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THE EFFECTIVENESS OF GROUP THERAPY IN THE PREVENTION OF MENTAL ILLNESS IN YOUTHS EXPOSED TO STRESS

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A research report submitted to the Faculty of Health Sciences,
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in partial fulfilment of the requirements for the degree of

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Supervisors: PROFESSOR B ROBERTSON
MRS GAYLE LANGLEY

I declare that:

THE EFFECTIVENESS OF GROUP THERAPY IN THE PREVENTION OF MENTAL ILLNESS IN YOUTHS EXPOSED TO STRESS

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

Dora Dorothy Sekhukhune

I declare that:

this work has been passed by the Committee for Research on Human Subjects of the University of the Witwatersrand and the Protocol Number is M 940527.

Dora Dorothy Sekhukhune

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ABSTRACT

THE EFFECTIVENESS OF GROUP THERAPY IN THE PREVENTION OF MENTAL ILLNESS IN YOUTHS EXPOSED TO STRESS

The present social and political conditions in the black West Rand townships have led to young people being vulnerable to mental illness. The said conditions include violence, unstable family life, grief, losing family members by violence, and unemployment. A combination of these issues predisposes the youth to developing unhealthy ways of coping with stress.

This is seen when conditions such as post traumatic stress and other physical and psychological symptoms are present, which could lead to mental illness. Such issues have made it clear that a support system is needed to assist the youth in coping with the demands of their reality.

The aim of the study was to establish whether group therapy was more effective than life skills training in the promotion of mental health and the prevention of mental illness.

This was a small preliminary comparative study in generating meaning to the youth regarding the ways in which they handle stressful situations and to alert them to the effect these have on them.

A black township on the West Rand was targeted for this study. A sample was randomly selected from youths residing in Kagiso township. Two groups of equal numbers were formed, i.e. the therapy group and life skill training group.

The following research tools were used to evaluate the efficacy of two interventions administered to the groups:

- Brief Psychiatric Rating Scale
- Descriptive Evaluation

The results showed that, although there was a marginal difference, Group Therapy was more effective in that feelings and behavioural aspects were addressed, whereas in Life Skills Training it was not.

Further research is needed in other townships, so that such a programme can be utilised as a preventive mental health measure.

TABLE OF CONTENTS

Title		
Declaration		i
Acknowledgements		ii
Abstract		iii
CHAPTER 1		
1.	Introduction	1
1.1	Problem Outline	1
1.2	Problem Statement	7
1.3	Research Question	9
1.4	Purpose of the Research	10
1.5	The Objectives	10
1.6	Significance of the Study	10
1.7	Definition of terms	11
1.8	Study Outline	13
CHAPTER 2		
2.	Literature Review	15
2.1	Introduction	15
2.2	General Background	15
2.3	The Township Youth	16
2.4	The Development of Youth Resistance in Kagiso Township	17
2.5	The Effect of Violence on Young People	19

2.6	Stressors Identified among the Youth of Kagiso	21
2.7	The Effects of Stress on Young People	22
2.8	Effects of Stress on Young People in Relation to Crisis Theory	24
2.9	Mental Health Approach	28
2.10	The Group Psychotherapy Approach within the Framework of Psychiatric Nursing	30
2.11	Yalom's Therapeutic Factors in Relation to this Study	35
2.12	Conclusion	38

CHAPTER 3

3.	Research Methodology	39
3.1	Introduction	39
3.2	Research Design	39
3.3	Population	40
3.4	Research Tools	45
3.5	Data Collection Method	54
3.6	Reliability and Validity	54
3.7	Ethical Consideration	55
3.8	Data Analysis	56
3.9	Conclusion	57

CHAPTER 4

4.1	Introduction	58
4.2	Method	58
4.3	Data Analysis	59
4.4	Analysis of the Two Groups' Brief Psychiatric Rating Scale	64

4.5 Interpretation of Results 111

4.6 Analysis within the Groups 113

4.7 Conclusion 117

CHAPTER 5

5.1 Introduction 118

5.2 Objectives 118

5.3 Limitations of the Research 120

5.4 Recommendations 122

5.5 Conclusion 124

6. REFERENCES 125

ANNEXURES

Annexure 1	Map of Kagiso	132
Annexure 2	Letter to Churches	133
Annexure 3	Letter to Participants	134
Annexure 4	Consent Form – Parent/Guardian	135
Annexure 5	Physical and Psychological Symptoms Inventory	136
Annexure 6	Brief Psychiatric Rating Scale	137
Annexure 7	Outline of Group Therapy Sessions	140

LIST OF TABLES

Table 4.1	Number of Youths Selected for Study	59
Table 4.2	Frequency Distribution of Mean Score of Brief Psychiatric Rating Scale : Group 1 Pre-test Results	60
Table 4.3	Frequency Distribution of Mean Scores of Brief Psychiatric Rating Scale : Group 2 Pre-test Results	61
Table 4.4	Frequency Distribution of Mean Scores of Brief Psychiatric Rating Scale : Group 1 Post-test Results	62
Table 4.5	Frequency Distribution of Mean Scores of Brief Psychiatric Rating Scale : Group 2 Post-test Results	63

LIST OF FIGURES

Figure 3.1	The Sampling Pattern	44
Figure 4.1	Question 1 - Somatic Concern	65
Figure 4.2	Question 2 - Anxiety	67
Figure 4.3	Question 3 - Emotional Withdrawal	69
Figure 4.4	Question 4 - Conceptual Disorganisation	71
Figure 4.5	Question 5 - Guilty Feeling	73
Figure 4.6	Question 6 - Tension	75
Figure 4.7	Question 9 - Depressive Mood	77
Figure 4.8	Question 10 - Hostility	79
Figure 4.9	Question 11 - Suspiciousness	81
Figure 4.10	Question 14 - Unco-operativeness	83
Figure 4.11	Question 15 - Unusual Though Content	85
Figure 4.12	Question 16 - Blunted Affect	87
Figure 4.13	Overall Comparison of Mean Scores of the Brief Psychiatric Rating Scale : Group 1	114
Figure 4.14	Overall Comparison of Mean Scores of the Brief Psychiatric Rating Scale : Group 2	116

CHAPTER 1

1. INTRODUCTION

1.1 PROBLEM OUTLINE

Young people occupy an important place in the life of any society. The future of any nation depends on the moulding of its young generation and the practical role that this generation plays in society (An Introductory Handbook on African National Congress, 1990:28).

In any given society, the youth needs to develop a healthy way of living in order to facilitate mental health and prevent any situation that may lead to physical and/or mental illness. Vlok (1990) defines physical and mental health as the 'maintenance of gratifying and rewarding interpersonal relationships, adequate recreation and continuous personal growth from a state of dependency and emotional immaturity, to a state of emotional maturity, autonomy and mature independence' (Vlok, 1990:295).

Unfortunately, for many South African young people, especially those living in the urban townships, the development of physical and mental health has been affected by the unrest in the townships during the apartheid years.

Kagiso, one such township, is situated in the West Rand region of Gauteng Province. It is twelve kilometres away from the Krugersdorp town (see Annexure 1). It is part of the Krugersdorp Transitional Local Council. It had a population of 450,000 according to the 1996 census.

Kagiso was developed as a dormitory residential town for housing of black workers and their families who worked mainly in the neighbouring towns, and factories on the West Rand.

Most residents occupy the rented town council houses. They are built identically in long rows and are very basic small two roomed and four roomed houses, built on tiny stands next to each other. Most of the houses have no electricity. Only main roads are tarred and have street lights. The rest of the streets are not tarred and are without street lights. Rental and services are paid monthly by the occupants.

There are two hostels which accommodate male migrant workers from the rural homelands. A monthly rental is paid to the town council for accommodation and services.

The hostels and township residents' income is generated through employment at the factories, local community hospital and adjacent towns.

Commuters use minibus taxis as a means of transport to town. Most residents purchase their monthly groceries in town and use the township corner shops for small items for daily use.

Youths attend school at the five high schools with a population of 800 to 1000 pupils at each high school.

Health care services are offered by eleven private general practitioners on a fee-for-service basis. There are two community based clinics and a community hospital servicing the entire population.

Recreational amenities are very scarce. For example, there is one swimming pool, one sports field with four tennis courts and a soccer ground.

Some of the most influential political activists have resided in this township.

During the early 1990's. the young people of this township were actively involved in political activities that resulted in violence and other forms of social disintegration.

The violence was regarded as part of the struggle towards liberation. The young people saw themselves as the generation that could eradicate social injustices and set their communities free from racial discrimination in South Africa.

This struggle was linked to the 1976 uprising when the youth rebelled against the introduction of Afrikaans as a medium of instruction in black schools.

Part of the impetus for the revolt came from the students' rejection of their parents' authority. Holland (1990:183) stated that they held their parents responsible for the continuing iniquities of apartheid, maintaining that the older generation had seldom initiated protests and had let things go too far without doing anything. Parents were seen as failures.

During 1991 and 1992, as the struggle for liberation intensified, the politically motivated violence escalated, with the youth at the forefront of the struggle. They disrupted schooling, destroyed property, barricaded the streets with stones and burning tyres, petrol-bombed vehicles, did the *toyi-toying* (dancing and chanting) and clashed with the authorities.

All the participating young people involved were regarded as 'comrades in the struggle'. The researcher as a resident of Kagiso township at the time, saw them taking the law into their own hands by forming 'street committees' whose role was to enforce various forms of protest deemed necessary.

For example, during the rent and consumer boycott, the street committees ensured that no resident paid rent or bought any goods in the neighbouring town of Krugersdorp. Any person caught breaking the boycott would be made to eat or drink the foodstuffs, such as raw meat or cooking oil. Other groceries were destroyed in front of the resident who had not obeyed the 'comrades'.

Parents lost control over their children. The authorities tried to intervene by enforcing law and order, but this resulted in further clashes between the youth and the police. The confrontation led to the township becoming ungovernable. Young people were uncontrollable and were left to roam the streets.

The youth increasingly abused marijuana (dagga) and alcohol and became involved in criminal activities such as assault, the destruction of property, housebreaking and theft.

These activities were justified as 'part of the struggle'. Everyone feared the 'comrades' and would obey any instructions they were given.

In some instances, the community members were prevented from going to work during the 'stay-aways'. This resulted in loss of income, unemployment and a disintegration of family values.

Wherever a community is going through social disintegration, there are also socio-economic problems. According to Ramphele (1992) some of the following behavioural patterns may be observed :

- Family disintegration, with rising rates of separation
- Single parenthood and teenage pregnancy

- A high crime rate and violence at all levels of social interaction: family, interpersonal, neighbourhood and in the wider community
- High levels of alcohol and drug abuse
- Low performance in all spheres of life, including school and skills training
- Despair and acceptance of the victim image
- Nutrition and housing problems
- Poor environmental hygiene

(Ramphele, 1992:11)

All of the abovementioned behavioural problems were present in the community of Kagiso, and as they became worse the tension and frustration of the youth increased.

During this time, most of the churches in the township began to organise youth clubs within the church setting. This was a way of addressing issues that the youth were faced with following the political violence. The Roman Catholic, Baptist, Methodist and the Anglican churches took the lead in forming the youth clubs. The membership ranged from 50 to 100 members. (Those young people who were not affiliated to churches, formed a township youth club).

The researcher, in the capacity of a psychiatric nurse and church member, was asked to become involved in activities of the youth clubs, which included giving talks and participating in workshops.

It was during these encounters, that it became obvious that many of these young people were presenting problems related to stress which, if not addressed timeously, could result in mental illness.

The youth of Kagiso were observed manifesting behaviours such as anxiety and confusion, emotional problems which included irritability, aggression, withdrawal, apathy, depression, regression, acting out, destruction of property and over-activity.

In 1993, the behaviour of the youth became even more militant and displayed defiant social behaviour such as dropping out of school and abusing drugs and alcohol, which in turn resulted in criminal activities such as rape, assault, housebreaking and car hijacking.

These problems compounded the stress levels of the youth. Moloto (1993:43) found that symptoms such as 'headache/migraine, palpitations, body tension, insomnia, nightmares and feeling of panic' occurred. It is at this point that these troubled youngsters looked for outside help.

The local general practitioners confirmed that an increased number of young people attending their practices presented with many of the above symptoms. They offered mainly medical treatment and referred patients to the psychiatric nurse for further assistance.

As a result of the referrals, the researcher, as a church member, became involved in individual psychotherapy with identified troubled youngsters in the township. She observed the effect of and reaction to stressful situations in young people. The fact that they were finding it difficult to cope with life, was illustrated in the statements made by the young people attending individual psychotherapy with the researcher, such as: 'I feel helpless'; 'I feel I am nobody'; 'I have continuous headaches'; 'My school work is suffering'; 'I do not want to talk to people'; 'I am mad at myself and I am continuously fighting with my parents'.

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From these statements it appeared that their stress levels were high, that they did not have adequate coping skills and that the situation could lead to mental illness if the young people were not helped.

The individual psychotherapy sessions were time-consuming and appeared unequal to help solve the growing problem.

1.2 PROBLEM STATEMENT

In Kagiso township, the mental health of young people in churches was adversely affected by the violence in the township environment.

The mental health problems of the youth were not only confined to Kagiso township, but were highlighted as a national problem. The 1994 annual report compiled by the Centre for Health Policy stated that the 'mental health problems were largely due to the current political climate, following the democratic elections' (Annual report compiled by the Centre for Health Policy, 1994:18).

The National Health Plan on mental health as proposed for the South African society by the African National Congress aimed at designing a comprehensive programme to address problems relating to mental health. The programme promoted greater involvement by communities and individuals in all aspects of their own lives.

The main aim of the mental health care programme was to ensure the physical and psychological well-being of all South Africans. This included the ability to conduct oneself in a healthy way in social, interpersonal and work-related relationships.

The National Health Plan advocated that policies should address:

- the promotion of healthy lifestyles
- prevention of mental disorder where possible
- promotion of awareness of mental health and mental illness issues
- the development of adequate mental health services
- address the sequalae of violence and civil conflict
- promote programmes aiming at developing youth and supporting effective parenting

(African National Congress: A National Health Plan for South Africa, 1994:46-47)

The Reconstruction and Development Programme (1994), in line with the National Health Plan, considered the poor mental health of the youth to be a major problem to be addressed.

The Reconstruction and Development Programme also emphasised that youth development must focus on enabling young people to realise their full potential and participate fully in society and their own future. It must restore the hope of the young people in the future and in their capacity to channel their resourcefulness and energy into reconstruction and development (The Reconstruction and Development Programme, 1994:73).

Therefore the Reconstruction and Development Programme must aim to promote mental health and increase the quality and quantity and accessibility of mental health support and counselling services, particularly for those affected by domestic or other violence (The Reconstruction and Development Programme, 1994:47).

As stated previously, it was not possible to continue with individual psychotherapy. The researcher considered whether group therapy would be more effective in addressing the problems that the young people were experiencing compared to an enabling programme such as life skill training. This would be in line with the National Health Policy.

Group therapy is seen as a collective treatment of psychological problems in which two or more people interact with one another, intimately sharing feelings, ideas and experiences in an atmosphere of mutual respect and understanding. This enhances self-respect, deepens self-understanding and helps a person to live and identify with others (Yalom, 1995:2).

The youths, when together, would be able to share those experiences that they had during the liberation struggle. They would also be able to express what they felt when they forced their elders to participate in the struggle and when the elders showed fear of them and obeyed their demands.

Some of the youth who had participated in violating the values, norms and culture of their family unit, would use group therapy to verbalise those feelings that up until now they had not been able to share with others.

The researcher decided to do a small preliminary comparative study to evaluate the effectiveness of group therapy as compared to life skills training as a means of preventing symptoms of mental illness in groups of young people attending a church in Kagiso.

1.3 RESEARCH QUESTION

How effective is group therapy as compared to life skills training in working with young people living in a township with high levels of violence and other forms of social disorganisation?

1.4 PURPOSE OF THE RESEARCH

The overall purpose was to do a small preliminary comparative study, to investigate whether group therapy was as, or more effective in lowering the stress levels of young people exposed to living with violence than giving life skills training. It was, therefore, decided to establish whether group therapy was more effective than life skills training in the promotion of mental health and the prevention of mental illness.

1.5 THE OBJECTIVES

- To determine the pre-testing and post-testing levels of symptomatology indicative of mental illness in two groups of young church members manifesting stress.

- To develop and present a Group Therapy programme aimed at assisting young people manifesting stress-related behaviour.

- To develop and present a programme for Life Skills Training to a second group of young people manifesting stress-related behaviour.

- To determine the young people's perception of the benefits of the programmes.

1.6 SIGNIFICANCE OF THE STUDY

Previous studies performed on young people had been more related to youths residing in Soweto. No research had been done on the prevention of mental illness in Kagiso youths exposed to stress.

This is a small preliminary comparative study. It is an attempt to evaluate how effective Group Therapy is, in comparison to Life Skills Training, in addressing the stress problems to which young people have been exposed.

1.7 DEFINITION OF TERMS

For the purpose of this study the following definitions were used:

1.7.1 Stress

Stress refers to a broad class of problem areas which tax the system, that is a physiological, social or psychological system, as well as the response of that system. The response depends on how the person interprets or appraises the significance of a harmful, threatening, or challenging event (Powell & Enright, 1990:3).

1.7.2 Youth

Gerdes (1989) says the functional definition of youth is 'a period during which individuals prepare themselves for adult responsibilities and roles relating to their occupation, marriage and parenthood, and define their identity, values and goals in respect of these. The period extends from approximately 18 to 22 years'. (Gerdes, 1989:276).

In this study youth is regarded as a young person between the ages of 16 and 22 years of age and still attending school. The researcher focused on school going youths.

1.7.3 General Practitioner

A private medical practitioner who is registered with the South African Medical and Dental Council.

1.7.4 Psychiatric Nurse Therapist

A person who has complied with the minimum requirements as stipulated by the South African Nursing Council, holds a certificate and is registered with the South African Nursing Council as a Psychiatric Nurse.

1.7.5 Group Therapy

Collective treatment of psychological problems in which two or more people interact with one another, intimately sharing feelings, ideas and experiences in an atmosphere of mutual respect and understanding, in order to enhance self-respect, deepen self-understanding and help a person live and identify with others (Beck, Rawlins and Williams, 1988:523).

1.7.6 Effectiveness

The positive psychological impact on the young people who have gone through sessions of group therapy or a course of life skills training sessions.

1.7.7 Mental Health

Mental Health refers to the ability of people, couples, families and communities to respond adaptively to external and internal stressors (Antai-Otong, 1995:120).

1.7.8 Mental Illness

Antai-Otong, (1995:122), states that mental illness occurs as available coping and adaptive mechanisms fail to handle stress. It may be manifested in various ways, such as ineffective problem-solving, poor reality testing and impaired cognitive functioning.

1.7.9 Health Education

Clarke (1992:127) describes Health Education as the use of a variety of learning experiences to facilitate changes in the direction of more healthy behaviour. It is a process that frees people to make health-related decisions based upon full knowledge of the consequences of their choices.

1.7.10 Life Skills Training

Refers to skills acquired through training which enables a person to interact meaningfully and successfully with the environment and with other people. Life skills can also enhance the quality of life and prevent dysfunctional behaviour (Rooth, 1995:2).

Life skills dealt with in this study were in a form of health education. For example: Aids prevention, health promotion, positive relationship and sexuality education. Verbalising of feelings and emotions and behavioural aspects were not dealt with in the presentation of the skills mentioned.

1.8 STUDY OUTLINE

Chapter 1 deals with the foundation of the study and addresses the trauma young people of Kagiso township underwent during the period of the so-called 'struggle'.

It also gives a description of the interaction of the youths with daily life and what could lead to stress if the youths were not properly supported.

The objectives of the study are discussed as well as what the researcher hopes to achieve by the end of the study.

Chapter 2 deals with the background literature reviewed.

Chapter 3 deals with the Research Methodology.

Chapter 4 deals with the results of the statistical analysis, the interpretation of the data before and after the implementation of Group Therapy and Life Skills Training and the evaluation of Group Therapy and Life Skills Training as perceived by the participants.

Chapter 5 discusses the results and offers conclusions and recommendations.

CHAPTER 2

2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter addresses the following:

- General background to the term 'youth' in townships.
- Definition of 'township youth', the activities township youths engaged in, and the stress they experienced as a result.
- Various therapeutic approaches.
- Finally, an explanation of Yalom's (1995) therapeutic factors of group interventions.

2.2 GENERAL BACKGROUND

Young people occupy an important place in the life of any society. The future of a nation depends on the moulding of its young generation and the practical role this generation plays in society. In this regard, society seeks to impart a definite outlook to the youth. (An Introductory Handbook on the African National Congress, 1994 : 28).

While young people are always seen as the future generation of a society, their future is clouded by social disintegration.

During the early 1990s South African young people were at the forefront of the political struggle. Normal schooling had been disrupted and violence was rife.

The researcher, as a resident of Kagiso township was of the opinion that it was obvious that the violence was being politically orchestrated and that the so-called third force (groups fomenting unrest on behalf of the state) was involved.

Mogano, (1993) stated that the media reports of the 1990s mentioned that young people in the township area mobilised themselves in response to the threat. Youth had been socialised to find violence acceptable and human life cheap (Gibson 1991:2). Young township residents were depicted in demonic and destructive terms. For example, they were seen as militaristic automatons, incapable of participating in their own destinies (Freeman, Lazarus & Sibeko, 1996:1). The literature reviewed often regarded the youth as a *'lost generation'* (Gibson, 1991; Mokwena 1992; Moloto, 1993).

