

Student Perceptions of Adolescent Wellness

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by

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Abstract

Although wellness has become a declared priority within education, a thorough exploration of the factors responsible for student wellness has yet to occur. There have been many studies with a focus on adolescent problems; however, wellness research is limited and non-holistic in its approach.

This dissertation sought to explore the adolescent wellness phenomenon and the factors influencing its enhancement through the experiences of adolescents and teachers. The primary purpose of the research was to explore adolescents' perceptions of wellness in two mid-sized Western Canadian high schools. The second purpose was to use a theoretical framework to describe the relationship between adolescent perceptions of wellness and the developmental dimensions of adolescent lives, the perceived influences on adolescent wellness, and the links between professional support (teachers) and students' perceived levels of wellness (low, medium and high-level wellness). To accomplish this, two hundred and eighty grade eleven students completed a wellness survey. Additionally, subgroups of 22 students and 6 teachers were asked to participate in focus group discussions.

It was found that wellness was a complex and multifaceted phenomenon. The study revealed that there were at least four dimensions contributing to the balance of wellness: physical (physical activity, nutrition, smoking, drugs and alcohol), psychological (self-esteem, media), spiritual and social (parents, teachers and peers). For many students, the dimensions were not considered equally important, but wellness was seen to involve maintaining a *balance* in life.

The findings of the study indicated that modifications to particular areas of educational practice should be considered when working to promote adolescent wellness

and some of the suggested change areas include: additional professional development, school health programming and committing to school partnerships with health care professionals such as nurses. Implications for educational policy included the support for professional development related to health education, policies that fiscally support the hiring of school health nurses, and policies that are reflective of adolescent developmental stages. Among the implications for research are a need to further explore the conceptualization of adolescent wellness in youth of all ages and in schools across the Canada, as well as the need for longitudinal studies which would allow for further investigation of wellness, and its validity beyond this study.

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Dedication

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Table of Contents

Permission to Use	i
Abstract.....	ii
Acknowledgements.....	iv
Dedication.....	vi
Table of Contents.....	vii
List of Tables	xvi
List of Figures.....	xix
CHAPTER ONE.....	1
The Problem.....	1
The Purpose of the Study	3
Emergence of the Research Questions.....	3
Significance of the Study	4
Delimitations.....	8
Limitations	8
Assumptions.....	9
Definitions of Terms	9
Outline of Dissertation.....	11
CHAPTER TWO	12
Review of the Literature	12
Review of Wellness	13
Adolescent Wellness.....	22
Adolescent Development.....	30

Theories of Human Development	31
John Bowlby Theory of Attachment	31
Erickson’s Theory of Development	32
Piaget’s Theory of Cognitive Development	33
Kohlberg’s Theory of Moral Development	35
Gilligan’s Theory of Moral Development	36
James Fowler’s Stages of Faith.....	37
Adolescent Physical Development	39
Physical Activity and its Relation to Development	40
Nutritional Implications for Development.....	41
Contributing Factors of Health Habits on Adolescent Development	43
Adolescent Spiritual Development	47
Definitions of Religion, Spirituality, and Spiritual Wellness	47
Research into Adolescent Spiritual Development	51
Adolescent Psychological Development.....	55
The Role of Self-Concept in the Development of the Self	55
The Role of Self-esteem in Adolescent Development	57
Adolescent Social Development	62
The Influence of Family on Adolescent Social Development	63
The Role of Peer Relationships.....	66
The Impact of the School Community	67
Summary of the Literature	71
A Conceptual Framework for Exploring Wellness.....	71

Summary	77
CHAPTER THREE	79
Research Methods.....	79
Case Study	79
Authentic Knowledge	79
Naturalistic Generalization	80
Emancipation	80
Interpretivism.....	81
Postpositivism.....	83
Mixed Methods Design.....	83
The Study’s Sample	86
Data Collection	86
Survey Research.....	88
The Adolescent Wellness Questionnaire	89
The Pilot Study	91
Statistical Analysis.....	93
Quantitative Validity and Reliability	95
Focus Group Research	97
Development of Focus Group Questions.....	99
Focus Group Analysis.....	100
Trustworthiness.....	105
Ethics.....	106
Summary	107

CHAPTER FOUR.....	108
Description of Questionnaire Results	108
Sites Participating in the Study	108
Responses to the Adolescent Wellness Survey.....	110
Collective Demographic Information	110
Descriptive Statistical Analysis	111
Summary of Descriptive Statistical Findings	120
Inferential Statistical Analysis	121
Correlations Analyses	121
Other Relevant Correlations	131
Summary of the Main Findings in the Correlations Analyses.....	132
ANOVA Analyses	133
Summary of the Analyses of Variance	147
Summary of the Results of all the Statistical Analyses.	149
CHAPTER FIVE	152
The Qualitative Findings of the Study: Themes and Subthemes.....	152
Student Experiences and Understandings.....	152
Understanding of Wellness Themes	153
Wellness Definitions.....	153
The Multidimensions of Wellness	154
The Characteristics of a Well Person.....	155
The Relationship Between Wellness and Development Themes	156
The Moderating Influences of Wellness Themes	157

Moderating Influences of Physical Development Themes	158
Understanding of Physical Development.....	158
Influences of Physical Development	159
Influence of Physical Activity	159
Influence of Nutrition	160
Influence of Smoking, Drugs and Alcohol	161
Influence of Body Weight.....	164
Influence of Parents on Physical Development	165
Moderating Influences of Spiritual Development.....	166
Understanding of Spirituality Development	166
Influence of Spiritual Development.....	168
Influence of Parents/Guardians on Spiritual Development	170
Influence of School on Spiritual Development.....	171
Influence of Peers on Spiritual Development	173
Moderating Influences of Psychological Development.....	174
Understanding of Psychological Development.....	174
Influence of Psychological Development	176
Influence of Parents/Guardians on Psychological Development.....	176
Influence of Peers on Psychological Development	177
Influence of Media on Psychological Development.....	179
Moderating Influences of Social Development	181
Understanding of Social Development	181
Influence of Social Development.....	182

Influence of Parents/Guardians on Social Development	182
Influence of Peers on Social Development.....	184
Influence of the School on Social Development.....	186
<i>Influence of Teachers</i>	186
<i>Influence of School Counselors</i>	188
<i>Influence of the School Environment</i>	188
<i>Influence of the School Programs</i>	189
Teacher Experiences and Understandings	190
Teachers' Understanding of Wellness	191
Wellness Definitions.....	191
The Characteristics of a Well Adolescent.....	192
The Moderating Influences of Adolescent Wellness	192
Influences of Adolescent Physical Development	192
Influences of Adolescent Spiritual Development	193
Influence of Parents/Guardians on Adolescent Spiritual Development	193
Influence of Peers on Adolescent Spiritual Development	194
Influence of School on Adolescent Spiritual Development.....	194
Influences of Adolescent Psychological Development.....	195
Influences of Adolescent Social Development.....	197
Summary of Qualitative Findings.....	200
Summary of Chapter Five.....	203
CHAPTER SIX.....	204
Reflections of the Study.....	204

The Research Questions.....	204
A Comparison of the Findings with the Literature	204
Adolescent Perceptions of Wellness.....	205
The Relationship Between the Adolescent Developmental Dimensions and Wellness.....	207
The Moderating Influences on Wellness	209
The Moderating Influences on Physical Development.....	209
The Influence of Physical Activity	209
The Influence of Healthy Eating.....	210
The Influence of Drugs, Alcohol and Smoking	211
The Influences of Body Weight on Physical Development.....	213
Discussion of the Influences of Physical Development.....	214
The Moderating Influences of Spiritual Development	219
The Moderating Influences of Psychological Development.....	224
The Effects of Media on Body Image Satisfaction.....	226
The Moderating Influence of Social Development.....	229
Influence of Parents	230
Influence of Peers	233
Influence of Teachers on Adolescent Wellness	238
Key Findings or Results of this Study	243
Wellness.....	243
The Relationship between Adolescent Development and Wellness.....	244
The Moderating Influencing Factors of Wellness	244

Influence of Teachers on Adolescent Wellness	245
Implications for Educational Theory, Practice, Policy and Research.....	245
Implications for Theory	245
Implications for Practice	246
Professional Development	246
School Programming	250
Committing to Partnerships	254
Implications for School Health Policy	256
Implications for Future Research.....	259
Final Thoughts and Concluding Comments	261
References.....	266
Appendix A.....	290
A-1 Moderator’s Guide (Student Focus Group).....	291
A-2 Moderator’s Guide (Teacher and Administrator Focus Group)	294
A-3 Final Version of the Wellness Survey	297
A-4 Summary of the Modified Survey Questions	310
Appendix B	312
B-1 Letter to Parents and Students.....	313
B-2 Letter to Teachers	315
B-3 Letter to the Director of Education	317
Appendix C	319
C-1 Consent Form for Student Participants (Focus Group).....	320
C-2 Consent Form for Student Participants (Survey).....	323

C-3 Consent Form for Teacher Participants	325
Appendix D.....	328
D-1 Summary of Student Responses	329
D-2 Summary of Smoking/Drugs/Alcohol	335
D-3 Summary of Other Questions	336
D-4 Summary of the ANOVA Analysis	337
Appendix E	344
E-1 University Ethics Approval.....	344
E-2 External Audit Report	344

List of Tables

Table 2.1 The Continuum of Wellness Research

Table 2.2 The Continuum of Adolescent Wellness Research

Table 2.3 Selected Theories of Human Development

Table 2.4 Adolescent Physical Development

Table 2.5 The Variances of Spiritual Definitions

Table 2.6 Adolescent Spiritual Development

Table 2.7 Adolescent Psychological Development

Table 2.8 Adolescent Social Development

Table 4.1 Summary of the Enrolment for the Two Sites

Table 4.2 Collective Demographic Information

Table 4.3 Student Perceptions: Contributions of the Developmental Dimensions to
Wellness

Table 4.4 Student Perceptions: Contributions to Physical Development

Table 4.5 Summary of Student Reported Smoking/Drugs/Alcohol Use

Table 4.6 Student Perceptions: Contributions to Spiritual Development

Table 4.7 Student Perceptions: Contributions to Psychological Development

Table 4.8 Student Perceptions: Contributions to Self-Esteem

Table 4.9 Student Perceptions: Contributions to Social Development

Table 4.10 Correlations Between Wellness Perceptions and the Developmental
Dimension Scales

Table 4.11 Correlations Between Wellness Perceptions and the Items Related to Physical
Development.

Table 4.12 Correlations Between Wellness Perceptions and Smoking/Drugs/Alcohol Use

Table 4.13 Correlations Between Wellness and the Items Related to Spiritual

Development.

Table 4.14 Correlations Between Wellness Perceptions and the Items Related to

Psychological Development (Self-concept and Autonomy).

Table 4.15 Correlations Between Wellness and the Items Related to Psychological

Development (Self-esteem).

Table 4.16 Correlations Between Wellness and the Items Related to Social Development

(Parental and Peer Support).

Table 4.17 Correlations Between Wellness and the Items Related to Social Development

(School).

Table 4.18 Correlations Between Adolescent/Parental Relationship and Parent

Connectedness.

Table 4.19 Correlations Between School Connectedness and Other Influences of School.

Table 4.20 Analysis of Variance for the Differences Among the Wellness Groups on the

Adolescent Developmental Dimensions

Table 4.21 Analysis of Variance for the Differences Among the Wellness Groups on the

Items Related to Physical Development

Table 4.22 Analysis of Variance for the Differences Among the Wellness Groups on the

Items Related to Physical Development (Body Weight, Body Image and Physical

Activity).

Table 4.23 Analysis of Variance for the Differences Among the Wellness Groups on the

Items Related to Spiritual Development.

Table 4.24 Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Psychological Development (Self-concept and Autonomy)

Table 4.25 Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Psychological Development (Self-esteem)

Table 4.26 Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Social Development (Peer and Family)

Table 4.27 Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Social Development (School)

Table 4.28 A Summary of the Characteristics of the High, Medium and Low-Wellness Adolescents.

Table 5.1 The Number and Gender of Student Focus Group Participants

Table 5.2 An Overview of the Student Themes

Table 5.3 An Overview of the Teacher Themes

List of Figures

Figure 2.1. The Ideal State of Wellness

Figure 2.2. A Comparison of the Ideal State of Wellness with Adolescent Perceptions of Wellness.

Figure 2.3. Student Perspectives of Stressors and Lines of Defense in Relation to Wellness.

Figure 3.1. Explanatory Mixed Methods Design.

Figure 4.1. Student Responses to the Statement “My Level of Wellness is.”

Figure 4.2. Student Responses to the Statement “I am Well.”

Figure 6.1. Adolescent Perceptions of Wellness.

Figure 6.2. Adolescent Perceptions of the Factors Influencing Physical Development.

Figure 6.3. Adolescent Perceptions of the Factors Influencing Spiritual Development.

Figure 6.4. Adolescent Perceptions of the Factors Influencing Psychological Development.

Figure 6.5. Adolescent Perceptions of the Factors Influencing Social Development.

Figure 6.6. Parental Influence on the Dimensions of Adolescent Wellness.

Figure 6.7. Peer Influence on the Dimensions of Adolescent Wellness.

Figure 6.8. Teacher Influence on the Dimensions of Adolescent Wellness.

Figure 6.9. Wellness and Students’ Sense of School Connectedness.

Figure 6.10. Wellness and Students’ Sense of Caring People in the School.

CHAPTER ONE

The Problem

The promotion of adolescent wellness is a complex issue facing professionals today. There is a notable interest among health and educational experts to foster the health and well-being of future generations; however, research into adolescent wellness is limited and non-holistic in its approach.

Fifty years ago Dunn (1959, p. 12) stated:

To most of us, this concept of positive health is seen through a glass darkly because our eyes have been so long turned in a different direction. When we take time to turn our gaze in a different direction, focusing it intently on the condition termed good health, we see that wellness is not just a single amorphous condition, but rather a complex state made up of overlapping levels of wellness. As we come to know how to recognize these levels objectively, we will realize that the state of being well is a fascinating and ever-changing panorama of life itself, inviting exploration of its every dimension. (p. 786)

Although voiced over five decades ago, the quote holds relevance as this statement summarizes the complexity of understanding wellness today and the current educational challenge of determining the factors responsible for student wellness.

Promoting health, academic achievement and social development through coordinated school-based programs has been gaining recognition around the world (Canadian Association of School Health, 2006). The Canadian Consensus statement (2007) was prepared and endorsed by several national organizations to promote a comprehensive school health promotion. This approach includes teaching health knowledge and skills in the classroom, creating health-enabling environments and facilitating links with parents and community members to support optimal health and learning.

The World Health Organization's Expert Committee on Comprehensive School Health Education and Promotion (2003) argued that health is a key factor in school entry as well as the physical, social and emotional attainment in school. The Public Health Agency of Canada (2005) recognized that the health and well-being of adolescents is affected by many different factors and promoted the notion of health within and beyond the classroom, encouraging values, skills and actions that fostered the healthy development of students. Furthermore, because children and youth spend so much time in school, school health programs play an important role in assisting families and communities to raise happy and healthy children (Health Council of Canada, 2006, p. 12). Provincially, the government stated in the *Role of the School Task Force Report* that "student wellness is critical to the success of our young people and to the future of Saskatchewan" (Saskatchewan Learning, 2002, p. 251). Clearly, adolescent wellness is being recognized as a central component in the achievement of effective learning outcomes and is emerging as a priority within education at all levels: provincially, nationally and internationally.

Two important question that arises from this emerging interest in adolescent wellness is "what are adolescent perceptions of wellness, and what are the factors influencing the enhancement of the youths' well-being?" Another query is "how are teachers perceived as influences of adolescent wellness?" These are questions fundamental to the enhancement of student wellness, yet the answers remain unclear.

For this dissertation, wellness was used synonymously with the notion of well-being.

The Purpose of the Study

The primary purpose of the research was to explore adolescents' perceptions of wellness in two mid-sized Western Canadian high schools. The second purpose was to use a theoretical framework to describe the relationship between adolescent perceptions of wellness and the developmental dimensions of adolescent lives, the perceived influences on adolescent wellness and the links between professional support (teachers) and students' perceived levels of wellness (low, medium and high-level wellness).

Emergence of the Research Questions

When I began my research into adolescent wellness, I soon discovered the ambiguity of the topic and the lack of understanding of the factors responsible for wellness. On questioning my colleagues about their experiences with adolescent wellness, each replied with a different response. One stated that she was working with adolescents to reduce injury caused by alcohol ingestion. Another colleague responded that she was working to reduce eating disorders and suicide in this population. These colleagues stated that they were promoting adolescent wellness, but clearly, they were working to prevent injury in this population. Among these colleagues there was great variance in the definition of adolescent wellness.

I suspected that, with the increasing complexity of adolescent lives, this population may also have unique experiences with wellness. The following research questions emerged from the interest of undertaking a further exploration of adolescent wellness:

1. What are adolescents' perceptions of wellness?

2. What is the perceived relationship between the adolescent developmental dimensions and their perceptions of wellness?
3. What are the perceived social, physical, spiritual, and psychological developmental influences on adolescent wellness?
4. What influences do teachers have on adolescent wellness, from the perspective of students?

Significance of the Study

I sought to understand the meanings and experiences of the adolescent wellness phenomenon through the perceptions of students and teachers. Specifically, I hoped to reveal the adolescents' understanding of development and wellness and the factors influencing their well-being. Furthermore, I aspired to learn how the teachers are influencing their wellness as I believed that this knowledge would provide insight into the development of more effective and sustainable educational wellness policies and programming and an environment that was supportive of healthy choices for the youth and their families.

After an extensive review of the wellness literature I discovered that, although research into adolescent wellness has increased over the last decade, a thorough exploration has yet to occur in the high school setting. Specifically, knowledge relating to the construct of adolescent wellness would be a relatively new contribution to the foundation of adolescent wellness research. While there are multiple methods of exploring adolescent wellness, few studies are comprehensive and most use a problem-based approach.

There have been a series of quantitative studies, primarily from one researcher and her graduates students, that used a model called the wheel of wellness, which has been applied to youth (Dixon Rayle, 2005; Hattie, Myers, & Sweeney, 2004; Makinson & Myers, 2003; Rayle & Myers, 2004). The intent of the application of the model was to improve the practice of counseling or to facilitate interventions with adolescents. Sharkey (1999) investigated the psychosocial factors related to wellness and determined if a relationship existed between these variables and risk-taking behaviours in adolescents. Other adolescent studies included a profile of health problems that exist among youth today (Hayward & Sanborn, 2002; Steiner, Pavelski, Pitts, & Mcquivey, 1998), and an exploration of subjective well-being and levels of life satisfaction (Ben-Zur, 2003; Gilman & Huebner, 2006; Katja, Paivi, Marja-Terttu, & Pekka, 2002). In college students, researchers have applied the wheel of wellness and evaluated perceived levels of wellness (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000; Myers & Mobley, 2004; Myers, Mobley, & Booth, 2003). Although these studies have contributed to understanding wellness, more in-depth, comprehensive adolescent wellness research was warranted.

