THE DEVELOPMENT AND EVALUATION OF A WELLNESS PROMOTION PROGRAMME FOR STUDENTS WITH DISABILITIES AT INSTITUTIONS OF HIGHER LEARNING WITH SPECIAL REFERENCE TO THE UNIVERSITY OF LIMPOPO (TURFLOOP CAMPUS)

by

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A thesis submitted in partial fulfillment of the requirements for the degree

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at the

UNIVERSITY OF ZULULAND

SUPERVISOR: Prof Dhlomo-Sibiya R.M

February 2010
Declaration

I declare that the thesis is my own work and has not been submitted for a degree at another university.

………………………………

M P MOGANE
Dedication

This work is dedicated to my daughter Barati, my mother, Modibone, my late father Mohlapong, my late brother Magampane, brothers and sisters, Bakgaditsi!
Acknowledgements

This study was an enormous undertaking that required incredible knowledge, dedication, persistence, perseverance and commitment. It has been a challenging, tiring and a brain-draining task, made possible only through support from caring people and the Almighty God.

I wish to express my sincere gratitude and appreciation to the following persons because without them this work would have not been completed:

- first and foremost Professor Dhlomo-Sibiya, my supervisor, for her patience, continuous encouragement, support and guidance;

- Dr A.K. Msimeki, my colleague, the Director of the Centre for Student Counselling and Development, for encouraging me to enroll for this degree and his valued assistance throughout this study;

- Mrs G.K Motshologane, the Director of the Disabled Students Unit (Reakgona) for her cooperation and patience;

- The students with disabilities who participated in this study and

- My mother, brothers, sisters, relatives and friends for their motivation, understanding, faith and trust in me. Most importantly my beloved daughter who was part and parcel of this whole project, starting from typing assignments, standing in long queues for registration, moving from one office to the other at the University of Zululand, transporting me to and from the University as well as the typing process of the thesis.

(iii)
Ms Mokowe Rahab Makwela, who patiently and diligently assisted me with the statistical analysis of the data.
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<thead>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ASSA</td>
<td>Albinism Society of South Africa</td>
</tr>
<tr>
<td>DA</td>
<td>Delay Avoidance</td>
</tr>
<tr>
<td>DPSA</td>
<td>Disabled People South Africa</td>
</tr>
<tr>
<td>EA</td>
<td>Educational Acceptance</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme</td>
</tr>
<tr>
<td>GQLCS</td>
<td>General Questionnaire on Life Competencies and Skills</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>INDS</td>
<td>Integrated National Disability Strategy</td>
</tr>
<tr>
<td>LA</td>
<td>Lecturer Acceptance</td>
</tr>
<tr>
<td>LSC</td>
<td>Life Competencies and Skills</td>
</tr>
<tr>
<td>SSHA</td>
<td>Survey of Study Habits and Attitudes</td>
</tr>
<tr>
<td>SDSQ</td>
<td>Self-Directed Search Questionnaire</td>
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</table>
SA       Study Attitudes
SH       Study Habits
SO       Study Orientation
SSI      Study Skills Indices
SAHRC    South African Human Rights Commission
StatsSa  Statistics South Africa
WHO      World Health Organisation
WM       Work Methods
ABSTRACT

The aim of this study was to determine the effects of a Wellness Promotion Programme on the “overall development of a group of students with disabilities at the University of Limpopo.”

The literature research that was conducted led to the following conclusions:

- students with disabilities at tertiary institutions experience a variety of problems, including physical, psychological and socio-cultural ones.
- the problems that students with disabilities experience can be addressed in a systematic and programmatic manner to enable these students to be more effective and successful in their studies and their lives. This is really the raison d’être of this study.

Two groups of students with disabilities at the University of Limpopo were used in this study, namely, the treatment and control groups. The purposive sampling technique was used to select the groups. A combination of Pre-test- Post-test and Post-test only, group design was used in the study. Both the treatment and control groups did the pre-test and post-test. The treatment group participated in a three-month Wellness Promotion Programme which served as the treatment.

Changes in the developmental level of the two groups were measured by means of the Survey of Study Habits and Attitudes (SSHA), the Life Skills and Competencies: General Questionnaire on Life Competencies and Skills (GQLCS) and the Self-Directed Search Questionnaire(SDSQ). Two versions of the t-test, one for correlated data and the other for uncorrelated data were used in the processing and analysis of the data.
The treatment group, unlike the control group, made significant pre- to post-test gains on all the three tests used in this study. The findings, therefore, led the researcher to conclude that the Wellness Promotion Programme that was presented to the treatment group enhanced the overall development of the students who were exposed to it. It was, therefore, recommended that the programme for students with disabilities be introduced at the University of Limpopo and at other tertiary institutions in South Africa.
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ORIENTATION TO THE STUDY

1.1 INTRODUCTION: Background of the study

The ushering in of a democratic dispensation in South Africa in 1994 has resulted in a radical shift in the attitude of governmental and non-governmental bodies as well as that of the general population towards people with disabilities. This new attitude can be seen at play in various government legislative enactments, in solemn pronouncements by various government representatives and the new employment practices in the world of work. The following quotation is a good example of these statements: “Among the yardsticks by which to measure a society’s respect for human rights, to evaluate the level of its maturity and generosity of spirit, is by looking at the status that it accords to those members of society who are most vulnerable: disabled people, the senior citizens, and its children” (The White Paper on an Integrated National Disability Strategy, Office of the Deputy President, 1997, p. (i)).

It further states that the concept of a caring society is strengthened and deepened when people recognise that persons with disabilities enjoy the same rights as everyone else, and that the society has a responsibility towards the promotion of the quality of their lives. Persons with disabilities should not be seen as objects of pity but as capable individuals who are contributing immensely to the development of society (The White Paper on an Integrated National Disability Strategy, Office of the Deputy President, 1997, p. (i)). Persons with disabilities should not be stripped off their dignity. As a result, community psychologists must play an active role in working with persons with disabilities so as to help them empower themselves to find joy and happiness as well as to fulfill their aspirations.

This new outlook towards the disabled in South Africa has, in a very telling and profound way, found expression in the educational arena in the “movement” which carries the general appellation of Inclusive Education. From pre-school to tertiary education, inclusive education has been promoted as one of the methods to ensure equal educational opportunities for those with various impairments; while still recognising their special educational needs (Despouy, 1993).
In South Africa the 2001 Education White Paper 6 on Special Needs Education outlines a process of integrating learners with special needs into mainstream schools. This twenty year development programme seeks to see to the conversion of special schools into resource centres with the additional establishment of full-service schools, which would be equipped to provide for the full range of the educational needs for all learners.

Inclusive education has also spread to tertiary educational institutions. More and more students who register to study at institutions of higher learning in our country are beset with various types of disability. Intensive and extensive support programmes and interventions are solely needed to help these students cope with problems of normal growth and development that are faced by youth all over the world as well as with the arduous demands of post matric study. Access to higher education for students with disabilities is slowly becoming more inclusive worldwide.

1.2 MOTIVATION FOR THE STUDY

The education of students with disabilities at tertiary level predates the democratisation of the South African Society. The efforts to educate the disabled at post school level were more advanced at historically white tertiary educational institutions than at historically Black ones. Students with disabilities at historically white universities and technikons went on to graduate in various study areas depending on their disabilities. This was not the case at historically black tertiary institutions where the inclusion efforts were half-hearted and haphazard in nature.

There was a lot of skepticism and doubt regarding the ability of disabled black youth to successfully complete tertiary education and study programmes. Many academic departments felt that there was no place in their programmes for students with disabilities, especially those with blindness and deafness. It is only recently that measures have been taken to establish specific units at historically black tertiary institutions which are dedicated to the care of disabled students. These units have been established at only a few of these institutions such as the University of Limpopo (Turfloop Campus) and the University of Venda for Science and Technology. There are no efforts to train the staff of these institutions to work effectively with these students. There are no specific orientatory and sustaining programmes for these disabled students.
Students with disabilities generally feel lost, neglected, rejected and highly inadequate in these huge and highly-populated institutions. These feelings are manifested in a variety of maladaptive behaviours and psychological conditions varying from academic failure, negative self-image and low self-esteem, stress, anxiety, depression and other serious mental conditions (Council Report CR 112, 2003, p (7)). The majority of these students struggle along on their own and suffer in silence. The prime motive for this study is to put together an intervention strategy that will promote and enhance the optimum adjustment and functioning of these students.

Students with disabilities at the University of Limpopo who report at the Centre for Student Counselling and Development for guidance, counseling and psychotherapy on their own or referred by various instances, present with a variety of issues, difficulties and problems such as anxiety, stress, depression and poor academic performance.

This situation prompted the researcher to carry out a systematic study of the challenges with which disabled students are confronted at the university. This investigation served as a pilot project and automatically feeds into the present study. The pilot study showed that the disabled students at the University of Limpopo are faced, inter alia, with physical difficulties, as well as serious problems in the key areas of psychological functioning, namely, the cognitive, affective and motivational components. The study also showed that the students are also faced with socio-cultural and spiritual challenges.

It became clear to the present researcher that a systematic programmatic intervention was sorely needed to address the difficulties with which these students are faced.

1.2.1 Why Limpopo Province?

The reason why the researcher chose Limpopo Province is that the researcher is working and researching in Limpopo Province. The province is one of the poorest provinces in the country, South Africa. It is situated +250 kilometres north of the Gauteng Province. The Province is characterised by various adverse factors and circumstances that predispose its people towards poor physical and mental development. Chief amongst these are poverty, illiteracy and dysfunctional family circumstances due to the migratory labour system. There is a strong relationship between disability and poverty. Poor people face greater risk of impairment or
disability. The occurrence of disability in a family, often places heavy demands on family morale, thrusting it deeper into poverty. Migratory labour including forced removals, urbanisation, racial discrimination and economic instability have been linked to increased levels of poor mental health which may at times result in various types of disabilities.

1.2.2 Why the University of Limpopo – Turfloop Campus?

The University of Limpopo (Turfloop Campus) is the major tertiary institution in the Province that admits the largest number of students with disabilities. Inclusive education is one of the cornerstones of the mission of the University. The researcher has realised that there are many students with disabilities who struggle to succeed academically.

The University of Limpopo was established on 01 August, 1959 as the University College of the North, placed under the academic trusteeship of the University of South Africa (UNISA). This formative relationship with UNISA was maintained until the South African Parliament promulgated the University of the North Act (Act No.47 of 1969), thus bringing to an end the college status as of 01 January, 1970. It thus became autonomous in 1970, named The University of the North. On 01 January 2005 the University of the North and the Medical University of South Africa merged and the new institution was named the University of Limpopo. The University of Limpopo is guided and directed by its Vision, Mission and Motto which are outlined below:

Vision: “To be a leading African University, epitomising excellence and global competitiveness, addressing the needs of rural communities through innovative needs.”

Mission: “A world class African University which responds to education, research and community development needs through partnerships and knowledge generation-continuing a long tradition of empowerment.”

Motto: “The University of Limpopo for human and environmental wellness in a rural context -finding solutions for Africa.”

The first intake of students with disability was in 1976. Advocate Joseph Malatji, was blind, was the first student to be admitted at the University of the North. He enrolled for the B.Juris
degree in the faculty of Law. He was brought to the university by Father Augustine of the Roman Catholic Church from Siloe School for the Blind. Father Augustine came frequently to the university to assist blind students with typing, braille, etc. He played a pioneering role in the education of students with disabilities to the university.

The second intake was in 1984. They were four students with blindness, one female and three males. The female student and one male enrolled for education while the other two enrolled for law. The third intake was in 1986. They were also had blind. Two of them enrolled for Law; one Social Work but later changed to Public Administration, and the fourth one registered for Education. The number kept on growing and students with various disabilities were admitted.

Although access to higher learning is still an issue in the country, the number of students with disabilities is gradually increasing.

The steady increase in the number of students with disabilities registered at the University of Limpopo (Turfloop Campus) can be seen in the tables presented below:

### 1.2.3 2006 Enrolment

**In the year 2006 the enrollment was as follows** (Committee for Persons with Disabilities: University of Limpopo – Turfloop Campus Minutes, 2006: 36).

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number of Students</th>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>Blindness</td>
<td>20</td>
<td>11</td>
<td>09</td>
</tr>
<tr>
<td>Partially sightedness</td>
<td>29</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Physical Impairment</td>
<td>44</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>02</td>
<td>00</td>
<td>02</td>
</tr>
<tr>
<td>Hearing &amp; Speech Impairment</td>
<td>02</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>Tourette’s Syndrome</td>
<td>01</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>98</strong></td>
<td><strong>47</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>

Table1: Enrolment of students in terms of disability.
Statistics according to the courses registered in 2006:

<table>
<thead>
<tr>
<th>Degree</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA (Social Work)</td>
<td>03</td>
<td>01</td>
<td>04</td>
</tr>
<tr>
<td>BA(Social Sciences)</td>
<td>27</td>
<td>20</td>
<td>47</td>
</tr>
<tr>
<td>Bed</td>
<td>02</td>
<td>00</td>
<td>02</td>
</tr>
<tr>
<td>BPharm</td>
<td>01</td>
<td>02</td>
<td>03</td>
</tr>
<tr>
<td>LLB</td>
<td>02</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>BCom</td>
<td>03</td>
<td>04</td>
<td>07</td>
</tr>
<tr>
<td>BSc Agric</td>
<td>01</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td>BAgic</td>
<td>00</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>BSc</td>
<td>04</td>
<td>04</td>
<td>08</td>
</tr>
<tr>
<td>BNutr</td>
<td>00</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>BOptom</td>
<td>00</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>BAdmin</td>
<td>02</td>
<td>04</td>
<td>06</td>
</tr>
<tr>
<td>BInfo</td>
<td>01</td>
<td>01</td>
<td>02</td>
</tr>
<tr>
<td>UNIFY</td>
<td>01</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
<td><strong>51</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

Table 2: Enrolment of students according to study direction

Moving away from home, family and childhood friends, to an unfamiliar place and culture, constitute an additional challenge at an age when most students are also negotiating significant developmental changes (Council Report CR112, 2003).

The stresses of university life, the multifaceted pressures such as financial constraints, growing competitiveness, heightened aspirations for achievement and material security might exacerbate feelings of isolation and alienation amongst these vulnerable students.

### 1.3 STATEMENT OF THE PROBLEM

The mission relating to inclusive education stated above is a noble one indeed. The strategy or ways and means of realising it, is to say the least, woefully inadequate.
The personnel, the intervention strategies, and the technologies needed to realise this noble mission are in short supply or totally non-existent, hence the need for this study. This study seeks to address the issue of an effective and efficient intervention strategy that will promote and enhance the inclusive education of disabled students at the tertiary education level.

1.4 AIMS AND OBJECTIVES OF THE STUDY

The major aim of the study is to compile a well-grounded psycho-social educational programme that will promote the effective adjustment and functioning of students with disabilities at tertiary education institutions.

The study aims at the promotion of optimum adjustment and academic success among students with disabilities through the implementation of appropriate general life skills, academic skills and the general wellness intervention programme.

The study seeks to accomplish the following objectives:

- To compile a wellness promotion programme that will encompass components that will address the physical, mental and socio-cultural aspects of the lives of students with disabilities.

- To field-test this programme on the appropriate population and sample.

- To evaluate this programme using appropriate evaluation methods and techniques.

- To assess the participants on three (3) variables, that is, study skills, life competencies and skills, and career choice and development.

- To promote optimum adjustment and academic success among students with disabilities through the implementation of appropriate general life skills, academic skills and the general wellness intervention programme.
1.5 HYPOTHESES

The Wellness Promotion Programme would positively influence study skills, the life competencies and skills and the career development and career choice of the group of students with disabilities who would be exposed to it.

The researcher further hypothesized that the post-test means of the treatment group would be significantly higher than the pre-test means of the same group on study skills, life competencies and skills, as well as on the group’s career development and career choice.

The researcher also hypothesized that the post-test means of the treatment group would be significantly higher than the post-test means of the control group on study skills, life competencies and skills, and on career development and career choice.

1.6 STUDY FOCUS

The present study focuses on three key areas in the life of students with disabilities, namely, Capacity for Effective Study; Effective Career Development and Career Choice; and the Acquisition of General Life Skills.

The programme that will be administered to the treatment groups is meant to enhance the performance levels of these students in these three areas. Three well-researched instruments will be used to assess the performance levels of the treatment students in these areas. The psychometric instruments concerned are the Survey of Study Habits and Attitudes (SSHA), Self Directed Search Questionnaire (SDSQ) and General Questionnaire on Life Competencies and Skills. More importantly, the assessment of post-treatment performance of the treatment groups would determine the efficacy or the lack thereof of the programme in increasing, raising or enhancing the performance levels of the treatment students in the three areas selected for study.

1.6.1 Study Skills

Study skills refer to the usual and recent recurrent methods and activities that are employed by the student in his daily academic work. Study skills as defined in this study
and as assessed by the Survey of Study Habits and Attitudes (SSHA), actually comprise two indices, namely, the Delay Avoidance (DA) and the Work Methods (WM). A combination of these two indices, namely the DA and WM indices yields or result in a broader index, namely the Study Habits index (SH); i.e. \( DA + WM = SH \).

On the other hand, the General Attitudes that the student adopts towards his teachers and towards the educational activity in general form a crucial aspect of his Study Skills repertoire. What this means is, the student’s attitude towards his teachers or lecturers. These attitudes as enunciated in the Wellness Programme and as assessed by the SSHA are labelled Lecturer/Teacher Acceptance (LA/TA) and Education Acceptance (EA). A combination of these attitudinal indices results in the broad index called the Study Acceptance (SA). An extremely important index of the study skills component is obtained by adding the values of the broad Study Habits (SH) and the Study Acceptance (SA) indices. This combination results in a still broader index of the study skills ability, and this very broad index is called Study Orientation index, i.e. \( SH + SA = SO \).

These three broad components of the Study Skills ability will be used to posit the question that follow below as well as the hypotheses emanating from these questions:

**Will the Wellness Programme significantly improve the Study Skills (study habits, study attitudes and study orientation) of those students who will be exposed to it?**

### 1.6.2 Life Skills

The second variable that the participants will be assessed on is the Life Skills component. The Life Skills component as conceptualised and formulated in this study and as assessed by the Life Skills test consists of six key areas. The following are the Life Skills areas in question, namely, Social and Community Development; Development of Person and Self; Self Management; Physical and Sexual Development; Career Development and Planning as well as Life and World Orientation.

The following question relate to the six areas of the Life Skills component of the Wellness Programme:
Will the Wellness Programme inculcate all the key areas of the life skills variables of the students who will be exposed to it?

1.6.3 General Career Development and Career Choice

The Self-Directed Search (SDS) questionnaire assesses three key areas relating to a person’s occupational interests, skills and values. This questionnaire seeks to establish whether a person’s interests, skills and values show Consistency, Differentiation and Congruency, in relation to his occupational preferences and choices. The following question relate to the Self-Directed-Search component:

Will the Wellness Promotion Programme significantly improve the Career Development and Career Choice of those students who will be exposed to it?

1.7 SIGNIFICANCE OF THE STUDY

Community psychologists have the responsibility of promoting mental health as well as preventing issues that may cause mental illness and other forms of illnesses. The intervention of a community psychologist is very important and necessary. This study would promote positive mental health and prevent ill-health amongst students with a variety of disabilities.

The study seeks to prevent ill-health, academic failure, self alienation, alienation from others, inability to actualise themselves optimally, inability to attain and reach their goals, inability to develop self-steering behaviour. To counteract all these negatives, the community psychologist, therefore, seeks to promote academic success, optimum adjustment, self-acceptance, self-esteem, and career development.

The study seeks to assist and support students with disabilities in enabling them to become independent in managing their disabilities and lifestyle as they study at institutions of higher learning and as they enter the world of work.

This study is important for the promotion of mental health because the students will learn about prevention of mental illness and promotion of mental health. The University of
Limpopo, other institutions of higher learning admitting students with disabilities as well as the wider community, sponsors, other stakeholders within and without the university will benefit from the study. The study will trigger the officials’ awareness of the challenges the students come across on campus and as a result they will understand the dynamics surrounding educating students with disabilities.

The study will also help other students on campus understand and learn how to live with students with disabilities. Other institutions will be motivated to enroll more students with disabilities; these students will also be attracted to enroll at institutions of higher learning knowing that they will get the necessary support when the need arises. Again, sponsors of these students will be motivated to sponsor more students knowing that the failure rate will go down, and the government will not lose the money invested in their education.

The study will form a base which will be used by other researchers to conduct an in depth study about tertiary education and students with disabilities. Furthermore, the study will contribute to policy formulation by tertiary education institutions and other instances relating to the education of youth with disabilities.

Tertiary education institutions will make considerable provision for the well-being of students with disabilities. The range of resources deployed by Higher Education Institutions will thus also increase so as to meet the requirements of the Special Education Needs and Disabilities Act of 2001. The University counselling service as the primary mental health care option for many students will also be resourced accordingly.

Furthermore, the study will contribute to theory building concerning an individual with disability regarding himself and his psychological and socio-cultural environment. In summary, the successful completion of this study will be of immense significance regarding the education of students with disabilities at tertiary educational institutions. The study will present to tertiary education practical ways and means relating to the caring and education of students with disabilities.

While the students are acutely aware of the plethora of service providers who can assist them, they seem not to be aware of and concerned about what they themselves should do to promote
their effective adjustment, welfare, and self-actualisation. The envisaged educational intervention programme will make these students more acutely aware of these services.

1.8 DEFINITION OF KEY WORDS

The definition of key words is a prerequisite for any disciplined scientific endeavour. Clear definitions play a pivotal role in the reader’s need to come to grips with the subject under study. The key concepts of this study are defined below:

1.8.1 Development

The term refers to the process of developing or being developed. It also refers to an outcome; result; new event; a working out in greater and greater detail, Barnhart, (1995).

1.8.2 Evaluation

To evaluate is to assess. This generally refers to determining the value, importance or worth of something. More specifically, the determination of how successful a programme has been in achieving the goals laid out for it at the outset, Reber & Reber, (2001).

1.8.3 Wellness

Wellness refers to that dimension of health that goes beyond the absence of disease or infirmity and includes the integration of social, emotional, mental, and physical aspects of health. The concept of wellness was first introduced in the United States of America in the 1970s, as an expanding experience of purposeful and enjoyable living. Wellness also refers to positive state, illness to a negative state, (Butler, 2000; Green & Kreuter, 1999 in Modeste and Tamayose, 2004).

Wellness is also conceptualised as the positive component of optimal health. Health interventions involve three strategies of disease and illness treatment, disease and illness prevention and health and wellness promotion, (Edwards, 2002, p.17).
Wellness describes a holistic state of physical, psychological, and spiritual well-being. It has also become associated with a number of traditional and alternative interventions, programmes and lifestyles aimed at fostering the pursuit and development of positive well-being and health.

1.8.4 Promotion

Promotion is that which contributes to the progress, development, or growth of, encourage by trying to make it happen, increase, or become more popular. Promotion is an action of helping to organise, starting something which, applies to any phase or stage of development.

Promotion also refers to the act of enhancing the mental and general wellness of individuals and or groups through a variety of activities, intervention strategies and programmes. It refers to the process whereby people are provided with knowledge and skill and encouraged and enabled to engage in physical, mental, socio-cultural and spiritual activities that seek to enhance their general and mental wellbeing. It is certainly more comprehensive and significant than the mere prevention of ill-health.

The World Health Organisation (WHO) describes health promotion as all measures that enable individuals, groups or organisations to have increased control over the determinants of health. The above measures therefore aim to improve the health of individuals, groups, organisations and communities.

1.8.5 Programme

The term “programme” has a number of possible meanings. A programme is commonly defined as a series of activities; a list of activities which are going to take place in the future. In addition, the process of planning, implementation and evaluation involved in programme development are often referred to. The United Nations Task Force on Rural Development (1984) defines a programme as an organised set of activities, projects, processes or services which is oriented toward the attainment of specific objectives.
Reber & Reber (2001) define programme as an extended plan of research. The term is used in this sense for the research of anything from a single individual to a whole institution and even to the abstract notion of the research activity in an entire field or discipline.

1.8.5 Students with Disabilities

According to the World Health Organisation (WHO) in The International Classification of Functioning, Disability, and Health (ICIDH-2), 2001, disability refers to “activity limitations, impairments, and/or restrictions in full participation”, (Nehring, 2005, p.30). The World Health Organisation further goes on to define disability as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. Disabilities are usually defined in educational institutions worldwide as either physical, visual, hearing, sensory impairments, learning and cognitive disabilities, or emotional impediments that limits a person’s movement, senses and activities.