2.3 THE TOWNSHIP YOUTH

In South Africa some young people became involved in joint activities with older groups, so becoming part of the youth culture in the struggle for liberation. These youngsters participated in political protests, meetings and the reinforcement of boycotts.

While politically involved youths drew most attention during the early nineties, there was also grave concern about a more broadly defined *'marginalised youth'*, such as gangsters and street children.

The definition of township youth is, therefore, a broad one. Since 1976 normal schooling had been disrupted. Many young people stayed in high school much longer than the minimum period of five years.

Due to social problems such as unemployment, a lack of housing, and poverty, some young people stayed with their families/parents and were regarded as youngsters, even at the age of 30 years.

Many young people were highly marginalised. Problems such as drug and alcohol abuse, teenage pregnancy and gangsterism were rife in schools, resulting in an underdeveloped *'culture of learning'*.

It is on this basis that a black youth was regarded as a person between the ages of 16 and 35 years. Freeman, Lazarus & Sibeko (1996:6) share this view and put a black youth between the ages of 16 and 30 years. Some of those belonging to youth organisations were even up to 35 years old.

For the purposes of this study, however, a *'youth'* is regarded as a young person between the ages of 16 and 22 years of age, who is still attending school.

2.4 THE DEVELOPMENT OF THE YOUTH RESISTANCE IN KAGISO TOWNSHIP

The period from the 1976 uprising to the early 1990s was marked by a major change in family relations. In their struggle against Apartheid, young people often felt that their parents had betrayed them.

They saw their parents as having failed to see the wider social issues and complained that their parents had dictatorial attitudes. They resented the fact that parents did not accept that young people were entitled to express their opinions and feelings (Freeman et al, 1996:11).

The researcher, as a resident of Kagiso, observed the sense of power that had developed among the young people. In fact, they had become more powerful than the adults.

Freeman et al (1996:12) stated that culturally and traditionally, young people were very subservient to adults and that the intergenerational consequences of the young people harnessing social and historical leadership were exaggerated.

Young people, as a group, shared not only a vision which the adults were not part of, but concentrated on actively participating in violent action which bonded them together, which in turn distanced them from traditional adult authority.

Straker (in Freeman et al, 1996) said that the youth had a sense of power and vision for the future. They saw themselves as leading the older generation to freedom. *'Liberation was in sight and they were the authors of it'* (Freeman et al, 1996:12).

In terms of authority, family tensions increased. The youth were not only going their own way, but also telling their elders how to conduct their lives.

Parents resented being told what to do by children, especially in the light of their authoritarian African cultural background. This type of behaviour was unacceptable to most adults and was often discussed among the elders in Kagiso.

Some parents were encouraged by certain forces to rise up against the intimidation and politics of the *'comrades'*. These actions only increased the determination of the youth. Violence in the townships increased.

The presence of the security forces and spiralling incidences of violence brought more and more youth into active resistance against the Government and its forces.

Many youths took the lead in stay-aways, school and consumer boycotts and action against collaborators and *'sell-outs'*. The youth formed structures such as street committees and 'people's courts'. As the violence escalated, they became more militant and confrontational with the elders in the townships, illustrating just how ineffectual parental control had become.

Freeman et al (1996:1) stated that traditional authority in the townships had become largely ineffective. They also quoted some well-respected community leaders and researchers as commenting that many youths had become fearless and had lost respect for human life, and that violence had become a way of life and of solving problems (Freeman, Lazarus, & Sibeko, 1996:1).

2.5 EFFECT OF VIOLENCE ON YOUNG PEOPLE

The effect of violence and other social disintegration stressors on the South African youth has been widely documented.

According to Dawes (in Freeman et al 1996) life stressors can have severe detrimental psychological effects on human beings.

The presence of the security forces and spiralling incidences of violence brought more and more youth into active resistance against the Government and its forces.

Many youths took the lead in stay-aways, school and consumer boycotts and action against collaborators and *'sell-outs'*. The youth formed structures such as street committees and 'people's courts'. As the violence escalated, they became more militant and confrontational with the elders in the townships, illustrating just how ineffectual parental control had become.

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2.5 EFFECT OF VIOLENCE ON YOUNG PEOPLE

The effect of violence and other social disintegration stressors on the South African youth has been widely documented.

According to Dawes (in Freeman et al 1996) life stressors can have severe detrimental psychological effects on human beings.

Nonetheless it is well documented that while some young people do develop serious psychological problems, others do not.

Freeman et al (1996:5) went on to say that whether young people coped or not depended on how the individual and significant others interpreted the stressors, as well as how the family had coped with adversity in the past. However, this should not detract from the fact that many people have been psychologically afflicted.

As part of the preventive and promotional aspect of the mental health strategy, the results of this research could improve young people's capacity to learn, help with issues such as improved interpersonal and parent-child relationships, conflict resolution and self-discipline and encourage young people to take a greater interest in their own future as well as that of society.

The strategy could be linked with the developmental stages in which young individuals prepare themselves for adult responsibilities. By adapting roles relating to their occupation, marriage and parenthood, they experience problems, especially if they attempt to define their identity, values and goals in a given environment (Gerdes, 1989:281).

Gerdes (1989:292) regards young people as individuals with attitudes, traits and values, but who also have needs to be fulfilled and set themselves goals which they would like to achieve. While having these plans in mind and being in transition, they are vulnerable to stress.

2.6 STRESSORS IDENTIFIED AMONG THE YOUTH OF KAGISO

Stress among young people in Kagiso township could be attributed to stressors such as violence and social disintegration.

Township youths have been exposed to high levels of violence almost on a daily basis (Straker & Garbarino, in Moloto, 1993).

As a result of the violence, schools were disrupted and families became disorganised; at the same time, squatter camps mushroomed because of the migration from rural to urban areas, and as the squatter camps grew, more violence became inevitable (Mogano, 1993).

The media images of the 1980s often showed black youths leading marches, casting stones at armed military and police vehicles, doing the *toyi-toyi* [chanting and dancing], and 'disciplining' people on the streets in 'street comm'tee' - capacity (a committee formed by groups of people residing in the same vicinity) (Moloto, 1993:43). Young people in Kagiso were no exception to this behaviour. From a psychological point of view, being exposed to such stressful situations on a daily basis is potentially damaging. Witnessing, participating in and being a victim of violence is viewed as trauma, with the potential to damage a person's ability to function effectively in the world (Straker, Stavrou & Garbarino in Moloto 1993). Moloto (1993) identifies such youths as casualties who can no longer function in everyday life. The definition includes those who avoid the pain in their lives by anaesthetising themselves by substance abuse, to such an extent that they are regularly unable to function.

The definition also includes those who indulge in criminal and other anti-social acts and those who are unable to block out the pain and show symptoms of anxiety and depression.

Such symptoms can manifest physically and/or psychologically. For example, some physical symptoms are palpitations, migraines and psychosomatic conditions. Psychological symptoms could include sleeplessness, nightmares, a lack of concentration, a loss of interest in own surroundings and a preoccupation with own thoughts.

2.7 THE EFFECTS OF STRESS ON YOUNG PEOPLE

Violence

According to Eagle (in Moloto 1993) violence can result in direct physical injury to victims and also has a severe psychological impact. Emotional numbness, a loss of interest in outside activities, sleep- disturbances, nightmares, a lack of concentration, poor school performance and psychosomatic symptoms have been the reasons for referrals to the Psychiatric Nurse Therapist (Moloto, 1993:41).

Moloto (1993:41) attributes such symptoms to post-traumatic stress, adding that they could be clinical symptoms of depression. Depression resulting from loss often makes the victim turn his anger inwards against himself rather than outwards against the cause of loss, for fear of possible retribution.

Physical Ailments

Increased heart-rate, high blood pressure, hyperventilation, dizziness, a tingling sensation, excessive perspiration and numbness can all be attributed to stress. When any of the above symptoms is experienced, the young person's performance in school is disrupted, resulting in poor academic results, inevitably causing even more stress.

Psychological Symptoms

Moloto (1993) categorised sleeplessness, nightmares, difficulty in ability to concentrate and impaired memory as symptoms of post-traumatic stress. Those symptoms fit in well with the diagnostic criteria of Post-traumatic Stress Disorder as described in the Diagnostic and Statistical Manual of Mental Disorder IV (American Psychiatric Association, 1994:425).

There are situations which Moloto (1993) views as not perpetuated by individuals. For example, a loss of employment due to companies dis-investing from South Africa in the 1980s. Such circumstances resulted in parents not being able to meet the needs of young people in terms of their educational or socio-economic needs or other aspects such as traumatic injuries sustained during violent action.

Such situations as are described in the previous paragraph often resulted in young people feeling helpless and hopeless, which in turn caused fear, worrying thoughts, distorted thinking, anxiety and depression.

Loss of Social Contact

Among young females, a restriction of movement and a loss of interest in outside life are often the result of violence in the community. Mokwena (1992) states that an increasing number of young women have been the victims of abduction and gang rape. This result in victims being dehumanised and emotionally traumatised. Young women are, therefore, victimised both directly and indirectly. They have to be ultra-cautious about their movements, which could cause them to lose contact with the outside world, since they have to be extra careful with whom they associate – which in itself puts a lot of stress on them (Mokwena, 1992:44).

2.8 EFFECTS OF STRESS ON YOUNG PEOPLE IN RELATION TO CRISIS THEORY

Tedeschi and Calhoun (1995:16) state that when challenges occur suddenly and unexpectedly, they are more likely to threaten psychological wellbeing. This is not to say that critical life problems that happen gradually and are expected cannot be highly stressful – they can. However, it is harder to achieve a resolution under very difficult circumstances when there is insufficient time to prepare those involved psychologically.

Events that are out of the ordinary are likely to be more difficult to handle. In part, this may be because unusual events are also likely to be sudden and out of control and cannot bring young people's experience to bear on unfamiliar events. For example, the practice of forcing people to eat raw meat and drink cooking oil is an unusual practice.

Another quality that makes an event traumatic is the degree to which it creates long lasting problems. Life circumstances that create enduring difficulties will be more likely to lead to significant psychological distress. In part, this distress may be due to the sense of hopelessness that is produced when certain events are acknowledged to be irreversible and unchangeable. During the unrest period, residents of Kagiso experienced an escalation in violence and there was no hope for change.

The irreversible changes can engender a lack of control and reveal few opportunities to take direct corrective action. It may be easy for people in sudden difficult situations to learn to feel helpless and become depressed (Tedeschi and Calhoun, 1995:18).

Blame is another quality that makes the event traumatic. Blaming others can be a sign that a person feels powerless over circumstances, to the extent that blaming others increases the individual's sense of helplessness. Psychological distress resulting from the events can be expected, for example, the youth of Kagiso were saying 'did we do something to cause this, or was it somebody else's fault?'

Current research indicates that people who blame others for their difficult circumstances are likely to have more psychological difficulties than are people who do not (Tedeschi and Calhoun, 1995:19).

Psychological Effects of Crisis

Cognitive Effects

Thoughts may intrude upon the individual more indirectly. The person may become a bit more vigilant particularly in matters related to crisis. Being exposed to highly negative events may decrease the individual's self-esteem (Tedeschi and Calhoun, 1995:21).

Emotional Effects

One emotion that many people experience is guilt. There is a painful feeling of remorse about what was done or what was left undone or unsaid. This may reflect a brief that certain actions may have prevented the event or that certain actions would have made loss more bearable. In situations where others suffered much more, the individual may experience the 'survivor guilt' seen in people who survived circumstances in which others perished or lost everything they had (Tedeschi and Calhoun, 1995:22).

Individuals going through crisis also often feel anger, irritability, fear and anxiety. The anger may be expressed at various targets and irritability may come and go. When the circumstances to which individuals are exposed involve significant threat to life, health, or to important property, it is likely that those individuals will feel apprehen. .e, worry and concern for some time following the events.

Behavioural Changes

One behaviour observed in people going through crisis is isolation or withdrawal from others. There may be an increase in drug use or abuse in crisis situations to assist in coping with the psychological distress and pain they are experiencing. Such drug abuse is a change in behaviour which can also result in aggressive behaviour.

Stress may lead to crisis. Stress invokes tension and anxiety. Wright (1986:3-5) states that there are phases that the individual goes through in crisis.

Phase One

A threatening situation occurs which disturbs the equilibrium. Past coping mechanisms are utilised but prove ineffectual in managing this novel situation. The hazard is seen as a threat to the individual's basic needs. In this impact phase there may be numbness and/or an inability to believe what is happening. Pain and anguish may be experienced.

Phase Two

There is a strong desire to do something about the situation. Fear may be expressed or felt. The feeling of ineffectiveness and lack of direction to move in are powerful and very distressing and can produce agitation and restlessness. Solutions may be sought and it may be obvious that these have been chosen with little thought as to their effectiveness. They may not even be directed at helping the situation but may produce frantic disorganised activity. The sense of hopelessness and inadequacy is increased when trial and error attempts to resolve the crisis fail.

Phase Three

As the individual moves into this phase, a rise in tension is seen. There will be periods of intense activity to try to resolve the situation. Resources are called in an attempt to find a solution and this causes an additional problem at this stage. The strength of feelings elicited by the older anxiety interferes and distorts the present situation. Panic and bewilderment are brought about by the absence of solution and resolution. This may result in noisy and erratic outbursts of behaviour.

Phase Four

In this phase the person can no longer endure the distress. Denial and/or withdrawal may occur and the individual may deny the need for assistance. Relatives may assume that the individual has 'gone mad'. At this stage, however, the individual is susceptible to intervention.

2.9 MENTAL HEALTH APPROACH

Stress manifests in a form of symptomatology, which could be physical, psychological and/or behavioural.

The approach of the African National Congress is that the Mental Health Policy is aimed at ensuring the psychological well-being of all South Africans, so enabling them to conduct themselves effectively in social, interpersonal and work relationships (African National Congress: A National Health Plan 1994:46).

Therefore, the mental health approach should include preventive, promotive, maintenance and restorative measures to help young people cope with stressors.

2.9.1 Preventive and Promotive Approach

The mental health approach can strengthen the resilience of those exposed to stress and enable them to live in the communities where the identified stressors prevail, through:

- forming and maintaining positive relationships with young people;
- assisting young people to accept themselves and others;
- helping young people build interpersonal relationships based on trust and involving them in helping others in order to learn interpersonal skills;
- helping young people manage stress through support systems; and
- helping young people learn how to manage conflict.

2.9.2 Psychotherapeutic versus Drug Therapy Approach

Coping Styles

There are numerous and varied approaches to the treatment of stress. These include drug therapy, psychotherapy, group therapy and/or a combination of all the above.

There are many schools of thought regarding using drugs in combination with psychotherapy in order to combat the physical and/or psychological symptoms of stress.

For example, the individual will not be able to communicate in group psychotherapy when experiencing a headache. The headache has to be alleviated before group psychotherapy.

Proponents of drug therapy maintain that drug treatment alone is necessary and sufficient and that drugs alone can be used to rectify the neuro-physiological dysfunction or biochemical deficiency which occurs when the individual is experiencing stress (Klerman in Motsepe, 1989:10).

On the other hand, proponents of psychotherapy maintain that drug treatment impairs the patient's progress in psychotherapy, as it increases his reliance upon biological treatment, fosters dependency on the physician and the drug and blunts the capacity for insight.

In addition, psychotherapy proponents believe that the more recently used drugs, for example minor tranquillisers (benzodiazepines), have a negative effect on psychotherapists in that they limit their skills by encouraging them to offer a quick and ready solution to the complex psychological problems of their clients (Jarvick in Motsepe 1989:11).

2.9.3 Psychiatric Nursing Approach

Psychiatric nursing is a goal-directed service to assist the individual, the family and the community to promote, maintain and restore health (Oral Roberts University, Anna Vaughn School of Nursing 1989-1990:196).

Moloto (1993) states that the psychiatric nurse's interaction with the adolescent is a scientifically-based process that includes the interrelated steps of assessment, diagnosis, planning, implementation and evaluation of the adolescent's healthcare needs.

By utilising the nursing process, the psychiatric nurse is able to direct the psychiatric nurse/client interaction in a goal-directed manner (Moloto, 1993:54).

2.10 GROUP PSYCHOTHERAPY APPROACH WITHIN THE FRAMEWORK OF PSYCHIATRIC NURSING

Group Therapy

Beck, Rawlins and Williams (1988) define group therapy as a treatment method in which clients meet at planned times with a therapist to focus on issues such as becoming self aware and understanding, improving interpersonal relationships, making behavioural changes or all three of the goals.

Group psychotherapy is the psychological treatment of emotional disorders, to effect change by means of group processes. Because of their peer group interaction and the influence of the peer group, young people often find it easy to fit into group psychotherapy.

The group is based on philosophical concepts and theories with specific content and goals. Positive, creative change is the major aim. Clients need to want to change some aspect of themselves and be willing to take the necessary steps to change. This may involve recognising and accepting aspects of themselves that may benefit from change or learning to make decisions to enhance the quality of their relationships.

Cohesiveness of members develops from the stresses and pain they experience, they focus on emotional problems, traumatic memories and unrecovered feelings and possibly from mutual identification with any specific reality problem area (Aguilera, 1990:31).

Goals of Group Therapy

Therapeutic goals for clients in group therapy are:

- To relieve tension and anxiety;
- To help the clients gain some insight into their problems;
- To assist the clients to resolve some of their conflicts; and
- To support them in replacing or changing maladaptive ones (Aguilera, 1990:32)

Composition of Therapy Group

The most common method of screening clients is the individual interview (Yalom, 1995:245).

In this study, the physical and psychological inventory form was used to select the participants who were experiencing some stress-related symptoms. The therapist in addition to acquiring information about such issues, should further interview the clients on how motivated are they for treatment, their ego strengths and personal history and attempt to predict how the client will behave in the group (Yalom, 1995:245). This was done by the researcher immediately after the physical and psychological inventory was analysed and a group of possible participants was identified. This was done to inform them of the results.

Yalom (1995) came up with the principles that could be followed when composing a group for therapy:

- Random selection of members could be utilised in forming a group for therapy.

- Clinical observation is another principle to follow. Yalom (1995) says that unfolding from clinical observation is the rule that degrees of compatibility must exist between the clients and the interpersonal culture of the group if change is to occur.

- Maintaining heterogeneity without creating isolation is to attempt to balance the group for such factors as transference towards the therapist, counter transference, passive aggression, ability to express affect, insight, introspective ability, homosexuality, heterosexuality and ego strength.

- Forming a group with the same age range is important. Yalom (1995) says if the group has too extreme an age range the life stage problems of some members may be so alien to others as to seriously impair cohesiveness.

- The group size should not be more than ten members. Yalom's personal experience and a consensus of the clinical literature suggests that the ideal size of an interactional therapy group is approximately seven or eight with an acceptable range of five to ten members. When a group is reduced to four or three members, it often ceases to operate as a group, member interaction diminishes and the therapists often find themselves engaged in individual therapy with the group (Yalom, 1995:276).

The Physical Setting

Group meetings may be held in any setting, provided that the room affords privacy, freedom from distraction and the opportunity to sit in a circle (Yalom, 1995:266). In this study a church's breakaway room was utilised for conducting the sessions. The area was accessible and gave the participants the opportunity to attend all the sessions because of its location and easy transport facility to and from the participants' home.

The groups were able to participate freely because of the privacy and freedom from any disruptions.

Open and Closed Groups

A closed group, once begun, shuts its gates and does not accept new members and usually meets for a determined number of sessions. Most closed groups are of brief duration, meeting weekly for six months or less (Yalom, 1995:263). In view of the fact that the members in this study were still attending school, a closed group was conducted and brief group therapy techniques were adopted. According to Yalom (1995) brief group therapy can achieve a specific goal and is thus ideal to deal with acute life crisis.

As youths in Kagiso were experiencing stress related to crisis due to unrest, brief group therapy in a form of a closed group was ideal in this study.

Duration of Group Therapy

The duration of group therapy is dependent on the therapist and the group, bearing in mind the goals aimed for (Yalom, 1995:268).

In this study, the group met for an hour on a weekly basis for a period of eight weeks. This was to retain the group throughout the sessions and maintain the group throughout for the purpose of comparing it with the group on life skills training.

Role of the Therapist

The role of the therapist is active and direct. The therapist functions as a participant leader in the group sessions, assisting the members to focus on the problem areas under discussion by restricting and diverting general social conversation and lengthy discussions of past occurrences that have no relevance to the present crisis of the individuals in the group. The therapist also acts as a group facilitator and must be skilful in understanding and acting on non verbal clues from the members of the group (Aguilera, 1990:36).

Yalom (1995) states that group therapy requires monitoring the verbal and non verbal communication of group members for content and process. The psychiatric nurse therapist is able to use the psychiatric therapeutic skills and methods indicated in Poggenpoel (1985) as resources in facilitating young people's pattern of interaction. The psychiatric nurse therapist as a group leader chooses themes and facilitates the discussions that occur.

The group leader works on the 'here and now' context of participants' experience. The group members help each other to develop a feeling of acceptance and belonging.

There are several therapeutic factors which become significant as curative factors in group psychotherapy (Yalom, 1995:7).

