DEPRESSIVE SYMPTOMS IN ADOLESCENTS: CONTRIBUTORY FACTORS AT HOME AND IN SCHOOL

BY

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Dep in adolescence.
Dep., nervous

DEDICATION

To my beloved mother who toiled and struggled through life but never failed to smile, serve the poor, concoct a home-made remedy for every ache and pain and willingly share these with the entire neighbourhood. You have served the people well, Mum and you will always be remembered by those who appreciated your wealth of knowledge and your caring nature. I thank you, Ma, for making me the person that I am.
May your soul rest in peace. (1918-2002)

To my beloved dad, you may have left this earth planet fourteen years ago but the words that you always uttered still ring in my ears:
"Think positively and nothing on earth will be impossible to achieve."
Knowing the kind and compassionate people that you and ma were, I know that you are richly blessed and enjoying the fruits of your good deeds in the loving arms of God in heaven (1913-1988).

To my soulmates, Prince, Princess and Emperor who sat with me through the darkest days and nights in my life and showered me with love and attention. God Bless You

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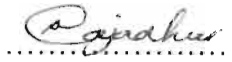
DECLARATION

I, Romela Devi Gajadhur, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor part thereof has been submitted for a degree at another university.



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ABSTRACT

Depression is a serious mental health problem in adolescents. Schools and primary health care providers are flooded with adolescents who have serious emotional and behavioural problems. Mental health specialists initially overlooked this condition, later argued against its existence, then recommended universal acceptance of it as a separate clinical entity very similar in nature to adult depression. More recently they have expressed concern over the adolescent's cognitive, linguistic, and socio-emotional development capabilities in relation to depressive symptomatology and treatment. Quality mental health services are essential to decrease the prevalence, economic toll and mortality that result from depression.

This study is a combination of qualitative and quantitative research methodologies. The principal objective of this study was to determine the prevalence of depressive symptoms in a sample of South African adolescents, to investigate contributory factors at home and in school, and elicit from the adolescent participants suggestions for improving the prevailing conditions. In order to establish the focus of the study four critical questions were posed:

- What is the prevalence of depressive symptoms in adolescents?
- What factors in the home contribute towards depressive symptoms?
- What factors in the school contribute towards depressive symptoms?
- What are the suggestions made by adolescents to improve the prevailing conditions?

To accomplish this delineation, a group of Grade 11 learners were identified by means of cluster sampling. The entire cluster was given the Beck Depression Inventory, which is a self-report scale for screening depressive symptoms. The results of the BDI revealed that 118/566 learners i.e. 20.84% displayed symptoms of depression. These learners i.e.118 who had scored between 19-29 on the BDI were then given a survey questionnaire to complete.

The findings of this study are consistent with other studies. An analysis of data confirmed previous reports of depressive symptoms in adolescents. Gender differences showing more females than males presenting with depressive symptoms were evident in the present study. Females had more responsibilities and not much support in the household chores that led to

feelings of frustration and anger. The adolescents expressed concern over their studying and living conditions.

In-depth interviews were used to gather information for qualitative analysis. From the content analysis of the interviews, three main themes were identified regarding the factors contributing towards depressive symptoms. Family Relationships (home), with communication, support, outside intervention and perceptions of their parents related to the first theme. The second theme related to peer/ sibling relationships associated with communication, support, other concerns, and perceptions of peers/siblings. The final theme related to school and included communication, support, performance and perceptions of school.

Recommendations made on the basis of the present findings included the need for better support structures at schools, with parents and peers/siblings. The qualitative findings indicated a need for social organizations to play a more significant role in the community.
Because of this potent combination of formal and informal influence, educators can be powerful resources for the development and continuity of intervention. Educators should be trained to recognize the markers of adolescent depression and to approach and refer them to a central person such as guidance counselors or social workers for initial screening and treatment if necessary

This study has contributed to research data in an area where there is a deficiency of information and understanding. The high prevalence of depressive symptoms in adolescents is a matter of great concern to all service providers. The contributory factors in the home and school that were identified should be attended to in order to improve the living and studying conditions of the learners.

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CHAPTER ONE

THE NATURE, PURPOSE AND SCOPE OF THE RESEARCH

1.1 INTRODUCTION

Over the past two decades, the study of depression in children and adolescents has become an area of extensive research in the fields of psychiatry, psychology and related disciplines including our school counselors and educators. Prior to this, depression in children and adolescents was seen as non-existent or very different from that of adults. Changes in behaviour were often attributed to "just being a teenager" (Reynolds & Johnston, 1994).

Although recent findings have changed these assumptions and suggest that depression is a major mental health problem within the youthful population, its identification and subsequent treatment remain a major problem because of lack of referrals, parental denial, and insufficient symptom identification training (Ramsey, 1994). There is also a growing realization that depression in children and adolescents cannot be treated in the same way as it is in adults.

Currently, psychiatric and behavioural disorders are the most significant of all health problems among young American people. The incidence of depression among youth age 9-17 has been estimated at 5% and only a minority are treated (Shaffer et al., 1996). Psychiatric and behavioural disorders, including depression, can have devastating effects at this age and often lead to school failure, violence and suicide. Moreover, research indicates that depressed youths are being seriously under-diagnosed and under-treated, causing a great burden to both individuals and society (Kirchner, Yoder, Kramer & Thrush, 2000).

Educators have considerable experience observing a range of normal adolescent behaviour and are in a favourable position to identify significant developmental and behavioural problems. This vital role must not be compromised by lack of

knowledge. Little research has been conducted to examine the effectiveness of programs that educate classroom teachers/educators and school personnel about depression among adolescents. Because one constant in the lives of most youth is school attendance, it is a natural setting in which educators and school personnel have the opportunity to provide education about depression, as well as render the initial link to treatment for learners in need or at risk. Research has shown that it frequently falls to the schools and the teaching profession to provide the initial link to treatment. As adolescent depression is treatable, and early identification and treatment have proved to be effective, public health approaches are needed to enhance early recognition and intervention for young people who suffer from depression. (Kirchner, Yoder, Kramer & Thrush, 2000).

Depression is by far the most common of psychiatric disorders, accounting for 75% of all psychiatric hospitalizations. Each year more than 100 million people worldwide develop clinically recognizable depression. Further more, during the course of a lifetime, it is estimated that 25% of the general population will experience at least one debilitating episode of depression. In addition to the enormous costs of this disorder in terms of lowered productivity, job absenteeism, and permanent withdrawal from the work force, there is also inestimable social damage: grief and pain, marital and family conflict, physical illness and death (Gotlib & Hammen, 1992).

Any signs of emotional disturbance, including depression, are a matter of considerable concern to educators in view of the close relationship that exists between a learner's mental health and performance in school, as well as his personality development. Kandel & Davies (1986) found that adolescents who displayed higher rates of depressive symptoms were less likely to finish high school.

Over the years the scope of education has gradually broadened to include the child's social and emotional development. It is now accepted that, in addition to an

intellectual life, learners also have an emotional one, and these two aspects interact very closely.

Adolescents, the subject of this study, become depressed for many reasons, for varying lengths of time, and to varying degrees. Disturbances in the child that were apparent are likely to be aggravated by the physical and psychological changes associated with adolescence. The number of changes required, particularly if too many occur at once, can overwhelm the young person. Although most individuals pass through adolescence without excessively high levels of "storm and stress", many do experience difficulty. Preventing depression is important since childhood depression in its severe and chronic form is linked to adult maladjustment and sometimes to suicidal behaviour (Harrington, 1993).

Locally, several newspaper articles have expressed concern about the rising rate of youth suicide. The headline of the Sunday Tribune Herald (2001,December 2nd) read as follows:

"Parents' high hopes linked to rise in suicide"

The article stated that teenage suicide is on the increase in the Indian community, and the main reason is the youngsters' inability to communicate with their parents. Teenagers would rather kill themselves than fail to meet "high and unrealistic" expectations set by their parents.

Leeman, (2002) in a local daily News article reported " Suicide rate jumps". The writer of this article stated that the pressures of coping in today's society are taking their toll. He continued by saying that suicide and attempted suicide are fast becoming one of the most prevalent medical problems in South Africa today, with a 50% increase in the incidence of attempted suicide in the African community in the past 10 years. Suicide is a danger as the rate of suicide increases markedly with the onset of adolescence (Hawton, 1986). The number of adolescent deaths from suicide in the United States has increased dramatically during the past few decades. From

1950 to 1990, the suicide rate of adolescents in the 15-19 year age group increased by 300% as stated by the Center for Disease Control and Prevention, (1994). It is the third leading cause of adolescent deaths, after accidents and homicides.

There is a paucity of research concerning depression in South African adolescents. The researcher firmly believes that extensive research should be conducted so that information on depressed adolescence of all cultural groups in this country can be compiled. National baseline data is necessary to provide a framework and a context for discussion, policy planning, implementation and evaluation.

Lack of information on adolescent depression in South Africa was the main motivation for pursuing this research study. This motive was further strengthened when the "school nurse" informed the researcher that, on one of her regular visits to a secondary school, she discovered that a large percentage of the learners were displaying symptoms of depression. She (the nurse) decided to report these findings to the school psychologist who is based in the Department of Education. This was done out of concern for the adolescents. She expected a qualified professional to be appreciative of her report. Unfortunately the psychologist stated that as a school nurse she should only do what is expected of her and not interfere with the psychological aspects of a learner. The psychologist did not attend to this matter thereafter. Apathy of this nature on the part of professionals makes it necessary for a study in this field if we wish to help our adolescents before it is too late. Educators can be empowered with knowledge to enable them to recognize depressed learners and assist them with some coping skills for survival initially, and thereafter refer them to professionals.

According to Gallanger, (1982) growing up in a transitional society where rapid changes are taking place poses major health problems to the adolescents. The South African youth, presently living in a post-apartheid era, where social change is still being experienced, may be at an increasing risk for developing emotional disorders.

Change is often experienced as very traumatic and stress in itself is becoming more a part of the everyday lives of young people (Grant, 1996).

In these transformative years, the educator is faced with numerous challenges in the classroom. Large numbers of learners per class coming from varying cultural backgrounds and different levels of educational attainment is very taxing for the educator. These factors make the task of the educator very complex and often too difficult for him/her to cope with the educational and behavioural problems that present in the classroom. Anecdotal evidence suggests that adolescents, who are faced with these problems, often do not know what to do, they become withdrawn, lonely, and critical of their failures, and often contemplate suicide.

Shevlin, in an article in The Sunday Tribune News (2002) stated that about 60% of South Africans who kill themselves suffered from depression. Depressed people often frustrate and alienate those around them. They seem to be completely self-absorbed, answer in monosyllables and show no interest in doing anything. This type of behaviour often engenders tremendous guilt in those around them. The educator has limited time in the class and finds it extremely demanding when he/she is confronted with behavioural problems as well. Much valuable instruction time is wasted trying to resolve behavioural and emotional problems. It becomes necessary for the parents as well as for educators to develop coping skills in order to guard against adolescents falling victim to depression.

Studies have shown that more than 20% of adolescents in the general population have emotional problems, and one third of adolescents attending psychiatric clinics suffer from depression (Fleming, Boyle, & Offord, 1993). Despite this, depression in this age group is greatly under-diagnosed, leading to serious difficulties in school, work and personal adjustment which often continue in adulthood. It becomes clear that depression in adolescents is a matter of great concern and further research in this

field is therefore imperative to improve the mental status and the general well being of the future society.

1.2 STATEMENT OF PURPOSE

The purpose of this study was to determine the prevalence of depressive symptoms in adolescents, to investigate contributory factors at home and in school and elicit from adolescents suggestions for alleviating prevailing conditions.

A further explanation of the purpose including procedure and instruments used is as follows:

- To establish the prevalence of depressive symptoms in adolescents (Beck Depression Inventory).
- To provide a description of the sample. (Survey Questionnaire)
- To investigate the home environment. (Survey Questionnaire)
- To investigate the school environment. (Survey Questionnaire)
- To conduct interviews for in-depth knowledge of the problem. (Interview Schedule)

It becomes necessary for the professionals to turn a period of great risks into one of great opportunities that represent humanitarian investments in renewing a good society. The school is the only institution that provides ongoing, long-term relationships with all the youth, since they are in contact with their educators for extended time, whereas some may spend as little as only a few minutes per day with their parents. Who then is in the best position to assist the adolescents if not the educators?

Appropriate intervention strategies at an early stage are beneficial to a country as it is more cost effective to prevent a problem rather than attempt to rectify it after it has occurred.

1.3 CRITICAL QUESTIONS

Four critical questions were framed to provide necessary data and insight into the prevalence of depressive symptoms in adolescents, investigate contributory factors at home and at school, and elicit suggestions from adolescents as to how to improve the conditions.

- What is the prevalence of depressive symptoms in adolescents?
- What factors in the home contribute toward depressive symptoms?
- What factors in school contribute toward depressive symptoms?
- What are the suggestions made by adolescents to improve the prevailing conditions?

1.4 RATIONALE FOR THE STUDY

Due to the lack of South African literature on depression in adolescents across all cultural groups, there is no indication as to what extent depression has affected the South African adolescents. The only available national statistics for South Africa were from 1992. Far more information is necessary for policy planning, evaluation and effective coping skills programmes to be developed for adolescents experiencing behavioural problems.

Educators can play a key role in aiding in the assessment of these disorders. Depression is now viewed with such concern that professionals in the education field feel obliged to find answers to vexing questions. It is not unusual to hear an educator talk about a learner displaying depressive symptoms and then express a wish to help him, if only he/she knew how. Such a situation raises question about the school's potential for assisting learners with persistent depressive moods. Can educators, firstly, handle "moderate" cases of depression with some help from their own limited psychological services and, secondly, serve as valuable members of a multidisciplinary team in the treatment of more serious cases requiring psychiatric

attention? Literature relating to the psychological treatment of adolescents leaves no doubt about this. Authorities such as Quay and Werry, (1986) recommend that an educational intervention should have "an eclectic orientation that combines features associated with several models". Although a great deal has been written overseas about depression in adolescents, South African studies on the subject are scarce.

Estimates of depression in school populations vary according to the criteria used. In an American study, Pearce found that between 12 and 20% of the children display depressive disorder. Learners within a school setting expressed decreased ability to deal effectively with the demands of the classroom and displayed poor interpersonal relationship with their peers. Such conditions make it necessary for the educator to become more knowledgeable about this disorder, and be more cognizant that other school-related difficulties may be an outcome of depression of adolescents (Shaw, 1988).

The alarming increase in teenage pregnancies, sexually transmitted diseases, drug and alcohol abuse, suicide and attempted suicide clearly indicates the magnitude of the problem that is affecting our adolescents. In South Africa, along with the increase in the percentage of adolescents who are sexually active, there is an increase in sexually transmitted diseases and teen pregnancies. HIV/AIDS is one of the greatest health threats confronting South Africa at present. In 1994 HIV infections amongst pregnant adolescents younger than 20 years was 6.47%. By 1997 it had risen to 12.7% and in 1998 it was 21.0% (Gouws, Kruger and Burger, 2000). In South Africa, more than 30% of all babies born each year are conceived by teenagers. Girls of 16 and younger give birth to about 50 000 babies each year (Die Burger 1990). In a study on self – poisoning in adolescents, Lifshitz (2002) found 84.5% of them ingested drugs and 10.5% non- – medicinal compounds. Suicide attempts were most frequently associated with transient depression, stemming from defects in child – family communication.

Appropriate early intervention is an extremely important way in which wastage of human potential can be minimized. The constant bombardment of articles reporting teenage suicide and depressed adolescents, together with the fact that educators as well as parents are often placed in a predicament when dealing with educational and emotional problems of their learners, underscores the fact that some research in this field would be of great benefit to parents, educators and the community at large.

A well - adjusted adolescent is an asset to the community in which she/he lives. For vulnerable adolescents, early identification of depression and engagement in prompt and comprehensive intervention programmes may prevent or postpone further episodes. The adolescents of the present generation have a greater degree of freedom than those of previous generations, and are expected to be accountable for their actions. This type of freedom may be overwhelming to some of the adolescents who are not yet ready to be in control and this tends to become problematic. This study will empower educators to be of assistance to adolescents who are experiencing problems.

The rationale underlying the design of this study may be stated as follows:

If those factors that promote symptoms of depression in adolescents can be identified, appropriate steps can be taken to equip them with coping skills to overcome obstacles that may be present in their environment that impacts negatively on them.

Further benefits of the study are likely to include the following:

- A category of emotionally disadvantaged learners would be assisted towards better adjustment.
- As a consequence, scholastic performance adversely affected by emotional blocks would probably improve.
- Improvements in these areas among citizens of any country are assets.

- The study will provide a baseline for further research into depression in adolescents.

The researcher is particularly well qualified to conduct this study since she is responsible for all learners and family welfare issues that arise at schools in which she is currently employed. It is hoped that this investigation will provide useful guidelines when further educational provisions are being planned for adolescents. It should enable the administrator to determine the effects of the existing system and to develop a greater awareness of those areas and policies that call for change. It is also expected that the study will provide future researchers with pointers for further investigation.

1.5 STRUCTURE AND ORGANISATION OF THE REPORT

1.5.1 Methodology in Brief

This study uses a combination of quantitative and qualitative methods. The use of a combination of research methods is referred to as triangulation (Temple, 1997). This method is used to validate data since the implementation of a variety of methods helps to overcome shortcomings of any particular one.

The methodology included a self - report measure of depression i.e. the Beck Depression Inventory, a survey questionnaire and a semi-structured interview. The Beck Depression Inventory (BDI) enabled the researcher to establish the prevalence of depression among Grade 11 learners. The survey questionnaire attempted to assess conditions prevailing at home and in school. The data from the survey questionnaire provided the context for examining in greater depth, the factors that could be impacting negatively on the learner. The open-ended sections of the questionnaire were analyzed qualitatively. Semi-structured interviews were conducted with eight of the highest scorers on the BDI. These interviews allowed for a more open discussion of the learners' concerns, and were analyzed qualitatively.

Results have been integrated and discussed in response to the critical questions that are posed in this research.

International research has provided data on many of the issues under investigation, and will be reviewed together with national trends in Chapter Two. Chapter Three provides a theoretical framework that underpins the investigation into adolescent depression. It explores the major theories and discusses in detail the theoretical framework that guided this research. Chapter Four indicates the specifics of the methodology, which included both quantitative and qualitative research data. This chapter includes the pre-test and pilot test conducted to validate the research instruments and provides the data that could be used for further planning of data collection and the analysis of results. Chapter Five documents the data collection and the quantitative analysis of results obtained from the BDI and the survey questionnaire. A detailed qualitative discussion and interpretation of the data produced by the open-ended questions in the survey questionnaire and the semi-structured interviews are recorded in Chapter Six. A combination of findings, recommendations, limitations, policy and curriculum planning and conclusions are presented in Chapter Seven. Tables have been included in text only where necessary. The rest will be found in Appendix C.

1.6 LIMITATIONS OF THE STUDY

The limitations of the study are alluded to throughout the report and discussed in more detail in the concluding chapter. One limitation of the study is the lack of representation of adolescents from all racial, socio-economic, and geographical areas. Research of this magnitude, which allows for all adolescents to be represented, is difficult for one individual and should be undertaken in a group project. There is need for more research in this field.

1.7 RESEARCH AND POLICY SIGNIFICANCE OF THE STUDY

The result of this research indicates that there is a large percentage of adolescents showing symptoms of depression, living in dysfunctional families and expressing discontentment with their lives. Government policies must consider the fate of the adolescents and appropriate changes should be included in the school curriculum and environment to cater for their needs.

Chapter Two reviews the literature on depression in adolescents and provides an international and national perspective.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Since the early 1980s, the study of depression in adolescents has emerged as a major research domain in the field of adolescent psychopathology. This attention to depression in youngsters came after many years of misconceptions, neglect, and even denial of depression as a disorder in children and adolescents (Cantwell, 1983; Poznanski, 1983). The changed perspective on depression is indeed fortunate, given the scope of the problem (Kovacs, 1989) and the fact that for many years, depression in children was viewed either as nonexistent, masked, or expressed in symptoms different to adults (Reynolds, 1985a). Most recent evidence indicates that the incidence of depression is much higher at younger ages than was previously recognized; that depression is associated with much impairment of psychosocial functioning, and that the recurrence risk is high (Harrington, 1993). Depression in adolescents is not just a passing phase. It is real and is the cause of a large number of failures in school performance and learning disabilities (Puig-Antich et al., 1985a).

This chapter will focus on the classification of depression, clarification of terminology and a general discussion based on various aspects and views on depression. This will encompass a review of literature organized around two important areas identified, namely home and school factors. International and national literature that is essential to provide the context for the research will be explored. A critical evaluation of studies that have researched depression in adolescents will focus on providing insight into the critical questions posed in Chapter One. The most advanced and extensive research in the field of adolescent depression has been conducted in the United States of America (USA). The discussion of the literature will begin with a broad international perspective and

conclude with national researches. The literature review will focus on significant findings that impact on the present study.

2.2 CLASSIFICATION OF DEPRESSION

Depression is classified as a mood disorder that can occur as a single episode in a lifetime (uncommon), as one of many episodes (most common), or as part of an alternation with mania (bipolar disorder). The guidelines for the classification and diagnosis of mood disorders have been developed and approved by the American Psychiatric Association (APA), and are published in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994).

Depressive disorders include major depressive disorder (unipolar depression), dysthymic disorder (chronic, mild) and bipolar disorder (manic-depression). These aspects of depressive disorder will be discussed briefly.

2.2.1 Major Depression (Unipolar)

Major depressive disorder is a serious condition characterized by one or more major depressive episodes. In children and adolescents, an episode lasts on average 7 to 9 months (Birmaher et al.1996a, 1996b). The diagnostic criteria and key defining features of major depressive disorder in children and adolescents are the same as for adults. However, studies have revealed that recognition and diagnosis is more difficult in adolescents because their expression of the symptoms varies with the developmental stage. Adolescents and children may also find it difficult to identify and describe their internal emotions or moods.

The criteria for the recognition of the symptoms of major depression (DSM IV, 1994) are listed below:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed

- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Five or more of these symptoms must persist for two or more weeks before a diagnosis of major depression is indicated (DSM-IV, 1994).

Signs that may be associated with depression in children and in adolescents may be expressed as follows:

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomach aches or tiredness
- Frequent absence from school or poor performance in school
- Talk of or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger or hostility
- Reckless behaviour
- Difficulty with relationships

Rao et al., (1995) stated that 60 to 70% of depressed children and adolescents are likely to experience the persistence or reccurrence of depression in adulthood.

2.2.2 Dysthymic Disorder - Dysthymia (Chronic, mild depression)

Dysthymic disorder is a mood disorder like major depressive disorder, but it has fewer symptoms and is more chronic. Because of its persistent nature, the disorder is especially likely to interfere with normal adjustment. The depressed mood persists for at least one year in children and adolescents and is accompanied by at least two other symptoms of major depression. The average duration of a dysthymic period in children and adolescents is about four years (Kovacs et al, 1997a). According to Birmaher et al, (1996), approximately 70% of individuals with early onset of dysthymic disorder will eventually develop an episode of major depressive disorder.

2.2.3 Bipolar Disorder (Manic Symptoms)

Bipolar disorder is a mood disorder in which episodes of mania alternate with episodes of depression. Frequently, the condition begins in adolescence. The first manifestation of bipolar illness is usually a depressive episode. The first manic feature may not occur for months or years thereafter, or may occur either during the first depressive illness or later, after a symptom-free period (Strober et al., 1995).
The criteria for the recognition of the symptoms of bipolar disorder are reflected below (DSM-IV, 1994).

- Severe changes in mood - either extremely irritable or overly silly and elated
- Overly-inflated self-esteem: grandiosity
- Increased energy
- Decreased need for sleep - able to go with very little or no sleep for days without tiring

- Increased talking - talks too much, too fast, changes topic too quickly, cannot be interrupted
- Distractibility - attention moves constantly from one thing to the next
- Hypersexuality - increased sexual thoughts, feelings or behaviours, use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard for risk - excessive involvement in risky behaviours or activities

The present study focused on determining "moderate" symptoms of depression in an educational context only. As an educator, the major concern of the researcher was towards obtaining baseline data pertaining to coping skills and improving the home and school environment for learners.

For convenience and clarity, studies relating to home and school factors were reviewed under several sub-headings. In practice, however, these factors are interrelated and interact to shape the adolescent.

2.3 CLARIFICATION OF TERMINOLOGY

2.3.1 Depression

Dixon (1987) states that depression is a mood disturbance continuum characterized by feelings of sadness, inferiority, inadequacy, hopelessness, dejection, guilt, or shame. There are four types of depression along the continuum: normal, chronic, crisis, and clinical. The distinction between these types is of degree, intensity, duration, cause, and hopelessness, with seriousness determined by an individual's level of psychosocial functioning and receptivity to treatment. Normal depression is a universally experienced emotion and is associated with events that affect an individual's mood at that time. The depressed feeling does not last longer than several days and does not interfere with the student's psychosocial functioning and

responsibilities (Dixon, 1987). In normal depression, the degree of guilt and loss of self-esteem is minimal and the student can alleviate the depressed mood in time. Chronic depression is often referred to as "trait" versus "state" and is caused by a variety of circumstances. Although more serious than normal depression, it is treatable. Depression during a crisis state results from an inability to solve the problem precipitated by the event and is characterized by debilitating feelings of dejection, sadness, and despair. In both body language and verbalization, the student reflects a sense of helplessness and hopelessness sometimes accompanied by suicidal ideations (Dixon, 1987). Clinically depressed students can manifest contrasting symptoms e.g. some may feel restless, others feel sluggish and fatigued. Thoughts of death and hallucination may be present (Allen, 1990). A clinically depressed adolescent may or may not return to maximum psychosocial functioning after prolonged therapy (Dixon, 1987). According to Carlson & Cantwell, (1980) depression embraces a multitude of symptoms that reliably co-occur. These include affective, cognitive, motivational, physical and vegetative symptoms (Kovacs & Beck, 1977).

Seligham (1975) defines depression as a disorder of the self. It can ensue when the individual finds himself helpless to achieve his goals or to escape his frustrations. Basically all these definitions indicate that the individual is mentally disturbed and will not be able to function optimally.

For the purpose of this study, the term depression is used to refer to those adolescents who are incapacitated sufficiently to under-perform in a school situation and who experience levels of anxiety that are higher than would be considered normal for this population, yet not serious enough to require diagnosis or treatment by a psychiatrist. Cases requiring detailed psychiatric intervention are not within the scope of this investigation.

2.3.2 Adolescence

Adolescence is defined as the period between childhood and maturity (Oxford Popular Dictionary, 1997). Adolescence usually refers to the period between 13 and 19 years of age. It is a period of transition between childhood and adulthood.
Adolescence is a time of emotional turmoil, mood lability, gloomy introspection, great drama, heightened sensitivity, rebellion and behavioural experimentation (Blackman, 1995). Adolescence is a period of life typically associated with great risks in the area of health and education (Hechinger, 1992). Few developmental periods are characterized by so many changes at so many different levels i.e. changes due to pubertal development, social role redefinitions, cognitive development, school transitions, and the emergence of sexuality (Takanishi, 1993).

Although ages 15 to 17 are the normal age limit for a grade 11 learner, the cluster method of sample selection required all grade 11 learners to be included in the research. This resulted in the inclusion of the broader age range that catered for learners who were 21 years old and were still in grade eleven. For the purpose of this study, adolescence within the age range of 15 through to 21 will be included to cater for the older learners who were in Grade 11.

2.3.3 Prevalence

Prevalence refers to the total number of individuals with X disorder in a given population. The prevalence of a disorder is calculated for a given period or for a point in time. Federal reports in the USA typically include the number of students with emotional or behavioural disorders counted at a particular time during the school year. Prevalence is often expressed as a percentage of the population; the total number of cases divided by the total number of individuals in the population. Thus, if 40 students out of a total population of 2,000 in a school or district are identified as having emotional or behavioural disorders, then the prevalence rate is 2 percent (Kauffman, 2001).

2.3.4 Incidence

Incidence refers to the rate of inception - the number of new cases of X disorder in a given population. Cases can refer to individuals or to episodes of the disorder (i.e. an individual might be counted more than once during the incidence period if he or she exhibits the disorder, subsequently does not exhibit the disorder or goes into remission, and then again exhibits the disorder). Incidence, like prevalence, may be expressed as a percentage of the population, but this can be misleading when episodes rather than individuals are counted. Incidence addresses the question "How often does this disorder occur?" whereas prevalence addresses the question "How many individuals are affected?" (Kauffman, 2001)

The purpose of this study was to determine the prevalence of depressive symptoms in adolescents and therefore necessitated looking into the prevalence and not the incidence of depression among adolescence.

2.3.5 Self-Concept

According to Purkney & Stanley (1991), self-concept may be defined as the totality of a complex and dynamic system of learned beliefs that each individual holds to be true about his or her personal existence. This belief system provides consistency in personality and predictability in behaviour. A child initially builds his concept of himself and makes his self-evaluation on the basis of reflected appraisals from his parents who, in the early years, are the main "significant others" in his world. Parental reaction to his attempts at the developmental tasks of infancy and childhood determines whether he sees himself as successful and capable or incapable and clumsy. He brings these self-judgements to the new tasks set up by the school and accordingly, either faces up to the demands of the school with confidence or assumes a doubtful, hesitant role as a learner.

An adolescent who, in the home, is loved for himself and accepted as he is, generally has a sound foundation on which to build. He also handles his encounters with his peers and educators with a great deal of confidence. On the other hand, an adolescent who, through parental rejection or overprotection, has had to strive for recognition, will probably have less relaxed relationships in new social situations, and this may have adverse consequences on his school performance (Levy, 1943). A feeling of hopelessness leading to depression is common when failure to perform is experienced.

Shirley (1942) states that "a secure and wholesomely loved child goes forth to meet new experiences in a spirit of adventure and comes out triumphant in his encounters with new places, new materials and new friends, young and old. A child that is over-sheltered and under-loved goes forth from home with misgivings and doubts, and gives the impression of inadequacy and immaturity in his encounter with new experiences that make him unwelcome either in the society of adults or children". Brage and Meredith (1994) found that self-esteem affects depression directly and indirectly through loneliness. Research over a long period of time has demonstrated that there is a significant relationship between self-concept and depression.

2.3.6 Suicide

The definition of completed suicide is " to kill oneself intentionally" (Kauffman, 2001). Suicide is an act of anger that is often accompanied by the hope that the person who finds the victim will be regretful and will suffer (Middleton-Moz, 1999). According to Stark (1990) suicidal behaviour is any action taken by the child that is instrumental in causing self-harm that could lead to death. The definitive factor is that it is purposive behaviour that is instrumental in carrying out the child's desire to kill him or herself. Maris, (1991) defined suicide as " any death that is the direct or indirect result of a positive or negative act accomplished by the victim, knowing or

believing the act will produce the result". Several studies have found a link between depression and suicide. A detailed discussion of this aspect will follow later.

2.3.7 Gender

The term "gender" replaces the term "sex" and denotes male/female as relational terms.

2.3.8 Learner

Children at school are referred to as pupils, scholars and students. The term "learners" has been recently adopted in the country to describe children who are still at school. In the present study the term "learner" will be used to refer to the individuals in the sample population.

2.3.9 Population

According to Seaberg (1988), population is defined as the total set from which the individuals or units of the study are chosen. A population is the totality of persons, events, organization units, case records or other sampling units with which a research problem is concerned. Arkava and Lane (1983) state that a population may be defined as a term that "sets boundaries on the study units".

2.3.10 Sample

Sample refers to the element of the population considered for actual inclusion in the study (Arkava & Lane 1983).

2.3.11 Interpretative

The term "interpretative" refers to the fact that the aim of qualitative research is not to explain human behaviour in terms of universally valid laws or generalization, but rather to understand and interpret the meanings and intentions that underlie every human action (Mouton, 1986).

2.3.12 Educators

The term 'Educators' replaces the term 'Teachers' in the present education system. When quoting verbatim from the learners, the word that is used by the learner will be recorded.

2.3.13 p value

In statistical testing, p value denotes the probability that the results obtained occurred due to chance alone. If one sets the p value at traditional 0.05% significance level, one is willing to accept the 1:20 or 5% probability that the results obtained occurred by chance alone.

2.4 FACTORS AFFECTING DEPRESSION

There is a long-running controversy about the cause of depression: some say that personal history or experiences cause depression, others argue that brain chemistry causes depression. Both psychology and drugs relieve depression in some cases, so the treatment does not clarify the causes. Although a definite cause of depression is unknown (Fraser, Martin, Hunter & Hudson, 2001), there are theories and hypotheses as to what causes mood disorders (Plus, 1994). However, the scarcity of literature related to depression in South African adolescents forces South African researchers to rely on research conducted in other countries and apply concepts and findings that they believe to be relevant to the South African context.

In order to have a clear understanding on the prevalence of depressive symptoms in adolescents and the contributory factors at home and in school, a detailed discussion on environmental, social, psychological, cognitive, family and school factors and genetic tendencies is necessary.

2.4.1 Environmental Factors Associated With Depression

The following environmental factors may induce a mood disorder in adolescents (Plus, 1994).

- Loss of a parent or a loved one
- Break-up of a romantic relationship
- Attention, conduct or learning disorders
- Abuse or neglect
- Trauma, including natural disasters

Studies have shown that daily stressors (e.g. responsibilities at home, arguments with peers, parental restrictions) mediate the association between major stressful events and psychological symptoms. Environmental events may trigger biological deregulation through disruption in the social fabric of an individual's life (Ehlers, Frank, & Kupfer, 1988).

2.4.2 Social Factors Associated With Depression

Substance abuse is often associated with depression. Depressed delinquents have been found more often to have a substance abuse disorder, along with other emotional and behavioural problems. Lewinsohn et al., (1995) found that risk for both major depressive disorder and substance abuse disorder was elevated by current depressive symptoms, internalizing behaviour problems, poor coping skills, inter-

personal conflict with parents, dissatisfaction with school grades, and externalizing behaviour problems. Normal behaviour of an adolescent is often reflected by an up and down mood. These moods may alternate over a period of hours or days. However, persistent depression with no periods of happiness leads to failing relations with family and friends, poor school performance, other negative behaviour and substance abuse. Both in children and adolescents, depressive disorders confer an increased risk for illness. Interpersonal and psychosocial difficulties persist long after the depressive episode is resolved. In adolescents, there is an increased risk of substance abuse and suicidal behaviour (Birmaher, Brent, Benson, 1998; Ryan, Puig-Antich, Ambrosini et al., 1987; Weissman, Wolk,Goldstein et al.,1999). These findings demonstrate that drug abuse has a bearing on adolescents. Although the present study did not attempt to evaluate the impact of drugs on learners, in some cases alcohol and drug abuse were such that learners on their own, volunteered this as information that impacts on their ability to study.

Adolescents in distress may turn to alcohol, carbohydrates, caffeine, and other substances to find relief from their stressful situation. These social factors may influence their depressive states negatively as the discussion below reflects:

- Drugs (especially heroin) are the most abused substance in the United States of America, showing alarming growth amongst youth, aged 12 to 17, a trend which seems to be taking off in South Africa as well. Ted Legget (2002), from the University of Natal pointed out that the pattern of drug-use across South African communities is shifting and all cultural groups are now being exposed to new drugs. At school level, adolescents are engaging in drugs to feel accepted, be a part of the community and to defy the authority of parents. This eventually leads to absenteeism from school, isolation from friends, "don't care" attitude towards schoolwork, physical illness, suicidal ideation and severed ties with friends and family (Sanofi-Synthelabo, 2002). Smetherham (2001) indicated that one in five teenagers in Cape Town

suffered from post – traumatic stress disorder after experiencing violence or emotional trauma and was likely to abuse alcohol or drugs unless treated.

- There is a 10-18% lifetime risk of chemical dependence in the general South African population, mainly involving alcohol (Sanofi-Synthelabo, 2002). With higher rates of illness, trauma and social problems, there is a higher prevalence of alcohol-related problems in general. Alcohol misuse often leads to alcohol dependence. It is often observed that adolescents take to alcohol as a means of escape from feeling anxious and unhappy. This is not a solution to the problem and often their problems are aggravated.

- Kandel and Davies (1986) reported that self-rating of dysphoria in adolescence was associated with heavy cigarette smoking. The Center for Epidemiologic Studies Depression Scale (CES-D) revealed that 15% to 21% of the general population suffers from depression as compared with 34% to 48% of the smokers. The research undertaken by Mort & Lemon (2000) showed a relationship existed between smoking characteristics and the prevalence of major depression. In a year - long study, researchers found that adolescents who smoked were nearly four times as likely to develop depression as their non-smoking counterparts (Song, 2000). Smokers usually begin as children, get addicted to the nicotine, and thereafter the choice to stop becomes an illusion (Thomas, 2000). Smokers with a history of major depression or depressive symptoms have a 50% less chance of quitting the habit than do non-depressed smokers (Mort & Lemon, 2000). Peters (2001) quoting American experts in her article stated that teenagers who smoked were more prone to depression, sleepless nights, crying spells and felt worthless.

- Caffeine, which is considered a stimulant, is often addictive. It has been reported that, when used in 'normal' amounts, it reduces cerebral flow by up

to 30%. Studies conducted by Bernstein, Carol, Dean, Crosby, Perwien & Benowitz, (1998) indicated that caffeine withdrawal may have a detrimental effect on attention and performance in scholars.

- Carbohydrate craving has been thought to be characteristic of patients with atypical depression. A survey by British mental health charity 'Mind' has revealed that in long term, caffeine and sugar have a negative effect on patients suffering from depression and these can perpetuate a cycle of fatigue (Anon, 2000b).

2.4.3 Psychological Factors

Biological changes at puberty affect body and self-image as well as how others see the adolescent. Social changes related to the move from elementary to secondary school, affect peer group relations and friendship. School changes are more frequent in adolescence and parental divorce may have a stronger impact on some aspects of adolescent development e.g. romantic relationships. Thus, the extent of potentially difficult changes in adolescence predicts increased psychological difficulty. Depression stands out among the psychological problems of adolescence, both for its impact on adjustment during the adolescent years and its long-term effects on adult psychological functioning (Petersen et al., 1993).

Negative body image is thought to lead to depression and eating disorders (Attie & Brocks-Gunn, 1992; Post & Crowther, 1985). Anxiety typically precedes depression and low self-esteem may lead to depression. The psychological processes related to depression may be different for boys and girls. One study reported that boys who were depressed at 18 years of age were aggressive, self-aggrandizing, and under-controlled in pre-school, whereas depressed 18 year-old girls were over-controlled in pre-school (Block, 1991).

2.4.4 Cognitive Factors

Adolescents show dramatic increases in cognitive ability and reasoning capacity (Graber & Petersen, 1991; Keating, 1990). Their increased capacity to reflect on the developing self and the future is thought to play a role in the possibility of experiencing depressed moods. Hammen (1990) outlined three general approaches to research on cognitive vulnerability to child-adolescent depression: information-processing models, depressive attributional style, and self-control cognitions. Although there is evidence of difference between depressed and non-depressed adolescents in each of these aspects of cognition, the role of cognitive processes as a causal factor in depression is not clear. For example, children and adolescents who attribute negative events to internal, stable and global causes are more likely to be depressed (Kaslow, Rehm, & Seigel, 1984).

Cognitive disturbances include a perception of low self-worth, negative expectations, and a disturbed self-image in which everything seems to be overwhelming, and everyday affairs become unmanageable. The ability to concentrate is decreased and forgetfulness as well as somatic, nihilistic and hypo-chondriacal delusions are present. Cognitive characteristics may include negative comments about one-self that indicate low self-esteem, excessive guilt and pessimism. Depressed learners often avoid demanding tasks and social experiences, show little interest in normal activities and seem not to be motivated by ordinary or special consequences.