There have been many studies on adolescent problems, and examples of deficit research on the adolescent population included: obesity (Janssen, Katzmarzyk, Boyce, King, & Pickett, 2004; Jean, Shiv, & Kathaleen, 2006; Katzmarzyk et al., 2004); drug and alcohol abuse (Health Canada, 2004b); suicide (Robert, Keith, Huebner, & Drane, 2004; Toumbourou & Gregg, 2002); violence (Brookmeyer, Fanti, & Henrich, 2006; Irwin, 2004; Roche, Ensminger, Ialongo, Poduska, & Kellam, 2006); pregnancy (Kahn, Kaplowitz, Goodman, & Emans, 2002); and eating disorders (McCabe & Ricciardelli,

2006; Skemp-Arlt, 2006). May and Katzenstein (2004) outlined the limitations to a problem-based approach, including how funding and programming has focused on fixing the problems and reducing the risk behaviours in adolescents rather than providing opportunities to promote health and wellness (p. 30).

Along with the increased interest to support and provide research into the well-being of youth, is the recognition that adolescence is a complex transition period where the child matures into an adult. This stage is distinguished by development in the physical, psychological, social and spiritual dimensions of life. The child's physical development is marked by significant growth in height and weight (Hockenberry & Wilson, 2007). Psychologically, the individual moves from relying on the judgment and authority of adults to making autonomous and responsible decisions (Canadian Institute for Health Information, 2005). The adolescent gains the cognitive ability to reason, dispute and theorize on an adult level (Piaget, 1962). Adolescence is also a time of changing social roles, relationship experiences, building identity and intimacy (Erickson, 2005). It is also a time for spiritual development. The adolescent develops moral philosophies and begins to question standards, rules, personal values and morals in a fashion separate from those held by his/her authority figures (Kohlberg, 1984b). This research may contribute knowledge of how to assist adolescents' to transition through this developmental period of their lives. In addition, and similar to Fowler and Dell (2006) views on faith development, this study may provide insight into how educators could be more prepared to teach at different developmental stages and to match their methods and communicative practices with the groups' range of stages.

Furthermore, adolescence can be characterized by experimentation with activities that may be beneficial or harmful to health (Canadian Institute for Health Information, 2005). Lifelong behavioural patterns, which can become protective factors for many chronic health conditions, may be established or strengthened (Hedberg, Bracken, & Stashwick, 1999). Moreover, “these behaviours, established during adolescence, may persist into adulthood, and the cumulative effects of ongoing health-compromising behaviours contribute to poor adult health outcomes” (p. 137). All these factors contribute to the multifaceted challenges that are commonly associated with adolescence and illustrate the urgent need for educational policy and program initiatives designed to assist adolescents in their journey to wellness.

As the wellness phenomenon continues to emerge as a priority, the school administrators, teachers and educational partners will undoubtedly seek evidence as to how to promote the well-being of their students. The research questions of this study addressed the promotion of adolescent wellness with a new vision. Adolescents were viewed from a positive lens, one that focuses not so much on the problems, but rather gives attention to a holistic approach, addressing all the unique characteristics and strengths of this population. Exploring adolescent wellness illustrated to youth that there were adults who care and were concerned with the overall health and wellness of this population. The process and findings of the study also encouraged students to think about their perceptions of wellness, and promoted dialogue concerning how youth could develop or maintain the ideal state of wellness. Finally, the knowledge gained from this research study provided direction for administrators, teachers, parents and community

partners to develop an educational environment that supports students to experience well-being, learning and life-long success.

Delimitations

The literature review and research design were delimited as follows:

1. The study was confined to high school students, aged 16 years or older, from two mid-sized Western Canadian Catholic high schools in April and May.
2. Although factors such as culture and socio economics have been cited as bearing influence on wellness, the literature for this study was delimited to an exploration of adolescent development and wellness from a holistic perspective. This delimitation limits the generalizability of the study.
3. The discussion of the results relating to body weight and drugs, smoking and alcohol was delimited to Piaget, as this theory provided a useful framework with which to assess the adolescents' cognitive development and decision-making abilities.

Limitations

Limitations to this study were as follows:

1. The depth of information and insights from this study were limited to data obtained by the questionnaire and focus group discussions.
2. The researcher developed focus group questions and the adapted Sharkey (1999) survey instrument, may have limited the descriptions of adolescent wellness collected from participants.
3. The study was limited by the number of students and teachers who were willing to participate and consent to the study.

4. The figures presented in the study were limited in their capacity to approximate reality.
5. The analysis of the influences of physical development was limited to the theoretical perspective of Piaget's theory.

Assumptions

The following assumptions were made in this study:

1. It was assumed that the students and teachers had the ability to communicate their perceptions of wellness, make rational decisions and identify the support systems available in the schools. The age of the participants and the ambiguity of the topic may have limited the participants' capacities to articulate their perspectives.
2. It was assumed that all the participants would enter into focus group dialogue with their peers and the researcher in such a way as to clearly and accurately express their personal experiences and perceptions of wellness.
3. It was assumed that the construct of wellness articulated for the research was appropriate for the study.

Definitions of Terms

Various sources were used to clarify certain terms and to aid in the correct usage.

Adolescence: Generally, adolescence is understood to be the period of life between 10 and 19 years of age (Goodburn & Ross, 1995). In this study, the adolescents who volunteered to be participants were 16 years or older.

Development: A process whereby young people must learn to adapt to the changes within their social environment (LeCroy, 2004). For example: The adolescent is expected to develop physically, psychologically, socially and spiritually.

Health Promotion: The process of enabling people to increase control over the determinants of health, and thereby improving their health. To reach a state of complete physical, mental and social well-being, an individual must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (Canadian Public Health Association, Health and Welfare Canada, & World Health Organization, 1986, p. 1).

Lines of Defense: Protect the client, keeping the system free from stressor reactions or symptoms. An example would be an educational program or policy (Neuman & Fawcett, 2002).

Stressors: tension-producing stimuli with the potential for causing system instability. More than one stressor can be imposed on the client system at one time and any stressor to some degree influences the client's reaction to all other stressors (Neuman & Fawcett, 2002).

Wellness or Well-being or Health: a system that is in a constant state of interaction with the environment. Wellness can only be achieved when the individual's system is in harmony with the external environment. I define wellness as the aggregate of the developmental dimensions of life. It is a state of balance between physical, spiritual, social and psychological developmental dimensions which assists the individual to cope more effectively with the possible imposing stressors from the external environment. The health of a client is constantly changing, rising or falling throughout

his/her life span because of continual adjustment of the client system to environmental stressors (Neuman & Fawcett, 2002).

Outline of Dissertation

Chapter one of this dissertation presented the purpose, research questions, significance of the study, delimitations, limitations, assumptions and definitions.

Chapter two reviewed: a) wellness, b) adolescent wellness, c) adolescent development, d) physical development (physical activity, nutrition and health habits), e) spiritual development, f) psychological development (self-concept, self-esteem), g) social development (family, peers, community). Chapter two also presented a conceptual framework for exploring wellness and the support systems within schools.

Chapter three stated the reasons for approaching this study (interpretivism and postpositivism assumptions), the methods (focus groups and survey). Also presented in this chapter were: a) the details of data collection, b) a brief overview of the issues of qualitative and quantitative reliability and validity, c) the potential ethical considerations.

Chapter four provided the results of the questionnaire.

Chapter five presented the qualitative data from both the student and teacher participants.

Chapter six presented: a) the research questions and a comparison of the findings with the literature; b) key findings and implications for educational theory, policy, praxis and future research; and c) final thoughts and concluding comments.

CHAPTER TWO

Review of the Literature

In this chapter I review, a) wellness, b) adolescent wellness, c) adolescent development, d) physical development (physical activity, nutrition and health habits), e) spiritual development (terminology and adolescent spiritual development), f) psychological development (self-concept, self-esteem), g) social development (family, peers, community). This chapter also presents a conceptual framework for exploring wellness.

Before embarking on my literature review, I knew that the term wellness was used frequently and that there was a lack of consistency between definitions thus, I was prepared for a complicated and difficult review. Despite this forethought, I was still overwhelmed with the amount of literature discussing wellness and adolescent development. Due to the comprehensiveness of this topic, I delimited my literature search into preconceived categories. However, I reviewed the literature once again after my data analysis in order to ensure that I had considered all the relevant literature and addressed the emerging concepts from the study. This secondary review allowed me to discover and compare concepts, problems and interpretation emerging from my findings with the data in the literature (Glaser, 1998).

I began my search with a review of the University of Saskatchewan catalogue, Medline, Web of Science, Cumulative Index to Nursing and Allied Health (CINAHL) and Proquest education journals and dissertations. Lastly, I searched on Google Scholar with the key word being wellness. When I entered the word wellness, approximately 1000-2000 articles were presented as possibilities, and thus, I learned to quickly limit my

search to adolescent, teenager, youth and wellness, well being or well-being. There were also many articles which had wellness in the name or abstract, but were focused on prevention; therefore, I further limited my search to the title only and years (1997-2008). The other problem that quickly surfaced was that most articles on wellness were focused on problems or issues within the adolescent population.

In my first search, I seemed to find several articles on wellness, but still there were few that were focused on adolescents. I then met with a professional librarian on two separate occasions to refine my search. Expanding my search to web science and a second search of the journal data bases resulted in several studies that have investigated adolescent wellness.

As a final check for accuracy and comprehensiveness of the assessment of the literature, I decided to review all the reference lists of the articles that I previously reviewed. Then, from the reference lists, I researched any potential articles that might be pertinent to my study. In completing this final review, I did not find any new names or articles. The literature review for this study was delimited to studies that focused on wellness from a holistic perspective and to categories of adolescent development.

Review of Wellness

Over the years, there have been significant changes in the conceptualization of health. Previously, there was an emphasis on the medical model that provided a prescriptive definition of health. In other words, the focus was on the treatment of symptoms, illness and chronic disease. Today, there has been a rethinking of the entire notion of health to include a focus of wellness promotion. In this study, wellness and health was used synonymously, and was intended to mean a state of balance between the

physical, spiritual, social and psychological dimensions of life. In other words, wellness was viewed as the aggregate of the adolescent developmental milestones.

In 1964, the World Health Organization began promoting wellness by defining health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity” (Sein, 2006, p. 1). Since this revolutionary statement was made, wellness has become a priority in both educational and health policies and programs.

Although many people have formulated various definitions of wellness, Halbert Dunn was the original founder of the concept. Dunn (1977) viewed wellness as more than a disease-free existence, and promoted wellness as an elevated state of superb well-being. Dunn (1977) defined wellness as “an integrated method of functioning which is orientated toward maximizing the potential of which the individual is capable, it requires that the individual maintain a continuum of balance and purposeful direction within the environment in which he is functioning” (p. 5). Integrated was used in the sense of interrelated and it was important to develop your whole body. Maximizing was defined as a sense of completeness in that the person was developing on a daily basis. Lastly, potential was defined as the capacity of individuals (Dunn, 1977). This definition laid the groundwork for the movement to wellness, and as such, many clinicians and researchers have since further developed the notion of wellness promotion.

John Travis was another prominent advocate of wellness promotion in the 1970's. Travis was known as the first physician to offer wellness services and educational opportunities to the general public and to other health professionals. Travis originally developed the illness/wellness continuum with illness and high-level wellness at opposite

ends of the continuum (Travis & Ryan, 1981). In this model, moving to the right of center indicated increasing levels of health and well-being and moving to the left showed a progressively worsening state of health (Travis & Ryan, 1981). Travis and Ryan recognized that this model might be misleading and contended that it is possible for people to be physical ill and still be orientated towards wellness.

Travis and Ryan (1981) further defined wellness as:

A way of living in which growth and improvement is sought in all areas. It involves a way of life where there are deliberate choices and self-responsibility, requiring conscientious planning and management. Living a wellness lifestyle is not by accident, it is a continuous effort to reach full potential—a process of gaining control of yourself and the environment. Wellness is an efficient channeling of energy that is received from the environment, transformed from within you, and sent on to affect the world outside. Wellness is the integration of body, mind and spirit, the appreciation that everything you do, think, feel, and believe has an impact on your state of health. Finally, wellness is the loving acceptance of yourself. (p. xiv)

Ardell was also inspired by Dunn to write and speak about high-level wellness.

Ardell (1977) defined high-level wellness as:

A lifestyle or an individual focused approach to pursue the highest-level of health within your capability. A wellness lifestyle is dynamic and integrated in that the individual incorporates aspects of each wellness dimension (self-responsibility, nutrition awareness, stress management, physical activity and environmental sensitivity). Such a lifestyle will minimize your chances of becoming ill and vastly increase your prospects for well-being. (p. 65)

Finally, “wellness is a way of life which the individual designs to enjoy the highest possible level of health and well-being” (p. 93).

During the 1970’s many of the investigations into wellness were focused on linking lifestyle factors and health. Belloc and Breslow (1972) investigated the relationship between whole physical health and daily activities. The purpose was to

examine the relationship between common health practices, including hours of sleep, regularity of meals, physical activity, smoking and drinking, and physical health status. The focus of the study was on the relationship of good health habits to individual wellness.

One prominent model of wellness used in nursing research is the Neuman's systems model that was originally developed in the mid 1970s. The model has since been revised; however, the Neuman's system (2002) model was based on the "conceptualization of a client's continuous relationship with environmental stress factors, which have the potential to cause a positive or negative reaction" (p. 3). In this model, health was viewed as a continuum and was equated with optimal system stability, that is, the best wellness state at any given time (Neuman & Fawcett, 2002). Wellness existed as a stable condition when the parts of the client system interacted in harmony with the whole system. Neuman and Fawcett (2002) stated that "the client system was a composite of five interacting variables (physical, psychological, sociocultural, developmental and spiritual), which are in varying degrees of development and have a wide range of interactive styles" (p. 16). Wellness was on a continuum of available energy to support the system in an optimum state of system stability. Thus, "wellness is a matter of degree, a point in a continuum running from the greatest degree of wellness to severe illness and death" (p. 3). The overall goal of this model was to develop individual interventions that would be appropriate to the clients' needs.

In the 1980's, Hettler developed a holistic model of wellness. Hettler (1980) designed a hexagon model of wellness that proposed six characteristics of human functioning that were essential to achieving wellness: physical, occupational, social,

intellectual, emotional and spiritual. Hettler (1980) defined wellness as an “active process through which the individual becomes aware of and makes choices toward a more successful existence, and these choices are greatly influenced by one’s self-concept and the parameters of one’s culture and environment” (p. 77). Despite Hettler’s attempt to approach wellness holistically, criticisms of this model included a continued emphasis on physical wellness, medicine and on present functioning. Specifically the model does not consider the social and psychological dimensions of life, and lacks the incorporation of a multidisciplinary approach to wellness (Myers et al., 2003; Myers & Williard, 2003).

Sweeney and Witmer (1991) developed a model called the “wheel of wellness”. This original wheel proposed five life tasks, depicted in a wheel that were interrelated and interconnected. The five tasks were spirituality, self-regulation, work, friendship and love. The overarching theme of the model was that changes in one area of wellness affected other areas, in positive or negative directions (Sweeney & Witmer, 1991). Many disciplines of research critiqued this original model for lacking important characteristics of healthy people.

Chandler, Holden and Kolander (1992) further developed Hettler’s model of wellness by suggesting the original model should be modified to a pentagon with each of five areas making up segments of the model. The five areas of the pentagon were intellectual, physical, emotional, occupational and social. In Chandler’s new model spirituality was not a separate component but rather an integral component of each of the five areas. In this model, working to achieve high-level wellness required the development of the spiritual component in each of the five dimensions of wellness

(Chandler et al., 1992). Chandler proposed that spirituality developed over time as one achieved balance and openness to the pursuit to wellness.

Other wellness programs included: cholesterol testing, nutrition workshops, family counseling, drug and alcohol rehabilitation, weight management and exercise regimens (Robbins, Powers, & Burgess, 1999). Although the programs were labeled as wellness programs, the focus was on the prevention of disease rather than the promotion of wellness.

Debkins (1994) provided a critique of the current health and wellness promotion models by stating their limitations and these were:

The tendency to oversimplify the concept and the process of personal well-being. They de-emphasize personal connections and relationships and over emphasize personal responsibility without a concomitant representation of the environmental milieu in which personal change and growth is to take place. They lack the ability to represent the reciprocally determined interplay and ambiguity that accompanies personal growth and behaviour change. (p. 54)

Debkins (1994) developed a multidimensional model that promoted the exploration, creativity, and critical thinking surrounding issues of race, class, and gender differences.

Myers, Sweeney and Witmer (2000) further developed the wheel of wellness. The new model proposed a holistic approach in which sixteen characteristics of healthy functioning were depicted in a wheel. The five life tasks were now defined as: spirituality, self- direction, love, friendship and work/leisure. The self-direction was further subdivided into: “(1) sense of worth, (2) sense of control, (3) realistic beliefs, (4) emotional awareness and coping, (5) problem solving and creativity, (6) sense of humor, (7) nutrition, (8) exercise, (9) self care, (10) stress management, (11) gender identity, and (12) culture identity” (Myers, Sweeney, & Witmer, 2000, p. 252). These researchers

viewed spirituality as the core characteristic of healthy people. The wheel of wellness model was unique in that there was a “multidisciplinary approach and theoretical grounding in theories of human growth and behaviour” (Myers et al., 2000, p. 251). The goal of this model was to provide a theory to advance the counseling practice. Moreover, these authors indicated that further research was needed to determine the most effective strategy to enhance wellness within each component of the model. Myers et al. (2000) also indicated that further research was also needed as the overlapping and interaction between the various life tasks has not been determined.

In 2004, Ardell decided to redefine wellness at the National Wellness Conference as:

The six defining characteristics of wellness are a strong sense of personal responsibility, exceptional physical fitness due to a disciplined commitment to regular/vigorous exercise and sound diet, a positive outlook and a devotion to and capacity for critical thinking, joy in life and openness to new discoveries about the meaning and purposes of life. (p. 6)

This new definition moved beyond personal well-being to address the social and political challenges that individuals might face today. Ardell’s (2004) intent was to facilitate the achievement of meaningful wellness within our complex and dynamic society.