Kgomosotho, (1995) defines persons with disabilities as people who are blind, deaf and dumb, and other persons who are substantially and permanently handicapped by illness, injury or congenital deformity or who are suffering from mental disorder.

The American With Disability Act (ADA) defines “individual with a disability” as an individual who has a physical or mental impairment that substantially limits one or more of the individual’s major activities, has a record of such impairment, or is regarded as having such an impairment.

Therefore, a student with disability is one who has a physical, mental or visual impairment that has a substantial and long-term adverse effect on his ability to carry out major or normal day-to-day activities.

1.8.6 Disabled

The term is used to characterise one suffering from a disability. Because of the many negative connotations which have developed around the term handicapped, many prefer this term to
refer to any individual who suffers from a condition that only superficially limits his or her functioning, Reber & Reber (2001).

A look at the concept disability, however, should alert the reader that the word superficially needs clarification. The notion entailed by the new usage is that the person may indeed suffer from a most severe (i.e. disabling) condition such as paraplegia but may nevertheless be quite capable of living a rich and fulfilling life provided that certain adjustments are made for the disabling condition such as the installation of ramps for wheelchairs, elevators, modified equipment at work or school, etc.

1.8.8 Institutions of Higher Learning

The term “Institution” refers to an organised system of social roles which is a persistent and significant element in a society and which focuses on basic human needs and functions. It also refers to a society, club, college or any organisation established for some public or social purpose; for example a university, (Barhart, 1995).

Higher learning refers to tertiary education. It is learning or education beyond matric. The World Book Dictionary defines higher education as education at a level beyond secondary school, especially college education. University is described as an institution of learning of the highest grade. Institutions of higher learning in this study, therefore refers to higher education; institutions that provide education that is provided by universities, vocational universities, community colleges and institutes of technology.

1.8.9 Disempowerment and Empowerment

Disempowerment is a major deterrent to psychological wellbeing. The development of conditions and programmes that enhance people’s empowerment should be seen as an essential route to follow in the quest for psychological wellness. The prominently disempowered groups in many societies include the non-dominant cultural groups, persons with disabilities, the elderly, children, women, the rural poor and the homeless. It also refers to perceived and actual control over one’s life and empowering interventions are those that enhance participants’ control over their lives (Rappaport, 1977).
The term “empowerment” has become a prominent word in many professional circles worldwide. The World Health Organisation, 1995 defines empowerment as the process of giving people power to choose and carry out improvements in their own lives. An essential part of empowerment is helping individuals believe that they have the ability to accomplish goals that they set for themselves (Potgieter, 1988).

1.8.10 Adjustment

Though it is difficult to get complete agreement about the meaning of adjustment, some generalised definitions draw upon the biological connotation of the concept. Lazarus (1969) defined adjustment to include “man’s efforts, successful and unsuccessful, to deal with life in the face of environmental demands, internal pressures, and human potentials” (p.x.).

Adjustment implies that individuals must deal with a succession of situations, each with its own peculiar demands. Adjustment can also be defined in terms of the adequacy of the way in which the person is generally effective in resolving life’s problems, while the maladjusted person is overwhelmed by these.

Fouché & Grobbelaar (1983) define adjustment as the dynamic process by which a person strives to satisfy inner needs through mature, efficient and healthy responses, while simultaneously striving to cope successfully with the demands of the environment in order to attain a harmonious relationship between the self and the environment. He thus asserts that the development of healthy relations within the self and the environment implies good adjustment.

According to Brown & Srebalus (1988), adjustment refers to “coming to terms with the important features in human life. It also includes coming to terms with the other human beings, becoming able to co-exist with them in relative harmony”, p.20.

Generally the term refers to the relationship that any organism establishes with respect to its environment. Reber & Reber (2001) state that the term refers to the social or psychological adjustment, and when used in this sense, carries clear positive connotations, e.g. well-adjusted. The implication is that the individual is involved in a rich, ongoing process of
developing his or her potential, reacting to and in turn changing the environment in a healthy, effective manner.

1.9 RESUMÉ

The information contained in this chapter suggests that the South African Government recognises the educational rights of persons with disabilities. In this chapter the background of the study was presented. Among the matters discussed in this overview are the reasons that have led to this study. Such reasons include the prevalence of disability among South African children and youth; the advent of the Inclusive Education Movement that seeks to have children with disabilities and youth educated in mainstream educational institutions rather than in special schools set aside for them.

This study took place at the Turfloop Campus of the University of Limpopo in the Limpopo Province. Policies that have been developed by this university and other tertiary institutions regarding the education of students with disabilities were outlined.

The nature, motivation, aims and objectives of the study were stated. The key focus areas of the investigation, namely study skills, life competencies and skills, and general career choice and development were also enunciated. The questions regarding whether the wellness promotion programme would significantly improve the three (3) variables of those students who would be exposed to the programme were posited.

The instruments used to evaluate the programme were each introduced. The significance of the study was indicated. Key concepts were broadly defined and described in the manner that would be clearly understood. All in all, this chapter has attempted to comprehensively bring together background information about the study.
CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The preceding chapter has demonstrated that the numbers of students with disabilities at the University of Limpopo (Turfloop Campus) have increased tremendously since the first intake in 1976. Since students attend special schools from grade R up to grade twelve (12), when they go to tertiary institutions they experience a number of challenges that warrant programmatic intervention and the attention of a psychologist.

In this chapter a detailed exposition of wellness will be outlined so that the reader can have a clear picture and understanding of wellness. The concepts that will be discussed below serve as a significant theoretical underpinnings of the entire study. They point to areas of human functioning where Wellness is compromised.

2.2 CAUSES OF DISABILITY

A significant proportion of disabilities and consequent disability faced by children throughout the world arise from preventable factors. Nowhere is this more evident than in South Africa. The causes of disability include the following:

2.2.1 Poverty: General sequelae of poverty such as illness, pre- and peri-natal problems, such as genetic disorders and birth trauma, injuries, accidents and violence are major contributory factors. Disability is also caused and increased by factors such as overcrowding, poor living conditions, lack of access to information and adequate diets (Schneider, in Simon-Meyer, 1999). McClain in the South African Human Rights Commission (SAHRC) Report on Disability states that “poverty causes disability and disability causes poverty” (2002, p.18).

The South African Human Science Research Council (2002), documents that there is a high incidence of disability amongst poor people. To affirm this, the World Health Organisation (2003) states that 80 percent of persons with disabilities in the world live in low-income countries, with the majority being poor and having no access to basic services, including
rehabilitation facilities. On the African continent the estimates are put between one and two percent of the population.

2.2.2 The “dop” system: In South Africa some causes of impairment have their roots in the apartheid dispensation in our country. For example, many children were born on farms where their parents were poorly paid, lived in appalling conditions and grew up in abject poverty. Common on those farms was the practice of the “dop” system of payment whereby wages were paid in part with wine. This practice resulted in high levels of alcoholism with foetal alcohol syndrome (FAS) a major problem. Studies in the Western Cape in South Africa, for example, have indicated an incidence of 5% of children suffering from FAS, the highest in the world, as contrasted with an average incidence of 0.4%. There is evidence that the wine used in the payments is shared with children, thus perpetuating the risk of high levels of alcoholism (Fletcher, 1995: Lansdown, 2003).

2.2.3 Inadequate nutrition, unhygienic living conditions, overcrowding, exposure to pesticide poisoning in the farms, accidents, violence and inadequate medical services all contribute to high levels of impairment. Inadequacy of primary health care and genetic counselling services; weak organisational links between social services; inadequate treatment of the injured when accidents occur; and the incorrect use of medication contribute towards disability (INDS, 1997).

Simon-Meyer (1999) believes that poor management management of chronic illnesses like diabetes and poor medical services for pregnant women in rural areas resulting in pre- and peri-natal problems are some of the contributory factors.

Violence is one of the major concerns in South Africa. It often results in severe injuries and/or loss of consciousness, with disabling and lifelong physical and mental consequences. Motor vehicle accidents as well as those occurring in the industrial and agricultural sectors also contribute towards the increase of disability (INDS, 1997; Helander, 1999). All these factors usually affect the poor communities and farm employees.
2.2.4 Diseases

In developing countries like South Africa, large numbers of people have long-lasting or recurrent disability resulting from bacterial or parasitic diseases, cancer, HIV and Aids (Helander, 1999).

The researcher elaborated on HIV and AIDS because in South Africa the spread is rapidly becoming a growing cause of disability amongst children. Current data indicates that 1 in 5 adults are infected with the HIV and 1 in 9 of the population as a whole. It is estimated that a quarter of women who attended public health facilities in 2000 were infected. Pregnant women in their twenties show the highest infection rate at 30.6% (Department of Health, 2003).

Recent projections on death rates published by the Medical Research Council of South Africa indicate that by 2010, one third of all deaths will be from HIV and AIDS and that by then, there will be 2 million AIDS orphans (Dorrington, Bradshaw, Johnson & Budlender, 2004).

2.3 TABOOS, MYTHS AND STIGMA REGARDING DISABILITY

Disability in South Africa, especially in the poor rural areas, is still surrounded by stigma and prejudice. Having a child with disability is associated with punishment, a curse and failure. Parents of children with disabilities often experience ostracism within the communities, and the birth of a disabled child doubles the likelihood of abandonment. In rural areas, it is common practice for men to leave their wives after the birth of a disabled child. It is the wife who is seen to blame for the impairment. Furthermore, this abandonment is not frowned on, indeed is largely condoned by local communities.

In urban areas, where men also frequently leave their wives after a disabled child is born, it seems that men are seeking to escape the associated pressures of caring for the child rather than the stigma associated with the birth. However, the consequences of the abandonment are the same. “The vast majority of disabled children are being brought up in single-parent households. For example, in one special school for 200 children, only 20 had a residential male parent”, (Landown, 2002).
The impact of these negative attitudes is that disabled children are frequently hidden from view, kept in backrooms, their existence and their human rights largely denied. Most people do not expect people with disabilities to have any potential for success rather, they seen them as a burden. Attitudes to disability are a major barrier to persons with disabilities’ full participation, from pity, awkwardness and fear, to low expectations about what these people can contribute (Massie, 2006). Stereotypical and negative attitudes hold people back. These cultural and social factors have a detrimental effect on the parents, the community, and most importantly, the child with disability.

2.3.1 Albinism

Although Albinism is a common condition in Africa, accurate knowledge and information about the condition in some countries on the continent is inadequate (Raliavhengwa, 2001). As a result of the unusual appearance and symptoms which are particularly striking in the Black population, Albinism is surrounded by many myths and beliefs which lead to discrimination and lack of acceptance by various communities (Kromberg and Jenkins, 1984).

In Nigeria the traditional views on Albinism associates it with inbreeding, and other weird aetiological theories ranging from the gods, to conception during menstruation, or to seeing frightening sights during pregnancy (Okoro, 1975). Zimbabweans believe that someone who has been unkind or unpleasant to an individual with Albinism would bear a child with Albinism (Lund, 1997).

In South Africa, like in other African countries, different cultural groups have different beliefs, myths, taboos and views about Albinism. For instance, there is a general belief that a child with Albinism is born as a result of various foods taken in excess during pregnancy or due to the mother conceiving during menstruation or positively as a sign of good luck (Sacharowitz, 1999). The Vendas in the Limpopo Province believe that individuals with Albinism do not die, but disappear.

It is stated in Sacharowitz (1999) that the Albinism Society of South Africa (ASSA) is educating communities on the various aspects of albinism and provides a support base for its members. The ASSA activities will thus help communities deal with the superstitions
associated with Albinism as a disability and also help individuals with the condition to be accepted by communities.

### 2.4 THE PREVALENCE OF DISABILITY IN SOUTH AFRICA AND THE LACK OF RELIABLE INFORMATION

The 1997 Integrated National Disability Strategy stated that “there is a serious lack of reliable information on the nature and prevalence of disability in South Africa. This is because in the past disability issues were viewed chiefly within a health and welfare framework. This led naturally to a failure to integrate disability into mainstream government statistical processes”, (Office of the Deputy President, 1997, p.1).

Other factors that lead to lack of reliable information about disability in South Africa are for instance differing definitions of disability, the use of different methodologies in the collection of survey data, negative attitudes towards persons with disabilities which undermine the conduct of research, poor infrastructure for persons with disabilities in underdeveloped areas, and levels of violence in society which have impeded data collection, (Office of the Deputy President, 1997).

According to the South African Human Rights Commission estimates of the prevalence of disability ‘from a range of sources suggest that more than seven percent of the total population or over three million people have moderate to severe disability’ (SAHRC, 2002,p.16). However, the data collected in the 2001 Census shows that there are 2 255 982 persons with disabilities among a total population of 44 819 778 (StatsSa, 2003). This therefore constitutes a prevalence rate of 5%, which falls between international estimates of 4% in developing countries and 7% in developed countries (Health Systems Trust, 1999). From these figures the South African prevalence of disability can only be estimated at somewhere between four and seven percent. These estimates however, remain contested by the Disabled People’s Organisation which argues that this is an underestimation of the number of disabled people in the country (DPSA, 2003).
2.5 TYPES OF DISABILITY

Anello (1998 as cited in Naidu et al. 2005) identified six types of disability, which are:

- Physical: they take the form of limitations in mobility and may result from neurological conditions, orthopaedic conditions or spinal cord injuries.
- Developmental or intellectual: these are usually associated with delayed or limited development in learning that affects a person’s ability to understand, remember or differentiate.
- Mental health or psychiatric: these include disorders such as Major Depression, Schizophrenia and Bipolar Disorders.
- Learning: these usually relate to a neurological dysfunction which affects the brain’s ability to process information, and may include dyslexia.
- Hearing: these can range from partial hearing loss to deafness;
- Visual: these can range in degree from poor vision to blindness.

2.6 CONCEPTUALISATION OF DISABILITY

Disability, its causes and remedies are understood in a variety of ways. Naidu, Haffejee, Vetten and Hargreaves (2005) argue that the conceptual framework applied by law and policymakers, as well as programme designers, influences the way they frame and address the needs of people with disabilities. In the same breath, the ways in which ordinary people think about or make sense of disability determines how they respond to persons with disabilities.

Views of different scholars regarding disability:

2.6.1 General view by the general population

There are people who view disability as:

- Punishment for sin, or as a means of inspiring or redeeming others (Gill, 1999). This is a religious or moral viewpoint.
- People who are unable to make life choices and, therefore, unable to participate as worthy citizens. To correct this view, non-disabled people or welfare-based institutions
were established which created a ‘caring environment’ as an alternative to persons with disabilities having to beg or hide away.

2.6.2 The medical model

This model views disability as a medical malfunction needing to be corrected. From this perspective disability is:

- Always a problem or measurable defect (rather than a way of being in the world);
- Seen to diminish the quality of life in some way (rather than merely changing the lifestyle);
- In need of cure or alleviation (rather than social accommodation); and
- To be addressed by medical experts (rather than other experts).

A sense of dependency, with health workers seen as central to the decision-making process of people with disabilities (Philpot and McLaren, 1997).

This model has resulted in the neglect of persons with disabilities’ wider social, economic and political needs and has translated into a more isolated existence for many people with disabilities (Gill, 1999).

In the medical model of disability the definition of disability thus focuses on the physiology of the impairment and the perceived deficits of the individual rather than on the barriers in society that prevent him or her from doing several things that need to be done.

On the contrary, opponents of the medical model argue that this way of looking at disability has contributed to the ongoing discrimination against and marginalisation of disabled people in a number of important but often unrecognised ways. Attention is distracted from issues of discrimination and the rights of people who have impairments. In this way, disability becomes something that is ‘imposed by society when a person with impairment is denied access to full economic and social participation’, (South African Human Rights Commission, 2002 p.10). It is asserted that if disability is looked at in this way, then a definition must describe the relationship between a person with impairment and the society or environment of which he or she is part. Oliver (1990) refers to this as the social model of disability.
2.6.3 The World Health Organisation

Drawing from the medical conceptualisation, the World Health Organisation (1980) distinguishes between impairment and disability:

- The World Health Organisation defines impairment as any loss or abnormality of psychological, physiological, or anatomical structure or function.
- Disability is defined as any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.
- In this way impairment is defined objectively in terms of observable function, while disability is defined in relation to what is considered ‘normal’ for an individual (UN, 2002).

2.6.4 The social model

According to the social model, disability refers to the disadvantage or restriction of activity caused by the way society is organised which takes little or no account of people who have physical, sensory or mental impairments. As a result such people are excluded and prevented from participating fully on equal terms in mainstream society. Disability is thus imposed on people with impairments who, as a result, become disabled not by their impairments, but by society (Union of the Physically Impaired Against Segregation, 1976 in Philpott & McLaren, 1997).

In the context of higher education, the above definition refers primarily to the relationship between a student with impairment and the process of teaching, learning and research. It is stipulated in the South African Higher Education Responses to Students with Disabilities that the collective disadvantage of disabled people is due to a complex form of institutional discrimination. This discrimination is said to be fundamental to the way society thinks and operates. The disability rights movement believes that the ‘cure’ to the problem of disability lies in restructuring society. The social action model of disability thus implies a paradigm shift in how we conceptualise disability.

The social model views disability as a human rights issue. It emphasises that the barriers disabled people face are the consequence of the psychological and social responses of
communities and the socio-political structure of societies, rather than individuals’ particular physical, mental or emotional impairments. McClaren (1997) and Saxton and Howe (1984) argue that this paradigm shift focuses on the ‘disabling world’ where people with disabilities are unnecessarily segregated, ostracised and mistreated. The social model thus calls for the removal of barriers that marginalize people with disabilities and instead challenges the disabling world.

In this perspective disability, according to Naidu et al (2005):

- Is part of the variety of human difference (and therefore does not need eradication because the individual’s difference is not the primary problem);
- Derives its meanings from society’s responses to individuals who deviate from cultural standards (and is not inherent in the individual);
- Depends on the quality of the arrangement between the individual and society (and not on the severity of the disability); and
- Can be addressed through a range of options, involving many experts, because problems of disability arise from a complex interaction between the individual and society, and are not attributable to the individual (Philpot and McClaren, 1997; and Saxton and Howe, 1984).

For example, this model believes:

- it is the stairs leading into a building that disable the wheelchair user rather than the wheelchair.
- it is the defects in the design of everyday equipment that cause difficulties, not the abilities of people using it.
- it is society’s lack of skill in using and accepting alternative ways to communicate that excludes people with communication disabilities.
- it is the inability of the ordinary schools to deal with diversity in the classroom that forces children with disabilities into special schools.

Gill (1999) further asserts that disability has recently become and seen as a social construction in response to biological variations.

- The social model views disability as a human rights issue.
Barriers persons with disabilities face are the consequence of the psychological and social responses of communities and the socio-political structure of societies, rather than individuals’ particular physical, mental or emotional impairments.

Philpot and McClaren (1997) and Saxton and Howe (1984) view this paradigm shift as focusing on the ‘disabling worlds’ where people with disabilities are unnecessarily segregated, ostracised and mistreated.

This model calls for the removal of barriers that marginalise those with disabilities and instead challenges the disabling world.

The social model is preferred as compared to the other models because it seeks to develop, empower and integrate disabled persons into society. The South African Government has adopted this model in its endeavour to more adequately cater to the needs of people with disabilities.

2.6.5 The Disability Rights Movement

The Disability Rights Movement argues that problems of disability arise not so much from individuals’ impairments but from the way that society is organised and perceives disability. The movement differentiates disability from impairment as follows:

- disability refers to the disadvantage or restriction of activity caused by the way society is organised which takes little account of people who have physical, sensory or mental impairments. This result in people with disabilities being excluded and prevented from participating fully and equally in mainstream society; and
- impairment refers to a part of the body which is impaired in some way and results in limitations in its functioning (Philpot and McClaren, 1997).

The above definition serves to shift the focus away from the disabled individual to the disabling society which sees disability as a product of the built environment which is reinforced by social values and beliefs (Bagilhole, 1997).
ISSUES AND CONCERNS ABOUT DISABILITY AT INSTITUTIONS OF HIGHER LEARNING

Issues and concerns about disability at institutions of higher learning relate first and foremost by grappling with the definition of disability. Research shows that there are many debates and a number of assumptions about what disability is in the higher education context. The concept of disability is highly contested. The way in which disability is understood and interpreted determines who the society defines as being disabled or having a disability, the prevalence of disability in our society and thus the size of the existing and potential pool of students with disabilities, and most importantly, what is needed at both systemic and institutional level to ensure equity for disabled students and prevent any form of unfair discrimination against them, (South African Higher Education Responses to Students with Disabilities, 2005).

Over the past 22 years there have been substantial challenges to dominant perceptions of and attitudes to disabled people. A person who has some kind of physical or sensory impairment is seen as being incapable of undertaking various activities in ways which are regarded as normal. Such notions of disability imply that people who have impairments will ‘always be seen as inferior, or second rate, or inherently flawed’, (Disabled People South Africa, 2001; p.10).

People with disabilities are seen as disabled because of the existence of impairment rather than because of the way society responds to the impairment and whether it provides the accommodation or support they may need to participate equally. Thus, a person who uses a wheelchair is regarded as disabled because he or she cannot walk up a flight of stairs rather than because society has failed to provide ramps to enable him or her to enter a building, (South African Higher Education Responses to Students with Disabilities (2005). Fulcher (1989) refers to this dominant way of understanding disability and the associated attitudes and responses to disabled people as the medical discourse on disability.

The Quality Assurance Agency of the United Kingdom has developed a code of practice to help institutions of higher learning achieve equitable and appropriate provision for students with disabilities. The code emphasises that institutions should be aware that disability covers a wide range of impairments including physical and mobility difficulties, hearing impairments, visual impairments, specific learning difficulties including dyslexia, medical conditions and
mental health problems. Some of these impairments may have few implications for a student’s life or study, while others may have little impact on day to day life but may have a major impact on a student’s study, or vice versa. Some students may be disabled temporarily by an accident or illness.

Institutions of higher learning are a good example of micro communities within macro communities. Students at these institutions also come across challenges that affect their academic achievement adversely. They also experience health-related factors affecting academic achievement. Examples include stress, sleep difficulties, concern for a troubled friend or family member, relationship difficulties, depression, anxiety, death of a friend or family member, alcohol and drug use, divorce, etc.

Given the potential negative impact of the critical health issues affecting academic success, retention, persistence and graduation, it is essential that institutions of higher learning create comprehensive services and programmes that advance the health of students as they foster the learning and personal growth of students.

Health campus strategies must be multidimensional, including educational environment approaches, and must be integrated across multiple departments, campus locations, and student learning activities, both inside and outside the classroom.

To successfully address the health and the well-being of our students, psychologists, student affairs professionals and members of staff in academic departments must plan and apply consistent educational methods and messages, policies, and enforcement practices, and must promote meaningful utilisation of campus and community resources for early intervention and treatment. The community-minded psychologist plays a great role in this regard.

Creating a healthy campus community may also require adjustments in admission procedures, academic requirements, residential life options, dining options and student activities. At the University of Limpopo where the present researcher is currently working, the factors mentioned above are generally addressed in a very inadequate manner. This seems to be the case at other institutions of higher learning.
2.8 Access to Institutions of Higher Learning

Institutions of higher learning are becoming increasingly aware of their social and legal obligations towards students with disabilities. Almost all institutions worldwide now admit students with disabilities because it is now a known fact worldwide that it is unlawful to discriminate in education on the grounds of disability, Council Report CR112, 2003. Institutions of higher learning are required by government to take steps to address the disadvantages suffered by people with disabilities. Access to education for people with disabilities is no longer an issue of privilege, it is a right.

The Bill of Rights states that “no person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3)”, The Constitution of the Republic of South Africa, S9(3). Subsection (3) lists those grounds as “race, gender, sex, religion, disability, and so on.”

In the section dealing with principles, the White Paper on Higher Education states that “The principle of equity requires fair opportunities both to enter higher education programmes and to succeed in them. Applying the principle of equity implies a critical identification of existing inequalities which are the product of policies, structures and practices based on racial, gender, disability and other forms of discrimination or disadvantage, and a programme of transformation with a view to redress.”

In the UK and other first world countries, access is also granted to students with mental health problems. In these countries, knowing well that, mental health problems can be severely disruptive to the student’s capacity to study and learn, students with mental illness are diagnosed and screened prior to admission for the institutions to prepare for them in advance. Although at the University of Limpopo students with mental illness are admitted, screening is not done prior to admission. The condition is only known to the institution after the student has relapsed.