2.4.5 Family Factors

The functioning of any family must be considered in terms of how effectively it organizes its structure and available resources to master the life challenges of adolescence. Adaptability, according to Olson (1988), involves a balance between maintaining a stable structure and allowing for flexibility in response to developmental and environmental challenges. Overly rigid organization or chaotic

disorganization tends to be highly dysfunctional and associated with symptomatic behaviour in adolescence. Families need to bend considerably to meet adolescents' needs for greater autonomy and self-control while providing a clear and consistent structure (Steinberg, 1981). The present study also focused on the attitudes and support structures of family members in creating a favorable environment for the adolescents.

Bibring (1953) maintains that a predisposition to depression is caused by lack of parental love during childhood. More recently, Beck (1967) has argued that depression in adulthood results from negative cognitions about the self, the world, and the future. These cognitions are postulated to have their origins in the early interactions of the child with his /her parents. Blatt (1974; Blatt & Homann, 1992) suggests that anaclitic and introjective depressions are due to failures during childhood to establish good relations with the parents and to develop adequate representations of the parents. Recent empirical investigations have converged to suggest that depressed individuals have had more aversive childhoods than have non-depressed persons. Blatt et al., (1979) found that depression was related to perceptions of the parents lacking in nurturance, support, and affection. In sum, the results of these studies indicate that depressed individuals are more likely to report early relationships characterized by low care, high overprotection, and hostile and abusive behaviour.

Montemayor (1983), in his review of conflict studies between adolescents and parents, concluded that there is considerable variability in the degree of conflict experienced. All families do conflict some of the time, but some families conflict most of the time. Healthy families are distinguished by clear, direct communication and the ability to acknowledge and resolve conflict. Dysfunctional families get caught up in cycles of blaming, criticism, and scape-goating that block empathy and problem solving. Showing interest in the adolescent as a person can facilitate more open communication and trust. This is shown to be partly true in the present study.

Although the quantitative analysis revealed that most of the adolescents enjoyed a good relationship with their parents, in the qualitative results, they expressed great concern regarding communication at home.

In several community surveys of mildly or non-clinically depressed youngsters, there was evidence of relatively negative parent-child relationships (e.g. Garrison et al., 1990; Hops et al., 1990; Kandel & Davies, 1986; Kaslow, Rehm, & Siegel, 1984; Lefkowitz & Testiny, 1985). Other factors implicated in the etiology of depression include rejection by parents (whether actual or physical) and even parental disharmony, which almost always diminishes the attention children receive from their parents and tends to lower their self-esteem (Lefkowitz & Tesiny, 1984; Long, 1986; Parker, 1983). A negative attributional style that may place persons at risk for becoming depressed stems largely from developmental experiences that foster a sense of incompetence and unworthiness. Especially important in this regard are parental childrearing practices that combine limited or inconsistent expressions of affection and low rates of reward with authoritarian control, power assertive discipline, and inducement of guilt. Such practices are found to hinder normal development of self-esteem, to increase a young person's vulnerability to feelings of helplessness and failure, and to generate a disposition towards depressive mood (Cole & Rehm, 1986; Kandel & Davies, 1982; McCraine & Bass, 1984). Other research has demonstrated that depressed children and adolescents are more likely than control subjects to be immersed in strained relationships and to perceive a lack of support from parents, siblings, and peers (Beck & Rosenberg, 1986; Compas, Slavin, Wagner, & Vannatta, 1986). The present study explored the parent-child relationship as a contributory factor towards depression and deemed this, among other factors, to be crucial.

Research by Billings & Moos, (1983) has consistently implicated quality of family relationships as factors in both adult and child depression. Both the initial cross-sectional study and the one year follow up investigation indicated that children's

physical and psychological functioning, as reported by the parents, was associated with parental reports of family arguments (which presumably included child-parent conflict). Parent-child conflict seems to be greatest during the period known as trans-puberty, when the physiological changes of pubertal development are at a peak. During this period, adolescents may begin to assert behavior autonomy in a number of areas, with parents sometimes reacting by making efforts to reassert their authority. Both parent and adolescents report increased emotional distance (Steinberg, 1987) and more intense family conflict over self-regulation (Papini, Clark, Barnett, & Savage, 1989). Hill and Holmbeck (1987) reported that the increased conflict and decreased emotional closeness of this period occur across socio-economic groups. Lee and Gotlib (1991b) have argued that children who experience parental marital discord, divorce, and parental psychopathology all demonstrate similar psychosocial difficulties.

According to Kauffman (2001) there is a significant correlation between parents' depression and a variety of problems in their children. Depressed parents may provide models of depressed behavior, reinforce depressive behaviour in their children or create a home environment that is conducive to depression (by providing few rewards for achievement, setting unreasonable expectations, emphasizing punishment, or providing non-contingent rewards and punishments). Depressed mothers often lack parenting skills, which could account for some of their children's affective and behavioural problems. Cummings and Davies (1999) noted that depressed mothers, when compared with non depressed parents, on the one hand were lax, inconsistent and generally ineffective in child management and discipline, yet, when they were not yielding to their child's demands they were more likely to engage in direct, forceful control strategies and were less likely to end disagreements in compromise. Having a depressed parent is a major risk factor for depression in childhood. Offspring of depressed parents are more likely than children of healthy parents to experience school and peer problems, high rates of depressive disorders as well as psychiatric disorders and problem behaviours. Both genetic and psychosocial

processes are likely to be involved with these outcomes (Hammen, 1991). However, in the present study the researcher focused on the psychosocial and not the genetic factors that contributed to depressive symptoms.

Adolescents reared in an environment of conflicts or divorces are more vulnerable to depression, as shown in studies by (Rastam, 1991; Spigelman & Spigelman, 1991). In a report by Nilzon & Palmerus (1997), it was evident that nine of the sixteen youths in the depressed-anxious group had experienced parental divorce, and eleven had experienced great marital disharmony and discord over a longer period of time. Parental divorce appears to amplify behavioural disturbances and depression in adolescents. The death of a loved one or growing up with a depressed parent constitutes strong risk factors for depression. Some dysfunctional processes involve the perpetuation of interpersonal deficits and depression across generations (Hammen, 1991). The current study also looked at factors that revealed the family composition and its impact on the learners.

Harrington (1993) adds to this by stating that many acute life stresses in childhood arise in the context of chronic adversities (e.g. parent-child separations) However, studies by Brown et al., (1986) on parental loss suggest that the risk or psychiatric disorder stems from the deficient parental care that follows the loss rather than the loss per se. Studies of children whose parents have been divorced shows how several different factors can contribute to the psychopathology that is associated with adverse experiences. Wallerstein & Kelly (1980) reports that in adolescents, the short-term impact can be quite marked, and some may show severe depression. Anger also occurs, with blame placed on the parent who left the family home. Studies have found that the impact of loss of a parent leads to a significant drop in school performance (Hollon, 1970).

In a study that examined the relationship among adolescents' negative thoughts, depressive moods, and family environment, results indicated that adolescents who

perceived higher family cohesion experienced fewer negative thoughts (Ayzin, Betul, Oztutuncu & Filiz, 2001). This may have resulted because members of cohesive families are sensitive to each other's needs. Problems are shared and communication is empathic. Lower cohesion, on the other hand, is associated with negative personality characteristics. When family members are less supportive of each other, this may lead to low self-esteem, anxiety and depression (Billings & Moos, 1984). In a similar study examining parent/adolescent relationships, the results were in keeping with the previous study. They indicated that adolescents who reported relatively warm parenting by both parents had a smaller association of stressful symptoms of depression as compared with other adolescents. Other adolescents who reported relatively harsher discipline by both parents had a higher association of stress with depressive symptoms (Barry & Cohen 1996).

Research has shown that a high level of emotional autonomy is associated with felt insecurity, less family cohesion, less use of parents as resources, greater rejection by parents and a more negative self-image (Ryan & Lynch, 1989). This would suggest that prevention programmes should seek to improve factors such as self-perception, self-esteem, and social relationships with peers and family bonding.

In a recent study on the relationship between the use of the Internet and depression and social isolation among adolescents, results indicated that high Internet use was related to weaker social ties (Sanders, Field, Diego, & Kaplan, 2000). Low Internet users reported significantly better relationships with their mothers and friends. However, these results do not imply directionality, as it was not possible for the researcher to determine whether adolescents with poor social ties gravitated towards the Internet activity or excessive Internet activity decreased social ties, or both. Learners in the present sample did not have this facility at their homes.

2.4.6 Peer And School Factors

Depressive reactions often take the form of poor peer relations, loss of interest in activities, diminished ability to think or concentrate, and complaints of fatigue (DSM-IV). Low peer popularity is related to depression and depressive symptoms (Jacobsen, Lahey, & Strauss, 1983). Among young adolescents, less closeness with a best friend, less contact with friends, and more experiences of rejection contributed to increase over time in depressive effect (Vernberg, 1990). Being depressed appears to contribute to poor relationships that are the strongest predictor of adult disorder (Sroufe & Rutter, 1984). In a study by Kurdek & Sinclair, (1988), seventh and ninth graders who perceived their friends as supportive reported fewer psychological and school-related problems than those with less supportive friendships. In another study, sixth graders who reported little emotional support from their friends also seemed more depressed, especially if they lived in single-parent families (Feldman, Rubenstein, & Rubin, 1988). Adolescents who described their friendships more positively had higher self-esteem than other adolescents (Mannarino, 1976; McGuire & Weisz, 1982; Townsend, McCracken, & Wilton, 1988). The correlation of friendship perceptions with self-esteem and other indicators of adjustment were comparable for boys and girls in studies that reported these data (Feldman et al., 1988). Peer relationship was investigated as one of the contributory factors in adolescent depression and was found to be a crucial factor since many adolescents felt alienated from peers and family members. This provided the researcher with a very good insight into the thinking patterns of the adolescents.

In his study, Perry (1987) found that eighth graders who had positive perceptions of their friendship group also had higher self-esteem, greater confidence about their social acceptance by peers, higher perceived athletic and scholastic competence and lower loneliness. Eighth graders who reported more conflicts in friendship groups had lower self-esteem, lower scholastic competence, and greater loneliness than adolescents who had fewer conflicts with friends.

Forming and maintaining satisfying relationships with peers is a central development task of adolescence. Adolescents who have close friendships and are accepted by peers typically are high in self-esteem, socially skilled, and academically successful (Berndt, 1988; Slavin-Williams & Berndt, 1990). Adolescents who lack supportive friendships or who are rejected by many of their peers show poor psychological, social, and academic adjustment (Berndt, 1989; Parker & Asher, 1987). Acceptance by peers is important since both friendship and peer-group acceptance acquire special significance during adolescence. Time spent with friends increases and time spent with family decreases at this stage. Adolescents report conflicts with friends roughly as often as younger children do; girls report roughly as many conflicts as boys do (Berndt, 1986a).

Peer rejection may result partly from problems in parent-child relationships (Putallaz, 1987). Ridicule or mocking is a negative form of humor that communicates hostility, anger, and dislike; it is an indication of peer rejection. Adolescents who report more positive experiences with peers, including experiences of "fun and joking with kids," also report less depression, lower anxiety, and higher self-worth than early adolescents who report more negative peer experiences, including ridicule (Kanner, Feldman, Weinberger, & Ford, 1987).

Studies of non-clinically depressed adolescents indicate an association between social functioning difficulties and depressive symptoms. Buhrmester (1990) found that both self-rated and friend-rated lower social competence were significantly associated with scores on a depression/anxiety factor. Hops, Lewinsohn, Andrews and Roberts (1990) administered various self-report questionnaires regarding perceived social relations to high school students and found a significant association between depression and perceived social support, and between depression and interpersonal sensitivity. Forehand et al., (1988) found that relatively depressed adolescents in their study were rated lower on social competence by teachers, but

only for those whose mothers were also relatively more depressed. Lack of acceptance by peers can create or reinforce self-doubt and hamper development. Rejected adolescents are vulnerable to psychological stress because they lack peer support and acceptance (East et al., 1987). Being disliked by many classmates could increase adolescents' inclination to dislike school and to drop out as soon as possible (Parker & Asher, 1987). The qualitative analysis in the current study pointed out that the learners did not enjoy a good relationship with peers, siblings, parents and educators.

The academic grades of both boys and girls appear to decrease over adolescence and depression may play a role. Pillay and Moosa (2000) in their study of depression in Black children found that the most common presenting problem was poor school performance (47.37%). In a study by Ebata & Petersen, (1992), boys who were depressed and engaged in minor delinquent activities had sharp grade declines relative to those who were only depressed or delinquent. Boys with no depressive episodes and no delinquent activities showed stable achievement over the course of adolescence. Puig-Antich et al., (1985a) found that depressed learners were more impaired than normal controls for the items measuring school behaviour and school achievement. Recovered depressed learners were functioning better in school than they had while depressed. They had better relationships with their educators and showed greater academic achievement than during their depressive episode (Puig-Antich et al., 1985b). However, this applied only to males, as the study showed that there was no relationship between depression and achievement for females.

A large proportion of the depressed adolescents are referred to a psychologist because of poor achievement in school. Their poor progress is attributed to lack of motivation, lack of effort, daydreaming, indolence and other poorly defined sources. However, these learners are found to suffer from definite features of depression that, though masked by other behaviour, are the true cause of poor performance. Toolan (1970) stated that where depression is responsible for poor school achievement, a

major complaint made by the learner is difficulty in concentration. Depression clearly disrupts children's cognitive, interpersonal, and academic functioning. Forhand, Brody, Long, and Fauber (1988) found that relatively more depressed adolescents had low grade point averages. Kandel and Davies (1986) found that adolescents who displayed higher rates of depressive symptoms were less likely to finish high school than were non-depressed youngsters, and the depressed girls completed significantly fewer years of education than did non-depressed girls. The present study investigated peer and school factors as contributory factor towards symptoms of depression and its link with academic performance.

2.4.7 Genetic Factors

Genetic factors are also implicated in depression. Studies have reported that identical twins are four to five times more likely than fraternal twins to show concordance for MDD (Kendler, Heath, Martin, & Eaves, 1986; Wender et al., 1986). An uncontrollable or internal factor associated with depression is the genetic predisposition of each individual. Certain types of depression (such as bipolar or manic depression) tend to run in the families, although this does not mean that there is always an inherited genetic risk involved. The susceptibility to anxiety and depression can be considered an inherited biological sensitivity to depression (Gilbert, 1997). Although this is significant contributory factor in depression, the present study focused mainly on psychosocial factors.

2.5 DEPRESSION IN ADOLESCENTS

2.5.1 Prevalence Of Depression

The prevalence of depression among the general school population of children ranges from 1.9% (Kashani & Simonds, 1979) to 13.9% (Pfeffer et al., 1984).

Lefkowitz and Tesiny, (1985) used a Peer Nomination Inventory of Depression (PNID) to identify depressed youths. This instrument identified 5.2% of their sample as exhibiting severe levels of depressive symptomatology. In another investigation, Albert and Beck (1975) studied an early adolescent population that completed a modified version of the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erlbough, 1991). They found that 33.3% of their sample reported a moderate level of depressive symptomatology when using adult cut-off scores. This figure seemed unreasonably high. They also found that 2.2% of the youngsters reported a severe level of depressive symptomatology.

Major depression is the most common of all psychiatric disorders (Desai & Jann, 2000; Medifile, 2000; Reynolds and Johnston, 1994). According to the World Health Organisation (WHO), major depression will become the second leading cause of disability worldwide by 2020 (Wells, 1999). Depression has been considered to be the major psychiatric disease of the 20th century, affecting approximately eight million people in North America. Adults with psychiatric illness are 20 times more likely to die from accidents or suicide than adults without psychiatric disorder (Lewinsohn, et al., 1994). Current evidence suggests that while adolescence is not a period of inevitable crisis, a significant number of adolescents do show symptoms of anxiety and depression. Some studies reveal that major depression often appears for the first time during the teenage years and early recognition of these conditions will have profound effects on later morbidity and mortality. Recent studies have shown that more than 20% of adolescents in the general population have emotional problems and one-third of adolescents attending psychiatric clinic suffer from depression (Fleming, Boyle, & Offord: 1993). Despite this, depression in this age group is greatly under-diagnosed, leading to serious difficulties in school, work and personal adjustments that often continued into adulthood. Psychiatrists, psychologists and officials from Non Government Organistions expressed concern at the increase in depressed adolescents cases that they were currently handling. The

majority of the problems were related to family, peer and educator relationships and school performance. (anecdotal evidence)

Despite significant advances in the management of depression over the last two decades, these disorders often go unrecognized by families and physicians alike. Depressive disorders in young people are often considered normal mood swings typical of a particular developmental stage. According to the National Institute of Mental Health (NIMH Sept. 2000), health care practitioners may be reluctant to prematurely "label" a young person with a mental illness diagnosis. This is also applicable to the South African society as many adolescents present with behavioural problems that are often ignored by the educators and parents. The educators don't have the skills to investigate the underlying causes and parents often don't have time or money to look into the problems.

A number of epidemiological studies have reported that up to 2.5% of children and up to 8.3% of adolescents in the United States of America (USA), suffer from depression (Birmaher, Ryan, Williamson et al., 1996). A recently published longitudinal study found that early onset of depression often persists, recurs and continues into adulthood, suggesting that depression in adults often begins in adolescence. An NIMH-sponsored study of 9 to-17 year olds estimates that the prevalence of any depression is more than 6% in a six-month period. The high prevalence of depression calls for health care providers, and all stakeholders to focus more closely on this disorder.

Every year, the United States of America (USA) spends approximately $44 billion on the treatment of depression alone (O'Conner, Gurbel & Serebruany, 2000; Wells, 1999). The cost to the health care system is high despite the fact that only a minority of depressed patients receives appropriate treatment (Eisenberg, 1992). Early diagnosis and treatment are critical to healthy emotional, social and behavioural development and to ensure financial savings to a country.

Many of the difficulties experienced by adolescents are owing to physical, emotional, intellectual and social developments being uneven and out of step with each other (Fisher, 1984). Brain imaging technologies have detected brain growth throughout childhood and into adolescence. The developing brain is vulnerable to traumatic experiences, drug abuse and unhealthy experiences (Anon, 2001b). It has been suggested that depressed adolescents should be screened for hypothyroidism and drug abuse as possible causes of depression (Plus, 1994).

The experiences of adolescents in the 2000's differ from those of any adult- parent or grandparent. Adolescents are experimenting with drugs, alcohol and sex at a far younger age. In a survey of high school seniors, 65% reported commencing the use of alcohol and 79% had smoked cigarettes by the ninth grade (Gans & Blyth, 1990). Adolescents become victims, witnesses or perpetrators of interpersonal violence, or live under constant threat of violence. Patta, (2002) reported that one in three adolescent girls are sexually active and 30 pregnant females were expelled from a particular secondary school in Kwa Zulu Natal. This finding was described as "shocking" and the departmental official being interviewed did not have statistics of pregnancy at other schools under his control. Sex education and women empowerment was necessary to avert this problem, as the males connected to the pregnancy were allowed to remain at school while the females suffered with the additional burden of taking care of the baby and not completing their studies in the current year. Concern at the rampant spread of HIV and Aids was also expressed. Learners with complex problems of this nature will eventually become depressed, as they have no coping skills available to them. A pregnant female interviewed in this study presented with similar problems. A detailed discussion of this interview is recorded in Chapter Six.

According to the World Health Organisation (WHO), depression affects approximately three to five percent of the world's population and it will be one of the

most debilitating conditions by the year 2020 (Anon, 2001a). Studies in adults and youth suggest that each successive generation since 1940 is at risk for developing a depressive disorder, and these disorders are being recognized at successively younger ages (Birmaher et al., 1998). Epidemiological studies suggest that between 10% and 29% of American adolescents from the general population have experienced a depressive disorder (Reynolds & Johnston, 1994).

The incidence of dsyphoric mood, depressive disorder and depression increases dramatically after puberty (Poznanski & Mokos, 1994). Radloff (1991) found dramatic increases in depressed moods between the ages of 13 and 15 years, a peak at approximately 17-18 years, and a subsequent decline to adult levels. The mid-adolescence peak was found to be higher for girls than for boys (Petersen, White, & Stemmler, 1991). It is estimated that 13% of all males and 20% of all females will suffer from depression at least once in their lifetime (Plus, 1994). This is when the gender incidence of these disorders alters. In childhood, boys and girls suffer either equally from depression (Sawyer & Arney, 2000) or more boys are prone to depression (Nurcombe, 1994). Although Birmaher, Ryan, Williamson et al., (1996) agree that boys and girls appear to be at equal risk for depression in childhood, they state that during adolescence, girls are twice as likely as boys to develop depression. At puberty, depressive symptomatology increases in females (Reynolds & Johnson, 1994) to a 2:1 ratio of females to males (Sawyer & Arney, 2000). This pattern is also reflected in adults (Poznazski & Mokros, 1994). It is estimated that between 40% and 70% of all suicide victims in the USA suffer from major depression (Desjarlais, Eisenberg, Good, & Kleinman, 1995). Gender differences were treated as crucial throughout the research. The design of the instruments and the consistent analysis of the data focused on whether there were significant gender differences in any of the elements.

In Hong Kong, a relatively large proportion of young people tend to be depressed. Using the Beck Depression Inventory, Shek (1991) found that 53% of the young

people in his Hong Kong sample had mild, moderate or severe levels of depression. Furthermore, according to Lo (1985), 16.8% of the deaths among Hong Kong young people between the ages of 15 to 24 were attributable to suicide.

Pillay and Moosa (2000) in their study of depression in Black children highlighted three common stressors. These were parent conflict (39.47%), substance abuse by father (15.79%) and physical or sexual abuse (10.53%). The most common presenting symptoms were poor school performance and enuresis.

No recent South African statistics on the incidence of depression on adolescents were available (Department of Mental Health services, 2002).

2.5.2 Stress And Depression

Today's adolescents are increasingly exposed to physical violence and disturbances in the world: school violence, political violence and murders, war in several countries and racial tension. All these and the feeling of threat to one's personal safety and the safety of one's loved ones can lead to extreme stress and emotional problems (Gouws, Kruger & Burger, 2000). Stress is the body's response to physical and mental demands and may require specific coping mechanisms for the adolescent to respond positively (Cush, 1994).

Typical developmental stressors include personal identity crises, acceptance by peer group and sexual relationships. In addition there is a problem of constant parental intervention as well as the conflict between the adolescent's search for peer acceptance and the submergence of his or her own identity in the conformity demanded by the peer group (Fisher, 1984). Research suggests that persistent or escalating stressful events (e.g. disagreements with parents) increase the risk for the development of adolescent depression or anxiety (Rueter, Scaramella, Wallace and Conger, 1999). Stoelb & Chiriboga (1998) cite broken homes, a family history of

psychiatric illness and/or suicidal behaviour, and childhood abuse/neglect as common factors in adolescent suicide. A lack of a sense of belonging is a good predictor of depression. An assessment of the adolescent family relationship as well as the relationship with peers and social network is essential (Hagerty & Williams, 1999). Some learners were living in a dysfunctional family that impacted negatively on their performance at school.

Violence appears to be a risk factor for the development of hostility and depressive symptoms. Research studies demonstrate a correlation between exposure to violence and depression (DuRant et al., 1995; Martinez & Richters, 1993). Adolescents who were victims of violence or witnessed violence against persons familiar to them had a significant incidence of depressive symptoms. According to DuRant et al., (1995) intra-familial violence was highly correlated with adolescent depression, hopelessness and lack of purpose in life.

The similarity to the South African experience is evident with the high crime rate prevailing in the country. A report by Arendse, (2001) indicated that more than 90% of the Western Cape high school learners showed signs of depression because they have either witnessed or been a victim of violence. Aside from psychiatric symptoms, adolescents who have been victims or witnesses of violence were likely to exhibit poor school performance and behavioural disorders, which jeopardizes their ability to function well later in life. Anecdotal evidence in this respect indicates that majority of the learners from the present sample had some experience of violence in their family or community that had a debilitating effect on them.

Anxiety and depression are part of everyday life and present at primary health care level with great frequency (Harding et al., 1980). Petersen et al., (1991b) found that adolescent females experienced more challenging and stressful circumstances than adolescent males, and these differences accounted for gender differences in depressed mood. Stress can be linked to different physiological problems including

anxiety and depression (Gilbert, 1997). Anxiety co-exists with depression in an estimated 29% of the cases (Wise and Rieck, 1993). Certain stresses (such as failed examinations, illness or unhappy relationships) have long-term implications. Environmental factors contributing to stress include family factors, parent-child conflict, traumatic events and physical illness. The characteristic intensity of adolescent emotion increases stress levels and accentuates the emotional imbalance that can disturb the teenager's sense of proportion, especially in late adolescence.

Academic and social demands made on adolescents tend to be very stressful and can lead to depression. There are also stressful pressures for unattainable academic and social goals. The pressure surrounding the studying for and writing of examinations is tremendous. Less sleep, an increase in the intake of tea and coffee, smoking and the use of 'energy boosters', have negative effects on the body during times of increased mental and physical stress (Penny & Penny, 2000). Parents' high expectations add to the pressure of performing in examinations. In the present study a number of cases cited parental pressure as a highly stressful factor. The qualitative analysis revealed learners concerns about their studies and drop in performance in school.

As the adolescent matures towards adulthood, other conflicts arise. There is the motivation for privacy and independence of decision versus the motivation for intimate association. In recent times, education has been extended and marriage delayed, and the period of dependence and subjugation to parental authority prolonged beyond the point where nature has decreed that young men and women are ready to live independent lives (Kairuz, 2002). These and other factors contribute to the stress levels of young people. Good relationships with parents, and by mid-adolescence with peers, appear to buffer negative effects of stressful life events.

Studies have shown that daily stressors (e.g. responsibilities at home, arguments with peers, parental restrictions) mediate the association between major stressful events

and psychological symptoms (Wagner, Compass & Howell, 1988). Depressed adolescents report more acute and chronic stressors than non- - depressed adolescents. In addition to this, depressed adolescents report fewer social resources including fewer supportive social relationships (Daniels & Moos, 1990). In experiments with animals which were exposed to stress but had the means to control that stress, different changes were observed: positive and active behaviour (as opposed to passive behaviour) were enhanced and neurotransmitters were increased (Gilbert, 1997). Thus the ability or the inability to cope with a situation can play a key role in the progression of depression.

The results of various studies specifically investigating the prevalence of self-reported anxiety and depression in children and adolescents revealed striking differences when compared with previously reported prevalence rates from studies worldwide. Ollendick and Yule (1990) investigated rates of depression and anxiety in school- age children from Britian and USA and found that 9.5% of the USA children could be identified as depressed and 10% of children from Britian could be similarly identified. In another study, Canadian researchers (Stavrakaki, Caplan-Williams, Walker, Roberts & Kotsopoulos, 1991) identified 25% of the Canadian children as anxious and 10% as depressed. Charman and Pervova (1996) found that rates of childhood depression are higher in Russian than those typically reported in Western countries. A similar picture emerged from studies conducted in other Eastern European countries. For example, in a study by Stambolova et al., (1991) rates of adolescent depression in Bulgaria were investigated and compared with previously reported data from Poland (Bomba et al., 1985). The researchers reported that between 35% and 40% of the Bulgarian adolescents were identified as depressed, compared with between 27% and 32% of the Polish adolescents. The rate of depression reported in these two studies is comparable to those of the Russian sample from Charman and Pervova's (1996) study and indicate that, compared with Western adolescents, a higher number of adolescents from Eastern European

countries can be identified as depressed. In Western Europe, rates of adolescent anxiety and depression are similar to those reported in other Western nations.

In Sweden, Olsson and von Knorring (1997) screened a population of 2,270 adolescents using a Swedish version of the Beck Depression Inventory (BDI; Beck, 1967; Beck, Rush, Shaw & Emery, 1979) and found that approximately 10% of the overall sample (14.2% of the girls, 4.8% of the boys) scored above a clinical cut-off score of 16. In a study in Italy, the researchers (Canton, Gallimberti, Gentile & Ferrara, 1989) found that 3.5% of their overall sample reported symptoms of anxiety and 3.8% of their overall sample reported depressive symptoms. Wittchen, Lachner, Perkonigg and Hoeltz (1994) found that 12.8% of adolescents in West Germany were clinically depressed, compared with 11.7% of the adolescents in East Germany. Although the researchers found no significant differences in the overall prevalence of depression between East and West Germany, they did find significant differences in the pattern of symptomatology. The East German adolescents were more likely than the West German adolescents to report loss of appetite, exhaustion and sleep disturbance, whereas the West German adolescents reported more details in relation to suicidal tendencies. Gender differences were also noted, with unemployed females from East Germany reporting higher rates of depression than any other group.

Anxiety is present in all psychiatric disturbances to a greater or lesser degree. In most cases there is no difficulty recognizing that anxiety is secondary, except in depressive illnesses, because anxiety is present in up to 70% of those with this illness, especially in the milder or atypical forms. According to Casey (1990), the one - year prevalence of depressive illness is between 3-17% and the lifetime incidence between 20-55%. However, it is well known that this condition is frequently neither diagnosed nor adequately treated. The findings of Rajendral and Pillay (1998) supported the view of high incidence of depression and anxiety disorders among patients attending general practice and that the detection of disorders by the general practitioners was generally poor.

(BJS) The Bremen Adolescent Study (1998) reported that 17.9% of all adolescents had one of the depressive disorders at some stage in their lives. Between the two depressive disorders examined, major depression was the more common, with a rate of 14%. Dysthymic disorder occurred less commonly, with only 5.6% of the adolescents reporting having had this disorder. Major depressive disorders were significantly higher for females than for males. Significant gender difference began after the age of 14 years. Overall, the BJS's lifetime frequency (17.9%) for major depressive disorders was comparable to those in other studies. Lewinsohn et al., (1993) reported high rates of depression among adolescents. The rate found by the first investigation was 20.4% and during the second was 25.3%. In a study by Reinherz, Lefkowitz, Pakiz, and Frost (1993) the lifetime rate for major depression was 9.4%, and in a study by Feehan et al., (1994) it was 16.7%. The present study also revealed 20.84% of the sample as displaying symptoms of depression on completion of the self-rating BDI instrument.

As for the gender difference, the BJS's findings replicated those of other studies (Lewinsohn et al., 1993; Reinherz, Giaconia, Lefkowitz, et al., 1993) that showed higher rates for depressive disorders in females than in males. The rates of depressive disorders increased with age, with the largest increase occurring between the ages of 14 and 15 years. The prevalence among children was similar for both genders, whereas among adolescents, the rate was generally three to four times higher for girls than for boys. In a study by Whitaker et al., (1990) the risk of depressive disorders by mid-adolescence was twice as high among girls than boys. A follow-up study by McGee, Feehan, Williams and Anderson (1992) also indicated a change of sex ratio toward female preponderance between the ages of 12 and 15. The high ratio of males to females in the present sample is in keeping with other research on depression (Kashani et al.,1983). The findings indicated 77 (65.2%) females as compared to males e.g. 41 (34.7%). The result of the present study is in keeping with the findings of other studies. A total of 41 (34.7%) males and 77 (65.2%) females displayed symptoms of depression from a sample of 118 adolescents.

As many as 17.9% of the depressed adolescents reported having a concrete plan for suicide, and 9.7% had even tried to commit suicide. Despite the high percentage of impairment, only three (2.1%) of the depressed adolescents had been treated in the in-patient services for their depression. Anecdotal evidence indicated that the cost factor often prevented families from seeking professional help.

2.6 SUICIDE IN ADOLESCENTS

2.6.1 Suicide And Depression

Several studies have found a relationship between depression and suicidal behaviour. According to Reynolds (1992b, 1994), depression is diagnostically and phenomenologically linked to suicide and suicidal behaviour. Approximately half of those who commit suicide have a diagnosis of depression (Goodwin & Runck, 1992). Depression is the most common psychiatric disorder in adolescence and this mental state may lead to serious consequences including suicidal behaviour. There are far more suicidal attempts and gestures than actual completed suicides. One epidemiological study estimated that there were 23 suicidal gestures and attempts for every completed suicide. However, it is important to pay attention to these as 10% of them went on to a later completed suicide. A depressed adolescent reports other symptoms such as substance abuse, somatic complaints and conduct disorder, but inquiry will usually reveal many symptoms similar to those found in depressed adults (Patton & Bowes, 1998).

Gender, age and ethnicity are three factors that appear most consistently in the literature regarding suicidal behaviour. Males complete suicide at a rate three times higher than that of females, although females attempt suicide two to eight times as often as males (McIntosh & Jewell, 1986; Weissmann, 1974). This pattern is substantiated by Watkins (2001) who stated that girls may be more likely to make suicidal attempts, but boys are more likely to make a truly lethal suicide attempt.

The research by Beck and his colleagues further indicated that suicidal individuals compound the depressive effect with a sense of hopelessness, a vision of the future holding little chance for improvement (Beck & Lester, 1973; Beck, Rush, Shaw & Emery, 1979; Beck & Weissman, 1974). This sense of being unable to escape from an intolerable situation makes the person particularly vulnerable to feelings of inadequacy and despair and a sense of hopelessness (Fisher, 1973). In fact, Prezant and Neimeyr (1988) suggested that cognitive variables such as hopelessness might account for as much as 96% of the relationship between depression and suicide. The depressed individual overestimates the magnitude and insolubility of problems that lead him to believe that death is the only acceptable solution. Shneidman (1985) emphasized that suicide is never a pointless act but is viewed as a means of extricating oneself from an unbearable problem situation or crisis. The worst consequence of depression is suicide.

It is estimated that 12% to 22% of America's youth under the age of 18 years are in need of mental health services (Anon, 1999b). In the case of juvenile offenders, more than half suffer from mental illness, 19% have suicidal thoughts and 58% have anxiety symptoms (Anon, 1998). Deliberate self-harm is a common health problem in the adolescent years, and is second to motor vehicle accidents as a cause of death in teenagers and young adults. Research indicates that adolescents usually seek general health care but primary care providers tend to under identify or miss mental health problems (Goldberg, Roghmann, McInerney & Burke, 1984; Fine, McIntire & Fain, 1986). Hawton, Cole, O'Grady & Osborn, (1982) reported that 50% of the adolescents in their study who had attempted suicide had seen a physician within one month of the event. In contrast, other studies (Slap, Vorters, Chaudhuri & Centor, 1989; Shaffer, 1974) indicated that only 27% to 30% of adolescents who manifested suicidal behaviour had a history of mental health care. Epidemiological surveys suggest that less than 25% of adolescents who need mental health treatment receive it (Tuma, 1989).

Schichor & Bernstein (1994) reported that in a group of teens reporting frequent feelings of being down and depressed, over 50% had previous suicidal ideation and 28% reported a previous suicide attempt. These findings are consistent with other studies. Smith and Crawford (1986) reported that in a "normal" high school population questioned about behaviour, 63% indicated some degree of suicidal ideation, and 8% reported having attempted suicide. The National Adolescent Student Health Survey (NASHS) of 1987 reported that 25% of the males and 42% of the females stated that they had some suicide ideation, and 18% of the females and 11% of the males had actually tried to commit suicide (NASHS, 1989).

The Center for Disease Control (CDC, 2000) reports that from 1980 to 1997, the rate of suicide among 15 – to - 19 - year-old adolescents increased by 11% and among those aged 10 to 14 by 109%. Suicide is responsible for more deaths in youth aged 15 to 19 than any other disease. Adolescents now commit suicide at a higher rate than the national average of all ages. In 1996, suicide was the third leading cause of death in 15 to 24 year olds and the fourth leading cause in 10 to 14 year olds. According to Watkins, (2001) a youth commits suicide every two hours in America. In 1997, more youth died from suicide than AIDS, cancer, heart disease, birth defects and lung disease.

A partial explanation for the trend in youth suicide may lie in an apparent rise in depression and substance abuse in the young, both commonly found in suicide completers (Chatterton, McTaggart, Baume & Harrison, 1999; Patton & Bowes, 1998). This has been attributed to the high unemployment rate among the youth. Males facing financial hardships are more vulnerable to suicide (Patton & Bowes, 1998). Suicides are not always reported. Most experts believe that statistics on reported suicides may be low and do not reflect the scope of the problem (Cush, 1994). Australia and New Zealand have led suicide trends in the 'Western' world

with a three-fold rise in suicide rates for young males over the last 30 years (Patton & Bowes, 1998)

In America, the rate of suicide by 15 - to 24 - year olds rose 214% between 1960 and 1990. When translated into everyday figures, there was an average of 13.3% youth suicides per day in 1990 (Cush, 1994). Most notably for the 15 - to 19 - year-olds, the suicide rate increased 304% since 1950, with the rate for males in this group escalating 403% (Anon, 2000c: 46). A recent survey in USA found that 60% of the teens surveyed knew another adolescent who had attempted suicide, and 6% had themselves made such an attempt (Desjarlais, Eisenberg, Good & Kleinman, 1995).

In Australia, the annual number of suicide deaths for females aged between 15 and 29 years has remained constant at approximately 6 per 100 000 inhabitants. For males in the same age group, the annual suicide rate has risen from 20 (in 1979) to 25 (in 1996) deaths per 100 000 inhabitants (Patton & Bowes, 1998). It is possible that 18% of children and adolescents in Australia meet the criteria for mental health problems, which may be as many as 85 000 girls and 115 000 boys (Smeaton, 1998). This is evident in misdemeanour, attention deficit and social troubles, and a three-fold incidence in the risk of drug and alcohol abuse.

Homosexuality may also be a risk factor for adolescents (Stoelb & Chiriboga, 1998). The pressure of identifying as homosexual in a homophobic culture is particularly confusing for the adolescent struggling with issues of acceptance. Rotheram-Borus et al., (1995) found that 30% of gay adolescent males had attempted suicide at least once and more than 50% of attempters had multiple attempts.

A study by Remafedi et al., (1998) examined the relationship between suicide risk and sexual orientation and found that suicidal intent and attempts were associated with bisexual and homosexual orientation in adolescent males, but not adolescent females. Exposure to suicidal behaviour of others influences the adolescent to attempt or commit suicide. Non-fictional newspaper and television coverage of

suicide has been associated with a statistically significant increase in adolescent suicide (Center for Disease Control, 1994).

In the United Kingdom, studies showed that violent methods accounted for most of the suicides, followed by gassing and overdose of a toxic substance (Donovan, 1996). The use of firearms was more prevalent in the USA than in the UK, but this could be related to the different firearm laws in these countries. The suicide rate has increased more than 200% for adolescents over the last decade (Offer, D & Schonert-Reichl, 1992). Although the literature review indicates that factors such as substance abuse, violence and suicide could be associated to depression, the present study excluded a detailed discussion on these factors as it was beyond the scope of this study.

In the South African context, Gouws, Kruger and Burger (2000) state that suicide of adolescents is increasing because they are exposed to greater stress while environmental support has decreased, leaving the adolescents vulnerable. The issue of suicide and depression has surfaced in the South African media. An article titled "Pressure to perform could spark suicides" (Langry, 2002) stated that traditional Indian families placing a high value on education is probably one of the reasons for the recent spate of suicides among Indian teens. The grim statistics revealed that a 15 year old grade 10 female shot herself, while another 15 year old was discovered hanging from the rafters of her home in Stanger, Kwa Zulu- Natal. In another incident, a 10 -year old male and a 14- year old female shot and killed themselves in Chatsworth, Kwa Zulu-Natal. Joan van Niekerk, a spokeswoman for the Childline, said that studies have found adolescents to be particularly stressed at this time of the onset of examinations. Problems often occur when stresses at home, school, with peers, and in other circumstances are concomitant with minimal social and emotional support. These problems are further exacerbated if the adolescence lacks adequate coping skills. Research has shown that many adolescents are at greatest risk for suicidal behaviours when they are experiencing major negative life events, having many daily hassles and have few social supports (Reynolds & Waltz, 1986).

