MASTER'S THESIS

Department of Psychology

University of South Africa (UNISA)

Title: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.

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Abstract

Adolescent mental illness contributes significantly to both the global and South African burden of mental health. The aim of this study was to explore adolescent mental health literacy, coping strategies and their perceptions of mental health mechanisms that mitigate the psychosocial challenges they encounter. To achieve this aim, the relationship between psychosocial stressors, coping, and psychosocial support and intervention was studied using a cross-sectional survey, which was administered in schools located in the Western Cape, South Africa. The study population comprised of adolescents aged from 15 years up to and including 19 years. Due to Covid-19 restrictions and limited access to schools the study was pivoted to the online platform. The surveys were administered via the relevant school's online portals. Statistical tests were computed to explain the differences between groups and the relationship between variables. The intended contribution of this study was to add to the existing body of adolescent mental health literature and to create the impetus for further research pertaining to adolescent mental health literacy and mental health prevention and intervention for this cohort in the South African context.

Keywords: Adolescence; mental health literacy; stressors; coping; resources

Abstrak

Adolessente geestesgesondheid dra aansienlik by tot sowel die globale as Suid-Afrikaanse las van geestesgesondheid. Die doel van hierdie studie was om adolessente geestesgesondheid geletterdheid, hanterings strategieë en hul persepsies van geestesgesondheid meganismes wat die psigososiale uitdagings wat hulle ervaar, verminder, te verken. Om hierdie doel te bereik, is die verhouding tussen psigososiale stressors, hantering meganismes en psigososiale ondersteuning en intervensie, ondersoek, deur gebruik te maak van 'n dwarssnit opname wat in skole in die Wes-Kaap, Suid-Afrika, uitgevoer is. Die studie populasie het bestaan uit adolessente tussen die ouderdomme van 15 en insluitend 19 jariges. As gevolg van Covid-19-beperkings en beperkte toegang tot skole is die studie na die aanlyn platform omgeskakel. Die opnames is deur die betrokke skool se aanlyn platvorms geadministreer. Statistiese toetse is bereken om die verskille tussen groepe en die verhouding tussen veranderlikes, te verduidelik. Die intensie van hierdie studie was om by te dra tot die bestaande liggaam van literatuur oor adolessente geestesgesondheid en om die aansporing te skep vir verdere navorsing oor adolessente geestesgesondheid geletterdheid en geestesgesondheid voorkoming en -intervensie vir hierdie groep in die Suid-Afrikaanse konteks.

Sleutelwoorde: Adolessensie; geestesgesondheid geletterdheid; stressors; hantering; hulpbronne.

Abstract

Izigulo ezimayelana nengqondo kulutsha okanye kwabafikisayo zinegalelo elikhulu kwimpilo yengqondo emhlabeni jikelele naseMzantsi Afrika. Injongo yoluphando ibikukuphonononga ukufunda ngempilo yengqondo kwabobafikisa, iindlela zokumelana nezinto nemibono ngeendlela zempilo yengqondo ezinciphisa imiceli mngeni ngokwasengqondweni abathi bayifumane. Ukuze kuphunyezwe lenjongo, kujongwe ubudlelwane phakathi kwezoxinzelelo lwengqondo, ukumelana nezinto, inkxaso ngezengqondo neenqubo ziye zafundwa kusetyenziswa uphando icross-sectional, oluqhutywe kwizikolo eziseNtshona Koloni eMzantsi Afrika. Oluphando lwenziwe kwabobafikisayo abaminyaka elishumi elinantlanu ukuya kwiminyaka elishumi elinethoba. Ngenxa yemiqathango ye Covid-19 nobunzima bokufikelela ezikolweni, oluphando lwaye lwenziwa kumaqonga asemoyeni. Uphando lwaqhutywa kumaqonga asemoyeni ezikolweni (online portals). Uvavanyo lweStatistics lweenziwa ukucacisa umehluko phakathi kwamaqela nokubonisa ubudlelwane. Igalelo loluphando kukwandisa ulwazi malunga nempilo yengqondo kulutsha okanye kwabafikisayo nokudala umdla kuphando olumayelana nokuqonda impilo yengqondo kwabo bafikisayo, ukukuthintela nemingeni kwimpilo yengqondo kweliqela kumhlaba waseMzantsi Afrika.

Amagama angondoqo: Abafikisayo, ukuqonda impilo yengqondo, abacinezeli, ukumelana, izixhobo

Declaration

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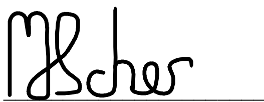
TITLE: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



30 January 2023

SIGNATURE **DATE**

Dedication

I acknowledge and dedicate this master's to my late parents Howard and Joyce Hart who have played such a vital role in my life and provided me with the foundations of resilience and resourcefulness I needed to fulfill my dreams in pursuit of my academic asperations. This master's dissertation is also dedicated to my husband, Philip, and to my children Dani, Josh and Tali who are staunch advocates of my endeavours and who have championed me throughout my studies and provide unwavering support, encouragement and technical assistance. Generous in their abundant and unconditional love for which I am eternally grateful.

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List Of Abbreviations

ALEQ – Adolescent Life-events Questionnaire	**MHL –** Mental Health Literacy
AHSQ – Actual Help-seeking Questionnaire	**MHLq** – Mental Health Literacy Questionnaire
ANOVA – Analysis of Variance	**POPIA –** Protection of Personal Information Act
AYFS – Adolescent Youth Friendly Services	**R-COPE –** Revised Coping Orientation to Problems Experienced
BASH-B – Brief Version of the BASH	**UNISA –** University of South Africa
CAMH – Child and Adolescent Mental Health	**WCED –** Western Cape Education Department
COVID-19 – Coronavirus disease of 2019	**WHO –** World Health Organisation
DoH – South African Department of Health	
GHSQ – General Help-seeking Questionnaire	
HIV – Human Immunodifficiency Virus	

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Chapter One

Introduction

1.1 Background

South Africa's mental health services are under-resourced and are characterised by the absence of guidelines for implementation of mental health policies, inadequate youth focus, and a curative rather than preventative orientation that seeks to promote mental health and well-being (Cooper et al., 2015). Mental health and illness in South African youth intersects with a number of societal stressors and social determinants of mental health, such as unemployment, peer pressure, unsupportive parenting and community resources, substance abuse, poverty and violence (Tomlinson et al., 2022). Adolescents aged 10-–19 years constitute 23% of sub-Saharan Africa's population and 18.5% of the total population in South Africa (Jonas et al., 2019). Investing in adolescent health and well-being has long-term overall health benefits and, in the context of this study, has implications for adolescent mental health and well-being for generations to come (Jonas et al., 2019). This calls for an approach that addresses reporting, interpersonal, social, and economic factors within an integrative and multidimensional framework that seeks to promote both the physical and mental health well-being of our youth (Cooper et al., 2015).

Mental health concerns in young people between the ages of 10 and 19 years of age account for 16% of the global burden of mental health (World Health Organization [WHO], 2021). These include health difficulties across the mental health spectrum and the varying extent to which they manifest as mental and behavioural impairment (Mansfield et al., 2020). Notwithstanding global and local endeavours in preventative and remedial efforts, the scope of mental health problems in adolescents is pervasive. Suicide accounts for one-third of deaths in adolescents aged 15-19, and in 2016 approximately 62 000 adolescents lost their

lives due to self-harm (WHO, 2021; WHO, 2022). Globally, between 10% and 20% of children and adolescents who suffer from a mental disorder are not diagnosed, nor receive appropriate intervention or treatment (Paruk & Karim, 2016; WHO, 2021; WHO, 2022).

Adolescents commonly adjust well to the significant psychosocial and biological changes that occur during this life phase. Maladjustment, while not perceived as pervasive, is manifest as a result of multifactorial determinants that intersect within the primary care-giving and socio-cultural context (Louw & Louw, 2014). Contextual stressors include family and peer relations and conflict, academic pressure, poverty, and violence (WHO, 2021; WHO, 2022). Maladaptive responses to those stressors have the propensity to develop into, and manifest, as pathology (Geldard et al., 2016). Depression, anxiety, self-harm, suicidal ideation, attempted suicide and completed suicide, eating disorders and post-traumatic stress disorders are among the most prevalent mental health concerns for adolescents, in the global context (Fuller, 2014). In addition, globally, substance abuse and mental health disorders are a significant cause of disability in children and adolescents and consequently contribute to the global burden of disease in these cohorts (Erskine et al., 2015; Sorsdahl et al., 2021). In the South African context, whilst the burden of adolescent mental health is unkown, Kleintjies et al. (2007, as cited in Baranne et al., 2018) suggest the prevalence of mental disorders in the adolescent cohort in South Africa constitutes 17%. This includes the following mental health disorders: generalised anxiety disorder (GAD), posttraumatic stress disorder (PTSD), major depressive disorder/dysthymia, oppositional defiant disorder (ODD) and attention deficit/hyperactivity disorder (ADD/ADHD), which are considered the primary diagnosed mental health concerns in the adolescent cohort (Mokitimi, et al., 2019). Exposure to contextual stressors and navigating developmental tasks in adolescence have a profound impact on adolescent development in all domains and account for psychological health and physical health and well-being across the lifespan (WHO, 2021). This includes the increased

occurrence of depressive spectrum disorders and an increased risk of adolescent suicide (Wenar & Kerrig, n.d.).

The departure point of the present research project aligns with the WHO's (2022) conceptualisation of mental health which encompasses optimal and productive functioning, coping with everyday stresses and overall well-being (WHO, 2022). Every member of society has the fundamental right to mental health and the structures that support their overall well-being, all of which impact on the individual and society (WHO, 2022). Furthermore, this paper rests on the premise that mental health literacy, that is, one's knowledge and understanding of mental health and illness (Jorm, 1997), together with perceptions and attitudes of what constitutes mental health and illness, are motivators for adolescents seeking out emotional support and predictors of both self-help strategies and help-seeking behaviours (Kutcher et al., 2016). It is relevant to note that adolescents' perceived stigma regarding mental illness, together with inadequate mental health literacy (MHL), and community resources, are considered barriers to accessing mental health care for young people (Babatunde et al., 2021). Klik et al. (2018), propose that self-stigma, which refers to the internalised notion of mental health, which is associated with shame (Clement, et al., 2014) and incorporated into an individuals self-concept, results in negative thoughts, feelings and attidues associated with mental illness, and consequently disrupts accessing mental health support services (Klik et al., 2018) and leads to a reduction in help-seeking behaviours (Clement et al., 2014). Furthermore, stigma related to treatment for mental health and gender stereotyped stigma are associated with barriers to help-seeking behaviours (Clement, et al., 2014). In addition, the availability of certain coping resources has been identified as mitigating factors to alleviate the detrimental consequences of stress among adolescents (Modecki et al., 2017). More specifically, the present research presupposes that mental health support services – aimed specifically at adolescents – exist and are available and accessible to

young people. It further contends that help-seeking behaviours are adaptive mechanisms and the ability of adolescents to recognise and leverage their strengths and skills and tap into resources, has a bearing on their conceptualisations of what constitutes stressors, what impacts their ability to cope and what facilitates their ability to thrive (Louw & Louw, 2014).

The development of a personal identity that serves as a blueprint to behaviour and incorporates one's values, beliefs, and morals as the standard against which one holds oneself personally accountable is of particular importance during adolescence (Havighurst, 1972, as cited in Dolgin, 2014). Adolescents whose socio-cultural context encourages the exploration and constant re-evaluation of one's identity, are more inclined to successfully navigate the developmental task of identity achievement (Kail et al., 2019). Developing an identity that is congruent with their personal values and beliefs is determined by the intersection between personal and socio-cultural factors (Kail et al., 2019). The pursuit of achieving psychological independence, autonomy, and self-regulation, implies acquiring the ability to function independently, be self-governing and develop a repertoire of both behavioural and emotional responses to the demands of their environments (Hardman, 2016). Inherent in this is the capacity and the motivation to access emotional support and mental health support structures as an adaptive response to the stressors that adolescents face.

South Africa's reforms of the Mental Health Care Act (2002) and the National Mental Health Policy Framework and Strategic Plan (2013-2020) aim to provide integrated health care services that are accessible, equitable and comprehensive, particularly as it pertains to community-based mental health care (The South African Department of Health [DoH], 2012). Notwithstanding, South Africa's mental health services remain under-resourced (De Lannoy et al., 2015). Only one out of ten people suffering from mental illness receive the care that they need. To a large extent, South Africa's mental health system is more reactionary and curative than being focused on the promotion of mental health and the

prevention of mental health disorders (Flisher et al., 2012; Patel et al., 2007). Kleintjies et al. (2006) estimated that up to 17% of children and adolescents in the Western Cape would be affected by a diagnosable, albeit treatable, mental disorder. In a study conducted by Mokitimi et al. (2022) it was revealed that less than 10% of children and adolescents in the Western Cape, who require both diagnosis and treatment, ever actually receive it. The cycle of poor mental health outcomes impacts overall functioning, which includes but is not limited to, poor school performance, family functioning, financial instability, poverty and crime (Tomlinson et al., 2022). Hence early intervention, treatment and prevention of childhood and adolescent mental health disorders is critical to both short and long-term outcomes for these cohorts, their families and society (Tomlinson et al., 2022).

The lack of service delivery and implementation of broad-based mental health strategies leaves both those suffering from and in need of mental health care, and the health care system itself, in crisis. Parental behaviours significantly impact adolescents' development and their propensity to be autonomous (Louw & Louw, 2014); as such the efficacy of mental health services is mediated by parental support. If parental attitudes towards psychological support are perceived as positive and the nature of the parenting style (authoritative) – one in which the bonds of attachment provide a secure base from which adolescents can navigate their developmental tasks and the demands of society – then a relationship can be assumed between positive parental mental health literacy and attitudes about mental health services, help-seeking behaviours and mental health outcomes in their adolescent children (Louw & Louw, 2014).

The healthy navigation and successful outcomes of adolescents' developmental tasks to attain independence and be productive adults is facilitated by adolescents' resourcefulness, seeking out the support they need, viewing this in the context of attaining independence, and

making appropriate and autonomous decisions (De Lannoy et al., 2015). Furthermore, adolescents' healthy development is underpinned by a myriad protective factors such as family, personal and community characteristics that enable and strengthen coping and resilience (Louw & Louw, 2014). Socio-cultural factors, together with parental attachment, influence education, self-esteem, resilience, and the interacting patterns between parents and children. These factors are linked to positive outcomes of mental health support and interventions and adolescent psychological well-being (Louw & Louw, 2016). Lifelong outcomes to health and mental health are strongly correlated to the adolescent's lived experience (De Lannoy et al., 2015). The preceding overview provides the backdrop for this study which seeks to explore adolescents' perceptions of mental health and illness, the stressors that they face and the coping strategies and resources they use to mitigate these stressors which are reflective of and meeting their developmental needs.

1.2 Description of the Study Problem

The South African Department of Health's National Adolescent and Youth Health Policy (DoH, 2017) focuses on promoting and supporting young people's health and well-being to facilitate the identification and management of risk factors and to develop and enhance young people's resilience (DoH, 2017). The policy also provides for Adolescent and Youth Friendly Services (AYFS), in partnership with the Integrated School Health Programme, through the implementation of interventions to promote health and well-being in childhood to benefit future development. However, current literature fails to produce evidence of the usefulness of these policies, their implementation, and the perceptions that adolescents have of the availability and accessibility of these services. In addition, the literature does not adequately address adolescent mental health literacy, nor does it identify the factors that influence and facilitate adolescent health-seeking behaviours which mitigate

psycho-social stressors that they face in accessing mental health services. The concept of health-seeking behaviours is a generic term that refers to behaviours related to all aspects of health and well-being. Whereas, the term help-seeking, in the context of this paper, aligns with the specific measures used in this study to address this component of the study as it pertains to behaviours related to addressing and mitigating mental health concerns in the adolescent cohort. The focus population of the study is school-going adolescents, rather than those that do not attend school or those who, while they fall within the age-parameters as delineated in this study, attend tertiary institutions. Seeking to understand what the stressors are that adolescents face, and what coping strategies and resources they use to mitigate these stressors, being one of the primary aims of the current study, can serve as the basis for early intervention and understanding the multifactorial aetiology of mental illness in adolescence which ultimately determines the trajectory of child and adolescent health and mental health (Shung-King et al. (eds), 2019).

1.3 Research Aims, Objectives and Research Questions

In light of the study problem delineated above, this study aims to explore adolescent mental health literacy, coping strategies, and adolescent perceptions of mental health mechanisms that mitigate the psychosocial challenges they encounter. The aim of the study will be actualised by the following objectives:

- To explore adolescent mental health literacy.
- To explore the challenges faced by adolescents in both personal and socio-cultural contexts.
- To explore the coping strategies used by adolescents to cope with their challenges.
- To explore adolescents' perceptions of internal and external resources they use to mitigate these challenges.

- To assess whether there are significant differences between adolescent mental health literacy, stressors, coping strategies, perceptions of resources, and barriers to help-seeking behaviours in terms of gender, age, population group,, grade, and type of school attended.

The following questions underpin the research objectives:

- How is mental health literacy conceptualised by adolescents in the Western Cape?
- What are the dominant challenges that adolescents face in their socio-cultural contexts?
- What are their perceptions of the availability and access to external resources in their socio-cultural contexts?
- What internal and external resources do they use to mitigate these challenges ?
- Are there significant differences between adolescent mental health literacy, stressors, coping strategies, perceptions of resources, and barriers to help-seeking behaviours in terms of gender, age, population group,, grade, and type of school attended?

Psychiatric disorders in adolescents are common and often pose many clinical challenges with regard to assessment and treatment. Mental illness in adolescents is associated with significant short- and long-term morbidity. There is, therefore, an urgent need to increase awareness, and improve screening, detection and treatment of mental illness in this vulnerable group. An integrated healthcare system that provides medical and mental healthcare at primary and secondary level is critical to address the mental healthcare gap in adolescent services.

1.4 Significance of the Study

The above discussion elucidates the primary focus of this study and the literature that is drawn upon supports the premise on which it is based. What is evidenced in the literature is that adolescent mental health care in general, and in South Africa in particular, has been largely left unattended. In a South African study conducted by Mokitimi et al. (2019), the findings by senior stakeholders, affirm the urgent need to strengthen child and adolescent mental health services. The results that emerged from this study reinforce the perception of the pervasive neglect of Child and Adolescent Mental Health (CAMH) services in South Africa (Mokitimi et al., 2019). These findings evidence the imperative to strengthen and improve CAMH services in terms of training, research, advocacy and service delivery (Mokitimi et al., 2019). Hence, the significance of this study lies in addressing the resultant gap in adolescent mental health care services; concerns around the perceptions that adolescents have of the value of these services; the accessibility of these services; and the nature of adolescent coping strategies and resources they consider as supportive when navigating psycho-social stressors. This highlights the need for advocacy pertaining to systemic implementation of adolescent-friendly counselling resources that are accessible both geographically and financially. It speaks to the necessity to educate young people (and their families), both in schools and at community level, regarding the value of counselling and psycho-emotional support; the role that it can play in mental health; and the impact of this in terms of mental health and well-being in the long term. This addresses the concerns related to the burden of disease that adolescent mental illness presents in all developmental domains, including the risks of suicide, violence, teenage pregnancy, substance abuse, the risk of poor academic achievement and the development of psychopathology in adulthood (Paruk & Karim, 2016).

The significance of the study also lies in uncovering the stigma that is attached to mental illness and how this is perceived by this cohort, within communities in South Africa in general, and in the Western Cape in particular. The author contends that changes in perceptions underpin this study and proposes, in line with research that has emerged in the literature, an integrative approach to adolescent mental health and well-being and a bottom-up perspective; rather than a top-down one. This requires an understanding of what it is that the youth themselves perceive they need to address their mental health concerns. In addition, understanding the youth's knowledge and perceptions of mental illness versus mental health and what resources they feel would benefit them both in the short and the long term is important for addressing mental health challenges among this cohort. Addressing these concerns from a life-span development perspective (Kail & Cavanaugh, 2016), also has the potential to ensure the most positive outcomes for adolescents' long term mental health and well-being.

The significance of this study, therefore, addresses both individual and systemic concerns about adolescent mental health care delivery and provides the foundation as to determining how best this may be addressed systemically through an integrative, bottom-up approach.

1.5 Summary and Organisation of Thesis

Chapter 1 of this study consists of the introduction which delineates a framework for the overall premise on which this study is based. It includes background information on the current global and South African status of adolescent mental health, intervention, and the apparent absence and lack of implementation and accessibility of mental health services to adolescents. Furthermore, the salient issues pertaining to the problems that this study aims to address are delineated. This includes statistics highlighting the nature and extent of mental

illness among adolescents worldwide, and in South Africa. In addition, the factors that underpin this study were highlighted and these included: the role that psycho-social factors and stressors that adolescents face play, and the significance of support in all its guises to mitigate the impact of these factors. Finally, the aims and objectives of the study are discussed followed by the significance of the study, which concludes this chapter.

Chapter 2 provides a comprehensive review of current and existing literature to support the premise on which this study is based and to address the aims and objectives of the study and, thus, give credence for the impetus of this endeavour. This includes adolescent mental health literacy, psychosocial stressors and coping strategies and resources. A section on the theoretical framework that underpins this study will be included to provide context for the overarching discussion of the contextual nature of the factors at play as they pertain to mental health and wellness among adolescents, both globally and in particular in the South African context.

Chapter 3 provides an account of the methodological approach to the study. The chapter commences with the research approach and design that underpin this study followed by the study setting, population and sampling. Next the data collection instruments, procedure, and the various types of data analyses used in this study are described. Ethical considerations, followed by the conclusion bring this chapter to a close.

Chapter 4 presents the results in relation to the findings, according to the research aims and key objectives as delineated in chapter one. Participants' demographic information is presented first, followed by the results of more robust analysis methods.

This study concludes with chapter 5 which provides a comprehensive discussion of the results of the study. In addition, it includes insights into the limitations of the study and

proposes recommendations for further study and exploration of this topic. This is followed by the conclusion which will bring this study to a close.

Chapter Two

Literature Review

2.1 Introduction

The previous chapter sketched the framework for this study by providing the background to the problem and the aims and objectives this study intends to address. This includes highlighting the question regarding adolescent mental health literacy and the coping strategies and resources adolescents use to mitigate the psycho-social stressors that they face. In support of the premise on which the present research is based, this chapter presents a comprehensive overview of the pertinent literature on current trends regarding adolescent mental health literacy, the factors that impact adolescent mental health, those that mitigate as well as those that facilitate or hinder adolescent help-seeking behaviours.

The literature review consists of a number of sub-sections that address the underpinnings of this study. It begins with a discussion on the adolescent phase of development and incorporates an overview of past and current research on adolescent development as well as mental health during this phase of development. Furthermore, it explores adolescent mental health policies and their implementation in the South African context. The sub-section that follows identifies psycho-social stressors and risk factors that adolescents face, both globally and in the South African context in particular. This includes poverty, unemployment, violence and crime, HIV, family and peer relationships and conflict and education concerns. The sub-section that follows addresses prevention and intervention and includes a discussion on youth mental health resources, treatment, and early intervention.

This is followed by a discussion on mental health literacy and all that it encompasses and covers topics such as knowledge and awareness of intervention services, resources and support structures related to adolescent mental health and illness as well as the implications it has on positive health outcomes. The following section focuses on factors that promote adolescent help-seeking behaviours which is closely allied to the next section which addresses coping strategies, followed by a section addressing resources and support structures. The discussion explores factors that promote adolescent help-seeking behaviours and coping strategies and highlights the resources that mitigate the stressors that adolescents face in the context of the barriers and facilitators to access these resources. This literature review concludes with a section focusing on adaptive coping which is one of the fundamental underpinnings of adolescent mental health literacy.

2.2 Adolescent Phase of Development

The life-span approach to development (Kail & Cavanaugh, 2016) espouses that to understand an individual's development at a particular stage, and to project the nature of development in all domains that might follow, it is necessary to understand the contextual determinants that preceded it. This perspective aligns with the nature versus nurture debate, which proposes that both biological and environmental factors influence and determine the trajectory of an individual's development, behaviour and responses in context (Louw & Louw, 2014).

Adolescents account for the largest global cohort. The World Health Organization (WHO), delineates this stage of development as ranging from ages 10 to 19 years (WHO, n.d.). This developmental stage is typically demarcated by the onset of puberty, referred to as early adolescence, through to late adolescence, which ranges from 18-21 years (Hardman, 2012). Its conceptualisation and understanding are socio-culturally constructed and

determined by the intersection of individual, biological and socio-cultural factors (Louw & Louw, 2014). In South Africa, 18 years is considered to delineate emerging adulthood, whereas in the United States, for example, 21 is considered the legal age of adulthood. Development during this stage occurs in all domains, including psycho-socially, and is marked by dramatic physical and cognitive growth and development (Louw & Louw, 2014). Adolescent developmental tasks entail the acquisition of "skills, knowledge, functions and attitudes" (Dolgin, 2014, p. 55). These tasks, according to Havighurst (1972, as cited in Dolgin, 2014), include (but are not limited to) the achievement of an identity, acceptance of a sex role and one's body, developing mature peer relations, acquiring a moral code of socially acceptable behaviour, achieving economic independence, and attaining psychological and emotional independence and autonomy (Dolgin, 2014).

Adolescent development and well-being are significantly influenced by the nature of the socio-cultural context and the lens through which adolescents are viewed, coupled with the expectations and opportunities society provides that align with their developmental tasks (Hardman, 2016). Adolescence is fraught with a multitude of changes and challenges in all developmental domains (Geldard et al., 2016). A young person's inability to confront these changes and challenges adaptively can lead to negative psycho-emotional and behavioural consequences (Geldard et al., 2016). Research supports the notion that mental health disorders can have their origin in childhood and adolescence (Paruk & Karim, 2016).

As argued by Tomlinson (2022), rather than merely being restricted to the mind, mental health is influenced by relationships, events in the child's life, and the environment in which that child grows up. Thus, it is important to regard mental health on a continuum, which includes considering the continually present "risk and protective factors at play –

where protective factors promote children's mental health, well-being and resilience, and risk factors intensify mental distress and increase the chances of children developing a mental disorder (Tomlinson et al., 2022, p. 28)".

2.3 Mental Health During Adolescence

The multifactorial determinants of mental health and illness which can either be protective or increase one's risk of developing mental illness underpin the National Mental Health Policy Framework and Strategic Plan 2013-2020 (DoH, 2012).

While adolescence is universally considered to be a healthy stage of development, the literature attests to the fact that 35% of the global burden of disease has its origins in adolescence (Jonas et al., 2019). Furthermore, adolescent mental health illness and injury accounts for 16% of this global burden of disease. Estimates indicate that of the 16%, 10-20% of adolescents who suffer from mental health conditions are underdiagnosed and undertreated (Jonas et al., 2019).

The successful transition from childhood to adulthood is dependent upon adaptive responses to the changes and challenges that the adolescent developmental stage presents (Geldard et al., 2016). For some adolescents, the bio-psychosocial and cognitive challenges are navigated with relative ease within a supportive parental and social context, while for others these challenges may be overwhelming and precipitate a crisis. Early childhood experiences, together with individual factors and environmental stressors, contribute to the individual's capacity to cope (Geldard et al., 2016). Related factors such as faulty early attachment, unsupportive parental relationships, genetic predisposition, education, and exposure to trauma negatively impact on the young person's ability to respond to the adolescent developmental tasks adaptively; impact the healthy transition to adulthood; and can result in the development of mental health problems (Geldard et al., 2016). Anxiety,

mood disorders and depression are deemed the most common mental health disorders manifest in adolescents and can have their origins in childhood whereby symptomology is present as early as at the age of six years (Baggerly, 2018). Their emergence can be attributed to the advent of puberty being experienced as overwhelming, or because of low self-esteem and related concerns, substance abuse, and peer rejection, among others (Hardman, 2016).

The Child and Adolescent Mental Health Policy (DoH, 2017) exists as an integrated framework to guide the establishment of childhood and adolescent mental health services in South Africa. The National Child and Adolescent Mental Health Policy Framework of 2003 is intersectoral in its approach and includes the health sector in general and families of children and adolescents (DoH, nd; Mokotimi et al., 2018). In addition, it has a life-span and integrative approach to early intervention and focuses on cultivating strength and resilience in adolescents and their families (Shung-King et al., 2019). It is important to note that the National Mental Health Policy Framework and Strategic Plan 2013-2020 has incorporated the Child and Adolescent Mental Health Policy (DoH, 2012). This highlights the need for multi-sectorial action and an intersectoral intervention approach (Shung-King et al., 2019). In addition, it highlights strengthening an early intervention approach through education and mental health literacy training as a means of preventing the long-term impact of exposure to environmental stressors such as domestic violence and alcohol- and drug-related stressors that adolescents face in the South African context. Notwithstanding the fact that it is deemed age-appropriate and progressive, it has failed to gain traction in the absence of funding and multi-sectorial collaborative efforts regarding implementation (Shung-King et al., 2019). This begs the question of leadership and governance regarding the training of health-care workers, specifically for this age group, and requires the strengthening and implementation of adolescent-specific policies that meet the unique needs of this cohort (Shung-King et al., 2019).