Increasing concern has been expressed about the mental health of students in higher education all over the world. The increasing number of students presenting with mental health problems reflects the rapidly increasing access of young people to higher education and the associated growth in student numbers, Council Report CR112, 2003.
Higher education has an important role to play in enabling people with established psychiatric problems to develop their personal, social and intellectual potential, and thereby to make a productive contribution to society. In certain cases entry to higher education is an important part of a patient’s recovery from psychiatric illness. However, caution is needed as institutions of higher learning imposes significant demands on the individual and may precipitate intolerable distress and illness relapse, Council Report CR112, 2002.

The South African first White Paper on Education and Training commits the Government of National Unity to a unified education and training system which is ‘committed to equal access, non-discrimination and redress’, White Paper on an integrated national disability strategy, 1997. In acknowledging a broader range of qualifications and acquired knowledge, The National Qualifications Framework will give people with disabilities better access to formal education and the job market. It is therefore important for persons with disabilities to be given equal access to institutions of higher learning so that they can be on par with their non-disabled peers.

The Council report CR112, 2002 mentions two important considerations which we have to take into account when researching about what persons with disabilities experience when they want to gain access into institutions of higher learning in South Africa. These are:

- lack of accurate, reliable and useful information about disability in South Africa. This problem affects the way the society measures the prevalence of disability in our society and the extent to which persons with disabilities have been discriminated against and prevented from accessing essential services such as education; and

- the difficulty experienced by persons with disabilities in South Africa, especially blacks who have been previously disadvantaged in a number of ways under the apartheid system, including substantial exclusion from all levels of education.

The majority of the White population with disabilities were disempowered by a system which saw them as a health and welfare problem; i.e. a medical model approach. On the contrary, Blacks’ disempowerment was exacerbated by the poverty and violence resulting from the
Apartheid system. It is, therefore, against this background that persons with disabilities’ experience in accessing higher education must be considered.

Looking at the South African History, in the few special schools which were available, the curriculum was “inappropriate” for preparing the learners for the world of work, where we found only a few of those schools offering tuition up to matriculation level (Department of Education, 1998). This system, therefore, equipped learners with minimum academic requirements for entry into institutions of higher learning. As such, the majority of persons with disabilities were barred from institutions of higher learning. As can be seen by what follows below, this situation has changed drastically.

2.9 THE UNIVERSITY OF LIMPOPO – TURFLOOP CAMPUS

Many institutions of higher learning including the University of Limpopo currently admit students with disabilities. For example, looking at the statistics at the University of Limpopo, Turfloop Campus from the year 1975 when the first student with disability was admitted, the numbers have increased tremendously; especially when we look at the University as one of the institutions of higher learning which caters for the rural poor.

2.9.1 Policy statement

The large numbers of students with disabilities enrolling with the University can no longer be ignored. The White Paper on Education and Training, Public Discussion Document (1997) is focusing on the development of education to ensure that the system becomes more responsive to the diverse needs of the learner population. This includes ensuring that the appropriate support service is provided to the learner. According to this document (1997, p.7) “support required by learners or the system itself includes teaching and learning support, including particular teaching and learning interventions, assistive devices, sign language, interpretations, etc.” Support provided through assistive devices includes brailling facilities, specialised communication devices and appropriate information technology.

The University of Limpopo’s motto is as follows: the University of Limpopo for human and environmental wellness in a rural context - finding solutions for Africa. This shows that the University is concerned about the wellbeing of its entire community. The University of
Limpopo believes in equality of all individuals. The Constitution of the Republic of South Africa, government policy documents and various pieces of new legislation make it clear that discrimination on the basis of disability violates the right to equality. It recognises that individuals are not always treated equally; students with disabilities experience discrimination; special measures are required to address the problems and needs of the disabled students, and mainstreaming is the first step towards eliminating prejudices against students with disabilities.

To achieve its objectives of social and academic integration of students with disabilities the University of Limpopo, therefore, commits itself, where possible, to provide access to academic programmes and facilities for these students. The policy’s purpose is to facilitate admission and full participation of the disabled students in University life.

2.9.2 Reakgona Disability Centre (Reakgona – translated “we are able”)

The University has a support service unit which caters for students with disabilities. This unit is called Reakgona Disability Centre. The unit aims at providing effective programmes and services through collaborative dealings with students, tutors, faculties, administration and other support services on campus. Such efforts demand mutual understanding and supportive attitudes from all concerned. The services provided include orientation and mobility, computer training, low vision reading training, Braille and audio library services.

Students with disabilities are as human as other students on campus. They experience personal, study, financial, course, academic, career, medical, etc. All these problems may cause stress and instability in their well-being hence the researcher deemed it necessary to introduce a wellness promotion programme for the students.

The vision, mission and objectives of the centre as stipulated in the draft policy and brochures follow below:

**Vision:** The centre strives to destroy limitations of body and mind and to open doors of opportunities for the persons with disabilities by providing accessible facilities with up-to-date technology so that they can plough back into the community skills and knowledge they have acquired.
Mission: the centre provides appropriate support to empower persons with disabilities on campus and in the community. Empowerment occurs through education, training, and development- encouraging independence and active participation in the academic and socio-economic world.

Objectives:
- To provide equity and the opportunity for full participation for the students with disabilities in both academic and social life.
- To put in place mechanisms that will help the students with disabilities to feel as part of the university community.
- To re-educate the university and the community to develop a positive attitude towards persons with disabilities.

The Unit recognises the need to develop and empower the disabled so that they can take full responsibility for their own lives and needs and to be active participants in the academic and socio-economic world which is becoming increasingly competitive. All in all, the centre aims at promoting total integration of the disabled students into the entire university community.

The University of Limpopo is not the only institution of higher learning in South Africa which has established a special unit to assist students with disabilities. Other tertiary institutions in the country have set up similar units to address the needs of these students.

The researcher is not going to review the relevant support units at all the tertiary institutions in South Africa, rather will take a brief look at the disabled students unit at one other university in the country, namely, the University of the Witwatersrand. This will give a portrayal of the efforts that tertiary education institutions are making to address the needs of students with disabilities. Wits started accepting students with disabilities in the mid eighties (ILO, 2005).

2.10 WITS POLICY ON DISABILITY

The University of the Witwatersrand has identified the need to ensure the diversification of staff and students as a strategic imperative, stating in its strategic plan that “the University community will reflect and respect diversity”. The university believes staff and students with
disabilities bring unique qualities, competencies and skills to the institution which serves to enrich and add value to the institution’s endeavours. The University thus aligns itself with The Promotion of Equity and Prevention of Unfair Discrimination Act4 (2000).

2.10.1 WITS statement of principle

The University of Witwatersrand is committed to the promotion of equal opportunity for all persons. It strongly supports the rights of people with disabilities to be involved in higher education both as employees and students.

“The University will foster and encourage amongst its staff and students positive and unprejudiced attitudes towards people with disabilities and shall make provisions, in so far as resources reasonably permit, for any service needed by and for people with disabilities” (University of the Witwatersrand Policy on Disability). The policy goes on to state that positive steps will be taken to encourage people to seek admission to or employment with the University regardless of disability; and also that the university will endeavour to ensure that teaching promotes an understanding of disability and that its research pursues the creation of knowledge around disability.

2.10.2 Students with disabilities at WITS

According to the Wits University policy, students with disabilities have rights like all South African citizens. The students have equal access to courses, programmes, academic adjustments and/or auxiliary aid; reasonable and appropriate accommodation, services, activities and facilities; confidentiality of all information pertaining to the disability with a choice of whom to disclose their disability to, except as required by law; and also that the students have the right to information reasonably available in accessible formats.

Concerning the issue of admissions, Wits University welcomes students with disabilities and admits them using the same criteria as for other students, such as academic ability and suitability for the course and degree.

Regarding teaching and examinations, Wits University’s standpoint, like that of the University of Limpopo, is that students are evaluated on their abilities not their disabilities. Where
practicable, methods of teaching and assessment are modified to take account of difficulties experienced by these students. These special arrangements minimise any handicap and they do not advantage students in any way.

2.11 CHALLENGES OF STUDENTS WITH DISABILITIES IN GENERAL

There are various challenges faced by students with disabilities at institutions of higher learning. The fact that students with disabilities attend special schools, both primary and high school, which exclude these students from the non-disabled persons, make them vulnerable when they enter institutions of higher learning. At institutions of higher learning, lots of communication is done and information is disseminated through normal writing, notice boards, circulars, newsletters, etc. This method of dissemination is not user-friendly to blind students.

Makgato (2005) in the University of Limpopo: Committee for Persons with Disabilities report outlined the following as some of the challenges faced by students with disabilities:

2.11.1 Special school versus university life

At special schools students live with other learners with disabilities. The numbers are lower than at the university; for example, at special schools you may find there are twenty learners in a classroom as compared to the university where students find themselves in massive classes where the numbers go up to three hundred or more. At the university there are students who were never exposed to those with disabilities (Makgato, 2005 in the University of Limpopo: Committee for Persons with Disabilities report). Sometimes when students with disabilities ask them to accompany them to certain classes or push them to lecture halls, they sometimes run away or tell them they were not going to the same lecture halls, only to find that when the disabled student arrives at the lecture hall, the same student is already there.

Some non-disabled students confess that they are scared of persons with disabilities while some indicate they were ashamed as their friends may think they are related to them. In high schools staff members are trained to work with students with disabilities. Emotional difficulties arise when students with disabilities face rejection from non-disabled students.
For this group of students to succeed in the new social environment, they need to integrate with the rest of the university community.

2.11.2 Coping with academic work

Students with disabilities are faced with the challenge to introduce themselves and to explain their disabilities to the lecturers. It is the responsibility of the student to guide the lecturers as to how they would like to be assisted because they have already been equipped with the requisite skills at primary and high schools. Some lecturers often mistake these with requests for pity, sympathy, overprotection, favour, etc. (Makgato, 2005 in the University of Limpopo: Committee for Persons with Disabilities report).

**Totally blind** students use tape recorders to take notes in class. These are transcribed into braille or students listen to the cassettes.

**Partially sighted** students usually take notes by writing and using tape recorders. Often times they find it difficult to read from the chalkboards. Their notes are typed in large print.

**Students affected by stroke:** This group of students is usually a little slower as compared to their peers. They may experience spelling and articulation problems.

Students with disabilities often submit assignments late as a result of time being consumed by the process of brailling material, seeking assistance from non-disabled students, being given special lecturers, and so on. Another factor is that the unit responsible for this community is severely understaffed.

Entry into institutions of higher learning presents the student with additional challenges at a time when the transition from adolescence into adulthood is in full swing. In addition to the usual physiological, emotional and cognitive changes associated with this developmental process, students are confronted with a number of major life events, including separation from family, friends and school peers, and having to adapt to a different structure and learning style which requires more self-reliance, self-motivation and self-teaching, Council Report CR112, (2003).

This means these students must master the generic tasks of coping with greater individual autonomy such as for example, taking responsibility for their budgets and finances, managing
their own physical and emotional welfare, and coping with unsupervised relationships and other experiences.

In the UK students with pre-existing mental health problems are entering institutions of higher learning in huge numbers. These students often arrive without any prior warning of their needs resulting in discontinuity of treatment and follow-up. This, added to other university stresses increases the likelihood of their breakdown. As many as 60% of first entering students report homesickness, and of all university students are at the greatest risk of developing mental health problems (Adalf et al, 2001). This can be compounded by the lack of a confiding relationship and a subjective feeling of loneliness which has shown to be correlated with symptoms of anxiety, depression, alcohol and drug misuse, and suicidal ideation (Curtona, 1982; Perlman & Peplau, 1984).

The numbers of students with disabilities are gradually increasing, but the number of staff members remains the same. With the increasing bureaucratic demands inherent to their work, academic staff members have less time to fulfill their pastoral role (Grant, 2002).

2.12 AN OVERVIEW OF WHAT WELLNESS IS

According to the New Brunswick Select Committee on Health Care (2001) wellness refers to the state of emotional, mental, physical, social and spiritual well-being that enables people to reach and maintain their personal potential in their communities. It is a holistic approach to the life-long spiritual, physical and emotional development of the individual. It includes all aspects of life, from business to educational institutions and the home. Wellness provides students, employees and management with the skills needed to make the right choices. High level wellness is a necessary condition for enhanced levels of individual performance (Eastern Cape Office of the Premier, 2007).

The five aspects of well-being are each important, but more importantly, they need to be in balance to enable individuals move towards improved wellness. The concept of community is important because the social context in which we live impacts on our well-being. Health promotion, prevention, and the determinants of health or factors that influence our health are also key components of the wellness paradigm.
The World Health Organisation defines health promotion as the process of enabling people to have increased control over, and to improve their health. The concept of having “control over” or being “empowered” to improve health is especially important. All in all, health promotion is about encouraging individuals and communities to make healthy lifestyle choices.

O’Donnell (1992) describes health promotion as the art of science of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices. Of these three, supportive environments will probably have the greatest impact in producing lasting change.

In general terms, prevention refers to preventing disease and injury. In terms of wellness, for example, Health Canada in the New Brunswick Select Committee on Health Care report (2001) defines prevention as activities aimed at reducing factors leading to health problems, disease and injury.

There are a number of interrelated factors that influence an individual’s health. These factors are referred to as the determinants of health. They include amongst others, income and social status; social support networks; education, employment and working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender and culture (New Brunswick Select Committee on Health Care report, 2001).

### 2.13 WHO IS RESPONSIBLE FOR WELLNESS?

The individual, the family, the institution, the community, the government and the physical and social environments are all responsible for wellness. In fact, wellness is a shared responsibility.
2.13.1 Individual responsibility

Individuals are believed to be ultimately responsible for their own health. It is a fact that not all of us have the same ability to make healthy lifestyle choices, because choice may be affected by factors such as income, education or an individual’s disability.

The message is really, showing how it (individual responsibility) actually affects other people. “If I don’t look after my own health for instance, this is what it is doing to my family. This is what it’s doing to my tax rate. We have to connect those things to the larger picture. Also, if I am healthy, these are the resources I bring to people. My actions influence the lifestyle of other people” Lyons (2001) in the New Brunswick Select Committee of Health Care report, 2001.

2.13.2 Family Responsibility

Emphasis is put on adults’ responsibilities towards their families. It is the responsibilities of parents to make good choices for their children. The pathway to wellness is influenced by experiences in the family in the first place, then at the school and in the community (Moskowitz, 1989, Beck et al., 1991 and NIDA, 1997). In summary, “families are responsible for the health of family members, and that parents are the most important “wellness” role models children have,” New Brunswick Select Committee of Health Care report, 2001.

2.13.3 Institutional Responsibility

Educational institutions, for example, carry a responsibility to all their students. This is in accordance with what traditionally and conventionally is known and accepted that when parents send children to school, they have faith and trust in the school. When children are at school, the teachers are their parents, i.e. the school is responsible for children when these children are at school. Equally the same, when learners are at institutions of higher learning, the institution is responsible for those learners. The academic institutions become surrogate homes for students and as such are expected to provide an environment that promotes total self-development (Phaswana-Nuntsu, 2002).

The provision of academic skills is equally important in the nurturing of each student’s individual personality and skills (Edmonds and Wilcocks, 1995). For the good health and
wellness of students, institutions are responsible in initiating programmes which will enhance students’ general well-being. This will result in fully functioning individuals who are actualising themselves in the physical, mental and spiritual components of being.

2.13.4 Community Responsibility

At the community level the wellness programmes depend upon the integrated efforts of community organisations, agencies, businesses, local communities, public and private organizations and their units Phaswana- Nuntsu(2002). In community psychology it is believed individuals are not only responsible for their own health, but also have a responsibility for the health of their communities. In the same breath, communities need to take responsibility for individuals. Individuals and communities need to be empowered to take action to improve health. Saint John in the Brunswick Select Committee on Health Care report (2001), states that “communities are natural places for wellness to take root.”

The entire university community is supposed to play a vital role in nurturing students. Personhood in African thought is defined in relation to the community. Mentiki (1984) in Ratele et al, 2004, states that individuals in association with communities can accomplish things which they are not able to accomplish otherwise.

Every community has developed strategies that seek to promote individual wellness. Rituals also play important roles in the promotion of individual psychological well-being and health. In nearly all African communities there are set processes and ceremonies which the individual must undergo as essential “Rite de Passage.” These ceremonies seek to ensure the individual’s effective adjustment to his role in life and thus enhance her mental well-being. The wellness programme in this study will serve the same purpose to students with disabilities.

2.13.5 Government Responsibility

The government plays a pivotal role in all programmes and projects of the communities. “Government’s role is essential and pivotal to laying the foundation for communities, schools, workplaces and families to strive for wellness,” Saint John Community Health Centre in the New Brunswick Select Committee on Health Care report (2001). In South Africa, to some
extent, some government departments contribute to wellness though programmes such as Employee Assistance Programmes (EAPs).

Regarding students with disabilities, the government is responsible in the sense that there are facilities for students with disabilities at some tertiary institutions, to alleviate financial stressors, students are awarded bursaries and disability grants.

### 2.13.6 Shared responsibility

Shared responsibility refers to a situation where responsibility is in the form of collaboration and partnerships. No one is to shirk responsibility off on someone else, instead we are each individually and collectively responsible for our own health and the health of others. The First Report of the New Brunswick Select Committee on Health Care stated that “Wellness is everyone’s responsibility!” All levels of government, business, universities, community groups, health care and social service providers, schools, families, and individuals are responsible for wellness and need to work together to address wellness.

### 2.13.7 Physical and social environment

The physical environment has a significant effect on a person’s wellness. Open, well landscaped and well-laid out external environments with appropriate vegetation and flowers are conducive to psychological wellness. Interior environments with large rooms, appropriate room de’cor, good lighting and adequate air flow engender and reinforce a general sense of psychological wellness in individuals. On the other hand, dilapidated surroundings and overcrowded and shabby interior environments are conducive to the development of a variety of psychological disorders such as immoral, criminal, and even homicidal behaviour. The environmental conditions in single sex hostels in large cities in South Africa, are a case in point and so are the huge squatter camp settlements that are found through the length and breadth of the country.

Regarding the social environments, the community psychologist needs to know what strategies he will use to make the family, school, community and the larger social environments conducive to the promotion of psychological wellness. The wellness of an individual is predicated upon the wellness of the immediate family.
Family wellness, in turn, is related to community and social wellbeing. Domestic wellbeing, in turn, is closely tied to employment opportunities, community support, and adequate social welfare services (Cicchetti, Rappaport, Sandler and Weissberg, 2000; Cowen, 1994, 2000; Prilleltensky, Nelson and Pierson, 2001).

2.14 THE IMPORTANCE OF SOCIAL SUPPORT

Students with disabilities need social support so that they can succeed in their studies. Social support refers to the feeling of being supported by others. This can be divided into components of emotional, social appraisal, informational and instrumental support. Bunk, in Hewstone; Stroebe & Stephensen (1996) states that literature on social support provides a great deal of evidence for the stress reducing features of affiliation.

Social support has been found to be beneficial in terms of stress reduction, an effect that has been observed in respect of such divergent stressors as the transition to parenthood, financial strain, health problems and work related stress. Emotional support occurring in the context of close relationships appears to be especially helpful more so as those under stress can talk to someone who is accepting, can receive feedback without feeling rejected and can be reassured about their worth as persons (Willis, in Hewstone, Stroebe and Stephenson, 1996). Duffy and Wong (1996) refer to social support as an exchange of resources between two individuals perceived by the provider or recipient to be intended to enhance the wellbeing of the recipient.

According to Cohen & Willis (1985) social support seems to result in a certain amount of protection when stressful events occur. It is important to remember that social support exerts a generally positive effect on psychological wellbeing which is not confined to stressful life events.

Social support enhances an individual’s wellbeing. Through social support, individuals especially in groups, make contact with others and this will gratify basic affiliative needs. When individuals perceive that others care for them, they feel a sense of belonging (Duffy & Wong, 1996). Social support, thus seem to enhance self-identity and self-esteem. It also works for all individuals who are experiencing life changes.
2.15 POSITIVE ASPECTS BROUGHT ABOUT BY WELLNESS PROGRAMMES

The Council Report CR112, 2002, p.12 emphasises the value of institutions of higher learning in the UK, for positive mental health and the excellent work undertaken by many institutions in enabling vulnerable students to benefit from higher education. Generally, learning in a constructive and stimulating environment can enhance self-confidence and a sense of achievement. Institutions of higher learning may also promote socialisation, independence and self-reliance. Challenges are addressed and resolved. Identities are also formed. All these positive aspects of student experience are powerful factors in promoting self-esteem, resilience and sound mental health that protects against psychiatric disorder, even in the face of adversity.

2.16 RESUMÉ

This chapter presented the literature review about disability. The meaning of the concept: “disability”, as well as its causes was discussed.

Inclusive education has taken root in many countries of the world. As a consequence of these developments, educational opportunities up to tertiary level are available to persons with disabilities. In South Africa tertiary educational opportunities for disabled persons, particularly blacks are just becoming available.

While more persons are making use of these opportunities and are enrolling at tertiary educational institutions, they are faced by several challenges. These include physical issues such as access to venues, facilities and amenities by the disabled students; especially the blind and those with physical disabilities. These challenges are also of a cognitive and socio-emotional nature.

While students with disabilities are very much aware of what several service providers should do to assist them, they seem to be not so aware and concerned by what they themselves should do to promote their effective adjustment, welfare, and self-actualisation. Wellness as an attitude to and a practice of life was discussed.
For inclusive education to unfold effectively, the challenges that are faced by students with disabilities need to be addressed. For these challenges to be dealt with effectively, a programmatic approach need to be utilised. Such an intervention programme should both be intensive and extensive. The programmatic intervention strategy in question constitutes the subject of the study.
CHAPTER THREE

METHODOLOGY AND DESIGN

3.1 INTRODUCTION

This chapter addresses the methodological issues relevant to this study. Fouché and De Vos (1998) define a research design as a blue-print or detailed plan of how a research study is to be conducted. This blue-print or plan offers the framework according to which data to investigate the research hypothesis or question are to be collected in the most economical manner.

Currently more than ever before, researchers advocate for the use of applied research methodology in human services professions. They argue that while basic research is necessary for knowledge development, it is imperative to conduct applied research as it goes beyond just finding facts (De Vos & Fouché, 1998; Rothman & Thomas, 1994; Bless & Higson-Smith, 1995, 2000; Bechhofer & Paterson, 2000; Bickman & Rog, 1998). Applied research thus provides possible solutions to contemporary practical problems and challenges by designing interventions which will help in solving them.

3.2 CONCEPTUALISATION AND COMPILATION OF THE PROGRAMME

The project planning phase consisted of activities that preceded the development of the programme. It assumed a prerequisite, that is a “material condition” that implied the existence of a “problematic human condition” which can be addressed by developing the technology the researcher had in mind, Phaswana-Nuntsu (2002). In this study the researcher did a pilot study on the adjustment challenges of students with disabilities at the University of Limpopo (Turfloop Campus) in 2006.

Through this pilot study the researcher had determined the key areas that constituted a problem to the students with disabilities. The key components of the programme, namely
Physical, Psychological, Social, Cultural and Spiritual resulted from the pilot study. The outcome of the pilot study greatly shaped the present study. The pilot study is briefly reviewed below.

3.2.1 Preamble: Pilot Study and the results thereof

At the University of Limpopo (Turfloop Campus) the number of students with disabilities from less privileged backgrounds is increasing and tables one and two bear testimony to this. These students are less protected from the vagaries of life and are, therefore, more likely to suffer mental ill health and to perform badly academically.

The researcher did a pilot study as a precursor to this study on the adjustment challenges of students with disabilities at the University of Limpopo in 2006. The participants comprised five (5) females and three (3) males aged between eighteen (18) and twenty-nine (29) years of age. It was found that:

The challenges students encounter may lead to poor academic performance as well as poor mental health caused by stress. It is, therefore, the duty of community psychologists in collaboration with relevant stakeholders to promote good mental health and prevent stress related issues which may result in poor health.

The pilot study consisted of intensive and extensive interviews that a highly experienced interviewer conducted with a purposely selected sample of students with various disabilities. The students with disabilities also completed a questionnaire designed to determine the key challenges with which they were confronted on a day-to-day basis.

The verbal responses of the participants to the various questions posed by the interviewer as well as the written answers to the various items of the questionnaire clearly showed that there were innumerable challenges with which the students with disabilities were confronted. This awareness appeared to be more accurate with regard to external challenges such as lack of physical access to facilities and amenities which they need to
use to succeed as students. Such awareness did not seem to be that strong when it came to social and psychological challenges which refer more to internal attributes and functions than external ones. At times their “internal” efficacies seemed to be exaggerated due to lack of effective self-knowledge.