The latest statistics for South Africa were reported in 1992, as doctors are no longer required to state the type of unnatural death involved on death certificates (Van Niekerk, 2001). In 1992, the statistics for intentional self-poisoning and self-harm indicated that of 2025 deaths, 160 (7.9%) occurred within the age group 14 to 24 years (South Africa: Statistics South Africa, 1996: pp 214-215). Strangulation, hanging or suffocation were the common modes of self-harm.

A perusal of the literature reveals the high prevalence of depressive symptoms in adolescents. The majority of the studies reviewed indicated that family factors such as poor parent/child relationship, lack of nurturance, support and affection, stress and anxiety in the homes and in the schools were contributing to depression. An autocratic parent hindered normal development of self-esteem and increased the vulnerability of the adolescents to feelings of failure that eventually resulted in depression. Poor peer popularity related to poor psychological, social and academic adjustment.

Chapter Three explores the theoretical framework for the present study.

CHAPTER THREE
A THEORETICAL FRAMEWORK ON MODELS OF DEPRESSION

3.1 INTRODUCTION

Conceptualization of depression in adults can be traced back to ancient times. Depression was one of the first mental disorders to be recognized and studied by psychiatrists and psychologists, the first well-documented case predating the time of Hippocrates (Dignon and Gotlib, 1985). Since that time, there has been a plethora of research examining the etiology, symptomatology, and treatment of depression in adults, and a number of diverse theories and models have been formulated to establish frameworks in which to view the depressed adult (Abramson, Seligman, & Teasdale, 1978; Beck, Rush, Shaw, & Emery, 1979; Coyne, 1976b; Lewinsohn, 1974). However, in contrast to the wealth of literature on depression in adults, relatively little research examining depression in children and adolescents exist.

Adolescent depression has gone through a series of contradictory formulations as theorists have attempted to understand this complex disorder in youngsters. Conceptualizations ranged from the belief that depression in children was non-existent, to the belief that depression is prevalent but its symptomatic manifestations differ from those in adults, to the assertion that symptoms indicating depression are the same across the age span from childhood to adulthood (Cicchetti, Rogosh & Toth, 1994).

While it is now accepted that depression is prevalent among children and adolescents, there are many views about the origins of depression. Many of these explanations represent downward extensions of theory and empirical findings from the study of depression in adulthood. These explanations include depression as a response to stress or negative life events, a consequence of distortions in cognition or attributional style, a result of learned helplessness arising from reinforcement

contingencies in the environment, the result of interpersonal skill deficits or lack of social support, an outgrowth of early unresolved loss or separation experiences, and a genetically inherited disorder resulting in neurophysiological anomalies (Rutter, Izard & Read, 1986).

A more recent explanation by Kauffman (2001) indicates that, in most cases, the cause of depression is not clearly understood. Some cases are evidently endogenous (a response to unknown genetic, biochemical, or other biological factors) and other cases are apparently reactive (a response to environmental events, such as death of a loved one or academic failure). Predictably, child abuse, parental psychopathology, and family conflict and disorganization are frequently linked to children's depression.

Although many attempts to develop individual etiological and conceptual models of depression have been made, the main focus has been on adult depressive reactions (Erickson, 1987). Professional and scientific literatures have progressed in identifying psychological and biological risk factors of depression, yet the delineation of these factors and their causal relation to depressive episodes remains an arduous task (Oster & Caro, 1990).

The focus of this research was to determine prevalence of depressive symptoms in adolescents, to investigate the contributory factors at home and in school, and to elicit from the adolescents suggestions for improving the prevailing conditions. Modern society is challenging and the social demands on adolescents are increasing at an alarming rate. The psychological effect of these demands and its consequences on the adolescents, justified the choice of a psychosocial model to frame the present study.

In this chapter, a general discussion of several models of depression will be reviewed with consideration to their applicability to the South African context and their

relevance to the present research. This will be followed by a detailed discussion of the psychosocial model of depression that relates more specifically to the present study.

3.2 PSYCHOLOGICAL THEORIES OF DEPRESSION

3.2.1 Introduction

Theories of depression attempt to explain both the etiology of this disorder and the co-occurrence of various symptoms of depression. People in every culture have sought to conceptualize unusual or disturbing human behaviour in terms of causal factors and to explore ways to eliminate, control, and prevent abnormal acts. Educators always struggled with how human behaviour; both troublesome and desirable; should be conceptualized (Kauffman, 2001). It is believed that if people are said to be rational and feeling persons, then cognitive and affective interventions will be attempted. On the other hand, if people are analyzed as products of environmental events, then antecedents and consequent events will be controlled in efforts to modify behaviour. Self-concept and self-esteem form an integral part of both emotional and behavioural development. Although there is considerable diversity among the major theories of depression with regard to their primary reliance on psychoanalytic, cognitive, or behavioural constructs in understanding this disorder, studies have also shown important commonalities among them and these aspects are discussed later.

3.2.2 Psycho-educational Model

This model shows concern for unconscious motivations and underlying conflicts, yet also stresses the realistic demands of everyday functioning of the school, home, and community. This psycho-educational model assumes that educators must understand unconscious motivations if they are to deal most effectively with academic failure and misbehaviour. The model advocates that educators ought to focus on helping the

learners acquire self-control through reflection and planning, and includes 'life space crisis intervention' to help youngsters to understand that what they are doing is a problem, recognize their motivations, observe the consequences of their actions and plan alternative responses to use in future. Emphasis is on the youngster's gaining insight that will result in behavioural change, not on changing behaviour directly (Kauffman, 2001). This model is partially relevant to the present study as the school was investigated as one of the factors in the research. This component incorporated aspects such as relationships with peers, school and academic achievement.

3.2.3 Cognitive-Behavioural Model of Depression

- **Behavioural Model**

Similar to the psychodynamic model, behaviourists view depression as a result of significant loss (Kovacs & Beck, 1977). Depression is seen as the consequence of inadequate reinforcement. Lewinsohn's social learning theory provides a concise account of behavioural depression. This theory suggests that depressive behaviours are determined by the presence or absence of reinforcers and maintained through the reduction of response-contingent reinforcing events (Lewinsohn & Hoberman, 1985). Limited positive reinforcement in the environment of an individual will lead to depression. Excess punishment, especially when it occurs at high rates and the adolescent has not mastered coping skills, may result in depression. According to Lewinsohn & Hoberman, (1985) the depressive behaviours stimulated by inadequate reinforcement are further strengthened by the need for sympathy from significant others. In some cases, others often avoid depressed adolescents because of the nature of the depressive behaviour. This results in minimal positive reinforcement and eventually intensifies the depression.

The most influential cognitive and behavioural theories of depression are the social-skills and activity-level perspective of Lewinsohn (1974), the cognitive model of Beck (1967, 1976), the twice-revised learned-helplessness theory (Seligman, 1975;

Abramson, Seligman, & Teasdale, 1978; Abramson, Metalsky, & Alloy, 1989), and the self-control model of Rehm (1977). Cognitive formulations of depression differ from behavioural theories in two important respects. Behavioural models of depression focus on overt behaviours and cognitive models emphasize the importance of covert behaviours such as attitudes, self-statements, images, memories and beliefs. Secondly, cognitive approaches to depression consider irrational cognitions and cognitive distortions to be the cause of the disorder (Gotlib & Hammen, 1992).

- **Cognitive Model**

The cognitive model of depression is primarily concerned with the relationship between human mental activity and the experience of depressive symptoms. Research has supported the role of cognition in depression (Beck, 1967; Rehm, 1977; Seligman, 1975). The cognitive model designed by Beck (1967,1976) posits the existence of schemata through which individuals filter and interpret their experience. These schemata are influenced by the person's developmental history prior to the onset of psychological stress. According to Beck (1967) individuals prone to depression, develop distorting negative schemata that often remain latent until activated by stressful events. When activated, the cognitive triad is evident. This is characterised by a negative view of the self, the world and the future. The negative view of the self is manifested in low self-esteem, a negative self-evaluation, increased self-criticism, and an underestimation of one's abilities. A negative view of the world is evident in the negatively biased explanations that are provided for situations that he/she encounters and for world events. A negative view of the future is associated with the development of hopelessness, and a negative expectation of the future. According to Beck, depressed individuals also develop schemas that distort the environmental stimuli to coincide with a derogatory self-image. These negative schemas are often created and exacerbated by faulty information processing, or consistent errors in logic, called cognitive errors. Individuals suffering from depression use these cognitive errors to evaluate events. This often leads to

negativistic, categorical, absolute, and judgmental thinking (Lewinsohn & Hoberman, 1985). The results of several studies examining the cognitive functioning of currently depressed persons are largely consistent with Beck's formulation that depressed individuals are characterized by a negative view of the self, that they perceive, interpret, and recall aspects of their environments more negatively than do non-depressed persons, and they engage in dysfunctional thinking.

- **The Learned- Helplessness Model**

Seligman's (1975) learned helplessness model of depression states that depression exists in people who perceive that they have no control over their environment. They develop a self-defeating attributional style which results in lowered motivation and reduced self-esteem. He argued that the main behavioural symptoms of learned helplessness result from the belief that responding and reinforcement are independent. He suggested that these symptoms are evident in depression as well, and advanced the model of learned helplessness as an analogue of this disorder, arguing that learned helplessness and depression have "parallel" etiology, symptoms, treatments, and prevention. In a study by Nolen-Hoeksema, Girgus, and Seligman (1986) that examined explanatory style, academic achievement and teachers rating of mastery-oriented and learned-helplessness behaviours in the classroom, it was revealed that helplessness in the classroom, poorer school achievement and depressive symptoms were significantly intercorrelated.

- **Self-Control Model**

The third cognitive model of depression, represented by Rehm's (1977) Self-Control Model was derived from the more general self-control theory of Kanfer (1970). According to him, problems manifest through deficits in three cognitive processes namely, self-monitoring, self-reinforcement, and self-evaluation. Depressed individuals ignore the future and tend to concentrate on immediate consequences of events. They attend to negative outcomes and focus on immediate reinforcements. This results in a negative view of the self, the environment, and the future. They set

high standards for positive self-evaluation and low standards for negative self-evaluation. Reduced self-esteem and increased feelings of helplessness and depression result from these maladaptive structures of self-evaluation (Lewinsohn & Hoberman, 1985)

Although these models have unique characteristics, there is also considerable overlapping in their views. The common themes include contingency reinforcement (social skills, activity levels), information-processing (self-schemata, cognitive distortions), view of self (self-evaluation, perceived competence), hopelessness, learned helplessness and self-control. Rehm (1977) asserted that themes could be viewed collectively and individuals could process their experience to draw inferences and judgements, which can be used to solve problems and make future decisions.

Research reveals that depressed children and adolescents differ from their non-depressed counterparts in the following cognitive and behavioural processes: contingent reinforcement, information processing, view of self, hopelessness, learned helplessness, and self-control. Depressed children have impaired interpersonal functioning with parents, siblings, peers, and teachers and these impairments tend to persist even on recovery from the depressive episode. Unlike the situation with regard to adults, there is insufficient evidence regarding participation by depressed and non-depressed youngsters in pleasurable and unpleasurable activities. It is also not clear whether or not depressed children manifest self-schemata different from those of their depressed counterparts (Kaslow, Brown &.Mee, 1994). Depressed youth have a low self-esteem that impacts on social and academic performance. They feel hopeless about their future and are at risk for suicidal behaviour.

3.2.4 The Psychoanalytic /Psychodynamic Model

Psychoanalysts regard depression as the imagined loss or real loss of a valued or loved "object" through death, separation, rejection, or symbolically, through the loss of some ideal or abstraction. The significant "object" loss early in the child's life is usually a parent and most often the mother. This loss serves as a diathesis, a vulnerability factor that leads to depression later if the child is confronted with a significant loss or disappointment. This diathesis-stress is also applicable to cognitive models of depression.

Abraham (1911/1985) theorised that individuals who were vulnerable to depression, experienced a marked ambivalence towards other people, with positive and negative feelings alternating and reciprocally blocking expressions of the other. He stated that this ambivalent form of relating has its origins in problematic object-relationships during childhood. As a result of repeated disappointments and frustrations, depressive persons form a permanent but unconscious linking of libidinal wishes with hostile destructive wishes. These hostile feelings initially directed towards others ("I hate them") are projected onto others ("they hate me") and then internalized and directed towards the self. This leads to overwhelming feelings of guilt, and the loss of appetite so often seen in depressed persons is a defence against the hostile wish to "incorporate" the love object.

Classical psychoanalytic theorists view depression as a failure of the normal mourning process. They describe a depressive syndrome as composed of self-criticism, guilt, loss of libido, and low self-esteem. They emphasize the loss in early childhood and the quality of mother-child relationship in the first year of life, as vulnerability factors for subsequent depression. Bowlby (1978,1981) stated that adult depression was related to the failure in early childhood to form a stable and secure attachment with the parents.

Traditional psychoanalytic model suggests that depression cannot occur in childhood because psychological self-representation is not sufficiently developed. They also contend that depression is a manifestation of conflict between the ego and the

superego. Dynamic psychiatry is concerned with hypothetical mental mechanisms and their interplay in the developmental process (Kauffman, 2001). Psychoanalytic theorists assume that the essence of emotional and behavioural disorders is not the behaviour itself but a pathological imbalance among the dynamic parts of one's personality (the id, the ego, and the superego).

The psychological models of depression have a bearing on the current study and will be utilized to incorporate the effects of social factors to determine their influence on the sample of adolescents displaying depressive symptoms.

3.3 BIOLOGICAL MODELS OF DEPRESSION

3.3.1 Introduction

Biological models range from genetic to neuroendocrine theories, and seek to provide etiological bases for depression (Reynolds, 1992). These models of depression can be divided into two main categories: those that focus on the role of genetic factors and those that emphasize biochemical aspects of depression.

3.3.2 Genetic Model

Most mental health professionals agree that depression has an organic basis. This means that depression is rooted in a person's chemical makeup that is largely determined by genetics. If a person's body chemistry is genetically linked to depression, it may take relatively little to trigger a depressive episode. According to studies, ancient drugs, like reserpine, cause depression; others like heroin or opium, cause elation. So there is reason to believe that some naturally occurring "chemical factors" in the brain could influence depression. Genetic factors in depression have been examined through twin/adoption studies among adults. Research has provided

some interesting evidence for a genetic component of depression. Greist and Jefferson (1984) give the following statistics in support of this idea:

- If one twin has depression, there is 70% chance that the other twin will develop depression.
- Immediate family of a depressed person has a 15% chance of developing depression.
- Distant relatives have a 7 % chance of developing depression.
- People who do not have depressed relatives have about a 2-3% chance of developing depression.
- Adoptees who experienced greater depression were more likely to have biological parents who suffered from an affective disorder.

Neurotransmitter actions and their interactions with antidepressant medications have been the focus of much biochemical research on depression. Whether a primary cause of depression or a secondary component, some evidence suggests that abnormalities in people who are depressed can be counteracted with antidepressant drugs (Kashani et al., 1981).

Upon examination of the above statistics, it is logical to conclude that increased genetic similarity with depressed relatives increases the chances of developing depression. The genes and the family environment are both involved, but several studies find that it is individual specific-environmental factors that influence depression and not shared family events, such as death of a parent.

3.3.3 The Biogenic Model

According to this model, human behaviour involves neuropsychological mechanisms; that is, a person cannot perceive, think, or act without the involvement of his or her anatomy and physiology. Theorists of these models believe that

recognition of the underlying biological problem is critical, but successful treatment may or may not be aimed at resolving the physiological flaw.

The model alone will not fulfil the present research needs since it is not yet possible to determine a way to repair brain damage, genetic process, or metabolic disorder. Consequently, an understanding of the physiological cause of the disorder and an appropriate adaptation of it will assist in achieving the desired results. Interventions associated with a biogenic theory include drug therapy, exercise, surgery, biofeedback and alteration of environmental factors that exacerbate the physiological problem (Kauffman, 2001).

3.3.4 Bio-psychosocial Model

Studies have shown that environmental, psychological, and biological factors contribute to a state of depression. A combination of these three models referred to as "bio-psychosocial model" is of relevance to the present study. However, for the purpose of this study, whilst the importance of biological factors was acknowledged, the investigation focused on psychological and social factors in an educational context.

Although it can be concluded that genetic factors influence the development of depression, studies of children of depressed parents indicated that it was difficult to attribute children's dysfunction directly to genetic transmission, since families experience a host of psychosocial factors (Gotlib & Hammen, 1992). It is evident that in addition to biological and non-biological factors that influence the origin of depression, psychosocial processes are important determinants of the course and severity of depression, as well as, response to treatment (Gotlib & Hammen, 1992).

3.4 PSYCHOSOCIAL MODEL

The psychosocial model is designed around the individual's continual interaction between the psychological and social factors. Psychosocial stress plays a prominent

role in most models of depression throughout the life span. Most predictive research has focused on childhood (Rutter et al., 1986). This later focus has been perpetuated by findings suggesting that the psychosocial markers of depression risk and presence are relatively constant across childhood and adolescence. The psychosocial models of depression have implicated many "abnormalities" as descriptors of the depressed state. These include dysfunctional cognitions, distressed relationships, anaclitic personality types, and deficits in social skills (Abramson, Seligman, & Teasdale, 1978; Beck, 1976; Brown & Harris, 1978; Hirchfeld, Kleman, Chodoff, Korchin & Barrett, 1976; Lewinsohn, 1974).

According to Hill (1983), five sets of psychosocial issues take on a special importance during adolescence: (a) discovering and understanding the self as an individual (identity); (b) forming close and caring relationships with others (intimacy); (c) establishing a healthy sense of independence (autonomy); (d) coming to terms with puberty and expressing sexual feelings (sexuality); and (e) becoming a successful and competent member of society (achievement). The development in each of these areas takes on special meaning during the adolescent years because of the extensive biological, psychological, and social changes taking place at this time and the potential implications of such "turmoil" for adolescents' functioning.

This model demonstrates the relations between personal and social resources and depression. Researchers believe that there is a difference between those experiencing high and low stress. Under high stressor conditions, personal and social resources affect coping. Resources include self-confidence, easygoingness, and family support, and these resources in turn predict effective coping under high stress conditions. In contrast, under low levels of stress the resource factors predict depression directly. Swindle, Cronkite, and Moos (1989) found that problem solving was related to less current depression, while emotion-focused coping was related to more current depression. Family conflict was a significant predictor of depression. Lewinsohn, Hoberman, and Roesnbaum (1988) in testing their complex psychosocial models of depression in Oregon found that both major and minor life events and chronic

conditions such as marital strain and unemployment were among the predictors of developing a diagnosable depression. With the exception of self-dissatisfaction, cognitive vulnerability factors in general did not predict the onset of depressive episodes. However, cognitions were associated with the prediction of self-reported depression scores. Lewinsohn et al., (1988) demonstrated the importance in depression of psychosocial factors, including stressful life events in adolescent community samples. Girls were more likely to report stressors than boys, and their depressive reactions to stressors were mediated to body image. Studies have shown that depression can be caused by reactions to situational stress, as well as from general medical illnesses, side effects of certain medicines, substance abuse, other psychiatric conditions, family history, and genetics (McCanless et al., 2002). Several researchers feel that one's environment is a possible contributor towards developing depression. Greist and Jefferson (1984) list the following environmental factors as possible contributors towards depression:

- Involvement in a difficult or lonely relationship
- Conflicts with family members, friends, and co-workers
- The death of a loved one
- Worries about the meaning of life
- Financial problems
- Sudden changes in one's life e.g. retirement, moving to a new city, or a new job.

The development of depressed mood, syndromes, and disorders during childhood and adolescence is the consequence of a complex array of personal and social factors. Evidence in studies has lent support to the role of psychological, familial, peer and broader social influences in depression amongst adolescents (Compas, Grant and Ey, 1994). The psychosocial model, based on psychoanalytic, behavioural, and cognitive schools of thought, has been highly influential in advances made in understanding, assessing, diagnosing, and treating depressed individuals. The present

study investigated contributory factors such as relationships with parents, peers/siblings and school in order to determine the effect these factors had on adolescents who displayed depressive symptoms. The current research will attempt to look at the factors and establish the link between negative environmental factors and depressive symptoms in the adolescents. The psychosocial model deals adequately with stressful factors that are being considered by the researcher and will therefore form the theoretical framework for the present study.

The purpose of this study was to determine the prevalence of depressive symptoms in adolescents, to investigate contributory factors at school and home and ascertain from adolescents suggestions for improving the prevailing conditions. The preceding discussion focused on depression in adolescents and the theoretical framework within which the study will be based. The methodology employed by the researcher that attempted to obtain valid and reliable information to answer the critical questions posed in this research will be discussed in Chapter Four.

CHAPTER FOUR
METHODOLOGY

4.1 INTRODUCTION

Thyer (1993) views a research design as a detailed plan for how a research study is to be conducted. Huysamen (1993) defines research design as

> "...the plan or blueprint according to which data are collected to investigate the research hypothesis or question in the most economical manner."

The purpose of this study was to determine the prevalence of depressive symptoms in adolescents, to investigate contributory factors at home and in school and ascertain from the adolescents suggestions for improving the prevailing conditions.

In order to achieve these primary objectives an attempt was made to answer the following critical questions:

- **What is the prevalence of depressive symptoms in adolescents?**

Information relating to this aspect was obtained by means of a Beck Depression Inventory.

- **What factors in the home contribute towards depression?**

Information relating to this aspect was obtained by means of a survey questionnaire.

- **What factors in school contribute towards depression?**

Information relating to this aspect was obtained by means of a survey questionnaire.

- **What are the suggestions made by the adolescents to improve the prevailing conditions**?

Information on this aspect was obtained from the survey questionnaire and the semi-structured interview.

4.2 RESEARCH APPROACH AND METHODS

The present study is exploratory and descriptive. Descriptive research according to Gay (1987), involves collecting data in order to answer questions concerning the current status of the subject of the study; it is concerned with the assessment of attitudes, opinions, demographic information, conditions and procedures. Descriptive data is usually collected through questionnaire surveys, interviews, or observation. The analysis of the data is quantitative and reporting of the data is mainly descriptive but can consider relationships between variables as well.

> "A descriptive study determines and reports the way things are."
>
> (Gay, 1987)

The research instruments i.e. the Beck Depression Inventory, the survey questionnaire and the semi-structured interview schedule, were pre-tested, pilot tested and validated before use. A detailed discussion of procedures used to obtain the sample, validate instruments and collect data, follows in this chapter. Chapter Five reports on the survey, the problems encountered in the process of data collection, the statement of results and a brief analysis of results.

4.3 METHODS OF DATA COLLECTION

A variety of methods may be used to collect data. The choice of a particular instrument depends upon the nature of the problem. If the existing instrument does not meet the researcher's specific needs, he/she may supplement them or even construct his/her own modified version (Lovell and Lawson, 1970). In the present study, there was a need to develop a questionnaire to administer to the sample in order to obtain information concerning adolescents' relationships and their home and school environment. Certain responses made by the adolescents on the survey

questionnaire required clarification. A semi-structured interview schedule was deigned and administered to validate their responses. Additional factors were also identified through several other sources such as study of literature, researcher's own observations, and anecdotal information from colleagues, parents and learners.

4.3.1 Choice And Description Of Research Area

Geographically, Durban may be divided into the following broad areas:

a) The Northern Areas
b) The Western Areas
c) The Southern Areas
d) The Central Areas

The present study was limited to one district, Phoenix, a suburb that falls in the Northern Area. The township of Phoenix lies twenty kilometres north of Durban and was specifically designed to cater for the lower income earners of the Indian community. The decision to situate the study in this area had three important advantages:

- There were several secondary schools in the area.
- The researcher was well acquainted with the area since she teaches in the neighbourhood.
- There was a reasonable number of African learners attending these schools who could be incorporated into the research.

4.3.2 Procedure To Obtain The Sample

The selection of the samples for the present project was a two-stage process involving:

- Selection of sample
- Selection of schools

4.3.2.1 Selection Of The Sample

The researcher decided to use Grade 11 learners to conduct the study for the following reason:

- The testing programme was scheduled for the latter part of the year, and in the event of a need for further testing, these learners would be available.
- Learners in this grade are between the ages of 15 and 19 and are likely to experience the conflicts related to this developmental stage.

4.3.2.2 Selection Of The Schools

The method of cluster sampling, a form of sampling in which groups and not individuals are randomly selected, was used. This method of sampling was regarded as the most viable one for the study. Permission was more likely to be granted by principals, who were concerned about disruption in schools, if intact classes of learners were surveyed.

The following steps were taken to ensure random selection of clusters:

- A list of the schools with a population of grade 11 learners was drawn.
- A total of 23 schools with a population of approximately 5099 learners were identified.
- The desired sample of 10% of the target population meant 2.3 or 3 schools constituted the sample. However, the total population of approximately 5099

meant a sample of approximately 500 should constitute the sample. The population of Grade 11 learners in each school varied. Therefore a total of 5 schools were selected which resulted in a sample of 606 learners.

- The clusters (schools) were randomly selected and every member of the cluster (grade 11 learners) was included in the sample. The larger number of schools ensured that the desired number of learners was eventually obtained.

The principals of the five schools were approached and informed about the study. The principal of one school stated that his staff was too busy and suggested that the researcher select another school or come back after two weeks. This suggestion did not suit the testing programme, as timeframes for the completion of the instruments had to be adhered to. The researcher envisaged problems later, since two instruments at a two-week interval would have to be implemented. She decided to do another selection of sample. The cluster sampling was revised in order to obtain the sample.

The following correspondence was sent to each school:

- Letters to the principals explaining the purpose and nature of the study.
- A letter applying for permission for the researcher to conduct the study at schools.
- A letter to the Governing Body Chairpersons requesting permission to conduct the research at their schools.
- A letter to the parents of learners requesting their permission to administer these tests to their children.

(Copies of these items are provided in Appendix A.)

4.4 RESEARCH INSTRUMENTS USED

The Beck Depression Inventory, a survey questionnaire and a semi-structured interview were used in the study to obtain data that would enable the researcher to answer the critical questions posed earlier in the chapter.

4.4.1 Beck Depression Inventory

The Beck Depression Inventory (BDI) (Beck 1967; Beck & Beck 1972) is the most prominent and frequently cited self-report measure of depression. It contains 21 items encompassing 4 major components of depression. Items are selected to represent the affective, cognitive, motivational, and physiological symptoms of depression. Item categories include mood, pessimism, crying spells, guilt, irritability, sleep and appetite disturbance, and loss of libido. For each of these categories of symptoms, there is a graded series of four alternative statements, ranging from neutral (e.g. "I do not feel sad," "I don't feel disappointed in myself") to a maximum level of severity (e.g. "I am so sad or unhappy that I can't stand it," "I would kill myself if I had the chance"). The items are scored from 0 to 3, with the sum of the scores representing the total BDI score, which can range from 0 to 63. Generally, a total BDI score of 0-9 indicates a normal non-depressed state; 10-18 reflects a mild level of depression; 19-29 reflects moderate depression; and 30-63 indicates a severe level of depression (Beck, Steer, & Garbin, 1988). These cut-off points are somewhat different from those often cited or in common use (Shaw, Vallis, & McCabe, 1985).

The popularity of this instrument is amply demonstrated in that in the 35 years since its introduction, it has been used in over 1000 research studies. Validity studies indicate good concurrent validity in terms of correlations with other measures of depression severity; 35 such studies are reported by Beck, Steer, and Garbin (1988). Overall, the BDI has had an impressive career in clinical research, and has the advantage of communicability because it is commonly used, as well as having established psychometric properties (Gotlib & Hammen, 1996).

Each item is made up of 4 statements. The scale is brief, easy to administer and widely available in various forms for different population, culture and age groups. The scale's creator, Aaron Beck, has made important provocative contributions to the theory of depression. The BDI is used as a screening tool, that is, to determine presence or absence of depression. The learner is required to do the following:

"Please read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling in the PAST WEEK INCLUDING TODAY! Circle the number that you have picked. If several statements in the group seem to apply equally, circle each one. Be sure to read all the statements in each group before making your choice". A copy of the BDI is included in Appendix B. The BDI has been used in South African studies e.g. in a study by Rajendral and Pillay which determined the incidence of anxiety and depression disorders in General Practice. It has been validated for use in this study by means of the Pilot Study.

4.4.2 The Survey Questionnaire

A questionnaire is an instrument with open or closed questions or statements to which a respondent must react. Different kinds of questionnaires can be distinguished, such as mailed or posted questionnaires, telephonic or group questionnaires (De Vos: 1998). In the absence of a validated instrument that could be used for the purposes of this research, an initial pre-test was undertaken with 12 learners and a pilot test with 30 learners from grade 11. A survey questionnaire was developed in stages to obtain data from learners who would provide answers to the critical questions. The decision was taken to construct and validate a questionnaire that focused on the home and school environmental factors rather than using an existing one. The data from the pre-test and pilot study provided baseline information, and was used to construct the final questionnaire.

The questionnaire was administered to a group rather than individually. Although it was time consuming, it had several advantages. It is unlikely that many adolescents would have filled in all the details required if the researcher were not present. The adolescents and the researcher had an opportunity to meet and develop a good rapport. Other advantages of the survey method using a questionnaire included the following:

- It provided the researcher with the opportunity of observing and gathering valuable qualitative supplementary data pertaining to the learner by looking at his attire, and his general appearance.
- The investigator was able to note whether there were signs of uneasiness or reluctance when subjects were asked to complete the questionnaires.

The data from the survey questionnaire was analyzed both quantitatively in Chapter Five and qualitatively in Chapter Six. (A copy of survey questionnaire is included in Appendix B.)

4.4.3 The Semi-Structured Interview

A semi-structured interview schedule was designed based on the findings of the survey questionnaire. This was done to confirm or verify statements made by the learners in the survey questionnaire. This resulted in obtaining detailed information from a sample of the learners. The methodology and results of the semi-structured interview will be discussed in greater detail in Chapter Six. (A copy of the semi-structured interview schedule is included in appendix B.)

4.5 PROCESS OF VALIDATION

4.5.1 Face Validity Of Questionnaire

Face validity is a desirable characteristic of a measuring instrument. It prevents negative encounters with the respondents. If this is not attended to prior to the commencement of the research it may adversely affect the results obtained in the research.

A questionnaire was constructed, and face validity established by requesting an educational psychologist, a teacher counsellor and a learner to comment on the questionnaire. Questionnaires were given in advance, respondents were interviewed and their responses noted. There was consensus that the questionnaire would provide valid information on biographical details, home and school environment and peer relationships. The educational psychologist advised that the open-ended section of the questionnaire be prioritized according to seriousness in order to enable learners to be more focused in their responses and recommendations. The teacher counsellor indicated concern that the African learners may not be able to supply all the information concerning their parents as they often lived away from them for long periods. The learner found the questionnaire to be relevant and necessary for the current climate. Since there were no major problems, the minor changes were implemented and it was ready to be administered.

The questionnaire consisted of six sections. The first section required the learners to fill in personal details. The second section required family details. Section C dealt with the home environment. Various questions were asked that eventually yielded a sound sense of the type of living conditions that the learners were exposed to. Section D required the learner to complete a rating of their school environment and section E required a response on relationships with their peers, parents and school. This last section attempted to elicit responses indicative of their perceptions of the problems and some possible solutions.

In order to undertake a research of this nature, the instruments to be used had to go through a process of validation to establish whether the learners would be able to understand the items. This was conducted in the form of a pre-test with 12 learners. If the learners were not able to fully understand and satisfy the requirements of these instruments then there would be a need to modify or amend them. This was followed by a pilot study of 30 learners.

4.5.2 Pre-Test Procedure and Results of the Survey Questionnaire

According to Singleton, Straits, straits & McAlister (1988), the pre-testing of a measuring instrument consists of " trying it out on a small number of persons having characteristics similar to those of the target group of respondents".

A pre- test was administered to serve as a process of validation of the instruments used in the present study. The sample size was 12, comprising 6 males and 6 females. The Beck Depression Inventory and the Survey Questionnaire were administered to the sample. However, four learners were absent. Two females who were absent could not be located. The researcher administered the remaining two tests at the learners' homes as they indicated that they were unwell and were willing to complete it at home. Since there was a time frame of two weeks for the completion of these questionnaires, the other two absentees had to be left out of the sample. There were 3 (25%) learners of the pre-test sample who scored above 19 on the BDI.

The quantitative results of the survey questionnaire conducted as a Pre-Test is as follows:

- The sample was made up of three Africans (30%) and seven Indians (70%), 60% of them were males and 40 % were females. Their ages ranged from 16

to 18 years. Father's age ranged from 39 years to 55 years and the mother's age ranged from 33 years to 50 years.

- 55.6% of the fathers and 80% of the mothers had secondary education. Although the education level was reasonably high, 70% of the mothers were housewives. Of the 30% that worked, 20% were machinists and 10% worked as cleaners in the factory. The father's occupation varied from an office assistant to an advisor.
- Only 62.5% of the sample lived with both parents and 37.5% lived with their mother.
- 28.6% of the sample indicated that they had no income.
- 60% of the sample indicated that they shared their bedroom whilst 70% stated that they used their bedroom to study.
- 70% of the sample indicated that they preferred to complete their homework at home but had to wait until everyone was asleep.
- 60% of the sample rated the cleanliness of the school and the school's furniture as "very bad".
- 50% of the sample was not satisfied with the assistance that they received from their librarian although they were happy with their teacher's attitude towards them.
- 50% of the sample indicated that their classmates' behaviour was bad.
- 40% agreed that their parent's expectations were too high.
- 40% of the sample agreed or partially agreed that they got angry when their parents discussed their work with others and 40% agreed that their parents expected them to do many extra curricular activities.
- 60% of the sample agreed that they were always willing to please others.

(Refer to Appendix C.2.1 for Tables)

A qualitative analysis of the open-ended questions (20,26,28,29,and 30) of the survey questionnaire revealed the following results in the Pre-Test:

- Six (60%) of the learners were not comfortable with sharing their rooms.
- Four (40%) did not share their rooms.
- Although 7 (70%) indicated that they preferred to study at home they had to wait for all the members of the family to sleep before commencing their studies. This was not suitable and often impacted on the quality of studying and performance.
- Five (50%) of the learners were disturbed when they studied at home and suggested moving out of the house to be more comfortable and accomplish their dreams.

An analysis of the learners' major problems encountered with parents, peers/siblings and school and their suggested solutions in the Pre-Test follows:

- **Problems with Parents**

Their expectations were too high; no proper communication took place at home; boyfriends were not allowed at home and they had no freedom.

Suggested Solutions

Parents must learn to trust their children and discuss issues concerning the family to resolve them.

- **Problems with peers/siblings**

Peers were not trustworthy; they gossiped and some siblings were favoured by their parents.

Suggested solutions

Peers should be more supportive of their friends.

Parents should treat all their children equally.

- **Problems with School**

Learners complained about the poor conditions of the toilets; classrooms; poor quality of teaching; poor discipline; drug trafficking; vandalism and poor sporting facilities.

Suggested Solutions

Have a clean up campaign; employ more caretakers; teachers should be more sympathetic and committed; increase the sporting facilities; charge learners for vandalism and expel those engaging in drugs.

This pre-test gave a clear indication that adolescents were confronted with problems that were impacting negatively on their school performance and their relationships with parents, peers/siblings and school.

The learners were asked to comment on these instruments. They indicated that they found the BDI and the questionnaire interesting and relevant, as many adolescents were experiencing problems and finding it difficult to cope with school, parent and peer pressure (anecdotal evidence from some learners). The term 'guardian' would need clarification as some learners filled in details of both parents and guardians. Learners stated that they did not encounter any problems in answering these instruments. This positive feedback confirmed that the instruments were suitable for grade 11 learners and no changes in the survey questionnaire were needed. The pilot study could be implemented.

Table 4.1 Overall Perceptions of Factors: Pre-Test

	School environment evaluation	Relationship with parents	Relationship with peers	Relationship with school
N Valid	7	10	10	10
N Missing	3	0	0	0
Mean	28.2857	29.7000	32.1000	33.7000
Std.deviation	4.6085	1.9465	4.8178	4.1913
Minimum	22.00	25.00	26.00	25.00
Maximum	35.00	32.00	40.00	39.00

From Table 4.1, mean for School environment evaluation indicates that the overall perception is positive. The perception ranges from positive (Minimum = 22) to neutral (Maximum = 35). This is also evident from the standard deviation.

4.5.3 The Pilot Project

The pilot study is defined in the New Dictionary of social work (1995) as the "process whereby the research design for a prospective survey is tested". Huysamen (1993) views the purpose of a pilot study as an investigation of the feasibility of the planned project and to bring possible deficiencies in the measurement procedure to the fore. Thus one can view it as the "dress rehearsal" of the main investigation.

4.5.3.1 Results of the Beck Depression Inventory

The pilot study comprised a class of 30 Grade 11 learners from a particular secondary school in Phoenix. Table 4.2 shows the scores of these learners on the Beck Depression Inventory.

Table 4.2 Results of Beck Depression Inventory (Pilot Study)

Scores	Number of learners	Percentages
19-29	4	14%
10-18	7	25%
0-9	17	61%
Total Returned	**28**	**93%**
Number not returned	**2**	**7%**

This table shows that 7 (25%) of the learners were displaying "mild" depressive symptoms. This reflected a very high percentage and the researcher decided to include only those learners displaying "moderate" symptoms of depression. The cut-off score of 19-29 indicated a "moderate" level of depression and was used for this study (Beck, Steer and Garbin, 1988). The number of learners displaying

"moderate" depressive symptoms on the BDI was significant with 4/28 (14%) of the sample population displaying "moderate" depressive symptoms.

4.5.3.2 Quantitative Analysis of the Survey Questionnaire

Some of the results will be explained in tables and others will be tabulated. Wherever necessary, the tables will appear in the Appendix for referral. The four learners who showed symptoms of "moderate" levels of depression, scoring between 19 and 29 on the Beck Depression Inventory, were then given a survey questionnaire to complete. A discussion on the results of the survey questionnaire will follow.

Table 4.3 High Score Learners According to Gender

Gender	Frequency	Valid Percent
Male	2	50.0
Female	2	50.0
Total	**4**	**100.0**

There were an equal number of males and females in this sample. The two males were 17 years old and the two females were 16 years of age. The total depressed sample was made up of Indians. This could have resulted from the fact that the class had 22 Indians and only 8 Africans. Under the previous apartheid laws of the country, the school targeted in this study was restricted solely for the use of Indians. In 1990 these laws were abolished allowing learners from all cultural groups to attend. African learners who were seeking admission at these schools often chose schools closer to their homes or on bus or taxi routes, hence the low percentage of Africans attending this school. Therefore this cannot be interpreted as a significant finding. Their parents' ages ranged from 30 to 55 years. One learner's father was deceased. The parents' level of education and their occupations are shown in Tables 4.4 and 4.5 respectively.

Table 4.4 Parents Level of Education

	Mother	Valid Percent	Father	Valid Percent
Secondary Education	3	75.0	1	25.0
Matriculation	0	0	1	25.0
College	1	25.0	1	25.0
Deceased	0	0	1	25.0
Total	**4**	**100.0**	**4**	**100.0**

Table 4.4 shows that of the eight parents, four had secondary education, one had completed his matriculation examination and two had a college education. One father had passed away. None of these learners lived with guardians. The educational level of the parents is a useful indication of the educational climate in which the children are reared. The above figures indicate that although these parents had a relatively good level of education, their children appeared disturbed and showed symptoms of depression.

Table 4.5 Parents Occupation

Occupation	Father	Valid percent	Mother	Valid Percent
Deceased	1	25.0		
Foreman	1	25.0		
Unemployed	1	25.0		
Costing clerk	1	25.0		
Machinist			3	75.0
Receptionist			1	25.0
Total	**4**	**100.0**	**4**	**100.0**

Although all the parents had some secondary education, 75% of the mothers worked in factories as machinists that entailed long hours away from home and not much contact with their children resulting in poor support structure. This had a negative effect on the children's development because communication was reduced, and quality time was not possible. Another factor that may have contributed to their depressed moods could have been from the fact that only 50% of the sample lived with both parents, 25% lived with their mother because her father was deceased and

25% lived with their mum during the weekdays and with their dad on the weekends. This was not the ideal situation for a learner to work optimally. Parents with the occupations of machinists, receptionist and foreman earned a combined income of between R1500-R2999. The parent employed as a costing clerk earned between R 3000-R4999. All four of them lived in Phoenix in flats that were provided by the council for low-income earners.

