The identification and management of learners with anxiety disorders in a South African inclusive educational setting

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DECLARATION

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THE IDENTIFICATION AND MANAGEMENT OF LEARNERS WITH ANXIETY DISORDERS IN A SOUTH AFRICAN INCLUSIVE EDUCATIONAL SETTING

I, Philippa Helen Fabbri, hereby declare that the above thesis is my own original work and that all sources used or referred to have been indicated and recognised by means of complete references.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it for examination at Unisa for another qualification or at any other higher education institution.

Signature: ____________________
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Date: 9 November 2020

DEDICATION

This research study is dedicated to all the learners that I have met, taught and shared special moments with. You have all touched my life in some way or another, and from when I entered the classroom for the very first time in 1990 as a student teacher to this present day, I knew that teaching would impact on my life in a big way.

To my school, Elsen Academy, which has become the school that I am the most proud of and which I feel blessed to call my workplace. This is where my dream of teaching became a reality.

To my colleagues at Elsen Academy, what you do on a daily basis to help and support the most vulnerable learners, is beyond miraculous. When I walk down the corridors and passages, I feel the love, I hear laughter and joy and I see engaged learners and teachers, actively learning and playing. It is a very special place to teach and learn.

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I feel privileged to have been able to call teaching my profession and vocation.

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ABSTRACT

As many as 8 to 11% of children and adolescents suffer from an anxiety disorder which can develop into specific phobias, social phobias, generalised anxiety disorders and obsessive behaviour. Childhood and adolescents are identified as the main risk developmental phases for the beginning of anxiety disorders and abnormal anxiety levels have negative effects on cognitive functioning, school performance and outcomes. If it were known why anxiety disorders in children was on the increase, some changes could be made to suitably accommodate these learners in schools. Learning barriers can also cause anxiety disorders, resulting in learners' poor performances academically.

A typical school community was selected to conduct the research. The main study objective was to facilitate the implementation of an education support plan, to enable learners with anxiety to participate in learning activities, and provide guidelines on the effective teaching and learning strategies for learners with anxiety disorders. What defines anxiety in learners at school, how are these anxiety disorders managed and what support is available, were the three main research questions posed. Relevant data was gathered via document analysis, questionnaires, observations and field notes and a mixed-method study approach and an interpretivist paradigm were chosen, with the researcher acting as a participant observer. Through a mixed methods approach, relevant in-depth information was generated and by choosing to conduct a case study, an in-depth analysis of anxiety disorders in learners and adolescents in their natural school setting was possible. The researcher's personal experiences and interactions with the learners, also allowed for a subjective epistemology.

A pyramid structure and framework was recommended to maximise support for learners experiencing an anxiety disorder. This framework is comprised of three pillars on which the learner's success rests, namely: the enrolment procedure, having a support team and effective communication. The teachers indicated that by really getting to know their learners and responding to their needs, they could reduce feelings of anxiety in their learners. Finally, a goal for the near future was set to reduce the unwanted rise of anxious distress in young learners and adolescents so that they can be the successful adults of tomorrow.

KEY TERMS

Anxiety disorders, adolescents, children, management, support, learning disorders, learning barriers, inclusivity, accommodations, cross-sectional case-study

ACRONYMS

AD	Anxiety Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CBT	Cognitive Behavioural Therapy
CD	Conduct Disorder
DBST	District Based Support Team
EBD	Extreme Behaviour Disorder
GAD	General Anxiety Disorder
GP	General Practitioner
LB	Learning Barriers
LD	Learning Disorders
LSP	Learner Support Policy
NGO	Non-Governmental Organisation
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
SAD	Separation Anxiety Disorder
SADAG	South African Depression Anxiety Group
SIAS	Screening, Identification, Assessment, Support
SBST	School Based Support Team
SENCO	Special Educational Needs Coordinator
SGB	School Governing Body
SMT	School Management Team

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CHAPTER 1
INTRODUCTION, BACKGROUND AND PROBLEM STATEMENT

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Children as young as three years of age are being treated for anxiety (Clark, 2017a/b/c/d, p. 2), and it seems as if the population living with an anxiety disorder (AD) is increasing in South Africa. If it were known why this was the case, some changes could possibly be made to accommodate these learners in schools.

Seventeen years ago, the researcher was running a successful private remedial practice and conducting assessments and remedial therapy in mathematics and language (reading and spelling skills), for learners attending mainstream schools in the Port Elizabeth area. Many of these learners not only had learning barriers, such as reading disorders or problems with working with numbers, but they also suffered from anxiety and other issues, such as feelings of hopelessness, helplessness and low self-esteem.

In 2006, with only 13 learners, the researcher and two colleagues, established an independent school, where learners could receive full-time remedial and emotional support. Parents also had the additional benefit of having a group of professionals, under the guidance of a case manager, tending to the academic and emotional needs of their child. These interventions included speech and language therapy, remedial therapy, occupational therapy, as well as play therapy and counselling.

Since 2006, the school has expanded and more learners are being referred, with learning barriers such as dyslexia, dyspraxia, ADHD (attention deficit hyperactivity disorder), ASD (autism spectrum disorder) and various anxiety disorders, including school phobia and general anxiety disorder (GAD).

Anxiety rarely occurs in isolation, and often occurs with other conditions such as oppositional defiant disorder, depression or other learning disorders such as ADHD. Hallahan, Kauffman and Pullen (2012 p. 182) stated that between 25 and 50% of ADHD sufferers also exhibit some form of emotional or behavioural disorder, with anxiety also being evident in around 15 to 35% of children. Jacobs and Wendel (2010, p. 35) cite studies that show that about a third of children with ADHD also suffer from anxiety disorders and that they worry about anything and everything. On the other hand, high school learners tend to display apathy or ‘no care’ attitude when they underperform and tend to do the bare minimum of their schoolwork, to the utmost frustration of both parents and teachers.

Mammarella, Marta, Ghisi, Bomba, Bottesi, Caviola, Broggi and Nacinovich (2016, p. 131) describe how they attempted to reveal psychological characteristics of children, aged between eight and eleven years, with different learning disability profiles. The study showed that often teachers were qualified to recognise the learning barriers that learners might have such as a reading problem or handwriting challenges but they were not equipped to manage the emotional needs of these learners, not to mention the psychopathological co-morbidities that accompanied them.

This lack of expertise results in teachers incorrectly labelling learners according to the behaviours that they see and not according to the underlying causes of these behaviours. For example, a learner might be seen to have ADHD because of extreme restlessness, lack of focus, constant fidgeting, and, as a result, often treated with stimulant medication. However, the underlying cause of these behaviours could be anxiety. In addition, often when a learner is misdiagnosed and placed on a stimulant medication for ADHD, the anxiety is exacerbated.

A review conducted by Cresswell, Waite and Cooper (2014) highlighted concerns with assessment and treatment of some of the different anxiety disorders, such as separation anxiety, generalised anxiety disorder, social anxiety disorder, panic disorder and agoraphobia in both children and adolescents. What Cresswell et al. (2014, p. 674) found was that most of these children and adolescents with anxiety disorders, did not seek out assistance.

The objectives of a study by Villabo, Gere, Torgersen, March and Kendall (2012, p. 75) were to examine critically the Multidimensional Anxiety Scale for Children (MASC), which measured physical symptoms, harm avoidance, social anxiety and separation/panic. The study by Villabo et al. (2012) concluded that assessments of child anxiety are best when they do not rely on one single method only. For example, although the MASC is an appropriate screening instrument for anxiety, a diagnostic dialogue with the interviewee is also helpful for the evaluation of high-scoring children (Villabo et al., 2012, p. 84).

Buss and McDoniel (2016, p. 14), published an article summarising research for various similarities among children who had been identified as temperamentally fearful and searched for various characteristics of children who were at risk for developing anxiety. Their findings revealed that discovering sub-groups of children that exhibited fearful temperaments improved prediction of who was at risk of developing anxiety problems.

1.2 PROBLEM STATEMENT

Learners with anxiety disorders often have difficulty coping with pressures from schools with personnel who know nothing or little about their conditions. Anxiety, a major contributor to learners' poor academic performance, is very often missed or overlooked in South African inclusive education schools. South Africa's current school curriculum is demanding, fast-paced, inflexible and filled with formal assessments, which seem to be playing a role in causing more and more learners to become stressed and anxious. As a typical learner spends between five and seven hours at school, this time should not be stressful and unpleasant because learners who are feeling anxious and overwhelmed will certainly not learn.

Another sub-problem statement is that educators are experiencing enormous pressure in an attempt to complete the prescribed curriculum within one academic year. As a result, the school environment is often one in which anxious and withdrawn adolescents, in particular, experience the most distress. Hallahan et al. (2012, p. 215) are of the view that in such cases, learners will struggle to meet the pressures and demands of everyday life and, therefore, need more support from their educators and parents.

1.3 STUDY AIM

Focusing on teaching and learning requires education authorities to, among other things, ensure that accessible quality education is provided to learners with anxiety disorders. While White paper 6 on inclusive education seeks to address the issue of special schools and special education, this study aims to ensure that education authorities recognise the need for more support in the classroom for learners experiencing anxiety disorders (2016, p. 260). This support, which would include the provision of accessible and quality education as well as the necessary services to enhance learners with anxiety disorders' full participation in the teaching and learning encounter. As a result, for the study, the researcher attempted to understand how learners with an anxiety disorder are perceived in schools and how their anxiety can be managed for them to continue making progress at school and mature into balanced and contented adults. Oaklander (1988, p. 132) points out that teachers need to value learners if they are to succeed academically, as learners who are "anxious or suffering in some way, or are feeling that they're not worth much, they are not going to learn".

1.4 STUDY OBJECTIVES

The main study objective is to facilitate the implementation of an education support plan, which would enable learners with anxiety to participate in learning activities, and provide guidelines on the effective teaching and learning strategies for learners with anxiety disorders.

1.5 RESEARCH QUESTIONS

The research questions and sub-questions are summed up as follows:

i) What defines anxiety, specifically in learners at school?
- Sub-question: How are learners experiencing an anxiety disorder identified or recognised?

ii) How are these anxiety disorders managed?
- Sub-question: How can educators and caregivers assist the learners to manage their anxiety so that they he or she can still function at school and be successful?

iii) What support is available for these learners?
- Sub-question: Can schools implement an education plan to enable learners experiencing AD to participate in learning activities?
- Sub-question: Can teachers be provided with guidelines on effective teaching and learning strategies for learners with anxiety disorders?

1.6 LITERATURE REVIEW

McMillan (2012, p. 21) explains that the literature review offers the study's theoretical or conceptual framework and relates to a scientist or researcher who is conscious of the hypothesis and who uses it to frame questions and methodologies. The theory surrounding anxiety, what it is and how it presents itself in a learner, as well as the extent of its prevalence and its intrusive nature, is relevant to understanding or providing a context for the study.

1.6.1 What defines anxiety disorders?

Although Kessler, Ruscio, Shear and Wittchen (2010, p. 31) identify that there may be many definitions for anxiety disorders, "the current definitions of anxiety disorders might substantially underestimate the proportion of the population with a clinically significant anxiety condition". As such, Kessler et al. (2010, p. 31) raise concerns that "as early-onset conditions, anxiety disorders typically begin prior to the vast majority of the other problems with which they are subsequently associated". However, it is the school-going population experiencing early-onset anxiety disorders, and this population seldom receives treatment, a situation that requires attention to ascertain whether early intervention would help address the enormous public health burden created by anxiety disorders throughout the globe. With this study, the researcher wanted to provide the reader with a clear understanding of how learners experiencing an anxiety disorder were identified or recognised.

Green, Berkovits and Baker (2015, p. 137) define an anxiety disorder as a condition that is identified when an individual's fear response becomes excessive and impairs functioning. The South African Depression and Anxiety Group (SADAG, nd.) have estimated that as many as eight to eleven percent of children and adolescents suffer from an anxiety disorder. In addition, children fear more than is realised and they often keep many fears to themselves (Oaklander, 1988, p. 238). These anxieties can also develop into specific phobias such as social phobias, generalised anxiety disorders and obsessive behaviour.

According to Beesdo, Knappe and Pine (2009, p. 484), childhood and adolescence is the core risk phase for anxiety to develop, and these may range from mild, brief or temporary to full-blown anxiety disorders. The South African Stress and Health Study conducted by Herman, Stein, Seedat, Heeringa, Moomal and Williams (2009) found that over 15% of South Africans experience some kind of anxiety disorder, however, a diagnostic decision cannot be made without first considering developmental differences such as cognition, language skills, and emotional understanding (Beesdo et al., 2009, p. 484). Moreover, Oaklander (1988) maintains that individuals pay too little attention to the fact that unless the psychological and emotional needs of children are met a society that does not value people will develop. Oaklander (1988) further explains that the emotional needs of learners ought to be given priority in the learning situation. Oftentimes, as teachers need to be therapists as well as teachers, there is a "need for more of this kind of training" with some teachers "seeking help on their own if they can't find it in the colleges or in the in-service programs of the school system" (Oaklander, 1988, p. 311).

1.6.2 Anxiety disorders in classroom situations and schools in general

The researcher has identified that anxiety disorders are having a negative impact on learners in classrooms all over the world, and that often there are other comorbidities that exist. The question from Kessler et al. (2010) with regard to whether early intervention might assist with minimising anxiety in the classroom was not discussed with this study but rather what approach could be adopted by teachers and parents to assist the learners with anxiety disorders in the classroom. It is important to consider how educators and caregivers can assist learners to manage their anxiety so that they can still function at school and be successful.

Cresswell et al. (2014, p. 671) concur with studies that anxiety disorders are among the most prevalent psychiatric illnesses in young people and typically adversely affect academic accomplishment, family life and leisure activities. These disorders also often co-occur with other anxiety disorders such as depression and behavioural disorders.

Cresswell et al. (2014, p. 671) explain that a further challenge in evaluating these anxiety disorders is that since anxiety disorders represent an extreme presentation of normal events, this distinction is made essentially on the basis of symptoms and the degree of impairment associated with them. Therefore, it is possible to view and understand children's anxiety disorders and the behaviour types that children present, as occurring on a spectrum from severe and intermittent, or occasionally present on the one side, to very severe, persistent and debilitating on the other. It is apparent to the researcher that the very severe, persistent and debilitating behaviours intrude on the learner's school life and can affect the manner the learner approaches certain activities, events, relationships, expectations and, oftentimes, their ability to cope in general in extreme cases.

In children with a specific phobia, the anxiety may be expressed by crying, tantrums, clinging to someone or not being able to move and a specific fear of animals such as dogs or spiders (Beesdo et al., 2009, p. 484). These behaviours are particularly common and usually temporary. Unless the fears lead to significant impairment and intrusion, when for example, a child that is afraid of dogs refuses to go to school for fear of meeting a dog on the street, diagnosis is not warranted.

Durant, Christmas and Nutt (2010, p. 304) acknowledge that it is common to experience anxiety as "anxiety is an emotion experienced as a part of everyday life and can be viewed as a continuum". On the one end of the scale, mild anxiety can improve a person's motivation, focus and productivity, however, at the other end of the scale, intense anxiety promotes survival in response to danger, meaning that human beings have the natural ability to flee, fight or freeze when danger is imminent. However, Durant et al. (2010, p. 304) identify that when intense anxiety occurs "at inappropriate times or to an excessive degree, anxiety can become pathological". In their study, Durant et al. acknowledge that there are six clinically recognised anxiety disorders allowing more specific study of different "anxiety syndromes" (2010, p. 304). Furthermore, Durant et al. (2010, p. 304) highlight the complexity of studying anxiety disorders as "underlying pathological processes of specific anxiety disorders remains limited", and "understanding of the neural basis of anxiety, specifically the role of different neurotransmitters, is of fundamental importance for the development of novel anxiolytics".

With a diagnosis of generalised anxiety disorder in children and adolescents, the anxieties and worries often focus on the quality of their performance or competence at school or in sporting events. However, there may also be excessive punctuality concerns or fears about catastrophic events such as earthquakes or nuclear war

occurring (Beesdo et al., 2009, p. 484). These learners are overly sensitive to taking assessments, receiving results back from tests or any form of competition such as sports days or swimming galas, and, therefore, they might prefer to be absent, rather than take part owing to the fact that the build-up creates excessive stress and anxiety for the learner.

Separation anxiety often becomes apparent at parties or when starting school. Children suffering from separation anxiety will insist that the caregiver accompany them, and they typically become preoccupied with morbid fears, such as worrying that their parents are going to become ill or die. This form of anxiety extends well into primary school and the learner worries about being away from home and people who are important in their lives, in case something serious occurs while the learner is at school.

1.6.3 What support services are available for learners with anxiety disorders in inclusive school settings?

In 2014, the Department of Education released a document entitled, 'Policy on Screening, Identification, Assessment and Support (SIAS)'. The aim of this policy was to provide a framework for creating a standardised procedure that school personnel could adhere to identify, assess and support learners who required additional input to improve their participation and inclusion in school.

The SIAS (2014) policy is also arranged and designed in such a way that it outlines and clarifies for teachers and schools, the support needed for all learners to enhance the delivery of the national curriculum. However, it does not specifically address emotional challenges such as anxiety. It makes use of the umbrella term, 'learning barriers' and attempts to provide a system for teachers, parents and other educational stakeholders to follow, when faced with a learner who is not making adequate progress, to minimise learning breakdown and potential school dropout.

According to the SIAS (2014) policy, the teacher is the main role-player in the screening and identification of the learner who might have a learning barrier. The assessment occurs either within the school or through a practitioner outside of the school community, for example, a psychologist and/or psychiatrist. The policy outlines the steps that a teacher should take to implement a support plan for a learner experiencing a learning barrier, so as to assist the learner so that he or she can remain in the school environment, be able to manage academic demands as well as other emotional and social demands. However, there are very few schools that have the resources to assess learners for learning barriers, and teachers also do not have adequate knowledge and training to assist. So often, although a vulnerable and anxious learner is desperate to fit in like his/her

peers and cope with the daily demands of school-life, he or she cannot. This research study identified what support there was available for parents, teachers and learners, for them to be self-aware and know how best to manage their anxiety so that it does not impact their lives in such a manner that they are disadvantaged.

1.6.4 Classroom management in a school and classroom situation for learners with anxiety

Teachers can be effective in assisting in prevention efforts to reduce the development of anxiety disorders in learners. Therefore, Moran (2015, p. 29) suggests the implementation of universal prevention programmes in schools since the onset of anxiety disorders are typically in childhood and adolescence. Moran (2015) also suggests that collaboration with school counsellors allows for the development of these efforts as they are focused on a comprehensive programme that addresses prevention for everyone. For the prevention programmes, it would make sense to include classroom lessons such as education about anxiety, relaxation skills, mindfulness and positive self-talk (Moran, 2015, p. 29).

According to Hayden (2016, p. 34), there are several programmes that are presently available for schools to use. Hayden (2016) refers to the Cool Kids Programme, the FRIENDS Programme the Skills for Social and Academic Success (SSAS) Programme, which have all been evaluated in the school setting. The common thread running through all of these interventions and Cognitive Behaviour Therapy (CBT) are cognitive restructuring and graded exposure, which is a necessary component to help learners address their fears and come to the realisation that certain situations and experiences are not as intimidating as they initially perceived them to be. This exposure also teaches learners that they have the skills to cope with scary situations.

Some programmes can also be administered to small groups of learners based on screening, led by a school counsellor, held during the day or after school. There can also be parent-therapist meetings to encourage home practice and facilitate ongoing communication. Additionally, clinicians can also give talks to teachers on anxiety and share evidence-based approaches. The family and school setting are very important in helping children manage their anxiety and these skills can be taught to everyone (Hayden, 2016, p. 35).

1.6.5 Effective teaching and learning strategies for learners with AD

According to the U.S. Department of Health and Human Services, Section 504 of the Rehabilitation Act of 1973, which is a national law that protects qualified individuals from discrimination based on their disability, children and adolescents diagnosed with anxiety disorders may be eligible for services, accommodations or modifications (Novotney, 2006, p. 1).

However, Hayden (2016, p. 42) identifies that children and adolescents with anxiety disorders do not always ask for help and many struggle through the day, only to experience tantrums and meltdowns at home. Therefore, it is essential to establish a positive relationship with the classroom teacher and have regular

check-ins to evaluate what helps and what does not. It can take time to develop the strategies that best help anxious learners but with a solid plan in place, anxious learners can thrive in the classroom setting and learn to manage their symptoms throughout the day.

Ludwig, Lyon and Ryan (2015, p. 45) also support that schools can provide access to young people who may not otherwise seek treatment in a traditional mental health specialty clinic. So, the incorporation of mental health treatment in lessons and school curricula, has the added potential to decrease the stigma regarding mental illness. However, Ludwig et al. (2015) find that various intervention protocols have not been actively researched and they report that "despite the existence of multiple intervention protocols with demonstrated efficacy for treating anxiety in youth, fewer well-researched interventions have been developed or adapted to address anxiety disorders in schools. Most of the interventions that have been researched in schools are delivered in group format and not individually".

1.7 THEORETICAL FRAMEWORK

This study is guided by Eyseneck's learning/behavioral theory. Hans Eyseneck was a psychologist and personality researcher and his theory in 1967 identified two types of personality, namely, the introverted and the extroverted. Eyseneck's later research added a third personality trait, neuroticism, which he proposed was characterised by the individual having "emotional instability and low tolerance for stress or aversive stimuli, and characterized by anxiety, fear, moodiness, worry, envy, frustration, jealousy, and loneliness" (in Mitchell & Kumari, 2016, p. 76).

The researcher chose to base the study on this learning/behavioural theory because in order to understand how to treat or manage and support someone with an anxiety disorder effectively, the causes of anxiety need to be explained. Mitchell and Kumari (2016, p. 74) explain that Hans Eysenck's learning/behavioural theory of anxiety, relies on two major dimensions, namely, extroversion/introversion and neuroticism whereby the neurotic individual is more prone to anxiety-provoking stimuli. According to Eysenck, anxiety, which is known as "conditioned fear", can also be learned but the emotional theory of uncertainty embraces the issue that being unsure of the future, can also cause anxiety (in Mitchell & Kumari, 2016).

McKay finds that, "anxiety sensitivity, has been investigated extensively for its association with anxiety disorders" (2016, p. 65) and it can be defined as the "degree that one appraises changes in physical sensations as potentially dangerous". In other words, people may be worried about symptoms that they might feel or what they might behave like in front of other people, as well as possible loss of control. For

McKay (2016, p. 65), another predictor of anxiety disorders is trait anxiety that encourages individuals into action when they are exposed to potentially threatening stimuli.

The interpretivist paradigm underpinning this particular research study included discussion of the theory and an attempt to propose a practical road-map to use and follow, in managing and supporting a child with anxiety at school. Gunbayi and Sorm (2018, p. 59) maintain that people can only “'understand' by occupying the frame of reference of the participant in action”, so they need “to understand from the inside rather than the outside”.

As pointed out by Thanh and Thanh (2015, p. 25), interpretative researchers do not search for results for, and from, their studies in rigid ways, but they rather engage with their participants, typically from people who own their experiences and are of a particular group or culture. The subjective approach is the analytical tool that was used for this type of study.

It can be concluded that there are other studies that deal with the research questions as posed, but there is a scarcity of research conducted in a South African context in this specific area. There are also very few reliable assessment measures for diagnosis of AD in children. Most of the evaluations involve the use of questionnaires for adults, which are then just adjusted for children. However, according to Groenewald (2013), the criteria and diagnoses for anxiety disorders have been validated for adults but not for children. This, therefore, renders them unreliable and subjective.

McKay (2016, p. 61) identifies the components that mark anxiety as “specific neural, physiological, cognitive, and behavioral components”. McKay also identifies three broad domains of thinking that have been evaluated for their specificity in anxiety, namely, intolerance of uncertainty, perfectionism, and overestimation of threat (2016, p. 63). The primary behavioural response associated with anxiety disorders is avoidance, and McKay identifies the situations, which are anxiety-provoking and can be separated into true alarms, false alarms, and conditioned alarms (2016, p. 64).

A true alarm would be, for example, when a potentially fatal car accident is avoided by reacting quickly and instinctively, whereas a false alarm would cause an individual to over-react to a sudden loud noise like a door slamming. Conditioned responses are associated with developing into the more specific phobias through learning from previous experiences and is also considered the basis for anxious avoidance in all anxiety disorders.

Mineka and Zinbarg (2006, p. 22) noted that by incorporating and including the role of genetic and erratic or unreliable variables, contemporary learning models can help identify who might be at a higher risk for developing anxiety disorders. These learning models also provide a way to targeting at-risk individuals based on their previous learning history (Mineka & Zinbarg 2006, p. 22).

In considering the treatment and management of anxiety, the researcher highlighted cognitive-behavior treatment (CBT), which essentially represents a combination of behaviour therapy and cognitive interventions. For Choi, Rothbaum, Gerardi and Ressler (2010, p. 294), the behaviour therapy component has evolved within learning theory and is based on the assumption that behaviour, which has been acquired via classical and/or operant conditioning, can be corrected and changed. This is dealt with in Chapter 2.

1.8 RESEARCH METHODOLOGY AND DESIGN

This study intends to establish how an existing policy, namely, the SIAS (2014) policy, can be enhanced to shift from a theoretical model in inclusive schools to a more practical model that can be implemented at all schools. To guide the study, the research questions identified were addressed using the mixed methods research approach.

1.8.1 Research approach

This researcher followed a mixed-method research design. In mixed-method research, the researcher uses both qualitative and quantitative research methods to conduct the study. Hence, the researcher can generate in-depth information by using this method of research via different data collection tools as well as through different data analysis techniques. Cresswell explained that by using both quantitative and qualitative methods, in combination, provides a better understanding of the research problem and question than either method by itself, which is why the researcher chose this method approach (2012, p. 535). The researcher felt that one method alone would not have been enough to address the research problem. This section is discussed more in detail in Chapter 4, Research Methodology.

1.8.2 Population and sampling

This study made use of purposeful sampling criterion, which, according to McMillan (2012, p. 105), is when the researcher chooses or selects cases because they will be particularly informative about the topic being investigated. The population for this study consisted of all the learners attending an independent school in Port Elizabeth, that caters for learners with special educational needs and learning barriers. Learners at the school receive full-time remedial and emotional support and parents have the additional benefit of a group of professionals, under the guidance of a case manager, tending to the academic and emotional needs of their

child or children. The participants in this study were learners that had been identified as suffering from anxiety and so exhibited similar characteristics and behaviours. These participants as well as their teachers and parents, comprised the sample. The sampling procedure is explained in detail in Chapter 3.

1.8.3 Instrumentation and data collection techniques

Data collection steps involved setting the boundaries for the study, collecting information as well as establishing the protocol for recording information. It was a vehicle through which the researcher collected information to answer the research questions. Since this would be a mixed-method study, both quantitative and qualitative questions were appropriate. The following instruments and data collection techniques were used in the study:

- **Document study**

The researcher began the process of selecting learners for the sample by reading through the learner files of learners in Grades 5-12 to narrow the study to a sample of learners having anxiety. Document studies included records and files detailing assessments and diagnoses conducted over the history of the life of each learner with anxiety. This ensured a strong understanding of the learner involved in the study and provided a form of triangulation regarding the parents' and the teachers' perspective of that learner. This type of data collection formed part of the qualitative study.

- **Questionnaires**

Questionnaires as data collection formed part of the quantitative study. The self-administered questionnaires were compiled by the researcher and were not standardised. They were completed by participants, including parents of learners with anxiety, the teachers involved and the learners themselves. The questionnaires were emailed directly to the parents as an attachment to an email that explained the purpose of the questionnaire. The learners received their questionnaires in a sealed envelope which included a cover letter explaining the purpose of the questionnaire. The teachers also received their questionnaires in a sealed envelope in their post boxes, which were located in the staff room. The completed questionnaires were then returned in the sealed envelopes to the researcher's post box for analysis.

With the questionnaires, the researcher asked what symptoms or behaviours the learner with AD had experienced, and whether certain experiences at school had exacerbated these symptoms or behaviours. Parent questionnaires investigated when the learner's symptoms became apparent and how an assessment was conducted. The researcher also enquired as to what the findings were and what recommendations were made in the reports following the assessments. Teacher questionnaires aimed to identify what behaviours

were observed in the learner and whether any activities or tasks that the learner was asked to do exacerbated these symptoms.

- **Informal observations**

Informal observations were used to confirm data gathered from questionnaires. The researcher received permission to observe educational situations in both the classroom setting and outside during recess on the playground. The researcher considered how the learners interacted with others, whether they made use of free or structured play and what sort of activities they engaged in. In the classroom, the behaviours of the children were observed, including their mannerisms, their ability to cope with teacher demands and how they attempted to handle their work. This included watching written activities as well as conducting observations during times when they were required to read aloud or do oral presentations. The time spent observing each learner in each setting was recorded so that consistency was ensured. This data collection formed part of the qualitative study.

- **Data analysis and interpretation**

Observations, questionnaires and the document study, provided the researcher with a large volume of data that required summarising and interpretation which formed the data analysis part of the study. The objective of the study was to explore trends, thoughts, explanations and understandings (McMillan, 2012). With learners experiencing anxiety, the researcher looked for prevalent threads, patterns and behavioural signs. The analysis was comprised of three steps, namely, organisation of the data, summarising the data and then interpreting the data to search for the patterns. All information was captured and stored in a table.

1.9 RELIABILITY AND VALIDITY OF GENERATED DATA

According to McMillan (2012, p. 137), "reliability is the extent to which participant and/or rater scores are free from error", in other words, how consistent the scores are. If a measure has a high reliability, this means that there are few or no inaccuracies in the scores, and if there is a low reliability, this indicates a great amount of error.

There are certain factors that will contribute to the imperfect nature of measurement, such as ambiguous questions, learners being tired or not interested in answering questions and therefore, they might answer differently on different occasions. Hence, where possible, the researcher needs to specify the degree of error that exists in specific, quantifiable terms (McMillan, 2012, p. 137). For example, it might be agreed that a

scale is a valid way to measure weight, but any particular scale could be broken or faulty and therefore, would provide an unreliable result when measuring the weight of an object.

Validity has been defined as the manner in which an instrument measures what it says it measures and where the emphasis is not on the instrument itself but on the manner in which it is used (McMillan, 2012, p. 131). McMillan (2012) also states that validity is an overall assessment of the extent to which theory and empirical evidence support interpretations implied in certain scoring uses or measures. An example of validity might be to agree that a measuring tape is a valid way to measure height but is not a valid way to measure weight so therefore, it shows that the same test instrument can be valid when it is used in one circumstance but can be invalid for another. The frameworks of assessing validity and reliability in this study are explained in detail in Chapter 4, Research methodology.

1.10 RESEARCH ETHICS/ETHICAL CONSIDERATIONS

Drew, Hardman and Hosp (2008, p. 79) explain that a researcher has a moral obligation to, as far as possible, protect the participants from harm, unnecessary invasion of their privacy, and to always attempt to promote and add to their well-being.

Throughout this process, the researcher was responsible for the ethical standards to which the study adhered and consistently respected the rights and privacy of both learners living with anxiety and their parents. Real names were not used in the study and the parental consent was received in writing before any interviews or discussions with the learner took place. Therapeutic research or experimentation on a child under the age of 18 can only be carried out if it is in the best interests of the child and if consent has been obtained from both the learner (if he or she is able to understand) and his or her parent or guardian) (UNISA, 2013). The researcher ensured that the participants were well informed about the purpose of the study.

Conflict of interest happens when researchers have interests that are not fully apparent and that may influence their judgments on what is published. Although the writer was a Director at the research site, there was no direct involvement with the students in the classroom or outside of the classroom.

Ethical clearance was requested from UNISA and granted (see Appendix P).

1.11 LIMITATIONS OF THE STUDY

Limitations comprise potential weaknesses in a study that are beyond the researcher's control. There are a number of variables that, according to McMillan, may restrict the outcomes of a study and these are limitations related to participant characteristics, and contextual characteristics that refer to when the research is conducted (2012, p. 370). The researcher was able to generalise to a degree that the characteristics of the learners experiencing anxiety within the school community where the study took place, would be the same as those within a different school community. The researcher also attempted to curb limitations as far as possible.