Myers, Luecht and Sweeney (2004) further revised the Wellness Evaluation of Lifestyle (WEL). The new instrument (4F-Wel) provided reliable scores for four distinct aspects of wellness: cognitive-emotional, relational, physical and emotional. The implications of this new wellness tool were directed towards clinical counseling. Myers and Sweeney (2008) further advocated to conceptualize wellness as the paradigm for

counseling. They concluded that the discipline of counseling was a wellness-orientated, strengths-based approach to optimizing human growth and development.

Table 2.1 has been constructed based on the literature review of wellness, and is presented in a format that is designed to illustrate the progress or increasing number of studies that have been completed in relation to wellness.

Table 2.1

<i>The Continuum of Wellness Research</i>				
1950s	Dunn (1959)-wellness was a complex state made up of overlapping levels.			
1960s	World Health Organization (1964)- health was a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.			
1970s	Travis (1970)- developed the illness/wellness continuum.	Belloc & Breslow (1972)- wellness was focused on linking lifestyle factors and health.	Neuman (1975)- Wellness existed as a stable condition when the parts of the client system interacted in harmony with the whole system.	Ardell (1977)- wellness was a lifestyle focused approach to pursue the highest level of health within your capability.
1980s	Hettler (1980) - designed a hexagon model with six characteristics to achieve wellness: physical, occupational, social, intellectual, emotional and spiritual.		Travis & Ryan (1981)- Wellness was the integration of body, mind and spirit	
1990s	Sweeney & Witmer (1991)- developed the wheel of wellness composed of five tasks: spirituality, self-regulation, work, friendship and love.	Chandler, Holden and Kolander (1992)- developed a pentagon model of wellness that included intellectual, physical, emotional, occupational and social dimensions and integrate spirituality into all the dimensions.	Debkins (1994) developed a multidimensional model that promoted the exploration, creativity, and critical thinking surrounding issues of race, class, and gender differences.	
2000	Myers, Sweeney & Witmer (2001)- further developed the wheel of wellness to include 16 categories.	Ardell (2004)- wellness was a strong sense of personal responsibility, exceptional physical fitness, a positive outlook and a devotion to and capacity for critical thinking, joy in life and openness to new discoveries about the meaning and purposes of life.	Myers, Luecht and Sweeney (2004)- further revised the Wellness Evaluation of Lifestyle (WEL) and the new scale provided reliable scores for four distinct aspects of wellness: cognitive-emotional, relational, physical and emotional.	Myers and Sweeney (2008)- concluded that the discipline of counseling was a wellness-orientated, strengths-based approach to optimizing human growth and development.

As depicted in Table 2.1, there were many studies and models of wellness that advanced the notion of holistic health in terms of mind, body and spirit. The intention of this review was to present the prominent theorists of wellness, and to illustrate that there was

a common theme within the models that suggested wellness was a complex state of balance between certain dimensions in life.

Adolescent Wellness

There are several models and definitions that have been developed with the intention of addressing wellness. However, these concepts have been applied primarily to adult populations. In this section I discuss the studies that have evaluated wellness in the adolescent population and college students. Similar to the review on wellness, I have organized this discussion chronologically, beginning with research studies in the 1990's.

Hatfield and Hatfield (1992) discussed the importance of combining cognitive development and practice with the wellness perspective. They defined wellness as “a process that involves the striving for balance and integration in one's life, adding and refining skills, rethinking previous beliefs and stances towards issues as appropriate” (p. 164). The higher stage of cognitive development empowered a person to consider more options regarding self-care and the transactions with the environment, and thus, both concepts and applications had potent positive implications for individual lives as well as for the common good (Hatfield & Hatfield, 1992).

Steiner, Pavelski, Pitts and Mcquivey (1998) developed and tested a Juvenile Wellness and Health Survey (JWHS-76). The factor analysis revealed five risk factors relevant to the adolescent population. These factors were general risk taking, mental health problems, sex-related risks, eating and dietary problems and general health problems (Steiner et al., 1998). The purpose of this tool was to identify a profile of adolescent health problems.

Sharkey (1999) evaluated adolescent wellness through both qualitative and quantitative methods. The first part of the study involved determining wellness themes and developing a framework relevant to the adolescent population. Using a phenomenology approach, the adolescents were asked to identify their perceptions of what was contributing to their overall well-being (p. 132). The five domains of wellness that were identified were physical, social including family and friends, emotional, and self-esteem (Sharkey, 1999). The second part of the study involved the creation and validation of an Adolescent Wellness Survey. The overall purpose of the study was to evaluate the percentage of variance that a multidimensional model of wellness would account for in selected risk behaviours of adolescents (p. vi). Results of the study indicated that the model was only partially successful in predicting risk behaviour in youth. Although Sharkey (1999) identified that this study was wellness orientated, the overall intent was to predict problem behaviour in youth.

As indicated in the review of wellness, Myers, Sweeney and Witmer (2000) proposed a holistic model of wellness and prevention over the life span. The assessment tool (Wellness Evaluation of Lifestyle) was used in youth, and corresponded to the concepts of the wheel of wellness that were previously identified. Although the authors have developed this tool with the intent to assess youth, it has been used primarily in young to older adults (Myers et al., 2000).

Dixon (2002) also explored adolescent wellness by examining the relationship among ethnic identity, acculturation, mattering, and six areas of wellness (spirituality, self-direction, schoolwork, leisure, love, and friendship). An analysis of the three structural equation models indicated that “mattering and acculturation explain a

significant portion of the variance for adolescents wellness; however, mattering was the strongest predictor of wellness” (Dixon, 2002, p. 118). The implications of this study were directed towards improving the practice of counseling.

Subjective Well-Being (SWB) was defined by Deiner (2000) as the general evaluation of one’s quality of life. The concept has been conceptualized as the three components: (1) a cognitive appraisal that one’s life was good (life satisfaction); (2) experiencing positive levels of pleasant emotions; (3) experiencing relatively low levels of negative moods (Deiner, 2000). Deiner, Sapyta and Suh (1998) argued that the criterion for well-being was subjective well-being as it allowed individuals to decide what was important in their life. Katja, Paivi, Marja-Terttu and Pekka (2002) examined adolescent well-being. Specifically, the study measured subjective well-being using a questionnaire called the Berne questionnaire of subjective well-being. The results of the study indicated that “school and body satisfaction, and self-rated good health explained 50% of the variance in female satisfaction” (p. 253). For males, they experienced the same variance as females but also included was low-intensity drinking (Katja et al., 2002). Although this study evaluated adolescent well-being, there is still a need to explore other important factors effecting adolescent development and overall wellness.

Hayward and Sanborn (2002) have also studied health outcomes in adolescents. Specifically, they have studied how puberty, hormones, ethnicity, and types of peer involvement accounted for the increased incidence of internal disorders (depression, anxiety, eating disorders) in adolescent females (Hayward & Sanborn, 2002). These were examples of “wellness” studies but clearly the focus was on the problems of adolescents.

Hartwig and Myers (2003) also presented a wellness paradigm as a possible approach to preventing, as well as treating, delinquent behaviours in adolescent females. The wheel of wellness model (Myers et al., 2000; Sweeney & Witmer, 1991) was presented as a preventative approach to female delinquent behaviour. Hartwig and Myers (2003) identified the benefits of this approach as: (1) “preventing delinquency from developing in adolescent girls through focusing on the strengths and (2) interrupting the cycle of offending in adolescence to adults by treating the adolescent appropriately” (p. 67).

Makinson and Myers (2003) also presented a model of wellness as a method of combating violence in adolescents. The wheel of wellness was applied once again as a model only this time the problem was violence. These researchers found that a wellness approach provided health professionals working with adolescents a theoretical base for addressing violence. Furthermore, the wheel of wellness provided the foundation for further understanding the multifaceted problems of violence. The applications of the wheel of wellness have been to the problems of adolescents. Once again the purpose of the application of the wheel of wellness was to assist counselors working with at-risk adolescents. Thus, there is still a need to explore wellness within the adolescent population who do not present with serious problems or risk-taking behaviour.

Ben-Zur (2003) investigated the associations of personal and parental factors with subjective well-being in adolescents. This researcher’s results indicated that mastery and optimism were related to the happiness and well-being of adolescents. Furthermore, “positive correlations were found between the adolescents’ and parents’ subjective well-

being and the adolescents' mastery and optimism were related to positive relationships with parents" (Ben-Zur, 2003, p. 67).

Hattie, Myers and Sweeney (2004) defended the wheel of wellness that was the basis for the WEL. A series of multivariate analyses of variance indicated differences in the means across the independent variables. When applied to adolescents, this group scored low on self-care, spirituality and work. Hattie, Myers and Sweeney (2004) stated:

With work and spirituality scales, respondents seemed to express a greater sense of satisfaction and contentment as they grow older and that students in high school are less likely to have sufficient life experience to reflect on their own or to feel satisfaction with their contributions through school and work. Regarding self-care, among the young there is a tendency for the young to take good health and safety for granted. (p. 361)

These authors indicated that there was still a need to further explore the factor structure across populations, and their implications have been directed towards counseling.

Dixon Rayle (2005) examined the relationship of perceived interpersonal and general mattering to overall wellness in adolescents. Results from this study indicated that "females perceived they mattered to their families more than males, and mattering significantly predicted wellness for females" (p. 753).

Gilman and Huebner (2006) examined subjective well-being in adolescents and the purpose was to examine the characteristics of adolescents who reported high levels of life global satisfaction through the Students Life Satisfaction Scale (Huebner, 2004). The students in the high life satisfaction group reported significantly adaptive functioning, high scores on a measure of social stress and attitudes towards teachers and high levels of intrapersonal functioning coupled with no signs of clinical depression (Gilman & Huebner, 2006).

Coatworth, Palen, Sharp and Ferrer-Wreder (2006) examined the relationship among activity participation, expressive identity and adolescent wellness (subjective well-being and internal assets). The results of the study indicated that most adolescents identified several activities as self-defining, and physical activity and self-defining activities were found to be related to wellness (Coatworth, Palen, Sharp, & Ferrer-Wreder, 2006). A self-defining activity was one that was identified as “an activity which makes the adolescent happy” (p. 159). Moreover, the study results indicated that “identity formation is an important developmental experience within activities and that adolescent identity can lead to wellness or positive adolescent outcomes” (p. 168). Adolescent activity, expressive identity and adolescent wellness were measured through questionnaires.

There are also studies that have examined wellness within the later adolescent or college population. Hermon and Hazler (1999) investigated the relationship between college students’ perceived well-being and the quality of their lives using the wheel of wellness as set out by Myers et al. A multivariate analysis revealed a significant relationship between the five dimensions of wheel of wellness and psychological well-being.

Adams, Bezner, Drabbs, Zambaranno and Steinhardt (2000) also developed and tested a holistic model of wellness. The model was founded on three principles: “(a) multidimensional, (b) balance among the dimensions, and (c) salutogenesis (defined as causing health rather than illness)” (p. 166). A Perceived Wellness Survey was developed in order to explore the relationships between measures of spiritual wellness and perceived wellness in undergraduate students. The finding of this study indicated

that “an optimistic outlook and sense of coherence must be present for life purpose to enhance a sense of overall wellness” (Adams et al., 2000, p. 165).

An American study examined the relationship among wellness, family environment and delinquency in adolescent females (Hartwig, 2003). The wheel of wellness was applied to a sample of female college students and the results illustrated that there were no significant differences between delinquent and non-delinquent students in relation to wellness and family environment. Myers, Mobley and Booth (2003) also used the wheel of wellness to evaluate wellness within the college student population and found that counseling students experienced greater wellness than the general population.

Myers and Mobley (2004) also applied the wheel of wellness to later adolescent participants and found that undergraduate students experienced lower levels of wellness than non-students. Once again, the purpose of both these studies was to develop appropriate counseling interventions.

Table 2.2 has been constructed based on the literature on adolescent wellness and is presented in a format that is designed to illustrate the progress and increasing number of studies that have been completed in relation to the promotion of wellness in youth.

Table 2.2

The Continuum of Adolescent Wellness Research

1992	Hatfield: discussed combining cognitive development and practice with the wellness perspective.		
1998	Steiner, Pavelski, Pitts and Mcquivey - developed and tested a Juvenile Wellness and Health Survey (JWHS-76). five risk factors which were general risk taking, mental health problems, sex-related risks, eating and dietary problems and general health problems.		
1999	Sharkey- Developed a wellness framework with five domains of wellness that were identified were: physical, social including family and friends, emotional, and self-esteem and created and validated an Adolescent Wellness Survey.		
2000	Myers, Sweeney and Witmer- developed an assessment tool called the Wellness Evaluation of Lifestyle		
2002	Dixon- mattering and acculturation explained a significant portion of the variance for adolescents wellness; however, mattering was the strongest predictor of wellness	Katja, Paivi, Marja-Terttu and Pekka- “school and body satisfaction, and self-rated good health explained 50% of the variance in female satisfaction.	Hayword and Sanborn- puberty, hormones, ethnicity, and peer involvement could account for increased incidence of internal disorders (depression, anxiety, eating disorders) in adolescent females.
2003	Hartwig and Myers- possible approach to preventing& treating, delinquent behaviours in adolescent females	Ben-Zur- mastery and optimism were related to the happiness and well-being of adolescents.	Makinson and Myers- wellness was a method of combating violence in adolescents.
2004	Hattie, Myers and Sweeney: students were less likely to feel satisfaction with their contributions through school and work and the young tended to take good health and safety for granted.		
2005	Dixon Rayle: found that females perceived they mattered to their families more than males, and mattering significantly predicted wellness for females.		
2006	Gilman and Huebner- students in the high life satisfaction group reported significantly adaptive functioning, high scores on a measure of social stress and attitudes towards teachers and high levels of intrapersonal functioning.	Coatworth Palen, Sharp and Ferrer-Wreder –most adolescents identified several activities as self-defining, and physical activity and self-defining activities were found to be related to wellness.	

A Continuum of College Student Wellness Research

1999	Herman & Hazler- significant relationship between the five dimensions of wheel of wellness and psychological well-being.		
2000	Adams, Bezner, Drabbs, Zambaranno and Steinhardt- an optimistic outlook and sense of coherence must be present for life purpose to enhance wellness.	Deiner: the criterion for well-being was subjective well-being as it allowed individuals to decide what was important in their life	

2003	Myers, Mobley &Booth- counseling students experienced greater wellness than the general population.	Hartwig- no significant differences between delinquent and non-delinquent students in relation to wellness and family environment.
2004	Myers &Mobley- undergraduate students experienced lower levels of wellness than non-students.	

As depicted in Table 2.2, in the last five years there has been an increased focus and research into adolescent wellness. There are models of wellness, such as the wheel of wellness, that have been applied to youth and these models have advanced the notion of holistic health. The intent of the application of the models was to improve the practice of counseling or to facilitate interventions with adolescents. Other adolescent studies included a profile of health problems that exist among youth today, subjective well-being and levels of life satisfaction. In college students, researchers have applied the wheel of wellness and evaluated perceived levels of wellness. With this review of wellness, I confirmed that there has been limited research on the factors responsible for adolescent wellness.

Adolescent Development

There are many important aspects of adolescent development. For the purpose of this study, adolescent development was defined as predictable growth and was categorized into four dimensions (physical, psychological, spiritual and social). This discussion begins with an overview of the major concepts presented in theories of human development. Then, due to the vast amount of literature on development within the adolescent population, I present a general review of the previously outlined categories of adolescent development.

Theories of Human Development

There are many theories of human development that offer plausible explanations for human behaviour; however, there is no single theory that adequately explains the complex transition from infancy through to adulthood. Therefore, I presented various theories in order to better understand the contributing factors to human development. This discussion is delimited to the major concepts presented by John Bowlby, Erik Erickson, Jean Piaget, Lawrence Kohlberg, Carol Gilligan and James Fowler.

John Bowlby Theory of Attachment

Bowlby's theory of attachment (1969) described certain patterns of response that occurred regularly in early childhood and traced how the patterns were to be discerned from the functioning of later personality. Bowlby (1969) proposed that child-caregiver interaction patterns were internalized early in life and that these early interactions guided future expectations and evaluations of relationships. In this theory it was argued that early childhood attachment significantly affected personality development. Bowlby (1988) stated that:

An adult personality is seen as a product of an individual's interactions with key figures during all the years of life and especially with attachment figures. Thus, children who have parents who are sensitive and responsive are enabled along a pathway. Those who have insensitive, unresponsive, neglectful, or rejecting parents are likely to develop along a deviant pathway which in some degree is incompatible with mental health. (p. 136)

The interaction among parents and child significantly affected development. For example: "children whose mothers respond sensitively to their signals and provide comforting bodily contact are those who respond more readily and appropriately to others" (Bowlby, 1988, p. 15).

With reference to adolescence, Bowlby (1988) presented the importance of parents providing a secure base. Bowlby (1988) stated:

The provision by both parents of a secure base from which a child or adolescent can make sorties into the outside world and to which he can return knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, and reassured if frightened. In essence, parents must be available, ready to respond or to assist. (p. 11)

This secure base provided the emotional equilibrium which adolescents were seeking during this time of transition. This sense of security fostered sensitivity to others, social competence and self-confidence (Bowlby, 1988).

A parent's attachment, interaction and ability to provide a secure base all significantly affected a child's ability to develop into a confident, sensitive and secure being. Furthermore, the safer the attachment of the child to the parent, the more able the child was able to develop relationships with others. This attachment theory presented an explanation why some children developed into healthy productive adults, and others did not.

Erickson's Theory of Development

Erickson (1968) proposed an eight stage theory of human development and stated:

Human growth is a lifelong series of conflict, inner and outer, which the vital personality weathers, re-emerging from each crisis with an increased sense of inner unity, with an increase of good judgment, and an increase in the capacity to do well according to his own standards and to the standards of those who are significant to him. (p. 92)

The eight stages were trust vs. mistrust, autonomy vs. shame, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus self-absorption, and integrity versus despair. Erickson (2005) argued

that a healthy child, given a reasonable amount of proper guidance, could be trusted to obey the inner laws of development. Progression through each stage required overcoming a crisis, and demanded resolution before the next stage could be satisfactorily negotiated. These crises were not viewed as detrimental but rather an opportunity to optimize potential (Erickson, 2005).

An adolescent would be in the stage of identity vs. role confusion. Erickson (2005) argued that:

Identity formation employs a process of simultaneous reflection and observation, a process taking place on all levels of mental functioning, by which the individual judges himself in the light of what he perceives to be the way in which others judge him in comparison to themselves and to a typology significant to them; while he judges their way of judging him in the light of how he perceives himself in comparison to them and to types that have become relevant to him. (p. 247)

Erickson (2005) also stated that adolescence was least stormy when the individual had been educated in the area of expanding technologies, and thus able to identify with new roles of competency and invention. If this were not the case, the adolescent mind would become explicit where the individual would continue to search for the ideal, ideas and skills. Furthermore, the adolescent was eager to seek approval by peers and teachers and to feel a sense of worthiness (Erickson, 2005). In sum, adolescent self-identity was dependent on a supportive environment in order to develop and integrate into the next stage.