The learners indicated that they were generally satisfied with the support they received from their parents, educators and siblings. Some schools did not have a counsellor and 50% of the learners rated the support that they received from the librarian as very bad. Seventy five percent of the sample shared their bedrooms and 50% indicated that they used their bedroom for studying. The remaining 50% used their lounge to study. Fifty percent indicated that they preferred studying at a friend's house. The cleanliness of the school and the school's furniture was rated by 100% of the sample as bad or very bad. Due to the conditions prevailing in their homes, learners indicated that if they had to do their homework at home, they would do it either when all household members were asleep, or when their household chores were complete. Fifty percent of them rated the number of learners in their class as bad to very bad. Fifty percent of the learners indicated their commitment to learning as neutral and 100% of them rated their performance in tests as neutral also.

Fifty percent of the sample agreed that their parents' expectations were too high; they ignored their parents when they talked, and were angry when their parents discussed their work with others. The thought of school made 25% of the sample sick and they tended to daydream at school. Fifty percent indicated that they did not finish their work at school. Twenty five percent stated that their teachers don't listen to them, 50% said that their teachers get angry with them; 75% indicated that they have lost interest in what their teachers say in class; 75% indicated that their teachers did not understand them and 50% felt that their work was getting worse. (Refer to Appendix C.2.2 for table.)

4.5.3.3 Qualitative Analysis of the Survey Questionnaire

A qualitative analysis of the open-ended questions (20,26,28,29 and 30) of the survey questionnaire revealed the following results in the Pilot Test:

- Three (75%) of the learners who shared their rooms preferred having their own room because they wanted privacy.
- Three (75%) of the learners who preferred studying away from home did so because it was more comfortable and they could get assistance from their friends.
- Fifty percent of the learners indicated that they studied after all at home were asleep. The remaining 50% had to complete their chores before studying.

An analysis of the learners' major problems encountered with parents, peers/siblings and school and suggested solutions yielded in the Pilot Study follows:

- **Problems with Parents**

Parents expectations were too high; no trust; too strict; compares with others and believes in others but not their children.

Suggested Solutions

Parents must learn to believe in their children; not compare them with others; grant freedom with friends, "Accept me the way I am and confront me about my wrongdoings".

- **Problems with peers/siblings**

Peers hurt their feelings by forming cliques

Suggested solutions

Peers should encourage and support all their classmates and work as a team.

- **Problems with School**

Learners complained about the poor sporting facilities; they cannot concentrate in class; lost interest in work; and poor teacher attitude as evident in the following quote "Some of the teachers don't give a DAMN about the pupils".

Suggested Solutions

The school needs a good leader to change things.

The qualitative results revealed that learners had several concerns that required attention in order to make their adolescent years more comfortable and pleasant.

Table 4.6 Overall Perceptions of Factors: Pilot Study

	N	Mean	Std.Deviation	Minimum	Maximum
	Valid				
School environment evaluation	4	31.7500	7.5443	23.00	39.00
Relationship with parents	4	25.7500	3.3040	22.00	29.00
Relationship with peers	4	35.5000	1.2910	34.00	37.00
Relationship with school	4	22.7500	11.9269	12.00	39.00

From Table 4.6, mean for School environment evaluation indicates that the overall perception is positive. The perception ranges from positive (Minimum 23) to neutral (Maximum 39). However the minimum for relationship with school is 12 and the maximum is 39.

4.5.3.4 Comments on Structure of Survey Questionnaire

The pilot study alerted the researcher to some of the problems she needed to solve prior to the main research and enabled her to gain insight and ideas that helped to improve the quality of the main study. The term 'guardian' was explained to the learners when the questionnaire was administered. The questionnaire, with the

inclusion of the Likert scale, was able to provide the information that could be used to answer the critical questions posed in this research project. The questionnaire was now suitable for use with the main sample.

4.6 PILOT STUDY: SEMI-STRUCTURED INTERVIEW

A male and a female learner were interviewed using the semi-structured schedule as a pilot test. The questions were designed as a follow-up from the findings of the survey questionnaire. The interview schedule required more details on the biographical details, family, peer and school relationships. The main purpose of the interview was for the researcher to obtain more information and clarity on certain vague responses of the adolescents in the survey questionnaire. This will be discussed in detail in Chapter Six.

4.6.1 Qualitative Analysis Of The Semi-Structured Interview: Pilot Study

Both learners had several concerns about the relationship between their parents, siblings, peers and school. They described their parents as too demanding, quarrelsome at times and not supportive. Peers were referred to as "selfish" and not worth having. Neither learner had any information regarding service providers such as social welfare agencies, school counselor, alcoholic anonymous or priests that were available to assist them in the community. These findings indicated that a study designed to determine the factors that were affecting adolescents and contributing to depressive symptoms will be beneficial.

4.6.2 Comments On the Semi-Structured Interview

The learners were requested to comment on the questions posed. They commented that they were familiar with the format and were able to answer the questions comfortably. They did not object to being taped. Questions needed to be probed

further and it became restrictive to follow the order as answers to other questions were given in the course of the discussion. However, this did not cause a problem as the researcher immediately transcribed the interview and slotted responses into the relevant sections. The learners indicated that the wording of the_interview was comprehensible and they were comfortable with the researcher. The pilot test indicated that the learners were able to cope with the semi-structured interviews, however, it became clear that certain precautions had to be taken during the main study. A discussion of these measures will follow.

4.7 CONTROL PRECAUTIONS

Arrangements were made with schools for the research to be conducted during guidance time so that the instruction time is not disrupted. This was not favourably accepted by one of the principals. The researcher was forced to adjust her free times to suit the requirements of the secondary schools to enable her to administer the tests. Some of these tests were conducted during the interval break of the school. Some learners had very irregular attendance. Waiting for the absent pupils to return to school to complete the tests proved futile in two cases. The researcher then obtained permission from the principal to contact the parents and she was able to complete the questionnaire at their homes. This was not the optimum condition for administering the questionnaire as learners tend to behave differently when they are in familiar surroundings and need to be coaxed to complete their questionnaire. Interfering neighbours who become curious 'spectators' and insist on being present also hinders progress. The researcher had to be patient and sometimes engage in conversations that were taking place to bide her time and wait for the correct moment to continue with the testing. The homes that she visited did not have separate study facilities for the children. Learners used the table in their kitchen to complete their homework. This prolonged the task even further as the place was crowded and the insistent neighbours did not improve the situation.

The number of days taken to complete the pilot testing was in excess of what was estimated. From the pilot study it became apparent that the school was the best place in which to complete the questionnaires. Learners tend to respond better when placed in a more formal situation.

4.8 THE TESTING PROGRAMME

The Beck Depression Inventory was administered first because it was the screening test used to identify those learners who were displaying symptoms of depression. It took approximately fifteen minutes per class to administer this test. Once the scoring was completed, those learners with a score of between 19 and 29 were considered as showing symptoms of depression. The next instrument, the questionnaire, was then administered to those learners who scored between 19 and 29 on the BDI. This took about 20 minutes to complete. On an average the researcher spent approximately two hours at each school for each test. The entire testing programme had to be completed within a period of two weeks in order for the data to remain valid. Some allowance was made for delays and 8 days were set aside to conduct and complete the testing.

The number of days taken to visit the schools was in excess of what had been estimated. There were several reasons for the slow progress. The instruments could only be administered during the teacher's relief period in order to avoid disrupting the teaching programme. On several occasions, the researcher had to return to the school to complete the questionnaire when learners were absent. The time needed to move from one school to another caused some delay.

The pre-test and the pilot testing of the instruments and the subsequent analysis of the data have established the reliability and validity of the research instruments. The quantitative statements of results of the BDI and the Questionnaire, discussed in Chapter Five will indicate further details of reliability and validity of statistics. The

qualitative results of the open-ended section of the survey questionnaire and the semi- structured interviews will be discussed in Chapter Six.

CHAPTER FIVE

STATEMENT OF RESULTS, ANALYSIS AND DISCUSSION OF DATA

The results will be discussed with reference to the purpose of the study and the critical questions posed in Chapter One. The statement of results is divided into two parts. Part One deals with the results of the BDI, the quantitative aspect of the survey questionnaire, and is largely descriptive. Part Two includes the qualitative analysis of the open-ended questions of the survey questionnaire and the semi-structured interviews. The quantitative analysis i.e. Part One is reported in the present chapter. The qualitative analysis i.e. Part Two will be discussed in Chapter Six. The statistics and tables included in the text were regarded as central to the discussion. Detailed statistical analysis can be referred to in Appendix C.

5.1 PURPOSE OF THE STUDY

The purpose of this study was to determine the prevalence of depressive symptoms in adolescents, to investigate contributory factors at home and in school and ascertain from adolescents suggestions for improving the prevailing conditions.

(i) Determining the Depressed Sample

Symptoms of depression were determined by the administration of a Beck Depression Inventory (BDI). It is the most frequently used self-report method of assessing depressive symptomatology. If used appropriately as a screening instrument or as an indicator of severity in symptoms, it serves well. The reason for the choice of this instrument was discussed in Chapter Four. The present study focused only on the symptoms that indicated a moderate level of depression. The

BDI served well for this study. For the present research a score of 19-29 (moderate level of depression) was used as the cut-off point. N.B. For the sake of simplicity, from this point forward the term "Depressed Sample" will be used exclusively to refer to those participants who scored between 19 –29 on the Beck Depression Inventory (refer to Appendix B.1 for copy of instrument)

(ii) Critical Questions

The answers to the critical questions that guided the research were used as a framework to discuss the results of the research. Gender, age, home and school environment, relationship with parents, siblings/peers, and school were examined. A detailed comparison based on race was not feasible due to unequal numbers of the two cultural groups. However, where possible, comparisons were made according to gender and race to highlight certain issues. The critical questions that follow are repeated to ensure consistency and focus:

- What is the prevalence of depressive symptoms in adolescents?
- What factors in the home contribute towards depressive symptoms?
- What factors in school contribute towards depressive symptoms?
- What are the suggestions made by the adolescents to improve the prevailing conditions?

5.2 PART ONE: BECK DEPRESSION INVENTORY AND SURVEY QUESTIONNAIRE

5.2.1 Data Collection

(i) Procedure

A list of five schools, randomly selected according to the procedure described in Chapter Four, was used to obtain the sample. Permission was obtained from the

Department of Education and Culture to conduct the research at former House of Delegates secondary schools. Several problems were encountered during the negotiations with the principals. Long delays were experienced in response to requests to conduct research. Some principals wanted to know how their schools were going to benefit. Offers of potted plants for the participating schools were made. The principals concerned accepted this offer, which was to be executed on completion of the research. One principal indicated that his staff was too busy to assist in this research. To avoid further problems, the list of five schools, which was compiled from the initial list of 23 schools, was adjusted and another school was substituted. This aspect will be discussed in detail later.

The following secondary schools were cooperative, permission was granted and returns received: Westham (pre-test and pilot project), Crystal Point, Solvista, Brookdale and Ferndale. The principal of Phoenix Technical School was reluctant to assist in the research, and suggested that the researcher should choose another school or come back in a few weeks time. Returning to his school would not be possible as the instruments had to be implemented within a timeframe of two weeks, therefore Stanmore Secondary School was included as a substitute.

The Beck Depression Inventory was distributed out to the total sample of 606 learners by the researcher after a brief introduction providing the reasons for the research. The learners were encouraged to question anything they did not understand. In instances where the researcher was not able to hand out the Beck Depression Inventory personally, the teachers were briefed in advance, and asked to hand out the instrument.

(ii) Returns and Analysis of the Beck Depression Inventory

From a total sample of 606 Beck Depression Inventory that were distributed to the learners, 566 (93.39%) of the learners returned the instrument fully completed. Forty

(6.6%) of the learners were absent on the day the BDI was administered. All those learners, who showed symptoms of depression were then given a survey questionnaire to complete. The breakdown of the score of the total sample on the BDI is reflected below.

- Normal, non depressed (Score of 0-9) = 202 (35.68%) learners
- Mild (score of 10-18) = 194 (34.27%) learners
- Moderate (score of 19-29) = 137 (24.20%) learners
- Severe (score 30-63) = 33 (5.8%) learners

5.2.2 The Survey Questionnaire

The questionnaire was constructed to provide both quantitative and qualitative data. The quantitative data was analyzed using the SPSS (Statistical Package for the Social Sciences) to provide the descriptive statistics and establish relationships where necessary. Tests included descriptive statistics, t-tests, chi-squares, and cross-tabulations. The level of confidence was set at 0.05 (95%), which is standard statistical information. The qualitative aspects of the questionnaire were analyzed by reading every questionnaire, categorizing the responses and analyzing emerging themes. Some of the responses have been included verbatim.

The statement of results and analysis will be divided into five sections, namely: Biographical details, Family profile, Home environment, School environment and Relationships. These will follow the same sequence as in the questionnaire (Copy of Survey Questionnaire in Appendix B.2).

5.2.2.1 Biographical Details

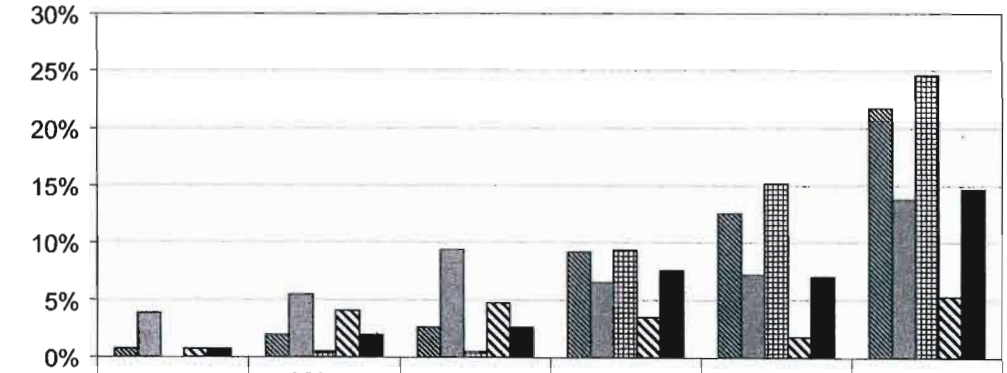
5.2.2.2 Description of the Sample

The sample will be described in terms of the schools from which the learners were drawn, the racial composition, gender and age distribution. The term "Depressed Sample" as indicated in the tables and in text in this chapter refers to those learners who showed symptoms of depression on the BDI.

(i) Distribution of the Total Sample According to School, Race and Gender

The following figure depicts the distribution of the total sample according to school, race and gender. This information was obtained from the survey questionnaire.

Figure 5.1 Histogram showing Distribution of Total Sample According to School, Race and Gender



	African Male	African Female	Total African	Indian Male	Indian Female	Total Indian
Solvista	0.7%	1.9%	2.7%	9.2%	12.5%	21.7%
Crystal Point	3.9%	5.5%	9.4%	6.5%	7.2%	13.8%
Stanmore	0.0%	0.5%	0.5%	9.4%	15.2%	24.6%
Ferndale	0.7%	4.1%	4.8%	3.5%	1.8%	5.3%
Brookdale	0.7%	1.9%	2.7%	7.6%	7.1%	14.7%

School	Africans		Indians		Total
	Male	Female	Male	Female	
Solvista	4	11	52	71	**138**
Crystal Point	22	31	37	41	**131**
Stanmore	0	3	53	86	**142**
Ferndale	4	23	20	10	**57**
Brookdale	4	11	43	40	**98**
Total	**34**	**79**	**205**	**248**	**566**

Figure 5.1 shows the total sample distribution according to schools, race and gender. The total African population was 113 of 566, i.e. 19.96%. The total Indian population was 453 of 566, i.e. 80.03%. It is evident that Crystal Point had the largest number of African learners in the sample. Stanmore Secondary had no African males and only three females in grade 11 although their total grade 11 population was 142. The findings in respect of race also varied. Some studies have detected no effect on race (Kandel & Davies, 1982; Costello, 1989). However, Schoenbach et al., (1982) found that depressive symptoms were more common amongst Blacks than in Whites. The histogram shows the percentages of the sample distributed according to the schools, race and gender. Stanmore Secondary School had the lowest percentage (0.5%) of African and the highest percentage (24.6%) of Indian learners. There is a significant intake of African learners in the remainder of the "exclusively Indian" post apartheid schools.

The Beck Depression Inventory served as an instrument to screen learners displaying depressive symptoms. A calculation of the total population from the five schools and the learners who displayed depressive symptoms at a moderate level (cut-off score of 19-29) when the BDI was administered, are reflected in Table 5.1.

(ii) Distribution Of The Total Sample And "Depressed Sample" Per School

Table 5.1 shows details of the total sample and the "depressed sample" in this study.

Table 5.1 Distribution of Total Sample and "Depressed Sample" per School

School	Roll	No. Present	Valid %	Dep. Sample	No. Ret.	Valid % of dep. Sample
Crystal Point	134	131	23.14	35	32	27.1
Brookdale	117	98	17.31	32	29	24.6
Stanmore	143	142	25.09	24	14	11.9
Solvista	153	138	24.38	32	30	25.4
Ferndale	59	57	10.07	14	13	11.0
Total	**606**	**566**	**99.99**	**137**	**118**	**100.0**

The number and valid percentage of the total sample and the depressed sample per school is indicated in Table 5.1. A total of 566 of 606, i.e. 93.3% completed the BDI. A total of 137 of 566, i.e. 24.20% showed symptoms of depression as classified for the purposes of this study. However, nineteen (19 of 137 i.e.13.86%) did not return their survey questionnaires. A total of 118 learners from the sample of 566 who showed symptoms of depression returned their questionnaire. This made up 20.84 % of the sample population. Solvista formed 24.38% of the total sample and 25.4% of the depressed sample. Stanmore had a population of 142 (25.9 %) of the total sample but only 11.9% of them displayed symptoms of depression. The smallest sample (10%) was from Ferndale but 11% of them displayed symptoms of depression. This information was extracted from the Beck Depression Inventory. All results discussed hereafter, were obtained from the implementation of the Survey Questionnaire.

(iii) Distribution Of "Depressed Sample" By Race And Gender

The distribution of African and Indian learners in Grade 11 who showed symptoms of depression according to the BDI is indicated in Table 5.2

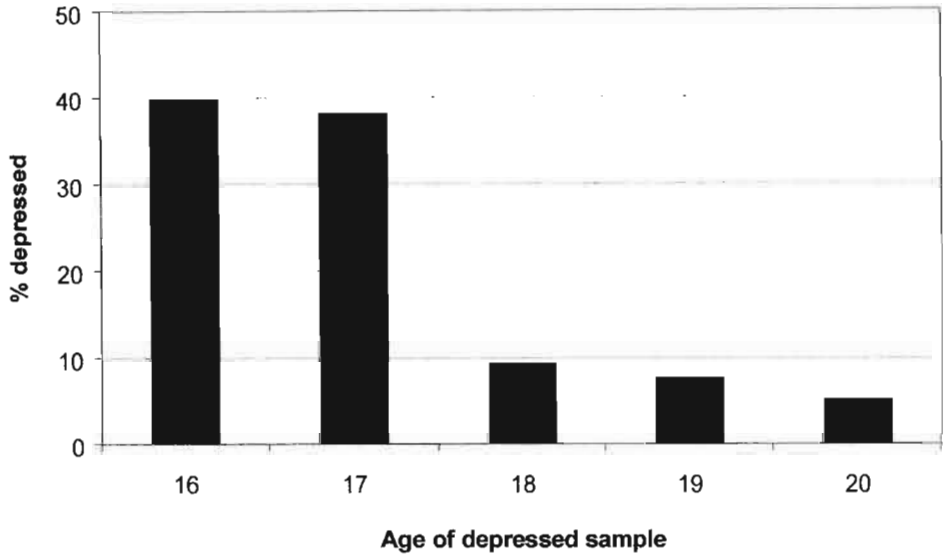
Table 5.2 Cross Tabulation of "Depressed Sample" by Race and Gender

Race		Male	Female	Total
African	**% within gender**	12 (27.9%)	31 (72.09%)	**43 (36.4%)**
Indians		29 (38.6%)	46 (61.3%)	**75 (63.6%)**
Total		**41 (34.7%)**	**77 (65.3%)**	**118 (100%)**

Table 5.2 shows that 43 (36.4%) of the total sample showing symptoms of depression were African and 75 (63.6%) were Indian. In terms of gender 77/118 (65.3%) of the learners showing symptoms of depression were females. A major feature of depression is the emergence of distinct gender differences with girls having much higher rates of disorder than did boys. For instance, it is estimated that the prevalence of depression in early to middle adolescence is 2.6% in boys and 10.2% in girls (Kutcher & Marton, 1989). The findings of the present study revealed that 31/43 (72.09%) of the "depressed sample" were African female and 46 (61.3%) were Indian females who showed symptoms of depression as compared to only 12 (27.9%) of African males and 29 (38.6%) of Indian males. A study by Teri (1982), who administered the BDI to 568 students in grades 9-12, found that there were more females than males in a group that had a high depression score.

(iv) Distribution of Total "Depressed Sample" By Age

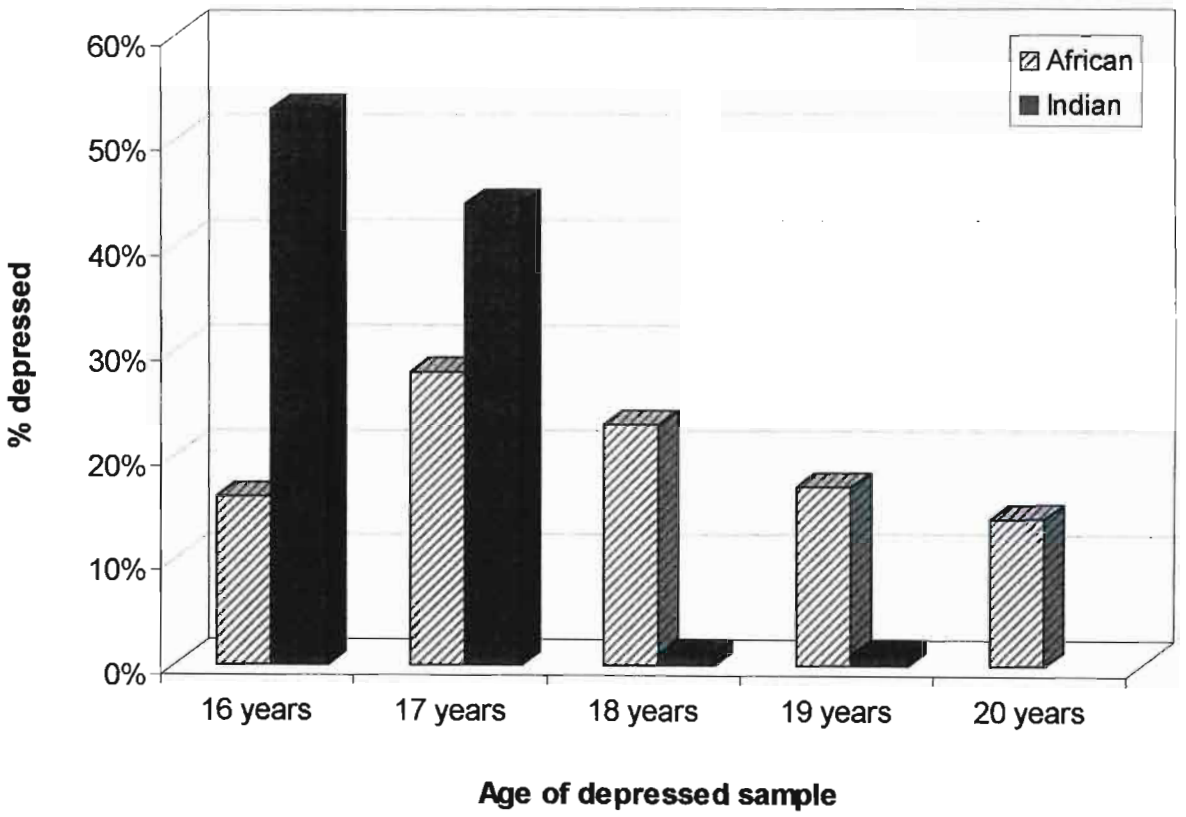
Figure 5.2 Histogram Showing Age of Total "Depressed Sample"



The age of the total depressed sample ranged from 16 years to 20 years and is indicated in Figure 5.2. The 16 years age group accounts for 39.8% of the sample and 38.1 % of the sample were in the 17 years age group. The majority of the learners were within the age limit of a grade 11. Six (5.1%) learners were 20 years old.

(v) Distribution Of "Depressed Sample" By Age And Race

Figure 5.3 Histogram: Comparison of "Depressed Sample" By Age and Race



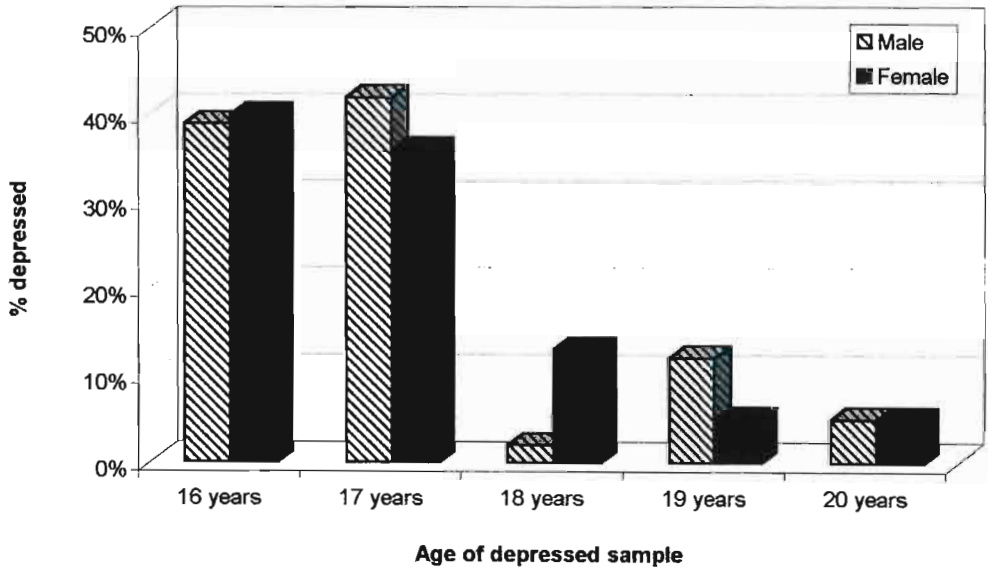
		16 YRS	17 YRS	18YRS	19YRS	20YRS	Total
African	**% within Race**	7 (16.2%)	12 (27.9%)	10 (23.25%)	8 (18.60%)	6 (13.9%)	**43 (100%)**
Indian		40 (53.3%)	33 (44%)	1 (1.3%)	1 (1.3%)	-	**75 (100%)**
Total		**47 (39.8%)**	**45 (38.1%)**	**11 (9.3%)**	**9 (7.6%)**	**6 (5.1%)**	**118 (100%)**

The age of African depressed learners ranged from 16 to 20 years with a mean age of 17.9 years (Std. Dev 1.3). The age of the Indian depressed learners ranged from 16 to 19 with a mean age of 16.5 years (0.6). (Refer to table C.4 in Appendix)

Figure 5.3 shows the age range of Indian and African learners. 53.3% of the Indian learners were 16 years of age and 44% were 17 years old. 18.6% of the African learners were 19 years old and 13.9% were 20 years old. Anecdotal evidence suggests that African learners in most schools are older than the other race groups, which may result in low self-concepts, a factor that leads to depression.

(vi) Distribution of "Depressed Sample" According To Age And Gender

Figure 5.4 Histogram: Distribution of "Depressed Sample" By Age and Gender



		16YRS	17YRS	18YRS	19YRS	20YRS	Total
Male	**% within Gender**	16 (39.02%)	17 (41.4%)	1 (2.4%)	5 (12.1%)	2 (4.8%)	**41 (100%)**
Female		31 (40.2%)	28 (36.3%)	10 (12.9%)	4 (5.1%)	4 (5.1%)	**77 (100%)**

Total		**47 (39.8%)**	**45 (38.1%)**	**11 (9.3%)**	**9 (7.6%)**	**6 (5.08%)**	**118 (100%)**

Figure 5.4 shows that majority of the females (31 i.e. 40.2%) were 16 years old and 17 (41.4%) of the males were 17 years old. Five (12.1%) of males and 4 (5.1%) females were 19 years old. A roughly equal percentage of males and females were 20 years old. Anecdotal evidence suggests that an over age learner often feels uncomfortable and embarrassed to be in the class. This may result in emotional problems that lower the performance in class.

(vii) Discussion of the Sample

The sample of 566 was drawn from five schools, with the majority from Stanmore Secondary. Indian learners constitute 453 (80.03%) and African learners 113 (19.96%) of the sample. The sample, while not representative of the racial demographics of the country, is representative of the population of learners in the type of schools selected for the purpose of this research. African learners in the former Indian schools in grade 11 are in the minority. Attempts to create a racial balance would have resulted in a sample that was not representative of the schools surveyed.

The following problems encountered have impacted on the number of respondents and representivity of the sample:

- Principals at some schools felt that they had more pressing problems to deal with and were very reluctant to allow the research to be conducted at their schools.
- A school randomly selected, Phoenix Technical, could not be used in the sample because the acting principal was reluctant to grant permission, as there was some examinations taking place at the school.

- Some of the educators at Stanmore Secondary were reluctant to assist in the distribution of the questionnaire even though the principal of the school had granted permission. This resulted in 10 questionnaires not being returned.
- At Westham Secondary School, the principal had granted permission, but educators were reluctant to assist. They were not co-operative with the principal and requested documents to prove that the research project had been approved by the Education Department. Documents granting permission to use the schools were given to principals when the researcher made her first visit. A discussion with colleagues indicated that the principal and staff were consequently having internal problems regarding the rationalization process and were not co-operative when he made requests.
- Many educators were not prepared to do any extra work since they were being declared in "excess" by the rationalisation process that was taking place in Kwa Zulu Natal. This resulted in a low morale as educators were not secure in their jobs and looked upon any extra work as a burden.
- African learners were far fewer in number.

The willingness of the school to participate in research and the conditions that prevail at the different schools affect the sample that a researcher eventually has to work with and such contingencies are often beyond his/her control. The problems of access to schools, the manner in which a researcher is accepted to conduct a research and the problems encountered in distribution and collection of the instruments is a matter of great concern to researchers.

5.2.2.3 Family Profile

5.2.2.3.1 Profile of Parents and Guardians

(i) Age

Table 5.3 Distribution of Age Analysis of Parents/ Guardians of Depressed Sample

	Father		Mother		Guardian	
Valid	**Freq.**	**Valid %**	**Freq.**	**Valid %**	**Freq.**	**Valid %**
N/a	1	1.0	-		103	87.3
<30yrs					5	4.2
30-35yrs	5	4.8	13	11.2	2	1.7
36-40yrs	15	14.3	42	36.2	2	1.7
41-45yrs	37	35.2	36	31.0	2	1.7
46-50yrs	20	19.0	18	15.5	2	1.7
51-55yrs	17	16.2	4	3.4	-	-
56-60yrs	2	1.9	1	.9	1	.8
>60yrs			1	.9	1	.8
Deceased	8	7.6	1	.8	-	-
Total	105	100	116	100	118	100
Missing system	13	11.0	2	1.7	-	-
Total	**118**	**100**	**118**	**100**	**118**	**100**

Among the sample it was observed that 15 learners lived with guardians. Five of these guardians were less than 30 years old and were providing support for adolescents whose ages were ranging from 16-20 years. Eight fathers (7.6%) and one (.8%) mother were deceased. The majority of the fathers were in the age group of 36-55 years i.e. 89/105 (84.7%). The majority of the mothers were between 30 and 50 years old i.e. 109/116 (93.9%). The profile of guardians was regarded as important. Anecdotal evidence indicated that a number of learners live with guardians (aunts, uncles, grandparents and older siblings) rather than their parents. A learner being placed in the care of a guardian while a parent perseveres with his/ her career leads to feelings of being unwanted or unloved. The respondents living with guardians totaled 12.7%. The range of age between 30 to 60 years indicated that older siblings and grandparents were guardians and the support provided by them would vary significantly. Anecdotal evidence indicated that grandparents found it very difficult to cope with the adolescents and often expressed a desire to place them in "homes".

Siblings also expressed frustration when burdened with the responsibility of taking care of their siblings. Some siblings took to drugs and were very problematic.

The highest percentage of fathers in both race groups was between 41 and 45 years old i.e. 38%. Forty-two (36%) of the Indian mothers were between 36 and 40 whereas 14 (33%) of the African mothers were between 41 and 45 years of age. (Refer to Appendix D.1)

The majority of the fathers of both males and females were between 41 and 45 years of age. 45% of the males' mothers were in the age range of 36 to 40 years whereas 34% of the females' mothers were between 41 and 45 years. (Refer to Appendix D.2)

(ii) Analysis of Parent's/Guardian's Level of Education

Table 5.4 Analysis of Education Levels of Parents and Guardians

	N/A	No Sch.	Prim.	Sec.	Matric	College	Univ.	Deceased	Tech	Tot.	Miss-ing	Tot.
Father	1	1 (.9 %)	16 (15%)	30 (28.3 %)	36 (33.9 %)	6 (5.6 %)	6 (5.6%)	8 (7.5%)	2 (1.8%)	106	12	**118**
Mother	-	4 (3.4 %)	17 (14.5 %)	58 (49.5 %)	29 (24.7 %)	8 (6.8 %)	-	1 (.85 %)	-	117	1	**118**
Guard.	103	1	2	2	7	1	1	-	-	117	1	**118**
Total	**104**	**6**	**45**	**90**	**72**	**15**	**7**	**9**	**2**		**14**	**118**

Table 5.4 shows that 66 (76.6%) of the fathers in the sample had secondary education including matriculation. Thirty-six, i.e. 33.9% of them had completed matriculation. Only 14 i.e. 13.2% of the fathers had tertiary education. The

educational level of mothers in the sample indicated that 87 i.e.74.3% had secondary education which included 29 i.e. 24.7% who had obtained a matriculation certificate. Only 6.8% of the mothers had tertiary education, 14.5% had primary school education and 3.4% had no formal education. Six percent of the guardians had obtained a matriculation certificate and 1.8% had tertiary education.

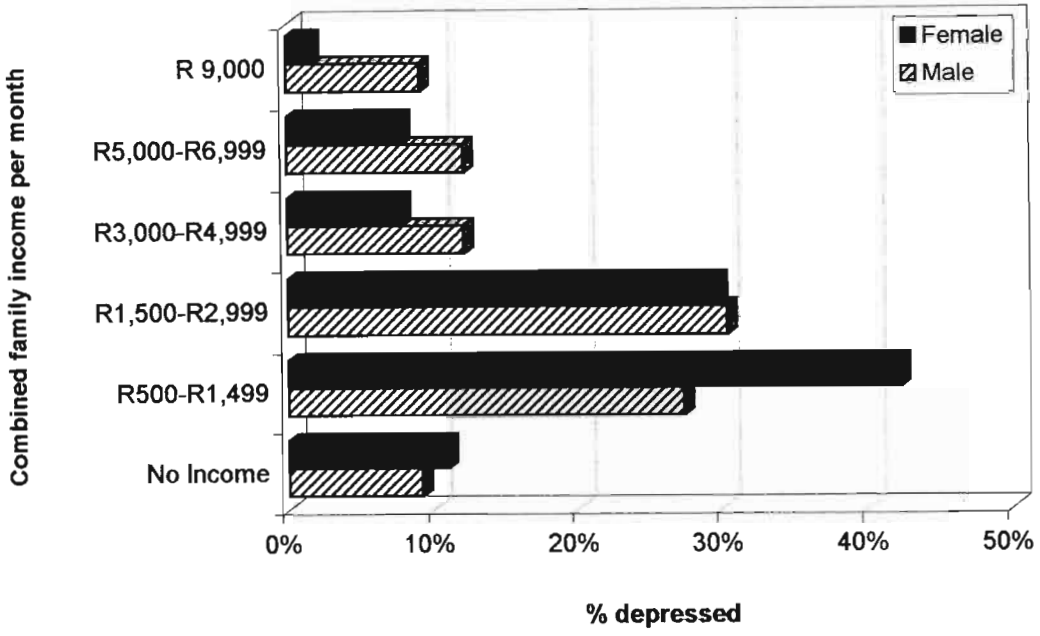
The educational qualifications of parents play a role in determining the climate in the homes. Parents with little or no education fail to understand the school's role in promoting the educational experiences of the learner, and do not create a positive climate in this respect. In a study by Fraser (1974) she found a correlation of 0,49 between the parents 'educational rating and school progress and a correlation of 0,42 between the parents' educational rating and the learner's IQ.

A number of investigations have found that decreased school performance is fairly common amongst depressed youths. Carlson & Cantwell (1979) reported that 48% of their sample of depressed children were experiencing academic difficulties. Parents' level of education and their aspirations for their children play a significant role in influencing adolescents' behaviour and attitudes. Better-educated parents (higher socio-economic status) tend to set more goals, put a higher value on education, and value work more than play (Tolan & Cohler, 1993).

The present study examined the educational levels of parents and found that 6/118 (5%) had no education whereas 35/118 (29.6%) had some primary education only. The frequency level of education and valid percentages of mothers, fathers and guardians can be referred to in Appendix D.3.

(iii) Income

Figure 5.5 Histogram: Comparison of Combined Income Per Month by Gender



		NO INCOME	R500-R1499	R1500-R2999	R3000-R4999	R5000-R6999	R9000	TOTAL
Male	% within Gender	3 (9.1%)	9 (27.3%)	10 (30.3%)	4 (21.1%)	4 (12.1%)	3 (9.1%)	**33**
Female		7 (10.9%)	27 (42.2%)	19 (29.7%)	5 (7.8%)	5 (7.8%)	1 (1.6%)	**64**
Total		**10 (10.3%)**	**36 (37.1%)**	**29 (29.9%)**	**9 (9.3%)**	**9 (9.3%)**	**4 (4.1%)**	**97**

Figure 5.5 shows the combined income and the Valid Percentage of the family. The majority of the females i.e. 27 (42.2%) fell within the income bracket of between R500.00 to R1499.00. The majority of the males, i.e. 10 (30.3%) fell in the R1500-R2999 income bracket. This high percentage of low-income earners indicated that these families were finding it very difficult to provide anything but the necessities for survival. Ten i.e. 10.3% of the families had no income for the month. Kaplan et al (1984) found that lower social class adolescents were more depressed than were

higher social class adolescents. Kandel and Davies (1982) found that low family income was associated with depressive symptoms.

Family income contributes to a learner's cognitive development directly and indirectly. Its more direct effects relate to such things as the relationship between income and nutrition; health; quality of school attended; the quality of the home as an information environment; the value attached to education, and the ability of the family to provide the kinds of educational support, equipment and experiences which foster school success. While the disadvantaged in general appear to report somewhat higher rates of depression, lifetime reports rates of depression often have not been found to differ by socio-economic group (Hirschfeld & Cross, 1982). Being unemployed was associated with depressive symptoms but the amount of support received modified the amount of depression (Golding, 1989).