McMillan (2012, p. 375) concludes by recommending that researchers should use their "best, reasonable, professional judgement". The situation may differ, as may the measures or subjects, but the variances may not be significant enough to affect the usefulness of the results and findings.

1.12 DELIMITATIONS OF THE STUDY

Delimitations are described by McMillan (2012, p. 370) as the boundaries, scope of interest and description of the thesis or dissertation and are defined so that the goals and objectives do not become impossibly large to complete. The main delimitations of the study were that the sample size was relatively small, and consisted only of learners with an anxiety disorder. A further delimitation might have been that the researcher worked alone and did not have assistance in gathering data or drawing up the results.

This topic was chosen for investigation and research, because of the researcher's particular interest and because of the need to provide some support and assistance to families, parents and teachers who dealt with learners experiencing AD on a daily basis.

1.13 SIGNIFICANCE OF THE STUDY

Ideally, the school environment is where learners and young people are stimulated, challenged, up-skilled and encouraged to become the best version of themselves. The home environment is the place where a child's basic needs such as food, shelter and security are provided for, but in many cases, this does not always occur, and the school environment may also not always be the positive experience that it should be. The positive influence of the school, the teacher, the therapist, and/or the mentor has an important part to play but this positive influence cannot always extend into the child's home environment.

The study is significant because it aimed to contribute to the body of knowledge and offer new insights into understanding how learners experiencing an anxiety disorder were identified or recognised. It also aimed to influence policy formulation to consider how educators and caregivers could assist the learners to manage the anxiety so that they could still function at school and be successful. Lastly, the study intended to influence policy implementation and practice providing support for parents, teachers and for the learners themselves.

Different people deal with anxiety in different ways. For Beesdo et al. (2009, p. 485), differentiating between normal and pathological anxiety can be especially difficult in children because as part of typical development, children manifest many anxieties and fears. What a parent sees might be different from what the teacher sees and what the doctor or psychiatrist sees in his/her office. An anxious child might withdraw and become quiet and sullen or might act out and become defiant or oppositional. These are the behaviours that are seen and often reported to parents and professionals by educators if the child is already at school, or by concerned family members. Meanwhile there could be an underlying cause, which is often ignored.

As anxiety also presents differently in different learners of different ages, it needs to be asked how this complicated disorder gets diagnosed when it is so difficult to recognise. The researcher provided the latest research and information on the different types of anxiety disorders and provided information on how learners with an anxiety disorder were identified or recognised by the adults that they spent the most time with, namely, their educators and parents. The researcher also gathered ways and means for these adults to assist the learners to manage the anxiety so that they could still function at school and be successful. Finally, the researcher wanted to identify what support was available for parents, teachers and for the learners themselves and to encourage a management plan for implementation, both at home and at school.

1.14 DEFINITIONS OF KEY CONCEPTS

Additional support needs:

"Additional support needs" refers to the fact that every learner requires some form of assistance and support, but some learners, for whatever reason, may require additional intervention or support within the school environment. Additional support needs can arise from any factor that causes a barrier to learning, whether that factor relates to a social, emotional, cognitive or linguistic disability, or to family and care circumstances (Department of Basic Education, 2014, p. 1). Hannell (2014, p. 113) states that anxiety is part of the way in which adults and children protect themselves from harm by becoming alert to dangers and

taking appropriate action. However, when anxiety impairs behaviour, for example, "frequent, excessive or unrealistic anxiety can impair normal day-to-day living and seriously incapacitate. If this occurs the anxiety is classified as a clinical disorder" (Hannell, 2014, p. 113).

Anxiety disorder:

Pathological anxiety is characterized by "persisting or extensive degrees of anxiety and avoidance associated with subjective distress or impairment" (Beesdo et al., 2009, p. 2).

Identification:

The term "identification" refers to how these learners are noticed by school personnel because of "certain poor behaviours, academic difficulties, and inconsistent school attendance" (Allison, Nativio, Mitchell, Ren & Yuhasz, 2013, p. 165). However, these are often early actual signs of a learner's mental health problems and of an anxiety disorder in particular.

Learner:

The "learner" is any child or adolescent that is in a school.

Learning environment:

The "learning environment" is a place or a setting away from home where learning occurs, in other words, it can refer to a school or somewhere that offers a formal curriculum. It does not refer only to a physical classroom but also includes the characteristics of the setting (Department of Basic Education, 2011, p. 6). For the purpose of this research, the "learning environment" setting was an independent school situated in Port Elizabeth, South Africa.

1.15 CONCLUSION

This chapter provided a summary of the introduction and background to the study and clarified the research questions, aims and study objectives for the reader. It also identified the theoretical framework, research methodology, and design.

According to Cresswell et al. (2014, p. 677), there is convincing evidence that good psychological treatment will benefit most children and young people living with anxiety disorders, provided that this condition is correctly diagnosed and managed well by all stakeholders. Every successful outcome has a particular method or process. There is no one-size-fits-all programme, but there are patterns or steps that assist in reaching a particular objective.

The child needs to be protected and his/her voice heard. The world, whether it is at school, at home or at a shopping mall, is a vast, inconsistent, unpredictable and confusing place. The journey with the child be it as the parent, the educator or the professional working with the child, must as far as is possible, be a pleasant one. It will be an adventure filled with surprises and sadness, successes and scares but should have the one common goal of leading them to an adulthood where they can be happy, content and where they can thrive.

Chapter 2 reviews the literature gathered to provide the background to the research study.

CHAPTER 2
LITERATURE REVIEW: ANXIETY DISORDERS

2.1 INTRODUCTION

In this chapter, various issues are discussed including the need to understand how learners experiencing an anxiety disorder are identified or recognised, consider how educators and caregivers can assist the learners to manage the anxiety so that they can still function at school and be successful, and lastly, identify what support there is available for parents, teachers and for the learners themselves. This review also investigates whether learning barriers experienced at school cause anxiety disorders and vice versa, the normal and expected behaviours in young children with regard to their experiences of fear and anxiety, and when such behaviours are a cause for concern are also be explored. Finally, there is a discussion of how educators and caregivers can reduce these anxieties so that the anxious learner can still function at school and be successful. Furthermore, the research seeks to identify what support is available for parents, teachers and for these learners.

2.2 EXPLANATION OF CHILDHOOD ANXIETY

There are various definitions for anxiety.

2.2.1 Definitions of anxiety - What is an anxiety disorder?

The National Institute of Mental Health (NIMH, 2018) is the lead federal agency for research on mental disorders. In explaining the difference between occasional anxiety and an anxiety disorder, the NIMH (2018) states that feeling anxious when faced with a problem at work, before taking a test, or making an important decision is normal and is occasional. However, an anxiety disorder becomes much more than just temporary worry or fear owing to an external factor (NIMH, 2018, para. 1). In this case, the anxiety never goes away and can get worse over time for someone with an anxiety disorder. Emotions can interfere with daily activities such as schoolwork, job performance and even relationships.

For a clinical definition of anxiety, Muris, Simon, Lijphart, Bos, Hale and Schmeitz (2017, p. 2) have identified two separate factors, where the first involves autonomic arousal and can be identified as fear and the second factor is characterised by tension, apprehension, and worry, and can best be defined as anxiety. Muris et al. (2017) further explain that when risk is close and imminent, a sense of fear typically occurs and its function is obvious, to protect the body from harm, either battling to remain alive or run away (fight or flight). For example, being approached by a vicious, snarling dog would result in a fear response. When there is a definite threat or a dangerous situation, normal fear arises however anxiety may also occur, even

when there is no danger or threat. Fear should not occur when a person walks by a friendly dog or a puppy. In this case, it would be seen as an abnormal fear response.

The National Institute of Mental Health estimated that anxiety disorders as a group constitutes the most common mental illness in America and can affect adults, children, and adolescents (NIMH 2018). People who suffer from anxiety disorders typically struggle with symptoms such as agitation, feeling tense, worry, and apprehension on a daily basis. These symptoms can become so debilitating that they prevent the person from living a normal life.

The nationally representative South Africa Stress and Health (SASH) study, conducted between 2002 and 2004, indicated that around 15% of the adult population in South Africa have an anxiety disorder (in Egbe, Brooke-Sumner, Kathree, Selohilwe, Thornicroft & Petersen, 2012). It is estimated that about one in five children and adolescents have a mental health disorder and around half of all mental illness and substance-related problems start at the age of 14 years (Paruk & Karim, 2016, p. 548).

According to Wehry, Beesdo-Baum, Hennelly (2015, p. 2), the onset of the first, or any anxiety disorder, typically occurs in adolescence and is therefore significantly earlier than the onset of depressive or substance use disorders. Wehry et al. (2015) also identify that for an anxiety disorder to be properly diagnosed, the fear or anxiety has to last usually six months or more, should be ongoing, and also not be a normal developmental phase (for example, young children being afraid of a stranger or being away from their parents).

Teachers are often regarded as being the first non-family members to identify mental health concerns, and parents often rely on them for guidance and support in these matters. However, teachers are not expected to diagnose children and most will prefer to try contain the issues within the classroom if they feel they have the appropriate skills to address the concerns. The alternative, according to Headley and Campbell (2013, p. 51) might be that teachers may refer to the school guidance counsellor for assessment and management, if the school provides this resource, or access alternative school supports if necessary, such as the headteacher or the teacher in charge of pastoral care.

Anxiety disorders in children are “woefully underdiagnosed” (Weir, 2017, p. 50). One of the reasons might be that anxiety symptoms differ from person to person. Children and young people with anxiety disorders may not present symptoms or complain of having anxiety as they may not understand why they feel like

they do and have difficulty expressing themselves, struggle to talk about experiences or be confused or embarrassed by them. Often parents and caregivers do not fully realise the severity of a child's anxiety, nor do they recognise that it needs to be treated. There is also the notion that the child will outgrow an anxiety phase. However, early diagnosis is important as many anxiety disorders in the community remain untreated, causing distress and impeding academic and social functioning.

According to Weir, anxiety is often a "gateway problem" (2017 p. 50) meaning that anxiety disorders increase the risk of other disorders, such as anxiety and depression, substance use disorders and suicide. Childhood anxiety is likely to persist without treatment, affecting the social and emotional functioning of a child and their overall quality of life.

In this section, the researcher provided and cited studies and information with regard to the understanding of childhood and adolescent anxiety disorder and how it can be defined.

2.2.2 Prevalence of anxiety disorders

The Anxiety and Depression Association of America (AADA) estimate that anxiety disorders are the most common mental illness in the United States, affecting 40 million adults aged 18 and older, or 18.1 percent of the population annually. The National Alliance on Mental Health (2017) estimates that anxiety disorders affect one in four children between 13 and 18 years of age. Research also shows that untreated children with anxiety disorders are at higher risk in terms of performing poorly in school, missing out on important social experiences and engaging in substance abuse.

The global current prevalence for anxiety disorders is 7.3% suggesting that one in 14 people around the world at any given time has an anxiety disorder and one in nine will experience an anxiety disorder in a given year (Baxter, Vos, Whiteford & Scott, 2012, p. 5).

Pathological anxiety, such as social phobia, has always existed and it could be wondered whether anything has changed over the last century? Bandolow and Michaelis have the view that anxiety is a feature of current times and the incidence of anxiety disorders has increased owing to certain changes in politics, society, the economy and the environment (2015, p. 327).

According to Schoenfield (2018, p. 1), the rise in anxiety and depression levels is not likely to be based on better ways to diagnose these conditions, but on the enhanced disturbance of our "social fabric", namely, the loss of meaningful jobs, social support, economic security and religious values.

The National Survey of Children's Health (NSCH) is the only national data source to evaluate the presence of anxiety and depression on a regular basis. Perou (2013, p. 3) states that in the 17 year and under population group, there was a 56% increase in diagnosed prevalence of anxiety disorders from 2003 to 2011.

The South African Depression and Anxiety Group refer to anxiety disorders as being the most common mental illness in South Africa and estimate that about one in every five South Africans are suffering, which amounts to around 11 400 000 people (SADAG, nd, para 2).

Stein, Williams and Kessler are of the view that there is an increasing awareness of the financial and social strain of mental disorders and there seems to be an interesting link between the early onset of mental disorders and the inability to finish high school (2009, para. 2). The South African Stress and Health study, conducted between 2002 and 2004, was the first nationally representative research study of common mental disorders (CMDs) in South Africa. The study indicated the lifetime CMD incidence among adolescents in South Africa is 30%, with anxiety disorders most common at 15.8% (Stein et al. 2009).

Weir believes that separation anxiety, social anxiety and generalised anxiety are the three most common types of anxiety disorders in children (2017, p.1). For the purpose of this study, only childhood anxiety will be discussed, as the study deals with the school-going population, and the sample size of 10 out of a school population of 131, provided a percentage of 7,6%. According to Rodebaugh, Weisman and Tonge (2018, p. 430), it was assumed that each anxiety disorder is explained as an interconnected system with one or more central definitions. This assumption from Rodebaugh et al. allows the focus to be on an "underlying central construct for each disorder" (2018, p. 430), and perhaps the central underlying constructs of these anxiety disorders have more in common with each other than the constructs associated with other mental disorders.

2.2.3 Types of anxiety disorders

According to Cresswell et al. (2014, p. 2), there have been some alterations in the arrangement and organisation of anxiety disorders and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes the following anxiety disorders: specific phobia, generalised anxiety disorder, social anxiety disorder (formerly social phobia), panic disorder and agoraphobia, which is now a diagnosis on its own. The

most common type of anxiety disorders are specific phobias, for example, an excessive fear of a specific object or situation, such as spiders, heights, flying or closed spaces.

In order to differentiate between occasional anxiety and an anxiety disorder, the NIMH states that feeling anxious when faced with a problem at work, before taking a test, or making an important decision is normal and is occasional but an anxiety disorder becomes much more than just temporary worry or fear owing to an external factor (2018, para. 1). In this case, the anxiety never goes away and can get worse over time for someone with an anxiety disorder.

Obsessive-compulsive disorder, post-traumatic stress disorder and acute stress disorder are included under obsessive compulsive and related disorders, while trauma-related and stressor-related disorders are no longer included within the anxiety disorders category.

With social anxiety disorder (namely social phobia or performance anxiety), people are overly worried about social encounters or situations that may involve being observed or judged by others. The National Alliance of Mental Illness (2017) describes social anxiety disorder or SAD as far more than just shyness. SAD causes intense worry about social encounters, often driven by irrational thoughts about being humiliated or embarrassed (NAMI, 2017, p.1). Someone with social anxiety disorder may avoid conversations, nor will they contribute to class discussions or offer ideas, and they may become isolated. Panic attacks are a common reaction to anticipated or forced social interaction.

Generalised anxiety disorder (GAD) is characterised by persistent and excessive worry about many different areas and this worrying takes up many hours each day, making it hard for the person to focus on or finish daily tasks.

Other anxiety disorders include separation anxiety disorder, which is developmentally appropriate in very young children but when the fear of being away from their parent persists or interferes with normal development, separation anxiety disorder is diagnosed. Selective mutism, agoraphobia (fear of being outside of the home in various situations), and panic disorder (recurring unexpected panic attacks and fear of having more panic attacks), are further types of anxiety.

According to the definition on the website of the American Academy of Child and Adolescent Psychiatry, panic disorder is characterised by haphazard and repeated periods of intense fear or discomfort, that occur

with other physical symptoms such as a racing heartbeat or feeling short of breath (2017, p.1). However, it is common and very treatable. These panic attacks can last a few minutes or a number of hours, and they frequently come on without any warning. The individual also tends to avoid many situations in which a panic attack may occur or in which help may not be available if the panic attack occurs.

Selective mutism is often mistaken for extreme shyness, but when this pattern persists and causes problems with performance and school work, selective mutism is diagnosed by a professional practitioner. A child with selective mutism is unable to speak in social situations where there is an expectation to speak (such as at school), but they are still able to speak in other settings, for example, with their family at home.

According to Tracy (2016, p. 1), agoraphobia is defined as an anxiety disorder characterised by intense fear associated with being in situations where the person may not be able to escape or where removing oneself might be difficult or embarrassing (for example, being on a bus or train). Agoraphobia is uncommon among children, but it may develop in adolescents, particularly those who also suffer with panic attacks.

2.2.4 Causes of anxiety disorder

It is necessary with this study to confirm that the different types of anxiety as listed in section 2.2.3 all differ in manifestation as well as causes. There is also the notion that childhood phobias and anxiety disorders originate from multiple, interacting vulnerability and protective factors, as well as the fact that cognitive development and maturation has a significant influence on this process. According to Muris et al. (2017, p. 173), who presents a new model for explaining the aetiology of childhood phobias and anxiety disorders, there appears to be a spectrum with normal fear and anxiety on the one side, and pathological anxiety, on the other. At each point in time, children and adolescents' level of anxiety is “determined by the current constellation of vulnerability and protective factors” (Muris et al., 2017). Muris et al. (2017) refers to vulnerability factors such as behavioral inhibition, negative parental rearing behaviors and information-processing abnormalities will tend to exacerbate or maintain fear and anxiety. On the other hand, protective factors like self-management, resilience, self-esteem and effective coping strategies reduce or shield the individual against these negative emotions. In other words, Muris et al. explains that when vulnerability is high and protection is low, the probability is such that a child or adolescent would display anxiety levels in the pathological range, and when this occurs repeatedly within a certain time frame, the individual may qualify for an anxiety disorder (2017, p. 174).

According to Kendall, Swan, Carper and Hoff, anxiety disorders among children and adolescents are caused by a combination of biological and environmental factors that interact with each other and lead to the development of a disorder (2018, p. 216). It is becoming more evident that some people may have a genetic predisposition toward anxiety, or perhaps have learned to feel anxious from a parent or other caregiver.

Kendall et al. (2018, p. 217) refer to new ways that scientists are able to learn more about these factors that may cause anxiety disorders. With further research and opportunities to study and understand these causes, even better treatment and prevention of anxiety disorders will be possible. For now, it is thought that heredity or biological factors, brain chemistry, personality and life experiences all play roles in anxiety disorders occurring.

- **Biological factors**:
  Biological factors include genes, as there is clear evidence that many anxiety disorders run in families. Kendall et al. (2018, p. 217) refer to studies that show that if one identical twin has an anxiety disorder, the second twin is more likely to have an anxiety disorder than in the case of non-identical (fraternal) twins. These findings suggest that a genetic factor, possibly activated by certain negative life experiences, affects an individual's vulnerability to these illnesses. According to Hannell (2014, p. 114), certain factors such as learning difficulties, parenting styles, social difficulties, family dysfunction, parental mental health problems or physical illness may well increase the tendency to be anxious.

- **Brain chemistry:**
  The primary thrust of biological studies in anxiety disorders has changed over the past two centuries. Developments in neuroimaging technology make it possible to define the reactivity and neurochemistry of the living brain (Bystritsky, Khalsa, Cameron & Schiffman, 2013, p. 34).

  The search to identify a specific "anxiety gene" has not yet been successful. Perhaps multiple genes play a role in the cause of child anxiety rather than a single gene acting as the primary causal factor (Kendall et al., 2018 p. 216). Kendall et al. (2018) refer to the serotonin system incorporating the serotonin transporter gene 5-HTT. Given that the selective-serotonin reuptake inhibitors have been effective in treating children and adolescents with anxiety, it is most likely that the serotonin system contributes to anxiety among this particular population.

These researchers also mention that "there has been some work examining dopamine genes, catechol-O-methyltransferase, and corticotrophin-releasing hormone/corticotrophin-releasing factor genes" in the study of people with anxiety disorders (Kendall et al., 2018 p. 216).

Bystritsky et al. find that individuals with abnormally high levels of certain brain neurotransmitters may have a greater tendency to experience anxiety (2013, p. 34). When these levels are abnormal, the brain may react inappropriately at times, causing anxiety symptoms. If these symptoms are relieved by certain medications that can change the level of chemicals in the brain, it is believed then that brain chemistry does play a role in the development of anxiety disorders. Bystritsky et al. (2013) also explain that serotonin regulates mood, aggression, impulses, sleep, appetite, body temperature and pain. Norepinephrine is involved in the fight or flight response and in regulating sleep, mood and blood pressure. Gaba helps to induce a sense of calm, relaxation and sleep. Bystritsky et al. state that there needs to be balance within the chemistry in the brain and any anxiety disorder is a combination of anxious emotions, abnormal processing of information, and insufficient coping skills (2013, p. 34). According to this anxiety model, overlapping neuronal circuits cause alarm responses, perceived processing of threats and behavioural coping.

- **Temperamental factors:**

According to Kendall et al. (2018, p. 218), there are factors that relate to a child's temperament, for instance if a child is inclined to be anxious or sensitive, this is usually obvious from a very young age. Personality may play a role, for example, people who have poor coping skills and low self-esteem may be more susceptible to developing anxiety disorders. Conversely, an anxiety disorder that begins in childhood may itself contribute to the development of low self-esteem.

- **Social or environmental factors:**

Kendall et al. (2018, p. 218) describe factors that include experiences such as being bullied, illness, problems at school, arguments with friends and major changes in the family, such as moving house or the divorce of parents. Life experiences may affect individuals' susceptibility to these mental illnesses. For example, as pointed out by Bystritsky et al. (2013, p. 31), individuals with any anxiety disorder often can identify when the symptoms started by relating a particular stressful time or event in their lives.

Anxiety does not result from any single risk factor of those listed. Instead, it occurs when several factors occur together.

> Buss and McDoniel (2016) describe a study in which their findings revealed that identifying subgroups of fearful temperament improves prediction of who is at risk for anxiety problems. While they argue that the causes and developmental course of anxiety symptoms is complex, they also point out that multiple studies have shown that extreme fearful temperament, originating during infancy, has become the best early predictor of anxiety (Buss & McDoniel, 2016, p. 15). This is seen when the child withdraws from and avoids or reacts fearfully to novel situations, for example, to clowns, puppets or mascots. In addition, Buss and McDoniel (2016, p. 18) find that fearful children tend to be socially reticent, characterised by frequent behaviour in peer interactions that can interfere with adaptive social engagement and lead to anxiety. Buss and McDoniel (2016) refer to “innate temperament dispositions” that would make children prone to developing fear and anxiety problems.
>
> Buss and McDoniel (2016, p. 18) refer to the most typical example is Kagan's (1994) construct of behavioral inhibition, which refers to inborn tendencies to be timid, fearful, and shy with unfamiliar people, and to respond with restraint, caution, and withdrawal to novel situations and objects. Underlying factors that are responsible for these behavioural differences also need to be considered as well as examine any external causes (for example, parents, peers) that influence the “trajectories” toward or away from risk, and decide if these differences translate to meaningful, real-world differences in outcomes (Buss & McDoniel, 2016, p. 18).

Finally, in this section, it seems important to thoroughly examine the influence of development on the emergence of normal and abnormal fear and anxiety. In the most recent research, “age might be employed as a proxy of development” (Muris et al., 2017, p. 190). However, it would certainly be necessary to employ more direct indices of social, cognitive and emotional development. However, these would require more longitudinal studies to be conducted, which are time-consuming and costly.

2.3 IDENTIFICATION OF CHILDHOOD ANXIETY

According to Headley and Campbell (2013, p. 48), anxiety disorders can have serious consequences for children in that they can lead to other psychological disorders later in life, and these individuals can also develop problems with relationships, social and psychological functioning, and can also lead to underperformance in the classroom and on the sports field.

2.3.1 Signs and symptoms

Fearful children tend to display social restraint or introversion, characterised by frequent hovering around where their significant adult or carer is, watching others from the sidelines instead of joining in, and exhibiting anxious behaviour in peer interactions. This can interfere with adaptive social engagement and result in anxiety.

When children start to fear more than what they should and show signs of an anxiety that impacts on their daily life such as not wanting to sleep with the light off, not wanting to stay over at a friend's house or not wanting to get up for school, this needs to be investigated. Stomachaches or headaches could also be signs that the child is feeling stressed or anxious. Parents and teachers can also exacerbate the problem if they do not know what to do. Because young children cannot always explain how they are feeling, they might become irritable, or withdrawn or they might lash out at a sibling or a pet, or refuse to go to certain places or do certain things.

SADAG (The South African Depression and Anxiety Group) lists the following common symptoms of anxiety on their brochure, Depression and Anxiety (nd):

- Feeling nervous, irritable or on edge
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation), sweating, and/or trembling
- Feeling weak or tired
- Experiencing difficulty concentrating
- Having trouble sleeping
- Experiencing gastrointestinal (GI) problems

A child might often report physical symptoms for which there seems to be no medical cause after a visit to the family doctor. Often the parent is asked various questions in an attempt to try and rule out a physical illness or condition such as gastric ulcer or irritable bowel syndrome. These, however, could also be brought on by stress, so a careful, methodical consultation would be needed.

Pine (2008, p. 1) states that the biggest differences between people suffering with anxiety and healthy people were not found in their responses to obvious danger but rather in their brains' response to subtle threats or ambiguous situations. However, for Pine, "anxiety results from a learning disorder rather than a reactivity disorder" (2008, p. 1). When anxiety is considered in this way, potential new treatments geared toward correcting a learning deficit can be sought.

2.3.2 Parental influences

Children tend to look to their parents for information about how to interpret situations. For example, if a parent seems consistently anxious and fearful, the child will determine that a variety of scenarios are potentially unsafe. Weir also writes that anxious parents are also more likely to model fearful behaviours for their children and even if parents do not model anxious behaviours, they can inadvertently reinforce their child's anxiety (2017, p. 11).

Sometimes, parents will go to extreme measures in trying to protect a child from an anxiety-provoking situation, for example, never leaving them with a babysitter, not allowing them to venture anywhere on their own, and constantly getting involved with a child's teacher in an attempt to make the child's life stress free. In such cases, the child never develops the skills to overcome challenges and will always be dependent on the parent. Overprotection from parents often interacts with their child's temperamental proneness for anxiety in such a way that behaviourally inhibited children run the greatest risk of anxiety disorders.

Pereira, Barros, Mendonza and Muris refer to different parenting styles and point out that research generally indicates that parenting styles characterised by "low warmth and high control" are associated with higher levels of childhood anxiety problems (2013, p. 400). Furthermore, if parents describe situations to their children as dangerous and irresolvable and express fear or anxiety, they teach their children that avoiding the unpleasantness or difficult situation is a way of coping. A more constructive parenting solution would be confronting it or dealing with it in the correct way so that it serves as a learning experience for future similar situations (Pereira et al., 2013, p. 400).

Further research is needed to discover exactly how parental factors increase children's anxiety levels. The study by Pereira et al. showed that anxious mothers modelled more anxious behaviours, which influenced the ways their children interpreted and thought about their environment and difficulties (2013, p. 400). Parents need to try to focus on dealing with things in a calm manner, thereby setting a good example for

their children. It also helps to ensure that children get a wide range of experiences and learn how to make their own decisions over small things.

With any intervention or support programme, the parent needs to fully understand the learner's anxiety disorder and what could be causing it so that they can be involved in the intervention as well and they may also require strategies to address their own feelings of anxiety.

2.3.3 In the classroom

An anxious child is generally not a happy, carefree one. Internalising disorders such as depression, anxiety, and thoughts of committing suicide are more difficult to detect. Behaviour problems, academic difficulties, and inconsistent school attendance are early or actual signs of mental health problems in learners and are referred to as externalising disorders. They are far easier to identify, as the behaviours are largely disruptive and noticeable.

Anxiety at school could either be consistent throughout the year or worsened at certain times, for example, during exam season or at the beginning of a new school year or term. The teacher would need to be in contact with the parent to manage the anxiety during these times. The different types of anxiety disorder and what the educator might observe in these learners who are sufferers of AD are discussed below.

i) Social anxiety and selective mutism

Social anxiety is the most common anxiety disorder and may affect as many as 7% of the population, according to Alkozei, Cooper and Creswell (2014, p. 1). The term, social phobia, is now termed social anxiety disorder and was introduced to describe the broad and generalised nature of the fears that form part of this disorder.

Alkozei et al. (2014, p. 220) warn that often a child or teenager with social anxiety disorder will go unnoticed when parents and teachers put it down to shyness and introversion as just part of normal adolescence. However, early support and intervention are crucial in the prevention of long-term impairment. Learners with social anxiety disorder are at a disadvantage in so many areas of life, especially with regard to their interaction with the world. They may perform poorly at school, have trouble attending classes and are less likely to make friends and to participate in extracurricular activities. They may even drop out of school or refuse to leave the house.

Selective mutism has been referred to as the fraternal twin of social anxiety. Wong (2010) refers to selective mutism is a rare and multidimensional childhood disorder that typically affects school-age children and is characterized by the persistent failure to speak in select social settings despite possessing the ability to speak and speak comfortably in more familiar settings.

ii) Separation anxiety disorder

Separation anxiety disorder is not part of a normal developmental phase, and according to Kendall et al., it is identified by the age-inappropriate fear of being away from home, parents or other family members (2018, p. 214). While it is typical for young children to go through some difficult adjustments after separations, such as having to go to school, or stay with a carer, children with separation anxiety do not make these adjustments easily.

Some children may feel safe as long as they are with a parent at home, while others may be unable to tolerate any physical distance and will shadow their parents around the house. On school mornings, they may have a lot of trouble getting ready, complaining about aches and pains they feel, cry, or get very angry and irritable. These children are often afraid to go on playdates at other children's houses, are not willing to attend sleepovers, field trips, or drive in someone else's car.

Kendall et al. explains that for a diagnosis, these symptoms must be significant for at least one month and must result in significant impairments in the individual and/or family functioning (2018, p. 215). At school, when separated from the parent, the teacher becomes the substitute so the child then clings to the teacher, until the parent arrives to take the teacher’s place again.

iii) General Anxiety Disorder (GAD)

According to Kendall et al. (2018), the most obvious characteristic of GAD is uncontrollable and excessive worry about a wide variety of events and activities. These children usually expect the worst and are often pessimistic thinkers (Kendall et al., 2018, p. 215). Their chronic worry is unreasonable and irrational given the actual circumstances. Excessive worry means worrying even when there is nothing wrong and in children, the worry is more likely to be about the quality of their abilities or performance, especially at school. Children with generalised anxiety often struggle with perfectionism which may drive behaviour such as excessive studying or extreme practicing (for example, with sports, or musical instruments), or a rigid focus on punctuality.

iv) Obsessive Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) in children and adolescents is defined as an imposing condition consisting of repetitive, intrusive thoughts (obsessions) and distressing repetitive acts (compulsions) (Barton & Heyman, 2016, p. 1). OCD is categorised as childhood-onset if obsessions and compulsions occur before puberty and can affect up to 3% of children. Barton and Heyman state that the average age of onset is approximately ten years of age, although children as young as five or six may develop the illness (2016, p. 1).

According to Barton and Heyman (2016, p. 1), factor and cluster analysis has shown that OCD is a heterogeneous condition with symptoms falling into five independent symptom dimensions:

- Contamination and cleaning
- Harm (aggressive), obsessions and checking
- Symmetry, ordering, repeating and counting
- Hoarding
- Sexual and religious obsessions

These symptoms can be noticed at school, for example, the OCD child frequently washes his/her hands or makes use of a hand sanitiser. The child may also have a perfectionistic approach to work resulting in a slow work pace and constantly making use of the eraser. The child may insist on lining up books or stationery on the desk and worries about whether his/her personal belongings have been touched or moved. There might be hair pulling or skin picking, exhibit noticeable habits, such as walking between cracks on the floor and be addicted to goodbye or hello rituals, or other rituals involving counting or repeating or not wanting to throw pencil sharpenings away.

v) Specific phobia

Ludwig, Lyon and Ryon explain that a specific phobia is an intense and very extreme reaction that is related to a specific organism or situation, for example, flying, heights, water, dogs, spiders, needles (2015, p. 49). If the child comes across the feared object or situation, he or she may become very distressed and upset, anxious and experience panic attacks. Phobias can become disabling and interfere with the child's usual activities. Specific phobias often go unnoticed in the school setting, as often a specific stimulus or situation is needed to trigger an anxious response unless the child experiences school phobia. In this instance, children

display severe anxiety regarding the prospect of attending school, which is often accompanied by somatic symptoms, such as stomachaches or headaches. The child may try to avoid school by asking to go home early, being absent or refusing to attend school.