Piaget's Theory of Cognitive Development

Jean Piaget was another prominent theorist in the area of adolescent cognitive development. According to Piaget (1973), the intellectual abilities of a child at a given age predicted certain types of emotional behaviours. For example, a child who did not

understand death would react differently to a grandparent's death than an older child who might understand this concept. Piaget (1973) further identified four key elements that guided development: maturation, experience, social interactions and equilibrium.

Maturation was the physical growth process, experience allowed children to discover for themselves, social interactions provided the experience as well as feedback, and equilibrium was the balance of the first three factors (Piaget, 1973). This equilibrium was the child's ability to balance or compensate to the external environment.

Piaget (1972) described the shift from childhood to adolescence as a movement from concrete to formal operational thought. The speed of development could vary from one individual to another and also from one social environment to another. Thus, some children might quickly advance, but this did not change the order of the stages that each child would pass through (Piaget, 1972). Formal operational thinking allowed the individual to think in abstract terms; thus, they could symbolically associate behaviour with abstract concepts.

Piaget (1972) also described the development of hypothesized reasoning. This reasoning was defined as the ability to think about possibilities, explanations, and to compare what they actually observed to what they believed is possible. Moreover, Piaget (1972) stated that:

Hypothetical reasoning changes the nature of discussions: a constructive discussion means that by using hypothesis the adolescent may be able to adopt the view of the adversary and draw the logical consequences that may be applied. The adolescent develops the capacity to understand and construct theories and to participate in society and the ideologies of adults. (p. 4)

In other words, with the development of formal thinking, the adolescent was more able to plan for the future and identified possible consequences of certain behaviours.

Kohlberg's Theory of Moral Development

Kohlberg is a well-known cognitive theorist who studied moral development across the human life span and his theory is based on an orientation to justice. This orientation had an ideal of a morality based on reciprocity and equal respect, and there was an assumption that “the developing child is a philosopher that is constructing meaning around the question of fairness” (Kohlberg, 1984b, p. xxvii).

Kohlberg (1984b) proposed a six-stage theory of development that involved a progression from pre-conventional to principled moral decision making. Each of the six stages was hierarchical, sequential and related to age. The stages of moral development were presented as structures of thinking about rules or principles obliging one to act because the action was seen as morally right (Kohlberg, 1984a). In each level of moral thinking, thinking became individual and behaviours were based on personal moral standards.

Preconventional thinking was based on an immediate physical or tangible reward. Older children and young adolescents functioned at a conventional level of moral reasoning in which absolute moral guidelines were seen to originate from authority figures such as parents or teachers (Kohlberg, 1984b). In other words, judgment about right and wrong was derived from a concrete set of rules. Principled moral decision making emerged in later adolescence. This level of reasoning involved adolescents beginning to question absolute standards and rules. Personal values and morals were separated from the standards held by authority figures (Kohlberg, 1984b).

The principled moral decision making stage was furthered characterized by what Kohlberg (1984a) described as “multiple principles of justice and includes the principle

of maximum quality of life for each, maximum liberty, equity or fairness in distribution of goods and respect” (p. 637).

Gilligan’s Theory of Moral Development

Gilligan (1982) proposed a theory of moral development that was based on the orientation of caring. From this perspective, the ideal was a morality of attention to others and responses to human needs (Gilligan, 1982). The caring orientation was rooted in the belief that moral decisions were shaped by relationships with others.

Gilligan (1987) further developed a two-pronged model of moral development that included both a justice and caring orientation. Gilligan (1987) described moral development as:

The basics of moral development (self, others and relationships) are organized in different ways. For example, from the perspective of someone seeking justice, relationships are organized in terms of equality and symbolized by a balance of scales. On the other hand, a caring perspective is focused on relationships that are characterized by attachment, and the moral ideal is one of attention and response. (p. 72)

According to Gilligan (1987), evidence of moral development was now the ability to entertain two different perspectives and to consider different views. Gilligan’s model illustrated that there were differences in how male and female adolescents developed morally. In fact, studies have found that although males and females might use both a justice and caring orientation to develop morally, males tended to focus on justice, while females were more likely to approach morality with a caring orientation (Gilligan, 1987; Walker, de Vries, & Trevethan, 1987).

James Fowler's Stages of Faith

Fowler (2006) also proposed a framework for understanding the evaluation of how humans conceptualize God and how the influence has an impact on core values, beliefs and meanings in their personal lives and their relationships with others.

Similar to previously identified theorists, Fowler argued that faith seemed to have a broadly recognizable pattern of development (Fowler & Dell, 2006). Faith was defined by Fowler and Dell (2006):

An integral, centering process, underlying the formation of the beliefs, values and meanings that give coherence and direction to persons' lives. Link them in shared trust and loyalties with others, ground their personal stances and communal loyalties in a sense of relatedness to a larger frame of reference and enables them to face and deal with the challenges of human life. (p. 36)

Fowler and Dell (2006) also stated:

As a child matures, physically, emotionally, faith accommodates the development of an expanding range of object relations exposure to the religious symbols and practices may nurture a sense of relatedness to the transcendent. (p. 36)

When relating to the development of faith in adolescence, Fowler (2006) identified a stage called the Synthetic-Conventional Faith. This developmental stage involves "revolutions in cognitive functioning and interpersonal perspective taking" (p. 39). Fowler (2006) argued that during this stage:

Youth develop attachments to beliefs, values and personal style that link them in con-forming relations with the most significant others among their peers, family and other non-family adults. Identity, beliefs and values are strongly felt, even when they contain contradictory elements. (p. 40)

Table 2.3 has been constructed based on the literature of human development.

Table 2.3

Selected Theories of Human Development

Bowlby	Infant interactions: guided future expectations and evaluations of relationships.	Parents could lead children towards a healthy personality pathway: sensitive and responsive parents were enabled along a pathway	Adolescents: needed a secure base so they could use to provide emotional equilibrium. Security promoted social competence and self-confidence.
Erickson	Identity vs. Role confusion: Identity formation employed a process of simultaneous reflection and observation. Peers were important, and develop independence from parents.	Adolescence: was least stormy when the individual was able to identify with new roles of competency and invention	Adolescents: were eager to seek approval by peers and teachers and to feel a sense of worthiness.
Piaget	Four key elements that guide development: maturation, experience, social interactions and equilibrium.	Transition to Formal Operations: allowed the individual to think in abstract terms, and from self-centered to other centered.	Hypothetical Reasoning: was the ability to think about possibilities, explanations, and to compare observations.
Kohlberg	Principled Moral Decision Making: adolescents question absolute standards and rules. Personal values and morals were now separate from the standards held by authority figures.	Moral Development is justice orientated: the adolescent constructed meaning and made decisions around the question of fairness and equality for all.	
Gilligan	Moral development with an Orientation of Justice: relationships were organized in terms of equality and symbolized by a balance of scales.	Moral development with an Orientation of Caring: relationships were characterized by attachment, and the moral ideal was one of attention and response.	Morality: Male and female adolescents approached it differently.
Fowler	Faith: seemed to have a broadly recognizable pattern of development	Synthetic-Conventional Faith. This developmental stage involves “revolutions in cognitive functioning and interpersonal perspective taking	Youth develop: attachments to beliefs, values and personal style that link them in con-forming relations with the most significant others among their peers, family and other non-family adults

As depicted in Table 2.3, each of these selected theories identified antecedents, complex challenges and potential influences on adolescent development. Each theorist presented concepts which contributed to the understanding of human growth and development.

Adolescent Physical Development

Physical development in adolescence is dependent on many factors, and therefore, I have delimited this discussion to the factors in which I have identified essential components to the promotion of physical development. These include: adequate physical growth, regular physical activity, healthy eating, and health habits such as smoking, alcohol or drug use.

Adolescence is a dynamic period of growth and maturation marked by rapid changes in skeletal and lean body mass. While all adolescents follow the same pattern of growth and development to maturity, the timing and tempo is different in each child. Genetics and nutrition were the most important determinants of the onset, rate and extent of growth (Hockenberry & Wilson, 2007).

Once the process of growth begins, the changes and progression are usually predictable. General growth includes accumulation of body mass, along with increases in height and weight. On average, “girls gain 5-20 cm in height and 7-25 kg in weight during adolescence and boys gain 10-30 cm in height and 7-30 kg in weight” (Hockenberry & Wilson, 2007, p. 817). There are also many other predictable physical developments in this age group: increases in size and strength of the heart and blood volume, increases in size and capacity of the lungs, an increased metabolic rate, and significant brain growth (Hockenberry & Wilson, 2007).

Physical Activity and its Relation to Development

Physical activity is an essential component to healthy development. There is a vast amount of literature documenting the positive correlation between participation in physical activity and adolescent functioning. Regular physical activity enhances physical development such as reducing risk for cardiovascular disease and high blood pressure, promotes healthy emotional development, reduces risk of depression, and promotes healthy sleep patterns (Brien & Katzmarzyk, 2006; Hockenberry & Wilson, 2007; Katzmarzyk, Janssen, & Ardern, 2003; McKinney, James, Murray, & Ashwill, 2005). Furthermore, there have been several studies that have reported a positive association between participation in physical activity and academic achievement (Crosnoe, 2001; Marsh & Kleitman, 2003; McHale, Crouter, & Tucker, 2001).

Despite the well-known positive effects of physical activity, there has been a general decline in energy expenditure through physical activity. For example, “In 2003, 76% of 12-14 year old males and 71% of 12-14 year females were moderately active in physical activity; among youth aged 15-19, rates decreased slightly in males to 74% and decreased significantly in females to 61%” (Canadian Institute for Health Information, 2005, p. 30). There were many contributing factors to the increased inactivity in children and adolescents. Increased reliance on technology, such as an increased amount of television and computer programming for children and lack of required physical activity classes in schools, were just two examples of potential reasons for the increasing amount of sedentary time (Tremblay & Willms, 2003). Furthermore, Hayes and King (2003) found that play has become sedentary, meaning that television, computers and video games were limiting opportunities for physical activity.

Evidence indicated that regular physical activity was required for healthy growth and development. Despite numerous studies correlating these positive effects, there was a decline in physical activity levels for youth. A low level of physical activity could seriously affect growth and development in this population.

Nutritional Implications for Development

Maintaining adequate nutrition to support rapid growth in adolescence is essential to healthy physical development. During this period of growth there is a subsequent increase in nutritional requirements. At the same time, there is a growing need for independence, peer acceptance, concern of physical appearance and active lifestyle (Hockenberry & Wilson, 2007). All these issues could lead to changes in eating habits and can have serious nutritional implications.

The nature of the food supply, increased reliance on foods consumed away from home, food advertising, marketing and promotion, and the low cost of energy dense foods all played a role in eating behaviour (Hockenberry & Wilson, 2007). The food industry has responded to these modern times by increasing the convenience of foods available (Anonymous, 2005). In addition, portion sizes (French, Story, Neumark-Sztainer, Fulkerson, & Hannan, 2001) and the availability of added sugars and fats (Megill, 2006) have also increased in the past twenty years. Clearly, adolescents' nutritional habits were influenced by many factors.

Due to these influences, adolescents were more likely to experience problems with dietary imbalances and excesses. Specifically, excess intake of calories, sugar, fat, cholesterol and sodium commonly occurred in this age group (Hockenberry & Wilson, 2007). Among Canadian youth, limited data indicated that more carbohydrates, energy

and fat from “other” foods (i.e., those foods that do not comprise one of the four recommended food groups by Health Canada such as soda pop, chips, or pizza pops) were consumed more by adolescents than by other age groups (*Canada Food Stats*, 2003; Starkey , Johnson-Down, & Gray-Donald, 2001). Another study found that, “among 12- to 14-year olds, 41% of males and 46% of females consumed fruit and vegetables five or more times a day; proportions were slightly lower for 15-to 19-year olds at 38% for males and 45% for females” (Canadian Institute for Health Information, 2005, p. 30). In other words, less than half of the adolescent population was eating an adequate amount of fruit and vegetables per day. There was also evidence that adolescents tended to have an inadequate intake of certain vitamins such as folic acid, vitamin B6, vitamin A and minerals such as iron, zinc and calcium (Hockenberry & Wilson, 2007).

These dietary patterns are a concern as these excesses and deficiencies can lead to serious health issues. One health concern is the increasing rates of overweight and obesity in Canada. Specifically, “rates have increased from 11% to 33% in boys and from 13% to 27% in girls for overweight, and from 2.0% to 10% in boys and from 2% to 9.0% in girls for obesity” (Tremblay, Katzmarzyk, & Willms, 2002, p. 538). Over a 15-year period in Canada, the prevalence of overweight and obesity has tripled among boys and doubled among girls. This suggests that not only have children become more overweight in the past few decades, but also that overweight children have been getting heavier.

Obesity poses both immediate and long-term implications for adolescents. Although complications from obesity were more frequently seen in adults, children and adolescents are experiencing significant health consequences as well (Hockenberry &

Wilson, 2007). For example, evidence suggested that T2DM, hyperlipidemia, and hypertension were not restricted only to adults but are becoming increasingly common among children (Katzmarzyk et al., 2004). Furthermore, overweight and obesity during childhood were strong predictors of obesity and cardiovascular disease in young adulthood (Janssen et al., 2005).

Along with obesity, eating disorders also pose a developmental concern for the adolescent population. Eating disorders are affecting adolescents with increasing frequency. Specifically, about 85% of young women age 15-17 who were average weight wanted to lose weight (Health Canada, 1999). The adolescent was depriving himself/herself of energy (calories) and protein that are crucial to growth (Hockenberry & Wilson, 2007). Moreover, there was evidence that adolescents with eating disorders may be losing critical tissue components, such as muscle mass, body fat and bone mineral during a phase of growth when dramatic increases in these elements should be occurring (Hockenberry & Wilson, 2007; McKinney et al., 2005).

Clearly, nutrition is a vital component of healthy growth and development. Adolescent nutritional habits are influenced by many factors, and unfortunately, these influences occur at a time when adolescents have increasing nutritional needs. Moreover, there are serious physical developmental implications of nutritional deficiencies and excesses during adolescence.

Contributing Factors of Health Habits on Adolescent Development

Health habits such as smoking, alcohol and drug use can also influence growth and development in adolescents. There are many reasons why adolescents may choose to use tobacco, alcohol and other drugs. Examples of possible reasons are that these

substances provide the opportunity to challenge authority, demonstrate autonomy, and peer acceptance (Hockenberry & Wilson, 2007). Moreover, evidence has suggested that many of the practices that contribute to health and wellness in adulthood were often established during adolescence (Hedberg et al., 1999). Therefore, it is important to recognize that these health habits have the potential to play a key role in adolescent wellness.

Smoking has been associated with many serious health diseases (Anonymous, 2007). Irwin (2006) found that persons who began smoking at a young age were at increased risk of illness and death attributable to smoking. Hedberg, Bracken and Stashwick (1999) also found that “behaviours such as smoking were established in adolescence and could continue into adulthood, and the cumulative effects of ongoing health-compromising behaviour contributed to adult-onset disease” (p. 137). Clearly, there are serious health risks associated with smoking.

Along with the many studies on the effects of smoking are the well-documented consequences of alcohol and drug use. According to Health Canada (2004a), nearly one quarter of current and former drinkers reported that their drinking had caused harm to themselves or to someone else in their lives. Substance use has also been associated with problems such as school drop out rates, delinquency, low academic achievement, family conflict, and verbal and physical assault (Addley, 2005).

The rates of substance abuse had been declining for many years; however, abuse has now been documented as increasing among youth and young adults. Health Canada (2004a) found that:

Alcohol is the substance most commonly used by Canadians. In the past 12 months before the survey, 79.3% of people aged 15 years or older consumed

alcohol. The survey also shows that among past-year drinkers, about 17.4% of youth under 18 years of age, and 34.1 % of youth 18 or 19 years of age consumed alcohol at least once per week. (p. 22). At least 70% of young people between the ages 18-24 have reported using cannabis at least once in their lifetime. Almost 30% of 15-17 year olds and just over 47% of 18-and 19-year olds have used cannabis in the last year. (p. 48). The rate of lifetime use and past year illicit drug use, other than cannabis is 30.6% and 17.8% for 18-19- year olds respectively. (p. 55)

This report indicated that there were many youth who were drinking alcohol and using drugs and were at risk of the previously mentioned harms. Alcohol consumption and drug use among adolescents had serious implications for physical development.

Smoking, alcohol and drug use in adolescence all have the potential to seriously impact development in this population. However, as stated earlier, it is not my intention to focus on the problems within the adolescent population. The purpose of this review is to identify the literature on the potential influences, antecedents and barriers to healthy growth and development in adolescence.

Table 2.4 presents a summary of the literature on physical development and has been developed to illustrate the multiple influences on adolescent development.

Table 2.4

Adolescent Physical Development

Physical Development	Growth- included accumulation of body mass, along with increases in height and weight	Cardiovascular- Increases in size and strength of the heart and blood volume	Pulmonary- increases in size and capacity of the lungs	Gastro-Intestinal- increased metabolic rate,	Neurological- significant brain growth
Physical Activity	Cardiovascular disease- reduced risk and decreased blood pressure.	Emotional- promoted development	Depression- reduced risk	Sleep- promoted healthy patterns	Academics- Promoted success and achievement.
Nutrition	Influenced By: nature of food supply, food advertising, increased availability of fast foods, marketing and promotion.	Excess intake- of calories, sugar, fat, cholesterol and sodium.	Inadequate intake- fruit and vegetables, vitamins such as folic acid, vitamin B6, vitamin A and minerals such as iron, zinc and calcium.	Obesity- in Canada, the prevalence of overweight and obesity has tripled among boys and doubled among girls.	Eating Disorders- were affecting adolescents with increasing frequency. Specifically, about 85% of young women age 15-17 who were wanted to lose weight.
Health Habits	Smoking- 20% of girls reported smoking as compared to 17% of boys and persons who begin smoking at a young age were at increased risk of illness and death attributable to smoking.		Alcohol- Substance use has been associated with problems such as school drop-out rates, delinquency, low academic achievement, family conflict, and verbal and physical assault and 17.4% of youth under 18 years of age, and 34.1 % of youth 18 or 19 years of age consumed alcohol at least once per week.	Drugs- Almost 30% of 15-17-year olds and just over 47% of 18 and 19-year olds have used cannabis in the last year. The rate of lifetime use and past year illicit drug use, other than cannabis is 30.6% and 17.8% for 18-19-years olds respectively.	