(iv) Occupation of Parents/Guardians

The occupational profile of the fathers indicated that a large percent (16.8) was unemployed, eight (6.7%) were deceased, seven (7.4%) were self-employed and two (2.1%) were retired. The occupations were wide ranging, with the highest percentage in a single occupation at only 5.3% as drivers. The following occupations are listed in order of the highest frequencies and stated as valid percentages: 4.2% supervisors; 4.2% managers; 3.2% clerks and builders; 2.1% carpenters; handymen; technical assistants; upholsterers; principals; salesmen; and waiters. The following occupations with a frequency count of one are listed: entrepreneur; train operator; guard; Spoornet; stationary cutter; teacher; inspector; printer; Durban corporation-cleaner; SA Navy; computer technician; taxi-driver, landscaper; mechanic; merchandiser; machine operator; tiler; boiler-make; head-waiter; warehouse-supervisor; foreman; container shifter SA breweries.

The majority of the mothers in the sample (52.0%) were unemployed, 2% were deceased and 1% was retired. The occupation of highest percentage of employed mothers (12.7%) was machinist in a factory, 2.9% were domestic workers and 2.9% were in the catering field. The following occupations were 2% and 1% range: nurse; administration official; teacher; quality control; service hand; shop assistant; cleaner; promoter; secretary; distributor; dispatch clerk; assistant manageress; floor supervisor; electronics operator; merchandiser; wage administrator; supervisor; upholsterer; security. There was a low percentage of professional occupation.

The majority of the guardians, i.e. 3.5% were unemployed, and the rest of the occupations had a frequency count of one and are as follows: receptionist, teller, factory worker, sales executive, machinist, teacher, pensioner, and manager.

5.2.2.4 Analysis of Data Pertaining to the Home and Living Environment of the Families

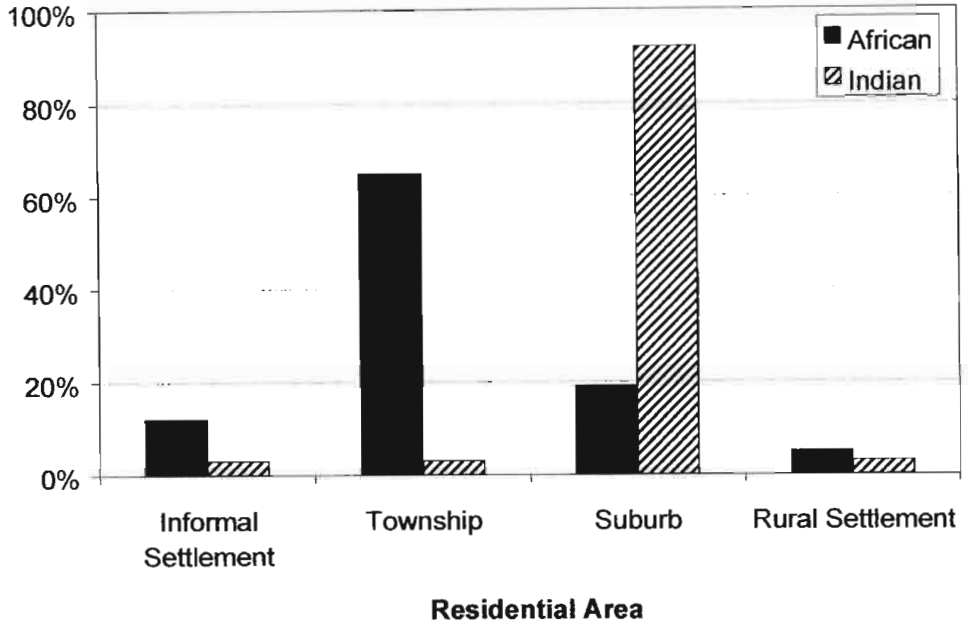
According to Chazan (1973) homelessness and bad housing conditions play an important part in breaking up families and causing ill health and strain with consequent adverse effects on learners progress and adjustment in school.

Douglas (1964) adds to this by pointing out that parents who are unskilled workers generally have a lower educational qualifications, show little interest in their children's schoolwork, have larger families and live in houses that do not have certain essential amenities.

It is against this background that it was decided to examine the relationship between learners displaying depressive symptoms and the comfort of their homes.

(i) **Residential area of the "depressed sample" according to race**

Figure 5.6 Graphic Representation of Residential Areas of "Depressed Sample"



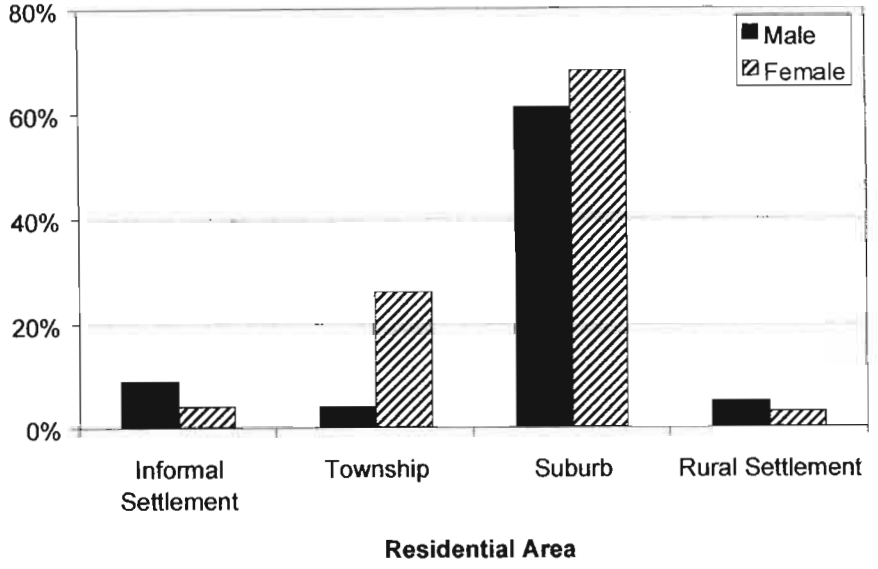
Race	% within Race Group	Informal Settlement	Township	Suburb	Rural Settlement	Total
African		5 (11.6%)	28 (65.1%)	8 (18.6%)	2 (4.6%)	**43 (100%)**
Indian		2 (2.6%)	2 (2.6%)	69 (92%)	2 (2.6%)	**75 (100%)**
Total		**7 (5.9%)**	**30 (25.4%)**	**77 (65.3%)**	**4 (3.4%)**	**118 (100%)**

There is a significant relationship between race of the depressed sample and residential area (X^2=68.5,p=0.000). (Refer to Appendix C.5.1 for table)

Figure 5.6 shows that twenty-eight (65.1%) of the Africans lived in townships and 69 (92%) of the Indians lived in a suburb. Seventy-seven (65.3%) of the depressed African and Indian lived in the suburb. The suburb referred to in this study is Phoenix, which is actually a township. It was used to differentiate between the

townships that Indians and Africans were allocated to live in during the apartheid regime. These were low quality houses made of hollowed blocks, comprising of one, two or three bedroom attached or six family flats which catered for the low socio-economic sector in society. The entire sample was from a low socio-economic area.

Figure 5.7 Histogram: Cross Tabulation of Sample According To Residential Area by Gender



Gender	% within gender Group	Informal Settlement	Township	Suburb	Rural Settlement	Total
Male		4 (9.7%)	10 (24.3%)	25 (60.9%)	2 (4.8%)	**41 (100%)**
Female		3 (3.8%)	20 (25.9%)	52 (67.5%)	2 (2.5%)	**77 (65%)**
Total		**7 (5.9%)**	**30 (25.4%)**	**77 (65.2%)**	**4 (3.3%)**	**118 (100%)**

There is no significant relationship between gender of the depressed sample and residential area (X^2=2.16,p=0.539). (Refer to Appendix C.5.2 for table)

Figure 5.7 represents the background of residential area of "depressed sample" in the study according to gender. The majority of both the males i.e. 25 (60.9%) and 52 (67.5%) of the females lived in a suburb. Four (9.7%) males and 3 (3.8%) females

lived in informal settlements. Thirty (25.4%) of both males and females lived in a township.

(ii) Parental Presence In The Home

Table 5.5 Whom Do You Live With? Cross Tabulation by Gender

		Both Parents	Father	Mother	Guardian	Siblings	Aunt & Uncle	Mother & step father	Total
Male	% within	23 (58.9%)	-	13 (33.3%)	3 (7.6%)	-	-	-	**39 (100%)**
Female		46 (62.1%)	1 (1.3%)	16 (21.6%)	7 (9.4%)	1 (1.3%)	2 (2.7%)	1 (1.3%)	**74 (100%)**
Total		**69 (61.1%)**	**1 (.9%)**	**29 (25.7%)**	**10 (8.8%)**	**1 (.9%)**	**2 (1.8%)**	**1 (.9%)**	**113 (100.0%)**

Missing data: 5

Respondents were required to indicate whom they lived with, to establish the type of family support that was available for the learner. Table 5.5 showed that 58.9% of the males and 62.1% of the females lived with both parents. A large number i.e. 13 (33.3%) of the males and 16 (21.6%) of the females lived with their mothers only. Kandel and Davies (1986) found that family dysfunction was one of the factors that predicted continuity of depressive symptoms to early adulthood, though this effect disappeared when the effects of intervening events were controlled for.

Table 5.6 Whom Do You Live With? Cross Tabulation by Race

		Both Parents	Father	Mother	Guardian	Siblings	Aunt & Uncle	Mother & step father	Total
African	% within Race	14 (33.3%)	-	17 (40.5%)	9 (21.4%)	1 (2.4%)	-	1 (2.4%)	**42 (100%)**
Indian		55 (77.5%)	1 (1.4%)	12 (16.9%)	1 (1.4%)	-	2 (2.8%)	-	**71 (100%)**
Total		**69 (61.1%)**	**1 (.9%)**	**29 (25.7%)**	**10 (8.8%)**	**1 (.9%)**	**2 (1.8%)**	**1 (.9%)**	**113 (100%)**

Missing data: 5

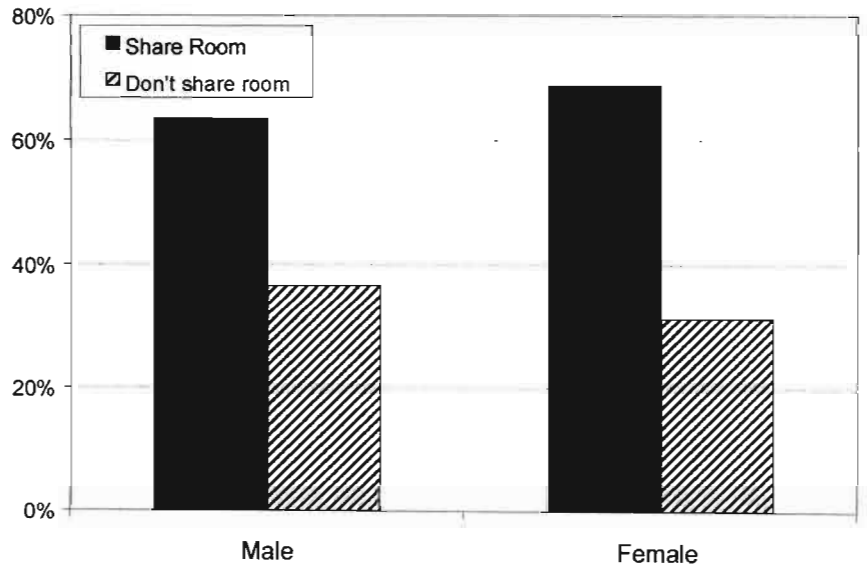
It is evident in Table 5.6 that amongst the Indian families, 55 (77.5%) of the learners lived with both parents whereas in the African families, only 14 (33.3%) lived with both parents. Seventeen (40.5%) lived with their mothers only.

Healthy parental concern in an adolescent's life plays a very important part in cultivating a positive attitude. The presence of both parents is vital. This study, however, showed that 44 /113 (38.9%) of the learners did not live with their fathers. They lived with either their mother or a guardian.

(iii) Living Arrangements in the Home

To identify factors present in the depressed sample's homes, learners described the sleeping arrangements that they were exposed to in their homes. Their responses according to gender are represented in the following histogram.

Figure 5.8 Histogram: Comparison of Sample Sharing Bedroom by Gender

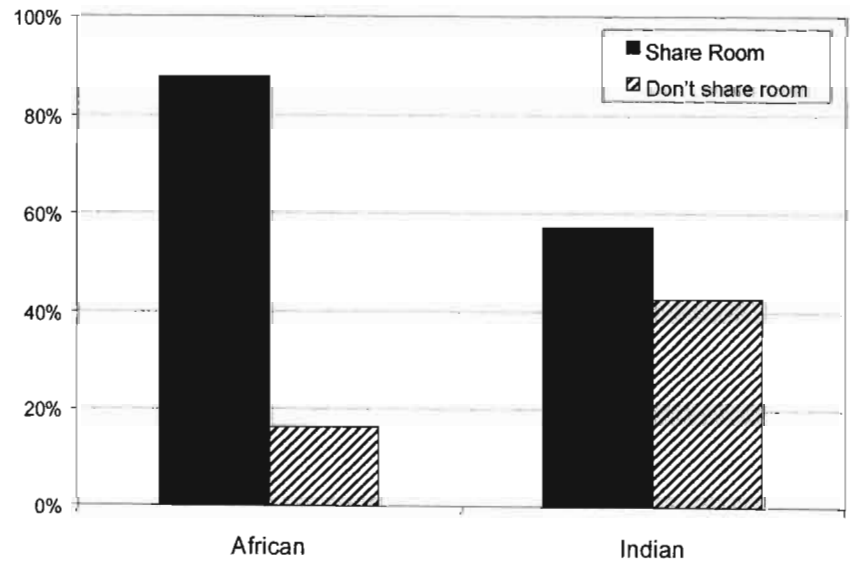


	% within gender	Share Room	Don't share room	Total
Male		26 (63.4%)	15 (36.6%)	**41 (100%)**
Female		53 (68.8%)	24 (31.2%)	**77 (100%)**
Total		**79 (66.9%)**	**39 (33.1%)**	**118 (100%)**

There is no significant relationship between gender of the depressed sample and sharing of room (X^2=0.355,p=0.551) (Refer to Appendix C.5.3)

Figure 5.8 shows that a very large percentage of the learners indicated that they shared their bedroom with others. Twenty- six (63.4%) males and 53 (68.8%) females shared their rooms. Sixty percent of the learners also stated that they used their bedrooms to do their homework and to study. Many of them expressed dissatisfaction at sharing their rooms (detailed discussion will be found in Chapter Six).

Figure 5.9 Comparison of Sample Sharing Bedroom by Race



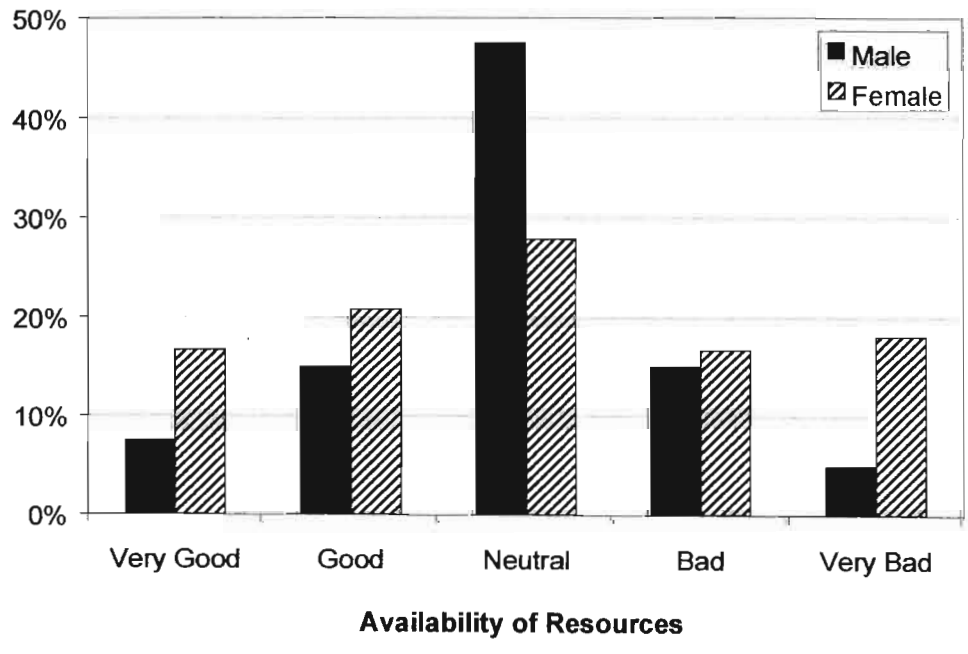
		Share Room	Don't share room	Total
African	**% within Race**	36 (83.7%)	7 (16.2%)	**43 (100%)**
Indian		43 (57.3%)	32 (42.6%)	**75 (100%)**
Total		**79 (66.9%)**	**39 (100%)**	**118 (100%)**

There is a significant relationship between race of the "depressed sample" and sharing of room (X^2=8.60,p=0.003). (Refer to Appendix C.5.4 for table)

Figure 5.9 showed that thirty-six (83.7%) Africans and 43 (57.3%) Indians share their rooms. Thirty-two (42.6%) of the Indians and 32 (16.2%) of the Africans do not share their bedrooms. The significant difference between races indicates that more African learners share their rooms.

(iv) Suitability of Study Structures in the Home

Figure 5.10 Availability of Resources According To Gender



	Very Good	Good	Neutral	Bad	Very Bad	Total
Male	3 (7.5)	6 (15.0)	19 (47.5)	6 (15.0)	6 (15.0)	**40 (100.0)**
Female	12 (16.7)	15 (20.8)	20 (27.8)	12 (16.7)	13 (18.1)	**72 (100.0)**
Total	**15 (13.4)**	**21 (18.8)**	**39 (34.8)**	**18 (16.1)**	**19 (17.0)**	**112 (100.0)**

Figure 5.10 showed that the majority of the learners remained neutral in their response the availability to resources in their homes. Six (15%) males and 13 (18.1%) females indicated that the resources at home were very bad. The lack of resources in a home is indicative of the emphasis and importance that is placed on educational progress by parents.

Table 5.7 Cross Tabulation of "Depressed Sample" by Gender According to the Room Used for Studying

		Bedroom	Lounge	Kitchen	Study	D/Room	Total
Male	% within gender	28 (68.3%)	11 (26.8%)	-	2 (4.9%)	-	**41 (100%)**
Female		43 (55.8%)	23 (29.9%)	7 (9.1%)	3 (3.9%)	1 (1.3%)	**77 (100%)**
Total		**71 (60.2%)**	**34 (28.8%)**	**7 (5.9%)**	**5 (4.2%)**	**1 (.8%)**	**118 (100%)**

There is no significant relationship between Gender and Rooms used for studying (X2=5.09,df=4,p=0.278). (Refer to appendix C.5.5 for table)

Table 5.7 showed that the majority of the males i.e. 28 (68.3%) and females i.e. 43 (55.8%) used their bedroom to study while (63.4%) of the males and (68.8%) of the females indicated that they shared their bedroom with other members of the family. (Figure 5.9) It is evident that most learners had to use other rooms to study as only 5 i.e. 4% had a study. This means that the majority study in a shared space

Table 5.8 Cross Tabulation of "Depressed Sample" According To the Room Used for Studying by Race

	% within Race	Bedroom	Lounge	Kitchen	Study	D/Room	Total
African		24 (55.8)	14 (32.6%)	5 (11.6%)	-	-	**43 (100%)**
Indian		47 (62.7%)	20 (26.7%)	2 (2.7%)	5 (6.7%)	1 (1.3%)	**75 (100%)**
Total		**71 (60.2%)**	**34 (28.8%)**	**7 (5.9%)**	**5 (4.2%)**	**1 (.8%)**	**118 (100%)**

Table 5.8 indicates that majority of the African i.e. 24 (55.8%) and Indian learners 47 (62.7%) used their bedroom to study whereas 28.8% used their lounge. Five (11.6%) of the Africans learners and 2 (2.7%) of the Indian learners used their kitchen to study.

The majority of the learners, comprising 51.2% males and 55.8% females, preferred completing their homework at home. Many of the females indicated that they had to finish their household chores before they can begin their homework. They found time late at night to begin their homework and therefore it was more convenient at home. More females than males preferred doing their homework either at their friend's house or at the library. (Refer to appendix D.4 for Table.)

Table 5.9 Choice of Place for Completion of Homework According To Race

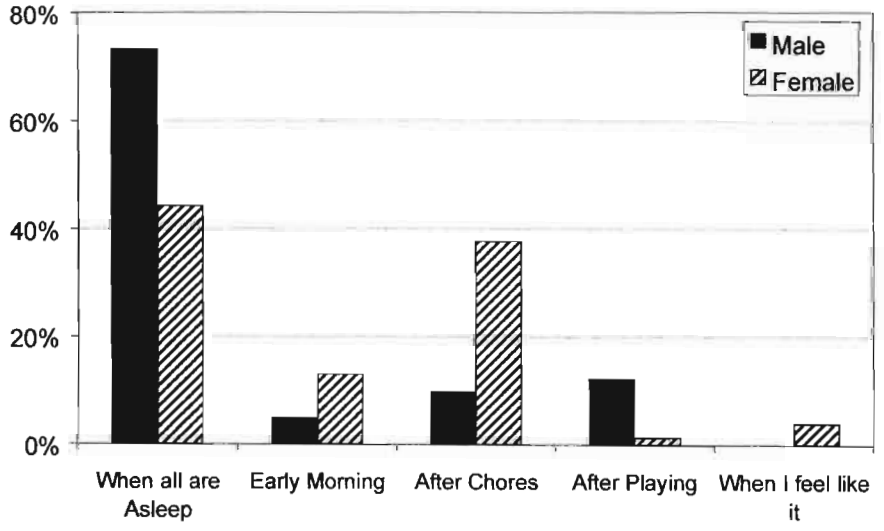
	% within Race	Home	School	Friend's House	Library	Total
African		15(34.9)	11(25.5%)	6 (14%)	11(25.6%)	**43(100%**
Indian		49(65.3%)	13(17.3%)	7(9.3%)	6(8%)	**75(100%)**
Total		**64 (54.2%)**	**24(20.3%)**	**13(11%)**	**17(14.4%)**	**118(100%)**

There is a significant relationship between race of the depressed sample and choice of place for completion of homework according to race (X^2=11.98,df=3,p=0.007). (Refer to Appendix C.5.6)

A larger percentage of the African learners preferred studying away from home i.e. at the library, school or at a friend's house whereas 49 (65.3%) of the Indian learners preferred studying at home. This is evident in Table 5.9.

(v) Study Arrangements In The Home

Figure 5.11 Histogram: Comparison of Preferred Time for Studying by Gender



		When all are Asleep	Early Morning	After Chores	After Playing	When I feel like it	Total
Male	% within Gender	30(73.2%)	2(4.9%)	4(9.8%)	5(12.2%)	-	**41 (100%)**
Female		34(44.2%)	10(13.0%)	29(37.7%)	1(1.3%)	3(3.9%)	**77 (100%)**
Total		**64(54.2%)**	**12(10.2%)**	**33(28.0%)**	**6(5.1%)**	**3(2.5%)**	**118 (100%)**

Figure 5.11 shows the preference of studying time displayed by the "depressed sample" according to gender and demonstrates that there is a significant relationship between gender of the "depressed sample" and preferred time for studying (X^2=21.177,df=4,p=0.000) (Refer to Appendix C.5.7). The majority of the males i.e. 30 (73.2%) and 34 (i.e. 44.2%) females preferred to study when all were asleep. Twenty-nine (37.7%) of the females had to complete their chores before they could begin with their homework. This aspect is discussed in detail in Chapter Six.

Table 5.10 Cross tabulation of Preferred Time for Studying by Race

	Race	When all are Asleep	Early Morning	After Chores	After Playing	When I feel like it	Total
African	% within	32(74.4%)	4(9.3%)	5(11.6%)	1(2.3%)	1(2.3%)	**43(100%)**
Indian		32(42.7%)	8(10.7%)	28(37.3%)	5(6.7%)	2(2.7%)	**75(100%)**
Total		**64(54.2%)**	**12(10.2%)**	**33(28%)**	**65.1%)**	**3(2.5%)**	**118(100%)**

There is a significant difference (X^2=12.61, df=4, p=.013) in the preference of studying time by race. (Refer to Appendix C.5.8)

A large majority of the Africans i.e. 32 (74.4%) but only 32 (42.7%) of the Indians preferred to study when all were asleep. However, 28 (37.3%) of the Indians also preferred doing their studying after completing all their chores. This is represented in Figure 5.10.

5.2.2.5 School Environment Evaluation

Adolescents were required to respond to various items concerning the school environment on the survey questionnaire. This enabled the researcher to establish areas of concerns of the learners.

(i) Evaluation of the school environment by Gender (Refer to Appendix D.5 for table)

Twelve (29.3%) of the males and 23 (30.3%) of the females indicated that the cleanliness of the school was bad. Eight (19.5%) of the males and 24 (31.6%) of the females stated that the school furniture was bad. Whilst a large percentage of the learners were committed to their studies, 13 (31.7%) of the males and 10 (13.3%) of the females were actually unsure of their performance. The learners enjoyed a positive relationship with their teachers but experienced problems with the librarian and the counsellors. Twenty-three i.e. 20% of the learners pointed out that they did not have a counsellor and 13 (11%) indicated that they did not have a librarian. Although a large percent of the sample indicated that they were neutral with regards to the behaviour of their classmates 12 (29.3%) of the males and 15 (20.0%) of the females reported that their behaviour was bad. However, a very large number (15 (36.6%) males and 30 (40%) females) remained neutral in their answers making them unsure of their position with regard to an item.

It is interesting to note that a large number of learners preferred to remain neutral in their responses to most items. The Department of Education and Culture's post provisioning norms for schools has led to an increase in numbers in class. Educators were still grappling with the new Outcomes Based Education and the influx of learners from other cultural groups. The large numbers of learners per class results in negative attitudes being adopted by some educators, especially when they were also declared as "excess" to the establishment. Hollinger & Offer, (1981); Packard, (1983) stated that "an overcrowded school leads to impersonal atmospheres and estranged environments".

(ii) Evaluation of the School Environment by Race

It is interesting to note that a large number i.e. 28 (37.2%) of the Indian learners complained about the cleanliness of the school compared to 7 (16.7%) of the

Africans. Comments on the condition of furniture at school once again revealed that 26 (34.7%) of Indian learners and only 6 (14.3%) of African learners found it to be bad. When asked to comment on their classmates' behaviour 5 (11.9%) Africans and 22 (29.7%) Indians stated that it was bad. Responses to the remaining items were good.
(Refer to Appendix D.6)

The Cronbachs Alpha score for school environment is 0.7019. These high values indicate a high degree of internal consistency amongst the items of school environment.

5.2.2.6 Relationship of Adolescents with Parents

(i) Cross tabulation of relationship with parents by gender (Refer to Appendix D.7)

A significant number of males i.e. 15 (37.5%) and females 32 (42.1%) indicated that their parents had high expectations of them and this pressurized them to perform academically. Twenty males (48.8%) and 30 females (41.3%) indicated that they were angered when their parents discussed their work with others. Twelve males (29.3%) and 18 females (23.7%) agreed that their family did not do things together. The majority of the males and females disagreed with the statement that their parents quarreled often. They indicated that their parents encouraged, guided and showed them love and care. Twenty-nine (25%) of the males and females agreed or partially agreed that they ignored their parents when they spoke to them.

It seems evident that with the exception of a few aspects, the learner's responses indicated that they enjoyed a satisfactory relationship with their parents. However, proper communication at home would have prevented learners from feeling pressurized to perform and angered by discussions about their work with others.

Hops et al. (1990) found that adolescent who reported problems in their relationships with parents were more stably depressed at two testing a month apart, and extent of family relationship difficulties correlated with level of depressive symptoms. Studies have found that the degree of suicidal thinking was related to reports of lower cohesion, more conflict, and other indicators of family dysfunction (Gotlib & Hammen, 1996).

ii) Cross tabulation of relationship with parents by race (Refer to Appendix D.8)

A quantitative analysis of the results indicated that 14 (33.3%) Africans and 16 (21.3%) of the Indians don't do things together with their family members. Twenty-one (51.2%) of the Africans and 26 (34.7%) of the Indians felt that their parents' expectations were too high. Thirteen (31.0%) Africans and 38 (51.4%) Indians were angered when their parents discussed their work with others. Although the majority of the learners from both race groups stated that their parents did not quarrel, 9 (22%) Africans and 6 (8.0%) Indians lived with parents who always quarreled. Although most of the Africans and Indians were satisfied with the support and affection provided by parents, 10 (25%) of the Africans felt that they did not receive adequate support and encouragement. Parental pressure to perform academically has resulted in an increase in teenage suicide. This aspect was discussed in the literature review. It is evident that both Africans and Indians responded similarly on most issues concerning parents.

5.2.2.7 Relationship of Adolescents with Peers/Siblings

(i) Cross tabulation of learners' relationship with siblings and peers by gender (Refer to Appendix D.9)

A discussion based on the pattern that emerged from the relationship between males and females and their siblings/peers as depicted in a Table (Appendix D.9) follows. Thirty-three (42.9%) females and 19 (47.5%) males strongly disagreed with the statement "friends don't share things". Both males and females had friends and siblings who acknowledged them as responsible people. Only 10% males and 22.4% females agreed that peers don't listen to them as opposed to 40% males and 27.6% females that disagreed with this statement. The majority of the males and females disagreed with the statement that they don't make friends easily and indicated that they were invited to functions organized by their friends. Six (15.4%) males 15 (19.7%) females agreed that they had arguments with their friends. Although the majority of males and females indicated that they enjoyed a good relationship with their siblings and peers, 18 males (46.2%) and 45 females (60%) stated that they were always willing to please. This is a sign of weakness that was further discussed during the interviews conducted in the research. The answers provided indicated that these learners were concerned about hurting the feeling of their peers and siblings and feared losing their friendship. They felt accepted and comfortable when they did things to please their friends.

(ii) Cross tabulation of learner's relationship with siblings and peers by race (Refer to Appendix D.10)

An analysis of relationships with peers/siblings and race revealed that 10 (23.8%) of the Africans as compared with 11(14.9%) of the Indians were unable to get peers to listen to them. A larger percentage of Africans, 33.3% (14) were not able to make friends easily as compared with 6.8% (5) Indians. Eighteen (43.9%) Africans and 45 (61.6%) Indians indicated that they were willing to please their friends all the time. More Indians, 15 (20.3%) compared with Africans 6 (14.6%) had arguments with others. Africans and Indians disagreed with most of the other items reflected in the Table (Appendix D.11)

5.2.2.8 Relationship of Adolescents with School

(i) Cross tabulation of learners' relationship with the school by gender (Refer to Appendix D.11)

Whilst 16 (21.3%) of the females agreed that the thought of school made them sick, 27 (36%) disagreed with this statement. Thirteen (32.5%) of the males also disagreed with this statement. Seventeen (42.5%) males and 29 (38.2%) females indicated that they did not daydream in class. Twenty-four (31.6%) females and 8 (20%) males agreed that their work in school was incomplete. Sixteen i.e. (40.1%) males and 37 i.e. (48.7%) of the females agreed or partially agreed that their work at school was getting worse.

(ii) Cross tabulation of learners' relationship with the school by race (Refer to Appendix D.12)

Despite the fact that majority of the Africans and Indians disagreed that the thought of school makes them sick, 7 (17.5%) Africans and 13 (17.3%) Indians did agree with this statement. Seven (17.1%) Africans and only 5 (6.7%) Indians daydreamed in class. In respect of "work incomplete in school" majority of Africans 18 (43.9%) agreed with this statement. The majority of the Indians 28 (37.3%) disagreed with this statement. A greater percentage of the Africans i.e. 8 (20.0%) compared with the Indians i.e. 7 (9.3%) indicated that they lost interest in what their teacher says in class. Eleven 27.5%) Africans and 15 (20.0%) Indians stated that their work at school was getting worse. A cross tabulation of learners' relationships with school by race indicated that areas of concern relating to the completion of work by Africans that need to be addressed.

The Cronbachs Alpha score for relationships is 0.8053. This high score indicates a high degree of consistency amongst relationships. Cronbachs Alpha measures the

reliability of scaled items. The concept of reliability refers to how accurate, on average, the estimate of the score is in a population of objects to be measured.

5.2.2.9 Descriptive statistics for the school environment, relationship with peers, parents and school

Table 5.11 Overall Perception of Factors

	N	Minimum	Maximum	Mean	Std. Deviation
School environment Evaluation	108	13.000	43.000	29.315	6.428
Relationship With parents	109	13.000	40.000	25.661	5.613
Relationship With Peers	111	14.000	40.000	28.459	5.697
Relationship With School	112	8.000	40.000	26.464	6.532
Valid N (listwise)	93				

As demonstrated in Table 5.11, the mean score for school environment evaluation is 29.315 indicating that respondents are generally satisfied but unsure about certain aspects. The standard deviation of 6.428 indicates that there was a wide range of attitude and this is also evident from the maximum and minimum scores. The minimum score indicate that some respondents were highly satisfied and the maximum score indicates that some respondents were dissatisfied. A similar pattern is evident with regard to the relationship with parents, peers and the school.

Group Statistics according to race and the relationships with parent, peer and school are presented in Table 5.12

Table 5.12 Overall Perceptions of Factors by Race

	Race group	N	Mean	Std.deviation
School-Environment Evaluation	Indian	35	26.9714	6.3454
	African	73	30.4384	6.2003
Relationship With Parents	Indian	39	24.5128	5.1803
	African	70	26.3000	5.7769
Relationship With Peers	Indian	38	26.9474	6.0222
	African	73	29.2466	5.3949
Relationship With School	Indian	38	24.9737	5.5434
	African	74	27.2297	6.8956

Table 5.13 Overall Perception of Factors (t-test)

		t-test for Equality of means		
		T	**Df**	**P value**
School Environment Evaluation	Equal variances Assumed	-2.699	106	.008*
Relationship With Parents	Equal variances Assumed	-1.605	107	.111
Relationship With Peers	Equal variances Assumed	-2.047	109	.043*
Relationship With Schools	Equal variances Assumed	-1.747	110	.084

From Table 5.12, the mean score indicates that both race groups were generally satisfied on all four dimensions. The large standard deviation shows a wide range of attitudes. On all four dimensions the African learners have a more positive attitude than do the Indian learners.

Table 5.12 shows results of t-test that was used to test the differences in perceptions of the factors between the Indian and African depressed learners.

From Table 5.13, there is a significant difference (p=0.008) in the perception of school environment between Indian and African learners. From Table 5.12, African learners are inclined to be more positive than are Indian learners.

There is no significant difference with regard to Relationship with parents and Relationship with schools between Indian and African learners. From Table 5.13, it is also apparent that there is a statistically significant difference in the relationship with peers between Indian and African learners. African learners are more inclined to a positive relationship with peers and Indian learners are generally negative.

Table 5.14 shows the mean and the standard deviation according to gender.

Table 5.14 Overall Perceptions Have Factors by Gender

	Gender	N	Mean	Std. Deviation
School Environment Evaluation	Male	40	30.5750	5.9566
	Female	68	28.5735	6.6204
Relationship With Parents	Male	38	25.9737	4.5943
	Female	71	25.2930	6.1129
Relationship With Peers	Male	39	28.6410	4.8204
	Female	72	28.3611	6.1491
Relationship With Schools	Male	39	26.6667	5.1623
	Female	73	26.3562	7.1887

Table 5.15 Overall Perceptions of Factors (t-test)

		t-test for Equality of means		
		T	**Df**	**P value**
School Environment Evaluation	**Equal Variances Assumed**	1.573	106	.119
Relationship With Parents	**Equal Variances Assumed**	.424	107	.672
Relationship With Peers	**Equal Variances Assumed**	.246	109	.806
Relationship With Schools	**Equal Variances Assumed**	239	110	.812

The results in Table 5.14 and Table 5.15 indicate no statistically significant differences with regard to the factors between male and female learners.

5.3 SUMMARY

The analysis of the BDI revealed that 118/566 (20.84%) of the learners displayed depressive symptoms. An analysis of the survey questionnaire showed that 43 (36.4%) were Africans and 75 (63.6%) were Indians. The gender differences were in keeping with other studies and showed 77 (65.3%) were females and 41 (34.7%) males. The majority of the learners' parents had a monthly income of between R500.00 - R2999.00. A large percentage of the learners lived with their mothers only. Majority of the learners shared their bedrooms and also used it to study. Many learners had to complete their household chores and wait for all to sleep before commencing with their studies. This was not an ideal study environment for the learners. Although the quantitative results elicited positive responses from some the items on the survey questionnaire, the qualitative analysis and the interviews were negative.

The data obtained from the survey questionnaire that lent itself to qualitative analysis, will be discussed in Chapter Six.

CHAPTER SIX

A QUALITATIVE ANALYSIS OF THE SURVEY QUESTIONNAIRE AND SEMI-STRUCTURED INTERVIEWS

6.1 INTRODUCTION

A detailed quantitative analysis of the survey questionnaire referred to as Part One, was dealt with in Chapter Five. The present Chapter presents the qualitative findings of the survey questionnaire and the semi-structured interviews. This section is divided into five major headings, namely:

- Qualitative methodology
- An analysis of the open – ended questions of the survey questionnaire
- Major concerns and suggested recommendations by adolescents
- General comments pertaining to the Survey Questionnaire
- Semi-structured interviews

A detailed discussion of the open-ended section of the survey questionnaire will be explained first, followed by the methodology and analysis of the semi-structured interviews. The discussion will revolve around broad headings that emanated from the responses of the learners. Ethical considerations that form an integral part of qualitative research will also be discussed.

6.2 QUALITATIVE METHODOLOGICAL ASPECTS OF THE CURRENT STUDY

The qualitative analysis of data was valuable to the present study to promote and verify knowledge obtained by means of quantitative data collection. This enabled the researcher, who was concerned with "why?" to substantiate responses of the learners. According to Dahlgreen & Fallsberg, (1991) the aim of qualitative research is to provide categories for the description and explanation of human and social

phenomena. This aspect was incorporated into the research as learners' responses in the survey questionnaire and the semi-structured interviews were grouped into categories.

As explained in Chapter One, the objective of the study was to determine the prevalence of depressive symptoms in adolescence, to investigate contributory factors at home and in school and ascertain from adolescents suggestions for improving the prevailing conditions.

The critical questions were:

- What is the prevalence of depressive symptoms in adolescents?
- What factors in the home contribute towards depressive symptoms?
- What factors in school contribute towards depressive symptoms?
- What are the suggestions made by adolescents to improve the prevailing conditions?

The first critical question, i.e. the prevalence of depressive symptoms in adolescents was achieved by using the Beck Depression Inventory. The findings revealed 118 (i.e.20.84%) of the sample displayed depressive symptoms. The quantitative analysis was discussed in detail in Chapter Five.

Information for the second and third critical questions was obtained by using a survey questionnaire. This questionnaire consisted of 30 questions. All the questions except 20, 26, 28, 29 and 30 were analyzed quantitatively and the results were discussed in Chapter Five. Questions 20, 26, 28, 29, 30 were analyzed qualitatively to enable the researcher to establish the thought patterns that emerged concerning the home and school conditions of the learners. In addition to this, interviews were conducted to obtain clarity on some responses of the adolescents mentioned in the survey questionnaire.

The fourth critical question was answered by exploring the suggestions offered by the learners concerning their problems. This information was obtained from the survey questionnaire.

The researcher included herself in the act of observation, interpretation and description of events as described by the participants during interviews. Observational interpretation is determined by the mood, the experience, the intention and the ability of the researcher (Engelbrecht, 1998). The trust of each learner had to be won in order to obtain an in -depth report on parents, school and sibling/ peer relationships.

6.3 PARTICIPANTS IN THE SEMI-STRUCTURED INTERVIEWS

The participants for the interview were selected from the original sample of adolescents who, according to the BDI, had displayed depressive symptoms. The selection procedure is described below.