According to McLoone, Hudson and Rapee (2006), school phobia is a set of symptoms with several possible causes and is often the result of separation anxiety disorder where the child does not want to go to school because they are hesitant to leave the parent. School phobia may also be due to social anxiety or specific phobia. It should not be confused with school refusal, which stems from problems such as learning difficulties, family dysfunction or issues of bullying.

vi) Panic disorder

The National Institute for Mental Health (2018) describes panic disorder as a type of anxiety disorder that typically starts in late adolescence or early adulthood, but it is still possible to develop this condition early on in life. It is more common in women than men, but not everyone who experiences panic attacks will develop panic disorder.

Experiencing a panic attack can be a frightening experience for a teenager, so it often causes avoidance behaviours. As a result, the individual avoids situations, places, and events that he or she believes may trigger a panic attack, such as school assemblies, shopping centres or sports matches or even travelling on public transport. Avoiding situations that may trigger a panic attack is a condition known as agoraphobia. Flanagan et al. believe that about one-third of those with panic disorder will also experience agoraphobia (2015, p. 47).

2.4 MANAGEMENT OF CHILDHOOD ANXIETY

Anxiety is an emotion that everyone has experienced at one stage or another in response to a particular situation or during the build-up to an event or occasion. However, when anxiety changes from being a friend to a foe that monopolises thoughts and takes up so much mental energy that there is little over for anything else, it requires intervention. As pointed out by Green et al. (2015), anxiety disorders are diagnosed when the fear and/or anxiety experienced by an individual becomes excessive and impairs functioning.

Each anxiety disorder develops differently. Green et al. (2015, p. 137) concur with other research about separation anxiety that it mostly occurs before the child starts formal schooling and then it seems to diminish

as the child matures. Social anxiety may also increase throughout a child's development and GAD tends to increase in girls but decreases in boys during later school-age years and adolescence.

Bandelow and Michaelis (2015, p. 333) found that the average age of onset for anxiety disorders is 11. Specific phobias and separation anxiety disorder start earliest, with an average age of onset of seven years. There is a widespread opinion, according to Bandelow and Michaelis (2015), that anxiety is a feature of our modern times, and that the prevalence of anxiety disorders has increased.

2.4.1 AD and its impact on the child

An anxiety disorder affects people. Not only the person or child living with it, but also their parents and family members, their friends and teachers and whomever they might interact with in situations where it may negatively affect functioning or performance, as well as impact a child's educational and social development.

Anxiety disorders frequently occur with other learning barriers or mental disorders. Children presenting with a single anxiety disorder are the exception. According to McLoone (2006) owing to excessive worry, anxious children may also experience concentration difficulties, which is a symptom shared by children with ADD (attention deficit disorder), or the anxious child may tend to avoid feared situations, a type of behaviour, which can easily be misinterpreted as oppositional behaviour. Therefore, there is a need for accurate diagnosis by means of quality assessment, conducted by an appropriate healthcare professional. Structured and semi-structured interviews can reliably assess anxiety disorder in children however, these take time and often require trained interviewers. Alternatively, Muris, Simon, Lijphart, Bos, Hale and Schmeitz find that a self-report questionnaire is also able to measure anxiety symptoms from the child's perspective (2017, p. 1). This is especially important because anxiety disorders are internalising (emotional) problems, which are often less observable than their externalising (behavioural) problems (such as oppositional-defiant disorder and conduct disorder), even to people directly involved with the young person.

Young people with anxiety disorders are unlikely to present for help independently. It is usually caregivers who raise concerns with their general practitioners. However, an assessment should include an opportunity for interviewing the young person on his/her own, as well as interviewing a parent, carer or another adult who knows the child well and can report on current and past behaviour. It is essential to assess for possible

co-existing mental health problems, neuro-developmental conditions, drug and alcohol misuse, and speech and language problems (Cresswell et al., 2014, p. 1).

McLoone et al. (2006, p. 225) mention that self-reporting can be useful for a significant group of children who report accurately, however the tendency for many anxious children to “fake good” also needs to be considered, which explains why the parent version is especially useful in the assessment of yery young children. Muris et al. (2017) refer to one such assessment called the ‘Screen for Child Anxiety Related Emotional Disorders-Revised version (SCARED-R)’, which is a self-report questionnaire for assessing the different types of anxiety disorder, where children rate how frequently they experience each symptom and scores for each dimension of anxiety, together with an overall score, are calculated.

There are many other anxiety-screening tools available online. Alternatively, a visit to the family’s general practitioner is usually the first step in getting treatment, once a proper diagnosis has been made. Parents might also feel that they need to consult with a psychologist or psychiatrist, especially if they are dealing with the older child where the set of behaviours or symptoms are more severe. In some cases, the psychologist and the psychiatrist might work together in the diagnosis and treatment of the anxiety disorder.

2.4.2 AD and its impact on the parents

The world is a very different one from fifty years ago. Stress levels are high and very often adults are so preoccupied with their own inability to cope in their daily lives that they rarely stop to consider how their children are coping. Dr Helen Clark, the Senior Child and Adolescent Psychiatrist at Chris Hani Baragwanath Hospital, explains that there is a perception that children remain protected from all the stress that their caregivers are dealing with and do not always understand what is going on and are, therefore, unaffected (Clark, 2017d). The reality is that they are right in the middle of it all and “experience that same trauma, just not directly but through the fallout from the impact of the stress on their caregiving systems on which they depend for their care” (Clark, 2017d, p. 3). Clark (2017d) argues that parents need to know that their children live in the same stressful world and that they may react to it in a similar way.

Often anxiety is a silent presentation as it is frequently missed at the first and often subsequent appointments with the child. Because it is experienced by the child as an internalised feeling, thought and/or bodily sensation the child might not express anxieties outwardly. Young children might also not have the verbal ability to express what they are experiencing or feeling.

An understanding of family dynamics is also important when a child is presented for evaluation. As pointed out by Clark (2017d, p. 3), in some families "children are encouraged to talk about their feelings and are taught the relevant vocabulary", however, in very stressed families, communication might be limited, as their main goal has become survival.

Anxious emotions are often externalised in the form of behaviours which are interpreted by parents, caregivers or teachers as "bad behaviours", and when these are not responded to in the appropriate manner, the level of anxiety in the child then increases.

In the article, Clark (2017d, p. 3) also refers to various clinical features that fall into the following categories:

- Emotional symptoms - sadness, crying, anger, tantrums, irritability or bluntness of emotion
- Cognitive symptoms - fearfulness, excessive worrying, repeated questioning, poor concentration
- Specific fears - fear of the dark, separation, going to school, crime, natural disasters
- Physical symptoms - headaches, stomach-aches, muscle tension, bedwetting, sleep difficulties
- Behaviours - nail biting, fidgeting, skin-picking, tremors, hair pulling, tantrums, aggression
- Social integration - withdrawal and isolation, struggling with friendships, bullying
- Personal - low self-esteem, fear of failure, attention-seeking, regression, manipulation behaviour
- Trauma-Related Anxiety - nightmares, "flashback" experiences, avoidance behaviour, pre-occupation and distress around thoughts or memories of an event

Adults need to see and hear their children better in order to be more aware of the fact that there are so many anxious children in homes and classrooms. When children put out these signals, adults need to detect and interpret them more carefully.

If the parents think that their child might have an anxiety disorder, it is important to have an assessment by a mental health professional. However, according to Ellis (2017, p. 3) the leading barrier to private healthcare in South Africa is the price. A major factor as to why so many anxiety disorders are not diagnosed, let alone

treated, is because of the elevated costs of medical aid, or even getting basic treatment. According to SADAG (nd) statistics on their website, more than 80% of South Africans cannot afford health care.

Parents might also not know that there is a problem and might adopt a wait-and-see approach, thinking that the behaviours that the child presents might just be a phase and that they will grow out of it however, this approach only exacerbates the problem. There is also a stigma attached to mental health problems, which is often why so many people do not seek help.

2.4.3 AD and its impact on the teacher

Teachers are in a key position to screen for mental health issues in the school setting. On the teacher's recommendation, a visit to a psychiatrist or a psychologist might be necessary. On the other hand, an unsympathetic teacher can also worsen things substantially by ignoring the child's struggles and challenges or by enforcing participation in activities and events when clearly the child is feeling uncomfortable or upset. The teacher might interpret the child's behaviour as manipulative, naughty or rude, instead of trying to investigate the underlying reasons for the child's conduct. School behaviour problems, academic challenges, and erratic school attendance can also be early or actual signs of mental health problems in learners. According to Allison et al. these are 'externalising disorders' that are relatively easy for teachers to identify (2013, p. 165).

The Policy on Screening, Identification, Assessment and Support (SIAS) provides a policy framework for the standardisation of the procedures to "identify, assess and provide programmes for all learners who require additional support to enhance their participation and inclusion in school" (SIAS, 2014, p. 1). It is also aimed at improving access to quality education for vulnerable learners and for those who experience barriers to learning, which can be as a result of a broad range of experiences in the classroom, at school, at home, in the community, and/or as a result of health conditions or disability (SIAS, 2014, p. 5).

SIAS (2014, p. 5) identifies that these barriers to learning and development may include the following:

a) Socio-economic aspects, namely, lack of access to basic services, poverty and under-development
b) Factors that place learners at risk, namely, physical, emotional and sexual abuse, political violence, HIV and AIDS and other chronic health conditions
c) Attitudes
d) Inflexible curriculum implementation at schools

e) Language and communication
f) Inaccessible and unsafe structural environments
g) Inappropriate and inadequate provision of support services
h) Lack of parental recognition and involvement
i) Disability
j) Lack of human resource development strategies
k) Unavailability of accessible learning and teaching support materials and assistive technology

The list makes no mention, however, of mental health challenges such as anxiety or depression, however these could be included under 'chronic health condition' or 'disability'.

Anxiety can go hand in hand with learning disorders. When learners begin to notice that something is more difficult for them than for the others and they start to fall behind, they can understandably become nervous. When learners stop doing and turning in homework, it could be because they are worried that it is not good enough.

Teachers need to be incredibly perceptive in identifying a potential anxiety disorder. The first step would be to have a discussion with the parents so as to share experiences and behaviours that have been noticed and that are impacting on the child's performance in the classroom. The parents should then take the child to see a general practitioner or a psychologist who would begin with interviewing the parents and making use of a questionnaire or checklist. Occasionally, the teacher will be asked to complete a checklist as well.

2.5 SUPPORTING CHILDHOOD ANXIETY

Teachers and educational leaders play an important role in addressing and reducing the anxiety of the learners in their schools. Learners often perceive and respond to specific teaching styles and interpersonal styles of their teachers that have an impact in reducing anxiety in the classroom. A positive and supportive atmosphere in the classroom and on the school campus, can make a big difference in supporting a learner with an anxiety disorder. In some instances, the school and classroom provide an excellent venue where real world experiences and opportunities to practice facing fears such as being in social situations, public speaking, making mistakes and writing exams. These opportunities can be facilitated by teachers, parents and sometimes even classmates can become that child's support coach and thus play an important role in the learner's recovery.

2.5.1 Classroom strategies

Moran (2015, pp. 30, 31) refers to certain accommodations that teachers can provide within the classroom. Some strategies could be part of an individualised education support plan. Moran (2015) also states that it is also important to note that many of these strategies may be beneficial for all learners and not just those with anxiety.

Strategies for teachers could include the following:

- Having a timetable or daily routine in a classroom that is well organised with clear expectations. It is also helpful to inform learners about changes ahead of time.
- Having an environment that is focused on the task and not results and provides for variety and creativity in learning and it reduces rivalry between learners and results in a more conducive, respectful environment. Such an approach may include allowing learners to work in groups.
- Incorporating group activities requires selecting the right learners to work together, and thereby initiating and encouraging positive collaboration.
- Providing a classroom pass system for learners with anxiety, thereby allowing them to leave class without drawing attention to themselves, which is important to the learners' self-esteem.
- Providing flexible and comfortable classroom seating where learners are permitted to sit close to the door so if they need to leave the classroom, they can do so without distracting the class or drawing attention to themselves.
- Providing for accommodations during tests and exams, such as extra time can reduce overall anxiety. Also allowing the learner to sit near an exit or at the back of a large venue, might assist with reducing anxiety symptoms.
- Allocating alternative assignments.
- Providing the learner with copies of notes, can reduce anxiety.
- Providing positive coping skills.

2.5.2 Communication channels

Moran (2015, p. 31) suggests that teachers should communicate regularly with the school counsellor and the parents and/or guardians, in order to provide feedback as to how the accommodations are working and how

the learner is managing on a daily basis in the classroom. If the learner visits an outside psychologist or psychiatrist, which is often the case, the parent will want to feed information from the teacher to that person, especially if the learner is being treated with medication. Sometimes the side effects from the medication affect the learner in class and the teacher will need to be aware of these. The learner might seem tired or more withdrawn, or might suffer from headaches or stomach-aches initially, and, therefore, the teacher needs to carefully monitor these at the start of treatment.

2.5.3 School curriculum

Learners face many societal pressures and challenges that may have a negative effect on their social-emotional and academic development. The current school curriculum should be reviewed and educational authorities need to realise that a more comprehensive social and emotional learning programme in schools is often lacking. Social and emotional learning is how people apply the required understanding, attitudes and abilities to comprehend and handle their feelings, set and attain positive objectives, demonstrate empathy towards their peers and others within the community, create and sustain positive relationships, and make responsible choices.

According to Jacobs (2011, p. 212), the learning area, Life Orientation (LO) is aimed at educating healthy, responsible young people who are able to live productive lives. In addition, the Personal and Social well-being study area, which forms part of the LO learning programme comprises of the study of self in relation to the environment and society (Jacobs, 2011, p. 212). Teachers are a vital component of these programmes and learners often will learn from the way some teachers behave and conduct themselves.

Because there is a positive connection between school culture and climate as well as the social and emotional proficiency of learners and their academic success, schools should endeavour to create a positive school environment, which involves the implementation of effective social and emotional learning programmes.

2.5.4 Private practitioners

Typically, a child’s problem must be noticed or identified by the primary caregiver, or parent and, subsequently, by a medical professional. In South Africa, GPs (general practitioners) are often the first medical professional that families consult, so are ideally positioned to support families themselves, as well as being increasingly seen as ‘gatekeepers’ to specialist health services. GPs rely on information from the

parent when dealing with the young child and with the older adolescent. Part of the consultation will include an interview as well as a questionnaire or checklist that the person completes.

According to O'Brien, Harvey, Young, Reardon and Creswell (2017, p. 888), childhood anxiety disorders can be challenging for GPs owing to their broad symptomology and the reliance on parental recognition. Their findings also indicated that GPs feel ill-equipped to deal with childhood anxiety disorders, furthermore, their study provided support for the view that there is a need for medical training to include greater emphasis on children's mental health.

2.5.5 The parents

There is much stigma and discrimination of people with mental illness in the settings of the Public Health Clinic (PHC), and this may result in delayed diagnosis and reluctance to attend ongoing care facilities (Egbe et al., 2014, p. 14). Egbe et al.'s (2014) study identified various causes of psychiatric stigma that included mistaken beliefs about mental illness that often lead to delays in the person seeking help. Experiencing psychiatric stigma was reported to worsen the health of service users and to hinder their ability to lead a normal life.

Often parents adopt a wait-and-see approach in order to delay visits to the health care practitioner. One of the reasons why this occurs is the stigma attached, another factor might be financial because of the cost of a consultation if there is no medical aid. Yet another reason might be denial that the issue is as severe as it is made out to be by the teacher.

Special programmes or family therapy sessions are often needed to assist the parents in managing their child with an AD, so that ignorance on the part of the parents does not exacerbate the condition.

2.6 CONCLUSION

Around 20% of children have a mental health disorder, but the majority of disorders are not detected and treated (Paruk & Karim, 2016, p.1). While the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes diagnostic criteria, that are generally similar for children, adolescents and adults, the psychiatric evaluation of the young person can be a lot more challenging. Paruk and Karim also identify that adolescence is involved with significant emotional and behavioural change, which makes distinguishing normal development from psychiatric illness difficult (2016, p. 1).

It is also crucial with this vulnerable population group, to raise awareness, enhance screening, detection and treatment of mental illness. This research study aims to provide parents and especially teachers with more information about this complex and highly-prevalent type of psychopathology, which is a burden to many youths and, inherently, is a silent threat to the future adult generation.

In Chapter 3, the theories surrounding the causes of anxiety are discussed, together with an outline of what the latest research includes with regard to support and management of anxiety disorders based on different theories.

CHAPTER 3
THEORETICAL FRAMEWORK

3.1 INTRODUCTION

In this chapter, the theories on the causes of anxiety are discussed as well as an overview of the latest research on the support and management of anxiety disorders based on different theories. The main study objective was to facilitate the implementation of a plan or strategy, which would enable learners with anxiety to participate in learning activities and provide guidelines on effective teaching and learning strategies for learners experiencing anxiety disorders.

According to Walliman, the study design offers a structure for information collection and analysis, and then suggests what research techniques would be most appropriate for the study (2011). For Walliman, this theoretical framework is the base on which knowledge is constructed (metaphorically and literally) for a research study as it provides the foundation for the study or the base on which all aspects of the study are built (2011, p. 14).

The concept of anxiety is better left open-ended and broad enough to embrace the probability that different cases of “anxiety” could have very different repercussions. In addition, anxiety disorders are common and seldom occur in isolation. Rather they occur with a wide range of other physical, mental and broader personal challenges or difficulties, which makes it a very complex topic to study.

It is the researcher’s hope that future studies will focus on the long-term financial implications of the illness and the effects of early interventions. These strategies should remedy the current context by providing support for the cost-effectiveness of early interventions so that anxiety disorders can be identified and those with these extremely common and impairing disorders can be assisted.

3.2 DIFFERENT THEORIES OF ANXIETY DISORDER DEVELOPMENT

Anxiety disorders typically begin before the other conditions with which they are typically associated. Yet, people with early-onset anxiety disorders seldom seek or receive any treatment or support. This reluctance to seek help needs to be investigated further as the lack of facilities and resources for children and young people with mental health conditions creates an enormous burden on the public health system. Although this research study was guided by learning behavioural theory, in particular, the researcher also identified two additional theories, namely, behavioural theory and cognitive theory to inform the study. Behaviourism and

cognitivism are two theories that explain the learning process of human beings. The behavioural approach focuses on behaviours, while the cognitive approach focuses on cognitive processes like memory and decision-making. The main difference between behavioural and cognitive learning theories is that behavioural learning theory only focuses on external observable behaviour while cognitive learning theory focuses on internal mental processes.

3.2.1 Behavioural theory

Behavioural learning theory concerns itself with the way behaviours are learned and, subsequently, unlearned. According to behavioural psychologists, the way a person learns something new is indicated by a change in knowledge or behaviour that is permanent. It can be the result of an experience or an event, that changes something within that person. In psychological terms, learning can occur consciously or sub-consciously without the person even being aware that they are learning. Any change in behaviour suggests that the person has learned a new response to a particular situation.

3.2.2 Cognitive theory

In the 1950s, a psychologist named Albert Ellis and a psychiatrist named Aaron Beck, independently developed two very similar theories, which resulted in effective forms of cognitive therapy. Tennyson and Volk (2015, p. 707) explain the difference between behavioural and cognitive learning theories. The former explains how the environment is involved, while the latter stresses the impact of thoughts, feelings, beliefs and perceptions in determining behaviour. Beck and Haigh (2014, p. 2) explain that the focus in cognitive learning theory is on how people might think about events they experience. For example, if thoughts are negative and dysfunctional, they would create extreme emotions, which then lead to maladaptive behaviours.

3.2.3 Learning behavioural theory

Cognitive behavior therapy (CBT) includes exposure therapy and therapeutic approaches designed to alter a person's dysfunctional patterns of thinking and behaving (Kaczkurkin & Foa, 2015, p. 337). This is based on a combination of behavioural therapies that presupposes that changing behaviours lead to changes in emotions and cognitions or thought processes. Cognitive therapy, on the other hand, focuses on changing cognitions, which is proposed to change emotions and behaviours.

Hans Eysenck's learning behavioural theory of anxiety depends on two major dimensions, namely, "extroversion/introversion and neuroticism whereby the neurotic individual is more prone to anxiety-provoking stimuli and so from this perspective, anxiety-proneness is inherited" (in Strongman, 1995, p.5). According to Eysenck (in Strongman, 1995), anxiety can also be learned and can be known as "conditioned fear".

The emotional theory of uncertainty refers to the fact that being unsure of the future can cause anxiety. The theorist, Mandler (in Strongman, 1995, p. 9) refers to the fact that fundamental distress is not caused by a specific event, but is rather due to being unsure of something or being in a state of unease.

Interpretative researchers seek results from their research cases, typically from people who own their experiences and are of a particular group or culture (Thanh & Thanh, 2015, p. 25). The interpretivist paradigm underpinning this study includes discussing the theory and attempting to propose a procedure that is used currently in an inclusive school setting that other schools could emulate and implement to better support children and adolescents with anxiety disorders.

Regardless of the child's age, CBT is the most effective treatment for anxiety disorders (Ludwig et al., 2015, p. 45). Ludwig et al. (2015) explain that CBT involves interventions that interrupt the cycle by addressing anxiety-provoking thoughts, feelings and behaviours. This intervention strategy and the reasons supplied by the learning behavioural theory were chosen to support this study. The reasons include:

i) Not enough is known and understood about childhood anxiety disorder and the prevalence of the condition is high.
ii) It needs to be considered whether anxiety is a particular behaviour, condition, disorder or disability. It also needs to be considered whether it is learnt or whether it just develops. Chronic anxiety, if left untreated, becomes a disability, in that it disrupts the person's quality of life and prevents him/her from living a normal life. Therefore, discussing the different disability models, clarifies this debate.
iii) Managing AD effectively, will depend on the approach that is used by practitioners and more often than not, teachers and parents will be involved in the management programme. They need to understand the clinical pathology involved to support the child adequately, and not make the condition even more debilitating.

3.3 CAUSES OF ANXIETY DISORDER

It needs to be considered what causes some people to have anxiety disorders and not others. Muris (2007, p. 190) explains that there are many potential risk factors involved and most people will experience multiple different combinations of these, such as neurobiological factors, genetic markers, environmental factors and life experiences. Muris (2007) describes a “dynamic multifactorial model” that comprises a broad spectrum of influences that have been seen as relevant for the origins of anxiety problems in young people.

Waszczuk, Zavos, Gregory and Eley (2013, para. 3) suggest that both nature and nurture play a role, and evidence from twin studies suggests a “complex aetiology” where moderate genetic and environmental influences on anxiety in childhood are implicated. In addition, some people may be at risk to develop AD but do not.

McKay identified four major factors causing emotional or behavioural disorders, namely, “biological disorders and diseases, pathological family relationships, undesirable experiences or negative cultural influences” (2016, p. 61). A child may have a predisposition to exhibit problem behaviour owing to these factors, and other factors might trigger it or increase the risk. Waszczuk et al. researched anxiety sensitivity, and their study showed that anxiety sensitivity at the age of eight is a significant predictor of anxiety symptoms in later years (2013, p. 3).

Muris et al. (2017, p. 165) proposes a “multifactorial model” as there is a continuum, with normal fear on one side and abnormal fear and anxiety on the opposite side. Most children have little fears that are part of their normal development, which come and go with time. However, there seems to be another group of children whose fears seem to dominate their thought-patterns owing to a genetic vulnerability.

3.3.1 Neurobiological factors

Beauchaine and Hayden (2016, p. 150) identify that the biological aspect of the biopsychosocial model refers to how the body responds to fear as well as genetic traits, and the brain functioning that is inherited from parents. However, if people are born with a sensitivity to anxiety and stress, this is not enough to create an anxiety disorder. Other biological factors such as disease, malnutrition and brain trauma, may also contribute to emotional or behavioural problems.

3.3.2 Environmental factors

According to Muris et al. (2017, p. 64), environmental influences result in the child receiving more negative information. Currently, the world that children are being born into is far more complex and threatening than previously, yet the family unit often does not seem to be able to protect and insulate the child from this world's threats. However, some young children are more resilient than others. When psychologists use the word "environment", they refer to all the external things that are happening around people, including life events and experiences, particularly social interactions with other people. The theory explains that people develop an anxiety disorder when they possess both biological and psychological vulnerabilities as well as a social environment that has triggered these vulnerabilities. Apart from the biological factors, environmental factors may also make some people more anxious, such as exposure to stressful situations, drug or alcohol use, a certain parenting style and trauma.

Parenting behaviour could also constitute a risk for anxiety disorders. Kendall et al. (2018, p. 217) explain that a very controlling parenting style is associated with the development of anxiety disorders. If the parent exhibits anxious behaviours or in cases where the child is neglected or rejected by the parent, this could give rise to anxiety disorders. Having recently experienced a traumatic event or very stressful event can be a risk factor for the development of anxiety across different age groups.

Wlassoff supports that biological factors influence anxiety disorders and believes that "both sensitivity and resilience to stress are determined by genes" (2015, para. 4). Some children already have emotional or behavioural disorders when they start school, others develop such disorders a little later. These disorders may become better or worse depending on how they are managed.

3.3.3 Personality traits

Researchers like Kendall et al. (2018, p. 216) hypothesised that the child's character or personality could play a role in the development of anxiety disorders especially in individuals who are highly-emotional and neurotic. With regard to personality traits, Muris et al. (2017, p. 64) identified the Five Factor Model of Personality that consists of the following five broad trait domains including:

- Neuroticism
- Extraversion
- Openness to experience
- Agreeableness

- Conscientiousness

This means that someone who is more neurotic or low on conscientiousness has more of a chance of developing an anxiety disorder, and, on the other hand, an individual who is low on trait extraversion is more likely to develop social phobia and agoraphobia (Muris et al., 2017, p. 64).

Furthermore, according to Jacofsky, Santos, Khemlani-Patel and Neziroglu (nd), the biopsychosocial model includes beliefs and percptions about experiences as well as environmental influences. These beliefs and perceptions affect how much people think they can control their environment and how they are able to assess and interpret what happens in their environment, which can either be dangerous or non-threatening.

The research study discussed the causes of anxiety and the related theories to further discuss and understand the current views with regard to how a child with anxiety is assisted. In section 3.4, the social versus the medical model of disability is discussed.

3.4 DISABILITY: DEFINITION AND MODELS

Hallahan et al. (2012, p. 6) reported that many people with disabilities have abilities that go unrecognised because of their limitations or challenges. It is these challenges that end up becoming the focus of concern and distract attention from their strengths and talents (Hallahan et al., 2012, p. 6). These same authors define disability as not being able to do something, or an incapacity to perform in a specific manner, however, not every inability to do something is a disability.

3.4.1 Medical model vs social model

Disability was perceived as a purely medical condition, where the question, “Do you have a disability?” is usually asked. However, according to UNICEF, this underestimates the true prevalence of disability, as many disabled individuals may prefer not to identify themselves as disabled because of shame, stigma or cultural standards (2013, p. 9). UNICEF (2013) also refers to the social model, which implies that the disabled person is disabled by circumstances that are beyond their control. With this approach, the attention shifts to trying to understand the amount of disadvantage and discrimination shown towards the individual, and the results of how the person is able to interact with his/her environment in a functional and productive manner (UNICEF, 2013, p. 9).

More than ten years after the adoption of Education White Paper 6 by the Department of Education in 2001, most learners with disabilities who attend school are still separated in “special” schools, which are schools for learners with disabilities (Donohue & Bornman, 2014, p. 2). According to Statistics South Africa, it is estimated that about five out of every 100 people have a disability (in Donohue & Bornman, 2014, p. 2). As a result, South African teachers are now being trained on how to accommodate diverse learners in a single classroom. This is in line with the social model of disability that views disability centrally as a “social construct created by an ability-oriented environment” (Donohue & Bornman, 2014, p. 4). Disability, in this sense, views the problem as a system and culture that fails to meet the needs of these individuals and not an intrinsic problem. The social model promotes inclusion and the removal of all barriers and separation that prevent people with disability from participating at the same level and in the same way as their non-disabled peers.

The medical model’s primary concern and emphasis is to diagnose and treat. However, this is challenged because of the fact that this emphasis on a person's biomedical condition is dehumanising, because it gives too much emphasis to the medical condition over and above the personhood of the disabled person (Dirth & Branscombe, 2017, p. 413).

Oliver (1990, p. 2) refers to a model of disability where “medicalisation” is just one component. The medical model creates prejudice and discrimination toward people with disabilities because it becomes a challenge to separate the disabilities from the individuals who live with them (Dirth & Branscombe, 2017, p. 415). Oliver (1990) argues that medical practitioners were able to diagnose and treat but were not trained to alleviate social conditions or circumstances. Doctors, however, do have a role to play in the lives of people living with a disability in that they can stabilise their initial condition and treat any illnesses which may arise, even if it is not related to the disability (Oliver, 1990, p. 4).

In contrast, Retief and Letšosa (2018, p. 3) argue that society has disabled people with impairments, and, therefore, societal change needs to occur rather than individual’s adjustment and rehabilitation. The social model connects an individual with a disability and his/her social environment. Dirth and Branscombe (2017, p. 415) refer to the social model that locates the source of difficulty in a person's environment and moves the focus away from individual limitations to the barriers to social inclusion created by disabling barriers, attitudes and cultures. While the medical model might consider someone who requires a wheelchair to be

disabled because of his/her cerebral palsy, for example, proponents of the social model would consider this same individual disabled because of a building not having a ramp or a lift.

The White Paper on the Rights of Persons with Disabilities (Department of Social Development, 2016) was compiled by socio-political activists living with disabilities. This paper argues that disability is imposed by society when a person with an impairment is prevented from full participation in all aspects of life, and when society fails to adhere to the rights and specific needs of individuals with these impairments (Department of Social Development, 2016, p. 30).

The question as to whether mental illness is regarded as a disability or not can easily be answered when looking at the effect that having a mental illness has on the person's quality of life, and his or her ability to function in the workplace and within the family nucleus.

Ryan, O'Farrelly and Ramchandani (2017, p. 86) suggest that childhood mental health problems could have lasting effects on opportunities that children can have in life. Behaviour problems constitute the most common mental health problem in early childhood, affecting between five and ten percent of young children (Ryan et al., 2017, p. 86). Ryan et.al argue that school failure, misconduct, relationship difficulties, mental illness and physical ill health are the negative outcomes that result from mental health problems (2017, p. 86).

3.4.2 High-incidence and low-incidence categories of disability

High-incidence disabilities occur most frequently and include learning disabilities, communication disorders, emotional disturbance and mild intellectual disabilities. On the other hand, disabilities that do not occur as frequently are known as low-incidence and include blindness, low vision, hearing loss and severe intellectual impairments.

Progress in meeting the needs of children and young people in the U.S. with disabilities has come about thanks to legislation that requires states and localities to include learners with special needs in the public education system. The Education for All Handicapped Children Act, later amended to become the Individuals with Disabilities Education Act (IDEA) requires all public schools to provide equal educational opportunities for all learners with disabilities (UNICEF, 2013, p. 24).

According to UNICEF (2013, p. 27), the South African Census 2001 included six types of disabilities that included disabilities relating to sight and hearing, disabilities relating to deafness or profoundly hard of hearing as well as emotional and communication disabilities.

3.4.3 Learners with emotional and behavioural disorders

For Hallahan et al. (2012, p. 206), emotional or behavioural disorders could occur with other disabilities, especially learning and intellectual disabilities. An emotional or behavioural disorder refers to extreme behaviour, that is chronic and unacceptable because of social or cultural expectations and taboos.

Two broad dimensions of disordered behaviour have been identified, namely, externalising and internalising behaviour. Where the one involves disruptive actions against others, the other involves inner mental or emotional conflicts, such as anxiety or depression. Hallahan et al. (2012, p. 215) identify that schools are places where anxious and withdrawn adolescents, in particular, experience the most distress.

A study conducted by Dare and Nowicki (2015, p. 218) identified learners that could simultaneously have both exceptional abilities and learning difficulties, in other words, they are “twice-exceptional” and have multiple labels. For example, a child who is gifted and talented (G/T) could also have a specific learning disability (SLD), or high ability learners might also be creative, and/or talented (Dare & Nowicki, 2015, p. 209).