In line with the above, it is useful to note that anxiety and depression are considered to be the most debilitating and pervasive mental health disorders in adolescence, often manifesting as co-morbidities, the aetiology of which is bio-psychosocial in nature (Hardman, 2012). However, despite the pervasive nature of these disorders in this cohort, they often go undiagnosed or even misdiagnosed, resulting in approximately 64% of teens not receiving treatment (Baggerly, 2018). Untreated teen anxiety and/or depression carries the risk of suicide and can negatively impact academic performance, social interaction, and lead to substance abuse and delinquent behaviour (Baggerly, 2018). Poor mental health literacy, lack of awareness of available mental health services together with the associated stigma and inadequate mental health resources account for the high percentage of adolescents who go untreated (Baggerly, 2018). Whilst a number of different types of stigma prevail, stigma is largely associated with stereotyping and discrimination and impacts both the individuals' views of their own mental illness (internalised stigma) and perceived stigma of others' attitudes, beliefs and behaviours towards those who are mentally ill together with stigma associated with those seeking mental health treatment and support (Clement et al., 2014). This begs the question of viewing stigma through a broader systemic lens, insofar as stigma intersects with racism, and gender stereotypes to exacerbate the stigma associated with help-seeking and thus result in barriers to help-seeking behaviours (Clement et al., 2014). This calls for a systemic review of mental health services which addresses both mental health literacy and mental health interventions aimed specifically at the adolescent cohort. Thus, it will ensure that the mental health interventions for this cohort adequately serve their unique developmental needs and address the psycho-social stressors and factors that are specific to this cohort. A literature review relating to these factors follows.

2.4 Psycho-Social Stressors and Risk Factors

A plethora of literature attests to the fact that the developmental phase of adolescents is accompanied by major life changes and an increase in the frequency of the occurrence of stressful life events (Camara et al., 2017). What remains unclear, however, is which factors constitute the main sources of stress, albeit that academic pressures, parental, intimate and peer relationships, together with financial pressure and uncertainty around the future remain at the centre of this debate (Camara et al., 2017). Mental health in general, and in adolescence in particular, pivots around the ability to respond and cope with negative events in ways that would be deemed appropriate and healthy (Tomlinson et al., 2022).

Psychosocial stressors, among others, are considered as risk factors for developing mental illness during adolescence (Paruk & Karim, 2016). These include anxiety, mood disorders and both stress and trauma-related disorders, which are highly correlated to the risk of teenage suicide (Paruk & Karim, 2016). In the South African context, adolescents are confronted with poverty, exposure to pervasive crime and violence, education concerns, unemployment and living in a country in which HIV remains a threat to public health, particularly in the adolescent cohort who continue to exhibit high infection rates (Shung-King et al., 2019). Socio-economic inequity and contextual adversity that pervade South African society and that of other developing countries, exacerbate the risk of developing mental health problems in this cohort. Furthermore, these adverse contextual factors are considered determinants, particularly for adolescents deemed to be at risk and hence vulnerable to developing mental health disorders (Louw & Louw, 2014).

Family, work, education, peer relationships, socio-economic and employment factors and the associated pressures, conflict, demands and expectations that emerge in these contexts are among the most significant challenges that adolescents may perceive as

the cause of stress (Geldard et al., 2016). Furthermore, family and peer relations can be supportive and protective as well as a source of interpersonal distress for adolescents and hence construed as potential risk factors (Camara et al., 2017). In addition, gangs, sexuality, risk-taking behaviours, body image, substance experimentation and abuse, managing perceived parental and peer influence and the tension between the dependence and protection of the primary caregiving context versus the need for independence and autonomy and navigating unfamiliar situations are all factors deemed to be challenges that young people face (Geldard et al., 2016).

In the South African context, adolescents' lives are fraught with a multitude of stressors as highlighted above. In addition, this phase of development requires adolescents to successfully navigate and achieve a number of developmental tasks (Dolgin, 2014), such as forming an identity and achieving independence and autonomy (Louw & Louw, 2014). Mastery of these developmental tasks and managing and coping with the psycho-social stressors adolescents face is mediated by the socio-cultural context which facilitates or confounds adaptive adjustment on the journey to adulthood (Geldard et al., 2016).

The literature consistently affirms that adolescents perceive interpersonal conflict as a primary source of distress. Context determines the nature of stress in the social domain and the stress that accompanies parental conflict associated with school performance, finances, and unemployment (Camara et al., 2017). Adolescents' context determines the nature of the source of support, be it protective, supportive or a stressor. Hence, adolescents' historical and cultural psycho-social responses to stress must be considered against their socio-cultural context and the pervading adolescent narratives (Camara et al., 2017).

Specific skills and principles need to be applied when working with this cohort, which differs significantly from those required when working with children and adults (Geldard et

al., 2016). The efficacy of age-appropriate interventions that are synchronous with the developmental needs of this cohort and their perceptions of what the stressors are that they grapple with, rests on this premise. This would include an understanding of the importance of both the stakeholders and the systems that impact and mediate adolescent development in all domains. What follows is a discussion delineating factors that are construed as preventative as well as highlighting resources for intervention.

2.5 Prevention and Intervention

Poor mental health correlates strongly with poor developmental outcomes for adolescents (Cooper et al., 2015). This includes the propensity for, and exposure to, violence and substance abuse and poor sexual health and educational outcomes. Poverty and mental illness strongly intersect, and a variety of societal factors are considered predisposing for vulnerable youth to develop mental illness (Cooper et al., 2015). Enhancing youth mental health impacts overall well-being and is a predictor to alleviating poverty and the burden of disease in adulthood (Cooper et al., 2015). Research indicates the necessity to explore mental health determinants in young people and implement both intervention and evaluation resources to provide for both the adequate treatment, and prevention of, mental health concerns in young people (Cooper et al., 2015).

The National Mental Health Policy Framework and Strategic Plan 2013-2020 (DoH, 2012) recognises the necessity of early intervention and prevention to address mental health in both children and adolescents. This includes recognising the crucial role of parents in transmitting values and beliefs, providing psycho-emotional support and the fundamentals of mental health literacy, as well as the crucial role of facilitating the development of autonomy, independence, and identity formation. Furthermore, the integrative approach recognises the

role of counsellors in providing support and knowledge to this cohort of the effective use of coping strategies and mechanisms to manage their stressors (DoH, 2017).

The present research supports the notion of early intervention and the multifactorial aetiology of mental illness in adolescence, which is reflective of the tension between the psychosocial factors that aggravate, such as, abuse, substance abuse, family discord and violence, death and crime versus mitigating protective factors such as the quality of parental, attachment, relationships and psycho-social support. The South African Department of Health's National Adolescent and Youth Health Policy (2017) seeks to provide Adolescent and Youth Friendly Services (AYFS) under the auspices of the Integrated School Health Programme. The focus is on promoting and supporting young people's health and well-being and the development of their resilience in pursuit of identifying and managing risks and supporting their future development (DoH, 2017).

2.6 Mental-health Literacy in Adolescence

Mental health literacy (MHL) refers to the knowledge one has about specific mental disorders, their causes, and the risk factors associated with specific mental disorders (Jorm, 1997 as cited in Dias et al., 2018; O'Connor et al., 2014). Knowledge about mental health includes awareness of what professional intervention services are available and understanding what factors promote help-seeking behaviours and those that serve to enhance personal mental health and well-being and the management thereof (Dias et al., 2018; O'Connor et al., 2014). In addition, positive mental health literacy implies having knowledge of first-aid skills and hence the ability to support others who might present with mental health concerns. Furthermore, it is allied to one's attitude about mental health and illness and is therefore a determining factor in help-seeking behaviours, on the one hand, and resistance to or barriers to help-seeking behaviours on the other (Dias et al., 2018). Jorm (1997 as cited in Campos et

al., 2016, p.62) defines mental health literacy as follows: "knowledge and beliefs about mental disorders which aid their recognition, management or prevention".

The concept of MHL has become more nuanced and it incorporates one's knowledge of different disorders (mental), risk factors associated with these mental disorders, what constitutes useful strategies to promote personal mental health and well-being, and attitudes and beliefs pertaining to the promotion of knowledge and help-seeking behaviours (Jorm, 2000). Concomitant to knowledge and beliefs is the related barriers to help-seeking and hence early intervention associated with perceived stigma relating to mental illness (Jorm, 2000). MHL assessment (in general), and in particular with the adolescent cohort, is a means of gauging individual knowledge gaps and beliefs about mental health and illness. It is also a valuable mechanism for informing mental health interventions with a view to promoting mental health literacy leading to positive mental health attitudes and behaviours (Jorm, 2000). This approach is of particular importance for the adolescent cohort as research supports adolescents' propensity to manage their own problems rather than seek professional help for psycho-emotional problems (Jorm et al., 2006; Sylwestrzak et al., 2015). Adolescent attitudes about mental health and illness are closely associated with help-seeking intentions, and mental health literacy correlates positively with help-seeking behaviours.

Adolescence is deemed a critical transition developmental phase to enhance MHL and to promote knowledge relating to access to mental health services (Mansfield et al., 2020). Personal knowledge and one's attitudes and beliefs underpin the factors that enhance one's ability to recognise, manage and prevent mental illness and therefore contribute to MHL and concomitant, positive health-seeking behaviours (Korhonen et al., 2019).

MHL is considered a prerequisite for early recognition and intervention in mental disorders, and for this reason, it has become a focus of research over the past few decades

(Dias et al., 2018). Assessing this construct is relevant for identifying knowledge gaps, erroneous or harmful beliefs and stigma associated with mental health issues, and thus informing the development of early interventions aimed at promoting mental health literacy as well as the evaluation of these interventions (Dias et al., 2018).

Concomitant to this, is service delivery itself, the quality of these services and the provision of interventions to increase the demand for specialised adolescent health care services (Tomlinson et al., 2022). In addition to adolescents' MHL, their motivation to seek out and utilise mental health services rests on a number of factors. These include their knowledge and understanding of the presence and availability of these services and the nature of what these services entail. In addition, perceived community support of these services and the value ascribed to these services (at community level), together with developing knowledge and skills at societal level create a society that is mental-health literate. Consequently, it develops a culture of prevention and intervention due to the impact this would have on adolescents' help-seeking behaviours (Jorm, 2000; Jorm 2011).

2.7 Help-seeking Behaviour During Adolescence

In a study conducted by Camara et al. (2017), the act of seeking out help emerged as an adaptive coping strategy in the face of stressful events for adolescents, particularly when construed as purposeful and positive support that meets their emotional or psychological needs. Furthermore, the study revealed that adolescents perceive emotional support as appropriate or effective when the source of support is familiar (family or friends) . As such, informal sources of support are sought out to address mental health concerns, rather than professional sources (Camara et al., 2017). Highet et al. (2002, as cited in Camara et al., 2017) posit that an adolescent's choice to disclose to an informal source of support versus a

professional one is determined by a number of factors. Of these, age and/or maturity is an important criterion. However, trust, opportunity, and the quality of the relationship (be it with family or friends) together with their availability, accessibility, and shared personal history are significant considerations (Highet et al., 2002, as cited in Camara et al., 2017).

Poor mental health literacy about disorders that occur in childhood and adolescence, inadequate resources, and the stigma associated with mental illness constitute significant barriers to accessing mental health services (Korhonen et al., 2019). Research indicates that despite the prevalence of mental disorders in adolescence, children and adolescents do not actively display mental health-seeking behaviours (Radez et al., 2019). Both internal and external factors are perceived as barriers and/or facilitators of adolescents' mental health-seeking behaviours. Individual factors include limitations in MHL and perceptions of what constitutes help-seeking, while social factors which align with the adolescent's developmental stage include, embarrassment associated with perceived stigma of mental illness (Radez et al., 2019). The effects of social stigma and related stereotyping and discrimination exacerbate barriers to help-seeking and can have a devastating impact on those suffering with mental illness as it can lead to difficulties integrating into society and hence social isolation, low self-esteem, discord in relationships and depression (Egbe et al., 2014). This is of particular relevance given that self-esteem declines during the adolescent stage of development and the prevalence of depression that is manifest in the adolescent cohort as supported by the literature above.

An Australian study explored the developmental changes relating to the social influences of health-seeking behaviours during adolescence (Rickwood et al., 2015). This study supports the notion that adolescence is a developmental period associated with vulnerability to developing mental health problems, and despite the apparent need to access

mental health services, young people are generally reluctant to seek out professional mental health services (Rickwood et al., 2015). Participants identified the inability to recognise symptomology, their desire to be self-reliant, and embarrassment related to the stigma associated with mental illness as factors that inhibit health-seeking behaviours (Rickwood et al., 2015). Other studies revealed that less than half of adolescents with mental health concerns receive the help that they need. In the United Kingdom, in particular, only 60% of adolescents who suffer from mental illness receive specialist intervention (Hassett et al., 2018).

Adolescents value emotional support that aligns with their needs and seek out support that is characterised by trust, familiarity, and friendliness (Camara et al., 2017). Factors that influence and determine whether young people access mental health services include, but are not limited to, financial constraints, availability and accessibility of services, parental attitudes together with adolescents' perceptions of the nature of the therapeutic relationship, trust and confidentiality (Radez et al., 2019). Early detection and psycho-education lie at the heart of these findings. Its relevance to the South African context pertains to the implementation of programmes aimed at facilitating positive societal attitudes towards mental health, reducing associated stigma and improving MHL among all its citizens, particularly in the adolescent cohort. This would include knowledge of mental health itself, what professional services entail, the nature of the therapeutic relationship and associated ethical best practices relating to the adolescent cohort. The need to address the disparity between the under-utilisation of services and the prevalence of mental health disorders in young people (Radez et al., 2019) to mitigate the negative, long-term impact of youth mental health problems, and the concomitant socio-economic burden this creates, demands an approach that is reliant on early detection, and the availability and accessibility of youth-friendly mental

health services, as espoused by the CAMH policy under the auspices of the South African Department of Health (DoH, 2017).

2.8 Coping Strategies

Interpersonal relationships are invaluable resources for adolescents to cope, and while protective on the one hand, it may be construed as a stressor on the other (Camara et al., 2017). Health choices are determined in the context of relationships (e.g., families, communities, etc.) and are influenced by a multitude of contextual factors (e.g., socio-economic status, norms, beliefs, government policies, etc.) that may either promote health-seeking behaviours or restrict access to health services (Mokotimi et al., 2019). Adolescent development must be considered in relation to the challenges that occur in the following domains: biological, cognitive, psychological, social, moral, and spiritual (Geldard et al., 2016). It must also be weighed against the personal (internal) and contextual (external) mechanisms that contribute to mitigating these challenges and help to facilitate adaptive responses to these psycho-social challenges (Geldard et al., 2016). Bronfenbrenner's Ecological Systems Theory speaks to the interaction between, and reciprocity of all systems on each other. Implicit in this is the influence of the larger systems on the individual and the family system (Louw & Louw, 2014; Geldard, et al., 2016). The present study acknowledges the family and primary care-giving context as being both supportive of, or a determinant of, mental health and/or illness in (childhood and) adolescents. The socio-cultural systems, in which the family is embedded, provide additional resources and mechanisms of psycho-social support which can directly or indirectly impact on the individual and the family (Kail et al., 2019).

2.9 Resources and Support Structures

In a study of the strengths, weaknesses, opportunities, and threats to CAMH services in the Western Cape (Mokitimi et al., 2019), senior stakeholders perceived the integrated and developmentally focused approach to mental health services in the Western Cape as a strength, while also highlighting the pervasive neglect of child and adolescent mental health service delivery in South Africa in general. It emerged that the Western Cape's three tertiary CAMH units are perceived as being well-structured, providing both an excellent and comprehensive standard of service which spans all age cohorts (Mokotimi et al., 2019). Notwithstanding, lack of implementation and the burden on families to ensure care for their children result in referrals that require crisis management and multi-disciplinary intervention in an already overburdened system. A pervasive lack of insight as to the nature of CAMH services and what it entails persists (Mokitimi et al., 2019). Persistent exposure to maladaptive and unsupportive contexts results in children and adolescents presenting with psychiatric co-morbidities. Inadequate treatment regimens, and inappropriate and limited resources are exacerbated by the lack of knowledge about mental illness and the stigma associated with it, particularly in vulnerable communities (Mokitimi et al., 2019). In addition, budget constraints and unrealistic expectations of CAMH staff, in tandem with societal stressors, were deemed as significant barriers to CAMH service delivery, which would impact on both availability of resources as well as access to dedicated CAMH resources (Mokitini et al., 2019).

Research supports the significant role of the parental/caregiving context, the role of peers (for the adolescent cohort), family and friends as informal sources of support. However, from a developmental perspective, this appears to be true for the younger adolescent while for older adolescents in pursuit of independence and autonomy, self-referral

to external sources of support is preferred (Rickwood et al., 2015). Parents play a pivotal role in the process of accessing professional mental health services for adolescents, and despite adolescents' apparent reluctance to avail themselves of these services, they are more inclined to engage in the services and seek out further help from adults following such an intervention (Hassett et al., 2018). Patterns of help-seeking behaviour emerge over the adolescent developmental phase with mothers appearing to be more encouraging than fathers; while older adolescents (especially girls) turn to their friends for support and/or self-refer when needing help (Rickwood et al., 2015). In the context of this paper, it would be important to acknowledge that families might choose to seek help from traditional healers first and as such this would delay early intervention from mainstream support services (Egbe, 2014). In addition, cultural attributions of the conceptualisation of mental illness plays a significant role in choosing to consult with Traditional and Alternative Healers (TAH), due to their ability to relate to the patients understanding of their illness and a shared understanding and conception of ancestral and supernatural forces at play (Zingela et al., 2018). Therefore, in order to understand how mental health is dealt with in the African context, it is important to consider the vital role and perspectives of traditional African conceptualisations of mental illness.

The burden of mental health support and resources is allied to the inadequate implementation of early prevention and intervention policies; as such child and adolescent mental health has been neglected (Mokitimi et al., 2019). In addition, early prevention and intervention reside within the primary caregiving context. It begs the question of the parental burden of responsibility, the nature of parental mental health literacy and parental perception of both the problem and the need to seek help. The outcomes of the study conducted into senior stakeholders' perceptions of the systemic neglect of CAMH services affirm the inadequate implementation of early identification and prevention policies (Mokitimi et al.,

2019). The findings support the underpinnings of this study as it relates to parental MHL and the impact on adolescent MHL and adolescent help-seeking attitudes and behaviours (Mokitimi et al., 2019).

Societal expectations and demands can overwhelm adolescents and their inability to cope can lead to maladaptive responses, including substance abuse and violent behaviour as coping strategies (Geldard et al., 2016). A systemic review of the barriers and facilitators to help-seeking behaviours in adolescents (Velasco et al., 2020) revealed that stigma, family beliefs and attitudes, mental health literacy, autonomy, and structural factors such as financial constraints and limited transport are considered as barriers for both intentions to seek help and to accessing mental health services. Facilitators of help-seeking behaviours include positive prior experience, MHL, and trusting and supportive relationships with parents, teachers, counsellors, and the community (Velasco et al., 2020). The literature identifies online intervention as a growing resource that aligns with the technologically driven mindset of the adolescent cohort. The accessibility of online counselling can mitigate the barriers to help-seeking behaviours associated with fear of stigma, confidentiality, and anonymity while at the same time supporting the developmental needs of adolescents to be autonomous and self-reliant (Rickwood et al., 2015).

2.10 Adaptive Coping

A study on the sources of social support as protective factors against psychological distress, conducted by Camara et al. (2017), in the Basque Country in Spain, revealed the intersection of family and peer relationships as sources of support, and stress, in adolescents and their ability to cope with the stressors that they face. These findings support the notion that help-seeking behaviour is an adaptive coping strategy, and its concomitant impact leads to a decline in internalised or externalised symptomology of unattended psychological

distress in the adolescent cohort (Camara et al., 2017). This study lacks consensus of what constitutes sources of stress and support in adolescence, but what is evident is that gender and culture are determinants in terms of how both social support and stress are experienced. In addition, this study alludes to the perceptions adolescents have of resources (parents, friends, and counsellors), relating to familiarity; opportunity and accessibility of the resources; the extent to which the personal attributes of the source of support are construed either negatively or positively, including trust and prior negative experiences; and how this influences adolescents' decisions to use these sources of social support (Camara et al., 2017).

A young person's ability to cope is multifactorial in nature. Personality traits and inherent temperament, self-esteem, and its related constructs (locus of control, self-efficacy, personal agency and competence) and problem-solving ability influence their use of coping strategies and the outcomes (Geldard et al., 2016). Successful coping, therefore, is determined by the young person's ability to use both internal coping strategies as well as external resources as facilitators of coping, such as parents, peers, friends, counsellors or taking time out to think, contemplate and strategise (Geldard et al., 2016). Differences in coping styles in collectivist and individualistic cultures have been identified and may yield either a proactive or a passive approach to coping (Austin et al., 2014). The former being more adaptive, action-oriented, and goal-directed while the latter is inclined to be avoidant.

Additionally, cognisance of adolescent development, individual coping styles and the intersection of socio-economic and cultural factors, as well as gender and the environmental contexts of young people, need to be considered when providing support and/or intervention to this cohort (Austin et al., 2014). Frydenberg and Lewis (1993, as cited in Geldard et al., 2016, p. 63) identified three coping styles: "solving the problem"; "reference to others"; and "non-productive coping". A problem-solving approach is couched in optimism, an active

engagement in social interaction and seeking out social support. The coping style "reference to others" implies actively seeking out support from the social, spiritual and/or professional domains. The final style "non-productive coping" is characterised by avoidance, the inability to cope and internalising the problem framed in self-blame (Geldard et al., 2016, p. 63).

The above literature review highlights the systemic view of the determinants of health choices, which occur in socio-cultural contexts and within relationships, families, communities, norms, beliefs, government policies, etc. It further alludes to the tension between the multitude of contextual factors that may either promote health-seeking behaviours or restrict access to health services in the adolescent cohort. Socio-emotional development in adolescence together with exposure to multiple stressors, contextual deprivation (poverty), mental health distress and punitive (harsh) parenting styles are highly associated with risky behaviours and have a compounding effect on health and well-being in adolescence (Louw & Louw, 2014). A systemic and integrative approach to health care and health promotion is indicated given the gaps that are evident in the conceptualisation of CAMH in South Africa. This necessitates an evidence-based approach, taking the developmental and mental health needs of children and adolescents into consideration and the inclusion of all the stakeholders, schools, families, and communities (Mokotimi et al., 2018). To ensure the efficacy of support to this adolescent cohort and the provision of age-appropriate resources, understanding and addressing the perceived stressors, mental health concerns and access to mental health intervention services for them is necessary to ensure that these resources serve as mitigating factors against the pervasive psycho-social stressors.

2.11 Theoretical Framework

This study was framed within an ecological lifespan theoretical lens (Kail et al., 2019). Health choices are determined in the context of relationships (families, communities,

norms, beliefs, government policies, etc.) and are influenced by a multitude of developmental and contextual factors, that may either promote adolescent health-seeking behaviours or restrict access to health services (Hassett et al., 2018).

Individual uniqueness and the complexity of factors that intersect across all domains of development across the lifespan capture the essence of the multidisciplinary approach to development as conceptualised in the life-span approach (Kail & Cavanaugh, 2016). Both biological and environmental factors play a role in development, which is inextricably linked to the context in which it unfolds. This study is framed by the underpinnings of both the life-span approach to development and Bronfenbrenner's Ecological Systems Theory (1977), which espouse the intersection between biological, psychological, socio-cultural, and life-cycle factors on development in all domains (Kail & Cavanaugh, 2016).

Embedded in this is the need to understand the uniqueness of each stage of development and the concomitant effect of one stage upon the other (Kail & Cavanaugh, 2016). The primary caregiving context impacts development in all domains (physical, emotional, cognitive) and significantly affects the developing child's worldview and ability to cope (Geldard et al., 2016). Bronfenbrenner's Ecological System's theory (1977) posits that development must be viewed within an individual's context and the complexity of factors and systems (e.g., parents, peers, schools, media, and government). The impact of these on health and mental health must be taken into consideration when working with the adolescent cohort in order to provide them with effective and age-appropriate psycho-socio-emotional support (Geldard et al., 2016). Research indicates that adolescents perceive various systemic level factors, including relationship demands, parental conflict, peer and school pressure, friendships, and a sense of belonging together with the demands of school (or university) and society as the most significant challenges (Geldard et al., 2016).

Allied to this, the quality of care-giving relationships and the nature of attachment influence a young person's ability to adjust adaptively to the biological and psychosocial challenges that adolescence presents, and the notion of storm and stress that is universally associated with this developmental stage can be simultaneously viewed as either adaptive or maladaptive (Louw & Louw, 2014). Camara et al., (2017) attest to this notion in so far as family may be construed as both protective and supportive, on the one hand, or a source of distress and a potential risk factor, on the other, as it pertains to adolescent mental health and illness. Bronfenbrenner's Ecological Systems theory supports the notion of the intersection of the home, school, socio-cultural and socio-political contexts, and the adolescent's developmental domains – physical, cognitive, and emotional (Hardman, 2016). In line with this perspective, specialist CAMH services can potentially mitigate the psycho-social and socio-cultural factors that are determinants of adolescent mental illness and well-being.

2.12 Conclusion

In this chapter, the existing literature on adolescent mental health and mental health literacy was reviewed. In addition, current trends in adolescent mental health and factors that impact and mitigate adolescent mental health as well as those that facilitate, or hinder adolescents' help-seeking behaviour were explored. The chapter concludes with the theoretical framework, i.e., ecological lifespan theoretical lens, that underpins the study. Overarchingly, what has emerged in this literature review aligns with the premise on which this study is based as it pertains to mental health literacy being the bedrock of early intervention and detection of mental health concerns, the implications it has for positive help-seeking behaviours, on the one hand, or the alternative being inadequate mental health literacy which perpetuates stigma and stereotypes and thus acts as a barrier to help-seeking behaviours. In addition, this literature review supports the crucial role of parents in the

formation of beliefs and attitudes towards mental health or illness and hence the propensity to seek out early detection and intervention. Finally, what emerged in this literature review is the critical role of the government in adopting a multifactorial and integrative approach to mental health in children and adolescents, and to provide specialised intervention that seeks to address the developmental needs of these cohorts. In particular, to approach mental health in (children and) adolescents from a systemic perspective given the propensity of undiagnosed and untreated mental illness to impact negatively across the lifespan in all domains of individuals. This would ensure that family, school, the community and society have a stake in identification, prevention, intervention and service delivery. The next chapter will focus on the methodology that outlines the procedures and techniques used in this study.

Chapter Three

Methodology

3.1 Introduction

The previous chapter consisted of the literature review which laid the foundations for the premise on which this study is based. What follows in this chapter is a discussion of the research approach and design for the study, the study setting, the study population, sampling and sampling size. In addition, it covers the data collection instrument, data collection methods and procedures, and the data analysis method, ensuring rigour and the ethical considerations that pertain to the study. The conclusion brings the chapter to a close.

3.2 Research Approach and Design

The research study is framed within a quantitative research design using the cross-sectional survey method. A quantitative approach was selected in order to identify and measure different types of variables and to identify and describe averages, frequencies and

correlations between these variables (Babbie, 2013). In addition, the relationships between the variables were statistically tested in order to gauge an understanding of adolescents' knowledge, beliefs and experiences regarding specific concepts and how these interact with their context. The ultimate objective of the study is to explore concepts that are under-researched with a view to generate new knowledge and ideas for further exploration and to add to the existing repository of knowledge.

The research design provides the template for the overall plan of the study, while the research method provides the tools to strategise on how the study-plan will be implemented (Sileyew, 2020). The aims and objectives and the research questions have driven the researcher's choices from inception with regards to the organisation of the project, with a view to yield data that gives credence to the research questions (Gorard, 2013).

The survey method enabled the researcher to collect data from a sample of the target population and to measure the data so that it reflects the characteristics, attitudes, and opinions representative of the larger cohort (Babbie, 2013). This method has the potential to yield a broad scope of information that will enable the researcher to gather information pertaining to numerous variables (Babbie, 2013). In addition, the information gathered facilitated the exploration of the effects of one variable upon another and between different constructs (Babbie, 2013).

3.3 Study Setting, Study Population, Sampling and Sample Size

The Western Cape, and more specifically a number of districts under the auspices of the Western Cape Education Department (WCED), served as the setting for this study, due to the researcher's geographic location which facilitated both ease of sampling and administration of the survey. Schools under the auspices of the WCED are categorised under eight Metro Districts. In this regard, it should be noted that Covid-19 restrictions and

regulations pertaining to access to schools in the Western Cape prevailed throughout the 2021 academic year and part of the 2022 academic year. Due to the Covid-19 restrictions, all interactions regarding permission to conduct the study with the relevant schools and school personnel (principals, principal personal assistants, and reception staff), took place via email and telephone, as well as through the online platform Zoom.