6.3.1 Purposive sampling

In purposive sampling researchers handpick the cases to be included in the sample on the basis of their judgement of their typicality. In this way, they build up a sample that is satisfactory to the specific needs (Cohen, Manion and Morrison, 2000). Purposive sampling was used for selecting the interviewees.

6.3.2 Selection criteria for the semi-structured interviews

The following selection criteria were employed for participants of this study:

- Two participants from each of the sample schools were selected.
- The selection was based on the highest scores attained in the Beck Depression Inventory.

- Two were selected in order to ensure that interviews could be carried out as planned and within the specified time. The second learner would only be interviewed if the highest scorer was absent, to clarify certain school related aspects that were contradictory to the information obtained or to confirm the information indicated in the survey questionnaire.

Consent to participate in the interviews was obtained from the parents, the school principal and the school governing body chairperson. Once the highest scorers from each of the five sample schools were identified, the principal was contacted and informed about the forthcoming interviews. The procedure was discussed with the principal at the first meeting and only dates and time were to be confirmed. Suitable dates and times were discussed and on the day of the interview the school was contacted once more to confirm whether the learner was present. The researcher then proceeded with the scheduled interview.

6.4 ETHICAL CONSIDERATIONS

Ethical considerations are inherent in any situation that involves more than one morally plausible resolution, or where there is a direct reference to the welfare or dignity of the individuals (Haddad, 2000). An important ethical consideration of this study was the learner's right to privacy. This includes the right to confidentiality and protection form intrusion (Allan, 1997). Although the learners' consent was obtained, this did not waive their right to privacy. The researcher did not probe into the private lives of the learners. The results of the qualitative study that are presented protects the identity of the learner. In accordance with the participant's right to privacy, names have been changed to protect their identities.

6.5 DATA COLLECTION

The data collection for this research took a multidisciplinary approach. It involved a combination of quantitative as well as qualitative research methodologies. The quantitative aspect is discussed in detail in Chapter Four. According to Denzin & Lincoln (1994), qualitative research is defined as a multi-perspective approach to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it. Mouton (1986) says the term "qualitative research", probably the most general, encompassing and widely accepted term, is an indication that this approach concentrates on qualities of human behaviour, i.e. on the qualitative aspects as against the quantitatively measurable aspects of behaviour. Both methods were needed in the present studying order to supplement the information obtained during the research since a comparison of depressed and non- depressed adolescents was not studied in this research.

6.5.1 Interviews

The interviews undertaken provided an opportunity to probe beyond a simple answer (Smith, 1992). This became necessary to supplement the statements made in the questionnaire to obtain clarity on certain issues. The interviews that were conducted with the adolescents had several advantages namely:

- The researcher is able to gather rich data in a relatively short space of time.
- Face to face contact with participants affords the researcher an opportunity to observe body language and put the participant at ease. This helps the researcher to obtain information in a relaxed atmosphere.
- It allows for immediate follow-up discussion that facilitates exploration and clarification of patterns.

Although arguments were raised against the interview method with regards to truthfulness of the verbal content, researcher bias and lack of replication of the

interview in other settings, the researcher found no reason for the learners to be misleading in their answers. Efforts were made to keep researcher bias that constitutes a real disadvantage, to a minimum. The interview lasted approximately 30 minutes, and was recorded on a micro-cassette. This procedure was explained to the learners, parents and the principals prior to implementation.

A semi-structured interview questionnaire was designed based on the findings of the survey questionnaire, pilot tested as explained in Chapter Four and then implemented. This was used by the researcher as a guide to obtain all the relevant information systematically. A copy of this instrument is included as Appendix B.3. The questions were introduced as part of the conversation. The emphasis was on establishing rapport that would enable the learners to speak more freely about their problems and not feel intimidated. Some notes were also taken in the course of the conversation as a means of data management and for purposes of transcribing quotes verbatim. Additional discussion was encouraged by re-framing questions, asking the learners to elaborate on statements made on the survey questionnaire and by clarifying expressions they had used. All interviews were conducted in English as this was the medium of instruction at the schools. The learners were informed that they should ask the researcher if they did not understand any aspects during the interview. All learners were fluent in English and no major problems were encountered. Detailed records were written after each interview. Data collection continued until sufficient information was obtained. This was completed after eight interviews were conducted.

6.6 DATA ANALYSIS

Analysis of data is a process of becoming familiar with the phenomena and the text, and it involves recognition of patterns (Engelbrecht, 1998). Qualitative analysis involves both description and interpretation (Dahlgreen & Fallsberg, 1991). The five main approaches to the data analysis are categorization of meaning, condensation of

meaning, narrative structuring, interpretation of meaning and ad-hoc methods for generating meaning. The most frequent form of interview analysis is probably an ad-hoc use of different approaches and techniques for meaning generation (Kvale, 1996). There is a free interplay of techniques during the analysis. This approach was considered suitable for the study. Certain techniques were used since the qualitative analysis was conducted to add clarity to the responses of adolescents' in the survey questionnaire and to obtain in-depth knowledge of their problems.

The main purpose of the open-ended section of the questionnaire was to extract information that would enable the researcher to establish the thinking patterns of the learner. These open-ended questions required the learners to indicate their personal feelings about the conditions at home and at school and to offer suggestions that would assist in improving the prevailing situation at home and in school. These questions were analyzed qualitatively. The quantitative data obtained from the survey questionnaire referred to as Part One was discussed fully in Chapter Five. The quantitative data dealt with valid percentages and cross tabulations of factors at home and in schools that were impacting on the learners. A qualitative analysis of the open-ended questions from the survey questionnaire referred to as Part Two will follow.

6.7 ANALYSIS OF THE OPEN-ENDED QUESTIONS OF THE SURVEY QUESTIONNAIRE

The survey questionnaire had several questions that required the learner to indicate the availability of space and their attitude and reactions to the study environment in their homes. Questions 20, 26, 28, 29, 30 of the survey questionnaire were open-ended and required learners to provide reasons for their responses. The expected outcome was that data could be analyzed to reflect cognitive processes without the constraints of a structured and prescriptive mode of answering. Perceptions of their environment, stereotypes, thinking and reasoning skills and their feelings could be

ascertained from these responses. The remaining questions were analyzed quantitatively and the results were discussed in detail in Chapter Five.

One of the critical questions as stated in Chapter One was to determine the role of contributory factors at home and in school in the incidence of symptoms of depression in the adolescents. The responses of the learners' to the open-ended questions from the survey questionnaire were analyzed to establish themes and categories that emerged. Responses were noted down as they were presented and frequencies established for each reason. Similar reasons were combined e.g. "there is too much disturbance in the house" and "the radio volume is too high all the time".

The responses were fairly consistent across race groups in variety, number and similarity. However, differences were observed in terms of gender. Female learners complained of being burdened with household chores, insufficient time to study, not being allowed to visit at night and their friends or boyfriends not being allowed to come home. Typical stereotypes of females being expected to cope with the household chores and complete their studies in their own time were prevalent. The responses will be presented by referring to the questions in the survey questionnaire.

The qualitative aspects of the open-ended questions of the survey questionnaire will be discussed. The quantitative analysis of the survey questionnaire (questions 1-19) was reported in Chapter Five.

6.7.1 Spatial Setting

A discussion of responses to the question, "How do you feel about sharing your bedroom?" (Question 20) follows.

The majority of the Indians and Africans were unhappy (negative responses) about sharing their bedrooms. Eighty-two (69%) responded negatively. Of this proportion,

35% were Africans and 65% were Indians. Although 31% of the sample i.e. 39% Africans and 69% Indians, replied in the positive, only 5 of the learners had a study. Learners had to be content with the study environment that they were exposed to, as there was no alternative. This was not the ideal situation for a learner to perform optimally.

6.7.1.1 Negative Responses

The negative responses of learners are reflected below in order of frequency. These responses can be grouped as "***extremely uncomfortable***:"

- "Too much disturbance; no personal space; no privacy, makes me feel horrible and I hate sharing".
- "I feel terrible as I am forced to share the room with my brother because the house is too small."
- "I feel very bad about sharing but I have no choice in the matter."
- " I feel very uncomfortable because I share the room with my parents. We rent in one room that we use as the kitchen and as the bedroom. I have to do all my work in this room as the landlord has six people in his family and there's only two other rooms for them."
- "I share my room with five members of the family and I am very unhappy about the set up at home."

6.7.1.2 Positive Responses

It is evident from the range of positive responses (31%) of the learners that the prevailing conditions were not really the ideal situation.

- ***Comfortable about sharing:***

Several of them stated that they were comfortable with sharing their bedrooms as they engaged in discussions during their bedtime.

"It's okay since I watch over my brother /sister at night."

- ***Compromising and accepting:***

Three of the learners indicated that they live in a one room flat and therefore have no choice and can't complain.

"It's okay since I'm not sharing the bed." "It's fine since only three of us are in that room."

- ***Reconciled:***

One learner stated:

"I am living in someone else's house. Although I am very unhappy with the situation there is absolutely nothing my parents or I can do. I am grateful that I do have this place to live in. That is the reason why I am not complaining." "I sleep in the lounge, so it's not so bad."

General discussions with learners about their home environment resulted in the following conclusions:

Feelings of "hate", "discomfort", "compromise" and being in a hopeless situation where the learner had no alternatives were prevalent. This lowered their self-esteem and made them feel "worthless." The discomfort experienced when sharing their rooms, and the crowded living environment resulted in stress in adolescents. This was an important factor that often led to underachievement in school. Studies discussed in the Chapter Two have established a link between living environment and performance at school.

6.7.2 Study Arrangements

In response to " Where do you prefer to complete your homework/studying? Why?" (Question 26) the learners were required to express their preference about the study arrangements that were available to them and to furnish reasons for their choice.

Learners were given a few venues to choose from. Their choices and the reasons are listed below according to frequency:

- Home: 64 i.e. 54% of the learners indicated that they would like to study at home. Some of the learners indicated that their elder sisters and brothers assist when problems are encountered, music can be played at home and it is relaxing, the refrigerator is close at hand. Others stated that the conditions at home were not suitable for studying purposes but their parents would not allow them to study elsewhere. This confirms that their choices were not acceptable to them but they were forced to remain at home and cope with situation.
- School: 24 i.e. 20% of them indicated that they preferred studying at school because peers always assist if difficulty is experienced.
- Library: 17 i.e.14% of them preferred to study at the library since they could concentrate better and there was no disturbance.
- Friend's house: 13 i.e.11% of the learners indicated that they liked to study at their friend's house because of space limitations at home and assistance can also be obtained.

The negative responses make it clear that the study environment was not conducive to learning. Many of them were forced to live and study under very trying conditions. With not many options available to them, they tried to be content with what was available. As reflected in Chapter Five, 37.1% of the learners' total family income per month fell in the R500-R1500 bracket and 10.3% had no income. Parents experience many serious problems on a daily basis and to improve study facilities is the least of their concerns.

Social class, educational attainment, occupational status, and exposure to stressors and resources to cope with them, bear an ambiguous relationship to depressive symptoms and disorders. While the disadvantaged in general appear to report

somewhat higher rates of depression (Brown & Harris, 1978), lifetime reports of depression often have not been seen to differ by socio-economic group (Hirschfeld & Cross, 1982).

6.7.3 State of Study Arrangements

In response to "How do you feel about the study situation at home? Why? What can you do to improve the situation?" (Questions 28,29,30) the learner's attitudes, reactions, and if possible, input for improvements to the study environment, were tapped. An adolescent's home situation impacts significantly on his affective development (Clarizio, 1994).

TABLE 6.1 Learners' attitude toward the study situation at home

	Race Group		Total
	Africans	**Indians**	
Positive	27 (41.5%)	38 (58.4%)	**65 (100%)**
Negative	14 (31.8%)	30 (68.1%)	**44 (100%)**
Total	**41(37.6%)**	**68(62.3%)**	**109(100%)**

Missing data: 9

Although 27 (41.5%) African and 38 (58.4%) Indian learners stated that they were satisfied with the arrangement as there was no disturbance at home, a large percentage however, suggested improving their study environment. Fourteen (31.8%) African and 30 (68.1%) Indian indicated that they were unhappy, uncomfortable, disturbed all the time, received no support at home, were tired after the chores, had no computers and their rowdy and interfering neighbours made the situation worse. The learners were required to state whether they could improve their

study situation or not. Their responses were analyzed as negative or positive and are reflected in the table below.

TABLE 6.2 Response of Learners to Improve the Study Situation

	Race Group		
	Africans	**Indians**	**Total**
Positive	24 (45.2%)	29 (54.7%)	**53 (100%)**
Negative	17 (32%)	36 (67.9%)	**53 (100%)**
Total	**41(39%)**	**65(61%)**	**106(100%)**

Missing data: 12

Table 6.2 shows that 24 (45.2%) of the African learners and 29 (54.7%) of the Indian learners were positive that they could make some improvement in their study situation. Seventeen (32%) of the Africans and 36 (67.9%) of the Indians replied in the negative. A larger percent of the Indians were negative with regard to being able to improve their study situation. The following comments reflects the negative responses in order of frequency:

- A large percentage stated that they "Can't change anything as my parents and siblings ignore me when I talk".
- "No idea what to do."
- "Parents won't listen to me."
- "Parents are not interested in improving the situation."
- "Television is in the room and nothing can be done about it as we are staying with other families."
- Two of the learners were very frustrated and said,

"I want to get out of this house after I complete the matriculation examination. Whether I pass or fail it does not matter. I will go away to Johannesburg, far away from my family."

The comments of the learners make it evident that quite a large number of them felt "helpless". They accepted the situation although they were not too happy with it. They were unable to change anything and some expressed extreme frustration at the situation. The conditions under which these adolescents had to study were not beneficial to them. The comment "parents are not interested in improving the situation" is indicative of a total lack of support structures and the negative environment that these learners live in.

The positive responses follow in order of frequency:

- In order to overcome the problems 11% of the learners indicated that they would study at their friends' homes, 20% indicated they will study at school and 14% stated they would go to the library.
- Learners suggested holding family meetings to discuss issues such as constant quarrelling, abuse of alcohol, blaring of the radio and watching television for too long periods.
- "Sleep after doing the chores and get up when all are asleep."
- "Try to work part-time and build my own room."
- "Ask my father to build a study."
- "Get a maid to do the work and relieve me of the chores so I can concentrate on my studies."
- "Buy a ceiling fan and a computer to enable me to work comfortably."
- "Pray to sort out the problems."

Adolescents had to reconcile with the fact that there was not much that could be done by them to change the situation and they had to contend with it. Although they replied in the positive their comments showed that they were not comfortable with

the existing conditions and offered several suggestions to improve the situation e.g. "get a maid to help with the chores" or "ask my father to build a study".

6.8 MAJOR CONCERNS OF LEARNERS: PARENTS, PEERS/SIBLINGS, AND SCHOOL

The last section of the survey questionnaire required the adolescents to list five major problems that they faced with their parents, peers/siblings and school and to make recommendations that would lead to improving the prevailing situation. A discussion of their comments and suggestions will be recorded according to themes that emerged from their responses.

6.8.1 Parents: Major problems encountered and solutions offered by learners

A quantitative analysis of the survey questionnaire discussed in Chapter Five indicated that adolescents were concerned about communication with parents. Other problems that could have been solved amicably arose as a result of poor communication. The qualitative aspects of the survey questionnaire also indicated poor communication with parents. Loarder et al., (1982) define communication as "directly observable verbal interchanges, paraverbal indicators (such as tone of voice) and nonverbal cues. It is important to make observations on some issues on communication as discussed by Loader et al., (1982).

- The types of messages that are passed among family members e.g. are they confusing or double binding messages? Are parents always making demands with little acknowledgement of positive behaviours?
- The vocal intonation with which communications are delivered e.g. does the father only shout at the children?
- Does the communication only include certain individuals to the exclusion of others e.g. do parents communicate directly or do they use their children to pass messages?

In Chapter Five, the quantitative data revealed that fifty-one, i.e.43.22% of the learners indicated that their parents angered them by discussing their work with others. Proper communication between parents and adolescents would avoid situations of this nature. The qualitative data indicated that adolescents encountered problems that they were unable to resolve. Their suggestions to improve the situation at home were ignored by their parents. Life for them was not pleasant and they did not have anyone to turn to. Many of them expressed concern about their parents' lack of interest towards creating a harmonious family life by continuously getting into arguments and overburdening them with household chores that resulted in insufficient time to study. They felt that parents had to adapt to changes taking place and treat all members of the family equally.

Below is a list of some of the major problems in order of frequency encountered by the learners in this study. These aspects can be classified under several broad headings.

(i) Problems with Parents

- " My parents are always comparing me with other children in our area."
- "My parents are always arguing among themselves and with us."
- "They expect me to do too many chores on a daily basis and that is why I cannot study or complete my homework properly and I get into trouble with my teacher."
- "My parents blame me all the time when things go wrong."
- "My parents are too strict and don't allow my boyfriend to visit me at home. They forget that I am old now and I need to have personal friends."
- "My parent's high expectations are placing me under pressure to perform beyond my capabilities. This is not fair because I don't have a room of my own where I can concentrate and improve my work."

- "My mother favours my sister all the time because she looks after the baby for her."
- "My parents do not trust or have an open relationship with us."
- "They ignore me or my views on any matter."
- "There is no provision made for freedom to go out. They are too serious about everything."
- " Parents are overprotective."
- "Vulgar words are used whenever there is an argument. I tend to use these words during my conversation and I get embarrassed."
- "I don't receive any attention when I am unwell."
- "Smoking, drinking and taking drugs are a major problem in my house".

From the above comments it is evident that adolescents are dissatisfied with their parents' attitudes. They perceived their parents as less cohesive, more conflictual, less expressive, non-trusting and more autocratic and thus feel they have little input in decision- making. According to Stark et al., (1990) these families engage in less social, recreational, or intellectual cultural activities. Poor self-esteem in adolescents may arise as a result of lack of trust, favouritism, high expectations and neglect displayed by parents.

Learners indicated that parents needed to make an effort to bring about positive changes in the home. This will result in a more conducive learning environment and create a congenial atmosphere in the home. The suggestions offered by the learners that may bring about these changes are listed in frequency order according to themes: these include communication, responsibilities, negotiations, expectations, parenting skills, outside intervention and hopelessness.

(ii) Family Relationships

- "The family members need to have a meeting and discuss issues in a calm manner rather than argue over them."

- "Rather than blaming others, parents must learn to solve problems by looking at themselves and seeing where they are going wrong."
- "We can only do what we are capable of and parents must not expect us to perform beyond that as the pressure is sometimes unbearable."
- "A family unit will function better if parents encourage an open and trusting relationship where we can discuss all issues and not only those that they want to listen to".
- "All children have a right to be heard and parents must listen to us even though they think that we are small, we can contribute to their discussions"
- "If a discussion takes place calmly, there will be no need for anger and vulgarity. My main concern is that I have picked up these vulgar words and I tend to slip up sometimes when I am talking. This is very embarrassing for me".

(iii) Responsibilities

Some learners indicated that parents were not being considerate and neglected their duties as parents. The responses reflected below expressed the feelings of these learners.

- "Parents must realize that we have a lot of school work to do and not burden us with too much household chores".
- "Every child has a right to medication and when I am sick I need someone to take care of me also. My parents and siblings must show me some attention when I am not well."
- Parents must spend their money in a better way rather than by drinking and smoking. They should spend their extra money in taking the family out so they can spend some time together and have a general discussion on anything that is troubling them in the home rather than coming home drunk or drugged and creating more problems."

(iv) Negotiations

Learners expressed a desire for parents to change and be more accepting of the present trends and way of life. They stated that:

> "Parents must relax the rules, allow freedom to go out in the evenings and to have boyfriends. They must realize that I am growing up and I have feelings for someone else."

(v) Parenting skills

Learners expected parents to be objective, warm and refrain from making comparisons. The following quotes reflect the views of the learners.

- "Parents must realize that all the children cannot be the same and therefore they should not make comparisons."
- "Parents must learn to treat all their children equally well and favouritism makes us feel like an outcast in our own home."
- "Parents must stop being overprotective because it makes us feel that we are not able to take care of ourselves."
- "Parents will have to learn to be affectionate in order for the family members to be happy."

(vi) Hopelessness

Some learners felt the situation was too bad to discuss or negotiate with their parents and stated that:

> "I will talk to a social worker/counsellor who understands me and will ask them to help me with my problem."

Some of the learners indicated that nothing could be done to improve the situation and they would rather leave home than stay in those conditions.

> "I will move out of the house because I can't change the situation".

Although the responses were separated into themes or categories, learners felt that effective communication would enable parents to arrive at suitable solutions to these problems. Poor communication can result in dysfunctional families. Many learners were rebellious and expressed a desire to leave home. Their suggestions of problem solving indicated that parental skills were lacking and there was a definite need for change in attitudes of parents towards them.

Puig-Antich and colleagues (1985a,b) found that preadolescent children with major depressive episodes had a significant impairment of their relationships with their parents. Mother and child relations were significantly more negative and were characterized by less communications and more hostility and rejection. The results of a number of diverse investigations have documented a consistent association between marital dysfunction and depression. Larson et al., (1990) in a study of children and adolescents' daily ratings of their activities, found there was a strong tendency of relatively depressed youngsters who want to avoid their families, suggesting a problematic relationship.

6.8.2 Peers/ Siblings: Major problems encountered and solutions offered by learners

Responses of adolescents in the survey questionnaire revealed that peers and siblings also experienced communication problems that often resulted in conflict and personal grief. Fifteen (19.7%) females and 6 (15.4%) males indicated that they had arguments with their others. The most common problems encountered with peers/siblings were as follows in order of frequency:

(i) Low self esteem

Learners indicated that they were unhappy when their friends ignored their views.

- "My friends and siblings often misconstrue what I say. They always want to be right. They underestimate me and make me feel uncomfortable all the time."
- "I always do things to please my friends."

(ii) Poor relationship with siblings

The quotes listed below are indicative of problems amongst siblings in the home.

- "Too many arguments among my brothers and sisters take place in our home."
- "My brother acts too bossy. He instructs us to do things around the house."
- "My family members are too lazy. They don't help with any house- work. This frustrates and angers me."
- "Favouritism is common in my home. My sister is always given the best and not asked to do any work."
- "My brother takes drugs daily."

(iii) Poor peer relationships

Learners experienced problems with peers and stated that they don't like to have friends because they could not be trusted.

- "Friends like to gossip, mock and ridicule me. They often ignore my views."
- "I cannot trust my friends."
- "Drug and alcohol abuse are a problem at schools."
- "There are many gang fights and it often continues outside after school."

The responses in the survey questionnaire revealed that major incidents of fighting were evident among African learners in the sample group where drugs were taken. A parent who lived on a farm wanted her children to study in Phoenix. She rented a room in Kwa Mashu and sent her two sons and two daughters to live in this room on

their own and fend for themselves. One of her sons turned to drugs and often stole from the house and made the lives of the others miserable. This is evident in the comment below:

"My brother hates me. He doesn't want to see me next to him. He takes drugs and often steals my bus fare so I can't go to school. I like to go to school everyday but when he steals my bus fare, I have to stay at home."

Diagnosing a learner who is showing symptoms of depression and treating him/her with either counseling or medication is inadequate if the learner is then allowed to return to a home that is contributing to her distress. Changing the home environment is important if learners diagnosed are to benefit from medication and psychotherapy. Learners expressed concern over siblings/ peers inability to listen and acknowledge them. They felt betrayed and unwanted by their friends when favouritism and gossip prevailed. Gossiping friends, who ridicule and mock them, make them feel "worthless." Lack of co-operation among family members in assisting with household chores often leads to feelings of frustration and anger.

The most frequent solution offered by the sample was improved communication among siblings and peers. The learners felt that the following suggestions could assist in improving the prevailing situation.

(i) Communication

- "Siblings and friends must engage in discussion to resolve any problems they encounter."

(ii) Outside Intervention

- "Seek the help of a counsellor who is an expert in the field."

(iii) Attitude and Compassion

- "Stop gossiping and hurting feelings of others. This can be achieved by engaging in a variety of activities to keep learners busy and meaningfully occupied."
- "Respect begets respect, respect your siblings and your friends if you want them to do the same."

The implementation of these suggestions by parents, peers and all service providers will result in the desired result being accomplished.

6.8.3 School: Major problems encountered and solutions offered by learners

In response to problems and solutions concerning school, learners expressed concern over various issues ranging from poor attitudes of learners, to dirty schools and even sexual advances made by educators. Trends that emerged as problems at school may be classified in broad categories such as "learners", "educators/ teachers" and "school". Solutions will be reported under the same broad categories.

(i) Learners

- "Some learners fight, drink, take drugs, and form gangs."
- "Poor attitude of learners and educators, bad discipline by learners and disrespect shown by the learners towards their educators."

(iii) Educators/Teachers

- "Teachers are judgmental, and assume things about us e.g. that all of us drink."
- "Teachers seem to be on a faultfinding mission, they don't explain aspects that we don't understand."
- "Staff members gossip about the learners."

- "Teachers don't encourage us when we have a problem even when we request for help. Some even insult us throughout the year if they hear that we have done something that was wrong."
- "Favouritism is quite common among teacher's children and pretty girls are popular."
- "Some teachers are racist."
- "Some teachers are "horny" and talk about sex during teaching time."
- "Teachers take personal leave and when they return they pressurize us with lots of work in a short space of time."

(iv) Schools

- "The schools are very dirty, toilets stink and cannot be used, the condition of the furniture is poor and there is a great shortage of textbooks."
- "Our schools do not have proper sporting facilities, the libraries are not operational and we don't have many sporting activities."
- "School fees are too high."
- "Theft and vandalism is common at school."

The comments made by the learners clearly show the problems they are experiencing at school with their educators and peers. The comment "pretty girls are popular" diminishes the self-concept of females if they do not fall in this category. They expressed several concerns that actually made them feel uncomfortable at school. Some learners were not really serious about their studies and got into trouble often. The educators' derogatory remarks and lack of support worsened the situation. The unhygienic conditions at school, theft, poor sporting facilities and exorbitant fees prevented it from being a pleasant environment. The following suggestions in response to the problems encountered were offered and if implemented, will eventually result in a more conducive learning environment. This, according to the constitution of the country, is a right of the learner.

(i) Learners

- "Troublesome children should be transferred."
- "All facilities that are meant for the learners must be improved."

(ii) Educators/Teachers

- "Teachers have to be more understanding and sympathetic towards the learners because most of us also have many problems at home which makes it very difficult for us to perform well in class. Instead of generalizing, teachers should call those learners who are drinking and punish them."
- "Teachers and learners must know the reason why they are at school. Teachers must teach for the total time allocated for the subject and detain disobedient learners."
- "All teachers should encourage the learners and not ridicule them when they make a mistake."
- "Teachers must be fair and listen to all sides of the story before passing judgment on the learners."
- "Problematic teachers should be replaced with committed teachers who are genuinely interested in helping the learners."
- "Teachers must refrain from talking about their personal lives in the teaching time."
- "Teachers must be tolerant of all cultural groups and their beliefs."
- "The learners will appreciate total commitment and no favouritism from the teachers."

(iii) School

- "The principal and the governing body members must employ more cleaners and make the school a better place for the learners to study."
- "Call in the police to monitor the school."
- "Purchase equipment with the fees collected instead of putting fences, tiles, curtains, and washing the roofs and wasting the money."

- "Vendors should not sell cigarettes to learners.
- "Random searches should be done to stop drugs, drinks and gangs from bringing the school to disrepute."
- "Posters depicting honesty, assembly talks on vandalism and theft should be done on a regular basis to instil good habits in the learners."
- Principals should acknowledge the problem of drugs and alcohol at their schools and get social workers and other organizations to have regular talks on the harmful effects of these substances.

It is evident that learner's suggestions to solve the problems ranged from a need for change in attitude of the peers, educators, principals and school governing body members failing which, outside intervention would be sought. Although some solutions offered seemed drastic, e.g. transfer of troublesome peers and replacing problematic teachers, recording these were necessary since they were reflected as major problems of the learners. However, consideration should be given to the very valuable input made by the learners with regard to peers, educators and the school as a whole.

A more in-depth account of learners' concerns will be elicited from the semi-structured interviews that were conducted for the purpose of elaborating on the learners' concerns.

6.9 RESULTS AND DISCUSSION: SEMI-STRUCTURED NTERVIEWS

6.9.1 Introduction

Ten high scorers were selected from the sample schools. It was discovered that two of the learners had failed and left school. This necessitated a selection of two more learners. On the day of the interview, two learners were absent. Eventually eight learners participated in the interview. Relevant biographical information for the

twelve learners is summarized in Table 6.3 and includes race, age, gender, date of interview, school attended and place of interview. In accordance with the participant's right to privacy, pseudonyms have been used to protect identities.

The interview with each participant, illustrating his/her unique contribution was included. A technical error prevented the recording of the interview with a participant named Duduzile. However, a detailed record immediately after the interview enabled the researcher to capture the main themes and quotes. This will be included in the chapter.

6.9.2 Biographical Information on Participants

6.9.2.1 Learners' Race, Age, Gender and School attended

The age of participants ranged from 16 years to 21 years, and is reflected in Table 6.3. The learners were of Indian and African cultural groups only.

Table 6.3 Race, Age, Gender and School Attended of Participants Interviewed for the Study.

Inter-view	Learner	Race	Age	Gender	Date of interview	School	Place/ Remark
1	Tatum	Indian	16	Female	Monday, 3 December	Brookdale S.S.	Conference room
2	Ndouhle	African	19	Female	Monday, 3 December	Brookdale SS	Conference room
3	Mahendren	Indian	16	Male	Monday, 3 December	Solvista S.S.	Conference Room
4	Witness	African	16	Female	Monday, 3 December	Solvista SS	Conference room
5	Fiona	Indian	16	Female	Tuesday, 4 December	Ferndale S.S.	DP'S office
6	Cedric	African	21	Male	Tuesday, 4 December	Ferndale S.S.	Failed - left school
7	Shiva	Indian	16	Male	Tuesday, 4 December	Ferndale S.S.	DP'S office - failed
8	Duduzile	African	17	Female	Wednesday, 5 December	Crystalpoint S.	DP'S office

Inter-view	Learner	Race	Age	Gender	Date of interview	School	Place/ Remark
9	Simangile	African	18	Female	Wednesday 5 December	Crystalpoint S.	Absent
10	Zempile	African	17	Female	Tuesday, 6 December	Crystalpoint S.	Failed - left school
11	Judy	Indian	16	Female	Wednesday, 7 December	Stanmore S.S.	Conference room
12	Jennita	Indian	17	Female	Wednesday. 7 December	Stanmore S.S.	Absent

According to the Table 6.3, the majority of the learners, except Cedric and Ndouhle, were within the age range of grade 11 learners. It is interesting to note that of a total population of 118 learners displaying depressive symptoms, the highest scorers comprised an equal number of Indians and Africans, namely six Africans and six Indians. Although other research findings concerning gender differences revealed that prevalence of depression in adolescent females were higher than in males, the limitation in the present study was that the number of males in the total sample was fewer. It was therefore not possible to support the actual view of differences in gender despite the data of highest scorers on the BDI being 75% females and 25% males.

Most of the participants expressed their opinions about their parents, peers, siblings and teachers freely. They did not show any reservations irrespective of whether these opinions were positive or negative. Some even indicated that the next participant would be able to confirm issues relating to school if the researcher so desired.

In order to introduce the reader to the possible contributory factors to adolescents displaying depressive symptoms, one of the eight interviews has been selected and presented in a narrative form. Verbatim quotes by the participant have been printed in italics. In addition to this, the verbatim transcript of another interview (with Witness) has been included in appendix D. This will provide the reader with an opportunity to experience the interview as it occurred. These two interviews were included because they provided a detailed insight into the major problems of stresses

and concerns that adolescents are being faced with. All eight interviews were analyzed and formed the data for this study. The themes identified during the interview will be presented in tabular form, followed by an integrative, thematic presentation of themes across the interviewees. The following broad headings were used to relate the narrative.

- Biographical and Family Details
- Family Relationship
- Peer Relationship
- Relationship with School
- Summary

These factors provided texture and were in keeping with the presentation of the qualitative data. Learner's voices were included as a way of authenticating the findings.

6.10 A NARRATIVE AS DESCRIBED BY NDOUBHLE

6.10.1 Biographical and Family Details

Ndouhle is a 19 year old African female, Grade 11 learner. Her parents are college graduates, in the teaching profession and in the age group of 41-45 years. She has two younger brothers and a younger sister. She is the eldest. The family lives in Brookdale, Phoenix, Durban, an area that was for the exclusive use of Indians prior to the dismantling of the Apartheid structure.

6.10.2 Family Relationship

Ndouhle stated that since her parents were quarreling all the time, there was not much communication in her home. Their expectations were too high but as a Grade

11 learner, she was not allowed sufficient time to complete her homework or study. She was expected to do all the household chores before beginning with her own studies. In order to have some time in the afternoon she decided to clean the house in the morning, before leaving for school. This was not working out for her as the house was messed by her younger siblings when she returned from school. This frustrated her. Although her parents earned a good salary i.e. R 3999-R4999 per month, family outings were minimal. There were no resources, e.g. computer, books etc. that she could use for her studies. She had to study in the lounge. She preferred staying with her aunt in Pinetown because it was quiet and peaceful there and she could study properly.

She stated that her parents did not support her in her studies. When she did try to study at home her parents always asked her to do some tasks and if she refused they replied:

"When we were studying, our parents expected us to do the work at home also and we could not refuse. We still passed with good results."

Ndouhle strongly believed that her parents would not change as clearly indicated by the following remark:
" They are the kind of people you cannot talk to, beside they don't listen when I talk about my needs. You should do what pleases them."

6.10.3 Peer Relationships

She indicated that she did not trust her peers as they always gossiped about her, this hurt her feelings and ended in numerous arguments. She was very disturbed since her friends only paid attention to her when others were absent and they had nothing else to do. Although she had one friend, she could not discuss her personal problems with her. She felt that her friend did not have a boyfriend therefore she would not be able

to appreciate the problems that she was facing. The only person she confided in was her boyfriend. She felt her peers treated her differently because she was an African. She was very conscious of her race. She indicated that the African learners behaved very badly and she felt ashamed about it. She felt hurt and abused by her peers and siblings and therefore preferred being alone most of the time.

6.10.4 Relationship with School

Her performance compared with the previous year was poor. Although she was trying hard she was not coping. She failed many subjects that she had passed previously. She said, "My school work has made me lose hope." She actually found school to be frustrating and all the work was stressing her. There was no counselor at school and the library was not operational. There was no educator with whom personal problems could be discussed and help received. The prevalence of theft at school was worsening. Overcrowding of classrooms made it impossible to get individual attention. The situation at school in most respects did not help to improve her performance. She indicated that she was attending school "for the sake of her parents".

6.10.5 Summary

Ndouhle was a very confident girl who spoke freely about all aspects that were questioned. She displayed symptoms of depression at the time when the questionnaire was administered. She was 8 months pregnant and was afraid of the future. Her parents were extremely angry with her and gave her no support. She was also concerned about her studies. Her grades were dropping. She has her baby now and although some of the fears that were prevalent at the time of her pregnancy had been sorted out, she has an additional problem of caring for her baby, coping with the household chores and finding time to study. As a result she felt uncomfortable and stressed all the time. If she turned to school for comfort, her peers made her feel

unwanted and at home her parents did not cater for her needs. She asked her aunt to allow her to study at her place but her aunt indicated that the baby would disturb her family. She leaves her baby in the care of a neighbour while she is at school. She expressed concern about the present and could not even think of the future. Her boyfriend's parents were not accepting and asked him to move out and support his baby and his girlfriend. She appeared to be cheerful but stated that,

"I may be showing everyone that I am cheerful, but really I am very sad. I have to cook, clean, look after the baby and then I try to do some studying. This is an impossible task".

She had no knowledge of organizations that could help her if she required it. She indicated that even if she had known of organizations that could be of help, her boyfriend would not allow her to accept it. She had no income and had to wait for handouts from her parents, family and neighbours to keep her baby comfortable.

Themes that emerged from this interview have been summarized in Table 6.4 with verbatim quotes illustrating the categories where possible. Ndoubhle did acknowledge that her problems were often all consuming. The researcher detected a desire for assistance from her boyfriend and his family to lighten her burden. The interview concluded with the hope that there will be a shift of focus placed on the forthcoming crucial examinations.

The narrative analysis has served to familiarize the reader with problems experienced by one participant. Many of the themes that emerged during the content analysis of Ndoubhle's interview were also present in the other interviews. A unit that is a verbatim quotation from the interviews, as selected to illustrate the category. These categories were then grouped into themes. The themes, categories and units were tabulated for each participant to provide an overview of similarities or differences

that were detected among them. An overview of the themes of the interviews can be read in Tables 6.4 to 6.11.

Table 6.4 Themes and Categories Identified During the Analysis of Ndoubhle's Interview

Themes	Category	Unit
Biographical details	Parents	College graduates, educators between 41-45 years old
	Sibling	I have two brothers and a sister. I'm the eldest.
	Residence	I live in Brookdale, Phoenix, KZN.
	Income-parents	R3999-R4999 per month
Family relationships	Communication	Poor, they quarrel all the time.
	Support	None, I'm expected to do household chores and study.
	Outside intervention	I don't know of any organizations. I can only talk to my boyfriend about my problems.
	Perception of parents	"They are the kind of people you cannot talk to"
Peer/sibling relationships	Communication	Poor, friends gossip and hurt my feelings.
	Support	They only accompany me when others are absent.
	Other concerns	I think household chores should be shared among siblings. Peers should be more accommodating and help in difficult times to lighten the burden.
	Perception of peers/ siblings	I don't trust my peers. Siblings don't help.
School	Communication	I can't discuss my problems with the teachers.
	Support	School has no counseling services. I got no support during my pregnancy. I was forced to cope on my own
	Performance	I'm finding it difficult to cope with my studies.
	Perception of school	I find it a very stressful place.

The themes from the content analysis of the interview of Tatum are summarized in Table 6.5. Tatum was outspoken and lived with her stepfather. She was experiencing problems with her biological father and felt responsible for her siblings.

Table 6.5 Themes and Categories Identified During the Analysis of Tatum's Interview.

Themes	Category	Unit
Biographical details	Parents	My stepfather is a graduate, mother matriculated. Father is a manager, mum is a housewife, age group of 30-35 years. My biological father remarried and doesn't care.
	Sibling	I have 3 sisters and 2 stepbrothers.
	Residence	I live in Phoenix, Durban
	Income	R4999-R5999.
Family relationships	Communication	Poor. I don't enjoy a good relationship with my parents.
	Support	I receive no support, care or love from them.
	Outside intervention	I receive no help from outside organizations.
	Perception of parents	My parents are very difficult to please. They refer to me as a "tart" instead of guiding me.
Peer/sibling relationships	Communication	Poor. Friends ignore me when I talk.
	Support	Peers are opportunists. They gossip and mock me.
	Other concerns	As the eldest child, I feel responsible for my siblings but I have no answers when they question me about my father's (biological) lack of interest in us.
	Perception of peers/ siblings	Peers are not to be trusted.
School	Communication	School personnel are not easily approachable.
	Support	My teachers refuse to explain aspects that I find difficult. They are absent often.
	Performance	Poor. I often daydream, don't complete my work.
	Perception of school	Nepotism frustrates and stresses me to such an extent that I lose interest in my schoolwork.

The next participant to be interviewed was Mahendran. He was a soft- spoken lad. He was not happy about the area in which he lived due to the constant sound of gun shots and crime.

