AN EXPLORATION OF ADOLESCENT RISK-TAKING BEHAVIOUR: A CASE STUDY ANALYSIS

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INDEX

LIST OF ADDENDUMA

LIST OF GRAPHS

LIST OF TABLES

LIST OF FIGURES

SUMMARY

Do adolescents of colour really engage in risk-taking behaviours as often generalised by the public? Are they in fact the alcohol, drugs, sex, and violence generation? This study attempts to investigate the conditions influencing the choices adolescents make prior to their engaging in risk-taking behaviours.

In the social sciences, concerns over adolescents' recklessly irresponsible behaviours have deep roots. In 1904 G. Stanley Hall depicted adolescence as misbehaving because of the storms and stresses of the transition from childhood to adulthood. Subsequently, social scientists produced substantial evidence that the storminess of adolescence is largely an over generalisation, which has not been empirically substantiated. In corroboration of this interpretation, this study also indicates that not all adolescents engage in risk-taking behaviour, and those risky individuals do not necessarily engage in all spheres of risk-taking. The majority of the target group only experimented with certain risk behaviours by engaging in them on one occasion only.

The specific high school was selected because the researcher knew the learners, as she was an educator there at the time. She was thus reasonably aware of the frequency, the nature and the severity of the risk-taking behaviours of the target group.

In general, the most important findings of the study signified a moderate level of participation in risk-taking activities. However, in certain spheres such as cigarette smoking, alcohol usage and sexual intercourse, an extreme participation level was reported. Certain factors such as gender, age, socio-economic conditions, parental (one or both) absence, and the respondents' attitude towards the specific behaviour, were discovered to have played an influential role in the target group taking risks.

Based on the reasons advanced for engaging in risk-taking behaviour, the researcher concluded that the following theories were applicable in explaining the behaviour of the respondents. These theories are the social learning theory, symbolic interactionist theory, social identity, the theory of reasoned action, and Maslow's hierarchy of needs.

The researcher trusts that this study will assist the reader to understand the complex contributing circumstances that the target group has to contend with in making decisions.

Key words: *adolescence, risk-taking behaviour, attitudes, social learning, symbolic interactionism, social identity, reasoned action, ethnicity, decision making.*

Chapter One

ADOLESCENT RISK-TAKING BEHAVIOUR AND ITS CONSEQUENCES

1.1 INTRODUCTION

South Africans, like other Western cultures, have come to believe that adolescence is naturally a time of *disorder,* thus associating adolescent behaviour that is characterised by *exploration* with behaviour that is *dangerous* and even *unacceptable*. The notion of the "*generation gap*" has to an extent become the conventional depiction of the barriers between adults and adolescents. Furthermore, adolescence is considered the stage in which parents or adults and their adolescent counterparts are *never meant to understand each other,* and the former are perceived as *fearsome creatures* who don't want to be guided. These myths compound and even validate parents' and adults' fears about adolescents.

Current thinking is beginning to acknowledge that adolescence is a *time of risk-taking* and is not completely destructive, and that furthermore, regular risk-taking is a normative, healthy developmental behaviour for adolescents[1]. A general awareness is that the majority of the adolescent population do not participate in unhealthy risks, and that adolescents need to take risks in order to develop into mature non-risk-taking adults.

It is when parents and adults assume that *all* risk-taking is dangerous or harmful to the quality of life of the adolescent, or that *all* risk-taking behaviours are counterproductive, that adolescents seem to react to this attitude and its associated behaviours.

Adolescents like younger children, require parental and/or adult support and guidance in healthy risk-taking ventures that enable growth and development. Therefore, should risk-taking become harmful, or harmful risk-taking ventures influence the quality of life of the adolescent adversely, it will be expected of parents and adults to prevent adolescents from

[1] http://search2.cometsystems.com/search.php?product

indulging in such risk-taking behaviour. On the other hand, in *not* viewing all risk-taking behaviours as harmful or dangerous or that certain risk-taking ventures could have positive consequences, it will require nothing less than a radical shift in attitude towards risk-taking, adolescents, parenting, and/or adult support and guidance.

It is little wonder that ex-President Nelson Mandela placed emphasis on the importance of the youth (or adolescent in South Africa) in his opening speech of the new democratically elected government when he read the poem *"The Child"* written by Ingrid Jonker. His remark that *"The youth of our country are the valued possessions of the nation. Without them there can be no future. Their needs are immense and urgent*"[2] is therefore a challenge to both parents and adults to invest in their "leaders of tomorrow". This would include investigative activities as described in this research endeavour.

1.2 THE ADOLESCENT STAGE: Various perspectives

During the adolescence stage the young experiment with many aspects of life, take on new challenges, investigate how sectors interconnect, and they use these processes to define and shape both their identities and their knowledge of the world. During this stage the adolescent learns how to think and act. Their developing cognitive skills play a major role as they take risks and learn to understand and value the consequences of their behaviour. Sequentially, experimenting with new behaviours and feelings can encourage more complex thinking, increase confidence, and help to develop their ability to assess and undertake risks in the future[3].

The different perspectives and approaches to adolescence and its development will be discussed. Reference will sporadically be made to the phenomenon of risk-taking behaviour as a component of adolescent development.

1.2.1 PSYCHOLOGICAL PERSPECTIVE

The major psychological theorists of adolescence from a psychosexual perspective, namely, Sigmund Freud, Anna Freud, and Peter Blos, attached great significance to the

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[2] Van Zyl Slabbert F. et al, 1994.
[3] Ponton L.E., 1998.

impact of sexual drives on the psychological functioning of the individual. These theorists view the onset of adolescence as a difficult time psychologically because of the increased strengths of these drives. This occurs concurrently with the adolescent's developing physical abilities to actually carry out sexual wishes and fantasies – which may come into conflict with social and internalised taboos.

Blos describes the adolescent stage as the second individuation process[4]. The first step in the journey toward the definition of selfhood occurs at the end of the second year of life, when the child experiences the power of a developing sense of control and ability to move away from his or her mother. Adolescent individuation of learning to sever some of the emotional ties with parents involves the recognition that emotional and sexual needs must be met from outside the family. According to Blos, this process has a sense of urgency stemming from the strength of drives, but it is also accompanied by feelings of isolation, loneliness and confusion, so that conflict and swings of emotion are inevitable concomitants.

Adolescent friendship can be particularly intense, as the withdrawal of affective bonds from family members frees up psychic energy to be re-invested in new relationships. Romanticism and falling in love are common as there is a need for these new relationships to replace the intensity of family ties and the feelings of loss that follow. It is as if adolescent romantic love occurs as a rebound from the lost and taboo relationships with family[5]. In order for the adolescent then to cope with individuation, the adolescent must experience some degree of ego regression. He or she becomes preoccupied with the drives, impulse, wishes, and fantasies that were characteristic of earlier development stages. Regression, or 'being childish' allows for the release of a certain amount of psychic energy which the adolescent can channel in new directions, and so gradually develop new coping mechanisms.

1.2.2 PSYCHOSOCIAL PERSPECTIVE

Erikson (1963) perceives the social environment as playing a major role in influencing an individual's personality. He views personality as developing in eight specific

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4 Blos P., 1962.
5 Moore S. & Rosenthal D., 1993.

stages, the outcome of each being dependent on the interactions between the child and the people he comes into contact with.

In his psychosocial theory, Erikson gives a description of the stages of life. It is presented in the form of an ideal concept, as in reality no one completes the cycle perfectly. The first five stages prepare the foundations for adolescence and adulthood, and may be briefly outlined as follows, with ages being approximate:

- *Stage 1:* Basic Trust versus Mistrust (Birth to 1½ years)
- *Stage 2:* Autonomy versus Shame (1 ½ to 3 years)
- *Stage 3:* Initiative versus Guilt (3 to 6 years)
- *Stage 4:* Industry versus Inferiority (6 to 12 years)
- *Stage 5:* Identity versus Identity Confusion (12 to 20 years)
- *Stage 6:* Ability to establish intimate relationships (18 to 25 years)
- *Stage 7:* A need for productivity and creativity (25 to 65)
- *Stage 8:* A sense of acceptance, inner peace and self-fulfilment (65 + years)

Stage 5 is the *stage of adolescence*, the culmination of all the preceding developmental stages that lead to physical, sexual and emotional maturity. Erikson views this stage as a search for identity, a psychological pause or 'time out', which allows the young person opportunities to experiment freely with different roles, attitudes and personalities, prior to making important life-decisions.

Should this stage not be resolved adequately, adolescence may be prolonged, perhaps indefinitely, with the adolescent avoiding making the choices and commitments necessary to give proper direction and meaning to his life.

The adolescent stage is divided into three sections, i.e. child adolescence, mid-adolescence, and adult adolescence. During *child adolescence* the individual is engaged with the question *"What is happening to me?"* while in *mid-adolescence*, the statement *"I'm almost grown-up, but I still need answers to a great many questions"* occupies the adolescent's mind. In *adult adolescence*, the individual is occupied with the question *"Who am I as a person, and where am I going in life?"* The adolescent's behaviour fits the section he or she is experiencing; it follows a sequence:[6]

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[6] Gillis Harley, 1994.

- **Child adolescence:** The emphasis is on learning to cope with the demands of rapid physical growth.
- **Mid-adolescence:** Experimenting with developmental changes in a number of different areas.
- **Adult adolescence**: Forming a meaningful and stable personal identity, and taking mature decisions with regard to one's future.

1.2.3 BEHAVIOURAL PERSPECTIVE

According to this perspective, the adolescent should be viewed within the context of the environment in which he or she interacts. Bronfenbrenner's ecological perspective (1989) provides a mechanism for explaining this phenomenon[7].

Lewin's classical equation, $B = F(P, E)$, is the starting point for Bronfenbrenner's ecology of human development. According to Lewin's equation, behaviour (as well as development) is a function of the *interaction* between the person and the environment[8].

From Bronfenbrenner's perspective, whenever Lewin spoke about human behaviour, he did so by always placing human behaviour in context: situational, interpersonal, sociological, cultural, historical, and of course, theoretical.

Bronfenbrenner's ecological model recognises the multiple layers of contextual influences on human development, and states that *adolescents have to adjust to an ever-changing, interrelated social and cultural environment.* He articulates four major systems that represent the context for child development: microsystem, mesosystem, exosystem, and macrosystem. These levels of context simultaneously affect the individual and interact with one another.

The *microsystem* refers to "*an immediate setting containing that person*" where interactions occur between the developing person and the environment. In essence, the microsystem is the most central level of context to the individual. Typical components of a microsystem for an adolescent include interpersonal relationships with family members, a peer network, and other social groups such as neighbours.

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[7] Te'Neil L., 2002. Review of General Psychology, March 2002.
[8] Lewin K., 1931.

The *mesosystem* indicates "*a system of microsystems*" through which different settings are linked. An example of this level of ecology might be the linkage between home and school. Bronfenbrenner also noted that considerable changes in any microsystem often demand an "*ecological transition*" within the mesosystem, such as when children move from primary to high school.

The last two systems of Bronfenbrenner's ecological model, the exosystem and the macrosystem, are more distal from the developing person. Within the *exosystem*, the adolescent does not directly participate in these interactions; however, decisions made at this level of context often greatly affect the adolescent. For example, interactions that occur within a parent's place of employment often have a significant impact on the microsystem level of the family.

The *macrosystem* is described as a broad societal blueprint that contains the core structures and values that compose a particular culture. Features of the macrosystem include political, religious, and educational value, health practice, appropriate standards for behaviour and appearance, and roles according to age, gender, and ethnicity.

The adolescent's development is powerfully influenced by mechanisms by which principles of multiculturalism, sexuality, substance abuse and violence are introduced to the adolescent. Apart from this ecological model, the two other distinct perspectives that facilitate these mechanisms are the *identity formation theory*[9] and *symbolic interactionist theory*[10]. These frameworks provide a contextual and developmental linkage of the individual with the surrounding environment.

1.3 ADOLESCENT RISK-TAKING BEHAVIOUR

Risk is described as a *"hazard, a chance of or of bad consequences, loss, etc., exposure to mischance"*[11]. Thus, risk-taking behaviour is viewed as behaviour that possesses the chance or possibility of bad consequences or loss. Although risk-taking sounds dangerous, it is a normal part of growing up for young adolescents[12]. Almost half of all

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[9] Discussed in paragraph 1.2.2 in this Chapter, and paragraph 3.2.1 of Chapter 3.
[10] Discussed in paragraph 3.2.5 of Chapter 3.
[11] The Concise Oxford Dictionary, 1984: 900.
[12] http://www.penpages.psu.edu/penpages_reference/28507/2850

adolescents are at moderate to high risk of engaging in one or more self-destructive behaviours, including unsafe sex, teenage pregnancy and childbearing, drug and alcohol use, underachievement, failure and dropping out of school, delinquent or criminal behaviours, suicide, practicing satanism, violence, unsafe driving, fighting, foul language and running away from home.

There are different viewpoints concerning adolescent risk-taking behaviour. Some authors suggest that adolescents engage in risk behaviour in order to demonstrate a mature status or to mark the conversion to adulthood. Others, like Elkind (1985), argue that risk behaviour is a consequence of heightened egocentrism and sensation seeking during adolescence. Various scholars view risk-taking behaviours as tendencies that depend on social and environmental factors such as family, peers, school, community, and cultural belief systems[13].

The social environment of adolescents changed rapidly in the 1980s, increasing risk for adolescent health behaviour. Two of the reasons are the huge influx of mothers into the labour market and the rise in single-parent families. Because of this occurrence, adolescents now spend less time with parents or adults, leaving greater time being unsupervised and for interaction with peers. The peer group thus replaces the family as the main socialising agent.

A natural part of the adolescent's growing up is the need for independence from his or her family. Some adolescents have trouble communicating their feelings and use anger to cover up their feelings of hurt or frustration. They would rather become violent, use substances, engage in sexual intercourse, or drop out of school than admit they hurt emotionally[14].

1.4 THE ROLE OF SCHOOLS IN ADOLESCENT RISK-TAKING BEHAVIOUR

Schools are an important context for the development of adolescent health behaviours. Because adolescents spend so much of their time in school, most of their social contacts are concentrated in the school environment where they develop social networks through interpersonal interaction with peers. Interactions with fellow learners and exposure

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[13] http://web17.epnet.com/citation.asp?tb=1
[14] Stark E., 1975: 49.

to friends' families and parents play important socialisation roles. They provide for example, for the normative structuring of behaviours and shaping of adolescents' aspirations for their future. The school context can influence adolescent behaviour through two mechanisms:

Firstly, the *school climate* may structure norms and values – adolescents see what is common and assume that such attitudes, expectations, and behaviours are socially acceptable. Therefore if for example, the school norm is to proceed to university, adolescents at the school will expect to do so.

Secondly, *school context* impacts attitudes and behaviours through perceived social and economic opportunities available. The composition of the social and economic status of the learners' parents in the school serves as a model of what students themselves might expect to achieve in their adult lives.

1.5 CONCLUSION

Risk-taking behaviour among adolescents is not accidental, uncontrollable, or unavoidable[15]. Many of the causal factors to an adolescent's tendency to engage in high-risk behaviour are changeable or flexible. Parents need to be aware of how and where they can intervene.

Adults and adolescents alike in fact need to be well informed about risks and about how young people perceive these risks. Parents, teachers, and other adults need to develop a comfort level for talking with adolescents about risk-taking and other issues. It is not a trouble-free process, and many shy away from it, but it is an essential step towards helping adolescents to develop healthy ways of maintaining a contented quality of life in which growth, change and development can manifest itself continuously.

The next chapter will provide a description of the methodology used for this research. Research objectives will be stated, and a design of all the chapters in the research report presented.

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[15] http://search2.cometsystems.com/search.php?product

Chapter Two

METHODOLOGICAL FOUNDATION AND ACCOUNTABILITY

2.1 INTRODUCTION

As adolescents develop more sophisticated reasoning ability, they look to their future through surfacing revenue prospects. This process is consequentially accompanied by the setting of educational and occupational aspirations that will shape their adult careers. However, with the numerous developmental opportunities open to adolescents, they engage in behaviours that have significant implications for health and emotional risks.

Adolescence is a period of exploration and discovery, and a time of making choices. It involves the making of choices that display their ability to comprehend health risks, weigh options, reflect on their behaviours, and consider the long-term consequences of their actions. A decision process that indicates these gesticulations therefore triggers their behavioural choices with varying risks to their health and well-being. Examples of these are risky actions (e.g. carrying a weapon) and risky non-actions (e.g. not using contraception during sexual intercourse) that may expose their emotional well-being and health to a significant risk. When smoking has its onset during adolescence, individuals are likely to continue engaging in this action throughout their lives, coupled with its long-term effects on health. Early alcohol and drug practice could result in violent behaviour patterns and crime involvement, with the conceivable consequence of premature death. Premarital sexual encounters render the risk of sexually transmitted diseases (STDs), including HIV/AIDS, as well as unintended pregnancies to the adolescent.

In this chapter the reader will be introduced to the methodological foundation and choices made during this research endeavour. These will enable the reader to assess the validity and reliability of the research outcomes.

2.2 RESEARCH OBJECTIVES

The ***general objective*** of the research was *to determine which risk-taking behaviours*[16] *adolescent learners at a Port Elizabeth high school*[17] *engage in*. The study's ***specific objective*** was *to explore specific intervention strategies that will, when applied, ultimately generate less risky (or non-risky) behaviour.*

2.3 HYPOTHESES

The following hypotheses are stated:

2.3.1 More male than female respondents will engage in risk-taking behaviours.

2.3.2 Younger (13 – 14 years) respondents will reveal less risk-taking behaviours than older (16 – 18 years and older) respondents.

2.3.3 Respondents from less affluent residential areas engage in more risk-taking behaviours than respondents from more affluent residential areas.

2.4 RESEARCH RESPONDENTS

The selection of respondents was based on certain criteria to increase the quality and validity of the research. These criteria are age, gender, school grade, and residential area. An exposition thereof is given.

2.4.1 Age

The ages of the respondents range from thirteen to eighteen[18] years. The school these respondents attend is situated in a previously labelled Coloured suburb, with registered learners from two previously disadvantaged designated groups, i.e. Black and Coloured.

The school's enrolment figures encompass the following picture:

- Number of registered learners: 975
- Grade distribution and percentage correlation of learners at school:

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16 For the aim of this research the focus is on three domains, viz. sexual, alcohol and drugs, and violent behaviour.

17 For reasons of confidentiality the name of the school is not provided.

18 Gillis H., 1994. (This age range forms part of the 5th stage of Erik Erikson's Psychosocial Theory, viz. Identity versus Identity Confusion Stage.)

Grades	8	9	10	11	12	Total
Number of Learners in School	250	275	188	162	100	975
Percentage of Total Learner Population	25.6	28.2	19.3	16.6	10.3	100

Table 1: Distribution of learners according to school grades

- Age range and percentage correlation of the total adolescent learners at school:
  - 13 – 20 years: 64% **(N = 625 – Adolescence)**[19]
  - 14 – 16 years: 70.9% **(N = 443 – Mid-adolescence)**
  - 17 – 20 years: 29.1% **(N = 182 – Late adolescence)** [20]
- Percentage correlation of ages of research respondent group:

AGE	13	14	15	16	17	18+	TOTAL
N / % of Respondent Group	16	16	16	18	16	18	**100**
% of Respondent Group in relation to Learners in School	1.64	1.64	1.64	1.84	1.64	1.84	**10.24**
% of Respondent Group to Total Adolescent Group	2.56	2.56	2.56	2.88	2.56	2.88	**16**

Table 2: Age distribution of respondent group

The 100 respondents represented 10,24% of the total group of learners and 16% of adolescents at the specific school.

2.4.2 Gender

The gender distribution of learners at the school was relatively equal. It encompassed the following picture:

- Gender distribution and percentage correlation of learners at school:

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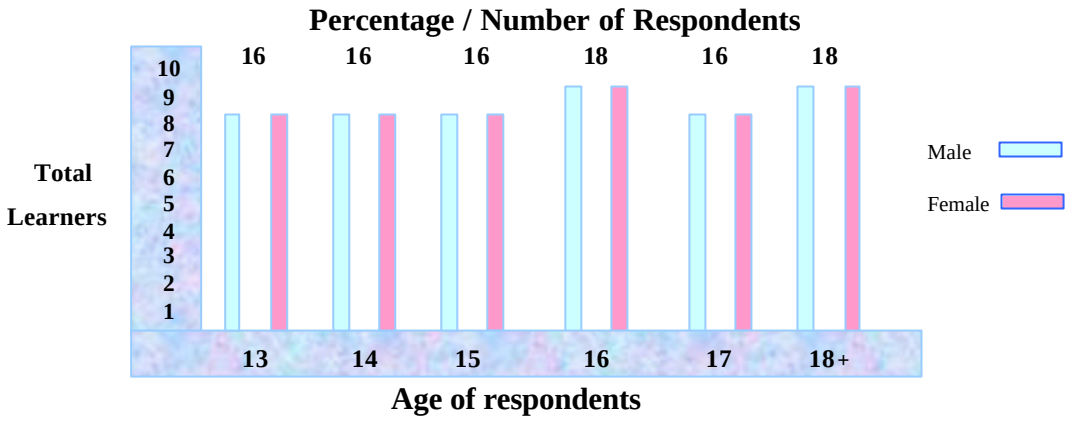
[19] There are 975 learners in the school. While 625 are between the ages of 13 to 20 years, the remainder (350) is either younger than 13 years or older than 20 years of age. The focus of this research is on the adolescent between the ages of 13 to 20 years of age.

[20] Gillis Harley, 1994. (Erikson's Psychosocial Theory).

Male: 58%

Female: 42%

- The following graph depicts the age and gender distribution of the respondents:



Graph 1: Age distribution of respondent group

2.4.3 School grades

The grades and ages of the respondents render the following picture:

AGE	Gr. 8	Gr. 9	Gr. 10	Gr. 11	N / %
13	16	-	-	-	16
14	8	8	-	-	16
15	1	15	-	-	16
16	-	2	8	8	18
17	-	-	8	8	16
18+	-	-	9	9	18
N / %	25	25	25	25	100
N of Learners per Grade	250	275	188	162	875
Respondents as % of each Learner Grade	10	9.09	13.29	15.43	47.81
Respondents as % of Grades 8 to 11	2.85	2.85	2.85	2.85	11.4

Table 3: Age distribution according to school grades

Sixteen per cent of the respondents (aged 13), can be viewed as being in their early adolescent years. Fifty per cent respondents (aged 14 to 16), falls within the mid- adolescent years, and thirty-four per cent of the respondents (aged 17 to 18+), falls within the late

adolescent years. Of the 875 learners that are currently in grades 8 to 11, approximately eleven per cent of the respondents fall within these (8^{th} to 11^{th}) school grades.

2.4.4 Residential areas

The majority of the learners at the school reside in three major areas. Of these three, the only *affluent area* is the one in which the school is situated. The other areas, which the researcher has combined in order to form a group on their own, possess little significance, because they house an insignificant number of learners in relation to the total school population. It is, however, worth mentioning that these areas possess the same qualities of the other two *less affluent residential areas*, with one major difference being that two of these three areas were previously classified as Black townships. Consequently they were even more neglected with even poorer people residing here. The third area grouped with them is a newly constructed area, whereby the residents were housed according to the new housing scheme, the Reconstruction and Development Programme (RDP).

The affluent area depicts a formal neighbourhood, an area that consists of built-up houses and structured tar roads. Most households do not contain more than five people, with most of the respondents living with both parents. The majority of the respondents from this area possess proper school uniforms, their school fees can be paid by the parents, and they have access to at least one meal, either pocket money or bread to take to school every day. The respondents from this area generally regard their financial situation as being *"richer than other families"*.

The area possesses the basic amenities such as electricity, ablution facilities, and access to running water. A large quantity of houses, approximately six churches, a library, a few formal shops, three schools, a clinic, a few doctor surgeries, a community centre, a sports field, a number of taverns and drug outlets make up the area. Other essential facilities, however, such as parks, a public swimming pool, family entertainment facilities, a post office, and a police station are absent in the area.

The less affluent areas portray a different picture altogether. They are non-formal areas with non-permanent houses and unstructured roads. Most of the houses in these areas lack the basic facilities such as electricity, ablution facilities, and running water. More than

seven people reside in most households, with most of the respondents living with either the mother or father, or other relatives. The school fees of the majority of the respondents coming from this area are not paid or are paid by someone other than the parents. These respondents do not possess the proper school uniforms and transport money to get to school every day. They also cannot afford to bring pocket money or something to eat to school every day, and most of them do not enjoy at least one meal every day. These respondents generally regard their economic condition as being *"poorer than other families"* or *"at the same level as other families"*.

There are a few churches, taverns and drug outlets in both these areas; only one of the two areas, however, has a day clinic, a day care centre (both run by the Catholic Church under the management of the well-known nun, Sister Ethel) and a primary school. There are no public libraries (only one on Catholic Church property, that is managed by another Catholic nun, Sister Noreen), no community centres, no doctor surgeries, and no sports fields in these areas. They also lack other important facilities (park, swimming pool, etc.), which are enjoyed by those from the more affluent areas.

The majority of the residents in all three of these less affluent areas receive state grants of some sort, which can be seen as either a positive or a negative condition, depending on the onlooker. According to the social worker[21] interviewed at Stepping Stones, the supply of state grant was just as a cunning tactic of the previous apartheid government to make these people (whom were mostly non-white, as the whites were granted the better jobs with good incomes) feel unworthy, incapable, shameful, degraded and less human. This robbed them of their sense of dignity and self-respect. They were taught that it is better to receive handouts than to work for your own assets.

The more affluent area is made up of people ranging from the worker through to the middle class. The majority of them are educated, employed and able to provide for the basic, educational and entertainment needs of their families. It is also within these parents' reach to provide their children with pocket money and luxury items.

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[21] For ethical reasons the social worker cannot be named. The researcher was only allowed to make mention of her attachment to Stepping Stones.

The majority of the people in the less affluent areas are uneducated, unemployed or they earn a very low income. They are often not capable of providing for their families with their basic material needs.

The following illustration depicts the division of the respondents according to their residential areas. It includes the age and gender criteria as well.

AGE	AREA 1[22]		AREA 2[23]		AREA 3[24]		AREA 4[25]		GENDER TOTAL		TOTAL
	M	F	M	F	M	F	M	F	M	F	
13	2	2	2	2	2	2	2	2	8	8	**16**
14	2	2	2	2	2	2	2	2	8	8	**16**
15	2	2	2	2	2	2	2	2	8	8	**16**
16	3	3	2	2	2	2	2	2	9	9	**18**
17	2	2	2	2	2	2	2	2	8	8	**16**
18+	2	2	3	3	2	2	2	2	9	9	**18**
TOTAL	13	13	13	13	12	12	12	12	50	50	**100**

Table 4: Age distribution according to residential area

Twenty-six per cent of the respondents live within the residential area in which the school is situated. Fifty per cent of the respondents live within a less affluent residential area when compared with the more affluent residential area in which the school is situated. A further twenty-four percent live in other residential areas that are, similar to the other two less affluent residential areas in the sense that they are characterised by a lower socio-economic affluence in relation to the area in which the school is situated.

The following depiction serves as a summary of the respondents' details concerning their area of residence, with whom they are residing, the number of people residing in one house, the number earning an income, their access to food and pocket money, the availability of transport and school fees, possession of the appropriate school uniform, and their judgement of their financial situation as compared to other families they know.

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22 Booysen Park, Port Elizabeth, South Africa.
23 Kleinskool, Port Elizabeth, South Africa.
24 Missionvale, Port Elizabeth, South Africa.
25 This area is a combination of Zwide, Kwa-Dwesi, and Jacksonville in Port Elizabeth, South Africa. These areas have the same socio-economic characteristics as Kleinskool and Missionvale.

Residential Areas		Area 1	Area 2	Area 3	Area 4	TOTAL
Staying with	Mother	4	9	10	8	31
	Father	2	7	6	7	22
	Both parents	17	4	3	4	28
	Other	3	6	5	5	19
	Total	26	26	24	24	100
Number of people in household	1-2	2	3	2	4	11
	3-4	9	5	6	4	24
	5-6	12	6	5	7	30
	7-8	3	8	7	6	24
	9 or more	0	4	4	3	11
	Total	26	26	24	24	100
Number of people earning an income	None	3	12	11	10	36
	1	8	8	10	9	35
	2	7	5	2	3	17
	3	5	1	1	1	8
	4 or more	3	0	0	1	4
	Total	26	26	24	24	100
Access to	± 1 meal daily	26	14	12	10	62
	Lunch pack	26	10	9	11	56
	Pocket money	20	7	4	6	37
Transport money	Do not use transport	26	10	0	13	49
	Yes	N/A	7	8	4	19
	No	N/A	9	16	7	32
	Total	26	26	24	24	100
School fees paid by	Not paid	2	12	8	9	31
	Parents	23	6	5	3	37
	Other family	0	4	8	5	17
	Other	1	4	3	7	15
	Total	26	26	24	24	100
School uniform	Yes	21	17	11	14	63
	No	5	9	13	10	37
	Total	26	26	24	24	100
Number of uniform sets	None	5	9	13	10	37
	1	7	10	6	8	31
	2	8	5	4	3	20
	More than 2	6	2	1	3	12
	Total	26	26	24	24	100
Financial comparison	Richer	17	4	1	3	25
	Poorer	4	13	15	10	42
	Same level	5	9	8	11	33
	Total	26	26	24	24	100

Table 5: Specific detail according to residential areas

2.5 RESEARCH PROCESS

The research process took in a sequence of preparation, implementation and concluding. In the *preparation phase* certain groundwork attempts were made to ensure goal attainment. In the *implementation phase* certain activities were put to practice for the imperative function of data collection, which in turn assisted with goal attainment. The aspiration in the *concluding phase* was to achieve the research objectives, and to accordingly furnish an account thereof. The following is a description of the research process and its important procedural activities.

2.5.1 Preparation Phase

2.5.1.1 Literature study

In any research endeavour the identification and study of relevant literature pertaining to the phenomenon being researched is an essential activity. This enabled the researcher to:

- gain an in-depth overview of the nature of the phenomenon.
- ascertain what information already exists about the phenomenon.
- ascertain the important contributors to the understanding of this phenomenon.
- design a research proposal that would deliver a valid and reliable research outcome.
- identify contributions that she could make towards a greater understanding of the phenomenon.

The bibliography of this treatise serves as the basis of this literature study, as well as the incorporation of relevant literature within the text of this treatise.

2.5.1.2 Content analysis of documents

At the commencement of the research, specific school records were obtained. These records included the following:

- Enrolment records.
- Learner misconduct and delinquency report cards.

The *enrolment records* indicated the number of learners at the school. From this their ages, gender, school grades and residential area could be determined. The purpose of this

step was to determine the eventual size and nature of the respondent group. It is understandable that the nature and content of these enrolment records are valid and reliable.

The *learner misconduct and delinquency report cards* specify learners' misbehaviour in the classroom as well as on the playground. In extreme cases of misconduct that may affect the school or its learners, a learner's delinquent behaviour off the premises of the school is also reported on. For reasons of confidentiality, no misconduct reported on these cards was linked to any specific learner that eventually completed the questionnaire as a respondent. However, these report cards did provide sufficient background information as to the type and nature of the misconduct. Indirectly it also provided information with regard to the type and nature of misconduct of learners residing in the specific residential areas. The contents of these report cards meet the criteria of reliability, as they have to be validated according to legislative procedures.

In using these documents the researcher had access to content that:

- is complete.
- is unbiased.
- is well documented.
- provides an overview of misconduct behaviours over any number of years.
- provides information of misconduct behaviours relating to age cohort groups, gender cohort groups, school grade cohort groups, and residential area cohort groups.

2.5.1.3 Experts

Another important activity during the preparation phase is to identify and interact with individuals, groups or organisations that specialise within the field of youth at risk.

Interviews were conducted with a representative from the *ATTIC Department of Brister House*[26] and a social worker at *Stepping Stones*[27]. These individuals provided the relevant crime statistics on youth at risk as well as HIV/AIDS statistical data. Statistics on teenage pregnancy were obtained from the Clinic Provincial Headquarters in Bisho.

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[26] Brister House is a governmental institution from where information on AIDS statistics can be obtained. Brister House is situated in Port Elizabeth, South Africa.

[27] Stepping Stones is a youth justice centre, an institution that conducts juvenile court cases, accommodates juvenile delinquents, and is responsible for the reconciliation of these adolescents with society. It is situated in a residential area close to the school.

Besides the fact that the information gained from these individuals or organisations provided a much needed background to the phenomenon in general, it also provided information:

- that could eventually be correlated with information documented on the misconduct report cards regarding those incidences of behavioural misconduct as well as cases of extreme misconduct behaviours perpetrated off the premises of the school.
- that would validate both theory (literature study) and data acquired by means of a questionnaire completed by the respondents, and the focus-group interview that was undertaken with a select target group guided by the researcher.

2.5.1.4 Construction of the questionnaire

Information gained by means of a literature study and interviews with individuals and organisations enabled the construction of a questionnaire. Thereafter the questionnaire was tested in the form of a pilot-study.

2.5.1.5 Pilot-study

The pilot-study was conducted by selecting a group of six adolescents (three males and three females) between the ages of 13 and 18 years from the local Catholic Church's youth group. These respondents did not participate in the eventual research. The main objectives of the pilot-study was to:

- test the feasibility of the questionnaire content and the administering of the questionnaire.
- rectify mistakes and to eliminate any ambiguities in the instructions to the respondent group or regarding the questions itself.
- ascertain first hand how the selected pilot-study respondent group viewed risk-taking behaviour as well as to engage in a discussion of their and their peers' risk-taking behaviours.

2.5.1.6 Finalisation of the questionnaire [28]

After rectifying mistakes and ambiguities in the questionnaire, the final draft was done. Thereafter the questionnaire was duplicated.

2.5.1.7 Sampling

In paragraph 2.4 of this chapter, the reader is furnished with information regarding the total learner population, as well as the eventual respondent group sample the researcher decided on. Mention was made of implementing the non-probability sampling technique as applied to qualitative research. The researcher, being an ex-guidance teacher at the school, was able to encourage learner respondent participation because of her standing with the learners.

The researcher combined the purposive and volunteer sampling method to encourage learners to participate in her research venture.

2.5.1.7.1 The purposive sampling technique

In order to produce reliable and valid research outcomes, the researcher decided to identify clear criteria that would be an indication of the nature of the total learner population or universum. These criteria are: age, gender, school grade and the residential area. The eventual research sample (100 respondents) would also reflect these criteria. To this extent the *purposive sampling technique* was implemented.

2.5.1.7.2 The volunteer sampling technique

Owing to the subjective nature of the content of the questionnaire, and to counteract the problem of validity regarding the responses to the questions, the researcher decided to maximise learner respondent participation and reliability of responding to the questions by seeking volunteers.

At the time of the fieldwork, the school was in its final stages of preparation for the end of the year examinations and in order not to create a disruption within the school, the researcher decided to seek an equal number of male and female respondents, between the

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[28] See Addendum 1.

ages of 13 – 18 years, in their 8th through to 11th grades, and who reside in the residential areas mentioned in footnotes 22 – 25 and paragraph 2.4.4 of this chapter. The volunteer respondents thus enabled the implementation of the *volunteer sampling technique*.

2.5.2 Implementation Phase

This phase in the research process is associated with the actual fieldwork. As mentioned previously, a questionnaire, guided by the literature study, was designed to collect specific data that would not only support or augment existing literature, but would also provide information regarding the nature of risk-taking behaviour of the research group.

2.5.2.1 Fieldwork: collection of data by means of a questionnaire

After liaison with the principal of the school, the 100 respondents where assigned to a venue large enough to ensure individual responses to the questions in the questionnaire. Bringing the respondents to one venue at the same time to complete the questionnaire under the supervision of the researcher prevented inter-respondent discussion and influence. This ensured greater reliability of answers and freedom of response bias.

To ensure that the respondents understood each question, the researcher read each question before the respondents answered it and was also in the position to immediately deal with any uncertainties as they arose.

After completion of the questionnaire, each learner was asked to hand it in individually, enabling the researcher to assess if all questions had been answered. Those questions that had not been answered or had deliberately been left out were regarded as 'non responses' because the respondent felt uncomfortable with the nature thereof.