With the Covid-19 restrictions in mind and due to geographical restrictions and pragmatics regarding access to schools, the researcher together with the supervisors restricted the sampling to the following four WCED metro districts: Metro Central, Metro East, Metro North and Metro South. Despite some Covid-19 restrictions being lifted during the data collection phase of the study, the researcher, under the guidance of the supervisors, decided to continue the process of administering the study online, by means of a Google form survey.

Adolescence is defined as an age cohort from 10 years up to and including 19 years of age (WHO, n.d.). However, the focus of this study was on adolescents attending high school i.e., Grade 10 to Grade 12 (Matric) learners in the Western Cape. Therefore, the population (N) for this study was adolescents, ranging in age from 15 years to 19 years attending schools across the four Metro districts named above. The rationale for the study's focus on adolescents 15 years to 19 years relates to the increased cognitive development in adolescents of this age and their ability to think more critically and conceptually as it pertains to the components of this study. In addition, whilst depression, anxiety and behavioural disorders are pervasive amongst the adolescent cohort in general, suicide, anxiety, depression are more prevalent in this age range, and suicide itself is deemed to be the fourth leading cause of mortality in this cohort (WHO, 2021). In addition, substance misuse such as alcohol and cannabis misuse appears to be more prevalent in this cohort, and importantly, at least half of the mental health disorders that pervade this cohort, have their onset by the age of 14 years (WHO, 2021).

At the outset, the sample population was intended to be randomly selected. One independent school and one public school from each Metro district, hence a total of eight schools; four from each type of school. With this in mind, public and independent schools were randomly selected from each Metro district. However, despite numerous efforts on the part of the researcher and 16 schools being approached via email and telephone, this method failed to yield positive responses from the randomised schools identified for the study. Hence only the schools that agreed to the researcher's request to participate in the online survey were included, all of which fell within the four Metro districts named above. Consequently, the researcher, together with the supervisors, agreed that the sampling should be more purposive and convenient. The researcher then purposively selected schools across all four Metro districts that had online mechanisms or portals in order to communicate with their student and parent body about the survey in the first instance, and in the second instance, whereby they were able to send the link for the survey to their learners. Thus, relying on the learners' access to data and internet for the completion of the survey.

The researcher contacted in excess of 30 schools (extended towards the end of the data collection process to include more than 40 schools) across all the districts, it should be noted that throughout this selection process the researcher was mindful to ensure that the sample was reflective of equity in terms of the type of school (i.e., independent, private and government school), gender (i.e., male and female) and the different age ranges within the adolescent cohort. The schools that committed to participate in the study agreed to send the survey out to their Grade 10, 11 and 12 learners, and did so within the timeframe. Ultimately, learners from only seven schools completed the survey, of which six schools were independent schools and only one school was a public school, yielding a final total sample (N) of 100 respondents. The discussion that follows addresses the methods and procedures of

data collection and includes a discussion on the measures used as the basis on which this study's survey items were based.

3.4 Data Collection Instruments

Data has been collected by means of a cross-sectional survey-type instrument, using the measures described below.

Adolescent mental health literacy was measured with a Portuguese sample using items based on the Mental Health Literacy Questionnaire (MHLq) (Campos et al., 2016). Exploratory factor analysis and Cronbach Alpha were used to determine the construct validity and internal consistency of the instruments' final structure (Campos et al., 2016). The final factor structure (33 items) of the MHLq had a Cronbach Alpha score of 0.84 and for internal consistency the Cronbach Alpha scores were the following: Factor 1, a=0.79; Factor 2, a=0.78; and Factor 3, a=0.72 (Campos et al., 2016).

Pursuant to this component of the study the items in this section of the questionnaire (see Section B, Appendix A), address the 3 primary factors identified by the original measures above (MHLq) (Campos et al., 2016), namely: factor 1, knowledge and stereotypes; factor 2, help-seeking and first-aid skills, and factor 3, self-help strategies (Campos et al., 2016; Zare et al., 2022). It should be noted that although the original measure is a three-factorial measure as delineated above, the researcher chose to create a four-factor approach to the survey to facilitate analysis as well as understanding by the respondents. Hence the factors and the related items that address adolescents' conceptualisation of mental health literacy are constructed as follows: Factor 1: Knowledge and understanding of mental health problems, signs and symptoms, risk factors and protective factors for mental disorders as well as factors that promote mental health. Factor 2: Erroneous beliefs and stereotypes that are associated with mental illness. Factor 3: First-aid skills and help-seeking behaviours, which

include behavioural intentions and indicators of predispositions to help. Factor 4: Self-help strategies explore behaviours that are construed as promoters of both formal and informal help-seeking (Campos et al., 2016; Zare et al., 2022). All items were assessed using a five-point Likert scale ranked from 1 = strongly disagree to 5 = strongly agree. This ranking was recoded to a 3-point scale ranging from 1 = strongly disagree, 2 = undecided and 3 = strongly agree. The MHLq was tested on (Portuguese) students aged 12 years to 17 years and found to be both valid and reliable with respect to identifying knowledge gaps and behavioural intentions and promoting mental health in this cohort (Campos et al., 2016)

Adolescent perceptions of the stressors they face were measured by using the Adolescent Life Events Questionnaire (ALEQ) (Hankin & Abramson, 2002).

The ALEQ (See Section C, Appendix A) measure consists of eight items which address experience or exposure over the preceding three-month period to the following stressors: peer relationships, loss/death, academic stress, parental conflict and financial stress (Hankin & Abramson, 2002). In terms of reliability, the measure has been shown to have high internal consistency reliability with Cronbach's alpha of .94 (Hankin & Abramson, 2002). and test-retest reliability for 2 weeks was $r = .65$ (Miloseva, et al., 2011). In the pilot study conducted with Macedonian adolescents aged 13 years to 17 years, whereby the instrument was back-translated from English to Macedonian, and good measures of internal consistency were confirmed ($\alpha = .89$) (Miloseva et al., 2011).

To assess adolescents' negative life events experiences, items from the original measure were adapted to address life events of adolescents in the Western Cape milieu, whose lived experience is riddled with pervasive negative life events not covered in the original measure and which the researcher had a particular interest in exploring. These items included those pertaining to loss and death, domestic violence, gang violence, drug and

alcohol use and violence. A five-factor approach to this measure was adopted and the factors include the following: Factor 1, Life events; Factor 2, School events; Factor 3, Friendship events; Factor 4, Romantic events; and Factor 5, Family events. All items were assessed using a five-point Likert scale ranked from 1 = strongly disagree to 5 = strongly agree. This ranking was recoded to a 3-point scale ranging from 1 = strongly disagree, 2 = undecided and 3 = strongly agree.

To assess adolescents' coping strategies (see Section D & Section E, Appendix A), the Revised COPE Inventory (R-COPE) was used in which five domains of coping were identified (Zuckerman & Gagne, 2003). The original measure consisted of 40 items used to measure coping styles and addresses these five domains of coping in response to stress, namely: self-help, approach, accommodation, avoidance and self-punishment. In this study items were adapted to meet the aims and objectives of this study and the resultant 25 items were evaluated using a five-point Likert scale ranging from never (1) to always (5). Instructions for these sections were provided to respondents to enable them to identify the extent to which they use each particular strategy for coping (Zuckerman & Gagne, 2003). The 5 R-COPE subscales were predicted prospectively from one situational variable (perceived control) and one dispositional construct (autonomy versus control orientation). In additional studies, the 5 subscales served as prospective predictors of several adjustment and well-being indices (Zuckerman & Gagne, 2003). These studies along with correlations between the five subscales and other variables demonstrated both convergent and discriminant validity of the R-COPE (Zuckerman & Gagne, 2003). Reliability of the sub-scales ranged as follows: Self-help .92; Approach .84; Accommodation .82; Avoidance .81 and Self-punishment .87 (Zuckerman & Gagne, 2003). In the development of the R-COPE as a tool to measure coping styles one of the studies addressed the notion of autonomy and related behaviours which are closely allied to well-being and coping styles. Albeit that the sample populations used in the

development of this tool did not fall within the age range of the participants in this study, it is valuable to note that the orientation of this tool aligns to the adolescent developmental task of attaining autonomy (Zuckerman & Gagne, 2003).

Help-seeking behaviours and attitudes were measured by using the General Help-Seeking Questionnaire (GHSQ). The sample comprised of 218 high school students in Australia. The measure comprises the Actual Help-Seeking Questionnaire (AHSQ) (see Section F, Appendix A), (Wilson et al., 2005), which identifies the sources of help (parent, counsellor, community source) using yes/no options to each item which are associated with the problems identified in the GHSQ. Four items measuring prior counselling experience based on yes/no options and the extent to which these sources of support are deemed helpful was measured using a 5-point Likert scale ranging from extremely unhelpful to extremely helpful (Wilson et al., 2005). For the purposes of this study these yes/no items were excluded from the questionnaire, albeit prior counselling experience was included in the demographic section of the questionnaire (see Section A, Appendix A). The GHSQ was found to be a reliable instrument with alpha values ranging from 0.87-0.75 (Olivari & Guzman-Gonzalez, 2017). This measure was developed as a means of assessing help-seeking intentions from different sources related to specific problems (Wilson et al., 2005). The original instrument was deemed valid and reliable for the adolescent population (Wilson et al., 2005).

For this study the researcher based the items in the questionnaire on the overarching principles of the original measure to ascertain which sources of help adolescents would perceive as helpful given specific problems they might be facing. The responses were based on five domains of resources and ranked from 1 to 5 in terms of how likely the respondents were to tap into a resource, depending on the problem they were facing. The resources were scored as follows: life-coach (1); counsellor/social worker/teacher/psychologist (2); close

friend (3); self (4) and parents (5). Questions such as, “if you were experiencing problems with your parents/guardian/s who would you most likely ask for help?” and “if you were having problems with your friends and peers who would you most likely ask for help?” and “if you thought you had a mental health problem who would you most likely ask for help?” were posed.

Finally, the brief 11-item BASH-B (Wilson et al., 2005) was included to identify the perceptions of the value of specific resources and the resultant barriers to seeking professional help. It consists of 11 items, each rated on a 5-point Likert scale ranging from strongly disagree to strongly agree (see Section G, Appendix A). For the purposes of this study the scale was recoded to 3 points ranging from strongly disagree (1); undecided (2) to strongly agree (3). In addition, five sub-scales were identified for the purposes of this study, namely: Professional; Religious; Friends; Parents and Self. The items were adapted once again to ensure that they addressed the aims and objectives of this study and as such items related to specific mental disorders were excluded from the survey. Items included: “If my school had a counsellor/psychologist/guidance counsellor or social worker I would feel comfortable to go and discuss my problems with them” and “If I had an emotional or psychological problem, I would trust a professional to help me”. The brief 11-item BASH-B had a Cronbach alpha coefficient of .83. The original instrument was deemed valid and reliable with adolescent populations (Wilson et al., 2002; Wilson et al., 2005). The psychometric properties of all the above-mentioned instruments indicate both their validity and their reliability when used with the adolescent cohort.

The final survey (Appendix A) comprised seven sections. The first section (A) contained demographic information related to age, gender, population group, grade and which type of school the respondents attended, as well as a question relating to whether a

professional/s worked at their school and whether they had previous counselling experience. Section B addressed the question of mental health literacy using 32 items divided into four domains namely: knowledge of mental health problems; erroneous beliefs and stereotypes; first-aid and help-seeking behaviours; and self-help strategies. Section C concerned the stressors and/or negative life events that adolescents face in their socio-cultural contexts and consisted of 15 items in the following domains: life events; school events; friendship events; romantic events and family events. Section D and Section E focused on coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors. Five domains or styles of coping were identified: self-help; approach; accommodation avoidance and self-punishment. All items were constructed in such a way as to address each of these domains. Section F addressed the question of help-seeking behaviours, help-seeking intentions and perception of resources. The items are based on a Likert scale to ascertain how likely or unlikely it would be that a respondent would use a particular resource when faced with specific (age-appropriate) problems. The resources identified for the purposes of this study were as follows: life-coach, counsellor/social worker/teacher/psychologist; close friends; self and parents. Finally, Section G addressed perception of resources and barriers to help-seeking behaviours. For the purposes of this study the following resources were identified: professional; religious; friends; parents and self. A 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5) was used to assess help-seeking intentions. The above discussion clearly delineates the measures used to address the aims and objectives of this study together with the questions related to the study as it pertains to the domains of the investigation, as illustrated in the title of this paper.

3.5 Data Collection, Methods and Procedures

At the outset of this study the survey was to be administered in-person at various schools to facilitate efficient collection of data and to ensure that no schools would be excluded from the study. However, Covid-19 prevailed and the researcher decided to pivot the study to the online platform due to Covid-19 related, in-person restrictions at the schools. It resulted in the study being delayed as WCED regulations stipulated that the study could not be administered during the 4th school term, it being an exam term. The researcher engaged the services of a colleague who constructed the survey from the written form into Google form. The items were checked to ensure that they aligned with the measures by which the data would be analysed.

An extensive editing process followed to cull the items and once this draft was approved, a pilot study was conducted with five participants, 3 female and 2 males ages 17years to 18 years. The pilot study was used to determine the efficacy of the survey; to get feedback on the items and the length of time it took for completion; and to ascertain if there were any glitches in the online portal (Appendix B). The feedback received was used to make additional edits to the structure of the survey, and to the items themselves, to ensure that they aligned to the factors from each of the measures. This included refining the "scenarios" in the MHL section (Section B, Appendix B), adding a number of items to ensure all aspects of the measures were addressed, and deleting all duplicate and superfluous items, hence time to complete the survey was cut significantly shorter from the original survey, albeit that the final survey contained 101 items, whereas the pilot only had 90 items, the format of the questions also facilitated quicker response-time. In addition, all reverse items were identified and in each section the items were checked to ensure that they spoke directly to the measure utilised to address each specific component of the study. This process assured the researcher that the

aims and objectives of the study were met. With regard to the instruments used in this study, albeit that not all items from each instrument were utilised and, in some cases, items were constructed by the researcher based on the domains/constructs the instrument was measuring and to ensure that all items addressed the appropriate dimensions. All measures had good factor structure and the sub-scales of each measure aligned with the aims and objectives such that the analysis yielded desired outcomes of the study.

All information pertaining to the study was provided at the start of the survey and informed consent options provided for both the participant and their parents, for those learners under the age of 18 years. The structure of the survey ensured that the participant could not continue with the survey until the informed consent options were filled in. In addition, the information was sent to all the participating schools principals to send out to the parent body providing sufficient time for parents to disseminate the information, access the survey to assess the nature of the questions without submitting the survey. In addition, the researcher's email address was provided in the cover letter, should either the participants or the parents have any questions pertaining to the survey, prior to them completing it. The final survey consisted of 7 sections and 101 items; Section A consisted of demographic data; Section B addressed MHL; Section C addressed psychosocial stressors; Section D addressed coping strategies; Section E & F addressed perception of resources and help-seeking behaviours respectively; and Section G addressed barriers to help-seeking. Herewith the link to the final survey that was administered to the participating schools: https://docs.google.com/forms/d/15Myo9NIKIwU-nEI9M0UQpHf_zoTkkA2qWS04qPNwrto/edit

POPIA concerns, expressed by some schools via email communication, were alleviated by reassuring schools that all respondents were guaranteed anonymity and

confidentiality. In addition, for one particular school, the option to fill in the name of the school by the participant was removed and replaced with the option of selecting either a public or an independent school. This separate survey link was sent directly to the contact person at the school. The data from the orginal survey (79 respondents) was transferred to an excel spreadsheet, and the data captured from the survey sent to the individual school (24 respondents) was captured on a separate xcel spreadsheet. These two spreadsheets were merged to facilitate the cleaning and coding of the data. In light of the separate data, the researcher concluded that it would be best to cluster the responses of the type of school respondents attended into two categories, namely, independent and public, rather than conduct the analysis with individual schools. Despite protracted and extensive efforts on the researcher's behalf, once the link was closed to participants, only one hundred and one (101) respondents accessed the survey. Of these, one respondent accessed the survey and chose not to submit resulting in their participation being logged, but none of their responses were captured. Consequently, in the final phase of cleaning the data, this respondent was deleted resulting in the final sample being N=100.

What follows is a discussion regarding the study setting and the procedure pertaining to the sample. The survey was administered as a once-off collection via an online Google form survey method. The researcher's initial contact with the school was by telephone and followed up with email communication. A cover letter was sent to each school principal and/or head of department (Appendix C), requesting permission to conduct the research with their learners. This was accompanied by a letter from the WCED (Appendix D) granting the researcher permission to conduct research at schools in the Western Cape. Following written receipt of permission to conduct research at each of the schools, the survey link, created by the researcher, was emailed to the respective schools (Appendix E) accompanied by the information brief (Appendix F) – (the same brief was embedded in the survey) for both the

learners and their parents for the purposes of informed consent. This brief provided comprehensive details of the study, and included the following: the purpose of the study, the intentions behind the use of the data, the confidential nature of the survey itself (its compliance with the POPIA act) and the storage of data. This information brief was embedded in the study in such a way that without both informed consent from parents (for respondents under 18 years of age) and assent from the learners, they were unable to participate in the study as it was set as a pre-requisite for the completion of the survey (Appendix G). Furthermore, the informed consent forms included information regarding accessing the link for the Google form survey, guidance regarding the completion of the survey, the nature of the questions in the survey and the nature of the responses that are required as per the various scales used in the survey. It also provided clarity regarding privacy and anonymity of the participants; the voluntary nature of the survey; and the learners' right to opt out at any time; as well as the implications of submitting the survey. It should be noted that the original cut-off date for completion of the survey was noted in the survey as June 10, 2022. However, due to a poor response rate, the deadline was extended to the 1st of October 2022 being the end of the third term, to make provision for the recruitment of an adequate sample. Initially 14 schools gave consent to conduct the research at their schools, this number extended to a total of 18 schools following the extended deadline. . Thiscomprised of eight (8) public schools and ten (10) private schools. However, in the final analysis only learners from one (1) of the public schools participated, whereas learners from six (6) of the independent schools participated. All these procedures align with the ethical standards and requirements as set out by Unisa for the purposes of this study.

3.6 Data Analysis Method

Basic descriptive and inferential statistics were computed to address the research questions, using the Statistical Package for Social Sciences (SPSS) IBM SPSS Statistics 27.0

software (IBM Corp., Armonk, NY, USA). Descriptive statistics were calculated to describe or summarise the data for the current study. To communicate the central features of the data, frequency tables, bar and pie charts were used to present the frequency with which a value or category occurred (Pretorius, 2007).

Whereas descriptive statistics focus on describing a set of data, inferential statistics endeavour to make inferences or estimates concerning a population (Babbie & Mouton, 2001). Inferential statistics are divided into two broad categories, i.e., parametric tests used for assessing relationships between variables, and non-parametric tests used for assessing differences between groups (Pretorius, 2007). The computation of parametric tests relies on strict assumptions regarding the distribution of the primary population from where the sample was drawn, including random sampling, normal distribution, homogeneity of variance, and no extreme outliers (Bobbitt, 2021; Pretorius, 2007). In contrast, the computation of non-parametric tests is not reliant on any restrictive assumptions regarding the parameters of the primary population. Since the sample was not randomly selected, nonparametric tests were utilised in this study to make inferences. Kruskal-Wallis and Mann-Whitney U tests were utilised to calculate differences between variables.

Mann-Whitney Test (U-test). The Mann-Whitney U test is a non-parametric test for two independent samples and is regarded as the nonparametric match to the two independent sample *t* test (Bobbitt, 2020a; Pretorius, 2007). The test is utilised to compute the "differences in the ranked positions of different scores in different groups" (Field, 2005, p.530), i.e., differences between two groups when the scores are usually not normally distributed (Bobbitt 2020a), and when the sample sizes are small ($n < 10$) (Field, 2005). However, it should be noted that non-parametric tests are also regarded as valid for normally distributed data, even though it has less statistical power than parametric tests (Campbell &

Shantikumar, 2016). Nevertheless, the U-test requires the following criteria to be met (Pretorius, 2007, p.191):

- There should be two independent groups
- The two groups are compared on one continuous variable

Considering that both these assumptions were being met, and the fact that the sample was not randomly selected, it was deemed appropriate to use the Mann-Whitney U-test for observing differences between the two groups in this study.

Kruskal-Wallis Test (H-test). The Kruskal-Wallis test can be regarded as the non-parametric match to the one-way Analysis of Variance (ANOVA) but does not have the same restrictive assumptions as ANOVA (Pretorius, 2007). The test is utilised to ascertain if a statistically significant difference exists between three or more independent groups' medians (Bobbitt, 2020b). However, it requires the following criteria to be met (Pretorius, 2007, p. 229):

- There are more than two independent groups, (i.e., the same participant cannot be in more than one group)
- There is one continuous variable on which the different groups are being compared

Considering that both these assumptions were being met, and the fact that the sample was not randomly selected, it was deemed appropriate to use the Kruskal-Wallis test for observing differences between three or more groups in this study.

3.7 Ensuring Rigour

To ensure rigour in this study, the research design was considered a good fit and appropriate to address the aims and objectives of the study as well as the projected outcomes of the study. The psychometric properties of each of the measures used were deemed reliable and valid as reported by the authors cited in this study. In addition, the authors noted that the

psychometric properties of the GHSQ, AHSQ and the BASH-B (instruments) reflect their validity and reliability when used with the adolescent cohort (Wilson et al., 2005). Furthermore, the processes of collecting the data were systematic and utilised the exact same methods and standards across the sample, thus the findings are deemed trustworthy. In addition, the pilot study conducted enabled rigourous editing and refinement of the items in each scale and to the structure and format of the survey itself to facilitate ease of access and completion. The pilot study, provided valuable information pertaining to the time for completion of the survey and to the nature of the questions as to their applicability to the measures and domains they were addressing. Feedback from the 5 participants provided useful insight into the nature of the questions and the extent to which these were appropriately articulated and relateable to the cohort at which the survey was aimed. Based on this pilot process, items were refined and duplicate items deleted and additional items added to ensure all the items addressed each of the domains in the sub-scales, thus ensuring rigor throughout the process of constructing an appropriate survey to address the research aims and objective.

3.8 Ethical Considerations

This research study has been conducted in accordance with the ethical guidelines as stipulated by Unisa. Ethical approval for this study was obtained from the Unisa Ethics Committee at the College of Human Sciences (Appendix H). In line with these ethical considerations, the researcher ensured transparency as to the nature of the study to all participants and the ethical principles of do no harm, voluntary participation, informed consent, and confidentiality were upheld (De Vos et al., 2011). Data collection was for research purposes only and by virtue of no personal information being captured or required (to comply with the POPIA act), the survey itself and hence all participants' responses were

anonymous and confidential. Permission to conduct the study at selected schools that fall under the auspices of the WCED was obtained in writing. A copy of this letter accompanied correspondence to each of the school principals or their designated staff members, who provided the researcher with permission to conduct the study at their schools (Appendix D).

The process by which the study was implemented met ethical standards and was carried out in accordance with the procedural details explained above. This was achieved through respectful communication with all schools and personnel, compliance with the WCED conditions of permission to conduct my research and as such not interfering with the school's academic processes and ensuring that the study was administered only during term 1 up to term 3. In addition, consent information was provided to the school principals prior to administration of the survey, to ensure the principal felt informed and to enable the school to send out the information brief separately to the parents ensuring that they had all the information they required in order to provide informed consent, as well as contact the researcher if they had any queries or concerns (Appendix F). In keeping with ethical guidelines for this study, information regarding the study, its purpose, the nature of the questions, the time to complete the survey, the storage of the data and all details pertaining to confidentiality, privacy and the voluntary nature of the study contained in the information brief, was embedded in the study. The survey was also set up in such a way that the participation of learners under 18 years of age was contingent on both their and their parents' consent. The format of the survey also made provision for a respondent to return to the beginning if they felt unsure or needed to double-check the information required prior to giving their consent. It also made provision for respondents to choose not to submit at the end of the survey, although they may have completed all the questions. Hence it fulfils the ethical consideration of informed consent and voluntary participation. In line with the ethical requirements pertaining to this study, the researcher's contact details, the supervisors contact

details and that of Unisa's Ethics Committee were also shared in the information letter, embedded in the survey as well as shared with each of the school principals. Thus ensuring that if any principal, parent and/or participant have any questions or concerns they were encouraged to reach out and all relevant parties to address these.

Administration of the survey took place via an online portal through a Google form survey. Each school that gave the researcher permission to conduct my study, provided both parents and learners with the information brief (Appendx I) I had constructed which outlined the overarching premise of the study, how to access the link, the purpose of the study and the nature of the questions. In addition, it covered aspects such as their voluntary participation, the importance and necessity of informed consent for learners under the age of 18, the informed consent protocol for participation in the survey, which was embedded in the survey, the utilisation of the data, the safe storage of data, and that all data would be treated as anonymous and confidential. This was coupled with the assurance that the use of the data will be for research purposes only and the contact details of the researcher were provided. For storage and safeguarding of the electronic data, it was encrypted and password protected with controlled access to the researcher and supervisors.

Following the last section of the survey, prior to completion, participants were once again reminded that their participation was voluntary. In the final stage of the survey, they were provided with the options to opt-out or to continue, and if they chose to continue they were given the option to complete and submit their survey via the online portal. In the event of any adverse responses to participation in the survey, all necessary steps were taken to assure the school principals, parents and learners that the researcher is committed to providing the necessary emotional support to mitigate any adverse (emotional) effects experienced by any of the participants. In addition to the researcher's email address being embedded in the

informed consent form, all school principals, parents and participants were provided with the researcher's email details included in the information distributed by each school to their parent body. This entire process entailed both continuous scrutiny and supervision.

3.9 Conclusion

This chapter focuses on the research design and methodology that underpin this study. It details the quantitative nature of the study using a cross-sectional survey design, its origins, its relevance to this study and its general characteristics. In addition, processes and ethical considerations regarding the administration of the survey are explored in this chapter. The following chapters build on from the methodological propositions made in this chapter by employing the proposed data presentation and analysis approaches to analyse the quantitative and qualitative data.

Chapter Four

Results

4.1 Introduction

The overall aim of this study was to explore adolescent mental health literacy, coping strategies and adolescents' perceptions of mental health mechanisms that mitigate the psycho-social challenges they encounter. In this chapter, the results of the study are presented in line with the objectives and research questions outlined in chapter 1 and the methods delineated in the preceding methodology chapter. The first section presents the descriptive statistics, including the demographic profile of study participants, the grade they are in, and the type of school they attend. The second section presents the results of the frequency distributions of the five measures which were used as the basis of the questions for the survey

and the third section presents the results from the inferential data to address the aims and objectives of the study.

Objective one was to explore adolescent mental health literacy. Objective two was to explore the challenges that adolescents face in both their personal and socio-cultural contexts. Objective three was to explore the coping strategies that adolescents use to manage their challenges and stressors. Objective four was to explore adolescents' perceptions of internal and external resources they use to mitigate their psycho-social stressors. The fifth objective was to assess whether there are significant differences between adolescent mental health literacy, stressors, coping strategies, perceptions of resources, and barriers to help-seeking behaviours in terms of gender, age, population group, , grade, and type of school attended. It also included adolescents' perceptions of resources and barriers to help-seeking behaviours as well as gender, age, population group, grade, and type of school adolescents attend.
The section that follows consists of the inferential results from the non-parametric tests, Kruskal Wallis and Mann-Whitney U analyses, that were conducted to ascertain differences between gender, age, population group, , grade, and type of school in relation to mental health literacy, psycho-social stressors that adolescents face, coping strategies that adolescents use, perceptions of resources and help-seeking behaviours and barriers to help-seeking behaviours.

4.2. Descriptive statistics

This section provides the descriptive statistics for the sample, which will be presented next. The sample characteristics were computed and are presented in Table 4.1, Table 4.2 and Table 4.3 as well as Figure 4.1.

4.2.1. Sample characteristics

This study was conducted with a total sample of N =100 learners from independent and public schools in the Western Cape. As the survey was administered on an online platform to each of the schools who then sent the link to their entire Grade 10, 11 and 12 student body. A systemic review of online response rates conducted by Poynton et al. (2019) yielded an average of 34.2% response rate. Notwithstanding, it is impossible to ascertain what the response rate was in the context of this study as I was not privy to the student body numbers of each of the schools. The respondents were in Grade 10, 11 and 12 at the time of completing the online survey. All the respondents 100% (N = 100) indicated that there was some form of psycho-emotional support at their school. The options they were provided with in the survey were psychologist/counsellor/guidance counsellor/social worker. This item also required the respondent to say "yes" if they were present at their school, or to stipulate "none" if there were no resources available at their school. Furthermore, 59% (n = 59) of the respondents reported having prior counselling experience, compared with 40% (n = 40) who reported not having had any previous counselling experience and the data of 1% of the respondents (n = 1) was missing.