Table 6.6 Themes and Categories Identified During the Analysis of Mahendran's Interview

Themes	Category	Unit
Biographical details	Parents	My parents have secondary education. My father is a waiter, between 45-50 years and mum is a housewife.
	Sibling	I have 1 brother and 1 sister. My sister completed grade 12 four years ago and can't find a job.
	Residence	We live in Brookdale, Phoenix.
	Income	Between R500 – R1499 per month.
Family relationships	Communication	We do not communicate effectively. They don't listen to my point of view on any matters. "I like to do something really bad and let's see what happens"
	Support	They don't show me any affection. I'm not sure how they feel about me.
	Outside intervention	I do not get any help from outside organizations.
	Perception of parents	They're poor example of parents. "They don't kiss and hug me to make me feel wanted." Confused!
Peer/sibling relationships	Communication	Peers gossip in class and creates problems for the entire class. No effective communication takes place.
	Support	I only have one friend that I can trust.
	Other concerns	I'm concerned about the racial remarks made at school and the lack of African teachers on the staff. I am very anxious about the forthcoming examinations.
	Perception of peers/ siblings	Friends are not to be trusted. Siblings are problematic.

Themes	Category	Unit
School	Communication	Communication lines are poor. Teachers don't understand me and get angry with me.
	Support	Teachers don't like me for no apparent reason. They spend instruction time talking about their private lives.
	Performance	My performance has deteriorated since conditions such as favouritism frustrates me and I lost interest at school.
	Perception of school	With all that's going on at school I can only say "Hopeless" for "even if we all try to change things nothing will change. It will still be the same, the teachers ways".

The next participant interviewed was Witness. She was a petite, soft-spoken African female who was confronted with many serious problems. She answered fully and felt a sense of relief after the interview. A summary of themes identified from the interview with Witness is presented in Table 6.7

Table 6.7 Themes and Categories Identified During the Analysis of Witness's Interview.

Themes	Category	Unit
Biographical details	Parents	My parents have secondary education. My mother's age is 36 and my father is 46. Mum is unemployed. Father has deserted us.
	Sibling	I have four siblings.
	Residence	I live in Kwa Mashu with my sister who is in Grade 10.
	Income	Nil

Themes	Category	Unit
Family relationships	Communication	Poor. I have not seen my father and my mum is gone back to the farm. We don't communicate.
	Support	I receive no support from my parents. They don't worry about my studies. "They don't really give me anything to make me happy."
	Outside intervention	I get some meals from my neighbours. I don't receive any counseling from the social workers.
	Perception of parents	I get no financial or emotional support from my parents. The situation is hopeless. I worry about what is happening in my life.
Peer/sibling relationships	Communication	My sister is too busy to talk to me at home. Peers are too controlling and don't listen to my story.
	Support	Peers are selfish and neglect me. Since my friends don't understand my problems, I don't discuss anything with them.
	Other concerns	The fact that my sister has left school to support me is a great concern for me. We have to also worry about food and bus fare to go to school. I missed school for three weeks as I did not have any money to travel to school.
	Perception of peers/ siblings	I see peers as someone who is only concerned about themselves. My sister's sacrifice is remarkable. I only hope that I pass so that I can repay her.
School	Communication	I am not able to discuss my problems with my teachers as they gossip. They make racial remarks that anger me.
	Support	Teachers are not supportive. They favour the intelligent learners.
	Performance	It is getting worse because of all the problems.
	Perception of school	Despite the problems at school, I feel happy because the conditions at home are depressing.

The discussion with Witness was followed by an interview with Fiona. She was forceful in her views and opinions. The themes from her interview are reflected in Table 6.8

Table 6.8 Themes and Categories Identified During Analysis of Fiona's Interview.

Themes	Category	Unit
Biographical details	Parents	My parents completed grade 12 and are in the age group of 41-45 years. My father is a builder and mum is a housewife.
	Sibling	I have two brothers and two sisters.
	Residence	I live with my mum in Phoenix.
	Income	My mum earns between R1500-R2999.
Family relationships	Communication	Poor. I'm unable to confide in my mother or discuss any matters with her.
	Support	I get no help from my parents. They don't cater for my needs.
	Outside intervention	I don't get help from outside organizations.
	Perception of parents	Problematic. Mother is divorced and still trying to come to terms with it and therefore is not concerned about the children.
Peer/sibling relationships	Communication	I often get into arguments and have a poor relationship with peers. The situation stresses me.
	Support	They do not help me with my problems. They are selfish and judgmental.
	Other concerns	I worry about my little sister as she has many years to spend at home with my problematic parents.
	Perception of peers/ siblings	I don't trust them. They hurt my feelings. They think I'm irresponsible and that they are more intelligent.
School	Communication	Teachers don't understand me and are often angry with me.
	Support	I don't get support because I daydream in class and this angers the teachers. They don't repeat aspects not understood by me.
	Performance	My commitment to learn is very bad. I don't complete my work in class.
	Perception of school	Boring! I lack interest in school.

The next participant to be interviewed was Shiva, a soft- spoken nervous lad who took a few minutes before he settled in and relaxed. He had failed his final examination and was very disturbed. Themes from the content analysis are summarized in Table 6.9

Table 6.9 Themes and Categories Identified During the Analysis of Shiva's Interview.

Themes	Category	Unit
Biographical details	Parents	Both my parents have secondary education. My mum's age is between 36-40 and my dad's is 41-45 years. My father is a supervisor and my mum is a housewife.
	Sibling	I have two brothers and a sister.
	Residence	I live in Phoenix, Durban.
	Income	+R 9000.00 per month.
Family relationships	Communication	There is no communication at home. We don't go anywhere together. This type of life troubles me and I often cant fall off to sleep.
	Support	I don't get any help from my parents but they humiliate me by discussing my performance.
	Outside intervention	I don't know of outside organizations to help me.
	Perception of parents	'Authoritarian'; no love, care or social outings take place in my house. "I switch off when they are around."
Peer/sibling relationships	Communication	Numerous fights result in poor communication.
	Support	My peers ignore me although I try to please them.
	Other concerns	What is wrong with me that I do not have friends?
	Perception of peers/ siblings	'Uncooperative.' No compassion is displayed. Makes me feel unwanted and lonely.
School	Communication	I lack commitment to work at school because there is poor communication between the teachers and me.
	Support	Teachers are unfair and I don't feel good at school. I'm not happy with the support from teachers.
	Performance	Deteriorating. Grades are dropping due to lack of commitment.
	Perception of school	Not the best place to be. Over-crowding, nepotism and fights are common feature at school

The next participant, Duduzile, was a shy person who indicated that she was feeling worse now as many things happened in her life. Her best friend died of tuberculosis. A summary of the themes identified from the interview with Duduzile is presented in Table 6.10.

Table 6.10 Themes and Categories Identified During the Analysis of Duduzile's Interview.

Themes	Category	Unit
Biographical details	Parents	My father has primary education but mum has no formal schooling. They were between 45-50 years old.
	Sibling	I have 4 sisters.
	Residence	I live in Amouti, Durban.
	Income	Between R1500-R2999.
Family relationships	Communication	Parents are too strict. They don't listen to any problems. My mother is too 'bossy' and demanding. This causes a lot of problems for the family.
	Support	My mother does voluntary work but is not able to help me with the housework so that I can complete my studies. I don't get any help with my studies.
	Outside intervention	I would like to get help but I don't know of any organizations.
	Perception of parents	My mother is "bossy." Father is more understanding.
Peer/sibling relationships	Communication	I am not able to discuss anything I don't have many friends.
	Support	My only friend died. "I don't believe in friends. They trick me. I don't trust them."
	Other concerns	My examinations are a major concern as I have failed three subjects. My mother needs to be told about the importance of studying time for the matriculation examinations.
	Perception of peers/ siblings	True friends are difficult to find so I rather not have any.

Themes	Category	Unit
School	Communication	I am unable to communicate my problems easily.
	Support	I don't enjoy the support of teachers. They are always threatening us. Some teachers have gone to teach in England and we have no one to do the subjects properly. Teachers also threaten us that if we behave badly then they too will leave us and go to teach elsewhere.
	Performance	I can't concentrate. I have failed a few subjects.
	Perception of school	"Too demanding and not supportive"

The last participant to be interviewed was Judy. She was not neatly attired and felt insecure. She was able to furnish all the details required by the researcher. Her parents were having personal problems that were affecting her. She did not have any goals in life and seemed confused and afraid of the future.

Table 6.11 Themes and Categories Identified During the Analysis of Judy's Interview.

Themes	Category	Unit
Biographical details	Parents	My parents have secondary education. Both are in the age group of 41-45. My father works for the Durban Corporation. Mum is a housewife.
	Sibling	I have four sisters and a brother.
	Residence	I live in Phoenix.
	Income	R1299-R2999 per month

Themes	Category	Unit
Family relationships	Communication	Poor. Parents are engrossed in their own problems and have no time for us.
	Support	I don't receive any support from my parents.
	Outside intervention	Social welfare organization has intervened due to the divorce of my parents and the problems at home.
	Perception of parents	I think they are selfish. As parents their duty is to provide for their children. Their personal problems are passed onto us.
Peer/sibling relationships	Communication	I have many arguments with my peers. No proper communication takes place to resolve issues. They tend to mock and ignore me.
	Support	No support is forthcoming. "Some of them make me feel like I'm not worth it." I am hurt at their behaviour and feel neglected.
	Other concerns	Problems at home would be easier to cope with if I had a few understanding and compassionate friends.
	Perception of peers/ siblings	'Opportunists' I am willing to do things to please them and they take advantage of it. Siblings are too small to understand the problems at home.
School	Communication	There is not much communication among the teachers and the learners. Most of them ignore me. I feel disappointed and lonely.
	Support	I don't receive any support from my teachers. They tend to favour those learners that they like.
	Performance	My results are getting worse as I daydream and don't complete my work for the day.
	Perception of school	The thought of going to school makes me sick. The environment needs to improve for me to feel better at school.

6.11 INTEGRATION OF THEMES IN RELATION TO HOME AND SCHOOL CONTRIBUTORY FACTORS

The themes presented in this study were the results of content analysis and where possible have been grouped together to project themes and sub-themes. All the participants in this study had displayed depressive symptoms as determined on the BDI. Although the various themes were presented in Tables 6.4 to 6.11 the findings will be integrated in relation to the contributory factors i.e. at home and in school.

It is now widely recognized that depression during adolescence has a tendency to occur with other disorders such as internalizing problems (e.g. anxiety/stress) and externalizing problems (e.g. aggression) (Compass, Connor & Hinden 1998). Stress refers to the amount of perceived 'pressure' that is experienced in various situations, and the lower the sense of perceived efficacy, the greater the sense of stress (Daya, 2001). Stressful events representing different life domains (e.g., family, peer relationships, academic achievements) have been compared in their association with depressive phenomena (Reynolds & Johnston, 1994). 'Stress', which was discussed as one of the psychosocial factors contributing to depressive symptoms in the literature review, seemed to be a common problem with all participants. All participants in the interview were stressed about school and their studies. Mahendran, Ndoubhle, Witness and Tatum indicated that the racial remarks, lack of support structure and favouritism at school were very stressful and they could not cope with their studies. Mahendran described his school situation as "hopeless". All participants expressed disappointment at the lack of support from their teachers. The findings related to school conditions that resulted in academic stress should be of great concern to the Department of Education and Culture. Learners have a right to supportive structures; stimulating sporting activities and committed educators. Research has shown that adolescent sport involvement was associated with less depressed mood, higher levels of achievement, and more social activities (Mechanic & Hansell, 1987). These variables can be monitored and learners should be assessed continuously to enable them to benefit maximally from the education system. Further

investigation into school and study related stress among adolescents is recommended.

Perceptions of the home and school were elicited from the content analysis and two themes were derived from the interviews. The first theme related to the home where family relationships including siblings, communication, support, outside intervention and perceptions of parents were investigated. The second theme related to the school and included peers, communication, support, performance and perceptions of school.

6.11.1 Themes Related To Home: Family Relationships

- **Sub-theme: communication in the home**

All the participants indicated that the communication in their homes with parents were poor. Parents were either too busy, too engrossed in their own problems or too strict to allow discussions with family members to resolve issues. Some parents did not want to listen to their children's point of view. Mahendran reacted negatively to this type of behaviour and said "I would like to do something that is really bad and let's see what happens." Witness was in an unfortunate position because she had not seen or heard from her parents since her mother had returned to the farm. Constant quarrels in Ndoubhle's home added to an unpleasant atmosphere and poor communication. The recognition of problems of this nature could be an important aspect in promoting proper communication.

- **Sub-theme: support structure in the home**

Effective support structures are of paramount importance for the harmonious functioning of a family. The findings from the interviews revealed that none of the learners' parents helped them with their school work. Female learners complained that they were expected to complete their household chores and then continue with their studies. They were often tired and unable to complete their studies. This got

them into trouble at school. One participant (Witness) said "they don't give me anything to make me happy." Many of them complained that their siblings were not helpful. All adolescents require strong support structures to guide them along this "terrible teens" period. The siblings were described as 'unhelpful".

- **Sub-theme: outside intervention**

It was interesting to note that none of the interviewees, except one learner (Judy) knew about a social organization that could render assistance when required by the community. She was aware of this only because her parents were divorced and were experiencing personal problems which necessitated the intervention by the social workers. Witness was given some assistance from her neighbours and Ndoubhle depended on her boyfriend when she encountered problems. This is an area that requires further investigation and all learners should be made aware of organizations that could be of assistance to them in difficult times.

- **Sub-theme: learners' perceptions of their parents**

The general perception was that parents did not do much to improve the lives of their offspring. They failed in their duty as parents by not providing love, care and support. Judy referred to them as "selfish" because they allowed their problems to impact negatively on their children. Shiva described his parents as "authoritarians" and "switched off when they were around." Poor perceptions and negative descriptions of parents make it necessary for change to take place to prevent the family becoming totally dysfunctional.

6.11.2 Themes Related To School And Peer Relationships

- **Sub-theme: communication with peers**

Most participants indicated that peers were not to be trusted. They gossiped, hurt their feelings, were too demanding and had too many arguments. Witness found peers to be too controlling.

- **Sub-theme: support from peers**

All participants expressed disappointment in peers. Fiona and Witness described them as "selfish." Ndoubhle was disappointed with friends because they were friendly with her only when their other friends were absent. They were "opportunists." One interviewee stated, "I don't believe in friends. They trick me. I don't trust them." Acceptance by peers is an essential part of adolescent development and education personnel should encourage this aspect at all schools.

- **Sub-theme: other concerns**

All the participants expressed concerns in their lives that were not allowing them to lead a carefree and enjoyable life. Reasons offered varied from too many chores that were limiting their study time to experiences of racism. It was very interesting to note that, despite the problems learners experienced, (Tatum and Fiona) they still had the caring qualities and expressed the need to be responsible for their siblings who were unfortunately placed in problematic situations. Judy expressed a desire to have a sincere friend who could help her cope with the stressful situation that prevailed at home.

- **Sub-theme: perceptions of peers**

Negative reactions were reflected by all the participants in the interview. Only two learners (Ndbouhle and Mahendran) indicated that they had one friend each. However, Ndbouhle was not comfortable with discussing her problems with her friend as indicated in her narrative. Majority of the learners stated that friends were not trustworthy, they were selfish, uncooperative, opportunistic and it was not worth having them.

This type of situation is a matter of concern to all stakeholders in society because social support is directly related to well being and it counters the effects of unusual stress (Rice, 1996). Adolescents rely on their friends for a sense of self-worth. Many adolescents are insecure and anxious about themselves; they lack secure identities

and they gain strength from their friends. Association with friends leads to the development of the necessary personal and social skills that help them to become a part of the adult world (Gouws, Kruger & Burger, 2000).

- **Sub-theme: communication at school**

All participants indicated that communication at school was poor. Teachers were not easily accessible. If learners discussed their problems with teachers, they later found out that the other teachers in the staff knew about their problems and some even mocked them. Fiona stated that teachers did not understand her and often got angry with her.

- **Sub-theme: support at school**

Based on the type of communication that learners and teachers engage in, one can conclude that support structures will also be of a poor quality. All participants expressed disappointment at the lack of support from their teachers. It is shocking to note that some teachers used threats of leaving the learners to teach in another country if they behaved badly or were problematic in class.

- **Sub-theme: performance at school**

Responses from learners ranged from 'grades are deteriorating' to 'poor.' They found it difficult to cope with their studies and often daydreamed and lacked commitment. Duduzile failed three subjects and although anxious about it, there was not much she could do to improve. She did not get any support from her parents or her teachers.

- **Sub-theme: perceptions of school**

All participants had negative feelings about school. Some of the comments worthy of noting were that "it was a stressful place, it was a boring place, it was too demanding and not supportive". Witness indicated that despite the problems she felt 'happy' at school since her home environment was worse.

Adolescents spend a considerable amount of time in school where they learn, develop skills and make friends and prepare and plan for the future. The negative perceptions described above will not enable these learners to achieve these objectives. It is important for educators and the school to provide support to all learners in order for them to achieve their objectives in life.

It is evident that professionals i.e. educators and non-professionals i.e. parents and peers were failing to execute their duties and a group of adolescents were passing through very difficult times with no assistance. The reader has been introduced to the home and school environment of the learners as elicited and understood by the researcher. It is evident that all the factors overlap in the adolescent's life. These and other relevant findings from the qualitative study were combined with the findings of the quantitative study in the final chapter.

6.12 CRITICAL QUESTIONS – SUMMARY OF FINDINGS

The aim of the qualitative study has been achieved. From the discussion it is evident that the learners were experiencing various problems in their homes and schools that impacted negatively on them. This can be seen in the discussion of the critical questions that follow:

- **What is the prevalence of depressive symptoms in adolescents?**

An analysis of the results of the Beck Depression Inventory revealed that 137/566 (i.e.24.2%) showed symptoms of depression by scoring between 19 and 29. However, 19 /137 did not return the follow-up questionnaire so the researcher's sample comprised 118/566 of the learners to proceed with the research.

This meant that 20.84% of the sample was investigated as showing symptoms of depression.

- **What factors in the home contribute towards depressive symptoms?**

The analysis of the survey questionnaire indicated that low income of parents prevented provision of satisfactory study facilities. Many learners complained about sharing their rooms, not having proper study facilities and being over-burdened with household chores. Poor communication and autocratic attitudes by their parents made life for these learners unpleasant. An analysis of the interview revealed total dissatisfaction by all participants concerning parents and siblings. Siblings were considered to be unhelpful and too "bossy". Poor parental attitude, lack of support structures, and not providing love and care resulted in stressful situations. Information on drugs and alcohol abuse, although not included in the survey questionnaire or the interview, were expressed as great concern by a proportion of the learners. These factors impacted negatively on the adolescent's academic achievement and social development.

- **What factors in school contribute towards depressive symptoms**?

The qualitative analysis revealed that peers were not trustworthy. They were perceived as selfish and opportunistic. The communication at school was poor. Educators were not supportive and favoured certain learners. This created an unpleasant environment at school. Other learners indicated that they could not understand the reason for being disliked by the educators. These conditions led to a negative self-concept that not only adversely affects the mental well- being of the adolescent but also influences social relationships with others and academic progress. The present situation was stressful to the learners and led to their performance deteriorating. The quantitative analysis indicated that 24 (31.6%) of the females did not complete their work in school and 12 (16%) felt that their teachers

did not understand them. Eight (20.5%) males and 18 (23.7%) females stated that their school-work was getting worse.

- **What are the suggestions made by adolescents to improve the prevailing conditions?**

Various suggestions were made by the learners to improve the conditions at home and at school and were discussed in detail in Chapter Five. However, many learners were convinced that there was nothing that could be done to make changes as their parents and teachers did not listen to them. A selection of suggestions made by learners will be included in the final chapter.

Chapter Seven concludes this study. In the final chapter the findings are summarized, limitations of the study discussed, and recommendations made for future research. Throughout the report reference has been made to the purpose of the study and the critical questions that guided the research. The concluding comments are a condensed summary of all the discussion that has already taken place. In order to maintain consistency, the purpose of the study will be reiterated and critical questions answered in an integrated discussion of all the findings.

CHAPTER SEVEN

FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

7.1 INTRODUCTION

As indicated in Chapter One, the purpose of the study was to determine the prevalence of depressive symptoms in adolescents, to identify the contributory factors and utilize the learners' insights into their own situations to develop appropriate strategies.

Quantitative and qualitative methodologies were selected for the purpose of this study. The aim of the combined studies was not to compare methodologies and their respective results, but to allow the one to complement the other to provide an overall picture of the adolescents who were displaying depressive symptoms and to identify the factors that contributed to it. The distinguishing feature of quantitative evidence is seen as manipulation of numeric data, and that of qualitative analysis the development and manipulation of concepts (Temple, 1997). The qualitative research is often exploratory in its objective and is sometimes used to generate hypotheses while qualitative studies are designed to test them. Because of their different applications, the two types of research are frequently viewed as complementary (Smith, 1999). Detailed findings of each methodology used in this research were reported in the appropriate chapters.

7.2 FINDINGS OF THE PRESENT STUDY

The results of the present study showed that 118/566 (20.84%) of the Grade 11 learners displayed symptoms of depression. The "depressed sample" was made up of 43 (36.4%) Africans and 75 (63.6%) Indians. Forty- one (34.7%) males and 77 (65.3%) females made up the sample. The gender difference is in accordance with

findings of other studies. Albert and Beck, (1975) noted an increase in depressive disorders and a change in gender ratio during adolescence. Females showed more depressed affect by age 14 –15 years and this persisted into adulthood (Petersen et al., 1993).

The sample lived in a low socio-economic environment where the educational level of the majority of the parents' ranged from primary school to completion of matriculation examination. However, their occupation placed the majority of the parents in the low- income bracket of R500.00 to R2999.00 per month. This prevented parents from being able to provide their children with certain necessities e.g. a study or a bedroom where uninterrupted studying could take place. Parents' occupation also required them to be away from home for long hours resulting in little or no quality contact time with their children. Majority of the Africans (87.7%) and Indians (57.3%) shared their bedrooms and expressed their dissatisfaction regarding the prevailing conditions at home. This is evident in the large percentage (74.4%) of the African and 42.7% of the Indian learners complaints that they had to wait until all members of the family were asleep before commencing with their studies.

A significant percentage of the males and females reported dissatisfaction with cleanliness of the school (29.3% males and 30.3% females), the school furniture (19.5%) males and 31.6% females), behaviour of their classmates (29.3% males and 20.0% females) and their performance in class (19.5% males and 16.0% females). Learners also expressed disappointment in the large number of learners in class and the poor support they received from their librarian and counsellors.

A poor relationship existed between learners and educators. Learners complained that educators were unsympathetic to their personal problems and were not willing to extend a helping hand when academic difficulties were experienced. Learners perceived the educators as uncommitted to their work and wasted the instruction time by talking about their personal lives. Favouritism displayed by educators

angered most of the learners. Educators should exercise racial tolerance and encourage learners at all times.

Impaired interpersonal functioning with parents, siblings, peers, and educators was evident among males and females of both races in the quantitative analysis and very prominent in the qualitative analysis. All participants in the interview expressed extreme disappointment at the lack of support from all these groups and individuals. This study raised various issues that can be explored further, such as commitment of parents, siblings, peers, educators' and social organisations towards reducing stress, alleviating the factors that led to depressive symptoms in adolescents thereby creating a congenial environment for all.

7.3 LIMITATIONS

The limitations of qualitative and quantitative studies were discussed in the findings of the different research methodologies. The main limitation of this study was that the sample was focused in one area only. The pre-apartheid "Indian" area and the cluster sampling did not make allowance for an equal number of African and Indian learners to be incorporated in the research. Ideally, a cross section of all cultural groups should have been included.

A matched sample although identified, was not investigated. The researcher concentrated on obtaining an in-depth knowledge on prevalence of depressive symptoms, factors that may have impacted on learners displaying depressive symptoms and their perceptions of suggested solutions to their problems only.

Although the literature review included substance abuse; school conduct; suicide; and delinquency as significant factors, however, the scope of the study did not permit an investigation of these factors. This research was confined to relationships between parents, peers/siblings, school and educators.

A cut off score of 19-29 for 'moderate" depression, according to Beck, Steer and Garbin (1988) was used and yielded 118/566 i.e. 20.84% as showing symptoms of depression. If "mild" cut off scores of 10 to 18 were used, a total of 194 (34.27%) of the adolescents fell in this category, and this large sample that was identified would have been beyond the scope of the present study.

7.4 RECOMMENDATIONS

Learners recommended a variety of suggestions that could be implemented to improve the prevailing situation they were faced with. Although these suggestions were more like a set of hopes or desires rather than sophisticated strategies, they gave an insight into their expectations of an ideal home and school life. Learners concerns about poor communication between parents, peers/siblings and educators were explicitly expressed.

Poor attitudes of all these individuals needed to be addressed. Learners desired a more pleasant atmosphere at school that was conducive to learning and would result in an improved academic performance. Co-operation by family members would make life more enjoyable for all at home.

Many programs have been designed to disseminate knowledge and to provide interventions for depression and suicide in the schools; however, little information exists about programs designed to raise teacher and school personnel awareness. Globally, in developed and developing countries alike, mental illness and health-damaging behaviours exact a tremendous toll in human suffering, evident in the distress and despair of individuals, the anguish of their families, in the social and economic costs due to lost productivity and increased use of medical aid. The tragedy is even greater because much of it could be avoided were we to commit ourselves to applying what we know and learning what we don't about prevention and treatment (Desjarlais, Eisenberg, Good and Kleinman, 1995).

- **EDUCATORS**

The quantitative findings of the current study indicated a need for better support structures at schools. The qualitative study drew attention to the extremely poor perceptions that adolescents in the interview had of their school and their educators. Educators are characterized as the "immediate transmitter, contact, and instrument of schooling" (Murphy, 1987). In addition to formal instruction, educators provide students with help in other aspects of their lives. Because of this potent combination of formal and informal influence, educators can be powerful resources for the development and continuity of intervention. Empowered educators who are trained to recognize the markers of adolescent depression and are able to approach and refer them to a central person such as guidance counsellors or social workers for initial screening and treatment will assist emotionally disadvantaged learners towards better adjustment. As a consequence, scholastic performance adversely affected by emotional problems would probably improve.

Smaller school size; opportunities for peer interaction; an orderly and non-oppressive school atmosphere; an emphasis on academics; teacher expectations for student mastery; and classroom management strategies should be the focus of the school. Specific educators should be encouraged to develop significant informal relationships with various learners who are often not involved in the more ongoing life of the school. Athletic programs, interest clubs, can provide opportunities for learners to gain skills, experiment with role structures, and enhance self-esteem (Newman & Newman, 1987). Schools can have courses in family living, psychology courses, or club hours that would allow preventative intervention programs to be integrated into an exciting curriculum. The
curriculum should be designed for adolescents to increase competence in decision-making and problem solving skills and to identify strengths within themselves. Educators should give special attention to ways in which a learner's depression may

affect and be affected by school performance. Parents, school personnel, community leaders, social workers and nurses should be invited to the class as consultants to participate in problem-solving workshops

Learners suggested that there was a need for educators to change their attitude, be objective and committed to their profession. Educators should accept all cultural groups and refrain from discussing personal issues during instruction time. Principals and school governing body members should adopt stricter measures with regards to vendors, drug trafficking, theft, discipline and cleanliness of schools.

- **PARENTS**

The quantitative findings of this study indicated that family environmental factors i.e. parental conflict, low socio-economic status and poor, overcrowded living conditions impacted negatively on the adolescents. The use of the bedroom or lounge to study necessitated the adolescent waiting for long hours for family members to fall asleep before commencing with their studies. This is reflected in the fact that 74.4% of Africans and 42.7% of the Indians in the sample had to wait for all to fall asleep before they could study. A better studying and living environment would help in improving the situation. The majority of the learners in the sample lived on an income of between R500 and R1499. The psychological factors that included the influences of interpersonal relationships such as lack of closeness, low self-esteem and lack of a supportive role by parents were evident in this study. Learners stated that their parents did not show them any love or affection. The qualitative findings revealed that their school and home environment were not congenial.

Learners suggested that parents should change their attitudes, treat all members equally and allow them freedom to enjoy their adolescent years. They also suggested that parents should show more affection and create a pleasant home environment. Parents should refrain from being over-protective and demanding.

- **PEERS**

The quantitative findings indicated 60% of the females and 46% of the males were willing to please their peers all the time. This was further supported in the qualitative study, as learners stated that they experienced problems with peers despite efforts made to please them. Peer counseling and the creation of peer culture may be useful methods of decreasing depression. Needs assessment should focus on multiple areas of functioning, including family functioning, peer interactions, and performance in school settings.

Peers should be encouraged to engage in discussions to resolve problems. Prevention of gossip and undesirable traits in learners could be achieved by the provision of extra-curricular activities. This would encourage learners to spend their time more beneficially and would discourage gossip.

- **SOCIAL ORGANISATIONS**

Not all intervention needs to be costly and complex. Cost effective strategies such as a simple leaflet with issues relating to depression and available social services in the province/country can be circulated to schools. This will assist in dispelling ignorance and creating an awareness about depression in the environment. (See Appendix E)

The qualitative findings indicated a need for social organizations to play a more significant role in the community. Only one participant in the interview was aware of social services that were available. To make the best gains in public health, it is essential to train primary care health workers to recognize depression and to treat it appropriately with drugs and counselling. The cost of effective treatment of depression is offset by the reduction in inappropriate medical visits. If depression is triggered by situational factors and exacerbated by biological vulnerability, significant opportunity exists for multiple levels of prevention programmes e.g. life skills training programmes show promise in providing coping skills to permit young

people to deal with situations that might precipitate depression. Social Service providers should increase adolescents' positive self-perceptions by referral to classes that improve test-taking and study skills. Such classes can improve grades, foster school success, increase overall school involvement, and assist the adolescent to join a positively labelled peer group. Educational programs on the effects of drugs and alcohol on the adolescents' physiology, personality, and social relationships should be conducted on a regular basis by the service providers. These programmes, dealing with the psychosocial problems should target the entire school and not the affected learners only. Educators and learners should be sensitized to the impact of negative labelling such as 'druggies' and should be a part of a general program whose goal is to make the school a more humane place. Preventative programmes by social workers should specifically target learners who are at highest risk for depression, e.g. those with a history of alcohol or drug usage, high family conflict, sexual or physical abuse, parents who are depressed and suicidal themselves. School nurses and social workers could be invited as consultants to participate in a problem-solving workshop. Class time may include defining a specific problem followed by a behaviour rehearsal of responses with the teacher, parent, or community leader and learner rehearsal of various scenarios and outcomes.

7.5 CONCLUSIONS

Well - trained practitioners are scarce, drugs and psychosocial interventions are unavailable or of poor quality, and even where expertise and resources exist, they seldom reach into the communities where the needs are greatest. The human rights of the mentally ill are often severely compromised, and mental health care is too often associated with social control. Innovative programs, financial investment, and creativity are needed to build programs that join local resources with professional knowledge. World Mental Health recommends improvements and innovations in mental health services for children and adolescents, in early detection and prevention of mental disorders, and in educational programs.

A support system should combine nurturance and feedback i.e. it should not simply be a process of giving of resources or nurturance but they must be coupled with feedback, guidance, and information. The care of the mentally ill should be discussed in national and regional health plans, including clear description of activities to be undertaken and appropriate budgetary allocation.

The future prosperity of all countries depends on the health, education and training of young people. Unfortunately, trends in mental disorders among children and adolescents have worsened in both rich and poor countries. To counter these trends, mental health services for children, must be integrated into all forms of health care. Priority must be given to cost-effective services that meet local needs. South Africa, a young democratic country, is undergoing social patterns of change since the abolition of apartheid in 1994. The resultant uncertainty that is being experienced by the adolescents may be overwhelming and may increase the risk of emotional disorders amongst them.

Our challenge is to develop innovative programs which provide bridge between mental health providers and school personnel to optimize the transfer of knowledge about psychosocial and behavioural problems, empowering them to eradicate symptoms as soon as observed, by counselling or referral.

At the level of curricula intervention schools should include courses in family living, psychology courses, or club hours that would allow preventative intervention programs to be integrated into existing curriculum. Curriculum units should be defined as increasing competence in decision-making and problem solving. When a competence - building programme is integrated into an existing curriculum, the learner and his family may view involvement and achievement in it as being equally as important as other areas of the curriculum. Such modifications in programme delivery minimize issues regarding family shame and reluctance to accept help. Curricula should to be designed to identify strengths within learners and areas they

assess as requiring support. Content on competence building should focus on enhancing the learners' internal sense of locus of control by increasing coping strategies such as problem-solving skills and methods of conflict resolution. This will lead to learners being less depressed and having a greater potential for increasing life choices, experiencing heightened self-esteem, and feeling of competence. Secondary prevention efforts include early problem solving, crisis intervention and referral for mental health treatment. Linkages between the school and the community based mental health services should be established. A crisis hot line staffed by peers, parents and other volunteers should be established.

Although school systems alone may not have the capacity to intervene effectively for all manner of depressive disorders, their isolation from community services certainly exacerbates the problem (Land & Levy, 1992). Implementing and institutionalizing programs such as those described in this chapter will serve to enhance the well-being of adolescents in ways that are institutionally feasible and developmentally appropriate.

It is clear that depression is a major, pervasive, and perhaps rapidly increasing problem for adolescents. There is however a need for a more extensive knowledge base to guide action. Significant morbidity of adolescence and adulthood could be ameliorated by attention to adolescent depression.

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APPENDICES

Appendix A: Correspondence

A.1 A copy of letter from the Department Of Education and Culture granting the researcher permission to conduct the study at schools.

A.2 A copy of a letters to the principals explaining the purpose and nature of the study and requesting permission to conduct the research.

A.3 A copy of a letter to the parents of learners requesting their permission to administer the research instruments to the learners

A.4 A copy of a letter to the Governing Body Chairperson requesting permission to conduct research at school.

APPENDIX B: Instruments used

B.1 Beck Depression Inventory

B.2 Survey Questionnaire

B.3 Semi-Structured Interview Schedule

APPENDIX C: Statistical Analysis

C.1 Cross tabulation by variables *

C.2 Frequencies*

C.2.1 Pre test frequencies*

C.2.2 Pilot Test frequencies*

C.2.3 Main Sample frequencies*

C.4 Means and standard deviations

C.5 Chi squares

C.5.1 Chi Square statistics: Cross tabulation of residential area by race

C.5.2 Chi Square statistics: Cross tabulation of residential area by gender

C.5.3 Chi Square statistics: Cross tabulation of sample sharing bedrooms by gender

C.5.4 Chi Square statistics: Cross tabulation of sample sharing bedrooms by race

C.5.5 Chi Square statistics: Cross tabulation of sample according to rooms used for studying by gender

C.5.6 Chi square statistics: Choice of place for completion of homework according to race

C.5.7 Chi Square statistics: Cross tabulation of preferred time for studying by gender

C.5.8 Chi Square statistics: Cross tabulation of preferred time for studying by race

* Raw Data that was not relevant in the final copies of the dissertation.

APPENDIX D: Tables

D.1 Distribution of "Depressed Sample" Parents/Guardians by Age and Race

D.2 Distribution of "Depressed Sample" Parents/Guardians by Gender

D.3 Frequency and Valid Percentages of Parents and Guardians Level of Education

D.4 Choice of Place for Completion of Homework According to Gender

D.5 Evaluation of School Environment by Gender

D.6 Evaluation of School Environment by Race

D.7 Cross Tabulation of Relationship with Parents by Gender

D.8 Cross Tabulation of Relationship with Parents by Race

D.9 Cross Tabulation of Learners' Relationship with Peers/ Siblings by Gender

D.10 Cross Tabulation of Learners' Relationship with Peers/ Siblings by Race

D.11 Cross Tabulation of Learners' Relationship with the School by Gender

D.12 Cross Tabulation of Learners' Relationship with the School by Race

APPENDIX E

Leaflet

APPENDIX A

CORRESPONDENCE

Republic of South Africa
Republiek van Suid-Afrika

EDUCATION AND CULTURE SERVICE
ONDERWYS EN KULTUURDIENS

(EX ADMINISTRATION: HOUSE OF DELEGATES)
(EX ADMINISTRASIE: RAAD VAN AFGEVAARDIGDES)

A.1

☎ (031) 3606911 Fax: (031) 374261

Truro House
Trurohuis
17 Victoria Embankment
Victoria Embankment 17
Private Bag X54323
Privaatsak
DURBAN
4000

Ref. No. A10/29/2/30
Verw. No.

Enquiries V. Abhilak
Navrae

1994-09-13

Ms R.D. Gajadhur
12 Duffy Crescent
AVOCA
4051

Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL SCHOOLS
Your letter dated 1994-07-15 and undated letter received on 1994-09-12 have reference

1. Permission is hereby granted to you to conduct your research at the 17 schools indicated in your letter provided that :

1.1 prior arrangements are made with the principals concerned;

1.2 participation in the research by educators and pupils is on a voluntary basis;

1.3 completion of questionnaires is done outside normal teaching time; and

1.4 all information pertaining to pupils and educators is treated confidentially and used for academic purposes only .

2. Kindly produce a copy of this letter when visiting/approaching schools.

3. The Department wishes you every success in your research and looks forward to receiving a copy of the findings.

Yours faithfully

EXECUTIVE DIRECTOR

940916/search/tm

A.2

59 BELMONT ROAD
EFFINGHAM HEIGHTS
DURBAN
4051
02/02/01

Dear Principal,

I am a student at the University Of Durban Westville, School of Educational Studies, currently studying towards a Doctorate Degree in Education.

My research requires me to administer a test to all Grade 11 learners at the selected schools. A structured questionnaire as a follow up process will be administered to those learners who score high on the first test.

The purpose of my study is to determine the prevalence of depressive symptoms in adolescents, establish the contributory factors and make recommendations to improve the prevailing conditions. This research is supervised by an Educational Psychologist. She will provide a follow- up service at the University of Durban Westville for learners who have problems and request assistance.

Your school was selected through a process of cluster sampling.
I seek permission to conduct my research at your school.

I enclose a letter from the Department Of Education And Culture granting me permission to conduct the research study in Departmental Schools.

If you require further information, please contact me at the following numbers:
School: 5075817
Home: 5633624 / 0829596009

Yours faithfully,

....

R.D.GAJADHUR DATE

A.3

59 BELMONT ROAD
EFFINGHAM HEIGHTS
DURBAN
4051
02/02/01

Dear Parent,

I am currently a student at the University Of Durban Westville, School of Educational Studies, studying towards a Doctorate in Education. My research requires me to administer a test and a questionnaire to all Grade 11 learners.

The purpose of my study is to determine the prevalence of depressive symptoms in adolescents, establish the contributory factors and make recommendations to improve the prevailing conditions.

My research is supervised by an Educational Psychologist. She will provide a follow-up service at the University Of Durban Westville for learners who have problems and request assistance.

Some of the items may be sensitive information but will remain strictly confidential and used only for research purposes.

The results of this study will assist parents and teachers with information to provide a supportive environment for learners who experience symptoms of depression.

I will appreciate it if you will grant me permission to administer these instruments to your child.

Your's Faithfully

.....

R.D.GAJADHUR

PARENT'S REPLY SLIP.....PLEASE TEAR AND RETURN.....

I,Mr./Mrs.....parent/guardian of .....Grade 11.... .. ..

grant permission to my child/ward to complete the test and the questionnaire for the benefit of Research and Education.

.....

Parent's signature

A.4

59 BELMONT ROAD
EFFINGHAM HEIGHTS
DURBAN
4051
02/02/01

Dear Chairperson, (S.G.B.)

I am currently a student at the University Of Durban Westville, School Of Educational Studies, studying towards a Doctorate Degree in Education. My research requires me to administer a test and a questionnaire to all Grade 11 learners in secondary schools. An interview may be required with a learner also.

The purpose of my study is to determine the prevalence of depressive symptoms in adolescents, establish the contributory factors and make recommendations to improve the prevailing conditions.

My research will be supervised by an Educational Psychologist. She will provide a follow-up service at the University of Durban Westville for learners who have problems and request assistance.

Some of the items may be sensitive information but will remain strictly confidential and used only for research purposes.

The results of this study will assist parents and educators with information to provide a supportive environment for learners who experience symptoms of depression.