2.5.2.2 Fieldwork: additional interviews

Interviews with the principal and certain teachers at the same school were also conducted. This was to reflect on the information contained in the school records, records of conduct and misconduct, and to ascertain their viewpoints regarding adolescent risk-taking behaviour, as well as the risk-taking behaviour of learners they had encountered during their years of teaching at the school.

2.5.3 Concluding Phase

In this final stage of the research process, the researcher supplied an account of the gathered data. The ultimate aim here was to ensure that the research objectives were reached. Literature that supported the findings was integrated into the research report in the form of a treatise.

2.6 RESEARCH METHODOLOGY

2.6.1 Methods

The focal point of the study rests on three domains of adolescent risk taking behaviour – drug related behaviours, violence (including weapon use) and sexual behaviour. The reason for this choice of focus is because these three risk-taking behaviours are regarded as having long-term consequences[29], and because educators view them as serious misconduct behaviours. There is a definite assumption that two of the three domains of focus, viz. sexual behaviour and drug taking, lead to sexual promiscuity with a greater possibility of contracting HIV/AIDS.

The study is a combination of quantitative and qualitative research. Quantitative research is applied in the sense that an empirical descriptive exploration of risk taking behaviour is done by using the survey procedure. By investigating the influences that personal, social, and economic factors have on adolescent behaviour, the researcher increases the descriptive nature of this research.

In applying this method, linked to a qualitative exploration of these behaviours by means of focus-group interviews, the researcher aimed to provide both knowledge and insight in adolescent risk taking behaviour.

The ultimate research aim is to suggest specific intervention strategies that will assist in reducing the dangers of risk taking behaviour associated with learners in the specific school.

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[29] http://web17.epnet.com/citation.asp?tb=1

2.6.2 Procedure and techniques

While the research method denotes the *nature* of the research endeavour, a research procedure refers to manner in which the method is *operationalised* during the research. In turn both the method and its associated procedure(s) guide the choice of research techniques.

It is theoretically possible to delineate between procedures and techniques. However, the following section provides the reader with an understanding of the choice of methodological procedures and associated techniques applied during this research, rather than to provide an exposition of such theoretical differences.

2.6.2.1 The Content Analysis procedure

The *enrolment records* indicating the ages, school grades and residential area of the learners, and the learner *misconduct and delinquency report cards*, were analysed. The content of these documents served among others to guide the researcher in her analysis of:

- the various respondent-cohorts (i.e. age, school grade and area of residence of the learner).
- the type and nature of youth at risk behaviour perpetrated within the premises of the school.
- the type and nature of sanctioning prescribed for each misconduct.[30]

Furthermore, these records also indirectly assisted the researcher in her choice of the type of questions that were eventually contained within the questionnaire. By analysing the content of the records, the researcher was to a certain degree able to gain knowledge about the behaviour of youth at risk, thus enabling the operationalisation of both the quantitative and qualitative research methods.

2.6.2.2 Social Survey Procedure

The social survey allows the researcher to obtain a variety of factual information about the respondents. The researcher applied this procedure for the following reasons:

- It provides information about the demographic characteristics of the respondent group, the nature of their social environment, the activities they perform in their

[30] This would give an indication of the seriousness of the misconduct or risk-taking behaviour.

environment, and information about their opinions and attitudes. *This was the main reason why the researcher elected to implement the social survey.*

- Its implementation is relatively uncomplicated. It encourages a number of consecutive research activities such as the identification and construction of a representative respondent group; the design of a questionnaire; the gathering of the data with the aid of a questionnaire; the analysis of the data and eventual writing of a research report. *The fact that the researcher wanted to obtain both descriptive and comparative factual and personal information from a relatively large sample or respondent group within a specific time frame, directed the researcher to choose this procedure.*
- It enables the researcher to apply various mathematical-statistical and other technological procedures to analyse information that is gathered by means of various descriptive techniques, such the questionnaire and interviews. *Besides this, the researcher decided to use the social survey procedure because it would eventually allow her to present her findings in table format increasing validity and reliability of her research endeavour.*

2.6.2.3 The questionnaire

As previously mentioned, the social survey allows for the implementation of the questionnaire. The researcher's decision to use the questionnaire as data-gathering technique was guided by the following reasons:

- It would enable her to gather specific information about a specific phenomenon.
- It would provide her with an opportunity to gather personal and other information from respondents according to the same standardised procedure, while giving her greater control over the research process and enable that all respondents respond individually to the same stimuli.
- It would enable her to eventually analyse and compare descriptive information that in turn would pave the way for her to test the set hypotheses.

While no research is or can be totally objective, the questionnaire can increase the possibility of objectivity should the researcher design the questions carefully, taking care not

to formulate leading questions, and where appropriate, to elicit a follow-up response to questions to provide depth of understanding as to why the respondent responded in a certain manner and in content to the question. *The decision of the researcher not to interview each respondent, nor to use the interview schedule, was not primarily influenced by financial or a time constraint factor, but rather by the personal nature of the information that was required. Also, the researcher had to implement her research within the parameters set by the principal of the school to ensure confidentiality and eliminate any possible victimisation that may have been perceived from the respondent's perspective.*

2.7 EXPOSITION OF THE RESEARCH REPORT

This treatise consists of ***eight*** chapters. A brief exposition of each chapter is as follows:

In ***Chapter One*** the reader will be introduced to the phenomenon of risk-taking behaviour and its consequences for the adolescent. ***Chapter Two*** will provide the reader with a motivation for methodological choices undertaken during the research endeavour. ***Chapter Three*** will orientate the reader to a theoretical exposition of adolescence and adolescent behaviour. The nature and consequences of risk-taking behaviour with reference to drugs and alcohol, violence, and sexual behaviour will be discussed in ***Chapters Four, Five and Six*** respectively. In ***Chapter Seven*** the research results and findings will be tabled and documented, while the most important findings will be discussed in ***Chapter Eight***. This chapter will also include recommendations made by the researcher.

2.8 CONCLUSION

In this chapter the researcher gives an exposition of the target group or respondent group that was studied. An indication of the research process that was followed is outlined. To ensure a valid and reliable methodology, the researcher gives an indication of her choice of research methods, procedures and techniques.

Holistically assessed, the content of this chapter attempts to provide information of a scientific approach to a phenomenon that has both objective and subjective content, and the researcher's attempt to gain and maintain control over the research process that will

eventually enable her to provide exploratory information that would guide the process of intervention to prevent adolescent risk-taking behaviour.

In Chapters Seven and Eight the researcher will provide the reader with the results gained from the various methodological strategies implemented. In the next chapter the adolescent stage and adolescent behaviour will be described.

Chapter Three

ADOLESCENCE AND ADOLESCENT BEHAVIOUR

3.1 INTRODUCTION

Various theorists have different descriptions for the term 'adolescence', but somehow these depictions have similar suggestions. The main theorists in this regard are Erikson (1963), Elkind (1961), Kohlberg (1978), Mead (1934), Tajfel, (1981), Piaget (1950), and Maslow (1968). Theories explaining adolescent behaviour include behavioural or social learning theories, symbolic interactionist theory, social identity theory, and field theory.

3.2 ADOLESCENCE

3.2.1 Erikson: *(Erikson's Identity Formation)*[31]:

Erikson (1963) composed an important explanation that describes the process through which identity development transpires during adolescence. Stage 5 of his eight-stage epigenetic model of life span development ties the concept of identity formation. According to Erikson, this stage, *identity versus identity confusion*, is the central challenge of the adolescent stage of development. He views this stage as a search for identity, an emotional standstill or 'time out', which allows the young person opportunities to experiment freely with different roles, attitudes and personalities, prior to making essential life-decisions.

Identity, as proposed by Erikson, refers to the adolescent's active search for his or her role, contemplation of personal strengths and weaknesses, and concurrent fusion of past, present, and future life experiences. The success or failure of negotiating future life stages of developing intimate relationships, fulfilling work goals, and contributing to society in general is dependent on a strong concept of identity emerging during adolescence. In addressing the task of identity formation, it was written:

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[31] Te'Neil L., 2002. Review of General Psychology, Volume 6.

> "The young person, in order to experience wholeness, must feel a progressive continuity between that which he has come to be during the long years of childhood and that which he promises to become in the anticipated future; between that which he conceives himself to be and that which he perceives others to see in him and to expect of him. Individually speaking, identity includes, but is more than, the sum of all the successive identifications of those earlier years when the child wanted to be, and often was forced to become, like the people he depended on."[32]

Adolescents continually search for information about themselves from others within specific situations. Erikson viewed the adolescent's interaction with friends as an acceptable and necessary involvement. Progress takes place in that the adolescent moves from an indisputable acceptance her or his parents' views to exploring peers' views to eventually determining her or his own view of the self. The adolescent struggles to answer key questions during the identity crisis about the present and future self.

3.2.2 Elkind

Elkind (1961) believed that the adolescent's ability to access thought is the major developmental task during early adolescence. As formal operational thought commences during this stage, the adolescent begins to conceptualise the thoughts of others as well as his or her own thoughts. Conversely, the early adolescent experiencing a state of egocentrism is preoccupied with his or her own appearance and behaviour. Elkind concluded:

> "One consequence of adolescent egocentrism is that, in actual or impending social situations, the young person anticipates the reactions of other people to himself. These anticipations, however, are based on the premise that others are as admiring or as critical of him as he is of himself ... in a sense, then, the adolescent is continually constructing, or reacting to, an imaginary audience." [33]

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[32] Erikson E., 1968: 87.
[33] Elkind D., 1974.

A most common imaginary audience construction to the adolescent is the anticipated fanaticism of how significant others will react to his or her death. A certain bittersweet pleasure is derived from anticipating the belated recognition of his good qualities.[34]

Contrary hereto, this belief in a sense of special uniqueness becomes false assurance that he will not die, that death will happen to others but not to him. Elkind called this compound set of beliefs in the uniqueness of his feelings and of his immortality *a personal fable*[35], an untrue story that the adolescent believes in.

This egocentrism diminishes at a later stage of adolescence. The imaginary audience, which may be regarded as a series of theories that the adolescent tests against reality, progresses into the real audience. With the realisation of reality, the adolescent is able to perceive his true self and he can establish true rather than self-centred relationships.

3.2.3 Kohlberg[36]

The work of Kohlberg (1978) on moral development must be acknowledged as a worthy contribution to the study of adolescence. The three levels and types of moral reasoning that Kohlberg distinguishes are:

- ***The pre-moral:*** in which the child is merely obedient or subservient, but does not fully understand why he or she conforms to the wishes of others.
- ***Morality of conventional rule-conformity:*** in which the child behaves in a correct or appropriate manner according to the rules and habits of the parents. In this way the child satisfies the needs for approval and recognition are being satisfied.
- ***Morality of self-accepted moral principles:*** in which adolescents observe and learn how, by maintaining the appropriate moral values, they contribute to a democratically established law that protects the rights of others.

The older adolescent develops a sense of right and wrong, as a mature and sophisticated cognitive ability is attained. During adolescence the individual's values and moral beliefs directly influence his or her way of behaving. This actuality becomes particularly significant in understanding antisocial or rebellious behaviour. Influential role

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34 Elkind D., 1974: 92.
35 Elkind D., 1974. See also Moore & Rosenthal, 1993: 18 & 129.
36 Allen-Meares P., 1995.

models in the adolescent's immediate environment (e.g. peers, parents, and relatives) also play a crucial role in the development of values and morals.

3.2.4 Maslow

From a humanistic point of view, the work of Maslow (1968) is considered as exceptionally important. Humanistic psychologists like Maslow perceive the individual's development as continual, growth that only stops once the individual has accomplished his or her full potential. Through his theory Maslow proposes that human behaviour is a result of a hierarchy of needs.[37] The initial most basic physiological demands increasingly cultivate into safety, belonging, and esteem needs, and finally conclude in self-actualisation. Each level directs behaviour toward the need level that is not being adequately met. The following table is a representation of the needs Maslow describes as the motivation or inspiration behind an individual's behaviour:

	Type of Need	Examples
1	Physiological	Thirst, sex, hunger
2	Safety	Security. stability, protection
3	Love and Belongingness	To escape loneliness; to love and be loved; to gain a sense of belonging
4	Esteem	Self-respect, the respect of others
5	Self-actualisation	To fulfil one's potentialities

Table 6: Maslow's hierarchy of needs[38]

The individual is thought to have an innate need for self-actualisation. As illustrated by the above table, only when lower-level needs are met (e.g. food, shelter, health care) can he or she move to higher levels of potential. Furthermore, a sense of self-esteem and affirmative response from others are required to reach full potential.

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[37] http://www.britannica.com/eb/article?eu=115598&tocid=12712
[38] http://ericae.net/pare/getvn.asp?v=5&n=11

3.2.5 Mead

The belief that a developing individual is influenced by repeated images from people closely and frequently involved with that individual was termed by Mead (1934) and Cooley (1902) as symbolic interactionism[39]. Mead highlighted the importance of communication in the linkage among individuals in a society. He emphasised the vital role of language and symbols employed to convey “culturally defined meanings". The appropriate symbols and images are then internalised and re-used by the specific individual. As the individual develops, he gains the ability to take the role of significant others and views himself from the perspective of those others. Consequently he believes that individuals develop their self-concept through interactions with significant others.[40]

3.2.6 Tajfel

In the social identity theory, Tajfel (1981) identified a close connection between an individual’s self-concept and membership in ethnic and other social groups. So to speak, an individual perceives himself at a relatively comparable level as he observes his ethnic group or other social groups he is attached to. An individual’s group identification and the integration of group membership into their self-concepts are ascribed to the need for an affirmative self-image. Tajfel argued that attachment to high-status groups contribute toward a positive self-image, whereas the opposite is true of membership in minority or low-status groups.[41]

3.2.7 Piaget

The theoretical framework of Piaget (1950) deals mainly with the development of cognition and intelligence. While experiencing development the child actively attempts to control and learn about his or her immediate environment. As the individual goes through a sequence of complex stages, he or she continually tries to make sense of the world.

According to Piaget, children discover ideas and behaviours as they experience their environment[42], and in this way they learn to deal with it. Through a specific type of mental

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39 Cooley C.H., 1902.
40 Mead G.H., 1934.
41 Bornman E., 1999. Journal of Social Psychology, Volume 139: 411.
42 Allen-Meares P., 1995.

action, which Piaget calls “operation”; the individual is able to transform information for specific intentions. This progression forms a central component of intellectual development.

Piaget has divided his theory into four major periods of intellectual development:

- Sensorimotor (birth to two years)
- Preoperational (two to seven years)
- Concrete operation (7 to 11 years)
- Formal operational (11 years and older)

Each stage forms the foundation for the next. Every newly learned skill is added to the next stage. Children integrate information and adapt to their environment, with a change in behaviour equivalent to every new circumstance. This process of assimilation and adaptation assists them in moving on to the next stage of their development.

The stage of formal operational thought, starting at the age of twelve and embracing the adolescent stage, comprises thought processes that include analysis. It involves the ability to critically examine the effects of one inconsistency with another and to think of possible consequences of actions. The adolescent’s thoughts are flexible, and they can include complex problem solving. Piaget believes that the social environment plays a critical role. Adolescents need to test ideas through experimentation and then analyse the results, which will ensure intellectual development.

3.3 PERSPECTIVES ON DETERMINANTS OF ADOLESCENT BEHAVIOUR

In order to increase understanding of the adolescent stage, five perspectives are analysed in terms of their relevance to adolescent behaviour. These perspectives include behavioural motivations, learning from significant others and through symbols and language, learning through membership in a specific ethnic or social group, learning from the environment, and behaviour as a result of certain attitudes the adolescent may hold.

3.3.1 Behavioural or social learning theory

The emphasis of behaviourism falls on the fact that learning results from the interaction of the individual with others in his or her environment. Through imitation and modelling various types of behaviour are taught to the individual upon interacting with the

environment. The child becomes conditioned to respond in a certain manner to a specific situation, but the response can be appropriate or inappropriate. The individual is incapable of exerting the correct response if not exposed to the appropriate responses, situations, and environments.

The social learning theory is based on a psychological concept, normally known as reinforcement. Social learning is the process whereby individuals collect information that shapes their responses to it from their environment. A child's upbringing is powerful because it provides models, and it rewards or punishes children for certain behaviours. The key concepts[43] of this theory include the following:

- **Expectations:** the individual's belief about likely results of actions
- **Observational learning:** the individual's beliefs based on observing others like self and/or visible physical results of desired behaviour
- **Behavioural capability:** knowledge and skills needs to influence behaviour
- **Self-efficacy:** confidence in ability to take action and to persist in the action
- **Reciprocal determinism:** behaviour changes resulting from interaction between person and environment; change is bi-directional
- **Reinforcement:** responses to a person's behaviour that increase or decrease the chances of recurrence

Over time and through observation, children learn by watching and they are rewarded or punished for behaving in specific ways. Although learning commences at birth, the concept of learning applies to the attainment of totally new responses and to improvements or changes in the occurrence of behaviour previously learned.

3.3.2 Humanistic Theory

Theorists pursuing the humanism concept suggest that all human beings are essentially free, with freedom of choice, and they are responsible for directing their own lives[44]. The humanistic perception of behaviour rests on the assumption that needs and motives are primarily responsible for behaviour. According to this perspective, whether

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[43] http://ReCAPPTheories&ApproachesSocialLearningTheory'sMajorConcepts.htm
[44] Corey G., 1982.

people engage in different behaviours to achieve the same goals or in the same behaviours to achieve different goals, the key to understanding behaviour lies within the purposes and motives that underlie and give rise to that behaviour.[45]

According to Maslow, the individual's usual conscious desires are not as important in themselves as are their underlying meanings. These deep-rooted desires are driven by certain goals or needs. These needs are perceived as the basis for behaviour and are referred to as basic human needs or the basis for human motivation.

Maslow distinguishes between low-level needs (levels 1-3) and high-level needs (levels 4-5). The low-level needs are referred to as "wants or primary needs" and normally exert stronger pressure on an individual to take action for fulfilment. The high-level needs are referred to as "secondary needs"[46] with normally a weaker force to act. The conclusion that can be made is that the higher (and less basic) a need is in the hierarchy, the weaker its potential influence on behaviour. It is only when these needs are met on a regular basis that the needs higher on the hierarchy exert stronger pressure to act.

The following illustration depicts the hierarchy of needs:

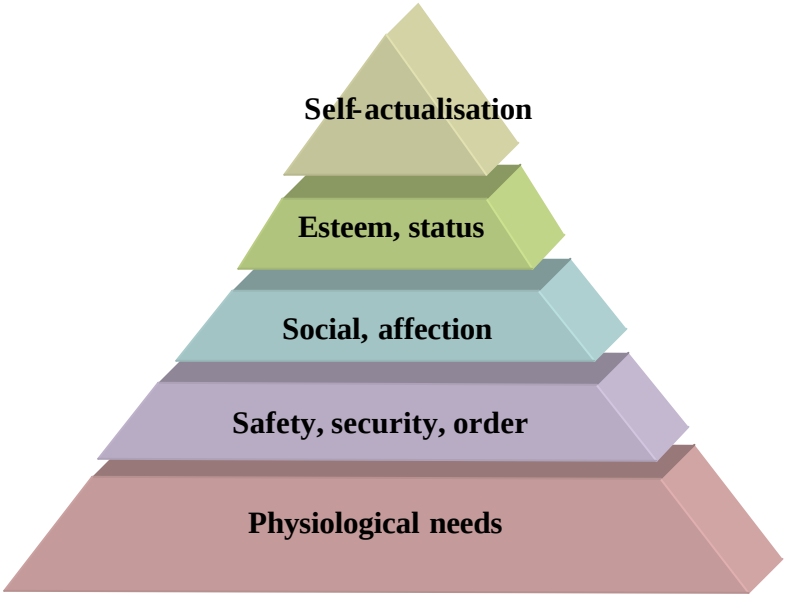

Figure 1: Maslow's need-satisfaction model[47]

[45] Cooper M.L., *et al*, 1998.
[46] Louw, D.A., *et al*, 1984.
[47] http://sol.brunel.ac.uk/~jarvis/bola/motivation/masmodel.html

Maslow defined five specific levels of needs and organised them in a hierarchy. These five needs are: self-actualisation, self-esteem, social, security, and physical needs[48]. For an individual to reach the level of self-actualisation he or she has to develop him or herself, in order to "move up" the hierarchy. At this level the individual is free from all ordinary concerns and may follow his dreams to become all he desires to be. It is uncertain whether many people reach this level.

3.3.3 Symbolic Interactionist Theory

Symbolic interactionism[49] is employed to show how the social control of different behaviour types lies in an interactionist formation of the self. The whole perspective is based on Mead's (1934) thesis that the self arises in challenging situations when an individual takes the role of significant others. The specific individual then views the self from the viewpoint of those others. The self, then, consists of a set of evaluations (or perceptions of evaluations or appraisals) of the self by others.

Behaviour is in large part a function of the meanings of self that are relevant to the specific type of behaviour. These meanings arise in part through labelling. In other words, the actual assessment of significant others (like parents, siblings, teachers, and peers) affects the evaluation the individual attaches to the self.

On the individual level Mead views role taking as the means to social control. The individual takes the role of others, observes himself from the viewpoints of others, and consequently applies his actions appropriately into a social interaction. This transaction involves five major processes that can affect behaviour:

- The specific ***meaning of the self as reflected appraisals*** (according to the specific evaluation of others, e.g. as a delinquent) should affect behaviour.
- ***Holding attitudes toward certain solutions*** to challenging situations will affect behaviour.
- ***Anticipating the reactions of significant others to behaviour.***

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48 http://www.nova.edu/~gibson/wk3notes.html

49 Heimer K., & Matsueda R.L., 1994. American Sociological Review, Volume 59: 366.

- ***Associating with peers*** would influence behaviour, both indirectly and directly. (E.g. delinquent peers would encourage the probability of delinquent behaviour.)
- ***Habitual or scripted responses established through previous experiences*** can occur in the absence of thoughtful reflection.

These five measures of role taking are important mechanisms on an individual level by which certain behaviour is shaped. Specifically, through role taking individuals also become aware of the likely reactions of others to certain behaviours; thus they can consider the consequences of such reactions for self-image, extrinsic rewards, and group membership.[50]

On a social system level Mead considers that the primary locus of control resides in families – in particular, in parent-child relationships. The following illustration is an example of how parents control their children's behaviour: when a child takes the role of the parents, he forms an image of himself as an object from the views of his parents. He predicts and then ultimately judges his parents' reactions to his behaviour. The peer group is a second important environment of control of adolescent behaviour. Peer groups serve as abstract significant others that provide concrete circumstantially encouraged motives and pressures. Therefore they are able to direct the behaviour of its members. Parents on the other hand, manipulate their children's peer groups by choosing a residential location and through direct supervision of their children's activities with their peers. The conventional social establishment, interaction and communication patterns of the school, condition the authority and influences of the peer group.

The following figure depicts a structural equation model of differential social control and behaviour, which in this case illustrates the influence of control on delinquency.

[50] Heimer K., & Matsueda R.L., 1994. American Sociological Review, Volume 59: 367.

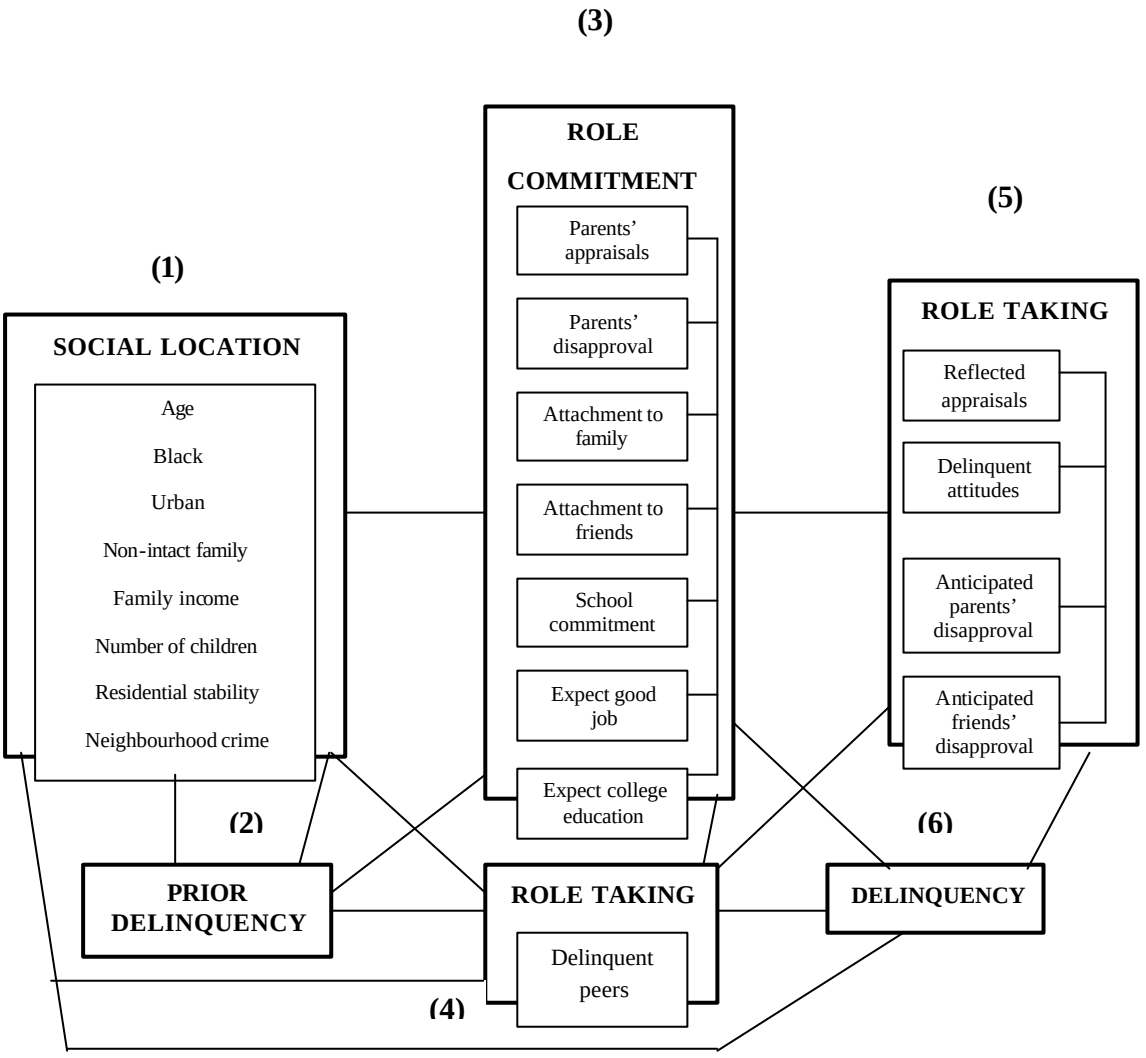

Figure 2: A model of differential social control and delinquency [51]

The model consists of six blocks of variables: (1) background variables measuring position in the social structure; (2) a measure of previous occurrence of delinquency; (3) variables measuring commitments to traditional roles, parental disapproval of behaviour, and appraisals by parents; (4) role taking measured by peer associations, whether positive or

[51] Heimer K., & Matsueda R.L., 1994. American Sociological Review, Volume 59: 374.

negative; (5) other variables representing the role taking process; and (6) an outcome variable of subsequent behaviour, in this case delinquency.

Thus, individuals develop commitment to traditional roles in part based on their objective position in the class, residential or ethnic structure.[52] The exogenous background variables – race, broken family, urban locality, family income, residential stability, and neighbourhood crime – reflect structural position and social disorganisation. The ages and number of siblings in the home are also included because both these variables have been found to predict antisocial behaviour or delinquency. Whether an individual commits himself to traditional roles depends on his attachment to family, attachment to peers, commitment to school, expectations of employment, and expectation of tertiary education.

3.3.4 Social identity theory

Part of the self-concept of an individual depends on the knowledge of the value and the emotional significance that the individual attaches to his group membership. This interest is referred to as social identity.[53] Ethnic identity, which is represented by the individual's involvement in the ethnic group, forms an important part of the social identity. The individual with a positive self-concept and ethnic identity will be actively involved in, will hold positive attitudes, be filled with a sense of belonging to, and be proud of his cultural group.

For adolescents from a minority ethnic group, identity formation also requires consideration of ethnic or racial group membership, a process that influences the development of ethnic or racial identity.[54] It is likely that adolescents from these minority racial groups will suffer from a sense of minority in some way or the other, if social identity is achieved. Apart from attaining social identity adolescents from minority ethnic groups still have to accomplish cognitive, emotional, and behavioural comparisons of belonging to a particular ethnic group.

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52 Heimer K., & Matsueda R.L., 1994. American Sociological Review, Volume 59: 373.
53 Tajfel H., 1981.
54 Spencer M.B., & Dornbusch S., 1990.

Ecological perspectives regarding social and ethnic identity have also emphasised the role significant others can play in the development of ethnic identity. One example of this perception is Kurt Lewin's (1931) classical equation, $B = F(P, E)$. When defined, this equation means that *behaviour* (as well as development) is a *function* of the interaction between the *person* and the environment. According to Lewin, human behaviour should always be observed and evaluated in its sociological, cultural, historical, and, theoretical contexts or environments. These models recognise the multiple layers of contextual influences on adolescent development.

Literature addressing racial socialisation has examined the transmission of values, beliefs, and other messages about adolescents' racial identity within a society. In summary, the racial socialisation literature emphasises the various different approaches taken by minority families to convey important messages, both positive and negative, to their children. Many South African adolescents today still suffer the consequences of an apartheid history, with a school *"system devised which will recondition us to accept perpetual inferiority"*.[55] They still have to endure non-encouraging and demotivating school environments and living conditions as well as being faced with the unlikelihood of employment and post-school education.

3.4 THEORIES OF BEHAVIOUR CHANGE

Since the beginning of social psychology social scientists have regarded behaviour as a component of attitudes.[56] Attitudes were first defined as "readiness for attention or action of a definite sort"[57] and viewed as individual cognitive processes that determine a person's actual and possible behaviour. This analysis therefore implies that a change in attitude causes change in behaviour. How are attitudes changed?

Attitudes have generally been divided into three components:[58]

- ***Affect:*** which consists of an individual's evaluation of, liking of, or emotional response to some object or person

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55 Luthuli A., in Hendricks B., 1985.
56 Zimbardo P. & Ebbesen E., 1969.
57 Ajzen I. & Fishbein M., 1980:13.
58 Zimbardo P. & Ebbesen E., 1969:7.

- ***Cognition:*** which is an individual's belief about, or factual knowledge of, the object or person
- ***Behaviour:*** which involves the individual's overt behaviour directed toward the object or person.

Because attitudes are defined in this way, in order to change behaviour, a good technique would include processes to change a person's emotional reactions toward an object or person, as well as the individual's factual knowledge about the object or person. Behaviour change occurs only if increased knowledge is accompanied by change in beliefs, social norms, and intentions.[59]

This study will focus on four models of behaviour change, i.e. the theory of reasoned action, the transtheoretical model of behaviour change, the formal attitude change approach, and the group dynamics approach.

3.4.1 Theory of reasoned action

The theory of reasoned action is based on the assumption that human beings are usually quite rational. They normally employ information available to them in an organised manner for the human mind to comprehend. Usually individuals consider the implications of their actions before engaging or not engaging in a certain action, therefore the categorisation of the approach as "a theory of reasoned action".[60]

The ultimate objective of the theory is to predict and understand an individual's behaviour. The initial step towards attaining this objective is to identify and evaluate the specific behaviour. When the behaviour has been clearly defined, the motivation behind it should be determined. The theory assumes that most actions are chosen and preferred, implying that an individual's *intention* to execute a behaviour or not as the immediate determinant of the action.

The second step in the analysis of the theory requires the identification of the determinants of intentions. Intention is a function of two fundamental determinants, one personal in nature and the other reflecting social persuasion. The personal factor is the

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[59] Segal B., 1989.
[60] Ajzen & Fishbein, 1980: 5.

individual's positive or negative evaluation of performing the behaviour; this factor is termed *attitude toward the behaviour.* The social aspect is the individual's opinion of the social pressures put on him to engage or not engage in the specific behaviour. Since it deals with perceived prescriptions, this factor is termed *subjective norm.*

Under normal circumstances individuals will indicate an intention to engage in a specific behaviour after positive assessment of the behaviour, and when they believe that significant others think they should perform the behaviour. It is therefore possible to predict and gain some understanding of a person's intention by measuring his attitude toward performing the behaviour, his subjective norm, and their relative weights.

The following figure illustrates how behaviour can be explained in terms of a limited number of concepts.

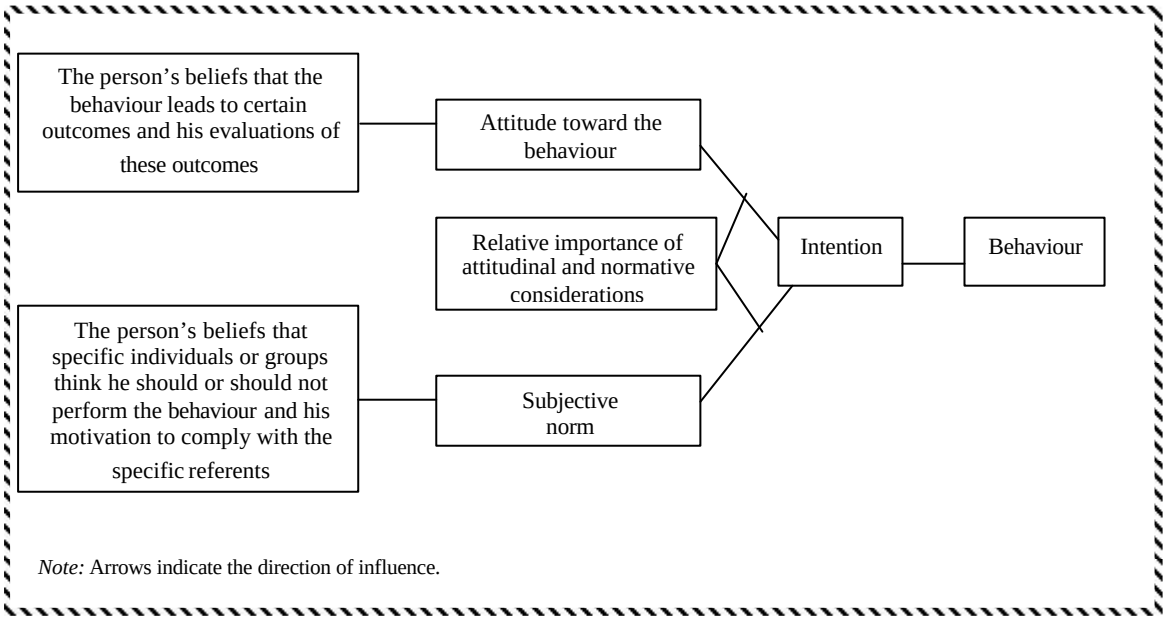

Figure 3: Factors determining a person's behaviour [61]

Through a series of interceding constructs the illustration traces the causes of behaviour back to the individual's beliefs. There is definite cycle from behaviour to beliefs, which supplies a more inclusive explanation for the causes for the behaviour.

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[61] Ajzen & Fishbein, 1980: 8.

In summary, attitudes always generate pressure to behave consistently with them. However, there are times when external influence and inappropriate reflection can cause people to behave inconsistently with their attitudes. Any attitude or change in attitude tends to produce behaviour that corresponds with it. If this correspondence does not emerge, it is an indication that other factors are involved in the situation.

3.4.2 The transtheoretical model of behaviour change

To stop performing new behaviour changes are part of everyday life. Numerous people have made the first move to behaviour changes only to relapse after a while. For the individual to be triumphant in engaging in the changed behaviour, it must be maintained. This process requires extensive time, effort, and energy. For an individual to achieve permanent changes in behaviour he will need willpower and a well-structured technique. Prochaska, Norcross, and DiClemente (1994) proclaim through the transtheoretical theory that behaviour change develops through different stages:[62]

- Stage 1: ***Pre-contemplation.*** Individuals in this stage do not believe they have a problem and have often constructed defences that aid in denial of the problem. The person has no intention of changing.
- Stage 2: ***Contemplation.*** Individuals acknowledge having a problem and begin to deliberately increase awareness and knowledge related to the problem. He or she seriously considers changing.
- Stage 3: ***Preparation:*** Before initiating behaviour change, individuals should re-evaluate themselves with respect to the problem, develop commitment to change, and construct a detailed plan for change. By the time they reach this stage, individuals begin to perceive greater benefits than barriers to change.
- Stage 4: ***Action.*** Behaviour change is initiated. Others are likely to recognise a person's progress toward change. After at least 6 months in the action stage, the person may move into the fifth stage.