To provide an overview of the demographic profile of students in the different schools within the Western Cape, Table 4.1 disaggregates the sample by population group, gender, and age. This is followed by Table 4.2 which delineates the grade each respondent was in at the time of completing the study. Table 4.3 together with Figure 4.1 provide a visual representation of the category of school each respondent attended at the time they completed the survey.

Table 4.1

Distribution of Demographic Data of Research Participants

Variable	Values	Frequency (*N*)	Percentage (%)
	Black	11	11.0%
Population	White	73	73.0%

Group	Coloured	9	9.0%
	Indian	3	3.0%
	Other	4	4.0%
	Total	100	100%
Gender	Female	60	60%
	Male	37	37%
	Other	3	3%
	Total	100	100%
Age	15	0	0%
	16	59	59%
	17	28	28%
	18	12	12%
	19	0	0%
	Missing	1	1.0%
	Total	100	100%

Table 4.1 above indicates that of the total sample (N=100), 11.00 % (n=11) were Black, 9.0% were Coloured (n=9), 3.0% (n=3) were Indian, 4.0% (n=4) of respondents identified as “other”, while the majority of participants were White (n=73, 73.0 %).

In terms of gender, it can be gleaned from the above table that the majority of participants were female (n=60, 60.0 %). Male respondents made up 37.0% (n=37), while those identifying as “other”, which constitutes non-conforming gender, made up the balance of 3.0% (n=3) of the respondents.

Table 4.1 shows that participants’ ages ranged from 15 to 18 years. This table demonstrates that the vast majority of respondents were in the age category of 16 years (n=59. 59.0%), followed by 28.0% (n=28) who fell into the 17-year age category. In addition, 12.0% (n=12) of respondents fell into the age category of 18 years, while 1.0% (n=1) of respondents failed to categorically state which age group they fell into.

Table 4.2 below provides an overview of the grade that the study respondents were in.

Table 4.2 - *Grade of Students*

Grade

	N	%
10	48	48.0%
11	35	35.0%
12	17	17.0%

Table 4.2 above indicates that of the total sample of respondents (N=100), 48.0% (n=48 were in Grade 10, while 35.0% (n=35) were in Grade 11 and the remaining 17.0% (n=17) were in Grade 12.

The following table disaggregates the type of school that respondents attended. As discussed in the methodology, managing the spread of schools across the different school districts in the Western Cape became untenable due to Covid-19 restrictions, and to overcome this challenge and to ensure rigour in the analysis process, the types of schools were clustered into two primary categories, namely; public (1) and independent (2).

Table 4.3

Category of School Attended

School

	N	%
1 Public	21	21.0%
2 Independent	78	78.0%
Missing System	1	1.0%

Figure 4.1

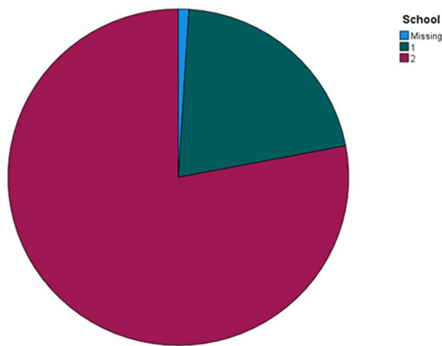

Figure 4.1 shows that the majority of respondents who participated in this study were from independent schools (78.0%, n=78), while the rest of the respondents attended public schools (21.0%, n=21).

What follows is the reporting of the frequencies and distributions for each of the measures used to address the aims and objectives of this study.

4.3 Student Mental Health Literacy (MHL)

As outlined in the methodology, to tap into the mental health literacy of the respondents the first 32 questions of the survey were based on the Mental Health Literacy Questionnaire (MHLq) (Campos et al., 2016). This aligns with objective 1 of the study, i.e., to explore mental health literacy among adolescents in the Western Cape. These questions speak to the following core domains: Factor 1 (MHL1) – Knowledge of mental health; Factor 2 (MHL2) – Erroneous beliefs and Stereotypes/Professional help-seeking awareness; Factor 3 (MHL3) – First-Aid skills and help-seeking behaviours and Factor 4 (MHL4) – Self-Help strategies. Table 4.4 below presents the results based on the responses to these items.

Table 4.4

Descriptive Statistics: Mental Health Literacy of Adolescents (MHL)

		Frequency and Percentage						
			Strongly/Agree		Undecided		Strongly/Disagree	
SCALES	**Variables**	**N**	***n***	**%**	***n***	**%**	***n***	**%**
Knowledge of Mental Health Problems	MH problems can affect ability to learn at school	100	100	100				
	Youth with MH problems require support	100	93	93	5	5	2	2
	MH problems can be treated	100	76	76	23	23	1	1
	MH affects how person feels	100	97	97	3	3		
	MH affects thoughts	100	99	99	1	1		
	MH affects behaviour	100	96	96	3	3	1	1
	Youth can suffer from MH problems like anxiety	100	99	99				1
	Youth can suffer from MH problems like depression	100	97	97	2	2	1	1
	Person with depression feels sad and miserable all the time	100	27	27	37	37	36	36
	Early detection of MH problems – better treatment options	100	78	78	15	15	7	7
	Drug and alcohol abuse can cause MH problems	100	84	84	12	12	4	4
	Not normal adolescent behaviour	100	42	42	39	39	19	19
	This is more than a mood swing	100	86	86	11	11	3	3
	Not normal reaction to stress	100	64	64	18	18	18	18
	More than general stress – could be sign of severe anxiety disorder	100	93	93	5	5	2	2
	Nothing to worry about – he/she is looking for attention	100	90	90	10	10		
	Normal adolescent behaviour	100	53	53	38	38	9	9
	Don't think anything wrong with him/her to worry about	100	97	97	3	3		
	Nothing to worry about – he/she is looking for attention	100	96	96	4	4		
	Normal reaction to stress	100	54	54	27	27	19	19
	TOTAL	**2000**	**1621**	**81.05**	**256**	**12.8**	**123**	**6.15**
Erroneous Beliefs and Stereotypes / Professional Help-seeking Behaviour Awareness	A counsellor/psychologist could help me	**100**	**61**	**61**	**29**	**29**	**10**	**10**
	Recommend they get professional help	**100**	**60**	**60**	**28**	**28**	**12**	**12**
	Don't know who he/she can get help from	**100**	**59**	**59**	**19**	**19**	**22**	**22**
	Don't know who he/she can get help from	**100**	**67**	**67**	**19**	**19**	**14**	**14**
	TOTAL	**400**	**247**	**61.75**	**95**	**23.75**	**58**	**14.5**
First-aid and Help Seeking Behaviours	Worried about my friend	**100**	**97**	**97**	**3**	**3**		
	Nothing wrong with him/her	**100**	**89**	**89**	**7**	**7**	**4**	**4**
	He/she needs help	**100**	**83**	**83**	**14**	**14**	**3**	**3**
	Be worried about my friend	**100**	**100**	**100**				
	He/she needs help	**100**	**93**	**93**	**6**	**6**	**1**	**1**
	Would do something to help	**100**	**97**	**97**	**3**	**3**		

	TOTAL	**600**	**559**	**93.7**	**33**	**5.5**	**8**	**1.33**
Self-Help Strategies	Sleep, exercise improve MH	**100**	**73**	**73**	**22**	**22**	**5**	**5**
	Doing something enjoyable can improve MH	**100**	**91**	**91**	**9**	**9**		
	TOTAL	**200**	**164**	**82**	**31**	**15.5**	**5**	**2.5**

As demonstrated in Table 4.4 above the responses are significantly skewed for all factors towards strongly agree, ranging from 99% on the upper end of the continuum to 53%% on the lower end. It thus supports high levels of mental health literacy pertaining to knowledge of what is construed as normal adolescent behaviour versus what is perceived as not normal. These items sought to ascertain knowledge relating to depression and anxiety, in particular, given that these disorders appear to be particularly prevalent in this cohort. The lower percentage of 61.75% for Factor 2 relating to stereotypes and erroneous beliefs confirms the strength of the respondents' mental health literacy. For Factor 3 – First-aid skills and help-seeking behaviours, 93.7% of respondents indicated the importance of, and their awareness of, help-seeking behaviours for themselves and for others. These responses are also indicative of the respondents' awareness of what is construed as normal versus abnormal adolescent psycho-emotional responses. For Factor 4 which addresses self-help strategies, 82.0% of respondents strongly agree that certain self-help strategies can be drawn upon to improve their mental health, indicating that while they agree with the concept of seeking help, it appears that most respondents indicate that they do not know where or from whom they could seek help (see Subscale 2; 59% and 67%).

4.4 Challenges Encountered by Students

Objective 2: To explore the psycho-social stressors faced by adolescents in both the personal and socio-cultural contexts.

The second objective of this study was to explore the psycho-social stressors that adolescents face. A critical factor for consideration regarding this question lies in the socio-cultural context of the Western Cape. Poverty, drug and alcohol abuse as well as gang violence and domestic violence are pervasive. As a result, the items selected from the ALEQ (Hankin & Abamson, 2002) measure were adapted to suit the needs of this study and to ensure that the questions posed addressed the concerns that adolescents face in this particular socio-cultural context. The items were clustered into five factors, namely: Life events, School events, Friendship events, Romantic events and Family events. All items address the objective of ascertaining adolescents' perceptions of the extent to which these factors are considered to be challenges and hence the cause of stress.

Table 4.5

Descriptive Statistics: Adolescents Psycho-Social Stressors (ALEQ)

		Frequency and Percentage						
			Strongly/agree		**Undecided**		**Strongly/disagree**	
SCALES	**Variables**	**N**	***n***	**%**	***n***	**%**	***n***	**%**
Life	Feeling stressed loss/death other than parent/s	100			7	7	93	93
	Feeling stressed alcohol/drugs use at home	100			4	4	96	96
	Feeling stressed violence in my community	100	16	16	10	10	74	74
	TOTAL	**300**	**16**	**5.3**	**21**	**7**	**263**	**87.7**
School	Feeling stressed with my schoolwork	100	91	91	1	1	8	8
	Feeling stressed about bad results on tests/report	100	85	85	3	3	12	12
	TOTAL	**200**	**176**	**88**	**4**	**2**	**20**	**10**
Friendship	Feeling stressed conflict with peers	100	39	39	11	11	50	50
	Feeling alone/isolated from peers	100	45	45	6	6	49	49
	Feeling bullied by my peers	100	13	13	2	2	85	85
	Feeling stressed: peer pressure to use drugs and alcohol	100	5	5	6	6	89	89
	TOTAL	**400**	**102**	**25.5**	**25**	**6.25**	**273**	**68.25**
Romantic	Feeling stressed: problems with girlfriend/boyfriend/partner	**91**	**27**	**29.67**	**14**	**15.38**	**50**	**54.95**
Family	Problems with parents/guardian	100	60	60	7	7	33	33
	Problems with parents about school performance	100	39	39	8	8	53	53
	Feeling stressed about financial problems at home	100	35	35	7	7	58	58
	Feeling stressed about violence at home	100	7	7	8	8	85	85
	Feeling stressed about loss/death of parent/guardian	100	22	22	9	9	69	69
	TOTAL	**500**	**163**	**32.6**	**39**	**7.8**	**298**	**59.6**

As can be gleaned from the results in table 4.5 above a significant number of the respondents (87.7%) disagreed to strongly disagreed that life events were a source of stress. On the other hand, the majority of respondents (88.0%) agreed to strongly agreed that school events are a major source of stress. Contrarily, most respondents (68.25%) felt strongly that friends were not a major source of stress in their lives, but a quarter of respondents (25.5%) did feel that friends are a source of stress. However, with regard to the remaining two factors (romantic events and family events), just over half of the respondents disagree to strongly disagree that these domains are a source of stress (54.95% and 59.6%, respectively), while almost a third of respondents did agree to strongly agree that romantic events (n=27; 29.67%) and family events (n=163; 32.6%) could be sources of stress, and the balance of respondents remained undecided.

4.5 Coping Strategies Used by Students

Objective 3: To explore the coping strategies used by adolescents to cope with their challenges.

The third objective of this study is to explore adolescent coping strategies in response to the challenges that they face (refer to section 4.3 above), which include meeting pre-determined adolescent developmental tasks. The items included in the survey were adapted from the R-COPE (Zuckerman & Gagne, 2003). Items were clustered under five domains, namely: Self-help, Approach, Accommodation, Avoidance and Punishment. The questions posed sought to identify the respondents' style of coping and the questions were adapted to align with the remaining two sub-sections which seek to address both internal and external resources and adolescent perceptions of various sources of support. Table 4.6 below disaggregates the results of the frequency distribution of adolescent coping strategies.

Table 4.6

Descriptive Statistics: Coping Strategies and Perceptions of Resources (R-COPE)

			Frequency and Percentage					
			Strongly/agree		Undecided		Strongly/disagree	
SCALES	**Variables**	**N**	***n***	**%**	***n***	**%**	***n***	**%**
Self-help	Allow self to show feelings to people I am close to	100	55	55	12	12	33	33
	Discuss my feelings with friends I trust	100	59	59	3	3	38	38
	I try to get emotional support from my family	100	43	43	12	12	45	45
	I talk to someone to help me find better ways to cope with my problems	100	49	49	7	7	44	44
	If I feel sad & anxious sometimes I go out to socialise with my friends	100	53	53	8	8	39	39
	If I feel sad & anxious I ask my parents/guardian help & support	100	40	40	10	10	50	50
	If I feel sad & anxious I seek help from friends I can trust	100	46	46	11	11	43	43
	If I have an emotional problem I talk to a professional	100	32	32	6	6	62	62
	TOTAL	**800**	**377**	**47.25**	**69**	**8.63**	**354**	**44.25**
Approach	I make an effort to do something to deal with situation/problem	100	66	66	14	14	20	20
	I try hard to prevent other things interfering with my plans to deal with the problem	100	57	57	23	23	20	20
	I take action to avoid the situation	100	58	58	23	23	19	19
	If I have emotional problems I monitor my own thoughts & feelings rather than ask for help	100	74	74	8	8	18	18
	When I feel stressed I ask parents/guardians for help/support	100	40	40	10	10	50	50
	When I feel stressed I discuss with friends to get help to cope	100	44	44	5	5	51	51

	TOTAL	**600**	**339**	**56.5**	**83**	**13.83**	**178**	**29.67**
Accommodation	I try to stay positive to help me cope even though I feel stressed	100	68	68	10	10	22	22
	I try to see my problem in different ways to help me cope	100	57	57	20	20	23	23
	I accept the reality that it happened or is happening	100	80	80	10	10	10	10
	I try to focus on something else I care about to help me cope	100	65	65	10	10	25	25
	TOTAL	**400**	**270**	**67.5**	**50**	**12.5**	**80**	**20**
Avoidance	I refuse to believe problem happening to me. I say to myself this isn't real	100	15	15	11	11	74	74
	I admit I can't deal with it & quit trying to find a solution	100	31	31	15	15	54	54
	I blame someone/something else for what happened or is happening to me	100	32	32	13	13	55	55
	I try to forget the whole thing	100	47	47	9	9	44	44
	TOTAL	**400**	**125**	**31.25**	**48**	**12**	**227**	**56.75**
Self-Punishment	I blame myself for the problem	100	64	64	12	12	24	24
	I think about what is troubling me all the time	100	54	54	19	19	27	27
	I criticise or lecture myself	100	74	74	5	5	21	21
	TOTAL	**300**	**192**	**64**	**36**	**12**	**72**	**24**

With regards to the various coping behaviours respondents utilised, the results in table 4.6 above indicate that with respect to self-help as a coping mechanism, respondents appear to be more or less split down the middle (47.25% agree to strongly agree, while 44.25% disagree to strongly disagree with the concepts) in terms of their perceptions regarding methods construed as being helpful to self. Items pertaining to a constructive action-oriented approach (Subscale 2) and accommodation as coping strategies are skewed towards agree to

strongly agree (56.5% and 67.5% respectively, whereas more than 50% of respondents disagree to strongly disagree with an avoidance approach to coping – 56.75%). Finally, with regards to the self-punishment style of coping 64% of respondents agree to strongly agree in so far as there appears to be a significant tendency to adopt this coping style.

4.6 Resources Used to Mitigate Challenges

Objective 4: To explore adolescents' internal and external resources and help-seeking behaviours they use to mitigate the psycho-social challenges that they face and their perceptions of counselling versus coaching as mechanisms to help mitigate these challenges.

To explore adolescents' help-seeking behaviours and perceptions of resources that mitigate the psycho-social challenges that they face, questions based on the GHSQ (Wilson et al., 2005) were adapted to meet this particular objective of the study. The items identified a problem in a particular domain (parents, school, psycho-emotional, romantic, friends and sexuality) with the purpose of ascertaining which source of psycho-emotional support adolescents prefer to tap into with regards to each domain. They were presented with five options, which were coded 1 to 5 as follows: Parents (1), Self (2), Close friends (3), Counsellor/Social worker/Teacher or psychologist (4) and Life Coach (5), from which they were asked to choose one option per question.

Table 4.7

Help-Seeking Behaviours (GHSQ)

		Frequency and Percentage									
		1 Life-Coach		2 Counsellor, Social Worker/Teacher or Psychologist		3 Close Friends		4 Self		5 Parents	
Variable	**N**	***n***	**%**	***n***	**%**	***n***	**%**	**n**	**%**	**n**	**%**
GHSQ1	100			28	28	34	34	26	26	12	12
GHSQ2	100			15	15	21	21	16	16	48	48
GHSQ3	100			17	17	17	17	45	45	21	21
GHSQ4	100			6	6	51	51	19	19	24	24
GHSQ5	100			9	9	15	15	34	34	42	42
GHSQ6	100			35	35	8	8	19	19	38	38
GHSQ7	100	1	1	17	17	28	28	36	36	18	18
GHSQ8	100	1	1	28	28	14	14	32	32	25	25

The results gleaned from table 4.7 overarchingly indicate that a life-coach is not valued as a resource at all. In the domain of experiencing problems with parents (GHSQ1), the responses were more or less evenly spread across self, close friends and professional help, except for life-coach (26%, 34% and 28%, respectively), while only 12% indicated that their parents are valued as a resource. GHSQ2 addresses the question of problems with school, work and teachers while GHSQ5 addresses problems with friends and peers. Respondents favour parents as a resource (48% and 42%, respectively), followed by close friends and self (21% and 34% respectively) which are moderately favoured, while professional help is slightly favoured (15% and 9% respectively), but excludes a life-coach with regards to

problems with peers. GHSQ3 explores experiencing psycho-emotional problems and 45% of respondents favour self as a resource, and the responses to the alternate resources are relatively evenly spread across the options with parents being moderately favoured (21%), while life-coach is not valued at all. GHSQ4 addresses the question of problems with romantic partners and friends emerge as the most valued resource (51%) while professional resources yield the lowest response (6%). GHSQ6 addresses mental health concerns and both parents (38%) and professionals (35%) – excluding a life-coach – emerge as valuable resources relative to the other options. Sexuality is explored through GHSQ7 and self emerges as the most valuable resource (36%) closely followed by close friends (28%). Professionals (excluding a life coach) and parents are equally represented (17% and 18%, respectively), while a life-coach received 1% of the responses. GHSQ8 addresses suicidal thoughts and responses are relatively evenly spread across self (32%), professionals (28%) and parents (25%), while a life-coach received 1% of the responses.

4.7 Perceptions of Resources and Barriers to Help-Seeking Behaviours

Objective 5: To explore adolescents' perceptions of resources and barriers to help-seeking behaviours.

To address the question regarding adolescents' perceptions of resources and potential barriers to help-seeking behaviour, questions were based on the abbreviated version of the BASH (Kuhl et al., 1997, as cited in Wilson et al., 2005) namely the BASH-B (Wilson et al., 2005). Five domains of resources were identified, namely: Professional, Religious, Friends, Parents and Self. The nature of the questions aligns with the preceding objectives with the aim of using differently formulated items to identify which resources adolescents perceive to be valuable within their socio-cultural contexts. This section seeks to address access and availability of resources as well as potential stigma and barriers to help-seeking associated

with mental illness as it manifests in adolescents' socio-cultural context, including, school, the community and religious milieus. 11 items were presented on a Likert scale, ranging from strongly disagree to strongly agree. The results are disaggregated in table 4.8 below.

Table 4.8

Descriptive Statistics: Coping Strategies and Perceptions of Resources (BASH-B)

		Frequency and Percentage						
			Strongly/agree		Undecided		Strongly/disagree	
SCALES	**Variables**	**N**	***n***	**%**	***n***	**%**	***n***	**%**
Professional	If my community had a special adolescent centre with counsellors/psychologists I would go to that centre to get help for my problems	100	42	42	32	32	26	26
	If my school had a counsellor/psycholgist, guidance counsellor/social worker I would feel comfortable to discuss my problems with them	100	31	31	28	28	41	41
	If I was having problems with my sexuality it would be best to seek help from professionals	100	25	25	35	35	40	40
	If I had an emotional/psychological problem I would trust a professional to help me	100	72	72	16	16	12	12
	If my friend was struggling with an emotional/psychological problem I would encourage them to seek help from a professional because they are trustworthy	100	85	85	13	13	2	2
	If I had an emotional/psychological problem I would not know where to go or who to ask to get professional help	100			18	18	82	82
	If I knew someone who had received professional help for their mental health problem this would encourage me to get professional help	100	67	67	23	23	10	10
	TOTAL	**700**	**322**	**46.0**	**165**	**23.57**	**213**	**30.43**
Religious	I would choose to go talk to a religious leader or counsellor about my problem	100	11	11	19	19	70	70
Friends	If had problems with my sexuality my friends would be the best source of help	100	30	30	29	29	41	41
Parents	If I had an emotional/psychological problem my parents would be a better source of help than a professional	100	26	26	33	33	41	41
Self	I think I should sort out my own emotional/ psychological problems rather than seek professional help	100	0	0	31	31	69	69

The results as indicated in table 4.8 above show that 46% of the respondents agree or strongly agree that if professional intervention was available either in their community or at school they would avail themselves of these services. In addition, they would trust a

professional to address their psycho-emotional concerns and would be willing to recommend their friends to a professional if they were struggling. Respondents also indicated that knowing someone who had received help for their mental health problems would encourage them to do the same. It should be noted that in this particular domain, a substantial number (n=30; 30%) of respondents strongly disagreed with this view, while 23.57% remained undecided. The vast majority of respondents (70%) indicated that they disagree or strongly disagree with the idea of speaking to a religious leader or counsellor about their problems. With regards to experiencing problems with sexuality, 41% of respondents indicated they disagreed to strongly disagreed that friends would be their chosen resource, while 30% agreed to strongly agreed and 29% indicated they were undecided. With regards to parents being a better source of help than professionals, 41% of respondents strongly disagreed, while 26% agreed to strongly agreed and 31% indicated they were undecided about parents being their preferred resource for support. Respondents disagreed to strongly disagreed (69%) with the notion that they should sort out their own problems rather than seek out the help of a professional. In addition, 31% of respondents indicated that they were undecided, while no respondents (0%) agreed or strongly agreed.

The sub-section that follows disaggregates the Inferential statistical results from the Kruskal Wallis and Mann-Whitney U non-parametric tests that were used to analyse the study's data.

4.8 Inferential Results

The students' demographics were measured on a number of scale items, including gender, age, population group, grade and type of school the students attended. Non-parametric analyses were conducted to ascertain whether there was a significant difference between these variables and different continuous variables as stipulated below. These

analyses were used because the parametric assumption of randomisation was violated. The ensuing research questions served as the focus for the inferential results:

Is there a difference between gender and:

a. Mental Health Literacy in terms of knowledge of mental health problems, erroneous beliefs and stereotypes, first aid and help-seeking behaviours and self-help strategies
b. Adolescents' concerns regarding socio-cultural stressors in terms of (1) negative life events (2) school events, (3) friendship events, (4) romantic events, and (5) family events that they face
c. Coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors including (1) self-help, (2) approach, (3) accommodation, (4) avoidance, and (5) punishment
d. Adolescents' perceptions of resources and barriers to help-seeking behaviours in terms of (1) professional, (2) religious, (3) friends, (4) parents, and (5) self

Is there a difference between age and:

a. Mental Health Literacy in terms of knowledge of mental health problems, erroneous beliefs and stereotypes, first aid and help-seeking behaviours and self-help strategies
b. Adolescents' concerns regarding socio-cultural stressors in terms of (1) negative life events (2) school events, (3) friendship events, (4) romantic events, and (5) family events that they face
c. Coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors including (1) self-help, (2) approach, (3) accommodation, (4) avoidance, and (5) punishment
d. Adolescents' perceptions of resources and barriers to help-seeking behaviours in terms of (1) professional, (2) religious, (3) friends, (4) parents, and (5) self

Is there a difference between population group, and:

a. Mental Health Literacy in terms of knowledge of mental health problems, erroneous beliefs and stereotypes, first aid and help-seeking behaviours and self-help strategies
b. Adolescents' concerns regarding socio-cultural stressors in terms of (1) negative life-events (2) school events, (3) friendship events, (4) romantic events, and (5) family events that they face
c. Coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors including (1) self-help, (2) approach, (3) accommodation, (4) avoidance, and (5) punishment
d. Adolescents' perceptions of resources and barriers to help-seeking behaviours in terms of (1) professional, (2) religious, (3) friends, (4) parents, and (5) self

Is there a difference between grade and:

a. Mental Health Literacy in terms of knowledge of mental health problems, erroneous beliefs and stereotypes, first aid and help-seeking behaviours and self-help strategies
b. Adolescents' concerns regarding socio-cultural stressors in terms of (1) negative life-events (2) school events, (3) friendship events, (4) romantic events, and (5) family events that they face
c. Coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors including (1) self-help, (2) approach, (3) accommodation, (4) avoidance, and (5) punishment
d. Adolescents' perceptions of resources and barriers to help-seeking behaviours in terms of (1) professional, (2) religious, (3) friends, (4) parents, and (5) self

Is there a difference between type of school and:

a. Mental Health Literacy in terms of knowledge of mental health problems, erroneous beliefs and stereotypes, first aid and help-seeking behaviours and self-help strategies

b. Adolescents' concerns regarding socio-cultural stressors in terms of (1) negative life-events (2) school events, (3) friendship events, (4) romantic events, and (5) family events that they face
c. Coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors including (1) self-help, (2) approach, (3) accommodation, (4) avoidance, and (5) punishment
d. Adolescents' perceptions of resources and barriers to help-seeking behaviours in terms of (1) professional, (2) religious, (3) friends, (4) parents, and (5) self

4.8.1 Differences According to Gender

A Kruskal-Wallis analysis of variance test was performed to ascertain whether there was a significant difference in mental health literacy between gender groups (male, female, and "other" genders); between adolescents' concerns regarding the stressors and/or negative life events that they face in their socio-cultural contexts and gender; coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors and gender; and adolescent perceptions of resources and barriers to help-seeking behaviours and gender. Pairwise comparisons were completed for all significant test results.

The Kruskall-Wallis test results of mental health literacy in terms of gender are presented in Table 4.9 below.

Table 4.9

Kruskal-Wallis Analysis of Mental Health Literacy by Gender

	Gender	n	Mean Rank	df	χ^2	p
Knowledge of Mental Health Problems	Female	60	54.35	2	2.684	.261
	Male	37	44.84			
	Other	3	43.33			
Erroneous Beliefs and Stereotypes	Female	60	55.72	2	5.247	.073
	Male	37	43.07			

	Other	3	37.83			
First-aid and Help-Seeking Behaviours	Female	60	55.64	2	7.930	.019
	Male	37	43.41			
	Other	3	35.17			
Self-Help Strategies	Female	60	46.88	2	13.807	.001
	Male	37	59.19			
	Other	3	15.67			

*Kruskal Wallis Test $p<0.05$

As can be observed from the Kruskall Wallis H-test results in Table 4.9 above, there was no statistically significant difference between knowledge of mental health problems and the different genders (χ^2 (df=2, N=100) = 2.684, $p>.05$) or between erroneous beliefs and stereotypes regarding mental health and the different genders (χ^2 (df=2, N=100) = 5.247, $p>.05$). The H-test further shows that there was a significant difference (p =.019) between first-aid and help-seeking behaviours and the different genders (χ^2 (df=2, N=100) = 7.930, $p = .019$). It is clear that girls (Mean Rank = 55.64) are more prone to first-aid and help-seeking behaviours than boys (Mean Rank = 43.41) and "other" genders (Mean Rank = 35.17). On the other hand, boys are significantly (df=2, N=100) = 13.807, $p = .001$) more prone to utilising self-help strategies (Mean Rank = 59.19) than girls (Mean Rank = 46.88) and "other" genders (Mean Rank = 15.67).