The Department has granted me permission to administer these instruments in all secondary schools. I will appreciate it if you will grant me permission to administer these tests at your school as it falls in my sample area.

Yours faithfully

.....
R.D.GAJADHUR.

****

REPLY SLIP PLEASE TEAR AND RETURN

I, Mr. /Mrs. .....chairperson of .....Secondary School grant permission to conduct the research with the learners of the above mentioned school.

....
Chairperson's Signature Date

APPENDIX B

INSTRUMENTS USED

B.1

BECK INVENTORY

Name.....School.....Date.....

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling in the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before you make your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds. I am purposely trying to lose weight by eating less. YES.....NO.....
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

B.2 # QUESTIONNAIRE FOR Gr. 11 LEARNERS (2001)

Dear learner, this questionnaire is to be completed by all Grade 11 learners at the school. The aim of the questionnaire is to gather information that will enable me to design a program to **assist learners who are showing symptoms of depression**. Information disclosed in this questionnaire will be treated with **strict confidentiality** and will be used solely for Research purposes. Please fill in the appropriate details by ticking (✔) in the box (❒) that applies to you. Thank You.

A. BIOGRAPHICAL DETAILS

1. Surname: _____

2. Christian name: _____

3. School: _____ 4. Class: _____

5. Gender 1❒ Male 2❒ Female

6. How old are you?

1❒ 15 yrs 2❒ 16 yrs 3❒ 17 yrs

4❒ 18 yrs 5❒ 19 yrs 6❒ over 19 yrs (specify) _____

B. FAMILY DETAILS

FATHER'S PROFILE

7. Father's Age?

1❒ younger than 30 yrs 2❒ 30 - 35 yrs 3❒ 36 - 40 yrs

4❒ 41 - 45 yrs 5❒ 46 - 50 yrs 6❒ 51 - 55 yrs

7❒ 56 - 60 yrs 8❒ Over 60 yrs

8. Father's Occupation? _____

9. Father's Education Level?

1❒ No schooling 2❒ Primary Education 3❒ Secondary Education

4❒ Matric 5❒ College 6❒ University

7❒ Deceased 8❒ Other _____

MOTHER'S PROFILE

10. Mother's age?

1 ☐ younger than 30 yrs	2 ☐ 30 - 35 yrs	3 ☐ 36 - 40 yrs
4 ☐ 41 - 45 yrs	5 ☐ 46 - 50 yrs	6 ☐ 51 - 55 yrs
7 ☐ 56 - 60 yrs	8 ☐ Over 60 yrs	

11. Mother's Occupation ? _____

12. Mother's Education Level?

1 ☐ No schooling	2 ☐ Primary Education	3 ☐ Secondary Education
4 ☐ Matric	5 ☐ College	6 ☐ University
7 ☐ Deceased	8 ☐ Other_____	

GUARDIAN'S PROFILE

13. Guardian's Age?

1 ☐ younger than 30 yrs	2 ☐ 30 - 35 yrs	3 ☐ 36 - 40 yrs
4 ☐ 41 - 45 yrs	5 ☐ 46 - 50 yrs	6 ☐ 51 - 55 yrs
7 ☐ 56 - 60 yrs	8 ☐ Over 60 yrs	

14. Guardian's Occupation? _____

15. Guardian's Level of Education?

1 ☐ No schooling	2 ☐ Primary Education	3 ☐ Secondary Education
4 ☐ Matric	5 ☐ College	6 ☐ University
7 ☐ Deceased	8 ☐ Other_____	

16. With whom do you live?

1 ☐ both parents	2 ☐ father	3 ☐ mother
4 ☐ Guardian	5 ☐ Other_____	

17. Please indicate approximate combined income per month of all members living in your home.

1 ☐ no income	2 ☐ R500-R1499	3 ☐ R1500 - R2999
4 ☐ R3000- R4999	5 ☐ R5000- R6999	6 ☐ R7000 -R8999
7 ☐ R9000 and more		

C. HOME ENVIRONMENT

18. Where do you live?

1 ☐ informal settlement 2 ☐ township 3 ☐ suburb

4 ☐ rural settlement 5 ☐ other (specify) _____

19. Do you share your bedroom with others? 1 ☐ Yes 2 ☐ no

20. If yes, how do you feel about sharing your room?

_____

_____

_____

Rate the following by ticking (✔) one answer that applies to you					
	Very Good	**good**	**neutral**	**bad**	**very bad**
21. Resources that you have in your study eg. Books, computer, internet?	①	②	③	④	⑤
22. Support that you get from your parents in your studies?	①	②	③	④	⑤
23. Support that you get from your siblings (brothers/sisters)?	①	②	③	④	⑤

24. When you are studying at home, which of the following rooms do you normally use?

1 ☐ your bedroom 2 ☐ lounge 3 ☐ kitchen 4 ☐ study

5 ☐ other (specify) _____

25. Where do you prefer to complete your homework/studying?

1 ☐ Home 2 ☐ school 3 ☐ friend's house 4 ☐ library

5 ☐ other (specify) _____

26. Why is that so?

_____

_____

_____

27. When do you prefer to study at home?

1 ☐ when all are asleep 2 ☐ early morning 3 ☐ after finishing chores

4 ☐ after playing 5 ☐ other _____

28. How do you feel about the study situation in your home?

29. Explain why?

30. What can you do to improve the situation?

D. SCHOOL ENVIRONMENT EVALUATION

Rate the following by ticking (✔) one answer that applies to you

	Very Good	good	neutral	bad	very bad
31. The cleanliness of your school	①	②	③	④	⑤
32. Your school's furniture	①	②	③	④	⑤
33. Your teacher's attitude towards the learners	①	②	③	④	⑤
34. Your classmates' behavior during lessons	①	②	③	④	⑤
35. Your commitment to learn at school	①	②	③	④	⑤
36. Your performance in your tests	①	②	③	④	⑤
37. The support you receive from your teachers	①	②	③	④	⑤
38. Your stay (time spent) at your school	①	②	③	④	⑤
39. The assistance you receive from your counselor	①	②	③	④	⑤
40. The assistance you receive from your librarian	①	②	③	④	⑤
41. The number of learners in each class	①	②	③	④	⑤

E. RELATIONSHIPS

Please rate each statement in the following way:
If the statement describes how you feel, put a tick (✔) in the column "**agree**". If the statement describes you partially then put a tick in the column "**partially agree**" If the statement does not describe how you feel, put a tick in the column "**disagree**" or "**strongly disagree**" depending on the extent.

1 = agree **2** = partially agree **3** = undecided **4** = disagree **5** = strongly disagree

Relationship with Parents	**1**	**2**	**3**	**4**	**5**
42. My family members don't do things together. e.g. playing games or going places.	①	②	③	④	⑤
43. My parents' expectations of me are too high.	①	②	③	④	⑤
44. I often ignore my parents when they talk to me.	①	②	③	④	⑤
45. I become angry when my parents discuss my work with others.	①	②	③	④	⑤
46. My parents expect me to do too many other extra-curricular activities	①	②	③	④	⑤
47. My parents are always quarreling.	①	②	③	④	⑤
48. My parents do not guide and encourage me.	①	②	③	④	⑤
49. My parents do not show me love and care.	①	②	③	④	⑤

Relationship with Peers/Siblings	**1**	**2**	**3**	**4**	**5**
50. My friends don't share things with me.	①	②	③	④	⑤
51. My friends say that I am not responsible.	①	②	③	④	⑤
52. Other children don't listen to me when I talk.	①	②	③	④	⑤
53. I don't make friends very easily.	①	②	③	④	⑤
54. Children tend to mock me all the time.	①	②	③	④	⑤
55. Friends do not invite me to their functions.	①	②	③	④	⑤
56. I am always willing to please everybody.	①	②	③	④	⑤
57. I get into too many arguments with children of my age group.	①	②	③	④	⑤

My relationship with School	**1**	**2**	**3**	**4**	**5**
58. The thought of school makes me sick.	①	②	③	④	⑤
59. I am always caught daydreaming at school.	①	②	③	④	⑤
60. I do not finish my work in school.	①	②	③	④	⑤
61. My teacher doesn't listen to me.	①	②	③	④	⑤
62. My teacher gets angry with me.	①	②	③	④	⑤
63. I lost interest in what my teacher says.	①	②	③	④	⑤
64. I think my teachers don't understand me.	①	②	③	④	⑤
65. My work at school is getting worse.	①	②	③	④	⑤

Thank you for filling in this questionnaire!

LIST SOME OF THE CHANGES YOU WOULD LIKE TO MAKE IN YOUR SCHOOL, HOME AND WITH YOUR PEERS/ SIBLINGS TO IMPROVE THE SITUATION.

List the five major problems that you have with your PARENTS in order of seriousness.

1.....
.....
2.....
.....
3.....
.....
4.....
.....
5.....
.....

Write down the changes you would make to improve each of the above.

1.....
.....
2.....
.....
3.....
.....
4.....
.....
5.....
.....
.....

Write down the FIVE major problems that you have with your PEERS/SIBLINGS.

1.....
.....
2.....
.....
3.....
.....
4.....
.....

5.....
.....

Write down some changes that you would make to improve each of the above.
1.....
.....
2.....
.....
3.....
.....
4.....
.....
5.....
.....

Write FIVE major problems that you have with your school in order of seriousness.
1.....
.....
2.....
.....
3.....
.....
4.....
.....
5.....
.....

Write down the changes that you would make to improve each of the above.
1
.....
.....
2.....
.....
3.....
.....
4.....
.....
5.....
.....
Any other comments you would like to make about problems you are experiencing:.....

B.3

SEMI-STRUCTURED INTERVIEW	NUMBER:

Dear Learner,
This interview schedule is to gather information that will enable me to assist learners who are showing **symptoms of depression**.
Information disclosed in this schedule will be treated with strict confidence and will be used for research purposes only. THANK YOU.

BIOGRAPHICAL DETAILS

1. Surname:.....(optional)
2. Christian Name:.....(optional)
3. Gender: .....
4. Age:.....
5. Brothers/ sisters.....

FAMILY RELATIONSHIP (Home)

6. Communication at home
7. Support
8. Outside intervention
9. Perception of parents

PEER/SIBLINGS RELATIONSHIP

10. Communication with peers/siblings
11. Support
12. Other concerns
13. Perceptions of peers/ siblings

RELATIONSHIP WITH SCHOOL

14. Communication with educators
15. Support
16. Performance
17. Perceptions of school

If you needed help will you be able to contact the organization concerned e.g.

Drug abuse organization	☐ yes	☐ no
Childline	☐ yes	☐ no
Alcohol anonymous	☐ yes	☐ no
School counselor	☐ yes	☐ no
Priest	☐ yes	☐ no
Psychologist	☐ yes	☐ no
Child welfare	☐ yes	☐ no

Thank You

APPENDIX C

STATISTICAL ANALYSIS

C.4 Means and standard deviation of "depressed sample" by age with race

	African	Indian
N	43	75
Minimum	16.00	16.00
Maximum	20.00	19.00
Mean	17.9	16.5
Std. Deviation	1.3	.6

C.5.1 Chi –square statistics: Cross tabulation of residential area by race

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	68.504a	3	.000
Likelihood ratio	74.810	3	.000
Linear by linear Association	40.562	1	.000
N of valid cases	118		

C.5.2 Chi –square statistics: Cross tabulation of residential area by gender

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	2.162a	3	.539
Likelihood ratio	2.053	3	.561
Linear by linear Association	.399	1	.528
N of valid cases	118		

C.5.3 Chi –square statistics: Cross of sample sharing bedroom by gender

	Value	Df	Asymp. Sig. (2-sided	Exact Sig. (2 sided)	Exact Sig. (1 sided)
Pearson chi-square	.355 b	1	.551		
Continuity correction a	.152	1	.696		
Likelihood ratio		1	.553		
Fisher's exact test				.681	.346
Linear by linear Association	.352	1	.553		
N of valid cases	118				

C.5.4 Chi –square statistics: Cross tabulation of sample sharing room by race

	Value	Df	Asymp. Sig. (2-sided	Exact Sig. (2 sided)	Exact Sig. (1 sided)
Pearson chi-square	8.600 b	1	.003*		
Continuity correction a	7.449	1	.006		
Likelihood ratio	9.191	1	.002		
Fisher's exact test				.004	.003
Linear by linear Association	8.528	1	.003		
N of valid cases	118				

C.5.5 Chi –square statistics: Cross tabulation of sample according to room used for studying by gender

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	5.096a	4	.278
Likelihood ratio	7.653	4	.105
Linear by linear Association	2.030	1	.154
N of valid cases	118		

C.5.6 Chi Square Statistics: Choice of place for completion of homework according to race

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	11.980a	3	.007*
Likelihood ratio	11.975	3	.007
Linear by linear Association	11.065	1	.001
N of valid cases	118		

C.5.7 Chi Square Statistics: Cross tabulation of preferred time for studying by gender

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	21.177 a	4	.000*
Likelihood ratio	23.354	4	.000
Linear by linear Association	4.662	1	.031
N of valid cases	118		

C.5.8 Chi Square Statistics: Cross tabulation of preferred time for studying by race

	Value	Df	Asymp. Sig. (2-sided
Pearson chi-square	12.613 a	4	.013*
Likelihood ratio	13.498	4	.009
Linear by linear Association	9.802	1	.002
N of valid cases	118		

APPENDIX D

TABLES

D.1 Distribution Of Depressed Sample Parents/ Guardians By Age And Race

AGE BY RACE											
		N/A	**<30**	**30-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**Deceased**	**Total**
Father	African % within Race Group	1 (3%	-	3 (9%)	5 (15%)	10 (29%)	7 (21%)	5 (15%)	1 (3%)	2 (6%)	34 (100%)
	Indian % within Race Group	-	-	2 (3%)	10 (14%)	27 (38%)	13 (18%)	12 (17%)	1 (1%)	6 (9%)	71 (100%)
Mother	African % within Race Group	-	-	6 (14%)	12 (29%)	14 (33%)	6 (14%)	2 (5%)	1 (2%)	1 (2%)	42 (100%)
	Indian % within Race Group	1 (.9%)	-	13 (11%)	42 (36%)	36 (31%)	18 (16%)	4 (3%)	1 (.9%)	1 (.9%)	116 (100%)
Guardian	African % within Race Group	31 (72%)	5 (12%)	1 (2%)	1 (2%)	1 (2%)	2 (5%)	1 (2%)	1 (2%)	-	43 (100%)
	Indian % within Race Group	72 (96%)		-	1 (1%)	1 (1%)	1 (1%)	-	-	-	75 (100%)

D.2 Distribution Of Depressed Sample Parents'/ Guardians' Age by Gender

CROSS TABULATION OF AGE BY GENDER												
		N/A	**<30**	**30-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**>60**	**Deceased**	**Total**
Father	Male %within gender	1 (3%)	-	2 (6%)	2 (6%)	13 (39%)	6 (18%)	7 (21%)	-		2 (6%)	33 (100%)

D.1 Distribution Of Depressed Sample Parents/ Guardians By Age And Race

AGE BY RACE											
		N/A	**<30**	**30-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**Deceased**	**Total**
Father	African % within Race Group	1 (3%	-	3 (9%)	5 (15%)	10 (29%)	7 (21%)	5 (15%)	1 (3%)	2 (6%)	34 (100%)
	Indian % within Race Group	-	-	2 (3%)	10 (14%)	27 (38%)	13 (18%)	12 (17%)	1 (1%)	6 (9%)	71 (100%)
Mother	African % within Race Group	-	-	6 (14%)	12 (29%)	14 (33%)	6 (14%)	2 (5%)	1 (2%)	1 (2%)	42 (100%)
	Indian % within Race Group	1 (.9%)	-	13 (11%)	42 (36%)	36 (31%)	18 (16%)	4 (3%)	1 (.9%)	1 (.9%)	116 (100%)
Guardian	African % within Race Group	31 (72%)	5 (12%)	1 (2%)	1 (2%)	1 (2%)	2 (5%)	1 (2%)	1 (2%)	-	43 (100%)
	Indian % within Race Group	72 (96%)		-	1 (1%)	1 (1%)	1 (1%)	-	-	-	75 (100%)

D.2 Distribution Of Depressed Sample Parents'/ Guardians' Age by Gender

CROSS TABULATION OF AGE BY GENDER												
		N/A	**<30**	**30-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**>60**	**Deceased**	**Total**
Father	Male %within gender	1 (3%)	-	2 (6%)	2 (6%)	13 (39%)	6 (18%)	7 (21%)	-		2 (6%)	33 (100%)

	Female %within gender	-	-	3 (4%)	13 (18%)	24 (33%)	14 (19%)	10 (14%)	2 (3%)		6 (8%)	72 (100%)
Mother	Male % within gender	-	-	4 (10%)	18 (45%)	10 (25%)	5 (13%)	2 (5%)	-	1 (3%)		41 (100%)
	Female %within gender	-	-	9 (12%)	24 (32%)	26 (34%)	13 (17%)	2 (3%)	1 (1%)		1 (1%)	76 (100%)
Guardian	Male %within gender	38 (93%)	1 (2%)	1 (2%)	1 (2%)	–	-	-	-			41 (100%)
	Female %within gender	65 (84%)	4 (5%)	1 (1%)	1 (1%)	2 (3%)	2 (3%)	-	1 (1%)	1 (3%)		76 (100%)

D.3 Frequency and Valid Percentages of Parents/Guardians Level of Education

	Father		Mother		Guardian	
	Frequency	Valid %	Frequency	Valid %	Frequency	Valid %
N/A	1	.9	-	-	103	88.0
No schooling	1	.9	4	3.4	1	.9
Primary ed.	1	15.1	17	14.5	2	1.7
Secondary ed	16	28.3	58	49.6	2	1.7
Matriculation	30	34.0	29	24.8	7	6.0
College	6	5.7	8	6.8	1	.9
University	6	5.7	-	-	1	.9
Deceased	8	7.5	1	.9	-	-
Technikon	2	1.9	-	-	-	-
Total	106	100.0	117	100.0	117	100.0
Missing System	12		1		1	
Total	118		118		118	

D.4 Choice of Place for Completion of Homework According to Gender

		Home	School	Friend's House	Library	Total
Male	% within Gender	21(51.2%)	11(26.8%)	4(9.8%)	5(12.2%)	41(100%)
Female		43(55.8%)	13(16.9%)	9(11.7%)	12(15.6%)	77(100%)
Total		64(54.2%)	24(20.3%)	13(11.0%)	17(14.4%)	118(100%)

D.5 Evaluation of school Environment by Gender

		Not Applicable	% gender	Very .good	% gender	Good	% gender	neutral	% gender	Bad	% gender	Very bad	% gender	Total	% gender
Cleanliness of school	Male			2	4.9	11	28.8	11	26.8	12	29.3	5	12.2	41	100
	Female			7	9.2	18	23.7	24	31.6	23	30.3	4	5.3	76	100
School furniture	Male			2	4.9	7	17.1	18	43.9	8	19.5	6	14.6	41	100
	Female			6	7.9	15	19.7	21	27.6	24	31.6	10	13.2	76	100
Teacher's attitude towards learners	Male			15	36.6	9	22.0	11	25.8	3	7.3	3	7.3	41	100
	Female			19	25.7	24	32.4	26	35.1	5	6.8	-		74	100
Classmates behaviour during lessons	Male			1	2.4	8	19.5	15	36.6	12	29.3	5	12.2	41	100
	Female			6	8.0	16	21.3	30	40.0	15	20.0	8	10.7	75	100
Your commitment to learn	Male			8	19.5	16	39.0	13	31.7	4	9.8	-		41	100
	Female			24	32.0	34	45.3	10	13.3	5	6.7	2	2.7	75	100
Your performance in class	Male			-		4	9.8	28	68.3	8	19.5	1	2.4	41	100
	Female			6	8.0	26	34.7	30	40.0	12	16.0	1	1.3	75	100
Support you receive from teachers	Male			12	29.3	12	29.3	13	31.7	4	9.8	-		41	100
	Female			22	29.3	27	36.0	24	32.0	2	2.7	-		75	100
Your time at school	Male			9	22.0	13	31.7	15	36.6	3	7.3	1	2.4	41	100
	Female			25	32.9	28	36.8	18	23.7	5	6.6	-		76	100
Assistance from counselor	Male	8	20.0	5	12.5	6	15.0	8	20.0	4	10.0	9	22.5	40	100
	Female	15	19.7	7	9.2	16	21.1	18	23.7	5	6.6	15	19.7	76	100

Assistance from librarian	Male	5	12.2	3	7.3	7	17.1	7	17.1	7	17.1	12	29.3	41	100
	Female	8	10.5	8	10.5	22	28.9	14	18.4	7	9.2	17	22.4	76	100
Number of learners in class	Male			4	9.8	8	19.5	17	41.5	6	14.6	6	14.6	41	100
	Female			8	11.0	25	34.2	24	32.9	8	11.0	8	11.0	73	100

D.6 Evaluation of School Environment by Race

	Race	race within %	N/A	Very .good	Good	neutral	Bad	Very bad	Total	Total %
Cleanliness of school	African		-	5(11.9%)	15 (35.7%)	13 (31.0%)	7 (16.7%)	2 (4.8%)	42	100%
	Indian		-	4 (5.3%)	14 (18.7%)	22 (29.3%)	28 (37.2%)	7 (9.3%)	75	100%
School furniture	African		-	6 (14.3%)	16 (38.1)	12 (28.6%)	6 (14.3%)	2 (4.8%)	42	100%
	Indian		-	2 (2.7%)	6 (8.0%)	27 (36.0%)	26 (34.7%)	14 (18.7%)	75	100%
Teacher's attitude towards learners	African		-	15 (37.5%)	18 (45.0%)	3 (7.5%)	2 (5.0%)	2 (5.0%)	40	100%
	Indian		-	19 (25.3%)	15 (20.0%)	34 (45.3%)	6 (8.0%)	1 (1.3%)	75	100%
Classmates behaviour during lessons	African			6 (14.3%)	13 (31.0%)	15 (35.7%)	5 (11.9%)	3 (7.1%)	42	100%
	Indian			1 (1.4%)	11 (14.9%)	30 (40.5%)	22 (29.7%)	10 (13.5%)	74	100%
Your commitment to learn	African		-	13 (31.7%)	18 (43.9%)	6 (14.6%)	4 (9.8%)	-	41	100%
	Indian		-	19 (25.3%)	32 (42.7%)	17 (22.7%)	5 (6.7%)	2 (2.7%)	75	100%
Your performance in class	African		-	1 (2.4%)	11 (26.8%)	21 (51.2%)	7 (17.1%)	1 (2.4%)	41	100%
	Indian		-	5 (6.7%)	19 (25.3%)	37 (49.3%)	13 (17.3%)	1 (1.7%)	75	100%

Support you receive from teachers	African		-	14 (34.1%)	15 (36.6%)	10 (24.4%)	2 (4.9%)	-	41	100%
	Indian		-	20 (26.7%)	24 (32.0%)	27 (36.0%)	4 (5.3%)	-	75	100%
Your time at school	African		-	10 (23.8%)	16 (38.1%)	13 (31.0%)	3 (7.1%)	-	42	100%
	Indian		-	24 (32.0%)	25 (33.3%)	20 (26.7%)	5 (6.7%)	1 (1.3%)	75	100%
Assistance from counselor	African		4 9.5%	3 (7.1%)	11 (26.2%)	13 (31.0%)	5 (11.9%)	6 (14.3%)	42	100%
	Indian		19 25.7%	9 (12.2%)	11 (14.9%)	13 (17.6%)	4 (5.4%)	18 (24.3%)	74	100%
Assistance from librarian	African		-	7 (16.7%)	16 (38.1%)	6 (14.3%)	7 (16.7%)	6 (14.3%	42	100%
	Indian		13 17.3%	4 (5.3%)	13 (17.3%)	15 (20.0%)	7 (9.3%)	23 (30.7%)	75	100%
Number of learners in class	African		-	4 (10.3%)	18 (46.2%)	16 (41.0%)	-	1 (2.6%)	39	100%
	Indian		- 8 (10.7%)	15 (20.0%)	25 (33.3%)	14 (18.7%)	13 (17.3%)		75	100%

D.7 Cross Tabulation of Relationship with Parents by Gender

	Gender		Agree	Partially agree	Undecided	Disagree	Strongly Disagree	Total
My family members don't do things together	Male	within %	12 (29.3)	6 (14.6)	2 (4.9)	13 (31.7)	8 (19.5)	41 (100)
	Female		18(23.7)	16 (21.1)	6 (7.9)	22 (28.9)	14 (18.4)	76 (100)
Parents expectations – too high	Male		15 (37.5)	10 (25.0)	5 (12.5)	8 (20.0)	2 (5.0)	40 (100)
	Female		32 (42.1)	16 (21.1)	9 (11.80	15 (19.7)	4 (5.3)	76 (100)
I ignore parents when they talk to me	Male		1 (2.5)	3 (7.5)	9 (22.5)	19 (47.5)	8 (20.0)	40 (100)
	Female		7 (9.2)	18 (23.7)	8 (10.5)	26 (34.2)	17 (22.4)	76 (100)
I get angry – they discuss my work with others	Male		20 (48.8)	2 (4.9)	4 (9.8)	9 (22.0)	6 (14.6)	41 (100)
	Female		31 (41.3)	10 (13.3)	8 (10.7)	16 (21.3)	10 (13.3)	75 (100)

Parent expects too many extra-curricular activities	Male		7 (17.1)	10 (24.8)	7 (17.1)	10 (24.4)	7 (17.1)	41 (100)
	Female		8 (10.8)	6 (8.1)	15 (20.3)	30 (40.5)	15 (20.3)	74 (100)
Parents always quarrelling	Male		3 (7.7)	8 (20.5)	6 (15.4)	12 (30.8)	10 (25.6)	39 (100)
	Female		12 (16.4)	9 (12.3)	9 (12.3)	26 (35.6)	17 (23.3)	73 (100)
Parents don't guide and encourage me	Male		7 (17.5)	1 (2.5)	5 (12.5)	8 (20.8)	19 (47.5)	40 (100)
	Female		9 (12.0)	10 (13.3)	4 (5.3)	27 (36.0)	25 (33.3)	75 (100)
Parents don't show love and care	Male		2 (4.9)	-	5 (12.2)	8 (19.5)	26 (63.4)	41 (100)
	Female		5 (6.6)	6 (7.9)	6 (7.9)	32 (42.1)	27 (35.5)	76 (100)

D.8 Cross Tabulation of Relationship with Parents by Race

	Race		**Agree**	**Partially agree**	**Undecided**	**Disagree**	**Strongly Disagree**	**Total**
Thought of school makes me sick	African	race	7 (17.5%)	2 (5.0%)	5 (12.5%)	21 (52.5%)	5(12.5%)	40 (100%
	Indian		13 (17.3%	8 (10.7%)	13 (17.3%	19 (25.3%)	22 (29.3%)	74 (100%
I'm always daydreaming	African	within	7 (17.1%)	6 (14.6%)	4 (9.8%)	16 (39.0%)	8 (19.5%)	41 (100%
	Indian		5 (6.7%)	12 (16.0%)	2 (2.7%)	30 (40.0%)	26 (34.7%)	75 (100%
Work incomplete in school	African		18 (43.9%)	9 (22.0%)	4 (9.8%)	8 (19.5%)	2 (4.9%)	41 (100%
	Indian		14 (18.7%)	12 (16.0%)	8 (10.7%)	28 (37.3%)	13 (17.3%)	75 (100%
Teacher doesn't listen to me	African		2 (5.0%)	3 (7.5%)	5 (12.5%)	24 (60.0%)	6 (15.0%)	40 (100%
	Indian		7 (9.3%)	11 (14.7%)	12 (16.0%)	24 (32.0%)	21 (28.0%)	75 (100%
Teacher gets angry with me	African		5 (12.2%)	5(12.2%)	4 (9.8%)	18 (43.9%)	9 (22.0%)	41 (100%
	Indian		8 (10.7%)	7 (9.3%)	11 (14.7%)	29 (38.7%)	20 (26.7%)	75 (100%
Lost interest in what teacher says	African	%	8 (20.0%)	4 (10.0%)	5 (12.5%)	17 (42.5%)	6 (15.0%)	40 (100%
	Indian		7 (9.3%)	13 (17.3%)	12 (16.0%	26 (34.7%)	17 (22.7%)	75 (100%
Teacher doesn't understand me	African		8 (20.0%)	4 (10.0%)	8 (20.0%)	18 (45.0%)	2 (5.0%)	40 (100%
	Indian		11 14.9%)	11 (14.9%)	16 (21.6%)	22 (29.7%)	14 (18.9%)	74 (100%

School work getting worse	African Indian		11 (27.5%) 15 (20.0%)	8 (20.0%) 19 (25.3%)	8 (20.0%) 12 (16.0%)	11 (27.5%) 17 (22.7%)	2 (5.0%) 12 (16.0%)	40 (100% 75 [100%

D.9 Cross Tabulation of Learners Relationship with Peers/ Siblings by Gender

	Gender		Agree	Partially Agree	Undecided	Disagree	Strong disagree	Total
Friends don't share things	Male Female		4 (10.0) 5 (6.5)	1 (2.5) 6 (3.9)	2 (35.0) 3 (3.9)	14 (35.0) 30 (39.0)	19 (47.5) 33 (42.9)	40 (100.0) 77 (100.0)
Friends say I'm not responsible	Male Female		- 6 (7.9)	4 10.0) 5 (6.6)	4 (10.0) 7 (9.2)	15 (37.5) 29 (38.2)	17 (42.5) 29 (38.2)	40 (100.0) 76 (100.0)
Children don't listen to me	Male Female		4 (10.0) 17 (22.4)	4 (10.0) 9 (11.8)	10 (25.0) 7 (9.2)	16 (40.0) 21 (27.6)	6 (15.0) 22 (28.9)	40 (100.0) 76 (100.0)
I don't make friends easily	Male Female	g ender	6 (15.0) 13 (17.1)	2 (5.0) 5 (6.6)	6 (15.0) 1 (1.3)	11 (27.5) 25 (32.9)	15 (37.5) 32 (42.1)	40 (100.0) 76 (100.0)
Children mock me always	Male Female		5 (12.8) 3 (4.0)	3 (7.7) 15 (20.0)	2 (5.1) 3 (4.0)	15 (38.5) 28 (37.3)	14 (35.9) 26 (34.7)	39 (100.0) 75 (100.0)
Friends don't invite me to functions	Male Female	within	5 (12.8) 4 (5.4)	1 (2.6) 4 (5.4)	4 (10.3) 3 (4.1)	11 (28.2) 9 (39.2)	18 (46.2) 34 (45.9)	39 (100.0) 74 (100.0)
I'm always willing to please	Male Female		18 (46.2) 45 (60.0)	11 (28.2) 11 (14.7)	3 (7.7) 3 (4.0)	3 (7.7) 8 (10.7)	4 (10.3) 8 (10.7)	39 (100.0) 75 (100.0)
Arguments with others	Male Female	%	6 (15.4) 15 (19.7)	3 (7.7) 9 (11.8)	4 (10.3) 9 (11.8)	18 (46.2) 28 (36.8)	8 (20.5) 15 (19.7)	39 (100.0) 76 (100.0)

D.10 Cross Tabulation of Learners Relationship with Peers/ Siblings by Race

	Race		Agree	Partially Agree	Undecided	Disagree	Strong disagree	Total
Friends don't share things	African	within race %	3 (7.0%)	6 (14.0%)	1 (2.3%)	21 (48.8%)	12 (27.9%)	43 (100%)
	Indian		6 (8.1%)	1 (1.4%)	4 (5.4%)	23 (31.1%)	40 (54.1%)	74 (100)
Friends say I'm not responsible	African		2 (4.8%)	5 (11.9%)	6 (14.3%)	16 (38.1%)	13 (31.0%)	42 (100%)
	Indian		4 (5.4)	4 (5.4%)	5 (6.8%)	28 (37.8%)	33 (44.6%)	74 (100%)
Children don't listen to me	African		10 (23.8%)	6 (14.3%)	8 (19.0%)	13 (31.0%)	5 (11.9%)	42 (100%)
	Indian		11 (14.9%)	7 (9.5%)	9 (32.4%)	24 (32.4%)	23 (31.1%)	74 (100%)
I don't make friends easily	African		14(33.3%)	3 (7.1%)	4 (9.5%)	14 (33.3%)	7 (16.7%)	42 (100%)
	Indian		5 (6.8%)	4 (5.4%)	3 (4.1%)	22 (29.7%)	40 (54.1%)	74 (100%)
Children mock me always	African		1 (2.5%)	6 (15.0%)	3 (7.5%)	18 (45.0%)	12 (30.0%)	40 (100%)
	Indian		7 (9.5%)	12 (16.2%)	2 (2.7%)	25 (33.8%)	28 (37.8%)	74 (100%)
Friends don't invite me to functions	African		5 (12.8%)	2 (5.1%)	2 (5.1%)	18 (46.2%)	12 (30.8%)	39 (100%)
	Indian		4 (5.4%)	3 (4.1%)	5 (6.8%)	22 (29.7%)	40 (54.1%)	74 (100%)
I'm always willing to please	African		18(43.9%)	11 (26.8%)	2 (4.9%)	5 (12.2%)	5 (12.2%)	41 (100%)
	Indian		45 (61.6%)	11 (15.1%)	4 (5.5%)	6 (8.2%)	7 (9.6%)	73 (100%)
Arguments with others	African		6 (14.6%)	4 (9.8%)	6 (14.6%)	16 (39.0)	9 (22.0%)	41 (100%)
	Indian		15 (20.3%)	8 (10.8%)	7 (9.5%)	30 (40.5%)	14 (18.9%)	74 (100%)

D.11 Cross Tabulation of Learner's Relationship with school by Gender

	Gender		Agree	Partially agree	Undecided	Disagree	Strongly Disagree	Total
Thought of school makes me sick	Male	gender	4(10.0)	3 (7.5)	11 (27.5)	13 (32.5)	9 (22.5)	40
	Female		16 (21.3)	7 (9.3)	7 (9.3)	27 (36.0)	18 (24.0)	(100.0) 75 (100.0)
I'm always daydreaming	Male		2 (5.0)	3 (7.5)	2 (5.0)	17 (42.5)	16 (40.0)	40
	Female		10(13.2)	15 (19.7)	4 (5.3)	29 (38.2)	18 (23.7)	(100.0) 76 (100.0)
Work incomplete in school	Male		8 (20.0)	9 (22.5)	6 (15.0)	11 (27.5)	6 (15.0)	40
	Female		24 (31.6)	12 (15.8)	6 (7.9)	25 (32.9)	9 (11.8)	(100.0) 76 (100.0)
Teacher doesn't listen to me	Male		5 (12.5)	7 (17.5)	6 (15.0)	13 (32.5)	9 (22.5)	40
	Female		4 (4.3)	7 (9.3)	11 (14.7)	35 46.7)	18 (24.0)	(100.0) 75 (100.0)
Teacher gets angry with me	Male	within	5 (12.5)	3 (7.5)	9 (22.5)	13 (32.5)	10 (25.0)	40
	Female		8 (10.5)	9 (11.8)	6 (7.9)	34 (44.7)	19 (25.0)	(100.0) 76 (100.0)
Lost interest in what teacher says	Male		5 (12.8)	7 (17.9)	8 (20.5)	13 (33.3)	6 (15.4)	39
	Female		10 (13.2)	10 (13.2)	9 (11.9)	30 (39.5)	17 (22.4)	(100.0) 76 (100.0)
Teacher doesn't understand me	Male	%	7 (17.9)	5 (12.8)	9 (23.1)	11 (28.2)	7 (17.9)	39
	Female		12 (16.0)	10 (13.3)	15 (20.0)	29 (38.7)	9 (12.0)	(100.0) 75 (100.0)
School work getting worse	Male		8 (20.5)	8 (20.5)	8 (20.5)	11 (28.2)	4 (10.3)	39
	Female		18 (23.7)	19 (25.0)	12 (15.8)	17 (22.4)	10 (13.2)	(100.0) 76 (100.0)

D.12 Cross Tabulation of Learner's Relationship with school by Race

	Race		Agree	Partially agree	Undecided	Disagree	Strongly Disagree	Total
Thought of school makes me sick	African	race within %	7 (17.5%)	2 (5.0%)	5 (12.5%)	21 (52.5%)	5(12.5%)	40 (100%
	Indian		13 (17.3%	8 (10.7%)	13 (17.3%	19 (25.3%)	22 (29.3%)	74 (100%
I'm always daydreaming	African		7 (17.1%)	6 (14.6%)	4 (9.8%)	16 (39.0%)	8 (19.5%)	41 (100%
	Indian		5 (6.7%)	12 (16.0%)	2 (2.7%)	30 (40.0%)	26 (34.7%)	75 (100%
Work incomplete in school	African		18 (43.9%)	9 (22.0%)	4 (9.8%)	8 (19.5%)	2 (4.9%)	41 (100%
	Indian		14 (18.7%)	12 (16.0%)	8 (10.7%)	28 (37.3%)	13 (17.3%)	75 (100%
Teacher doesn't listen to me	African		2 (5.0%)	3 (7.5%)	5 (12.5%)	24 (60.0%)	6 (15.0%)	40 (100%
	Indian		7 (9.3%)	11 (14.7%)	12 (16.0%)	24 (32.0%)	21 (28.0%)	75 (100%
Teacher gets angry with me	African		5 (12.2%)	5(12.2%)	4 (9.8%)	18 (43.9%)	9 (22.0%)	41 (100%
	Indian		8 (10.7%)	7 (9.3%)	11 (14.7%)	29 (38.7%)	20 (26.7%)	75 (100%
Lost interest in what teacher says	African		8 (20.0%)	4 (10.0%)	5 (12.5%)	17 (42.5%)	6 (15.0%)	40 (100%
	Indian		7 (9.3%)	13 (17.3%)	12 (16.0%	26 (34.7%)	17 (22.7%)	75 (100%
Teacher doesn't understand me	African		8 (20.0%)	4 (10.0%)	8 (20.0%)	18 (45.0%)	2 (5.0%)	40 (100%
	Indian		11 14.9%)	11 (14.9%)	16 (21.6%)	22 (29.7%)	14 (18.9%)	74 (100%
School work getting worse	African		11 (27.5%)	8 (20.0%)	8 (20.0%)	11 (27.5%)	2 (5.0%)	40 (100%
	Indian		15 (20.0%)	19 (25.3%)	12 (16.0%)	17 (22.7%)	12 (16.0%)	75 [100%

APPENDIX E

LEAFLET

DEPRESSION IN ADOLESCENTS (Appendix E)

Feeling depressed? Talk to someone NOW!

Depression can affect people of any age, race, ethnic, or economic group

Myths often prevent people from doing the right thing. Common myths about depression are:

Myth: It's normal for adolescents to be moody; they don't suffer 'real' depression

Fact: Depression is not just being moody; it can affect adolescents.

Myth: Telling an adult that a friend might be depressed is betraying their trust.

Fact: Depression saps the energy and self-esteem, interferes with the person's wish to get help. True friends will share this concern and get help.

Myth: Talking about depression makes it worse.

Fact: Talking to parents, friends, social workers, or psychologist will help.

Symptoms of Depression

- You feel sad and cry a lot
- You feel guilty for no reason
- Life seems meaningless
- You have a negative attitude
- You lose interest in doing things that you previously liked
- You forget and can't concentrate
- You get irritated often
- You sleep a lot more or find it hard to sleep
- You lose your appetite
- You think about death

If you have these symptoms then GET HELP!

You can ask for help from:

- Parents
- Educators
- Counselors
- Trusted family members
- Your family doctor
- Your priest

Contact Numbers in KZN/ South Africa:

Dept Of Welfare: 4028000

Mental Health: 3042404

Phoenix: 5023628

Psychiatry Services:3374392

Life Line Durban: 3122323

Depression and Anxiety Support Group: 011 7831472/6