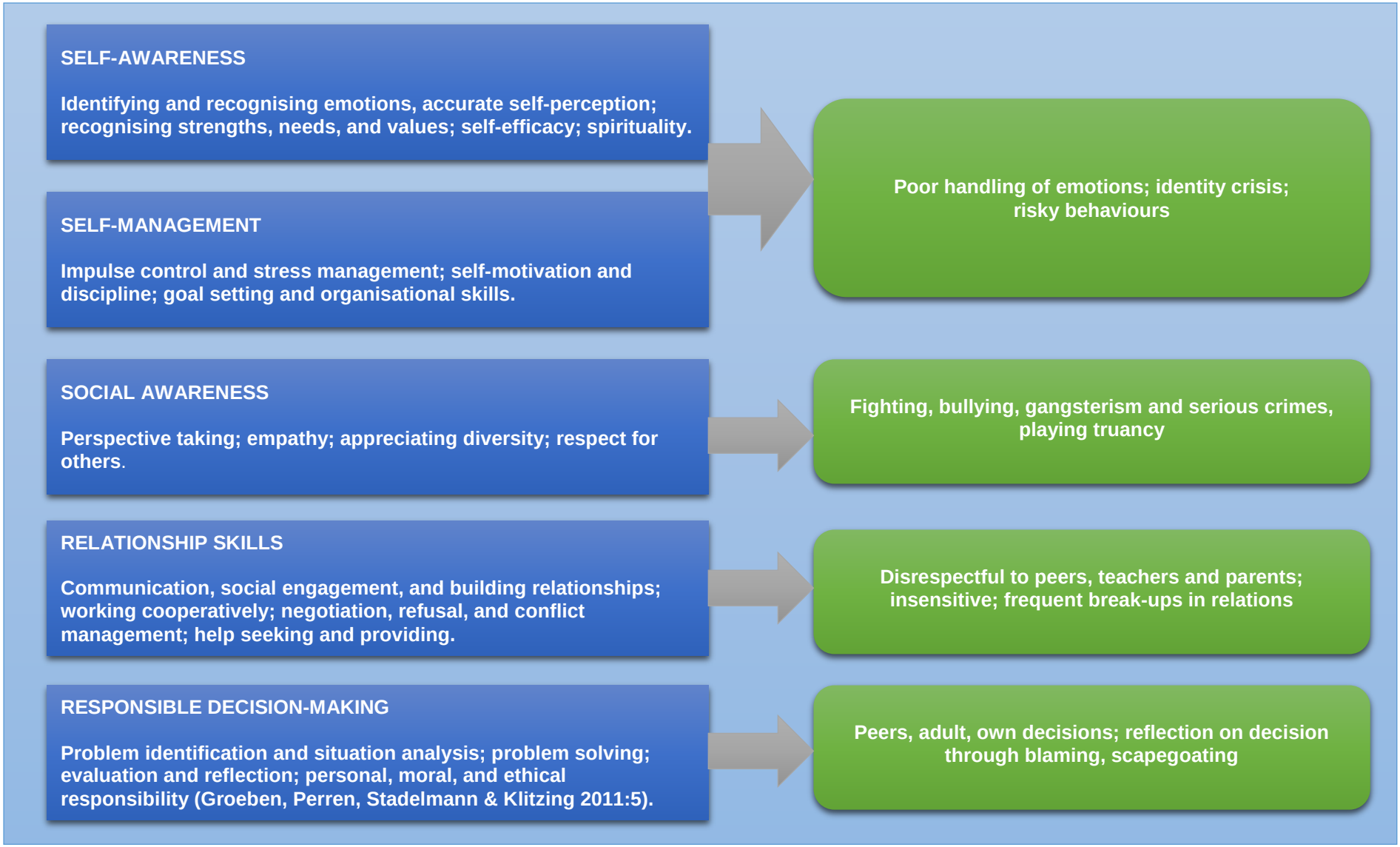

Figure 4.20: SEL competencies and the study findings

4.4 CONCLUSION

In this chapter both quantitative and qualitative results were presented and results were based on SEL model using the EHC grid. The results answered the research questions posed. Both quantitative and qualitative results revealed similar findings. The results showed that there is a great link between the adolescents' life circumstances and the vulnerability to social and emotional problems which are indicators of mental health problem that need interventions.

CHAPTER 5

DISCUSSIONS OF STUDY FINDINGS

5.1 INTRODUCTION

This chapter aims at discussing and synthesising the findings of the study. Synthesis will be based on the analyses done in the previous chapter and interpretation and merging in the discussion of the major key findings will be linked to the Social and Emotional Learning (SEL) model that underpinned the study.

5.2 INTERPRETATION OF THE MAJOR FINDINGS OF THE STUDY

The study revealed that promotion of adolescent mental health in schools is hampered by the life situations adolescents find themselves in. Life events that were implicating the majority of the participants were bereavement (37%), family situations(29%) and being bullied (24) in school. Belonging to a gang was found to be a strategy used by respondents for coping in this study..

5.2.1 Bereavement

The majority of adolescents reported that losing a key caregiver such as a parent or guardian in their lifetime affected their mental health negatively. In order to cope with the loss of the loved one adolescent sought comfort from alcohol, drug use and unsafe sexual encounters (Thupayagale 2009:169). A study by Thupayagale (2009:163) on experiences of adolescents orphaned by AIDS found that anxiety, depression, withdrawal and anger were common end results of parental loss. Demmer and Rothschild (2011:15) study of bereavement among South African adolescents due to HIV/AIDS also shows that loss of a close family member can have adverse effects on the mental health of the adolescents. Other studies have linked bereavement among adolescents with poor school performance, withdrawal and depression (Berg, Rostila, Saarela & Hjern 2014: 1; Dyregrov, Dyregrov, Endjo & Idsoe 2015:187). Interviews with school teachers affirmed that these were also common among the students especially those belonging to gangs or terrorised by gangs.

5.2.2 Family situation

One other major finding of the study was concerning the adolescents' family living situations. Most study participants reported experiences with the separating and/or divorcing parents, absence of one parent and parental rejection and how it affected their well-being. The intact family factor has been viewed as protective in nature in the development of adolescents. Literature revealed that, although during adolescence a tendency to shift away from family influence prevails, family remains protective nature for adolescent health, with parenting behaviours predicting positive outcomes. For instance, high levels of parental monitoring, family norms and attitudes are thought to prevent adolescents from peer violence, and risk taking with drugs and alcohol, sexual behaviours and serious crimes (Viner, Ozer, Denny, Marmot, Resnick, Fatusi & Currie 2012:1647; Parkes, Waylen, Sayal, Heron, Henderson, Wight & Macleod 2014:507; Jablonska & Lindberg 2007:656).

Disorganisation in the family structure destabilises ties that adolescents have, which would have provided protective factors against risk development (Parkes et al 2014:508). Jablonska and Lindberg (2007:657) concur that children who witnessed family dissolution, which in most cases is preceded by high levels of conflict between parents, tend to model aggressive behaviours. The aftermath of the frequent transition in the family structure also increased risk of adverse outcomes on the social and emotional well-being of the children.

Parental bonds and support among adolescents are associated with high self-esteem which is a crucial personality trait essential to act as a buffer in risk development. Individuals with a high self-esteem are thought to be self-confident and self-satisfied. On the other hand, individuals with a low self-esteem are generally vulnerable to stress, anxiety, loneliness and depression (Backer-Fulghum, Patock-Peckham, King, Roufa & Hagen (2011:477). Negative parental bonds through unaffectionate relationships with the child have been the cause of adolescents using alcohol and drugs, involvement in risky and disruptive behaviours and easily recruitment into gang activities and crime (Backer-Fulghum et al 2011:477; McGrath & Noble 2010:83; Ncube & Madikizela-Madiya 2014:43).

A significant number (29%) of respondents indicated having witnessed parental separation or divorce and on further exploration during interviews the majority of participants revealed being forced by these circumstances to live with non-parental family relatives such as older siblings, aunts and/or uncles.

5.2.3 Bulllying

A high proportion of adolescents revealed having experienced bullying by peers in school. McGrath and Noble (2010:83) describe the various forms of bullying in schools as verbal, physical and social exclusion. Being teased, rejected or socially excluded put most children at high risk of developing emotional and behavioural disorders. For this study the significant proportion (24%) of adolescents who were bullied ended up skipping classes or joining an opposition gang.

Gangsterism is described by Ncube and Madikizela-Madiya (2014:43) as the formation of groups which aim at defending themselves physically against violence from other groups. The tendency is for adolescents who have been bullied to join gangs to bully against the perpetrators. This would, in turn, escalate into violent behaviours among school pupils. Fear of being bullied by gangs may generate negative emotional outcomes like mental distress. This finding is also supported in literature. Patel et al (2008:313), Calderella et al (2009:51) and Ogden and Hagen (2014:31) confirmed that being bullied may result in depression, anxiety and social exclusion, which if untreated, may develop into mental health disorders. McGrath and Noble (2010:83) concur that continuous peer teasing, rejection and social exclusion are common characteristics of children at risk of emotional and behavioural disorders. Anxiety and depressive symptoms will further lead to social avoidance behaviours and distrust which will limit the individual from positive peer interactions and thus may further perpetuate being bullied. This also explains the study findings revealing a high proportion (48%) of adolescents exhibiting withdrawal as feature of handling emotions.

5.2.4 Handling of emotions

The study's statistical analyses clearly indicate that most school adolescents, at least once in their life stage of adolescence, are challenged by their emotions. These emotions have been reported to be caused by significant and difficult situations

adolescents find themselves faced with and include anger, withdrawal and/or depression. According to the SEL framework, in respect of self-awareness, the individual should be able to recognise and name one's emotions and as a measure of self-management and relationship management, these should be expressed effectively and with adequate and healthy coping mechanisms. This study further revealed that some adolescents who experienced negative emotions handle them inappropriately indulging in alcohol, fighting and risky sexual behaviours. A meta-analytic review of the influence of discrete emotions on judgement and decision making by Angie, Connely, Waples and Kligyte (2011:1395) reveals that affect and cognition influence decision-making and identified discrete emotions such as anger, sadness and fear as more likely to be linked to negative and risky events. Durlak et al (2011:405) too highlight the effects of emotions on adolescents as either facilitating or impeding school connectedness or engagement.

The negative outcomes of the risky behaviours adversely affect adolescents' social-emotional well-being and mental health (Thupayagale-Tshweneagae & Mokomane 2013:89). Other studies (Ajuk 2013:52; Weare & Nind 2011:i29) have also alluded to the fact that a large proportion of mental health problems among school-going adolescents are a result of negative experiences of school. Literature reveals the transition of adolescents from middle school to high school as posing numerous challenges and is seen as a high risk period for engaging in risky behaviours (Carney, Myers, Louw & Okwundu 2014:6). The peer social rejection and exclusion and ultimate lack of school connectedness, may lead to poor academic performances and impaired mental health (Carney et al 2014:6). The current study also revealed a 60% proportion of failing or poor performance by grade 10 students who have just joined high schools from middle schools.