The Kruskal-Wallis test results above showed whether there are differences between the different gender groups but does not indicate which groups differ from others (Field, 2005). To determine the actual groups that differ from one another, we conducted pairwise Mann–Whitney tests with Bonferroni corrections. Thus, "instead of using .05 as the critical value for significance for each test, the critical value of .05 is divided by the number of tests conducted" (Field, 2005, p.550), yielding a critical value of .0167. By adjusting the *p*-value, we can significantly reduce the probability of making a type I error between the set of multiple comparisons (Bobbit, 2020a). The pairwise comparison results for gender and first-aid and help-seeking behaviours are depicted in Tables 4.10 and 4.11 below.

Table 4.10

Pairwise Comparisons of Gender – First-Aid and Help Seeking Behaviour

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Other – Male	8.239	13.739	.600	.549	1.000
Other – Female	20.475	13.540	1.512	.130	.391
Male – Female	12.236	4.784	2.558	.011	.032

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.10 pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (p = 1.000; .391; .032) are greater than 0.0167 (.05/3 = 0.0167).

Table 4.11

Pairwise Comparisons of Gender – Self Help Strategies

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Other – Male	31.217	13.527	2.308	.021	.063
Other – Female	43.523	13.726	3.171	.002	.005
Male – Female	-12.306	4.780	-2.575	.010	.030

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.11, the pairwise post-hoc Dunn’s test with Bonferroni adjustments was significant only for the “other vs female” gender paired comparison since the observed critical value of .005 is less than .0167 (.05/3 = .0167).

The following table presents the results of the Kruskal-Wallis test computed to establish whether gender has an effect on the socio-cultural contextual stressors (i.e., negative life events, school events, friendship events, romantic events, and family events) that adolescents face.

Table 4.12

Kruskal-Wallis Analysis of Socio-cultural Stressors by Gender

	Gender	*n*	Mean Rank	*df*	X^2	*p*
Life Events	Female	60	53.84	2	6.776	.034
	Male	37	43.38			
	Other	3	71.50			
School Events	Female	60	53.30	2	3.048	.218
	Male	37	46.51			
	Other	3	43.67			
Friendship Events	Female	60	57.00	2	13.064	.001
	Male	37	37.93			
	Other	3	75.50			
Romantic Events	Female	60	50.94	2	.049	.976
	Male	37	49.91			
	Other	3	49.00			
Family Events	Female	60	53.27	2	6.510	.039
	Male	37	43.43			
	Other	3	82.33			

*Kruskal Wallis Test $p<0.05$

The test statistics in Table 4.12 above indicate that there was a statistically significant difference in negative life events in terms of gender (χ^2 (2, N = 100) = 6.776, p = .034) and in friendship events and gender (χ^2 (2, N = 100) = 13.064, p = .001), as well as family events and gender (χ^2 (2, N = 100) = 6.510, p = .039). This indicates that the gender of adolescents significantly contributes to the socio-cultural stressors related to life events, friendship events, and family events. The results further show that "other" gendered individuals are significantly more likely to have experienced various socio-cultural stressors, including negative life events (Mean Rank = 71.50), friendship events (Mean Rank = 75.50), and family events (Mean Rank = 82.33). A non-significant difference was found in school events and gender (χ^2 (df=2, N=100) = 3.048, p = .218) and romantic events and gender (χ^2 (df=2, N=100) = .049, p = .976) since the p-value is greater than 0.05.

Table 4.13

Pairwise Comparisons of Gender and Life Events

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Male – Female	10.463	4.995	2.095	.036	.109
Male – Other	-28.122	14.346	-1.960	.050	.150
Female – Other	-17.658	14.138	-1.249	.212	.635

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.13 above, pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (p = .109; .150; .635) are greater than 0.0167 (.05/3 = 0.0167).

Table 4.14

Pairwise Comparisons of Gender and Friendship Events

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Male – Female	19.068	5.856	3.256	.001	.003
Male – Other	-37.568	16.818	-2.234	.025	.076
Female – Other	-18.500	16.574	-1.116	.264	.793

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.14 above, following the procedure recommended by Dunn, alpha was set at 0.0084 (0.05/3 = .0167, two-tailed) corresponding to a critical value of 2.39 (Field, 2005). Pairwise comparisons of all groups indicated that there was a significant difference (p = .003) in values for the "male vs female" gender paired comparison since the observed a of .003 is less than 0.0084). There were no significant differences in values between the other paired comparisons because the observed critical values were greater than 0.0167.

Table 4.15

Pairwise Comparisons of Gender and Family Events

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Male – Female	9.834	5.991	1.642	.101	.302
Male – Other	-38.901	17.205	-2.261	.024	.071
Female – Other	-29.067	16.956	-1.714	.086	.259

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.15 above, pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (p = .302; .071; .259) are greater than 0.0167 (.05/3 = 0.0167).

Table 4.16 presents the results of the Kruskal-Wallis test computed to establish whether there is an effect of gender on the coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors (i.e., self-help; approach; accommodation, avoidance, and self-punishment).

Table 4.16

Kruskal-Wallis Analysis of Coping Strategies and Perceptions of Resources by Gender

	Gender	***n***	**Mean Rank**	***df***	**X^2**	***p***
Self-help	Female	60	50.93	2	1.613	.446
	Male	37	51.49			
	Other	3	29.67			
Approach	Female	60	47.88	2	7.394	.025
	Male	37	57.64			
	Other	3	14.83			
Accommodation	Female	60	49.58	2	.396	.820
	Male	37	52.50			
	Other	3	44.33			
Avoidance	Female	60	55.13	2	11.385	.003
	Male	37	40.04			
	Other	3	87.00			
Self-Punishment	Female	60	52.55	2	5.711	.058
	Male	37	44.62			
	Other	3	82.00			

*Kruskal Wallis Test $p<0.05$

As can be gleaned from the Kruskall Wallis H-test results in Table 4.16 above that there was no significant difference between self-help as a coping strategy and gender (χ^2 (df=2, N=100) = 1.613, *p*>.05); accommodation as a coping strategy and gender (χ^2 (df=2, N=100) = .396, *p*>.05), and self-punishment as a coping strategy and gender (χ^2 (df=2, N=100) = 5.711, *p*>.05). The H-test further shows that there is a significant difference between the different genders and approach style of coping (χ^2 (df=2, N=100) = 7.394, *p* =.025). Boys (Mean Rank = 57.64) are more prone to taking constructive action to manage stressors than girls and "other" genders. In addition, the results show that there is a significant difference between genders and the avoidance style of coping. Specifically, "other" genders are significantly (p.003) more prone to using avoidance strategies (Mean Rank=87.00) than girls and boys (df=2, N=100) = 11.385, *p* =.003) as a coping strategy to manage stressors.

Table 4.17

Pairwise Comparisons of Gender and Approach as a Coping Strategy

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Other – Female	33.050	17.007	1.943	.052	.156
Other – Male	42.802	17.257	2.480	.013	.039
Female – Male	-9.752	6.009	-1.623	.105	.314

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.17 above, pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (*p* = .156; .039; .314) are greater than 0.0167 (.05/3 = 0.0167).

Table 4.18

Pairwise Comparisons of Gender and Avoidance as a Coping Strategy

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Male – Female	15.084	5.983	2.521	.012	.035
Male – Other	-46.959	17.183	-2.733	.006	.019
Female – Other	-31.875	16.934	-1.882	.060	.179

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .050.
a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.18 above, pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (p = .035; .019; .179) are greater than 0.0167 (.05/3 = 0.0167).

The ensuing table presents the results of the Kruskal-Wallis test computed to establish whether gender has an effect on young people's perception of resources and barriers to help-seeking behaviours (i.e., professional; religious; friends; parents and self).

Table 4.19

Kruskal-Wallis Analysis of Perception of Resources and Barriers to Help-Seeking by Gender

	Gender	***n***	**Mean Rank**	***df***	***X*^{2}**	***p***
Professional	Female	60	50.95	2	.085	.958
	Male	37	49.54			
	Other	3	53.33			
Religious	Female	60	48.13	2	3.595	.166
	Male	37	55.57			
	Other	3	35.50			
Friends	Female	60	53.09	2	1.611	.447
	Male	37	46.00			
	Other	3	54.17			
Parents	Female	60	48.23	2	2.900	.235
	Male	37	55.57			
	Other	3	33.33			
Self	Female	60	50.83	2	.048	.977
	Male	37	49.86			
	Other	3	51.67			

*Kruskal Wallis Test p<0.05

The results in Table 4.19 above of the Kruskal Wallis test computed to determine whether there were statistically significant differences between the mean scores of young people's perception of resources and barriers to help-seeking behaviours (i.e., professional; religious; friends; parents and self) and gender, revealed no statistically significant difference (X^2 (2, N =99) = .085; 3.595; 1.611; 2.900; .048; p>.05) between subscales and total scores as all the p-values were greater than 0.05. Since the overall test results were not significant, pairwise comparisons between the three gender groups were not computed.

4.8.2 Differences in Terms of Age

A Kruskal-Wallis test was computed to ascertain whether there was a significant difference in mental health literacy between different age groups (16, 17, and 18 years); between adolescents' concerns regarding the stressors and/or negative life events that they face in their socio-cultural contexts and age; coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors and age; adolescent perceptions of resources and barriers to help-seeking behaviours and age.

The Kruskall-Wallis test results of mental health literacy, according to age, are presented in Table 4.20 below.

Table 4.20

Kruskal-Wallis Analysis of Mental Health Literacy by Age

	Age	***n***	**Mean Rank**	***df***	**X^2**	***p***
Knowledge of Mental Health Problems	16	59	48.29	2	.793	.673
	17	28	51.00			
	18	12	56.08			
Erroneous Beliefs and Stereotypes	16	59	55.25	2	5.301	.071
	17	28	41.32			
	18	12	44.42			
	16	59	51.00	2	1.627	.443
	17	28	51.21			

First-aid and Help Seeking Behaviours	18	12	42.25			
Self-Help Strategies	16	59	49.58	2	1.070	.586
	17	28	48.27			
	18	12	56.08			

*Kruskal Wallis Test $p<0.05$

The results of the *H*-Test tests computed to determine whether there were statistically significant differences between the mean scores of mental health literacy, according to age, revealed non-statistically significant differences (X^2 (2, N =99) = .793; 5.301; 1.629; 1.070; $p>.05$) between subscales and total scores as all the p-values were greater than the alpha level. This indicates that age is not a factor as far as mental health literacy among adolescents is concerned. Since the test results were overall not significant, pairwise comparisons between the three age groups were not computed.

In terms of mean ranks, 16-year-olds scored higher on the erroneous beliefs and stereotypes dimension (Mean Rank = 55.25), followed by 18-year-olds (Mean Rank = 44.42), while 18-year-olds had higher scores on knowledge of mental health problems (Mean Rank = 56.08) than 17-year-olds (Mean Rank = 51.00), and on self-help strategies (Mean Rank = 56.08) than 16-year-olds (Mean Rank = 49.58). In addition, 17-year-olds scored slightly higher in one dimension, i.e., first-aid and help-seeking behaviours (Mean Rank = 51.21) than 16-year-olds (Mean Rank = 51.21).

The Kruskall-Wallis test results of the stressors and/or negative life events that adolescents face in their socio-cultural contexts, according to age, are presented in Table 4.21 below.

Table 4.21

Kruskal-Wallis Analysis of Stressors and Negative life-events by Age

	Age	*n*	Mean Rank	*df*	X^2	*p*
Life Events	16	59	50.74	2	1.471	.479
	17	28	51.71			
	18	12	42.38			
School Events	16	59	51.31	2	.688	.709
	17	28	48.36			
	18	12	47.42			
Friendship Events	16	59	51.13	2	.252	.882
	17	28	48.04			
	18	12	49.04			
Romantic Events	16	59	46.83	2	3.280	.194
	17	28	52.07			
	18	12	60.75			
Family Events	16	59	50.42	2	.062	.970
	17	28	48.88			
	18	12	50.54			

*Kruskal Wallis Test $p<0.05$

The results of the computed Kruskal Wallis Test to determine whether there were statistically significant differences between the mean scores of the stressors and/or negative life events that adolescents face in their socio-cultural contexts and age revealed that there were no statistically significant differences between subscales and total scores as all the p-values were greater than the alpha level ($p>0.05$). This indicates that age is not a factor as far as the stressors and negative life events encountered by adolescents is concerned. However, in terms of mean ranks, 16-year-olds scored higher in two dimensions, i.e., school events (Mean Rank = 51.31) and friendship events (Mean Rank = 51.13); 17-year-olds also scored higher in one dimension, i.e., negative life events (Mean Rank = 51.71), and 18-year-olds also scored higher in two dimensions, i.e., romantic events (Mean Rank = 60.75) and family events (Mean Rank = 50.54). Since the test results were overall not significant, pairwise comparisons between the three age groups were not computed.

The Kruskall-Wallis test results of coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors, according to age, are presented in Table 4.22 below.

Table 4.22

Kruskal-Wallis Analysis of Coping Strategies and Perceptions of Resources by Age

	Age	***n***	**Mean Rank**	***df***	X^2	***p***
Self-help	16	59	46.80	2	3.530	.171
	17	28	50.86			
	18	12	63.75			
Approach	16	59	44.50	2	5.826	.054
	17	28	56.32			
	18	12	62.29			
Accommodation	16	59	45.94	2	3.109	.211
	17	28	55.68			
	18	12	56.71			
Avoidance	16	59	48.99	2	4.955	.084
	17	28	57.89			
	18	12	36.54			
Self-Punishment	16	59	51.82	2	.629	.730
	17	28	47.43			
	18	12	47.04			

*Kruskal Wallis Test $p<0.05$

In Table 4.22 above, the values indicate that the views of adolescents of different ages did not differ significantly in the R-Cope subscales and total scores (X^2 (2, N =99) = 3.530; 5.826; 3.109; 4.955; .629; $p>.05$). This indicates that overall, the age of students does not significantly contribute to the coping strategies and perceptions of resources that adolescents use to manage the psycho-social stressors they encounter. However, in terms of mean ranks, 18-year-olds scored higher in three dimensions, i.e., self-help (Mean Rank = 63.75), approach (Mean Rank = 62.29), and accommodation (Mean Rank = 56.71), except for avoidance and punishment. Since the test results were overall not significant, pairwise comparisons between the three age groups were not computed.

The Kruskall-Wallis test results of adolescent perceptions of resources and barriers to help-seeking behaviours, according to age, are presented in Table 4.23 below.

Table 4.23

Kruskal-Wallis Analysis of Perception of Resources and Barriers to Help-Seeking by Age

	Age	*n*	Mean Rank	*df*	X^2	*p*
Professional	16	59	49.85	2	2.852	.240
	17	28	45.25			
	18	12	61.83			
Religious	16	59	48.95	2	.311	.856
	17	28	51.29			
	18	12	52.17			
Friends	16	59	48.47	2	.518	.772
	17	28	52.86			
	18	12	50.88			
Parents	16	59	48.68	2	1.754	.416
	17	28	55.25			
	18	12	44.25			
Self-Punishment	16	59	49.60	2	.049	.976
	17	28	50.41			
	18	12	51.00			

*Kruskal Wallis Test $p<0.05$

No significant difference ($p>.05$) was found between the mean scores among adolescents of different ages in terms of resources and barriers to help-seeking as all the *p*-values exceeded .05, as indicated in Table 4.23 This reveals that overall, the age of students does not significantly contribute to adolescent perceptions of resources and barriers to help-seeking behaviours. However, in terms of mean ranks, 18-year-olds scored higher in three dimensions, i.e., professional (Mean Rank = 63.75), religious (Mean Rank = 62.29), and self (Mean Rank = 56.71), except for friends and parents. Since the test results were overall not significant, pairwise comparisons between the three population groups were not computed.

4.8.3 Difference According to Population Group

A Kruskal-Wallis test was computed to ascertain whether there was a significant difference in mental health literacy between population groups (Black, White, Coloured, Indian, Other); between adolescents' concerns regarding the stressors and/or negative life events that they face in their socio-cultural contexts and population group, coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors and population group, adolescent perceptions of resources and barriers to help-seeking behaviours and population group.

The use of racial categories in this study were deemed important to the projected outcomes of this study and as it aligns with the aims and objectives of the study. Also, because it pertained to identifying differences between groups and the sub-scales of the measures used. Population group was self-reported by the respondents and the categories decided upon by the researcher in consultation with the supervisors. Classification on the basis of population group has implications for data collection, data analysis and reporting of the findings for this study.

The Kruskall-Wallis test results of mental health literacy, according to population group, are presented in Table 4.24 below.

Table 4.24

Kruskal-Wallis Analysis of Mental Health Literacy by Population Group

	Population Group	N	**Mean Rank**	***df***	X^2	***p***
Knowledge of Mental Health Problems	Black	11	54.73	2	3.289	.511
	White	73	52.38			
	Coloured	9	41.22			
	Indian	3	40.00			
	Other	4	33.38			
Erroneous Beliefs and Stereotypes	Black	11	46.50	2	2.060	.725
	White	73	49.99			

	Coloured	9	48.67			
	Indian	3	67.50			
	Other	4	62.13			
First-aid and Help-Seeking Behaviours	Black	11	51.45	2	2.431	.657
	White	73	50.62			
	Coloured	9	54.72			
	Indian	3	31.33			
	Other	4	50.63			
Self-Help Strategies	Black	11	41.91	2	6.977	.137
	White	73	53.96			
	Coloured	9	40.39			
	Indian	3	49.67			
	Other	4	34.38			

*Kruskal Wallis Test $p<0.05$

As can be observed from the Kruskall Wallis H-test results in Table 4.24 above, there was no significant difference between knowledge of mental health problems and population group (χ^2 (df=2, N=100) = 3.289, $p>.05$) and erroneous beliefs and stereotypes regarding mental health and population group (χ^2 (df=2, N=100) = 2.060, $p>.05$); first-aid and help-seeking behaviours and population group (χ^2 (df=2, N=100) = 2.431, $p>.05$); and self-help strategies and population group (χ^2 (df=2, N=100) = 6.977, $p>.05$). Since the test results were overall not significant, pairwise comparisons between the five population groups were not computed.

Table 4.24 above, also indicates that Black adolescents scored higher on knowledge of mental health problems (Mean Rank = 54.73), Indian adolescents scored higher on erroneous beliefs and stereotypes (Mean Rank = 67.50), Coloured adolescents scored higher on first-aid and help-seeking behaviour (Mean Rank = 54.72) and White adolescents scored higher on self-help strategies (Mean Rank = 53.96).

The Kruskall-Wallis test results of the stressors and/or negative life events that adolescents face in their socio-cultural contexts, according to population group, are presented in Table 4.25 below.

Table 4.25

Kruskal-Wallis Analysis of Stressors and Negative life-events by Population Group

	Population Group	***n***	**Mean Rank**	***df***	X^2	***p***
Life Events	Black	11	54.68	2	2.342	.673
	White	73	50.54			
	Coloured	9	40.67			
	Indian	3	53.00			
	Other	4	58.50			
School Events	Black	11	45.86	2	4.629	.328
	White	73	49.12			
	Coloured	9	60.00			
	Indian	3	60.00			
	Other	4	60.00			
Friendship Events	Black	11	59.95	2	7.358	.118
	White	73	48.61			
	Coloured	9	51.17			
	Indian	3	25.50			
	Other	4	76.25			
Romantic Events	Black	11	45.55	2	1.276	.866
	White	73	51.40			
	Coloured	9	48.50			
	Indian	3	42.17			
	Other	4	58.50			
Family Events	Black	11	54.82	2	2.528	.640
	White	73	48.19			
	Coloured	9	60.83			
	Indian	3	45.67			
	Other	4	61.13			

*Kruskal Wallis Test $p<0.05$

The results of the Kruskal Wallis Test computed to determine whether there were statistically significant differences between the mean scores of stressors and/or negative life events that adolescents face in their socio-cultural contexts and population group revealed no statistically significant difference between subscales and total scores (X^2 (2, N = 100) = 2.342; 4.629; 7.358; 1.276; 2.528; $p>.05$) as all the p-values were greater than the alpha level ($p>0.05$). This indicates that population group is not a factor as far as mental health literacy among adolescents is concerned. Since the test results were overall not significant, pairwise comparisons between the five population groups were not computed.

However, the mean ranks indicate that individuals from the "other" population group category consistently scored higher in all dimensions (Mean Ranks = 58.50; 76.26; 58.50; 61.13). Except for the school events dimension, they scored the same as individuals categorised as Coloured and Indian (Mean Rank = 60.00). The second highest score for life events was attained by Black individuals (Mean Rank = 54.68) as well as for friendship events (Mean Rank = 59.95), whereas, White individuals scored the second highest for romantic events (Mean Rank = 51.40) and Coloured individuals for family events (Mean Rank = 60.83).

The Kruskall-Wallis test results of coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors, according to population group, are presented in

Table 4.26 below.

Table 4.26

Kruskal-Wallis Analysis of Coping Strategies and Perceptions of Resources by Population Group

	Population Group	***n***	**Mean Rank**	***df***	***X*²**	***p***
Self-help	Black	11	42.45	2	2.859	.582
	White	73	52.17			
	Coloured	9	40.17			
	Indian	3	60.33			
	Other	4	58.00			
Approach	Black	11	38.27	2	5.980	.201
	White	73	52.55			
	Coloured	9	38.11			
	Indian	3	71.67			
	Other	4	58.63			
Accommodation	Black	11	52.09	2	3.760	.439
	White	73	52.97			
	Coloured	9	36.50			
	Indian	3	39.17			
	Other	4	41.13			
Avoidance	Black	11	66.36	2	5.521	.238
	White	73	46.68			

	Coloured	9	57.67			
	Indian	3	57.33			
	Other	4	55.25			
Self-Punishment	Black	11	54.68	2	2.379	.666
	White	73	50.68			
	Coloured	9	50.83			
	Indian	3	56.33			
	Other	4	30.63			

*Kruskal Wallis Test $p<0.05$

The values in Table 4.26 above, indicate that the coping strategies and perceptions of adolescents from diverse racial backgrounds did not differ significantly in the R-Cope subscales and total scores (X^2 (2, N =100) = 2.859; 5.980; 3.760; 5.521; 2.379; $p>.05$). This indicates that overall, the population group of students does not significantly contribute to the coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors. Since the test results were overall not significant, pairwise comparisons between the five population groups were not computed.

However, in terms of mean ranks, Indian students scored higher in three dimensions, i.e., self-help (Mean Rank = 60.33), approach (Mean Rank = 71.67), and self-punishment (Mean Rank = 56.33), White students scored higher for accommodation (Mean Rank = 52.97), and Black students scored higher for avoidance (Mean Rank = 66.36).

The Kruskall-Wallis test results of adolescent perceptions of resources and barriers to help-seeking behaviours, according to population group , are presented in Table 4.27 below.

Table 4.27

Kruskal-Wallis Analysis of Perception of Resources and Barriers to Help-Seeking by Population Group

	Population Group	***n***	**Mean Rank**	***df***	**X^2**	***p***
Professional	Black	11	58.27	2	3.273	.513
	White	73	51.00			
	Coloured	9	36.61			
	Indian	3	43.50			

	Other	4	56.50			
Religious	Black	11	35.50	2	5.478	.242
	White	73	53.00			
	Coloured	9	50.33			
	Indian	3	50.33			
	Other	4	46.63			
Friends	Black	11	48.64	2	1.958	.743
	White	73	51.72			
	Coloured	9	39.22			
	Indian	3	56.00			
	Other	4	54.63			
Parents	Black	11	31.09	2	6.593	.159
	White	73	52.60			
	Coloured	9	55.50			
	Indian	3	58.00			
	Other	4	48.75			
Self-punishment	Black	11	53.18	2	9.728	.045
	White	73	48.70			
	Coloured	9	46.11			
	Indian	3	51.67			
	Other	4	85.00			

*Kruskal Wallis Test $p<0.05$

The results in Table 4.27 above of the Kruskal Wallis test computed to determine whether there were statistically significant differences between the mean scores of young people's perception of resources and barriers to help-seeking behaviours (i.e., professional; religious; friends; parents and self) and population group, revealed no statistically significant difference between subscales and total scores for all ($p>.05$) except for one subscale, "Self-punishment" which was found to be significant (X^2 (2, N =100) = 9.728; p.045) with adolescents from the "other" racial category achieving the highest score (Mean Rank = 85.00). In terms of mean ranks, Indian students scored higher in two dimensions, i.e., friends (Mean Rank = 56.00) and parents (Mean Rank = 58.00), while White students scored higher on the religious subscale (Mean Rank = 53.00), and Black students scored higher on the professional subscale (Mean Rank = 58.27. Individuals from "other" population groups scored much higher than other population groups on self (Mean Rank = 85). Table 4.28 below provides the results of the pairwise comparisons for the self-punishment dimension.

Table 4.28

Pairwise Comparisons of Population Group and Self-Punishment

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]
Coloured – White	2.588	8.211	.315	.753	1.000
Coloured – Indian	-5.556	15.494	-.359	.720	1.000
Coloured – Black	7.071	10.446	.677	.498	1.000
Coloured – Other	-38.889	13.966	-2.785	.005	.054
White – Indian	-2.968	13.691	-.217	.828	1.000
White – Black	4.483	7.517	.596	.551	1.000
White – Other	-36.301	11.935	-3.042	.002	.024
Indian – Black	1.515	15.138	.100	.920	1.000
Indian – Other	-33.333	17.751	-1.878	.060	.604
Black – Other	-31.818	13.570	-2.345	.019	.190

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.

Asymptotic significances (2-sided tests) are displayed. The significance level is .050.

a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.28 above, pairwise comparisons of all groups indicate that there were no significant differences in values between the different pairs of population groups because the observed critical values are greater than 0.0167 (.05/3 = 0.0167).

4.8.4 Differences According to Grade

A Kruskal-Wallis test was computed to ascertain whether there was a significant difference in mental health literacy between adolescents in different school grades (Grades 10, 11, and 12); between adolescents' concerns regarding the stressors and/or negative life events that they face in their socio-cultural contexts and school grade; coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors and school grade; adolescent perceptions of resources and barriers to help-seeking behaviours and school grade.

The Kruskall-Wallis test results of mental health literacy according to grade of students are presented in Table 4.29.

Table 4.29

Kruskal-Wallis Analysis of Mental Health Literacy by Grade

	Grade	N	Mean Rank	*df*	X^2	*p*
Knowledge of Mental Health Problems	10	48	47.35	2	1.101	.577
	11	35	53.30			
	12	17	53.62			
Erroneous Beliefs and Stereotypes	10	48	56.48	2	4.301	.116
	11	35	45.99			
	12	17	42.91			
First-aid and Help Seeking Behaviours	10	48	51.67	2	.604	.739
	11	35	50.76			
	12	17	46.68			
Self-Help Strategies	10	48	50.44	2	.001	.999
	11	35	50.51			
	12	17	50.65			

*Kruskal Wallis Test $p<0.05$

The results of the *H*-Test tests computed to determine whether there were statistically significant differences between the mean scores of mental health literacy, according to grade, revealed no statistically significant differences (X^2 (2, N = 99) = 1.101; 4.301; .604; .001; $p>.05$) between subscales and total scores as all the p-values were greater than the alpha level ($p>0.05$). This indicates that school grade is not a factor as far as mental health literacy among adolescents is concerned. Since the test results were overall not significant, pairwise comparisons between the five population groups were not computed.

However, Grade 10 adolescents scored higher on erroneous beliefs and stereotypes (Mean Rank = 56.48) and first-aid and help-seeking behaviours (Mean Rank = 51.67) and Grade 12 (Mean Rank = 53.62) adolescents scored slightly higher than Grade 11 adolescents (Mean Rank = 53.30) on knowledge of mental health problems. However, only marginal differences were reported in the scores for self-help strategies among the different grade groups.

The Kruskall-Wallis test results of the stressors and/or negative life events that adolescents face in their socio-cultural contexts, according to grade, are presented in Table 4.30 below.

Table 4.30

Kruskal-Wallis Analysis of Stressors and Negative life-events by Grade

	Grade	***n***	**Mean Rank**	***df***	***X*²**	***p***
Life Events	10	48	48.81	2	.477	.788
	11	35	52.36			
	12	17	51.44			
School Events	10	48	49.23	2	.879	.644
	11	35	53.03			
	12	17	48.88			
Friendship Events	10	48	49.03	2	2.077	.354
	11	35	48.20			
	12	17	59.38			
Romantic Events	10	48	44.82	2	6.261	.044
	11	35	52.54			
	12	17	62.32			
Family Events	10	48	49.52	2	.982	.612
	11	35	48.81			
	12	17	56.74			

*Kruskal Wallis Test $p<0.05$

The results of the computed Kruskal Wallis Test to determine whether there were statistically significant differences between the mean scores of the stressors and/or negative life events that adolescents face in their socio-cultural contexts, and school grade, revealed no statistically significant differences (p>0.05) between subscales and total scores except one sub-scale, romantic events, (χ^2 (2, N = 100) = 6.261, p = .044). This indicates that Grade 12 respondents (Mean Rank = 62.32) increasingly experience romantic events as psycho-social challenges compared with Grade 10 and l1 respondents.