The participants displayed a great deal of awareness of these challenges. They even went on to suggest ways and means whereby these challenges could be addressed. Sometimes this acute awareness of the challenges faced by students with disabilities translated itself into a huge grievance with undertones of entitlement.

The students have also expressed a heightened level of perception of the alleged lack of concern, sensitivity and caring by their educators and caregivers; be they lecturing staff, residence officers and managers, university administrators, officers in various government departments and so on.

To a very large extent the participants’ verbal and written responses tended to point to an external locus of control for the participants. Perhaps this was to be expected given the daunting and “hostile” physical, social and psychological milieu with which the students with disabilities are confronted on a daily basis.

The person with disability has constantly to focus on these inhospitable elements of his world and cope as best as he can. He or she feels he is under constant challenge to deal effectively with these elements. Often times he or she feels he is a “helpless victim” who is unfairly called upon to meet challenges that are well beyond his capabilities. The world is too tough for him and there is pretty little or nothing that he can do about it.

Taking a global look at the participants’ responses a general lack of internal locus of control becomes apparent. As stated above, this is in keeping with the life and world view of disablement. The general attitude here is that “since I am a disabled person there is not much that I can do to help myself. The world around me must go out of its way and come to my assistance.” And yet, any personal growth and development and eventual
self-actualisation starts and ends with the self; in this sense effective actualisation becomes self-actualisation within an enabling physical, psychological, socio-cultural and spiritual environment.

In conclusion, the report reveals that there are several challenges faced by students with disabilities at tertiary educational level. These challenges relate to access to venues, facilities and amenities by students with disabilities; especially the blind and those with physical disabilities. The challenges faced by these students are also of a cognitive and socio-cultural nature. These challenges also assume a spiritual dimension.

The services provided to students with disabilities by various providers are perceived as inadequate. While these students are acutely aware of what a plethora of service providers can do to assist them they seem to be not so aware of and concerned about what they themselves should do to promote their effective adjustment, welfare, and self-actualisation.

One of the key educational policies in post-apartheid South Africa is Inclusive Education. As a matter of fact Inclusive Education is also advocated in several countries of the world. For Inclusive Education to unfold effectively, the challenges that are faced by students with disabilities need to be addressed. For these challenges to be dealt with effectively, a programmatic approach should be utilised. Such intervention programme should be both intensive and extensive.

3.3 RESEARCH DESIGN

A Descriptive Survey and a Quasi-Experimental Designs were used in this study. The Descriptive Survey Design basically describes the population to be studied. More particularly it describes the sample (in this case, the purposively selected sample of students with disabilities of the University of Limpopo-Turfloop Campus), what intervention programme will be applied to the treatment group, what data will be
collected before and after the treatment, the data gathering procedure as well as the interpretation of the data (Grinnel, 1995).

A Quasi-Experimental Design was integrated with the Descriptive Survey Design. In research, true experiments are used to gather valid data. However, if a true experiment is not feasible, quasi-experimental procedures are the next best approach (Shaughnessy & Zeichmeister, 1994). Quasi-experiments do not meet some of the rigorous demands of true experiments.

Quasi-experiments do not, for example, meet the following major criterion of a true experiment, namely, effective or absolute control of all the variables. Such control relates particularly to the assignment of subjects randomly to the experimental and control groups. This is seen as the most critical defining characteristic of the true experiment (Judd; Smith & Kidder 1991). Such randomised assignment is not made in this study. However, use will be made of treatment and control groups. An independent variable, namely, the wellness promotion programme, will be applied to the group. The pre- and post-treatment status of both groups will be evaluated after the presentation of the programme to the treatment group.

Quasi-experimental designs are especially used in programme evaluation (Shaughnessy & Zechmeister, 1994). The quasi-experimental design will be used in this study because it will facilitate the evaluation of the programme that is being studied.

Programmes attempt to set in motion a sequence of events expected to achieve desired goals. In this study the programme that will be presented to the target group aimed at promoting the wellness of the target group. The experimental design in this study is geared to the achievement of this goal.
3.4 POPULATION AND SAMPLE

Intervention researchers choose a constituency or population with whom to work. A population manifesting issues that are of current or emerging interest to researchers and society is selected. The research population as defined by (Hall & Hall, 1996; Grinnel (Jnr) & Williams, 1990; Grinnel (Jnr) et al., 1993; Bless & Higson-Smith, 2000 and Rubin & Babbie, 1997) is the totality of persons or objects with which a study is concerned.

Fifty seven (57) students participated in the study. This included thirty two (32) females and twenty five (25) males. The population from which the sample was drawn consisted of students with disabilities. The sample, therefore, included blind, partially sighted, physically impaired, albinos, tourette syndrome, cerebral palsy, and speech and hearing impaired students. The ages ranged between eighteen (18) years and thirty two (32) years, males and females, doing the following degrees: BA(Social Work), BA(Social Sciences), BEd(Education), BPharm(Pharmacy), LLB(Law), BCom(Commerce), BScAgric (Agriculture), BA Agric(Agriculture), BSc(Science), BNutr(Nutrition), BOptom(Optometry), BAdmin(Administration), BInfo(Information Science) and UNIFY (the University Foundation Year).

A purposive sampling technique was used to draw the sample. This type of sample is based entirely on the judgement of the researcher, in that a sample is comprised of elements that contain the most characteristic, representative or typical attributes of the population (Singleton et al., 1988). In this instance the researcher believes that the sample will be representative of all students with disabilities. The judgement of the individual researcher is obviously too prominent a factor in this type of sample (De Vos et al., 2005).

Two strategies of purposive sampling were used in this study, namely, typical case sampling and extreme or deviant case sampling (Teddlie & Yu, 2007). Typical case sampling: as the phraseology indicates, typical case sampling seeks to draw cases that are
representative and exemplary of the population. Extreme or deviant case sampling, which is also known as ‘outlier sampling’ involves selecting those cases near the ‘ends’ of the distribution of the cases of interest, Teddlie & Yu, (2007). Extreme or deviant case sampling involves selecting those cases that are the most outstanding or deviant in terms of some issue or topic of interest. It provides interesting contrasts with other cases thereby allowing for comparability between the groups or across the cases.

In the current study Purposive sampling is predicated on the assumption that the researcher has sufficient knowledge related to the research problem to allow selection of “typical” persons for inclusion in the sample (Grinnel, 1998).

3.5 PROCEDEURE

3.5.1 Data collection and method of presentation

The compiled programme was presented to the sample using a variety of approaches such as lectures, workshops, guidance, counselling and psychotherapy in groups as well as one-to-one sessions.

The programmatic intervention was presented to the treatment group only, after the pre-treatment status of the participants was determined.

The content of the Wellness Programme for students with disabilities (The Independent Variable) comprising the key components as stated above is presented in the next chapter.

The researcher presented the programme. She was assisted by a colleague who holds a PhD Degree in Psychology and Education. The testing was carried out by the researcher. The delivery strategies included various approaches as stated above. The researcher realised that through workshops and group discussions the participants felt that they were being heard and accepted, they were more willing to express both positive and negative
thoughts, feelings, opinions and judgements because they felt the venue was a safe environment.

As the treatment group recognised strengths and weaknesses and started to attain success in the discussions and deliberations they seemed to gain confidence, self-esteem and self-actualisation. The reader needs to note that individual counselling and psychotherapy were given to those participants who presented with specific personal problems.

3.5.2 Instruments used to evaluate the programme

The researcher used three survey instruments to evaluate the effects of the Wellness Promotion Programme on the students who had been exposed to it, namely, the treatment group. These instruments are the Survey of Study Habits and Attitudes: Form C (SSHA); Self-Directed-Search Questionnaire (SDSQ) and Life Skills and Competencies: General Questionnaire on Life Competencies and Skills (GQLCS).

The instruments that have been selected are meant to determine the baseline developmental level of students with disabilities on the various indices. These questionnaires also seek to determine the level of development or gain on the various developmental indices after the application of the independent variable to the treatment group.

The general rationale for selecting these instruments is that, while they offer a cross-sectional or “current level” of development in terms of these indices, they are also very useful in guiding and assisting students with disabilities to achieve a higher development level on these relevant indices. This will become clear as the researcher gives a very brief review of each of these three instruments.
3.5.2.1 Self-Directed Search Questionnaire (SDSQ)

The Self-Directed Search occupational interest questionnaire was originally developed in the USA by J.L. Holland in order to provide a questionnaire which would fit in with the structure of his theory of career choice, and which could also be used in career guidance practice (Gevers et al. 1997). Research shows that the SDS has been used by over 22 million people worldwide and has also been translated into 25 different languages and its results have been supported by over 500 research studies (Holland, 2001). Holland’s theory is based on his Hexagonal Model of Occupational Themes.

The SDS is a highly practical, brief test that is appealing in its simplicity (Holland, 1985). The instrument is a self-administered, self-scored, and self-interpreted test of vocational interest. Its purpose is to measure the six RIASEC (Realistic, Investigative, Artistic, Social, Enterprising and Conventional) vocational themes. The SDS serves a very useful purpose in providing a quick and simple format for prompting young persons to examine career alternatives (Gregory, 2000). The SDS can thus be seen as one of the most effective and successful occupational interest questionnaires in the world. This questionnaire was adapted for South African use by the Human Sciences Research Council (HSRC), which was done under licence of Psychological Assessment Resources, Odessa, Florida; USA (Gevers et al. 1997).

Regarding reliability and validity of the instrument, the reliability coefficients (KR-20) of between 0.53 and 0.87 for the different fields have been reported (Holland, 1971). These values are very acceptable. In the study conducted by Gade, Fuqua and Hurlburt (1984), it was found that all the fields of the SDS correlate with each other, even in the fields which are opposed to each other. This supports the validity of the theoretical structure of occupational interests, as defined by Holland. The statistically significant correlations are in the order of 0.01 level.

“Since the SDS is not an achievement or ability test, no time limit is set, but the questionnaire can be completed within 30-40 minutes” (Gevers et al. 1997, p.17). The
questionnaire consists of 228 items. The Self-Directed Search questionnaire assesses key areas relating to a person’s occupational interests, skills and values. This questionnaire seeks to establish whether a person’s interests, skills and values show consistency, differentiation and congruency in relation to his occupational preferences and choices.

The purpose of the Self-Directed Search Questionnaire is to promote effective career planning and decision-making as it facilitates the establishment of a correlation between personal information and the information about the world of work. The items of the SDS are based on the activities the testees prefer, the skills they have or are familiar with, and the occupations they are interested in.

Three indices are applied in the SDS Questionnaire, namely consistency, congruency and differentiation. Congruency is, however, the most significant of these indexes. Before we go into the definition and explanation of the congruency index, we need to restate Holland’s theory and postulations about a person’s Career or Vocational Development and Career Choice. Holland’s theory of occupational choice links information about a person with information about the world of work.

The information about self, such as interests, values, skills and other personality traits culminate into six personality types. These personality types are the Realistic Type(R), the Investigative Type (I), the Artistic Type (A), the Social Type(S), the Enterprising Type(E) and the Conventional Type(C).

Holland’s theory also postulate that the personalities of individuals in the same occupations correspond; and that individuals working in the same occupational environment, with the same personality traits, are inclined to react in a similar way to most situations; thus creating discrete career or work environments. These career environments correspond to Holland’s personality types indicated above, namely Realistic(R), Investigative (I), Artistic (A), Social(S), Enterprising (E) and Conventional(C) work environments.
Congruency indicates the degree of correspondence between a personality type and occupational environment. This correspondence is determined after an individual has completed an SDS Questionnaire and his SDS code has been obtained which can be compared to the occupational code.

The highest degree of congruence occurs when a personality type, e.g. Realistic, shows a preference for or practices his occupation in the same environment, i.e. Realistic environment. The second degree of congruence is when a personality type, e.g. Realistic expresses a preference for or practices his occupation in an adjoining environment, e.g. the Conventional environment. The third degree of congruence occurs when a personality type, e.g. Realistic is found in alternative environments, e.g. Enterprising or Artistic environments. However, if a personality type, e.g. Realistic expresses a preference for or works in an opposite environment, e.g. Social, there is no correspondence or congruence.

These personality types and their corresponding work environments are portrayed in the hexagonal figure given below:

Figure 3.1 Holland’s hexagonal model of interest

Holland’s theory of career development and career choice, which is embodied in the SDS Questionnaire, points to career planning as a “life-long” process. Accordingly, the choice of an occupation is not a single, fixed point in the life of an individual when a decision must be made about future career (Scholossberg, 1984).
Career Development and Career Choice is a very important component of overall personal maturity and effective adjustment. Appropriate choice of study direction and ultimate occupation makes for ultimate wellness and happiness. In other words such an effective choice results in “round pegs in round holes and obviate the existence of square pegs in round holes.” Career Development and Career Choice occupies a preeminent position in the Wellness Programme used in this study. While Career Development and Career Choice is partially evaluated by the General Questionnaire on Life Competencies and Skills, this important index of Wellness is mainly assessed by the Self Directed Search Questionnaire.

Career development thus begins much earlier than the last year of school and continues even after one leaves school; for example, until after retirement (Super, 1980). Thus career planning is an ongoing process with each phase of life presenting new problems and requiring unique solutions and choices. This is a very difficult and demanding task for all students. However, it presents a hugely difficult even traumatic challenge to the students with disabilities.

For starters the careers that are “open” to students with disabilities are quite limited in terms of the prevailing social stereotypes and prejudices. The disabled students themselves start off with very low expectations of themselves, poor self-image and low self-esteem. They hardly believe that they are cut out to follow the careers that are pursued by their more able-bodied counterparts.

The “gate-keepers” to jobs, professions and careers, namely, the academics, professionals, and administrators are not particularly helpful in promoting the career development of students with disabilities. They use one reason or another to exclude students with disabilities from their career fields. For instance, they argue that students with disabilities will either not cope with the rigorous and arduous study programmes or that they will be unable to meet the demanding professional requirements in their fields. They sometimes give an apparently plausible excuse that they have not been trained to
educate students with disabilities and would thus not be able to cope with this group of students.

This whole career development “mine field” is very discouraging to students with disabilities. It is one of the key areas of their lives that constitute a great challenge and generates a great deal of unhappiness in them. This militates against the development of a sense of efficacy and wellbeing in these students. An instrument such as the SDS enables a counsellor to walk the students through this “mine-field”: always exhorting, encouraging and guiding the students towards a more effective career choice. The student’s sense of wellbeing is thus enhanced.

3.5.2.2 Survey of Study Habits and Attitudes (SSHA)

The Brown-Holtzman Survey of Study Habits and Attitudes Form C was constructed for use with students at Universities and colleges for tertiary education as a supplement to the SSHA Form H which is used in secondary schools.

The Survey of Study Habits and Attitudes (SSHA) is a psychological test that measures the motivation, study habits, and attitudes of students towards school. The purpose of this survey is to furnish an inventory of study habits and attitudes to serve as a foundation for self-improvement. If used effectively, this inventory can help students to obtain a better understanding of how to study properly. This can enable students to discover many of their study faults (Brown & Holtzman, 1996).

The reliability coefficients, in the order of 0.8 and higher, which have been reported in the test manual are considered as very satisfactory (Gevers, do Toit & Harilall, 1997). Validity coefficients for the scales were obtained by correlating first-year students’ scores on the scales to, inter alia, their end of the year examination results. The large number of highly significant positive correlations between SSHA scores and the examination results should therefore be interpreted as a favourable indication of the SSHA scales’ validity (du Toit, 1996).
All in all the SSHA seeks to achieve the following goals:

- to identify students whose study habits and attitudes are not so effective and differ from those who obtain high marks
- to help lecturers and others to understand those students who have academic problems
- to provide a basis to help these students improve their study habits and attitudes and thus more fully realise their potentialities
- the SSHA also serves as a diagnostic tool which provides the lecturer and counselor with a standardized means of systematically analysing some important feelings, attitudes and practices regarding the student’s academic work. In this way the lecturer or the counsellor is able to give assistance and counselling to those students who are in need of help.

Academic success contributes significantly to a student’s wellness. Amongst other things academic success has a positive effect on the student’s self-image, self-concept and self-esteem. While this is the case with non-disabled students, it is particularly applicable to students with disabilities who generally have a poor self-concept and low self-esteem.

Tertiary education students in general experience a lot of difficulties with various aspects of their academic work such as effective reading, studying, note-taking, the writing of tests and examinations. The academic problems that are experienced by students with disabilities are far more serious and endemic than are experienced by so-called “normal” students, i.e. students without disabilities. As a consequence, students with disabilities in general take a longer time to complete their study programmes than those without disabilities. A significant number of these students dropout of their courses completely. The psychological fallout of this situation is quiet devastating to the students with disabilities.
3.5.2.3 Life Skills and Competencies: General Questionnaire on Life Competencies and Skills (GQLS)

The purpose of the GQLCS questionnaire is to determine an individual’s competency and skills in different fields. The knowledge gained from the use of the questionnaire helps one to identify those competencies and skills which may possibly cause problems (Jacobs, Olivier, & Gumede, 1992). The GQLS has been developed at the renowned South African Human Sciences Research Council, and has been normed for the South African population. The reliability and validity indices have been found to be at an acceptable level.

The GQLCS is the most comprehensive of the three survey instruments used in this study. It covers all the key areas of an individual’s life, ranging from the physical to the spiritual realms. To provide a substantiation of this statement, a brief review of this questionnaire is given below.

The questionnaire consists of six indices. Each index covers a particular area of a person’s life. The areas of life which are covered by these indices are given below (Jacobs, Olivier, & Gumede, 1992).

- Community and social development: deals with mental health, community responsibility, human rights, road safety and technological development.
- Development of person and self: covers issues relating to leadership, literacy, education, self-concept and self-assertion, peer group influence and identity development.
- Self-management: refers to matters such as time management, self-steering or self-management, financial management, handling of stress, effective study methods and communication skills.
- Physical and sexual development: deals with acceptance of and coping with one’s own body, exertion and recreation, a healthy lifestyle, alcohol and drug abuse, sexuality education and guidance.
• Career planning and development: focuses on general career planning and development, problem solving and decision-making, finding and keeping a job, entrepreneurship and work values.

• Life and world orientation: the life and world view, “*Leben und Weltaanschauung*”, index covers the more sublime aspects of a person’s life which include a person’s experiences in the family, education, cultural, political and religious orientation as well as a general life and world view.

In this study the GQLCS is used to achieve the following:

• to establish the degree to which students with disabilities have acquired the various skills.

• more importantly, the questionnaire is used as a diagnostic tool to find out the gaps in knowledge and skills relating to the various areas of life.

• the questionnaire is used as a didactic aid in raising the skills levels of the students with disabilities in the various areas that are assessed by the various indices.

• the questionnaire is also used to establish whether the wellness promotion programme has enabled the treatment group to acquire these life skills and competencies which are needed by the students with disabilities at the present time and in the future.

The well being of an individual is greatly determined by the degree of his/her skill in dealing with him-/her-self, as well as his/her physical, socio-cultural and spiritual worlds.

3.5.3 The treatment group

The treatment group comprised twenty five (25) students of whom fourteen (14) were females and eleven (11) were males from various study disciplines.
The research design entails the pre-testing and post-testing of both the treatment and control groups. The reader needs to note that the matching or comparison is made between the treatment and the control groups as well as between the treatment groups themselves. Afterwards when the treatment group has been exposed to the benefits of the programme and the control group has not, the difference between them is attributed to the programme. The pre-test post-test movement in the scores of the treatment groups will also indicate the effectiveness of the programme.

The programme was presented to the treatment groups after both the treatment and control groups were pre-tested. The programme ran for a period of three (3) months. After three (3) months, the group was tested again – post-tested- to see if there was a difference between the treatment and control groups that could be attributed to the independent variable.

3.5.4 The control group

The control group consisted of thirty two (32) students, eighteen (18) were females and fourteen (14) were males also from various study disciplines.

The control group was also tested twice; i.e. first together with the treatment group before the intervention programme was presented to the treatment group. The control group was not exposed to the intervention strategy (the independent variable, i.e. the programme). The control group was then tested again for the second time with the treatment group after three (3) months.

3.5.5 Treatment and control groups

The pre-testing and post-testing of the two groups was conducted on the same days. The groups were told about the aim of the study. They were also told that their participation would be of immense benefit to most students with disabilities at various institutions of
higher learning in the country and that they themselves together with the present researcher were going to be empowered by the whole process.

Both the treatment and control groups took a pretest at the same time, after which the independent variable, which is the programme designed by the researcher, was presented only to the experimental group, and thereafter both groups took the posttest. The design applied is illustrated as follows:

Experimental group:  \[ R \quad O_1 \quad X \quad O_2 \]
Control group :  \[ R \quad O_1 \quad O_2 \] where \( O_1 \) represents the pre-tests, \( O_2 \) represents the post-tests and \( X \) the independent variable.

Programmes attempt to set in motion a sequence of events expected to achieve desired goals. In this study the programme that was presented to the treatment group was aimed at promoting the overall wellness of the targeted group. This experimental design is an elegant way to find out how this programme will achieve the stated goals.

3.6 DATA ANALYSIS

Data will be analysed by using the statistical techniques obtained from the Statistical Package for Social Sciences (SPSS). The t-test for paired samples and that for independent samples will be used to determine the significance or lack of it for the obtained data.

3.7 ETHICAL CONSIDERATIONS

Informed consent was obtained from the participants, and they were informed that their participation in the study was voluntary. They were also informed that they were free to withdraw from the project at any time; that it was possible that they may not personally experience any advantages during the project although their participation might prove advantageous to others, they were also encouraged to ask questions that they might have
regarding the project. The aim of the study was explained to the participants. Information relating to the participants was kept confidential.

The control group was altogether barred from participating and attending the lectures and other activities presented by the researcher for the duration of the experiment. As it is unethical to prevent the control group from receiving this important information, the researcher therefore presented the same content to this group at a later stage.

3.8 RESUMÉ

In this chapter the methodology used in the study was fully discussed. The methodological issues in question included the research design as well as the drawing up of the sample. The descriptive and quasi-experimental designs were used in the study. The quasi-experimental design is particularly useful in the evaluation of programmes.

Treatment and control groups were drawn from the population. A purposive sampling technique was used in compiling these groups. The independent variable, namely the Wellness Promotion Programme was presented to the treatment group and withheld from the control group. Both the treatment and control groups were pre-tested before the wellness promotion programme was presented to the treatment group. The two groups are then post-tested after the independent variable had been presented to the treatment group.

The independent variable; that is, the Wellness Promotion Programme comprises a very broad content that is divided into the several segments. The programme is fully discussed in chapter four (4) below. A variety of methods were used to present the programme. These included the didactic or lecture method, individual and group guidance and counselling as well as individual or group psychotherapeutic interventions whenever these were indicated.

Three instruments were used to evaluate the efficacy or otherwise of the programme since they were used in the pre-testing and post-testing of both the treatment and control
groups. These instruments are discussed in detail in this chapter. The t-test for paired and unpaired samples was used to analyse the data.
CHAPTER FOUR

THE PROGRAMME PRESENTED TO STUDENTS

4.1 INTRODUCTION

A wellness promotion programme would be presented to the target group. An overview of the programme will be outlined in this chapter. This chapter also seeks to show that psychological wellness does not just occur on its own, but should indeed be promoted and enhanced through effective pragmatic intervention.

De Vos (1998) asserts that a programme entails steps to be taken, resources to be employed and other elements necessary to carry out a given course of action hence this chapter will also outline the programme in detail.

The programme comprises of the physical, psychological, affective, conative, social, cultural and spiritual domains.

4.2 THE PHYSICAL COMPONENT

4.2.1 Healthy Physical Life Style

Healthy physical life style refers to the following:

- healthy eating habits- eating and following a balanced diet, eating three meals per day, avoiding too much snacks, eating when hungry, not skipping meals and detoxifying the natural way.
- avoidance of the intake of physically debilitating substances: alcohol, tobacco, dagga, hard drugs and other intoxicating beverages, causes of drug and alcohol abuse, what is addiction, the use and abuse of alcohol and drugs, the harmful effects of alcohol, tobacco and drugs.
• engagement in appropriate physical exercise and sports: climbing stairs rather than using stairs, running at least one kilometer a week, exercising regularly.
• healthy sex habits and practices: having protected sex, using condoms, not having sex with an infected person, not having sex with multiple partners, not having sex with someone who injects drugs, not using drugs which may lead to unsafe sexual behaviour and abstaining from pre-marital sex.