Strategies and mechanisms employed in the handling of emotions show the need for interventions and programs to improve and develop social skills to direct these situations positively and thus improve the quality of life of the adolescents. This was raised by both school health nurses and school teachers in the study.

5.2.4.1 Drug and alcohol use

The study found that about 86% of school-going adolescents use drugs and alcohol to cope with the stresses that they face. This has been the picture in both rural and urban school settings with males having the highest proportions. Carney et al (2014:6) describe adolescent alcohol and substance abuse as risk factors for other problem behaviours. The nature of high school with decreased parental monitoring challenges adolescents who are from elementary schools and thus provides them with opportunities to experience substance abuse and other risky behaviours. Backer-Fulghum et al (2011:477) describe use of alcohol during stressful situations as providing an individual with a reinforcer (removing an aversive stimulus) to escape from the negative thoughts and feelings of the situation.

Drinking in order to cope has several negative consequences for health and well-being such as increased risk of injury due to involvement in fights and road accidents; high risk of sexual behaviours and risk of suicidal ideation and behaviours. Bashirian, Hidarnia, Allahverdipour and Hajizadech (2012:54) assert that there is a link between alcohol and drug abuse with problems of academic performance, truancy and school drop-out and adolescents with low self-control are more likely to abuse alcohol and drugs leading them to engage in crime and deviant behaviours. Drug and alcohol use were exacerbated by peer influence as reported in most adolescent interviews.

International and local surveys on substance use reveal highest the prevalence of substance abuse among adolescents. According to Carney et al (2014:6), the prevalence rates of substance abuse in South Africa is 50% for alcohol, 15% cannabis, 12% inhalation or prescription drug use. This statistical presentation concurs with the study findings in which 25% of respondents revealed using alcohol and/or drugs to handle difficult situations.

5.2.5 Fighting

Fighting as a way of handling emotions and dealing with difficult situations was reported by almost 50% (N=100) of the participants in the study. Many studies on violence indicated how rife this is in South African schools (Westhuizen & Maree 2009:43; Ncube and Madikizela-Madiya (2014:43) with mass media daily reporting of incidents. Physical

fighting as violent perpetration has been commonly observed in males and those who engage in alcohol and drug use. Characteristics of individuals who associate with violence perpetration include impulsivity, difficult temperaments, and/or prior experiences with maltreatment (Matjasko, Needham. Grunden & Farb 2010:1053). These individuals increasingly interact with deviant peers and thus form gangsterism.

5.2.6 Risky sexual behaviors

Indulgence in risky sexual behaviours as a stress moderator when faced with difficult situations or celebrations of good events has been revealed in the study findings. Several studies attest to this citing the individuals' search of solace (Tshweneagae 2012:1; McGrath & Noble 2010:45). Risky sexual behaviours form part of a variety of risk behaviours that jeopardise one or more elements of health or development and there is substantial covariation of the risk behaviors among adolescents (Blum, McNeely & Nonnemaker 2001:54). Risky sexual behaviours have been highly associated with alcohol and drug abuse and violent behaviours. Literature revealed that individuals who are victims of abuse, social exclusion and rejection with low self-esteem resort to risky sexual behaviours as a way of seeking acceptance and comfort (McGrath & Noble 2010:45).

Negative consequences of risky sexual behaviours have led to the increased rates of teenage pregnancy in schools indicating heightened risk for sexual transmitted diseases and HIV infections among adolescents. The study findings too highlighted a significant proportion of adolescents reporting being pregnant during their schooling. Individual interviews with these participants revealed how their pregnancy affected them in terms of academic progress, self-image and their relationships with peers. A number of studies on teenage pregnancy and experiences of young women who became pregnant whilst in school revealed the negative and moralistic responses from teachers and peers which resulted in shame and secrecy about pregnancy that adversely affected the adolescents' emotional and physical well-being and ultimately led to the decision to quit schooling even after pregnancy (Ngabaza & Shefer 2013:106; Shefer, Bhana & Morrell 2013:1). Although the country's constitution and current educational policies support continued education of pregnant adolescents, communities view teenage pregnancy as a moral threat and continue to stigmatise pregnant adolescents. The hostile environments in school and outside school continue to put pressure on adolescents to

decide to leave school thus undermining their constitutional rights to equal educational opportunities (Ngabaza & Shefer 2013:107). Early school leaving jeopardises their potential for life success, making them prone to multiple high risk behaviours such as depression and suicide, alcohol and substance abuse.

Poor judgement and decision making are factors in adolescents' vulnerability to risk taking behaviours. Although most of the adolescent participants in the study reported that their decision making was influenced by adults and by themselves, the findings show that there is a preference for peer influence. This is not uncommon with the adolescents' social emotional development characterised by heightened sense of independence and self-reliance through peer relationship as described in Figure 2.1 (Chapter 2). The envisaged benefit for adolescents seeking and upholding peer influence and interaction was voiced out by participants during interviews as gaining of a sense of belonging, identity and peer acceptance and positive peer relationships.

Besides the major study findings that indicated social and emotional difficulties facing adolescents in high schools, a considerable proportion of the study results revealed positive factors that would mediate for risk development. According to Centers for Disease Control and prevention (CDC) (2009:3) and Ogden and Hagen (2014:15), positive factors include individual or environmental characteristics, conditions or behaviours that reduce the effects of stressful life events, increase an individual's ability to avoid risks or hazards and promote social and emotional competence to thrive in all aspects of life now and in the future. The current study revealed that 53% (n=167) of participants' responses pertaining to self-awareness indicated that they felt confident. Self-confidence is a co-characteristic of self-esteem which is related to the regulation of emotional states called feeling of self-worth. Self-confidence has also been seen as a buffer against the risky behavior of drug abuse. Individuals with high self-esteem are self-confident and self-satisfied and able to resist risky behaviours (Barker-Fulghum et al 2012:478). Lowered self-esteem is linked to anxiety, withdrawal and depression. Some participants (52%) indicated that winning an award at school supports good mental health with 17% of the participants acknowledging that even being selected for a leadership role in school such as that of a class monitor gives one confidence, hence a good precursor for good mental health.

Having a goal that one wants to achieve also promotes one's mental health. 75% of the participants indicated that their goal is to become a professional with 25% indicating that they would like to be artists. Having a positive view of one's future has been seen as a positive factor that contributes to increasing pupils' school connectedness and improving academic performance (CDC 2009:2). A strong need to want to achieve something good, receive compliments or gain appreciation and recognition for one's achievement contributed to self-esteem, self-worth, confidence and happiness (Landstedt 2010:33).

5.3 CONCLUSION

This chapter discussed the major findings of the study and situated the findings within what is already described in the literature. Either findings that either contributes negatively or those that contribute positively to mental health promotion were discussed. The findings of the study have been supported in literature. However, using gangs as a protective measure and as a means of belonging and gaining identity is a new finding of this study. It is this finding that the researcher will use positive gangsterism to promote mental health of school-going adolescents in the next chapter.

CHAPTER 6

PROPOSED SOCIAL AND EMOTIONAL LEARNING PROGRAMME FOR THE PROMOTION OF ADOLESCENT MENTAL HEALTH IN HIGH SCHOOLS

> *"Social and emotional development and the recognition of the relational nature of learning and change are the fundamentals of human learning, work and accomplishment. Until this is given proper emphasis, we cannot expect to see progress in making schools safer, drug free, with fewer students who don't care and want to drop-out, or with better tolerance of people who are different."*

(McGrath & Noble 2010:84)

6.1 INTRODUCTION

This chapter describes a proposed an evidenced-informed social and emotional learning (SEL) programme for the promotion of adolescent mental health in schools. The design of the proposed SEL programme is the end product of the study that explored experiences with social and emotional problems of adolescents in high school. Figure 6.1 depicts conceptualisation of the study processes and findings from Phases I to II. Using the SEL model as a guide throughout the study phases, the study identified social and emotional difficulties that the adolescents are faced with and are the targets of the proposed SEL programme in order to promote positive mental health.

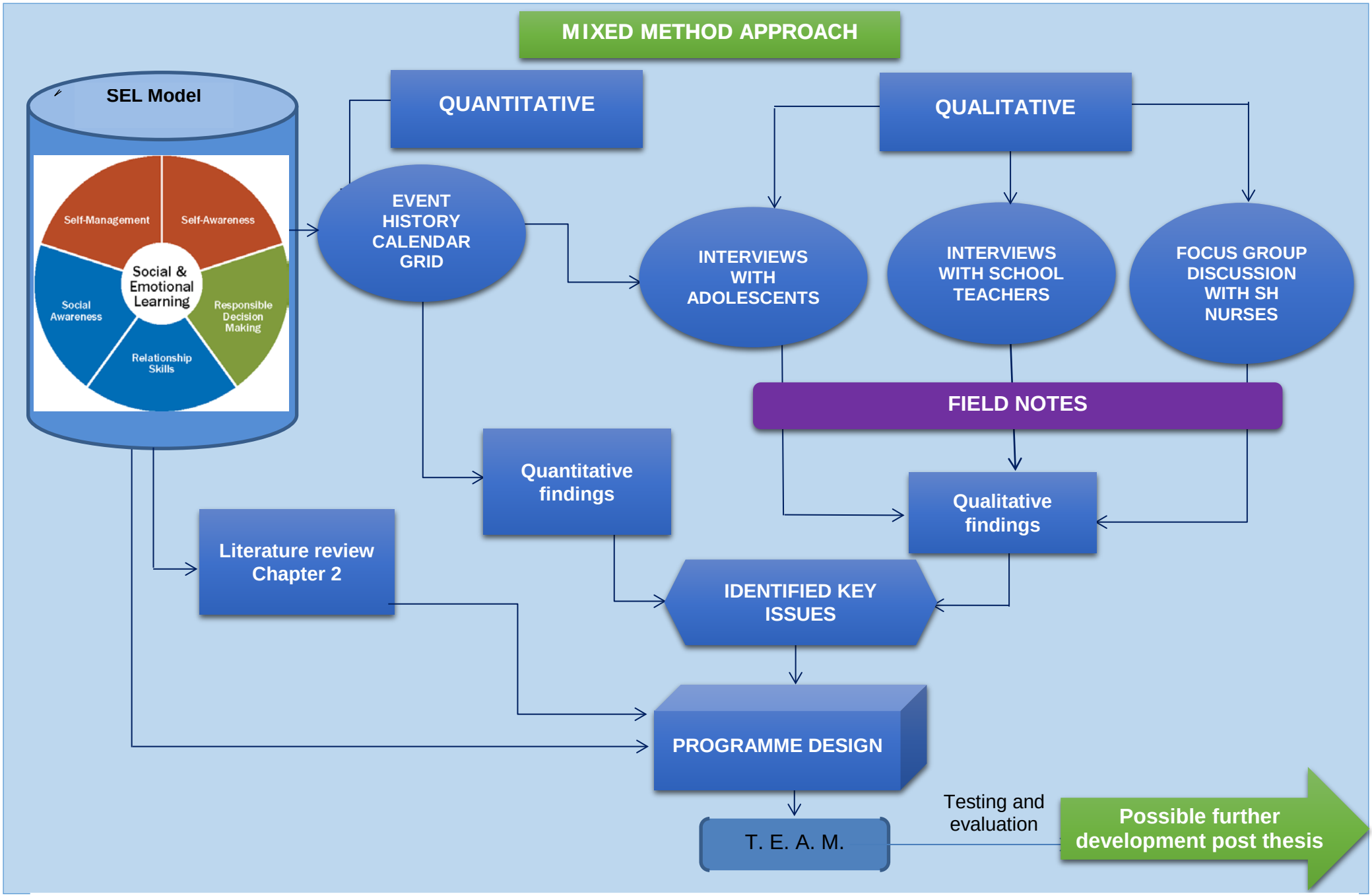

Figure 6.1: Conceptualisation of the research findings (Phase I) and programme design (Phase II) (compiled by researcher)