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[62] http://www.ed.gov/databases/ERIC_Digests/ed429053.html

- Stage 5: ***Maintenance.*** Though change is maintained more easily now, some vigilance is still required to avoid slips or setbacks. If and when the change becomes so automatic that there is no possibility of reverting to a former behaviour, the goal "Termination" is reached. This maintenance phase should last for about six months.

To some, behaviour change seems easy and straightforward, but it is not either. Prior to the attempt to change behaviour, it is advisable that the individual make realistic assessments concerning the time, attention, and effort. It would be to the individual's advantage if he possesses and utilises the proper knowledge and skills in the various processes of change. A full set of tools is needed as well, as a new individual is built.

3.4.3. The formal attitude change approach

This Yale (Yale University) approach is a consequence of a learning theory orientation. It is of the assumption that people are capable of rational thought, of processing information. According to this approach, people can be motivated or provoked to attend to a communication and to learn its contents. They are also able to integrate these communications into their verbal selection of responses when this learning is rewarded. Thus the instrument of change is a formal, structured and controlled communication. The agent of change is either the actual or anticipated reward for agreeing with the communicator, or else the awareness of the logical and rational necessity for accepting the information and position advanced.[63]

3.4.4 The group dynamics approach

In contrast to the formal attitude change approach, the group dynamics approach is derived from a cognitive, field-theory orientation. This approach assumes that man is a social being who needs other people as a basis for (a) self-knowledge, (b) determining appropriate responses to environmental demands, and (c) channelling and regulating his current behaviour through the operation of group norms. The instrument of change is a group norm discrepant with the individual's attitude or behaviour, a norm that may be communicated

[63] Zimbardo P. & Ebbesen E., 1969.

informally. The agent of change is pressure toward uniformity within the group, coupled with a need to be accepted in the group, or a fear of being rejected from it.

3.5 CONCLUSION

The human being develops habits to protect his or her health, physical and emotional well-being early in life. The adolescent stage is especially important for developing these habits. On the other hand the adolescent is also exposed to the initiation of behaviours related to smoking, drug and alcohol use, violent behaviour, and sexual risk taking.[64] Because adolescent behaviours may serve as better predictors and warning signals of disease after age 45 than adult health behaviours, interventions with children and adolescents are important. Only a few adolescents emerge from the stage of adolescence with 'ideal' health habits. Thus, mastering behaviour change is important to the quality of life.

In the next chapter, the nature and consequences of adolescent risk-taking behaviour with reference to drugs and alcohol will be discussed. The aim would be to re-emphasise the need for behaviour change among these group members.

[64] http://www.ed.gov/databases/ERIC_Digests/ed429053.html

Chapter Four

DRUGS AND ALCOHOL – ITS NATURE AND CONSEQUENCES

4.1 INTRODUCTION

In the past young people have generally been protected from the use, overuse and abuse of habit forming or sedative substances[65]. Most societies had previously recognised their harmful effects on both body and minds of growing adolescents. There has been a blanket ban on children and adolescents using alcohol.

South African society has become highly permissive. Beverages containing alcohol are easily available in abundance. Drinks are available at homes, restaurants, hotels, shebeens, bottle stores, and shack shops to name but a few. There is no enforcement of the statute that states an individual has to be 18 years or older in order to be sold alcohol, and an identity document is seldom requested as proof of age. The abuse of drugs and alcohol by young people is a problem that is escalating at an alarming rate. Of particular concern is the trend of progressively younger age groups, from as young as eight or nine years, to become involved with drugs in the form of inhalants and alcohol.

4.2 DRUGS

Any chemical substance, which has the potential of being abused, is a drug[66]. While chemicals like tin, lead, gold, and nicotine[67] have harmful effects on the body, especially in high doses and when used over an extended period of time, inhalants have dangerous chemicals that are toxic to the human body. Most cough mixtures contain properties that have the potential of being misused. Drugs, such as marijuana, cocaine, ecstasy, and heroin,

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65 Gumede M.V., 1995.
66 Gillis H., 1994.
67 http://www.utexas.edu/research/asrec/

to mention a few, have properties known to lead to addiction and in some cases are the cause of death. What then are the causes of drug and inhalant use?

4.2.1 POSSIBLE CAUSES OF DRUG AND INHALANT USE

According to Gillis (1994) the following may trigger the use of drugs:

- **A desire for acceptance by the peer group.** Adolescents have an increasing need to confirm their normality by 'being with it', and a need to belong to the group.[68] They therefore tend to give in to peer pressure by participating in the same activities, sharing similar beliefs and likings, and following the same dress code as their friends. The early stages of drinking or smoking almost always take place as part as a group activity.
- **Curiosity.** It is natural for an adolescent to want to explore adult ways of behaving and satisfying needs, and the challenge and risks this entails. In this way they want to prove their social competence.[69]
- **Copycat behaviour.** The tendency of society to accept as normal the increasing use of drugs such as tranquillisers, stimulants and sedatives, has resulted in a more relaxed attitude towards drugs in general. In a home environment where parents and other adults continually expose adolescents to drug-related ways of behaviour, for example, habitual alcohol drinking to relieve tension, taking aspirin to ease a headache, using supplements to boost the energy level, or taking medications to sleep, the use of drugs becomes the accepted norm. During the development process towards adulthood, young people experiment with different role models, and there is a tendency to identify with cult heroes and pop stars, many of whom are openly associated with some form of drug taking.
- **A progressive need to relieve anxiety or boost self-confidence, when other methods of coping prove inadequate.** The adolescent period is often accompanied by sporadic phases of stress[70] and tension, and drugs, by creating an artificial sense of well being, offer a temporary refuge from the realities of the world.

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[68] See footnote 72.
[69] See footnote 72.
[70] http://www.cdipage.com/teens_stages.shtml#adolescence

Generally speaking adolescents who are at risk of drug (and alcohol) use and/or abuse are those with a family history of substance abuse, who are depressed, who have a low self-esteem, and who feel like they do not fit in or are out of the mainstream.[71]

South African adolescents not only have to cope with the persuasive effects of a permissive South African society, but they also have to learn to cope with the fact that employment and further educational prospects might not be readily forthcoming at the completion of their school year. It is a basic human need to be able to believe in a hopeful future with genuine prospects.[72] The high rate of unemployment, anger and awkwardness as a result of the legacy of apartheid and inequality, and a general atmosphere of disorder may have the same impact on their decision to take to drugs and alcohol to escape the reality of not being able to fulfil their need of employment and after school education and training. *(This attitude of despondence and frustration was also identified as one of the reasons given by the respondents in this research for risk-taking behaviour).*

4.2.2 SOCIAL INFLUENCES ON DRUG TAKING

The social learning theory of Bandura[73] states that children naturally imitate the behaviour of others, either other children and adults, or siblings and their parents, often without the gain of a direct reward. Interaction with the environment, which provides models, punishment or rewards for certain behaviours, determines this process directly.

Learning takes place by observation, followed by imitation and modelling that forms the child's behavioural pattern. After some time the child is conditioned[74], whether appropriate or not, to respond to a specific situation. The child has no way of knowing what is appropriate until he or she has been exposed to other responses, situations and environments. Parents, peers, society, and the media may exhibit social influences on adolescents' drug taking.

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71 http://www.focusas.com/SubstanceAbuse.html

72 http://www.ianr.unl.edu/pubs/family/g1322.htm
According to this article by Herbert G. Lingren, three fundamental human needs are crucial to survival and to healthy development, i.e. (1) to be a valued member of a group, (2) to become a socially competent individual, and (3) the need to believe in a promising future with real opportunities.

73 http://www.etr.org/recapp/theories/index.htm

74 Allen-Meares P., 1995.

Adolescents are more likely to use drugs if their parents use it regularly and are more tolerant of drug use[75]. It is through the process of social learning that children assume this behaviour is normal and in role taking they model their parents. Other factors concerning the parents that could possibly have an influence on adolescents' drug use are factors such as having both parents work, one or both parents absent, separated parents who compete for the child's love, or parents who shower their children with huge amounts of pocket money.

Friends have a big influence on adolescents. The adolescent individual might give in to drug taking to fit in with the crowd, to portray an adult role, to win the opposite sex's favour, or to acquire group membership. The friends of adolescents have a bigger influence on cigarette smoking behaviour than any other influence.[76]

The phenomenon of social change played a major role in society becoming so permissive with regard to adolescent drug and alcohol use. The possible reasons why members of society allows this occurrence to take place, could be the fact that times are so stressful (think of work-related stress, unemployment, high cost of living, crime, potential for conflict among countries, unhappiness with political situation, etc.) that people could not be bothered what the neighbour or the neighbour's children do.

The media plays a huge role in what children and adolescents perceive to be the real message. Television and movies do not portray drugs as something bad and illegal; therefore they are responsible for the fact that adolescents view the current drug problem through rose-tinted glasses. The media, especially television, thus conducts its message as a social learning technique.

4.2.3 TYPES OF INHALANTS / DRUGS AND THEIR CONSEQUENCES

4.2.3.1 Inhalants

Sniffing the fumes of various common products such as aerosol paint, spray or even gasoline can produce effects that are more serious than any of the other drugs.[77] Glue, paint thinner, nitrous oxide, benzene, video head cleaner, laughing gas, aerosol sprays, cleaning fluids, solvents and liquid white wash are products easily available to young people. The

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75 http://ohioline.osu.edu/flm02/FS14.html
76 http://www.vincenter.org/96/delener.html
77 Smith J., 1995.

inhaled vapours reach the brain quickly and cause disorientation, lack of co-ordination, and impaired judgement. If the vapours are inhaled deeply, or a large amount is used over a short period of time, the user is in danger of several brain damage or death. Repeated sniffing can result in fatigue, loss of appetite, nausea, sneezing, nosebleeds, headaches, muscle weakness and abdominal pain. Other more serious effects are permanent damage to the nervous system, disconnected mood swings and violent behaviour, damage to the lung, liver and kidney, dangerous chemical imbalances in the body, and finally hepatitis or peripheral neuropathy from long-time use.[78] Adolescents who use inhalants for the first time might acquire serious respiratory problems and permanent brain damage.

4.2.3.2 Drugs

The drug varieties[79] heroin, cocaine, ecstasy, tobacco, and marijuana will be discussed.

(a) ***Heroin*** is a sedative addictive drug that is prepared from and acting like morphine (an alkaloid narcotic principle of opium) illicitly used to produce intense euphoria.[80] Symptoms are stages of intense rapture and exhilaration, yet experiencing extreme calmness whilst being alleviated from pain. Effects[81] it has on the user include:

- Addiction
- Slow and slurred speech
- Slow gait or way of walking
- Constricted pupils, droopy eyelids, impaired night vision
- Vomiting after first use and very high doses
- Decreased sexual pleasure, indifference to sex
- Reduced appetite
- Constipation
- "Nodding off" (with high doses)
- Respiratory depression or failure

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78 http://www.prevlink.prg/getthefacts/facts/inhalants.html
79 Learners who formed the target group used these drugs and one other, i.e. F2.
80 The Concise Oxford Dictionary, 1984: 467.
81 http:www.prevlink.org/getthefacts/facts/heroin.html

- Increased risk of exposure to HIV, hepatitis, and other infectious diseases if injected
- Dry, itching skin and skin infections
- Death from overdose

Other names use for heroin are smack, horse, brown sugar, mud, junk, black tar, dope, and big H. According to numerous sources, an increase is revealed in new, young users who are being enticed by inexpensive, high-purity heroin that can be sniffed or smoked instead or injected. Heroin has also made itself evident in more affluent communities.

(b) ***Cocaine*** was once thought to be a wonder drug that would not cause addiction. People did now know that it can be highly addictive. It is a drug from coca, used as local anaesthetic and as stimulant.[82] *Crack* is the street name for tiny chunks or "rocks" of cocaine. It is smoked, and it makes a crackling sound when it burns. Crack also acts as a stimulant and as a painkiller. A summary of the effects[83] it has on the user entails:

- Addiction
- Pupil dilation
- Elevated blood pressure and heart rate
- Increased respiratory rate
- Increased risk of exposure to HIV, hepatitis, and other infectious diseases if injected
- Paranoia
- Seizures
- Heart attack
- Respiratory failure
- Constricted peripheral blood vessels
- Restlessness, irritability, anxiety
- Tactile hallucinations
- Insomnia

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82 The Concise Oxford Dictionary, 1984: 178.
83 http:www.prevlink.org/getthefacts/facts/cocaine.html

- Increased body temperature
- Death from overdose

Cocaine is an extremely dangerous drug. Apart from the above-mentioned effects, other dangers associated with cocaine use include the narrowing of blood vessels, an interference with the brain's nerve cells, a malfunctioning nerve system, brain seizures and mental illness.[84]

The stimulation caused by cocaine creates a sensation much like the scary thrill of riding a roller coaster. This is what cocaine users call a *rush.* Cocaine also causes a *high* that is like an intense sense of happiness, but it only lasts for a few minutes. Then it turns into a lasting feeling of restlessness, irritability, and general depression.[85] Other names for this drug include coke, snow, nose candy, flake, blow, Big C, lady, white, and snowbirds.

(c) ***Ecstasy*** pills could be white, grey, green, pink, blue, yellow, or speckled. They are extremely dangerous[86], because they contain pure poisonous substances. Other than the main substances, many very different secondary substances can be contained in different Ecstasy pills. The secondary substances, like caffeine and testosterone, can cause very different and serious side effects. Effects[87] the user experiences include:

- Psychiatric disturbances including panic, anxiety, depression, and paranoia
- Muscle tension
- Nausea
- Blurred vision
- Sweating
- Increased heart rate and blood pressure
- Tremors
- Hallucinations
- Reduced appetite
- Sleep problems

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84 Smith J., 1995.
85 Smith J., 1995.
86 http://www.prevlink.org/getthefacts/facts/ecstasy.html
87 http://www.prevlink.org/getthefacts/facts/ecstasy.html

- Fainting
- Chills
- Involuntary teeth clenching
- Rapid eye movement

Other names for ecstasy are XTC, Adam, and MDMA. It is also referred to as club drugs, as they are used by adolescents and young adults at all-night parties such as "raves" and dance clubs. Ecstasy is colourless, tasteless and odourless, and can therefore discreetly be added to beverages by individuals who want to intoxicate or sedate others. In recent years there has been an increase in reports of club drugs used to commit sexual assaults.

(d) ***Tobacco*** is a plant[88] with narcotic leaves used for smoking, chewing, or snuff. It is an addictive drug that contains nicotine that stimulates the brain to make the user feel more aware and relaxed. Cigarette smoking is an active aspect in more deaths than all the other drugs combined.[89] Consequences of cigarette smoking include emphysema, chronic bronchitis, lung cancer, heart disease, and oral cancer. Passive smoking is as dangerous as active smoking. Environmental tobacco smoke, e.g. exhaled by smokers, is a cancer-causing agent. Extended exposure contributes to malfunction in the lungs, lung cancer, heart disease, and other cancers. In children, passive smoking may result in reduced growth, breathing problems, middle ear infection, and asthma. Other effects that smokers expose themselves to include:

- Addiction
- Heart and cardiovascular disease
- Cancer of the lung, larynx, oesophagus, bladder, pancreas, kidney, and mouth
- Emphysema and chronic bronchitis
- Spontaneous abortion, pre-term delivery, and low birth weight
- Diminished or extinguished sense of smell and taste
    - Frequent colds

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88 The Concise Oxford Dictionary, 1984: 1124.
89 http://www.prevlink.org/getthefacts/facts/tobacco.html

- Smoker's cough
- Gastric ulcers
- Premature and more abundant face wrinkles
- Stroke

Nicotine has neurological effects on the brain and is therefore connected to mental health. In adolescents the effect is even more obvious, because their relationships to peers and parents create situations where their mental health is involved[90], and thus increase the likelihood of acquiring a variety of anxiety disorders in early adulthood. Cigarette smoking is associated with several other risky behaviours, including alcohol and marijuana use, fighting, weapon carrying, and engaging in unprotected sex.[91] Other names for cigarettes or tobacco are smoke, bone, coffin nail, and cancer stick.

(e) ***Marijuana*** is grown from a plant called the cannabis, which grows wild most of the time. At first marijuana was thought to be harmless, but people's attitudes and ideas have changed as the negative effects have become known. The concentration of the active chemical, THC, is addictive and changes the mind and body, personality and character. Effects[92] of marijuana include:

- Bloodshot eyes
- Dry mouth and throat
- Impaired or reduced comprehension
- Altered sense of time
- Reduced ability to perform tasks requiring concentration and coordination, such as driving a car
- Paranoia
- Intense anxiety or panic attacks
- Altered cognition, making acquisition of new information difficult
- Impairments in learning, memory, perception, and judgment

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90 http://serendip.brynmawr.edu/bb/neuro/neuro02/web1/bmartin.html
91 http://www.focusas.com/Tobacco.html
92 http://www.prevlink.org/getthefacts/facts/marijuana.html

- Difficulty speaking, listening, thinking, retaining knowledge, and problem solving

A marijuana user becomes confused and with time and space becomes distorted. The individual's judgement, logic, and memory are almost always impaired. Continued heavy use can cause serious mental and emotional problems. Marijuana users tend to be aggressive and violent. Smoking marijuana increases the risk of lung cancer even more than tobacco[93]. One joint (rolled marijuana) irritates the lungs about as much as a whole pack of cigarettes. Other names for marijuana are pot, weed, pot reefer, grass, dope, Ganja, Mary Jane, herb, skunk, boom, kif, gangster, chronic, and 420.

In conclusion, drug use in general is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, poor judgement that puts them at risk for accidents, violence, unplanned and unsafe sex, and suicide. Adolescent risk-taking behaviour and its related outcomes, triggered by tobacco use, unsafe sex and pregnancy, drug and alcohol abuse, and gang violence cause a substantial drain on medical resources, the social welfare system, the courts, and the quality of life of society in general.

4.3 ALCOHOL

Alcohol is a colourless volatile inflammable liquid that intoxicates. It is a depressant that retards thinking and actions, because it acts on the brain and affects all parts of the body. Normally the human liver breaks down about one drink per hour, while the rest of the alcohol travels throughout the body, affecting behaviour, judgement, perception, and motor skills such as driving and operating machinery. Alcohol affects crucial driving skills such as quick reflexes and vision.[94] It is probably the reason why alcohol is involved in countless fatal car crashes. The risk of an accident is even higher with an intoxicated, inexperienced adolescent driver behind the wheel.

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[93] Smith J., 1995.

[94] http://www.prevlink.org/getthefacts/facts/alcohol.html

4.3.1 ADOLESCENTS AND ALCOHOL

Both adolescents and parents perceive alcohol as the "lesser of two evils" because it is legal. There is proof regarding parents' and society's tolerance towards this under age alcohol consumption. Numerous research endeavours have concluded that the age of initiation to alcohol determines the individual's future alcohol consumption. The younger the age at which the individual has his first alcohol drink, the more likely he will abuse alcohol or become an alcoholic.[95]

These days many alcoholic beverages are manufactured in a wide variety of the most delicious fruity flavours, which appear in eye-catching holders, but contain a high alcohol percentage. These tasty wines attract the younger adolescents, especially the females. A craving for this sweet alcoholic cooler stems from a common neuro-chemical mechanism[96] that also brings on the sweet tooth-concept, so common among adolescents and children. The shocking news that young children and adolescents take alcohol in their juice bottles and that they "inject vodka into oranges and suck them at school" was recently revealed in a magazine.[97]

According to a Stanford University study, there is a perception that music videos on television influence adolescent alcohol behaviour. Adolescents who often watch television, especially music videos, are more likely to become teenage drinkers.[98]

Alcohol is connected to three leading causes of adolescent deaths, i.e. cars accidents, murders, and suicides. Heavy drinking may also inhibit the development of adolescent growth, as the human brain develops until the age of twenty-one years.

Adolescent females often receive their first drink of alcohol from their boyfriends, who may be older than them and who probably drink as well.[99] It is probable that the alcohol he provides serves as payment in exchange for sex, or it acts as the assisting agent towards seduction. Because females have smaller amounts of body water to dilute the alcohol, they have higher concentrations of alcohol in their blood than males have after drinking identical

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95 http://www3.cnn.com/HEALTH/9801/14/alcohol.warning/
96 http://abcnews.go.com/sections/business/DailyNews/alcohol_pop_010509.html
97 Van Rensburg R., You Magazine, 12 December 2002: 14.
98 http://www.focusas.com/Alcohol.html
99 http://www.health.org/govpubs/rpo993/#

amounts of alcohol.[100] This means that female adolescents become intoxicated more quickly and to a greater extent than males. Alcohol use in adolescents is a highly probable forecast for sexual intercourse and unprotected sex. Adolescent girls who drink alcohol are more likely to have sex, most probably without a condom than girls who do not partake of alcohol. The result of this risky behaviour is unplanned pregnancies and sexually transmitted diseases like HIV/AIDS and gonorrhoea. Many girls also indicate that alcohol helps them to cope with circumstances and makes forget, for a while at least, about their problems.[101]

Adolescents belonging to close families are les likely to use alcohol. They are connected to their family and thus do not need to prove themselves to the group they desire membership of. If they are that closely connected, then the adolescent will probably know whether the parents approve of a particular behaviour or not. The parents will know the friends of the adolescent child as well.

4.3.2 INFLUENCES ON ADOLESCENT ALCOHOL USE

Just as in the case of drugs and inhalants, adolescents learn alcoholic behaviour from the environment. The same social factors associated with drugs influence adolescents to use alcohol, with some additions. The influences[102] leading to alcohol use include the parents, media, access, peers, boredom, and stress.

- **Parents:** Children of parents who drink alcohol will very likely also use alcohol, based on role-taking, the social learning theory, and symbolic interactionism. All three terms agree that through interaction the observer learns to attach meaning to specific behaviours, and then acts these out according to the value he or she attaches to the behaviour. The parents' behaviour communicates a message to their children, and when alcohol is used by them or is allowed in the house, they are saying it is permissible for the adolescent child to drink alcoholic beverages. Many adolescents actually receive their first drink from the parents who might be unaware of the damage they are doing.
- **The Media:** The media portrays alcohol use in an appealing and fascinating light. Sports heroes, models, and pop culture icons reinforce the idea that drinking is widely

[100] http://www.health.org/govpubs/rpo993/#res20
[101] http://www.health.org/govpubs/rpo993/#res8
[102] http://ohioline.osu.edu/flm02/FS14.html

accepted by society. Even if the adolescent is being told that alcohol use at this stage is incorrect, this type of mixed messages will confuse, yet intrigue him further.

- **Easy Access:** The legal age in South Africa for buying and consuming alcohol is 18. Yet adolescents report having easy access to alcohol. They obtain alcohol from a number of sources, even from their parents' own cupboards, alcohol cabinets and refrigerators. Older friends or siblings may also buy alcoholic substances for under aged youths. The family also often consume alcohol at the dinner table or at other celebrations.

- **Peers:** Alcohol intake is a social behaviour that involves other interactants. Because adolescents tend to be drawn to friends, adolescents with friends that drink or abuse other illegal substances are more likely to drink alcohol. It might be another way for these adolescents to earn group membership and portray an adult status. The adolescent attaches specific value to the reward that he receives from this behaviour, which will determine if he or she will engage in this behaviour again. If the value is positive, the adolescent is likely to repeat this action. If the reward holds a negative value, the adolescent will probably not repeat the action.[103]

- **Boredom:** If the community or the residential area lacks enough recreational, educational and sport facilities, it is likely that the adolescent and young adults in the area will become bored. When they reach the stage of extreme boredom, they are more prone to consume alcohol because they lack a positive channel for experimentation.

- **Stress:** Stress is a normal part of growing up. Teens who do not have effective strategies for dealing with stress and change may perceive alcohol drinking as an appropriate way to cope, especially when parents and others who use alcohol as a way to “kick back and relax”, reinforce this behaviour.

4.3.3 EFFECTS AND CONSEQUENCES OF ALCOHOL

There are many negative consequences of under age alcohol drinking on physical and mental health, academic performance, and crime. These are listed as:

- Dizziness

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[103] Homans G.C., 1950. (This inference is made according to Homans’ Social Exchange Theory, i.e. Proposition 3: The Value Proposition – reward and punishment.)

- Addiction (alcoholism)
- Slurred speech
- Disturbed Sleep
- Nausea
- Vomiting
- Hangovers
- Impaired motor skills
- Violent behaviour
- Impaired learning
- Foetal alcohol syndrome
- Respiratory depression and death (high doses)
- Cirrhosis and cancer of the liver
- Excessive drinking can lead to decreased testosterone in a man's body and cause impotence.

The drinking of large quantities of alcohol may cause alcohol poisoning, which can cause unconsciousness and even death. Alcohol damages the organs of the body, such as the brain tissue, heart muscle, and the reproductive organs. By causing a rise in the user's blood pressure, the risk of a heart attack or stroke is predictable. Other effects are stomach ulcers, poor nutrition, and sexual dysfunction. If alcohol is taken with other drugs and medication, an impairment of coordination, an alteration in the blood pressure, seizure, convulsions, and even death may be the consequence. Other names include beer, wine, liquor, cooler, malt liquor, and booze.

4.4 THE STAGES OF ADOLESCENT SUBSTANCE ABUSE[104]

Fraser (1987) recommends two social perspectives on adolescent use and abuse of substances. The first focuses on separate stages of drug involvement, and the second tries to identify risk factors for different kinds of substances. For the first model, there is the assumption that drug involvement begins with experimentation. This experimentation is

[104] Allen-Meares P., 1995.

followed by use, which is followed in turn by abuse. There is also a progression of mild to strong in substance use. The stages of addiction are identified as follows:

Stage 1 ~ Experimentation with drugs - occasional tobacco or alcohol use.

Stage 2 ~ Regular use of alcohol and tobacco.

Stage 3 ~ Use of marijuana in conjunction with alcohol and/or tobacco.

Stage 4 ~ Use of multiple drugs or what is referred to as poly-drug use. Many adolescents do not reach this stage.

The function of family and other environmental conditions are also recognised in the development of adolescent substance use. Conditions that affect substance abuse include an alcoholic or drug-using parent, drug or alcohol-using peer groups, poor school conditions, and lack of nurturing learning.

The second risk-factor perspective suggests that there are many paths to drug or alcohol use. These paths include low self-esteem, poor grades, family dysfunction, a stressful lifestyle, depression, destructive peer group affiliations, and parents who use drugs or alcohol. All these factors may encourage the adolescent to escape to the use of drugs or alcohol as a means of coping.

4.5 THEORIES OF ADDICTION[105]

According to Alexander (1987) there are two fundamentally different views of addiction. The first is the *disease model*, which suggests that there are casual links between processes that lead to addiction or make an individual susceptible to it. A person may have either a genetic predisposition to addiction, or vulnerability attributable to childhood trauma, environmental stressors, or exposure to drugs.

The second view, known as the *adaptive model,* also identifies several casual factors, starting with environmental stressors (e.g. family breakdown, poverty, pressures of employment, failure to achieve) and lack of self-confidence attributable to negative environmental reinforces (e.g. pressure from peers) that result in the maladaptive response known as addiction. Whereas the disease model locates the problem in the individual (as part of a family), the adaptive model locates much of the problem in the environment.

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[105] Allen-Meares P., 1995.

4.6 WARNING SIGNS OF ADOLESCENT SUBSTANCE ABUSE[106]

The most general appearances attached to the adolescent if drugs or alcohol are being abused are compiled in tabular format below:

Area	Symptoms
Physical	Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough.
Emotional	Personality change, sudden mood changes, irritability, irresponsible behaviour, low self-esteem, poor judgment, depression, and a general lack of interest.
Family	Starting arguments, breaking rules, or withdrawing from the family.
School	Decreased interest, negative attitude, drop in grades, many absences, truancy, and discipline problems.
Social problems	New friends who are less interested in standard home and school activities, problems with the law, and changes to less conventional styles in dress and music.

Table 7: `Warning signs of adolescent substance abuse in specific areas`

4.7 CONCLUSION

Adolescence is a time for trying out new experiences. Adolescents use drugs for many reasons: curiosity; because it lets the user 'feels good' after taking it; it reduces stress and frustration, and it allows them to gain confidence in themselves. It is difficult to determine which adolescents will experiment and stop and which will develop serious problems.

Wright[107] (1994) captures the use of drugs in one single thought: "…demons and drug dealers often use the same opening line ('Just try a little; it will feel good')". According to Wright the concept of "evil and "demons" do not easily fit into a modern scientific worldview. Still, people seem to find it useful, and apply it for its symbolic content.

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106 http://www.focusas.com/WarningSigns.html

107 Wright R., 1994: 368.

There is indeed a force devoted to tempting people into various pleasures. These pleasures do not bring long-term happiness to them and it may bring great suffering and anguish to others.

In the following chapter an exploration of the domain of violence and the adolescent will be presented. The reader will be provided with information as to why adolescents become violent, the effects violence has on them, and the long-term consequences violence has on the adolescent.

Chapter Five

ADOLESCENCE AND VIOLENCE – RELATED BEHAVIOUR : ITS NATURE AND CONSEQUENCES

5.1 INTRODUCTION

Violence refers to a situation or feature that involves great physical force, intimidation, outrage or injury, which at times is unlawfully exercised. By acting in a violent manner, the rights of the victim are often disrespected and violated. As many adolescents seemingly have little respect for social norms and because they harbour feelings of invincibility, they sometimes engage in violent behaviour either to protect themselves or to harm someone else.

There are numerous media reports of adolescents committing violent crimes and it is a known fact that some residential areas are unsafe because of gang-related violent activity. It seems that these adolescents have developed an impersonal and insensitive attitude toward human life and resort to violence and killing to settle their disagreements. Where adolescents have become members of a gang, they also learn to participate in violent activities, as violence is characteristic of most gang-cultures.

5.2 THE ADOLESCENT, VIOLENCE, AND WEAPON CARRYING

The adolescent stage has naturally come to be known as a tumultuous time, a time to try out new things and to take risks. However, at times it can be difficult to determine which risks are positive and exploratory, and which are dangerous. Adolescents need to define themselves as separate individuals who want to be recognised by adults for the unique people they are.[108] Many of them become rebellious and at times violent in their attempt to accomplish this quest. In their struggle to reveal their uniqueness, they realize that they have to "fight" for a place in the sun, which may easily border on violent behaviour. Apart from

[108] http://search2.cometsystems.com/search.php?product

the adolescents' effort to prove themselves to adults, they also have to prove their uniqueness and value to peers and significant others. Being violent can be the key to feeling as one with the group, and a sign of adulthood.

Adolescents are "not little, and they fight back".[109] These words describe adolescents and their periodic outrages well. Fighting with the parents and siblings as a natural trait of the stage, is not meant as a personal attack but a desire for greater independence. Although they want independence, they still they need to belong to their family, be allowed to try out new things and make mistakes, they want to be cared for and loved by their parents, and importantly they want their parents (or other adults) to be supportive and understanding.

At times adolescents have a habit of overreacting. In their natural tendency of "fighting back", the consequences of their overreacting can be devastating. Examples of this can be seen in newspapers and magazines daily. Not so long ago two teenagers were convicted of an attempted murder of a Rhodes University professor and her pregnant researcher friend[110], and in another incident another adolescent murdered her sister in a fit of rage.[111]

The carrying of weapons makes it even easier for an adolescent to commit a violent act[112], and the more dangerous the weapon, the more severe the violent act and the more traumatic the consequences. As young people with limited experience, they do or do not understand the consequences of their actions. The greater the degree of the adolescent's drive to achieve obvious uniqueness, the harder the fight "for a place in the sun", the more violent the adolescent becomes, the less the consequences are considered. Adolescents of today have greater access to more dangerous activities than earlier, and violence has increased exponentially. Research has also shown that adolescents who carry guns ("gun-toting") are more likely than others to engage in certain high-risk behaviours[113], such as excessive alcohol use, driving under the influence, drugs, unprotected sex, and engaging in violent behaviours.

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109 http://search2.cometsystems.com/search.php?product
110 The Herald, 4 September 2002.
111 Coetzee C., You Magazine, 31 October 2002: 15.
112 http://www.geocities.com/keikoden/KTaylor.htm
113 http://www.nlm.nih.gov/medlineplus/alphanews_t.htm#Gun-Toting

5.3 CAUSES OF ADOLESCENT VIOLENT BEHAVIOUR

Most violent adolescents learn about and become desensitised to violence in the parental home. Through observation[114] and attaching meaning to the communication at home, many adolescents learn that aggression and anger is solved by physical or verbal violence. The following factors[115] contribute to an adolescent's adoption of a violent character:

- **A lack of family structure:** Aside from love and sustenance, there is nothing adolescents need more than order. The most important source of violence by and among adolescents is family breakdown. Family disintegration is the root cause of many social and economic problems. Research has shown that adolescents from single-parent homes were consistently more likely to be late for school, be absent, subject to disciplinary action, and more than twice as likely to drop out of school altogether.
- **Television violence promotes adolescent violence:** Almost since its inception, television has been the most persistent and powerful mass medium. For most adolescents, television in its various guises exerts more influence than school or church, because they spend more time watching television that they spend on any other waking activity. In certain cases the television has become the child's medium and a good babysitter. Rarely do parents control what children watch or how much they watch. Research has proved that a causal connection does indeed exist between violence behaviour and television.
- **Adolescents are easily persuaded.** They learn how to behave from each other. When an individual sees how others act, their act becomes a model for him or her to imitate. In this way, people sometimes make the unthinkable thinkable, and the impossible possible. There is definitely a copycat aspect involved when looking at the impact television has on behaviour, especially with the effect of advertising. Adolescents are easily desensitised to violence on television, because it tells them that violence is an everyday occurrence, a justified form of self-defence. Adolescents who live in

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[114] The Social Learning Theory - http://www.etr.org/recapp/theories/index.htm
[115] Bender D.L., *et al*, 1992.

communities where violence is common are particularly vulnerable, and research has proved that young males growing up in poverty, in homes that lack non-violent male role models, are the most susceptible to television's violence-promoting message.

- **A learned behaviour:** According to most non-Freudian psychologists aggression is a learned behaviour, one that can be unlearned. The family and social environment teach children how to behave, according to the social learning theory. Therefore it is the family and the social environment that teach adolescents to use violence in order to solve problems. Through the process called *modelling*, youngsters learn how to behave aggressively by watching others use violence to their advantage and then imitating what they have seen.
- **Child abuse:** Juveniles who kill often seem to come from broken families in which one or both parents are disturbed, neglectful, or abusive. Many juveniles who kill have parents who are alcoholics or mentally ill, and have generally witnessed or have been directly victimised by domestic violence.
- **Rock lyrics:** Research[116] suggests a strong relationship between antisocial or destructive behaviour and a preference for rock music with destructive themes. It is therefore reasonable to assume that destructive lyrics (explicitly advocating and promoting homicide, suicide, or satanic practices [HSSR]) in rock music and music television, similar to aggressive themes in television drama and film, do have a negative impact on behaviour. It is thus possible that destructive lyrics, combined with other factors such as dysfunctional families, substance abuse, and problems in school, do lead to antisocial and destructive behaviour among adolescence.
- **Greed or poverty:** All economic crime – burglary, theft, drug dealing, and street robberies – involve the potential for violent confrontations. Accounts of first explorations of economic crime typically emphasized a certain amount of explicitly economic motivation combined with a search for excitement and the desire to establish a reputation among peers.
- **Drug use*:*** Several individuals, as a result of short-term or long-term use of certain drugs may become excitable, irrational, and exhibit violent behaviour. Some drug

[116] http://www.cnn.com/HEALTH/9811/02/mtv.drinking/

users engage in economically oriented violent crimes in order to support their costly drug use. Violent crime naturally accompanies involvement with any illegal substance.

- **Youth gangs:** Young people join gangs because of poor parenting, peer pressure, and poverty.[117]
- **Bigotry (prejudice):** Racial slurs are the most common adolescent actions, accompanied by physical violence, graffiti, destruction of property and various other acts. In South Africa these behaviour patterns are not uncommon.