According to Ostrow (1990) knowledge of what constitutes risk is obviously a prerequisite for voluntary health-promoting behaviour change. Knowledge about HIV and AIDS and other health-threatening diseases have been seen to be playing a role in motivating initial behaviour change particularly in persons who see themselves as being at relatively low risk and are initially less informed about these diseases and the routes of transmissions, for example, genetically, in terms of obesity; and sexually transmitted infections in terms of sexual behaviours.

Knowledge alone does not necessarily ensure long-term healthy sexual behaviour, healthy eating habits and drinking behaviour change. Concerning the Sexually Transmitted Infections (STIs) and the belief in the efficacy of one’s behavioural modifiability are strong restrospective predictors of reported sexual behaviour change from unsafe to safe practices.

4.3 THE PSYCHOLOGICAL COMPONENT

4.3.1 Cognitive Domain and the acquisition of academic skills

4.3.1.1 Organising and planning

Timetabling one’s work for the whole week, making a list of things to be done, having a revision timetable leading up to exams, handing in homework on time, studying where there are no destructions and disturbances and prioritising what to study first. All in all this involves planning for the effort one will have to put into his studies as well as the
distribution of time amongst various subjects. One has to draw up a timetable that will include most of his daily activities such as attending lectures, studying, participating in sport, using leisure time, attending workshops, etc.

4.3.1.2 Interest and maintaining motivation

Lindhard (1983), states that motivation is that which makes people want to do something even when it is very difficult, tiring and boring. A person’s motivation plus his intelligence determine how well he will do in school. It also refers to knowing why one is doing particular subjects and degree/diploma/certificate. One also has to think about the career that one wants to qualify into, thinking of what one wants to become in life, knowing why one is studying and taking tests and exams. Studying for long stretches without a break could be strenuous. The results could be obtaining low marks and one would not be able to enjoy what one studies.

4.3.1.3 Reading for learning

Reading around a subject before it is dealt with in class, over-viewing the contents and training in skilled eye-movements in which the meaning of the printed symbols is elaborate is essential. Preparation is thus necessary before the decoding of meaning as one reads.

4.3.1.4 Memory training and mind mapping

Before a person can learn things, he almost always has to commit them to memory so that he can remember what he is learning before he can have a complete learning experience. Learners have to remember that memorising is not learning. It is, therefore, not the best way to learn, except for those things which simply have to be remembered than learnt, e.g. dates, quotes from history, formulae and lists of things like the periodic table in chemistry, etc. (Nyamapfene, 2000).
Trying to commit things to memory by going over them several times is not the easiest or most effective way of learning things. One has to develop systems of remembering different types of information by for example creating a set of associations, grouping, learning landmark dates, re-live history and imagining oneself as a participant or victim, using mnemonics and working in groups.

There are strategies which are used in reading. Besides managing to remember names and dates, testing one-self after study breaks, after a day and at regular intervals to a test or exam is equally useful for the learner. Such techniques would help one remember things, trying to understand what one ought to remember. This could facilitate the transfer from short-term memory to long-term memory.

### 4.3.1.5 Effective listening and note-taking

Listening and note-taking are closely related. Attentive listening will enable one to take good notes; while note-taking helps one to concentrate better on what one is hearing or reading (Msimeki, 1988).

Before the learner can take down notes, one has to listen carefully to the lecturer. When one is studying from a text book, key ideas have to be followed and thought about before jotting them down.

### 4.3.1.6 Essay writing

In all academic work the ability to write well is an extremely important skill because there is hardly an area of learning for which a certain amount of writing will not be required. Writing an essay is a demanding and complex operation. Many students find themselves complaining when they get a poor mark for an essay and often argue that they have included all the facts, which they can establish by comparing with what their peers may have written. A good essay demands that one demonstrates one’s knowledge of the subject, comprehension, application, analytical skills, ability to synthesise information
into a coherent whole and capacity to evaluate the worth and relationships of various points and arguments (Nyamapfene, 2000).

Much of one’s school work (depending on the degree one is doing) is presented in the form of essays. A great deal of answers in tests and exams are given in the form of essays. Essays are not only written in language subjects. It is therefore very important to master the skill of essay writing. This also refers to finding out before one starts to write an essay what is really being asked of him/her, using books, talking to people and reading around the topic, making an essay plan, making sure the handwriting is readable, making sure spelling errors are checked, reading over the essay before handing it in and following the required structure.

4.3.1.7 Preparing for and taking tests and exams

“Examinations, in one form or another, are a fact of life. The sooner you acknowledge and accept this fact, the sooner you can begin to find ways of dealing with this reality” (Nyamapfene, 2000, p.64). Study leads to tests and exams. A test is a short version of an examination. Tests and examinations have value. They are meant to measure how well one has learnt something and how well you have understood it. Tests stimulate students to study throughout the year thus promoting good and regular study habits in them. The best time to start preparing for tests and examinations, and the best way to be ready for tests and examinations is the first day one takes a course and to revise one’s work throughout the duration of the course and not to leave it until the last minute.

Planning has to be done in advance, with a positive attitude for learning. One needs to build confidence and be fully prepared for it. This would entail setting sufficient time as well as eating healthily. Preparation for examinations calls for one to devote ample time towards effective study. This would mean having a revision time-table in which to go through previous examination papers in study groups as well as individually in one’s own spare time.
In addition to this, one has to systematically revise one’s notes in preparing for the impending examinations. When examinations arrive, one needs to approach them in a systematic and relaxed manner. One should thoroughly study the question paper and answer all the questions as best as he or she possibly can. Attending lectures and giving one’s-self time to relax is the key to succeed in taking tests and examinations.

**4.3.1.8 Discovering and developing one’s abilities**

How a person uses his abilities is determined by maturity. A mature person takes the responsibility for his own development. He takes the responsibility of developing his abilities, and turns them into skills. At the end one becomes competent in what one does.

An individual’s abilities can be explained in terms of actual performance (achievement) and potential (aptitude). Actual performance refers to what one is able to accomplish at a given moment in terms of activities such as school work, sports, work outside school, etc.

Potential is performance not yet shown. This is an individual’s ability/capacity in various areas which has not yet been shown or fully utilised. If one does not know what he is capable of he would not strive to utilise as much of his abilities as he possess. He will perform below his potential.

Abilities determine one’s competence. Competence basically means doing well appropriately that which a person’s abilities and life role suggest that he should be doing.

People are perceived to be competent if they are effective in interactions with both the physical and social environments (Cowen, 1994). Many of these competencies relate to one’s current life tasks, whether these have to do with school work for a child or job performance for an adult. Other competencies involve more generic interpersonal skills like, for example, communication skills, listening skills, interaction skills and appropriate assertiveness skills. The presence of such skills enhances a person’s psychological wellness.
Cowen (2000) states that empowerment without competence, just as competence without empowerment limits psychological wellness, and that the presence of both can advance wellness by giving people a fuller sense of mastery over their environments and control over their lives.

4.4 AFFECTIVE DOMAIN

4.4.1 Inculcation of adequate self-image

Self-concept refers to the convictions one has about who they are. A major component of self-concept is self-regard. Self-concept and self-esteem: students are being encouraged to be positive about themselves, to see the positive side of their personality and gain confidence. People with low self-esteem lack confidence in themselves, feel inferior to others and expect criticism. Those with a positive self-esteem accept themselves as they are, try to make good use of their strong points and abilities, attempt to overcome their weak points and make use of opportunities that come their way or that they themselves create. These inner uncertainties may lead to shyness, social withdrawal, and failure to achieve, or to engage in inappropriate efforts to please other people, or forced attempts at sociability (Gelder, Mayou & Geddes, 2000).

4.4.2 Acknowledgement and appropriate expression of emotions

Emotion refers to a complex feeling state with psychic, somatic and behavioural components that is related to affect and mood (Kaplan & Sadock, 1998). People’s emotional experiences occupy the attention of all mental health professionals. Emotion derives from basic drives such as feeling, sex, reproduction, pleasure, pain, fear, and aggression which all animals share. Kaplan & Sadock further assert that human emotions such as affection, pride, guilt, pity, envy, and sentiment are largely learned and most likely are represented in the cortex. Within the cortex, several studies have suggested a hemispheric dichotomy of emotional representation.
The left hemisphere houses the analytical mind but have a limited emotional repertoire, the right hemisphere appears to be dominant for affect, socialisation and body image. Damage to the right hemisphere produces affective disorders, loss of the visual aspects of dreams, and failure to respond to humor, shadings of metaphor, and connotations.

Emotional intelligence is all about having the skill to manage our emotions in such a way that they work for us and not against us. It is about being able to identify what makes us feel good or bad. Emotional intelligence is also about having the skill and power to decide how to move from a negative state of mind to a positive one, and be conscious of how our actions may affect other people. It is about having the awareness, sensitivity and skills to stay positive and maximise our long-term happiness and wellbeing. Once an individual start to develop this skill he is well on his way to managing his life properly. Self-acceptance involves managing your emotions. When one is being more self-aware he learns to understand his own feelings, good or bad.

### 4.4.3 Managing negative emotions and bad feelings

Managing negative emotions and bad feelings is about being able to describe one’s feelings, not getting overwhelmed by bad feelings. When we are angry we often sound more upset than we really feel. This is because we allow our emotions to influence our behaviour. We are thus not thinking rationally. We use our understanding and our feelings and emotions in order to think logically and rationally. Often we act inappropriately and blow things out of proportion when we are angry. We also struggle to make good decisions and lose our perspective on things. By learning to regulate and accept our emotions we become more flexible and innovative in stressful situations.

If one is unsure of his goals and values and does not know where he is going in life, he may find himself an unhappy person. He may also find it difficult to control his emotions in such a way that he experiences decreased happiness. It is important to know that emotions can affect one’s performance.
4.5 CONATIVE DOMAIN

4.5.1 The development of achievement motivation

Henry Murray in Kaplan and Sadock (1998) defines motivation as a need that is aroused by internal or external stimulation; once aroused, motivation produces continued activity until the need is reduced or satisfied. It is a state of being that produces a tendency toward action. Social motives such as the need for recognition and achievement, also account for behavioural patterns; e.g. studying hard in order to get good marks. The intensity of motivation to achieve any task in a particular situation is determined by at least two factors, which are the achievement motive (desire to achieve) and the likelihood of success.

“People show marked individual differences in the values placed on objects and goals. Some students strive for As; others depreciate the importance of grades and place higher value on intellectual satisfaction or on extracurricular activities. The expectancy factor refers to the subjective probability that, with the expenditure of sufficient effort, the object may be acquired or the goal reached”, Kaplan & Sadock, 1998.

4.5.2 Goal setting and goal achievement

A person should as early as he can, establish the aims and goals which he would want to strive for in life. A person without goals in life just drifts about like a ship without a rudder. He does not know where he is going; he does not have a specific destination. To lead a meaningful existence, a person must decide on a destination, plan how to reach that destination and do what is necessary to reach the destination.

The process of goal setting should apply in one’s daily life. A student may have his ultimate career goal as that of becoming a teacher. He must therefore first pass his first degree before proceeding to do method of teaching. He must also think of doing practical
work. Even here he would have set several other intermediate goals before he can reach his ultimate goal. If people think of their final goals without doing something about their immediate goals, they are acting in an immature way— they are merely day-dreaming (Msimeki, 1988). Goals set must be realistic.

4.5.3 Discovering and developing one’s interests

Being able to describe what one’s interests are, being able to find out about one’s interests are other characteristics of maturity. An interest refers to a relatively constant orientation or attitude towards something. An interest does not change from day to day. When a person has an interest in something it does not imply that that person has an ability to do it, for example a student may have a strong interest in volley ball although he is a bad player.

Interest plays an important role in determining the effort an individual is prepared to put into a task. Students put more effort into the subjects they are interested in, and this is often evidenced by the discrepancies amongst the marks they obtain in their subjects; for example, one finds a student’s academic record with very high marks and very low marks.

4.5.4 The development of resilience and a persevering attitude

This refers to how a person manages his or her problems. Coping is regarded as the ability to take decisions and to make progress in spite of pressures, obstacles and setbacks. It means being in control of a situation and this includes being able to handle or deal with uncertainty, worry and stress. A person who manages to cope is realistic and practical, he does not underestimate or overestimate his own abilities. Such a person has reliance and a persevering attitude.

When such people are faced with a problem, they think over it calmly and logically and try to get the best solution for it. Mature coping includes the ability to accept failure and
turn it into useful experience. It includes the ability to recover after catastrophic events such as the loss of a loved one, a limb, or a job by accepting realistically what cannot be changed.

4.5.5 Leadership

A generally accepted definition of leadership states that leadership is the process whereby one individual influences others to willingly and enthusiastically direct their efforts and abilities towards attaining defined group or organizational goals (Nel, Gerber, Van Dyk, Haasbroeck, Schultz, Sono & Werner, 2001). According to this definition, leadership involves the exercise of influence and not coercion. Leadership is very much a two-way relationship and empowerment; not only does the leader influence and empower the followers, but the followers also exert influence and empowerment over the leader.

Leaders need to have certain qualities and characteristics. These may include the ability to create a vision and to excite people to try and achieve the impossible; have an external energy and an inner strength that see them through tough times; have a mental ability that enables them to make effective decisions much faster than most other people. It also means allowing team members to grow and carry out tasks without interruption; delegate power to others; have the ability to tap into people’s souls; being emotionally intelligent; enhance people’s confidence by understanding and dealing appropriately with their emotions and concerns; the ability to adapt to the needs of different situations and people.

As a leader, one needs to have the ability to influence people. That ability should be based on various sources of power such as reward power, coercive power, legitimate power, referent power and expert power. In very simple terms a leader is a person who has followers. Leaders are often identified by characteristics such as good communication skills; being more intelligent than the average of the group; self confident; decisive; alert and energetic; considerate and sensitive to the needs of others with good organisational skills. Leaders need to be good at the tasks assigned to the group; show good judgement
when making decisions and they are fully functioning persons with healthy personalities and are able to cope competently with different situations and people.

The abilities, characteristics and qualities of a leader would determine whether the leader is an autocrat or democrat. Again, we have leaders like natural leaders, heredity leaders, elected leaders as well as situational leaders.

4.6 THE SOCIAL DOMAIN

The aim of this domain is to promote social awareness in an individual. One of the fundamental characteristics of personhood is being “Dahrsein”, which implies being “Mitsein” (Msimiki, 1988:225). Because of the interdependence between individuals and the community, personhood cannot be defined solely in terms of physical and psychological attributes (Menkiti, 1984 in Ratele et al. 2004:4-24). The importance of community in self-definition is summed up by Mbiti’s (1969) dictum ‘I am because we are, and since we are, therefore I am’ (214). For an individual to promote his own self-actualisation as well as that of other people with whom he comes into contact, he or she must develop an awareness of his social infra-structure and how he or she can utilise it.

4.6.1 Giving and receiving feedback (Johari window)

Effective learning is facilitated by good interpersonal communication. The Johari window model focuses on the balance of these exchanges between the parties. It was devised by Joseph and Harry Ingham, hence its name. This model illustrates the effects of self-disclosure and feedback in increasing personal and interpersonal awareness. An understanding of the model can help you facilitate relationships in either group or one-to-one contexts. The four panes of the window are as follows:
The things that one knows about oneself which are known to others include the information that one and I both share. What one does not know about oneself which is known to others is also referred to as the blind spot; this area consists of things you have noticed about me, about which I am unaware. What one knows about oneself, which is unknown to others contains things that I am aware of and have not disclosed to you, the façade. Lastly, the things one does not know about oneself which are unknown to others contain the unknown.

<table>
<thead>
<tr>
<th>Known to you</th>
<th>Known to others</th>
<th>Not known to you</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE THINGS YOU KNOW ABOUT YOURSELF WHICH ARE KNOWN TO OTHERS:</strong></td>
<td><strong>WHAT YOU DO NOT KNOW ABOUT YOURSELF WHICH IS KNOWN TO OTHERS:</strong></td>
<td><strong>Not Known to you</strong></td>
</tr>
<tr>
<td>Your beginnings and your past, your education, your family, your work history and training, your achievements. Your personality and your maturity, your interests, personal skills, your values, some of your limitations.</td>
<td>How others see you and assess your ability, intelligence and potential, as well as your limitations. How they assess your personality, maturity, character, your manners, irritations, degree of vanity, tolerance stress levels and sincerity. Your ability and consistency, charisma or dullness, self-assurance and selflessness. How they plan to help you or use you, and what opportunities and future they see you. Some of them will know if you snore.</td>
<td></td>
</tr>
<tr>
<td><strong>WHAT YOU KNOW ABOUT YOURSELF WHICH IS UNKNOWN TO OTHERS:</strong></td>
<td><strong>THE THINGS YOU DO NOT KNOW ABOUT YOURSELF WHICH ARE UNKNOWN TO OTHERS:</strong></td>
<td><strong>Not known to you</strong></td>
</tr>
<tr>
<td>Your feelings about yourself and about your competence. Your need for company and for love. Your feelings about some others, the relationships you wish to enter into and the trust you have in some people. Your dreams, fantasies, hopes, goals and plans. Your real abilities and your perceived limitations, fears and anxieties and guilt. Your level of confidence and self-esteem. The degree to which you wish to change yourself. Some of your past history, your failures and some of your weaknesses. Your health. Your bank balance.</td>
<td>Your future and your opportunities. Your health and your luck.</td>
<td></td>
</tr>
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Self-disclosure, refers to being yourself; recognising and owning your opinions, values and feelings; understanding that these are no more valid than anyone else’s. We can share these with others remembering that they are only our ‘map of the world.’ Feedback is about getting to know other people’s ‘map world’; their opinions, values, experiences, expectations, etc. Effective relationships occur if there is fair balance between self-disclosure and feedback (Luft, 1970).

4.6.2 Relating to others

The nature and quality of one’s social and interpersonal relationships are very important for the present and for the future. Getting along with others determines one’s happiness, success and failure. An individual person is responsible for the type of relationships that exist between himself or herself and parents, lecturers, friends, peers, partner, etc. (Msimeki, 1988).

Establishing and maintaining good human relationships is very crucial to mankind. The way one regards himself would have a direct influence on how he gets along with others. It is important to cultivate the qualities of a healthy personality such as self discipline and self control, honesty, loyalty and responsibility. There are numerous personal characteristics one must acquire and develop in order to establish good relations with others. These include acceptance and respect of others as they are, unconditional love, friendliness and interest, sincerity and tact, consideration of others, etc.

4.6.3 Communicating effectively

“The single adequate form for verbally expressing authentic human life is open-ended dialogue. Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. In this dialogue a person participates wholly and throughout his (sic) whole life; with his eyes, lips, hands, soul, spirit, with his whole body and deeds. He or she invests his or her entire self in discourse,
and this discourse enters into the dialogic fabric of human life, into the world symposium,” (Bakhtin, 1984/1993).

Communication also refers to a process in which two or more elements of a system interact to achieve a desired outcome or goal (Barker & Grant, 1996). Because we view communication as a process, we also perceive it to be dynamic, ever-changing and unending. Another important aspect of communication that needs to be noted is that we need to realise that communication events do not occur in isolation from one another. Each interaction that you have affects each one that follows, and not always in a simple, direct manner.

Students will be taught about the differences between formal and informal communication. When people are involved in formal communication such as public speaking or mass communication, they pay more attention to both verbal and non-verbal messages. For instance, we use language more precisely and pay more attention to grammar. Additionally, we are more concerned about the image we create in those with whom we are communicating.

All in all, communication refers to sharing ideas, giving opinions, finding out what you need to know; explaining what you want; working out differences and misunderstandings with others; expressing your ideas. These are the essential elements of being able to relate to and work with other people. Without communication there can be no relationship. The value of having good and effective listening skills and communication skills; saying what one really means, making one’s self understood, being able to put points across, are all very important aspects of effective communication.

4.6.4 Being assertive

To be assertive requires that people have confidence in their judgement and sufficient self-esteem to express their opinions. Assertiveness and social skills training teach people how to respond appropriately in social situations, to express their opinions in acceptable
ways, and to achieve their goals. A variety of techniques, including role modelling, desensitization, and positive reinforcement (reward of certain behaviour) are used to increase assertiveness. Social skills training deals with assertiveness but also attends to a variety of real-life tasks, such as food shopping, looking for work, interacting with other people, and overcoming shyness (Kaplan & Sadock, 1998).

Being assertive refers to the ability to express feelings constructively and to be open to others about what one wants. This would maximise the chances of one getting the kind of relationship he or she wants, the job he or she wants, the friends he or she wants, the society he or she wants and the life that he or she wants. This would make one to be more confident, less punishing to others, less frustrated and less anxious.

The more assertive we are, the less likely we are to be aggressive, as aggression is usually fueled by frustration. Being assertive also refers to saying what you want, standing up for your rights, speaking your truths, asking, saying ‘NO’, disagreeing, giving and receiving praise, giving and receiving criticism. All in all, being assertive is about expressing positive feelings, expressing negative feelings as well as standing up for your rights.

Students are engaged in assertiveness activities which would help them to cope effectively with their disabilities and to behave in an assertive way. Gelder; Mayou & Geddes (1999) suggest direct but socially acceptable expression of thoughts and feelings, analysis and practice of the social behaviour in every day life.

Students are also taught to be able to differentiate between assertion, aggression and non-assertion, as well as knowing the skills of being assertive.

4.6.5 Stress management

As human beings, students with disabilities are, at any given time of their lives, susceptible to uncontrolled assaults on their wellness. They also live in the shadow of chronic violence or abuse, of rampant incurable pandemics such as HIV and AIDS, close
family members pass on, parents divorce, people lose their jobs, unanticipated disasters destroy people’s worlds, the terrors of aggression and war are visited upon us.

These students are also stressed by various aspects of their lives as students, especially by their studies. Students are taught about anxiety, stress and depression. Anxiety refers to feeling of apprehension caused by anticipation of danger, which may be internal or external. It is an alerting signal; it warns of impending danger and enables a person to take measures to deal with threats.

An event is perceived as stressful depending on the nature and on the person’s resources, psychological defenses, and coping mechanisms. A stressful life event or situation, internal or external, generates challenges to which the organism cannot adequately respond (Kaplan & Sadock1998).

The normal response to sudden stressful events is an emotional response coupled with a coping strategy or defense mechanism which serves to limit the intensity of the emotional response. The emotional response is anxiety or depression. Anxiety is the normal response to threatening experiences; depression is the normal response to loss (Gelder et al 2000). In general terms, depression refers to the psychological feelings of sadness.

The actual coping strategy is avoidance of the situation, or direct reminders of it, and of talking or thinking about it. The most frequent defence mechanism is denial, experienced as a feeling that the events have not really happened. As the stressors recede, these processes recede: memories of the event return gradually and can be thought over and talked about with less distress (Gelder et al 2000).

At the end of the session the students shall have learned the following: Knowing how to manage and cope with stress. Understanding what anxiety is, what stress is and what depression is. Knowing the causes, signs and symptoms of anxiety, stress and depression; being able to recognise when one is under stress, how to prevent, and being able to cope with anxiety, stress and depression.
The ability to cope effectively with stressful life events and conditions is a key pathway to good health and wellbeing. Some life stressors are often seen as presenting an opportunity for growth, if the person has the psychological resources to manage stressors. Community psychologists need to capacitate these students to cope with the vagaries of life.

### 4.6.6 Time management

Time management was introduced to students to help them achieve challenging and demanding academic and life goals. The skills associated with time management have grown in importance. Croft (1996), states that time management is one of life’s fundamental skills and is becoming increasingly important as the world speeds up and we run more and more activities in parallel. He goes on to say that time management is not an ideal name, but is the best name we have for the ability to use your time on the things that matter.

Getting the most from how one spends his/her time, getting the most out of new situations. It requires one to periodically look at the way you spend your time; plan how you will do your projects and assignments; evaluate the importance of the assignments and projects so that one does not spend considerable time on jobs that do not warrant it. There is need to delegate effectively if one is a group leader; take priorities into consideration; review work procedures often to see if some steps can be eliminated or done more efficiently; make it a practice to keep reminder lists of things to do and balance work and leisure.

### 4.6.7 Making effective decisions

Decision making can occur at several levels. The first and perhaps the most basic level is that of the individual acting to satisfy his basic needs. According to Maslow, human beings are motivated by a hierarchy of needs, the highest being the need for self-actualisation or the need to become all-that one is capable of becoming. Much of the
decision making accomplished by an individual relates to the solution of problems – personal, employment, or social problems.

In our complex society, individuals usually find need-satisfaction as members of groups that have particular purposes. Often they must compromise their personal desires if the group is to arrive at a consensus. Therefore, group decisions represent more than just a collection of desires of the individual members. Group choices reflect a special synthesis of compromised desires of individual members. It is also true that a group normally provides a broader range of knowledge and a variety of critical viewpoints that may facilitate a more penetrating analysis of a given problem.