6.2 THEORETICAL BASIS

The SEL model by CASEL (2015) has provided the framework for the study and the designed programme. The SEL defined in the model, entails a process of teaching children and adolescents skills needed to handle themselves, their relationships and their work more effectively and ethically. These skills include recognizing and managing emotions, developing caring and concern for others, establishing positive relationships, making responsible decisions and handling challenging situations constructively and ethically. These comprise the core elements of the five SEL competencies (Humphrey 2013:3). These are skills essential for children and adolescents to calm themselves when angry, make friends, resolve conflicts respectfully and make ethical and safe choices (CASEL 2009:3). This SEL definition, and the five social and emotional competencies of the model guided the exploration of adolescents' experiences with social and emotional problems in high schools and the proposed programme also.

Humphrey's (2013:3) description of the elements in the definition of SEL was aligned to fit the proposed programme. That SEL is viewed as a process and therefore entails:

- A course of action, a method or practice in which schools are involved.
- Participants are school children and adults and each and every member of the community.
- The purpose of this programme is to teach skills which are social-emotional in nature, that are both intrapersonal (within the individual such a managing one's emotions) and interpersonal (between the individual and others such as establishing positive relationships).
- A universal (used by the entire school) and essential process for provision of fundamental skills for life effectiveness (social and emotional health and well-being and academic success).

Several empirical studies discussed in Chapter 2 of this study assert that SEL programming's focus is on developing people's personal, interpersonal and problem solving skills through teaching them how to recognise and manage the emotions, set and achieve positive goals, appreciate the perspectives of other, establish and maintain positive relationship, make responsible decisions and handle interpersonal situations

effectively (Axford, Blyth & Schepens 2010:9; Durlak et al 2011:406; Buchanan. Gueldner, Tran & Merrell 2009:189). Durlak et al (2011:406) also assert that teaching social and emotional skills is a buffer to developmental problems including both internalising and externalising problems such as aggression and depression. They further revealed that students who lack social-emotional competencies become less connected to school and this affects their academic performance, behavior and health. School therefore plays an important role in raising healthy children through not only fostering cognitive development but also social and emotional development, thus leading to improved well-being and academic performance

It is therefore based on these aforesaid grounds that the proposed programme seeks to promote social and emotional health and well-being of the school-going adolescents through social and emotional learning programme. Wells, Barlow and Stewart-Brown cited in O'Mara and Lind (2012:204) describe social and emotional health and well-being as:

> *"Including self-confidence, assertiveness, empathy, the capacity to develop emotionally, creatively, intellectually and spiritually, capacity to initiate and sustain personally satisfying relationships, and the capacity to face problem, resolve and learn from them*, *to use and enjoy solitude, to play and have fun, to laugh at oneself and at the world".*

Social and emotional health and well-being are therefore used synonymously with mental health. Kendal, Keeley and Callery (2011:245) describe social and emotional well-being as the precursors of mental well-being or positive mental health and as such are a relevant focus of strategies to improve mental health. Social and emotional competencies therefore are skills that underlie mental health with empirical evidence supporting that failure to meet developmental milestones in intra- and interpersonal competence domains lead to an increased risk of psychopathology (Humphrey 2013:29; Durlak et al 2011:405; Kendal et al 2011:245). The following measures of positive mental health and well-being of school children and adolescents affirm this and include:

- Emotional health – being happy and confident, not depressed and anxious.
- Psychological health – being resilient and autonomous.

- Social/relational health – having good relationships with others, not behaving in a way that can cause them harm, such as bullying (Humphrey 2013:30).

Evidence, therefore, points to the fact that early intervention to address social emotional difficulties of adolescents can prevent clinical problems and may be more successful than waiting until they are enmeshed in the adolescent's personality (Humphrey 2013:29, Durlak et al 2011:405, Kendal et al 2011:245). Beckham (2009:26) draws a comparison between SEL and common existing prevention and promotion initiatives. Whilst SEL is related to the youth development and prevention initiative its significant difference lies in that it systematically addresses numerous social and emotional variables that place adolescents at risk for school failure, such as lack of engagement in school and inability to manage emotions. On the contrary today's prevention and promotion initiatives are uncoordinated, fragmented and assume a quick fix which does not contribute to a collective effectiveness when a problem arises. The study findings attest to these as reactive approaches which were reported to be used in schools when a specific problem arises. This study thus proposes an inclusive approach based on SEL which instead of focusing on a single subject or problem, such as drug abuse or gangsterism, covers the entire spectrum of social and emotional competencies.

6.3 DEVELOPMENT OF THE INTERVENTION/PROGRAMME FOR PROMOTING ADOLESCENT MENTAL HEALTH IN HIGH SCHOOLS

Both the quantitative and qualitative data described the key issues of the study findings which are handling emotions, formation of destructive gangs, alcohol and substance abuse, disrespectfulness and adolescent pregnancy.

6.3.1 Handling emotions

Anger outbursts which often lead to fights with peers, school teachers and parents were identified as inability to self-regulate. This according to CASEL is an inability to recognise and manage emotions in order to respond to conflict in a calm and assertive way. According to Landstedt (2010:39) and CASEL (2013:3), individuals who have trouble managing anger become aggressive and bully others frequently. Besides being bullies they also end up being more vulnerable to victimisation (CASEL 2013). Self-

regulation is viewed as a critical component of success in academic and in life generally. Teaching and learning in schools is seen as having strong social, emotional and academic components with emotion seen to facilitate or impede children's academic engagement, work ethic, commitment and ultimate school success. School pupils with the ability to self-regulate had greater impulse control and paid more attention to their studies thus leading to better academic grades (Brackett, Reyes, Rivers, Elbertson & Salovey 2012:219; Durlak et al 2011:405).

6.3.2 Formation of destructive groups

Many participants highlighted belonging to a gang as a way of belonging and having an identity. The following excerpts from the interviews attest to this effect:

> "Two years ago, I was transferred to another school and I had to belong to a gang to survive." (Male adolescent 19 years)

> "I was a leader of a gang in another school … had to abandon school fearing for my life as another gang wanted to kill me; I had to change schools." (Male adolescent 18 years)

> "A student belonging to the group of gangsters outside school, had disruptive behaviours, stealing from others … but later he feared for his life as he could not go out of school until we involved his parents to buy him out of the gang." (Teacher's report on gangsterism in school).

Adolescence is seen as time for opportunity and risk but has identity crisis as one of its characteristics. The definition of adolescence itself as a stage of "no longer a child but not yet an adult", leaves one to choose identification. Because of the heightened need to belong and dominant peer influence, adolescents tend to identify themselves with peers who then influence their behaviours (WHO 2009:15). If, therefore one associates oneself with peers of bad influence, there is a greater possibility of getting involved in maladaptive behaviours like gangsterism. Ncube and Madikizela-Madiya (2014:43) describe gangsterism as a global phenomenon, the presence of which in schools leads to high violent victimisation and serious crime problems. The presence of youth gangs in schools has been linked with the availability of drugs and easy recruitment to the gangs are more likely to be among those who emit behaviours of poor academic

performance, truancy, attrition, and antisocial behaviours due to low self-esteem. The study findings strongly corroborate this as school teachers reported identified pupils with disruptive behaviours as were those who perform poorly academically, play truancy and ultimately fail to complete schooling. According to Matjasko et al (2010:1055), there is a likelihood of deviant or violent adolescents to seek out similar friends who reinforce the maladaptive behaviours and this confounds the influence for a formation of typical peer network. Belonging to a gang gives them a sense of identity. According to Bracket et al (2012:219), this false identity oftentimes leads to adverse developmental effects and thus damages protective emotional connections with school and academic engagement. Al-Hendawi (2012:125) concurs that the lack of engagement in schools leads to the development of negative emotions about learning, low level achievement and consequently dropout from school.

Research on bullying in schools highlights the consequences and tendencies of victims of bullying to club together in retaliation against the bullies. This leads to formation of groups amongst pupils who gang against others (CASEL 2013). There is need, therefore, to create healthy school environments that nurture individual basic psychological needs such as safety, autonomy and belonging (Humphrey 2013:53). Ncube and Madikizela-Madiya (2014:44) further describe this environment as being inclusive and democratic enough to help foster openness, a sense of ownership, commitment and responsibility to all its stakeholders

6.3.3 Alcohol and substance abuse

Most adolescents reported alcohol and substance use as a coping mechanism against stressful and significant events. Alcohol and drug abuse is currently one of the important threatening behaviours among adolescents with several potential negative consequences for health and well-being. Associated problems include truancy, poor academic performance and school dropout. A linkage between substance abuse and poor self-control perpetuates involvement in crime and deviant behaviours (Bashirian et al 2012:54). This was highlighted by one of the study participants (a school teacher) who described that most adolescents with disruptive behaviours like stealing from others, are under performers and abuse alcohol and drugs.

It is therefore critical to ensure that an intervention for promotion of mental health does equip adolescents with positive coping strategies and the ability to refuse temptation to drug use.

6.3.4 Disrespect

Rebellious actions against authority by adolescents have been rife in schools. This has been explained as the adolescent's need for independence from adult influence and more alignment with their peer influence. According to Fontaine and Fletcher (2004:23), rebellious behavior might also be a protective mechanism used to hide from parents or guardians that they are doing something that contradicts parental guidance or rules. Lack of respect and sensitivity towards teachers, parents and peers emerged from the study participants. Inability to handle emotions such as anger outburst towards parents, teachers and peers is indicative of disrespectful behaviours as reflected in the study findings. Considering the current prevalence of oppositional defiant disorders (6.0%) reported of South African adolescents by Flisher et al (2012:150), developing responsible and respectful school children is essential.