As depicted in Table 2.4, there are many factors affecting physical development.

Adolescence is characterized by predictable physical growth, and there is evidence that indicates that both nutrition and physical activity are essential to healthy growth and development. Furthermore, obesity and eating disorders have been linked to serious

health consequences. Alcohol, drugs and smoking can also significantly impact health with the cumulative effects contributing to adult onset disease.

Adolescent Spiritual Development

Along with the development of the notion of wellness has been the recognition that spirituality is an essential component to people's health and well-being. Spiritual wellness has become an emerging interest in many disciplines including health and education. Since I have delimited my review of wellness and adolescent wellness to studies that have focused on health from a holistic perspective, I have already reviewed many studies that have identified spirituality as an essential component of wellness. Therefore, in order to avoid repetition, this section will be uniquely asymmetrical when compared to the other categories of this literature review.

In this section I present a discussion of spirituality and religion, and then I describe some common definitions of spiritual wellness. Although research on adolescent spiritual wellness is limited, I present some studies that have been focused on youth. Similar to Robbins, Power and Burgess (1999), I have chosen to define spirituality as the discovery of purpose in life, a sense of right and wrong and personal values and beliefs, and all are essential components of spiritual wellness. Spiritual development is the process of growth strengthened by one spiritual experience after another, which ultimately leads to a new way of life in thought and spirit (Benjamin & Looby, 1998).

Definitions of Religion, Spirituality, and Spiritual Wellness

Spirituality and religion have been defined by many; thus, I have chosen to present a few of the definitions in order to illustrate their similarities and differences.

Spirituality is a broader concept representing a person's beliefs and values; it is a dimension of humanness, while religiosity refers to institutional beliefs and behaviours that are part of the broader concept of spirituality (Ingersoll, 1994; Ingersoll & Bauer, 2004). Religion is a part of spirituality, and for many it is an expression of their spirituality. Religiosity has been defined by Hinterkopf (1994) as a public matter, often expressed in group religious participation. Elkins, Hedstom, Hughes, Leaf and Saunders (1988) defined religion as:

The incubator and reservoir of the world's most vital spiritual values. However, in their work they suggest that there is a broader definition of spirituality, one that does not equate with religious beliefs, rituals and practices. Spirituality is defined as a way of being and experiencing that comes through awareness transcendent dimension and is characterized by values in regard to self, others, nature, life and whatever one considers to be the ultimate. (p. 8-10)

Spirituality was further defined by Wolfe (2004) as making sense and giving meaning to the world. Myers and Willard (2003) defined spirituality as the "capacity and tendency present in all human beings to find and construct meaning about life and existence and to move toward personal growth" (p.149). Hinterkopf (1994) spoke to a spiritual experience as a "presently felt phenomenon, involving an awareness of the transcendent dimension that brings new meaning and that leads to growth" (p. 166).

There are also many definitions of spiritual wellness. Spiritual wellness has been defined as the development of inner self and one's soul (Robbins et al., 1999). Spiritual wellness is a way of living that views life as purposeful, pleasurable and seeks out life sustaining and life enriching options. Spiritual wellness involves "experiencing life and reflecting on that experience in order to discover personal meaning and purpose in life,

and involves developing a clear and comfortable sense of right and wrong, and it clarifies your personal values and beliefs” (Robbins et al., 1999, p. 12).

Spiritual wellness is a construct that reflects spiritual health (Ingersoll & Bauer, 2004). Myers, Sweeney and Whitmore (2000), developers of the Wheel of Wellness, concurred that spirituality was a dimension of wellness, and explained the phenomenon as “an awareness of a being or force that transcends the material aspects of life and gives a deep sense of wholeness or connectedness to the universe” (p. 252). The spiritual dimension is a “positive sense of meaning and purpose in life” (Adams et al., 2000, p. 166). Hettler (1980) also defined spiritual wellness as “ongoing involvement in seeking meaning and purpose in human existence” (p. 78). DiLorenzo, Johnson and Bussey (2001) discussed spirituality as “involving a complexity of feelings, thoughts, and attitudes about oneself in the world, and when positive, they work to regulate the individual's sense of self-esteem in a healthy manner” (p. 259). Hodge (2001) stated that “spirituality involves an experiential relationship with God” (p. 154).

Table 2.5 has been constructed based on the definitions of spirituality, religion and spiritual wellness and presents the multiple definitions and factors influencing adolescent spiritual development.

Table 2.5

The Variances of Spiritual Definitions

Definitions of Religion	Religiosity refers to institutional beliefs	Religion is a part of spirituality, and for many it is an expression of their spirituality.	Religiosity is a public matter, often expressed in group religious participation.	Religion is the incubator and reservoir of the world's most vital spiritual values.	
Definitions of Spirituality	Spirituality is a broader concept representing a person's beliefs and values; it is a dimension of humanness.	Spirituality is defined as a way of being and experiencing.	Spirituality is making sense and giving meaning to the world.	Spirituality as the "capacity in all human beings to find and construct meaning about life and existence and to move toward personal growth.	Spiritual experience, involves an awareness of the transcendent dimension that brings new meaning and leads to growth.
Definitions of Spiritual Wellness	Spiritual Wellness is a construct of spiritual health.	Spiritual Wellness provides a sense of right and wrong, and clarifies one's personal values and beliefs.	Spiritual Wellness involves seeking meaning and purpose in human existence.	Spiritual Wellness involves a complexity of feelings, thoughts, and attitudes about oneself in the world.	Spiritual Wellness involves an experiential relationship with God.

As depicted in Table 2.5, spirituality and religion are related but not synonymous, and thus, one can develop spiritually and not be affiliated with any religion. On the other hand, a person can choose to express his/her spirituality through participation in religion. When I analyzed the definitions of spiritual wellness, it was clear that there was a common view that developing spiritually might include growth in a person's sense of right and wrong, connectiveness, meaning and purpose in life, values and beliefs and a relationship with God. These definitions illustrate once again the multiple factors influencing adolescent development.

Research into Adolescent Spiritual Development

Despite the limited research into adolescent spiritual wellness, I did find a few examples of studies that have focused on this concept. Kessler (1998) explored adolescent spirituality through the development of a program called “passages”. This is a curriculum designed for adolescents and integrates heart, spirit, community and academics. From the students’ stories and questions, Kessler has mapped a guide to spiritual development in adolescents. The six concepts he included were: (1) the search for meaning and purpose, (2) the longing for silence and solitude, (3) the urge for transcendence, (4) the hunger for joy and delight, (5) the creative drive, and (6) the need for initiation (Kessler, 1998). The common thread of these concepts was that adolescents needed to experience a deep connection. Kessler’s intent was to link the void of spirituality in adolescents to the increasing rates of violence, drugs, and self-destructive behaviours in adolescents.

Hodge, Cardenas and Montoya (2001) conducted a study on Hispanic adolescents that measured the effects of spirituality and substance use. The finding of this study indicated that spirituality was a deterrent to marijuana and other drugs. The focus of the study was to explore the effects of spirituality on the prevention of negative outcomes such as drugs and violence.

Cummins (2002) argued that arts were essential to adolescent spiritual development and he stated that each student had a voice, a unique and creative self and an innate need to express his/her own world, and that students must be provided with the opportunity to be creative. Arts was the main way that students could celebrate and express their thoughts and ideals (Cummins, 2002).

Grainger and Kendall-Seatter (2003) furthered this notion of art and spirituality by studying the relationships between drama and spiritual development. These authors argued that improvisation provided the opportunity for children and youth to “build a sense of community, self-knowledge, develop empathy, search for meaning, purpose and experience a sense of transcendence” (p. 25). Drama opportunities could empower youth to become spiritually richer by maximizing their human potential and recognizing their capacity to learn (Grainger & Kendall-Seatter, 2003).

Schultz (2003) examined the impact of spirituality on overall wellness of adolescents. Results from this study indicated that spirituality had a positive linear correlation with overall wellness. Spirituality positively predicted emotional, physical, social, environmental and intellectual wellness. Wellness was positively correlated with the spirituality construct of connectiveness to self, to the world and to others (Schultz, 2003).

Purdy and Dupey (2005) claimed that their Holistic Flow Model of Spiritual Wellness addressed “how to grow and develop spirit in order to make life tasks richer” (p. 97). In other words, their model could be used to develop spiritual wellness in order to enrich the individual’s quality of life. This model was unique in that the spirit was considered the dynamic and constant changing dynamic core of human life. The model included the following life tasks: companionship, mind, life’s work, emotions, body, beauty and religion, and has been applied to college students. The intent of this model was to assist psychologists and counselors in their practice to promote balance, meaning, satisfaction and happiness in their clients’ lives (Purdy & Dupey, 2005).

Good and Willoughby (2006) also examined the interaction between religion and spirituality on psychosocial adjustment in adolescents. The results illustrated that the religious youth reported more positive adjustment than the non-religious youth (regardless of the level of spirituality). The secondary analysis indicated that the advantage for religion might not be from church attendance but rather from the sense of belonging to a community (Good & Willoughby, 2006). The positive social adjustment was measured through a reduction of risk behaviours such as less delinquent behaviour and lower levels of drug and alcohol use. In sum, this study illustrated the importance of spirituality in adolescent development.

Table 2.6 has been constructed based on the adolescent spiritual development literature and presents the evidence illustrating the urgent need for further research into adolescent spiritual development that will provide insight into the development of evidence-based educational policy and programs.

Table 2.6

Adolescent Spiritual Development

1998	Kessler: found that adolescents needed to experience a deep connection. His intent was to link the void of spirituality in adolescents to the increasing rates of violence, drugs, and self-destructive behaviours in adolescents.
2001	Hodge, Cardenas and Montoya found that spirituality was a deterrent to marijuana and other drugs.
2002	Cummins argued that arts were essential to adolescent spiritual development Arts were the main way that students could celebrate and express their thoughts and ideals.
2003	Schultz examined the impact of spirituality on overall wellness of adolescents and found that spirituality had a positive linear correlation with overall wellness. Grainger and Kendall-Seatter studied the relationships between drama and spiritual development, and found that drama opportunities could empower youth to become spiritually richer by maximizing their human potential and recognizing their capacity to learn.
2005	Purdy and Dupey claimed that their Holistic Flow Model of Spiritual Wellness addressed “how to grow and develop spirit in order to make life tasks richer”, and enriched the individual’s quality of life.
2006	Good and Willoughby: examined the interaction between religion and spirituality on psychosocial adjustment in adolescents and found that the religious youth reported more positive adjustment than the non-religious youth.

As depicted in Table 2.6, the studies that have explored adolescent spiritual development are limited. However, the literature presented addressed the important role of spirituality in the prevention of risk taking behaviour in adolescence. There are also researchers exploring the role of arts and drama as a method of promoting spiritual development. Spirituality may contribute significantly to the state of adolescent wellness, but clearly there is a lack of evidence supporting this notion. Further research into adolescent

spiritual development can provide insight into the development of evidence-based educational policy and programs.

Adolescent Psychological Development

There are several important factors influencing an adolescent's psychological development. For the purposes of this study, psychological development is defined as the predictable growth in self-esteem, self-concept and autonomy with each of these concepts contributing to complexity of human development. In this section, I delimit this discussion to the potential challenges, influences and barriers to self-concept and self-esteem.

The Role of Self-Concept in the Development of the Self

The development of self is affected by many different factors. Factors such as economic, social, culture and politics all may potentially influence adolescent self-concept. Identity is not an individual creation, but rather, individuals are positioned in social relationships that contribute to the creation of identity (Saltman, 2005). Furthermore, Harter (1990) also viewed adolescent self-concept as a social construction. For example, "the peer group is a source of values, directives, feedback and social comparison while the parents' expectations and evaluations also play a major role and may conflict with the values of the peer culture" (p. 353). Similarly to these authors, I define self-concept as the socially constructed personal beliefs about oneself. The individual answers the question "who am I" and "the answer is only meaningful in the context of one's relationships to others and to one's position in a social group" (Oyserman, 2004, p. 3). I have further delimited the discussion of self-concept to the role of family, peers and sports participation in the development of the self.

Dusek and Hill (1981) found that adolescent self-concept was a result of continual and gradual growth based not only on social circumstances but also on emergent competencies and skills. In other words, the adolescent self-concept did not undergo a sudden change, but rather there was a gradual nature of change. This study did not support the idea that adolescence was a time of stress and upheaval.

Parental support has also been found to affect self-concept. Helsen, Vollebergh and Meeus (2000) found parental support was one of the best indicators of emotional problems in adolescents. This study confirmed a shift in adolescent relationships where perceived parent support declined and peer support increased. In the situations where the adolescents reported low levels of parental support there was also the tendency to report high levels of peer support and the highest levels of emotional problems. Other studies also confirmed that perceived parental involvement was related to positive development of self-concept in adolescents (Fehrmann, Keith, & Reimers, 1987; Flouri & Buchanan, 2003; Gibson & Jefferson, 2006).

Another important factor in the development of self-concept is relationships with peers and the structure of the peer networks. Connolly and Konarski (1994) found that peer network structure and quality of friendships were significant predictors of self-concept. The results of this study suggested that both social connections and social support were associated with enhanced peer self-concept in adolescence (Connolly & Konarski, 1994). Friendship quality contributed significantly to an increased sense of self-concept, which attested to the importance of peer relationships on psychosocial development.

Sports participation has also been found to increase self-concept in adolescents. Donaldson and Rowan (2006) found that increased levels of sports participation had a positive relationship with emotional and behavioural well-being, particularly self-concept. Results also showed that the youth with increased perception of sport-related competencies reported significantly fewer emotional and behavioural problems than did children who were actually competent in sports (Donaldson & Ronan, 2006).

The Role of Self-esteem in Adolescent Development

There are many definitions of self-esteem and, as a result, this concept has been associated with various dimensions of human behaviour. The term self-esteem includes cognitive, affective, and behavioural elements (Reasoner, 2004). It is cognitive in that the individual answers the question “who am I”. It is affective in that people are emotional beings. Finally, this concept is behavioural because self-esteem has been associated with skills such as decision making, assertiveness and resilience (Reasoner, 2004).

Mruk (1999) identified key concepts throughout the array of definitions of self-esteem. The key features were the basic components of self-esteem, the lived qualities of self-esteem and the basic dynamics of self-esteem, especially how it was open to change over time (Mruk, 1999). In other words, the foundations of self-esteem connected this human phenomenon with competence and worthiness. Second, self-esteem involved processes such as acquiring values, making comparisons on the basis of them, becoming aware of the results and feeling the impact of the conclusions. Finally, self-esteem fluctuated overtime (Mruk, 1999).

Self-esteem is also understood in relation to positive mental and psychological well-being. For example, there have been many studies that correlated high self-esteem with happiness, enhanced initiative, good personal adjustment, internal sense of control and good coping mechanisms (Baumeister, Campbell, Krueger, & Vohs, 2003). On the other hand, there have been studies that connected a negative self-esteem with a number of concerning negative possibilities. For example, there were studies that suggested that low self-esteem during adolescence predicted negative consequences during adulthood such as depression, a sense of unworthiness and increased anxiety (Donnellan, Trezesniewski, Robins, Moffitt, & Caspi, 2005).

Similar to Mruk (1999) I define self-esteem as the “the lived status of one’s *competence* in dealing with challenges of living in a *worthy* way over time” (p. 26). A sense of competence is having the conviction that one is generally capable of producing desired results, being confident in our ability to think, as well as to make appropriate decisions (Reasoner, 2004). The worthiness component of self-esteem is tied to whether or not a person lives up to certain fundamental human values, such as finding meanings that foster human growth and making commitments to them in a way that leads to a sense of integrity and satisfaction. Finally, “self-esteem is embedded in our perceptions, expressed through our feelings and our behaviours, with carrying degrees of awareness” (Mruk, 1999, p. 28).

There are many potential influences on adolescent self-esteem. This review begins by discussing the potential influence of parental involvement and parental expectations. Then, I identify studies that have examined quality of peer relationships, sports participation and success in relation to high levels of self-esteem.

Parental influence has been identified as an important factor in determining self-esteem. Demo (1987) reported that adolescents who felt that their parents participated in their educational and recreational activities were more likely to report high self-esteem. Gecas and Schwalbe (1986), Flouri and Buchanan (2003) and Barber, Chadwick and Oerter (1992) also found a positive relationship with adolescents' perceptions of parental behaviour (praise and affection from parents, autonomy granting and participation) and self-esteem.

Certain parental attitudes have also been linked to the development of self-esteem in adolescents. There also have been studies that have examined the relationship of parental attachment and self-esteem to adolescent psychological health. Wilkinson (2004) found that the quality of attachment relationship established between an adolescent and his/her parents tended to influence the quality of peer attachment relationships that they formed. Moreover, the results indicated that both parental and peer attachment contributed to psychological adjustment. For example, "close, secure and trustworthy relationships with parents and friends lead adolescents to evaluate their own attributes and worth more highly" (Wilkinson, 2004, p. 490). In sum, there was strong support of a positive association between parent affection and support and adolescent self-esteem.

Clearly defined parental expectations have also been positively associated with adolescent self-esteem. Setting high but not impossible expectations has been linked to self-esteem (Mruk, 1999). Furthermore, setting goals let the adolescent know that certain behaviour was acceptable and other was not. For example, Hockenberry and Wilson (2007) found that effective conflict resolution within families created an environment that

promoted healthy adolescent development. Moreover, parental expectations for mature behaviour on part of the adolescent and enforcing reasonable limits for behaviour formed the basis of effective parenting.

Friendship quality has also been associated with self-esteem in adolescence. Keefe and Berndt (1996) found that adolescents, whose friendships involved positive features, also had higher scores of self-acceptance and self-esteem. On the other hand, youth whose friendships had more negative features viewed their own conduct as less appropriate and were generally less happy about themselves. Corsano, Majorano and Champretavy (2006) and Dekovic and Meeus (1997) also found that friendship was important in the promotion of adolescent psychological wellness. Specifically, these studies found that psychological development depended on acceptance and integration into a peer group, and as the individual matured, the adolescent continued to need the support of his/her parents. Finally, the Canadian Institute of Health Information (2005) found that youth who reported high levels of peer connectedness were also more likely to report high self-worth, excellent or very good health status and low levels of anxiety (p. 48).

Laursen, Furman and Mooney (2006) examined adolescents' relationships with mothers, close friends and romantic partners in relation to perceived self-worth and competence. The results of this study found that adolescents who reported high social support in all three relationships had higher self-worth and greater interpersonal competence. In sum, all these studies confirmed that relationships had a significant influence on adolescent self-esteem.