5.4 KEY RISK FACTORS FOR VIOLENCE

Identifying and understanding the dynamics that place adolescents at risk for violent victimisation and perpetration is the first step toward violence prevention.[118] There are a number of individual and social factors that increase the possibility of violence during adolescence and young adulthood. Some of these factors clustered in four areas, are indicated in the following table:

INDIVIDUAL	FAMILY	PEER/SCHOOL	NEIGHBOURHOOD
History of early aggression Beliefs supportive of violence Social cognitive deficits	Poor monitoring or supervision of children Exposure to violence Parental drug/alcohol abuse Poor emotional attachment to parents or caregivers	Associate with peers engaged in high-risk or problem behaviour Low commitment to school Academic failure	Poverty and diminished economic opportunity High levels of transience and family disruption Exposure to violence

Table 8: **Risk factors for violent behaviour**

[117] Stark E., 1995.
[118] http://www.cdc.gov/ncipc/youthviolence/fact.htm

The influence of certain of these factors could be reduced or cancelled if important role players in society assist and lend their support. Of these role players, the parents and the school probably have a major role to play.

5.5 REDUCING ADOLESCENT VIOLENCE

As inferred in the previous paragraph, parents, the community, schools, and the law have the means to lessen adolescent violence.[119] A number of ways were identified to make this achievable. These methods are supplied in tabular format as compiled by the researcher:

Area	Solutions
Law	Violent adolescents should not only be sent to juvenile systems and left to commit crime again, but they should be punished sufficiently and then rehabilitated.
	Adolescent violence should be addressed the same way other public health threats like smoking, drunken driving, or drug abuse get treated,
Parents	Take guns away from adolescents.
	Reduce children's exposure to violence.
	Children should be taught how to manage anger.
	Teach adolescents non-violent ways to deal with anger.
	Discipline adolescents and keep guns away from them.
	Teach them helpful skills.
Community	Crime prevention program. Job programs or other employment. Reduce neighbourhood violence, which will reduce school violence. Doctors could be a great help in adolescent violence.
School	Expel violent adolescents from school. Ensure a safe learning environment.

Table 9: Solutions to adolescent violence

5.6 ADOLESCENT SUICIDE

Suicide is ranked[120] as the third highest cause of death among older adolescents and college or university students. Events found to be instrumental in impulsive suicide attempts normally include the break-up of an important relationship, belittling or loss of self-respect in

[119] Bender D.L., et al, 1992.
[120] http://www.nami.org/youth/treatabuse.html

front of friends, parental rejection, death of someone close, feelings of social isolation, extreme pressures at home or at school, poor academic performance, and imitative or 'copycat' behaviour.[121]

Any suicide attempt should be considered an urgent plea for help, and a person who speaks of committing suicide *must* be taken seriously. Individuals who eventually attempt suicide almost always signal their intention to do so in advance. Largely because of ignorance, the cry goes for help goes unheeded. An example of such an extreme deed was published on the front page of a local newspaper[122] about a young girl who was sixteen years of age and was found dead in a hotel room. She had run away from home two weeks prior to the discovery of her body. Police suspect she committed suicide by taking an overdose of drugs. Lying next to her body police found crack, marijuana, cocaine, and other substances. It was also noticeable from a photograph of this 16 year old that she wore a T-shirt with the words 'BAD GIRL' printed on it. It is as if these words provided evidence of how she felt about herself.

Three aspects of relating to suicide will be discussed in the following sections. Firstly, Durkheim's perspective on suicide; secondly, the possible causes of suicide, and thirdly, a discussion about the significant risk factors to suicide.

5.6.1 SOCIOLOGICAL THEORIES OF SUICIDE

Emile Durkheim's sociological theory of suicide argued that suicide results from the society's strength or weakness of control over the individual. Durkheim identified four basic types of suicide that reflect the individual's relationship to society: egoistic, altruistic, anomic, and fatalistic suicide.[123]

- **Egoistic suicide:** the individual lacks the ability to fully integrate into society. Largely left to themselves, victims of egoistic suicide are neither connected with, nor dependent on their community.
- **Altruistic suicide**: the individual is overly integrated into a group so that he or she feels no sacrifice is too great for the larger group.

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[121] Gillis H., 1994: 161.
[122] The Herald, 26 July 2002.
[123] Berman A.L & Jobes D.A: 1992.

- **Anomic suicide**: the victim is not capable of dealing with a crisis in a rational manner and chooses suicide as the solution to a problem. Anomic suicide occurs when the individual's accustomed relationship with society is suddenly and shockingly altered.
- **Fatalistic suicide:** the individual's freedom is deeply restricted by excessive societal regulation. Victims of fatalistic suicide feel they have no viable future.

5.6.2 INFLUENCES ON SUICIDE

While Durkheim differentiates between four types of suicide, providing an understanding that either a too strong or too weak *integration*, or a too strong or too weak *normative control* is the cause of suicide behaviour, most researchers are of the opinion that a complex set of factors interacts with the adolescent's biological, emotional, intellectual and social stages of development contributing to the adolescent committing suicide.[124] The more important factors are compiled in tabular format by the researcher:

BIOLOGICAL	EMOTIONAL	INTELLECTUAL	SOCIAL
- Depression due to chemical imbalance - Physical illness - Physical disability - Learning disability - Chemical changes during puberty - Physical dependency on drugs or alcohol	- Sadness; stress - Impulsive behaviour - A sense of powerlessness - Loss, grief, loneliness - Low self- esteem - Anger or rage - Guilt; - Hopelessness - A sense of being overwhelmed - Anxiety - Confusion about sexual identity - Emotional dependency on substances	- Inability to communicate feelings - Perfectionism - Pressure to achieve or perform - Self- criticism - Unrealistic view of death - Revenge - Exaggeration of faults or mistakes	- Isolation; - Withdrawal - Friendlessness - Lack of social skills - Unpopularity - Feelings of not belonging - Embarrassment before peers - Labelled as "crazy," "stupid," or "different" - In trouble at home, school or with the law - A runaway

Table 10: Suicide influences according to areas of development

[124] http://www.emh.org/youthsuicide

5.6.3 RISK FACTORS FOR SUICIDE

Although several factor have been identified as playing a role in adolescent suicide attempts, the most important factors for *actually committing* suicide are the existence of a mood disorder, having made an attempt in the past, and the accessibility of a firearm in the house.[125] The most important of these was having a firearm in the house. Factors that make a suicide attempt more likely include the following:

- Depression
- Substance abuse
- Child abuse victim
- Close family members who have committed suicide
- Close family members who have tried suicide
- Previous suicide attempts
- Access to firearms
- Bipolar Disorder
- Relationship problems
- Attention Deficit Hyperactivity Disorder

5.7 GANGS AND DELINQUENTS

A gang is any group with a name and an area to defend. Some gangs are primarily social. They hang out together, support one another in school, and play sports on the street. Most of the times gang members come from the poorest inner-city areas.[126] Gangs often form along racial or ethnic lines, from cultural solidarity to drug trafficking. Drug gangs are the more organised and the most dangerous kind. They are formed solely for the purpose of making money. Risks are taken, not for adventure, but for profit.

Gangs award the individual with feelings of worth, belongingness, and at times wealth. Adolescents who join up with gangs more often than not suffer from a low self-esteem and a low level of confidence. They usually join gangs as a result of peer pressure, poverty, and poor parenting. [127]

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[125] http://www.ianr.unl.edu/pubs/family/g1322.htm
[126] Stark E., 1995.
[127] Brendtro L.K., *et al.*, 1990.

These gangs replace the individual's family and redesign his or her role model figure. The leader becomes the father and the other members the siblings. Loyalty to the gang is consequently no problem for the individual, including an indescribable value they attach to the other members. Apart from the family group it replaces, the gang also replaces the individual's other friendship groups; they provide an instant group of best friends. The negative side of this loyalty is that the individual can never have friends outside the gang, so it is difficult for the individual to interact with others and experience and observe different opinions and habits. An individual who joins a gang usually completes his life in one of two ways: jail or death.

Adolescents mostly become delinquents because they have lost their sense of purpose. In the past, the goal of life was to ensure the survival of oneself and the tribe. According to Victor Frankl the struggle for survival has collapsed. The new question becomes "survival for what purpose?" More and more people today have the means to live by, but no meaning to their existence. Adolescents cannot develop a sense of their own value unless they have opportunities to be of value to others.[128]

Frustrated in their attempts to achieve, adolescents may seek to prove their competence in distorted ways, such as skill in delinquent activity. Others have learned to retreat from difficult challenges by giving up. The remedy for these problems is involvement in an environment with abundant opportunities for meaningful achievement. Fighting against feelings of ineffectiveness, some adolescents assert themselves in rebellious and violent ways. Those adolescents who believe they are too weak or incapable of managing their own lives, become pawns of others. These young people need opportunities to develop the required skills and the confidence to assert positive leadership and self-discipline.

5.8 CONCLUSION

Violence is a phenomenon as old as man itself. Whereas the violent adult perpetrator is severely frowned upon, mixed feelings exist about the adolescent who engages in violence. While violence is usually directed at others, it is also directed at the self.

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[128] Brendtro L.K., *et al.,* 1990.

There are many reasons or causes for violence that is perpetrated against others and the self – ranging from societal factors and conditions to the inability of individuals to cope constructively with their thoughts, feelings and decisions.

While these factors and conditions may be used to generalize violence, South African society itself may present past and current causative factors and conditions that perpetuate violent behaviour in adolescents. It is thus not inappropriate to suggest that various social forces exist that have the potential to impact in negative ways upon South African youth, and more specifically, the adolescent. There is a need to redirect youth culture into positive modes of social practice and to reintegrate adolescents into society in a more meaningful manner.

The following chapter presents a discussion of the sexual behaviour of the adolescent. Aspects that will be covered include the reasons, affects, and consequences of adolescent sexual activity. Selective strategies will be referred to as reduction or prevention of this risky behaviour.

Chapter Six

ADOLESCENT SEXUAL BEHAVIOUR

6.1 INTRODUCTION

Adolescents have to deal with major developmental concerns such as sexual attitudes and behaviour. They have to establish a sense of sexual identity, i.e. a sense of maleness (masculinity) and femaleness (femininity); learn to conform to suitable principles that accompany this identity, and determine attitudes towards issues such as masturbation, pre-marital sex, abortion, possible homosexual impulses, and other important opinions[129].

Social forces shape adolescents' sexuality by establishing and re-establishing values and norms relating to sexuality and its accompanying concerns. These forces include the physical and psychological characteristics of the adolescent. The particular setting in which adolescents live their lives shape the decisions they make about their sexuality, the values and attitudes they hold, and the behaviours they engage in. At any given time, choices about sexual behaviour will reflect the different physical, social, and economic environments in which adolescents live, their personal qualities and their life testimonies.

In this section of the treatise, the influences of intrinsic, family, peer, and social background have on adolescent sexuality will be discussed. This section will explore the 'problematic' nature of adolescent sexuality, as well as its association with drug and alcohol abuse and adolescent behaviour. The relationship between adolescent attitudes and behaviour, together with the motives adolescents have for engaging in sexual intercourse, is also investigated.

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[129] Gillis H., 1994.

6.2 ADOLESCENCE AND SEXUAL DEVELOPMENT

During early adolescence sexual interest and experimentation develop into flirting and petting. However, passion only plays a more important role once the individual reaches mid-adolescence. It is during late adolescence that dating becomes more serious, and adolescents begin to recognise and appreciate one another in new ways, hence gaining valuable experience in different aspects of sexuality. Adolescence is amongst others the experiencing of emotional intimacy with or without sexual closeness.

In an attempt to understand sexual development from a perspective other than from relevant theories dealing with this, there are a number of scenarios that are related to sex and sexuality that the adolescent needs to deal with. While not all adolescents will find themselves in these scenarios, the impact thereof upon others may create opportunities for learning and decision-making in terms of their dealing with their own sexual development and sexuality. Gillis[130] mentions the first four scenarios, with the researcher adding a fifth:

(a) **Sex typing:** Prior to and much so during adolescence, it is expected of them to adapt to the socially approved sexual role of the male or female cohort to whom they belong to or identify with. During these years the family, peer influences, and teachers reinforce this. The media, especially the television media, provides countless role models with whom the adolescent may identify.

(b) **Counselling in sexually related matters:** Adolescents may find it difficult to determine appropriate guidelines for sexual behaviour. It can however become an embarrassment for the adolescent to turn to adults with their questions. They therefore turn to peers to find answers to these questions or to discuss topics that may be considered socially taboo, or that are viewed as undesirable in some way or the other. The helping and/or interactive relationship plays an essential role in creating an environment in which adolescents can discuss their concerns freely as well as to obtain guidelines for various sexual behaviours.

(c) **Masturbation and homosexuality:** Although not unusual in the adolescent's development, there are two activities that occasionally cause adolescents to experience various feelings of discomfort. It is not uncommon for adolescents to

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[130] Gillis H., 1994.

indulge in occasional homosexual-type of activities, whilst experimenting with different aspects of sex and sexuality.

(d) **Teenage pregnancy:** There is always the possibility of the adolescent falling pregnant. Besides the fact that an unwanted pregnancy creates various problems for both the adolescent father and mother, their being young places them in an emotionally disadvantaged position of having to cope with an unwanted pregnancy as well as with having to parent a child or having someone else rearing the child. While such emotional trauma of an unwanted pregnancy directly impacts on the adolescent and his / her family, it may create learning opportunities for their peers.

(e) **HIV / AIDS:** With the growing rate of HIV / AIDS in South Africa and its impact on those that have been diagnosed or dying from this disease, many opportunities have been created for adolescents to gain knowledge about sex and the use of contraceptives to prevent HIV / AIDS, and how to deal with their sexuality.

In summary then, there is more to sexuality than the acquiring of a gender-related behaviour. There are learning opportunities found in the various scenarios as discussed above. During adolescence there is a need for unambiguous information and guidelines regarding sex and how to cope with their sexuality, two important developmental tasks adolescents have to cope with during this life phase.

6.3 SOCIO-CULTURAL FACTORS

Race and ethnic identity often interact with poverty. Children born of minority racial and ethnic families, are frequently both impoverished and constrained socially and psychologically by the limited resources in their environments.[131] Institutional racism and sexism restrict the available opportunities.

The cultural and ethnic backgrounds of children have much to do with how they view their futures and their opportunities that appear to be available to them. If children see the adult members of their racial or ethnic group entrapped by poverty, isolated by racism, lacking adequate education, and holding few (if any) dreams for the future, their goals and

[131] Allen-Meares P., 1995.

aspirations will be adversely affected. When they compare themselves with a peer reference group of the majority, they are likely to internalise the differences and develop poor self-esteem and negative outlooks on life. Logan (1981) argues present theories of child development give little attention to the role of culture on development. In fact, they tend to minimise this dimension. For example, blacks experience a variety of restrictions, frustrations, and conflicting messages that can affect the quality of their emotional and psychological functioning from birth to death. In practice, the adaptations and behaviour accommodations of minorities are often labelled deviant and pathological.

Children develop ethnic awareness, self-identification, and attitudes early in life; as they grow and their world widens, cultural factors play a more important role in their life socialization. This is especially true of those minority children who become aware that they occupy lower status, have less power, and enjoy fewer economic resources than their non-minority peers. For example, black children are at risk because of structural factors in society that hinder their optimal development. They face racial prejudice in the schools, and their parents face it in their place of employment. Discrimination in the workplace leads to economic dependency for many black families.

The critical developmental task of all minority children seems to be the acquisition and internalisation of positive identity formation in a society that frequently rejects their characteristics (colour, physical features, etc.). Because of these factors, these children are particularly at risk. Identity is formed through a series of exchanges between children and the various environments in which they function. Thus identity is intimately related to their observations of and experiences with their socialisation agents. It is also the cause of their risk-taking behaviour as a response to their adolescent experience in the midst of perceived racialism, oppression and disillusionment with their future prospects.

6.4 THEORIES OF ADOLESCENT SEXUALITY

All theories of adolescent development award sexuality a central place in discussing the transition from child to adult. The budding sexual urges that emerge at puberty should be combined with other aspects of the adolescents' lives and channeled adaptively.

With puberty, changes at the psychological level have to do with preparation for taking on adult roles, including sex and procreation. There is a shift in the adolescent's primary orientation to the family to a reliance on peers. The adolescent needs the peer group to provide guidelines for attitudes and behaviour, for clarification of purpose and the development of interpersonal skills and mind-sets. In this way the adolescent learns to locate or establish himself within a network of like-minded and similar others[132]. This process and development occurs as a result of the adolescent's expanded cognitive skills, thus allowing him or her to evaluate alternative points of view, and to recognise that many points of view, including their own, may have merit.

Four main approaches[133]describe sexuality in adolescence. These are briefly discussed as follows:

6.4.1 FOCUS ON NATURE

6.4.1.1 The psychological theory: Sigmund Freud attaches great significance to the impact of sexual drives upon the psychological functioning of the person. Freud views the onset of adolescence as a difficult time psychologically, because of the increased strengths of these sexual drives. This occurs concurrently with the adolescent's developing physical abilities to actually carry out sexual wishes and fantasies – which may come into conflict with social and internalised taboos.

6.4.1.2 The psychosocial theory: Erik Erikson differs somewhat from the psychological theorists when he emphasises the potential of the environment to alter and shape the course of life adjustment, over and above biological factors.

6.4.2 SEXUALITY AND THE SOCIAL CONTEXT

6.4.2.1 Sexual socialisation model: In their model, Lerner and Spanier (1980) integrate many aspects of sexuality in order to describe the fully functioning person, giving prominence to the role of learning and experience in sexual development. They maintain that

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[132] Moore S. and Rosenthal D., 1993.
[133] Moore S. and Rosenthal D., 1993.

sexuality develops through a life-long process of sexual socialisation as conscious and unconscious attitudes form and alter through childhood, adolescence, middle, and old age. These shifting attitudes, together with changing physical desires and capacities, form the basis for new behaviours.

The task for the adolescent is to integrate the physical, social and emotional aspects of sexuality with other developmental domains.

They argue that the following aspects of development together comprise the process of 'sexual socialisation':

- Development of a sex-object preference
- Development of gender identity
- Development of sex roles
- Acquiring sexual skills, knowledge and values
- Development of dispositions to act in sexual contexts

6.4.3 BLENDING NATURE AND NURTURE

6.4.3.1 The biosocial model of adolescent sexual behaviour: Edward Smith (1989) has produced a model for adolescent sexual behaviour that explains biological and psychological influences and their interactions. He limits his emphasis to the prediction of various aspects of sexual behaviour, such as age of initiation of intercourse, frequency of sexual activity, number of partners, contraceptive practices and the like.

While psychosexual theorists take account of biological influences in a general way only, Smith's biosocial model considers specific, potentially measurable biological aspects of adolescence and uses these to predict sexual behaviour. He also suggests a range of social processes that encourage or discourage sexual involvement, modify the form in which sexual behaviour is expressed, and define appropriate sexual partners.

6.4.4 SOCIOCULTURAL INTERPRETATIONS OF SEXUALITY

6.4.4.1 Sexual scripts: The analysis of a society's sexual norms is important in understanding the sexual behaviours of individuals. Gagnon and Simon (1973) use the term 'sexual scripts' to describe the stereotypic and customary ways in which people behave

sexually, and the social instructions for this behaviour. These scripts refer to what people do sexually, (e.g. courting) and at times direct our desires. For example, scripts provide guidelines as to who will be judged as attractive and desirable within a particular culture. Gagnon and Simon argue that men and women are socialised to follow different sexual scripts and that much of what has been interpreted as a function of a biological sex drive is, in fact, culturally determined.

6.5 CAUSES OF ADOLESCENT SEXUAL ACTIVITY

Together with sexual attitudes, biological, psychological, and sociological influences all play a role major role in understanding adolescent sexuality. These include the impact of puberty and factors such as family and peer influences, the role of cultural norms, race and social class attachment, and education.

6.5.1 Social influences

Social influences such as the family and religion exert their influence in three ways:[134]

- They provide the norms for acceptable sexual behaviour.
- Individuals in powerful roles in these institutions use norms as the basis for informal controls.
- There are often rules that constrain sexual behaviour through fear of institutional sanctions. In fact, the extent of religious belief is strongly related to teenage sexual behaviour. More religious adolescents are less likely to engage in sexual intercourse, although church involvement is no guarantee that adolescents will be spared from sexual activity.[135]

Parents are regarded as the primary socialising agents through modelling and the establishment of norms for their children. Their influence extends over a variety of beliefs and behaviours. To demonstrate, parents who hold traditional attitudes to sex and communicate these to their adolescent daughters will influence their sexual behaviour. These

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[134] Moore S. and Rosenthal D., 1993.
[135] http://www.geocities.com/pastorbuhro/sermons/report.htm#13

girls are less likely to have sex at an early age. Adolescent girls who are close to their mothers are also more likely to abstain from sex before marriage.[136]

In the adolescent stage, peers become more important in forming adolescents' beliefs and regulating their behaviour. Peer influence can operate in a number of ways. Firstly, adolescents can obtain information about sex from their friends, which may serve to guide their decision-making about sex. Secondly, adolescents can accept peer attitudes about sexuality. The strong desire of many young people to be like their admired peers and part of a group can lead them to engage in the sexual behaviours, and express the sexual attitudes that they perceive as characteristic of a particular 'hero' or group.

In addition to the transmission of knowledge, peer influence works through the transmission of attitudes. Fishbein and Ajzen (1975), in their theory of reasoned action, argued that the possibility that an adolescent will perform a particular action depends on the attitudes or values he or she perceives significant (normative beliefs) others hold towards the specific action.[137]

6.5.2 Race

One of the most powerful influences on adolescents' sexual experience is race. The reasons for racial difference are complex. Some theorists believe that the socio-economic differences between blacks and whites account for the racial inconsistency in sexual behaviour. Others hold cultural norms responsible when arguing that there are significant differences in the acceptability of early sexual experience. Different outlooks of the different race groups on marriage and childbearing affect people's attitudes to early sexual activity.

6.5.3 Social class

Living in poverty is associated with early sexual activity, possibly through the impact of poor life satisfaction and even poorer prospects. While many adolescents aspire to good jobs and adequate incomes, with all the security that these imply, the reality is that many are trapped in a cycle of poverty. Consequently the lack of options and desirable alternatives for

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[136] The Southern Cross, September 18, 2002: 4.
[137] Ajzen I. & Fishbein M., 1980.

the future lead some adolescents to increased sexual activity as a way of achieving immediate, if short-lived, pleasure.[138] With a lower socio-economic status it is assumed that adolescents' health, social and educational access and opportunities are limited, thus imposing upon them negatively. Poverty and ethnic minority status have always been associated with increased adolescent sexual activity, adolescent pregnancy and sexually transmitted infection rates.[139]

Poverty and low socio-economic status especially put adolescents at risk. Youth from low-income families experience higher rates of poor physical and mental health, are more likely to engage in delinquent acts, have early and unprotected sexual intercourse, and are more likely to experience adolescent pregnancy, be arrested, and drop out of school.[140]

Belonging to a specific social class (or race group for that matter) assists in the individual's establishment of a self-esteem and social identity. If the adolescent suffers from a low self-esteem, it is probable that he or she will oppose cultural norms and rules, including engaging in premarital sexual intercourse, as a way of affirming the self-esteem.

A correlation between adolescent sexual activity and parental education and family income could also be made[141], probably because these two factors affect the adolescent's desire to gain education and work prospects.

6.5.4 Location

The nature of the inner-city environment may be another reason for the association between poverty and early sexual activity. Living in an environment characterised by poor and crowded housing and serious social disorganisation, adolescents are often exposed to many forms of deviant behaviour, as well as to sex, at a very young age.

Sexual experience, and particularly the age at first intercourse, represents critical indicators of the risk of pregnancy and sexually transmitted diseases. Adolescents, who experience sexual commencement at a younger age, are exposed to these risks over a longer

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138 Moore S. and Rosenthal D., 1993.

139 http://ehostvgw5.com/jndetail.asp?booleanTerm="JournalofMarriage&Family"maindatab=AcedemicSearch.htm

140 http://web17.epnet.com/citation.asp?tb=1

141 http://www.etr.org/recapp/research/index.htm

period of time. Because sexual intercourse during the adolescent years, especially first intercourse, is often unplanned, it is often unprotected by contraception. In addition, adolescents who have early sexual experience are more likely at later ages to have more sexual partners and more frequent sexual intercourse. Furthermore, usually when risk-taking behaviour occurs early in adolescence, risks of negative consequences are heightened. Adolescents who initiate health-risk behaviours such as sexual intercourse and involvement with drugs at an early age frequently have poorer health later on in life, lower educational attainment, and less economic productivity than their peers, increasing the probability of future poverty.[142]

6.5.5 Cultural or societal norms

The South African society provides many sources of messages arising from the communication of victimisation. The power balance of sexual encounters is portrayed as residing with men, who are ready to exploit women in the service of their sexual urges.[143] Hence, women are potentially victims and must be protected by parents and by society (for example, by means of laws against sexual harassment). The message of this discourse is that women have limited power in sexual negotiation, and the implicit consequence is that they also have limited responsibility, whether it involves "saying no", using contraceptives or planning for a future career.

In South Africa it seems as if a well-established youth culture has developed. With a general consistency in the ways of thinking, feeling, and acting that are characteristic of a large number of adolescents, their powerful influence in shaping adolescents' opinion and behaviours can be recognised in the conformity of adolescents to current fashions in clothes, music, and leisure activities. The area of sexuality is just as subject to this influence as any other.

Adolescents receive much of their information about sexual norms and behaviours from this subculture. From their point of view, they supply sets of beliefs about what adolescents should be doing. These beliefs are communicated through various media directly

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142 http://web17.epnet.com/citation.asp?tb=1

143 Moore S. and Rosenthal D., 1993.

targeted at adolescents and young people. Influences include publications for adolescents, movies and television designated to appeal to this age group, as well as music, songs, and rock videos. Among the print media, magazines and romantic fiction (such as Mills and Boon romances) are particularly popular among adolescent girls, and soft porn such as *Playboy* is popular among the boys. These and other fiction magazines contribute to the creation of principles about relationships between the sexes, sexual expression and power.

Adolescents are also presented with role models in the form of current pop stars. Today's adolescents are more likely to hear explicitly sexual lyrics such as *Ja Rule's* "*Smokin and Ridin*" referring to having sex after having smoked marijuana. The popular video clips of pop singers frequently give powerful messages about sexuality, not only in terms of their lyrics but also of their actions. Popular music and dancing has been linked to a mating ritual, in which rhythm and simulated sexual movements provide sexual release and indicate sexual attraction.

6.5.6 Education

It is assumed that higher levels of educational achievement and clear educational goals are related to lower rates of premarital sex for both adolescent males and females. The achieving student is likely to come from a relatively well-to-do family, to place a high value on achievement, to be more goal-oriented, and able to plan for the future. All these characteristics may lead to a low likelihood of sexual involvement at an early age. Perhaps involvement in a sexual relationship distracts adolescent girls from their studies and, conversely, involvement in studies makes them less interested in a sexual relationship (or less interesting to boys).

Adolescents who reveal a "nothing to lose" attitude or prospect about the future, engage in more risky behaviours than adolescents who have great future expectations.[144] For instance, adolescents with expectations of early mortality or failure might be more likely to engage in delinquent or violent behaviours, or become sexually active at a young age.

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[144] http://web17.epnet.com/citation.asp?tb=1

The following diagram is a depiction of the influences on adolescent sexual activity:[145]

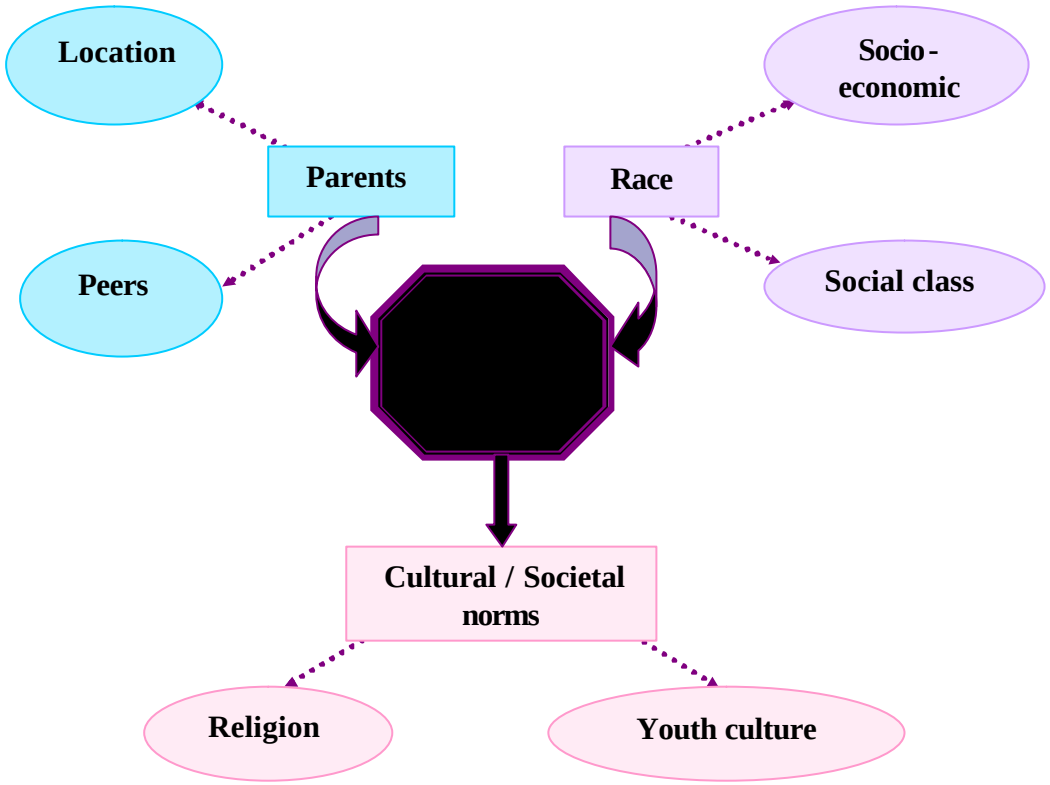

Figure 4: **Influences on adolescent sexual activity**

6.6 DELINQUENCY, DRUG USE AND SEXUAL ACTIVITY

Jessor and Jessor (1975, 1977) associate sexual activity during mid-adolescence with slight forms of delinquency and substance use or abuse. They suggest that all three forms of behaviour are part of a general deviance syndrome with a common prototype[146], which links with the previous details illustrating the influence certain factors have on adolescent risk-taking. The prototype takes on the following structure:

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[145] This diagram is the researcher's own formation.
[146] Elliott D.S. & Morse B.J., 1989. Youth & Society, September 1989, Volume 21.

- Adolescent males are more likely to engage in sexual intercourse than adolescent females.
- The mean frequency of sexual intercourse is higher for sexually active females in the adolescent panel than for males.
- Black (non-white) adolescents of both sexes are more likely than white adolescents to engage in sexual intercourse.
- Adolescents from lower social classes exhibit a higher occurrence rate than adolescents from middle social classes.
- Urban adolescents have a high occurrence of sexual intercourse.
- Sexual intercourse prevalence is higher for older than for younger adolescents.
- The male-female sex ratio is much lower from the age 18 to 21; in fact there is a monotonic decreasing sex ratio with age up through age 20.

This research has found similar findings to those mentioned by Jessor and Jessor (see Chapters 7 and 8).

6.7 MOTIVATIONS FOR SEX

According to the functionalist perspective, there are key sexual risk-taking and motivational dimensions thought to underlie human behaviour (i.e. approach vs. avoidance, autonomy vs. relatedness). The need to have sex for different reasons predicts distinctive patterns of sexual risk-taking. This perspective gives account for the various needs and goals that such behaviour can serve.

Sexual behavioural patterns do not change easily, therefore value is given to the presence of persuasive forces that maintain and promote these behaviours. Focusing on the reasons why adolescents have sex, or the functions served by sex, is a critical step toward understanding adolescent sexual activity and for the planning of intervention strategies. Different needs serve as motivation for sex to different adolescents, and the same needs are not always satisfied in the same manner by different adolescents. Thus, whether people engage in different behaviours to achieve the same goals or in the same behaviour to achieve different

goals, the key to understanding is contained within the purposes and motives that underlie and give rise to the behaviour.[147]

6.7.1 A heuristic model for identifying major domains of sexual motivation[148]

This model recognises two distinctions that appear mostly relevant to understanding emotionally driven interpersonal behaviour, such as sexual behaviour. These distinctions focus on (a) whether the behaviour is motivated by a desire to avoid a negative outcome or to pursue a positive one and (b) whether the behaviour is primarily internally, self-focused, self-directed and self-controlled or whether it is primarily externally or socially focused and controlled.

Behaviours that involve the pursuit of positive or pleasurable experiences (appetitive behaviours) are divided from behaviours that involve the pursuit of positive behaviours that involve the avoidance of, or escape from, negative or painful ones (aversively motivated behaviours). Thus, adolescents may engage in sexual intercourse based on appetitive behaviours or aversively motivated behaviours.

Whether or not an adolescent engage in sexual activities also depends on the extent to which he or she seeks a social goal, which also signifies a striving for mastery and control of one's emotional experience.[149] In contrast, Cooper M.L., *et al* (1998), assume that other-focused goals are motivated by attachment or collective needs, such as having sex to achieve intimacy and communion in a relationship, or by a desire to gain or maintain approval from a socially significant individual or group, such as having sex to impress one's peers.

As shown in the following figure, these two dimensions can be crossed to yield four categories of motives; (a) *appetitive self-focus motivations*, such as having sex to enhance physical or emotional pleasure (i.e., enhancement motives); (b) *aversive self-focused motives*, such as having sex to cope with threats to self- esteem or to avoid or minimize negative emotions (i.e., coping motives); (c) *appetitive social motives*, such as having sex to achieve

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147 Cooper M. L., *et al.*, 1998.
148 Cooper M. L., *et al.*, 1998.
149 McAdams (1984) in Cooper M. L., *et al.*, 1998.

intimacy with another (i.e., intimacy motives); and (d) *aversive social motives*, such as having sex to avoid social censure or to gain another's approval (i.e., approval motives).

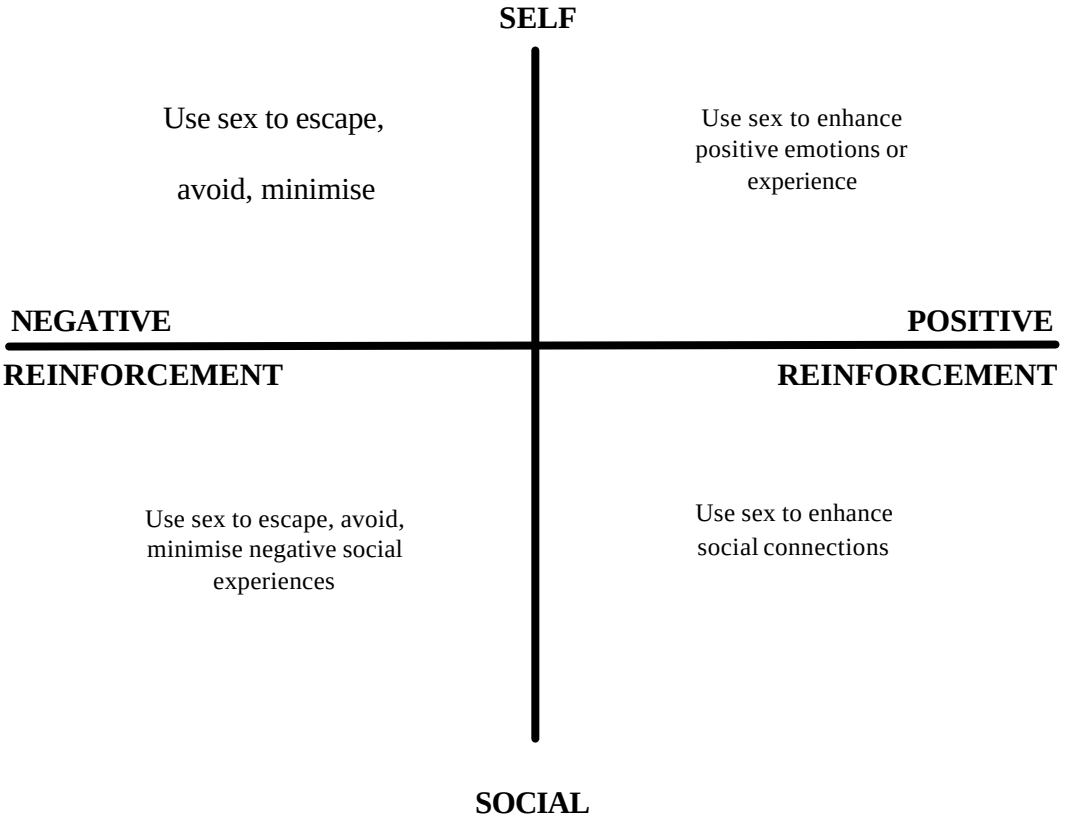

Figure 5: Schematic model of motives dimensions[150]

Thus, although both types of motives are pursued in an interpersonal context and both can be seen as ultimately originating from a desire to manage one's emotions, these motive types differ in the degree to which the outcomes sought exist primarily on an internal, individual level or on a social level.