Learners who have emotional/behavioural disorders (EBD) are among those least often identified as twice-exceptional and seldom feature in educational research. According to Dare and Nowicki (2015, p. 214), EBD negatively affects educational performance and as these learners have such extreme strengths and weaknesses, schooling can be very frustrating and often lead to feelings of anxiety and fear of failure in academic tasks and academic underperformance.

3.5 THE ANXIOUS CHILD AND SUPPORT FOR THE PARENTS

In inclusive education, the importance of support is emphasised (social model) rather than the treatment of a problem that needs to be fixed (medical model). Anxiety disorder, therefore, is viewed in the social model as a condition that requires ongoing support and empathy by parents and teachers. A proper assessment would lead to more effective as well as more efficient intervention and support (Dygdon & Dienes, 2014, p. 12).

Behaviour therapy and cognitive therapy have been presented as distinct therapies. CBT integrates attempts at changing thought patterns and corresponding behaviours through experiments. However, Linden and Hewitt (2018, p. 284) find that behavioural and cognitive therapy are often conceptualised as “overlapping” in literature:

> …throughout much of the literature in clinical psychology, one finds the use of the term cognitive-behavioural therapy (CBT) as if the cognitive and behavioural therapies were so overlapping that they always needed to be mentioned in the same breath.

Private practitioners make use of both therapy forms to treat anxiety disorder. Muris et al. believes that behaviour therapy is based on the fact that behaviour could be changed, whereas the cognitive component believes that all normal and abnormal human behaviour is controlled by thought processes (2017, p. 226).

Parents need to be proactive in seeking out support for their anxious child. Usually their first port of call is their community clinic or doctor, depending on the severity of the anxiety and whether the symptoms are behaviour-based, or whether they are physical/somatic symptoms. A full discussion of the treatment process is not germane to this study, but mention of the options available to the parent or to the child concerned would be relevant.

Parents tend to prefer psychological interventions over medication for the treatment of anxiety disorders in children and young people. However, a combination of CBT and pharmacology seem to provide the most effective treatment results. Muris et al. advise that cognitive-behavioural therapy should be regarded as the treatment of choice for childhood anxiety disorders (2017, p. 264).

The treatment of child anxiety has traditionally been the responsibility of specialised centres, community health clinics and private psychologists working in cooperation with concerned parents. However, more recently, there has been a move to utilise the resources of schools to assist in the identification and management of childhood anxiety. Schools are able to provide real-life settings and scenarios to challenge the learner's anxieties, whether they consist of social fears, general worries or separation anxiety.

McLoone et al. agree that the staff in schools are in an excellent position to monitor at-risk children and intervene with prevention and early intervention programmes prior to the development of major dysfunction (2006, p. 225). Parents also need to receive information about suitable treatment for anxiety and of support that is best-suited for the challenge of appropriately supporting their children and family therapy sessions, which might be required.

By cooperating and collaborating with school personnel, doctors could help teachers identify stress factors in the school setting and reduce risks for children and adolescents in that setting. Mental health professionals use a variety of methods and tools to do a proper assessment. Clark (2017d, p. 13), of the Child, Adolescent and Family Unit at Chris Hani Baragwanath Hospital, finds that the role of the few specialist mental health practitioners would be to run training courses for other professionals (for example, nursing sisters, teachers, social workers) and lay volunteers to enable them to assist in the identification and management of learners with anxiety disorders in their schools and communities.

Learners spend six to eight hours, five days a week at school, so the school presents an ideal opportunity to access large numbers of children, provided the staff are adequately trained and supported. Attention needs to be paid to those factors, such as bullying and corporal punishment, within the school environment that increase the risk of anxiety in learners. These should be addressed first, remembering, however, that many may be beyond the power of an individual school to change without community and government department involvement.

Education and training of teachers in identifying learners at risk and on ways to work with and support identified and vulnerable learners within a classroom setting is essential. The Proactive Education Group is an NGO that offers training and workshops for teachers at schools on how to address bullying, and how to develop school policies aimed at the well-being of learners.

Certain teachers could also be trained to act as counsellors. These teachers should be identified educators at schools that learners know they can go and see, or to whom others can refer. Counselling does not take the place of therapy, but given the minimal resources for therapy and the number of learners struggling, these teacher-counsellors would be rendering a very special service to learners whose only hope is affirmation and support from the school.

Groups could be run within schools by trained staff, NGOs (for example, SADAG) or by mental health professionals from within their community. There could be a review of the use of the Life Orientation programme in schools, which could incorporate guidelines preparing a young person to cope and survive in their specific community with all its challenges, for example, socio-economic issues, substance abuse, crime, teenage pregnancy and cults. Each school community would then be identifying and looking after its own learners's needs.

3.6 LEARNERS WITH BEHAVIOURAL DISORDERS

According to Ogundele (2018, p. 9), it has been established that mental health problems in children and adolescents include several types of emotional and behavioural disorders, including disruptive behaviour, depression, anxiety and pervasive developmental disorders (for example, autism), which are characterised as either internalising or externalising problems. Disruptive behavioural problems such as temper tantrums and oppositional actions, for example, defiance or conduct disorders, are the most common behavioural problems with preschool and school age children. They are referred to as externalising disorders and are the most common referral to paediatric and mental health clinics.

Oppositional defiant disorder (ODD) is a mild form of antisocial behaviour and is identified by patterns of aggressive and defiant behaviour toward authority figures over a period of at least six months. According to Beauchaine and Hayden (2016, p. 141), symptoms include violations of minor rules, temper tantrums, argumentativeness, provocative behaviour and stubbornness. It is often the case that noncompliance and aggressive behaviour are comorbid, however, they may require separate treatments. The complexity of ODD and CD makes diagnosis and determination of long-term outcomes challenging.

School heads and teachers face enormous pressures in their endeavours to ensure the academic success of all learners within their school and teachers have the difficult task of maintaining high academic results while also having to manage behaviours in their classrooms. According to Clark (2017d, p. 14), the increasing level of anxiety in children in SA has reached a crisis and must receive the attention it deserves from the highest levels. Furthermore, Clark (2017d) identifies that distress and anxiety do not respect socio-economic class.

3.7 SUPPORT FOR LEARNERS WITH BEHAVIOURAL DISORDERS

School can be very important to learners from unstable and dysfunctional home backgrounds for provision of safe, predictable, supportive spaces to foster development and hope. Shortcomings in the school system, together with difficulties in the home environment, could also add to anxiety in the child. School should be where anxiety cases missed at home are detected and brought to clinical attention. Therefore, schools should become the safe spaces that vulnerable young people need.

The school environment could also create barriers to learning. It is the responsibility of educators to make sure that their learning environments are as conducive to learning as possible. Two key dimensions are the psychosocial and the physical learning environments. The former covers psychological and social factors

that have consequences for satisfaction, health, wellbeing and ability to perform effectively. The physical environment refers to the classroom space, infrastructure and furniture, noise level, class size, displays and resources (SIAS, 2014, p. 5).

3.8 INCLUSION AND THE SOCIAL MODEL OF DISABILITY

According to the White Paper on the Rights of People with Disabilities, inclusion is regarded as a universal human right and aims to embrace the diversity of everyone regardless of language, creed, gender, disability or any other differences (Department of Social Development, 2016, p. 180). Inclusion implies shifting from a model where the individual has to change to a model where the system needs to change. It requires a move away from referring to the specialness of people and rather talking about how society can accommodate and respond to a wide range of individual differences and needs.

According to Stormont, Herman and Reinke (2015, p. 39), the classroom represents a small social community, where learners could achieve success in environments where there are clear expectations, where consequences are equal and consistent, and where positive attention is preferred over negative attention. In other words, interventions that provide a predictable, structured and nurturing environment benefits all learners but especially, learners at risk. Moreover, teachers could help learners with internalising problems by improving their own classroom management skills.

Teachers could also provide environments that encourage the use of coping skills where learners learn how to monitor their moods or take risks. The environment also needs to support new experiences that could lead to positive outcomes.

The aim for introducing the Screening, Identification, Assessment and Support (SIAS) policy in the education system was to overhaul the process of identifying, assessing and providing programmes for all learners who required additional support to enhance participation and inclusion. It is a policy framework that aims to standardise procedures to identify, assess and provide programmes for all learners who require additional support in school (SIAS, 2014, p. 1). Educators play a big part of this policy and if implemented correctly, the SIAS shifts the emphasis to a holistic, all-inclusive framework where a whole range of possible barriers to learning could be considered. Depending on the resources available, support for the learner is crucial to ensure a successful outcome.

An educator that has the information and knowledge to identify the problem, could assess, discuss with the parents and refer to the school's School-based Support Teams (SBST) system, that is, if it exists and is functioning adequately. According to the SIAS (2014) policy, the SBSTs are the teams established by schools to put support in place.

If the SBST is unable to provide the necessary support to the learner within a six-month period, the team co-ordinator must then refer the learner to the District-Based Support Team (DBST). Where high-level support at school level is lacking, the DBST provides the next level to provide additional support. The SBST provides the DBST with evidence of learner support and should always involve the parents and inform them about decisions taken to further support the learner.

Because school communities are so different owing to their varying locations and resources, their different leadership styles and personnel as well as different parent bodies, it is virtually impossible to have a system that will suit everyone. Unless the gap between the haves and the have-nots is drastically narrowed, there will be little progress with the successful implementation of White Paper 6 (2016) and the SIAS (2014) policy document. Although there is more mention of learners with visible signs of disability such as blindness or cerebral palsy, there is very little discussion about learners with emotional and behavioural challenges such as anxiety disorders, which is why a new approach to assist learners with anxiety in the classroom and at home.

3.9 CONCLUSION

Anxiety in young people could be overcome with various types of treatment options, though not all types of treatment are effective. Literature has identified cognitive behaviour therapy as an effective treatment option, but not all mental health service providers are trained in these procedures. Teachers have it in their power to make a difference to all learners by treating their current anxieties, and by building a more learner-friendly society for the future. Chapter 4 discusses the research design and methodology of the study.

CHAPTER 4
RESEARCH METHODOLOGY AND DESIGN

4.1 INTRODUCTION

There are various forms of research design suitable for different types of research projects. With this chapter, the research plan for conducting this study is outlined including the research paradigm, population and sampling as well as instrumentation and data collection techniques.

McMillan acknowledges that the purpose of research is to provide sound understanding and explanations that can become knowledge (2012, p. 8). Being a researcher is about finding answers to research questions by identifying a subject to study, finding and collecting data or information, scrutinising it carefully and then presenting the results in such a way that others will learn from the conclusion or findings. Research involves presenting a range of practical problems that need to be solved.

The research problems for this study are summed up under three sections, such as understanding what defines anxiety, specifically in learners at school and how these learners with an anxiety disorder are identified or recognised. The second question deals with how these anxiety disorders are managed and how educators and caregivers can assist the learners to manage their anxiety. The final issue is concerned with what support is available for these learners and whether schools can implement a plan to enable learners with AD to participate in learning activities.

4.2 RESEARCH PARADIGM

According to Kivunja and Kuyini (2017, p. 26), paradigm is the term used in educational research to describe a researcher's 'worldview', namely, the perspective, or thinking that informs or influences the meaning or interpretation of the research data. It comprises the researcher's personal beliefs and opinions about the world and guides the research action or investigation. A paradigm orchestrates the study from deciding on the subject of the study to the study methodology and even how the findings are interpreted.

In this interpretivist research paradigm that was chosen, the research was value-bound, in that the researcher was part of what was being researched, and could not be separated, so was subjective. The advantages of this paradigm were that the researcher was able to describe and understand the participants and their experiences within the social context of the school setting. This was the natural setting and, therefore,

valuable data was collected directly and provided the researcher with valuable insights leading to further action.

However, some limitations were also highlighted, in that, as intepretivists aim to gain deeper understanding and knowledge of phenomena, the study tends to leave out verifying validity and usefulness of research outcomes by using scientific procedures. The second disadvantage is that it tends to be a subjective study rather than objective in nature and, therefore, outcomes may be tainted by the researcher's bias – personal beliefs, desires and attitudes that needed to be prevented from influencing the study in any way. The last limitation of interpretivism deals with focusing too much on current phenomena rather than the empowerment of individuals and societies.

Levers (2013, p. 3) identifies that interpretivist research is led by the investigator's beliefs, opinions and feelings about the world and how it should be understood and studied. The interpretive paradigm has its focus on recognising and explaining the meaning of human experiences and actions (Levers, 2013, p. 3). Although the interpretivist researcher accepts more than one answer as correct, Kivunja and Kuyini (2017, p. 26) point out that the main aim of the interpretivist paradigm is to understand the viewpoint of the subject, rather than the observer's standpoint. Hence, the main emphasis is on the subject or person and his/her own viewpoint, in other words, it is a socially-constructed reality.

An interpretivist paradigm was deemed most appropriate for this study. As pointed out by Kivunja and Kuyani (2017), research in the field of special education that makes use of the interpretivist paradigm, requires that the researcher not focus on the disability, barrier or label as the subject to be studied. The researcher should rather have conversations and interactions with the teachers, learning support assistants, parents and learners themselves, to better understand the particular needs of the learner (Kivunja & Kuyani, 2017, p. 37). The paradigm chosen directly affected what would create reliable data and how the results were interpreted. When a study is interpretivist in nature, it seeks to understand the experiences of a large group of people. Therefore, the skills needed to interpret their experiences becomes an important consideration of methodology. This also ties in with the social model of disability, which explains how the person is affected more by the attitudes, opinions and views of other people, rather than the disability that is intrinsic to the individual.

4.2.1 Epistemology

In research, epistemology is the study of the nature and scope of knowledge and justified belief. It deals with how knowledge is acquired and how it can be shared with others (Kivunja & Kuyani, 2017, p. 27). It describes how something is known or understood, and focuses on human knowledge and consciousness. It was also beneficial to the study that the researcher had acquired this form of consciousness, and so was equipped to broaden and deepen the full understanding of anxiety disorder in this field of research.

A subjectivist epistemology point of departure implies that the researchers interpret their data through their own thought patterns, influenced by their own interactions with participants. The researchers and their subjects are caught up in socially-interactive processes, therefore, they will come to know something as real because of personal experiences of real life within the natural settings investigated. By conducting field research, the researcher could observe the participants in a natural setting and by using questionnaires and observations to gather data, the researcher's personal experiences and interactions with the learners at the school, allowed for a subjective epistemology.

4.2.2 Ontology

Levers (2013, p. 2) defines ontology as the "study of being". It asks the questions beginning with 'what' and is concerned with the non-fiction world as opposed to the fiction world. For example, it asks, How is it known if someone is real or not? What perceptions or assumptions are made in order to believe that something is real or makes sense to us? For Kivunja and Kuyini, ontology is the philosophical study of the existence or reality, of whether something exists or not and where it fits in the universe, in other words, to what category does it belong (2017, p. 27).

The ontological assumption of this study was based on the researcher's own experiences as a teacher and being an inclusive education specialist. The researcher was very concerned about the issues surrounding anxiety in learners, the lack of accommodation and assistance and often-times exclusion of these learners because of the barriers they experienced.

The theory behind a relativist ontology means that the researcher believed that the situation that was being studied had several realities, and that those realities could be explored and meanings reconstructed or constructed through personal interactions and relations between the researcher and the research participants and subjects. The study tried to understand and formulate common elements and ideas surrounding learners

with anxiety disorders. The case study method provided the researcher with a bird's eye view to look for and identify the subjects' similar traits, behaviours, emotions and perceptions.

4.2.3 Axiology

According to Kivunja and Kuyini (2017, p. 28), axiology is the study of value and refers to the making decisions of value, namely, the right decisions relating to research. Axiology is concerned with the ethical and moral issues involved in research. It also considers the different components and stages of the research, the subjects or participants, the data and the audience to which the results of the research will be reported. A balanced axiology requires that the final results from the study should adequately reflect the values of the researcher, and that the report of the findings should be balanced and valid.

4.3 RESEARCH APPROACH

Research is either quantitative or qualitative or a combination of both and these terms refer to two different research traditions or paradigms. According to McMillan (2012, p. 11), quantitative research has the objective of obtaining a result consisting of a single true reality or, at least, reality within known probabilities. However, qualitative research involves a different approach in which more than one reality is possible stemming from the subjects' thoughts, opinions and perceptions, and there is a focus on understanding and creating a story that is less on numbers and more concerned with verbal narratives and observations (McMillan, 2012, p. 14).

Mixed-method research provided the researcher with both qualitative and quantitative research methods to conduct the study. The reason for the use of mixed methods research in this study was to use qualitative data to develop an instrument for the qualitative approach. On the other hand, the quantitative method assisted in avoiding being biased because it allowed the researcher to be detached from the participants, while the questionnaires were being distributed and returned. Therefore according to Cresswell (2012, p. 535), mixed methods research is not simply collecting two distinct "strands" of research— qualitative and quantitative but it also consists of merging, integrating, linking, or embedding the two "strands."

The researcher made use of document study, questionnaires, observations and field notes to gather the data that was needed for this mixed-method study. This qualitative approach allowed the researcher to put together the pieces to form a more complete picture than if only a quantitative or qualitative methodology had been chosen. A single approach to a research study has limitations, therefore, as is pointed out by

McMillan (2012, p. 317), sometimes the best way to answer these important research questions is to make use of both qualitative and quantitative methods in the same study, which was the approach that the researcher selected.

A series of case histories of learners currently attending a small independent school was used as the setting for the research study. Field work observations, questionnaires and other techniques were used to understand the environment where the study took place. These case histories formed the foundation of this study to provide a window into the lives of these learners.

4.4 RESEARCH DESIGN

According to Kothari (2004, p. 7), research design is used to systematically solve the research problem and it might also be understood as a “science of studying how research is done scientifically”. The research methodology includes various steps that are followed by a researcher in studying the research problem along with the logic behind the steps.

A sequential exploratory design was used where some of the qualitative data was gathered first, followed by a quantitative phase. So the mixed methods researcher begins with qualitative data and then collects quantitative information and the purpose of an exploratory sequential mixed methods design allows first gathering qualitative data to explore a phenomenon, and then collecting quantitative data to explain relationships found in the qualitative data. Results from the qualitative data analysis, i.e. the in-depth collective case histories was used to help determine the focus and type of data collection in the quantitative phase, which included gathering of data from the questionnaires. The in-depth collective case histories formed the first phase of the study and provided a window into the lives of the learners, who were selected as the sample, i.e. learners with anxiety.

The collective case study was chosen as there were multiple cases (more than one learner with an anxiety disorder) within the single study. The sequential exploratory design permits a researcher to first explore a topic by identifying qualitative themes and generating theories, and then use that exploration to guide a subsequent quantitative examination of the initial qualitative results to develop a measurement instrument based on the qualitative results. The quantitative examination occurred in the form of the questionnaires sent to the learners, parents and teachers.

4.4.1 Research questions

The first step in a research study is to decide on a specific research question. Kothari (2004, p. 12) refers to two types of research problems, namely, "those which relate to states of nature and those which relate to relationships between variables". Kothari (2004) identifies two steps in formulating the research problem, namely, understanding the problem thoroughly, and rephrasing it into meaningful terms from an analytical point of view.

In deciding on the research questions for this study, the researcher began by discussing with colleagues the issue of anxiety in schools, and which learners received support as well as intervention for anxiety in the classroom and at school. Following discussions and conducting an extensive literature review, it was apparent that learners with anxiety disorders were often overlooked in the classroom, especially if they internalised their anxiety and became withdrawn or depressed. The externalising behaviours are the ones that cause the most havoc and it is these learners that often are expelled or who drop out of the system. In addition, teachers are seldom adequately equipped to support learners with anxiety disorders and parents are often not in a position to assist either.

The aim of this research study was to describe the journey that needed for the learner in question, so that it was successful for parent, teacher and learner. The research questions were summed-up under three sections, namely:

- What defines anxiety, specifically in learners at school and how these learners with an anxiety disorder are identified or recognised?
- How are these anxiety disorders managed and how can educators and caregivers assist the learners to manage the anxiety so that he or she can still function at school and be successful?
- What support is available for these learners, can schools implement a plan to enable learners with AD to participate in the activities of learning and can teachers be provided with guidelines on effective teaching and learning strategies for learners with anxiety disorders?

4.5 LOCATION

A school record review of learners diagnosed with anxiety disorders was undertaken at an independent school in the Central area of Port Elizabeth. The school mainly caters for learners with special educational needs and often these learners might have emotional issues that are comorbid with learning barriers. The

entry requirements to the school are that the learner must have recently undergone a psycho-educational assessment within the last 12 months indicating a learning barrier. The school receives referrals from clinicians (medical practitioners, psychologists and psychiatrists) and also accepts direct referrals from parents and teachers. Once a referral comes in via the school admission's office, a file is opened and a psychosocial history as well as a background investigation is undertaken. In addition to interviewing the parent(s) or guardian together with the learner, the learner is given the opportunity to visit the school for a week, for the inter-disciplinary team, comprising the SENCO (Special Educational Needs Co-ordinator), class teacher, phase head, school principal and school counsellors to conduct observations and gather more information about the learner.

The team reviews the learner's file thoroughly and at the end of the visit, meets again with the learner's parents to provide feedback and make the necessary recommendations with regard to further placement of the learner.

4.6 POPULATION AND SAMPLING

For Kothari (2004, p. 56), the first step in developing any sample design is to "clearly define the set of objects, technically called the Universe, to be studied". This universe can be finite or infinite, but, for the purpose of this study, the population for the study was finite and was comprised of all the learners attending an independent school in Port Elizabeth. There were 131 learners, and the participants in this study were ten learners (five males and five females) that had been identified as having anxiety. As they presented with similar characteristics and behaviours, they were receiving some form of emotional support. These ten participants as well as their teachers and parents comprised the sample.

4.6.1 Sample

The biographical and background information about the learners in the study are summarised in the following paragraphs from the oldest to the youngest.

L1 (DOB 09/02/2000) was born full-term. Milestones: average. She attended a mainstream primary school but repeated Grades 2 and 5. Her mother reported that she struggled academically in most subjects and she was not able to work independently. She required a lot of support from her teacher and homework in the afternoons and evenings took a long time to complete. As a result, it became a very stressful experience. The mother decided to move her to her current school, following a scholastic assessment that revealed a

significant difference between verbal and non-verbal abilities, with a severe reading disorder. Even with the remedial support in the classroom, she was still struggling to make progress and so it was further recommended that she be transferred to the vocational class at the same school. Her mother requested to rather keep her in the mainstream class. Her teachers reported that her anxiety levels were very elevated.

L2 (DOB 19/10/2001) was diagnosed with neurofibromatosis at the age of seven years and had to wear a brace every day under her school uniform. She was bullied at school and would complain of stomachaches and headaches on days when she needed to undress in front of classmates for sport or PE lessons. She developed anxiety symptoms, and underwent an assessment (no medication prescribed). She was referred for occupational therapy and play therapy because of her above average levels of anxiety. Anxiety medication was prescribed. She slept in the same room with her parents at night. In 2014, she had a re-assessment with a psychologist who recommended that counselling continue. She moved schools when she started high school in 2014. Currently, anxiety is being monitored and she is seeing a counsellor on a weekly basis.

L3 (DOB 18/09/2002) was born full-term (normal birth). While pregnant, her mother was in a car accident. The learner developed a dairy allergy as a baby and had had many lung infections resulting in hospital visits with pneumonia. She was diagnosed with ADHD, but no medication was prescribed. Both an MRI and an EEG were done. She started on Epilim and other medication to address an iron deficiency. At the age of seven, she started school at a mainstream school after repeating Grade R but struggled academically and with the pace of the work. She was transferred into the special class at the same school. She remained in the special class until 13 years of age. Her parents chose to remove her from school and her father began homeschooling her, as she was becoming very anxious and her self-confidence had declined. Her parents requested a scholastic assessment to decide on high school placement. Concentration and anxiety were a concern. The psychologist suggested that she should transfer to a school for special needs. She was also taking a mood suppressant at night. In 2017, she moved schools and was placed in the vocational skills class. Her anxiety was being monitored and she was seeing a counsellor on a weekly basis.

L4 (09/09/2003) was born one week after his due date. He reached his developmental milestones late. At the age of six years, he was taken for an occupational therapy assessment and weekly therapy was recommended, but this was not regular nor consistent. He began to take medication for concentration (Ritalin LA 20mg) and repeated Grade R. In 2012, he went for a re-assessment with an occupational

therapist who recommended remedial therapy and special school placement. She also reported that his concentration was weak and his work pace was very slow. The learner also suffered from low self-esteem and anxiety. He went for a scholastic assessment and was found to have average intellectual functioning. A re-evaluation of medication was recommended as well as to continue with remedial classes for Maths and English. He was referred to an audiologist for CAPD (Central Auditory Processing Disorder) assessment. He moved to the current school, medication was discontinued and he had a Conners Assessment, where the results showed elevated levels of ADHD (inattention) and anxiety. Medication was re-introduced with Ritalin 10mg and counselling on a weekly basis.

L5 (DOB 03/06/2004) was previously at school in Dulwich College (Shanghai). He was referred for psychological assessment, as he was not making satisfactory progress at school. The educational psychologist recommended special school placement, medication for concentration, OT, speech therapy and referral to paediatrician for further assessment for anxiety. When he moved to South Africa, he was placed at the current school. He was taking medication for anxiety symptoms and inattention. He underwent further scholastic assessment and weekly counselling for emotional support was recommended and he was also diagnosed with ASD (Autism Spectrum Disorder).

L6 (DOB 05/07/2005) was born full-term via emergency C-section. Her mother was in labour for four days, was too stressed to breast feed and was advised to bottle-feed. Most of the developmental milestones were reached within average timeframes. Her mother was diagnosed with postnatal depression. At the age of two years, she suffered a near drowning experience. She was diagnosed with ADHD and started taking Ritalin in Grade 1. Her family relocated and the parents were divorced. The learner and her mother relocated again and she attended a mainstream school. She struggled with reading, Maths and writing and was referred for remedial therapy, occupational therapy and play therapy to deal with the divorce. She relocated again and underwent a scholastic re-assessment, as she was struggling to keep up with the work. She relocated again and joined the current school. She was taking Ritalin LA and Methylphenidate 10mg top up. Her auditory perception skills were well below average and she struggled with organisational skills, planning and taking responsibility for making her own choices. She was referred for counselling and was currently having weekly sessions at school.

L7 (DOB 25/05/2005) developed anxiety symptoms and was referred to a paediatric psychiatrist. He was diagnosed with Autism Spectrum Disorder and was prescribed medication for anxiety, irritability and

impulsivity (Prozac, Risperdal). He was also referred for speech and language therapy, occupational therapy, physiotherapy, play therapy and counselling (current). His parents relocated and he began schooling at the current school. He continued with weekly speech and language therapy, occupational therapy and play therapy. He also underwent a psychological assessment and it was recommended that he undergo a medical examination to determine the appropriateness of current medication. It was found that he met the criteria for diagnosis of anxiety and depression. It was recommended to continue with weekly emotional support, concessions for exams (namely, small venue and planning aid).

L8 (DOB 15/02/2006) experienced academic difficulties in Grade 1 and became insecure, and lacked confidence. He was referred for a psychometric assessment and was recommended special school placement, remedial classes and speech/language therapy. No medication was suggested. He moved schools and later underwent further psychological assessment and was recommended to attend remedial classes, occupational therapy, speech and language therapy, and counselling for emotional support. The learner tended to stutter when anxious. No formal diagnosis had been made to date.

L9 (DOB 18/07/2007) had a normal, full-term birth but his mother reported going through extreme emotional trauma while pregnant. At the age of four years, he was diagnosed with autism spectrum disorder and was referred to a special school catering for learners with autism. After spending two years there, he was transferred to a mainstream school and underwent a scholastic assessment. It was recommended to delay Grade 1 for a year and continue with speech and language therapy and occupational therapy. He was also referred to an audiologist for an assessment. The family relocated and he had to move schools where he remained for two years. He was prescribed medication for concentration, anxiety, depression and something to help him sleep. He became withdrawn and apathetic towards school work. His parents separated and he relocated again and moved to the current school. He was taking Methylphenidate for concentration and Sertraline for depression and anxiety.

L10 (DOB 19/12/2007) fell into a swimming pool when she was three years old and developed water phobia. She started at a mainstream school in Grade 1 but was not coping academically. She underwent a scholastic assessment and then was referred for further evaluation by a paediatrician, occupational therapist and a remedial assessment was also conducted. It was recommended to change schools to one with smaller classes and where she could receive weekly counselling for emotional support. Concerta was prescribed for concentration.

There were six teachers, who taught these learners either a language subject or mathematics that agreed to take part in the research study and ten parents. The other teachers in the school were excluded. The biographical and background information for the teachers in the study are summarised in Table 4.1.

Table 4.1: Biographical and background information of teacher participants

	Age	Qualifications	Teaching experience (years)	Department
T1 F	51	B. Prim. Ed.	27	Intermediate
T2 F	47	B. Prim. Ed.	24	Intermediate
T3 F	41	B. Prim. Ed.	16	Intermediate
T4 M	38	B. Ed.	13	Intermediate
T5 F	38	B. Ed.	13	Senior
T6 F	27	B. Ed.	4	Senior

Table 4.1 illustrates that the teachers that participated in the study were all qualified with four or more years of teaching experience.

According to McMillan (2012, p. 105), criterion sampling involves "selecting individuals with certain important characteristics". This study made use of criterion purposeful sampling, where participants that all had certain important characteristics, were chosen. This technique, according to Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015, p. 533), allowed the researcher to select participants on the basis of identified characteristics, knowledge or experience with the phenomenon of interest and, therefore, would be able to add value to the study. An advantage of choosing this sampling technique was that the participants would be information rich for the topic that was being researched.

With this study, the learner records were reviewed and the researcher looked specifically at the initial history, the psychological assessment conducted by an outside psychologist, school reports and demographic data in the files. Information in the files was obtained by reviewing the notes written by the SENCO stemming from meetings held with the parents, the psychosocial history, the psychological assessment and the demographic data in the file. All information was collected on a data collection sheet (see Table 5.2). The ages of the learners were also taken into account and learners in Grades 1 to 4 were excluded from the study. The reasons for this were that they might not have been able to read and answer the questions in the

questionnaire adequately. Learners in Grade 5 and higher would be better able to provide the necessary insight and comprehension.

The letters about the study were sent to the parents (see Appendix H) and to the teachers (see Appendix G).

4.7 INSTRUMENTATION AND DATA COLLECTION TECHNIQUES

McMillan explains that researchers must select from a large number of measures or instruments to gather their information or data (2012, p. 320). The researcher chose to use instruments that would be the most suitable data collection techniques for this study. As a result, document and artifact analysis provided the researcher with background history on the learners in the sample, the questionnaires or semi-structured written interviews provided personal feedback and relevant information from the participants. Finally, the informal observations also allowed the researcher entry into the field without imposing or disrupting the day-to-day activities at the school,

4.7.1 Document and artifact analysis

The document and artifact analysis were the first data collection technique used as the researcher first read through the learner files to gain a greater depth of descriptions and understanding about the learners. The learner files included school reports, assessments from practitioners such as occupational therapists, speech therapists and/or psychologists and psychiatrists, examples of learner work, as well as their Learner Support Programmes (LSP), school application forms and parent questionnaires.

When the learner’s applications arrived at the school, the previous teacher was also requested to complete a detailed questionnaire about the child (see Appendix O). Therefore, there was a lot of very relevant and important information documented in the files, which was treated as strictly confidential. The learner files and records thus provided an indepth understanding of the learner participants involved in the study as well as triangulation regarding the parent and teacher perspectives of these learners.

4.7.2 Questionnaires

A questionnaire is a written document that contains statements or questions used to obtain certain information from participants. The questionnaires were completed by participants, including the parents of the learners in the study, the learners themselves and their teachers. They provided an efficient way to obtain important information about the research problems and contained statements or questions that were used to receive information from the participants. The researcher chose to make use of a written questionnaire as

opposed to conducting semi-structured interviews with participants during the study. As interviews were time-consuming, the researcher decided that sending the questions to the participants in a questionnaire would be far more convenient and less imposing or anxiety-provoking.