2.11 YALOM'S THERAPEUTIC FACTORS IN RELATION TO THIS STUDY

Universality

The youths will begin to have security in knowing that others are experiencing the same problems, pain, feelings, behaviour or thoughts. They will realise that there is no human deed or thought that is fully outside the experience of other people.

As young people perceive their similarity to others and share their deepest concerns, they benefit further from catharsis and acceptance (Yalom, 1995:9).

Instilling Hope

Group members will begin to be hopeful that the way they feel is not unique but universal, and it is hope that keeps patients in therapy. Young people will benefit from encountering others who have the same problems and have coped with them effectively.

Members are often willing to share their experiences and give testimonies. The Alcoholics Anonymous (AA) group is a good illustration of this principle in action. The nurse therapist should believe not only in herself but also in the efficacy of the group in its ability to instil hope (Yalom, 1995:6).

Faith, too, is therapeutic. For example, the efficacy of faith healing is based on hope and one's own conviction.

Imparting Information

Behaviour is a learned process, therefore young people will learn to behave in an acceptable manner through studying how others conduct themselves and imitating what they see.

Bandura (in Yalom, 1995:16) has long claimed that social learning cannot be adequately explained on the basis of direct reinforcement. He has successfully treated a large number of individuals with snake phobias, for instance, by asking them to observe their therapist handling a snake.

In group therapy, young people will be asked to observe how other youths with similar problems conduct themselves.

Group Cohesion

Clients in group therapy consider group cohesiveness to be a prime source of help in their therapy experience. They value the acceptance they receive from the group. In the same way, young people will value the acceptance of their peers in therapy.

Highly cohesive groups are known to have an overall higher outcome and a greater level of self-disclosure (Yalom, 1995:9).

Interpersonal Learning

The stress experienced by young people emanates from disturbed interpersonal relationships. The purpose of group therapy is to help young people develop distortion-free, gratifying interpersonal relationships (Yalom, 1995:9).

Catharsis

The 'here and now' approach will help young people express feelings they could not have expressed previously. The group becomes engaged in self-disclosure and self-exploration, thus gaining understanding of themselves.

Altruism

A selfless interest in other people and their well-being is learnt by both giving and receiving. Those youths who are demoralised, who feel worthless and believe that they have nothing to offer, who consider themselves a burden, will begin to realise that what they have to offer to others is helpful.

This will help them gain self-esteem. They learn to offer support, reassurance, suggestions and insight and to share similar problems (Yalom, 1995:13).

Corrective Recapitulation of the Primary Family Group

The young person who participates in group therapy might enter therapy with the history of a highly unsatisfactory experience in his/her primary family group.

The therapeutic group will, therefore, substitute for the initial primary group, the family, and may be compared to it. The comparison and substitution will permit the individual to nullify past learned group interaction and expectations and to create for himself/herself a new set of experiences and expectations.

Existential Factors

These will help members to deal with the meaning of their own existence.

Development of Social Interaction Techniques

In this process the techniques and skills necessary for social interaction will be explored, experimented with and evaluated by the group within the context of group therapy.

The outcome will be to learn new patterns of acceptable social interaction (Yalom, 1995:10).

2.12 CONCLUSION

Stress has a negative effect on young people's internal environment that causes them to react, either physically or psychologically, or both. Mental health approaches aim to redress these human imbalances in a promoting, maintaining and restorative manner.

The nurse therapist utilises group therapy to assist young people exposed to stress in regaining their coping abilities so as to restore the imbalances caused by stress.

CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 INTRODUCTION

A preliminary investigation into the efficacy of two different interventions, i.e. Group Therapy and Life Skills Training administered to youths exposed to stress, and the research methodology used in conducting this research will be discussed

This will be followed by a discussion of the sampling method, the research tools and the method of data collection.

3.2 RESEARCH DESIGN

A small preliminary comparative study was undertaken on two groups of young people manifesting stress symptoms. In consultation with an experienced researcher, in the Faculty of Health Sciences of the University of the Witwatersrand, it was agreed that, as a preliminary investigation, a sample of twenty participants, ten for Group Therapy and ten for Life Skills Training would be sufficient.

This sample size poses a distinct limitation to this study as does the fact that the population is confined to young people attached to a church youth group. They may not, therefore, be representative of the population and consequently this study cannot be generalised.

The purpose of the pre-test – post-test design in this study was to evaluate the effectiveness of Group Therapy in comparison to Life Skills Training in addressing the problems encountered by youths exposed to stress and their perceptions of Group Therapy and Life Skills Training.

3.3 POPULATION

The population consisted of two hundred young people attending formal youth clubs in four churches in the Kagiso township, Krugersdorp on the West Rand.

These churches were chosen because they had formal youth clubs, which are regularly attended.

3.3.1 Sampling

Stage 1

Four of the largest congregations namely: Roman Catholic, Anglican, Baptist and the Methodist were selected as research sites. The researcher visited these four churches on the day of their regular youth meetings and requested the members to complete the physical and psychological symptoms inventory form designed specifically to elicit stress. This is a Likert type scale developed by Powell and Enright (1990) to assess the general physical and psychological level of stress/comfort experienced by people (see Annexure 5).

The respondents had to identify how frequently the symptoms occurred by making use of a four point scale.

It is a self monitoring instrument that the clients would complete on their own. Self monitoring helps the clients to see their difficulty in a different way. This helps the clients to redefine the problems in a structured cognitive-behavioural way rather than in their catastrophic idiosyncratic way. The information gained from the self monitoring sheet is then used in therapy sessions as a basis for discussions (Powell and Enright 1990:55). Self monitoring related to mood disturbance, physical symptoms, catastrophic thoughts, avoidance thoughts and general effects on specific areas of everyday life. Once this map has been plotted, interventions can be specifically targeted at particular areas. Powell and Enright (1990) stated that the form was perceived as being useful to both therapists and clients in helping to map out a profile of each client's stress. It can also provide a useful baseline from which to work, and from which progress can be measured (Powell and Enright, 1990:57).

The completion of the abovementioned form by the clients helped the young people gain insight into their problems and was an effective way of assisting the researcher to identify potentially stressed individuals who might benefit from the two interventions prepared for this study.

One hundred and seventy eight young people between the ages of 16 and 22 completed the form. All items included in the physical and psychological inventory form were discussed with the young people, to make sure that they understood what each item meant.

Because all participants use English as a second language, the researcher went to the extent of explaining all of the questions to them in both Tswana and Zulu. These are the languages commonly used in this region of South Africa. This was to make sure that they understood what was expected of them, for example, where respondents had to identify how frequently their symptoms recurred.

Stage 2

All one hundred and seventy eight forms were scrutinised to identify young people manifesting stress symptoms.

Seventy eight could be considered for sample selection, as their responses ranged between 'occasionally' to 'most of the time' on aspects indicating the presence of stress related symptoms in the physical and psychological inventory form.

Stage 3

Of the seventy eight respondents manifesting stress symptoms, a random sample of twenty was drawn. The small sample of twenty with ten in each group was to facilitate the sessions in Group Therapy. A group of ten people in Group Therapy is regarded as a number that can be handled effectively and facilitate interaction during Group Therapy sessions. Typically, therapy groups are composed of five to ten members. A group of seven or eight members is considered ideal. Therapy with fewer than five yields less effective interaction, more than ten means less focus on individuals, diluting group potency and effectiveness (Beck, Rawlins, and Williams, 1988:523).

A random number table was set up using the number of seventy eight individuals who were suitable for the study. A random number table using the digits from 1 to 78 was drawn. This was done in such a way that each number was equally likely to follow any other. The researcher then placed a finger at any number with her eyes closed. The number selected was the starting point moving in any direction.

All numbers picked from 1-38 were allocated to group one and those numbers picked from 39-78 were allocated to group two until an equal number of ten in each group was reached (Polit and Hungler 1991:155). The two equal groups were assigned to different interventions; that is Group 1, was allocated to undertake Group Therapy and Group 2, Life Skill Training.

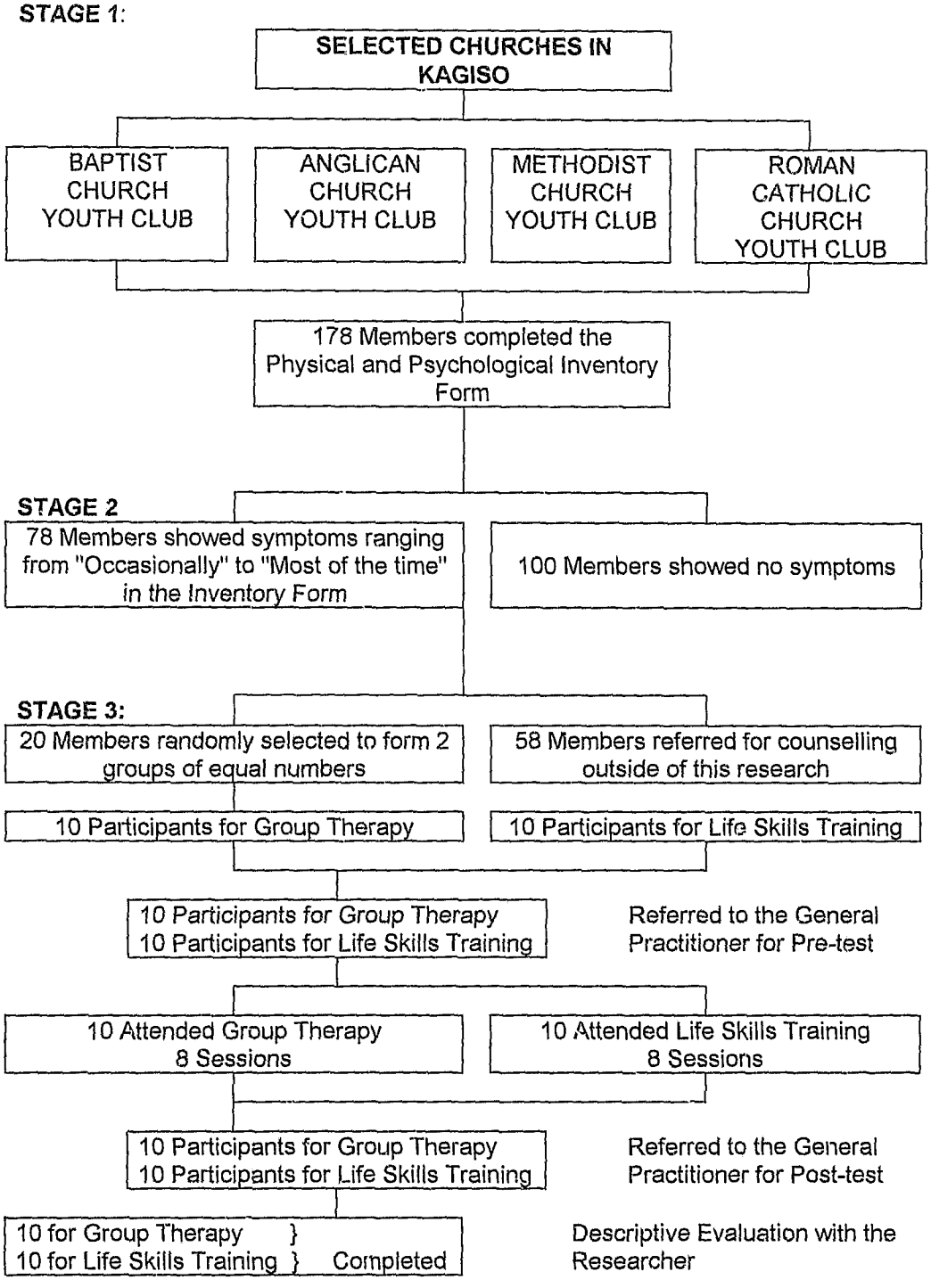
Random selection was utilised so that every participant had an equal chance of being assigned to either group. There were six females and four males for Group Therapy and an equal number of five males and five females in Life Skills Training. Although there were young males and females in each group the researcher did not focus on gender when doing the analysis in this study.

Randomisation is regarded as the most trustworthy and acceptable method of equalising groups (Polit and Hungler, 1991:261).

The sample was small, as this was an investigative study, and ten was seen as the ideal number to participate in a Group Therapy session.

The remaining fifty eight respondents who manifested stress symptoms were referred for counselling outside of the research. This was for ethical reasons. (See figure 3.1 for schematic illustration of sampling process)

Figure 3.1 THE SAMPLING PATTERN



3.4 RESEARCH TOOLS

The following research tools were used to evaluate the efficacy of the two interventions administered to the groups.

- The Brief Psychiatric Rating Scale
- Description Evaluation

The researcher used methodological triangulation to address the same issue, to confirm findings and to obtain both breath and depth of information. The questionnaire yielded a sizeable amount of data and the focused interviews provided insight about the meaning and interpretation of the results.

Focus group is helpful when used as a method of probing information obtained from quantitative surveys to achieve a greater understanding of the issues extrapolated (Krueger, 1994:11).

3.4.1 Brief Psychiatric Rating Scale

The Brief Psychiatric Rating Scale consists of eighteen different symptoms related to the presence of mental illness designed by Overall and Gorham, (1962) and adapted by Pekane, (1989) (Overall and Gorham, 1962 in Pekane 1989:65).

The different symptoms are arranged on a seven point scale relating to mental health status of the individual. The eighteen symptoms represented are the following: somatic concern, anxiety, emotional withdrawal, conceptual organisation, guilt feelings, tension, mannerisms and posturing, grandiosity, depressive mood, hostility, suspiciousness, hallucinatory behaviour, motor retardation, unco-operatativeness, unusual thought content, blunted affect, excitement and disorientation.

Every symptom is allocated a ranking in terms of the seven point scale: not present, very mild, mild, moderate, moderately severe, severe and extremely severe. Numbers had to be allocated to these ranks from 1 'not present' to 7 'extremely severe'. Some alterations had to be made for ethical reasons, so that the information would remain confidential. For example, the name of the participant would be replaced with a questionnaire number represented by column (1-2). A column was made for the pre-test and post-test and was represented as column (3). Symptoms on the rating scale were then each allocated from (4-21).

This is a validated scale as it is used widely and it was used by Pekane (1989) in her study on mental health education of families of African psychiatric patients: Traditional Health Practices versus Western Psychiatric Treatment. The study was conducted in South Africa.

Twenty youths involved in this study were each interviewed by the General Practitioner experienced in psychiatric conditions according to the items as indicated in Annexure 6. The researcher was not involved during the interviews to eliminate bias.

The symptoms covered in the interviews were as follows:

- **The psychosomatic symptoms** such as somatic concern, anxiety and tension.

- **Cognitive symptoms** such as conceptual disorganisation, unusual thought content.

- **Behavioural symptoms** such as feelings of guilt, hostility and suspiciousness.

- **Affective symptoms** such as excitement, depressive mood, emotional withdrawal and blunted affect.

The form was used as a comparison before and after interventions on both groups of young people.

The general practitioner did not know the criteria for selection of the young people for the study, nor did she know to which study group the young people had been assigned. (This general practitioner had been the source of referral of clients in need of therapy to the psychiatric nurse therapist).

3.4.1.1 *Group Therapy*

The purpose of Group Therapy was to treat the psychosomatic and emotional disorders to effect change by means of a group process. The emphasis on this group was on attitudes, emotions and behaviour and mood of individuals during the sessions. The process helped the young people verbalise their feelings, they were able to share their experiences within a structured group setting. The group members helped each other to develop a feeling of acceptance and belonging.

The Group Therapy Programme was designed using Yalom's therapeutic factors for group interaction (see Annexure 7). The approach consisted of three phases, namely, the orientation phase, working phase and the termination phase (Beck, Rawlins and Williams, 1988:531).

Orientation Phase

The orientation phase had two sessions. During this period the group got to know each other. Rapport was established with the nurse therapist and with each other. Contracts were negotiated and responsibilities of members and the nurse therapist were outlined. All participants undertook to attend all sessions.

Working Phase

There were four sessions held during this phase. The group began to open up with one another and a sense of belonging began to develop among the group members.

The feeling of togetherness was demonstrated through the support that they gave each other. All feelings, positive and negative were openly addressed, using the 'Here and Now' approach (Yalom, 1995:7).

Termination Phase

The group was prepared for termination in the last two sessions. This was to deal with separation anxiety, as the feeling of attachment with the nurse therapist and the group was felt during therapy sessions.

Each member gave his/her personal view of the group interaction and how each one benefited from the group.

3.4.2 Life Skills Training Programme

These sessions focused on the provision of factual information. Respondents participated in discussion of the content. The researcher took care that the behavioural and emotional tone were different whilst interacting with this group.

Life Skills Training was done with a group of ten participants. Various methods and visual aids were used during the presentation. The content included issues that affect young people in their daily lives, and which were broken down into eight sessions.

Topics dealt with were as follows:

- Healthy relationships with parents, siblings and peers and how to conduct themselves in such relationship (for example, demonstrating respect towards the elders).

- Puberty and its meaning to the adolescent; teenage pregnancy and the complications thereof.

- Sexually transmitted diseases and the prevention thereof.

- HIV positive and AIDS related diseases.

- Personal hygiene, care of the skin, body cleanliness.

- Nutrition and a healthy diet.

- The importance of exercise, recreation and relaxation. How to go about developing a programme to integrate exercise, recreation and relaxation.

Orientation Phase

The implementation of the Life Skills Training Programme went through the same process as the Group Therapy Programme where the participants went through an orientation phase. In the first session, the members of the group got to know one another. All participants undertook to attend all sessions.

Presentation Phase

The programme was presented in seven sessions. The young people were encouraged to participate more fully. Questions were encouraged and discussions were used throughout. Issues raised by the group were first clarified, after which problem-solving methods were applied to them.

Summary and Conclusion

The last day of sessions was used to evaluate the topics dealt with in order to decide whether the young people's needs had been met.

Each group member gave his/her personal view on the topics handled and how they benefited from the information received.

3.4.3 Descriptive Evaluation

On completion of the eight sessions of Group Therapy Programme and Life Skills Training Programmes, the researcher evaluated the sessions through a focus group discussion with each group.

The focus group was a carefully planned discussion designed to obtain perceptions and insight on Group Therapy and Life Skills Training. It was a way of identifying trends and patterns in perceptions. Careful and systematic analysis of the discussions provided clues and insight as to how these programmes were perceived. These insights were then used to develop more efficient follow-up in a quantitative way and enabled the researcher to make inferences about the larger population (Krueger, 1994:29).

The idea of the focus group was to promote self disclosure among the participants. The focus group enabled the researcher to get in touch with the respondents and discover how those respondents saw reality, for example, how the respondents felt when they forced their elders to obey their instructions when it is not practised traditionally.

Evidence from focus group interviews suggests that people do influence each other with their comments and in the course of a discussion, the opinions of the individual might shift (Krueger, 1994:11).

The researcher created a permissive environment that nurtured different perceptions and points of view, without pressurising participants to plan or reach consensus. The researcher facilitated the session in such a way that it enabled the participants to share their ideas and perceptions. For example, the township lingo (multiple languages) was used to stimulate a discussion.

Group members influenced each other by responding to ideas and perceptions. A non-directive interview technique was used where open ended questions were asked, and allowed the individuals to respond without setting the boundaries or providing clues for potential response. This open ended approach allowed each member ample interviewing opportunity to comment, explain and share experiences and attitudes during the sessions. Non-directive interviewing was used to shift attention from the researcher to the respondents.

Questions asked in the focus group interview were simple. The questions were asked in a group environment and this was followed by skilful probing. This resulted in the participants being able to divulge emotions that would not have emerged in other forms of questioning.

The researcher encouraged comments of all types both positive and negative. She also encouraged the respondents right from the beginning to venture alternative explanations, for example, by saying 'there are no right or wrong comments or opinions in this group, please share your experiences and points of view even if they differ from what others have said'. The researcher was careful not to make judgements about the responses. This was done, for example, by controlling body language that might communicate approval or disapproval.

The evaluation was not tape recorded as the researcher felt that the use of the tape recorder would be intrusive, (many members felt that their 'comrades' had previously been sold out to the authorities through the use of tape recordings). However, the researcher did take extensive field notes.

The researcher utilised an interview guide to ensure that issues deemed important were covered. She went through several different types of questions and each served a purpose. There were opening questions, introductory questions, transition questions, key questions, ending questions, summary questions and final questions. The researcher encouraged participants right from the beginning to give alternative explanations.

The questions asked of those who had gone through Group Therapy were to explore alternative explanations or views of the issues under discussion. The questions were, for example:

- Now that you are back in this group after a break, what are your expectations?

- How did you feel when you had to be in a group of people that you did not know?

- What was it like to be in a group of people that you did not know?
- What were your experiences working with the group?
- What made you begin to discuss your problems freely?
- How did you feel when members asked direct questions when you had raised an issue?
- How do you feel now that we are terminating the sessions?

The questions asked of those who had gone through the Life Skills Training were:

- Now that you are back in this group, what are your expectations?
- What was it like to be in a group of people that you did not know?
- What have you learned from the sessions that you went through?
- What was it like when I started to introduce the topic on sexuality?
- What was your experience when you had to share the information acquired in the sessions that you went through?
- What else would you have liked to learn?
- If you are given another opportunity to attend such sessions what would you like to learn?
- How do you feel now that we are terminating this session?

3.5 DATA COLLECTION METHOD

This was done in three stages.