In line with statements mentioned in this section, answers supplied by the target group in this study to the question of why they engage in sexual intercourse, were to cope with negative emotions (e.g., feeling lonely or tense), to "feel better", to impress peers, to be accepted by the group, and to affirm one's attractiveness.

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[150] Cooper M. L., *et al*., 1998.

6.8 CONCLUSION

Adolescent sexuality is not an isolated phenomenon, but occurs within a general context of involvement in problem behaviour, and is influenced by various factors. It is also clear that the transition from a virgin to a non-virgin is a function of gender and age. Additionally, the typical temporal sequence of delinquency followed by drug use and then by sexual intercourse, suggests that sexual intercourse does not represent initial involvement in problem behaviours, but follows entry into other non-normative forms of behaviour.[151] The general indication is that sexual intercourse among adolescents is embedded in a more common pattern of problem behaviours and usually discloses a common tendency of the adolescent to engage in risk-taking behaviour.

The following chapter will reveal the relevant findings gained from the group-administered questionnaire during this research endeavour. The research results and findings will be supplied in the forms of tables and graphs.

[151] Elliott D.S. & Morse B.J., 1989. Youth & Society, September 1989, Volume 21.

Chapter Seven

RESEARCH RESULTS AND FINDINGS

7.1 INTRODUCTION

In Chapter Two an account was given of the methodological process and choice of data-gathering techniques implemented during this research endeavour. The contents of this chapter will provide an account of the data obtained from the respondent group regarding their alcohol, drug, violence, and sexual behaviour. The reader will also be provided with comparative information concerning the nature of risk-taking behaviours of learners who reside in the various residential areas.

In order to present both quantitative and qualitative data, the researcher will provide data that was gained by means of a group-administered questionnaire[152], from information that was received from interviews the researcher had with important experts[153] in the field of adolescents at risk, and a number of teachers at the school in which the research was conducted.

In most instances *quantitative data* will be presented in tabular format[154], while *qualitative data*[155] will be presented in descriptive format to either validate quantitative findings, or to provide a better understanding of the risk-taking choices that are made by the respondent group.

The data received from the group-administered questionnaire was processed by means of a computer software program, ***Statistica AX*** (version 6, series 0602). This software program enabled the researcher to tally the responses on a spreadsheet. By using variables such as age, gender, and residential area, the researcher was able to draw her inferences

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[152] See Addendum I.
[153] A social worker at Stepping Stones and a representative from the ATICC department at Brister House.
[154] Tables were compiled from the responses obtained from the group-administered questionnaire.
[155] Data gained from the interviews with experts, some of the teachers at the specific school, and the focus group.

pertaining to risk-taking behaviours (i.e. substance use, sexual and violence behaviours) of the target group.

To provide a greater understanding of adolescent risk-taking behaviour, and to test the hypotheses[156] that were formulated prior to the actual field research, the researcher also designed relevant multi-variable tables (e.g. age, gender and drug-taking behaviour).

While the aim of this chapter is to present the data that was gathered during the period of field research, the researcher also aims to analyse the data and provide an exposition of the findings relevant to adolescent risk-taking behaviours.

7.2 DATA RELATING TO GROUP-ADMINISTERED QUESTIONNAIRE

7.2.1 ALCOHOL-RELATED BEHAVIOURS[157]

7.2.1.1 Past and current alcohol usage

ALCOHOL USE BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL N = 100**		**N**
GENDER N	**F 8**	**M 8**	**F 8**	**M 8**	**F 8**	**M 8**	**F 9**	**M 9**	**F 8**	**M 8**	**F 9**	**M 9**	**F 50**	**M 50**	**100**
Yes N (Did have) **%**	7 87.5	8 100	4 50	7 87.5	8 100	8 100	9 100	9 100	7 87.5	7 87.5	9 100	5 55.5	44 88	44 88	**88** **88**
No N (Did not have) **%**	1 12.5	0 0	4 50	1 12.5	0 0	0 0	0 0	0 0	1 12.5	1 12.5	0 0	4 44.5	6 12	6 12	**12** **12**
Currently N Using Alcohol %	2 28.6	4 50	1 25	6 85.7	3 37.5	4 50	3 33.3	4 44.4	5 71.4	5 71.4	4 44.4	5 100	18 40.9	28 63.6	**46** **52.3**

Table 11: Past and current alcohol use according to age and gender

It is noted that:

1. the majority of the respondents (88%) used alcohol at one time or another.
2. of the 88 respondents that on occasion used alcohol, 52.3 per cent (18 female and 28 male respondents) currently use alcohol.

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156 See Chapter 2 paragraph 2.3.

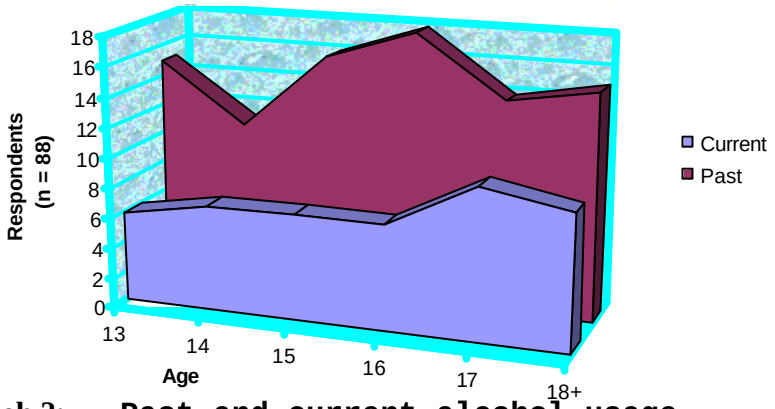
157 Each finding has been allocated a number to enable, amongst others, the testing of the formulated hypotheses.

It should also be noted that:

3. of the 52.3 per cent respondents that currently still use alcohol, 39.1 per cent are female respondents and 60.9 per cent are male respondents.
4. 46 per cent of the total respondent group (i.e. 40.9 per cent of the total female respondents and 63.6 per cent of the total male respondents) currently still use alcohol.

Furthermore:

5. an equal percentage of the total female (88 per cent) and male (88 per cent) respondents have at one time or another used alcohol.
6. more male (63.3 per cent) than female (40.9 per cent) respondents still use alcohol. This translates into 28 per cent male and 18 per cent female respondents of the 46 per cent that currently still use alcohol.



Graph 2: Past and current alcohol usage according to age

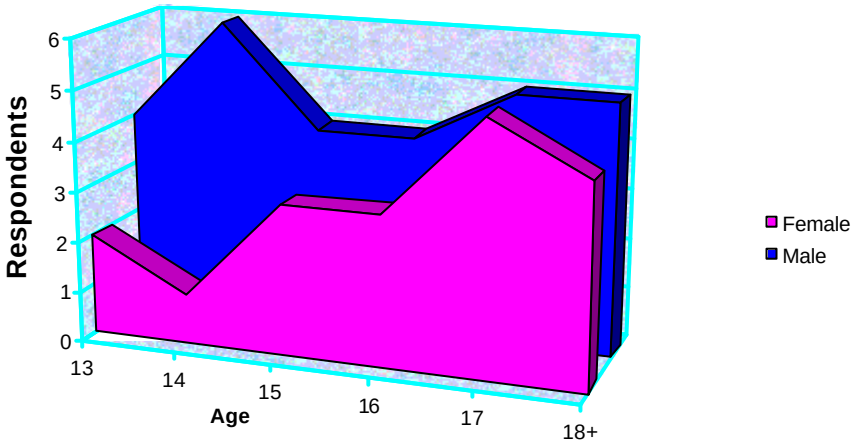
When comparing occasional alcohol intake at any one time or another among the various age cohorts, it has been found that:

7. only two of the age cohorts (i.e. the 13 and 14 year age cohorts) indicate that male respondents more than female respondents (100% : 87.5% and 87.5% : 50% respectively) have used alcohol.

8. all male and female respondents in the 15 and 16 year of age cohorts (i.e. 100%) indicated that they have used alcohol at one time or another.
9. both the gender groups in the 17 year age cohort, although at a lower percentage rate than the 15 and 16 year age cohorts, have indicated that they have used alcohol at one time or another.
10. in only one age cohort (i.e. 18 years and older) females more than males (100%: 55.5%) have used alcohol at one time or another.

The scenario changes when relating current alcohol use (i.e. continued alcohol use after first alcohol in-take) to the ages of the respondents:

11. more male respondents in each cohort, except for the 17 year of age cohort, indicated that they still use alcohol.
12. the two gender groups in the 17 year of age cohort indicate an equal number of respondents currently still using alcohol.



Graph 3: Current alcohol use according to age and gender

7.2.1.2 First alcohol encounter

AGE AT FIRST ALCOHOL ENCOUNTER															
AGE	-13		13		14		15		16		17		18+		N 88
GENDER	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
N	8	12	6	14	13	9	9	7	5	3	0	1	0	1	88
%	9.1	13.6	6.8	16	14.8	10.2	10.2	8	5.7	3.4	0	1.1	0	1.1	100
TOTAL	20		20		22		16		8		1		1		88
%	22.7		22.7		25.0		18.2		9.1		1.1		1.1		100

Table 12: Initial alcohol encounter according to age and gender

From the contents of this table it is noted that:

13. 88 per cent of the respondent group has already used alcohol at some time or another (as also previously reported).
14. only 11.3 per cent of the respondents used their first alcohol when they were older than 15 years of age, while the majority (88.7 per cent) of the respondents were younger than 16 years of age at the time of their first alcohol intake.
15. 22.7 per cent of the respondents indicated that they were younger than 13 years of age, while 22.7 per cent of the respondents indicated that they were 13 years of age (i.e. early adolescent phase) at the time of their first alcohol intake.

When age and gender are correlated:

16. male respondents were more likely than female respondents to use their first alcohol at a younger age (younger than 13 to 13 years of age: 29.6 per cent) than female respondents for the same age cohorts (15.9 per cent).
17. most female respondents indicated that they used alcohol for the first time before they reached the age of 16 (40.9 per cent), with the largest percentage of respondents indicating their first alcohol intake between the ages of 14 and 15 years (25 per cent).

18. most male respondents indicated that they used alcohol for the first time prior to their 17th year (47.8 per cent), with the largest percentage indicating their first alcohol intake under the age of 13 years and younger (22.7 per cent).

7.2.1.3 First alcohol encounter and current alcohol use

Age at first alcohol encounter and current alcohol use															
AGE	**-13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N = 88**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
First Encounter N	8	12	6	14	13	9	9	7	5	3	0	1	0	1	**88**
%	9.1	13.6	6.8	16	14.8	10.2	10.2	8	5.7	3.4	0	1.1	0	1.1	**100**
Current Use N	N/A	N/A	2	4	1	6	3	4	3	4	5	5	4	5	**46**
%	N/A	N/A	4.3	8.7	2.2	13	6.5	8.7	6.5	8.7	10.9	10.9	8.7	10.9	**100**

Table 13: Age at first encounter and current alcohol use by gender and age

From the contents of this table it is noted that:

19. 47.7 per cent of the respondents who had used alcohol do not use alcohol currently.

20. more than half (52.3 per cent) of the total respondents that used alcohol at one time or another, currently still use alcohol.

When age and gender are correlated it was found that:

21. 88.6 per cent of the respondents had their first alcohol usage before their 17th year, while the current intake for the same age cohorts (under 13 to 15) is lower (i.e. 43.5 per cent), as previously reported.

22. 11.4 per cent of the respondents had their first alcohol usage between the ages of 16 and 18 years and older, while 56.5 per cent in the same age cohorts currently still use alcohol.

23. there is an indication that in the areas, first alcohol encounter and current alcohol use, male respondents do so more (60.9 and 39.1 per cent respectively) than female respondents (53.4 : 46.6 per cent).

24. only 2.3 per cent of the respondents in the 13 and 14 year age cohorts previously used alcohol, whereas the percentage for these age cohorts currently using alcohol amounts to 41.3%.
25. 28.3 per cent of the respondents in the 17 and 18 year and older age cohorts previously used alcohol, while 47.4 currently still do so.
26. information gained suggests that some respondents have been using alcohol for a number of years.

7.2.2 DRUG-RELATED BEHAVIOURS

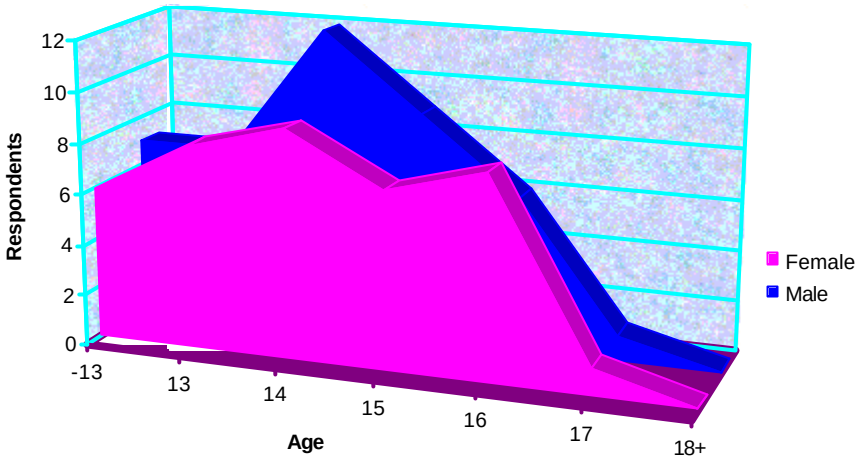
7.2.2.1 First cigarette encounter

AGE AT FIRST CIGARETTE USE															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**81**
N	6	7	8	7	9	12	7	9	8	6	1	1	0	0	**81**
%	7.4	8.6	10	8.6	11.1	14.8	8.6	11.1	10	7.4	1.2	1.2	0	0	**100**
TOTAL	**13**		**15**		**21**		**16**		**14**		**2**		**0**		**81**
%	**16**		**18.5**		**25.9**		**19.8**		**17.3**		**2.5**		**0**		**100**

Table 14: Initial cigarette encounter according to age and gender

From the contents of this table it is noticed that:

27. no respondent started cigarettes smoking at the age of 18 years and older.
28. a small proportion (2.4 per cent of the 81 per cent) that smoked cigarettes at one time or another, started smoking at the age of 17 years.
29. the majority of the respondents started smoking between the ages of 13 to 16 years.



Graph 4: Initial cigarette usage according to age and gender

Furthermore:

30. more male (8.6 per cent) respondents than female (7.4 per cent) respondents were introduced to cigarette smoking before the age of 13 years.

31. in only three out of seven age cohorts were more males than females introduced to cigarette smoking (i.e. 13 years and younger age cohort [8.6 : 7.4]; 14 years age cohort [14.8 : 11.1]; and the 15 year age cohort [11.1 : 8.6]).

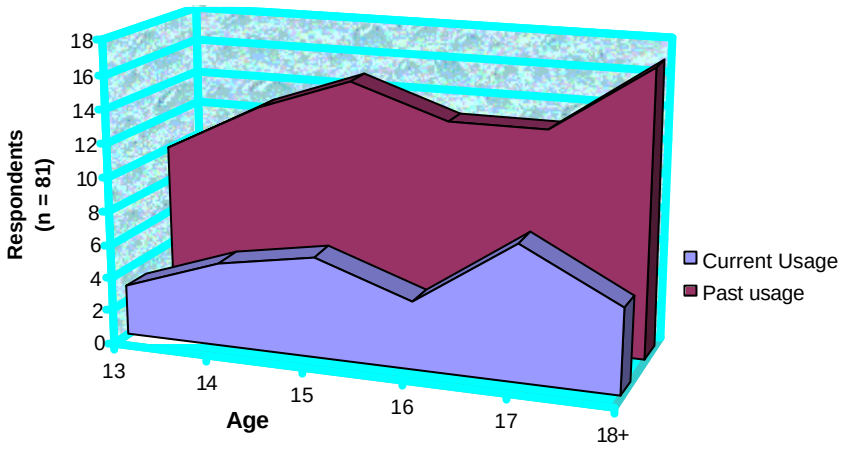
7.2.2.2 Past and current cigarette usage

CIGARETTE USE BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL N = 100**		**N**
GENDER	**F**	**M**		**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**100**
N	**8**	**8**	**8**	**8**	**8**	**8**	**9**	**9**	**8**	**8**	**9**	**9**	**50**	**50**	
Yes N	5	5	7	6	7	8	6	7	6	7	8	9	39	42	**81**
(Did have) **%**	62.5	62.5	87.5	75	87.5	100	66.7	77.8	75	87.5	88.9	100	78	84	**81**
No N	3	3	1	2	1	0	3	2	2	1	1	0	11	8	**19**
(Did not have) **%**	37.5	37.5	12.5	25	12.5	0	33.3	22.2	25	12.5	11.1	0	22	16	**19**
Currently N	1	2	2	3	3	3	2	2	5	3	3	2	16	15	**31**
Smoking %	20	40	28.6	50	42.9	37.5	33.3	28.6	83.3	42.9	37.5	22.2	41	35.7	**38.3**

Table 15: Past and current cigarette use according to age and gender

From the contents of this table it is noted that:

32. 81 per cent of the total respondent group has smoked cigarettes at one time or another.
33. 38.3 per cent (41 per cent female and 35.7 per cent male respondents) of this 81 per cent are currently smoking cigarettes.
34. of the total respondent group 31 per cent (16 per cent female and 15 per cent male respondents) currently smoke cigarettes.



Graph 5: Past and current cigarette usage according to age

When comparing cigarette usage among the two gender groups:

35. more male (84 per cent) than female (78 per cent) respondents have smoked cigarettes one time or another.
36. more female (46.2 per cent) than male (35.7 per cent) respondents currently smoke cigarettes.

When comparing cigarette smoking at any one time among the various age cohorts, it is noticed that:

37. in the age cohorts 15 years to 18 years and older, a relatively constant pattern of smoking exists between the female and the male respondents (Compare: 7:8, 6:7, 6:7, 8:9), with a difference of one respondent between the two gender groups.

38. it is only in the 14 year of age cohort that more female (87.5 per cent) than male (75 per cent) respondents used cigarettes at one time or another.

39. in all the other age cohorts (except for the 13 year age cohort; 62.5 per cent for both sexes) more male than female respondents smoked cigarettes at one time or another.

7.2.2.3 First cigarette encounter and current cigarette use

AGE AT FIRST CIGARETTE ENCOUNTER AND CURRENT CIGARETTE USE															
AGE	**-13**		**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL N=81**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
First Encounter N	6	7	8	7	9	12	7	9	8	6	1	1	0	0	**81**
First Encounter %	7.4	8.6	10	8.6	11.1	14.8	8.6	11.1	10	7.4	1.2	1.2	0	0	**100**
Current Use N	N/A	N/A	1	2	2	3	3	3	2	2	5	3	3	2	**31**
Current Use %			3.2	6.5	6.5	9.7	9.7	9.7	6.5	6.5	16.1	9.7	9.7	6.5	**100**

Table 16: Initial cigarette encounter and current cigarette usage according to age and gender

It is noted that:

40. 38.3 per cent of the total respondents, who smoked cigarettes at one time or another, are currently still smoke cigarettes.

41. no respondents started using cigarettes at the age of 18 and older, while 16.1 per cent respondents in this age cohort currently smoke cigarettes. This is also an indication that some respondents have been smoking for some time.

7.2.2.4 First marijuana encounter

AGE AT FIRST MARIJUANA ENCOUNTER															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**23**
N	0	3	2	4	3	4	3	2	1	0	1	0	0	0	**23**
%	0	13	8.7	17.4	13	17.4	13	8.7	4.4	0	4.4	0	0	0	**100**
TOTAL	**3**		**6**		**7**		**5**		**1**		**1**		**0**		**23**
%	**13**		**26.1**		**30.4**		**21.7**		**4.4**		**4.4**		**0**		**100**

Table 17: Initial marijuana encounter according to age and gender

From the contents of this table it is noted that:

42. male respondents started using marijuana at an earlier age than their female counterparts did.
43. the majority of the respondents (91.3 per cent) started using marijuana before the age of 16 years.
44. only 8.7 per cent of the respondents started using marijuana since the age of 16 years.
45. when comparing the percentages for the 13 year old and younger, and the 13 years of age cohort to that of the 14 years of age cohort, more male than female respondents started using marijuana at one time or another (Compare: 13 : 0; 17.4 : 8.7; and 17.4 : 13 per cent respectively).
46. more female respondents started using marijuana between the ages of 15 to 17 years of age (Compare: 13 : 8.7; 4.4 : 0; and 4.4: 0 respectively).
47. no respondents started using marijuana at the age of 18 years and older.

7.2.2.5 Past and current marijuana usage

MARIJUANA USE BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		**N 100**
GENDER N	**F 8**	**M 8**	**F 8**	**M 8**	**F 8**	**M 8**	**F 9**	**M 9**	**F 8**	**M 8**	**F 9**	**M 9**	**F 50**	**M 50**	
Yes N (Did have) **%**	1 12.5	1 12.5	1 12.5	3 37.5	0 0	1 12.5	2 22.2	1 11.1	3 37.5	4 50	3 33.3	3 33.3	10 20	13 26	**23** **23**
No N (Did not have) **%**	7 87.5	7 87.5	7 87.5	5 62.5	8 100	7 87.5	7 77.8	8 88.9	5 62.5	4 50	6 66.7	6 66.7	40 80	37 74	**77** **77**
Marijuana N Currently %	0 0	0 0	0 0	1 33.3	0 0	1 100	0 0	1 100	2 66.7	2 50	0 0	3 100	2 20	8 61.5	**10** **43.5**

Table 18: Marijuana encounter according to age and gender

From the contents of this table it is noted that:

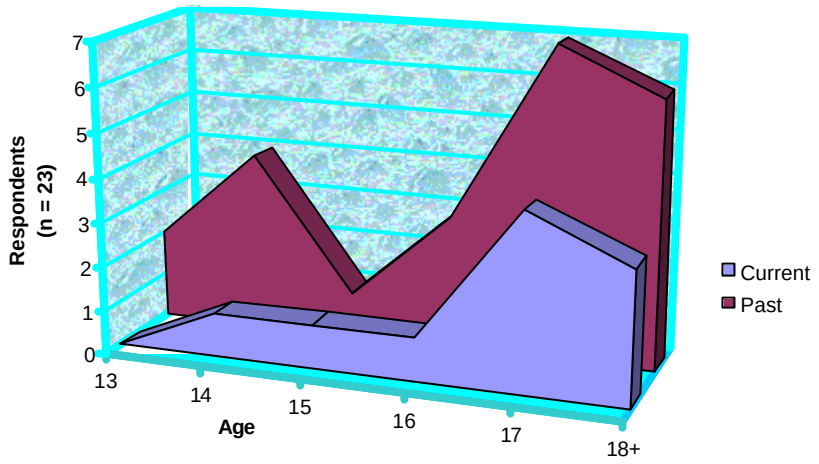
48. 23 per cent of the total respondent group used marijuana at one time or another.
49. there is little difference between male and female respondents that used marijuana one time or another.
50. of the 33 respondents that used marijuana one time or another 43.5 per cent were female and 56.5 per cent male respondents.
51. more male respondents (34.8 per cent) than female respondents (8.7 per cent) are currently using marijuana.

When comparing the age cohorts with each other, it is noted that:

52. the 17 year age cohort had the highest number of respondents who used marijuana at one time or another (30.4 per cent).
53. none of the female respondents in the 15 year age cohort had ever used marijuana.
54. in all the age cohorts more male than female respondents had used marijuana at one time or another, while an equal number of respondents in the 16 year age cohort used marijuana at one time or another.
55. in all age cohorts there are more male than female respondents who currently still use marijuana.

56. none of the respondents in the 13 year age cohort currently use marijuana, although this cohort contributed to 8.7 per cent of the respondents that indicated that they had used marijuana at one time or another.

57. the 17 year age cohort still has the highest number (17.4 per cent) of respondents currently using marijuana.



Graph 6: **Past and current marijuana usage according to age**

Furthermore:

58. more male respondents used marijuana at one time or another than female respondents and currently still do so (compare 56.5 : 43.5 and 34.8 : 8.7 per cent respectively).

7.2.2.6 First marijuana encounter and current marijuana use

AGE AT FIRST MARIJUANA ENCOUNTER AND CURRENT MARIJUANA USE															
AGE		**-13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N=23**
GENDER		**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
First Encounter	**N**	0	3	2	4	3	4	3	2	1	0	1	0	0	0	**23**
	%	0	13	8.7	17.4	13	17.4	13	8.7	4.4	0	4.4	0	0	0	**100**
Current Use	**N**	N/A	N/A	0	0	0	1	0	1	0	1	2	2	0	3	**10**
	%			0	0	0	10	0	10	0	10	20	20	0	30	**43.5**

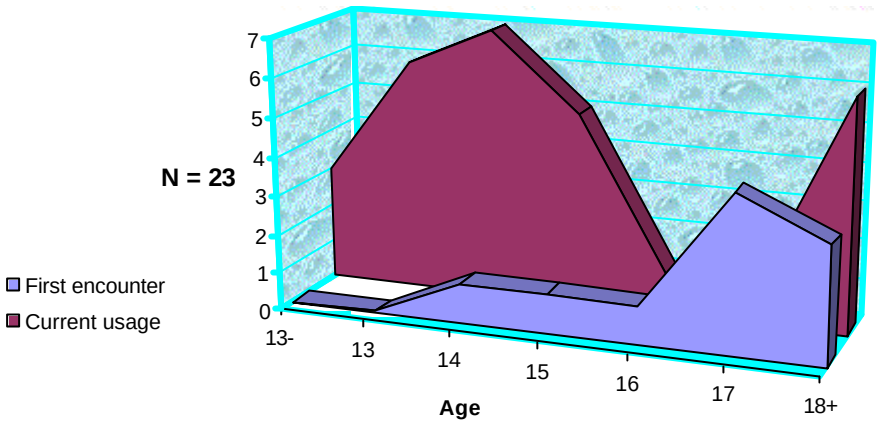
Table 19: Initial and current marijuana usage according to age and gender

This table depicts the findings that:

59. while no respondent started using marijuana at the age of 18 years and older, this age cohort has the highest number of respondents currently using marijuana. This would imply that some respondents have been using marijuana for some time.

60. the youngest male respondent currently using marijuana is 14 years of age, while the youngest female respondent currently using marijuana is 17 years of age.

61. less than half (43.5 per cent) of the respondents who used marijuana at one time or another, are currently still using it, as the following graph illustrates.



Graph 7: First and current marijuana usage according to age

7.2.2.7 First drug or inhalant encounter

AGE AT FIRST DRUG /INHALANT ENCOUNTER															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**16**
N	0	4	4	2	2	0	3	0	0	0	0	1	0	0	**16**
%	0	25	25	12.5	12.5	0	18.8	0	0	0	0	6.2	0	0	**100**
TOTAL	**4**		**6**		**2**		**3**		**0**		**1**		**0**		**16**
%	**25.0**		**37.5**		**12.5**		**18.8**		**0**		**6.2**		**0**		**100**

Table 20: Initial drug or inhalant encounter according to age and gender

From the contents of this table it is noted that:

62. male respondents were initiated to drugs or inhalants before female respondents were.
63. in the 13 to 15 year age cohorts, more female than male respondents were initiated to drugs or inhalants.
64. no respondents started using drugs or inhalants at the age of 18 years and older.
65. the drug or inhalant initiation ages for female respondents were thirteen to fifteen years.

66. for males the initiation ages were younger than thirteen (through to seventeen) years of age.

67. the majority of the respondents had been introduced to drugs and inhalants by the age of thirteen years.

7.2.2.8 Past and current drug or inhalant usage

DRUG OR INHALANT USE BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		
GENDER N	**F 8**	**M 8**	**F 8**	**M 8**	**F 8**	**M 8**	**F 9**	**M 9**	**F 8**	**M 8**	**F 9**	**M 9**	**F 50**	**M 50**	**N 100**
Yes N	0	0	1	3	2	1	2	1	2	2	2	0	9	7	**16**
(Did) **%**	0	0	12.5	37.5	25.0	12.5	22.2	11.1	25.0	25.0	22.2	0	18	14	**16**
No N	8	8	7	5	6	7	7	8	6	6	7	9	41	43	**84**
(Not) **%**	100	100	87.5	62.5	75.0	87.5	77.8	88.9	75.0	75.0	77.8	100	82	86	**84**
Currently N	0	0	1	1	1	1	0	0	2	1	0	0	4	3	**7**
Using Drugs %	0	0	100	33.3	50	100	0	0	100	50	0	0	44.4	42.9	**43.8**

Table 21: Drug/inhalant encounter according to gender and age

From the contents of this table it is noted that:

68. 16 per cent of the total respondent group used drugs or inhalants at one time or another.

69. 43.8 per cent of these respondents, who had used drugs or inhalants one time or another, are currently still using drugs or inhalants.

Furthermore:

70. slightly more female than male respondents who had used drugs or inhalants at one time or another currently still do so.

71. 56.2 per cent of the total respondent group that used drugs or inhalants at one time or another are female respondents, while 43.8 per cent are male respondents.

72. 44.4 per cent of the total respondent group that currently use drugs or inhalants are female respondents, while 42.9 percent are male respondents.

73. comparing all age cohorts, two (the 14 year and 17 year age cohorts) of them contain the most respondents that had used drugs or inhalants at one time or another (25 per cent).
74. the 17 year age cohort contains the most respondents that currently use drugs or inhalants (42.9 per cent).
75. none of the 18.8 per cent respondents in the 16 year of age cohort that used drugs or inhalants at one time or another do so now.
76. in the 18 year and older age cohort none of the 12.5 per cent respondents that used drugs or inhalants one time or another, currently still use it.
77. in the 18 and older age cohort no male had used drugs or inhalants one time or another, or is currently doing so, however, this is not the case with marijuana usage.

7.2.2.9 First drug or inhalant encounter and current use

AGE AT FIRST DRUG/INHALANT ENCOUNTER AND CURRENT USE															
AGE	-13		13		14		15		16		17		18+		TOTAL
GENDER	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
First Encounter N	0	4	4	2	2	0	3	0	0	0	0	1	0	0	16
First Encounter %	0	25	25	12.5	12.5	0	18.8	0	0	0	0	6.2	0	0	100
Current Use N	N/A	N/A	0	0	1	1	1	1	0	0	2	1	0	0	7
Current Use %			0	0	14.3	14.3	14.3	14.3	0	0	28.5	14.3	0	0	100

Table 22: Initial and current drug or inhalant usage according to gender and age

Table 22 indicates that:

78. 56.2 per cent of the respondents who used drugs or inhalants at one time or another currently do not use it.
79. whereas 62.5 per cent of the total respondents, who had used drugs or inhalants at one time or another, started using it before and at the age of 13, no respondent in this age cohort currently use drugs or inhalants.

80. the majority of the respondents who used drugs or inhalants at one time or another were initiated to it between the ages of 13 and 15 years (93.8 per cent).

81. more female than male respondents used drugs or inhalants when they were between the ages of 13 and 15 years old (i.e. 25 : 12.5; 12.5 : 0; and 18.8 : 0 per cent respectively).

82. no respondent started using drugs or inhalants between the ages of 16 and 18 years of age. Neither are there any that currently use drugs or inhalants.

83. there is almost an equal number of male and female respondents that currently use drugs and inhalants, except for the 17 years of age cohort, where the percentage division among female and male respondents is 28.5 : 14.3 per cent.

7.2.3 VIOLENCE-RELATED BEHAVIOURS

7.2.3.1 Current weapon use

CURRENT WEAPON USE BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		**FINAL TOTAL**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
N	**8**	**8**	**8**	**8**	**8**	**8**	**9**	**9**	**8**	**8**	**9**	**9**	**50**	**50**	
YES N	0	3	2	4	2	4	2	5	1	3	2	4	9	23	**32**
%	0	37.5	25	50	25	50	22.2	55.6	12.5	37.5	22.2	44.4	18	46	**32**
NO N	8	5	6	4	6	4	7	4	7	5	7	5	41	27	**68**
%	100	62.5	75	50	75	50	77.8	44.4	87.5	62.5	77.8	55.6	82	54	**68**
CARRY GUN N	0	1	0	0	0	2	1	4	0	2	1	3	2	12	**14**
%	0	33.3	0	0	0	50	50	80	0	66.7	50	75	22.2	52.2	**43.8**

Table 23: Weapon encounter according to age and gender

From the contents of this table it is noted that:

84. 32 per cent of the total respondent group carries a weapon of some kind.

85. more male (28.1 per cent) than female respondents (71.9 per cent) carry a weapon of some kind.

86. no female respondent in the 13 year age cohort carries a weapon.

87. the 13 year age cohort has the lowest percentage of respondents who carry weapons (9.4 percent).
88. the age cohort with the highest percentage of weapon-carrying respondents is the 16 year age cohort (21.9 per cent).
89. 43.8 per cent of the respondents who carry weapons, carry guns.

Furthermore:

90. more male respondents (85.7 per cent) carry guns than female respondents (14.3 per cent).
91. the 16 year age cohort also has the highest percentage of gun carriers, i.e. 35.7 per cent.
92. the youngest male respondent who carries a gun is 13 years old, while the youngest female respondent who carries a gun is 16 years old .

7.2.3.2 First weapon encounter

AGE AT FIRST WEAPON USE															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**32**
N	2	8	2	4	1	6	2	2	0	2	2	1	0	0	**32**
%	6.3	25	6.3	12.5	3	18.7	6.3	6.3	0	6.3	6.3	3	0	0	**100**
TOTAL	**10**		**6**		**7**		**4**		**2**		**3**		**0**		**32**
%	**31.2**		**18.8**		**21.9**		**12.5**		**6.2**		**9.4**		**0**		**100**

Table 24: Initial weapon encounter according to age and gender

The table depicts the information that:

93. 32 per cent of the respondents carry weapons.
94. the majority of the respondents (31.2 per cent) carried weapons before the age of 13 years.
95. both female and male respondents started carrying weapons for the first time prior to being 13 years of age.

96. no respondent started carrying a weapon at the age of 18 years and older.

7.2.3.3 SUICIDE BEHAVIOUR

7.2.3.3.1 Suicide attempts

SUICIDE ATTEMPTS BY AGE AND GENDER															
AGE	**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		
GENDER N	**F 8**	**M 8**	**F 8**	**M 8**	**F 8**	**M 8**	**F 9**	**M 9**	**F 8**	**M 8**	**F 9**	**M 9**	**F 50**	**M 50**	**N 100**
YES N	2	1	2	1	1	1	4	0	3	1	4	2	16	6	**22**
(Attempted) **%**	25	12.5	25	12.5	12.5	12.5	44.4	0	37.5	12.5	44.4	22.2	32	12	**22**
NO N	6	7	6	7	7	7	5	9	5	7	5	7	34	44	**78**
(Did not) **%**	75	87.5	75	87.5	87.5	87.5	55.6	100	62.5	87.5	55.6	77.8	68	88	**78**

Table 25: Suicide attempts according to age and gender

From the content of the table it is noted that:

97. 22 per cent of the total respondent group has attempted suicide.

98. more female (72.7 per cent) than male respondents (27.3 per cent) attempted suicide; a ratio of just more than 2 : 1.