There were ten questionnaires sent out to the parents via email. In addition, ten questionnaires were hand-delivered to the learners and there were six questionnaires that were placed in the posting boxes for the teachers. The forms were in sealed envelopes and these were then returned to the researcher for analysis. With the questionnaires, the researcher wanted to know what symptoms or behaviours the learner with anxiety experienced, and whether certain experiences at school exacerbated the symptoms or behaviours. The learners completed Appendix D, the parents completed Appendix E and the teachers were given Appendix I to complete.

Parent questionnaires investigated when the child's symptoms became apparent and how an assessment was conducted. The researcher also enquired as to what the findings were and what recommendations were made in the reports following the assessment. The assessments were usually conducted by psychologists working in private practice who had previously assessed the child. Teacher questionnaires aimed to identify what behaviours were observed in the learner and whether any class activities or tasks exacerbated these symptoms.

4.7.3 Informal observations

McMillan (2012, p. 164) states that observations can be high-inference and low-inference and also rely on the researcher's skill in describing behaviour as it occurs naturally in the field. Low-inference observations require the researcher to write down exactly what is happening and what is seen and requires no interpretation of behaviours, whereas high-inference observation requires the researcher to make and record a judgement or interpretation.

Informal observations were used to confirm data gathered from questionnaires. The researcher had to seek permission to observe educational situations in both the classroom setting and outside during recess on the playground. The researcher observed how the learners interacted with others, whether they made use of free or structured play and what sort of activities they engaged in. In the classroom, the behaviours of the learners were observed, including their mannerisms, their ability to cope with teacher demands and how they

attempted their work. This also included watching written activities, and also those times when they were required to read aloud or do oral presentations.

The behaviours were recorded on Appendices J and K. The researcher had a list of possible behaviours that may have been observed, and whenever that behaviour occurred, a tally was placed next to that behaviour.

The time spent observing each learner in each setting was recorded so that there was consistency. The success of an ethnographic investigation is often determined by how long the observations were. Field notes were used to record these experiences. Behaviour is best understood as it occurs without external constraints and control, and the situations context is also very important, for example, a setting can have an influence on the way human beings behave. In addition, a particular setting and situation could produce behaviours that are different from the behaviours observed in a different setting. For example, a learner's behaviour on the playground at recess might be very different from his or her behaviour in the classroom.

McMillan explains that researchers must select from a large number of measures or instruments to gather their information or data (2012, p. 320). Since this was a mixed-method study, both quantitative and qualitative questions were appropriate and the type of data was collected at the same time and each method was given equal attention.

4.8 DATA ANALYSIS AND INTERPRETATION

For LeCompte (2000, p. 146), analysis requires turning data into results. Analysis is also like taking apart puzzles and reassembling them again. However, if there are pieces missing from the puzzle or pieces broken or bent, it cannot be completed. In the same way, research results cannot be accurate or reliable if pieces of data are incomplete or biased. Kothari (2004, p. 122) refers to data, after collection, having to be processed and analysed in accordance with the outline laid down for the very purpose of the research plan. It ensures that all relevant data for making contemplated comparisons and analysis has been collected. Analysis also implies editing, coding, classification and tabulation of collected data.

The observations and field notes and questionnaires produced a large quantity of information that needed to be summarised and interpreted. The field notes were critically-examined and synthesised. Common threads, themes, patterns and signs of behaviour in learners with AD were identified.

All twenty-six questionnaires that were disseminated were returned. As soon as data was collected, so that it was still fresh in the mind of the researcher, the information was summarised and detailed notes written. The notes included time/date details, common themes or patterns, and any other observations. The researcher organised the data into the different types, those being the observation notes, questionnaires and documents/artefacts. Questionnaires were also grouped according to who had completed them. This step also involved reading and re-reading the material (data) in its entirety, making notes of thoughts that sprang to mind and writing summaries of each transcript or piece of data that had been analysed. McMillan (2012, p. 297) refers to this type of data as “etic data” as they are representations of the researcher, whereas “emic data” contain information provided by the participants in their own words. The objective with this step was to condense all of the information to key themes and topics that could provide some answers to the research question.

The second step, according to LeCompte (2000), was finding items, which were the specific things in the data set that researchers code, count and assemble into research results. By rereading field notes and results from questionnaires, the researcher identified items relevant to the research questions (LeCompte, 2000, p. 148). The researcher coded the material, where a code was a word or a short phrase that descriptively captured the essence or elements of the material. It was also important to review the research questions to compare them with the data collected and identify any missing pieces of information.

The third step involved organising items into classes or subgroups, and McMillan refers to a category as an idea “that is formed from coded data” and “represents the meaning of similarly coded information” (2012, p. 299). Researchers look for things that look exactly alike, things that differ slightly or things that differ a great deal. Using meaningful criteria or rules helps to make these comparisons easier. This allows for patterns and themes to be created and is involved in seeing how to include similar items. Reviewing the data and mentally processing it for themes or patterns that were exhibited, ensured that the researcher focused on these patterns and themes as they appeared in subsequent data that was collected.

The researcher identified common patterns of behaviour in the learners with AD, feelings and emotions from the parents, experiences and feelings from the teachers, different approaches to getting the AD diagnosis, comparisons with regard to treatment options, attitudes towards school and other challenges that might occur. The answers were then grouped into themes, for example, the most commonly experienced symptoms of anxiety, the most common feelings from parents about their child’s AD and successful treatments.

Next was the data analysis and processing part, to arrange it in a concise and logical order. After identifying themes or content patterns, the researcher assembled, organised and compressed the data into tables that assisted in identifying systematic patterns and interrelationships across themes and/or content.

Conclusion drawing and verification were the final step in qualitative data analysis. The process entailed stepping back and interpreting what all the findings meant. Determining how the findings helped answer the research question(s) and, lastly, constructing an overall narrative and summary of the research problem.

4.9 CREDIBILITY, TRANSFERABILITY, DEPENDABILITY & CONFIRMABILITY

In research conducted following the interpretivist paradigm, the positivist research criteria of internal and external validity as well as reliability should be replaced with four alternative criteria of trustworthiness and authenticity, namely, credibility, dependability, confirmability and transferability (McMillan. 2012, p. 302).

- **Credibility**

McMillan (2012, p, 302) defines credibility as "the manner in which the data, data analysis, and conclusions are accurate and trustworthy within a study". It relies on the quality of the measurement, for example, if the measurement is faulty, the results will not be useful. For this study to be credible, the researcher observed the participants from a distance and was involved in the setting for a prolonged period of time to provide appropriate details for the research. This was possible because of the researcher's daily involvement in the school. Cresswell (2014, p. 303) refers to "saturation" that would eventually occur with prolonged engagement, but that additional observations or interviews would not add new results, which is the reason that the researcher felt that three months of observation was an appropriate length of time.

Researchers, through self-reflection, should also admit that their subjectivity may play a role to influence results, but "direct examination of this subjectivity, through the researcher's reflection, can add to credibility in the study" (McMillan, 2012, p. 304). The researcher chose to investigate and research this particular topic, because of the interest that she had and the need to provide some support and assistance to families, parents and teachers who deal with learners with AD on a daily basis. Schools are generally not equipped to deal with learners who are extremely anxious.

The role of the researcher in qualitative research was one of closeness, involvement and trust, and this role was evolving, as opposed to the role of the researcher in quantitative research, which is distant, short-term,

detached and uninvolved. McMillan describes the importance of working closely with participants and location “to provide details for the narrative that presents the results” (2012, p. 302).

The researcher reflection was to attempt to, firstly, evaluate herself and existing preconceived ideas and biases, which might potentially influence the results of the research. This evaluation is explained by McMillan (2012, p. 304) as the researcher’s need to be aware how his/her perceptions are influenced “by gender, socioeconomic status, or position, will influence his or her expectations, interpretations, and conclusions”. These evaluations can also take the form of reflective field notes, which are speculations, feelings, interpretations, ideas and hunches that are subjective notions related to the research. Reflections might also include introspective discussions about researcher opinions, attitudes and prejudices. These reflections would be kept separate from the descriptive information and would be identified as observer comments.

According to Unisa’s Policy on Research Ethics, researchers should be competent and accountable and act responsibly in their research efforts (UNISA, 2013). The researcher had the learners’ best interests at heart and strove to ensure that the values such as honesty and integrity always remained at the forefront of any action or event.

- **Dependability**

The criterion of dependability should be used in interpretivist research in preference to the criterion of reliability. Anney (2014, p. 278) states that dependability is especially important with regard to trustworthiness because it establishes the research study’s findings as consistent and repeatable, in other words, it refers to the ability of observing the same outcome or finding under similar circumstances.

Because this researcher was dealing with human behaviour, which is by its very nature continuously variable, contextual, and subject to multiple interpretations of reality, it would not be possible to reproduce exactly the same results in every study, however, the researcher could make extrapolations, which would be influenced by the researcher’s own construction of meaning and interpretations. In other words, if the study took place at another site or school, the same or similar conclusions could be made using the same data instruments, those being document analysis, questionnaires and informal observations.

- **Transferability**

According to McMillan, the notion of transferability should mainly be used with qualitative research as it refers to applying and comparing the results to other contexts and environments (2012, p. 305). It makes it easier for the researcher wanting to apply the results to the research setting to know whether there was a good fit or not, namely, if it made sense to generalise. With this research study, it provided enough contextual data so that readers of the study would be able to relate those findings to their own contexts and school settings, also relating back to dependability.

- **Confirmability**

If the results of the research project can be authenticated by others that are in the same field, this impacts on confirmability. The goal of this criterion is to aim to eliminate any biases, or at the very least, to minimise bias to prevent contamination of the results of the data analysed. As pointed out by Kivunja and Kuyini (2017, p. 34), the findings need to be from experiences and ideas of the informants, rather than the preferences and perceptions of the researcher. This study was confirmable because the researcher captured the exact words used by the participants in their answers from the questionnaires, and the observation sheets consisted of checkboxes indicating whether the behaviour was observed or not, preventing the researcher from adding anything or contaminating any results (see Appendices M and N). The research study was reviewed by a colleague in the same field who provided feedback and added to the credibility and confirmability of the project.

4.10 RESEARCH ETHICS

According to McMillan (2012, p. 19), ethics is concerned with what is wrong or right, bad or good, proper or improper and universities often have specific ethical guidelines for conducting research with human subjects as well as a board that will need to review and approve studies in which there is interaction with or an intervention with humans. McMillan points out that the function of the review board is to provide an independent judgement about the ethics of the research and to ensures that there is compliance with federal regulations (2012, p. 19).

4.10.1 Anonymity and confidentiality

According to UNISA’s policy on research ethics (UNISA, 2013, p. 15), all who participate in research have the right to privacy to the extent permitted by law. For this study, data remained anonymous and/or confidential in that real names of the learners were not used and no-one was aware which learners and parents were participants in the study. When the learner completed the questionnaire, it was explained that

confidentiality and anonymity would be safeguarded at all times. The protection and best interests of learners were seen as being of prime importance.

Throughout this research process, the researcher was responsible for the ethical standards to which the study adhered and respected the rights and privacy of both parents and learners living with AD. Real names were not used in the study and parental consent was received in writing (see Appendix B), before any interviews or discussions with the child participant took place. The researcher was open and honest with the subjects, which required full disclosure.

Once the researcher received approval for the study, permission to use the school as the study site was received in writing (see Appendix A) and the researcher commenced with the document/learner record study to select the learner participants by reading through learner files and reports. Once the researcher had the files of the learners who could potentially form the sample, the parents and the teachers were approached and sent letters that explained the study fully and they were given an opportunity to request more information from the researcher. Only once all the consent letters had been returned, the questionnaires were sent out. Appendix C was used to request assent from learners in a secondary school to participate in the research project and Appendix F was used to request assent from learners in a primary school to participate in the research study. Appendix G and H were used to request participation from the parents and teachers, respectively.

Data remained, and will remain, anonymous and confidential at all times. When conducting questionnaire surveys, it was explained that confidentiality and anonymity would be protected. The protection and best interests of participants were of prime importance. The researcher arranged for the preservation and confidentiality of research records for one year after the submission of the report and/or the results of the study and will be stored in the school's strongroom, which remains locked at all times.

4.10.2 Respect for human dignity

With this research study, the participants were protected from physical and mental discomfort as well as harm. If the child participant was already seeing a therapist, the therapist was made aware of the study that was taking place and the written ethics clearance, as granted by the UNISA review board, was made available. Participants could withdraw from the study, if they no longer wished to take part, without any

penalty or risk and at no time were they coerced to participate. Therefore, participation was voluntary. Bias and subjectivity were also limited as far as possible.

4.10.3 Respect for persons

According to Unisa's Policy on Research Ethics (UNISA, 2013, p. 3), researchers should act responsibly and strive to attain the highest possible level of excellence, integrity and scientific quality in their research. As the special needs co-ordinator, the researcher always had the learners' best interests at heart and ensured that the values such as honesty and integrity always remained at the forefront of any action or event. Interaction between participants and the researcher were conducted with the utmost professionalism and integrity with the knowledge that the study was dependent on the involvement and participation of the learners, their parents and teachers.

4.10.4 Beneficence

Research should be undertaken for the benefit of society to maximise public interest and social justice (UNISA 2013, p. 9). According to Drew et al. addressing the issue of harm is the cost versus benefit ratio that involves comparing the potential benefits of a given study with the potential risks to the participants (2008, p. 65). Hence, this study aimed to offer learners with anxiety disorder, together with their parents and teachers, a clear and concise procedure for accessing the support and assistance needed to remain in the school system and cope with their anxiety challenges.

4.10.5 Informed consent

The researcher's task was to ensure that participants had a complete understanding of the purpose of the study, the methods that were used, the risks involved and the demands placed upon them as participants. Each participant also understood that he or she had the right to withdraw from the study at any time.

Drew et al. identifies that the two forms of consent are direct and substitute, and direct consent is the most preferred because the agreement to participate is obtained directly from the person to be involved in the study (2008, p. 33). Drew et al. further states that there are three parts to obtaining informed consent, namely, capacity, information and voluntariness and all three elements must be present for consent to be effective (2008, p. 64).

In terms of capacity, the Head of the school, where the research was conducted, was contacted to request permission for the research to be conducted on the premises of the school (see Appendix A).

The teachers at the school, who were involved with the learners on a daily basis, were given letters informing them about the research and requesting their permission to be participants (see Appendix G). The participant learners who were younger than 18 years, were contacted via their parents. Consent was obtained from the parent, together with the learner's assent. Learners were also identified as having anxiety. The researcher sent a letter to the parents explaining the purpose of the study and requesting permission for their child to be included in the sample. The researcher chose to have ten learners in the sample. The learners were asked on a child-friendly form for their assent to participate in the study (see Appendices C and F).

The information was planned and presented in such a manner to be completely understood by the participants. It was the researcher's responsibility to see that this was accomplished.

The third factor, as explained by Drew et al., is voluntariness, which is concerned with the right to exercise choice and requires that throughout the entire research process, no such explicit or implicit "constraint or coercion" is made by the investigator (2008, p. 33).

4.10.6 Avoiding deception

Deception refers to either omission, where the researcher does not completely disclose important aspects of the study or commission, where the researcher gives false information about the investigation, either partially or totally. There should be no enticement of people in the name of research (Drew et al., 2008, p. 67). The researcher confirmed that no deception took place in the study.

4.10.7 Justice

When selecting participants for a research study there are usually certain criteria that need to be met, but it should also be fair, besides being scientific. Institutional review boards (IRBs) provide assurance that no ethical violations occur in any given study. An IRB reviews the purpose of the research and the proposed methodology in terms of potential risks or benefits to the participants involved. The Unisa Review Board granted permission for the study to be conducted (see Appendix P). A research study can be negatively impacted if there is any breach of integrity, whether it be intentional or unintentional. The participants in this study were ten learners (five males and five females) that had been identified as having anxiety. As they presented with similar characteristics and behaviours, they were receiving some form of emotional support. These ten participants as well as their teachers and parents comprised the sample.

4.10.8 Conflicts of Interest

According to McMillan (2012, p. 17), ethics are concerned with "what is right and wrong, good or bad, or proper or improper" and conflict of interest happens when researchers have interests that are not fully apparent and that may influence their judgments on what is published. With this in mind, researchers need to take extra effort to ensure that their conflicts of interest do not influence the methodology and outcome of the research. The researcher was aware of limiting personal bias so that personal beliefs, desires and attitudes did not influence the research and conclusions.

4.11 CONCLUSION

In this chapter, a detailed description of the research method was presented. The research design, sampling, data collection methods, data analysis and interpretation, quality assurance measures and ethical considerations of the study were discussed. The researcher also illustrated how evidence was to be constructed by integrating data-collection methods. Chapter 5 presents the data obtained and analysed by means of the theoretical framework established in the literature review.

CHAPTER 5
DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

The main aim of this study was to understand the effects of anxiety on learners at an independent inclusive school as well as how to manage and support the impact of anxiety so that these learners can continue to make progress in school.

In Chapter 4, the research design, methods of data collection and interpretation were discussed. It was explained that this study had followed a mixed methods approach using both quantitative and qualitative methods. Chapter 4 further provided an explanation of the data collection methods and an overview of quality measures as well as the ethical considerations that were adhered to during data collection and interpretation. In this chapter, the quantitative and qualitative data results are presented, analysed and interpreted. The research plan and data collection techniques are described in the Table 5.1.

Table 5.1: Research plan and data collection techniques

Focus of the study	Data collection methods, techniques and type	Key research questions
Phase 1: Prior to gaining entry into the field, the researcher studied the literature regarding anxiety disorder in learners and the different types of anxiety and identifying the causes and prevalence.	**Qualitative:** Articles and journals Books Websites Blogs Policies and other relevant documents regarding learners experiencing anxiety disorder	What defines anxiety, specifically in learners at school? How are learners with an anxiety disorder identified or recognised? How are these anxiety disorders managed? How can educators and caregivers assist the learners to manage the anxiety so that they can still function at school and be successful? What support is available for these learners? Can schools implement a plan to enable learners with AD to participate in the activities of learning? Can teachers be provided with guidelines on effective teaching and learning strategies for learners with anxiety disorders?
Phase 2: Deciding on where the research would occur and which learners would form part of the study.	**Qualitative:** Reviewing document study including school reports, assessment reports, parent and teacher questionnaires, medical reports and learner support documents, provided much needed background information about the learners.	Which learners have been identified as having anxiety for this study? Which parents have granted permission for their children to take part in this study and which teachers have agreed to take part in this study?

	Sending out cover letters and consent forms to teachers, parents and learners.	
Phase 3: Using observation checklists and field notes during informal observations and during class visits and recess.	**Qualitative:** Observing the learners, making field notes and completing observation checklists. **Quantitative:** Administering questionnaires	How do learners with anxiety disorder behave in the classroom, and on the playground? What are the common elements or behaviours that are observed in these learners? What are the common threads from the questionnaires? What are the similarities and differences noted in the responses?
Phase 4: Analysing and interpretating data to determine results. Making sense of the data.	Consolidating, reducing and interpreting data. Organising and displaying data	Do learners experiencing anxiety disorder feel supported and accommodated in their school? What are teachers currently doing to support these learners and what should they avoid doing?
Phase 5: Designing a support strategy that teachers and parents can follow to assist learners experiencing an anxiety disorder within schools and at home. A support strategy provides a guideline to be followed to support the learner experiencing anxiety disorder.	Using the questions from Phase 4, to explain the steps to be followed within the support strategy.	

5.2 PHASE 3

Phase 3 discusses the study's observation and field note practices as well as the administration of the questionnaires.

5.2.1 Observation and field notes

Walliman (2018, p. 100) referred to a method of gathering data through observation rather than asking questions. Walliman (2018) supports observation for data collection as the researcher is able "to take a detached view of the phenomena, and be 'invisible', either in fact or in effect (namely, by being ignored by people or animals)". For this study, there was a certain amount of detachment that assumed an absence of

involvement in the group, even if the subjects were aware that the observation was occurring. While the observation was taking place, the researcher made notes and checked off certain behaviours that were observed on checklists.

The field notes and observation sheets provided valuable information about the learners' behaviour inside and outside of the classroom (see Appendices M and N). The researcher spent three months from January 2019 to the end of March 2019 at the site gathering data for the case study. Besides the document reviews and questionnaires, the researcher also recorded detailed field notes while observing during class and lesson time as well as during recess (see Appendices K and L).

The questions to be answered from the observation and field notes were:

- How do learners with anxiety disorder behave in the classroom and on the playground?
- What are the common elements or behaviours that are observed in these learners?

During lesson time

The time spent doing observation was divided between class time and recess time. Each learner was observed for three lessons and for two recesses during the months spent at the site. The observation sheets were completed for each observed time slot and for the lessons taking place at the time.

The teachers had indicated to the researcher, which lessons should be observed, as learners behaved differently depending on which subject was being taught and, therefore, the researcher divided the time between these subjects and informed the teachers when the class visit would be taking place, so that the teacher was prepared to have a visitor in the classroom.

For L7, the outdoor Physical Education lesson on the sports field created great anxiety in that he remained close to the coach, repeatedly touched his head and would cower and duck if the ball came anywhere near to where he was standing. L7 did not really take part in the lesson but kept a close eye on where the ball was at all times and who was moving closer to him while the game was taking place. He looked uncomfortable and very anxious during the lesson, however, during an English lesson, the learner behaved very differently and the signs of anxiety were almost non-existent.

On the other hand, L9 was very happy and seemed to thoroughly enjoy the outdoor lesson and took part very willingly. However, during the Afrikaans lesson, this same learner was quiet, disengaged and struggled to remain focused. He slouched in the chair with his head propped up by his hands and yawned repeatedly.

The school also held an inter-house sports day at the athletics track close by. The teachers were present to receive the learners when they were dropped off in the morning and some of the parents remained to watch the events. The school encouraged all learners to participate in his/her own way. For example, they could be cheerleaders, supporters or competitors. The teachers were also all given the responsibility on the day of supporting and encouraging the learners at the school.

The researcher was able to make notes while observing the ten learners and this also provided important data for the study during a noisy, unstructured and unpredictable event. For example, L8 became upset when the team that he belonged to was not winning. He became withdrawn and refused to take part in any further events. During the break, he went to his mom where she was sitting and she had to try to encourage him to participate once the break was over.

During recess

There were two slots during the school day set aside for recess. The first recess was 25 minutes long and the second one lasted for 20 minutes. There was always a teacher or a teacher assistant outside during recess and the learners could also buy snacks and sandwiches from the tuck shop.

The researcher observed each learner twice during their recess time. The behaviours observed by the researcher were that often the learners with anxiety would remain close to the teacher who was on duty and often preferred to be on their own rather than engage with a group or they only engaged with a small group of friends. These learners paced up and down and preferred to walk around rather than sit on a bench or on the grass. They seldom participated in a game, avoided any rough play and engaged in conversation only if someone spoke to them first. These behaviours aligned with Kendall et al.'s (2018, p. 214) findings as they described learners who avoided giving a class presentation, answering questions in class, or other social situations such as joining a conversation, meeting new people and attending social events or refusing to participate.

5.2.2 Administering questionnaires

Questionnaires formed part of the qualitative research approach. The learners (L1-L10) were given questionnaires to complete. L5 and L6 completed their questionnaires at school and returned them on the very same day. L9 completed the questionnaire with the asstance of a teacher, as his reading and language ability required that he received assistance when reading information. The rest of the learners completed their questionnaires at home and returned them within a couple of days. The teachers (T1-T6) were asked to

answer eight questions involving their own personal experiences teaching learners with anxiety (see Appendix J). The questionnaires were also given to the parents to complete (see Appendix H). All but one of the questionnaires were completed by the mothers, although they were sent to both parents, together with a covering letter explaining the purpose of the research study. The parent participants were referred to as P1-P10 and they were required to answer 12 questions, four of which only required Yes or No answers.

The first research question was What defines anxiety, specifically in learners at school, and the sub-question asked how are learners with an anxiety disorder identified or recognised? The parents were asked, “Has your learner been identified as having an anxiety condition?” The majority or 83.3% of the parent participants answered Yes and 16.7% answered No. They were also asked whether their child had been diagnosed with an anxiety disorder. One-third of the learners had visited a psychiatrist, another third were referred to a psychologist and a third had visited their paediatrician.

In terms of general symptoms and behaviours, the parents were asked what symptoms were present and what behaviours were they noticing. The symptoms presented and noticed included:

- Stuttering when anxiety was heightened, nervous and apprehensive with work, low self-esteem, which could present as melt downs (P8)
- Crying for no apparent reason, she tells me she feels down but there is nothing bothering her (P3)
- Not controlling her emotions and would constantly be scratching her pimples open on her body (P2)
- Becoming frustrated easily and fears trying out new things and takes a while to adapt (P7)
- Becoming aggressive when having to perform tasks, especially tasks where she lacked knowledge or confidence (P1)
- Having anxiety when doing school-related work. Anxiety was further enhanced by parent’s lack of knowledge to adequately support her (P6)
- Being unable to sleep in own room, and having parents lie down with her until she fell asleep (P10)
- Not being very noticeable for us unless he verbalised it, however, doctors had picked up quite severe anxiety (P4)

- Crying, whimpering, becoming very clingy and doing certain rituals over and over again when anxious, and having trouble being closed in a room or alone in the car (P9)

These symptoms were reiterated by Kendall et al. (2018, p. 218) who found that children and adolescents with separation anxiety may avoid being alone or being away from their parents. In addition, children and adolescents with social anxiety may avoid a variety of social situations, including attending school, birthday parties, extra-curricular activities, among others. Children and adolescents experiencing general anxiety may avoid also any situation that could be an object of their worry, such as taking tests, doing homework and watching the news. Parents of children and adolescents experiencing anxiety may model and/or accommodate avoidance behaviours, which can be a factor that serves to maintain unwanted levels of anxiety.

5.3 PHASE 4

Phase 4 included data analysis and interpretation as well as conclusion drawing and verification.

5.3.1 Analysis and interpretation

For the researcher, the goal of the analysis process is to "discover patterns, ideas, explanations, and understandings" (McMillan, 2012, p. 297). Data analysis comprises all the processes and procedures whereby the researcher moves from the data that has been collected, into some form of explanation, understanding or interpretation of that which is being investigated. It involves the recording and identification of themes and telling the story that emanates from data that is collected.

For McMillan (2012), the first step in data analysis is organising data and separating it into workable units or segments. Data can be categorised as emic or etic data. Emic data is data that contains "information provided by the participants, in their own words" (McMillan, 2012, p. 297). On the other hand, etic data "provides the researcher's interpretation of the emic data", which can be illustrated by using themes or conclusions that will explain trends and findings (McMillan, 2012). For the study, the researcher looked for words, phrases or events that seemed to stand out and then created a pattern for these topics. Coding was used to identify, relate and theorise about common content and/or underlying themes.

McMillan (2012, p. 295) identifies that using observation, questionnaires and document analysis as data collection techniques "results in a great amount of data that must be summarized and interpreted". McMillan (2012) also points out that there will be pages of field notes that will need to be studied and processed.

Analysis takes place during the data collection phase as well as after all the data has been gathered. Hence, the aim for this study was to condense all of the data collected into key themes and topics that could shed light on the research question. This was an ongoing process throughout the research study. The researchers identified patterns, or conditions that looked exactly alike, things that differed slightly or things that differed a great deal. Using meaningful criteria or rules facilitated the making of these comparisons.

For this study, the researcher grouped the data according to specific question answers regarding anxiety. For example:

- What does anxiety look and feel like?
- Where and when does it become a problem?
- How does it interfere with daily life?
- Why is the learner affected and when was it first experienced?

The answers were grouped into themes, such as the most commonly experienced symptoms of anxiety, the most common feelings from parents about their child's AD and successful treatments used.

After identifying these themes or content patterns, the researcher assembled, organised and compressed the data into a display that facilitated conclusion drawing. This assisted in arranging the data in new ways and in identifying systematic patterns and interrelationships across themes and/or content.

Conclusion drawing and verification were the final steps in the qualitative data analysis process, which entailed stepping back and interpreting what all the findings meant and being able to determine how far these findings helped in attempting to answer the research question(s). Walliman (2018, p. 132) referred to conclusion drawing and verification as enabling the researcher to "explore relationships and gauge the relative significances of different factors".

5.3.2 Summary of results from learner questionnaires (see Appendices E and F)

As pointed out by Cresswell et al. (2014, p. 674), "the challenge in assessing for the presence of anxiety disorders is distinguishing pathology from 'normal' developmentally appropriate fears and worries". Structured interviews and questionnaires provide the most common measures for identifying an anxiety disorder.

Owing to time constraints and ethical considerations, the researcher chose to collect questionnaire responses from the learners, instead of conducting structured interviews. Walliman argues that "scientific objectivity should be maintained as much as possible" (2018, p. 43), therefore, the researcher, being an authority figure at the school, did not want to negatively influence the learners' feelings or emotions. As a result, it was felt that the latter strategy, namely, structured interviews might have caused unnecessary anxiety for the learners. Walliman (2018) also refers to questions about rapport being raised if research entailed close communication between the researcher and the participants, which provided another valid reason as to why the researcher preferred to not conduct interviews.

The questionnaire responses revealed that the following items were common to the majority of the learners, in causing them anxiety/worry:

- Visiting unfamiliar places
- Receiving poor grades
- Having nightmares
- Attempting to miss school
- Having physical symptoms of anxiety
- Not having an effective coping strategy for dealing with anxiety
- Having to rely on a parent or a teacher for help

The research results were indicated as a percentage number of learners. For example, 60% of the learners indicated that they worried that something was wrong when their hearts beat fast. L9 said that he worried when his heart beats too fast and L8 said that he did not like it when his heart was racing. L7 said that his stomach felt hollow and he became very hot and sweaty.

Nearly three-quarters or 70% of the learner participants stated that they worried about school and their marks. One learner participant (L2) said, "I worry about exams, projects and my marks", and another L6 said, "I get scared about tests and failing, homework" (see Appendices E and F). Seventy percent of the parent responses in the parent questionnaires also validated that academic performance and school-related activities caused the anxiety symptoms.

Kendall et al. (2018, p. 215) recognise that common general anxiety disorder concerns included worry about school (for example, grades, tests, homework). They also identified an adolescent with severe test-related

worries that experienced task-interfering thoughts (for example, “I am going to fail. I can’t do this”) (Kendall et al., 2018). These thoughts inspired maladaptive behaviours such as procrastination to avoid negative emotions triggered by studying or even over-preparation at the expense of other responsibilities or activities.

5.3.3 Summary of results from parent questionnaires (see Appendix I)

Kendall et al. (2018, p. 221) recommend that when working with youth, it is important to gather information from “multiple sources (youth, parents, teachers)”. Multiple informant reports should, therefore, aid case conceptualisation and help to ensure accurate diagnoses.

Some key items that emerged from the parents’ responses to their questionnaires included:

- 80% stated that the diagnosis had caused strong feelings within the parent
- 70% knew what their child was anxious about
- 90% were aware that anxious behaviours were having a negative impact on their child’s life
- 60% followed the recommendations made by professionals
- 60% felt that their child was still negatively affected by anxiety but that they were better equipped to help their child

5.3.4 Summary of results from teacher questionnaires (see Appendix L)

Hallahan et al. (2012, p. 211) identify the importance of a teacher’s judgement or opinion as being “a valid and cost-effective method of identifying learners with emotional or behavioural disorders”. Hallahan et al. (2012) also describe what was expected of educators who work with learners with emotional and behavioural problems, and point out that competent teachers can make a significant difference in the lives of the learners with whom they work. Not only does teaching these learners demand a thorough knowledge of learner development and high expertise in instruction, but it also requires a “high level of professional competence and ethical judgement to conform to these expectations” (Hallahan et al., 2012, p. 203). Moreover Hallahan et al. also assert that learners who exhibit disorders when they enter school “may become better or worse according to how they are managed in the classroom” and, therefore, their “school experiences are no doubt of great importance” (2012, p. 210).