The scope of decision making does not stop at the level of the group. It also goes to the level of organisation where it is expressed primarily through the basic functions of the manager which include planning, organising, staffing, directing, and controlling. “The scope of decision making is indeed wide. It commences at the level of the individual and extends to the deliberations of the groups that compose the organisation. Organisations, in turn, make up the overall system of enterprise, which forms part of the total society; and societies make up nation-states that espouse compatible or conflicting ideologies, the sum total of which constitutes the whole world” (Harrison, 1975, p. 11).

In general the process of decision making follows the eight steps outlined as follows: identifying the problem; defining objectives; making a pre-decision; generating alternatives; evaluating alternatives; making a choice; implementing a choice and making a follow up.

People differ in the way they go about making decisions; i.e. there are differences in the general approaches people take in making decisions. In general, research has shown that there are meaningful differences between people with respect to their orientation toward decisions – their decision styles.
Whereas some people are primarily concerned with achieving success at any cost, others are more concerned about the effects of their decisions on others. Furthermore, some individuals tend to be more logical and analytical in their approach to problems whereas others are more intuitive and creative.

**What a decision is.** Types of decisions: simple decisions have effects that are not so important and short-lived while complex decisions have effects that are long-lasting and sometimes influence your life. The principles of decision-making include aims, information, solutions and decision. What do you want to achieve? What is your goal or purpose? What are your values? Decision making involves finding out the information and facts that you need to know because certain facts may influence your decision as well as finding out possible solutions as they may be several solutions to your problem. Testing one’s solutions for reality: are one’s solutions practicable, can they be carried out?

The decisions that one makes depend firstly on one’s personality: one’s values, temperament and method of facing up life situations (wishing, escape, playing safe, and responsibility). Secondly one’s decisions depend on external factors which one cannot change, e.g. laws, physical abilities, etc.

To facilitate decision making one has to decide which solutions are best for him. People make decisions in different ways like for example they escape, wish, play safe, delay, always have only one priority, take risks, refuse responsibility, take responsibility, are too logical or are too emotional.

Students are helped and motivated to accept who they are and to know more and understand the meaning of decisions. They are also taught to take responsibility and accountability for the choices they make.

Adair (1997) suggests a “classic” five-step approach which he believes is very helpful when making decisions. He goes on to say that it does not mean one should follow it
blindly in all situations. These steps are defining the problem, collecting relevant information, generating feasible options, making the decision and implementing and evaluating. One can also make a decision by listing the advantages and disadvantages, examining the consequences of each course, testing the proposed course against the yardstick of your aim or objective and weighing the risks against the expected gains.

4.6.8 Choosing a career, finding a job, keeping a job and coping with unemployment

The days when career choices were made “by accident” and career paths were unplanned are over. Choosing a career field starts early, and planning a career is vital in today’s competitive working environment. When choosing a career it is important to take a good look at yourself. Factors to be considered include one’s personality, interests, skills and how other people see you. These factors can then be matched to a career family that has similar characteristics. One has to know one’s personality attributes, interests, values, skills and abilities.

Analysis of the various careers and life stages of people shows that the most important decision a person makes is what career to follow. It is generally accepted that what employees accomplish and derive from their careers will depend on the congruence between their personality and the job environment. Although some people are forced by circumstances to follow certain careers, others choose their occupations in accordance with their personality (Nel et al, 2001).

As the world is becoming increasingly globalised, a person’s career is more than a means of earning a livelihood. It is a way of life. The individual’s career enables one to actualise oneself physically, psychologically, socio-culturally and spiritually. One’s self-knowledge, one’s social prowess and one’s education are important for the person’s self-actualisation in his career. Self-knowledge is the basis of all forms of knowledge in African thought. Self-knowledge does not result from the maturation of integrity held principles. It ensues from a person’s relationships with others, including the social
environment. It moves from the direction of the social environment (social relationships and practices) to the internal world of the individual (Ratele et al, 2004).

4.7 THE CULTURAL DOMAIN

Leisure time is time which one does not use for work. It is free time or spare time. It is time to be used for non-work related activities. Leisure time gives people time to relax after lectures and work.

Leisure time can be used effectively and fruitfully. Some learners may ask questions such as can leisure time be valuable, can activities for leisure be planned, are there leisure time activities. During leisure time people get the opportunity to regenerate their energy for them to manage to study or do other work again with renewed energy and enthusiasm. Leisure time activities can help one to develop and improve one’s physique, personality and psyche.

When one plans one’s leisure time activities one would be guided by the amount of ‘free’ time available. One can include the following as his leisure time activities: physical and sporting activities, creative activities and hobbies, mental activities, collective activities, visiting activities, social activities and passive relaxation activities (Msimeki, 1988).

4.8 THE SPIRITUAL DOMAIN: discovering values and beliefs

Values are an individual’s personal standards of conduct and they are also the standards by which we measure other people’s behavior and goals. This refers to the universal and eternal values that are espoused by the great religions of the world such as to love our neighbours as ourselves. Every individual, community and nation should seek to uphold and promote the realisation of these values. Individuals should try to know what their values are. People who know their values are purposeful, positive and decisive (Lindhard, 1983). In African cultures humanism (ubuntu) is one of the cherished values. African humanism entails the recognition of a person’s worth and dignity as a human being.
Becoming or *inkambo* (‘life journey’ or lived experience) is manifest in the relationship between the person and others, including the surrounding environment. The analysis of the saying ‘*umuntu ngumuntu ngabantu*’ already testifies to this (Ratele et al, 2004).

Discovering and clarifying one’s values and beliefs: being able to describe what is important to one’s self, being clear about what is important to one’s self, being able to find out what one’s beliefs are/what one believes in is a key component of the values clarification component of this Wellness Programme.

### 4.9 APPROACHES USED IN DELIVERING AND IMPLEMENTING THE PROGRAMME

A number of approaches were employed in the current study. These approaches include lectures, workshops, group work, counselling and psychotherapy on a one-to-one basis. The approaches are encouraging, supportive and provide a non-threatening atmosphere.

Professionals in the helping professions, according to Zastrow (1992) have the obligation to continue to learn a wide variety of preventive approaches so that they can select from their “bag of tricks” the approach which, given a unique set of problems, is apt to be most effective. Community psychologists therefore need to keep abreast of current investigations and participate in research activities in order to develop new facts, techniques, skills and approaches so as to successfully address emerging psycho-social problems.

The basic consideration in selecting the presentation methods of the programme was the full participation of the participants. The full participation had to express itself in the following essential features of effective learning, namely, involvement, experience, significance attribution, and the structuring of self-concept (Msimeki, 1988).
For a person to learn effectively, his/her whole being must get engaged in the activity; he/she must be involved in the learning act as a person- somatically, cognitively, affectively, and conatively.

The students’ minds are not like clean slates on which the things they are to learn are inscribed. The new material the students have to learn is therefore assimilated into the cognitive structure. The nature of the material to be learned and the manner in which is presented will determine whether the students experience the activity in a positive or negative way. The students must find the material meaningful. That material must be presented in such a way as to promote significance attribution on the part of the students.

Additionally, the educational approach which suggests that extensive and carefully orchestrated educational programmes have some impact on attitudes and behaviour, especially among the youth is one of the approaches used in the study. Ritson (1994) postulates that education is one of the fundamental educational approaches hence the author deemed it necessary to employ this approach.

We also have the experiential education, which aims at providing opportunities for learning new behaviour by modeling and practice. De Beer and Swanepoel (1998), state that experiential learning could be regarded as learning by doing as it allows practical, hands-on, action-based experience. In this study the methods of information conveyance included group discussions, role-plays, and informal conversations.

The programme also emphasised the promotion of positive youth development through the youth empowerment process. The South African government encourages the involvement of young people in issues that affect their lives unlike the previous government, which marginalised the youth (Youth Update, 2000). It also encourages integrated youth development programmes that consider South African youth in their own unique contexts.
4.10 Capacity for effective study

The fact that some students, especially the disabled ones, with the requisite scholastic aptitude underachieve in academic work while others with only average or mediocre aptitudes do comparatively well, presents a big challenge to educators.

One of the major reasons for the poor academic performance of the students with average and above average scholastic aptitude is their lack of requisite academic skills. One of the key components of the wellness programme that is subject of this research is the academic skills component. The academic skills component of the wellness programme seeks to enhance the capacity of the treatment group to study effectively. The capacity or ability for effective study consists of the presence of effective study methods, high motivation for studying, as well as appropriate attitudes towards scholastic or academic activities which contribute to academic achievement.

4.11 RESUMÉ

In this chapter the researcher presented the Wellness Promotion Programme as an intervention strategy, addressing the physical, psycho-social, the spiritual and the cultural problems experienced by students with disabilities. The Wellness Promotion Programme was based on the results of the pilot study that was carried out on a few disabled students selected from the targeted population. The three psychometric instruments that are used to evaluate the effects of the Wellness Promotion Programme are also discussed.

Because of the variety of the disabilities manifested by the students, the programme and the questionnaires were written in braille and enlarged to accommodate those with visual impairments. In the chapter that follows the results obtained are presented, analysed and interpreted.
CHAPTER FIVE

PRESENTATION, INTERPRETATION AND DISCUSSION OF RESULTS

5.1 INTRODUCTION

In the previous chapter the overall methodology of the study was presented. In this chapter the researcher will present, interpret and discuss the results.

The aim of this study was to develop, evaluate and investigate the effects of a Wellness Promotion Programme on a group of students with disabilities at one of the Institutions of Higher Learning in South Africa- the University of Limpopo (Turfloop Campus).

5.2 RESULTS OF THE STUDY

The Wellness programme was presented to the treatment group for three months from the beginning of February through the end of April, 2008 and it consisted of the following units: the Study Habits and Attitudes unit; the Life Skills unit and the Career Search Skills unit. After the treatment, both the treatment and control groups were post-tested on the three tests indicated in chapter three that were used for pre-testing. The statistical techniques used in the study were obtained from the Statistical Package for Social Sciences (SPSS).

The t-test for paired samples (correlated data) and that for independent samples (uncorrelated data) were used to determine the significance or lack of it for the obtained data. All hypotheses were tested at the .05 level of significance.

The results are presented and discussed in terms of the developmental indices measured by the three tests employed in this study (these broad indices are the Study Skills, Life Skills, as well as Career Development and Career Choice).
In this chapter the hypotheses are stated in the null form and the results relating to each are presented. These null hypotheses are grouped under the three indices of students wellness referred to, above.

All the hypotheses in this study are one-tailed, but there is no option in SPSS to specify a one-tailed test. Owing to this, all the p-values presented are for the two-tailed tests. In order to get the p-value for a one-tailed test, a p-value for the two-tailed test is divided by two if the t-value falls in the correct tail. If the t-value falls in the wrong tail (t-value value is negative when it is expected to be positive or vice versa), then the p-value for the one-tail test would be 1-(p-value for two-tailed)/2.

The results of this study are presented below:

5.3 STUDY SKILLS

The question relating to study skills was posited as follows in chapter one:
Will the Wellness Programme significantly improve the Study Skills of those students who will be exposed to it?

5.3.1 Female Treatment (pre-test) versus Female Treatment (post-test)

This section presents the null hypotheses and their tests results about the mean pre-test and mean post-test scores of the female treatment group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes questionnaire.

The null hypotheses of the three components of the Study Skills Index, namely, Study Habits, Study Attitudes and Study Orientation are presented below:
\textbf{H_0 5.3.1.1.1} \\
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Habits Scale of the Survey of Study Habits and Attitudes.

\textbf{H_0 5.3.1.2.1} \\
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Attitudes Scale of the Survey of Study Habits and Attitudes.

\textbf{H_0 5.3.1.3.1} \\
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Orientation Scale of the Survey of Study Habits and Attitudes.

\textbf{Table 5.1} seeks to test the three null hypotheses indicated above that the mean post-test scores of the female treatment group is significantly higher than the mean pre-test scores of the same group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes.

The paired sample t-test method was appropriate to use since the two scores (pre-test scores, i.e. scores before the programme and post-test scores, i.e. scores after the programme) were obtained from the same students. In this case \(p=0.000\). The three \(p\)-values \(<0.0001/2 =0.00005\), \(<0.0001/2 =0.00005\) and \(<0.0001/2 =0.00005\) given under “Sig. (2-tailed)” lead to the rejection of the null hypothesis, that is, the mean post-test scores of the female treatment group will be significantly higher than the mean pre-test scores of the same group at the 0.05 level of significance. Hence the mean difference in the scores (pre-test and post-test) is not equal to zero, which implies that the mean of the post-test scores of the female treatment group is significantly higher than the mean pre-test scores of the same group for the three Study Skills Indices (Study Habits, Study Attitudes and Study Orientation) are statistically different at the 0.05 level of
significance. Thus the programme was effective in improving and in enhancing the study skills of those students who were exposed to it. The relevant null hypotheses were rejected.

Results relating to null hypotheses 5.3.1.1; 5.3.1.2.1 and 5.3.1.3.1 are presented in table 5.1 below.

**TABLE 5.1: Female treatment pre-test vs. Female treatment post-test – Study Skills indices**

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&lt;sub&gt;0&lt;/sub&gt; 5.3.1.1.1</td>
<td>Pair 1 Study Habits Pre-test – Study Habits Post-test</td>
<td>-30.786</td>
<td>15.055</td>
<td>4.024</td>
<td>-7.651</td>
<td>13</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;0&lt;/sub&gt; 5.3.1.2.1</td>
<td>Pair 2 Study Attitudes Pre-test – Study Attitudes Post-test</td>
<td>-36.929</td>
<td>16.569</td>
<td>4.428</td>
<td>-8.339</td>
<td>13</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;0&lt;/sub&gt; 5.3.1.3.1</td>
<td>Pair 3 Study Orientation Pre-test – Study Orientation Post-test</td>
<td>-28.571</td>
<td>14.538</td>
<td>3.885</td>
<td>-7.354</td>
<td>13</td>
<td>.000</td>
</tr>
</tbody>
</table>

**5.3.2 Male Treatment (pre-test) versus Male Treatment (post-test)**

This section presents the hypotheses and their tests results about the mean pre-test and mean post-test scores of the male treatment group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes questionnaire. The following hypotheses (H<sub>0</sub>5.3.2.1.1; H<sub>0</sub> 5.3.2.2.1 and H<sub>0</sub> 5.3.2.3.1) relate to the results presented in Table 5.2.

**H<sub>0</sub> 5.3.2.1.2**

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Habits index of the Survey of Study Habits and Attitudes.
**H₀ 5.3.2.2.2**
The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Attitudes index of the Survey of Study Habits and Attitudes.

**H₀ 5.3.2.3.2**
The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Study Orientation index of the Survey of Study Habits and Attitudes.

To test the three null hypotheses (H₀ 5.3.2.1.2, H₀ 5.3.2.2.2 and H₀ 5.3.2.3.2), the mean post-test and the mean pre-test scores of the male treatment group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes were analysed by means of the t-test for paired samples method. The results of the analysis indicate that the mean of the post-test scores of the male treatment group is significantly higher than the mean pre-test scores of the same group on the three Study Skills Indices (Study Habits, Study Attitudes and Study Orientation) with p-values <0.0001/2 = 0.00005, <0.0001/2 =0.00005, and <0.0001/2 =0.00005, respectively as indicated in Table 5.2. The null hypotheses in this regard were all rejected.

Results relating null hypotheses 5.3.2.1.2; 5.3.2.2.2 and 5.3.2.3.2 are presented in Table 5.2 below.

**TABLE 5.2:** Male treatment pre-test vs. Male treatment post-test – Study Skills indices

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H₀ 5.3.2.1.2</td>
<td>Pair 1</td>
<td>Study Habits Pre-test - Study Habits Post-test</td>
<td>-23.364</td>
<td>9.511</td>
<td>2.868</td>
<td>-8.147</td>
<td>10</td>
</tr>
<tr>
<td>H₀ 5.3.2.2.2</td>
<td>Pair 2</td>
<td>Study Attitudes Pre-test - Study Attitudes Post-test</td>
<td>-23.636</td>
<td>8.090</td>
<td>2.439</td>
<td>-9.690</td>
<td>10</td>
</tr>
<tr>
<td>H₀ 5.3.2.3.2</td>
<td>Pair 3</td>
<td>Study Orientation Pre-test - Study Orientation Post-test</td>
<td>-20.364</td>
<td>10.043</td>
<td>3.028</td>
<td>-6.725</td>
<td>10</td>
</tr>
</tbody>
</table>
5.3.3 Female Treatment (post-test) versus Female Control (post-test)

This section presents the null hypotheses and their tests results about the differences between the mean post-test of the female treatment group and mean post-test scores of the female control group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes test.

The following are hypotheses (H0 5.3.3.1.3, H0 5.3.3.2.3 and H0 5.3.3.3.3) relating to the results presented in table 5.3, table 5.4 and table 5.5, respectively.

H0 5.3.3.1.3
The mean post-test scores of the female treatment group will not be significantly higher than those from the mean post-test score of female control group on the Study Habits index of the Survey of Study Habits and Attitudes.

H0 5.3.3.2.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Study Attitudes index of the Survey of Study Habits and Attitudes.

H0 5.3.3.3.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Study Orientation index of the Survey of Study Habits and Attitudes.

The mean post-test scores of the female treatment and control groups on the three indices of the Survey of Study Habits and Attitudes questionnaire, namely Study Habits, Study Attitudes and Study Orientation were analysed by means of the t-test for independent samples.
“Group Statistics” in Tables 5.3(a), 5.4(a) and 5.5(a) give a summary of the statistics for each group (mean, standard deviation and standard error of the mean). Tables 5.3(b) 5.4(b) and 5.5(b) provide the test results for the difference between the mean scores between female treatment and female control groups and have been performed together with the equality of variances (standard deviations) where the t-values, mean differences and standard error of the mean difference yielded by this analysis are also presented.

In Tables 5.3(b) 5.4(b) and 5.5(b), the p-values of 0.912, 0.576 and 0.443 assures equality of variances for the three tests. The three p-values (<0.0001/2 = 0.00005, <0.0001/2 =0.00005, and <0.0001/2 =0.00005) given in Table 5.3(b) 5.4(b) and 5.5(b) under “Sig (two-tailed)” point that the mean post-test score of the male treatment group is significantly higher than the mean post-test scores of the female control group on the Study Habits, Study Attitudes and Study Orientation, respectively. This is an indication of the effectiveness of the programme. The null hypotheses were thus rejected.

Results relating to null hypotheses H₀ 5.3.3.1.3 are presented in tables 5.3 below.

**TABLE 5.3: Female treatment post-test vs. Female control post-test – Study Habit Score**

**TABLE 5.3(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Habits Scores (SSI)</th>
<th>Female Treatment Post-test</th>
<th>Female Control Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>Female Treatment</td>
<td>76.86</td>
<td>18.212</td>
</tr>
<tr>
<td>Female Control</td>
<td>68.75</td>
<td>19.212</td>
</tr>
</tbody>
</table>

**TABLE 5.3(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Habits Scores (SSI)</th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.012</td>
<td>.912</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>5.331</td>
<td>26.979</td>
</tr>
</tbody>
</table>

TABLE 5.3: Female treatment post-test vs. Female control post-test – Study Habit Score
Results relating to null hypothesis $H_0$ 5.3.3.2.3 are presented in table 5.4 below:

**TABLE 5.4:** Female treatment post-test vs. Female control post-test – Study Attitudes Score

**TABLE 5.4(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Attitudes Scores (SSI)</th>
<th>Female Treatment and Female Control</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td>75.79</td>
<td>18.536</td>
<td>4.954</td>
<td></td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>43.06</td>
<td>16.551</td>
<td>3.901</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 5.4(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Attitudes Scores (SSI)</th>
<th>Levene’s Test for Equality of Variances</th>
<th>$t$-test for Equality of Means</th>
<th>Mean Difference</th>
<th>Std. Error Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>T</td>
<td>df</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.320</td>
<td>.576</td>
<td>5.267</td>
<td>30</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>5.191</td>
<td>26.369</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

98
Results relating to null hypothesis $H_0$ are presented in table 5.5 below:

**TABLE 5.5:** Female treatment post-test vs. Female control post-test – Study Orientation Score

**TABLE 5.5(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Orientation Scores (SSI)</th>
<th>Female Treatment and Female Control</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td>78.00</td>
<td>16.478</td>
<td>4.404</td>
<td></td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>47.22</td>
<td>20.547</td>
<td>4.843</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 5.5(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Orientation Scores (SSI)</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>Mean Difference</th>
<th>Std. Error Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
<td>df</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.605</td>
<td>.443</td>
<td>4.572</td>
<td>30</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>4.702</td>
<td>29.955</td>
<td>4.702</td>
<td>29.955</td>
</tr>
</tbody>
</table>

**5.3.4 Male Treatment (post-test) versus Male Control (post-test)**

This section presents statistical tests about the differences between the mean post-test of the male treatment group and mean post-test scores of the male control group on the Study Habits, Study Attitudes and Study Orientation indices of the Survey of Study Habits and Attitudes questionnaire.
The following are the null hypotheses (H\textsubscript{0} 5.3.4.1.4, H\textsubscript{0} 5.3.4.2.4 and H\textsubscript{0} 5.3.4.3.4) relating to the results presented in table 5.6, table 5.7 and table 5.8, respectively.

**H\textsubscript{0} 5.3.3.1.4**

The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Study Habits index of the Survey of Study Habits and Attitudes.

**H\textsubscript{0} 5.3.4.2.4**

The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Study Attitudes scale of the Survey of Study Habits and Attitudes.

**H\textsubscript{0} 5.3.4.3.4**

The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Study Orientation index of the Survey of Study Habits and Attitudes.

The mean post-test scores of the male treatment and control groups on the three indices of the Survey of Study Habits and Attitudes tests, namely Study Habits, Study Attitudes and Study Orientation were analysed in Tables 5.6, 5.7 and 5.8 by means of the t-test for independent samples technique. P-values of 0.327, 0.828 and 0.975 indicates no significant difference on the variances (standard deviations) of the Study Habits, Study Attitudes and Study Orientation test scores for the male treatment and male control groups. There is an indication of a significant difference of the mean scores of the Study Habits, Study Attitudes and Study Orientation tests between male treatment and male control groups with p-values of 0.003/2=0.0015, 0.004/2=002 and 0.001=0.0005 provided in respectively. The three null hypotheses above were rejected.
Results relating to the null hypothesis H₀ 5.3.4.1.4 are presented in table 5.6 below:

**TABLE 5.6**: Male treatment post-test vs. Male control post-test – Study Habit Score

**TABLE 5.6(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Habits Scores (SSI)</th>
<th>Male treatment and Male Control</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Treatment Post-test</td>
<td>70.18</td>
<td>14.845</td>
<td>4.476</td>
<td></td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td>48.93</td>
<td>16.891</td>
<td>4.514</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 5.6(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Habits Scores (SSI)</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>1.003</td>
<td>.327</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.343</td>
<td>22.658</td>
</tr>
</tbody>
</table>

Results relating to null hypothesis H₀ 5.3.4.2.4 are presented in table 5.7 below:

**TABLE 5.7**: Male treatment post-test vs. Male control post-test – Study Attitudes Score

**TABLE 5.7(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Attitudes Scores (SSI)</th>
<th>Male treatment and Male Control</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Treatment Post-test</td>
<td>66.50</td>
<td>12.921</td>
<td>4.086</td>
<td></td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td>48.57</td>
<td>14.064</td>
<td>3.759</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 5.7(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Attitudes Scores (SSI)</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.049</td>
<td>.828</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.229</td>
<td>20.510</td>
</tr>
</tbody>
</table>
Results relating to the null hypothesis $H_0$ 5.3.4.3.4 are presented in table 5.8 below:

**TABLE 5.8:** Male treatment post-test vs. Male control post-test – Study Orientation Score

**TABLE 5.8(a): Group Statistics**

<table>
<thead>
<tr>
<th>Study Orientation Scores (SSI)</th>
<th>Male treatment and Male Control</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Treatment Post-test</td>
<td></td>
<td>70.91</td>
<td>14.251</td>
<td>4.297</td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td></td>
<td>50.00</td>
<td>14.331</td>
<td>3.830</td>
</tr>
</tbody>
</table>

**TABLE 5.8(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Study Orientation Scores (SSI)</th>
<th>Levene’s Test for Equality of Variances</th>
<th>$t$-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.001</td>
<td>.975</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.632</td>
<td>21.677</td>
</tr>
</tbody>
</table>

**5.4 LIFE SKILLS AND COMPETENCIES: GENERAL QUESTIONNAIRE ON LIFE COMPETENCIES AND SKILLS**

**5.4.1 Female Treatment (pre-test) versus Female Treatment (post-test)**

This section presents the hypothesis and their tests results about the mean pre-test and post-test scores of the female treatment group on Life Competencies and Skills test scores, namely; Community and Social Development, Development of Person and Self, Physical and Sexual Development, Career Planning and Development and Life & World Orientation.