99. slightly more respondents belonging to older age cohorts (16 years to 18 years and older) attempted suicide than respondents belonging to younger age cohorts (13 years to 15 years).

7.2.3.3.2 First suicide attempt

AGE AT FIRST SUICIDE ATTEMPT															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**22**
N	2	1	4	1	5	0	3	3	2	0	0	1	0	0	**22**
%	9.1	4.6	18.1	4.6	22.7	0	13.6	13.6	9.1	0	0	4.6	0	0	**100**
TOTAL	**3**		**5**		**5**		**6**		**2**		**1**		**0**		**22**
%	**13.6**		**22.7**		**22.7**		**27.3**		**9.1**		**4.6**		**0**		**100**

Table 26: Initial suicide attempt according to age and gender

The content of this table depicts that:

100. 22 percent of the total respondent group had attempted suicide at one time or another (as previously reported).
101. the majority of these respondents attempted suicide between the ages of 13 and 15 years (86.4 per cent) and it could be assumed that they were in their mid-adolescent years.
102. a smaller number of respondents attempted suicide between the ages of 16 years and 18 years and older (i.e. 13.6 per cent).

7.2.4 SEXUALLY RELATED BEHAVIOURS

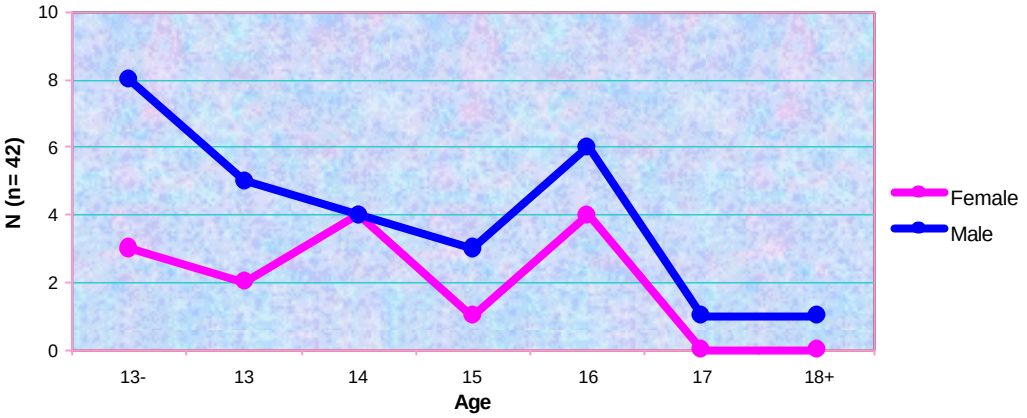
7.2.4.1 First sexual encounter

AGE AT FIRST SEXUAL ENCOUNTER															
AGE	**- 13**		**13**		**14**		**15**		**16**		**17**		**18+**		**N**
GENDER	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**42**
N	3	8	2	5	4	4	1	3	4	6	0	1	0	1	**42**
%	7.1	19.1	4.8	11.9	9.5	9.5	2.4	7.1	9.5	14.3	0	2.4	0	2.4	**100**
TOTAL	**11**		**7**		**8**		**4**		**10**		**1**		**1**		**42**
%	**26.2**		**16.7**		**19.0**		**9.5**		**23.8**		**2.4**		**2.4**		**100**

Table 27: Initial sexual encounter according to age and gender

This table depicts the information that:

103. the majority (26.2 per cent) of the respondents who had sexual intercourse at one time or another did so before the age of 13 years.
104. both gender groups were introduced to sex before the age of 13 years.
105. 95.2 per cent of the respondents who had sexual intercourse at one time or another did so before the age of 17 years, meaning that
106. only 4.8 per cent of the respondents who had sexual intercourse at one time or another did so when they were 17 or 18 years and older.
107. the female respondents were slower in becoming sexually active than male respondents. The following graph illustrates this point.



Graph 8: Age at first sexual encounter according to gender and age

7.2.4.2 Past and current sexual activity

SEXUAL ACTIVITY BY AGE AND GENDER															
AGE		**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		**N**
GENDER	**N**	**F 8**	**M 8**	**F 8**	**M 8**	**F 8**	**M 8**	**F 9**	**M 9**	**F 8**	**M 8**	**F 9**	**M 9**	**F 50**	**M 50**	**42**
Yes (Did)	**N**	0	2	1	4	2	2	5	7	5	6	1	7	14	28	**42**
	%	0	25	12.5	50	25	25	55.6	77.8	62.5	75	11.1	77.8	28	56	**42**
No (Did not)	**N**	8	6	7	4	6	6	4	2	3	2	8	2	36	22	**58**
	%	100	75	87.5	50	75	75	44.4	22.2	37.5	25	88.9	22.2	72	44	**58**
Sexually Active	**N**	0	1	0	3	2	2	3	4	5	4	1	6	11	20	**31**
	%	0	50	0	75	100	100	60	57.1	100	66.7	100	85.7	78.6	71.4	**73.8**

Table 28: Sexual encounter according to age and gender

The content of this table reveals that:

108. 42 per cent of the total respondents group had sexual intercourse at one time or another.

109. more male (66.7 per cent) than female respondents (33.3 per cent) had sexual intercourse at one time or another, implying a ration of 2 : 1.

110. none of the 13 year old female respondents had sexual intercourse prior to answering the questionnaire.
111. the majority of the respondents (73.8 per cent) who had sex before belong to the older age cohorts (16 to 18 years and older).
112. the younger age cohorts (13 to 15 years) contain 26.2 per cent of the respondents who have had sexual intercourse at one time or another.
113. in every age cohort more male than female respondents had sexual intercourse, except for the 15 year age cohort where the percentage indicated for both male and female groups is equal (i.e. 4.8 per cent).

Table 28 indicates that:

114. 73.8 per cent of the respondents who had sexual intercourse at one time or another are currently still sexually active.
115. more male (64.5 per cent) than female respondents (35.5 per cent) are currently still sexually active.
116. more respondents of the older age cohorts (16 to 18 years and older) are currently sexually active than respondents of the younger age cohorts (13 to 15 years) [74.2 : 25.8 per cent respectively; a ratio of almost 3 : 1].
117. the single highest number of respondents who are currently sexually active is the 17 year age cohort (i.e. 29 per cent).
118. the youngest sexually active female respondent is 15 years of age, whereas the youngest male sexually active respondent is 13 years of age.

7.2.4.3 Contraceptive behaviour

CONTRACEPTIVE BEHAVIOUR BY AGE AND GENDER																
AGE		**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		**N 42**
GENDER		**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
Sexually Active	**N**	0	1	0	3	2	2	3	4	5	4	1	6	11	20	**31**
	%	0	50	0	75	100	100	60	57.1	100	66.7	100	85.7	78.6	71.4	**73.8**
YES (Sexually active and using Contraceptives)	**N**	0	0	0	1	0	2	1	3	3	2	0	4	4	12	**16**
	%	0	0	0	33.3	0	100	33.3	75	60	50	0	66.7	36.4	60	**51.6**
NO (Sexually active and not using contraceptives)	**N**	0	1	0	2	2	0	2	1	2	2	1	2	7	8	**15**
	%	0	100	0	66.7	100	0	66.7	25	40	50	100	33.3	63.6	40	**48.4**
USE CONDOMS REGULARLY	**N**	0	0	0	1	0	1	0	1	0	1	0	1	0	5	**5**
	%	0	0	0	100	0	50	0	33.3	0	50	0	25	0	41.7	**31.3**
USE CONDOMS IRREGULARLY	**N**	0	0	0	0	0	1	0	2	0	1	0	3	0	7	**7**
	%	0	0	0	0	0	50	0	66.7	0	50	0	75	0	58.3	**43.8**

Table 29: Contraceptive behaviour according to age and gender

From the contents of this table it is noted that:

119. 31 per cent of the total respondent group is sexually active, as previously reported.

120. 51.6 per cent of the sexually active respondents use contraceptives.

121. more sexually active male (38.7 per cent) than female (12.9 per cent) sexually active respondents use contraceptives.

122. more sexually active male (25.8 per cent) than female (22.6 per cent) sexually active respondents do not use contraceptives as well.

123. 41.7 of the sexually active male respondents use condoms[158] regularly, while 58.3 per cent of them do not use condoms regularly.

[158] Condom use during sexual intercourse minimise the risk of contracting HIV/AIDS.

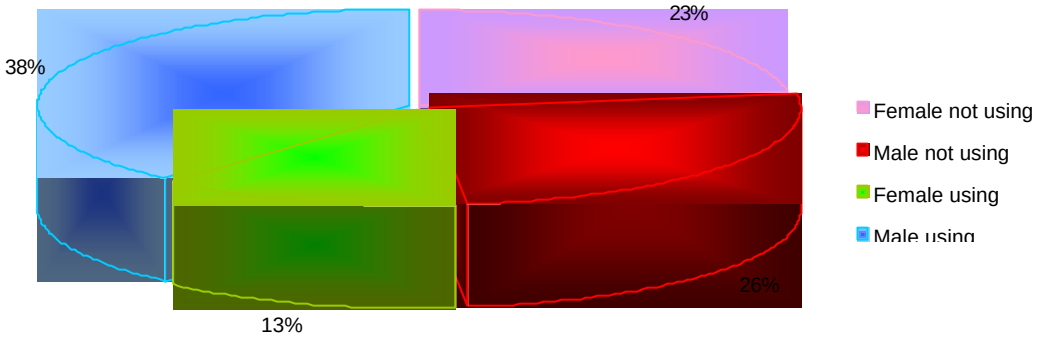
When comparing the age cohorts, it is noted that:

124. 25.8 per cent of the respondents in the 13 to 15 year age cohorts are sexually active, while only

125. 37.5 per cent of these respondents use contraceptives.

126. 74.2 per cent of the respondents in the 16 to 18 year and older age cohorts are sexually active, while only

127. 56.5 per cent of these respondents use contraceptives.



Graph 9: Contraceptive usage according to gender

Male respondents and condom-usage:

128. 30 per cent of the sexually active male respondents belong to the younger age cohorts (13 to 15 years), while

129. 50 per cent of these respondents use condoms (66.7% regularly and 33.3% irregularly).

130. 70 per cent of the sexually active male respondents belong to the older age cohorts (16 to 18 years and over), and

131. 64.3 per cent of these respondents use condoms (33.3 % regularly and 66.7% irregularly).

7.2.4.4 Drugs/alcohol and sexual behaviour

DRUGS / INHALANTS, ALCOHOL, SEXUAL AND CONTRACEPTIVE BEHAVIOUR																
AGE		**13**		**14**		**15**		**16**		**17**		**18+**		**TOTAL**		**N 100**
GENDER		**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	
N		**8**	**8**	**8**	**8**	**8**	**8**	**9**	**9**	**8**	**8**	**9**	**9**	**50**	**50**	
Sexually Active	**N**	0	1	0	3	2	2	3	4	5	4	1	6	11	20	**31**
	%	0	12.5	0	37.5	25	25	33.3	44.4	62.5	50	11.1	66.7	22.6	40	**31**
Using drugs/ inhalants / alcohol before sex	**N**	0	1	0	2	2	1	3	2	5	4	1	3	11	13	**24**
	%	0	100	0	66.7	100	50	100	50	100	100	100	50	100	65	**77.4**
Sexually Active & not using contraceptives	**N**	0	1	0	2	2	0	2	1	2	2	1	2	7	8	**15**
	%	0	100	0	66.7	100	0	66.7	25	40	50	100	33.3	63.6	40	**48.4**
Drugs / inhalants / alcohol before sex & not using contraceptives	**N**	0	1	0	2	1	0	2	1	2	2	1	2	6	8	**14**
	%	0	100	0	66.7	50	0	66.7	25	40	50	100	33.3	54.5	40	**45.2**

Table 30: Drugs/alcohol before unprotected sexual intercourse

From the contents of this table it is noted that:

132. 31 per cent of the total respondent group is sexually active.

133. 77.4 per cent of this sexually active group use either drugs or alcohol before engaging in the sexual activity, while

134. 45.2 per cent of these sexually active respondents use drugs or alcohol before sex, and they do not use contraceptives.

Comparing the ages of the respondents it is noted that:

135. respondents of the older age cohorts (16 to 18 years and older) use drugs or alcohol before sexual intercourse (75 per cent).

136. 25 per cent of the respondents that use alcohol or drugs before sex belong to the younger age cohorts, 13 to 15 years.

137. more respondents in the older age cohorts (16 to 18 years and older) use drugs or alcohol before sex, while they also do not use contraceptives.

Concerning gender, it is noted that:

138. more male (41.9 per cent) than female (35.5) respondents that are sexually active use drugs or alcohol before sexual intercourse.
139. more male (25.8 per cent) than female respondents (19.4 per cent) that are sexually active use drugs or alcohol before sex, and they do not use contraceptives.
140. all of the female respondents that are sexually active use drugs or alcohol before engaging in sexual intercourse.
141. 54.5 per cent of the female respondents who used drugs or alcohol before sex do not use contraceptives.
142. 40 per cent of the male respondents who use drugs or alcohol before sex do not use contraceptives.

7.2.5 GENERAL EMOTIONAL STATE OF RESPONDENTS

EMOTIONAL STATE			
STATE N	**F 50**	**M 50**	**TOTAL 100**
Not Happy	2	5	**7**
Not Happy, Nor Unhappy	13	9	**22**
Happy	14	10	**24**
Very Happy	21	26	**47**

Table 31: General emotional state according to gender

From the contents of this table it is noted that:

143. 22 per cent of the respondents are not happy (*"not happy"* and *"not happy nor unhappy"*).
144. the majority of the respondents (71 per cent) are happy (*"happy"* and *very happy").*

145. 70 per cent of the female respondents are generally happy (*"happy"* and *"very happy"*), implying that

146. 30 per cent of the female respondents are generally unhappy *("unhappy"* and *"not happy nor unhappy"*).

147. 72 per cent of the male respondents are generally happy (*"happy"* and *"very happy"*), implying that

148. 28 per cent of the male respondents are generally unhappy ("*unhappy* and *"not happy nor unhappy"*).

7.2.6 RESIDENTIAL AREAS AND RISK-TAKING BEHAVIOUR

7.2.6.1 Risk-taking behaviour in all residential areas

Risk-taking activities by Areas							
Areas[159]	**1**	**2**	**3**	**4**	**Total**	**%**	**Mean**
Alcohol Use	9	14	13	10	46	19.8	11.5
Cigarette Use	5	7	10	9	31	13.4	7.7
Marijuana Use	2	3	3	2	10	4.3	2.5
Drugs / inhalants	3	2	0	2	7	3	1.8
Weapon Use	6	10	7	9	32	13.8	8
Suicide Attempts	3	5	6	8	22	9.5	5.5
Sex	4	8	8	11	31	13.4	7.7
No Contraceptives	2	5	4	4	15	6.5	3.8
Drugs or inhalants, alcohol and sex	3	6	10	5	24	10.3	6
Drugs or inhalants, alcohol, sex and no contraceptive s	2	4	3	5	14	6	3.5
Total	**39**	**64**	**64**	**65**	**232**	**100**	**58**

Table 32: Categories of risk-taking behaviour according to residential areas

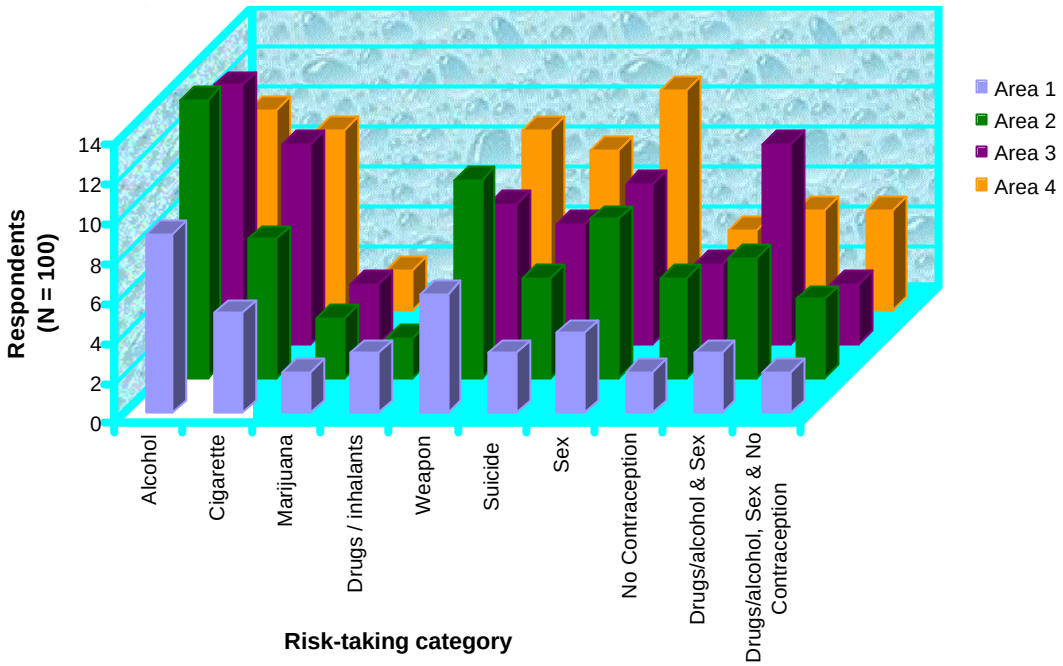
[159] See paragraph 2.4.4 and footnotes 22 – 25 of Chapter 2 for a full description of the four residential areas.

From the contents of Table 32 it is noted that:

149. 232 (with a median of 25 per cent) current risk-taking behaviour incidences occur in these four areas.
150. area 3 has the highest incidences (28.5 per cent) of risk-taking behaviour.
151. area 1 has the lowest incidences (16.8 per cent) of risk-taking behaviour.
152. areas 2 and 4 contain 27.6 and 28 per cent risk-taking incidences respectively.
153. alcohol usage is the highest risk-taking category in three areas (1 – 3), making up 15.5 per cent of the total number of incidences, with
154. sexual behaviour being the highest in one area (area 4), calculating to 4.7 per cent of the total number of incidences.

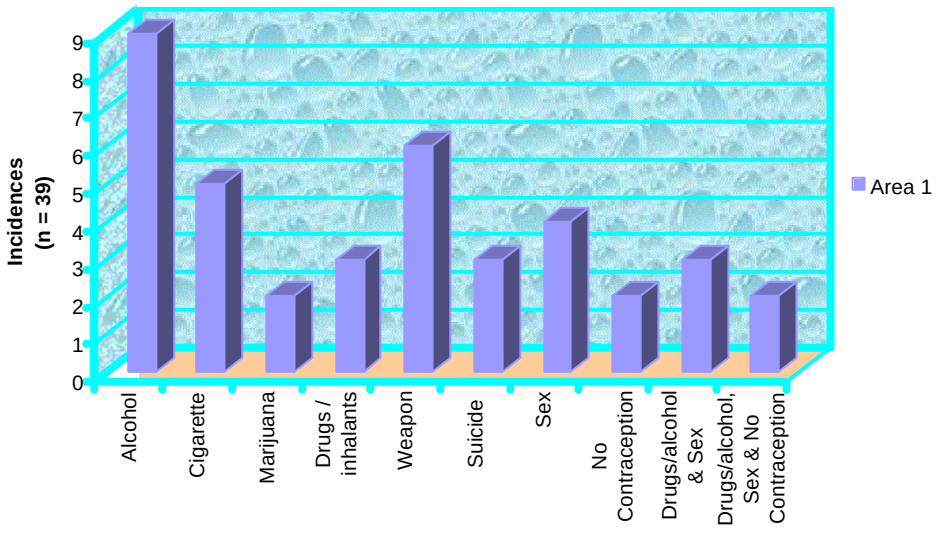
When each area is studied it is noted that:

155. the highest risk-taking category in three areas is alcohol usage, i.e. area 1: 19.6 per cent; area 2: 30.4 per cent; area 3: 28.3 per cent.
156. the highest risk-taking category in area 4 is sexual behaviour, i.e. 35.5 per cent.
157. the two lowest risk-taking categories are marijuana usage and drugs or inhalant usage, i.e. 4.3 and 3 per cent respectively.



Graph 10: Risk-taking category according to residential area

7.2.6.2 Risk-taking behaviour in the individual residential areas



Graph 11: Area 1 according to risk-taking activities

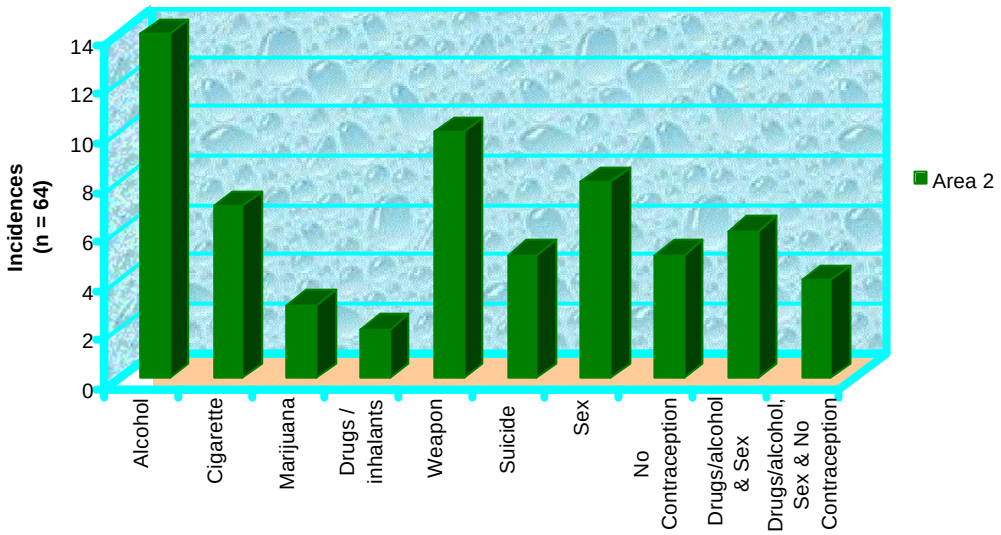
When each area is studied individually and with the assistance of Graph 11, it is noted that:

158. area 1 contains an occurrence of 16.8 per cent risk-taking activities.

159. in this area the highest risk-taking activity is alcohol use, i.e. 23 per cent.

160. the second highest activity is weapon use, i.e. 15.4 per cent.

161. the activities with the lowest percentages (5.1 per cent) are (a) marijuana use, (b) sexual active but no contraceptives, and (c) drugs/inhalants or alcohol before unprotected sexual intercourse.



Graph 12: Area 2 according to risk-taking activities

Graph 12 illustrates the information that:

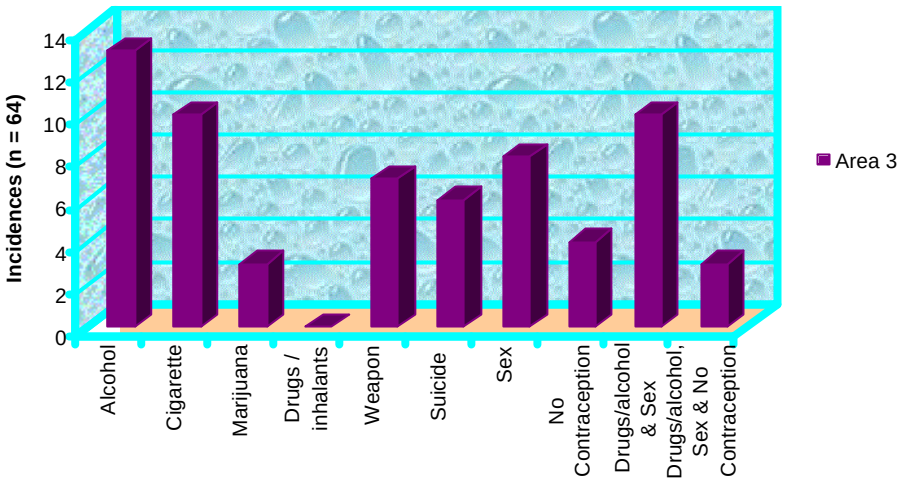
162. area 2 contains an occurrence of 27.6 per cent risk-taking activities.

163. the highest risk-taking activity is alcohol usage, i.e. 21.9 per cent.

164. the second highest risk-taking activity is weapon use, i.e. 15.6 per cent.

165. the lowest risk-taking activity, drugs or inhalants, has an occurrence of 3.1 per cent.

166. marijuana also has a low occurrence level, i.e. 4.7 per cent.



Graph 13: **Area 3 according to risk-taking activities**

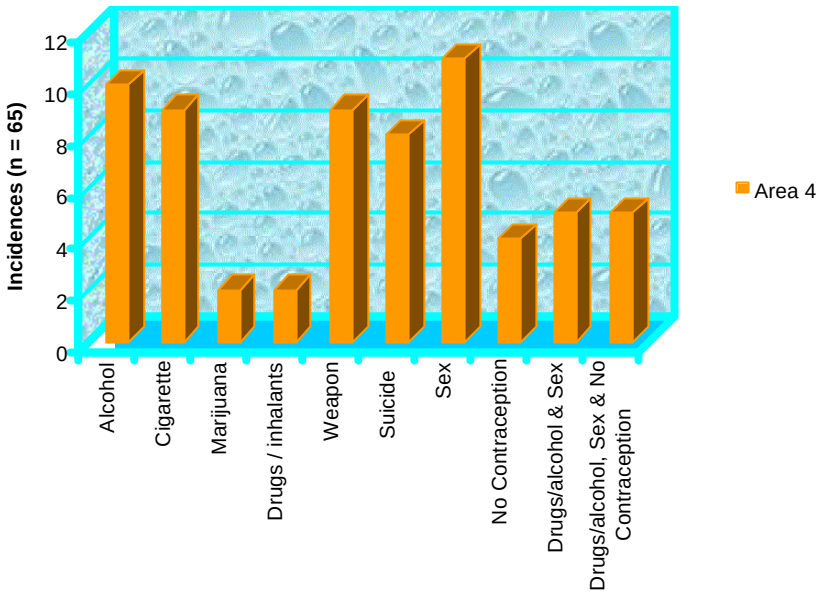
This graph illustrates that:

167. area 3 contains an occurrence of 27.6 per cent risk-taking activities.

168. the highest risk-taking behaviour occurrence (20.3 per cent) is alcohol usage.

169. the second highest risk-taking occurrences are (a) cigarette smoking and (b) drugs/inhalants or alcohol usage before sexual intercourse, i.e. 15.6 per cent.

170. the lowest occurring (nil per cent) risk-taking behaviour is drugs or inhalants.



Graph 14: Area 4 according to risk-taking activities

This graph portrays the information that:

171. area 4 contains the highest risk-taking occurrences among the four residential areas, i.e. 28 per cent.

172. the highest risk-taking occurrence (sexual intercourse) contains a percentage of 16.9 per cent.

173. the second highest risk-taking activity is alcohol usage with an occurrence of 15.4 per cent.

174. the lowest risk-taking activities are (a) marijuana usage and (b) drug/inhalant usage with an occurrence of 3.1 per cent.

7.3 DATA RELATING TO INTERVIEWS

7.3.1 Interviews with experts

Interviews were held with two experts, namely a social worker at *Stepping Stones* and a representative from the *ATTIC department at Brister House*. Significant responses were

categorised in themes according to the questions in the semi-structured questionnaire[160] that was used for the interview.

These interviews were conducted in an informal manner. The interview with the representative at Brister House was conducted over the telephone after which certain statistics[161] were faxed to the researcher. The interview with the social worker took place at the Centre, after which additional statistics[162] and other information were also supplied to the researcher.

A summary of the first interview includes themes such as:

- Adolescents' SKAV's (skills, knowledge, attitudes and values) towards:
  (a) HIV/AIDS
  (b) premarital sex
  (c) multi-partner sex
  (d) unsafe sex, and
  (e) intervention with the aim of assisting adolescents in decision-making and responsible living.
- The interviewee[163] was of the opinion that adolescents possess a nonchalant attitude toward HIV/AIDS.
- According to her they also greet the required knowledge facilitated to them by teachers, AIDS workers, and clinic nurses with indifference.
- She is of the belief that changing the adolescent's negative values into more positive ones would almost be impossible without the help of other stakeholders.
- Adolescents also need to be taught skills to assist them in decision-making and problem solving.

At the question whether she thought that if these above mentioned issues were addressed it would change the current picture, she responded positively in the affirmative.

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[160] See Addendum II.
[161] See Addendum IV.
[162] See Addendum V.
[163] For ethical reasons the name of the representative cannot be named. The researcher was only allowed to make mention of her place of employment.

The interview with the social worker was also very fruitful. The researcher was greeted with a story of "The starfish"[164]. The organisation beds its approach on the morals contained in this story. Against the wall in her office hung a framed photocopied article from a local newspaper, *The Evening Post*, dated 10 December 1999:3. The photo and the article were under the title "*PE Youth Justice Centre receives award*". The centre was awarded the *National Impumelelo Innovations Award*, which was an acknowledgement of their contribution towards the transformation of the child and youth care system in South Africa. In 1998 it was awarded the *Nelson Mandela Make a Difference Award*, and in the year 2000 it was rewarded with the *Certificate of Achievement* from the *CAPAM International Awards Programme 2000*.

A summary of this interview includes issues as to:

- why adolescents become criminals.
- what happens to them once they come into contact with the law and the justice system.
- how successful their resocialisation is.
- what society's attitude is towards them.
- what the circumstances at home and the socio-economic position are.

According to the social worker, the disorganised home life and the socio-economic disposition of the family could be viewed as the main factors contributing to the adolescent's criminal lifestyle. It is out of need that these youngsters steal, rob, break in, prostitute, and sell illegal and stolen goods. She also believed that many of the incidences of crime began with experimentation and innocent risk-taking. Because these youngsters lacked the skills to decide when to withdraw from criminal activities, or to quote her exact words, "*to call it quits*" they had already come into conflict with the law. She, like the representative at Brister House, was also of the opinion that adolescents could benefit from being taught appropriate coping skills, adopting suitable attitudes, by being receptive to valuable knowledge, and to be willing to adopt more constructive values.

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[164] See Addendum VI. This story is also available on the Internet under the same title.

She indicated that adolescents were arrested and brought to the centre for housebreaking, shoplifting, robbery, being intoxicated, being in possession of ecstasy or marijuana, running away from home, and rape.

7.3.2 Interviews with teachers at school

The researcher conducted interviews with five teachers who taught at the school of the respondents. Interviews were conducted at the school during their administration period. The responses from the informal interviews, directed by a semi-structured questionnaire[165], were also categorised in themes related to adolescent risk-taking behaviour.

A summary of the interviews with teaching staff is given:

- Adolescents treated cigarette smoking as common practice and did not see any risks involved in smoking.
- Evidence of cigarette smoking could be found in the learners' odour and by other physical signs.
- An agreement was accordingly reached that the majority of learners at school smoke cigarettes, and that they smoke on school property.
- No real agreement could be reached on marijuana usage, basically because teachers did not know which signs to look for.
- Not one of the interviewees had ever caught a learner smoking marijuana on school property.
- Only one interviewee was certain that marijuana was being used on school property, but could not substantiate this opinion.
- All the interviewees were convinced that learners were consuming alcohol, more than what is realised.
- The predominant agreement was that many female learners use alcohol.
- Reasons given why female scholars consume alcohol are:
  (a) one interviewee[166] maintained that more females were caught drinking on school property.

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[165] See Addendum III.

[166] This teacher served on the discipline committee at the school; therefore the teacher was well informed with the misbehaviour types learners engage in.

(b) an assumption was made that the female learners' boyfriends and other males, sometimes older than the girls themselves, would bribe them with alcohol for sex (This statement seems to support the indication in Table 30 that sexually active female respondents use drugs/inhalants or alcohol before sexual intercourse.[167])

- Certain learners could be identified by name as sellers of drugs, but not one interviewee was fully certain whether they used it or not.
- No learner had ever been discovered in the possession of drugs or inhalants on school property.
- Certain interviewees had their suspicions about certain learners being drug users, but they could not validate their suspicion.
- Violence was the one domain that "*wrecked all discipline at the school*" according to one interviewee.
- Some of the teachers admitted to being afraid of some learners.
- Violence at school was often observable.
- Learners either engage in physical fights with other learners, in arguments, use foul language, or fought with teachers concerning certain matters.
- The school had lost a number of learners in the past due to suicide (about two suicides per year for the last five years).
- A number of adolescents were falling pregnant thus providing evidence that there seems to be a high incidence of adolescent learners being sexually active.
- Of the interviewees were in agreement that many of the girls whom had 'seemed pregnant' would suddenly not be, and this was attributed to apparent abortion or miscarriages.
- No agreement could be reached on the question as to which domain of risk-taking behaviour was regarded as dominant at the school.
- Consensus was achieved on the leading areas of risk-taking in order of assumed incidence, i.e. cigarette smoking, alcohol consumption, violence and sexual activities.

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[167] Also see findings number 140 in this chapter.

- Agreement was reached that risk-taking prevention techniques could assist the learner in making the right choices.
- These techniques should include the teaching of appropriate skills, knowledge, attitudes and values (SKAV's).

7.4 CONCLUSION

From the findings it is clear that adolescent respondents take risks that could be harmful to their physical, emotional and future quality of life. Most of the times the reasons given for engaging in these risks would seem to the adult or those individuals that render a service to the adolescent that such reasons are invalid or subjective. However, in attempting to understand adolescent's behaviour it seems that one would have to place oneself in the shoes of the adolescent in attempting to understand their characteristic reasoning for and attitude about their risk-taking behaviours.

In the final chapter of this treatise, an attempt will be made to provide greater insight into the nature of this reasoning, attitude and decision-making, and to suggest recommendations to enable adolescents to gain insight into their risk-taking behaviour and to suggest how various stakeholders could join knowledge, experiences and skills to deal constructively with this phenomenon.

Chapter Eight

DISCUSSION OF FINDINGS

8.1 INTRODUCTION

In Chapter 7 the findings obtained during the survey were reported on. In this chapter these findings will be summarised and discussed. The most significant findings will be summarised in order to highlight the fundamental differences between certain aspects concerning the risk-taking behaviour of the target group. These summaries are sporadically furnished in the form of tables and graphs to visually illustrate the distinctions between certain findings. They will also be utilised to evaluate the hypotheses[168] formulated prior to the actual fieldwork. The findings referred to in this chapter also appear in the previous chapter under the analysis numbers indicated in the footnotes.

A discussion will follow the findings of each risk-taking domain, and reference to applicable literature will be made to substantiate these results.

8.2 DISCUSSION OF FINDINGS[169] OF THE SURVEY QUESTIONNAIRE

8.2.1 Alcohol-related behaviours

From the findings of this risk-taking domain the following summary is formulated:

- of the 88 respondents that used alcohol at one time or another, 52.3 per cent currently use alcohol.
- of the respondents that currently use alcohol, 60.9 per cent are male respondents and 39.1 per cent are female respondents.
- except for the 17 year old age cohort where there is no percentage difference between male (71.4%) and female (71.4%) respondents, all other age cohorts indicate that more male than female respondents currently use alcohol.

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[168] See paragraph 2.3 of Chapter 2.

[169] The most important findings of each risk-taking activity are noted in this section of the research. All findings relate to the findings in Chapter 7.

The abuse of alcohol by adolescents is a problem that is escalating at an alarming rate. From the data collected it is evident 46 per cent of the target population currently use alcohol, and that more male than female respondents are using it.

Reasons for this phenomenon could be derived from the (open) responses supplied by the male respondents. The majority of them use alcohol because their friends are doing it. They want to feel accepted by their peers and portray an image of being "cool" when in the company of friends who drink alcohol. Most of the respondents indicated that their friends were with them the first time they had alcohol and that they were influenced by them to drink alcoholic beverages. Many of them wanted to experience the effect it would have on them. Others as a form of punishment after losing a bet, they had to prove that they could "finish the bottle" and so escape further 'punishment'. Nearly half of the male respondents indicated that their parents played an influential part on their drinking alcohol and that they would not stop with such behaviour even if they were discovered taking alcohol. In other words, if their parents drink alcohol, then they assume they have the right to do so also.

Alcohol consumption could be triggered off by more than one aspect. The popular reason is the desire for acceptance by their peers.[170] Adolescents have an increasing need to prove their 'being with it', in the sense of participating in whatever their friends do. The early stages of alcohol drinking are characterised as being part of a group activity. Being curious about alcohol drinking is another trigger. The adolescent is generally inclined to want to investigate adult ways of behaving. Also they have a desire to satisfy their needs irrespective of whether the manner in which these needs are met entails challenges and risks with negative consequences.