From the teacher questionnaire responses, various common behaviours could be observed in learners experiencing anxiety including visible signs such as skin picking, nail biting and hair pulling. T1-T4 also

noticed tearfulness, irritability, distractibility, fidgetiness and lack of focus. Sixty percent of the teachers indicated that learners showed that they were anxious through their behaviour rather than being able to verbalise feelings of anxiety or worry. Flanagan et al. (2015, p. 46) listed some behaviours suggestive of anxiety that would more likely be observed at school. These behaviours included having difficulty with concentration, avoiding reading aloud, raising their hand, answering questions in class, not eating in front of others, not using school bathrooms, appearing isolated and on the fringes of the group or standing near a group at recess but not participating.

Also, typically, school activities that caused anxiety included anything the learner found challenging, any occasion that put the learner on the spot, or any situation where the learner was singled out for something. Teachers agreed that the learners needed support in the form of an adult to whom they could communicate, for example, either a teacher or a counsellor with whom they could discuss specific interventions or solutions.

All the teachers indicated that the learners would try to avoid the activity or task that made them feel anxious. For Kendall et. al. (2018, p. 218), avoidance of “anxiety-provoking stimuli” is the “hallmark behavioral sign of anxiety across the lifespan” (2018, p. 218). In addition, all the teachers referred to occasions and situations where they had made accommodations for learners suffering anxiety. For the summary of the teachers’ responses (see Appendix L).

5.3.5 Policies and reality

According to the Inclusion in Education Perspectives on Inclusive Education in South Africa (2018, p. 4), the current education support services system to facilitate the implementation of inclusive education, comprising School Based Support Teams (SBSTs) and District Based Support Teams (DBSTs), was preceded by a medical model-dominated support system within the previous special education paradigm. The medical model was centred around diagnosis and treatment, whereas the social model referred to support and accommodations that should be put in place if a person has a disability or condition. Because this is an educational study and refers to learners experiencing an anxiety disorder, and how to provide the systems, strategies and the necessary support for learners, their parents and their teachers, it was deemed necessary to examine existing policies and educational documents to ascertain what assistance for this group of learners was already in place in schools.

In 2001, the Department of Education issued a framework policy document called White Paper 6: Special Needs Education, Building an Inclusive Education and Training System. The Inclusive Education South Africa (2018, p. 4) document was a response to the "post-apartheid state of special needs and support services in education and training" .Two main findings from the report were that only a small percentage of learners experiencing barriers were receiving specialised education and support, usually on a racial basis, and that the education system had generally failed to provide services appropriate to the diverse needs of learners.

Although since 2001, the Department of Education has issued a number of other documents about specific parts of the inclusive education system, the inclusive education system should be implemented by 2021. These documents included guidelines for inclusive learning programmes, namely, information concerning the setting up of district-based support teams, full-service schools and special schools as resource centres (in 2005), guidelines to ensure quality education and support in special schools (in 2007), the National Strategy on Screening, Identification, Assessment and Support (in 2008) and, finally, Guidelines for Full-Service and Inclusive Schools (in 2010).

The "South African Integrated School Health Policy" was introduced in 2013. It aimed to strengthen the country's school health services. The main focus of the policy was to manage and support teaching and learning processes for learners who experience barriers to learning within the framework of the National Curriculum Statement Grades R-12 (Department of Health, 2013). The policy was also aligned with other Department of Basic Education strategies, which aimed to support teachers, managers, districts and parents in schools. South African schools' health programmes have struggled in the past because of poor management, inequitable distribution of resources and an historical lack of collaboration between the Departments of Health and Basic Education.

No. 17 of 2002, the Mental Health Care Act, provided a legal framework for mental health (Buchner-Eveleigh, 2016, p. 318). This act aimed to provide appropriate care, treatment and rehabilitation services for people with mental health care problems. It highlighted the rights and duties of mental health care users, but did not give priority to learners and young people with mental health concerns. For Buchner-Eveleigh (2016, p. 318), as the act made "very little specific reference to the care, treatment and rehabilitation of learners", it did not "give priority to their mental health care needs".

With this research study, one of the aims was to identify what support was available for these learners experiencing anxiety and to provide schools with a plan to enable learners experiencing an anxiety disorder to participate in the activities of learning as well as to provide teachers with guidelines on effective teaching and learning strategies. The researcher has found that the policy is silent on support to be provided to this group of learners. In addition, there was not much guidance for educators or parents on how best to support and guide a learner experiencing an anxiety disorder. The policy documents derived from the South African Constitution and the South African Schools Act, stated that all learners are entitled to support at school level and this support should be rendered by a School Based Support Team (SBST). Literature reviews and research findings indicated that schools are expected to establish these teams, but no guiding principles are readily available to schools as to the effective establishment and functioning of these so-called teams. The unavailability of guiding principles and the apparent challenges experienced with the effective establishment and functioning of these teams has led to a need for further research, which has as its focus, proper establishment of guiding principles to schools for the effective establishment and functioning of the SBSTs.

According to the findings of a study conducted by Van Niekerk and Pienaar, for the effective establishment and functioning of an effective SBSTs an “eco-systemic approach such as Bronfenbrenner’s eco-systemic theory needs to be used” (2018, p. 12). Bronfenbrenner’s eco-systemic theory explains that schools form part of a social system and “based on this fact schools, in close collaboration with other interrelated systems and sub-systems involved in learner support, should aspire to support and address institutional, learner and educator needs” (in Van Niekerk & Pienaar, 2018, p. 11). Moreover, this study highlights the importance of establishing School Based Support Teams (SBST) within an Inclusive Education setting, where their core responsibility would be to address barriers to learning systemically. In addition, the importance of collaboration with various stakeholders such as the school management team (SMT), school governing body (SGB), SBST members is recommended as well as the appointment of a coordinator for this team. Additionally, the SBSTs should provide support within the school to learners, educators and parents, hence, Van Niekerk and Pienaar conclude, based on their research that “it is evident that an eco-systemic model will be conducive for the effective establishment and functioning of the SBST” (2018, p. 9).

The “support programmes”, which are the structured interventions that schools are meant to be following, according to the SIAS (2014, p. 8) policy, are:

a) to provide specialist services by specialised professional staff, such as speech therapy

b) to provide curriculum differentiation including adjustments and accommodations in assessment

c) to provide specialised assistive technology such as speech recognition software

d) to train and mentor teachers, managers and support staff

However, in the SIAS (2014) policy, there is no mention of how to support a learner with emotional and behavioural problems. These questions, therefore, must be articulated:

- Where are the specialised professional staff, for example, speech therapists and occupational therapists?
- How does one adjust and accommodate an anxious learner during assessments?
- What assistive technology is made available for the anxious learner?
- Who is going to train and mentor teachers, managers and support staff?

5.3.6 Case study at an inclusive, independent school in Port Elizabeth

Port Elizabeth covers 251 square kilometers of the Nelson Mandela Bay metropolitan area and is South Africa's sixth largest metropolitan municipality. The city is South Africa's fifth largest city in terms of population and the second largest in terms of area. It has a population of around 1.1 million and the main languages spoken are English, Afrikaans and IsiXhosa. According to Statistics SA (2011), IsiXhosa is spoken by 53,2% of the residents as their mother tongue, Afrikaans is the mother tongue of 28,9%, and English, 13,3%.

Independent schools are private schools, registered with the Department of Education for offering basic education programmes. As opposed to public schools, they have certain features or rights and this applies both to the way they are legally sanctioned and to the way in which they operate. For example, they may follow their own distinctive missions (including a particular ethos, faith or certain philosophy values). In each independent school, parents/caregivers, teachers and learners have defined roles. The role of the teacher is to provide a sound and efficient educational experience. The role of the parent/caregiver is to provide for the physical needs of the learner in terms of food, shelter and clothing. The learner exists between two environments, the home and the school.

In Phase 5, a support strategy that teachers and parents can follow to assist learners experiencing an anxiety disorder within schools and at home is designed.

5.4 PHASE 5

In terms of providing a support strategy that teachers and parents can follow to assist learners experiencing an anxiety disorder within schools and at home, a Learner Support Plan is implemented at the research site and can be adopted at other inclusive schools. In the questionnaires, the parents were asked, what recommendations have been made to assist your learner? Some of the replies included providing alternative schooling, providing a small venue for writing exams, using an iPad, reader and scribe during exam times, using medication, providing emotional support and ongoing counselling sessions from professionals.

The teachers were asked, what accommodations (if any) are made for the learner at school? T3 allowed learners to wait in the classroom before school began if the noise of the playground was too much for them and provided assistive devices, such as calculators and number charts for Maths. T4 allowed a learner to wait in a quiet space when necessary, and T2 recommended making sure that the learner received play therapy or counselling when necessary. T1 suggested providing a small venue during exams as well as providing assessment dates and scopes well in advance.

The research question and sub-questions probed whether there was available support for learners experiencing anxiety and whether an education plan to enable learners experiencing anxiety disorders to participate in the activities of learning could be implemented. The research questions also probed whether the teachers were provided with effective teaching guidelines and learning strategies to assist learners experiencing anxiety disorders.

5.4.1 Framework for learner support

The second research question to be answered in this study was how were these anxiety disorders managed and how educators and caregivers could assist the learners to manage the anxiety so that they could still function at school and be successful. The researcher proposed that the lens through which support for learners experiencing anxiety disorders in schools were viewed should be based on the social model of disability. The social model was thus deemed preferable because it acknowledges that disability is a social issue and assesses the impact that barriers have on the full participation, inclusion and acceptance of persons with disabilities as part of mainstream society (Department of Social Development, 2016, p. 21).

Based on the findings of this study and keeping in line with the SIAS (2014) policy that should be implemented at all schools, the following pyramid structure and framework was recommended to maximise

support for learners experiencing an anxiety disorder. This framework is comprised of three pillars on which the learner's success rests, namely:

- Pillar One: Enrolment Procedure
- Pillar Two: Support Team
- Pillar Three: Effective Communication

Figure 5.1 illustrates a proposed structure for providing support to learners in schools.

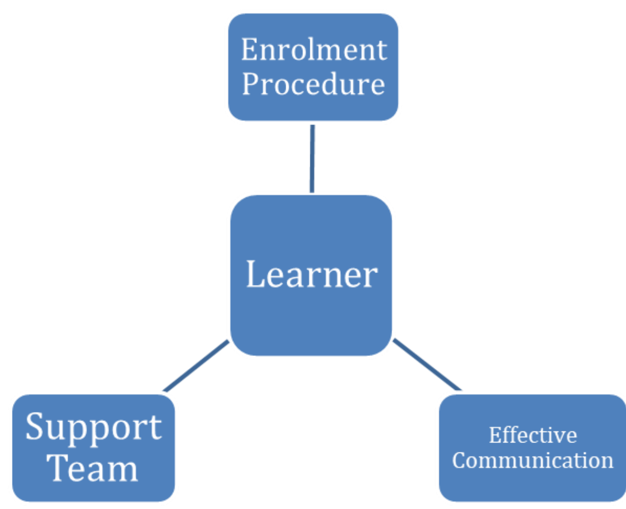

Figure 5.1: Three pillars of learner support

5.4.1.1 Pillar One

This pillar includes the enrolment procedure, which must be followed when a new learner applies for enrolment at a school. Unfortunately, not all schools follow an efficient admissions procedure. Circular no. 13 of 2018 was sent to all public schools in the Eastern Cape dated 26 March 2018, and stated that "the Department of Education has noted with concern that most schools are not administering learner admissions properly" (p. 2). It further requires all schools to "establish learner admission committees to administer learner admissions properly and liaise with the District Admission committee" (Eastern Cape Department of Education, 2018). In addition, the admission policy of a public school and the administration of admissions by an education department must not unfairly discriminate in any way against an applicant for admission.

The enrolment procedure followed at the school where the research study took place ensures that admission takes place all year and that there are no closing dates for enrolling a new learner. The reason for this is that unless classes are full, no learner should be prevented from being able to benefit from the programmes on offer at the school. Furthermore, the process ensures that the correct steps are followed and that a newly-

created file for each learner is opened. These are the first steps in helping the new arrival become a confident and successful learner.

Step 1 - Document review and file creation

Admission forms, assessments and previous school reports as well as medical background are all provided by the parents on admission of their learner to the school. The school's Admission Office creates a learner file and passes all the information to the Special Educational Needs Coordinator (SENCO) for review. The SENCO gathers the information and summarises all the documents to provide a clear picture of the learner's strengths and challenges. Any queries or questions arising from the file are noted for the intake interview. The file is passed on to the department head, where the application is being made. The department or phase head reads the file and presents the information to the phase teachers during their weekly phase meeting. The file is then returned to the admissions office and an intake interview is scheduled.

Step 2 - Intake interview

The interview is attended by the learner, his/her parents or caregivers, the phase head, the head teacher and the SENCO. The learner's file is referred to in the meeting so as to clarify and confirm any further statements or information given by the parents or caregivers. The learner attends the interview for him/her to have the opportunity to meet the SENCO and head teacher and to ask any questions that he/she might have about the school. Once the observation dates have been decided, the meeting is closed. The SENCO accompanies the learner and parents to the class, which he/she will observe and introduces the learner to the other learners to prepare the class and the learner for the observation visit. Showing the prospective new learner his/her classroom and peers eliminates or minimises any unnecessary anxiety.

Step 3 - Observation of pre-acceptance "visit"

The visit takes place over five school days. The learner may wear the school uniform from the previous school to show that he/she is visiting and has not yet joined the class. The learner takes part in all school activities, including after school sport and homework classes. The SENCO observes how the learner interacts and behaves in class as well as during recess time. At the end of the observation period, the SENCO calls a meeting with the teachers who have been teaching the learner and a feedback form giving input regarding the learner's co-operation and interaction in the class, behaviour towards teachers and peers, and attitude and academic abilities is completed. Any emotional concerns are highlighted on the feedback form. The benefits of the observation visit are three-fold, namely, for the learner to undergo a school

experience here at this school, to allow for a report-back to his/her parents on a daily basis, and for the support team to get to know the learner and discover what his/her emotional needs might be.

Step 4 - Feedback interview

Following the observation period, a follow-up meeting occurs with the parents/caregivers, phase head, school head and the SENCO. The feedback from the parents and teachers is discussed. If the academic team believes that the learner will benefit from attending the school, the learner is accepted. If needed, concerns are raised and recommendations are made in order to ensure that support measures and interventions are put in place from the beginning. A starting date is decided on.

The learner is accepted on probation for three months and his/her progress and behaviour are closely monitored by the teachers. If there are areas of concern, these are discussed at the LSM (learner support meeting).

Parent participants stated in their questionnaires that their children preferred structure and routine and did not react well to change. This is why having a step-by-step process when starting something new or giving advance notice is preferred rather than springing things on an anxious learner and then having to deal with the consequences of the learner's reaction. Kendall et al. (2018, p. 217) point out that parents also "exhibit certain behaviours and characteristics that contribute to the development and maintenance of anxiety in their learners". Thus, the enrolment procedure is clearly explained to both parents and the learner during the first interview so that everyone is well aware of what needs to take place and possibility of a parent's or a learner's anxiety can be pre-empted or at least minimised.

5.4.1.2 Pillar Two

Cresswell et al. highlight the need for a team approach, as young people with anxiety disorders are unlikely to seek help independently from their parents, and it is the parents who commonly raise concerns to general practitioners (2014, p. 671). This realisation was voiced in the parent questionnaire answers with the participants stating that they had shared their concerns with someone else, for example, a family member, close friend or their family doctor. In other words, parents tended to discuss issues with the people who know their child best. By sharing their concerns, they could receive advice and suggestions as to what to do in their child's best interest.

Building a team to help a learner struggling with anxiety in school is crucial, if the school journey is going to end in success. Team members share information, expertise and responsibility for the learner and support each other through plan development and implementation. The School-Based Support Team, which is identified and explained in the Screening, Identification, Assessment and Support (SIAS) policy (SIAS, 2014), may consist of a teacher, a school counsellor, a school social worker, a therapist, and/or the learner in some cases. Each school should have a support team that is established to look after the emotional welfare of their learners. A small school with fewer than 150 learners could have one team but in the larger schools, there could be a support team for each phase.

The SIAS policy shifts the focus from the individual learner deficit to the support programme that is to be implemented (SIAS, 2014, p. 14). The principles of support include that support should no longer focus only on the diagnosis and treatment of individual learners' disabilities through individual attention by specialist staff such as speech therapists and/or psychologists.

Typically, a learner's problem must be noticed or identified by the primary caregiver, or parent and, subsequently, by a medical professional, which is why the researcher feels strongly that the support team should include the private practitioner. In South Africa, GPs (general practitioners) are often the first medical professional that families consult, so are ideally positioned to support families themselves as well as being increasingly seen as 'gatekeepers' to specialist health services. GPs rely on information from the parent when dealing with the young child and with the older adolescent(s), so part of the general practitioner's consultation could include an interview as well as a questionnaire or checklist that the person completes.

According to O'Brien et al. (2017, p. 888), childhood anxiety disorders can be challenging for GPs owing to their broad symptomology and the reliance on parental recognition. Their findings also indicated that GPs feel ill-equipped to deal with childhood anxiety disorders. Furthermore, their study provided support for the view that there is a need for medical training to include greater emphasis on learners's mental health.

5.4.1.3 Pillar Three

The importance of honest and effective communication cannot be over-emphasised. Parents/caregivers play a pivotal role in the early identification of barriers, where observations and comments can lead the teacher into locating the exact nature of the barriers that a learner experiences, which is why it is so important to involve parents in the school community (SIAS, 2014, p. 35).

There is much stigma and discrimination of people with mental illness in the settings of the Public Health Clinic (PHC), and this may result in delayed diagnosis and reluctance to attend ongoing care facilities (Egbe et al., 2014, p. 14). The Egbe et al. (2014) study identified various causes of psychiatric stigma that included mistaken beliefs about mental illness that often led to delays in the person seeking help. Experiencing psychiatric stigma was reported to worsen the health of service users and to hinder their ability to lead a normal life.

Often parents adopt a wait-and-see approach to delay visits to the health care practitioner. One of the reasons why this occurs is the stigma attached, another reason might be financial because of the cost of a consultation if they are not on a medical aid, and yet another reason might be denial that the issue is as severe as it is made out to be by the teacher. Special programmes or family therapy sessions are often needed to assist the parents in managing their child experiencing anxiety, so that ignorance on the part of the parents does not exacerbate the condition.

Moran (2015, p. 31) suggests that teachers should communicate regularly with the school counsellor and the parents and/or guardians, to provide feedback as to how the accommodations are working and how the learner is managing on a daily basis in the classroom. If the learner visits an outside psychologist or psychiatrist, which is often the case, the parent will want to feed information from the teacher to that person, especially if the learner is being treated with medication. Sometimes the side effects from the medication affect the learner in class and the teacher will need to be aware of these. The learner might seem tired or more withdrawn, or might suffer from headaches or stomachaches initially, and, therefore, the teacher needs to carefully monitor these at the start of treatment.

There are team meetings held during the term, and the SENCO uses information provided by the teachers to compile a learner support document (see Appendix P). Specific challenges are listed and goals and objectives are decided upon to support the learner going forward over the next three months. A specific therapy or intervention such as speech therapy or occupational therapy may be recommended. The SENCO then meets with the relevant therapist to discuss the objectives and to ensure that they are realistic and attainable over the following three months.

The LS meeting summary is emailed to the parents/caregivers so that they are aware of the suggestions that were made. The learner is also placed in a “category of support”. The SIAS (2014, p. 14) policy document

includes a table that indicates three levels of support (namely, low, moderate and high) as well as the organisational and resourcing requirements and the implications for implementation. The support categories described in Table 5.2 were adapted and implemented at the school where the research study took place. It provided a framework for the teachers and the support team to identify what levels of support were identified for each learner and what was needed to be implemented. With this guideline, six levels of support were identified.

Table 5.2: Categories of support

Cate gory	Levels of support provisioning to address barriers	Description Academic	Description Emotional / Behavioural
1	Low levels	Full participation at grade level. No requirements for additional learning and teaching support. No adaptation or concessions required.	No emotional/psychological support is required.
2	Low levels	Full participation at grade level. Minor modifications with additional support within the classroom are necessary so to improve and maximise learning outcomes. Adaptation planned and managed at grade level, at the teacher's discretion, for example, oral checks, extra lessons.	Some emotional support may be required. This will be discussed in LS (learner support) meetings and the learner will be referred for therapy, if deemed necessary. Therapy (short-term) to address issues such as organisational skills, study skills or social skills.
3	Moderate levels	Participation in all aspects with assistance at grade level. Additional support and or facilitation is required in a number of areas to maximise learning outcomes. This may include remedial therapy, speech or occupational therapy. Adaptation is planned and managed. Exam concessions maybe given, for example, oral check, extra time or reader.	Emotional support is needed, for example, weekly therapy sessions with a counsellor. The school's code of conduct and disciplinary procedures are to be followed.
4	Moderate levels	Participation in activities with ongoing assistance at grade level. Additional support is required in many areas, including ongoing monitoring and adaptation to facilitate participation and maximise learning outcomes. Facilitation during teaching of certain subjects may be necessary. Exam concessions are necessary.	The learner's need for emotional support requires more than twice a week therapy, to cope with academic requirements. A behaviour/incident report is implemented. Meeting with the parents is arranged. Need to refer to clinical psychologist or psychiatrist for further support recommendations.

5	High levels	Requires a separate and modified programme or curriculum with full support in many areas. Facilitation is often recommended.	At this stage therapy is no longer effective; there is no improvement with medication and the learner is not able to function socially or academically. The learner may need to be referred for further assessments and evaluations. Meeting with the parents is arranged.
6	No level descriptor	The school is no longer able to meet the specific academic needs of the learner. This descriptor applies to: ● Subject choices made at any grade level that the school is unable to accommodate. The decision for academic exclusion is made at the discretion of the school's management team.	The school is no longer able to meet the specific emotional / psycho-social needs of the learner. This descriptor applies to the following: ● Specific physical, emotional and academic difficulties ● Emotional and behavioural needs are beyond the support team scope of practice and the learner is thus referred. The decision for exclusion is made at the discretion of the school's management team.

It is important to note that a learner may be on different categories of support for academic or emotional / behavioural reasons. For example, a learner could be on a Category 1 for academics but on Category 3 for emotional/behaviour reasons. It is also possible for a learner to move up or down on the categories of support, depending on current experiences or the learner's progress at the time. In other words, it is not a static assessment, such as a test score, but the idea is rather to create movement so that progress is seen and can be monitored.

Once a year, the parents/caregivers are invited to attend a case conference for their child. The meeting is also attended by the head teacher, SENCO, teachers and intervention therapists such as the remedial therapist, speech or occupational therapist or anyone who had supported the learner's progress in any way. Every person has an opportunity to report back on progress or to raise any further concerns or challenges. The learner remains on the same "category of support" or may move up or down, depending on the progress that has been documented in the learner's school/academic report and/or learner support document. After every meeting that is held to discuss the learner, the learner support document is updated and reviewed.

The researcher recommended keeping the parents informed of any concerns that teachers might have. Parents stated that they had preferred too much communication from the school rather than too little. A daily email from the teacher that detailed any homework to be done, provided some feedback on class

participation and progress helped to ease parent anxiety and encouraged positive communication between school and home.

5.4.2 Classroom strategies

All of the teachers mentioned the importance of offering support and/or interventions for the anxious learner for them to function at school. T1 suggested that if a learner found reading difficult, it was better to provide the opportunity for the learner to read alone with the teacher rather than in a group, as this would often help alleviate the fear. T2 provided certain tools to help them, for example, a number chart or counters to help with a Maths task. It was important to have a teacher who understood that learners were feeling anxious and should be attentive and make attempts to talk to the learner about how they were feeling. T4 suggested giving something to the learner to hold or squeeze in their hand (for example, a stress ball). T5 suggested making use of a small venue during exams to ease anxiety, instead of insisting that the learner write in a large venue like the school auditorium. T6 stated that it was important that all teachers should be made aware of learners who were anxious, assist them when needed by offering additional alternatives or intervene in cases such as when a learner was being bullied. All the teachers agreed that interventions were needed, for example, if the anxiety was subject-related, they might need a facilitator in a specific subject, they might also need to have regular therapy sessions with a counsellor or psychologist, and a referral to a doctor for medication might also be needed.

Teachers in the study provided certain accommodations within the classroom for learners experiencing anxiety. Some of these strategies formed part of the Learner's Support Programme. These strategies for teachers included the following:

- Having a visual timetable or daily routine in a classroom that was well-organised with clear expectations. It was also helpful to inform learners about changes ahead of time.
- Having an environment focused on the task and not results as well as providing for variety and creativity in learning. This reduced rivalry between learners and provided a more conducive, respectful environment. Such an approach might include allowing learners to work in groups.
- Incorporating group activities required selecting the right learners to work together, and thereby initiating and encouraging positive collaboration.

- Providing a classroom pass system for learners experiencing anxiety, thereby allowing them to leave class without drawing attention to themselves, which was important for the learners' self-esteem.
- Having flexible and comfortable classroom seating where learners were permitted to sit close to the door so if they needed to leave the classroom, they could do so without distracting the class or drawing attention to themselves.
- Providing for accommodation during tests and exams, such as extra time could reduce overall anxiety. Also allowing the learner to sit near an exit or at the back of a large venue, might assist with reducing anxiety symptoms.
- Allocating alternative assignments.
- Providing the learner with copies of notes, could reduce anxiety.

These guidelines were provided in terms of offering an effective teaching and learning strategy for learners experiencing anxiety disorders, which formed part of the third research question.

The current school curriculum should be reviewed and educational authorities need to realise that a more comprehensive social and emotional learning programme in schools were lacking. Social and emotional learning is how people apply the required understanding, attitudes and abilities to comprehend and handle their feelings, set and attain positive objectives, demonstrate empathy towards their peers and others within the community, create and sustain positive relationships, and make responsible choices (Clark, 2017d, p. 13).

Jacobs (2011, p. 212) provides an answer for the sub-question of research question three, on whether schools could implement a plan to enable learners experiencing anxiety disorder to participate in the activities of learning. For Jacobs (2011, p. 212), Life Orientation (LO) as a learning area provides this learning strategy as it is aimed at educating healthy, responsible young people who are able to live productive lives. In addition, the Personal and Social well-being study area, which forms part of the LO learning programme comprises the study of the self in relation to the environment and society (Jacobs, 2011, p. 212). Teachers are a vital component of these programmes and learners often will learn from the way some teachers behave and conduct themselves.

Because there is a positive connection between school culture and climate and social and emotional proficiency of learners and their academic success, schools should endeavour to create a positive school environment, which involves the implementation of effective social and emotional learning programmes.

5.5 CONCLUSION

The mixed method approach for this study yielded both quantitative and qualitative data for analysing, interpreting and understanding the challenges faced by learners with anxiety in an inclusive school environment.

The quantitative aspect of the study was provided for via the questionnaires completed by the learners themselves, their parents and teachers. Common themes and patterns were identified and used to formulate remedial actions and direct a process for creating a school model, that could provide support both for learners experiencing anxiety and for school personnel who work with these learners.

The qualitative study findings were on the researcher's observations and field notes as well as the document analysis that was done at the beginning of the study when the learners were selected for the sample.

Chapter 6 is devoted to data interpretation, which discussed the meaning of these findings in terms of the original question, the theoretical framework, insights gained from the literature study and the researcher's experience. In addition, the main themes emerging from the empirical data and the thematic interpretations are explored. Recommendations for further research in this area were also discussed.

CHAPTER 6
SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

The study investigated childhood anxiety and the impact that it had on learners and adolescents in the schooling environment. The study also looked at the prevalence and causes of the disorder and the various ways that this disorder could be managed/treated/supported in the classroom and at home.

The study began with the research outline that provided a complete summary of the research study, including an outline of the study background and motivation for the study. It also clarified the theoretical framework, research methodology and design, data collection techniques and significance of the study.

Chapter 6 provides interpretations of the data and concluding remarks on the main findings of the study. It also makes recommendations as well as outlines the limitations and strengths of the study. In addition, suggestions for further fields of study emanating from this investigation are proposed. The chapter closes with some final reflections.

6.2 SUMMARY: LITERATURE REVIEW AND CASE STUDY

The researcher conducted a literature review to gather information from various sources and theorists to understand the topic of anxiety in learners comprehensively and to compare findings and studies from other countries with those from South Africa. The literature review, firstly, highlighted the definitions of anxiety, the types of anxiety, the prevalence of this condition and the causes. The review also provided explanations on the identification and management of anxiety disorders, the concepts and theories critical to the study, and provided the foundation on which the study could be formulated and planned. The findings of the study augmented the literature on anxiety disorders with information about the extent of its prevalence in South African schools.

Chapter 3 discussed the theories surrounding the causes of anxiety and the latest research findings on anxiety disorder management as well as support for learners and adolescents with anxiety disorders. The chapter also highlighted the definitions of disability and the different disability models. It described the contrast between the medical and social disability models. It also referred to low incidence versus high incidence categories of disability. Finally, the chapter concluded with a discussion of the social model of disability and inclusion.

In Chapter 4, the research design and methodology were outlined, which McMillan (2012, p. 13) refers to as the "plan for carrying out a study". The research design provided a framework for the collection and analysis of data and gave an indication of which research methods were most appropriate for this study. Hence, a mixed method approach was selected with the case study allowing for an investigation of the topic in far more detail than would have been possible if a larger number of participants had been used. The data collection methods were also identified and explained in Chapter 4 as well as a discussion of how the ethical issues pertaining to the study were handled. The roles of reliability and validity were also highlighted.

Chapter 5 provided interpretations and discussions of the study's findings. The quantitative and qualitative data results were presented, analysed and interpreted. Summaries of the results of the questionnaires are presented in Appendices E, I and L. Several themes emerging from the questionnaire responses from the learners, teachers and parents were analysed. The majority of the learners admitted being anxious about their schoolwork and their marks, and also having to go somewhere where they might not know anyone. The theme emerging from the teacher questionnaire, was that if the teachers were aware of the child's anxiety, they would make accommodations to remove or minimise the anxiety-provoking situation, to try and ensure that the child's performance at school was not impaired in any way. Teachers also indicated their willingness for training so as to provide better support for the learners in question. The parent questionnaires revealed that their most common ways of attempting to assist their child were via medication, counselling and changing schools. Also, 66,7% reported that anxiety ran in their family.

Finally, the researcher provided a procedure that was currently implemented in an inclusive school setting that other schools could emulate to better support learners and adolescents experiencing anxiety disorders.

This sixth and final chapter draws conclusions from the study.

6.3 SUMMARY OF THEMES IN RELATION TO RESEARCH QUESTIONS

The main study objective was to facilitate the implementation of an action plan for school personnel to follow when a learner experiencing anxiety required intervention and support. The study also aimed to provide guidelines on effective teaching and learning strategies for these learners. This study, therefore, provided evidence to:

- understand how learners with an anxiety disorder were identified or recognised

- consider how educators and caregivers could assist the learners to manage the anxiety so that they could still function at school and be successful
- identify what support was available for parents, teachers and for the learners themselves
- facilitate the implementation of an intervention and support action plan for learners experiencing anxiety
- provide guidelines on the effective teaching and learning strategies for learners with anxiety disorders

The research questions and emerging themes are discussed below:

6.3.1 What defines anxiety specifically in learners at school?

Emerging theme: What are some of the things that define learners with anxiety at school? What are the normal, expected behaviours versus abnormal, unexpected behaviours in learners with regard to their experiences of fear and anxiety?

The literature review indicated that anxiety disorders were the most common mental illness in South Africa with about 20% of South Africans affected (SADAG, 2019). Studies revealed that learners and adolescents with anxiety experience increased interpersonal and peer difficulties compared with their non-anxious peers. For example, McKay (2016, p. 48) pointed out that anxiety disorders negatively impacted educational attainment, and that learners and adolescents with an anxiety disorder often experienced extreme anxiety at school, resulting in concentration difficulties and decreased academic performance. AD can also impact marital functioning, employment and role performance.