6.3.5 Adolescent pregnancy

Teenage pregnancy had also been cited as a cause for evoking emotional problems. Teachers and school nurses alluded to the fact that pregnant pupils tend to be cheeky, moody and short tempered. Empirical evidence on teenage pregnancy reveals that though the constitutional rights supported by educational policies permit pregnant young women to be schooling, the negative and moralistic responses they meet within the school environment and outside school adversely affect their social emotional well-being and mental health (Ngabaza & Shefer 2013:106; Shefer et al 2013:2). Adolescents' risky sexual behaviors with resultant pregnancies have been linked with both externalising (conduct disorders) and internalising problems (anxiety, depression) which destabilise ties adolescents may have with family, school and healthy peers (Parkes et al 2014:508). For instance, adolescents with aggressive or antisocial behaviour become progressively alienated by peers, family and school and become closer to delinquent peers. The result is a great likelihood to be part of gang activities. Risky sexual behaviours expose them to teenage pregnancy and sexually transmitted diseases.

There are many studies that have associated adolescent gangsterism with teenage pregnancy (Parkes et al 2014:509; Minnis, Moore, Doherty, Rodas, Auerswald, Shiboski & Padian 2008:1102). In a study by Minnis et al (2008:1102) on gang exposure and pregnancy incidents reported that adolescent girls who have sexual partners in the same gang were most likely to get pregnant. Despite enormous innovative strategies used in school settings to communicate messages about safe sexual behaviour, the rate of adolescent pregnancy continues to increase (Taylor, Dlamini, Khanyile, Mpanza & Sathiparsad 2012:441).

The above key issues were highlighted by participants as occurring during their attempts to cope with difficult situations including bereavements, bullying, separation of parents, academic failures, threats from gangs. According to Fischer et al (2012:150), exposure to stresses is a risk factor for psychological disorders in adolescents. Therefore the study findings show contribution to the social ailments that impact on mental health and require a universal approach to ameliorate them, hence the proposed universal intervention. A universal approach described by Humphrey (2013:31) is,based on the notion that “an ounce of prevention is worth a pound of cure”, a more inclusive preventive and promotive approach that entails equipping young people with skills to become resilient. Its inclusivity refers to it being beneficial to the entire population in question, providing the information or skills to all individuals without screening or with less focus on within child problems and is delivered over a prolonged period of time (Ogden & Hagen 2014:13; Humphrey 2013:31).

Reversing the status quo in high schools as indicated by the study findings to give participants the right to enjoy school and engaged productively forms the crux of the proposed intervention.

6.4 PROPOSED UNIVERSAL PREVENTIVE INTERVENTION FOR THE PROMOTION OF ADOLESCENTS’ MENTAL HEALTH IN SCHOOLS

An acronym TEAM has been used to refer to the proposed intervention which entails:

T = Treating each other with respect

E = Engaging in schools; earning the right to be at school and have supportive peers

A = Acknowledging differences of strengths and weaknesses in both self and others

M = Membership in positive gangs to promote social and emotional well-being, teach adolescents to look out for one another, respect others strengths and weaknesses and to learn to live responsibly at schools as a community (see Figure 6.2).

TEAM as an intervention takes into consideration the heightened need by all adolescents to want to belong to something or to be with someone. According to Groeben, Perren, Stadelmann and Klitzing (2011:4), the need for a sense of belonging is a fundamental human motivation to initiate and maintain social interactions using prosocial and self-oriented social skills. Patel et al (2008:317) too identify sense of belonging, together with self-esteem, engagement, control and quality of life and intellectual and emotional well-being as individual indicators of mental health. TEAM will therefore center all its activities on the facilitation of the sense of belonging, ownership and complete engagement of pupils in schools that will contribute positively to the social-emotional well-being which is in opposition with the aims of destructive gangs. Working as a team in schools was what emerged from the study participants (adolescents, school health nurses and teachers). Participants concurred that collaborative effort could minimise the social and emotional problems amongst adolescents. The teaming up has to begin with the adolescents themselves hence the focus of this intervention. Sturgeon (2007:37) also affirms that programme strategies that maximise active ownership and participation of people in health promotion initiatives bring positive results to sustainability of the programme.

As another effort to promote positive youth development, TEAM will differ from interventions aimed at reducing risk factors only in that its focus is on enhancing skills, building assets and promoting resilience to achieve positive adolescent mental health. This is in line with what WHO (2004:28) advocates in all interventions for mental health promotion; e.g., that they should aim at reducing identified risk factors and enhancing

known protective factors. TEAM therefore takes into consideration the need for the creation of school environments or climate settings that would provide mutual supportive relationships between adults and adolescents in schools. This would encourage school achievement, problem solving and civic engagement (Rivers, Brackett, Reyes, Elbertson & Salovey 2013:86). The school settings essential according to Rivers et al (2013:87), are those related to meeting the social and emotional needs of the school-going adolescents and include interactions between and among students and teachers that are empowering, caring, supportive, safe and orderly.

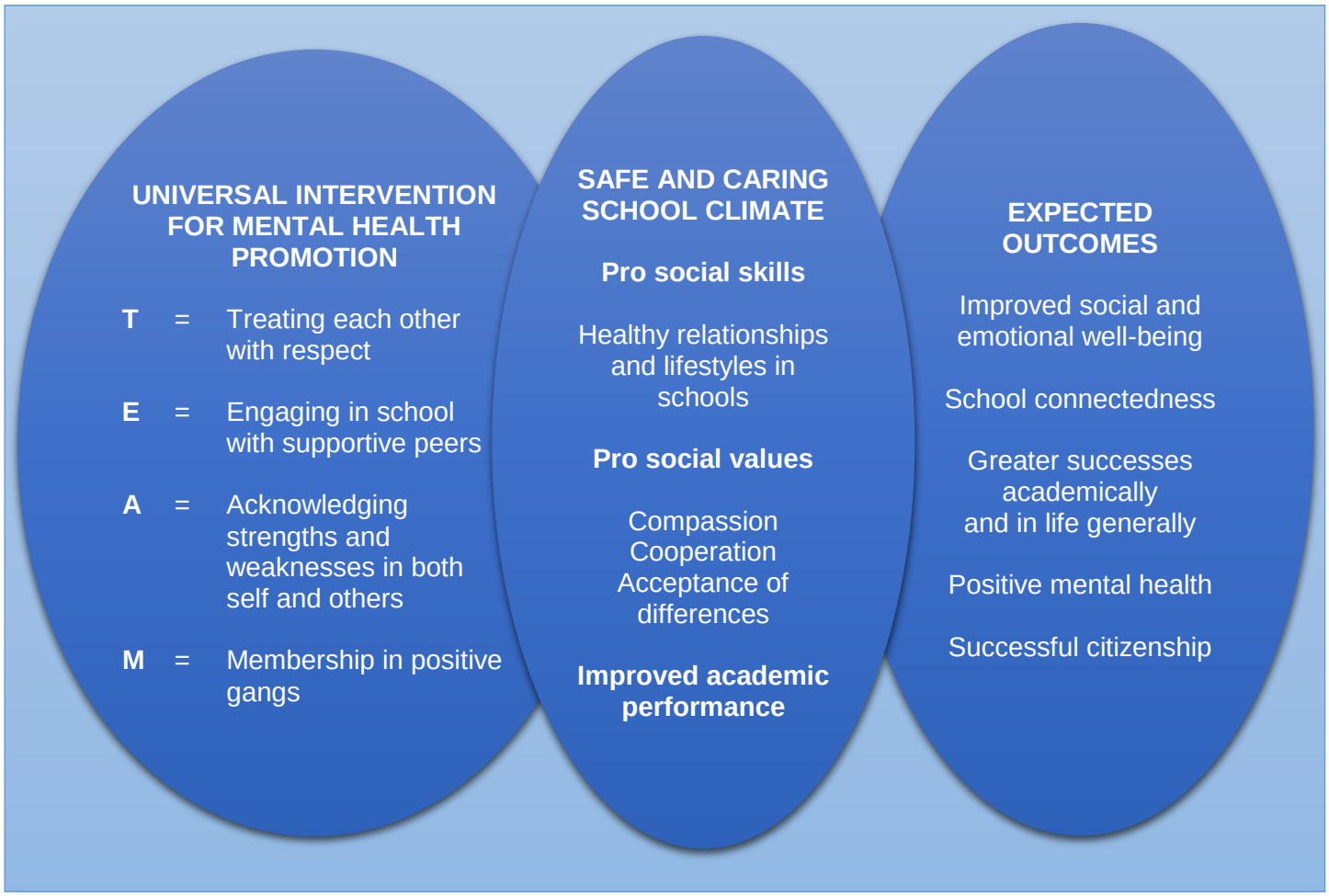

Figure 6.2: TEAM intervention for adolescent mental health promotion

6.4.1.1 Aims of TEAM intervention programme

As a universal intervention, TEAM aims at:

- Promoting healthy lifestyles in schools through building of positive relationships
- Reducing early pregnancy and substance use through instilling prosocial values
- Minimising trauma through violence
- Promoting healthy schooling and school connectedness
- Promoting responsible citizens

6.4.1.2 Activities of TEAM

The main activities espoused by the TEAM comprised the following essential components:

- **Classroom and SEL teaching activities**

Teacher led course lessons and activities incorporating the emotional competence skills (self-awareness, self-regulation and social awareness) and relational/pro social skills (relationship skills and responsible decision making).

- **Positive gang/buddy system**

The proposed programme envisages that positive youth gang membership will promote the use of humour, build confidence, assertiveness, and instill prosocial values and conflict resolution in a safe and non-threatening buddy environment.

- **Post-school activities**

These include walking, doing school assignments and talking together (a protective crew). This would mediate against risk development which is common practices beyond school periods.

6.4.1.3 Processes of TEAM development and implementation

- **Classroom and SEL teaching activities**

  - Flexibility and local adaptation of the implementation of the classroom activities should be geared towards promoting mental health. To meet this goal activities should be geared towards developing competences that promote mental health (such as cooperation, resilience, sense of optimism, empathy, positive and realistic self-concepts) and promoting prosocial skills and values (Weare & Nind 2011:i66). As the TEAM intervention programme seeks to contribute to the life skills' component of the syllabus, SEL teaching activities are expected to be infused into the existing LO curriculum with the whole school's support. Brackett et al (2012:219) affirm that programmes that are integrated into both school classrooms and systems are likely to be sustainable. The researcher highly advocates that the proposed programme be embedded in all aspects of the school's environment and includes social interactions, self-reflective activities and teaching.
  - Class meetings and discussion forums will be mandatory to identify, discuss pertinent issues and solve problems within gangs collaboratively. These could also be platforms for students to exercise autonomy to set norms and values of the gangs.
  - The creation of a safe, caring and inclusive school culture will provide a conducive environment for the students-teacher interactions during TEAM intervention processes. McGrath and Noble (2010:87) attest that the presence of a safe, caring classroom climate will foster cooperative learning that promote positive interactions based on mutual assistance, encouragement and the sharing of information and resources. A positive school climate has been associated with academic achievement, decreased absenteeism and lower rate of suspension and students who perceive a positive climate in their school more likely to demonstrate high levels of social competence and report fewer personal problems (CASEL (2015:11). TEAM intervention will need such supportive psychosocial environment to prevail as foundational to its success.