Table 4.31

Pairwise Comparisons of Grade and Romantic Event

Sample 1-Sample 2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj. Sig.[a]

Grade 10-Grade 11	-7.720	5.667	-1.362	.173	.519
Grade 10-Grade 12	-17.501	7.196	-2.432	.015	.045
Grade 11-Grade 12	-9.781	7.537	-1.298	.194	.583

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same.
Asymptotic significances (2-sided tests) are displayed. The significance level is .050.
a. Significance values have been adjusted by the Bonferroni correction for multiple tests.

As indicated in Table 4.31 above, pairwise comparisons of all groups indicate that there were no significant differences in values between groups because the observed critical values (*p* = .519; .045; .583) are greater than 0.0167 (.05/3 = 0.0167).

The Kruskall-Wallis test results of coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors, according to grade, are presented in Table 4.32 below.

Table 4.32

Kruskal-Wallis Analysis of Coping Strategies and Perceptions of Resources by Grade

	Grade	***n***	**Mean Rank**	***df***	***X*²**	***p***
Self-help	10	48	50.70	2	.824	.662
	11	35	47.79			
	12	17	55.53			
Approach	10	48	46.32	2	1.955	.376
	11	35	54.57			
	12	17	53.91			
Accommodation	10	48	45.27	2	4.234	.120
	11	35	58.10			
	12	17	49.62			
Avoidance	10	48	46.59	2	3.394	.183
	11	35	57.69			
	12	17	46.74			
Self-Punishment	10	48	50.75	2	.341	.843
	11	35	48.70			
	12	17	53.50			

*Kruskal Wallis Test $p<0.05$

The values in Table 4.32 above, indicate that the coping strategies and perceptions of adolescents in different school grades did not differ significantly in the R-Cope subscales and

total scores (X^2 (p>.05). This indicates that overall, the current grade of students does not significantly contribute to the coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors. Since the test results were overall not significant, pairwise comparisons between the three grade groups were not computed.

However, in terms of mean ranks, Grade 11 students scored higher in three dimensions, i.e., approach (Mean Rank = 54.57), accommodation (Mean Rank = 58.10) and avoidance (Mean Rank = 57.67), whereas Grade 12 students scored higher in two dimensions, i.e., self-help (Mean Rank = 55.53), and self-punishment (Mean Rank = 53.50).

The Kruskall-Wallis test results of adolescent perceptions of resources and barriers to help-seeking behaviours, according to grade, are presented in Table 4.33 below.

Table 4.33

Kruskal-Wallis Analysis of Perception of Resources and Barriers to Help-Seeking by Grade

	Grade	***n***	**Mean Rank**	***df***	**X^2**	***p***
Professional	10	48	50.81	2	3.678	.159
	11	35	44.84			
	12	17	61.26			
Religious	10	48	50.97	2	3.738	.154
	11	35	49.50			
	12	17	51.24			
Friends	10	48	51.48	2	2.445	.295
	11	35	45.59			
	12	17	57.85			
Parents	10	48	52.42	2	1.205	.547
	11	35	51.00			
	12	17	44.06			
Self	10	48	50.63	2	.024	.988
	11	35	50.71			
	12	17	49.71			

*Kruskal Wallis Test p<0.05

The results in Table 4.33 above of the Kruskal Wallis test computed to determine whether there were statistically significant differences between the means scores of young

people's perception of resources and barriers to help-seeking behaviours (i.e., professional; religious; friends; parents and self), and school grade, revealed no statistically significant difference (X^2 (2, N =100) = 3.678; 3.738; 2.445; 1.205; .024; p>.05) between subscales and total scores as all the p-values were greater than 0.05. Since the test results were overall not significant, pairwise comparisons between the three grade groups were not computed.

However, in terms of mean ranks, Grade 12 students scored higher in three dimensions, i.e., professional (Mean Rank = 61.26), religious (Mean Rank = 51.24) and friends (Mean Rank = 57.85), whereas Grade 10 students scored higher in the "parents" dimension (Mean Rank = 52.42), and Grade 11 students scored higher in the "self" dimension (Mean Rank = 50.71).

4.8.5 Differences According to Type of School

Mann-Whitney U-tests were computed to ascertain whether there were differences in mental health literacy between the type of school adolescents attended (independent or public); between adolescents' concerns regarding the stressors and/or negative life events that they face in their socio-cultural contexts and type of school; between coping strategies and perceptions of resources that adolescents use to manage psycho-social stressors and type of school, and between adolescent perceptions of resources and barriers to help-seeking behaviours and the type of school they were attending.

The Mann Whitney-U test results of mental health literacy according to type of school are presented in Table 4.34 below.

Table 4.34

Mann Whitney-U test results of Student Mental Health Literacy by Type of School

Dimensions	***Type of School***	***N***	***Mean Rank***	***Sum of Ranks***	***U***	***Z***	***p***
Knowledge of Mental Health Problems	Public Independent	21 78	42.69 51.97	896.50 4053.50	665.500	*-1.323*	*.186*
Erroneous Beliefs and Stereotypes	Public Independent	21 78	47.81 50.59	1004.00 3946.00	773.000	-.406	.686
First-aid and Help Seeking Behaviours	Public Independent	21 78	54.60 48.76	1146.50 3803.50	722.500	-1.057	.291
Self-Help Strategies	Public Independent	21 78	31.29 55.04	657.00 4293.00	426.000	-4.252	<,001

Mann-Whitney Test p<0.05

As can be observed from the Mann-Whitney U results in Table 4.34 above, there were no significant differences in mental health literacy in students from public and independent schools in three of the MHL subscales (knowledge of mental health problems, erroneous beliefs and stereotypes, and first-aid and help seeking behaviour) and total scores (U= 665.500; 773.000; 722.500; p>.05). The test revealed a statistically significant difference in self-help strategies of adolescents in public schools (*Mdn* = 6, n = 21) and independent schools (*Mdn* = 6, n = 78), *U* = 426.000; z = -4.252; p = <0.001, *r* = -0.43) which is considered a medium effect size (Cohen, 1988).

In terms of mean rank, however, independent school adolescents scored higher in three dimensions, knowledge of mental health literacy (Mean Rank = 51.97), erroneous beliefs and stereotypes (Mean Rank = 50.59) and self-help strategies (Mean Rank = 55.04) whereas, public school adolescents scored higher in first-aid and help-seeking behaviours (Mean Rank = 54.60).

The Mann-Whitney test results of the stressors and/or negative life events that adolescents face in their socio-cultural contexts, according to type of school, are presented in Table 4.35 below.

Table 4.35

Mann-Whitney Test Stressors and/or Negative Life Events by Type of School

Dimensions	***Type of School***	***N***	***Mean Rank***	***Sum of Ranks***	***U***	***Z***	***p***
Life Events	Public	21	59.21	1243.50	625.500	-2.004	.045
	Independent	78	47.52	3706.50			
School Events	Public	21	49.86	1047.00	816.000	-.037	.970
	Independent	78	50.04	3903.00			
Friendship Events	Public	21	55.29	1161.00	708.000	-.984	.325
	Independent	78	48.58	3789.00			
Romantic Events	Public	21	48.67	1022.00	791.000	-.274	.784
	Independent	78	50.36	3928.00			
Family Events	Public	21	68.52	1439.00	430.000	-3.370	<,001
	Independent	78	45.01	3511.00			

The Mann-Whitney U results in Table 4.35 above indicate statistically significant differences in how psycho-social stressors are construed by adolescents attending public (*Mdn* = 3, n = 21) and independent (*Mdn* = 3, n = 78) schools in the life events subscale (*U* = 625.500; z = -2.004; p = .045, *r* = -20) which is a small effect size (Cohen, 1988) and by adolescents in public (*Mdn* = 7.50, n = 21) and independent (*Mdn* = 9.00, n = 78) schools in the family events subscale (*U* = 430.000; z = -3.370; *p* = <.001, *r* = -0.34), which according to Cohen (1988) is a medium effect size. No significant differences were found in the three other subscales (school, friendship and romantic events) and total scores (*U*= 816.000; 708.000; 791.000; *p*>.05). This finding indicates that stressors and negative life events relating to school, friendships and romantic relationships are no different for adolescents from public or independent schools. When we look at the mean ranks of public and independent schools, we observe that students from public schools achieved higher scores in

three dimensions, life events (Mean Rank = 59.21), friendship events (Mean Rank = 55.29) and family events (Mean Rank = 68.52) whereas, adolescents attending independent schools achieved higher scores in school events (Mean Rank = 50.04) and romantic events (Mean Rank = 50.36). Thus, it can be surmised that students from public schools construe their life , friendship and family event experiences more negatively than students who attend independent schools.

The Mann-Whitney test results of coping strategies and perceptions of resources that adolescents use to mitigate their psycho-social stressors, according to type of school, are presented in Table 4.36 below.

Table 4.36

Mann-Whitney Test Analysis of Coping Strategies and Perceptions of Resources by Type of School

Dimensions	*Type of School*	*N*	*Mean Rank*	*Sum of Ranks*	*U*	*Z*	*p*
Self-help	Public	21	35.48	745.00	48.21	-2.618	.009
	Independent	78	53.91	4205.00			
Approach	Public	21	41.45	870.50	1012.50	-1.550	.121
	Independent	78	52.30	4079.50			
Accommodation	Public	21	47.90	1006.00	775.000	-.389	.697
	Independent	78	50.56	3944.00			
Avoidance	Public	21	53.50	1123.50	745.500	-.638	.524
	Independent	78	49.06	3826.50			
Self-Punishment	Public	21	48.21	1012.50	781.500	-.332	.740
	Independent	78	50.48	3937.50			

The Mann-Whitney U-test revealed a statistically significant difference in coping strategies and perceptions of resources in adolescents in public schools (*Mdn* = 14, n = 21) and independent schools (*Mdn* = 19, n = 78), for the self-help subscale (U = 48.21; z = -2.618; p = .009, r = -26) which is an above small effect size (Cohen, 1988). There were no significant differences in mental health literacy in students from public and independent schools in the other four R-Cope subscales (approach, accommodation, avoidance, self-

punishment) and total scores (U = 1012.50; 775.000; 745.500; 781.500; p>.05). The mean ranks in Table 4.36 above, also indicate that students from independent schools achieved higher scores in all dimensions, i.e., self-help (Mean Rank = 53.91), approach (Mean Rank = 53.91), accommodation (Mean Rank = 50.56), and self-punishment (Mean Rank = 50.48), except for the avoidance subscale, where adolescents from public schools scored higher (Mean Rank = 53.50). This can be construed as meaning that students in public schools appear to rely on an avoidance style of coping rather than on being proactive in seeking help or solutions, or making accommodations to cope, which students from independent schools indicate as a preferable style of coping.

The Mann-Whitney test results of coping strategies and perceptions of resources and help-seeking behaviours, according to type of school, are presented in Table 4.37 below

Table 4.37

Mann-Whitney Analysis of Perception of Resources and Barriers to Help Seeking Behaviours and Type of School

Dimensions	***Type of School***	***N***	***Mean Rank***	***Sum of Ranks***	***U***	***Z***	***p***
Professional	Public	21	43.24	908.00	677.000	-1.225	.220
	Independent	78	51.82	4042.00			
Religious	Public	21	49.71	1044.00	813.000	-.064	.949
	Independent	78	50.08	3906.00			
Friendship	Public	21	47.10	989.00	758.000	-.557	.578
	Independent	78	50.78	3961.00			
Parents	Public	21	39.40	827.50	596.500	-2.033	.042
	Independent	78	52.85	4122.50			
Self	Public	21	49.14	1032.00	801.000	-.194	.847
	Independent	78	50.23	3918.00			

As can be observed from the Mann-Whitney U results in Table 4.37 above, there were no significant differences in means scores of resources and barriers to help-seeking behaviours in students from public and independent schools in four subscales (i.e.,

professional; religious; friendships, and self) and total scores (*U*= 677.000; 813.000; 758.000; 801.000; *p*>.05). The results further reveal a statistically significant difference in resources and barriers to help-seeking behaviours in adolescents in public schools (*Mdn* = 14, n = 21) and independent schools (*Mdn* = 14, n = 78) for the parents subscale (*U* = 596.500; z = -2.033; *p* = 0.042, *r* = -0.20), which is considered a small effect size (Cohen, 1988). Thus, students from independent schools tend to draw on parents as a resource. The mean ranks also show that students in independent schools achieved higher scores in all dimensions, i.e., professional (Mean Rank = 51.82), religious (Mean Rank = 50.08), friends (Mean Rank = 50.78), parents (Mean Rank = 52.85), and self-help (Mean Rank = 50.23).

4.9 Conclusion

Non-parametric analyses were conducted to infer results, based on the following research questions: adolescent mental health literacy; psycho-social challenges; coping strategies and perception of resources and help-seeking behaviour and barriers to help-seeking. Data was collected from a total of 100 adolescents aged 16-18 years using an online survey. Descriptive and inferential analyses were computed to analyse the data. The majority of participants were White (73.0%), the majority of the recipients were female (60.0%) and 59.0% of the respondents were aged 16 years. Additionally, the majority of the participants attended independent schools (78.0%) and a total of 48% of the respondents were in Grade 10.

More specifically, the researcher computed the Kruskal-Wallis test (Analysis of Variance) to determine whether there were statistical differences between a number of demographic variables with more than two categories (gender, age, population group, and grade) and different continuous variables. Results computed for mental health literacy vis-à-vis gender, age, population group and grade, overall revealed significant differences between

first-aid and help-seeking behaviours (MHL3) as well as self-help strategies (MHL4) and the different genders. No significant differences were found with regards to age, population group and grade, so they are not a factor in terms of MHL among adolescents. Results pertaining to psycho-social stressors yielded significant differences between gender in three domains namely: negative life events; friendship events; and family events. Gender thus contributes to the experience of psycho-social stressors in these domains. No statistical differences were found in terms of age and population group, hence they are not considered a factor with regards to psycho-social stressors. However, romantic events emerged as statistically significant, indicating that it is perceived as a psycho-social stressor, particularly for Grade 12 learners, indicating that respondents' grade is a factor in terms of what constitutes a stressor. Results computed for coping strategies and perception of resources yielded significant differences between genders in both the approach and avoidant styles of coping. With regard to age, population group and grade, no statistically significant differences were found, indicating that none of these factors contribute to the coping strategies and perceptions of resources that adolescents use to manage psycho-social stressors. Finally, the results pertaining to adolescents' perceptions of resources and barriers to help-seeking behaviour revealed that neither gender, age nor grade are factors in terms of adolescents' perceptions of resources and what constitutes a barrier to help-seeking behaviours. However, a significant difference was found on the sub-scale of self-punishment, where adolescents from the "other" racial category had the highest score.

Mann-Whitney U-tests were computed to ascertain whether there were differences in mental health literacy between the type of school adolescents attended (independent and public); between adolescents' concerns regarding the stressors that they face in their socio-cultural contexts and type of school; between coping strategies and perceptions of resources that adolescents use to manage psycho-social stressors and type of school; and between

adolescent perceptions of resources and barriers to help-seeking behaviours and the type of school they were attending. The findings revealed a statistically significant difference in self-help strategies (MHL4) of adolescents in public versus independent schools. In addition, the results showed statistically significant differences between adolescents in public and independents schools in the life events sub-scale and the family events sub-scale. This is indicative that psycho-social stressors emanate from these domains for all learners, irrespective of the type of school they attend. Type of school appears to be a factor with regards to coping strategies and perceptions of resources, only in as far as it pertains to the self-help sub-scale as a statistically significant difference emerged between adolescents from public and independent schools in this domain. The results revealed a statistically significant difference in perception of resources and barriers to help-seeking behaviours in adolescents attending public and independent schools, only for the parents sub-scale. The result indicates that learners from independent schools are more prone to draw on parents' support as a resource.

The above chapter provided a detailed discussion of the descriptive statistics and the inferential results that emanated from the Kruskal Wallis and Mann-Whitney U analyses of the study's data. The results highlighted the presence and/or absence of statistical differences between various demographic variables with more than two categories (gender, population group, age, and grade) and a number of continuous variables used to address the objectives of this study.

Chapter 5 follows with a detailed discussion of the findings gleaned from the descriptive and inferential analyses of the data collected for this study. The discussion aligns with the measures used to address the research questions and objectives of this study, namely: Objective 1, Adolescent mental health literacy (Section B, Appendix A); Objective 2, Psycho-social stressors (Section C, Appendix A); Objective 3, Coping strategies (Section D

& E, Appendix A); Objective 4, Perception of resources and help-seeking behaviours used to mitigate these challenges (Section F, Appendix A) and Objective 5, Perception of resources and barriers to help-seeking behaviours (Section G, Appendix A).

The chapter includes a synopsis of both the limitations of the study and recommendations for further exploration and ends with the conclusion which brings this paper to a satisfactory close.

Chapter Five

Discussion and Conclusion

5.1 Introduction

The results section above provided an overview of the descriptive and inferential statistics of the measures that were used to address the six objectives of this study. This chapter provides a comprehensive discussion of the findings, drawing on the supporting literature that aligns with the primary objectives of the study, as outlined in Chapter 1. It begins with a discussion on the demographics of the respondents in the study and extrapolates the spread in terms of gender, age, population group, grade, and type of school. It also provides insights into the associations between variables pertaining to the primary components of this study, namely: mental health literacy, stressors, coping strategies, perception of resources and help-seeking behaviours and perception of resources and barriers to help-seeking. Furthermore, differences between variables and groups are explored as it pertains to gender, age, grade, population group and the type of school respondents attended. The limitations of the study and opportunities for further research is explored, followed by the conclusion.

5.2 Demographics of Survey Participants

The study comprised 100 (N) learners from both public (n = 21) and independent (n = 78) schools, although one respondent did not specify the type of school they attended, the respondents were 60% female, 37% male and 3% identified as “other”. The study focused on adolescent learners aged 15 to 19, but only 16- to 18-year-olds responded, the majority of which were 16 years (59%); 17-year-olds made up 28% and 12% were 18 years old with one respondent not specifying their age. The majority of the respondents were White learners (73%), 11% were Black, Coloured (9%), and Indian (3%) while those learners identifying with the racial category “other” (3%) made up the balance of the sample. Of the total sample every respondent identified that their school had some form of psycho-emotional support available. A total of 59% of respondents reported having previous counselling experience, 40% indicated they had no prior counselling experience and 1% of this data was missing. This data was used to conduct descriptive statistics and frequencies to inform the non-parametric analyses. Thus, the inferential statistics, based on gender, age, population group, grade and type of school were computed to address the objectives of the study, as noted in the introduction to this chapter. What follows is a detailed discussion, supported by the relevant literature, of these results as it pertains to each of these objectives.

5.3 Adolescent Mental Health Literacy

The results computed for mental health literacy vis-à-vis gender, identified significant differences between first-aid and help-seeking as well as self-help strategies and the different genders. In the pairwise comparisons no significant differences were found between genders in first-aid and help-seeking behaviors. However, in the self-help domain a significant difference was only found between “other” genders and females. Notwithstanding, females were more inclined to identify with first-aid and help-seeking behaviours than males, with males tending to make greater use of self-help strategies than both females and “other”

genders. These findings address the domains of mental health literacy as proposed by (Jorm, 2000). It therefore appears that females have greater knowledge of available professional resources for intervention and how to help others (Jorm, 2000). It can therefore be inferred that they have a greater capacity to be proactive in their help-seeking behaviour (Jorm, 2000). Males appear to rely on their knowledge of what constitutes healthy behaviours to support their mental health or actions that are construed as preventative such as exercise, socialising and engaging in enjoyable activities. These findings support the notion that (traditional) gender role ideologies are a strong determinant that shape attitudes towards mental health (Swami, 2012).

Age, population group and grade are not construed as factors regarding MHL for adolescents. However, it is valuable to note that 16-year-olds scored higher on erroneous beliefs and stereotypes, perhaps their lack of mental health literacy could account for this. The 18-year-old cohort scored higher in the domain of knowledge about mental health compared with the 17-year-old cohort, and higher on self-help strategies than 16-year-olds. Prescribed adolescent developmental tasks to attain independence (Dolgin, 2014), could account for this differential in mean ranks regarding their propensity to align with self-help strategies in pursuit of their autonomy (Dolgin, 2014).

With regards to population group, there were no significant differences in MHL across population groups and it can be surmised that their understanding of MH issues is measurably similar. It is, however, valuable to note that Black learners scored the highest on knowledge of mental health problems, White adolescents scored the highest on self-help strategies, while Indian adolescents scored the highest on erroneous beliefs and stereotypes, and Coloured adolescents scored the highest on self-help strategies. The implications are that Black respondents appear to have greater knowledge of what constitutes mental health and

related mental illness and associated problems. Indian respondents, however, tend to adhere to more stereotypical beliefs regarding mental health and illness and this reflects negatively on their mental health literacy. Coloured respondents appear to align more with first-aid and help-seeking behaviours, and White respondents indicate that self-help strategies, such as exercise and engaging in pleasurable activities support mental health, which align with positive mental health literacy. Notwithstanding these findings, since the results were not significant, it would be important to explore this further with a more representative sample.

In addition, these findings address the overarching theoretical framework of this study in terms of which it may be plausible to infer that the socio-cultural context of the respondents' accounts for the differing scores in the various sub-scales of mental health as it pertains to population group. According to Bronfenbrenner's Ecological Systems Theory (Kail & Cavanaugh, 2016), health choices are determined in the context of one's socio-cultural milieu. As such, attitudes, norms, and beliefs determine one's attitude to health choices, help-seeking behaviours and one's conceptualisation of mental health or mental illness (Hassett et al., 2018). Furthermore, this study espouses a life-span approach to development. With this in mind, it is the intersection of a multitude of factors (biological, psychological, socio-cultural and developmental) that impacts one's knowledge of and attitude towards mental health in general and to mental health literacy in particular (Kail & Cavanaugh, 2016). Hence, it is the complexity of all the systems that needs to be taken into consideration in terms of what factors account for the responses in all domains of MHL, and in particular, as it pertains to age-appropriate interventions (Geldard et al., 2016).

The results computed regarding MHL and type of school yielded no significant differences in the knowledge of mental health domain, erroneous beliefs and stereotypes domain or the first-aid and help-seeking domain. However, the test revealed a medium effect

size (Cohen, 1988) regarding self-help strategies of adolescents in public schools versus independent schools. As such this difference is considered statistically significant in so far as adolescents from independent schools have a greater propensity to subscribe to self-help strategies than adolescents from public schools. Furthermore, it is worth noting that adolescents from independent schools scored higher on knowledge of mental health, erroneous beliefs and stereotypes, and self-help strategies. Adolescents from public schools scored higher in self-help strategies.

Research reveals that mental health literacy has implications for both early identification and intervention regarding mental disorders (Campos et al., 2016). In addition, mental health promotion rests on both mental health literacy and the concomitant cognitive and social skills that are associated with the conceptualisation of mental health literacy and its attributes (Campos et al., 2016). Zare et al. (2022) posit that cultural differences between the participants may account for the statistical differences in some domains. Culture impacts, help-seeking behaviour, the nature of support systems and the type of resources participants are able and willing to access. TAH play a significant role in the treatment of and conceptualisation of mental health and illness (Zingela et al., 2018). In addition, socio-cultural context and the resultant social determinants such as poverty, violence, the nature of households and the infrastructure of communities, perhaps mediates mental health literacy in so far as information and psycho-education is disseminated and understood. Furthermore, it can account for the stigma and meaning individuals ascribe to mental illness and how they communicate their concerns around their health (Zare et al., 2022). Madlala et al. (2020) espouse that variable differences in MHL exist between participants from urban and township settings and this indicates the need for community-based education to heighten awareness and knowledge of mental health and illness. In light of the results and the discussion above, the researcher, while reluctant to draw any conclusions given the inferential nature of these

results, posits that overarchingly public knowledge and attitudes towards mental health and illness (Jorm, 2000), together with education and an integrative and systemic approach to adolescent development, lie at the heart of mental health literacy. Knowledge has significant implications for prevention and early intervention and positive long-term outcomes (Jorm, 2000).

5.4 Psycho-Social Stressors That Adolescents Face

Psycho-social stressors are considered as risk factors in the development of mental illness during adolescence (Paruk & Karim, 2016). Adolescence can be a stressful developmental stage, but most adolescents navigate this phase of development in a healthy way, despite the fact that universally, anxiety and depression are pervasive at this stage of development and correlate significantly with teenage suicide (Paruk & Karim, 2016). Contextual stressors in the South African context such as poverty, crime, gang violence, domestic violence and drug and alcohol abuse are risk factors highly associated with the development of mental disorders in adolescence (Louw & Louw, 2014), particularly for those adolescents considered to be at risk or vulnerable.

The results gleaned from the analyses of psycho-social stressors that adolescents face in the Western Cape were computed by gender, age, population group, grade and type of school. The results indicate that gender significantly contributes to the experience of psycho-social stressors in the domains of life events, friendships events and family events. In addition, adolescents who identified as “other” gendered appear more likely to experience negative life events, friendship events and family events as stressors. When pairwise comparisons were made between gender and life events and family events, no significant differences in values were found, as critical values were greater than the expected *p*-value. However, in the pairwise comparisons of all gender groups and friendship events, a

significant difference in values for the "male vs female" gender-paired comparison was observed. It thus indicates that females experienced friendship events as a greater source of stress than males. These findings differ slightly from a study conducted by Bakker et al., (2010), which revealed that both girls and boys perceive peer influence – in particular peer rejection – to be a significant stressor. Notwithstanding these results, prior research supports the notion that gender and age differences exist in terms of the frequency with which adolescents experience stressors (Ge et al., 1994, as cited in Jose & Ratcliffe, 2004). Furthermore, the occurrence of stressors appears to be more frequent for females, particularly in middle adolescence from 15 to 17 years of age (Geldard et al., 2016; Louw & Louw, 2014). Ge et al., (1994, as cited in Jose & Ratcliffe, 2004) reported that boys are less vulnerable to stressors than girls, and that in fact, girls appraise stressors as more threatening, hence their experience of psycho-social stressors is more intense than that of boys (Jose & Ratcliffe, 2004).

With regards to age as it pertains to psycho-social stressors, no statistically significant differences were found. As such, age was not found to be a factor for this cohort in terms of negative life events that adolescents face. It is worth noting that 18-year-olds scored higher in both romantic events and family events compared with 16- and 17-year-olds. Maturation and developmental stage may account for these differences as it is more common for adolescents of this age to be engaged in romantic relationships and place a significant value on these relationships. Furthermore, in terms of their developmental tasks in seeking independence and autonomy (Geldard et al., 2016), this would account for the additional stress that perhaps conflict with parents/guardians would evoke, compared with their younger counterparts.

No significant differences were found between the mean scores of stressors that adolescents face, and population group, as all p-values were greater than the alpha level. In

terms of what can be inferred from the results, it can be surmised that respondents who identified with the "other" population group category scored higher in all dimensions, except for school events, in which they scored the same as learners categorised as Coloured and Indian. Learners who identified as being Black scored the second highest for life events and for friendship events. White learners scored the second highest for romantic events and Coloured respondents for family events. With regards to psycho-social stressors and grade, a statistically significant difference was found on only the romantic events sub-scale. Grade 12 respondents scored the highest in this sub-scale.

Results pertaining to psycho-social stressors and type of school indicate a small to medium effect regarding type of school and life events and the family events sub-scale. These results must be considered in terms of the socio-cultural context of the learners in which environmental stressors and family violence and discord (for example) may play a significant role in adolescents' lived experiences. On the other hand, there do not appear to be any significant differences between learners from public and independent school's experiences of stressors in the school, friendship, and romantic events sub-scales. The higher mean ranks of learners from public schools allude to their experience of negative life, friendship and family events as constituting a greater source of stress compared with learners from independent schools. It is critical to note in the context of the Western Cape, that environmental stressors relating to poverty, unemployment and crime, among others, could account for these differences. Context does mitigate and act as a protective mechanism, on the one hand, i.e., family relationships and community structures, or play a role in perpetuating these stressors in the form of family discord, domestic violence, unemployment, and financial insecurity (Lund et al., 2021,).