The different types of anxiety in learners were explored within the literature review and that there is also increased family dysfunction and caregiver strain, when a child with anxiety forms part of the family dynamic (Kendall et al., 2018, p. 213). The literature review also revealed that anxiety and worry, phobias and fear, depression and stress are inter-related. The varied theories of anxiety, namely, learning theory and existential, psychoanalytic and psychodynamic theories were discussed, as also the fact that anxiety can develop in learners at any stage of their development and is caused by a variety of factors and situations. Anxiety can cause psychosomatic illness and exhibits common symptoms that can be identified by parents, caregivers and teachers, such as headaches, irritability and stomach aches.

It can be concluded that the questionnaire responses from parents, teachers and learners verified and endorsed the behaviours that were generally seen in learners experiencing anxiety and the learners were also able to describe these feelings in themselves. The study thus answered the first research question by describing these behaviours and anxiety symptoms that were identified in the literature review and summarising the teachers' responses in Appendix K.

6.3.2 How are these anxiety disorders managed?

Emerging theme: Proper management of anxiety disorders in the school setting is needed, but, more importantly, the school and the learners themselves need to form partnerships.

In South Africa, the Constitution, the South African Schools Act, and the Education White Paper 6 of 2001, provide the foundation for an education system that is inclusive and emphasises equality, human dignity and freedom from discrimination (2010). The Screening, Identification, Assessment and Support (SIAS, 2014) policy, specifically aims to identify the barriers to learning that are experienced by learners as well as the support and intervention that is required. It also addresses lack of parental recognition and refers to the need to establish partnerships between teachers and with parents to equip them with the necessary skills for effective participation in their learners' learning and school lives.

Parents are encouraged to be actively involved and to take an interest in the teaching, learning and assessment of their learners, and to consult community-based clinics and/or other professional practitioners, including teachers, to conduct an initial assessment and to plan a suitable course of action for the child.

Two-thirds or 66.7% of the parents in the current research study, indicated in their questionnaire that they had sought out a referral for their child with a private practitioner or medical institution. The majority or 88% had received a diagnosis of an anxiety disorder, thereby indicating that seeking assistance and some support for their child had provided the majority of the parent participants with some feedback.

While inclusive practice at school-wide level focuses on organisational development and school restructuring and improvement, it is at the classroom and individual level that learners are in need of support and where many barriers to learning can be addressed. The teacher and parent/caregiver must form a team in identifying and recognising that a learner is in need of support.

This study concurred with Moran (2016, p. 28) who stated that "it is not the responsibility of teachers to diagnose learners with anxiety, but there are many other roles appropriate for teachers". The systems of support needed to address academic, behavioural, and emotional needs of learners should include both prevention and intervention efforts with learners. A third aspect that needed to be addressed was classroom accommodations. The SIAS (2014, p. 22) policy stated that "specialised support resources, personnel, programmes and facilities needed on a lower-frequency basis, will be provided at circuit or district level for learners at ordinary schools, and these will include learning support, remedial education, assistive devices, counselling, rehabilitation and therapeutic services". In terms of provision of specialist services by specialised professional staff, the challenge is that the demand for specialist services such as counselling, therapy or assessments far exceeds the number of specialised professional staff available to attend to the services required. Clark (2017a, p. 3) confirmed this point when stating that the "high cost and limited availability of resources to the individual child" exacerbates this social problem.

6.3.3 How are these learners with anxiety disorders supported?

Emerging theme: Provision of support to learners experiencing anxiety disorders.

Icebergs are deceiving because what is seen on the surface is usually only a small fraction of what lies below. Observing the behaviour of an anxious child is sometimes like looking at the tip of an iceberg; beneath the surface behaviour are layers of emotions and experiences.

A child experiencing anxiety can be supported at school, especially during stressful times such as writing assessments and exams. The teacher could ask the learner to indicate where they would prefer to be seated to feel more comfortable. This could be towards the back of the venue or on the side. If practical, a smaller venue could be also be provided for those learners. Appendix I included recommendations from the teachers on what accommodations could be provided for the learner experiencing anxiety at school, including:

- allowing the learner to wait in the classroom before school begins if the noise of the playground was too much
- allowing a learner to go to a quiet space when necessary
- making sure that the learner receives play therapy or counselling, if necessary
- allowing any learner who finds assembly challenging to sit at the back near the door or sit closer to their teacher
- providing a small venue during exams

- assessment dates and scopes well in advance
- assistive devices such as calculators, number charts in Maths

The SIAS policy refers to assistive technology, which is an umbrella term that includes “assistive, adaptive, and rehabilitative devices for learners with disabilities and also includes the process used in selecting, locating, and using them in an education context” (2014, p. vii). In terms of what assistive technology and devices could be made available for the anxious learner in the classroom, teachers could also allow for noise-cancelling headphones, stress balls, fidget toys, time out to go for a walk outside or the learner could make use of calming music or meditation apps downloaded onto a cellphone.

It is also possible to apply for a concession if a learner has a diagnosed anxiety disorder and, if granted, they can be provided with an amanuensis. The process to apply for concessions for examinations is detailed in the SIAS (2014, pp. 72, 73) policy.

The SIAS (2014) process is a tool for early intervention. It is designed specifically to help practitioners assess needs at an earlier stage, and then work with families, alongside of other practitioners and service providers, to meet those needs. The training of practitioners to be equipped to assess learners’ needs must occur at school level. The teacher’s role in an inclusive environment is crucial and a “conceptual understanding of inclusion and the diverse needs of learners, including those with disabilities, is required” (SIAS, 2014, p. 33). Included in the SIAS (2014) policy is the Learner Profile document that provides a tool for teachers to plan interventions and support for all learners as part of the teaching and learning process. The teacher and all who are directly involved with the learner on a daily basis are expected to apply the SIAS process, with the teacher assuming the role of case manager to drive the support process (2014, p.34).

The SIAS (2014) policy outlined the implementation of the teacher training that was to occur. In 2015/2016, all foundation phase teachers were to be trained and in 2016/2017, 20 000 teacher members of SBSTs in 5000 ordinary schools were to be trained. In 2017/2018, a further 20 000 teacher members of SBSTs in 5000 ordinary schools were meant to receive training (SIAS, 2014, p. 23). For the SIAS (2014) policy to work effectively for the benefit of all learners experiencing barriers to learning, teachers will need to be familiar with the policy and be able to implement the process. This will require regular training and support beyond the initial orientation.

The literature review revealed that fear of failure, social anxiety, school phobia and other general anxiety disorders, were often missed by teachers and school personnel and, therefore, the child’s challenges often became exacerbated. Parents, on the other hand, often are in a position to notice feelings of embarrassment, disgust, loneliness, tiredness and frustration in their anxious child but do not often equate these to anxiety (Ludwig et al., 2015, p. 45). The summarised questionnaire responses from the child, parents and teachers clearly demonstrated how these results positively aligned with the findings from the literature review. Appendix E summarised the learner responses to the statements of whether their teachers or parents helped them when they were “scared of anxious” as:

> My parents know how to help me when I am scared or anxious: five learners responded “somewhat true” and three learners responded “very true”
>
> My teachers know how to help me when I am scared or anxious: four learners responded “somewhat true” and five learners responded “very true”

The outward signs of anxiety are therefore often easily identified by the caring adult, however, this is only the first step in screening and identification. Referring the learner for further assessment and evaluation, is the next step (assessment) and then finally, providing the necessary support and intervention that is recommended by the medical practitioner or counsellor, becomes the final section of the journey (support).

It could be concluded that failure to identify or respond to general anxiety disorders by teachers and school personnel could lead to the exacerbation of a learner’s challenges. The SIAS (2014) policy also referred to assistive devices and technology that could be provided to learners experiencing barriers to learning, but it could be concluded that this is not applicable to learners experiencing anxiety disorders since policy did not mention this group/sector of learners. Intervention plans or strategies to support these learners are not in place as the SIAS policy is silent on this group of learners and it could be concluded that the SIAS policy outlining the implementation of the teacher training did not materialise (2014).

6.4 RECOMMENDATIONS BASED ON EMERGING THEMES

The rationale behind these recommendations comprise increasing awareness about anxiety in children across all ages, as the diagnosis is often missed, creating structures at the different levels of society to address anxiety when it presents, addressing causative stressors and finding ways to address anxiety by increasing resilience in all children to these stressors to which they will definitely be exposed.

6.4.1Training the teachers

Education and training of teachers on identifying learners at risk and on ways to work with and support identified and vulnerable children within a classroom setting is vital. According to the SIAS (2014, p. 34) policy, the teacher and all who are directly involved with the learner on a daily basis are expected to apply the SIAS process. The teacher must assume the role of case manager to drive the support process. Information gained from external assessments should serve only to enhance the understanding of the interventions needed and should not be central in decision-making around support. The knowledge and wishes of the parents/caregivers must carry the ultimate weight in any decision-making process.

Moran (2015, p. 29) suggested that it would make sense to provide classroom lessons on anxiety, including education about anxiety, relaxation skills and positive self-talk. Mindfulness programmes could also assist learners in managing their symptoms. Certain teachers could act as counsellors, namely, an identified person at school that learners know they can go and see. Counselling does not take the place of therapy, but these teachers would be rendering a very important service to learners whose only hope might be the school.

Clark (2017a, p. 3) suggested having group courses that are conducted within schools by trained staff, NGOs such as FAMSA, SADAG or by mental health professionals from within their community. These courses could prepare learners to cope and thrive in their community with all its challenges such as socio-economic, substance abuse, crime, teenage pregnancy and cult practices. Each school community would then be identifying and looking after its own learners' needs.

6.4.2 Educating the parents

Parents/caregivers must play a meaningful role in forming a partnership with the teacher and the school to ensure that the support process as outlined in the SIAS policy is implemented as parent/caregiver "participation in the SIAS process is not a matter of choice, but is compulsory" (SIAS, 2014, p. 46). The only way that parents will be able to do this, is if they understand what the SIAS policy is all about.

Schools could hold parent evenings and workshops to deal with mental health issues and emotional wellness. According to the pupil survey results, only 30% felt that their parents knew how to help them when they were scared or anxious, but 50% felt that their teachers knew how to assist. Two-thirds or 67% of parents remarked in their questionnaire that there was a family history of anxiety, and the literature review also revealed that if a child has an anxiety disorder there is a strong possibility that a parent suffers as well.

Clark (2017a, p. 3) stressed that the child should not be seen in isolation but rather the precipitating and perpetuating factors within the family should be investigated and addressed. Parent support groups where parents and caregivers can share thoughts and experiences with each other are also extremely helpful. These could run at the schools by trained school personnel or by outside organisations dealing with mental health issues.

6.4.3 Empowering the learners

Posters could be created and stuck up around the school which had information about personal development and emotional wellbeing. Learners could also be encouraged to look after one another as 70% of the learners admitted that they often worried about school performance and their marks, by openly discussing these issues and providing academic support in the form of remedial classes or tutoring, such causes of anxiety could be lessened. The learners also stated in their questionnaires that they did not always know how to manage their anxiety symptoms. Learners could be taught coping strategies and ways to identify their anxiety triggers.

Clark (2017a, p. 3) suggested involving the learners in drawing up and applying school policies surrounding bullying, substance abuse and emotional abuse, for example. Schools need to have, and bring to the continuous attention of learners and caregivers, their policies as well as create new specific policies for challenges facing them as individual schools, depending on what issues are relevant. These policies should be strictly adhered to and schools should be accountable to them.

6.4.4 Involving the community

Groups targeting certain ages of learners, clubs designed to promote life skills, social skills, coping skills or "Big Brother" groups could provide a safe space through which learners can develop a sense of self. Youth groups at churches and community centres have a role to play, as do sport clubs. Clark argues that "communities, schools, families and, ultimately, each individual child cannot be really assisted without the 'buy-in' of the various government departments whose policies build and fund them" (2017a, p. 2).

6.4.5 Creating awareness through the media

These media avenues provide excellent opportunities to consider. People watch certain television shows, they tune in regularly to community radio shows and are influenced by the opinions of talk show hosts. SADAG, via their website also present regular interviews, which spread important information and

encourage community ventures and support. The community is best able to focus on the needs of its own children and families, however, organisation is crucial to get such projects off the ground with assistance from NGOs and business and focusing attention on those places where people visit regularly, such as community health clinics, municipal offices, churches, shopping malls and, again, schools. Social media campaigns and advertisements assist to spread the message about this mental health issue.

6.4.6 Improving the referral process

Paruk and Karim (2016, p. 548) recognise the need for intervention studies as “although the evidence base for management of psychiatric disorders in adolescents is improving, there is still a dire need for further pharmacological and psychosocial intervention studies”. Paruk and Karim (2016) also identify the need to form an alliance involving family and school and make use of a multimodal treatment plan including psycho-education and pharmacological and psychosocial interventions.

The issue of what is classified as a barrier to learning needs to be addressed. The SIAS policy referred to barriers to learning as “difficulties that arise within the education system as a whole, the learning site and/or within the learner him/herself which prevent access to learning and development” (2014, p. vii). The policy also mentioned specialised support that is provided or facilitated and health, including mental health, should form part of the integrated school health programme. The researcher feels that anxiety, as a learning barrier, is largely underestimated and policy and whitepapers make no mention of anxiety as a disorder.

There is an urgent need to increase awareness, improve screening, detection and treatment of mental illness in these children and adolescents as well as ensure an integrated healthcare system providing medical and mental healthcare at primary and secondary level. This is critical to address the mental healthcare gap in adolescent services (Paruk & Karim, 2016, p. 548).

Within each school, some learners may already be connected with an outside intervention team, such as a therapist, psychiatrist, and/or support group, while others may not. In these cases, it might fall to school personnel to assist the learner to connect to further support agents in their community. Two-thirds or 66.7% of parents stated in their questionnaire responses that it was an easy process to get referred to a private professional, meaning that the referral process occurred outside of the school. By creating these honest and transparent networks between the school, the parent and the practitioner, the child’s wellbeing remains at the centre of this triangle.

6.5 STUDY RELEVANCE

Through a mixed methods approach, which was adopted for this study, relevant in-depth information was generated. Also, by choosing to conduct a case study (also referred to as field research), an in-depth analysis of anxiety disorders in learners and adolescents in their natural school setting was made possible. In other words, the learners' behaviours could be studied as they occurred naturally.

The researcher was able to spend three full months from the beginning of January 2019 to the end of March 2019 observing the participants, gathering information and striving to gain a full understanding of the challenges and needs facing this group of learners. McMillan points out that for good action research to be conducted, the researcher should have a genuine interest in the study (2012, p. 355). McMillan (2012) also refers to the "process validity" of a study, which applies to the way in which the study is conducted, in that it requires the research to be dependable and competent. The researcher took thorough measures to ensure that data collection methods were effective and appropriate for obtaining the information needed to answer the key research questions that were posed for the study. It was also important that all questionnaires were returned which meant that the researcher had to send reminders to parents and teachers to complete and send back the forms.

The final two issues that determine the integrity and validity of a study, according to McMillan (2012, p. 355), are "catalytic validity" and "dialogic validity". These have to do with the extent to which study participants are compelled to take action to bring about change. In this case, anxiety is an issue affecting so many people and if the findings in this study can bring about change and provide assistance to more learners, it would have achieved something of great importance. The researcher was encouraged and motivated to complete the study because of the positive responses and interest shown by the participants. Dialogic validity is related to how the results of the study will be shared and discussed. For example, researchers have the opportunity to write articles for journals, the popular press (and even social media) summarising and sharing their research results. In terms of this research, it is possible to have a workshop for teachers and parents at schools that would provide a means of continuing and extending the dialogue regarding this important issue, which impacts so markedly on learning and teaching. Moreover, this would provide a means of combating the stigma attached to having a mental illness.

6.6 STUDY LIMITATIONS

There were various limitations for the study relating to lack of research, participants and contextual characteristics.

6.6.1 Lack of existing research

There are insufficient studies that deal specifically with the under 18-year-old population group in South Africa. Dawes, Lund, Sorsdahl and Meyers (2012, p. 2) alluded to the fact that prevalence studies of mental illness among learners and young people in South Africa make use of small and unrepresentative samples and diagnostic instruments used have not been validated in the local context.

As a result, ways to strengthen individuals, families, communities and systems and remove societal barriers to improve the recognition of mental health problems are needed. If the appropriate strategies are implemented, the mental health of South African learners and adolescents will not only be improved but can contribute to the social and economic progress of the country by improving the quality of mental health provision (Flisher, Dawes, Kafaar, Lund, Sorsdahl, Myers, Thom & Seedat, 2012, p. 18). According to Mokitimi, Schneider and de Vries, nearly 40% of all South Africans are under the age of 18 years and the mental health burden for this sector of the population is of great concern (2018, p. 14). In their report Mokitimi et al. (2018, p. 14) identified that publicly available documents and research studies were hard to find and further research will be required.

6.6.2 Limitations related to participants and contextual characteristics

Participants in the study were comprised of ten learners attending an inclusive independent school and, therefore, the findings cannot be generalised to all schools with learners experiencing anxiety. There were five males and five females ranging from 12 to 18 years of age in this case study. This age group was selected as the learners would have the required insight and maturity to be able to answer the questions in the questionnaire. They had also lived with an anxiety disorder for a number of years, and had been attending the particular school where the research had taken place for more than a year. They had therefore, been exposed to the policy and strategies that are discussed further in this chapter.

As the school is a small, urban, independent school, the parent body consists mainly of middle-class working parents. The majority of the learners (66.7%) in the study, therefore, had access to private healthcare and for parents, as mentioned in the questionnaire getting a referral to a private practitioner had been relatively easy. However, if the study were to be conducted in a rural area where resources were scarce,

the results would most likely be different. McMillan identifies “democratic validity” (2012, p. 355), which is concerned with the representation of the participants in the process of conducting the research or their “validity” as data sources as well as “outcome validity”, which is the extent to which the results coming out of the study are viable and effective. Although the sample for this study was relatively small, the results from the questionnaires were consistent with findings and information gathered in the literature review.

Participants were observed during certain lessons, which were well-structured and follow a certain sequence as well as during recess, which was relatively unstructured and unpredictable. McMillan refers to “ecological validity” (2012, p. 372), and the factors that affect the ecological validity of this research were to be found in the type of school, the position of the school, the size of the school and the socio-economic status of the school community.

6.7 RECOMMENDATIONS FOR FUTURE RESEARCH

As this particular study focused on learners between the ages of 12 and 18 years and took the form of a mixed method case study at a small, independent school, the following areas for future research became evident:

- Incidences of anxiety disorders amongst learners in pre-schools, crèches and lower primary schools could be investigated to discover whether early identification and intervention could prevent challenges later on in their school careers.
- Learners and adolescents with anxiety in more diverse schooling environments require further investigation to draw comparisons and develop support strategies that could be implemented at all schools.
- Field research at tertiary institutions and in the workplace could help to create awareness and provide support for learners and employees experiencing anxiety disorders.
- Identify and explore the barriers that continue to prevent effective Child and Adolescent Mental Health (CAMH) policy and service development.

It is further recommended that this study be replicated in other districts and that interviews as well as questionnaire surveys be conducted with learners suffering anxiety disorders. These data sources may elicit richer information about living with and managing an anxiety disorder.

6.8 CONCLUSION AND CLOSING REMARKS

A valuable credo is "know thy neighbour". In this context get to really know the learners in the school and create that sense of community. The learner questionnaire results revealed that 50% of the respondents indicated that their teachers knew how to help them when they were anxious or scared. Learners with anxiety disorders, may have needs that go beyond the scope of what can be provided in the school setting and school personnel may need to make a referral for further testing to determine if a learner is eligible for special concessions or accommodations. The teachers indicated overwhelmingly in their questionnaires that by really knowing their learners and responding to their needs, they could reduce feelings of anxiety in their learners.

A goal for the near future is to reduce the unwanted rise of anxious distress in young learners and adolescents so that they can be the successful adults of tomorrow.

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APPENDICES

Appendix A

Request for permission to conduct research at Elsen Academy

The Identification and Management of Learners with Anxiety Disorders in a South African Inclusive Educational Setting

31 January 2019

Mr Mark Barclay
Headmaster
0415823289
mark@elsen.co.za

Dear Mr Barclay

I, Philippa Fabbri, am doing research under supervision of Prof. Maguvhe, a professor in the Department of Inclusive Education, towards a D. Ed at the University of South Africa. We are inviting you to participate in a study entitled "The Identification and Management of Children with Anxiety Disorders in a South African Inclusive Educational Setting".

The purpose of this research study is to understand why the prevalence for children with anxiety is on the rise and to learn how to better identify and support these children at home and at school.

Your school has been selected because the site is information rich and the researcher is able to access the relevant records and files of the children who will be selected for the sample.

The study will entail questionnaires being completed by parents and certain students at the school and the researcher will seek permission to observe educational situations in both the classroom setting and outside during recess on the playground, and document study of the children's files which would include psychological assessments, school reports and any other relevant material that would assist in the research.

The benefits of this study are that the researcher will attempt to understand why anxiety disorders in children is on the rise in our country, how are these children understood or diagnosed and how can we manage and treat their anxiety, in order for them to continue making progress at school or at growing up into balanced and contented adults? The researcher also aims to challenge an existing practice or situation, expose the problems and propose a particular model or procedure that teachers and schools can follow when referring a child for an evaluation to a professional such as a paediatrician or psychiatrist.

There are no potential risks involved in this study.

There will be no reimbursement or any incentives for participation in the research.

Feedback procedure will entail providing the parents with a copy of the research findings and inviting parents to an information evening where they will be thanked for their participation. The teachers will also be given an opportunity to meet with the researcher for a presentation. A copy of the research will be made available for them to read.

Yours sincerely

Philippa Fabbri

Appendix B
Requesting parental consent for minors to participate in a research project

Dear Parent

Your son/daughter is invited to participate in a study entitled:

"The Identification and Management of Learners with Anxiety Disorders in a South African Inclusive Educational Setting".

I am undertaking this study as part of my doctoral research at the University of South Africa.

The purpose of this research study is to understand why the prevalence for children with anxiety is on the rise and to learn how to better identify and support these children at home and at school.

The researcher also aims to challenge an existing practice or situation, expose the problems and propose a particular model or procedure that teachers and schools can follow when referring a child for an evaluation to a professional such as a paediatrician or psychiatrist.

I am asking permission to include your child in this study because he/she has been diagnosed with anxiety and is currently in our intervention and support programme at Elsen Academy.

If you allow your child to participate, I shall request him/her to complete a short questionnaire, which will ask what symptoms or behaviours the child with AD experiences, and whether certain experiences at school exacerbate the symptoms or behaviours.

Any information that is obtained in connection with this study and can be identified with your child, will remain confidential and will only be disclosed with your permission. His/her responses will not be linked to his/her name or your name or the school's name in any written or verbal report based on this study. Such a report will be used for research purposes only.

There are no foreseeable risks to your child by participating in the study. Your child will receive no direct benefit from participating in the study; however, the possible benefits to education are that educators will be better able to understand anxious behaviours in children and therefore will be more equipped to support and manage them in the classroom. Neither your child nor you will receive any type of payment for participating in this study.

Your child's participation in this study is voluntary. Your child may decline to participate or to withdraw from participation at any time. Withdrawal or refusal to participate will not affect him/her in any way. Similarly, you can agree to allow your child to be in the study now and change your mind later without any penalty.

The study will take place during regular classroom activities with the prior approval of the school and your child's teacher.

In addition to your permission, your child must agree to participate in the study and you and your child will also be asked to sign the assent form which accompanies this letter. If your child does not wish to participate in the study, he or she will not be included and there will be no penalty. The information gathered from the study and your child's participation in the study will be stored securely on a password locked computer in my locked office for five years after the study. Thereafter, records will be erased.

There will be no reimbursement or any incentives for participation in the research.

If you have questions about this study, please ask me or my study supervisor, Prof Maguvhe, Department of Inclusive Education, College of Education, University of South Africa. My contact number is 0415823289 and my e-mail is philippa@elsen.co.za. The e-mail of my supervisor is maguvmo@unisa.ac.za

Permission for the study has already been given by Mr. Barclay and the Ethics Committee of the College of Education, UNISA.

You are making a decision about allowing your child to participate in this study. Your signature below indicates that you have read the information provided above and have decided to allow him or her to participate in the study. You may keep a copy of this letter.

Name of child Signature Date	Name of parent Signature Date	Researcher: P. H Fabbri Signature [signature] Date: 31 January 2019

Appendix C
Requesting Permission from learners to participate in a research project

Title: The Identification and Management of Learners with Anxiety Disorders in a South African Inclusive Educational Setting

Dear ___________ Date ________________

I am doing a study on anxiety as part of my studies at the University of South Africa. Your principal has given me permission to do this study in your school. I would like to invite you to be a very special part of my study. I am doing this study so that I can find ways that your teachers and counsellors can use to help and understand anxiety better. This may help you and many other learners of your age in different schools.

This letter is to explain to you what I would like you to do. There may be some words you do not know in this letter. You may ask me or any other adult to explain any of these words that you do not know or understand. You may take a copy of this letter home to think about my invitation and talk to your parents about this before you decide if you want to be in this study.

I would like to ask you to complete a short questionnaire about how anxiety makes you feel and what sort of things you do, to manage your emotions and feelings.

I will write a report on the study but I will not use your name in the report or say anything that will let other people know who you are. Participation is voluntary and you do not have to be part of this study if you don't want to take part. If you choose to be in the study, you may stop taking part at any time without penalty. You may tell me if you do not wish to answer any of my questions. No one will blame or criticise you.

When I am finished with my study, I shall return to your school to give a short talk about some of the helpful and interesting things I found out in my study. I shall invite you to come and listen to my talk.

The benefits of this study are to help other parents and teachers to be better able to assist and support their child with anxiety at school and to identify a proper procedure to follow in order to get the support needed for the child. There are no risks involved.

You will not be reimbursed or receive any incentives for your participation in the research.

If you decide to be part of my study, you will be asked to sign the form on the next page. If you have any other questions about this study, you can talk to me or you can have your parent or another adult call me at 0415823289. Do not sign the form until you have all your questions answered and understand what I would like you to do.

Researcher: Philippa Fabbri Phone number: 0415823289

Do not sign the written assent form if you have any questions. Ask your questions first and ensure that someone answers those questions.

WRITTEN ASSENT

I have read this letter which asks me to be part of a study at my school. I have understood the information about my study and I know what I will be asked to do. I am willing to be in the study.

Name of child	Name of parent	Researcher: P.H Fabbri
Signature	Signature	Signature
Date	Date	Date: 31 January 2019

Appendix D
Learner Questionnaire

Thank you for your willingness to assist in my research. It is much appreciated.

Please complete this questionnaire giving as much detail as possible.

Please indicate in the block which is most applicable to you.

	Not true	Somewhat true	Very true
I worry a lot about certain things or going to certain places.			
I worry about going somewhere that I have not been to before or where I will not know people.			
When my heart beats fast, I worry that something is wrong.			
When I feel like I am not getting enough air, I get scared that I might suffocate.			
I often worry about school and my marks.			
I often have nightmares.			
I often have headaches.			
I often have stomachaches.			
Sometimes I cry, have tantrums or cling to my mom or dad when I need to.			

My parents know how to help me when I am scared or anxious.			
My teachers know how to help me when I am scared or anxious.			

What makes you scared? ____

What do you do when you are scared? _____________________________________

How do you feel when you are scared or anxious?

____
____
____

Do you sometimes not want to go to school? _________

If yes, why? ____

Have you ever had to miss school because you were worried about something? _____

If Yes, please explain ____

Appendix E
Patterns/Themes emerging from Learner Questionnaires

Etic data - patterns or themes emerging from the data that answer the research questions. Q1: What defines/causes anxiety? Q2: How is anxiety managed? Q3: What support is available?	Emic data - responses from learners	Not true	Somewhat true	Very true
Q1	I worry a lot about certain things or going to certain places.	30%	40%	30%
Q1	I worry about going somewhere that I have not been to before or where I will not know people.	10%	60%	30%
Q1	When my heart beats fast, I worry that something is wrong.	30%	10%	60%
Q1	When I feel like I am not getting enough air, I get scared that I might suffocate.	40%	30%	30%
Q1	I often worry about school and my marks.	10%	30%	70%

Q1	I often have nightmares.	50%	40%	10%
Q1	I often have headaches.	40%	40%	20%
Q1	I often have stomach-aches.	40%	40%	20%
Q1	Sometimes I cry, have tantrums or cling to my mom or dad when I need to.	40%	50%	10%
Q3	My parents know how to help me when I am scared or anxious.	20%	50%	30%
Q3	My teachers know how to help me when I am scared or anxious	10%	40%	50%

Appendix F
Summary of Statements from Learner Questionnaires

Theme or pattern	Emic data
What makes you scared?	• Needles, small spaces, heights. • The dark, small rooms, heights. • Exams, projects and my marks. • What people think. • Snakes, low marks for Afrikaans, completing my homework, grizzly bears, sharks, cytotoxic venom, burglars, my dogs and cats running away. • Tests and failing, homework. • When I don't do good in school. • Dangerous animals and weapons. • Lots of people around me and crowds; going to the mall. • That someone will bully me because of my appearance and how I act.
What do you do when you are scared?	• Panic. • I roll my eyes back into my head. • Take deep breaths. • I start scratching, sometimes cutting, I get uptight and I start raising my voice. • Cry, hide away under my duvet, continue thinking about it over and over. • I stutter, and I try to calm myself down. • I think happy thoughts or I count. • I push the tips of my fingers together until it hurts. • I can talk to someone like my teacher. • I don't want a lot of people around me, I would rather be alone. I feel better when I run a lot or play soccer.
How do you feel when you are scared?	• It feels like I can't breathe. • I feel sad. • I tense up. • Worried, fearful, useless and a stupid/freak. I worry about failing. • Frustrated, my heart beats too fast, weak, emotional. • Terrified, nervous. • My heart is racing, I sweat, I get headaches, I think scary thoughts. • My stomach feels hollow and I get very hot and sweaty. • My body shakes.

Do you sometimes not want to go to school?	● Yes, because some people make me feel unwelcome: they judge me and I feel like I don't belong there. ● Yes, I worry about Afrikaans and tests and exams. ● Yes, so we have no homework. ● Yes, mostly because I am tired but it's where I get the most stressed. ● Yes, I have been bullied a lot and I don't want to get more bullied. ● Yes, I get scared when I have to go to Assembly. ● Yes, because I think that I didn't do good in class.
Have you ever had to miss school because you were worried about something? If yes, please explain.	● Yes, the concert last year because I wasn't ready to go on stage and I had an attack. I cried a lot and I couldn't get out of bed. I wanted to hide. ● Exam times, but I did go. ● Yes, because our whole class was fighting with each other and it made me stressed. ● Yes, a girl in my class had a bullying streak and kept on bullying me so I stayed at home because of the verbal bullying.

Appendix G
Participant information sheet and consent (Parents)

Date ______________________

Title "The Identification and Management of Children with Anxiety Disorders in a South African Inclusive Educational Setting"

DEAR PROSPECTIVE PARTICIPANT

My name is Philippa Fabbri and I am doing research under the supervision of Mbulaheni Maguvhe, Professor in the Department of Inclusive Education towards a PhD at the University of South Africa. We are inviting you to participate in a study entitled "The Identification and Management of Children with Anxiety Disorders in a South African Inclusive Educational Setting".

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore the prevalence of anxiety disorders in children and to investigate how best to support their teachers, parents and the children themselves.

WHY AM I BEING INVITED TO PARTICIPATE?

You are invited because, as a parent, you would be able to offer some valuable insight into how your child with anxiety might struggle in the classroom environment or at social activities and what behaviours are apparent. I obtained your contact details from the Headmaster at Elsen Academy, which is where the study will be taking place. There will be ten children in the study, their parents, teachers and counsellors.

THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves questionnaires that include questions about when your child was diagnosed, if a formal diagnosis has been made and what you observe with regards to your child's challenges both at home and at school and especially with regards to occasions such as sports day, school concert, etc. This questionnaire should take approximately 10 minutes to complete.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. However, once you have submitted the questionnaire, you will not be able to withdraw from this study.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

The researcher has chosen to investigate and research this particular topic, because of the interest that she has and the need to provide some support and assistance to families, parents and teachers who deal with children with AD on a daily basis. The purpose of this study is to explore the prevalence of anxiety disorders in children and to investigate how best to support their teachers, parents and the children themselves.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There should be no inconvenience and/or discomfort to the participants. You will be sent the questionnaire and once you have completed it, you will be asked to return it to the researcher either via email or in a sealed envelope and placed in the researcher's post box.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

You have the right to insist that your name will not be recorded anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet in the school storeroom where all the learner files and exam papers from the past 5 years are kept. All electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After the 5 year period is up, the hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no payment or financial incentive for your participation in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the CEDU at Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Philippa Fabbri on 0833608468 or email philippa@elsen.co.za.

Should you have concerns about the way in which the research has been conducted, you may contact

Prof. M.O. Maguvhe

Department Inclusive Education
Sunnyside Campus
Building 10
Office1-94
Tel: (012) 481 2768
E-mail: maguvmo@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

P. Fabbri

CONSENT TO PARTICIPATE IN THIS STUDY (Return slip)

I, __________________ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname (please print): ______________________________

Participant Signature ____________________________

Date ____________

Researcher's Name & Surname (please print): Philippa Fabbri

Researcher's signature

Date _19 January 2019_

Appendix H
Parent Questionnaire

Thank you for taking the time to complete this questionnaire that forms part of my research study. Please complete all the questions and return to me via my email at philippa@elsen.co.za.

Alternatively, place it in an envelope and send it to me via your child.

1) Has your child been identified as having an anxiety condition? (tick one answer)

- Yes
- No

2) If YES, at what age were they referred and to whom?

____

____

3) Was it an easy process to get your child referred? Yes (provide a reason)

____

No (provide a reason) ____

4) How did you feel after the diagnosis was made? (if not diagnosed, leave this question blank)

____

____

____

5) What symptoms were present and what difficulties did your child have?

____

____

____

6) Who was involved in the referral process? (Tick all that apply)

- Doctor
- Paediatrician
- Psychologist
- Psychiatrist
- Teacher
- Family member
- Other

7) What recommendations have been made to assist your child?

____

____

____

8) What events or experiences affected your child the most before he/she was referred?

____

9) Do these experiences or events still affect your child today? (Tick one answer).

- Yes
- Sometimes
- A little bit
- No

10) How do you assist him/her in dealing with these experiences or events?

(if you answered NO in Question 9, leave this blank)

11) If you answered NO to Question 1, does your child experience any anxiety or worry that tends to impact on their daily life? (tick one answer)

- Yes
- No

12) Have you or any other direct family members suffered from or with anxiety? (tick one answer)

- Yes
- No

Appendix I
Summaries of Responses from Parent Questionnaires

Etic data - patterns or themes emerging from the data that answer the research questions. Q1: What defines/causes anxiety? Q2: How is anxiety managed? Q3: What support is available?		Questions from parent questionnaire	Emic data
Q1		Has your child been identified as having an anxiety condition?	83.3% Yes 16.7% No
Q1		If YES, who were they referred to for the diagnosis?	25% - psychiatrist 25% - psychologist 25% - paediatrician 25% - no formal diagnosis
Q1		Was it an easy process to get your child referred?	66.7% Yes 33.3% No
		How did you feel after the diagnosis was made? (if not diagnosed, leave this question blank)	• Anxious myself. • We wanted to find out more about anxiety. • Helpless, overwhelmed, saddened, guilty, overprotective, fearful. • Concerned as it's not healthy for a child to experience anxiety. • Relieved as he could now get help but also guilty.

Q1		What symptoms were present? What were you noticing?	● Stutters when anxiety is heightened, nervous and apprehensive with work, low self-esteem, can present as melt downs. ● Crying for no apparent reason and she tells me she feels down but there is nothing bothering her. ● Could not control her emotions and would constantly be scratching her pimples open on her body. ● Gets frustrated easily and fears trying out new things and takes a while to adapt. ● Aggression when she has to perform tasks, especially tasks where she lacks knowledge or confidence. ● Anxiety when having to do school-related work. Anxiety is further enhanced by our lack of knowledge to adequately support her. ● Unable to sleep in own room. Had to lie down with her until she fell asleep. ● Not very noticeable for us unless he verbalizes it: however, doctors have picked up quite severe anxiety ● Symptoms: He cried, whimpered, became very clingy and did certain rituals over and over again when anxious. He had trouble being closed in a room or car alone (claustrophobic).

Q3		What recommendations have been made to assist your child?	• Alternative schooling. • Small venue, iPad, reader and scribe during exam times. • Medication. • Emotional support and ongoing sessions from professionals. • Therapy and medication. • He has been placed on anti-anxiety medication. • Counselling, medication and a change in school.
Q1		What events or experiences affected your child the most before he/she was referred?	• Academic performance, speaking in front of others, stressful unfamiliar people or places and a change in routine. • Divorce of parents. Ritalin made anxiety worse and since changing to Concerta has made a significant difference. • Not too sure as most of the diagnoses have pointed to delayed cognitive and physiological development. • Anxiety began from Grade R as a result of Neurofibromatosis. Got worse when peers started writing hate letters and bullying her. Even mentioned suicide at age of 11yrs. • He tends to get anxious at school or with school work. • Going out to public places, changes in routines, change in plans with no warning, parents' divorce, school events (especially sports), closed doors and being alone.

Q1		Do these experiences or events still affect your child today?	66.7% Yes 16.7% A little bit 16.7% Sometimes
Q2		How do you assist him/her in dealing with these experiences or events?	• Talking calmly, removing him from situations. • Talk through how he could be feeling. • Love bomb, distract him. • When something is bothering her, instead of bottling it up like she did in the past, she will come and tell me something is bothering her or needs answers. We then have a chat about how she is feeling and what has made her feel the way she is feeling and we work through it together. • I try and find out the reason for her anxiety. I can sense her agitation - she starts scratching until she bleeds and starts to talk very loudly. Does not cope with change, especially when it comes to school work because she battles with her visual perception and takes ages to learn. • None as yet - still to work it out. • I reassure him and talk him through it (although this rarely works), prepare him as much as possible for changes in routine or plans; we avoid events that bring on too much anxiety

Q1		Have you or any other direct family members suffered from or with anxiety?	66.7% 33.3%	Yes No

Appendix J
Teacher Questionnaire

Thank you for your willingness to assist in my research. It is much appreciated.

Please complete this questionnaire giving as much detail as possible.

1) What behaviours do you observe in a child when he/she is feeling worried or anxious?

2) What activities or experiences at school can cause a child to become anxious or fearful?

3) How do you know that he/she is feeling anxious or how does he/she show you that he or she is anxious?

4) What support does the anxious child require in order to function at school?

5) Are there interventions that are needed?

6) Does he/she avoid certain activities or experiences that make him/her feel uncomfortable and if so, what are they?

7) What recommendations have you made to assist?

8) What accommodations (if any) are made for the child at school?

Appendix K
Summary of responses from teacher questionnaires

What behaviours do you observe in a child when he/she is feeling worried or anxious?

- Asking to go to the bathroom a lot.
- Often trying to avoid tasks or activities - they will often start a conversation to avoid a challenging task.
- Sometimes a child will be very tearful or clingy. They need extra hugs and encouragement.
- Visible signs can be biting nails or picking at their skin.
- Sometimes becoming argumentative or aggressive - without even realising it.
- Some children become very quiet and withdrawn, while others will become extremely chatty.
- Fidgeting, shifting around, repeating certain movements, looking around at others' reactions, difficulty concentrating, tearful, distracted.
- Tendency to be ill-disciplined or cause distractions in class. Others tend to withdraw themselves from the class.
- Crying, nail biting, fidgeting, restlessness, foot tapping, leg shaking, clicking of pen.
- The child struggles to focus and fiddles around instead of doing the work.
- The child puts his/her head on the desk or wants to be left alone.

What activities or experiences at school can cause a child to become anxious or fearful?

- Anything a child might find challenging. Reading, writing and Mathematics are often main causes of anxiety.
- Children who find social situations challenging, e.g. find break time or Phys Ed lessons difficult as these situations cause them extreme anxiety.
- Being put on the spot or in the limelight, homework not done, assessments, being bullied, inability to understand the subject content, or inability to complete tasks.
- Not being able to socialize well with others. Not being able to achieve as well as others. Teachers picking on a student for not achieving well or not understanding.
- Bullying, etc. tests/ exams; fear of failure; having to face or accept 'set' consequences (e.g. detention for swearing or demerit for homework not being done).
- When the child doesn't understand the work or the instructions given.
- The attitude of the teacher can also play a role.

How do you know that he/she is feeling anxious or how does he/she show you that he/she is anxious?

- Some children are able to tell you that they are feeling scared or have a tummy-ache (which can often mean they are anxious).
- Asking to go to the bathroom whenever a certain subject is being done is often a clear indicator.
- Asking numerous questions to avoid a certain subject.
- Mainly through their behaviour, e.g. asking the same question repeatedly to ensure clarity.
- Student may act aggressively or show anger, or the student may cry easily.
- Some students act out by disobeying daily rules.
- You can see them crying and biting their nails, having a worried or concerned look on their faces.
- He/she doesn't make eye contact and doesn't want to be noticed.
- The child might refuse to do the activities.

What support and/or interventions does the anxious child require in order to function at school?

- If a child finds reading difficult, being given the opportunity to do it alone with the teacher rather than in a group will often help alleviate the fear. Being provided with tools to help them- e.g. a number chart or counters to help with a Maths task.
- Having a teacher who understands that they are feeling anxious. The teacher must be attentive and make attempts to talk to the child.
- Being given something to hold or squeeze in their hand. (e.g. a stress ball). It is also helpful if a child goes to play therapy or counselling to acquire skills to help with his / her anxiety.
- They need encouragement, acknowledgement for small achievements. They need to know that parents and teachers believe in them and support them.
- Use of a small venue during exams.
- Therapy and/or medication is probably needed in more severe cases. A teacher or a peer to speak to about the causes of concerns and to be presented with solutions.
- Teachers must be aware of students who are anxious; assist them when needed by offering additional alternatives or intervene in cases such as when a student is being bullied.
- Yes, interventions are needed: e.g. if the anxiety is subject-related, they may need a facilitator in a specific subject. They may also need to have regular therapy sessions with a counsellor or psychologist.
- Referral to a doctor for medication might also be needed.

Does he/she avoid certain activities or experiences that make him/her feel uncomfortable and if so, what are they?

- Yes - if a child finds break-time stressful it is important to have options and a buddy to help him / her.
- If a child is avoiding a reading or math task, I will sit with her and talk her through the task or activity. I will also make sure that they have the necessary aids available to them.
- Yes - they will avoid people or tasks that cause anxiety.
- Yes - students tend to be absent when they do not want to face an assessment such as a test or an oral. Students in this situation tend to have excuses not to participate: for example, many students have weekly excuses as to why they cannot participate in something like Phys. Ed.
- Yes, if anxiety is subject-related, they might ask for frequent bathroom breaks when they have that subject (avoidance).
- Work can be incomplete.
- Yes, subjects like Physical Education, and activities like reading and doing oral presentations.

What recommendations have you made to assist these children with anxiety disorders?

- I will work with the parents and the child to find ways of helping them overcome the anxiety or at least to be able to cope with it.
- I also reward the child whenever a task that causes anxiety has been completed, e.g. when we have completed this you may build a puzzle or Lego - something the child enjoys.
- A child who finds reading challenging: I will let them read a sentence and then I will read a sentence. I also allow that child to read alone with me and not in a group.
- By breaking work into smaller chunks.
- Teachers to assist students academically. Teachers can encourage and motivate students.
- Have strict policies in place to deal with bullies.
- In my subject (mathematics) I recommend assistive devices (calculators, number charts etc), extra time and emotional support.
- I invite the child to do a one-on-one oral presentation or reading activity during break- time.

What accommodations (if any) are made for the child at school?

- Allowing children to wait in the classroom before school begins if the noise of the playground is too much for them.
- Allowing a child, a quiet space when necessary.
- Making sure that the child receives play therapy or counselling if necessary.
- If any children find assembly challenging, they can sit at the back near the door or sit close to their teacher.
- Therapy available when needed.

- Small venue during exams.
- Assessment dates and scopes given well in advance
- Therapy and homework club.
- Counselling, individual attention, smaller classes, facilitation, assistive devices such as calculators, number charts, etc. in Maths.

Appendix M
30-minute Observation Record class time

30 minute Observation Record
Class Time

Name ....
Date.. Time ....

Very good 1 2 3 4 5 Very poor

Frequency of Behaviour Time:	5	10	15	20	25	30
Lesson: *(where sat? Who sat with?)*						
Interest in the lesson						
Listening to instructions						
Concentration span during lesson						
Starting tasks						
Staying on task						
Able to work independently						
Asks for help						

Fidgety or squirmy in seat						
Struggles to remain in seat						
Asks a lot of questions						
Asks for help						
Asks to use the bathroom						
Is afraid of making mistakes						
Seems irritable or grouchy						
Avoids participating during group activities						
Often says “I can’t do it” or “I don’t know.”						
Dealing with a challenging task						
Speaking or singing to self while working						
Responding to correction						
Responding to encouragement						
Constantly seeks approval						

Complains of headache or stomach ache						
Often uses eraser						
Works slowly						
Rushes through work to finish						
Compulsive behaviours or repetitive behaviours						
Nervous habit, e.g. bites nails or picks skin						
Acts extremely sensitive						
Anxious facial expression e.g. bites lip, frowns						
Muscles are tense						
Refuses to eat at snack time						

General comments:

Appendix N
30-minute Observation Record at Recess

30 minute observation record at recess

Name ……………………………

Date... Time ....

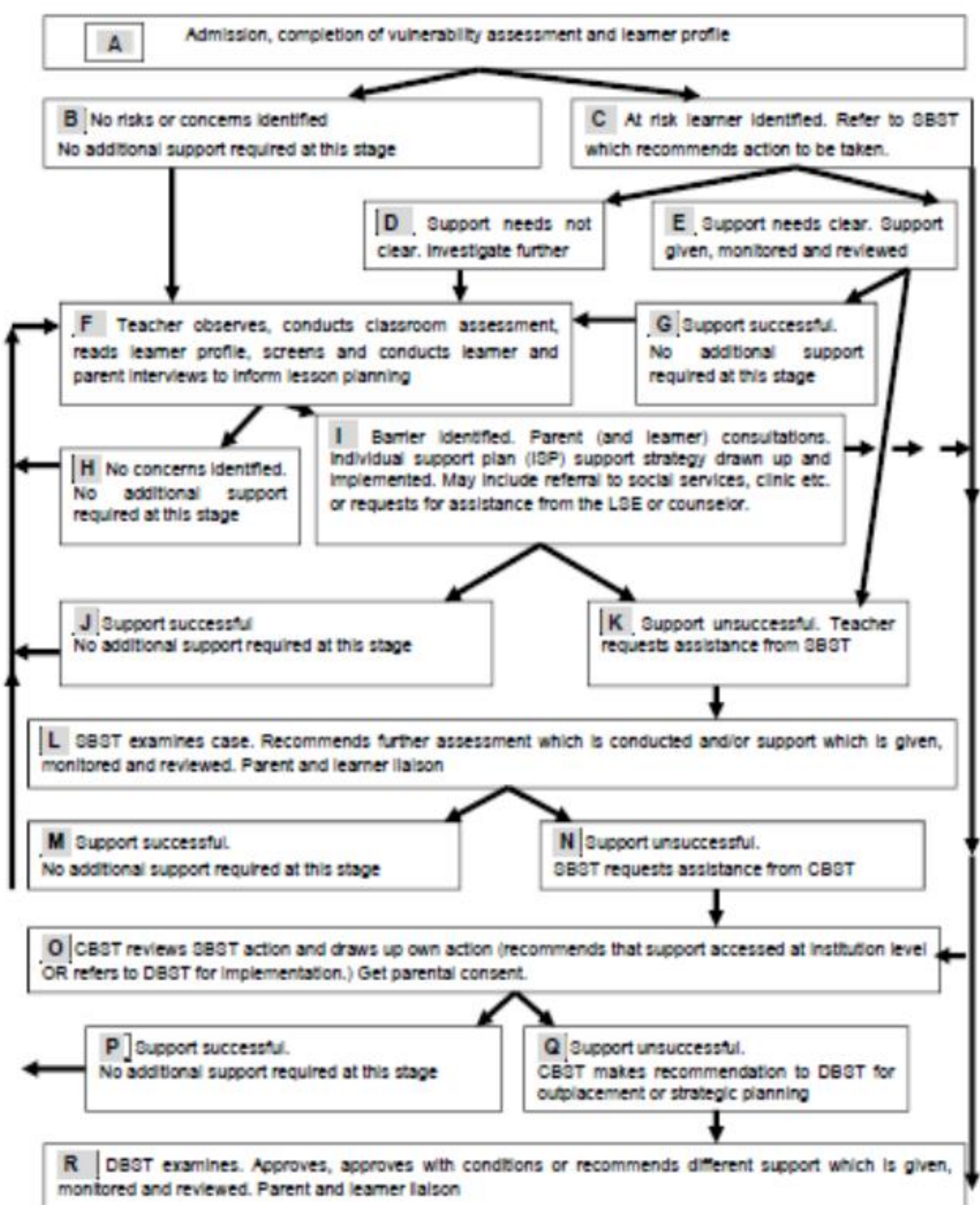
Very good 1 2 3 4 5 Very poor

Frequency of Behaviour Time:	5	10	15	20	25	30
Outdoors *(What did the child do? Where did he/she sit/play? With whom?*						
Sat alone						
Sat with a group						
Joined in with a game						
Walked around by him/herself						
Talks to him/herself						
Stayed near teacher						
Went to tuck shop						
Interacted with others						

Repetitive behaviours						
Anxious expression						
Nail biting or skin picking						
Irritable or moody						
Avoids rough play						
Fantasy play						
Refuses to eat snack						
Uses restroom						
Cries or gets easily upset						
Other observations:						

General comments:						

Appendix O
SIAS process for individual learners



Appendix P

UNISA Ethics review letter

UNISA COLLEGE OF EDUCATION ETHICS REVIEW COMMITTEE

Date: 2018/09/12

Ref: 2018/09/12/31159877/49/MC
Name: Mrs PH Fabbri
Student: 31159877

Dear Mrs Fabbri

Decision: Ethics Approval from 2018/09/12 to 2023/09/12

Researcher(s): Mrs PH Fabbri
E-mail address: 30806887@mylife.unisa.ac.za
Telephone: + 27 81 499 1279

Supervisor(s): Name: Prof M Maguvhe
E-mail address: maguvmo@unisa.ac.za
Telephone: +27 12 481 2768

Title of research:

The Identification and Management of Children with Anxiety Disorders in a South African Inclusive Educational Setting

Qualification: PhD in Inclusive Education

Thank you for the application for research ethics clearance by the UNISA College of Education Ethics Review Committee for the above mentioned research. Ethics approval is granted for the period 2018/09/12 to 2023/09/12.

*The **medium risk** application was reviewed by the Ethics Review Committee on 2018/09/12 in compliance with the UNISA Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.*

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the UNISA College of Education Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after the expiry date **2023/09/12**. Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number **2018/09/12/31159877/49/MC** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Kind regards,

Dr M Claassens
CHAIRPERSON: CEDU RERC
mcdtc@netactive.co.za

Prof V McKay
EXECUTIVE DEAN
Mckayvi@unisa.ac.za

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Appendix Q

Language Editing Certificate

To:	**TO WHOM IT MAY CONCERN**
From:	Dr Marcelle Harran
Date:	23 October 2020
Re:	**LANGUAGE PRACTITIONER DECLARATION**

This is to confirm that Dr Marcelle Harran completed a linguistic and technical edit of the Doctor of Philosophy thesis submitted by Philippa Helen Fabbri entitled:

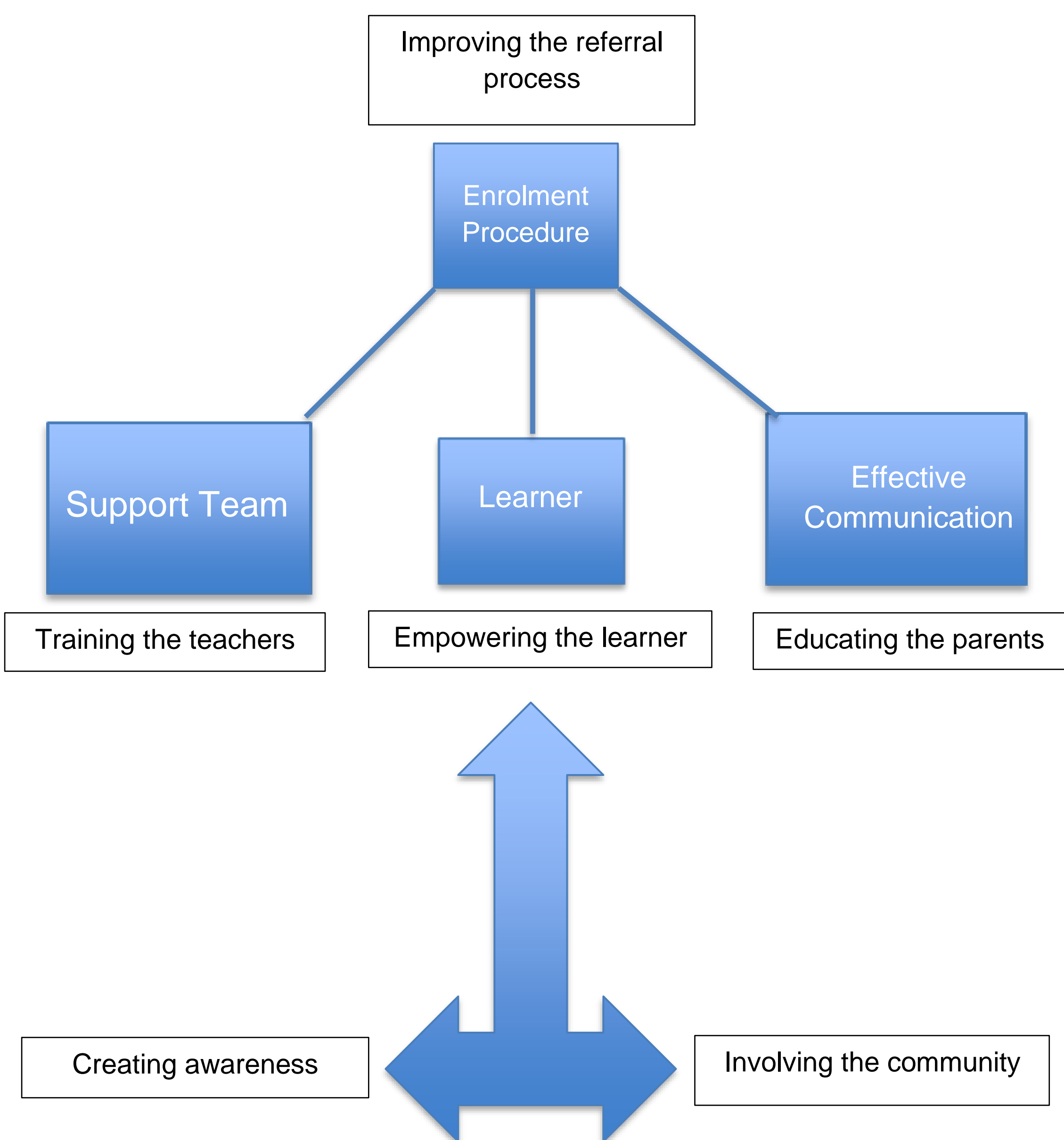
The identification and management of learners with anxiety disorders in a South African inclusive educational setting

Regards

Dr Marcelle Harran
Research Associate
Faculty of Arts
Nelson Mandela University
+27 733399731
mailto:marcelle.harran@mandela.ac.za

Appendix R

Diagram of Framework/Model



ABSTRACT FOR TRANSLATION INTO THREE AFRICAN LANGUAGES:

Afrikaans

IsiZulu

IsiXhosa

Name:	Philippa Helen Fabbri
Student Number:	3115 9877
Degree:	Doctor of Philosophy

Topic of research: **THE IDENTIFICATION AND MANAGEMENT OF LEARNERS WITH ANXIETY DISORDERS IN A SOUTH AFRICAN INCLUSIVE EDUCATIONAL SETTING**

OPSOMMING

Tot tussen 8% en 11% van kinders en adolessente ly aan angsversteurings wat tot spesifieke fobies, sosiale fobies, veralgemeende angsversteurings en obsessiewe gedrag aanleiding gee. In die kinder- en adolessensiejare is die risiko van angsversteurings hoog. Abnormaal hoë angsvlakke het ŉ skadelike uitwerking op kognitiewe funksionering, skolastiese prestasie en uitkomste. As ons geweet het waarom angsversteurings by kinders aan die toeneem is, kon op skool vir hierdie kinders voorsiening gemaak word. Leerhindernisse kan ook tot angsversteurings en swak akademiese prestasie aanleiding gee.

ŉ Tipiese skoolgemeenskap is vir die navorsing gekies. Die studiedoelwit was om ŉ onderrigsteunplan waarvolgens angstige leerders aan leeraktiwiteite deelneem, te implementeer, en om riglyne vir doeltreffende onderrig- en leerstrategieë vir leerders met angsversteurings te gee. Wat leerders by die skool angstig maak, hoe angsversteurings bestuur word, en watter hulp beskikbaar is, was die drie navorsingsvrae. Deur dokumentontledings, vraelyste, waarnemings en veldaantekeninge is toepaslike data ingesamel. Daar is op gemengde metodes is as studiebenadering en ŉ vertolkende paradigma besluit. Die navorser het as deelnemer-waarnemer opgetree. Toepaslike, indringende data is met gemengde metodes

gegenereer. Op grond van ŉ gevallestudie is angsversteurings by leerders en adolessente in hul natuurlike skoolomgewing deurtastend ontleed. ŉ Subjektiewe epistemologie was moontlik vanweë die navorser se eie belewenisse van en omgang met die leerders.

ŉ Piramidestruktuur en raamwerk is aanbeveel om leerders met angsversteurings soveel as moontlik te help. Hierdie raamwerk berus op die drie pilare waarvan leerdersukses afhang, te wete die inskrywingsprosedure, ŉ ondersteuningspan, en doeltreffende kommunikasie. Onderwysers het laat blyk dat hulle angstigheid by leerders kan verminder deur hulle goed te leer ken sodat hulle leerders se behoeftes kan bevredig. Ten slotte is ŉ doel vir die afsienbare toekoms gestel, naamlik om angsversteurings by jong leerders en adolessente te verminder sodat hulle as die suksesvolle volwassenes van môre kan ontpop.

ABSTRACT

As many as 8 to 11% of children and adolescents suffer from an anxiety disorder, which can develop into specific phobias, social phobias, generalised anxiety disorders and obsessive behaviour. Childhood and adolescence are identified as the main risk developmental phases for the beginning of anxiety disorders. Abnormal anxiety levels have negative effects on cognitive functioning, school performance and outcomes. If it were known why anxiety disorders in children were on the increase, some changes could be made to suitably accommodate these learners in schools. Learning barriers can also cause anxiety disorders, resulting in learners' poor performances academically.

A typical school community was selected to conduct the research. The main study objective was to facilitate the implementation of an education support plan, to enable learners with anxiety to participate in learning activities, and to provide guidelines for the effective teaching and learning strategies for learners with anxiety disorders. What defines anxiety in learners at school, how are these anxiety disorders managed and what support is available, were the three main research questions posed. Relevant data were gathered via document analysis, questionnaires, observations and field notes. A mixed-method study approach and an interpretivist paradigm were chosen, with the researcher acting as a participant observer. Through a mixed-methods approach, relevant in-depth information was generated and by choosing to conduct a case study, an in-depth analysis of anxiety disorders in learners and

adolescents in their natural school setting was possible. The researcher's personal experiences and interactions with the learners also allowed for a subjective epistemology.

A pyramid structure and framework was recommended to maximise support for learners experiencing an anxiety disorder. This framework is comprised of three pillars on which the learner's success rests, namely: the enrolment procedure, having a support team, and effective communication. The teachers indicated that by really getting to know their learners and responding to their needs, they could reduce feelings of anxiety in their learners. Finally, a goal for the near future was set to reduce the unwanted rise of anxious distress in young learners and adolescents so that they can become the successful adults of tomorrow.

ABSTRACT FOR TRANSLATION INTO THREE AFRICAN LANGUAGES:

Afrikaans

IsiZulu

IsiXhosa

Igama Lomfundi: Philippa Helen Fabbri

Inombolo Yomfundi: 3115 9877

Iziqu: UbuDokotela kuyiFilosofi

Isihloko socwaningo: **UKUHLONZWA KANYE NOKUPHATHWA KWABAFUNDI ABANEZINKINGA ZOKUKHATHAZEKA ESIMWENI SEMFUNDO EYINHLANGANISELA ENINGIZIMU AFRIKA**

ISIFINQO

Izingane ezingaba yi-8 kuya kuyi-11% zinenkinga yokukhathazeka, engakhula ibe ukwesaba okuthile, ukusaba kwezenhlalo, ukuphazamiseka kokukhathazeka okujwayelekile nokuziphatha okungalawuleki. Ubuntwana nobusha bukhonjwa njengezigaba zokuthuthuka eziyingozi ukuqala kwezinkinga zokukhathazeka. Amazinga wokukhathazeka angajwayelekile anemiphumela emibi ekusebenzeni kwengqondo, ukusebenza kwesikole kanye nakuyimiphumela. Ukube beyaziwa ukuthi kungani izinkinga zokukhathazeka ezinganeni zikhula, bekungenziwa ezinye izinguquko ezabe zizolekelela laba bafundi ezikoleni. Izithiyo zokufunda nazo zingadala ukuphazamiseka kokukhathazeka, okuholele ekungenzi kahle kwabafundi ezifundweni.

Umphakathi ojwayelekile wesikole wakhethwa ukwenza lolucwaningo. Inhloso enkulu yocwaningo kwakuwukwenza lula ukuqaliswa kohlelo lokusekelwa kwezemfundo, ukwenza abafundi abanokukhathazeka bakwazi ukubamba iqhaza emisebenzini yokufunda, nokunikeza imihlahlandlela yamasu wokufundisa nokufunda asebenzayo kubafundi abanenkinga

yokukhathazeka. Okuchaza ukukhathazeka kubafundi esikoleni, zilawulwa kanjani lezi zinkinga zokukhathazeka nokuthi yikuphi ukwesekwa okutholakalayo, yimibuzo emithathu eyinhloko yocwaningo ebuziwe. Imininingwane efanelekile yaqoqwa ngokuhlaziywa kwemibhalo, imibuzo, ukubonwa kanye namanothi athathwa ngesikhathi kwenziwa ucwaningo. Indlela yokufunda ehlanganisiwe nezindlela zokuhumusha zikhethiwe, umcwaningi esebenza njengomqapheli obambe iqhaza. Ngohlelo lwezindlela ezixubekile, ulwazi olufanele nolujulile lwenziwa futhi ngokukhetha ukwenza ucwaningo lwesigameko, ukuhlaziywa okujulile kwezinkinga zokukhathazeka kubafundi nalabo basesigabeni sokuba yintsha esimweni esijwayelekile sabo semvelo sesikole kungenzeka. Isipiliyoni somcwaningi ngamunye kanye nokusebenzisana kwakhe nabafundi nakho kuvumele ukuba iphistemoloji ezenzakalelayo.

Kunconywe isakhiwo nohlaka lwephiramidi ukukhulisa ukwesekwa kwabafundi ababhekene nenkinga yokukhathazeka.. Lolu hlaka luqukethe izinsika ezintathu lapho impumelelo yomfundi eyame khona, okuyilezi: inqubo yokubhalisa, ukuba neqembu elisekelayo, kanye nokuxhumana okusebenzayo. Othisha baveze ukuthi ngokwazi ngempela abafundi babo nokubhekana nezidingo zabo, bangehlisa imizwa yokukhathazeka kubafundi babo. Ekugcineni, kwahloselwa inhloso yekusasa elincishisiwe ukunciphisa ukukhuphuka okungafuneki kokukhathazeka kwabafundi abancane nentsha ukuze babe ngabantu abadala abaphumelelayo bakusasa.