- **Positive gang/buddy system**

Positive gang formation is aimed at encouraging members to collaborate and cooperate with each other on academic and non-academic activities. Characteristics and norms of a peer group/gang such as socially competent peer group members and peer group support of pro-social behaviors play the most determining influence in the health and educational outcomes of the individual member (CDC 2009:6). McGrath and Noble (2010:82) also assert that positive high quality peer relationships in schools are more likely to lead to pupils experiencing positive outcomes which include positive mental and physical health, improved academic performance and successful adult relationships.

Conversely poor relationships with peers are more likely to compel young people to abuse drugs, engage in or with peer groups that support socially disruptive behaviours, report anxiety and depression and fail to complete schooling. From a mental health nursing perspective, group interventions have proven powerful in developing individual's self-understanding,conquering unwanted thoughts and feelings and changing behaviours (Boyd 2008:189). Based on these assertions, the creation of a positive gang/buddy system as a group intervention is essential to improving the social and emotional well-being of school-going adolescents.

The following criteria for the formation of gangs are advisable but not conclusive:

- Grouping of individuals who reside in the same vicinity, board the same school bus/school transport
- Grouping of individuals in similar school grades
- Grouping may be heterogeneous

Stages of group formation will include orientation, choosing leaders and formation of group principles, norms and values. Group activities may be both academic and non-academic. These may include activities to nurture and promote the use of humour, assertiveness, self-confidence, and a safe environment for recognition of strengths and weaknesses and overall prosocial values. The prosocial values according to McGrath and Noble (2010:85), include compassion, cooperation, and acceptance of differences, respect, friendliness/inclusion, honesty, fairness and responsibility.

- **Post-school activities**

Post-school activities will provide a protective social net for adolescents. Being part of a stable peer network will protect adolescents from being victimized or bullied and will help them refrain from after school activities with antisocial behaviours (CDC 2009:6). For instance, currently bullying and gang activities, unsafe sex practices and substance use are common experiences after school. Schools are seen as microcosms of society within which they are located and are therefore vulnerable to the social ills that prevail in their surroundings (Ncube & Madikizela-Madiya 2014:44). The school thus bears responsibility to protect children and youth from the external negative elements of the broader society by equipping them with coping mechanisms and skills. Post school group activities and responsibilities should therefore entail togetherness and knowing each other's whereabouts, engaging with each other academically and/ or otherwise post school.

6.4.1.4 Feedback and evaluation sessions

Evaluation sessions and feedback are periodically needed to assess progress and problems of group functioning under the guidance of the respective class teachers. These may take the form of periodic and frequent meetings or evaluation sessions of the TEAM gangs and may provide platforms for TEAM gangs to:

- Share and discuss identified challenges
- Showcase strengths and positive outcomes
- Make challenges stepping stones to larger goals

On a quarterly basis/semester depending on the school policies these TEAM gangs may be assessed with a prize awarded for the best performing group. The TEAM will be measured by their pass rates and reports from teachers and parents.

6.5 IMPLEMENTATION

The researcher will facilitate implementation of the TEAM programme as a post-doctoral project. The implementation will start with sharing of the proposed project with school

administrators and management teams in schools. This would be followed by training of local teachers in two selected schools.

6.6 CONCLUSION

This chapter proposed and presented the development of the TEAM intervention programme aimed at promoting adolescent mental health in schools. The programme was developed based on literature and the findings of the study. TEAM programme would be interactive and owned by the schools, and all stakeholders, including school-going adolescents. Interactive programmes foster development of interpersonal relationships, communication skills, and understanding among peers (Tobler, Roona, Ochshorn, Marshall, Streke & Stackpole 2000:275).

CHAPTER 7

SUMMARY, RECOMMENDATIONS AND STRENGTHS AND LIMITATIONS

7.1 INTRODUCTION

Chapter 7 presents the overall conclusion of the study, study limitations and recommendations.

7.2 SUMMARY

Mental health disorders in adolescence, which are categorised into externalising and internalising problems, have been a great burden in public health. The challenging circumstances adolescents find themselves in throughout this developmental stage and the risky behaviours they display in order to cope with the life challenges increase their susceptibility to mental disorders. South African youth risk behaviours identified by various survey reports indicate that alcohol and substance abuse, risky sexual behaviours as well as violent criminal behaviours are very common (Rawatlal & Petersen 2012:346). The study findings confirmed these findings with violence in schools being in the form of bullying which escalated into formation of gangs that further involve adolescents into other serious delinquent behaviours. Consequently these had adverse effects to the adolescents' social-emotional well-being and mental health. The associated poor academic performance, due to inability to connect or engage in school and ultimate drop-outs by adolescents prove to be the negative outcomes that adversely impact on country's health economy. The ensuing mental health problems resulting from risky behaviours of adolescents such as depression and anxiety and the accompanying stigma further increase the health-illness burden that the country is already faced with due to the scourge of HIV/AIDS and other non-communicable diseases (Flisher et al 2012:149; Mason-Jones et al 2012:7; Peltzer et al 2008:494)

Schools as places where children and adolescents spend most of their time are therefore seen as venues for mental health services and mental health promotion. School-based mental health services with an emphasis on universal promotion and

prevention are deemed essential to enable psychological and psychophysiological development of adolescents. There strategies that emphasise positive relationships among adolescents' peers and their school teachers, enhancing protective factors and reducing risk and stress factors are to be core components in order to promote the social emotional well-being and mental health of school-going adolescents

The purpose of the study was to develop a social and emotional learning programme for the promotion of school-going adolescent mental health**.** In order to realise the purpose of this study the following questions were answered:

- What are the experiences of high school adolescents in dealing with social and emotional problems?
- What are the experiences of high school teachers and school health nurses with regard to social and emotional problems of adolescents?
- What are the approaches used by school-going adolescents, teachers and school health nurses in handling social and emotional problems?
- What are the needs of the study populations that would inform the development of the programme for social and emotional learning?

The study was supported by the Social and Emotional Learning (SEL) model by CASEL (2013:7). The model emphasises the five core social competencies which were used as bases throughout the study to inform the designing and development of the quantitative data collection instrument (EHC grid) up to the development of the adolescent mental health programme. A two phased research process was followed to achieve the aforementioned objectives.

Phase 1 involved a sequential mixed methods approach undertaken to explore the experiences of school-going adolescents in dealing with social and emotional problems from two different school settings that is rural and urban high schools. Quantitative data using the Event History Calendar were collected from the study sample and thereafter a convenient subset of the larger study sample was purposively recruited for qualitative data collection. Individual interviews with the adolescents followed the EHC grid and were audio-taped. Additional triangulation of data sources was done with the inclusion of interviews of school teachers and focus group discussions with school health nurses to augment and enrich the data regarding social and emotional problems of adolescents

in high schools. The two sets of data were analysed separately but merged and collated during interpretation and discussion. Quantitative data analysis and interpretation using frequency tables, bar chart and graphs and descriptive statistics was followed by thematic analysis for qualitative data. Further sifting and refining analysis during interpretation and discussion yielded key major areas of the findings used in Phase 2 of the study.

Phase 2 focused on the development of the proposed universal intervention for the promotion of adolescent mental health based on social and emotional learning. The major findings identified in phase one provided an evidenced basis for the proposed intervention. The TEAM, which is an acronym for the proposed intervention for the promotion of adolescent mental health, is a universal approach based on social and emotional learning which seek to promote positive relationships among school-going adolescents through use of positive gangs, improve attachment and connectedness during and after school in an endeavour to mediate risk development and thus promoting adolescent mental health.

7.2 RECOMMENDATIONS

The following recommendations are based on the findings of the study and the proposed intervention programme for the promotion of adolescent mental health.

7.2.1 Recommendation to policy makers

The following recommendations to policy makers are proposed:

- Development of a policy on inter-sectoral collaboration between mental health professionals and school teachers in the promotion of mental health.
- Promotion of adolescent mental health should be re-emphasised in the integrated school health policy.
- Adoption of “TEAM” as a universal intervention programme for mental health promotion in schools.
- Improvement of school health services infrastructure with both human and material resources. For example, augment school health services teams with the

services of advanced psychiatric nurse professionals, psychologists and social workers in both rural and urban schools.

7.2.2 Recommendations to the basic education directorate and school teachers

- Inclusion of the TEAM programme into the school curricula to ensure that adolescents resiliency is promoted.
- Implement the TEAM programme for early identification of behavioural changes in school-going adolescents and report or refer promptly negative changes to school health nurses and parents where applicable.
- Participation in educators' development programme on mental health issues

7.2.3 Recommendations regarding School health services practice

The following are proposed for the school health and mental health nursing practice:

- Use of the Event History Calendar as an assessment tool to obtain baseline mental health status of school-going adolescents.
- Counselling services for adolescents with bereavement and increased identification of trauma.
- Involvement in the community activities by school health nurses to identify social issues that might impede the mental health of school-going adolescents.
- Conduct mental health education, orientation and/or in-service education sessions for school teachers on behavioural changes leading to mental disorders, managing groups such as TEAM and referral of social, emotional and behavioural disorders.

7.2.4 Recommendation regarding nursing education

Literature reflects limited or minimal training for mental health professionals on the school based mental health promotion field which leads to misidentification or over/under diagnosis of child and adolescent mental disorders (Morris et al 2011:1239). The researcher therefore recommends that mental health nursing curricula should include the TEAM programme as a health promotion strategy.

7.2.5 Recommendations regarding further research

This study was done in one district in the Eastern Cape region of South Africa. The researcher recommends that studies of comparable significance be conducted in other South African Provinces, as well as other African countries which are underdeveloped, and developed countries to establish empirically whether there are any similarities or differences in their findings.

The researcher further recommends that the intervention programme developed should be implemented in the schools where the study was conducted and in other schools. Evaluation should then be conducted to the extent to which the proposed programme can be effective.

7.3 STRENGTHS AND LIMITATIONS OF THE STUDY

The study had both strengths and limitations.

7.3.1 The Strengths

The use of mixed methods using the same tool was the strength of this study as it both evaluated the EHC as a qualitative tool and as a quantitative tool. The link between the two is also strength of the study. Although the study relied on self-reports, the accuracy of and reliability of self-reports by adolescents have been verified in previous research (Riley 2004; Thupayagale 2009). The researcher was able to attract a large number of participants to the quantitative portion of the study. There was a low dropout rate of participants.

The systematic yet reflexive process of gathering qualitative data and performing the analysis is a positive aspect of the study. The development of the TEAM programme was designed through a rich interaction with participants and closeness of the data.

7.3.2 The Limitations

Despite the high response rate, the study focused on three highest school grades, grades 10-12 and excluded lower grades which might have yielded different results. If more probing could have been done with all participants richer information possibly would have been obtained. For instance, interesting information on the adolescents' experiences in some of the EHC grid were detected during analysis and these if followed up might have given more insight into what adolescents face. For instance, some participants mentioned changes in their households as being difficult situations.

The use of one municipality's local health service area nurses could also be limiting as one school health team was exposed to similar working conditions. Findings from the qualitative portion of this study cannot be generalized to other groups.