Stage 1

Pre-testing of the twenty participants by the general practitioner, using the Brief Psychiatric Rating Scale. The general practitioner who was knowledgeable in psychiatric conditions assisted in the pre-test – post-test examination. The researcher was not allowed to see the results of the pre-test, because that might have affected the way in which the therapy would be conducted.

Stage 2

After the pre-test, the participants were divided into their respective groups. At the end of the eight sessions, both groups were post-tested by the general practitioner, who made use of the Brief Psychiatric Rating Scale. This was to establish whether there had been any change in the symptomatology.

Stage 3

At the end of both the Group Therapy and Life Skills Training, a focus group evaluation was conducted on each group by the researcher as set out above.

3.6 RELIABILITY AND VALIDITY

The Brief Psychiatric Rating scale as a pre-test – post-test instrument in this study was not administered by the researcher herself, in order to limit bias. This instrument was successfully implemented by Pekane (1989) in her study among the families of African psychiatric patients.

Powell and Enright (1990:57) stated that they had designed a physical and psychological symptoms inventory using questions that had been used by other authors for research purposes.

3.7 ETHICAL CONSIDERATIONS

3.7.1 Consent

The parents of all participants below the age of 21 were requested to sign consent on their children's behalf, (see Annexure 4). Those above the age of 21 years signed their own consent, (see Annexure 3).

It was explained to both the Group Therapy and Life Skills Training group that they were free to discontinue if they so wished, and that arrangements would be made for them outside of the study when the need arose.

All those respondents whose responses had ranged between 'seldom' and 'most of the time' in the physical and psychological symptom inventory and who did not form part of the study, were referred for counselling outside the study.

Those who needed further attention after the termination of the study, were referred for further counselling to help them address their individual problems.

If requested to do so, the researcher undertook to give respondents and their parents feedback on the results of the study on its completion and prior to publication.

3.7.2 Anonymity and Confidentiality

Care was taken in the Group Therapy evaluation to discuss the issue of confidentiality with all participants and the normal constraints of confidentiality within the groups applied. As sharing of experiences was neither expected nor encouraged with the Life Skills Training sessions, the issue was not explored in detail with the Life Skills Training group.

Respondents were encouraged to supply relevant information, with the assurance that they would remain anonymous. No mention of names was made during Group Therapy sessions or Life Skills Training.

The names of the participants were known to the researcher and the general practitioner only, for the purpose of follow-up on completion of the study, or if needed for ethical reasons.

The names of the participants were later replaced by column (1 or 2) in the Brief Psychiatric Rating Scale, for the sake of anonymity.

3.8 DATA ANALYSIS

Because of the sample sizes of the data, the method was that of non - parametric statistics, specifically the Mann-Whitney and Wilcox Signed Rank Tests. The frequency analysis of prevailing symptoms, as these appeared in the measuring research tool, were calculated and captured on computer statistical analysis.

The results of the pre-test and post-test were compared in respect of the groups that underwent Group Therapy and Life Skills Training, respectively.

3.9 CONCLUSION

In this chapter the research design and research method have been described.

The pre-test – post-test design for evaluating the effectiveness of Group Therapy and Life Skills Training was discussed. The research tools, namely the Brief Psychiatric Rating Scale and the descriptive evaluation were discussed, as well as how they were implemented.

Group Therapy and Life Skills Training were discussed and how they were implemented. The methods of data collection were also discussed.

CHAPTER 4

4.1 INTRODUCTION

This chapter contains the analysis of the data, which falls into two parts.

Part A will deal with the comparison of the mean score of the pre-test and post-test, using the Brief Psychiatric Rating Scale (BPRS).

Part B will present a narrative description of the final evaluation of both groups. The aim was to probe the respondents' perception of the benefit of Group Therapy versus that of Life Skills Training.

4.2 METHOD

Distribution-free or non-parametric statistical methods were used. The researcher used the Mann-Whitney U and Wilcox Signed Rank tests.

The Mann-Whitney U test was used to determine whether independent samples have been drawn from the same population or from different populations having the same distribution (Richards & La Cava, 1983:416).

The two groups were extracted from a population with continuous and symmetrical distributions. This will apply mainly where intra-analysis is considered. Here the Wilcox Signed Rank test was used, otherwise the Mann-Whitney U test was applied when inter- or between-group analysis was considered.

PART A

4.3 DATA ANALYSIS

TABLE 4.1 NUMBER OF YOUTHS SEL. .D FOR STUDY

Total Number of Youths Registered at Clubs	Number of Youths Considered for the Selection who Completed Physical and Psychological Inventory Checklist	Number of Youths Considered for Further Selection	Final Group Selected for Study
200	178	78	20
100%	89%	39%	10%

The total population (200) attending the youth clubs consisted of 200 respondents of both sexes. Only 178 respondents completed the physical and psychological inventory checklist. (See Annexure 5.)

The inventory checklists were scrutinised and all respondents (78) in the group that answered 'occasionally' to 'most of the time' in respect of positive symptoms of stress, formed the final sample, of which (20) were drawn.

The respondents were further divided into Group 1 and Group 2 by random selection.

TABLE 4.2 FREQUENCY DISTRIBUTION OF MEAN SCORE OF BRIEF PSYCHIATRIC RATING SCALE: GROUP 1

PRE-TEST RESULTS

RESPONSE	SCORE	MEAN OF TOTAL SCORES	PERCENTAGE
Not Present	1	124	68.9%
Very Mild	2	34	18.9%
Mild	3	14	7.8%
Moderate	4	8	4.4%
Moderately Severe	5	0	0
Severe	6	0	0
Extremely Severe	7	0	0

N = 10 **TOTAL SCORES = 180**

According to the pre-test scores for Group 1,69% of the respondents' scores manifested no symptomatology; 27% demonstrated a 'very mild' / 'mild' symptomatology and only 4% of the respondents' scores showed a 'moderate' symptomatology.

TABLE 4.3 FREQUENCY DISTRIBUTIONS OF MEAN SCORES OF BRIEF PSYCHIATRIC RATING SCALE: GROUP 2

PRE-TEST RESULTS

RESPONSE	SCORE	MEANS OF TOTAL SCORES	PERCENTAGE
Not Present	1	135	75%
Very Mild	2	25	13.9%
Mild	3	19	10.6%
Moderate	4	1	0.56%
Moderately Severe	5	0	0
Severe	6	0	0
Extremely Severe	7	0	0

N = 10 **TOTAL SCORES = 180**

Only 25% of the pre-test respondents scored in the 'very mild' to 'mild' range of responses. The majority (75%) of the scores fell into the symptom-free group.

TABLE 4.4 FREQUENCY DISTRIBUTION OF MEAN SCORES OF BRIEF PSYCHIATRIC RATING SCALE: GROUP 1

POST-TEST RESULTS

RESPONSE	SCORE	MEANS OF TOTAL SCORES	PERCENTAGE
Not Present	1	148	82.2%
Very Mild	2	32	17.8%
Mild	3	0	0
Moderate	4	0	0
Moderately Severe	5	0	0
Severe	6	0	0
Extremely Severe	7	0	0

N = 10 **TOTAL SCORES = 180**

According to post-test scores for Group 1 the majority (82.2%) of the respondents show no symptomatology and only 17.8% of scores fell into the 'very mild' category of symptoms.

TABLE 4.5 FREQUENCY DISTRIBUTION OF MEAN SCORES ON BRIEF PSYCHIATRIC RATING SCALE: GROUP 2

POST-TEST RESULTS

RESPONSE	SCORE	MEANS OF TOTAL SCORES	PERCENTAGE
Not Present	1	145	80.5%
Very Mild	2	29	16.1%
Mild	3	6	3.33%
Moderate	4	0	0
Moderately Severe	5	0	0
Severe	6	0	0
Extremely Severe	7	0	0

N = 10 **TOTAL SCORE = 180**

The post-test scores of Group 2 show that 80.5% of the respondents are symptom-free, whilst 19.4% fall into the 'very mild' category. When comparing the Group 2 results of the pre-test and post-test to each other, there is an improvement of 5.5%.

4.4 ANALYSIS OF THE TWO GROUPS' BRIEF PSYCHIATRIC RATING SCALE

This part consisted of eighteen questions.

Data is presented in the form of graphs and yielded the following findings

Question 1

SOMATIC CONCERN

Teenagers and adolescents are more concerned with their physical health. They fear physical illness. Any disturbance regarding their physical appearance could result in stress and problems such as eating disorders.

Group 1

Group 1 in the pre-test showed that respondents scoring 'mild' (20%) and 'very mild' (50%) symptoms of stress were in fact concerned.

The post-test results following group therapy showed a shift to 50% 'very mild' and 50% 'not present'. The results therefore showed a 0.05% improvement.

Group 2

The pre-test results showed that 50% of respondents showed no concern, while 50% showed very 'mild' fear regarding their physical health.

Following Life Skills Training, the post-test results showed an improvement of 20% moving from 'very mild' to 'not present', leaving 30% in the 'very mild' column. An improvement, therefore.

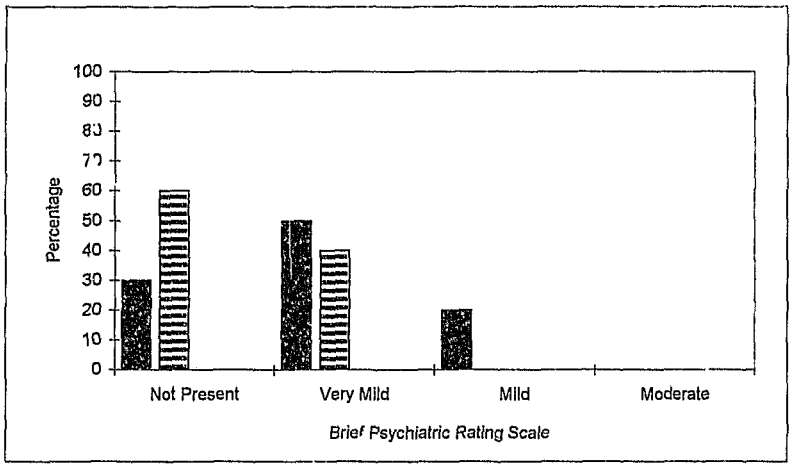


Figure 4.1 [a] Percentage of Group 1 respondents who showed Somatic Conern

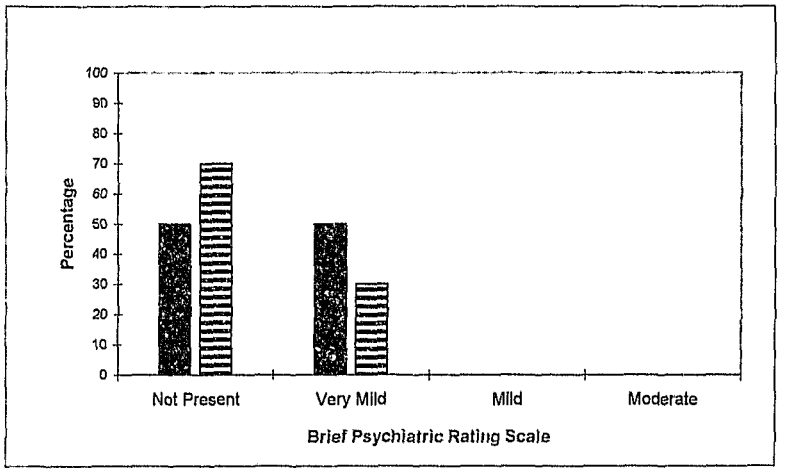


Figure 4.1. [b] Percentage of Group 2 respondents who showed Somatic Concern

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 2

ANXIETY

The question eliciting symptoms of anxiety was asked to find out whether youths were experiencing this symptom, because the situation in Kagiso was very stressful from the early 1990s up to 1994, as was outlined in previous chapters.

The question addressed issues such as worry, fear, and over-concern about the present situation as well as what the future holds for them.

Group 1

This group's results showed that only 10% of the respondents presented no symptomatology. The rest of the results showed a spread of 'very mild' (30%), 'mild' (20%) and 'moderate' (40%) anxiety.

The post-test results showed a shift of 60%, moving from 'mild' and 'moderate' anxiety respectively to 'very mild' (80%) and 'not present' (20%).

The results showed an improvement of 1.1%.

Group 2

The pre-test results showed that the whole group was experiencing some form of anxiety in a 'very mild' way (20%) as well as a 'mild' way (80%).

The post-test results showed a slight reduction (10%) of the group not experiencing anxiety whereas 90% still experienced anxiety in a 'very mild' and 'mild' form.

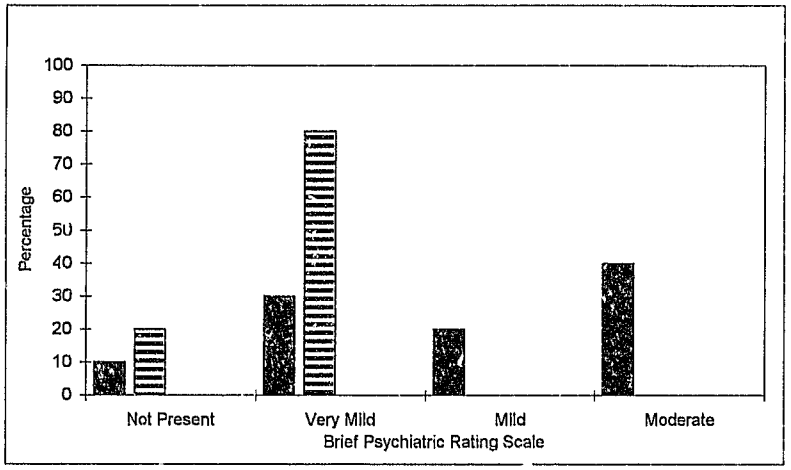


Figure 4.2 (a) Percentage of Group 1 respondents who showed Anxiety

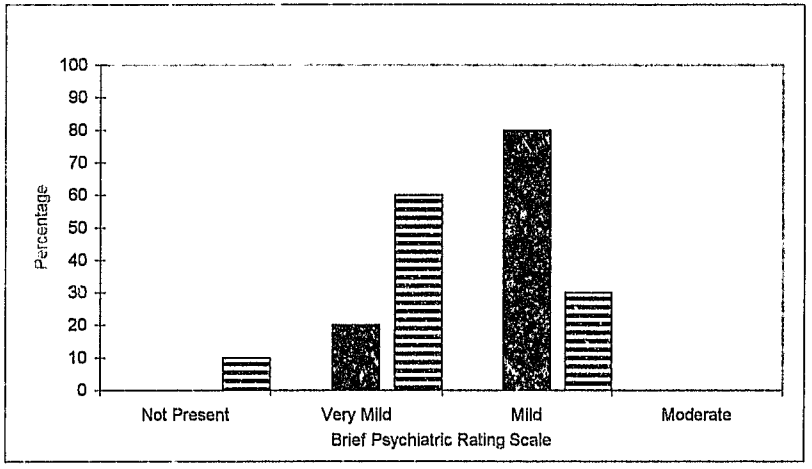


Figure 4.2 (b) Percentage of Group 2 respondents who showed Anxiety

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 3

EMOTIONAL WITHDRAWAL

When the struggle for liberation intensified, violence and crime increased. Crimes such as rape escalated. Young people, particularly females, became more vulnerable. The situation could lead to emotional withdrawal, i.e. being afraid to interact with people, and a tendency to isolate oneself because of fear.

This question was asked to address issues such as a lack of spontaneous interaction, poor relations with others and isolation from others (which could in itself lead to stress if not addressed).

Group 1

The pre-test results showed that 30% of the respondents had 'very mild' symptoms and 10% 'mild' symptoms, while 60% showed no symptoms at all.

Post-test results showed that there was a shift, in that only 10% showed 'very mild' symptoms while 90% showed no symptoms at all. There was therefore a 0.05% improvement.

Group 2

Pre-test results ranged from 'not present' (60%) to 'mild' (20%) and 'very mild' (20%). Whereas the post-test results did show a very slight change with 70% showing no symptoms, 20% of respondents still showed 'very mild' symptoms and 10% 'moderate' symptoms. During Life Skills training, feelings and emotions were not addressed. As a result the post-test showed a move toward 'moderate' which did not show during the pre-test.

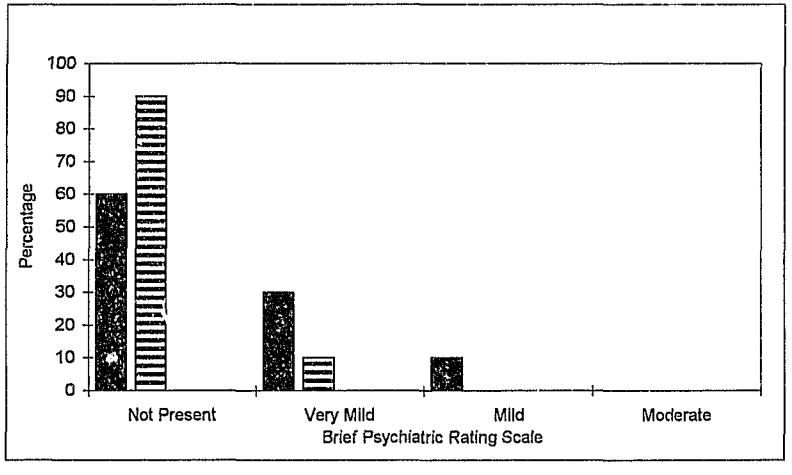


Figure 4.3 (a) Percentage of Group 1 respondents who showed Emotional Withdrawal

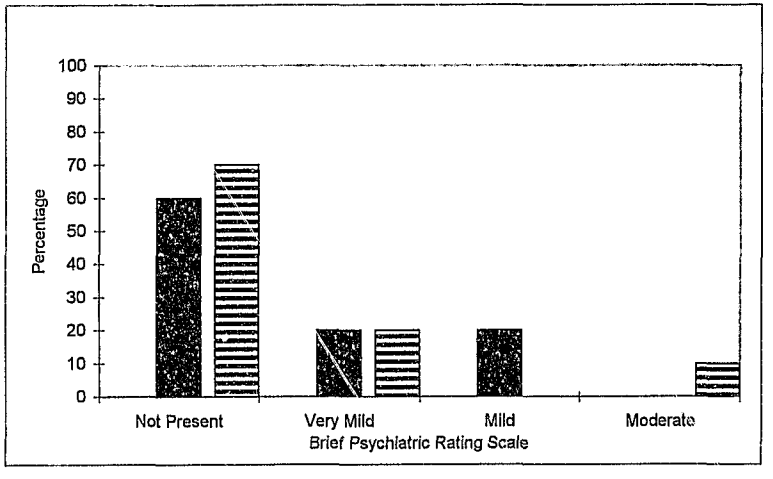


Figure 4.3 (b) Percentage of Group 2 respondents who showed Emotional Withdrawal

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 4

CONCEPTUAL DISORGANISATION

This question addressed issues such as thought processes, confusion, disconnection, disorganisation and disruption. These could be seen in people with mental disorders. The question was asked to check the level of conceptualisation in the youths and to exclude early signs of mental illness.

Group 1

The pre-test results showed that only 10% experienced 'very mild' symptoms, while 90% showed no symptoms. That was an indicator that the group was not yet at the level of pathology.

Following interaction in group therapy, the 10% that experienced symptomatology of a 'very mild' nature improved - the post-test results showed no symptoms.

Group 2

Pre-test and post-test results showed that the group had not reached the level of showing pathological symptoms.

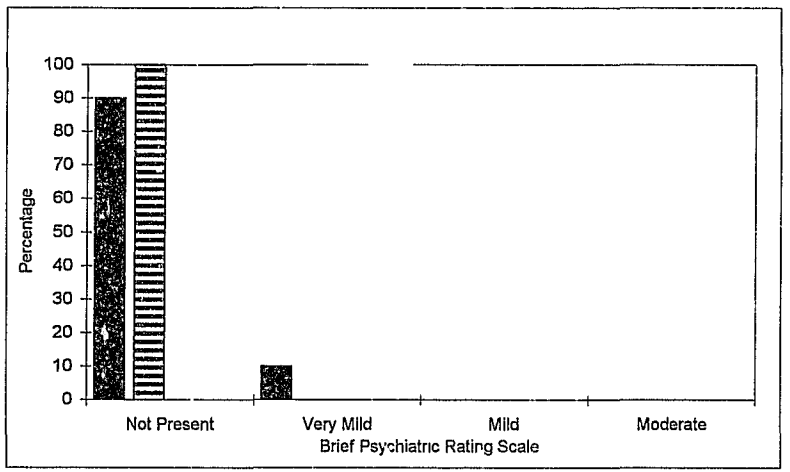


Figure 4.4 (a) Percentage of Group 1 respondents who showed Conceptual Disorganisation

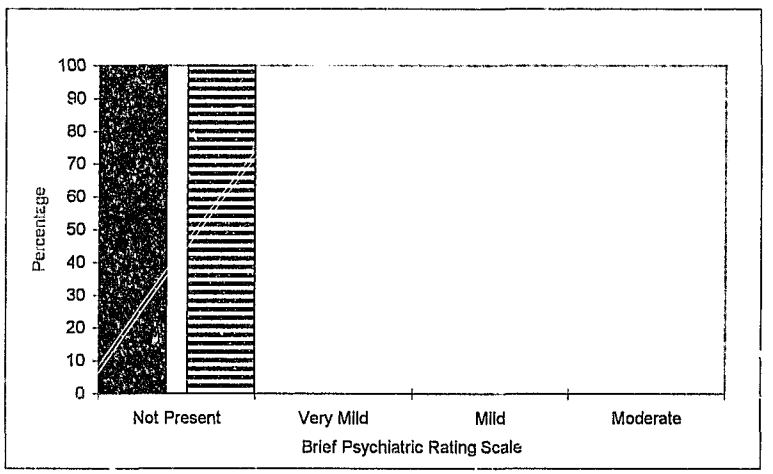


Figure 4.4 (b) Percentage of Group 2 respondents who showed Conceptual Disorganisation

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 5

FEELINGS OF GUILT

This question was asked to check whether the youths were feeling guilty about what had happening during the struggle era; whether they were blaming themselves for their actions, particularly when they had to disregard the values, norms and customs of their families and society; whether they showed any remorse for past behaviour.