The following are null hypotheses ($H_0$ 5.4.1.1.1, $H_0$ 5.4.1.2.1, $H_0$ 5.4.1.3.1, $H_0$ 5.4.1.4.1, $H_0$ 5.4.1.5.1 and $H_0$ 5.4.1.6.1) relating to the results presented in table 5.9.
$H_0$ 5.4.1.1.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Community and Social Development index of the General Questionnaire on Life Competencies and Skills.

$H_0$ 5.4.1.2.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Development of Person and Self index of the General Questionnaire on Life Competencies and Skills.

$H_0$ 5.4.1.3.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Self Management index of the General Questionnaire on Life Competencies and Skills.

$H_0$ 5.4.1.4.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Physical and Sexual Development index of the General Questionnaire on Life Competencies and Skills.

$H_0$ 5.4.1.5.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Career Planning and Development index of General Questionnaire on Life Competencies and Skills.

$H_0$ 5.4.1.6.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the Life and World Orientation index of the General Questionnaire on Life Competencies and Skills.
To test the null hypotheses $H_0$ 5.4.1.1.1, $H_0$ 5.4.1.2.1, $H_0$ 5.4.1.3.1, $H_0$ 5.4.1.4.1, $H_0$ 5.4.1.5.1 and $H_0$ 5.4.1.6.1 the mean post-test and pre-test scores of the female treatment group on the six indices of the General Questionnaire on Life Competencies and Skills were subjected to analysis using the t-test for paired samples. The mean differences yielded by the analyses which are reflected on Table 5.9 are all different from zero with the same p-value of $<0.0001/2=0.00005$ at the .05 level of significance. This indicates that the mean post-test score of the female treatment group is significantly higher than the mean pre-test score of the same group on all the indices of the Life Competencies and Skills, (Community and Social Development, Development of Person and Self, Self Management, Physical and Sexual Development, Career Planning and Development and Life & World Orientation). All six null hypotheses that are stated in this regard were rejected.
Results relating to the six null hypotheses in question are presented in Table 5.9 below.

**TABLE 5.9:** Female treatment pre-test vs. Female treatment post-test – Life Competencies and Skills (GQLCS)

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Paired Differences</th>
<th>T</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paired 1</td>
<td>Community and Social Development Pre-test - Community and Social Development Post-test</td>
<td>-2.571</td>
<td>.514</td>
<td>.137</td>
</tr>
<tr>
<td>Paired 2</td>
<td>Development of Person and Self Pre-test - Development of Person and Self Post-test</td>
<td>-1.857</td>
<td>.535</td>
<td>.143</td>
</tr>
<tr>
<td>Paired 3</td>
<td>Self Management Pre-test - Self Management Post-test</td>
<td>-1.786</td>
<td>.893</td>
<td>.239</td>
</tr>
<tr>
<td>Paired 4</td>
<td>Physical and Sexual Development Pre-test - Physical and Sexual Development Post-test</td>
<td>-2.143</td>
<td>.535</td>
<td>.143</td>
</tr>
<tr>
<td>Paired 5</td>
<td>Career Planning and Development Pre-test - Career Planning and Development Post-test</td>
<td>-2.071</td>
<td>.616</td>
<td>.165</td>
</tr>
<tr>
<td>Paired 6</td>
<td>Life and World Orientation Pre-test - Life and World Orientation Post-test</td>
<td>-2.071</td>
<td>.475</td>
<td>.127</td>
</tr>
</tbody>
</table>

**5.4.2 Male Treatment (pre-test) versus Male Treatment (post-test)**

This section analyses the mean pre-test and post-test scores of the male treatment group the six indices of the Life Competencies and Skills questionnaire, namely; Community and Social Development, Development of Person and Self, Self Management, Physical and Sexual Development, Career Planning and Development and Life & World Orientation.
$\textbf{H}_0\ 5.4.2.1.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Community and Social Development index of the GQLCS.

$\textbf{H}_0\ 5.4.2.2.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Development of Person and Self index of the GQLCS.

$\textbf{H}_0\ 5.4.2.3.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Self Management index of the GQLCS.

$\textbf{H}_0\ 5.4.2.4.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Physical and Sexual Development index of the GQLCS.

$\textbf{H}_0\ 5.4.2.5.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Career Planning and Development index of the GQLCS.

$\textbf{H}_0\ 5.4.2.6.2$

The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Life and World Orientation index of the GQLCS.

The six null hypotheses (\(H_0\ 5.4.2.1.2; H_0\ 5.4.2.2.2; H_0\ 5.4.2.3.2; H_0\ 5.4.2.4.2; H_0\ 5.4.2.5.2\) and \(H_0\ 5.4.2.6.2\) ) given above were analysed by means of the t-test for paired
samples and all the mean differences were found different from zero at the .05 level of significance. This indicates that the mean post-test scores of the male treatment group is significantly higher than the mean pre-test score of the same group on all the indices of the Life Competencies and Skills questionnaire, (Community and Social Development, Development of Person and Self, Self Management, Physical and Sexual Development, Career Planning and Development and Life & World Orientation) with p-values <0.0001/2=0.00005, <0.0001/2=0.00005, <0.0001/2=0.00005, <0.0001/2=0.00005, <0.001/2=0.0005 and <0.0001/2=0.00005, respectively. The six null hypotheses which were tested were thus rejected.

**TABLE 5.10: Male treatment pre-test vs. Male treatment post-test – Life Competencies and Skills (GQLCS)**

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>T</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community and Social Development Pre-test – Community and Social Development Post-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.1.2</td>
<td>Pair 1</td>
<td>-1.900</td>
<td>.568</td>
<td>.180</td>
<td>-10.585</td>
<td>9</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.2</td>
<td>Pair 2</td>
<td>-1.600</td>
<td>.516</td>
<td>.163</td>
<td>-9.798</td>
<td>9</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.3</td>
<td>Pair 3</td>
<td>-1.700</td>
<td>.675</td>
<td>.213</td>
<td>-7.965</td>
<td>9</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.4</td>
<td>Pair 4</td>
<td>-1.600</td>
<td>.516</td>
<td>.163</td>
<td>-9.798</td>
<td>9</td>
<td>.000</td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.5</td>
<td>Pair 5</td>
<td>-1.400</td>
<td>.966</td>
<td>.306</td>
<td>-4.583</td>
<td>9</td>
<td>.001</td>
</tr>
<tr>
<td>H&lt;sub&gt;5&lt;/sub&gt; 5.4.2.6</td>
<td>Pair 6</td>
<td>-1.900</td>
<td>.568</td>
<td>.180</td>
<td>-10.585</td>
<td>9</td>
<td>.000</td>
</tr>
</tbody>
</table>

**NB:** One of the male students in the treatment group did not sit for the Life Competencies and skills test hence the degrees of freedom for paired samples is 9.
5.4.3 Female Treatment (post-test) versus Female Control (post-test)

This section analyses the mean post-test scores of the female treatment and female control groups on the six indices of the Life Competencies and Skills questionnaire, namely; Community and Social Development, Development of Person and Self, Self Management, Physical and Sexual Development, Career Planning and Development and Life & World Orientation.

H₀ 5.4.3.1.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Community and Social Development index of the GQLCS.

H₀ 5.4.3.2.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Development of Person and Self index of the GQLCS.

H₀ 5.4.3.3.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Self Management index of the GQLCS.

H₀ 5.4.3.4.3
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the control group on the Physical and Sexual Development index of the GQLCS.
**H₀ 5.4.3.5.3**
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Career Planning and Development index of the GQLCS.

**H₀ 5.4.3.6.3**
The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the Life and World Orientation index of the GQLCS.

To test the six null hypotheses H₀ 5.4.3.1.3; H₀ 5.4.3.2.3; H₀ 5.4.3.3.3; H₀ 5.4.3 2.4.3; H₀ 5.4.3.5.3 and H₀ 5.4.3.6.3 given above, the mean post-test score of the female treatment and control groups were subjected to an analysis by means of the t-test for independent samples. As can be seen from Table 5.11(a) to Table 5.16(b), all the mean differences are found to be significantly different from zero (p<0.0001/2 = 0.00005, p<0.0001/2 =0.00005, and p<0.0001/2 =0.00005, p<0.0001/2 = 0.00005, p<0.0001/2 =0.00005, and p-value = 0.004/2=0.002, respectively) at .05 significance level. Thus the mean post-test scores of the female treatment group are significantly higher than the mean post-test scores of the female control group on all indices of the Life Competencies and Skills questionnaire. The six null hypotheses which are given above were, therefore, all rejected.
Results relating to the six null hypotheses given above are presented in Table 5.11 below:

**TABLE 5.11: Female treatment post-test vs. Female control post-test – Community and Social Development**

**TABLE 5.11(a): Group Statistics**

<table>
<thead>
<tr>
<th>Community and Social Development</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td>3.44</td>
<td>.705</td>
<td>.166</td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>1.71</td>
<td>.726</td>
<td>.194</td>
</tr>
</tbody>
</table>

**TABLE 5.11(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Community and Social Development</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.004</td>
<td>.952</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>6.772</td>
<td>27.667</td>
</tr>
</tbody>
</table>
Table 5.12: Female treatment post-test vs. Female control post-test – Development of Person and Self

**TABLE 5.12(a): Group Statistics**

<table>
<thead>
<tr>
<th>Development of Person and Self</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Person and Self – Female Treatment Post-test</td>
<td>3.50</td>
<td>.786</td>
<td>.185</td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>2.00</td>
<td>.679</td>
<td>.162</td>
</tr>
</tbody>
</table>

**TABLE 5.12(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Development of Person and Self – Female Treatment Post-test and Female Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>F</strong></td>
<td><strong>Sig.</strong></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>2.259</td>
<td>.143</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>5.783</td>
<td>.000</td>
</tr>
</tbody>
</table>
Table 5.13: Female treatment post-test vs. Female control post-test – Self Management

### TABLE 5.13(a): Group Statistics

<table>
<thead>
<tr>
<th></th>
<th>Self Management</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Management – Female treatment Post-test</td>
<td>3.61</td>
<td>.698</td>
<td>.164</td>
<td></td>
</tr>
<tr>
<td>Female Treatment Post-test and Female control Post-test</td>
<td>2.00</td>
<td>.961</td>
<td>.257</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 5.13(b): Independent Samples Test

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.392</td>
<td>.536</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>5.283</td>
<td>22.907</td>
</tr>
</tbody>
</table>
Table 5.14: Female treatment post-test vs. Female control post-test – Physical and Sexual Development

**TABLE 5.14(a): Group Statistics**

<table>
<thead>
<tr>
<th>Physical and Sexual Development</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td>3.71</td>
<td>.686</td>
<td>.166</td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>2.21</td>
<td>.699</td>
<td>.187</td>
</tr>
</tbody>
</table>

**TABLE 5.14(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Physical and Sexual Development - Female Treatment Post-test and Female Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.024</td>
<td>.878</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>5.961</td>
<td>27.657</td>
</tr>
</tbody>
</table>
Table 5.15: Female treatment post-test vs. Female control post-test – Career Planning and Development

**TABLE 5.15(a): Group Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Career Planning and Development</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td></td>
<td>4.22</td>
<td>.647</td>
<td>.152</td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td></td>
<td>2.14</td>
<td>.949</td>
<td>.254</td>
</tr>
</tbody>
</table>

**TABLE 5.15(b): Independent Samples Test**

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>2.203</td>
<td>.148</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>7.025</td>
<td>21.899</td>
</tr>
</tbody>
</table>
Table 5.16: Female treatment post-test vs. Female control post-test – Life and World Orientation

TABLE 5.16(a): Group Statistics

<table>
<thead>
<tr>
<th>Life and World Orientation</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female treatment Post-test</td>
<td>3.00</td>
<td>.594</td>
<td>.140</td>
</tr>
<tr>
<td>Female Control Post-test</td>
<td>2.14</td>
<td>.864</td>
<td>.231</td>
</tr>
</tbody>
</table>

TABLE 5.16(b): Independent Samples Test

<table>
<thead>
<tr>
<th>Life and World Orientation – Female treatment Post-test and Female Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>6.181</td>
<td>.019</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.173</td>
<td>22.032</td>
</tr>
</tbody>
</table>

5.4.4 Male Treatment (post-test) versus Male Control (post-test)

This section analyses the mean post-test scores of the male treatment and male control groups on six indices of the Life Competencies and Skills questionnaire, namely; Community and Social Development, Development of Person and Self, Self Management, Physical and Sexual Development, Career Planning and Development and Life & World Orientation.
H₀ 5.4.4.1.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Community and Social Development index of the General Questionnaire on Life Competencies and Skills.

H₀ 5.4.4.2.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Development of Person and Self index of the General Questionnaire on Life Competencies and Skills.

H₀ 5.4.4.3.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Self Management index of the General Questionnaire on Life Competencies and Skills.

H₀ 5.4.4.4.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Physical and Sexual Development index of the General Questionnaire on Life Competencies and Skills.

H₀ 5.4.4.5.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Career Planning and Development index of the General Questionnaire on Life Competencies and Skills.

H₀ 5.4.4.6.4
The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the Life and World Orientation index of the General Questionnaire on Life Competencies and Skills.
To test the six null hypotheses $H_0$ 5.4.4.1.4; $H_0$ 5.4.4.2.4; $H_0$ 5.4.4.3.4; $H_0$ 5.4.4.4.4; $H_0$ 5.4.4.5.4 and $H_0$ 5.4.4.6.4 given above, the mean post-test scores of the male treatment and control groups were subjected to an analysis by means of the t-test for independent samples. As can be seen from Table 5.17(a) to Table 5.22(b), the mean post-test scores of the male treatment group are significantly higher than the mean post-test scores of the male control group on all indices of the Life Competencies and Skills questionnaire ($p < 0.0001/2=0.00005$, $< 0.0001/2=0.00005$, 0.003/2=0.0015, $< 0.0001/2=0.00005$, 0.003/2=0.0015 and 0.0032/2=0.0016, respectively) at the .05 significance level. The null hypotheses indicated above were all rejected.

Results relating to the six hypotheses given above are presented in Table 5.17 below:

Table 5.17: Male treatment post-test vs. Male control post-test – Community and Social Development

**TABLE 5.17(a): Group Statistics**

<table>
<thead>
<tr>
<th>Community and Social Development - Male Treatment Post-test and Male Control Post-test</th>
<th>Male treatment Post-test</th>
<th>Male Control Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>Std. Deviation</td>
<td>Std. Error Mean</td>
</tr>
<tr>
<td>3.50</td>
<td>.760</td>
<td>.203</td>
</tr>
<tr>
<td>2.10</td>
<td>76</td>
<td>.277</td>
</tr>
</tbody>
</table>

**TABLE 5.17(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Community and Social Development - Male Treatment Post-test and Male Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.223</td>
<td>.642</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>4.078</td>
<td>17.729</td>
</tr>
</tbody>
</table>
Table 5.18: Male treatment post-test vs. Male control post-test – Development of Person and Self

**TABLE 5.18(a): Group Statistics**

<table>
<thead>
<tr>
<th>Development of Person and Self</th>
<th>Male treatment Post-test</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male treatment Post-test and Male Control Post-test</td>
<td>Male Control Post-test</td>
<td>3.43</td>
<td>.756</td>
<td>.202</td>
</tr>
<tr>
<td>Male treatment Post-test</td>
<td>Male Control Post-test</td>
<td>2.00</td>
<td>.667</td>
<td>.211</td>
</tr>
</tbody>
</table>

**TABLE 5.18(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Development of Person and Self – Male Treatment Post-test and Male Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>2.130</td>
<td>.159</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>4.892</td>
<td>20.911</td>
</tr>
</tbody>
</table>
Table 5.19: Male treatment post-test vs. Male control post-test – Self Management

**TABLE 5.19(a): Group Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Self Management</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Management – Male</td>
<td>Male treatment Post-test</td>
<td>3.36</td>
<td>.929</td>
<td>.248</td>
</tr>
<tr>
<td>Treatment Post-test</td>
<td>Male control Post-test</td>
<td>2.20</td>
<td>.632</td>
<td>.200</td>
</tr>
</tbody>
</table>

**TABLE 5.19(b): Independent Samples Test**

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.630</td>
<td>21.978</td>
</tr>
</tbody>
</table>
Table 5.20: Male treatment post-test vs. Male control post-test – Physical and Sexual Development

**TABLE 5.20(a): Group Statistics**

<table>
<thead>
<tr>
<th>Physical and Sexual Development</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male treatment Post-test</td>
<td>3.71</td>
<td>.611</td>
<td>.163</td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td>2.70</td>
<td>.483</td>
<td>.153</td>
</tr>
</tbody>
</table>

**TABLE 5.20(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Physical and Sexual Development</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Male treatment Post-test and Male Control Post-test</td>
<td>.674</td>
<td>.420</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>4.535</td>
<td>21.704</td>
</tr>
</tbody>
</table>
Table 5.21: Male treatment post-test vs. Male control post-test – Career Planning and Development

**TABLE 5.21(a): Group Statistics**

<table>
<thead>
<tr>
<th>Career Planning and Development</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male treatment Post-test</td>
<td>4.21</td>
<td>.699</td>
<td>.187</td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td>3.00</td>
<td>1.054</td>
<td>.333</td>
</tr>
</tbody>
</table>

**TABLE 5.21(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Career Planning and Development - Male Treatment Post-test and Male Control Post-test</th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>1.319</td>
<td>.263</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>3.177</td>
<td>14.552</td>
</tr>
</tbody>
</table>
Table 5.22: Male treatment post-test vs. Male control post-test – Life and World Orientation

TABLE 5.22(a): Group Statistics

<table>
<thead>
<tr>
<th>Life and World Orientation</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male treatment Post-test</td>
<td>3.00</td>
<td>.877</td>
<td>.234</td>
</tr>
<tr>
<td>Male Control Post-test</td>
<td>2.20</td>
<td>.789</td>
<td>.249</td>
</tr>
</tbody>
</table>

TABLE 5.22(b): Independent Samples Test

<table>
<thead>
<tr>
<th>Life and World Orientation – Male treatment Post-test and Male Control Post-test</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.162</td>
<td>.691</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>2.337</td>
<td>20.725</td>
</tr>
</tbody>
</table>

5.5 GENERAL CAREER DEVELOPMENT AND CAREER CHOICE: SELF DIRECTED SEARCH (SDSQ)

5.5.1 Female and Male Treatment (pre-test) versus Female and Male Treatment (post-test) – SDSQ

In this section the mean differences in the pre- and post-test scores of the female treatment group on the congruence index of the Self-Directed-Search Questionnaire are analysed. The same analysis is carried on the mean differences in the pre- and post-test scores of the male group on the congruence index of the SDSQ.
\(H_0\) 5.5.1.1.1
The mean post-test score of the female treatment group will not be significantly higher than the mean pre-test score of the same group on the congruence index of the Self-Directed-Search Questionnaire (SDSQ).

\(H_0\) 5.5.1.1.2
The mean post-test score of the male treatment group will not be significantly higher than the mean pre-test score of the same group on the Congruence index of the Self-Directed-Search Questionnaire (SDSQ).

To test null hypotheses \(H_0\) 5.5.1.1.1 and \(H_0\) 5.5.1.1.2 the mean pre-test and post-test scores of the female treatment group were analysed using the t-test for paired samples. The same analysis was carried out for the mean pre- and post-test scores for the male control group on the congruence index of the Self-Directed-Search Questionnaire. It can be seen from Table 5.23 that the mean differences for the female treatment (pre-test and post-test) scores were greater than zero at the .05 level of significance. This proves that the mean post-test scores of the female and male treatment groups are significantly higher than the mean pre-test scores of the same groups on the congruence index of the Self-Directed-Search questionnaire (\(p<0.0001/2 = 0.00005\) and \(p<0.0001/2 = 0.00005\)).
Table 5.23 below presents results concerning the two null hypotheses H₀ 5.5.1.1.1 and H₀ 5.5.1.1.2 in question.

**Table 5.23**: Female & Male treatment pre-test vs. Female & Male treatment post-test - Self-Directed-Search (SDSQ) Scores

<table>
<thead>
<tr>
<th>Null Hypo Thesis</th>
<th>Paired Differences</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
<td>Std. Error Mean</td>
<td></td>
</tr>
<tr>
<td>H₀ 5.5.1.1.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pair 1</td>
<td>Female Treatment Pre-test (SDS) - Female Treatment Post-test (SDS)</td>
<td>-2.500</td>
<td>.855</td>
<td>.228</td>
</tr>
<tr>
<td>H₀ 5.5.1.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pair 2</td>
<td>Male Treatment Pre-test (SDS) - Male Treatment Post-test (SDS)</td>
<td>-2.727</td>
<td>.467</td>
<td>.141</td>
</tr>
</tbody>
</table>

5.5.2 Female Treatment (post-test) versus Female Control (post-test) - SDSQ

In this section, the mean differences in the mean post-test scores of the female treatment and control groups in the congruence index of the Self-Directed-Search Questionnaire are analysed.

**H₀ 5.5.2.1.3**

The mean post-test score of the female treatment group will not be significantly higher than the mean post-test score of the female control group on the congruence index of Self-Directed-Search Questionnaire (SDSQ).

It can be observed from Tables 5.24 (a) and 5.24(b) below that the mean post-test scores of the female treatment group is significantly higher than the female control group on the congruence index of the Self-Directed-Search Questionnaire (SDSQ) (p< 0.0001/2=0.00005) at the 0.05 level of significance. Thus the programme has been effective in raising the career development level of these groups of female students in terms of the Self-Directed-Search Questionnaire. The relevant null hypothesis was thus rejected.
Table 5.24: Female treatment post-test vs. Female control post-test – Self-Directed-Search (SDS) Scores

**TABLE 5.24(a): Group Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Female Treatment Post-test and Female Control Post-test (SDS)</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Directed-Search (SDS) Scores</strong></td>
<td>Female Treatment Post-test</td>
<td>3.86</td>
<td>.535</td>
<td>.143</td>
</tr>
<tr>
<td></td>
<td>Female Control Post-test</td>
<td>1.72</td>
<td>.958</td>
<td>.226</td>
</tr>
</tbody>
</table>

**TABLE 5.24(b): Independent Samples Test**

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Directed-Search (SDS) Scores</strong></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>5.510</td>
<td>.026</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>7.988</td>
<td>27.555</td>
</tr>
</tbody>
</table>

5.5.3 Male Treatment (post-test) versus Male Control (post-test) - (SDSQ)

This section presents an analysis of the mean post-test scores of the male treatment and male control groups of the congruence index of the Self-Directed-Search Questionnaire.

**H0 5.5.3.1.4**

The mean post-test score of the male treatment group will not be significantly higher than the mean post-test score of the male control group on the congruence index of the Self-Directed-Search Questionnaire (SDSQ).

In order to test the null hypotheses H0 5.5.3.1.4, the mean post-test scores of the male treatment and the male control groups on the congruence index of the Self-Directed-Search Questionnaire (SDSQ) were subjected to an analysis by means of the t-test for
independent samples. The resulting analysis proves that at the .05 significance level, the mean post-test score of the male treatment group is significantly higher than the mean post-test score of the male control group on the congruence index of the Self-Directed-Search Questionnaire ($p<0.0001/2=0.00005$). The null hypothesis postulated in this regard was, therefore, rejected.

**Table 5.25**: Male treatment post-test vs. Male control post-test – Self-Directed-Search (SDS) Scores

**TABLE 5.25(a): Group Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Male Treatment Post-test and</th>
<th>Male Control Post-test (SDS)</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Directed-Search</td>
<td>Male Treatment Post-test</td>
<td>4.00</td>
<td>.000</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>(SDS) Scores</td>
<td>Male Control Post-test</td>
<td>1.79</td>
<td>1.122</td>
<td></td>
<td>.300</td>
</tr>
</tbody>
</table>

**TABLE 5.25(b): Independent Samples Test**

<table>
<thead>
<tr>
<th>Self-Directed-Search</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>(SDS) Scores</td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>22.539</td>
<td>.000</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>7.386</td>
<td>13.000</td>
</tr>
</tbody>
</table>
5.6 DISCUSSION OF RESULTS

5.6.1 Preamble

This section of the dissertation seeks to go into detail in analysing the results of this study. The purpose of this analysis is to find out how the main question of this investigation has been answered through the data that have been collected and analysed. In brief, the question is whether a multifaceted wellness programme can enhance the overall development of students with disabilities.