Bowker, Gadbois and Cornock (2003) found that sports participation positively predicted self-esteem. This study also found that “feminine individuals who participated in competitive sports reported lower levels of perceived athletic competence and global self-worth, but reported higher self-esteem when they participated in more noncompetitive sports” (p.1). Marsh and Kleitman (2003) also found that participation in sports had positively affected adolescent self-esteem.

Success has been found to have a profound effect on adolescent self-esteem. Mruk (1999) asserted the view that success was important for self-esteem because of the connection to the competence component in the definition of self-esteem. However, not all forms of success were the same as an individual might be very successful in school but hold low self-esteem. In this case, the success could be a result of compensation for low self-esteem, and the individual might be working hard due to a fear of failure (Mruk, 1999).

Table 2.7 is constructed based on literature on adolescent psychological development.

Table 2.7

Adolescent Psychological Development

Self-Concept	Low levels of parental support -there was also the tendency to report high levels of peer support and the highest levels of emotional problems.	Parental involvement was related to positive development.	Peers -quality of friendships were significant predictors of self-concept. Social connections and support were associated with enhanced peer self-concept in adolescence.	Sports participation has also been found to increase self-concept in adolescents. Increased levels of sports participation had a positive relationship with emotional and behavioural well-being, particularly self-concept.	
Self-Esteem	Parent Involvement -adolescents who felt that their parents participate in their educational and recreational activities were more likely to report high self-esteem.	Parental Expectations -Setting high but not impossible expectations had been linked to self-esteem.	Peers -adolescents, whose friendships involved positive features, also had higher scores of self-acceptance and self-esteem.	Sports Participation -found that participation in sports had positive effects on adolescent self-esteem.	Achievement -success was important for self-esteem because of the obvious connection to the competence component in the definition of self-esteem.

As depicted in Table 2.7, self-concept and self-esteem were found to be significant positive influences on adolescent development. This evidence clearly indicates the complexity of the adolescent psychological developmental dimension of life.

Adolescent Social Development

Social development is defined as the growth of supportive relationships in families, school community and peers, and research indicates that healthy development in this dimension of life can limit engagement in risky behaviour in youth (Canadian Institute for Health Information, 2005, p. 37). Callaghan (2006) also found “high school

students who reported support systems also reported practicing healthier behaviours” (p. 203). This section includes a discussion of the protective factors of family, peers and the school community all which contribute to healthy social development.

The Influence of Family on Adolescent Social Development

There are many family characteristics that have been identified as potential influences in the social development of the adolescent. In this section I discuss the influences of family structure, attachment, parental monitoring and style. For the purpose of this study family is defined as a “dynamic unit functioning over the lifetime of its members” (Mangham, McGrath, Reid, & Stewart, 1995, p. 3).

Family structure is changing over time as the high rates of divorce and the decisions of single people to have children have increased. Specifically, “the number of divorced population remained the fastest growing group in 2004-2005 (3.4%) with the divorce population representing 5.9% of the total population compared to 1.7% in 1975” (Government of Canada, 2005, p. 9). As a result, many adolescents live within blended families, thus living in families with two females, two males or step-parents (London, Ladewig, Ball, & Bindler, 2007). There is also a growing number of single parent families; according to the 2001 census there are 1,311,190 single parent families in Canada (Government of Canada, 2001). Changes in family structure have been accompanied by an increase of dual working parents. In other words, the traditional family of a working father and a stay-at-home mother of two children is no longer the norm in society.

The family relationship can significantly impact adolescent development in the case of divorce. Videon (2002) examined the effects of parent-adolescent relationship

and parental separation on adolescent well-being. The results of this study indicated that parent-adolescent relationships prior to marital dissolution moderated the effects of parental separation and the likelihood of risk-taking behaviour (Videon, 2002).

Moreover, the higher the adolescent satisfaction with the same-sex parent relation, the greater chance for delinquent behaviour when the adolescent was separated from this parent. On the other hand, if there was a strong adolescent-parent relationship, then there was less chance that the youth would engage in risk taking behaviour (Videon, 2002).

Changes in family structure and parental employment have resulted in adolescents having more unsupervised activity. For some adolescents, the decrease in adult supervision could result in an increase in risk-taking behaviours such as substance abuse and sexual intercourse (London et al., 2007). Moreover, lack of adult supervision also decreased opportunities for adolescents to communicate and be intimate with parents. Although it was recognized that an increased amount of time did not equate with quality time, there was a continual need for sufficient time for adolescents to communicate and develop intimate relationships with their parents (London et al., 2007).

Parental monitoring can also positively effect social development. Parental monitoring refers to the extent parents take interest in where their children are, whom they are with and what the adolescent is doing (McLaren, 2002). The *Canadian Institute of Health Information* (2005) found that “among youth aged 12-15 years, higher levels of parental monitoring were associated with less use of tobacco and drugs, but was not related to levels of self-worth” (p. 40).

Similar to attachment in early childhood, connection between adolescents and parents can influence adolescents’ transition to increased autonomy and healthy

adulthood (Doyle & Moretti, 2000). Secure attachment appears to facilitate emotional, cognitive and social development. Allen, Moore, Kupermine and Bell (1998) found that adolescent attachment experiences that reflected balance, perspective, autonomy and open acknowledgement of the attachment were more likely to be socially accepted by peers and less likely to experience internalization of feelings or to engage in delinquent behaviours. Dornbusch, Erickson, Laird and Wong (2001) found that “adolescent attachments to family and school tended to reduce the overall frequency, prevalence, and intensity of deviant involvement such as cigarette smoking, alcohol and marijuana use” (p. 396). Resnick, Bearman and Blum (1997) also found that adolescents who felt close to their parents showed more positive psychological development and were less susceptible to negative peer pressure.

Another important factor in families is parenting style. A nurturing parenting style is more likely to result in good developmental outcomes such as educational achievement, emotional and psychological well-being (McLaren, 2002). Nurturing parenting refers to the “extent to which parents are nurturing, warm, and accepting while at the same time setting clear limits to behaviour and consequences for breaking the rules” (p. 9). Devore and Ginsburg (2005) argued “parental monitoring, open parent-child communication, supervision and high quality parent-child relationships deter involvement in high-risk behaviours” (p. 460).

Parents can have a significant impact on an adolescent’s life. Parents influence where the adolescent lives, as well as his/her contact with community resources and neighbors (McLaren, 2002). Parents also have a significant influence in the choice of school and values of education and future career choices. Hall-Lande, Eisenberg,

Christenson and Neumark-Szainer (2007) asserted that parental role modeling of healthy relationships with other adult peers can positively influence adolescent social development. The review of the literature clearly illustrated that family structure, parent-adolescent relationships, parent role-modeling and parenting style all had a significant impact on adolescent development.

The Role of Peer Relationships

Adolescent relationships provide opportunities for youth to develop social and emotional skills. Peers can serve as sources of information, role models of social behaviour and sources for social reinforcement (London et al., 2007). The transitional period of social development varied from peer-to-peer and across different societies and cultures. Regardless of the social experience, close relationships among peers could potentially promote healthy social development in adolescents.

McLaren (2002) found that friendships could be associated with improved grades, reduced emotional problems and enhanced cognitive skills. There was also evidence that suggested that when youth interacted with peers who modeled positive behaviours, these relationships contributed to positive outcomes. For example, an adolescent who associated with friends with good grades was also more likely to abstain from using tobacco, drugs and alcohol (Omen et al., 2004). Another study from the Canadian Institute of Health Information (2005) found that peers who reported high level of peer connectedness also tended to report high levels of self-worth and very good health. “Among female youth, higher levels of peer connectedness are associated with higher levels of self-worth and lower levels of anxiety. Among males there were similar findings except that the anxiety levels were not associated with peer connectedness”

(Canadian Institute for Health Information, 2005, p. 48). Clearly, there are many positive aspects of close peer relationships.

Peer relationships have also been associated with negative health outcomes in adolescents. Hall-Lande, Eisenberg, Christenson and Neumark-Sztainer (2007) found that peers play a key role in adolescent psychological health. Their findings revealed that adolescents who feel close connections to peers are at decreased risk for depressive symptoms, suicide attempts and low-self-esteem. Kobus (2003) found that peer relationships contributed to adolescent cigarette smoking. Youth who were friends with smokers were more likely to smoke themselves. Best friends, peer groups and romantic partners have all been found to contribute to the smoking or non-smoking behaviours of youth (Kobus, 2003).

The Impact of the School Community

I recognize that the general community can influence development; however, this review was delimited to the school community. Santorum (2005) stated:

After family and religion congregations, schools may be the most fundamental institution in society. Schools are directly involved in the raising of children; schools are value laden and value-transmitting institutions, and are enormous generators of social capital. Schools bring together parents, families and whole communities in a common endeavor with common ideal, and thereby building ties and solidarity. (p. 352)

Supportive school environments that foster resilience and asset building, safety and social connectedness all work to promote the healthy development of youth (Canadian Association for School Health, 2007). Clearly, school experiences can significantly influence adolescent development.

Schools are a setting in which adolescents can develop socially, psychologically, spiritually and physically. Socially, the adolescent will have the opportunity to develop relationships with peers, teachers and administrators. Psychologically, the adolescent will be given opportunities to develop the knowledge, skills, and behaviours for healthy decision making (Canadian Association for School Health, 2007). Spiritually, the student will have the opportunity to be mentored, develop spiritually, and engage in moral discussions. There are many physical activities offered in order to promote healthy growth and development. Finally, the school environment allows for school staff and teachers to role model and support health and wellness skills, behaviours and attitudes (Canadian Association for School Health, 2007). All these school experiences have the potential to promote wellness within the adolescent population.

In light of the increase in school violence and bullying, safety within the school environment has become more and more important. May and Katzenstein (2004) found that feeling safe at school was strongly linked to better physical and emotional health and lower levels of risk-taking. Eisenburg and Aalsma (2005) found that students who were repeatedly targeted for teasing and harassment were more likely to have higher absence rates and report symptoms of depression. Clearly, safety is important to the healthy growth and development of youth.

Schools can foster student health and success through the promotion of certain developmental assets. Scales (2000) argued that the school organization, structure, curriculum, instruction, co-curricular programs, support services and partnerships all can work to promote the protective developmental assets. These assets were listed as: school engagement, achievement motivation, positive peer influence, co-curricular programs,

conflict resolution, completing homework, restraint, developing healthy adult relationship, cultural competence and decision- making and resistance skills (p. 87).

Moreover, school engagement can also promote development in youth. The *Canadian Institute for Health Information* (2005) found:

School engagement or connectedness is defined as the degree of importance that a youth may place on doing well academically, learning new things, making friends, participating in extracurricular activities, getting involved in activities such as school council and expressing opinions in his/her class. Among youth aged 12-15 years, students who reported feeling engaged with their school were less likely to report using marijuana, alcohol and tobacco and were more likely to report high self-worth, excellent or very good self-rated health status, lower levels of anxiety and fewer associations with peers who engaged in criminal behaviour. (p. 42-43)

May and Katzenstein (2004) found that youth who were highly connected to school reported better health and fewer risky behaviours than those who reported moderate to low school connectedness. Mcneeley, Nonnemaker and Blum (2002) presented evidence that positive health behaviours were associated with adolescents perceptions of caring people at their school and school connectedness. Finally, Bonny, Britto, Klostermann and Hornung (2000) found that decreasing school connectedness as associated with four modifiable risks such as declining health status, increasing nurse visits, cigarette use and lack of extracurricular involvement. These studies have outlined that a safe school environment where the students felt connected to the school could promote wellness within the adolescent population.

Table 2.8 was constructed based on the adolescent social development literature.

Table 2.8

Adolescent Social Development

Family	Family Structure- parent-adolescent relationships prior to marital dissolution moderated the effects of parental separation and the likelihood of risk-taking behaviour .	Parent/adolescent relationship- adolescents who felt close to their parents showed more positive psychological development and were less susceptible to negative peer pressure.	Parenting Style- higher levels of parental nurturing were associated with higher levels of self-rated health and self-worth, lower levels of anxiety and fewer contacts with peers who engage in criminal behaviour.	Parental Monitoring-, higher levels of parental monitoring were associated with less use of tobacco and drugs, but were not related to levels of self-worth.
Peers	Friendships- could be associated with improved grades, reduced emotional problems and enhanced cognitive skills.	Peer Connectedness- high level of peer connectedness also tended to report high levels of self-worth and very good health.		Peer relationships have been associated with negative health outcomes such as smoking in adolescents.
School Community	Supportive school environments- fostered resilience and asset building, safety and social connectedness all worked to promote the healthy development of youth.	School Engagement- students who reported feeling engaged with their school were less likely to report using marijuana, alcohol and tobacco and were more likely to report high self-worth, excellent or very good self-rated health status.		School connectedness- youth who were highly connected to school reported better health and fewer risky behaviours.

As depicted in Table 2.8, supportive relationships within family, peers and the school community can limit engagement in risky behaviour and provide protective factors in relation to potential environmental stressors. The literature clearly illustrates that peers, family and school community all contribute to the positive enhancement of social development in youth.

Summary of the Literature

The progression of adolescent development involves transitions in physical, psychological, spiritual and social dimensions of life. Adolescence is characterized by a rapid physical maturation that can be significantly influenced by nutrition, physical activity and health habits. Youth may also experience growth in their sense of right and wrong, experience connectiveness, find meaning and purpose in life, values and beliefs, and build or further a relationship with God. Psychologically, adolescents build self-esteem and self-concept. Research has also illustrated that relationships that adolescents hold with their parents, peers and school community are important factors contributing to the enhancement of well-being. In sum, there are many factors contributing to the development and wellness of adolescents.

The Canadian Pediatric Society (2007) acknowledged that:

When child and youth health is viewed through a lens, as distinct problems to be solved one at a time, we fail to see the complex network of forces and relationships that influence the health and well-being of children and youth. Only with a holistic view can we ensure that children and youth have the best possible chance to grow and develop to their full potential. (p. 2)

This study explored the perceptions of adolescent wellness with a holistic approach. The findings were used to make suggestions for developing evidence-based educational policies and programming aimed at promoting the health and wellness of our future generations.

A Conceptual Framework for Exploring Wellness

The Neuman's Systems Model (2002) is well-known in nursing literature as it presents a broad, comprehensive holistic perspective that can be used in a

multidisciplinary setting. It is for these reasons that I chose to utilize many of the ideas from this nursing theory to build my own conceptual framework to explore wellness.

A theoretical framework was used to explore the idealistic perceptions of adolescent wellness. The framework was used to better understand and describe: a) the relationship between wellness and the developmental dimensions of adolescent lives, b) the antecedents, stressors and influences on adolescent wellness, and c) the relationship between professional support (teachers) and students' perceived levels of wellness (low, medium and high-level wellness).

Similar to Neuman's Systems Model (2002), I described wellness as a system that is in a constant state of balance between the physical, spiritual, social, and psychological developmental dimensions. Wellness was the aggregate of the developmental dimensions of life. These dimensions were active, constantly changing, interrelated, and assisted the adolescent to cope more effectively with the possible imposing stressors from the external environment. The dimensions were not considered in isolation but rather as part of the whole state of wellness.

Similar to LeCroy (2004), development was defined as a process whereby young people must learn to adapt to the changes within their social environment. Figure 2.1 is used to illustrate the conceptualization of the idealistic state of wellness. Of note, due the comprehensiveness of this topic it was not possible to explore all the potential factors influencing adolescent, and thus, I delimited my conceptualization of wellness into four preconceived categories. I realize that there are other possible variables, such as culture, socioeconomics and other community influences, which have not been considered in this

study. I recognize that these are important factors which may be considered in future studies of adolescent wellness.

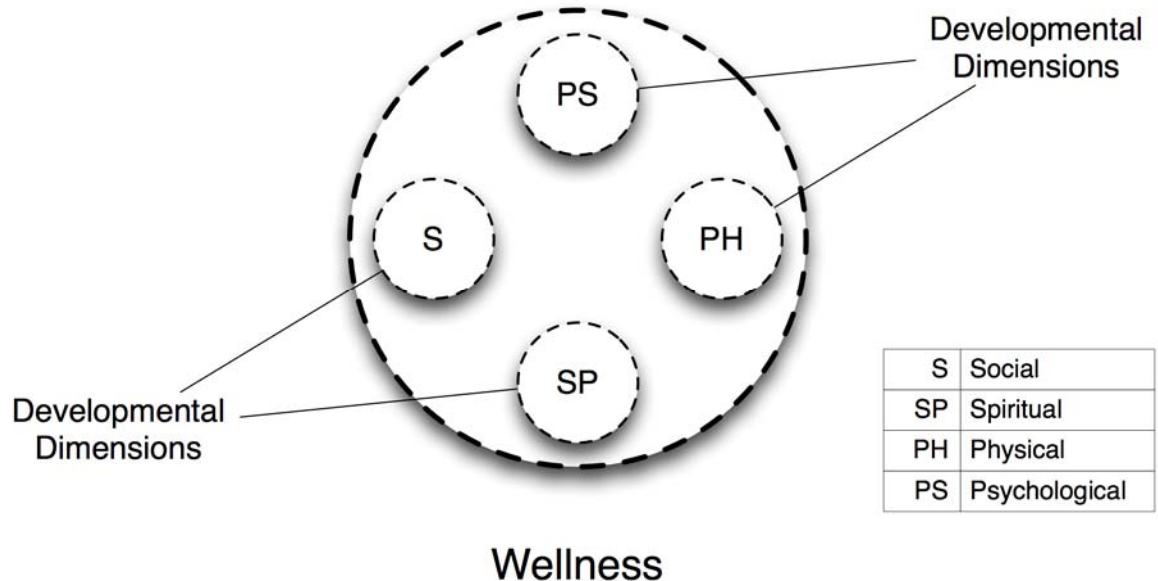


Figure 2.1. The ideal state of wellness as defined by the aggregate of the developmental dimensions of life.

As depicted in Figure 2.1, I viewed wellness in both an ideal and perceived state. The ideal state of wellness was defined as the predictable growth of the four developmental dimensions. In order to achieve wellness, the adolescent must predictably develop in all four developmental dimensions of life. In other words, the students must achieve certain developmental milestones in order to realize wellness and the absence of growth in one dimension would lead to a lower sense of wellness. This conceptualization was derived from extensive research into the literature on adolescent wellness and development. The perceived state was defined as the adolescent's meanings and experiences of wellness and was this study's primary source of data.

I realized that the student's perceptions of wellness may not be congruent with my conception. Thus, I used the findings of this study to compare and discuss the differences, between the ideal state and adolescent perceptions of wellness. Figure 2.2 is used to illustrate the potential contradictions between the proposed ideal state of wellness and the adolescent's perceptions of wellness.