It would be useful in the context of the study to infer that the discussion on the above differences may be attributed to contextual factors such as the frequency and intensity of these experiences and whether or not protective factors (family, friends, school and community) are at play to mitigate these stressors. Lund et al. (2021; p. 42), speak of "social determinants" such as "poverty, food insecurity, inequality, violence" among others that impact CAMH across the lifespan. The social determinants refer to family and societal structures, and it is noteworthy that CAMH is impacted by stressors that are both in the immediate context as well as those that are perhaps in the macro or meso systems (educational, political, socio-economic, community, etc.) (Lund et al., 2021). Community and family relationships and structures (Lund et al., 2021) can mitigate or fuel the impact of factors considered to be in the distal domain. In addition, they may be the source of risk for adolescents' mental health due to, for example, family discord or family violence. They may also play a vital role in building resilience in adolescents to the extent that they provide supportive loving environments in which adolescents feel accepted and as a result are less inclined to develop mental health problems due to the impact of contextual stressors (Lund et al., 2021). It is meaningful to note that culture and gender are considered as determinants in terms of how both stress and social support are experienced (Camara et al., 2017). All of the stressors mentioned above which are deemed pervasive (in general) in adolescents' milieus, have no doubt been exacerbated by the Covid-19 pandemic, which has added a myriad additional stressor for adolescents to navigate and manage. These included disrupted education, death and loss, disruption to social networks and connections, unemployment, and food insecurity, to name a few, but this aspect falls beyond the purview of this study. The impact on adolescents' mental health, particularly pertaining to anxiety, is potentially devastating both in terms of short and long-term mental health outcomes. Mokitimi (2021) notes the following, "COVID-19 has heightened the rate of suicide among children and

adolescents in various areas. It has heightened anxiety and depression as a result of the virus, disease and losses people have experienced.” (University of Cape Town [UCT] News, 2021)

5.5 Coping Strategies and Perception of Resources That Mitigate the Psycho-Social Stressors that Adolescents Face.

Mokitimi et al. (2019) posit that the determinants of health choices are influenced by a multitude of factors which may either promote health-seeking behaviours or pose restrictions on access to services. Bronfenbrenner’s Ecological Systems Theory addresses the intersection of all systems on each other (Louw & Louw, 2014; Geldard et al., 2016). As such, adolescent developmental challenges (a bio-psychosocial perspective) in all domains must be considered in the context of internal and external factors that play a role in mitigating psycho-social challenges and facilitating adaptive responses to them. The family and primary care-giving context may be either supportive or a determinant of risk and mental health problems for adolescents, and together with the socio-cultural context to which the family is inextricably linked, acts as a pivotal resource mechanism of psycho-social support to mitigate stressors (Kail et al., 2019).

In terms of the 5 domains of coping strategies, these were clustered as adaptive coping which constitutes approach, accommodation and self-help and maladaptive coping – which includes avoidance and self-punishment – as proposed by Zuckerman and Gagne (2003). Adaptive coping speaks to adolescents’ sense of autonomy and self-awareness and correlates positively with self-help coping strategies. In addition, an internal locus of control is associated with autonomous behaviour and approach and accommodation tendencies to coping (Zuckerman & Gagne, 2003). On the other hand, adolescents with an external locus of control tend to present with avoidant and self-punishment responses to coping.

The results from the non-parametric analysis revealed statistically significant differences between genders and the approach style of coping. This implies that males are more inclined to be proactive, to plan and to suppress any other activities that are construed as competing, in order to cope, in comparison with females and “other” genders (Zuckerman & Gagne, 2003). In addition, a statistically significant difference was found for gender and the avoidance style of coping, which implies that respondents who identified as “other” gendered, are more prone to using an avoidance style of coping. This style of coping entails being in denial, disengaging both behaviourally and mentally from the problem or cause of stress, and blaming others (Zuckerman & Gagne, 2003). In the pairwise comparison for both these domains of coping, no significant difference in values between groups was observed. It is useful to note that in the development of the R-COPE measure the researcher noted that women reported greater use of self-help, accommodation and approach styles of coping compared with men (Zuckerman & Gagne, 2003). In addition, accommodation and self-punishment were adopted when the stressor itself was construed as being as a consequence of the respondent’s behaviour.

Results pertaining to coping strategies and perception of resources by age, population group and grade indicate that these two factors do not contribute significantly to adolescents’ coping strategies and perceptions of resources that mitigate psycho-social stressors. It is worth noting, however, that 18-year-olds scored higher in self-help, approach, and accommodation. On the avoidance sub-scale, 17-year-olds scored the highest, and for self-punishment, 16-year-olds scored the highest. According to Zuckerman and Gagne (2003), the ability to make autonomous choices and regulate one’s behaviour emanates from an internal locus of control and aligns with one’s values and needs, the nature of which has implications for well-being. Furthermore, well-being is determined by the extent to which one copes adaptively, and by implication, the same factors determine both well-being and coping style

(Zuckerman & Gagne, 2003). When there is an integrated sense of self and one's needs, the expression of self is in one's autonomous choices, and as such manifests in self-help strategies and an approach style to coping (Zuckerman & Gagne, 2003). In the results pertaining to grade and coping strategies it is useful to note in the context of the discussion pertaining to age and coping, that Grade 11 learners scored highest in the approach, accommodation and avoidance domains of coping. Grade 12 respondents scored highest in the self-help and self-punishment domains of coping. Self-help and accommodation styles of coping incorporate actual help-seeking behaviours and acceptance when things cannot change. The approach style of coping incorporates being actively engaged in solving the problem or acceptance in the face of no solution (Zuckerman & Gagne, 2003). Age and grade are determinants of these cognitive processes which rest on the bio-psychosocial framework of development. Adolescents' developmental task of attaining independence and autonomy, particularly in older adolescents (17-19 years) may account for the high scores in these domains of coping, both for age and grade. On the other hand, when an integrated sense of self is not intact, such as in younger or middle adolescence, then coping styles such as avoidance and self-punishment will ensue (Zuckerman & Gagne, 2003).

No statistically significant findings for population group and coping were evident, but it is valuable to note that Indian respondents scored the highest in self-help, approach and self-punishment. White learners scored the highest for accommodation and Black learners scored the highest for the avoidance style of coping. In light of these findings, it is useful to note that socio-cultural context is considered a determinant of either an adaptive, action-oriented style of coping versus a more passive or avoidant approach to coping (Austin, 2014) and as such this could account for the findings in this domain.

Finally, a statistically significant difference in coping strategies and perception of resources was found between learners of public and independent schools for the self-help sub-scale, albeit only a small effect size (Cohen, 1988). Students from independent schools, however, scored the highest in all domains, except for the avoidance sub-scale, in which respondents from public schools achieved higher scores. Socio-cultural context (which includes family, community, and school), construes value and meaning to constructs, including those that pertain to coping in all its domains.

5.6 Perception of Resources and Barriers to Help-Seeking Behaviours

Adolescents' accessing of mental health services is determined by a multitude of factors, including financial ability, access and availability of services, and adolescents' perceptions of the nature of the therapeutic relationship, trust, and confidentiality (Radez et al., 2019). Positive societal attitudes to mental health and reducing stigma associated with mental illness impact significantly on adolescents' perception of resources and their help-seeking efforts. In addition, parental and societal beliefs and positive attitudes towards mental health and mental illness play a significant role in either creating barriers to help-seeking or facilitating help-seeking behaviours (Rickwood & Braithwaite, 1994). Willingness to seek help in the first instance and willingness to seek professional help in the second are determinants of an orientation towards help-seeking. Furthermore, factors such as locus of control, self-awareness, being open to disclosing mental health, knowing someone who had sought professional help and the perceived confidence in professionals by the social group are all determinants of actual help-seeking behaviours (Rickwood & Braithwaite, 1994).

The Kruskal Wallis test to determine whether there were statistically significant differences between the mean ranks of adolescent's perceptions of resources and barriers to

help-seeking behaviours by gender, revealed no statistically significant differences between the subscales and total scores. Males scored the highest in the religious and parents sub-scales. Respondents who identified as "other" gendered scored the highest in the remaining domains. With regards to age, no statistically significant results were yielded, hence age does not appear to be a factor with regards to perception of resources and barriers to help-seeking behaviours. However, it is worth noting that 18-year-olds scored the highest in the professional sub-scale, the religious subscale and the self-punishment sub-scale. However, for population group the self-punishment sub-scale yielded statistically significant results with adolescents who identified in the "other" racial category achieving the highest score, although in the pairwise comparison no statistically significant results were yielded. Indian students scored the highest in the friendship sub-scale and on the parents sub-scale. Black respondents scored the highest on the professional subscale, indicating that they value professional intervention as a resource. White students scored higher in the religious sub-scale. With regards to grade, no statistically significant differences were found, however, Grade 12 learners achieved the highest scores in the professional, religious and friendship dimensions. Rickwood and Braithwaite (1994, as cited in Nagai, 2015) contend that the social network serves as an informal source of support, and appears to be the initial source of help-seeking. Furthermore the propensity of individuals to seek help from informal sources, rests on the severity with which individuals' experience their psycho-emotional problem (Rickwood & Braithwaite 1994, as cited in Nagai, 2015). Assuming an adolescent is willing to seek professional help, the quality of their social ties will serve as a determinant to actual help-seeking behaviours. Furthermore, they contend that gender is a consistent predictor of help-seeking behaviours (Rickwood & Braithwaite, 1994), girls being more likely to exhibit help-seeking behaviours than boys. Close, trusting relationships have an impact on behaviour, but are not a predictor of orientation to help-seeking. Intention to seek help correlates with

positive prior counselling experience and actual help-seeking behaviour; the nature of the problem and the resource associated with the helping behaviour or intervention (Wilson et al., 2005). Additional insights to emanate from this study were the correlation between the intention to seek help vis-à-vis self-reporting of what constitutes barriers to professional help-seeking. In addition, willingness to disclose mental health/illness impacts help-seeking behaviours and appears to be more prevalent in females. When experiencing psychological distress, males will avoid seeking professional help or are not inclined to disclose their mental health status. The results overall indicate that older adolescents place value on professional and friendship resources. The above literature supports this in so far as the nature of the problem determines the source of support that will be identified as appropriate for the presenting problem.

The Mann-Whitney U analysis of perception of resources and barriers to help-seeking behaviours and type of school revealed a statistically significant difference in the parents sub-scale in relation to adolescents from public and independent schools, albeit a small effect size (Cohen, 1988). These results suggest that parents are construed as being a valuable resource. It is useful to note that respondents from independent schools scored consistently higher in all sub-scales. It may be inferred from this result that adequate mental health literacy might account for this significant result.

Barriers to help-seeking is determined by a multitude of systemic factors, including financial constraints, lack of access to services and lack of awareness of services, among others (Swami, 2012). Poor mental health literacy has a negative impact on help-seeking behaviours to address psychiatric concerns as does negative attitudes towards mental health intervention. As a result, this impacts compliance and treatment protocols (Swami, 2012). Lack of knowledge about mental health and illness and inadequate understanding of

symptoms and causes of mental illness, as well as what constitutes protective and supportive factors, lead to a lack of awareness of how symptoms present. It also leads to a lack of understanding of what factors are protective and what factors are facilitators of help-seeking behaviours versus what factors prohibit access to professional help and help-seeking behaviours (Radez et. al. 2019). The multidimensional nature of MHL alludes to the myriad of factors that intersect as determinants of help-seeking intentions and help-seeking behaviours (Goodfellows et al., 2022). Knowledge alone is not a predictor of help-seeking behaviours. Factors such as stigma, perceptions of and the nature of the source of help (formal or informal), gender, one's sense of autonomy, self-efficacy style of coping, particularly in the adolescent context, access and availability of support services and attitude mediate behaviour. It is the intersection of these factors that impact the dimensions of MHL, help-seeking intentions, the barriers to help-seeking and actual help-seeking behaviours (Goodfellows et al., 2022).

5.7 Limitations and Recommendations for Further Research

A limitation of this study lies in the low response rate, hence the small sample size. The measures are skewed in terms of the overall demographic makeup of the respondents. The majority of respondents are from independent schools, the majority are female, and the majority are White. While the objectives of the study have been addressed and the inferential analyses have yielded valid results, due to non-randomised sampling, the inadequate sample size and demographic distribution across all domains, the results cannot be generalised to the larger population of this cohort. In line with these limitations placed on the study by the small sample it would be important for future research to recruit participants from multiple categories of schools to ameliorate this effect. Of note is that the limited sample size might also be as a result of pivoting the study online, rather than the original approach which would

have been to administer the study on site in the various schools during life-skills lessons period, thus perhaps providing the potential (assuming the majority of parents would have given consent) for yielding a larger sample size. Furthermore, the small sample size of those participants who identified as "other" gendered is an additional limitation as it prevents the interpretations and comparison to other groups. In addition, the distribution of scores showed little variance in the mean ranks, hence many of the Kruskal Wallis analyses yielded no statistically significant difference. Even when there were differences, the Mann Whitney U analyses revealed no differences in the values between groups, thus making it difficult to draw inferences regarding the groups and the impact of these results on the various measures and variables. Furthemore, the sample was limited to school-going adolescents between the ages of 15 years to 19 years, and excluded youth who do not attend school or older adolescents who fall in the 18 years to 19 years range who already attend tertiary institutions.

The limitations evidence the need to include adolescents across the entire age range as delineated in this study, so as to obtain broader perspectives on the research questions. In addition, the limitations provide impetus to explore a number of these domains with a larger randomly selected sample, across all the Metro districts that fall within the domain of the Western Cape Education Department. Thus, potentially alleviating the type of school bias and resultant participant bias that emerged in this study. This would allow for the computation of more robust analyses that would yield results that can be generalised across the adolescent cohort in the Western Cape in particular, and potentially the adolescent cohort in South Africa. It is important to note that recruitment for this study was confounded by the COVID-19 pandemic and hence the bias towards independent school participants who may have had easier access to data and internet. An additional consideration in terms of the limitations of the study pertaining to the online mechanism of the survey, relates to potential participants being unable to complete the survey due to shared computer/technology thus not granting

them privacy or confidentiality, which might also account for the low response rate to the survey. Finally, what can be construed as a limitation of the study is the fact that the study was not offered in a variety of different local languages, nor was the tool cross-culturally adapted to meet the contextual needs of the participants and to support the literature that underpins this relevance.

Notwithstanding these limitations it is important to reflect on the strengths of this study in and of itself and in the context of adolescent mental health concerns that pervade South Africa. Providing a foundational study that addresses MHL in particular has the potential to provide impetus for early intervention programs, community-based psycho-education campaigns, and school-based psycho-education programs and support services which creates awareness and knowledge-base of mental health issues that plague this cohort. With awareness and knowledge about mental health, the nature of coping and support, people and adolescents in particular, can feel empowered to make choices that support their overall health and mental well-being.

An additional strength of this study pertains to bringing to awareness the intersection of the social construction of the meaning of mental health and cultural definitions and responses to mental health care. This begs the question of an integrated and multifactorial approach to adolescent mental health issues and the absence of service delivery to provide age-appropriate mental health services for this cohort. As evidenced by the research in this study, in the South African context an intersectoral approach to mental health which considers socio-cultural perspectives on mental health and well-being and the unique developmental needs of the adolescent cohort is vital to address the mental health needs of adolescents both in the Western Cape and in South Africa.

Although the measures address the research questions and the aims and objectives of the study, the items need refinement to yield greater variance in the item responses (Bjornsen et al., 2017). Another key limitation was that the survey was a compilation of various international instruments that was only piloted with a small sample in the Western Cape. It is thus recommended that a full validation study with a larger sample be conducted to ensure contextual relevance and validity. In addition, recommendations are made to extend the sample for the study so that it includes adolescents in the age-range as delineated above who do not attend school due to dropping out or having chosen to complete their studies with a General Education Diploma (GED), thus finishing school in Grade 9, which is generally at age 15 years, as well as adolescents in the specified age range who attend tertiary institutions. Furthermore, it would be recommended to further extend the focus of the study to include items that address behaviours that promote mental health and help-seeking orientations as well as help-seeking behaviours amongst adolescents. In addition, it would be a recommendation of further study of this nature to ensure that such a measure was made available in different languages and cross-culturally adapted to ensure socio-cultural relevance and to potentially have a positive impact on response rate from diverse school sectors. Thus, garnering a larger sample more diverse and representative of the socio-cultural context that is South Africa is imortant. A larger sample provides impetus for more robust analyses the findings of which may potentially be generalised across the adolescent population in terms of the domains being assessed.

Research clearly articulates the challenges related to the implementation of CAMH policies and programmes and as such CAMH services have reached crisis proportions (Flisher et al., 2012; Tomlinson et al., 2022). The pervasive impact of youth mental illness impacts young people themselves and their families and impairs development across the life-span and perpetuates the cycle of mental illness and intergenerational violence and poverty

(Tomlinson, et al., 2022). Resultant impairment in functioning impacts school performance, drop-out rates and can lead to engagement in risky behaviours such as substance misuse, acting out and criminal behaviour. Research in this study supported by a plethora of literature, encourages early identification, intervention and support. Thus, further recommendations that emanate from this study support the prioritising of this approach by leaders, laws and policy makers and to adopt a systemic lens with which to view CAMH (Tomlinson et al., 2022).

A further recommendation would be to undertake a research process of developing a standardised South African measure of mental health literacy which could potentially have a significant impact on prevention, early recognition, intervention, and treatment of adolescent mental illness. Such a study has the potential to impact implementation of age-appropriate adolescent mental health services in the Western Cape and in South Africa. Ultimately, what has emerged from this study is the vital role mental health literacy plays in mental health, mental illness, early detection, prevention, and intervention approaches to adolescent mental health. Recommendations are to explore this further and contribute to this growing body of literature to inform systemic approaches to adolescent mental health and well-being and all that this encompasses, on multiple systemic levels.

Conclusion

Mental illness contributes significantly to the burden of disease in the Western Cape (Jacob & Coetzee, 2018). Mental health problems in adolescents can manifest as pathology in adulthood and impact functioning in multiple domains such as academic achievement, poor parental and peer relationships (Zare et al., 2022). Ultimately, limitations in mental health literacy, perceptions of help-seeking, perceived stigma and embarrassment of mental illness all constitute barriers to help-seeking behaviours (Korhonen et al., 2019; Radez et al., 2019). From a developmental perspective young people are reluctant to seek help due to the desire for independence, autonomy and self-reliance being highly valued at this age. (Rickwood et al., 2015), addresses the question of self-regulation and alludes to its role in well-being and coping (Zuckerman & Gagne, 2003). In addition, parental attitudes and adolescents' perception of the trustworthiness of resources will determine positive help-seeking behaviours or act as a barrier to help-seeking behaviour (Radez et al., 2019). Mastery of the developmental tasks and coping with the psychosocial stressors that adolescents face, is mediated by the socio-cultural context which may impede development and create barriers to help-seeking, or it may be a facilitator in which adaptive coping prevails (Geldard et al., 2016). A young person's ability to cope is multifactorial. Positive, supportive family relationships, peer and community structures mediate the impact of stressors on adolescents, and together with MHL, adaptive coping styles in conjunction with mental health support services will encourage responses to mitigate the psycho-social stressors they face (Mokitimi et al., 2019).

Overarchingly, what emanates from this study is the vital role that MHL plays in mental health and well-being, and in relieving the burden of disease related to adolescent mental illness (Jonas et al., 2019). MHL is inextricably bound to under-utilised resources,

stigma and societal attitudes and beliefs about mental illness. Focusing on the promotion of MHL can address evidenced-based prevalence of mental disorders in adolescents (Jorm, 2000) and mitigate the negative mental health outcomes in this cohort (Radez, et al. 2019). Concomitant to this is that improved MHL, which includes first-aid and self-help knowledge (Jorm, 2000), is associated with positive attitudes towards help-seeking behaviours. Perception and attitude lie at the heart of mental health literacy that ultimately facilitates positive mental health habits and help-seeking behaviours. Mental Health Policy and program implementation should focus on strengthening MHL and promoting help-seeking behaviours (Tomlinson et al., 2022). CAMH services and policy should be bolstered, multisectorial stakeholders (Mokitimi et al., 2019) should be consulted and play a role in implementation and a life-span, socio-cultural, intergenerational approach adopted to ensure Policy development and inclusive implementation to ensure the mental health and well-being of children and our youth and to ensure that they thrive (Tomlinson et al., 2022)

This study highlighted the systemic nature of the determinants of health, which occur within the intersection of socio-cultural contexts, family and friendship relationships, community and the broader society. It addresses the tension between the myriad contextual factors that either facilitate adaptive health-seeking behaviours which promote health and well-being or prove to be barriers to help-seeking behaviours and as such perpetuate negative attitudes towards mental health and hence early recognition and intervention. This begs the question of adopting an integrative, multi-modal, equitable, life-span approach to child adolescent mental health, in order to provide age-appropriate services that address the adolescents' unique developmental needs and in which all stakeholders (family, school and community) are included (Mokitimi et al., 2018) and which meet the needs of the society

and communities it serves.

Mental health literacy is construed as the foundation for early recognition and early intervention of mental health concerns (Campos et al., 2016). The assessment of mental health literacy in adolescents reveals their attitudes, knowledge and beliefs pertaining to mental health and the barriers to early recognition and intervention (Campos et al., 2016). It is this knowledge that can contribute to education about mental health and mental illness, it has the potential to inform mental health policies and intervention strategies that pertain to adolescent mental health and which promote mental health. In addition, assessing gaps in knowledge and erroneous beliefs can inform the development of mental health literacy promoting interventions.

What is evident from the literature and data yielded in this study is the intersection between MHL, the stressors that adolescents face, the coping strategies they use to mitigate these stressors and the extent to which adaptive coping, which rests upon MHL, impacts help-seeking intentions, help-seeking behaviours, barriers to help-seeking and the promotion of mental health. MHL is the mechanism around which prevention, early detection and intervention pivots (Campos et al., 2016). MHL provides the impetus for help-seeking behaviours, which in turn promotes positive mental health outcomes.

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Appendix A - Study Survey Questionnaire

ADOLESCENT MENTAL HEALTH QUESTIONNAIRE

INTRODUCTION

Thank you for agreeing to complete the survey. There are five/six sections to the questionnaire. Kindly make sure that you answer every question.

A. DEMOGRAPHIC DETAILS

1. Please indicate your age category. (**Select one option only)**.

01	02	03	04	05
15 years	16 years	17 years	18 years	19 years

2. Which gender do you identify with? (Do not read)

Female	1
Male	2
Transgender Female	3
Transgender Male	4
Non-Conforming Gender	5
Other	6
[DNR]	7

3. Which population (race) group do you identify with? (Do not read)

Black	1
White	2
Coloured	3
Indian	4
Other	5
[DNR]	6

4. What grade are you in?

01	02	03
Grade 10	Grade 11	Grade 12

5. Which school do you currently attend? (Please state below)

…………………………………………………………………………………………..

6. Is there a psychologist/counsellor/guidance counsellor/social worker at your school? (Please state which one there is and if there is none please state No.
……………………………………………………………………………………………

6. Have you ever had counselling? (State Yes/No)

……………………………………………………………………………………………

B. MENTAL HEALTH LITERACY

The following questions aim to identify your thoughts and ideas on mental health.

Please indicate whether you strongly agree; agree; neither agree nor disagree, disagree or strongly disagree with the following statements (*Kindly select only one option per question*):

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Mental health problems can affect a young person's ability to learn at school.	1	2	3	4	5
2. Youth with mental health problems require support.	1	2	3	4	5
3. Mental health problems can be treated.	1	2	3	4	5
4. The mental health of a person affects the way they feel.	1	2	3	4	5
5. A person's mental health affects their thoughts.	1	2	3	4	5
6. The mental health of a person can affect their behaviour.	1	2	3	4	5
7. Youth can suffer from mental health problems like anxiety?	1	2	3	4	5
8. Youth can suffer from mental health problems like depression?	1	2	3	4	5
9. A person with depression feels sad & miserable all the time.	1	2	3	4	5
10. A counsellor or psychologist could help ME with a mental health problem if I had one.	1	2	3	4	5
11. Getting enough sleep and exercising can help improve mental health.	1	2	3	4	5
12. Doing something enjoyable can help improve mental health (sport, music, dance, being creative, socialising)	1	2	3	4	5
13. Early detection of mental health problems can lead to better treatment options.	1	2	3	4	5
14. Drug and alcohol abuse can cause mental health problems?	1	2	3	4	5

15. Read the following scenario and answer the questions that follow.

A close friend who regularly plays sport with you twice a week suddenly feels sad and tired, doesn't have energy, becomes gloomy, loses interest in usual activities, and does not want to participate anymore, gets angry for no reason, and just wants to be alone.

With regards to the above scenario, please indicate whether you strongly agree; agree; neither agree nor disagree; disagree; or strongly disagree:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. I would be worried about my friend.	1	2	3	4	5
b. I don't think there is anything wrong with him/her to be worried about.					
c. I would think he/she needs help.	1	2	3	4	5
d. I would recommend that they get professional help.	1	2	3	4	5
e. I don't know who he/she can get help from.	1	2	3	4	5

What makes you think he/she NEEDS help or DOES NOT need help?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
f. This is not normal adolescent behaviour.	1	2	3	4	5
g. This is nothing to worry about because he/she is just looking for attention.	1	2	3	4	5
h. This is more than a mood swing because there is a drastic change in his/her attitude and behaviour.	1	2	3	4	5
i. This is normal adolescent behaviour	1	2	3	4	5

16. Read the following scenario and answer the questions that follow.

A friend of yours experiences anxiety, complains of breathing difficulty, frequent headaches, sleeplessness, and prefers to be alone, which negatively affect his/her relationships, participation in extracurricular activities, his/her schoolwork, and interferes with normal daily living.

With regards to the above scenario, please indicate whether you strongly agree; agree; neither agree nor disagree; disagree; or strongly disagree:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
j. I would be worried about my friend.	1	2	3	4	5
k. I don't think there is anything wrong with him/her to be worried about.	1	2	3	4	5
l. I would think he/she needs help.	1	2	3	4	5
m. I would do something to help my friend.	1	2	3	4	5
n. I don't know who he/she can get help from.	1	2	3	4	5

What makes you think he/she NEEDS help or DOES NOT need help?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
o. This is NOT a normal reaction to stress.	1	2	3	4	5
p. This is nothing to worry about because he/she is just looking for attention.	1	2	3	4	5
q. This is more than a general stress because sometimes what may seem like usual teen struggles can actually be a sign of a more severe anxiety disorder.	1	2	3	4	5
r. This is a normal reaction to stress.	1	2	3	4	5

Section C: What are your thoughts about the main causes of stress that Adolescents (youth) face in their environments.

The following questions are answered on a scale as follows: 1= Never 2= Very seldom 3= Unsure 4 = Sometimes 5= Often .

Please indicate your answers by putting a X in the box that matches your answer.

	Never	Very seldom	Unsure	Sometimes	Often
Feeling stressed with my schoolwork?					
Having problems with my parents/guardians?					
Feeling stressed about bad results on my tests or report?					
Problems with my parents about my school performance?					
Feeling stressed about conflict with my peers?					
Feeling stressed about problems with my girlfriend/boyfriend or partner?					
Feeling alone and isolated from my peer group?					
Being bullied by my peers?					
Feeling stress because of financial problems at home?					
Feeling stressed about violence at home?					
Feeling stressed about the loss/death of a parent/s/guardians?					
Feeling stressed about the loss/death of someone close to me (other than my parents/guardians)?					
Feeling stressed about alcohol or drug use in my home?					
Feeling stressed because of peer pressure to use drugs and alcohol?					
Feeling stressed about violence in my community?					

Section D: What coping strategies do adolescents use to manage their stress?

Commented [TN1]: Reduce to 3 questions per sub-section

The following questions are answered on a scale as follows: 1= Never 2= Very seldom 3= Unsure 4 = Sometimes 5= Often.
Please indicate your answers by putting a X in the box that matches your answer.

Self-help Strategies: How often do you use the following coping strategies when you are feeling stressed or have problems?	Never	Very Seldom	Unsure	Sometimes	Often
I allow myself to show how I feel about things to people I am close to					
.I discuss my feelings with friends that I trust					
I try to get emotional support from family					
I talk to someone to help me find better ways to cope with my problems.					

2. Approach	Never	Very seldom	Unsure	Sometimes	Often
I make an effort to do something to deal with the situation/problem					
I try hard to prevent other things from interfering with my plans to deal with the problem					
I take action to avoid the situation					
3. Accommodation					
I try to be stay positive to help me cope, even though I might be feeling stressed about problems I might have.					
I try to see my problem in different ways to help me cope with it.					
I accept the reality of the fact that it happened or that it is happening now?					
I try to focus on something else I care about to help me cope					

4. Avoidance	Never	Very Seldom	Unsure	Sometimes	Often
I refuse to believe that the problem is happening to me and I say to myself "this isn't real"					
I admit to myself that I can't deal with it and I quit trying to find a solution.					
I blame someone or something else for what happened to me or for what is happening to me.					
I try to forget the whole thing.					

5. Punishment	Never	Very Seldom	Unsure	Sometimes	Often
I see that the problem is because of myself or something I have done or said. I blame myself.					
I just think about what is troubling me all the time.					
I criticize or lecture myself.					

Section E: What internal and external resources do Adolescents use to mitigate these stressors?

Commented [TN2]: Here you could list all the possible responses and ask them to select the responses they would most likely use

Please choose one of the options to each of the questions by putting a X in the box that best indicates your answers.