Some of the youths were forced to participate in these activities against their will. The researcher wanted to assess how they felt when they were forced to participate.

Group 1

The pre-test results showed that 20% of the group had 'mild' symptoms, while 60% showed 'very mild' symptoms. Only 20% did not show any symptoms. Having gone through group therapy, 40% showed 'very mild' symptoms and 60% no symptoms.

There was therefore a 0.05% improvement in the post-test results.

Group 2

The pre-test results showed 60% of respondents with 'very mild' symptoms and 40% no symptoms.

Post-test results showed a 20% decrease in the 'very mild' and an increase of 10% in the 'not present' column. There was therefore not much improvement in this group

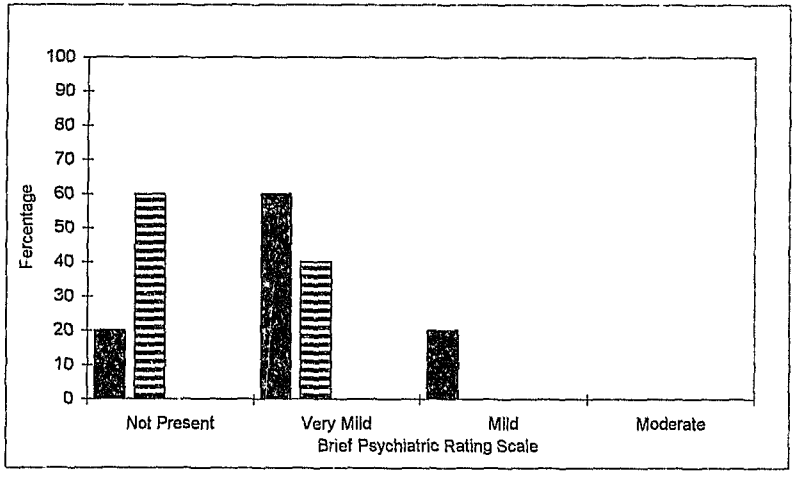


Figure 4.5 (a) Percentage of Group 1 respondents who showed Feelings of Guilt

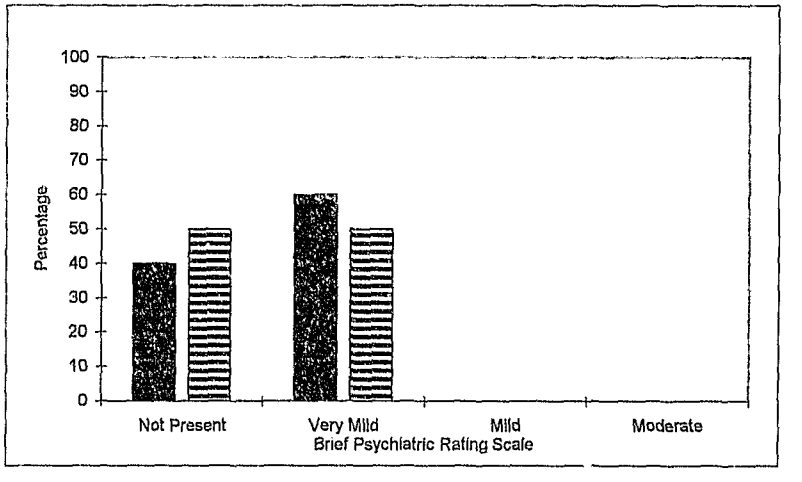


Figure 4.5 (b) Percentage of Group 2 respondents who showed Feelings of Guilt

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 6

TENSION

Tension is one of the symptoms in people experiencing stress. This symptom can manifest physically or psychologically or both. Physically the individual experiences body stiffness, shoulder pains, and neck stiffness, while psychologically the individual will be experiencing nervousness, agitation.

Group 1

The pre-test results showed that the group experienced only 'mild' to 'moderate' tension. The results showed that only 10% did not have any symptoms while 60% experienced 'very mild' and 30% 'moderate' symptoms.

The post-test results showed that 60% had 'very mild' symptoms while 40% showed no symptoms. The results in the post-test therefore showed that there had been an improvement.

Group 2

Pre-test results in this group showed that the respondents' symptoms ranged from 'very mild' to 'mild' and 'moderate'. Only 20% of the respondents showed no symptoms, while 60% of the respondents were in the 'mild' column with only 10% in the 'very mild' and 'moderate' columns respectively.

The post-test results showed a 10% increase in the 'not present' column. The 'very mild' group showed an increase from 10% to 40% while the 'mild' showed a decrease from 60% to 30%.

The results showed, therefore, that there had been an improvement of 0.01%.

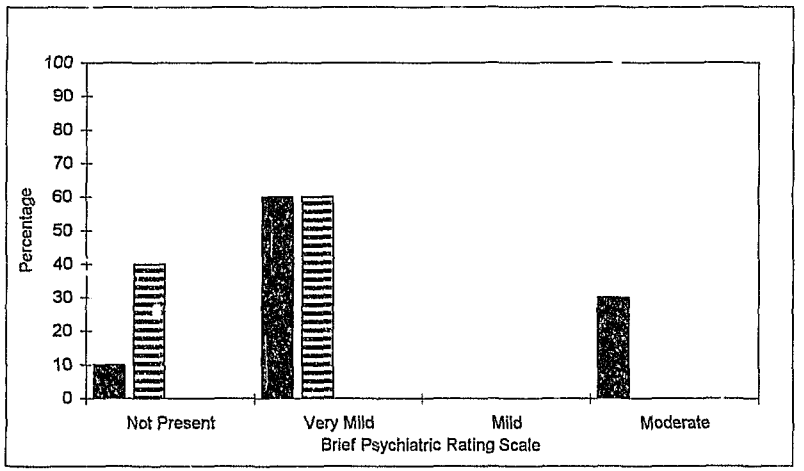


Figure 4.6 (a) Percentage of Group 1 respondents who showed Tension

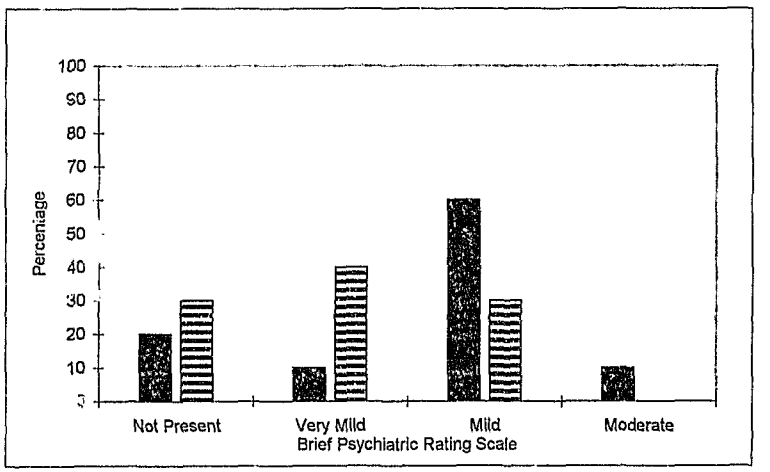


Figure 4.6 (b) Percentage of Group 2 respondents who showed Tension

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 9

DEPRESSIVE MOOD

This question addressed feelings of sorrow, being at the lowest ebb, being despondent and pessimistic.

These could be the result of having been exposed to stressful situations in the family, and/or in the township itself. The person feels helpless and can see no way of overcoming the situation. The fear that there is no way out could result in increased depression and could lead to mental illness if not addressed.

Group 1

The pre-test showed that 40% of the respondents presented no symptoms while 50% showed 'very mild' symptoms and 10% 'mild' symptoms.

The post-test results showed only 20% having 'very mild' symptoms and 80% no symptoms.

Group 2

The pre-test results showed 40% of respondents with no symptoms, 50% with 'very mild' and 10% with 'mild' symptoms. The post-test showed an increase of 10% in the 'mild' and a decrease of 10% in the 'very mild' group. There was no change in the 'not present' column.

During Life Skills Training affect was not addressed. As a result of the post-test showed a move toward 'moderate' which did not show during the pre-test.

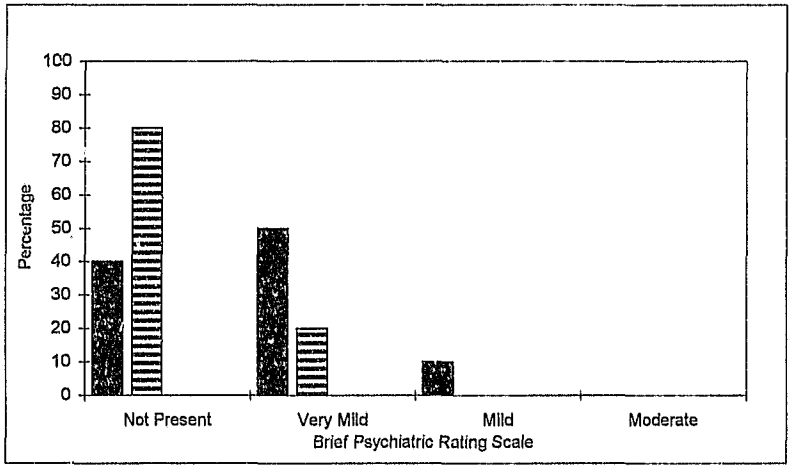


Figure 4.7 (a) Percentage of Group 1 respondents who showed Depressive Mood

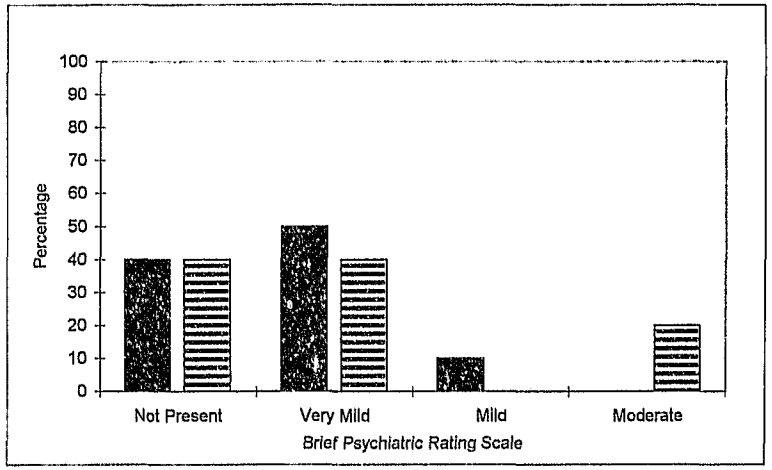


Figure 4.7 (b) Percentage of Group 2 respondents who showed Depressive Mood

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 10

HOSTILITY

This question strove to reveal symptoms such as animosity, aggressive behaviour and disdain for others. Hostility results in the physical and psychological state being affected because the person is feeling very angry towards others. The anger will manifest in the behaviour and feelings of the individuals.

Group 1

The pre-test results showed that only 10% showed the symptom of hostility. The statistical analysis of the post-test results showed no symptoms.

Group 2

The pre-test and post-test results showed no symptomatology.

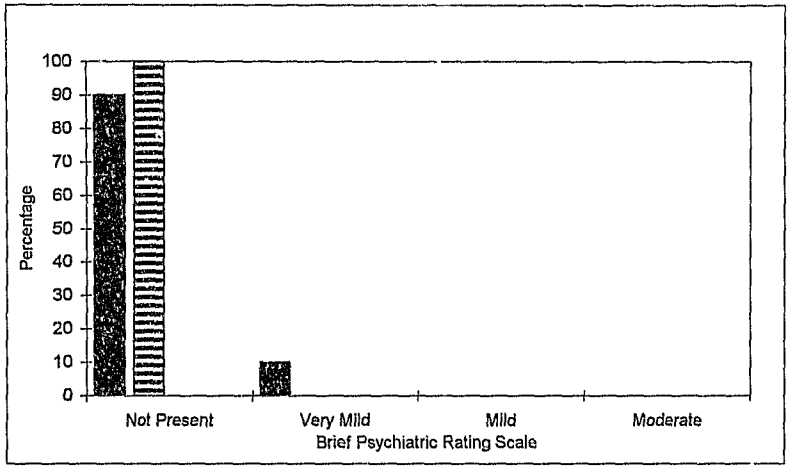


Figure 4.8 (a) Percentage of Group 1 respondents who showed Hostility

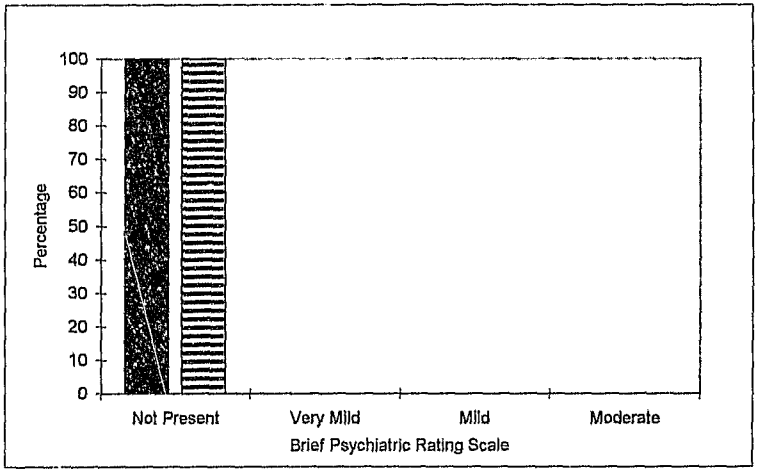


Figure 4.8 (b) Percentage of Group 2 respondents who showed Hostility

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 11

SUSPICIOUSNESS

This question addressed issues such as a mistrust of others, a belief that others harbour malicious or discriminatory intent towards oneself. The question was asked to elicit the element of mistrust, seeing that the youth in Kagiso township had been exposed to various forms of interrogation and harassment.

Group 1

In Group 1, the pre-test showed that the respondents' suspiciousness took a 'very mild' (20%) and 'mild' form (30%), while 50% of respondents were not suspicious.

After the group therapy, there was an improvement, in that 70% of respondents showed no symptoms of suspiciousness while 30% still showed 'very mild' symptoms.

Group 2

The pre-test showed that 70% of respondents were not suspicious, while 30% were suspicious. The post-test results showed no change.

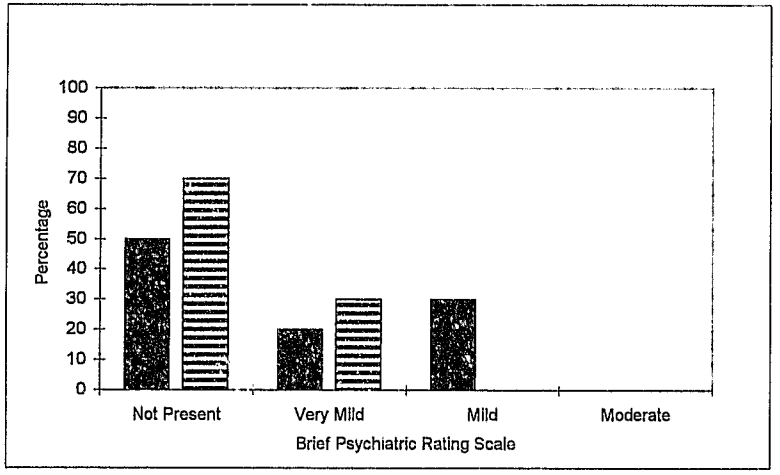


Figure 4.9 (a) Percentage of Group 1 respondents who showed Suspiciousness

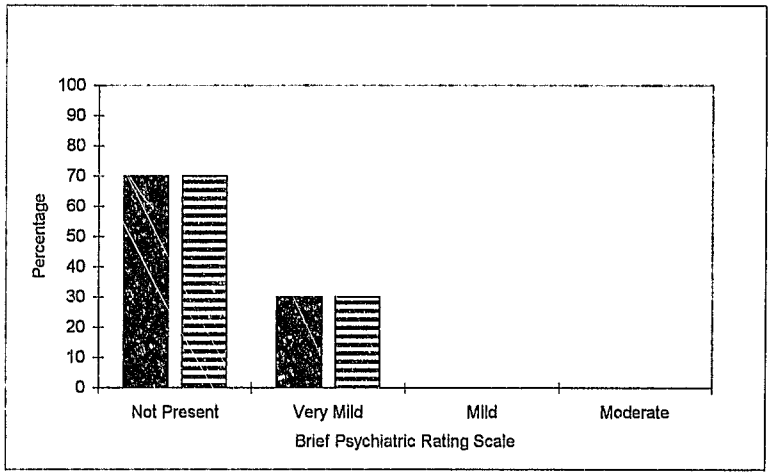


Figure 4.9 (b) Percentage of Group 2 respondents who showed Suspiciousness

KEY
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 14

UNCO-OPERATIVENESS

This question was aimed at addressing problems such as resistance, a rejection of authority, or extreme caution, making the individual difficult to deal with, but especially the resistance that had been part of the culture during the struggle for liberation. If not addressed, unco-operativeness could lead to the young person having learned that it is a normal way of life. The researcher included this question to establish whether such behaviour existed in the respondents.

Group 1

The pre-test results revealed that 60% of respondents did not present such behaviour, while 40% of respondents showed 'very mild', 'mild' and 'moderate' unco-operativeness.

After Group Therapy, there was a change in that only 20% displayed uncooperative behaviour while 80% showed no symptoms at all.

There had been an improvement of 0.05% in the post-test results.

Group 2

The pre-test results revealed that 70% of the respondents showed no symptoms, 10% of the respondents showed 'very mildly' symptoms and 20% 'mild' symptoms.

Post-test results revealed that there had been no change in the respondents who had no symptoms, i.e. 70%, while the remaining 30% showed 'very mild' and 'mild' symptoms.

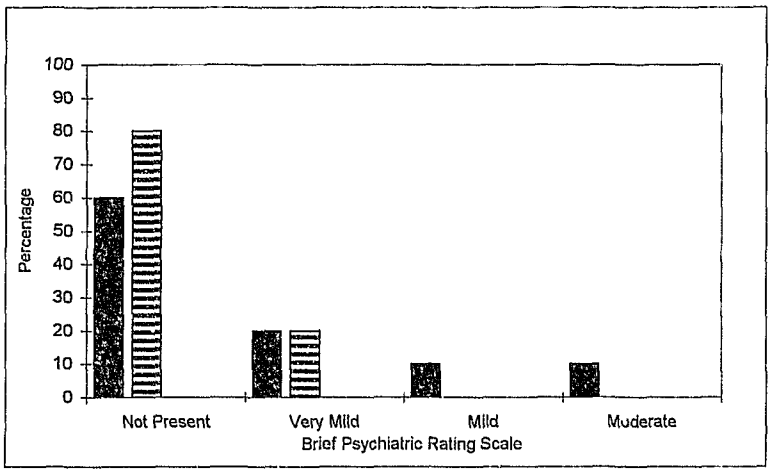


Figure 4.10 (a) Percentage of Group 1 respondents who showed Unco-operativeness

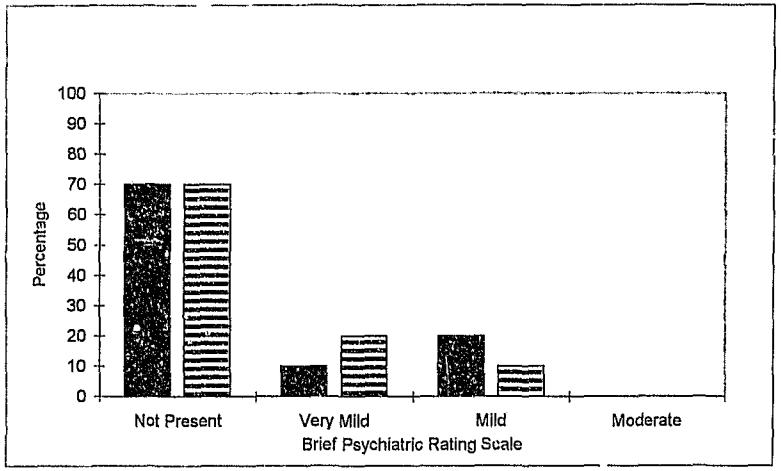


Figure 4.10 (b) Percentage of Group 2 who showed Unco-operativeness

KEY

GROUP 1 PRE-TEST

POST-TEST

GROUP 2 PRE-TEST

POST-TEST

Question 15

UNUSUAL THOUGHT CONTENT

When the youths completed the physical and psychological inventory list, it came to light that many of them were experiencing nightmares.

This question was asked to find out whether the youths were experiencing unusual, odd, strange or bizarre thoughts. Such thoughts could, if not addressed, lead to conceptual disorganisation, which is a symptom of mental illness.