5.6.2 Group comparisons for which the null hypotheses were tested.

As was indicated earlier, three components of overall youth development were identified; namely study skills, general life skills and career development. Research hypotheses emanating from specific questions in the selected and measurable components of youth development have been tested. We shall take a brief look at these components of development that have been selected for study, that is, our dependent variables, which seem to have been positively influenced by the wellness programme.

5.6.2.1 Study Skills

5.6.2.1.1 Study Habits; Study Attitudes and Study Orientation

The first dependent variable in this research is Study Skills; which is subdivided into three indices; namely Study Habits, Study Attitudes and Study Orientation.

The Wellness Programme resulted in significant improvements in the treatment group on all the indices of the Study Skills component.
5.6.2.1.2 Discussion of study habits, study attitudes and study orientation as assessed by the Survey of Study Habits and Attitudes (SSHA)

The Wellness Programme thus seems to have had a significant effect on the students who were exposed to it regarding their study habits, study attitudes and study orientation. This is one of the key findings of the study.

Students at tertiary educational institutions experience tremendous difficulties with studying. As indicated earlier, this is especially the case with students with disabilities. The fact that the Wellness Programme could bring about such significant change in the disabled students in terms of their study habits, attitudes and orientation means that this programme can be used to produce a salutary effect on these students in all these features of study skills.

The results which the treatment group posted on the Survey of Study Habits and Attitudes gain more meaning when the detailed attributes measured by this questionnaire are analysed. The survey is actually designed to measure four primary qualities, namely, delay avoidance (DA), work methods (WM), teacher approval (TA), and educational acceptance (EA). The three indices (study habits, study attitudes and study orientation) that are measured in this study are a combination of the four attributes indicated above (DA, WM, TA and EA).

A further analysis of these attributes or scales and the way they combine to form the three basic measures that are assessed by the SSHA (Survey of Study Habits and Attitudes) will reveal the deep psychological constructs that are evaluated by the questionnaire.

Briefly stated, delay avoidance (DA) refers to the promptness with which one tackles and completes one’s work (Du Toit, 1996). In academic situations, the student firmly deals with his proclivity to procrastinate, postpone or defer commencing with or completing his assignments. Such work habits are normally associated with stress, anxiety or even depression. Students with disabilities usually experience varying degrees of these
psychological problems in their daily lives and work at tertiary educational institutions. The results of this study show that subsequent to the exposure to the Wellness Programme the treatment group could handle the study problems related to procrastination and deferment.

Work methods (WM) give an indication of the student’s use of effective study methods, his efficiency in carrying out assignments, and the extent to which he goes about his study in the most effective way (Du Toit, 1996).

Difficulties with study methods are encountered by all students. However, a student’s disability seems to exacerbate this situation. Specific types of disability impact on a person’s capacity for effective study in different ways, for example, the near-sighted, the blind, the spastic, etc. This fact, notwithstanding, disability as such, has an adverse effect on a person’s ability to study effectively. Issues of self-efficacy are also at play here. Matters of self-concept, self-image and self-esteem are also involved.

The Wellness Programme presented an extensive study skills course to the treatment group. The results indicate that subsequent to their exposure to the Wellness Programme, these students were now in a position in which they could say to themselves: “We can – Re a kgona”. In short, the Wellness Programme enabled the treatment group to acquire the study methods which tend to raise the efficiency and effectiveness of their work as students. Delay Avoidance (DA) and Work Methods (WM) combine to produce student’s Study Habits (SH), which provide a measure of a student’s academic behaviour (Du Toit, 1996).

The next two key attributes assessed by the SSHA are Teacher Approval (TA) and Educational Acceptance (EA). Teacher Approval (TA) refers to the student’s attitude towards the lecturers and their classroom behaviour and methods (Jones, 1997). The average teacher in the mainstream secondary school seem to be less accommodating, less caring and less nurturing than the teacher at a special school to which the learners with disabilities normally go.
The teachers at special schools are adequately prepared to deal appropriately with students with disabilities than teachers at the mainstream schools. The lecturers at tertiary educational institutions are therefore far removed from the “nurturing teachers” of the special school who take the student by hand and spoon-feed him/her. At tertiary level the student is on his/her own, and will need to negotiate through the difficult, if not, downright hostile environment inside and outside the lecture room.

The university lecturers are seen as uncaring and even combative by these students. The lecturers on their part complain that they have not been trained to handle students with disabilities. Some programme managers bar students with disabilities from enrolling in their study areas.

It is however gratifying to note that the Wellness Programme brought about a huge shift in the treatment group’s attitudes towards their lecturers.

The students still recognize the hard and difficult attitudes that some lecturers have towards them, but are prepared to live and work more effectively in such adverse environments. Indeed students still face issues of power, control and acceptance which impacts negatively on their self-worth. Because the treatment group seems to be prepared to go the extra mile in relating to their lecturers, the lecturer-student relationship should, in terms of these results, improve exponentially.

The second attribute assessed by the SSHA is the Educational Acceptance (EA) scale which refers to the student’s appreciation and approval of educational objectives and ideals, practices, and requirements (Du Toit, 1996).

The assumption of the education system as well as that of the teachers or lecturers is that these ideals and objectives are essential to the learners’ development into mature adults. However, research has shown that this is not necessarily the case; that the learners, who are the recipients of such educational efforts are, at best, not in sync with these educational interventions and at worst, actually reject these well-intentioned efforts. Such
attitudes are especially prevalent among the underprivileged in multicultural societies such as the United States of America where students with disabilities, the Blacks, Hispanics and Native American students have problems with the ideals and objectives of the American Education System. These students tend to score significantly lower on the SSHA than White students (Hurburst, Krocker & Gade, 1991).

The low educational acceptance scores among students with disabilities and disadvantaged students suggest that their felt needs are not being met in contemporary schools, and therefore their poor attitudes towards their education may lead to poor academic performance as well as low levels of persistence and academic survival. These students seem to feel that such curricula which stress cognitive and academic excellence in a sequential, time-pressured setting, do not address such key issues as identity, self-worth, interpersonal relationships, and community inter-connectedness. Such students thirst for a holistic education which emphasizes personal and social development, creative learning processes, and the integration of cognition, affect, and responsible action (Shapiro, 1983).

The Wellness Programme brought about a shift in a positive direction in the attitudes of the treatment group towards their lecturers. More significantly, the Programme also resulted in a positive shift in the attitudes of the treatment group towards the various curricula programmes in which they were involved. Such attitudinal shifts both towards their teachers and their education were not observed in the non-treatment group.

As indicated above, the study habits (SH) scale is made up of the delay avoidance (DA) and the work methods (WM) scales, and the study attitudes (SA) scale comprises the lecturer acceptance (LA) and the educational acceptance (EA) scales (Du Toit, 1996). Both study habits and study attitudes of the treatment groups were significantly enhanced by the Wellness Programme.

The last scale of the SSHA, that is, study orientation, consists of a combination of all the scales discussed above and provides a measure of the overall position taken by a student
toward his work. This is really a summary of a student’s orientation towards his academic work.

The treatment group’s orientation towards their academic work shifted dramatically subsequent to their exposure to the Wellness Programme. The treatment group’s new study orientation can be expressed in terms of two terms: enhanced sense of self-efficacy and a shift from an external towards an internal locus of control.

According to Bandura (1997), self-efficacy is a person’s belief in his ability to perform in a certain manner to complete certain tasks or solve certain problems. It is a belief that one has capabilities to carry out the actions required to manage present and future life situations. Lack of a sense of self-efficacy results in a poor self-concept and low self-esteem. These in turn result in huge amounts of stress, anxiety and depression. These negative feelings and traits strongly characterize persons with disabilities and have a crippling effect on their work and lives.

The lowered sense of self-efficacy that we find in persons with disabilities is exacerbated by a tendency by these persons to have an externalized locus of control. Locus of control is an important aspect of personality. A locus of control orientation is a belief about whether the outcomes of our actions are contingent on what we do (internal locus of control) or events outside our personal control (external control orientation) (Rotter, 1966; Zimbardo, 1985). Persons with disabilities tend to locate most of the issues that affect their lives to factors outside themselves. This is particularly the case with deficiencies, weaknesses and failures. As a result, persons with disabilities are reluctant to take responsibility and accountability for their lives. They tend to lay blame on people and situations outside themselves for their failure and their woe.

The Wellness Programme seems to have caused the treatment group to shift their locus of control from outside to strengths and capabilities as well as weaknesses and deficiencies inside themselves. Recognition of these capabilities seems to have enhanced the sense of
self-efficacy of these students. These students seem to have become highly motivated with a generalized positive attitude towards life.

Tables 5.1, 5.2, 5.3(a), 5.3(b), 5.4(a), 5.4(b), 5.5(a), 5.5(b), 5.6(a), 5.6(b), 5.7(a), 5.7(b), 5.8(a) and 5.8(b) present the data reflecting the changes that the Wellness Programme has brought about in the treatment group’s study habits, study attitudes and study orientation.

The results of this study show that the SSHAQ provides the counsellor or any other person working with students with disabilities with a diagnostic tool to systematically analyse some important practices, attitudes and feelings regarding the students’ academic work. A profile of a student’s study habits and attitudes can easily be constructed indicating short-comings that may lead to poor achievement. The shortcomings can then be ameliorated or eradicated through the use of the Wellness Programme.

5.6.2.2 General Questionnaire on Life Skills Competencies and Skills

The General Questionnaire on Life Competencies and Skills comprises the following indices:

1. Community and Social Development
2. Development of Person and Self
3. Self Management
4. Physical and Sexual Development
5. Career Planning and Development
6. Life and World Orientation

The various treatment and control groups took the questionnaire and the results have been provided above.
5.6.2.2.1 Discussion of Life Skills and Competencies as assessed by the General Questionnaire on Life Competencies and Skills

The GQLCS was used to assess the life Skills component of the Wellness Programme. This component was indeed a key aspect of the Wellness Programme. The life skills component sought to focus on facilitating the development of abilities and skills of the treatment group to enable them to cope with all aspects of their lives at university.

Furthermore, the life skills teaching programme endeavoured to empower students to take responsibility for their lives, their learning and their future. Lindhard and Dlamini (1990) define life skills as “practical skills in the art of living”. Nelson-Jones (1991) emphasizes the importance of making choices and decisions. He further goes on to define life skills as “personal responsible sequences of choices in specific psychological areas conducive to mental wellness” Nelson-Jones (1991).

The life skills component of the Wellness Programme also sought to stimulate the development of self-reliance and self-empowerment in the treatment group. “Self-empowerment is a process of taking increasingly greater charge of yourself and your life” Hopson & Scally (1985).

At the pre-test both the treatment and control groups showed very little by way of self-empowerment as measured by the following scales of the GQLCS, namely, the Development of Person and Self scale, the Self Management scale, as well as the scales on Physical and Sexual Development and that on Career Planning and Development. At the post-test, the treatment group achieved high scores on these four scales as well as in the other two. At the post-test the control group scored poorly on all the scales of the GQLCS. This result indicates that persons with disabilities have very low capacity for self-empowerment. However, the Wellness Programme seems to have generated and enhanced the capacity for self-empowerment in those students who comprised the treatment group.
The Wellness Programme did not only engender a self-empowering and self-steering spirit in the group of students with disabilities who were exposed to it, it also brought about a great deal of capacity and maturity in dealing with their social and spiritual worlds. The pre-test performance of both the treatment and control groups on the Community and Social Development as well as the Life Orientation scales was poor. However, after the presentation of the Wellness Programme to the treatment group, this group’s performance on the two scales in question was significantly higher than that of the control group on these scales. This shows that the Wellness Programme enabled the members of the treatment group to acquire attitudes, skills and competencies which enabled them to have a healthier relationships with the social milieu in which they found themselves. They developed an ability to focus more on other people as well as the community at large and less so on themselves as victims and objects of pity. They also seem to have developed the ability to fulfill their civic duties and responsibilities more effectively.

The Wellness Programme enabled the treatment group to develop a personal world view “Leben-und-Welt-Aanscauung”. This is a life and world orientation that enables the student with disability to put himself/herself to one side and take a view of the social, political, cultural and religious worlds as an independent, autonomous being. He/she also is able to recognize the duality of his/her nature and existence, that while he/she is an independent and autonomous being, he/she at the same time is part of these socio-political, cultural and religious milieux, and that they too are also part of him/her. This in reality is the essence of a mature person.

The life skills and competencies which the Wellness Programme engendered in the treatment group are portrayed in tables 5.9, 5.10, 5.11(a), 5.11(b), 5.12(a), 5.12(b), 5.13(a), 5.13(b), 5.14(a), 5.14(b), 5.15(a), 5.15(b), 5.16(a), 5.16(b), 5.17(a), 5.17(b), 5.18(a), 5.18(b), 5.19(a), 5.19(b), 5.20(a), 5.20(b), 5.21(a), 5.21(b), 5.22(a) and 5.22(b).

In conclusion the sense of helplessness, self-pity control and entitlement were greatly mitigated and reduced in the treatment group. The treatment group did far much better
than the control group on all the six indices of the General Questionnaire on Life Competencies and Skills. This clearly indicates that the Wellness Programme was highly successful in assisting the treatment group in acquiring the desirable life skills and competencies which are essential for success in life and the engendering of a sense of wellness.

5.6.2.3 The Self-Directed Search Questionnaire

The following index of the Self-Directed Search Questionnaire, namely, congruency, was employed to evaluate the Career Development of the treatment group. The career development and career maturity of the treatment and control groups were thus assessed in terms of this key index. As the results presented above indicate, the Wellness Programme seems to have significantly raised the career and maturity levels of the treatment groups.

5.6.2.3.1 Discussion of Career Development and Career Choice as assessed by the Self-Directed-Search Questionnaire

Holland (1997) makes the assertion that career development and career choice problems may stem from any one of the three components of the career choice paradigm. These components are personal characteristics, occupational knowledge, and decision-making skills. Problems may arise in anyone or in all of these components.

Persons with disabilities have generalized attitudes and beliefs that they are not capable of doing the jobs that are available in the world of work. They generally regard themselves as helpless victims who are incapable of doing productive work and contributing to the common wealth. These attitudes and beliefs are reinforced by the stereotypes and discriminatory practices that the general public directs towards people with disabilities.
All these factors have an adverse effect on the personalities of persons with disabilities. These people have warped and negative ideas about themselves in relation to a variety of jobs. A poor self-concept and low self-esteem compound the inaccurate ideas that they have towards themselves. The Wellness Programme intentionally and purposefully sought to change these negative self-images and self-concepts. The Programme thus brought about a dramatic change in the group’s attitudes towards themselves.

Disadvantaged youth in general, but students with disabilities in particular, have very scanty information about the world of work. These young people have very few or no career role models in their families. The environment is also not that enriched to stimulate their vocational interests. Whether they grow up in an impoverished or enriched environment in terms of careers, students with disabilities tend to do very little to go out of their way to find the information that they may need.

The inability to initiate action, be enterprising and a lack of a go-getter attitude hinders them from going out to get the information they need to make wise career choices. The treatment and control groups we are dealing with in this study come out of a population that is highly disadvantaged. The students also suffer from various types of disability as well. At the pre-test the two groups showed extremely poor knowledge of the world of work. After the presentation of the Wellness Programme to the treatment group, the occupational knowledge of this group increased significantly.

The third component of the career development and career choice paradigm is a person’s capacity to match his personal characteristics to the requirements of specific jobs and careers. This is in fact the real career choice process. This is an analyzing and synthesizing process that requires cognitive, affective and behavioural effort that does not come easily with persons with disabilities. The Wellness Programme sought inter alia to address this component of the career development and career choice paradigm.

The success of the Wellness Programme in promoting the career development and career choice of students with disabilities can be seen in the degree of congruency which the
treatment group achieved in its performance on the SDS. Congruency reflects the degree of correspondence between a personality type and a specific occupational environment.

As indicated above, the personality type of an individual is obtained from his performance on the SDS. While the occupational environments are job features of specific jobs to which persons with specific personality types respond in a similar way. Correspondence is established after an individual has completed an SDS questionnaire and his SDS code has been obtained which can be compared to the occupational code. This then provides the degree of congruence in a person’s career choice. The higher a person’s degree of congruence, the higher his career maturity and the lower a person’s degree of congruence, the lower the career maturity of that person.

Prior to the administration of the Wellness Programme to the treatment group, the degree of congruence of the treatment and control groups on the SDS was very low indeed; pointing to the low level of career maturity for both groups. However, after the presentation of the Wellness Programme to the treatment group, the degree of congruence for this group’s SDS codes and the codes for the occupational environment increased significantly. The pre- and post-test increase in the treatment group’s degree of congruence of the SDS was quite dramatic. For example, those students who had their highest work codes as Realistic also indicated that they would also like to work in a Realistic work environment; those who had their highest work code as Artistic would also prefer to work in an Artistic work environment.

This reflects the efficacy of the Wellness Programme on promoting the career development and career maturity of students with disabilities. The profound changes in the career maturity of the treatment group that was inculcated by the Wellness Programme are reflected in tables 5.23, 5.24(a), 5.24(b), 5.25(a) and 5.25(b).

In summary, the Wellness Programme enhanced the career development, career maturity and career choice of students with disabilities who were exposed to it.
Three instruments, namely, the Survey of Study Habits and Attitudes: Form C, Self-Directed-Search and Life Skills and Competencies: General Questionnaire on Life Competencies and Skills were administered to both the treatment and control groups. Subsequent to this, the Wellness Programme was presented to the treatment group and withheld from the control group. These three instruments were then re-administered to both groups (treatment and control).

The results of the two administrations of the three instruments indicated above on the treatment and control groups have been reported and discussed in this chapter. The results clearly point to the efficacy of the Wellness Programme in promoting the development of students with disabilities in key areas of their lives as students at the University of Limpopo.

These key areas include the acquisition of general life skills and competencies; the capacity and ability for effective study, and appropriate maturity levels in terms of career development and career choice.

Consequently, the Wellness programme eminently proved its efficacy in promoting the all round development of students with disabilities at the University of Limpopo.
CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

In this final chapter of the dissertation the main aim of the investigation is restated, a summary of the entire study given, conclusions drawn and recommendations made.

The following constituted the aims of this investigation:

- the compilation of the Wellness Promotion Programme that would address the physical, mental, and socio-cultural components of the lives of students with disabilities.
- the field-testing of the programme on the appropriate population and sample.
- the evaluation of the programme using appropriate evaluation instruments, viz: Survey of Study Habits and Attitudes; Life Skills and Competencies and Self-Directed Search questionnaires.
- the promotion of optimum adjustment and academic success among students with disabilities through the implementation of appropriate general life skills, academic skills and the general wellness intervention programme.

6.2 SUMMARY OF RESULTS

The results which are presented, interpreted and discussed in chapter five are shown in tables 5.1 to 5.25. These results have led to the following conclusions:

- the first dependent variable in this study was study skills: The programme resulted in significant improvements in both female and male treatment groups in all the indices of the study skills component. The mean post-test scores of both the female and male treatment groups were significantly higher than the mean post-test scores of both female and male control groups.
• the second dependent variable was life competencies and skills: After exposure to the Wellness Promotion Programme, both female and male treatment groups showed significant pre- to post-test increase on their mean score on all the six indices of the GQLCS. The mean post-test scores of both female and male treatment groups were significantly higher than the mean post-test scores of both female and male control groups. This shows that the programme did have a positive effect on the life skills and competencies of the treatment groups.

• the third dependent variable was career development and career choice: After exposure to the programme, both female and male treatment groups posted significantly higher post-test scores as compared to its pre-test scores on the congruency index of the SDSQ. Secondly, the mean differences in the mean post-test scores of both female and male treatment groups were significantly higher than the mean post-test scores of both the female and male control groups on the congruence index of the SDSQ.

All in all, the treatment groups did significantly better than the control groups in the post-tests in all the three variables. Also, the treatment groups did better in the post-tests than in the pre-tests. Thus the study has achieved its goal.

6.3 CONCLUSIONS

The study was a success because:

• the Wellness Promotion Programme that sought to address the physical, mental, and socio-cultural challenges faced by students with disabilities was indeed compiled.

• this programme was used as an independent variable. The programme was field-tested on the appropriate population sample. In this regard it was presented to a
group of students with disabilities (the treatment group) and withheld from another group of students with disabilities (the control group).

- the effectiveness of this programme in promoting the development and enhancement of key areas in the life and work of students was evaluated key means of the three instruments that were used in the study; namely the Study Skills Questionnaire, the General Questionnaire on Life Competencies and Skills and the Self-Directed Search Questionnaire.

- the participants were assessed on three (3) variables which are study skills, life competencies and skills and career choice and development. The Programme that was presented to the treatment group did enhance the study skills, general life competencies and skills, and the career planning and development, career choice, and the general career maturity of the students who participated in it.

The major aim of the study which was to compile a well-grounded psycho-social educational programme that will promote the effective adjustment and functioning of students with disabilities at tertiary education institutions, to promote optimum adjustment and academic success among these students through the acquisition of appropriate life skills, academic skills and the general career choice skills was achieved.

6.4 EDUCATIONAL SIGNIFICANCE OF THE STUDY

- The results of this study have given credence to the idea that the various activities that are used to guide the students with disabilities can be structured into a Wellness Programme. These results have also shown that such a programme can provide a systematic and effective intervention strategy for the promotion of the overall development of the student with disability.
• This study has shown that for effective programme delivery, a variety of methods and strategies should be used. Such methods should range from the lecture methods to the more personal one-on-one approaches used in guidance, counselling and psychotherapy.

• The successful presentation of a wellness programme such as this to students with disabilities, will necessitate the existence of knowledgeable and committed staff. Workshops with staff in the academic departments as well as those in student residences are clearly indicated.

• The education of students with disabilities is an expensive undertaking. The effective implementation of a wellness programme such as the one used in this study will mean the dedication of some financial resources in this direction. Tertiary educational institutions and government departments must be prepared to make the necessary investments in the education of students with disabilities.

• The study has documented the efficacy of programmatic intervention in the promotion of the growth and development of students with disabilities. The introduction of such comprehensive wellness programmes in all tertiary educational institutions in the country is therefore not only feasible, but, will most probably make a huge difference in the education of students with disabilities in our country.

• The programme would prevent ill-health, academic failure, self alienation from others, inability to actualise themselves optimally, inability to attain and reach their goals, inability to develop self-steering behaviour. To counteract all these negatives, the programme would promote academic success, optimum adjustment, self-acceptance, self-esteem, and career development.
6.5 LIMITATIONS OF THE STUDY

The most fundamental constraints are briefly indicated below:

- although the experimental design in this study was rigorous enough, the implementation of this programme on other students with disabilities, while it will, in all probability, result in exponential growth and development in such students, need to be approached with some caution. Replication in similar settings could provide the basis for further generalisation.

- the subjects in the treatment and control groups were not randomly assigned to these groups. Complete randomisation was not possible because of the nature of the experimental design.

- a follow-up testing might have been run, say, six months after the post-tests to determine the durability of any observed changes in the treatment groups. More significantly, such assessment might have established the existence of any delayed effects the programme might have had on programme participants.

6.6 RECOMMENDATIONS

- The proposal should be presented to relevant stakeholders relating to the use of the programme in the education of students with disabilities.

- This programme should be adopted at the University of Limpopo and at other tertiary institutions in South Africa.

- Staff at the Disability Students Units of tertiary education institutions should be capacitated to present this or similar programmes to students with disabilities at these institutions.
• Staff in academic departments, in administrative areas and in residences should be conscientised to the needs and general situations of disabled students.

• Tertiary education institutions should invest in the education of students with disabilities in terms of staff and other relevant resources.

• Senior students with disabilities should be trained as peer educators or counsellors to render assistance to other students with disabilities; after all they know “where the shoe pinches”.

• Staff responsible should link up with Unlimited, the Services SETA department that deals exclusively with the workplace rights and needs of people with disabilities, which will in turn inform students with disabilities about the Ibility Portal (web-based portal) catering for the needs of disabled people.

6.7 CONCLUSION

Comprehensively the aim of this investigation was the enhancement of the growth and development of students with disabilities through the use of a Wellness Programme. If the Wellness Programme achieved this heightened growth and development in these students, it then would have proved its efficacy in this regard. The Programme eminently succeeded in promoting such growth and development in students with disabilities at the Turfloop Campus of the University of Limpopo. The programme should, therefore be adopted for use with students with disabilities at other tertiary institutions in South Africa.
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