7.4 SIGNIFICANT CONTRIBUTIONS OF THE STUDY

The study showed a number of social ailments adolescents face that impact on their mental health promotion in schools. There was limited school based mental health programmes reported in South African schools in literature. The need for more initiatives on promotion of adolescent mental health in schools was evident from the study findings. The major findings such as alcohol and drug use and a need to belong also revealed that social and emotional problems with negative outcomes on the adolescent mental health are still prevalent.

The proposed universal intervention programme, TEAM, for the promotion of adolescent mental health is aimed at minimising the occurrence of behaviours associated with risky development and mental health problems and if implemented appropriately can be applied in both developed and developing countries. The researcher envisages that the proposed use of positive gangs as an intervention strategy would in turn bring about positive outcomes from gangs such as high quality peer relationships, enhanced protective factors and risk and stress factor reduction, as opposed to outcomes associated with destructive gangsterism.

The study used an Event History Calendar as both quantitative and qualitative tool that yielded comprehensive results. The tool therefore can be used by school health nurses

in high schools as it is believed that it can assist them in collecting holistic information on the social and emotional well-being of the adolescents and determinants thereof needed in the planning of adolescents' mental health promotion based using the "TEAM" programme in high schools.

7.5 CONCLUSION

Chapter 7 gave an overall summary of the study and also discussed the strengths and limitations of the study. Recommendations from the study were also made for future research and for the use of policy makers, school teachers and school nurses.

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ANNEXURES

ANNEXURE A

Ethical Clearance Certificate:

Department of Health Studies, Unisa

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/248/2013

Date: 20 November 2013 Student No: 654-695-1

Project Title: Promotion of adolescent mental health through a social and emotional learning programme in the South African high schools.

Researcher: Faniswa Honest Mfidi

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Prof GB Thupayagale-Tshweneagae
Qualification: D Tech
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

UNIVERSITEIT VAN SUID-AFRIKA
PRETORIA
UNIVERSITY OF SOUTH AFRICA

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ANNEXURE B1

Letters requesting permission to conduct the study:

Department of Health, Province of the Eastern Cape

The Directorate - Primary health care services
Department of Health
BISHO
30th September 2014

Dear Sir/Madam
Re: Permission to conduct research in the King Sabatha Dalindyebo District, Eastern Cape Province.

I am a PhD candidate and lecturer at the University of South Africa, Department of Health Studies. I am requesting permission to conduct a research study in the primary health care services in KSD District. The study is undertaken for the fulfilment of a PhD degree and is entitled "***The Promotion of adolescent mental health through social and emotional learning programme in South African schools".***

The purpose of the study is to explore experiences of school health nurses in dealing with social, emotional and behavioural problems of school going adolescents in high schools with the aim of developing a social and emotional learning programme for the promotion of adolescent mental health. Data collection will be through semi-structured interviews. These interviews will last approximately 45minutes and will be audiotaped with the permission of the prospective participants.

A copy of the summary of the findings will be made available to your office on completion of the study.

Yours sincerely
……
Ms FH Mfidi

Permission to do the research at the primary health care services as requested is hereby approved

Directorate for Primary health care services
Eastern Cape

Mr/Mrs/Ms……

……
Signature of the Director

OFFICIAL STAMP

The District Manager
Primary health care services
KSD District
MTHATHA
11 December 2014

Dear Madam

Re: Permission to conduct research in the King Sabatha Dalindyebo District, Eastern Cape Province.

I am a PhD candidate and lecturer at the University of South Africa, Department of Health Studies. I am requesting permission to conduct a research study in the primary health care services in KSD District. The study is undertaken for the fulfilment of a PhD degree and is entitled "***The Promotion of adolescent mental health through social and emotional learning programme in South African schools".***

The purpose of the study is to explore experiences of school health nurses in dealing with social, emotional and behavioural problems of school going adolescents in high schools with the aim of developing a social and emotional learning programme for the promotion of adolescent mental health. Data collection will be through semi-structured interviews. These interviews will last approximately 45 minutes and will be audiotaped with the permission of the prospective participants.

A copy of the summary of the findings will be made available to your office on completion of the study.

Yours sincerely
……

Ms FH Mfidi

ANNEXURE B2

Letters requesting permission to conduct the study:

Department of Basic Education, Province of the Eastern Cape

The Director
Department of Basic Education
Bisho
Eastern Cape Province
10 October 2014

Dear Sir/Madam

Re: Permission to conduct research in the King Sabatha Dalindyebo District, Eastern Cape Province.

I am a PhD candidate and lecturer at the University of South Africa, Department of Health Studies. I am requesting permission to conduct a research study in the high schools in KSD District. The study is undertaken for the fulfilment of a PhD degree and is entitled "***The Promotion of adolescent mental health through social and emotional learning programme in South African schools".***

The purpose of the study is to explore experiences of school going adolescents and school teachers in dealing with social, emotional and behavioural problems in high schools with the aim of developing a social and emotional learning programme for the promotion of adolescent mental health. Data collection will be through self-reports using event history calendars and semi-structured interviews. These interviews will last approximately 45minutes and will be audiotaped with the permission of the prospective participants.

A copy of the summary of the findings will be made available to your office on completion of the study.
Yours sincerely

…….
Ms FH Mfidi

Permission to do the research at the high schools in the KSD district as requested is hereby approved

Director- Department of Basic education
Mthatha District
Mr/Mrs/Ms
…….

…….
Signature of the Director

OFFICIAL STAMP

12 December 2014
The Director
Mthatha District Office
Department of Basic Education

Dear Sir/Madam

Re: Permission to conduct research in the King Sabatha Dalindyebo District, Eastern Cape Province.

I am a PhD candidate and lecturer at the University of South Africa, Department of Health Studies. I am requesting permission to conduct a research study in the high schools in KSD District. The study is undertaken for the fulfilment of a PhD degree and is entitled "***The Promotion of adolescent mental health through social and emotional learning programme in South African high schools".***

The purpose of the study is to explore experiences of school going adolescents and school teachers in dealing with social, emotional and behavioural problems in high schools with the aim of developing a social and emotional learning programme for the promotion of adolescent mental health. Data collection will be through self-reports using event history calendars and semi-structured interviews. These interviews will last approximately 45minutes and will be audiotaped with the permission of the prospective participants.

A copy of the summary of the findings will be made available to your office on completion of the study.
Yours sincerely

…….
Ms FH Mfidi

Permission to do the research at the high schools in the KSD district as requested is hereby approved

Director- Department of Basic education
Mthatha District
Mr/Mrs/Ms …….
…….

Signature of the Director

OFFICIAL STAMP

12 December 2014
The Principal
……
……

Dear Sir/Madam

Re: Permission to conduct research in your high school under King Sabatha Dalindyebo District, Eastern Cape Province.

I am a PhD candidate and lecturer at the University of South Africa, Department of Health Studies. I am requesting permission to conduct a research study in your high school. The study is undertaken for the fulfilment of a PhD degree and is entitled "***The Promotion of adolescent mental health through social and emotional learning programme in South African high schools".***

The purpose of the study is to explore experiences of school going adolescents and school teachers in dealing with social, emotional and behavioural problems in high schools with the aim of developing a social and emotional learning programme for the promotion of adolescent mental health. Data collection will be through self-reports using event history calendars and semi-structured interviews. These interviews will last approximately 45minutes and will be audiotaped with the permission of the prospective participants.

A copy of the summary of the findings will be made available to your office on completion of the study.
Yours sincerely

……
Ms FH Mfidi

Permission to do the research at the above named high schools in the KSD district as requested is hereby approved

The Principal
……High School
Mr/Mrs/Ms ……
……
PRINT SURNAME & INITIALS Signature of the Principal

OFFICIAL STAMP

ANNEXURE C

Letters of approval to conduct the study:

Eastern Cape Department of Health

Province of the Eastern Cape Education

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	11th December 2014	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Ms F.H. Mfidi

Re: Promotion of adolescent mental health through a social and emotional learning programme in the South African high schools

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

PGDP EASTERN CAPE

Ikamva eliqaqambileyo!

Province of the
EASTERN CAPE
EDUCATION

STRATEGIC PLANNING POLICY RESEARCH AND SECRETARIAT SERVICES
Steve Vukile Tshwete Complex • Zone 6 • Zwelitsha • Eastern Cape
Private Bag X0032 • Bhisho • 5605 • REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)40 608 4773/4035/4537 • Fax: +27 (0)40 608 4574 • Website: www.ecdoe.gov.za

Enquiries: B Pamla Email: babalwa.pamla@edu.ecprov.gov.za Date: 28 November 2014

Ms. Faniswa Mfidi
1 Preller Street, Muckleneuk
Pretoria
0001

Dear Ms. Mfidi

PERMISSION TO UNDERTAKE A DOCTORAL STUDY: PROMOTION OF ADOLESCENT MENTAL HEALTH THROUGH A SOCIAL AND EMOTIONAL LEARNING PROGRAMME IN SOUTH AFRICAN SCHOOLS

1. Thank you for your application to conduct research.
2. Your application to conduct a research in five High Schools under the jurisdiction of Mthatha District of the Eastern Cape Department of Education (ECDoE) is hereby approved based on the following conditions:
    a. there will be no financial implications for the Department;
    b. institutions and respondents must not be identifiable in any way from the results of the investigation;
    c. you present a copy of the written approval letter of the Eastern Cape Department of Education (ECDoE) to the Cluster and District Directors before any research is undertaken at any institutions within that particular district;
    d. you will make all the arrangements concerning your research;
    e. the research may not be conducted during official contact time, as educators' programmes should not be interrupted;
    f. should you wish to extend the period of research after approval has been granted, an application to do this must be directed to Chief Director: Strategic Management Monitoring and Evaluation;
    g. the research may not be conducted during the fourth school term, except in cases where a special well motivated request is received;

h. your research will be limited to those schools or institutions for which approval has been granted, should changes be effected written permission must be obtained from the Chief Director: Strategic Management Monitoring and Evaluation;

i. you present the Department with a copy of your final paper/report/dissertation/thesis free of charge in hard copy and electronic format. This must be accompanied by a separate synopsis (maximum 2 – 3 typed pages) of the most important findings and recommendations if it does not already contain a synopsis.

j. you present the findings to the Research Committee and/or Senior Management of the Department when and/or where necessary.

k. you are requested to provide the above to the Chief Director: Strategic Management Monitoring and Evaluation upon completion of your research.

l. you comply with all the requirements as completed in the Terms and Conditions to conduct Research in the ECDoE document duly completed by you.

m. you comply with your ethical undertaking (commitment form).

n. You submit on a six monthly basis, from the date of permission of the research, concise reports to the Chief Director: Strategic Management Monitoring and Evaluation.

3. The Department reserves a right to withdraw the permission should there not be compliance to the approval letter and contract signed in the Terms and Conditions to conduct Research in the ECDoE.

4. The Department will publish the completed Research on its website.

5. The Department wishes you well in your undertaking. You can contact the Director, Ms. NY Kanjana on the numbers indicated in the letterhead or email nelisakanjana@gmail.com should you need any assistance.