Groups 1 and 2

The pre-test results showed that only 10% of the respondents suffered 'very mild' symptoms while 90% suffered no symptoms.

The post-test results showed that the respondents suffered no symptoms.

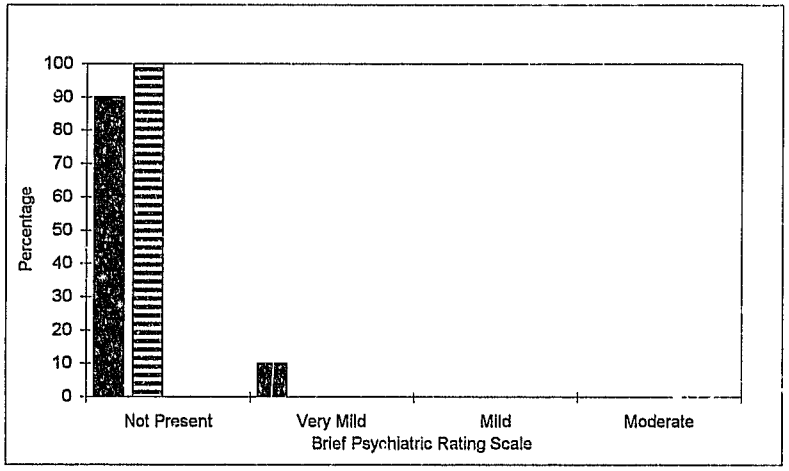


Figure 4.11 (a) Percentage of Group 1 respondents who had Unusual Thought Content

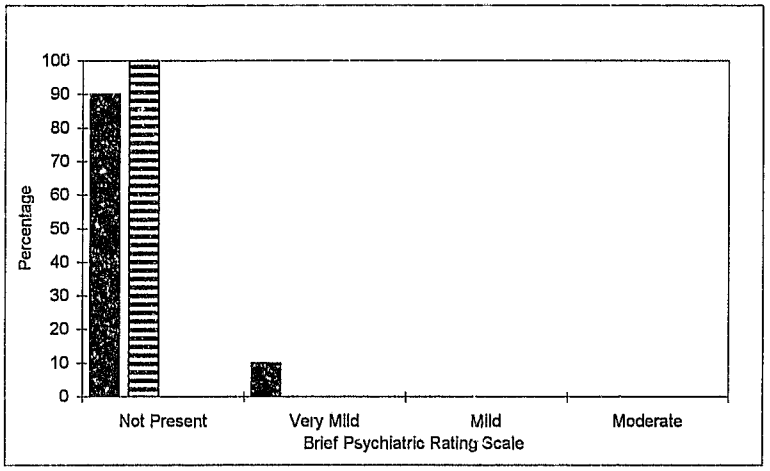


Figure 4.11 (b) Percentage of Group 2 respondents who had Unusual Thought Content

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Question 16

BLUNTED AFFECT

This question addressed issues such as reduced emotional t[illegible], reduction in normal intensity of feelings. The question was asked to find out to what extent the youths had internalised the actions they had taken during the period when young people were forcing the residents of Kagiso to adhere to the consumer boycott. Had that behaviour caused a reduction in the normal intensity of their feelings?

Group 1

Both the pre-test and post-test results showed that only 10% of respondents showed 'very mild' symptoms, while 90% showed no symptoms at all.

There had therefore been no change in the respondents' results.

Group 2

The pre-test and post-test results showed no symptomatology.

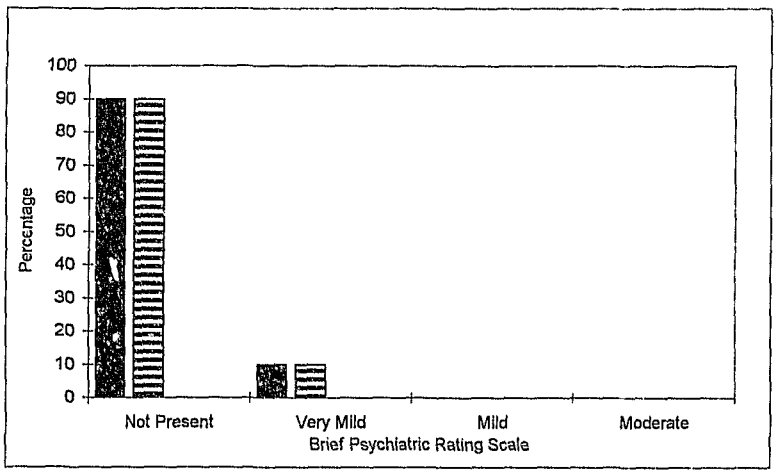


Figure 4.12 (a) Percentage of Group 1 respondents who showed Blunted Affect

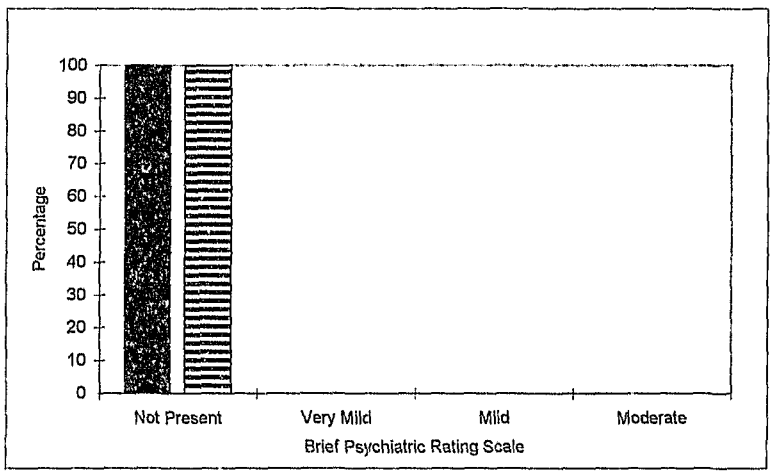


Figure 4.12 (b) Percentage of Group 2 respondents who showed Blunted Affect

KEY:
GROUP 1 PRE-TEST
POST-TEST
GROUP 2 PRE-TEST
POST-TEST

Questions 7, 8, 12, 13, 17, 18

7. MANNERISMS AND POSTURING

Refers to peculiar bizarre behaviour, unnatural motor behaviour.

8. GRANDIOSITY

The person has a tendency to exaggerating, be self-opinion, there is arrogance or a feeling of unusual power within oneself.

12. HALLUCINATORY BEHAVIOUR

There is a perception without external stimuli. This behaviour could be expressed using the five senses, i.e. touch, smell, hearing, sight, taste.

13. MOTOR RETARDATION

There is a tendency of being slow in movement and speech. This could also result in reduced body tone.

17. EXCITEMENT

The person experiences hyperactivity, increased reactivity, agitation, restlessness, talkativeness (or is unusually talkative).

18. DISORIENTATION

The lack of proper association for person, place or time.

The above questions were included in the questionnaire simply to exclude any form of symptomatology that could possibly lead to mental illness.

The pre-test and post-test results in both Group 1 and Group 2 showed no symptomatology. This was an indication that both groups had not yet reached the level where the symptoms of mental illness were present.

PART B

EVALUATION OF GROUP THERAPY AND LIFE SKILLS EDUCATION PROGRAMME

Data from the groups' narrative of what transpired during the interaction was also analysed and this will be presented in this section.

EVALUATION OF GROUP THERAPY

The group consisted of 10 youths, both males and females, between the ages of 18 and 22 years. All 10 of the youths were attending high school at the time.

Initial Contact with the Group

Initial assessment was done separately with each individual member, to ascertain the background information and to confirm the individual's willingness to participate.

The group was again brought together after eight sessions of group therapy to evaluate the outcome of the therapy. The facilitation of this phase was accomplished by questioning the members of the group, explaining the purpose and process of group therapy and validating the observations made by respondents during therapy.

Township lingo (multi-language) was adopted by the group to facilitate better understanding among members, as well as greater participation. The group did not feel comfortable with sessions being recorded, as stated before. The researcher therefore took extensive notes on what transpired during the interaction. That narrative was translated literally, as it had been expressed by the youths.

Because all the participants were still attending school, the evaluation session was held three months after therapy, i.e. during the school holidays.
The purpose of h[illegible]ng this session was to evaluate the effectiveness of group therapy and its impact on young people as compared to the Life Skills programme that the other group went through.

NARRATIVE OF WHAT TRANSPIRED IN THE DISCUSSION WITH THE GROUP (*Literal translation*)

Respondents will be referred to as **RES**
Nurse therapist will be referred to as **NT**

NT I have brought you together today to talk about our experiences that we had in our interaction during the past month. Are we ready to share those experiences?

RES 7 Today I am brave to start to talk. I know what to say, but I do not know how. Maybe I should let the others say what they want to say and I will be the last one to say something.

NT Respondent 7, I am happy that you say you are brave to start a conversation. What is it that you wanted to tell us? We are here to listen to your story.

RES 7 I feel I am able to talk with people. Just to start a talk. Remember that I used to be very quiet. If I have to start to talk with a stranger I used to sweat a lot. Since I started coming here, I no longer sweat when I talk with people. My father used to scare me a lot because if you say something, maybe joking, then he becomes angry, then it's a big hiding. Even if you say you are sorry, he will continue to beat you until he is tired.

That is why I prefer not to talk too much because I might say something that could lead to trouble. Now I have learned to say the right things, and I think before I talk. Since then I no longer say things that make my father angry. I now understand why he used to be angry. My father wants me to be something in life and I did not see it that way, you know. Now I am cool, and no more troublesome. I am going to study hard at school and finish my matric.

RES 2 During my first two sessions I found it difficult to talk about myself. I did not know what to say and how I should say it. I thought I would make a fool of myself, but as time went on I was the most talkative person. I began to realise how important it is to talk to other people about your own problems.

RES 4 I felt the same, you know. Do you think I was able to talk with my friends here? (looking at the Nurse Therapist).

NT Is there anybody who would like to answer that question? (looking at the rest of the members).

RES 1 You, Respondent 4, you want to take us back to the days of group therapy.

NT What were the days of group therapy like?

RES 1 Those were the days when some of us experienced the pain and anger. I do not want us to talk about it anymore. We had enough. I am tired of hearing these stories of fathers, mothers, sisters, grannies and what have you!

NT I wonder whether we shouldn't give other Respondents the opportunity to talk about their experiences?

RES 1 When you guys started asking me questions after I told you about my stepfather, I felt you were attacking me. I though you did not understand the situation that my mother and I were going through. Later when Respondent 1 said she had a similar father, I said to myself, *whoa!* I am not the only person with a similar problem. That is why I asked you, Respondent 1, whether you father was an assaulter.

Today I feel I can stand up to anybody who thinks he could push me around. I am a strong man now. I now understand when people say you must talk about our problems. Simply they say talk it out. Talk, we will listen. Hey! It works like magic.

NT What is this magic you are talking about?

RES 6 Talking to other people. Did it not work for you?

RES 3 You will never hear me complaining of headaches. Never again. Muzi, a fellow comrade of mine, said to me that if I have headaches I must smoke Ganja 'Dagga' (marijuana). It will take my headache away. I will never do that again. He misled me you know! I am going to tell him how he should treat his headaches.

NT What happened to the headaches? What will you tell Muzi?

RES 3 Headache is gone, gone with the wind! I think I understand why I used to get headaches. Its because I used to worry a lot. Now I must talk with someone if I have a problem, because problems are almost the same when you come to realise what we talked about in our group. I want to share this with my comrades, especially Muzi. How do I go about doing what we have been doing? (looking at the Nurse Therapist).

NT We have a Lifeline in Krugersdorp. They train young people who are interested to be lay-counsellors to help others. At the end of this session I will tell you more about Lifeline.

RES 10 I was surprised by the manner in which you people talked about your anger and frustrations that you experienced at home and only to find out in this group that you can actually talk about your anger and other people say, 'Oh! I am also angry right now'. What is most encouraging for me was that it is acceptable to be angry and to talk about how you feel when you are angry. I did not know how I felt when I was angry until I came to this group.

RES 2 *Ya*! It is true that I used to say to my sister that I am angry but I did not understand what it feels like to be angry. I just had this lump in my throat and at that time I would be very angry. I wonder if anybody who saw that I was angry and asked what it feels like to be angry, what I would have said to him then. Today I can actually have a feeling of excitement and I can explain why I say I am excited.

RES 5 When I said to the group, I feel angry, somebody else would say, I am also feeling angry about what you have just said because I had a similar experience. That is why when Respondent 1 said our fathers are twins, we laughed, but when you compared what they do, it is more or less the same things.

RES 8 I begin to understand why my mother is forever quarrelling with everybody at home. It is because she is stressed. I need to support her all the time. She needs my support.

RES 1 My mother swears, my father swears, my sister swears and everybody swears at my place, and this makes me angry. I cannot continue living with people who are forever swearing at me. You people did not tell me how I should conduct myself when people are swearing like this.

RES 9 Nobody is going to tell you how you should conduct yourself, Respondent 1. All we talked about was that this should not bother you, as you are not alone. I think we agreed that we can never change our parents, but we can support one another and talk about people like your folks who are behaving like this. Think of solutions of how we could begin to accept the situation that we can never change. Your parents will continue to swear as long as they are not aware that they are hurting you. Perhaps you should begin to talk about how you feel when they swear, like what we did in our exercises.

NT I do not think we should be going back to talk about how we are going to handle situations as they arise. The purpose of our being together today is to talk about our experiences in therapy. Respondent 1, I will talk with you after this session to see how we could take this issue further. Is that acceptable?

RES 1 Yes!

NT This is our final interactive session. I would like to take this opportunity to thank you most sincerely for the time that you have granted me and the forthrightness that you have displayed throughout the interaction.

QUALITATIVE ANALYSIS OF THE NARRATIVE

The facilitation of this phase was accomplished by monitoring verbal and non-verbal communication among group members for content and process that is, the actual meaning of words and actions and understanding themes and interactions among group members. Based on the group's needs, the nurse therapist facilitated the discussion of the process that occurred.

The nurse therapist used communication techniques such as listening, clarifying, questioning, interpreting, reflecting feelings, supporting, probing, confronting and summarising to facilitate the evaluation process.

IDENTIFIED THEMES WHICH FACILITATED THE EVALUATION AND THE ACTION OF THE GROUP

Theme identified:

- Fear of starting a conversation; and

- Physical reaction (body sweat) when in company of other people

Group's Action

By being warm, supportive and empathetic towards the group member, they encouraged the member to participate in the group.

Problem identification by the group and assisting the member in expressing his or her own feelings openly was seen among group members.

Theme Identified

- Identifying with one another with regard to a problem experienced.

Group's Action

Instilling hope, because 'I am not alone in this problem'. This encouraged members to share their innermost feelings about the problem that one member was experiencing, and to identify with that member.

It also encouraged an exchange of ideas and facilitated interaction and communication among themselves, with the aim of reaching consensus on the issue raised.

Theme Identified

- The group perceived themselves as the victims of the anger and stress experienced by their parents.

Group's Action

Interaction among the group, sharing of information, expressing feelings freely and discussing among themselves helped them to release the tension they were experiencing. Group members helped one another to confront a problem and reached consensus on how to develop new behaviours.

Theme Identified

- The ability to identify a problem experienced by parents. (Mother stressed)

Group's Action

The group was able to provide feedback on observed behaviour, related to the feelings of a member. Therefore inner growth, acquiring new coping skills to help themselves and others and the ability to gain strength and believe in oneself, were seen in the group.

Theme Identified

- Personal growth related to skills demonstrated to themselves and to others in respect of attempted solutions which are ineffectual or possibly detrimental such as smoking of marijuana.

Group's Action

Information was given on marijuana smoking and the dangers thereof. Particulars were given of the contact for follow-up. Also sharing of information with peer group on information acquired.

The group could differentiate between the good and bad behaviours, thus discouraging the member from associating with friends who encouraged bad behaviour. However, the member took it upon himself or herself to help the friend acquire new skills to cope with the problem. This demonstrated growth and maturity.

Theme Identified

- Happiness and hopefulness related to the ability to identify and cope with anger.

Group's Action

Active listening of group members when a member expressed anger and being able to identify with that member.

Ability of members to explore feelings among themselves. An exchange of ideas was encouraged and group members were supportive.

The pledge to help their peer group deal with feelings that resulted in physical and psychological symptoms.

WHAT DID THE GROUP LEARN FROM THE GROUP INTERACTION?

It was most encouraging to hear the young people pledging themselves to assist friends with similar problems. (As a result, when a satellite centre of Lifeline was opened in Kagiso township, some of the youth went for counselling courses and they are now rendering voluntary services at the centre).

Initiating a conversation with one another was difficult at first. The group expressed discomfort in the beginning. With time, group members began to talk to one another. One respondent said she had regarded herself as a shy person before but now felt that she could interac. with other people. She was encouraged to continue practising interacting with her peer group at school.

Comments by one Respondent

"I have learned to deal with my anger. I have been an angry child, now I have realised that I am gaining nothing by being angry all the time. Instead I suffer these headaches."

DEALING WITH THOSE YOUTHS WHO STILL HAD PROBLEMS FOLLOWING THE TERMINATION OF THE THERAPY

One respondent said "My mother swears, my father swears, my sister swears and everybody at my place swears and this still makes me feel angry. I cannot continue living with people who are forever swearing at me. You people did not tell me how I should conduct myself when people are swearing like this."

The group showed their empathy by expressing their views with regard to the behaviour of the respondent's parents. As a way forward, the respondent will be referred for further psychotherapy, so as to address the anger he was still displaying.

One young person said that she still perspired profusely each time she came to the group. She had never learned how to relax when she was among people. She, too, was referred for further therapy.

The three members who still expressed feelings of anger and frustration were also followed up to ensure that they attended the Lifeline counselling sessions.

DISCUSSION

The researcher instilled positive feelings among the group members, mainly focusing on how the members united with one another, sharing feelings and how they trusted and supported one another during the therapy sessions.

In reflecting their feelings the group members realised how important it was to express and discuss their emotions with other actively listening group members.

In the end, the group had the confidence that they would be able to share their feelings whenever they encountered problems, because they realised that keeping feelings to themselves affected them physically and emotionally.

In this study Group Therapy has proved to be successful. The psychiatric nurse will be able to utilise the study to prevent the occurrence of stress among young people.

EVALUATION OF LIFE SKILLS EDUCATION PROGRAMME

The target group of Life Skills participants were brought together after 8 sessions.

The content of the Life Skills Training programme was utilised to evaluate the impact of the programme. The emphasis was placed on personal hygiene, eating habits, sexually transmitted diseases and the importance of having healthy relationships with parents and siblings as well as returning to our cultural and traditional African way of showing respect for our elders.

Because all the participants were still attending school, the evaluation session was conducted 3 months after the implementation of the programme, i.e. during school holidays.

The sessions were summarised. Township lingo (multi-language) was utilised, and instead of recording the sessions, the researcher kept extensive notes.

The narrative below was translated literally, exactly as expressed by the participants.

The purpose of bringing the group back was to evaluate the effectiveness of the Life Skills Programme and its impact on youths, compared to the group that went through the Group Therapy sessions.

For various reasons it was difficult to get the whole group together again. The researcher ended up with seven (7) participants for the feedback session. Three of the youths did not return for this session because they had to join their parents who had returned to the rural homelands due to loss of employment.

The group was given the opportunity to introduce themselves to each other again and to state how they had each experienced the sessions previously.

NARRATIVE OF WHAT TRANSPIRED IN THE DISCUSSION WITH THE GROUP (*Literal translation*)

Participants will be referred to as **PM**

Researcher will be referred to as **R**

R I have brought you together again to talk with you about the experiences you had in this group and whether you have gained anything by attending this programme. Is there anything that you would like to share with us?

PM5 I believe that a Life Skills programme should be taught at every school because it was eye-opening to realise how important it is to take care of oneself. I am referring to taking care of the body by keeping it clean, feeding the body with food that is right and to prevent disease. What is very scary for me is the AIDS. I always hear about AIDS everywhere but what I have learned here and the pictures you showed us in that book are frightening. I told my friends at school about it. They wanted to know more about AIDS. That is why I say, why don't you teach this programme at our school? I am sure that a lot of my classmates would attend.

As for eating the right food, you know, I was watching the children during break time. They were eating from 'quarters' (bread and atchar = a spicy pickle) to 'magwenya' (doughnuts = fried dough) with 'cans' (fizzy cold drinks, i.e. Coke). Some of them here were sucking 'stock sweets' (lollipops) and eating chocolate. (Everyone laughed.) Ever since the sessions on eating I made up my mind that I should eat correct food. I always carry my lunch box from home. I eat a sandwich of brown bread and a filling of either tomato or cheese and I drink juice. Ever since I started carrying my lunch box, I have saved on my pocket money. (More laughter.)

I am serious, you must come to our school and talk to the children. I am sure they will listen to you.

R PM5, thank you for your input. There is a School Health Nurse who visits schools on a regular basis. I will contact her and give her your valuable input in this regard.

PM3 I know that I must reduce the 'chocs' (chocolate) that I eat everyday. My skin will become better. Do you see that since I stopped eating 'chocs' my 'pimples' (acne) have reduced? I agree with PM5 that such topics should be taught at school.

What I have learned from these classes is that I do not feel shy to talk about my 'body' (sexuality) and what it means. When you know what is happening with your body, then you can begin to take care of yourself.