Many adolescents drink alcohol because other adults at home do. This copycat behaviour is also normal among adolescents as it makes them feel "more grown-up and independent". Many parents actually allow their children to drink alcohol and some would even buy it for the adolescent. In an article in a recent magazine[171], it became evident that parents are not aware of the effect 'granting permission' has on their adolescent child, in this

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[170] Gillis H., 1994.
[171] Van Rensburg R., 2002: 14.

case buying 'cases of coolers' for her daughter's 13th birthday party' and 'teaching their child to drink responsibly'.

The majority of the female respondents surveyed in this research indicated that they enjoyed the taste of alcohol and that it made them relax. Their response concerning the taste of the wine could be supported by the fact that there are many new flavours of wine bottled in attractive containers on the market, and that the beverage tasted sweet[172] and fruity. Female adolescents are known to be more likely than male adolescents to mention that they drink alcohol to escape their problems or because they were frustrated or angry. Adolescent females were particularly susceptible to peer pressure when it comes to alcohol consumption. They are also more likely than male adolescents to consume alcohol to 'fit in with their friends'.[173]

Adolescent females often are introduced to alcohol by their boyfriends, who may be older and more likely to drink.[174] Earlier in this report the researcher made the assumption that their sexual partners bribe the female adolescents with alcohol in order to engage in sexual acts with them, or that they consume alcohol prior to the sexual act to ease the passage of the sexual act. This statement however warrants further research.

8.2.2 Drug-related behaviours

8.2.2.1 Cigarette usage

From the findings of this risk-taking domain, the following summary is formulated:

- slightly more male (84 per cent) than female (78 per cent) respondents have smoked cigarettes one time or another.
- of the 81 per cent respondents that smoked cigarettes, 38.3 per cent (i.e. 19.8 per cent female and 18.5 per cent male respondents) have continued to do so.
- the 31 respondents that currently smoke cigarettes consist of more female (51.6 per cent) than male (48.8 per cent) respondents.

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172 Baumgartner M., 2002.
171 http://www.health.org/govpubs/rpo993/
172 http://www.health.org/govpubs/rpo993/

The majority of the respondents indicated that they smoke cigarettes because their parents, other adults or their friends smoke. Responses like *"everybody at school smokes"; "I was drunk"; "it looks cool", and "I don't see anything wrong with it"* are examples of reasons given for their cigarette smoking. Basically the responses conveyed the message that there is nothing wrong with cigarette smoking and that it is not as bad as the other risk-taking activities. These respondents think it is not wrong for an adolescent to engage in this risk-taking behaviour. They also stated that they would not stop the behaviour if their parents were to discover that they smoked cigarettes. Many adolescents often engage in cigarette smoking as a way of coping with the effects of a poor relationship between them and their parents, or to cope with difficult emotional conditions such as depression and anxiety.[175] Another reason cited was that they were or are influenced by their peers.[176]

Some female respondents commented that smoking helped them to lose weight or assisted them in not gaining weight. These respondents are of the opinion that cigarette smoking subdues their craving for sweets and chocolates.

Being intoxicated is an age-old excuse given for many risky actions, but in the case of cigarette smoking there seems to be value in the statement *"I was drunk"* and therefore used tobacco whilst under the influence of alcohol. This research indicates a smoking pattern connected with a range of health compromising behaviours. Adolescents who are involved in fights, carry weapons, engage in higher-risk sexual behaviour and use alcohol and other drugs also smoked.[177] This statement does not indicate that all adolescents that smoke tobacco will necessarily indulge in these risk-taking behaviours, rather that those that do, seem more likely to smoke tobacco. However, this statement also warrants further research.

8.2.2.2 Marijuana usage

From the findings of this risk-taking domain the following summarisation is formulated:

- of the 23 respondents that had used marijuana one time or the other 43.5 per cent were female and 56.5 per cent were male.

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[175] http://serendip.brynmawr.edu/bb/neuro/neuro02/web1/bmartin.html
[176] http://www.vincenter.org/96/delener.html
[177] http://www.vincenter.org/96/delener.html

- more male respondents (80 per cent) than female respondents (20 per cent) are currently using marijuana.
- more male respondents (80 per cent) than female respondents (20 per cent) are currently using marijuana.
- the current marijuana use (70 per cent) is mostly found among the 17 year and older age cohorts.

Not many respondents (only 10 per cent) engage in marijuana usage. The main reason cited for engaging in this activity is *"to please my friends"*. Respondents who engaged in this activity at one time or the other did so to experiment with marijuana as a recreational drug. They provide reasons such as *"marijuana makes me clever"; "it helps me forget my problems"; "I smile at life when I have smoked"*, and *"it is the custom of the Rasta religion"* for using marijuana.

Reasons for not using marijuana include statements such as that *"it is expensive and illegal"; "it causes cancer"; "could get me into trouble with my parents"; "it made me smell"* and *"it leaves yellow marks on the palms of the hands"*.

8.2.2.3 Drug or inhalant usage

From the findings of this risk-taking domain the following summary is formulated:

- 43.8 per cent of these respondents, who had on occasions used drugs or inhalants, are currently still doing so.
- slightly more female 56.2 per cent) than male respondents (43.8 per cent) had used drugs or inhalants at one time or another.
- slightly more female (57.1 per cent) than male respondents (42.9 per cent) currently use drugs or inhalants.
- there is no significant difference of drug or inhalant use between male and female respondents or the various age cohorts.

On the question why they were using drugs, respondents answered that they used it as an energy-giving substance when they frequent nightclubs. When they've used drugs, especially *ecstasy* (which they refer to as 'E'), they are able to dance all night and still go

home and study. Other reasons such as drugs helping them to relax, to forget about their problems, and to lift their spirits are also given. One respondent answered that the drug put her on *"cloud nine"* and makes her feel happy.[178]

The reasons for not using drugs were very similar to the reasons given for not using marijuana. These reasons, among others, were that drugs are illegal, expensive, and dangerous, and that it makes a person appear unintelligent as it damages the brain. Adolescents who use drugs or inhalants often exhibit impulsive, irrational, and violent[179] behaviour.

8.2.3 Violence-related behaviours

8.2.3.1 Weapon usage

From the findings of this risk-taking domain the following summarisation is formulated:

- more male (71.9 per cent) than female respondents (28.1 per cent) carry a weapon of some kind.
- more male respondents (85.7 per cent) carry guns than female respondents (14.3 per cent).
- the youngest male respondent who carries a firearm is 13 years old, while the youngest female respondent who does so is 16 years old.
- the 13 year age cohort has the lowest percentage (9.4 per cent) of respondents who carry weapons.
- the 14 to 16 age cohorts, and the 18 and older age cohorts, are more likely than the other age cohorts to carry weapons
- the majority of the respondents who carry guns are 16 and older (78.6 per cent) while the other gun carrying respondents are younger than 16 years of age (21.4 per cent)

The reactions of the specific respondents were that they wear weapons to protect themselves in case they got into a fight either on their way to school or at school. Many of the respondents who carry weapons reside in environments in which the adolescent is

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[178] Smith J., 1995.
[179] Bender D. L. *et al*., 1992.

constantly exposed to violent behaviour. According to the social learning theory the family and the social environment teach adolescents to use violence to solve problems[180]. Most of the respondents who carry weapons also use alcohol, cigarettes, drugs or inhalants.

The respondents who did not wear weapons indicated that they do not believe in violence, or they fear being robbed of and hurt by their own weapons.

8.2.3.2 Suicide behaviour

From the findings of this risk-taking domain, the following summary is formulated:

- 22 per cent of the total respondent group has attempted suicide
- more female (72.7 per cent) than male respondents (27.3 per cent) had attempted suicide
- the age cohort 18 years and older contains the highest percentage of respondents that attempted suicide, i.e. 27.3 per cent
- more respondents of older age cohorts (16 years to 18 years and older) attempted suicide than younger age cohorts (13 years to 15 years), i.e. 63.6 : 36.4 per cent

Possible reasons why more females attempted suicide than males could be derived from the fact that adolescent females tend to be overly concerned about trivial matters like body weight; inability to lose weight; physical appearance; their state of happiness, and being unsuccessful in 'portraying of a good image'[181]. The responses to the open question of why they (female respondents) who attempted suicide also resonate this state of affairs, with a general sense of unhappiness with their own appearance. Examples of their responses are: *"I'm fat"* or *"I do not have a good body"*. Many of them feel ugly or do not have trendy clothes to wear when they go out. Many female respondents indicated that they are generally unhappy at home or specifically that they have attempted suicide because they do not get along with their parents (mostly the mother) or other siblings, and because *"nobody likes me"*.

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[180] Bender D. *et al*., 1992.
[181] Thatcher W.G. *et al*., 2002.

Male respondents however were not as overly concerned about their self-image or their physical appearance. They were inclined to mention the following contributory reasons for their attempted suicide: being in trouble with the law or their parents; after doing something that they should not have done, and because they fear their parents (mostly the father). Some of the respondents, who have attempted suicide, display no interest in life and harvest a sense of hopelessness about their present conditions as well as their future, especially regarding future employment. It is generally expected that changes in the economic welfare of youth - the gap between the economic aspiration and reality - lead to increased adolescent stress and consequent violent behaviour, including suicide[182].

The respondents who did not attempt suicide spoke of the fear of death, and indicated that they had no desire to die at such a young age, but to live and enjoy life.

8.2.4 Sexually related behaviours

8.2.4.1 Sexual activity

From the findings of this risk-taking domain the following summary is formulated:

- of the sexually active respondents, more male (64.5 per cent) than female respondents (35.5 per cent) are sexually active
- of the respondents who on occasions had sexual intercourse, more female (78.6 per cent) than male respondents (71.4) are currently sexually active.
- more respondents of the older age cohorts (16 to 18 years and older) are sexually active than respondents of the younger age cohorts (13 to 15 years), i.e. 74.2 : 25.8 per cent respectively.

For the majority of the sexually active respondents, sexual activities started out as experimentation, to *"see what it is like"* or to be able *"to say I have also done it"*. Other responses included *"to prove I am a man"; "to prove I can do it"; "girls like it"; "they (girls?) want to have sex"; "to relieve me of my stress*", and the age-old classic *"everybody is doing it"*.

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[182] Berman A.L. & Jobes D.A., 1992.

Nearly every sexually active female respondent thinks that her partner loves her and by having sex with her is his way of showing his love.[183] Many of them also responded that they only have one sexual partner. The majority of the respondents did not think it is wrong for an adolescent to have sexual intercourse, *"as long as they loved one another"*. Some even had the hope that they would fall pregnant and that their boyfriends would marry them.

The respondents indicated several different reasons or conditions for having sexual intercourse. More than 50 per cent indicated that love and trust for the sexual partner are significant reasons for having sex. Some also cited the following as reasons for having sexual intercourse*: "a beautiful woman or attractive man"; "a nice body"; "a willing partner"* and *"every time the opportunity is there"*. Factors that would seem to play a role in preventing sexual relations or risk-taking sexual behaviour such as *'developing non-sexual relationship ties'* and *'first getting to know the partner's sexual history'* did not play a major role in the respondents choice not to have sex. Nearly 30 per cent of the male respondents indicated that having a "*one night stand"* is acceptable, while a few indicated they would engage in sexual activity for no reason at all.

Of the respondents who were not sexually active, several declared their desire to "save themselves for their future marriage partners". A small percentage indicated that sex before marriage is a sin and that they would be punished if they engaged in any sexual activity. A few others do not want to take the risk of contacting HIV/AIDS, nor acquire a bad reputation. A few stated that they do not want an unwanted pregnancy, as it would interfere with their current schooling and that if they should fall pregnant, they would not be able to complete their schooling. This would also have negative consequences for their future employment or prevent them from gaining a tertiary qualification.

The main source of the respondents' information concerning sexual behaviour and HIV/AIDS is the peer group. The majority indicated that they would rather seek guidance from a friend over the guidance of their parents, pastors or teachers. However, literature regarding information about sex indicates that information that adolescents obtain from their friends is not always correct, and that it may include long-standing myths about fertility, relationships and sexual activities. This information, whether correct or false, serves to guide

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[183] Moore S. & Rosenthal D., 1993.

the adolescent's decision-making about sex, and there is a tendency to rather accept the attitudes of their peers regarding sex than any other socialisation agent.[184]

A small number of church-attending respondents indicated that they are also sexually active. Where church involvement appears to contribute to a "more restrictive attitude concerning premarital sex and less sexual experience"[185], there is however no assurance that church-attending adolescents will not become sexually active.

8.2.4.2 Contraceptive behaviour

From the findings of this risk-taking domain the following summarisation is formulated:

- 31 per cent of the total respondent group is sexually active.
- 51.6 per cent (16 respondents) of the sexually active respondents use contraceptives, while 48.4 per cent (15 respondents) do not use contraceptives.
- more sexually active male (38.7 per cent) than sexually active female (12.9 per cent) respondents use contraceptives.
- slightly more sexually active male (25.8 per cent) than sexually active female (22.6 per cent) respondents do not use contraceptives.
- 43.8 per cent of the sexually active male respondents that use contraceptives do not use condoms regularly.
- 37.5 per cent of the sexually active respondents in the 13 to 15 years age cohorts use contraceptives.
- 56.5 per cent of the sexually active respondents in the 16 to 18 years and older age cohorts use contraceptives.
- 64.3 per cent of the sexually active male respondents in the 16 to 18 and older years age cohorts use condoms (33.3 % regularly and 66.7% irregularly).

The increased sexual activity among adolescents has led to concerns about adolescent females' heightened risk of unwanted pregnancies, the risk of contacting transmissible diseases (STDs), and/or HIV/AIDS[186]. It is logical to expect, in the light of these threats to

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[184] Moore S. & Rosenthal D., 1993.
[185] http://www.geocities.com/pastorbuhro/sermons/report.htm
[186] Moore S. & Rosenthal D., 1993.

adolescents' well-being and sexual health, that young people would have adopted contraceptive methods – in particularly the use of condoms – with great readiness. With the results shown in Table 30 there is evidence that many of these adolescent respondents were ignoring sexual health messages and warnings, thereby increasing the negative consequences of their risk-taking behaviour on their general well-being or quality of life.

According to Moore and Rosenthal (1993), the percentage of sexually active adolescents who do not use contraceptives, is higher for males than females, as well as for older than younger adolescents. However this research found that the figures for sexually active male and female respondents who do not use contraceptives are nearly equal. The comparison between younger and older females seemed to be in line with other research findings.

Whilst not participating in sexual activity would prevent risk-taking behaviour, the use of condoms during sexual intercourse would lessen risk-taking behaviour. However, only twenty-five per cent of the male respondents that are sexually active use condoms, while seventy-five percent either use these irregularly or not at all. This indicates that more sexually active male respondents participate in risk-taking behaviour.

The erratic use of contraception was to an extent clarified by the (open) responses gained from the female respondents such as their fear that their sexual partners might think that they are prepared for casual sex; their fear that a negative reputation might be attached to their names; that visiting a family planning clinic may increase the risk of being seen by others who knew them, and their fear that their parents might find out that they are sexually active.

The sexually active male respondents who are not using condoms justify their behaviour with statements such as *"not taking showers in raincoats"; "not eating a sweet with its paper"; "flesh to flesh is the best", and "it is messy"*. These statements portray no consideration for the female partner and her future, and a prejudiced indication that condoms interfere with their enjoyment of sex. This is also an indication of risk-taking behaviour with major consequences for others rather for the self.

Among those respondents for whom contraception is perceived as an option to decrease risk-taking behaviour, attitudes vary. For some respondents using contraception, it

is inconsistent with a view that sex is, or should be, spontaneous and unpremeditated. For a number of the respondents sexual intercourse is or should be an unplanned and an "on the spur of the moment" decision or activity and even if they do use a contraceptive, they would rather prefer not to do so.

8.2.4.3 Drugs/inhalants, alcohol and contraceptive use with sexual intercourse

From the findings of this risk-taking domain the following summary is formulated:

- 77.4 per cent of the sexually active respondents either use drugs/inhalants or alcohol before engaging in the sexual activity.
- 45.2 per cent of these sexually active respondents use drugs/inhalants or alcohol before sex, and they do not use contraceptives.
- 75 per cent of respondents of the older age cohorts (16 to 18 years and older) use drugs/inhalants or alcohol before sexual intercourse, while
- 25 per cent of the respondents who use alcohol or drugs/inhalants before sex, belong to the younger age cohorts, 13 to 15 years.
- more respondents (71.4 per cent) in the older age cohorts (16 to 18 years and older) use drugs/inhalants or alcohol before sex, and they do not use contraceptives.
- of the respondents that use drugs/inhalants or alcohol before sex and without using contraceptives belong to the younger age cohorts (13 to 15 years).
- more male (41.9 per cent) than female (35.5) of the sexually active respondents use drugs/inhalants or alcohol before sexual intercourse.
- more male (25.8 per cent) than female (19.4 per cent) of the sexually active respondents use drugs or alcohol before sex, and do not use contraceptives.

Nearly half the sexually active respondents that do not use contraceptives use drugs/inhalants or alcohol before sex. This group is labelled as the 'risk-and-be-damned'.[187] All sexually active female respondents use drugs/inhalants or alcohol prior to sexual intercourse. Adolescent females who consume alcohol are twice as likely to have sex as those who do not. Nearly four in ten sexually active adolescents who use alcohol have had

[187] Moore S. & Rosenthal D., 1993:130.

sexual intercourse with four or more individuals.[188] This means that the female respondents who drink alcohol could also be labelled as 'risk-and-be-damned". Such behaviours would thus increase the negative consequences of risk-taking behaviours considerably.

8.3 SUMMARY OF QUANTITATIVE FINDINGS

Based on the main findings of the study thus far, the most prominent issues in view of the general research objective are supplied in the form of a summary table.

Objective	Field	Current Incidences	%
General Objective: To determine which risk-taking behaviours adolescent learners at a Port Elizabeth high school engage in.	Alcohol use	46	19.8
	Cigarette smoking	31	13.4
	Marijuana use	10	4.3
	Drug/inhalant use	7	3
	Weapon use	32	13.8
	Suicide attempts	22	9.5
	Sexual activities	31	13.4
	Non-contraceptive use	15	6.5
	Drugs/inhalants or alcohol before sex	24	10.3
	Drugs/inhalants or alcohol before sex and no contraceptives	14	6
	Total	**232**	**100**

Table 33: Findings linked to the general objective

From the contents of this table, the risk-taking activities can be arranged in descending order:

i. Alcohol use
ii. Weapon use
iii. (a) Cigarette smoking and (b) Sexual activities
iv. Drugs/inhalants or alcohol before sex

[188] http://www.cspinet.org/booze/alcyouth.html

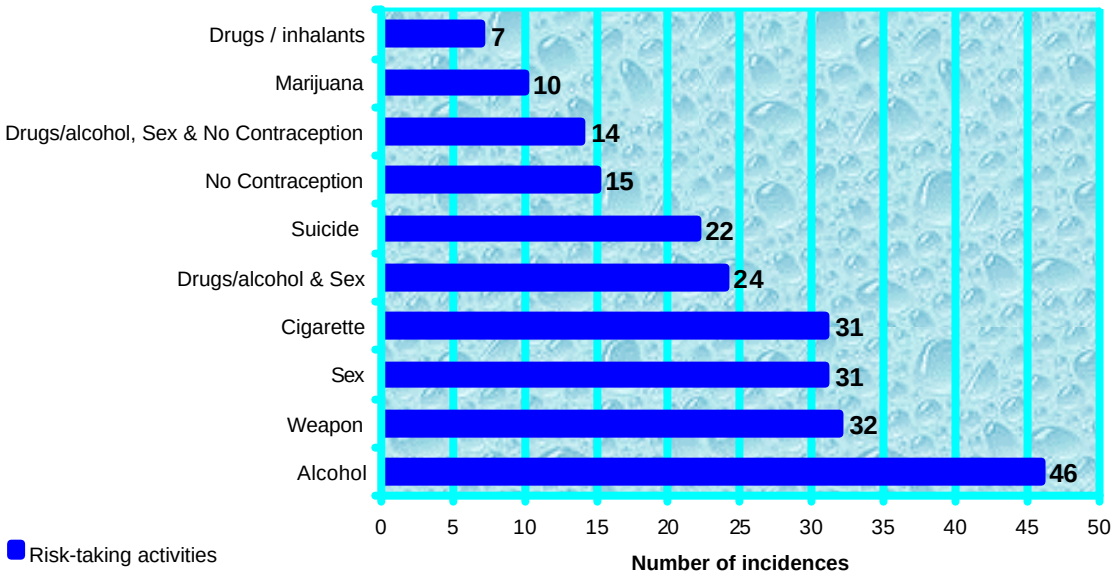
v. Suicide attempts

vi. Non-use of contraceptives

vii. Drugs/inhalants or alcohol before sex and no contraceptives

viii. Marijuana use

ix. Drug/inhalant use



Graph 15: Risk-taking activities in descending order

The graph above illustrates that:

- The most significant risk-taking activities the target group engage in are alcohol use (19.8 per cent), weapon use (13.8 per cent), sex and cigarette smoking (13.4 per cent each), drugs/inhalants or alcohol before sex (10.3 per cent), and suicide attempts (9.5 per cent).
- The least significant risk-taking activities the target group engage in are drug/inhalant use (3 per cent), marijuana use (4.3 per cent), drugs/inhalants or alcohol before unprotected sexual intercourse (6 per cent), and the non-use of contraceptives (6.5 per cent).

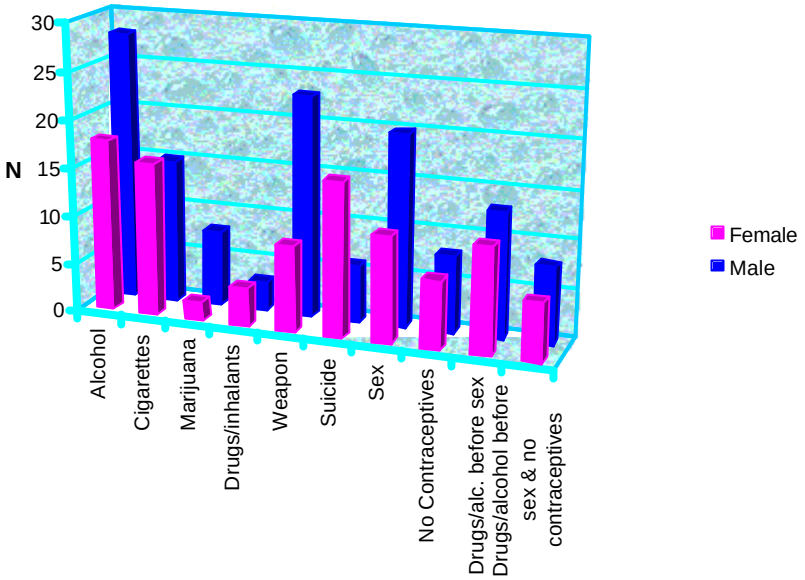
8.4 TESTING OF THE HYPOTHESES

Sufficient findings prove that adolescent learners at the specific high school in Port Elizabeth do engage in risk-taking behaviour. Certain hypotheses, which were formulated before this research was conducted, will now be evaluated.

8.4.1 Hypothesis 1: *More male than female respondents engage in risk-taking behaviours.*

Female N = 50	Risk-taking behaviour category	Male N = 50
18	Alcohol	28
16	Cigarettes	15
2	Marijuana	8
4	Drugs/inhalants	3
9	Weapon	23
16	Suicide	6
11	Sex	20
7	No Contraceptives	8
11	Drugs/alcohol before sex	13
6	Drugs/alcohol before sex & no contraceptives	8
100	**TOTAL: 232**	**132**

Table 34: `Risk-taking category and gender`



Graph 16: Risk-taking categories according to gender

Hypothesis 1 can be accepted in the case of this respondent group, as is substantiated by Table 34 and Graph 16, which state that:

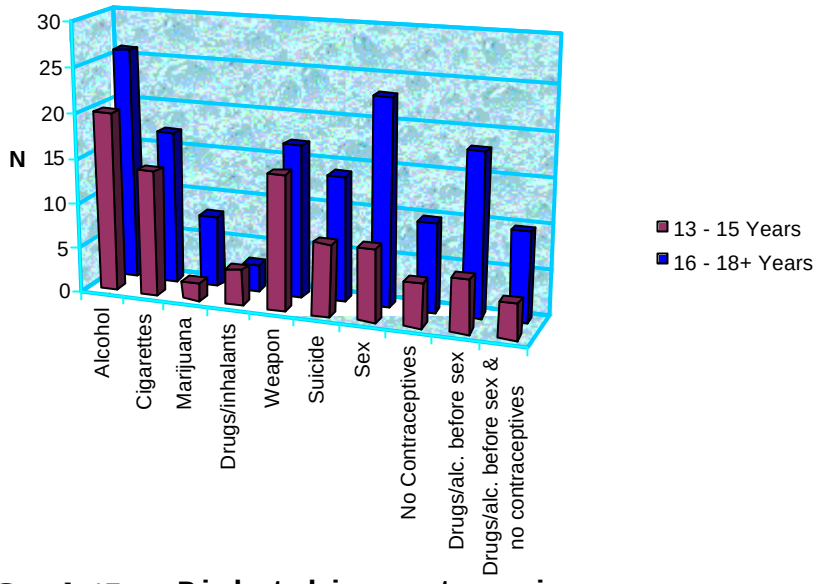
- the male respondents are responsible for the higher percentage (56.9 per cent) of risk-taking incidences than the female respondents (43.1 per cent).
- in seven out of the ten categories of risk-taking the percentages are higher for male than female respondent involvement.
- male involvement dominates in the categories:
  - alcohol -, marijuana -, and weapon usage,
  - sexual behaviour, including the non-use of contraceptives, and drug-use before sex,
  - drug-use and the non-use of contraceptives combined.
- in these above-mentioned categories the involvement between male and female respondents is 62.8 : 37.2 per cent.
- the female dominance in three categories, i.e. cigarette -, drug usage, and suicide behaviour calculates to female 60 and male 40 per cent.
- in Graph 16 the three dominant categories of risk-taking behaviour are alcohol usage (12.1 per cent), weapon use (9.9 per cent), and sexual behaviour (8.6 per cent).

- these three dominant risk-taking categories appear among the male respondents.
- the three dominant risk-taking categories among female respondents are alcohol use (7.8 per cent), cigarette smoking 6.9 per cent), and suicide attempts (6.9 per cent).

8.4.2 Hypothesis 2: *Younger (13 – 15 years old) respondents reveal less risk-taking behaviours than older (16 – 18 years and older) respondents.*

Younger Adolescents Age: 13 -15	Risk-taking behaviour category	Older Adolescents Age: 16-18+
20	Alcohol	26
14	Cigarettes	17
2	Marijuana	8
4	Drugs/inhalants	3
15	Weapon	17
8	Suicide	14
8	Sex	23
5	No Contraceptives	10
6	Drugs/alcohol before sex	18
4	Drugs/alcohol before sex & no contraceptives	10
86	**TOTAL: 232**	**146**

Table 35: `Risk-taking behaviour category according to age`



Graph 17: Risk-taking categories according to age cohorts

Hypothesis 2 can be accepted, as is substantiated by Table 35 and Graph 17, which state that:

- respondents from the older age groups (16 to 18+ years) indicate a higher involvement in risk-taking behaviour than respondents in the younger age cohorts (13 – 15 years), i.e. 62.9 : 37.1 per cent.
- in nine out of the ten categories of risk-taking, the percentages are higher for the older age cohorts (61.7 per cent) than the younger age cohorts (35.3 per cent), with
- the only category of dominance for the younger over the older age cohorts being the area of drug or inhalant usage, i.e. 1.7 : 1.3 per cent.
- in Graph 10 the three dominant categories of risk-taking behaviour are alcohol usage, sexual behaviour, and drug or alcohol use before sex (appearing among the older age cohorts), i.e. 11.2 : 9.9 : 7.8 per cent.

8.4.3 Hypothesis 3: ***Respondents from less affluent residential areas engage in more risk-taking behaviours than respondents from more affluent residential areas.***

Hypothesis 3 can be accepted as it is substantiated by the contents of Table 32 and Graph 10 (see Chapter 7) which state that:

- the correlation of the area and risk-taking category, ranked from highest to lowest, has the following picture:
- Area 3: 28.5 per cent
- Area 4: 28 per cent
- Area 2: 27.6 per cent
- Area 1: 16.8 per cent
- the dominant risk-taking categories are alcohol (6 per cent in area 2), alcohol again (5.6 per cent in area 3) and sexual behaviour (4.7 per cent in area 4).
- the lowest (0 per cent) risk-taking category is drugs or inhalant usage in area 3.

It is therefore evident in the case of this respondent group that adolescents from *less affluent residential areas* display behaviour with higher risks than adolescents from areas that are categorised as more affluent.

8.5 RECOMMENDATIONS

Although this research endeavour is an attempt to explore adolescent risk-taking behaviour within the confines of a group dynamics perspective, this has not been done in the 'traditional sense of the word'. This research has rather been an attempt to provide an understanding of the *nature of adolescent risk-taking behaviour*, and more specifically to explore the *type* of risk-taking behaviours that are *characteristic in the school* in which respondents are taught. Also, to explore the possible *factors and conditions* that would include group dynamic factors and/or conditions contributing to risk-taking behaviour characteristic of adolescents in the particular school. This enabled the researcher to explore the presence of peer, environmental and other group dynamic influences on the adolescent's decision to participate in risk-taking behaviour.

There is sufficient evidence in this research endeavour, as well as from past research on adolescent risk-taking behaviour (as indicated in the various chapters in this treatise) to

substantiate that group dynamics factors and conditions such as peer pressure, parent-adolescent relationship, attitudes about the self, social comparison between the self and others, nature of the community environment, and other factors play an important contributory role in why adolescents participate in risk-taking behaviours.

In considering the approach to a study of risk-taking behaviour, the researcher could perhaps have isolated a specific group as a *case* to study. In attempting to isolate such a group, a number of methodological problems would have been created for the researcher. Besides this, it would have only provided information pertaining to the case under study. However, *there is a need for an understanding of how group interaction promotes, maintains or prevents risk-taking behaviour, while also enabling insight into how various group environments promote, maintain or prevent risk-taking behaviour among adolescents.* It was from this group dynamics perspective that the researcher undertook her study and now attempts recommendations to put into practice both group dynamics and sociological insights to assist the particular school as well as important stakeholders in the community to deal constructively with the issue of adolescent risk-taking behaviour.

The researcher therefore proposes the following recommendations:

8.5.1 that *similar research be conducted* in schools in the Nelson Mandela Metropolitan area (also see 8.6.5) or if sufficient funds are available, in schools in the Eastern Cape School Circuit according to a methodologically approved sample in order to:

- ascertain the nature of risk-taking behaviour of adolescents.
- ascertain the nature of risk-taking behaviour characteristic of adolescents within individual schools.
- compare risk-taking behaviour of adolescents within these schools.
- design a holistic programme of risk-taking intervention and prevention.

8.5.2 that besides attempting to have her *findings published in a scientific journal,* organise a w*orkshop for the staff at the school* in order to:

- present her findings.
- petition their collaboration and motivation.

- formulate a strategic plan to decrease risk-taking in adolescent behaviour in the school.
- suggest appropriate content for an intervention programme to deal with the holistic nature and consequences of current risk-taking adolescent behaviour.
- suggest appropriate content for a prevention programme to actively illuminate future risk-taking adolescent behaviour.
- lay the foundation for an *Adolescent Risk-taking Committee* [ARC] (see 8.6.3), *Adolescent Risk-taking Intervention or Prevention Teams* [ARIP Teams] (see 8.6.4), and *Peer Support Groups* (see 8.6.8).

8.5.3 that an *Adolescent Risk-taking Committee* (ARC) be established with the possible aims of:

- bringing together important stakeholder representatives (i.e. those government and non-government organisations rendering a service to the adolescent; teaching staff; parents and adolescent learners) that are motivated to assist adolescents in their risk-taking behaviour
- initiating future research
- establishing *ARIP Teams* and undertaking the training of individuals (*ARIP Team* members) that will be tasked with presenting either intervention and/or prevention programmes in the various schools (see 8.6.4)
- assisting in the creating of *Peer Support Groups* to assist ARIP Teams in their endeavours as well as fulfilling an important peer support function
- designing risk-taking intervention and prevention programmes
- educating teaching staff, parents and the general population in the nature and consequences of risk-taking behaviour of adolescents
- fund-raising to equip *ARIP Teams* tasked with implementing intervention and/or prevention programmes with the necessary apparatus, appropriate knowledge base, and relevant skills in presenting such programmes
- liaising specifically with appropriate government departments (e.g. education, health, and others) to elicit their assistance in reducing adolescent risk-taking behaviour,

and/or organisations dealing with youth at risk that have broken the Law (e.g. *Stepping Stones*, Port Elizabeth)

- initiating impact research to ascertain the success of the intervention and/or prevention programmes that have been implemented from time to time.

8.5.4 that an initial *ARIP Team* (also see 8.6.6) be established within the school that participated in this research, in order to:

- present an intervention and prevention programme for adolescents of the school
- act as a structure within the school to whom defaulting scholars (e.g. those scholars that carry weapons to school; smoke on the school premises; have been identified as substance users, etc.) can be assigned to assist them in not engaging in risk-taking behaviour and to solicit their participation in helping their peers.
- create various *Peer Support Groups* and train these adolescent members to assist their peers in choosing not to engage in risk-taking behaviours.
- periodically assess the impact of both the *ARIP Team* and *Peer Support Groups* and to suggest and implement recommendations to assure a continuous level of quality input and outcome.
- make themselves available to other schools that may follow suite to assist them in creating and maintaining their own *ARIP Team* and *Peer Support Groups.*
- gain recognition and collaboration from relevant government and non-government organisations for their contribution to assisting adolescents in their risk-taking behaviour, and/or in preventing and/or eliminating such behaviours.

8.5.5 that where *research on adolescent risk-taking behaviour in other schools* is conducted and where valid and reliable conclusions indicate the presence of risk-taking behaviour among adolescents, *ARIP Teams* and *Peer Support Groups* be established.

8.5.6 that the programme of intervention and/or prevention, whether for the school that has been the focus of this study, or for any other school, should only be *implemented by those stakeholder-representative presenters* (i.e. the *ARIP Teams*) that:

- have engaged with each other in the design of such a programme of intervention and/or prevention as a team.
- have obtained specialised training in the presentation of intervention and/or prevention programmes and that have been accessed as being competent to present such programmes.
- have developed themselves into a team with a clear purpose, objectives and competence base prior to their implementing the programme for a specific school.
- are willing to commit themselves to developing and maintaining a long-standing relationship with adolescents at risk.
- not only consist of those individuals that represent the various organizations that render a service to the adolescent, but also consist of selected learner representatives from the school (current research target school) or schools (future targeted schools) to encourage a socially-engaged approach to intervention and/or prevention of risk-taking behaviour among adolescents.

8.5.7 that the nature of each programme of intervention and prevention should be based primarily on the type and nature of adolescent risk-taking behaviour characteristic of each individual school and on the needs of adolescents that attend the school in an attempt to prevent that programmes are designed with a generalised focus.[189]

8.5.8 that adolescent peers, especially rehabilitated adolescents, are trained and assisted by the *ARIP Teams* to establish, develop and administrate *Peer Support Groups* in schools in collaboration with the staff of the school, parent members of the governing

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[189] Such programmes should not be confused with Life Skills programmes. Intervention programmes dealing with adolescent risk-taking behaviour are developed bearing the type and nature of risk-taking behaviour of the adolescent in a particular school in mind, as well as the needs expressed by such adolescents, while prevention programmes are mainly aimed at the learner population that has not yet reached adolescents, or aimed at preventing risk-taking contamination taking place in those schools such as the one that was the focus of this research endeavour.

body of the school, and members of the learner representative council. *Peer Support Groups* would provide an important supportive function within schools and perform a constructive role as primary socialisation agent.

8.5.9 that it would not be the aim of the *ARC* or the *ARIP Teams* to re-invent the wheel, or to replace existing structures, but to ensure that a socially-engaged approach is developed between relevant stakeholders to deal constructively with adolescent risk-taking behaviour.