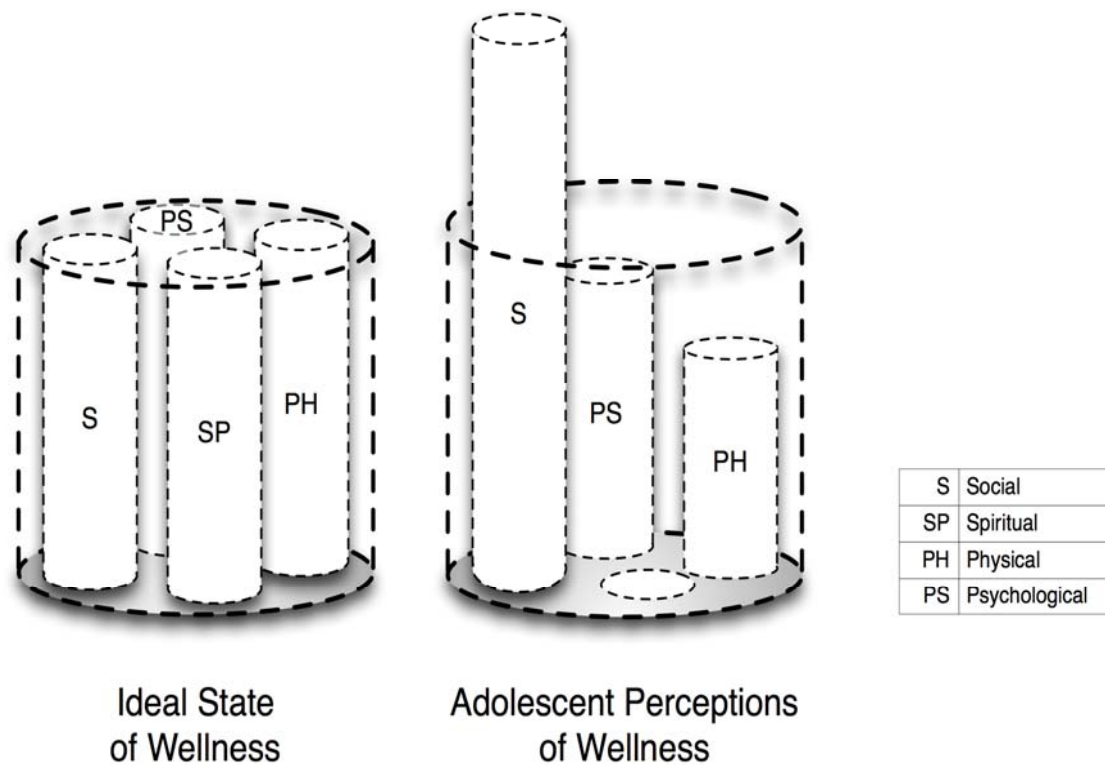


Figure 2.2. A comparison of the ideal state of wellness with adolescent perceptions of wellness.

As depicted in Figure 2.2, there might be significant differences between my conceptions of wellness when compared to adolescent perceptions. The students might indicate that wellness was not the predictable growth of certain developmental dimensions of life. In fact, the students might identify that one dimension could be flat, (meaning there has not been growth in that developmental dimension), or that one dimension could be

significantly higher (meaning that there has been significant growth in this developmental dimension). In other words, the student might identify high-level wellness despite the fact that a certain developmental dimension had yet to develop. For example, a student might identify a high-level wellness that was made up of a low-level of spiritual development and a high-level of social development.

The next intent was to explore the influences on the student's perceived level of wellness. I explored whether students identify specific levels of wellness, and what was the relationship between professional support (teachers) on the student's perceived level of wellness.

Figure 2.3 illustrated the significantly revised conceptualization, originally developed by Neuman (2002), of the potential relationship between the perceived levels of wellness and professional support.

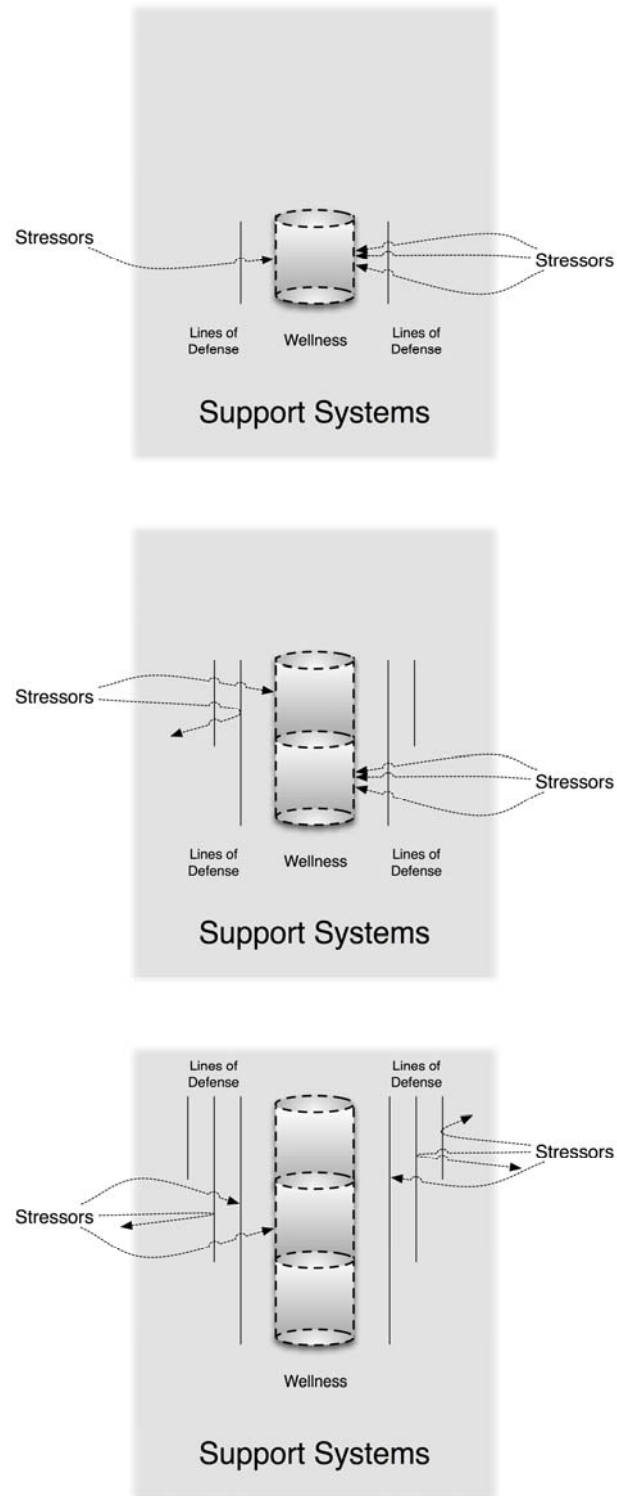


Figure 2.3. Student perceptions of stressors and lines of defense in relation to wellness.

As depicted in Figure 2.3, I predicted that as the student's perceived levels of wellness increased, so does the number of available educational resources and support systems. Thus, the support systems were creating a barrier or lines of defense protecting the students from the imposing stressors in life. The greater the number of lines of defense, the more likely the adolescent would be able to maintain a state of balance between the developmental dimensions of life. The lines of defense protected the student from the imposing stressors and this would result in high-level of wellness. I expected the students who perceived a moderate-level wellness would also identify moderate level of support and resources. Finally, I anticipated that the students who perceived themselves at a low-level wellness would have more life stressors and fewer lines of defense or support systems. I predicted that the number of lines of defense or support systems was related to the adolescent's ability to maintain a state of wellness.

Once again, these predictions of wellness and support systems might be contradictory to the adolescent perceptions. I explored these inconsistencies in order to better understand the relationship between wellness, development and the school support available to the students. This knowledge was used to suggest new directions for educational policy and programming.

Summary

The ambiguity of this topic, the lack of understanding of the factors responsible for wellness, the focus on the problems of adolescents, and the evidence pointing to the limitations of this approach all illustrated the urgent need to explore wellness within this population. This study was unique in that the students identified an ideal state of wellness and its potential relationship with development. Furthermore, the adolescent

identified what support systems are needed to enhance wellness. As recommended by the Canadian Pediatric Society (2007), this study used a holistic approach to explore the multiple influences on the health and well-being of adolescents. The meaning and support that participants identify provided insight into the development of more effective and sustainable educational wellness policies and programming, and an environment that was supportive of healthy choices for youth.

CHAPTER THREE

Research Methods

This chapter explains why I chose a multiple site case study design, and the concepts that were discussed are authentic knowledge, naturalistic generalization and emancipation. Then I present two assumptions that guided this study interpretivism, postpositivism, and include a discussion of my mixed methods design. The details of the sample and the data collection, a discussion of survey research, development of the instrument, the statistical analysis and the reliability and validity are provided. Next, I discuss focus group research, the development of focus group questions, the thematic analysis and the trustworthiness of the study. The chapter concludes with ethical considerations and a brief summary.

Case Study

A multiple site case study is generally undertaken because the researcher wants to understand a case in order to investigate a phenomenon (Stake, 2005). The case I chose to study was adolescent wellness in two mid-sized Western Canadian high schools. Similar to other case researchers, I intended to explore the case with depth and rigor, but the overall intent was to pursue my external interest which was to understand wellness (Stake, 2005). A multiple site case study design allowed for an in-depth examination of the high school students' experiences and perceptions of wellness.

Authentic Knowledge

This study was justified as there is potential to develop authentic knowledge. Justifying a case depends on making the process of the study accessible so that it is possible to evaluate the reasonableness of the study (Kemmis, 1980). In other words, a

case study design created the condition for the reader to imagine himself in the social world of the case being studied. Rich descriptions within a case study were used to develop the imagination of the reader. Developing these real images created authentic knowledge. The study is “authentic in the sense that it is grounded in the circumstances of the reader’s life and validated by his own experiences” (Kemmis, 1980, p. 128). I communicated the details of the study in a way that facilitated the reader’s understanding of the situation, which promoted the creation of authentic knowledge.

Naturalistic Generalization

This study design was also justified because it allowed me to convey the story of the participants in a way that facilitated naturalistic generalization. Naturalistic generalization can occur when people generalize from personal and vicarious experiences (Kemmis, 1980). This rich understanding of the case may have provided opportunity for the readers to experience the case vicariously. Through the collection of thick descriptive data, I provided insight into wellness so that readers could relate to the experiences and context and evaluate the case. This evaluation process could result in the recognition of similarities to cases of interest and thus establish a basis for naturalistic generalization.

Emancipation

The study design was also justified because the knowledge developed has the potential to be emancipatory. This study was both political and strategic in the sense that insight reached through a case study design has the capacity to change the particular situation being studied (Kemmis, 1980). Politically, adolescent wellness is recognized as a central component in the achievement of effective learning outcomes and is a priority within education at all levels: provincially, nationally and internationally. As wellness

reemerges as a priority in education, administrators, teachers, parents and community partners will undoubtedly seek out evidence that helps to promote adolescent wellness in schools. It is my hope that the knowledge gained from this research study will provide direction for the development of an educational environment that supports students to experience well-being, learning and life-long success.

Strategically, I hope that increasing the understanding of adolescent wellness and providing insight into the value of community partnerships will increase the warrant for contracting nurses back into schools. Previously, schools within the John A. MacDonald school district each had a nurse who worked on a daily basis to promote the health of the children and adolescents. However, over the last two decades the nurses' involvement in schools have been minimal, as the nurses are no longer only assigned to a school but also have multiple other community commitments. It is my hope that the knowledge from this study will provide awareness of the issues that reinforce the importance of an interdisciplinary approach and that nurses would be once again assigned to each school within the district to work on a daily basis. I believe these changes will enhance the ability of adolescents to achieve and/or maintain wellness and increase the potential for emancipation of the youth.

Interpretivism

All research is guided by “a set of beliefs and feeling about the world and how it should be understood and studied” (Denzin & Lincoln, 2005, p. 22). Furthermore, “the researcher approaches the world with a set of ideas (ontology) that specifies a set of questions (epistemology) that is then examined in a specific way (method)” (p. 21). I

have approached this study with an interpretive humanist perspective, and as a result, this assumption shaped the nature of the research questions and the subsequent analysis.

The ontological assumption of the study was that social reality was fundamentally a work of ideas and meanings, which could not exist independently of the human subjects who create and interpret the meaning (Mclean, 1999). Moreover, “the participants are active creators of their worlds rather than being passively shaped by social processes” (p. 27). Guba and Lincoln (1989) stated:

The ontological question is answered by asserting that there exists multiple, socially constructed realities unguided by natural laws, causal or otherwise. Phenomena are defined depending on the kind and amount of prior knowledge and the level of sophistication that construction brings to the task. Truth is defined as the most informed and sophisticated construction on which there is consensus among individuals most competent to such a construction. (p. 86)

The epistemological understanding was defined as valid knowledge of the social world that was derived from the construction of interpretive understandings of the meaning of social interaction for its participants (Mclean, 1999). Guba and Lincoln (1989) stated:

The epistemology question is answered by asserting that it is impossible to separate the inquirer from the inquired into. It is precisely their interaction that creates the data that will emerge from the inquiry. Furthermore, an inevitable element of the inquiry mix is the values of the inquirer and therefore, these values cannot be ignored; their very influential role in all inquiry must be acknowledged. (p. 88)

With this approach the participants in the study were active creators of their reality. The students were involved in the construction of knowledge and understanding of wellness. The students’ perceptions and experiences were the primary source of data

for the study. The teachers, counselors and administrators were also asked to identify positive influences, barriers and antecedents to adolescent wellness.

Postpositivism

This study also included a focus on the postpositive paradigm. Guba and Lincoln (1999) argued that “in the postpositivist perspective, reality can never be fully apprehended, only approximated” (p. 22). This perspective relies on multiple methods as a way of capturing as much of reality as possible. Furthermore, emphasis on measuring and descriptions of possible relationships were a priority. Quantitative methods were necessary in this portion of the study as it was my intent to investigate the trends, generalizations and relationships between the adolescent developmental dimensions and wellness.

Mixed Methods Design

According to Creswell (2002), there have been significant movements from educational and social science investigators to combine research methods of data collection. Guba and Lincoln (1989) argued that:

The methodology depends on the response to the ontological and epistemological questions, and assert that the inquiry must be carried out in a way that will expose the constructions of the variety of concerned parties, open each to critique to the terms of other constructions, and provide the opportunity for revised or entirely new constructions to emerge. (p. 89)

Creswell and Plano Clark (2007) identified that mixed methods research provides more comprehensive evidence for a studying a research problem than either qualitative and quantitative research alone. Furthermore, “the combination of qualitative and quantitative data provides a more complete picture by noting trends and generalizations as well as in-depth knowledge of the participants perspectives” (Creswell & Plano Clark,

2007, p. 33). This design is used when “the researcher wants to directly compare and contrast quantitative statistical results with qualitative findings or to validate or expand quantitative results with qualitative data” (p. 64).

This study explored adolescent perceptions of wellness and the possible relationship between adolescent development and wellness. Also investigated was the relationship between professional (teachers) support and student’s perceived level of wellness. Given these research questions, mixed methods were justified as this approach was the most appropriate to address the research problems and sufficiently draw conclusions of the adolescent wellness phenomenon.

After determining that mixed methods were suitable, I then decided on an explanatory design. According to Creswell (2002):

An explanatory mixed method design consists of “first collecting quantitative data and then collecting qualitative data to help explain or elaborate on the quantitative results. The rationale for this approach is that the quantitative data and results provide a general picture of the research problems; more analysis, specifically through qualitative data collection, is needed to refine, extend or explain the general picture. (p. 566)

Figure 3.1 is used to illustrate the process of an Explanatory Mixed Methods Design.

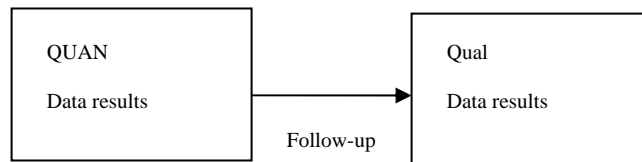


Figure 3.1. Explanatory mixed methods design.

From “Educational Research; Planning, Conducting and Evaluating Quantitative and Qualitative Research,” by J. W. Creswell, 2002, p. 565. Copyright 2002 by Pearson Education, Inc., Upper Saddle River, New Jersey.

As illustrated in Figure 3.1, in an explanatory design the quantitative data is collected first and then the researcher follows up with qualitative data. The survey was the study's primary source of data as these results most appropriately addressed the research questions and provided a general picture of the research problem. Moreover, quantitative methods were suitable for this study as it was my intention to explain 1) the possible relationship between wellness and the developmental dimensions of adolescent lives, 2) the possible relationship between professional support (teachers) and students' perceived levels of wellness (low, medium and high-level wellness), and 3) measure certain developmental behaviours, i.e. smoking, in adolescents. Due to the highlighted emphasis of the quantitative data, the survey was completed and introduced first in the study, and also represented a significant aspect of the analysis.

Strauss and Corbin (1998) stated "qualitative methods can be used to obtain intricate detail about phenomenon such as feelings, thought processes, and emotions that are difficult to extract or learn about through conventional methods" (p. 11). According to Denzin and Lincoln (2005):

Qualitative research is a situated activity that locates the observer in the world. It consists of interpretative, material practices that make the world visible. Qualitative research involves an interpretive, naturalistic approach to the world and this means that qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)

Qualitative methodology assists the researcher to explore the most relevant details of the phenomenon (Glaser, 1992). The qualitative data was completed after the survey, and were used to refine and support the quantitative findings and provided more detail and explanation of the general problem. A qualitative approach was a logical

methodological choice for this study as it was my intention to understand, make sense of and interpret the student's perceptions, experiences and meanings of wellness.

The Study's Sample

The sample was purposeful in that the informants were likely to be knowledgeable about the phenomena the researcher was investigating (McMillan & Schumacher, 2001). I have chosen a purposeful sample in order to maximize the range of information (Guba & Lincoln, 1999).

The criteria for entering into the study was that the participants were 16 years or older, were enrolled in at least one grade eleven class, were present on the day of data collection, and were willing to volunteer to participate in the research. The students submitted a signed student assent form in order to participate in the study. I chose this age group as the literature indicated that students in this age category should be, or close to being, physically, spiritually, psychologically and socially developed (Hockenberry & Wilson, 2007), and thus should be adequately competent to relate their wellness beliefs and experiences (Hockenberry & Wilson, 2007). I was certain that these students would be able to provide the information to address the purpose of this study.

Data Collection

I collected data in two mid-sized Western Canadian high schools. Prior to data collection, I contacted the principals from both the school to receive permission to collect data in the school. In both cases, the principals made all the arrangements for data collection times and dates for the survey and focus groups.