At home my mother did not want to hear anything about my body. I asked her many questions and she only said it was part of growing up. I just shouldn't sleep around with boys, because it will lead me into trouble. What 'trouble', she didn't say.

In these classes at least I was able to tell my friends that when you reach my age, your body begins to change and that there are hormonal changes and results thereof. When I told my mother about the classes and what we learned, she told me that she had never been taught by 'Granny' (her mother) about such matters. She just saw things happening to her and had never really confided in Granny. She told me that when you, Sis' Dee, spoke to them as the parents you said you were going to teach us about our bodies and they said they were happy because they can never find themselves talking to their children about such matters.

That is why I also support PM5 that you should also teach other children at our school as well. You should know that I do not go to the same school as PM5.

R The School Health Nurse here in Kagiso should be visiting all the schools. I will communicate with her in this regard. It is encouraging to hear that you were very attentive when we discussed these topics.

PM7 PM3, you are lucky when you say you have stopped eating chocolate. For how long will you stop?

PM3 I told myself that if I want to get rid of the 'pimples' (acne) then I must stop eating chocs. Look at my face (turns her face to PM7). Do you see any new pimples? (PM7 shakes his head). You see, if you are prepared to do something, do it.

PM7 Well, I would like you to talk to my girlfriend, 'cause when I spoke to her about her eating habits she did not believe me. During break at school she eats what PM5 was telling us earlier. We were all laughing when PM5 was telling us, but I am telling you people, she does not want to stop.

As for AIDS, it is very scary. I told myself that I must take care of myself. Ever since I started to take these classes I bath everyday. I thought that as a man, you must always have a certain smell that some guys always have. (The girls giggled). Since I started bathing everyday I do not have it. So it shows that it is important to take care of your body well.

As for 'Ubuntu' (to be humane) I would like to say that I have realised that young people are undermining their elders. They refer to their mothers as 'magressa' (slang for granny). They call them by their first names like Sis' Thando and so forth. No more respect. I agree we should bring 'Ubuntu' back and respect our parents.

Maybe that is why young people are like this today - smoking dagga, bunking school, raping from babies to the elderly, as well as hijacking cars. All this stems from the fact that they have lost respect for their parents.

We are fortunate to be reminded of our tradition. Maybe we should remind our friends too. You will see youths wearing traditional attire at functions but they don't really respect it. (They all laugh). I am serious, guys. Why symbolise something, yet you cannot practice it? It is important that we remind these people of our traditional practices that we have learned in these classes.

R A very important point you are raising. I am pleased that you are reinforcing 'Ubuntu' in us. Let us go back to our friends and colleagues at school and the youth clubs and begin to talk about 'Ubuntu' with them.

PM4 I am really happy to be back at the classes. I really enjoyed them and it's like today we are here to do revision about what we learned. I want to share my experience with you after I have attended these classes.

At our youth club we do have a 'Nurse' (Professional Nurse) and the other Sister (a nun) who visited us. They were talking about the spreading of AIDS and how we could prevent it. I was a bright one because I could also talk about what I learned at these classes.

I also told them about the book that you showed us with those pictures of how AIDS could damage the body. They said they would come and talk to you about those classes that you had with us.

For me, I enjoyed every single topic that we talked about. That is why I can still remember what we talked about, because the classes were 'free' (relaxing) and I could say what I wanted to say at any time without being stopped or being shy. As for 'Ubuntu' we must all talk about it to our friends.

PM10 I also heard from a friend of mine who attended the talk at your youth club that there was a girl who knew a lot of stuff and the Sisters were happy. Was that you? Well done, you represented us all. That was good. (They all applauded).

R The more I listen to your feedback the more I realise how important it was to have interaction with people like yourselves in this type of programme.

PM10 Much has been said about the programme and what every one of us has learned. As for me, I do not want to repeat what the others have already said but want to bring a new concept of empowerment. I feel empowered by the information that I have gathered in this programme. For me it was eye-opening, thought- provoking and very interesting. Sharing such information with my friends at school was very easy, because I told them about these discussions with ease.

To my surprise most of the guys that I hang around with were not knowledgeable about how our bodies develop to adulthood and what you experience in that process. One friend of mine said he read about puberty but did not quite understand certain issues. When I told him about the changes that happen and how and why, only then did he begin to understand why such things were happening to his body. So it is important that these things be taught to us at school. I really enjoyed the interaction with the rest of the group.

PM6 We talked about how we could stay away from trouble, such as using preventative measures to ensure that we don't contract diseases. What still bothers and terrifies me is that no matter how well I look after myself, danger is always lurking around. I could always get raped by an oblivious infected person and contract that vile disease, AIDS, or some other sexually transmitted disease.

R I hear what you are saying to us. I know it is scary, but remember we spoke about taking care of ourselves. Females are at greater risk, so avoid walking alone in the evening or at night, especially in dark, deserted areas. Type of dress is also important. Females should also not open their doors to strangers, especially when alone at home. Walking in groups also minimises this risk factor.

These are but some of the precautions females should take, to prevent crimes such as rape.

Do any of you still remember what we said regarding the steps to take if you find yourself in a situation such as has been described by PM6?

PM4 I remember we said if you happen to be raped by an unknown person, you should not keep quiet about it but go to the clinic or the nearest police station and report the matter. The clinic will draw blood for various tests and will give you treatment immediately, to try and kill the germs that you might have got. The problem is, people get scared, and don't report the matter to anyone. I, too, would be afraid if I was raped and had to talk about the ordeal. That is what terrifies me the most.

PM10 I think if you girls listened to what Sis Dee told us in the previous classes and what was said today, you can avoid being raped. So, I still say, protect yourselves as much as you can to avoid ending up with the troubles that could keep you miserable for the rest of your life.

PM6 This was my only fear that kept on coming to my mind whenever rape was mentioned. Now I know what to do in case it happens. One can never know what could happen to you. Gone are the good days of Ubuntu in our townships. We girls are always in alert mode. We never get to relax and be ourselves.

R It is good that we express our feelings in this regard. The purpose of this programme is to make you aware of things that can happen, to make you vigilant, to practice caution. It helps you to equip yourself with coping skills, such as the ones discussed in these sessions.

PM1 I agree with what is being said. I feel I have acquired some coping skills that I needed to take my life further. One hears about such issues as discussed but when you want to know more, you are told this is adult talk. I am happy that when you talked to our parents about participating in these classes you told them what you would be teaching us.

My mother said to me that she could not have done much, except telling me to take a daily bath. These classes were really interesting and I wish I could attend them from time to time. This place is a chance for me to really voice my problems, and get some answers. It also makes me aware of other people's problems, which I was never aware of.

R You are participating in youth clubs. I would like to encourage you to attend these meetings regularly and begin such discussions in your meetings. PM10 talked about empowerment. By discussing such issues with your friends at school, as well as your peers in the community, you are well on your way to empowering others. In the end, most of the youth of Kagiso will be knowledgeable with this information that you have gained from these sessions. Knowledge is power and with it you will never go wrong. Sharing it is also one of its greatest powers.

This is our final interactive session. I would like to know how you felt while interacting with each other and about how the sessions were conducted as well as about my participating in all of this. I have heard how the programme has empowered you, now I would like to hear about your feelings.

PM10 I felt shy in the beginning when I had to introduce myself to the group. As we interacted I began to relax but when you talked about the body issues (sexuality) I felt embarrassed. But later on I began to relax again and wanted to know more about such issues and the topic ended up being the most interesting one because we moved from the body issues to other topics that opened my eyes. Thank you very much for having afforded me this opportunity.

PM4 The same with me. I thought I would never have opened my mouth in these discussions but you made me gain confidence. Even at school my teachers are saying I am able to talk and share my views with the class. I feel great that I have attended these classes.

PM7 When you are told to attend something that you don't know at first ... I came with mixed feelings of whether to attend or not to attend. But when you said in the beginning that we are free to leave at any time, it was OK. I felt like standing up and leaving but I did not have the guts to do so.

I have never been in a group as close as we were, and sharing experiences together. You made us feel so close and made me feel confident that I could begin a conversation and express my views without feeling bad. You accepted me as I am and made me feel good about myself. Thank you.

PM6 I did not feel shy nor did I have mixed feelings but I had this funny feeling of, what are we going to gain in the end? But with time I began to realise that you were trying to give us the light and I felt good that I was hearing things that my friends were not aware of. Now I really feel good that I was offered this chance to attend these classes. Thank you very much.

PM5 I am hearing everybody saying I feel... I feel... When I started with the classes I felt nothing inside me. This was like attending some biology classes at school.

With time, I realised that this was different because here we were encouraged to share our fears. I was nervous about such issues and that was when I began to have this feeling of wanting to know more about the topics discussed. I still feel nervous about some of the diseases that we talked about.

In the end now I feel great that I am now knowledgeable and feel safe that I can protect myself. Thank you very much for having afforded me this chance to attend with these guys, because now we are friends here.

PM3 When I hear everybody talking about what it was like in the beginning and how it is today, I realise that I was not the only one experiencing this feeling. I was like PM7 in the beginning, wanting to stay away, but I was curious, that is why I kept on coming. During our third session I became comfortable and started to open up.

Remember, I did not know the group then, so I had to start by getting used to them and that was when I started to be talkative and enjoy the sessions. I enjoyed every moment thereafter. I feel great today.

R *It is encouraging to hear that you have learnt so much and how grateful* you are. I would also like to thank you most sincerely for the time that you have granted me and the forthrightness that you have displayed throughout the interaction. I will be getting in touch with you soon for a programme that you should attend later. Thank you.

DISCUSSION

The group dealt with the content of the topics presented. The researcher did not go too much into addressing the feelings the participants expressed. The researcher dealt with separation anxiety again and encouraged the group to attend the sessions that would be arranged for them.

The group will be referred for therapy outside of this study because the group was formed out of the sample according to the inclusion criteria.

4.5. INTERPRETATION OF RESULTS

The interpretation of the results will be done on the basis of the Pre- and Post-test analysis between and within the two groups.

The evaluation of the two groups after the Group Therapy and the Life Skills Training will then be analysed.

4.5.1 ANALYSIS BETWEEN THE GROUPS

Analysis Between Group 1 and Group 2 : Pre-test Results

According to the results of the analysis, there was no difference between the mean scores of the two groups before Group Therapy and Life Skills Training.

The results set a point of departure for the analysis and interpretations of the post-test results for the two groups.

According to the statistical analysis this was either that:

- there was no difference between the mean scores of Group 1 and Group 2 before the test

  or

- there was a difference between the mean scores of Group 1 and Group 2 before the test

The former statement would be accepted if the Test Statistic U of either group was less than or equal to the tabulated value at the 5% significance level.

Data:	U-B^G1	U-B^G2	U-O.05
	54.5	63	23

On the basis of the above data it was, therefore, concluded that there seemed to be no difference between the mean scores of the two groups before the test.

The results showed that the groups had been extracted from a population with continuous and symmetrical distribution.

Analysis between Group 1 and Group 2 : Post-test Results

According to the statistical analysis it was either that:

- there was no difference in the mean scores within Group 1 and Group 2 after the test

  or

- there was a difference in the mean scores of group 1 and Group 2 after the test

The former statement would be rejected if the test statistic of either Group 1 or Group 2 after the test was less than or equal to the U value at 5% significance level.

Data:	U-A^G1	U-A^G2	U-0.05
	66.66	34.33	23

On the basis of the above calculations it was, therefore, concluded that there seemed to be no difference in the mean scores of the two groups after the test.

The results set a point of departure in the analysis and interpretations of the post-test results for the two groups, since they implied that the mental status of the two groups had been 'at par' before the test.

Statistically there was no difference between the two groups. However, a comparison of the figure 4.13 and figure 4.14 post-test results showed a difference between the mean scores of Group 1 and that of Group 2.

4.6 ANALYSIS WITHIN THE GROUPS

Pre-test and Post-test Results : Group 1

See Figure 4.13 which was used to gain insight into the meaning of the overall results.

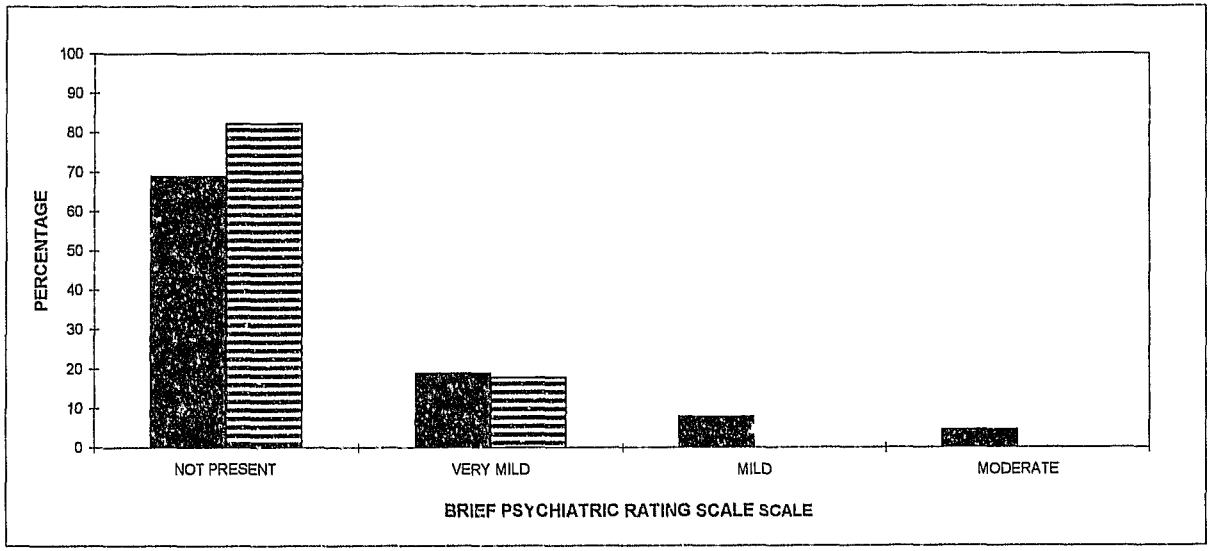


Figure 4.13 Percentage of overall comparison of mean scores of Group 1 respondents on the brief psychiatric rating scales

KEY
PRE-TEST

POST-TEST

According to the statistical analysis it was either that:

- there was no difference between the mean scores within group 1 before and after the test

  or

- the mean scores within Group 1 after the test were lower than before

The former statement would have been rejected if the T-statistic of the positive differences had been less than or equal to the tabulated value at twice the 5% significance level.

Data:	T^(+)	T^(-)	T-0.05
	0	55	11

The above calculations were that the T-table value was 11, which was obviously greater than the test statistic and therefore in favour of a statement that the mean scores within Group 1 after the test were lower than before.

Figure 4.13 shows that there has been a shift from 'moderate', 'mild' and 'very mild' to an increase in the 'not present' response and a decrease in the 'very mild' response respectively.

The difference in the end, in the researcher's opinion, seems to indicate that group therapy did have an effect on group 1.

Pre-test and Post-test Results : Group 2

See Figure 4.14 which was used to gain insight into the overall results. This figure depicted a situation of the group before Life Skills Training. One observes that their mean scores are distributed across the **BPRS** up to 'moderate' response.

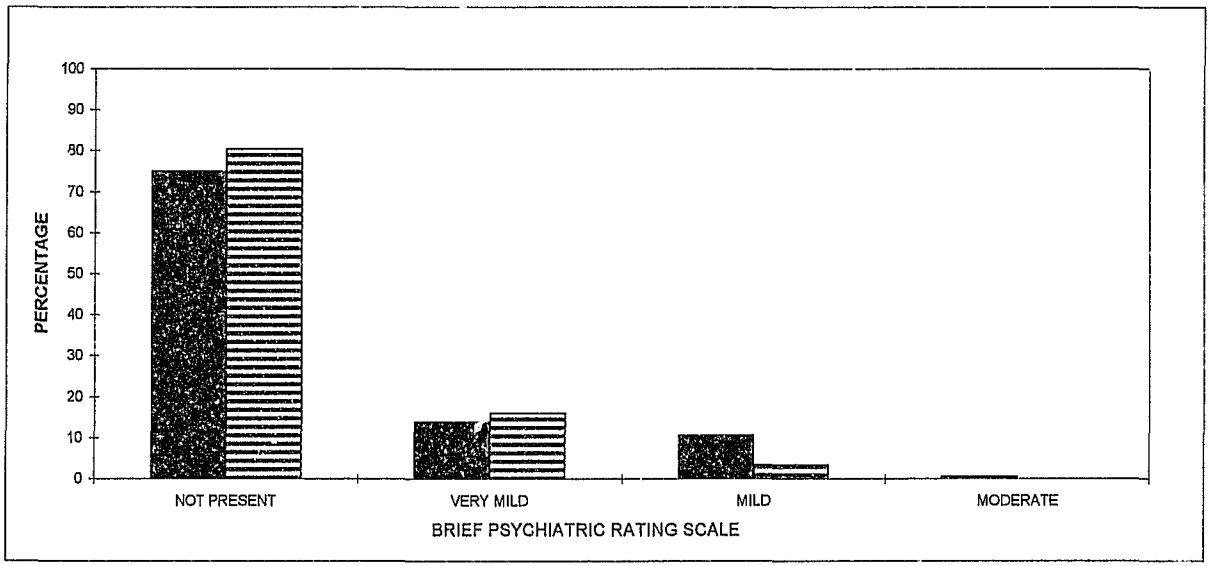


Figure 4.14 Percentage of overall comparison of mean scores of Group 2 respondents on the briwf psychiatric rating scales

KEY
PRE-TEST
POST-TEST

According to the statistical analysis, it was either that:

- there was no difference between Group 2 pre-test and post-test in terms of the mean scores

  or

- there was a difference in the mean scores of Group 2 before and after the test.

The former statement would have been rejected if the test statistic T had been less than or equal to the tabulated value at the 5% significance level.

Data:	T^(+)	T^(-)	T-0.05
	0	36	11

The above calculation shows that the tabulated value being 11, there is no difference between Group 2's pre-test and post-test results in terms of the mean scores.

Figure 4.14 shows that there has been a very slight shift in terms of the mean scores. However, from a statistical point of view, the shift was so slight that it could not be recognised.

Part B of the data analysis supports the findings in Part A. The narrative as presented has revealed that the interaction with youth during group sessions has influenced the results as indicated above.

4.7 CONCLUSION

In this chapter the data was analysed using the Brief Psychiatric Rating Scale questions and the narratives from both groups that underwent Group Therapy and Life Skills Training. The findings were discussed in the form of statistical calculations, graphs and tables.

CHAPTER 5

COMMENTS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

The purpose of this study was to evaluate the effectiveness of Group Therapy on young people exposed to stress.

The research question that guided the study was: How effective was group therapy as compared to life skills training in working with young people living in a township with high levels of violence and other forms of social disorganisation?

In this chapter, the set objectives will be evaluated, to determine whether they have been achieved.

Limitations of the research will be highlighted and the recommendations will be discussed.

5.2 OBJECTIVES

5.2.1 Objective 1 was to establish the stress-related symptomatology displayed by the groups.

In this study it was revealed that the young people concerned did, to a certain extent, display symptomatology which was stress-related. The responses to the Brief Psychiatric Rating scale questions presented in figures 1.0 to 12.0 show that the symptoms were present from 'very mild' to 'moderate' according to the rating scale. Questions that were included to exclude mental illness indicated that both groups had not yet reached the level where symptoms of mental illness were present.

5.2.2 Objective 2 was to develop a series of group therapy sessions that were to address stress-related symptomatology.

Group therapy has been successfully described as a resource that can be utilised by the psychiatric nurse therapist as a way of facilitating the mental health of yc : xposed to stress.

Therapy sessions have been developed by the researcher to facilitate the interaction among the youth to facilitate the promotion, maintenance and restoration of mental health of youth exposed to stress.

Youth exposed to stress experienced group interaction through the use of Yalom's therapeutic factors to gain insight into how they can approach complex situations through interaction with one another.

Youth exposed to stress are not a 'lost generation', they can be assisted through group therapy to become valuable members of society.

Group therapy was helpful in assisting youth exposed to stress to recover from negative effects of violence and to acquire inner strength, hope and skills in order to help themselves and other youths in similar situations.

5.2.3 Objective 3 was to develop and present a programme for life skills training to a second group of young people manifesting stress-related behaviour.

Life skills programme has been successfully described as a resource that can be utilised to facilitate health education among youth.
Topics presented were relevant to youth's development. Youth gained knowledge and skills in the prevention, promotion and maintenance of a healthy way of living. Youth found that the information acquired could be shared with other youths in their schools.

The interaction with youth in the presentation did not demonstrate any emotional attachment with each other as a group nor did they express their feelings and behavioural aspects which could have facilitated healing as they were exposed to stress.

Life skills training is useful as a source of information sharing but cannot assist youth exposed to stress to acquire inner strength, hope and skills in order to acquire self control and be able to help others in a group.

5.2.4 Objective 4 was to determine the young people's perception of the benefits of the programmes.

The researcher described the interaction with the young people during the focus group. The perception among the youth in both groups revealed that each programme presented was found to be useful to them. The suggestion by the group that went through life skills training that they would like to share the information at their schools is a clear indication of the perception created by the youth that it was a worthwhile programme. The same was expressed by the group that went through group therapy. They also wanted to assist other youths who have been exposed to stress by joining the lay counsellors training offered by Life Line project in Kagiso township.