NY KANJANA
DIRECTOR: STRATEGIC PLANNING POLICY RESEARCH & SECRETARIAT SERVICES

FOR SUPERINTENDENT-GENERAL: EDUCATION

ANNEXURE D

Information leaflets and informed consent

Information leaflet and informed consent for students

TITLE OF THE STUDY

Promotion of adolescent mental health through a social and emotional learning programme in South African high schools.

Dear Participant,

As a Student in this high school, you have been selected to participate in this study that will be conducted in your school premises. This information leaflet contains information that will help you to understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher, Ms Faniswa Mfidi at any time.

1. The nature and purpose of this study

The fact that you are a school going adolescent who has together with your peers/fellow students experienced the social, emotional and behavioural challenges posed to you by this transitional period, called adolescence, your participation in the study that seeks to develop a school-based social and emotional learning (SEL)programme for the promotion of adolescent mental health will be crucial.

As the study will be conducted in two phases, your participation will be required in the 1st phase where the researcher will explore and describe your experiences with regard to social, emotional and behavioural problems.

2. Explanation of the procedure to be followed

As a student you will be required to compile and fill in an event history calendar (EHC) with regard to your experiences of social and emotional problems within the past five years. This will take you approximately 40mins. After that the researcher will conduct face to face interview of each of you in order to obtain rich information and clarity on what is written in the EHC. This will also provide the researcher with in-depth understanding of your experiences of social and emotional development. This interview will take approximately 45minutes and will be digitally recorded to ensure that every conversation is captured verbatim. As a measure to protect the participants' identity and ensure confidentiality you will not write your name in the EHC instead a code will be given and after data analysis the recorded information will be disposed of.

3. Risk and discomfort involved

There may be some discomfort during the completion of the EHC and following individualised interview. However should you experience discomfort either physical or emotionally, the researcher will allow you to withdraw from the study, offer your some debriefing or refer you for psychological counselling. However your identity as a participant will be kept confidential. Your participation into this study will also require some of your time and effort.

4. Benefits of study

A social and emotional learning programme that the study seeks to design will be used to assist students in the development of their social and emotional competencies that would enable them to face various challenges posed by adolescence and thus improve their academic achievement. The programme will be of use to all people in the care or who are interacting with adolescents and at the end promote a mentally healthy adolescent who later would grow into a productive and successful adult. As a participant one will gain knowledge as to how assessment of aspects in your social and emotional development is done.

5. Your right as a participant

Your participation in the study is entirely voluntary. You can refuse to participate or withdraw at any time during the study without giving any reason or and no penalty will be meted out.

6. Ethical approval

The research has been granted ethical clearance and approval by the Department of Health Studies Higher Degrees Committee, at UNISA. Permission to undertake this study has been obtained from the Provincial Department of Education, Umthatha District Office and the school principal and school governing body(SGB). Through the principal the parents' assent has been requested.

7. Additional information

If you have any questions about the research you are welcome to contact Higher Degrees Committee in the Department of Health Studies, UNISA

Tel: 012 429 2195

Fax: 012 429 6688

Email: tshweg@unisa.ac.za

For any question about your participation in this study, you should contact the researcher, Ms Faniswa H. Mfidi.

Contact No. Work: 012 4296731

Cellphone: 082 200 7653

Email address: mfidifh@unisa.ac.za

Alternatively you can contact my supervisor Prof G. Thupayagale-Tshweneagae

Work: 012 4292195

Email address: tshweg@unisa.ac.za

8. Compensation

Your participation is voluntary. No compensation will be given for your participation.

9. Confidentiality

All the information you provided in this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

Consent to participate in this study (Phase I)

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I confirm that the person asking my consent to take part in this study told me about the nature, process, risk, discomforts and benefits of the study. I have also received, read and understood the above written information regarding the study. I am aware that the results of the study, including personal details will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objections to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

Participant's name..... (Please print)

Participant's signature.....Date.....

Investigator's name..... (Please print)

Investigator's signature.....…Date.....

Witness name..... (Please print)

Witness signature.....Date.....

Information leaflet and informed consent for Teachers

TITLE OF THE STUDY

Promotion of adolescent mental health through a social and emotional learning programme in South African high schools

Dear Participant,

As a Life orientation teacher, you have been selected to participate in this study that will be conducted in your school premises. This information leaflet contains information that will help you to understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher, Ms Faniswa Mfidi at any time.

1. The nature and purpose of this study

The fact that you are working as a teacher in a high school, you interact on a daily basis with school going adolescents who by virtue of their developmental stage exhibit or experience social, emotional and behavioural challenges. Therefore your participation in the study that seeks to develop a school-based social and emotional learning (SEL) programme for the promotion of adolescent mental health is very crucial. In order to achieve this aim the researcher is required to first explore and describe your experiences in dealing with students with social, emotional and behavioural problems.

2. Explanation of the procedure to be followed

You are requested to participate in the unstructured individual interview that will be conducted within the school premises at the time convenient to you. The interview will last approximately 45minutes and will be digitally recorded and transcribed thereafter. As a measure to protect your identity and ensure confidentiality your name will not be attached to the information you have supplied and after data analysis the recorded information will be disposed of.

3. Risk and discomfort involved

There is no discomfort foreseen during the individualised interview. However should you experience discomfort either physical or emotionally, the researcher will allow you to withdraw from the study, and/or offer your some debriefing or refer you for psychological counselling. However your identity as a participant will be kept confidential. Your participation into this study will also require some of your time and effort.

4. Benefits of study

A social and emotional learning programme that the study seeks to design will be used to assist students in the development of their social and emotional competencies that would enable them to face various challenges posed by adolescence and thus improve their academic achievement. The programme will be of use by all people in the care or who are interacting with adolescents and at the end promote a mentally healthy adolescent who later would grow into a productive and successful adult. As a participant one will gain knowledge as to how assessment of aspects in your social and emotional development is done.

5. Your right as a participant

Your participation in the study is entirely voluntary. You can refuse to participate or withdraw at any time during the study without giving any reason and no penalty will be meted out.

6. Ethical approval

The research has been granted ethical clearance and approval by the Department of Health Studies Higher Degrees Committee, at UNISA. Permission to undertake this study has been obtained from the Provincial Department of Education, Mthatha District Office and the school principal and school governing body (SGB).

7. Additional information

If you have any questions about the research you are welcome to contact the Higher Degrees Committee in the Department of Health Studies, UNISA
Tel: 012 429 2195

Fax: 012 429 6688

Email: tshweg@unisa.ac.za

For any question about your participation in this study, you should contact the researcher, Ms Faniswa H Mfidi

Contact No. Work: 012 4296731

Cellphone: 082 200 7653

Email address: mfidifh@unisa.ac.za

Alternatively you can contact my supervisor Prof G. Thupayagale-Tshweneagae

Work: 012 4292196

Email address: tshweg@unisa.ac.za

8. Compensation

Your participation is voluntary. No compensation will be given for your participation.

9. Confidentiality

All the information you provided in this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

Consent to participate in this study (Phase I)

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I confirm that the person asking my consent to take part in this study told me about the nature, process, risk, discomforts and benefits of the study. I have also received, read and understood the above written information regarding the study. I am aware that the results of the study, including personal details will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objections to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

Participant's name..... (Please print)

Participant's signature.....Date.....

Investigator's name..... (Please print)

Investigator's signature.....Date.....

Witness name..... (Please print)

Witness signature.....Date.....

Information leaflet and informed consent for School health nurse

TITLE OF THE STUDY

Promotion of adolescent mental health through a social and emotional learning programme in South African schools

Dear Participant,

As a school health nurse, who in your work interacts with school going adolescents, you have been selected to participate in this study. This information leaflet contains information that will help you to understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher, Ms Faniswa Mfidi at any time.

1. The nature and purpose of this study

The fact that you are working as a school health nurse in the KSD district and providing services to all the nearby High schools, you interact on a daily basis with school going adolescents who by virtue of their developmental stage exhibit or experience social, emotional and behavioural challenges. Therefore your participation in the study that seeks to develop a school-based social and emotional learning (SEL) programme for the promotion of adolescent mental health is very crucial.

In order to achieve this aim the researcher is required to first explore and describe your experiences in dealing with students with social, emotional and behavioural problems.

2. Explanation of the procedure to be followed

You are requested to participate in 2 focus group interviews that will be conducted in the the offices of the local service area (LSA) for health. The first focus group will last for approximately 1½hours and will be digitally recorded and transcribed thereafter. As a measure to protect your identity and ensure confidentiality your name will not be attached to the information you have supplied and after data analysis the recorded information will be disposed of.

3. **Risk and discomfort involved**

There is no discomfort foreseen for the focus group interview. However should you experience discomfort either physical or emotionally, the researcher will allow you to withdraw from the study, offer your some debriefing or refer you for psychological counselling. However your identity as a participant will be kept confidential. Your participation into this study will also require some of your time and effort.

4. **Benefits of study**

A social and emotional learning programme that the study seeks to design will be used to assist students in the development of their social and emotional competencies that would enable them to face various challenges posed by adolescence and thus improve their academic achievement. The programme will be of us to all people in the care or who are interacting with adolescents and at the end promote a mentally healthy adolescent who later would grow into a productive and successful adult. As a participant one will gain knowledge as to how assessment of aspects in your social and emotional development is done.

5. **Your right as a participant**

Your participation in the study is entirely voluntary. You can refuse to participate or withdraw at any time during the study without giving any reason and no penalty will be meted out.

6. **Ethical approval**

The research has been granted ethical clearance and approval by the Department of Health Studies Higher Degrees Committee, at UNISA. Permission to undertake this study has been obtained from the Provincial Department of Health, District Manager in KSD and Manager for school health services KSD-LSA.

7. **Additional information**

If you have any questions about the research you are welcome to contact the Higher Degrees Committee in the Department of Health Studies, UNISA

Tel: 012 429 2195

Fax: 012 429 6688

Email: tshweg@unisa.ac.za

For any question about your participation in this study, you should contact the researcher, Ms Faniswa H Mfidi.

Contact No. Work: 012 4296731

Cellphone: 082 200 7653

Email address: mfidifh@unisa.ac.za

Alternatively you can contact my supervisor Prof G. Thupayagale-Tshweneagae

Work: 012 4292195

Email address: tshweg@unisa.ac.za

8. Compensation

Your participation is voluntary. No compensation will be given for your participation.

9. Confidentiality

All the information you provided in this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

Information leaflet and informed consent for Parents

TITLE OF THE STUDY

Promotion of adolescent mental health through a social and emotional learning programme in South African schools

Dear Parent/Guardian,

Your son/daughter who is attending ……..high school as a Grade…..……learner has been selected to be amongst the students who will be participating in the above named research. The researcher hereby requests your permission in this regards. This information leaflet contains information that will help you to understand your child's role in the study. If there is any need for further clarification, please feel free to contact the researcher, Ms Faniswa Mfidi at any time.