Two scenarios thus exist:

- The creation and development of a new structure (*ARC*) with related substructures (*ARIP Teams* and *Peer Support Groups*) to deal with adolescent risk-taking behaviour in schools.
- The expansion or refinement of existing structures to ensure that intervention and/or prevention programmes for adolescents at risk are designed that are based on relevant research outcomes regarding risk-taking behaviour of learners in schools in South Africa, as well as on the needs of these learners, while giving thought to insights gained from group dynamics.

8.6 CONCLUSION

All three hypotheses tested are ***accepted***. The researcher, however, cannot make the assumption that these findings apply to the entire population of adolescents at the school in which the research was undertaken. For this, it would have been methodologically sound to include the total learner population. However, these findings are consistent with various research findings gained from literature study as indicated in the relevant sections of this treatise.

BIBLIOGRAPHY

1. Ajzen I. & Fishbein M., 1980. **Understanding Attitudes and Predicting Social Behavior.** New Jersey: Prentice-Hall, Inc.

2. Allen-Meares P., 1989. **Adolescent Sexuality**. New York: Haworth Press Inc.

3. Allen-Meares P., 1995. **Social Work with Children and Adolescents.** New York: Longman Publishers.

4. Bailey K., 1982. **Methods of Social Research.** New York: Macmillan Publishing Co. Inc.

5. Baumgartner M. **Starter Drinks? Sweet Booze Attracts Teens, Says Group** http://abcnews.go.com/sections/business/DailyNews/alcohol_pop_010509.html

6. Bender D.L. et al, 1992. **Youth Violence.** San Diego, USA: Greenhaven Press, Inc.

7. Berman A.L & Jobes D.A: 1992. **Adolescent Suicide Assessment and Intervention.** Washington, D.C: American Psychological Association.

8. Blos P., 1962. **On Adolescence.** New York: Free Press.

9. Blumer H., 1969. **Symbolic interactionism: Perspective and method.** Englewood Cliffs, NJ: Prentice Hall.

10. Bornman E., 1999. **Self-image and Ethnic Identification in South Africa.** Journal of Social Psychology, 1999. Volume 139: 411 – 425.

11. Brendtro L.K., Brokenleg M., Van Bockern S., 1990. **Reclaiming Youth at Risk: Our Hope for the Future.** Indiana: National Educational Service.

12. Buhro B., **True love waits:** http://www.geocities.com/pastorbuhro/sermons/report.htm

13. Cooley C. H. 1902. **Human nature and the social order**. New York: Scribner.

14. Cooper M.L., Powers A.M., Shapiro C.M., 1998. **Motivations for sex and risky sexual behavior among adolescents and young adults: A functional perspective.** Journal of Personality and Social Psychology. Volume 75 (6): 1528 – 1558.

15. Corey, G., 1982. **Theory and Practice of Counseling and Psychotherapy**. California: Wadsworth, Inc.

16. Daniels V and Horowitz L.J, **Being & Caring**, 1984. California: Mayfield Publishing Company.

17. DiPaolo M., 1999. **The Impact of Multiple Childhood Trauma on Homeless Runaway Adolescents.** New York: Garland Publishing, Inc.

18. Dooley D., 1995. **Social Research Methods.** New Jersey: Prentice-Hall, Inc.

19. Du Toit B.M, 1991. **Cannabis, Alcohol, and the South African Student.** Ohio: Ohio University Press.

20. Elkind D., 1974. **Children and Adolescents.** Oxford: Oxford University Press, Inc.

21. Elliott D.S. & Morse B.J., 1989. **Delinquency and drug use as risk factors in teenage sexual activity.** Youth & Society – a quarterly journal, September 1989. Volume 21, number 1: 32 – 60. Sage Publications, Inc.

22. Erikson E., 1968. **Identity: Youth and crisis.** New York: Norton.

23. Freedman D.S., & Thornton A.T., 1990. **The Consumption aspirations of Adolescents.** Youth & Society – a quarterly journal, March 1990. Volume 21, number 3: 259 – 281. Sage Publications, Inc.

24. Gardiner J., & Gardiner H., 1990. **Satanisme: Suid-Afrika se Jeug in Versoeking**. Cape Town: Struikhof.

25. Gillis H., 1994. **Counselling Young People.** South Africa: Lynn Publications.

26. Gumede MV, 1995. **Alcohol Use and Abuse in South Africa – A Socio-Medical Problem - Youth and Alcohol.** Pietermaritzburg, SA: Reach Out Publishers.

27. Heimer K., & Matsueda R.L., 1994. **Role-taking, Role Commitment, and Delinquency: A theory of differential social control.** American Sociological Review, June 1994. Volume 59, Number 3: 365 - 390.

28. Hendricks B., 1985. **Education for the Transformation in an Apartheid Society.** Mount Oliver Review, Summer 1985. Volume 1, number 2: 46 – 53.

29. Homans G.C., 1950. **The Human Group.** New York: Harcourt, Brace.

30. Hovelmeier K., 1989. **Common Sense and Your Teenager.** The Penrose Press.

31. Internet Articles:

a) http://www.cspinet.org/booze/alcyouth.html
b) http://www.penpages.psu.edu/penpages_reference/28507/2850
c) http://web17.epnet.com/citation.asp?tb=1&_ug=dbs1&rn=1
d) http://web17.epnet.com/citation.asp?tb=1
e) http://www.ianr.unl.edu/pubs/family/g1322.htm
f) http://www.tipsonteens.org/topics/risktaking.html
f) http://www.britannica.com/eb/article?eu=115598&tocid=12712
g) http://ericae.net/pare/getvn.asp?v=5&n=11
h) http://ReCAPPTheories&ApproachesSocialLearningTheory'sMajorConcepts.htm
i) http://sol.brunel.ac.uk/~jarvis/bola/motivation/masmodel.html
j) http://www.nova.edu/~gibson/wk3notes.html
k) http://www.ed.gov/databases/ERIC_Digests/ed429053.html
l) http://www.geocities.com/keikoden/KTaylor.htm
m) http://www.ianr.unl.edu/pubs/family/g1322.htm.
n) http://www.cdipage.com/teens_stages.shtml#adolescence
o) http://www.focusas.com/SubstanceAbuse.html
p) http://www.etr.org/recapp/theories/index.htm
q) http://ohioline.osu.edu/flm02/FS14.html
r) http://www.vincenter.org/96/delener.html
s) http://www.prevlink.prg/getthefacts/facts/inhalants.html
t) http:www.prevlink.org/getthefacts/facts/heroin.html
u) http:www.prevlink.org/getthefacts/facts/cocaine.html
v) http://www.prevlink.org/getthefacts/facts/ecstasy.html
w) http://www.prevlink.org/getthefacts/facts/tobacco.html
x) http://serendip.brynmawr.edu/bb/neuro/neuro02/web1/bmartin.html
y) http://www.focusas.com/Tobacco.html
z) http://www.prevlink.org/getthefacts/facts/marijuana.html
aa) http://www.prevlink.org/getthefacts/facts/alcohol.html
bb) http://www3.cnn.com/HEALTH/9801/14/alcohol.warning/

cc) http://abcnews.go.com/sections/business/DailyNews/alcohol_pop_010509.html

dd) http://www.focusas.com/Alcohol.html

ee) http://www.health.org/govpubs/rpo993/#

ff) http://www.health.org/govpubs/rpo993/#res20

gg) http://www.health.org/govpubs/rpo993/#res8

hh) http://ohioline.osu.edu/flm02/FS14.html

ii) http://www.focusas.com/WarningSigns.html

32. Johnson D.S., 1991. **Creative Rebellion**, Mystic Garden Press, Crestone, CO, USA.

33. Joint United Nations Program on HIV/AIDS: **South Africa HIV/AIDS Statistics.** http://www.avert.org/safricastats.htm

34. Kvale S., 1996. **InterViews: An Introduction to Qualitative Research Interviewing.** California, USA: SAGE Publications, Inc.

35. Lindsay J. & Rodine S., 1989. **Teen Pregnancy Challenge: Book One.** California: Morning Glory Press Inc.

36. Lindsay J. & Rodine S., 1989. **Teen Pregnancy Challenge: Book Two.** California: Morning Glory Press Inc.

37. Lingren H.G., 1997. **High Risk Youth**, G97-1322-A: http://www.ianr.unl.edu/pubs/family/g1322.htm

38. Louw D.A. *et al*, 1984. **Menslike Ontwikkeling.** Koedoespoort, SA: Sigma Press.

39. Maartens M. & Maartens N., 1994. **So werk 'n Tiener se Ratwerk.** Vereeniging, South Africa: Christian Publishing Company.

40. Magazines and Newspapers:

a. Coetzee Carol, **You Magazine**, 31 October 2002: 15.

b. **The Herald**, 26 July 2002.

c. **The Herald**, 4 September 2002.

d. Van Rensburg Richard, **You Magazine**, 12 December 2002: 14.

41. Malekoff A., 1997. **Group Work with Adolescents.** New York: The Guilford Press.

42. Mann P.H., 1976. **Methods of Sociological Enquiry.** London: Billing & Sons Ltd.

43. Margow R., 1990. **SEX: What to tell Children.** Cape Town, SA: Oxford University Press.

44. Margow R., 1993. **Wat wil jy weet? 'n Boek vir Suid-Afrikaanse Tieners.** Cape Town, SA: Oxford University Press.

45. Maslow A.H., 1970. **Motivation and Personality.** New York: Harper & Row Publishers, Inc.

46. Mead G.H., 1934. **Mind, Self, and Society: From the standpoint of a social behaviorist.** Chicago: University of Chicago Press.

47. Moore S. & Rosenthal D., 1993. **Sexuality in Adolescence.** London: Routledge.

48. Muuss R.E., 1988. **Theories of adolescence**. New York: McGraw-Hill.

49. Owens T.J., 1994. **Two Dimensions of Self-esteem: Reciprocal effects of positive self-worth and self-deprecation on Adolescent problems.** American Sociological Review, June 1994. Volume 59, Number 3: 391 – 407.

50. Ponton L.E., 1998. **The Romance of Risk – risk-taking by teenagers.** Issue: September 1998: http://search2.cometsystems.com/search.php?product

51. Prochaska J.O., Norcross J.C., & DiClemente C.C., 1994. **Changing for good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward.** New York: Avon Books.

52. Rose S. 1998. **Group Work With Children and Adolescents.** California: SAGE Publications, Inc.

53. Saylor E.S., & Aries E, 1999. **Ethnic Identity and Change in Social Context.** Journal of Social Psychology, 1999. Volume 139(5): 549 – 566.

54. Scott D., **Evaluating the National Outcomes: Youth--Social Competencies:** http://ag.arizona.edu/fcr/fs/nowg/sc_decision.html

55. Seale R., 1996. **Liefde, Seks & Jy.** Vereeniging, South Africa: Christian Publishing Company.

56. Segal B., 1989. **Perspectives on Adolescent drug abuse.** New York: The Howarth Press Inc.

57. Smith J., 1995. **About drugs: The war close to home.** New York: The Rosen Publishing Group.

58. Spencer M.B. & Dornbusch S., 1990. **American minority adolescents**. (In Feldman S. & Elliot G. (Editors.), **At the threshold: The developing adolescent.** Cambridge, MA: Harvard University Press.

59. Stark E., 1995. **Everyt hing you need to know about street gangs.** New York: The Rosen Publishing Group, Inc.

60. Tajfel H., 1981. **Human Groups and Social Categories.** Cambridge, UK: Cambridge University Press.

61. Te'Neil L., 2002. **A Conceptual Framework for Examining Identity, Media Influence, and Social Development.** Review of General Psychology, March 2002. Volume 6, number 1: 73 – 79. Educational Publishing Foundation, Inc.

62. The Concise Oxford Dictionary, 1984. New York: Oxford University Press.

63. Van Horn J, 1998. **Risk-Taking a Part of a Teen's Growing Up—News:** http://www.penpages.psu.edu/penpages_reference/28507/285

64. Van Schalkwyk M., 2002. **A Tribute to Youth Day: 16 June 1976 and Beyond.** Youth Developme nt Journal, Special Edition. South Africa: Youth Development Network.

65. Van Zyl Slabbert F. *et al*, 1994. **Youth In the New South Africa.** Pretoria, SA: HSRC Publishers.

66. Wright Robert, 1994. **The Moral Animal.** London: Little, Brown and Company.

67. Zimbardo P. & Ebbesen E., 1969. **Influencing Attitudes and Changing Behavior.** California: Addison-Wesley Publishing Company.

ADDENDUMA

ADDENDUM I

Group Administered Questionnaire

No.	

UNIVERSITY
OF
PORT ELIZABETH

SCHOOL OF SOCIAL SCIENCES AND HUMANITIES

Researcher: Ms V. Dietrich

QUESTIONNAIRE

DO NOT write your **name** on this questionnaire. The answers you give will be treated as confidential, and nobody else except the researcher will read your answers. Choose the alternative that applies to you by marking it with a **CROSS (X)** in the applicable block, and answer the questions where needed **on the lines.**

Please be honest in all your answers. Completing the questionnaire is voluntary. You have the right not to answer a question if you do not feel comfortable answering it. If you decide not to answer a question, draw a line across the whole question and the alternatives to the question.

A. PERSONAL INFORMATION:

1. How old are you?

Younger than 13 years old	
13 years old	
14 years old	
15 years old	
16 years old	
17 years old	
18 years and older	

2. Are you?

Female	
Male	

3. In which residential area do you stay?

_____

4. Do you stay with:

Your mother	
Your father	
Both mother and father	
Other: (Please specify):	

5. If you stay with EITHER your mother/ father/ other people, what is the MAIN reason for this?

_____

_____

6. How many people, including yourself, are there in your household?

1 – 2 persons	
3 – 4 persons	
5 – 6 persons	
7 – 8 persons	
9 or more persons	

7. How many people in your household are earning an income?

None	
1 person	
2 persons	
3 persons	
4 persons or more	

8. Do you have access to the following?

Item	Yes	No
At least one meal every day		
Bread/anything to eat to take to school every day		
Pocket money every day		

9. If you are making use of public transport (tax, bus or lift club) to get to school, do you have money for transport every day?

I do not make use of public transport to get to school	
Yes, I do have money for transport every day	

No, I do not have money for transport every day	

10. Who paid your school fees?

My school fees could not be paid	
My parent(s)	
Other family member(s)	
Other:	

11. Do you have the proper school uniform?

Yes	
No	

12. If you do have a school uniform, how many sets do you own?

I do not own the proper school uniform	
One set	
Two sets	
More than two sets	

13. If you compare your own family to other families you know, would you say you are:

Richer than other families	
Poorer than other families	
At the same level as other families	

14. Would you say that you and your family have a close relationship?

Yes	
No	

15. Given the following activities, how often (number of times) do you and your FAMILY NORMALLY spend time together in the course of 30 days?

Activities	Frequency						
	0 times	1 – 5 times	6- 10 times	11-15 times	16-20 times	21-25 times	26-30 times
Church							
Shopping							
Watching TV							
Mealtimes							
Go to movies							
Sightseeing							
Other:							

16. Given the following activities, how often (number of times) do you and your FRIENDS NORMALLY spend time together in the course of 30 days?

Activities	Frequency						
	0 times	1 – 5 times	6- 10 times	11-15 times	16-20 times	21-25 times	26-30 times
Church							
Shopping							
Watching TV							
Sleep-over							
Going to movies							
Visiting friends							
Disco / Nightclubs							
Sightseeing							
Other:							

17. If you should have some FREE TIME, would you rather spend it with your family, with specific member(s) of your family or with your friends?

Family	
Friend(s)	

18. What is the MAIN reason for your choice in the previous question?

_____

_____

19. Who of the following people would be the FIRST you would turn to with sex-related questions?

Teacher	
Parent(s)	
Friend	
Religious instructor	
Other	

20. What is the MAIN reason for your answer in the previous question?

_____

_____

21. Do you consider your general behaviour to be risky (putting your physical self or your health at risk)?

Yes	
No	

22. What is the MAIN reason for your answer to question 21?

_____

_____

B. DRUG BEHAVIOUR:

23. Have you ever tried cigarette smoking, even one or two puffs?

Yes	
No	

24. If your answer to the question 23 is YES, what is your MAIN reason for trying or puffing cigarette smoking?

_____

_____

25. If your answer to question 23 is NO, what is your MAIN reason for not trying or puffing cigarette smoking?

_____

_____

26. How old were you when you tried cigarette smoking, even one or two puffs?

I have never tried cigarette smoking	
Younger than 13 years old	
13 years old 14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

27. Who was with you the first time you tried cigarette smoking, even one or two puffs? (NO NAMES! Only write "friend, brother, etc. for example.)

_____

28. Did this person(s) influence you to smoke?

Yes	
No	

29. If you have answered yes in the previous question, who influenced you?

(DO Not MENTION ANY NAMES!)

_____

30. Do you currently smoke cigarettes?

Yes	
No	

31. Do you think it is wrong for a young person (still attending school) between the ages of 12-20 to smoke cigarettes?

Yes	

No	

32. What is the MAIN reason for your answer in question 31?

_____

_____

33. Have you ever smoked or tried cigarettes smoking ON SCHOOL PROPERTY?

I do not smoke cigarettes at all	
I do smoke cigarettes at school	
I smoke cigarettes, but not at school	

34. Do any of your friends drink alcoholic beverages? (Excluding for religious purposes!)

Yes	
No	

35. Have you ever drunk alcoholic beverages? (Excluding for religious purposes!)

Yes	
No	

36. How old were you when you had your first drink of alcohol?

I have never had a drink of alcohol	
Younger than 13 years old	
13 years old 14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

37. Who was with you when you had your first alcoholic beverage? (No names! E.g. friends, brother, sister, etc.)

_____

38. What type of alcoholic drink did you have the first time you drank?

_____

39. Have you ever drunk alcohol ON SCHOOL PROPERTY?

I do not use alcohol at all	
I do use alcohol at school	
I do use alcohol, but not at school	

40. Are you currently using alcohol?

Yes	
No	

41. What is the MAIN reason for your answer to question 40?

_____

_____

42. Do you think it is wrong for a person (still attending school) aged 12-20 to drink alcohol?

Yes	
No	

43. What is the MAIN reason for your answer to question 42?

_____

_____

44. Have any of your friends used marijuana (also called dagga, grass, pot or 'boom'?

Yes	
No	

45. Have you ever used marijuana?

Yes	
No	

46. If your answer to question 45 is YES, what is your MAIN reason?

_____

_____

47. If your answer to question 45 is NO, what is the MAIN reason for your answer?

_____

_____

48. How old were you when you tried marijuana for the first time?

I have never tried marijuana Younger than 13 years old	
13 years old	
14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

49. Do you currently use marijuana?

Yes	
No	

50. What is the MAIN reason for your answer to question 49?

_____

_____

51. Do you think it is wrong for a person (still attending school) aged 12-20 years to use marijuana?

Yes	
No	

52. What is the MAIN reason for your answer to question 51?

_____

_____

53. Have you ever used marijuana ON SCHOOL PROPERTY?

I do not use marijuana at all	
I do use marijuana on school property	
I use marijuana, but not at school	

54. Have you ever used any of the following drugs or inhalants? How old were you then?

Drug / Inhalant	Yes	No	Age
Cocaine			
Crack			
Ecstasy			
Powder			
Petrol			
Laughing gas			
Glue			
Aerosol spray			
Other:			

55. Do you currently use illegal drugs or inhalants?

	Drugs	Inhalants
Yes		
No		

56. What is the MAIN reason for your answer to question 55?

_____

_____

57. Do any of your friends use illegal drugs or inhalants?

	Drugs	Inhalants
Yes		
No		
I do not know		

58. Do you think it is wrong for a person (still attending school) aged 12-20 years to use drugs or inhalants?

	Drugs	Inhalants
Yes		
No		

59. What is the MAIN reason for your answer to question 58?

_____

_____

60. During the past 12 months, has anyone OFFERED you an illegal drug ON SCHOOL PROPERTY?

Yes	
No	

61. Did you accept the drug that was offered to you on school property?

I was not offered drugs at school	
Yes, I accepted the drug	
No, I did not accept the drug	

62. Are drugs being sold ON SCHOOL PROPERTY?

Yes	
No	
I do not know	

63. Do you BUY of the drugs that are sold at school?

Drugs are not sold at school	
Yes	
No	

64. Do any of your friends BUY of the drugs sold at school?

Drugs are not sold at school	
Yes	
No	

65. Do any of your friends SELL drugs at school?

Yes	
No	
I do not know	

66. Do you SELL drugs at school?

Yes	
No	

C. SEXUAL BEHAVIOUR:

67. Where have you learned about sex? Mark (with an X) as many as you want.

Parent(s)	
Brother(s) or sister(s)	
Other member(s) in your household	
Friend(s)	
Teacher(s) at school	
Visitor(s) to school	
TV or other forms of media	
I can't remember	

Other:	

68. Have any of your close friends ever had sexual intercourse?

Yes	
No	
I think so I do not know	

69. Have you ever had sexual intercourse?

Yes	
No	

70. How old were you when you had sexual intercourse for the first time?

I have never had sexual intercourse	
Younger than 13 years old 13 years old	
14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

71. What were your reasons for having sex the very first time?

_____

_____

72. Are you currently sexually active?

Yes	
No	

73. What is the MAIN reason for your answer to question 72?

_____

_____

74. Do you think it is wrong for a person (still attending school) aged 12-20 years to be sexually active?

Yes	
No	

75. What is the MAIN reason for your answer to question 74?

_____

_____

76. Indicate (with an X) whether you use contraceptives and if you use it regularly:

Birth control method	**Using?**		**Regularly?**		
	Yes	**No**	**Yes**	**No**	
I am not sexually active					
The time(s) I have (had) sex, I do (did) not use any method					
Condom					
Birth control pills					
Injection					
Other method:					

77. If you are sexually active and you are NOT using contraceptives, do you INSIST that your partner use safety measures?

I am not sexually active	
Yes	
No	

78. If you answered YES or NO to question 77, what is the MAIN reason for your answer?

_____

_____

79. If you answered YES to question 77, which safety measure(s) do you INSIST on?

_____

80. What is your MAIN reason for insisting on this particular contraceptive?

_____

_____

81. Do you think it is wrong for a person (still attending school) aged 12-20 years to use birth control methods?

Yes	
No	

82. What is the MAIN reason for your answer to question 81?

_____

_____

83. Who do you think should take responsibility in using safety measurement causes such as condoms or birth control pills?

The male partner	
The female partner	
Both partners	
Not one of the two	

84. Have you and your partner discussed contraception before your sexual activity?

I have never had sex	
Yes, we have discussed contraception before sex	
No, we have not discussed contraception before sex	

85. Have you ever been pregnant?

I have never had sex before	
Yes	
No	
I am male	

86. Have you ever made someone else pregnant?

I have never had sex before	
Yes	
No	
I am not sure I am female	

87. Indicate the activity the following people would be AGAINST if they were to know that you engage in any of these activities:

	CIGARETTE SMOKING	**ALCOHOL USE**	**MARIJUANA USE**	**DRUG TAKING**	**SEXUALLY ACTIVE**
I do not engage in this activity					
My parent(s)					
My friends					
My brother(s) or sister(s)					
My teacher(s)					
The pastor, priest, etc.					
Other:					

88. Indicate whether you will STOP engaging in any of these activities mentioned in question 87, if the following people were to find out about them:

Person(s)	**Yes**	**No**
My parent(s)		
My friends		
My brother/sister		
My teacher(s)		
The pastor, priest, etc.		
Other:		

89. Why, generally speaking, do you think would the people you indicated be against the activities you indicated in question 87?

_____

_____

_____

90. The last time you had sexual intercourse, did you drink alcohol and/or use drugs BEFORE the sexual deed?

I have never had sexual intercourse	
YES, I used alcohol and/or drugs before sex	
NO, I did not use alcohol and/or drugs before sex	

91. Indicate whether the following reasons or conditions are acceptable or justifiable to have sexual intercourse:

Reason/condition	Yes	No
Love		
Trust		
"One night stand"		
A beautiful woman or attractive man		
Nice body		
Friendship		
Willing partner		
Knowing the partner's history When the desire is there		
Every time the opportunity is there		
Other:		

92. Where have you learned about AIDS?

Source	Yes	No
Parent(s)		
Brother(s) or sister(s)		
Other member(s) in your household		
Friend(s)		

Teachers at school		
Visitors to school		
TV or other forms of media		
I can't remember		
Other:		

93. Do you consider the risk of AIDS before you engage in a sexual activity?

I have never had sex	
Yes	
No	

D. VIOLENCE – RELATED BEHAVIOUR:

94. Do any of your friends carry a weapon such as a gun, knife, or club?

Yes	
No	
I am not sure	

95. Do you NORMALLY carry a weapon?

Yes	
No	

96. What is the MAIN reason for your answer to question 95?

_____

_____

_____

97. Which type of weapon do you carry?

I do not carry a weapon	
Gun	
Knife	
Club	
Other:	

98. Do you think it is wrong for a person (still attending school) aged 12-20 to carry a weapon?

Yes	
No	

99. What is the MAIN reason for your answer to question 98?

_____

_____

100. Since which age do you carry a weapon?

I do not carry a weapon	
Younger than 13 years old	
13 years old	
14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

101. Do your friends carry a weapon ON SCHOOL PROPERTY?

Yes	
No	
I am not sure	

102. Do you carry a weapon ON SCHOOL PROPERTY?

Yes No	

103. What is the MAIN reason for your answer to question 102?

_____

_____

104. Have you or your friend(s) ever been physically threatened by another learner at school?

	Yes	**No**	**I do not know**
My friend(s)			
Myself			

105. Have any of your friends ever attempted to commit suicide?

Yes	
No	
I do not know	

106. Do you think it is wrong for a person aged 12-20 years to commit suicide?

Yes	
No	

107. What is the MAIN reason for your answer to question 106?

_____

_____

_____

108. Have you ever seriously CONSIDERED attempting suicide?

Yes	
No	

109. Have you ever ATTEMPTED to commit suicide?

Yes	
No	

110. What is the MAIN reason for your answer to question 109?

_____

_____

_____

111. How old were you the first time you attempted to commit suicide?

I have never attempted suicide	
Younger than 13 years old 13 years old	
14 years old	
15 years old	
16 years old	
17 years old	
18 years or older	

112. How happy are you generally?

Not happy	
Neither happy, nor unhappy	
Happy	
Very happy	

Thank you very much for your help.

ADDENDUM II

Questionnaire: Experts

University of Port Elizabeth

SCHOOL OF SOCIAL SCIENCES AND HUMANITIES

Questionnaire A: Stepping Stones

1. What are the main reasons, in your opinion, why adolescents become criminals?
2. What are the steps the centre takes when an adolescent is brought here by the police?
3. Is it possible for you to supply the researcher with statistics concerning adolescent crime and other risk-taking behaviours?
4. How successful are your re-socialisation programmes?

Questionnaire B: Brister House

1. What are adolescents' attitudes towards HIV/AIDS according to your opinion?
2. What skills, knowledge and values, do you think, do adolescents need to change this picture?
3. Is it possible for you to supply the researcher with Port Elizabeth or Eastern Cape HIV/AIDS statistics?

Researcher: Ms V. Dietrich

ADDENDUM III

Questionnaire: Teachers

University of Port Elizabeth

SCHOOL OF SOCIAL SCIENCES AND HUMANITIES

Questionnaire

1. Do your know of learners at your school that engage in the following activities:
   - 1.1 Cigarette smoking
   - 1.2 Marijuana use
   - 1.3 Alcohol use
   - 1.4 Drug use
   - 1.5 Violence-related activities
     - 1.5.1. Weapon use
     - 1.5.2. Suicide attempts
   - 1.6 Sexual activities
2. Which of these activities do the learners engage in most of the time?
3. Do you think there are any differences between risk-taking behaviour and factors such as age, gender, residential area, and family affluence? Motivate.
4. Generally, what are the learners' attitudes like in areas mentioned in question 1?
5. Do you think that the learner's attitude determines his or her behaviour?
6. If so, do you think it is possible to change the learners' risky attitudes towards certain risk-taking behaviours? If so, how can this be attained?
7. Is there anything else in this regard that you want to share with the group or me?

Researcher: Ms V. Dietrich

ADDENDUM IV

HIV/AIDS Statistics ATTIC
Brister House

CENTRE: **ATICC, Brister House**
TELEPHONE: **(041) 506 1911**
FAX NUMBER: **(041) 506 1486**

EASTERN CAPE (WESTERN SUB-PROVINCE)

DATE: 01.01.2002 to 30.03.2002

TOTAL CASES: 2 176 (1 789 comparable figure to last year)
AVERAGE AGE: 29.9 (excluding Paediatrics)
TOTAL DEATHS: 350 (287 comparable to last year)
AVERAGE AGE AT DEATH: 29.0

TOTAL CASES	MALE	%	FEMALE	%	PAEDIATRIC	%	UNKNOWN	%
2 176	850	39.0	1 200	55.1	120	5.5	6	0.4

***DEATHS**

TOTAL	ADULTS	PAEDIATRIC	
24	15	9	**Diagnosed this year**
294	269	25	**Diagnosed previous year**
32	22	10	**Diagnosed elsewhere**
350	306	44	**Total**

BREAKDOWN BY GROUPS

	BLACK	COLOURED	WHITE	ASIAN	UNKNOWN	TOTAL
MALE	788	60	2	0	0	850
FEMALE	1 100	100	0	0	0	1 200
UNKNOWN	2	4	0	0	0	6
SUB TOTAL ADULTS	1 890	164	2	0	0	2 056
PAEDETRICS	120	0	0	0	0	120
TOTAL CASES	2 010	164	2	0	0	2 176

ORIGIN OF HIV CASES

PORT ELIZABETH	OUTSIDE PORT ELIZABETH	UNKNOWN	TOTAL
1 790	386	0	2 176

CENTRE: ATICC, Brister House
TELEPHONE: (041) 506 1911
FAX NUMBER: (041) 506 1486

LATEST HIV/AIDS STATISTICS
EASTERN CAPE (WESTERN SUB-PROVINCE)

DATE: 01.01.2001 to 31.12.2001
TOTAL CASES: 7 537 (6 837 comparable to previous year)
AVERAGE AGE: 29.0 (excluding Paediatrics*)
TOTAL DEATHS: 1 200 (1 021 comparable to last year)
AVERAGE AGE AT DEATH: 29.4 years

TOTAL CASES	MALE	%	FEMALE	%	PAEDIATRIC	%	UNKNOWN	%
7 537	2 544	33.7	4 429	58.9	480	6.3	84	1.1

***DEATHS**

TOTAL	ADULTS	PAEDIATRIC
300	255	45
715	599	116
185	130	55
1 200	984	216

BREAKDOWN BY GROUPS

	BLACK	COLOURED	WHITE	ASIAN	UNKNOWN	TOTAL
MALE	2 232	300	10	2	0	2 544
FEMALE	3 884	540	2	3	0	4 429
UNKNOWN	71	13	0	0	0	84
SUB TOTAL ADULTS	6 187	853	12	5	0	7 057
PAEDETRICS	438	42	0	0	0	460
TOTAL CASES	6 625	895	12	5	0	7 537

ORIGIN OF HIV CASES

PORT ELIZABETH	OUTSIDE PORT ELIZABETH	UNKNOWN	TOTAL
5 004	2 533	0	7 537

* Paediatric cases = cases below 13 years of age.
* DEATHS: Surveillance on death reporting has been increase.

ADDENDUM V

Statistics: Juvenile Delinquent Centre

STEPPING STONES

REPORT OF JUVENILES (PERSONS UNDER 18) IN POLICE DETENTION

REGION: Port Elizabeth

ATTENTION: Mrs. Burrel

AREA: Stepping Stones

TELEPHONE: 041 – 481 2147

MONTH: September 2002

FAX NUMBER: 041 – 481 3251

POLICE STATION	NUMBER YOUTHS DETAIONED AT STEPPING STONES	NUMBER REMANDED BY MAGISTRATES TO OTHER HOLDING FACILITIES	TOTAL AT MIDNIGHT ON 3RD THURSDAY OF THE MONTH
ALGOA PARK	37	19	25
BETHELSDORP	51	9	36
GELVANDALE	62	22	32
HUMEWOOD	29	19	13
KABEGA PARK	20	7	13
KINKELBOS	2	0	2
KWADWESI	11	6	10
KWAZAKHELE	31	17	24
MOUNT ROAD	65	11	35
MOTHERWELL	37	12	28
NEW BRIGHTON	28	12	11
SWARTKOPS	6	6	5
WALMER	13	4	12
TOTAL	**389**	**144**	**246**

ARRESTS OF JUVENILES [PERSONS UNDER 18 YEARS OLD]

REGION: Eastern Cape

AREA: Port Elizabeth

MONTH: September 2002

CRIMES COMMITTED	
Type of crime committed	**Total**
Housebreaking	95
Shoplifting	42
Robbery	23
Possession of dagga	9
Possession of stolen goods	14
Malicious injury to property	18
Attempted murder	8
Theft of motor vehicle	9
Theft out of motor vehicle	14
Possession of fire-arm and ammunition	6
Murder	7
Riotous behaviour	9
Assault with intent to do grievously bodily harm	8
Fraud	3
Loitering to commit prostitution	2
Theft	5
Attempted theft	3
Indecent assault	5
Rape	8
Driving motor vehicle without license	1
Possession of ammunition	2
Warrant of arrest	11
Trespassing	7
Drunk in public	3
Assault committed	1
Possession of abalone	1
Stock theft	1
Pointing of fire-arm	3
Armed robbery	7
Loitering	9
Attempted housebreaking	6
Attempted rape	2
Crimen injuria	1

Total	389

ARRESTS OF JUVENILES [PERSONS UNDER 18 YEARS OLD]

REGION: Eastern Cape

AREA: Port Elizabeth

MONTH: September 2002

GENDER	
Males	342
Females	47
AGES	
15 – 17 Years	273
7 – 14 Years	116
0 – 6 Years	0
DAY WHEN THE CRIMES WERE COMMITTED	
Monday	48
Tuesday	59
Wednesday	47
Thursday	35
Friday	65
Saturday	85
Sunday	50
TIME WHEN CRIMES WERE COMMITTED	
06:00 - 08:59	46
09:00 – 11:59	59
12:00 – 14:59	88
15:00 – 17:59	64
18:00 – 20:59	45
21:00 – 23:59	40
00:00 – 02:59	24
03:00 – 05:59	25

ARRESTS OF JUVENILES [PERSONS UNDER 18 YEARS OLD]

REGION: Eastern Cape

AREA: Port Elizabeth

MONTH: September 2002

CRIME COMMITTED

Type of crime committed	Total	Total Released
Housebreaking	95	49
Shoplifting	42	29
Robbery	23	12
Possession of dagga	9	6
Possession of stolen goods	14	10
Malicious injury to property	18	13
Attempted murder	8	6
Theft of motor vehicle	9	3
Theft out of motor vehicle	14	5
Possession of fire-arm	6	5
Murder	7	5
Riotous behaviour	9	9
Assault with intent to do grievously bodily harm	8	6
Fraud	3	3
Loitering to commit prostitution	2	0
Theft	51	35
Total	**318**	**196**

ADDENDUM VI

The Starfish


The Starfish

Once upon a time there was a wise man
who used to go to the ocean
to do his writing.
He had a habit of walking
on the beach
before he began his work.

One day he was walking along
the shore.
As he looked down the beach,
he saw a human
figure moving like a dancer.

He smiled to himself to think
of someone who would
dance to the day.
So he began to walk faster
to catch up.

As he got closer, he saw
that it was a young man
and the young man wasn't dancing,
but instead he was reaching
down to the shore,
picking up something
and very gently throwing it
into the ocean.

As he got closer he called out,
"Good morning! What are you doing?"

The young man paused,
looked up and replied,
"Throwing starfish in the ocean."

"I guess I should have asked,
why are you throwing starfish
in the ocean?"

"The sun is up and the tide is going out.
And if I don't throw them in they'll die."

"But, young man, don't you realize that
there are miles and miles of beach
and starfish all along it.
You can't possibly make a difference!"

The young man listened politely.
Then bent down, picked up another starfish
and threw it into the sea,
past the breaking waves and said-
"It made a difference for that one."