5.3 LIMITATION OF THE RESEARCH

5.3.1 The Sample Size

The sample size posed a distinct limitation to this study as does the fact that the population is confined to young people attached to a church youth group.

The sample included only those youths who were attached to the youth clubs in the four selected churches. It was not universally inclusive. The inclusion of those youths in the township not attached to youth clubs could have drawn all those young people, irrespective of age, who regard themselves as youths by virtue of their still living with their parents, according to the definition of 'youths' in the township. This would have influenced the group process and the results.

5.3.2 The Use of the Instruments

The Psychiatric Rating Scale is normally utilised for persons who display psychiatric symptoms and it is, where possible, completed by a Psychiatrist. In this study the BPRS was completed by a General Practitioner with psychiatric nursing qualifications. The questionnaire was utilised in this study because the aim was to focus on the prevention of mental illness among young people exposed to stress.

It is possible that a small group does not give a true reflection of the experiences and the results of group therapy. However, if group therapy were conducted with different groups experiencing different problems, there may have been different findings.

5.3.3 Practical Problems Encountered

Participants in both groups were still attending school. It was therefore difficult to have all group members together except when they are on school holidays. Focus group was therefore conducted three months after group therapy and life skills training was done. The possibility of a halo effect cannot be excluded.

Three members in the Life Skills Training group could not attend the focus group discussion conducted three months later. The reasons being that their parents had to return to the rural homelands due to unemployment. Therefore the input on the perception on the programme was based on 7 of the total 10 participants. It was therefore difficult to locate the three participants even during school holidays.

5.4 RECOMMENDATIONS

As a result of the findings in this study, the following recommendations are made:

5.4.1 The churches in Kagiso should launch Group Therapy programmes to address the problems of young people. By so doing, they will create an environment that will be conducive for young people to express their feelings and frustrations.

The present health care services focus mostly on primary health care services, which address mainly physical aspects such as maternal and child health and overlook the mental and emotional aspects, particularly in young people who have been exposed to stress because of the violence that has been plaguing our country.

This idea is supported by Dr R Zwi, the Provincial Director for Mental Health, who was reported in *The Star* to have said that most health systems ignore the mental and emotional aspects of health, despite the fact that their prevention and treatment were effective and affordable. Fortunately, Dr Zwi is working to integrate mental health services into the primary health care system (Simon, J. 1996 *The Star* 9 October).

5.4.2 Members of the churches in Kagiso who are health professionals should be recruited and equipped with psychiatric clinical skills and knowledge that will assist them while working in the community, to assess, plan and implement programmes in the promotion of mental health among young people in churches. When the programme becomes successful it will spread through the township of Kagiso.

Health professionals at Kagiso township clinics should continue with the rehabilitation programmes that they have implemented and be able to evaluate the effectiveness of their programmes to prevent the relapse of those who were the victims of stress.

5.4.3 Such programmes should be supervised by skilled psychiatric health professionals to make sure that they are fully implemented, in the interest of all young people.

5.4.4 Support systems must be provided to the health care professionals dealing with such programmes. This should be done in the form of training and development, and supervision by the more experienced nurse therapist.

5.4.5 This study has been limited to four churches in Kagiso, with a sample of 20 participants. Therefore, the results can only highlight the existence of some problems that young people are experiencing. One cannot generalise in this regard.

For this reason, the study should be repeated in Kagiso township in future, with a greater sample of young people exposed to stress following violence, so that a broader picture could be given and results be spread to other churches in Kagiso.

5.5 CONCLUSION

The promotion of mental health in young people could result in the promotion of a healthy nation, since young people are regarded as the future generation of this country.

The need to motivate all health professionals in Kagiso township is important, so as to assist in the development young people, equipping them with Life Skills Training while Psychiatric Nurses could address psychological issues.

These recommendations are provided for health professionals working in the various communities, in psychiatric practice, psychiatric nursing education and in the research field. These health professionals would ensure that when they interact with young people, they realise that their feelings need to be acknowledged whenever young people experience stress, to prevent the occurrence of mental illness.

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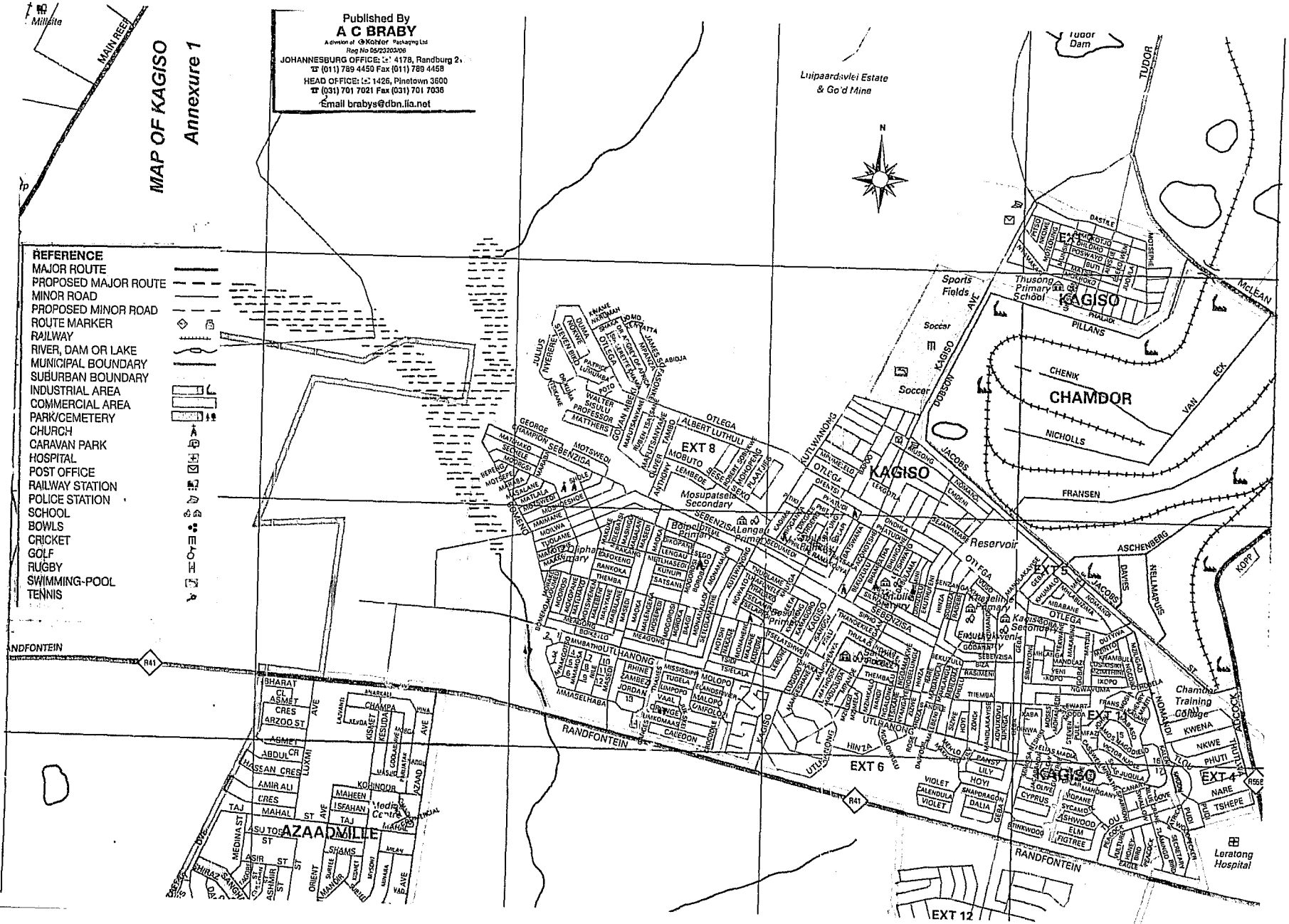
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ORANGE
UMKOMAAS
CALEDON
JORDAN
AMBEE
MOLOPO
LANGSHIVER
UMFOLOZI
TSELALA
MOGOROSI
MOKOENA
MOKOENE
MOKOTSHOANA
MOKOTSHOANA
MOKOTSHOANA

Annexure 2

P O Box 335
P O KAGISO
1744

Date: .....

THE PRIEST / CO-ORDINATOR/ CHURCH COUNCIL

..... CHURCH

P O KAGISO

1744

Dear Sir/Madam,

I am at present a student at the University of the Witwatersrand pursuing a Master of Science (Psychiatric Nursing) degree.

The aim of my study is to introduce a supportive programme for young people exposed to stress in our community, through group therapy.

This is a preventative measure against mental illness, to which our young people are vulnerable due to the stressful situations they find themselves exposed to these days.

I intend having sessions of group therapy with the selected group over a period of four weeks.

I, therefore, cordially request your permission to allow the youths in your church to participate in this programme.

In addition, consent will be requested from individual parents/guardians for those participants who are below 21 years of age. Those above 21 years of age will need to sign consent on their own behalf.

Thank you for your consideration in this matter and I hope to hear from you soon.

Yours faithfully,

DOROTHY SEKHUKHUNE (Mrs)

Annexure 3

P O Box 335
P O KAGISO
1744

Date: .....

Dear Participant

I am presently a student at the University of the Witwatersrand, pursuing a degree of Master of Science [Nursing].

My study aims at introducing a supportive programme to the youth exposed to stress in our community through group therapy.

This is a preventive measure against mental illness which our youth are vulnerable due to the stressful situations that they find themselves exposed to.

I will be having group therapy sessions with yourself and other youths. I intend to hold eight sessions over a period of four weeks.

I, therefore, cordially request consent from you to participate in this programme.

I can assure you that confidentiality will be maintained and you will remain anonymous and your identity will not be disclosed at any time.

Participation in this study is voluntary. You may discontinue your participation at any time. Such discontinuation will in no way affect you, however, should you discontinue sources of referral will be made for you outside of the context of this research.

Should you give permission please complete the portion underneath and return it in your next youth club meeting.

Thank you for your consideration in this matter.

Yours faithfully,

DOROTHY SEKHUKHUNE (Mrs)

I who is years old hereby *give/does not give permission to participate in this programmes as stated above.

Signature Date

* Delete whatever is not applicable

Annexure 4

P O Box 335
P O KAGISO
1744

Date: .....

Dear Parent / Guardian,

I am at present a student at the University of the Witwatersrand pursuing a Master of Science (Psychiatric Nursing) degree. My study aims at introducing a supportive programme for young people exposed to stress in our community, through Group Therapy.

This is a preventive measure against mental illness, to which our young people are vulnerable due to the stressful situations that they find themselves exposed to. I will have group therapy sessions with your son/daughter and other youths. I intend to hold eight sessions over a period of four weeks.

I, therefore, cordially request your consent for your son/daughter to participate in this programme.

I assure you that confidentiality will be maintained, that your son/daughter will remain anonymous and that his/her identity will not be disclosed at any time.

Participation in this study is voluntary. You may withdraw your son/daughter and let him/her discontinue participation at any time. Such discontinuation will in no way affect your son/daughter, however, should you discontinue, your son/daughter will be referred to sources outside of the context of this research for further counselling.

Should you give permission, please complete the portion underneath and return it with your son/daughter for his/her next youth club meeting.

Thank you for your consideration in this matter.

Yours faithfully,

DOROTHY SEKHUKHUNE [Mrs]

I, parent/guardian
of who is years old, hereby *give/do not give permission for my son/daughter to participate in the programme stated above.

Signature: Date:

* Delete whatever is not applicable

Annexure 5

PHYSICAL AND PSYCHOLOGICAL SYMPTOMS INVENTORY

(Powell & Enright, 1990)

Name **Address:**

Telephone

Number

Martial Status: **Age:**

Please ***TICK*** the appropriate choice as to how often you have experienced the following Physical and Psychological symptoms during the past few weeks.

		Not Present	Occasionally	Often	Most of the Time
1.	Palpitations				
2.	Breathlessness				
3.	Chest pains or discomfort				
4.	'Choking-or-something' sensation				
5.	Dizziness or feeling unsteady				
6.	Tingling or numbness				
7.	Hot and/or cold flushes				
8.	Sweating				
9.	Fainting				
10.	Trembling or shaking				
11.	Upset stomach/diarrhoea				
12.	Headache/migraine				
13.	Dry mouth:difficulty in swallowing				
14.	Tension in jaw/neck/shoulders				
15.	Worrying thoughts through your head				
16.	Feeling of panic				
17.	Struggle to fall asleep or spend sleepless nights				
18.	Experience nightmares				
19.	Lost interest in yourself				
20.	Any other symptoms that worry you				

Annexure 6

BRIEF PSYCHIATRIC RATING SCALE

OVERALL & GORHAM, 1962 (adapted by PEKANE, A.S., 1989)

Name: _____ **Address:** _____

Tel No.: _____ _____

QUESTIONNAIRE NUMBER ☐☐ (1-2)

PRE-TEST (1) or POST-TEST (2) ☐ (3)

DIRECTIONS: **Place an X in the appropriate box to represent level of severity of each symptom.**

KEY:	
NP	NOT PRESENT
VM	VERY MILD
MILD	MILD
MOD	MODERATE
MOD SEV	MODERATELY SEVERE
SEV	SEVERE
EX SEV	EXTREMELY SEVERE

		NP	VM	MILD	MOD	MOD SEV	SEV	EXT SEV	
1.	SOMATIC CONCERN - preoccupation with physical health, fear of physical illness, hypochondria								(4)
2.	ANXIETY - worry, fear, over-concern for present or future								(5)
3.	EMOTIONAL WITHDRAWAL - lack of spontaneous interaction, isolation, deficiency in relation to others								(6)
4.	CONCEPTUAL DISORGANISATION - thought processes confused, disconnected, disorganised, disrupted								(7)

		NP	VM	MILD	MOD	MOD SEV	SEV	EXT SEV	
5.	FEELINGS OF GUILT - self-blame, shame, remorse for past behaviour								(8)
6.	TENSION - physical and motor manifestations or nervousness, over-activation, tension								(9)
7.	MANNERISMS AND POSTURING - peculiar, bizarre, unnatural motor behaviour (tics excluded)								(10)
8.	GRANDIOSITY - exaggerated self-opinion, arrogance, conviction of unusual power or abilities								(11)
9.	DEPRESSIVE MOOD - sorrow, sadness, despondency, pessimism								(12)
10.	HOSTILITY - animosity, contempt, belligerence, disdain for others								(13)
11.	SUSPICIOUSNESS - mistrust, believe others harbour malicious or discriminatory intent								(14)
12.	HALLUCINATORY BEHAVIOUR - perceptions without normal external stimulus correspondence								(15)
13.	MOTOR RETARDATION - slowed, weakened movements or speech, reduced body tone								(16)
14.	UNCO-OPERATIVENESS - resistance, guardedness, rejection of authority								(17)

	NP	VM	MILD	MOD	MOD SEV	SEV	EXT SEV	
15. UNUSUAL THOUGHT CONTENT - unusual, odd, strange, bizarre thought content								(18)
16. BLUNTED AFFECT - reduced emotional tone, reduction in normal intensity of feelings								(19)
17. EXCITEMENT - heightened emotional tone, agitation, increased reactivity								(20)
18. DISORIENTATION - confusion or lack of proper association for person, place or time								(21)

Annexure 7

OUTLINE OF GROUP THERAPY SESSIONS

PHASE I : THE RELATIONSHIP PHASE

Session 1

The purpose of this phase:

Each participant is to have the opportunity of experiencing group members and observe group leadership.

Building up a positive relationship with the group members and to ascertain their suitability for group therapy.

Members are encouraged to talk among themselves in order to get to know each other.

The nurse therapist explains to the group what group therapy is.

The nurse therapist asks the members what their expectations are.

A contract will be drawn between the members and the nurse therapist.

The following will be included in the contract:

- Number of sessions to be held
- Dates and times and time limits for the sessions
- Venue
- Conditions of therapy
- Conditions of termination

- Rules for group therapy sessions are set by the group members

The nurse therapist gives a summary of what happened and the group does the same.

Session 2

Continued relationship building.

The nurse therapist helps the group create a climate of warmth among the group.

The nurse therapist encourages the group to clarify common problems.

The nurse therapist asks the group to write down on paper what interferes with their daily functioning.

The group members discuss among themselves what their problems are.

The nurse therapist evaluates the use of therapeutic factors by the group and points out to group members the importance of the group identifying common problems together.

The nurse therapist summarises what the group members have decided as to what their problems are.

The nurse therapist asks the group members how they have found the group session.

The nurse therapist gives the group homework, for them to think about how problems could be addressed.

PHASE II : WORKING PHASE

Session 3

The nurse therapist encourages the group to initiate a discussion.

The nurse therapist restates the homework and invites the group to discuss the problems that they have listed.

The nurse therapist facilitates the process of group members helping each other tackle the problems. The group members pinpoint common problems so that they can work together.

The nurse therapist asks the group to think of ideas on how to solve their common problems. The group members work together in looking for possible solutions to their problems.

The nurse therapist gives minimal guidance and lets the group members work together.

The nurse therapist reinforces the therapeutic factors during the working phase.

The nurse therapist evaluates the performance of the group and the group dynamics, and reflects these to the group.

The nurse therapist asks the group members to define their objectives and aims, to see if they agree with one another.

The nurse therapist gives a short summary of the objectives and aims listed and a short description of the problems identified.

The nurse therapist asks the members how they have found the session.

Session 4

Group members are asked to write down any idea that comes to mind that they think could help them solve or handle their problems.

The group members then discuss what each member has written.

They look at the positive issues that come out of their discussion and also deal with the negative issues mentioned.

The group members then choose a/the method of solving their problems.

The group members are encouraged to argue their views until they reach consensus.

The nurse therapist helps the group to implement the ideas or strategies that they have adopted in solving their problems.

The nurse therapist evaluates their interaction and uses therapeutic factors as a learning experience for the group.

The nurse therapist gives a short summary of the strategies adopted and asks the group members to do the same.

The nurse therapist gives the group the opportunity to report on the different ways in which they can implement their chosen idea(s).

The group is given a chance to work out a way of solving a common problem.

The nurse therapist asks the group members how they have found the session.

Session 5

The nurse therapist gives the group members a chance to practice what they have decided in solving a particular problem.

The nurse therapist assigns a stressful problem to them and asks the group members to roleplay in handling the situation.

The nurse therapist asks the group to apply the strategies used to addressing the problem in their roleplay.

The nurse therapist gives an evaluation of how the problem was handled and reinforces the therapeutic factors in discussing the way they have handled the problems.

The nurse therapist asks the group how they felt about roleplaying.

The nurse therapist asks all members to summarise how they are feeling 'right now'.

The nurse therapist gives feedback on the performance of the members.

Session 6

The nurse therapist gives each group member the opportunity to evaluate what has been happening in the group from the beginning to date.

The nurse therapist summarises what has been said and asks each member how he/she feels 'at the present moment'.

The nurse therapist works with the group on feelings that are in the room and encourages group members to acknowledge those feelings.

The nurse therapist acknowledges the feelings expressed and again brings up therapeutic factors and how important they are when dealing with problems that are identical to one another.

The nurse therapist brings about the role of being a support group to one another when faced with a problem.

The nurse therapist summarises what transpired in the group and asks the group to do the same.

The nurse therapist asks the members how they feel about the session.

PHASE III : TERMINATION PHASE

Section 7

The nurse therapist asks the group members to evaluate the effect of the group on themselves.

The nurse therapist evaluates the use of therapeutic factors on group members.

The nurse therapist gives a summary of ways the group has handled issues and asks the group to do the same.

The nurse therapist introduces termination of the group and invites group members to talk about their feelings about termination.

The nurse therapist addresses the feelings brought up and reflects them to the group.

The nurse therapist addresses separation anxiety.

Every member is given the opportunity to express her/his feelings and how he/she has experienced the group in terms of the therapeutic factors outlined throughout the sessions.

The nurse therapist handles the feelings as they come.

The nurse therapist again brings up the issue that the group will be separating very soon and summarises what transpired in the sessions held and how they could use this opportunity in their own lives.

Session 8

The group members are given the opportunity to report back on how they have started to implement what they have learned in the group and what the outcome has been.

The nurse therapist evaluates how members have implemented their problem-solving strategies and gives feedback to the group on how effective their strategies have been.

The nurse therapist encourages the members to continue working towards resolving their problems in the manner that they have been practising throughout group therapy.

Termination. This is the last session. Separation anxiety is dealt with by the nurse therapist and feelings of separation are acknowledged.

The nurse therapist encourages the members to support one another and work together towards resolving problems, stressing especially that they belong to youth clubs, and they should have realised that they are not the only ones experiencing certain problems.

The nurse therapist summarises what happened in the session and asks the members to do the same.

The nurse therapist summarises what has transpired since the initial formation of the group.

Expectations of the members are revisited, to see if they have been or are being achieved.

The nurse therapist asks the members to evaluate each session and summarise what they have learned in each session.

The nurse therapist gives the summary of the evaluation process and asks the members to do the same.

The nurse therapist asks the members how they are feeling now that it is the last session.

The nurse therapist acknowledges their feelings and reflects them to the group.

The nurse therapist arranges with group members to telephone her in four weeks' time to report on how they are feeling.

The nurse therapist thanks the group members for their participation.

Author Sekhukhune D D
Name of thesis The Effectiveness Of Group Therapy In The Prevention Of Mental Illness In Youths Exposed To Stress Sekhukhune D D 1998

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