1. **The nature and purpose of this study**

The fact that your child is a school going adolescent who together with other peers/fellow students are faced with social, emotional and behavioural challenges posed to them by this transitional period, called adolescence, their participation in the study that seeks to develop a school-based social and emotional learning (SEL) programme for the promotion of adolescent mental health will be crucial.

As the study will be conducted in two phases, your child will be required to participate in the 1st phase where the researcher will explore and describe experiences of school going adolescents with regard to social, emotional and behavioural problems.

2. **Explanation of the procedure to be followed**

The students will be required to compile and fill in an event history calendar (EHC) with regard to their experiences of social and emotional problems within the past five years. This will take approximately 40mins. After that the researcher will conduct face to face interview of each student in order to obtain rich information and clarity on what is written in the EHC. This will also provide the researcher with in-depth understanding of their experiences of social and emotional development. This interview will take approximately 45 minutes and will be digitally recorded to ensure that every conversation is captured verbatim. As a measure to protect the participants' identity

and ensure confidentiality their names will not be used in the EHC and after data analysis the recorded information will be disposed of.

3. Risk and discomfort involved

There may be some discomfort anticipated during the completion of the EHC and following individualised interview. However should the discomfort be experienced either physical or emotionally, the researcher will allow the participant to withdraw from the study, offer him/her some debriefing or refer for psychological counselling. However one's identity as a participant will be kept confidential. Participation in this study also requires some of your child's time and effort.

4. Benefits of study

A social and emotional learning programme that the study seeks to design will be used to assist students in the development of their social and emotional competencies that would enable them to face various challenges posed by adolescence and thus improve their academic achievement. The programme will also assist all people in the care or who are interacting with adolescents and at the end promote a mentally healthy adolescent who later would grow into a productive and successful adult. As a participant, your child will gain knowledge as to how assessment of aspects in his social and emotional development is done.

5. Your right as a participant

Your child's participation in the study is entirely voluntary. You can refuse him to participate or withdraw him at any time during the study without giving any reason and no penalty will be meted out.

6. Ethical approval

The research will first be granted ethical clearance and approval by the Department of Health Studies - Higher Degrees Committee, at UNISA before data could be collected; permission from the Department of Education in the Province and in the district; from the school principal and school governing body(SGB) will be sought.

7. Additional information

If you have any questions about the research you are welcome to contact the Higher Degrees Committee in the Department of Health Studies, UNISA.

Tel: 012 429 2195

Fax: 012 429 6688

Email: tshweg@unisa.ac.za

For any question about your participation in this study, you should contact the researcher, Ms Faniswa H Mfidi

Contact No. Work: 012 4296731

Cellphone: 082 200 7653

Email address: mfidifh@unisa.ac.za

Alternatively you can contact my supervisor Prof G. Thupayagale-Tshweneagae

Work: 012 4292196

Cellphone: 082 200 7653

Email address: tshweg@unisa.ac.za

8. Compensation

Your participation is voluntary. No compensation will be given for your participation.

9. Confidentiality

All the information you provided in this research will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

Consent to participate in this study (Parental assent)

The participation of your child in this research is subject to reading and accepting the above information and signing the informed consent document below. A copy of the signed consent document will be given to you.

INFORMED CONSENT

I confirm that the person asking my consent to take part in this study told me about the nature, process, risk, discomforts and benefits of the study. I have also received, read and understood the above written information regarding the study. I am aware that the results of the study, including personal details will be anonymously processed into research reports. I am allowing my child to participate willingly. I have had time to ask questions and have no objections to his/her participation in the study. I understand that there is no penalty should I wish she/he discontinue with the study and my withdrawal will not affect him/her in any way.

Parent's/ Guardian name..... (Please print)

Parent's/ Guardian Signature.....Date.....

Investigator's name..... (Please print)

Investigator's signature.....Date.....

Witness name..... (Please print)

Witness signature.....Date.....

ANNEXURE E

Event History Calendar (Questionnaire)

EVENT HISTORY CALENDAR: ……..Code No:

YEARS		2010	2011	2012	2013	2014
AGE						
SCHOOL GRADE						
GENDER & RACE						
INSTRUCTIONS:						
FIRST: Think about the **PAST YEARS** of your life and answer each question below	**THEN:** Write each answer under the year it happened and action/s taken to deal with					
Life events						
What are your goals in life	**Example**: personal or academic					
What important thing happened to you (good or bad	**Example**: First date; initiation; received an award; got pregnant; first sexual encounter; juvvy, arrests, detained, separated from girlfriend/boyfriend etc.					
What important event happened to your family	**Example**: Moved to a new house; parents got new jobs; new birth family; Parent divorced, moving away, death, loss of job					

What important event had happened at school	Example: good grade, got suspended, bullied, blamed/punished unfairly						
Personal and social competencies							
(i)Personal awareness: Recognising strengths and weaknesses	Example: Confidence, shyness, bold, self-centred, sense of humour, time management						
Recognizing one's emotions and thoughts and their influence on behaviour	Example: recognize your own or others' anger, happiness, sadness						
(ii)Regulating and Handling one's emotions: Controlling moods/impulses Managing stress	Example: your behaviour when angry, happy, sad include fight, cry talk about, break objects, drink or smoke, eat a lot, engage in sexual activity -Involve in extramural activity, stay alone, listen to music, drink or smoke sleep/eat less/a lot						
(iv)Relationship and support system: Whom do you live with?	Example: mother/father/ both, step/adoptive parents, sibling, guardian, girl/ boyfriend						

How do you relate to family,	Example: good, sour, fighting, listen obediently						
friends and	Close/ no friend, frequent breakups with friends/girl/boy. Self-centred, empathic and sensitive to other's feelings, listen and show respect.						
school	Playing truant, respectful to teachers and peers, teachers overly strict, buddies						
Role model: who is your role model What does your role model signifies	Example: A celebrity, important person like Mr President, principal, Teacher, family member Example: Principled, good moral value,						

(v)Dealing with significant incidents: -feeling depressed/lonely - peer pressure and peer victimization	Example: take alcohol/drug, talk about, suicidal ideas, smoke weed/nyaope, indulge in unsafe sex, sleep/eat less/lots Resistant, go along, fight back, runaway,						

Modified adaptation from: Fisher and Lee (2012:782)

Please write anything that has not been covered that you feel is significant for you

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ANNEXURE F

Editor’s letter

Prof. S. Tichapondwa Modesto
Fountain Technologies (Pty) Ltd
D.Lit et Phil (UNISA); MA-ESL (UZ) BEd Cure (UNISA), Bachelors (Hons) (M.Ed (UZ), DHM (BATEC); Cert Law (UNISA)
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EDITORIAL CERTIFICATE – COPY EDITING

(24 January 2016)

ROMOTION OF ADOLESCENT MENTAL HEALTH THROUGH A SOCIAL AND EMOTIONAL LEARNING PROGRAMME IN HIGH SCHOOLS

by

FANISWA HONEST MFIDI

This serves to confirm that the above-named document has been edited for language. In terms of the linguistic dimension, the following aspects were closely addressed :

1. General orthographic aspects e.g. hyphenating compound adjectives such as decision-making, school-going, etc. or suggesting more appropriate words for a given concept e.g. instead of saying' do research, it is more scholarly to say, 'conduct research'
2. Spelling
3. Tense use at different stages of the write-up
4. Logical flow of argumentation, and logical timing of new ideas
5. Cohesion and coherence of the thinking process as expressed verbally. Examples include : repetition of the same ideas, lack of agreement between subject and object of a sentence
6. Syntax as it relates to structuring, ambiguity and appropriateness of diction. Examples include lengthy sentences that are complex, and should be reduced to two or three, thereby acheiving clarity of intended meaning ; poor punctuation that prejudices clarity and sense

ANNEXURE G

Additional Quantitative data analysis

(Chi-square test results)

QUANTITATIVE DATA ANALYSIS
Chi-Square tests of independence

Table 4.12: Chi-square test of independence to determine impact of gender on experiences of adolescents in dealing with social and emotional problems				
Dimension	**Chi-square value**	**p-value**	**Decision**	**Cramer's V**
Dealing with significant events	49.494	.000**	*Null hypothesis is rejected*	.576
Handling of emotions	27.010	.000**	*Null hypothesis is rejected*	.367
Stress management	20.089	.000**	*Null hypothesis is rejected*	*.317*
Relationship management	12.862	.005**	*Null hypothesis is rejected*	*.257*
Decision-making	10.812	.004**	*Null hypothesis is rejected*	.244
Reflection on decisions	10.095	.006**	Do not reject the null hypothesis	.279
Personal awareness	13.952	.001**	*Null hypothesis is rejected*	*.289*
Events at school	32.677	.000**	*Null hypothesis is rejected*	.522

Table 4.13: Chi-square test of independence to determine impact of school setting on experiences of adolescents in dealing with social and emotional problems				
Dimension	**Chi-square value**	**p-value**	**Decision**	**Cramer's V**
Handling of emotions	64.152	.000**	*Null hypothesis is rejected*	.566
Relationship management	17.711	.001**	*Null hypothesis is rejected*	*.302*
Reflection on decisions	8.988	.011*	Do not reject the null hypothesis	.263
Events at school	37.010	.000**	*Null hypothesis is rejected*	.555

Table 4.14: Chi-square test of independence to determine impact of age on experiences of adolescents in dealing with social and emotional problems				
Dimension	**Chi-square value**	**p-value**	**Decision**	**Cramer's V**
Dealing with significant events	24.535	.002**	*Null hypothesis is rejected*	.406
Stress management	26.694	.001**	*Null hypothesis is rejected*	*.365*
Decision making	10.930	.027**	*Null hypothesis is rejected*	.246
Reflection on decisions	12.569	.014*	*Null hypothesis is rejected*	.311
Personal awareness	22.320	.000**	*Null hypothesis is rejected*	*.366*
Events at school	16.121	.013**	*Null hypothesis is rejected*	.367

Table 4.15: Chi-square test of independence to determine impact of grade on experiences of adolescents in dealing with social and emotional problems				
Dimension	**Chi-square value**	**p-value**	**Decision**	**Cramer's V**
Dealing with significant events	19.967	.010*	*Null hypothesis is rejected*	.366
Stress management	35.541	.000**	*Null hypothesis is rejected*	*.422*
Decision making	12.584	.013*	*Null hypothesis is rejected*	.264
Events at school	27.846	.000**	*Null hypothesis is rejected*	.482

Table 4.16: Chi-square test of independence to determine impact of gender and school setting on experiences of adolescents in dealing with social and emotional problems					
Dim**ension**	**School setting**	**Chi-square value**	**p-value**	**Decision**	**Cramer's V**
Dealing with significant events	Urban	17.991	.001**	*Null hypothesis is rejected*	.526
	Rural	50.130	.000**	*Null hypothesis is rejected*	.773
Stress management	Urban	9.600	.048*	*Null hypothesis is rejected*	*.336*
	Rural	19.726	.001**	*Null hypothesis is rejected*	*.414*
Decision making	Urban	29.977	.000**	*Null hypothesis is rejected*	*.624*
	Rural	12.199	.002**	*Null hypothesis is rejected*	*.342*