If you had an emotional problem, what would you do to help yourself deal with the problem? Place a X in the box, next to each question, that best indicates your answer.	Never	Very seldom	Unsure	Sometimes	Always or Often
If I feel sad and anxious sometimes, I go out to socialize with my friends?					

If I feel sad and anxious, I ask my parent/s or guardian for help and support?
If I feel sad and anxious, I seek help from friends I can trust?
If I have an emotional problem I talk to a professional (e.g., Doctor, community clinic counsellor, counsellor at school or a psychologist, social worker, or guidance counsellor)?
If I have emotional problems, I monitor my own thoughts and feelings rather than ask for help.
When I feel stressed sometimes, I ask my parents/guardians for help and support.
When I feel stressed sometimes, I discuss it with my friends to get help to cope?

Section F: Help-seeking Behaviours

Please choose one of the options to each of the questions by putting a X in the box that best indicates your answers.

	Parent/s	Self	Close Friends	Counsellor, social worker/ teacher or Psychologist	Life Coach
1. If you were experiencing problems with your parent/s or guardian/s, who would you most likely ask for help? .	1	2	3	4	5
2. If you were having problems at school with your schoolwork, or teachers, who would you most likely ask for help?	1	2	3	4	
3. If you were having emotional problems (feeling sad or anxious), who would you most likely ask for help?	1	2	3	4	
4. If you were having a problem with your girlfriend or boyfriend or partner who would you most likely ask for help?	1	2	3	4	
5. If you were having problems with your friends and peers who would you most likely ask for help?	1	2	3	4	5
6. If you thought you had a mental health problem who would you most likely ask for help?	1	2	3	4	5

Commented [TN3]: See this question – what if they would seek help from more than one person? Perhaps we need to say – select the most appropriate – or who would you most likely seek help from

Commented [TN4]: This question is a double-barrel question as it suggest the professional help – remove (psychologist...) as it is covered in the responses that they must select from.

Check all the questions below and do the same logic check

7. If you were having problems with your sexuality who would you most likely ask for help?	1	2	3	4	5
8. If you were having suicidal thoughts who would you most likely ask for help?	1	2	3	4	5

Section G: Perceptions of Resources

Please choose one of the options to each of the questions by putting a X in the box that best indicates your answers.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
If my community had a special adolescent center with counsellors and psychologist who worked only with helping adolescents, I would go to that center to get help for my problems?					
If my school had a counsellor/psychologist/guidance counsellor or social worker, I would feel comfortable to go and discuss my problems with them?					
I would choose to go and talk to a religious leader or religious counsellor (pastor/minister/counsellor) about my problems?					
If I was having problems with my sexuality, it would be best to seek help from a professional?					
If I had problems with my sexuality my friends would be the best source of help?					
If I had an emotional or psychological problem my parent/s or guardian would be a better source of help than a professional					
16. If I had an emotional or psychological problem, I would trust a professional to help me?					
If my friend was struggling with an emotional or psychological problem, I would encourage them to seek help from a professional because they are trustworthy?					
If I had emotional or psychological problems I would not know where to go or who to ask to get professional help?					

I think I should sort out my own emotional or psychological problems rather than go and seek help from a professional?

If I knew someone who had received help from a professional for their mental health problems, this would encourage me to also go and get help from a professional

Appendix B - Pilot Survey Questionnaire

RESEARCH SURVEY: PILOT STUDY

Adolescent mental health literacy, coping strategies and perceptions of resources to Mitigate psychosocial challenges in the Western Cape

A. DEMOGRAPHIC DETAILS

1. Please indicate your age category. (**Select one option only)**.

01	02	03	04	05
Grade 10	Grade 11	Grade 11		

2. Which gender do you identify with? (Do not read)

Female	1
Male	2
Transgender Female	3
Transgender Male	4
Non-Conforming Gender	5
Other	6
[DNR]	7

3. Which population (race) group do you identify with? (Do not read)

Black	1
White	2
Coloured	3
Indian	4
Other	5
[DNR]	6

4. What Grade are you currently in?

01	02	03	04

10	11	12	

5. Which school do you currently attend? (Please state below)

…………………………………………………………………………………………..

6. Is there a psychologist/counsellor/guidance counsellor/social worker at your school? (Please state which one there is and if there is none please state No.

…………………………………………………………………………………………

6. Have you ever had counselling? (State Yes/No)

…………………………………………………………………………………………

B. MENTAL HEALTH LITERACY

The following questions aim to identify your thoughts and ideas on mental health.

Please indicate whether you strongly agree, agree,neither agree nor disagree, disagree, strongly disagree:

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
17. Mental health problems can affect a young person's ability to learn at school.	1	2	3	4	5
18. Youth with mental health challenges require support.	1	2	3	4	5
19. Mental health problems can be treated.	1	2	3	4	5
20. The mental health of a person affects the way they feel.	1	2	3	4	5
21. A person's mental health affects their thoughts.					
22. The mental health of a person can affect their behaviour.					
23. Early detection of mental health challenges can lead to better treatment options.	1	2	3	4	5
24. If a friend of mine developed a mental health problem, I would advise him/her to seek medical help.	1	2	3	4	5
25. I would listen to a friend who suffered from a mental health problem unconditionally, without judging or criticizing.					
26. If a friend of mine suffered from a mental health issue, I would support him/her.	1	2	3	4	5

27. I would advise a friend who was experiencing mental health issues to seek help from a psychologist or counsellor.	1	2	3	4	5
28. If a friend of mine became depressed, I would recommend him/her to seek professional help.					
29. I would rather not sit next to someone who suffers from a mental health issue in my class.	1	2	3	4	5
30. I would rather not work on a group task with someone in my class who suffers from a mental health issue.	1	2	3	4	5
31. A counsellor or psychologist could help me with a mental health problem if I had one.					
32. If I had a mental health problem, I would seek help from a counsellor or psychologist.	1	2	3	4	5
33. If I had a mental health problem, I would seek help from a close friend.	1	2	3	4	5
34.	1	2	3	4	5
35.	1	2	3	4	5
36.	1	2	3	4	5

DEPRESSION [Remove this heading once completed – for your reference only when doing analysis]

37. Read the following scenario and answer the questions that follow.

A close friend who regularly plays tennis with you twice a week suddenly feels sad, tired, don't have energy, becomes gloomy, loses interest in usual activities and don't want to play tennis anymore, gets angry for no reason, and just wants to be alone.

With regards to the above scenario, please indicate whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
s. I would be worried about my friend.	1	2	3	4	5
t. I don't think there is anything wrong with him/her to be worried about.					
u. I would think he/she needs help.	1	2	3	4	5
v. I would do something to help my friend.	1	2	3	4	5
w. I don't know who he/she can get help from.					

What makes you think he/she NEEDS help or DON'T need help?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
x. This is not normal adolescent behaviour.	1	2	3	4	5
y. This is nothing to worry about because he/she is just looking for attention.					
z. This is more than a mood swing because there is a drastic change in his/her attitude and behaviour.	1	2	3	4	5
aa. This is normal adolescent behaviour	1	2	3	4	5

ANXIETY

38. Read the following scenario and answer the questions that follow.
A friend of yours experiences anxiety, complains of breathing difficulty, frequent headaches, sleeplessness, and prefers to be alone, which negatively affect his/her relationships, participation in extracurricular activities, his/her schoolwork, and interferes with normal daily living.

With regards to the above scenario, please indicate whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
bb. I would be worried about my friend.	1	2	3	4	5
cc. I don't think there is anything wrong with him/her to be worried about.	1	2	3	4	5
dd. I would think he/she needs help.	1	2	3	4	5
ee. I would do something to help my friend.	1	2	3	4	5
ff. I don't know who he/she can get help from.	1	2	3	4	5

What makes you think he/she NEEDS help or DON'T need help?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
gg. This is not a normal reaction to stress.	1	2	3	4	5
hh. This is nothing to worry about because he/she is just looking for attention.	1	2	3	4	5
ii. This is more than a general stress because sometimes what may	1	2	3	4	5

seem like usual teen struggles can actually be a sign of a more severe anxiety disorder.					
jj. This is a normal reaction to stress.	1	2	3	4	5

Schizophrenia

39. Read the following scenario and answer the questions that follow.

A friend of mine told me that he/she is constantly being followed or observed and someone is trying to control him/her remotely. I noticed that his/her behaviour became odd. He/she often gets confused whilst talking and jump from one subject to another for no logical reason. He/she has started to withdraw socially as he/she fears that he/she will be harmed. He/she started wearing the same clothes for a few days and neglected his personal hygiene.

With regards to the above scenario, please indicate whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
kk. I would be worried about my friend.	1	2	3	4	5
ll. I don't think there is anything wrong with him/her to be worried about.	1	2	3	4	5
mm. I would think he/she needs help.	1	2	3	4	5
nn. I would do something to help my friend.	1	2	3	4	5
oo. My friend may suffer from a mental health disorder.	1	2	3	4	5

What makes you think he/she NEEDS help or DON'T need help?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
pp. This is not normal adolescent behaviour.	1	2	3	4	5
qq. This is nothing to worry about because he/she is just looking for attention.	1	2	3	4	5
rr. This is more than just a teenage phase because there is a drastic change in his/her thoughts and behaviour.	1	2	3	4	5
ss. This is normal adolescent behaviour	1	2	3	4	5

Appendix C - Master Letter to Schools Requesting Permission to Conduct Research

MASTER PERMISSION LETTER

Request for permission to conduct research at <insert name of organisation or institution>

Title: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate Psychosocial challenges in the Western Cape.

Principals Name:
School:
Address:
Tel:
Email:

Dear

Thank you for taking my call regarding my proposed research study and permission to conduct the study with your Grade 10, 11 & 12 learners.

My name is Michelle Scher and I am a MA research student, doing research toward a Master's degree in Psychology, at the University of South Africa (UNISA) under supervision of Dr. Naiema Taliep, a Senior Researcher at the Institute for Social and Health Sciences at the University of South Africa (UNISA). We would be grateful if you would grant us permission to conduct this research study with some of your high school students. The title of the study is: **Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.**

The aim of the study is to explore adolescent mental health literacy, coping strategies and their perceptions of mental health mechanisms that mitigate the psychosocial challenges they encounter.

Due to COVID-19 the study has been pivoted to an online format, in order to comply with all COVID-19 protocols. The study will entail the completion of an online questionnaire to be administered via your student data base to your Grade 10's, 11's and 12's. The questionnaire will be in a Google Form format and a link will be provided to you which will need to be sent to the student cohort as per the study. The parent and participant information sheets and the parent and participant consent forms are embedded in the survey for ease of access. All responses will be received by me for dissemination and analysis.

As the researcher, I believe that the nature of the study and its related questions, is relevant to both the context of the life-orientation lessons and to this cohort at which it is aimed. The benefits of this study are to contribute to the body of literature on adolescent mental health in general and to provide impetus for further study based on the outcomes of the study as it pertains to adolescent mental health literacy and the contextual factors that mitigate the stressors that adolescents in the Western Cape face.

Potential risks are minimized due to the non-confronting nature of the questionnaire items as well as since the questionnaire is anonymous, as such no person nor their data may be identified.
Feedback procedure will entail a report on the outcomes of the data being provided to both the Western Cape Education department as well as to yourself as the principal. In addition, each participant will be provided with the researcher's personal email address should they wish to discuss the findings.
We would deeply appreciate you granting us permission to conduct this study at your school. We assure both yourself, your staff and the learners that the participation and completion of the study does not need to impact on their studies or their academic commitments. Furthermore, the study will be carried out with respect for the well-being of all the participants and the school in accordance with strict ethical guidelines and practices as required by the University of South Africa, under whose auspices this study will be carried out and for which I have received ethical clearance.
The overarching premise of the study aligns with the WCED Life Orientation learnings and if framed in this way, perhaps it would encourage students to respond.
Once I have received your permission, I will forward the google form link for you to send out. I am mindful throughout to ensure that this process does not become burdonsome for you, the school or your learners. With this in mind, please be assured that the entire process will take place within the ethical guidelines as set out and approved by the UNISA, to which I am bound.

Please find attached for your perusal, the letter from the WCED granting me permission to conduct the study as well as the Participant/Parent Information.

We look forward to hearing from you and thank you in advance for your time and consideration.
Yours sincerely
M. I. Scher
Michelle Ilana Scher
Student Researcher at the University of South Africa
Student number: 4558316
Email: 4558316@mylife.unisa.ac.za
Dr. Naiema Taliep: talien@unisa.ac.za

Appendix D - WCED Letter Granting Permission to Conduct Research

Directorate: Research

meshack.kanzi@westerncape.gov.za
Tel: +27 021 467 2350
Fax: 086 590 2282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20210219-1112
ENQUIRIES: Mr M Kanzi

Mrs Michelle Scher
8 Princess Road
Fresnaye
Cape Town
8005

Mrs Michelle Scher,

RESEARCH PROPOSAL: ADOLESCENT MENTAL HEALTH LITERACY COPING STRATEGIES AND PERCEPTIONS OF RESOURCES TO MITIGATE PSYCHOSOCIAL CHALLENGES IN THE WESTERN CAPE.

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **27 January 2022 till 30 June 2022.**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Mr M Kanzi at the contact numbers above quoting the reference number.
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

    The Director: Research Services
    Western Cape Education Department
    Private Bag X9114
    CAPE TOWN
    8000

We wish you success in your research.

Kind regards,
Meshack Kanzi
Directorate: Research
DATE: 27 January 2022

1 North Wharf Square, 2 Lower Loop Street, Foreshore, Cape Town 8001
tel: +27 21 467 2531

Private Bag X 9114, Cape Town, 8000
Safe Schools: 0800 45 46 47
wcedonline.westerncape.gov.za

Appendix E - Letter to Principals with Link to Survey

MASTER PRINCIPALS COVER LETTER

PERMISSION GRANTED TO CONDUCT RESEARCH

Title: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate Psychosocial challenges in the Western Cape.

Principals Name:
School:
Address:
Tel:
Email:

Dear

RE: MA RESEARCH STUDY: ADOLESCENT MENTAL HEALTH LITERARCY SURVEY

Thank you for your willingness to allow me to conduct my research study with the Grade 10, 11 & 12 learners at your school.

Please find attached the following documents in support of my study: The Information letter which provides all details pertaining to the study and is the same information provided (embedded in the study) for both parent and learners in order to facilitate their consent; the letter from the WCED granting me permission to conduct research at schools in the Western Cape and a cover letter for your learners.

In addition, please find the link below to the questionnaire/survey for your learners to complete, which can be sent via your online portal or emailed to your students: Grade 10, 11 & 12's

https://docs.google.com/forms/d/15Myo9NIKIwU-nEI9M0UQpHf_zoTkkA2qWS04qPNwrto/edit?usp=sharing

The information sheet and consent forms are embedded in the questionnaire. They cover all ethical considerations for which I have received approval from the ethical committee at UNISA.

The subject of the study and the content aligns with the Life Orientation learning outcomes of the curriculum. I would be grateful if you could point this out to your learners, in the hope that they will be motivated to participate.

Attached is a cover letter, which also contains the link for your learners, that you might wish to include when you send out the notification requesting their participation in the study. I have provided this for you for ease of access and to facilitate the process from your side, should you wish to use it.

I truly believe that this study and the data that emerges will have benefit to understanding adolescent perceptions of mental health, their coping strategies and perceptions about the

resources that support their mental health concerns. Given the pressures that adolsecents face in general and under COVID conditions, this study has even more relevance today.

Should you require any further information or if you have any queries or concerns, please feel free to contact me via my email noted below.

With heartfelt gratitude.

Michelle Scher

Student number. UNISA 4558316

Emal: 4558316@mylife.unisa.ac.za

Appendix F - Parent Information and Learner Informed Consent Brief

PARENT INFORMATION SHEET

01 May 2022

Title: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.

Dear Parent

My name is Michelle Scher, and I am doing research with Dr. Naiema Taliep, a Senior Researcher at the Institute for Social and Health Sciences at the University of South Africa (UNISA), toward a master's degree in Psychology, at the University of South Africa (UNISA). We are inviting you to participate in a study entitled: **Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape**.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out what adolescents (youth aged between 15 and 19 years), know about mental health and mental illness. This study will explore and understand what events and experiences adolescents consider to be stressful and challenging, what coping strategies they use to navigate these challenges and what resources (such as social workers, counsellors, psychologists, teachers, parents etc.) they use to help manage these challenges.

WHY IS MY CHILD BEING INVITED TO PARTICIPATE?

The study focuses on adolescents aged from 15 years to 19 years of age, attending selected high schools in the Western Cape.
Permission to conduct the study was granted by the Western Cape Education Department. Permission was also granted by your child's school principal to carry out the research and administer the survey to the Grade 10's, 11's and 12's in your school. The POPI Act (2013) *[the Protection of Personal Information Act, nr 4 of 2013, ensures that your personal information will be protected at all times. Due to COVID-19 social distancing regulations, the survey will be sent to your child via the school's online portal, data base, to which I have no access and the portal that your child will access to complete the survey will not capture any identifying, personal information. The survey will only contain their age, gender, name of school and current grade and it will be administered to their class/grade through their school's online portal data, for them to complete, should you agree to allow them to participate.*

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?
The study involves the completion of an online survey (questionnaire). They will be asked questions such as: Youth can suffer from mental health problems such as anxiety? Mental health problems can be treated? They will also be asked about the kinds of stress youth experience: Feeling stressed about schoolwork? Problems with parents about your school performance? Being bullied by your peers? There are questions about how they cope with the stress or problems you experience: I discuss my feelings with friends I trust? I try to get emotional support from family. I make an effort to do something to deal with the situation or problem? A further section asks questions about what they do to manage these problems and the stress you experience: If I feel sad and anxious, I seek help from friends I can trust? When I feel stressed sometimes, I ask my parents/guardians for help and support? The second last section asks questions about who they would be most likely to seek help from if they were experiencing problems with their parents, or with their peers etc and the final section asks questions about what they think of the different kinds of support there is available to them when they are experiencing problems or feeling stressed: If your school had a counsellor/psychologist/social-worker/ would you feel comfortable to go and discuss your problems with them? If your community had a center especially for youth to go and discuss their problems, would you go?
The survey consists of 7 sections and completion of the survey/questionnaire should take them approximately 10-20 minutes. The link to the survey will remain open until the 10th June 2022, should they agree to participate, it would be appreciated if they did so prior to this date.

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

Participating in this study is voluntary and they are under no obligation to consent to participation. If they do decide to take part, once you have read this information sheet on the online portal consent to their participation and they have done the same, then you are able to keep this information sheet and be asked to sign a written consent form online to indicate your agreement to allow your child to participate. They are free to withdraw at any time and without giving a reason prior to submitting their survey. Please note however, that once they have SUBMITTED their questionnaire they are NOT able to withdraw their submission. Do remember however, that as no identifiable, personal information needs to be provided, their submission and participation is completely anonymous and confidential.

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

The potential benefits relate to their understanding of what mental health entails and their contribution will add to the data that will be used in the final thesis and discussion of the results of the survey. All participants data will add value to this study for the researcher and to the body of literature regarding this important topic as well as the potential to provide important information regarding mental health policies and the need and implementation of resources for the adolescent cohort to support their mental health literacy and their mental well-being.

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

As this survey is online, there are no foreseeable risks to your child personally. In addition, there are no risks of being identified by either the researcher, their school or anyone that analyses the data, as no identifiable personal information is required. However, if they feel uncomfortable at any point following the completion of the survey or you have concerns. You are welcome to contact the researcher who will be willing to provide support for you. Should you have any queries prior to giving consent please feel free to contact the researcher Mrs. Michelle Scher: 4558316@mylife.unisa.ac.za

WILL THE INFORMATION THAT THEY CONVEY TO THE RESEARCHER AND THEIR IDENTITY BE KEPT CONFIDENTIAL?

Their name will not be recorded anywhere, and no one will be able to connect them to the answers they give, therefore their participation is anonymous. Their answers will be given a code number and they will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. This way you are assured that all information provided is confidential and anonymous to anyone else involved with this research study, including my supervisors, anyone involved with the coding and analysis of the data or reviewing the paper for ethical purposes and for publication

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

All survey responses will require a link for access and as the owner of the survey only I have access to the data. With regards to sharing the data, this will only be done for the purposes of coding and analysing the data and once again as there is no personal identifying information, all the data they provide remains anonymous and confidential and safely stored on the researcher's computer hard drive. Any further use of the data will require additional ethical approval from the University, and it will be stored for up to a period of 5 years. Electronic data will be destroyed after 5 years using the relevant software.

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

No payment or financial reward will be paid for participation in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written ethics approval from the Research Ethics Review Committee of the University of South Africa (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 the researcher. In addition, If you require any further information or want to contact the researcher about any aspect of this study, please contact the research: Mrs. M.I. Scher via email: 4558316@mylife.unisa.ac.za

Should you have any concerns about the way the research has been conducted you are welcome to context the researcher's supervisor Dr Naiema Taliep on the following email address: talien@unisa.ac.za

In addition, you may contact the research ethics chairperson of the University of South Africa's Research Ethics committee: Dr. Rheta Visagie – Manager: Research Integrity & Research Support Directorate, UNISA. Tel: 012-4292478. Email: visagrg@unisa.ac.za.

Thank you for taking the time to read this information sheet and for your willingness to agree to your child's participation in this study.

MI SCHER

MICHELLE I. SCHER (MRS)

4558316@mylife.unisa.ac.za

Appendix G - Participant U18 Brief and Informed Consent Information

PARTICIPANT INFORMATION FOR CONSENT

UNDER 18 YEARS

01 May 2022

Title: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.

Dear Prospective participant

My name is Michelle Scher, and I am doing research with Dr. Naiema Taliep, a a Senior Researcher at the Institute for Social and Health Sciences at the University of South Africa (UNISA), toward a Master's degree in Psychology, at the University of South Africa (UNISA). We are inviting you to participate in a study entitled: Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out what adolescents (youth aged between 15 and 19 years), know about mental health and mental illness. The study will explore what events and experiences adolescents consider to be stressful and challenging, what coping strategies they use to navigate these challenges and what resources (such as social workers, counsellors, psychologists, teachers, parents etc) they use to help manage these challenges.

WHY AM I BEING INVITED TO PARTICIPATE?

The study focuses on adolescents aged from 15 years to 19 years of age, attending selected high schools in the Western Cape and as your school was one of those selected for this study and you fall into the age and grade category that this study is concerned with. I am inviting you to participate in this study. Permission to conduct the study was granted by the Western Cape Education Department. Your school principal has also granted me permission to conduct the survey to the Grade 10's, 11's and 12's at your school. You will receive a link to give consent to complete the survey on an online portal. Or you may choose not to consent as this is not compulsory. The POPI Act (2013) (*the Protection of Personal Information Act, nr 4 of 2013), ensures that your personal information will be protected at all times. I have no access to your school's data base and no personal information regarding your name or address is required for this survey. The survey will only contain your age, gender, name of school and your grade and will be administered to your class/grade via the school's online portal, data base, which is administered by your school and not by me directly to ensure confidentiality of personal information.*

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves the completion of an online survey (questionnaire). You will be asked questions such as: Youth can suffer from mental health problems such as anxiety? Mental health problems can be treated? You will also be asked about the kinds of stress youth experience: Feeling stressed about school work? Problems with parents about your school performance? Being bullied by your peers? There are questions about how you cope with the stress or problems you experience: I discuss my feelings with friends I trust? I try to get emotional support from family? I make an effort to do something to deal with the situation or problem? A further section asks questions about what you do to manage these problems and the stress you experience: If I feel sad and anxious I seek help from friends I can trust? When I feel stressed sometimes, I ask my parents/guardians for help and support? The second last section asks questions about who you would be most likely to seek help from if you were experiencing problems with your parents, or with your peers etc and the final section asks questions about what you think of the different kinds of support there is available to you when you are experiencing problems or feeling stressed: If your school had a counsellor/psychologist/social-worker/ would you feel comfortable to go and discuss your problems with them? If your community had a center especially for youth to go and discuss their problems, would you go?

The survey consists of 7 sections and completion of the survey/questionnaire should take you approximately 10-20 minutes. The link to the survey will remain open until the 10th June 2022, should you agree to participate, please ensure you complete the survey prior to this date.

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, once you have read this information sheet on the online portal you will be given this information sheet to keep and be asked to sign a written consent form online to indicate your agreement to participate. You are free to withdraw at any time and without giving a reason. Please note however, that once you have SUBMITTED your questionnaire you are NOT able to withdraw your submission. So be sure that you are a willing participant and do remember that as no identifiable, personal information needs to be provided, your submission and participation is completely confidential.

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

The potential benefits for you relate to your understanding of what mental health entails and your contribution will add to the data that will be used in the final thesis and discussion of the results of the survey. All participants data will add value to this study for the researcher and to the body of literature regarding this important topic as well as the potential to provide important information regarding mental

health policies and the need for and implementation resources for the adolescent cohort to support their mental health literacy and their mental well-being.

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

As this survey is online, there are no foreseeable risks to you personally. In addition there are no risks of being identified by either the researcher, your school or anyone that analyses the data, as no identifiable personal information is required. However, if you feel uncomfortable at any point following the completion of the survey or if you have any queries or concerns about the research or the nature of the questions, you are welcome to contact the researcher who will be willing to assist you and provide support for you. Please feel free to contact the researcher Mrs Michelle Scher on the following email address: 4558316@mylife.unisa.ac.za

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

Your name will not be recorded anywhere, and no one will be able to connect you to the answers you give, therefore your participation is anonymous. Your answers will be given a code number and they will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. This way you are assured that all information provided is confidential and anonymous to anyone else involved with this research study, including my supervisors, anyone involved with the coding and analysis of the data, such as the statistician. Your responses will be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Kindly note that a report of the study may be submitted to your school for their information and a journal article reporting on the results of the study will be submitted for publication. However, as you are not required to provide your name or any other identifying informaiton, your responses are completely anonymous.

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

All survey responses will require a link for access and as the owner of the survey only I have access to the data. With regards to sharing the data, this will only be done for the purposes of coding and analysing the data and once again as there is no personal identifying information, all the data you provide remains anonymous and confidential and safely stored on my computer hard drive. Any further use of the data will require additional ethical approval from the University.

For future research or academic purposes; 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. Electronic data will be destroyed after 5 years using the relevant software.

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

No payment or financial reward will be paid for participation in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written ethics approval from the Research Ethics Review Committee of the University of South Africa (UNISA). A copy of the approval letter can be obtained from the researcher. In addition the permission to conduct the research in your school was received by the Western Cape Education Department, a copy of which has been forwarded to your school principal.

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 the researcher. In addition, should you require any further information or want to contact the researcher about any aspect of this study, please do so using the following email addresst: Mrs. M. I. Scher 4558316@mylife.unisa.ac.za
Should you have any concerns about the way the research has been conducted you are welcome to context the researcher's supervisor Dr Naiema Taliep on the following email address: talien@unisa.ac.za

Furthermore, Should you have any concerns about the way in which the research has been conducted, you may contact the research ethics chairperson of the University of South Africa's Research Ethics committee: Dr. Rheta Visagie, Manager: Research Integrity & Research Support Directorate, UNISA. Tel: 012-4292478. Email: visagrg@unisa.ac.za.

Kindly note that this information serves to enable you to make an informed decision to consent to participating in the study. You will be required to click yes or no on the survey to indicate whether you consent or not. In order to complete the survey you will need to say yes, however, you are under no obligation to do so and should you not consent, you are welcome to just exit the link. Please remember that as you are UNDER 18 you will require your PARENT/S to read the information and to provide their consent by clicking the box embedded in the survey, should they AGREE to your participation. Once you have both consented you will be permitted to continue with completing the survey.

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

MICHELLE I. SCHER (MRS)
4558316@mylife.unisa.ac.za

Appendix H - Ethical Clearance (UNISA)

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

Researcher(s): Michelle Llana Scher **E-mail: 4558316@mylife.unisa.ac.za**

Supervisor(s): Dr N. Taliep **E-mail: Naiema.Taliep@mrc.ac.za**

Title: *Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape.*

Degree Purpose: MA

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***Low risk application** was **reviewed*** by College of Human Sciences Research Ethics Committee, on **26 January 2021** 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.
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 College 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

Open Rubric

confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

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 require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(26 January 2024).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ***2020*****-CHS-4558316** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature :

Signature : PP

Dr. K.J. Malesa
CHS Ethics Chairperson
Email: maleskj@unisa.ac.za
Tel: (012) 429 4780

Prof K. Masemola
Executive Dean : CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2298

Appendix I - Editor's Letter

January 30, 2023

To Whom it May Concern

This serves to confirm that I am a professional journalist and editor and that I edited Michelle Scher's Master Thesis titled "Adolescent mental health literacy, coping strategies and perceptions of resources to mitigate psychosocial challenges in the Western Cape".

Should you have any queries, please contact me at: 0726606211. My email address is: davidgcapel@gmail.com.

Yours faithfully,

David Capel