I used a computer survey for half of the students and by request of one administrator; I copied the computer survey and used a pencil and paper survey. The

survey was completed by 280 students in grade eleven from the two schools that were chosen for this study and who met the inclusion criteria. There was a time designating for each class to complete the survey and this ensured that every student had equal opportunity to complete the survey and that I was present to further clarify the directions. (Appendix A3). There was a good overall response rate overall on the survey (61%) as any student in grade eleven present on the day of data collection completed the survey.

As a guest within the school system, I asked the principal to suggest teachers and students who may be interested in participating in the proposed focus groups in this study. The focus groups for the students were conducted at the school. I held five student focus groups (one was a mix of gender, two all female and two all male) with 3-8 students per group (Appendix A1). The focus groups were organized by the administrators in the school and therefore, I had more female focus group participants than male.

There were two focus groups, made up of volunteers from a special physical education class. The students were permitted to volunteer for the study during the lunch hour and into the scheduled class time. The remaining three focus groups were held after school and this time may have limited the participants who were willing and available to volunteer.

I do not have any evidence that I limited my focus group discussions to a particular stratum of students. Due to time constraints and the students' willingness to volunteer, it is possible that my focus groups had an underrepresentation of students who would be characterized as "high risk students."

I also held one focus group for teachers (Appendix A2). The focus groups time was approximately one-two hours long, and I discussed all the developmental dimensions in each focus group.

Students were informed about the intent of the study, and they were guaranteed that the information would be held confidential. I assured the students that the information would not be passed on to other students, parents, teachers or administrators. The teachers were also informed of the intent of the study and were reassured that the data would be kept confidential.

Survey Research

Survey research has become a popular research method as the tool allows researchers to collect information quickly from a large population of people. There are several advantages of survey research; McMillan and Schumacher (2001) stated:

Three reasons for this popularity are versatility, efficiency and generalizability. Surveys are popular because a credible amount of information can be collected at a relatively low cost. The most important reason for the popularity is that small samples can be selected from a larger population in ways that permit generalization to the population. Surveys are often the only means of obtaining a representative description of traits, beliefs, attitudes and characteristics of a population. (p. 305)

It was not my intention to validate an adolescent wellness survey, but rather to describe the possible relationships between adolescent developmental behaviours and wellness. I was interested in understanding if there was a correlation between the adolescent developmental dimensions and wellness. For example, in this study, health habits such as nutrition and physical activity were explored in relation to wellness. Another example was an evaluation of the relationship between perceived support of parents and/or teachers with a level of wellness (low, medium or high).

Furthermore, the survey allowed me to describe the relationship between support and the adolescent's perceived level of wellness. The ANOVA analysis determined if there were significant differences between the students' levels of wellness and the items related to adolescent development. For example, the ANOVA analysis measured whether there were significant differences between the low, medium and high-wellness groups in their perceptions of body satisfaction. Finally, the survey also allowed me to measure certain developmental characteristics of the adolescent population. For example: the survey measured how many grade eleven adolescents were smoking and/ or drinking alcohol in the school.

The Adolescent Wellness Questionnaire

Although there are questionnaires, such as the Berne questionnaire of subjective well-being by Katja, Paivi, Marja-Terttu and Pekka (2002), to examine life satisfaction and subjective well-being, none have addressed wellness as a concept with four dimensions as described in the literature review. However, as indicated in chapter two, Sharkey (1999) created and validated an Adolescent Wellness Survey (AWS) that was used on high school students in the United States. The AWS was composed of five factors (physical, emotional, self-esteem, social wellness-family, and social wellness-friends). In this investigation, the AWS was used to measure the independent variable (wellness domains) and then a multiple regression analysis was performed to determine the model's ability to predict risk-taking behaviour. There were some good ideas presented in Sharkey's survey, and thus, I chose to utilize and modify some of the items presented in the AWS (10 in total) to build my own survey to explore wellness. See Appendix A-4 for the items used from Sharkey's survey. The remaining items were

developed based on an extensive review of the literature. The questionnaire was logically sequenced into four developmental dimensions as the instrument was designed according to the construct of adolescent wellness, which was developed and presented in chapter two. The questionnaire included five sections for a total of 63 questions, and the items were included in Appendix A-3.

The first section sought demographic information including gender and age, and asked respondents to rate their perceived level of wellness (four items total). The second section (physical development) asked respondents to reflect on their beliefs relating to body weight, nutrition, physical activity, and provided descriptive data on the students' rates of smoking, drugs and alcohol use, physical activity levels and fruit/ vegetable consumption (15 items total). There were several different scales used in the first and second sections. Appendix A-3 provides samples of all the scales.

All the items in sections three-five used a Likert scale where there were five possible responses (strongly agree, agree, neutral, disagree, strongly disagree). Section number three (spiritual development) asked respondents to reflect on their opinions relating to the students' sense of connectedness, purpose in life, sense of right and wrong, and personal values and beliefs (9 items total). Section number four (psychological development) sought information relating to self-esteem, self-concept, and independence (23 questions total). The fifth section (social development) asked the respondents to describe their coping skills, and relationships with friends, family and school (12 items total).

Finally, the items were combined to form a developmental scale for each of the four dimensions (physical, spiritual, psychological and social). The physical

developmental scale was further divided into sub-scales in order to increase the cohesiveness between the items. The first subscale (substance use) included items on the rates of substance use and the second sub-scale (health) integrated items related to body weight, physical activity and nutrition.

The Pilot Study

A pilot study was used to test the validity of the adolescent wellness survey. A small secondary Catholic high school was selected for the pilot study. Prior to data collection, I contacted the principals from the school to receive permission to collect data in the school. The principal made all the arrangements for data collection times and dates for the grade eleven students to complete the pilot survey. Twenty students volunteered to complete the paper and pencil survey. The pilot test was administered by the researcher, thus providing opportunity for clarification of the questions and the directions.

The information obtained from the pilot was used to modify the instrument for the actual study. First, the original instrument had four possible responses for the majority of the questions (strongly agree, agree, disagree and strongly disagree) and, during the analysis, I found that many students had drawn a line between two answers. Based on this knowledge, I added a neutral response to 53 of the questions. This modification resulted in five possible responses for the students (strongly agree, agree, neutral, disagree, and strongly disagree).

Another significant change to the survey arose based on the questions from the pilot study participants. The original instrument asked the question “I am psychologically developed” and similarly “I am socially developed.” There were several

students that made statements that indicated they did not understand the question. An example of a student question was, “what is psychological development,” which means that the question had the potential to be interpreted in many ways and was confusing for the students. Thus, I eliminated questions #3 “I am physically developed,” #19 “I am spiritually developed,” #29 “I am psychologically developed,” #53 “I am socially developed.” In replacement of these questions, I developed four separate heading: Physical Development, Spiritual Development, Psychological development and Social Development. After each of these heading, I organized all the questions relating to the particular area of development immediately following. For example, all the physical development survey questions immediately followed the physical development heading.

I also clarified four other questions that were similar in nature. For example, the pilot question “physical development contributes to my overall sense of wellness” was changed to “Physical development (bodyweight, nutrition, physical activity, smoking, drugs and alcohol) contributes to my overall sense of wellness.” The question “spiritual development contributes to my overall sense of wellness” was changed to “spiritual development (sense of connectedness, purpose in life, a sense of right and wrong, personal values and beliefs) contributes to my overall sense of wellness.” The question “psychological development contributes to my overall sense of wellness” was changed to “psychological development (self-esteem, self-concept, and independence) contributes to my overall sense of wellness.” Lastly, the question “social development contributes to my overall sense of wellness” was changed to “social development (coping skills, parents, friends and school) contributes to my overall sense of wellness.”

In sum, results from the pilot study were used to clarify instructions used in administering the instrument and more accurately predicted the time needed to complete the questionnaire. Due to the modifications to the instrument, the pilot survey results were not used in the analysis for the study.

Statistical Analysis

Descriptive and inferential statistics were computed using SPSS (Statistical Package for Social Science) software. The descriptive statistics used were means, frequencies and standard deviations. This analysis was used to assess general trends and measure variability of the data.

Correlations were used to examine possible relationships between all the items measuring the four developmental areas and wellness. The developmental scales were also correlated with the wellness composite. Correlations research, as described by McMillan and Schumacher (2001), were concerned with “assessing relationships between two or more phenomena and involves a statistical measure of the degree of relationship” (p. 34). There were two items measuring wellness (I am well and My level of wellness) in the survey. The “I am well” statement had five possible responses (Strongly agree, agree, neutral, disagree and strongly disagree) and the ‘my level of wellness’ statement had three possible responses (high, medium and low). Due to the different response scales, the statements were combined to form a composite wellness variable. According to Cresswell (2002), the standard z-score enables a researcher to compare scores from different scales. The procedure for converting to a z-score includes subtracting the subject’s score from the mean of all the scores, and dividing by the standard deviation. After converting each subject’s score on each variable to a standard z-score, I then added

the two scores to form a composite score. There were three categories used to describe the correlations between the developmental dimensions and the wellness composite (Minimal: 0-2.5, Moderate: 2.6-6.0 and Strong: 6.1-10).

A factorial ANOVA was used to analyze the independent variables. ANOVA, as described by McMillan and Schumacher (2001), allowed “the researcher to test the differences between all groups and make more accurate probability statements. A factorial ANOVA is defined as two or more independent variables being analyzed together” (p. 373). One way ANOVAs were conducted to compare the wellness groups [low (n=12), medium (n=148) and high (n=120)] on all of the individuals items measuring each of the four developmental areas, as well as the each of the four developmental dimensions.

Post-hoc tests: Student-Neuman-Keuls (SNK), Levines and Tamhanes were used to illustrate statistically significant differences between the low, medium and high-wellness groups. The Student-Neuman Keuls assumes equal variances. Therefore, I used the Levines in order to test for equal variances. According to Munro (2005), the assumption of homogeneity of variance has been met when the Levine’s test has a significant level greater than 0.05. When Levines showed unequal variances, I was unable to use SNK because I did not meet the assumption of equal variances. De Muth (2006) argued that “Tamhanes is a conservative post-hoc test, and is appropriate for when variances are unequal” (p. 256). Thus, Tamhanes was used in the cases of unequal variances. This test is designed to make it more difficult to find significant differences, and therefore, lowered the risk for Type I error rate. Cresswell (2002) defines Type I error: when the researcher rejects the null hypothesis when it is actually true.

Quantitative Validity and Reliability

I am aware that a primary concern in quantitative research is to maximize internal validity. Mcmillan and Schumacher (2001) stated that “internal validity of a study is a judgment that is made concerning the confidence with which plausible rival hypothesis can be ruled out as explanation for the results” (p. 326). However, as stated earlier, it was not my intention to validate the survey questions, but rather to ensure that the inferences made from the data were appropriate and meaningful. There are few well developed questionnaires as adolescent wellness is a new and emerging priority, and thus, the items examined in this study have provided the preliminary groundwork for testing the questionnaire as a reliable mean of assessing adolescent wellness.

The questionnaire was theoretically derived and based on the construct of adolescent wellness that was developed through an extensive literature review. To establish content validity, I ensured the questions were suitable by requesting feedback on the items of the survey from my committee members. Based on their suggestions, the questionnaire and scales were refined and the language was clarified where necessary. Furthermore, face validity was examined through the pilot test and the administration of the questionnaire. The items were developed with the intention of being transparent, relevant and easy to understand and the pilot test allowed respondents to write comments on the individual items and the questionnaire as a whole. Face validity was evidenced in the pilot as the participants stated that the items were “straightforward” and there were few questions or concerns relating to their understanding of the items. The pilot test determined whether the questions and directions were clear and the time required to

complete the survey (McMillan & Schumacher, 2001). After examining the pilot data, I adapted the survey.

McMillan and Schumacher (2001) stated:

Reliability is also important in research as it refers to the consistency of measurement which is the extent to which the results are similar over different forms of the same instrument or occasion of data collection. It is suggested that reliability is enhanced when all subjects are given the same directions and have the same time frame in which to answer the questions at the same time of the day. (p. 248)

I promoted reliability by setting up a common time for the students to complete the survey, and I was present in the school in order to clarify directions. Mcmillan and Schumacher (2001) argued that this test is the most appropriate reliability for survey research.

The internal reliability was examined on the four dimensions of wellness using Cronbach's alpha coefficient. Using the data for the study, separate scales were produced for each of the four developmental dimensions. The physical developmental scale was further divided into sub-scales in order to increase the correlations between the items. The first subscale (substance use) included items on the rates of substance use and the second sub-scale (health) integrated items related to body weight, physical activity and nutrition and their coefficients were .65 and .67, respectively. For the three developmental dimensions (psychological, spiritual and social) the coefficients ranged from .86-.92 and were judged to demonstrate adequate reliability. The total coefficient for the four developmental dimensions was .92, and provided support for the wellness construct of this study.

Focus Group Research

Focus groups were used in this study to explore the details about the wellness phenomenon such as feelings, thought processes, and emotions that were difficult to explore through the survey. Kamberelis and Dimitriadis (2005) stated:

The advantage of focus groups is that the researcher will be able to interview a large number of students with relatively low research costs. Focus groups often produce data that result in powerful interpretive insight. Moreover, the synergy generated within homogenous collectives often reveals unarticulated norms and normative assumptions. They also take the interpretive process beyond the bounds of individual memory and expression to mine the historical collective memories and desires. Focus groups foreground the importance not only of content, but also expression, because they capitalize on the richness and complexity of group dynamics. (p. 903)

One of the most important reasons for focus groups is to benefit from the interactions of the research participants. In an effective group discussion, issues often emerge from the discussion that would not normally evolve if the moderator were asking opinions of each participant in a one-to-one format (Greenbaum, 2000). Ideas were elicited from the group atmosphere.

According to Peterson-Sweeney (2005), “the research method can be helpful to disempowered populations, such as children and adolescents that may be reluctant to express their voice in a one-to one interview” (p. 104). Moreover, the use of focus groups allowed for the interactions and stimulation of group thought. Peterson-Sweeney (2005) also stated:

The adolescents may feel pressured, when interviewed individually, to answer a certain way, or they think that the interviewer would like them to respond in a certain way. Young people may also be reluctant to express their true feelings with an adult interviewer or may be too nervous to talk within such an interview. The outcome of a focus group work is often rich, empirical data about the issue that is being discussed. (p. 104)

The focus group atmosphere could be an effective method of promoting the voices of youth that would normally not be heard. Kamberelis and Dimitriadis (2005) concurred that focus groups have been used to elicit and validate collective testimonies and to give voice to the previously silenced by creating a safe space for sharing one's life experience. One of the strong elements of the focus group was the security that people feel when discussing sensitive subjects with others who are similarly affected (Greenbaum, 2000).

Fontana and Frey (2005) argued that there are several skills that a researcher should incorporate into the group interview process. The interviewer should consider the following: keep any one person from dominating the group, encourage all people to participate, manage the dynamics of the group, and be sensitive to the evolving patterns of group interaction (Fontana & Frey, 2005). These authors found that it was important to be flexible, objective, empathetic, persuasive and a good listener (p. 704).

Another important consideration was the selection of group participants. Bloor, Frankland, Thomas and Robson (2001) stated:

Interaction between participants is a key feature of focus groups and careful consideration of group composition is vital. In order to have a productive group, it is important to develop groups based on homogenous characteristics of participants (age, sex, ethnicity). There must also be sufficient diversity to encourage discussion. (p. 20-21)

These authors expressed that careful consideration of participants and effective moderation of focus groups can result in a safe atmosphere, an opportunity for all people to participate, and an economical method of data collection. Thus, it was a suitable approach to explore wellness with adolescents.

Development of Focus Group Questions

I conducted the focus groups interviews using a combination of semi-structured and unstructured questions that were developed and sequenced based on the adolescent developmental dimensions. An unstructured interview involves asking open-ended questions that permit the participants to create response possibilities (Creswell, 2002). In addition, the semi-structured questions were phrased to allow for individual responses but were specifically intended to answer the research questions of the study. In each focus group, I asked the participants about what wellness was to them. Then I asked a series of questions to solicit their perceptions of the factors influencing adolescent wellness (school and family). (Appendix A-1).

Sub-questions for this study asked about the students' perceptions of adolescent development, and the format was the same for each of the developmental categories (physical, psychological, spiritual and social). An example of these questions is presented next.

Physical development questions. The first broad question I asked was: what is physical development to you? I then asked further specific questions that resulted in overlap and provided rich descriptive data. Are there positive or negative influences on your physical development? Does physical development contribute to your overall sense of wellness? If so, how? (Appendix A-1)

As I continued to collect and analyze data, I recognized that my questions needed to become more specific and directed towards answering the research questions. In this case, I asked questions based on the responses of students in past focus groups. For example, students in previous focus groups indicated that body weight did not affect

physical development. Based on this knowledge, I told the students these results and asked if they could explain why students did not perceive body weight affecting their physical development.

Focus Group Analysis

A thematic analysis was consistent with an interpretivist approach, and thus it was used as a basis for the focus group data analysis. Braun and Clarke's (2006) approach to qualitative analysis was chosen as a framework to analyze the qualitative data as they described a thematic analysis as "a method for identifying, analyzing and reporting patterns or themes within data" (p. 79). Furthermore, they claimed that this method of analysis provided a flexible and useful research tool that could potentially provide a rich and detailed account of the data. They identified a six step approach to a thematic analysis and these were:

- 1) Familiarizing yourself with your data, immersing yourself in the data to the extent that you are familiar with the depth and the breadth of the content,
- 2) Generating initial codes, this phase involves the production of initial codes from the data,
- 3) Searching for themes, involves sorting the different codes into themes, and collating all the relevant coded data extracts within the identified themes,
- 4) Reviewing the themes, involves refinement of the themes,
- 5) Defining and naming themes, determining the essence of what the theme is about, and determining what aspect of the data each theme captures,
- and 6) producing the report, the task of telling the complicated story of your data in a way that convinces the reader of the merit and validity of your analysis. (p. 93)

In step one, the data was transcribed and I began to familiarize myself with the data. As stated by Braun and Clark (2006), "it is vital that the researcher emerge themselves in the data to the extent that you are familiar with the breadth of the content" (p. 87). Keeping with this knowledge, I read the transcripts searching for meaning and patterns within the data. I also made notes within the transcripts and reread my field

notes that were taken with each focus group. Of note, as I had the transcripts transcribed word for word, I prepared the data for analysis by removing some expressions (i.e. ums, like, you know), and I removed any proper names in order to maintain anonymity.

Step two involved generating initial codes from the data. Throughout this study, I have organized each phase of research with the intention to describe the possible relationships between adolescent developmental behaviours and wellness. Thus, my initial codes were organized into wellness and developmental (physical, psychological, physical and spiritual) dimensions.

Step three involved considering how different codes would combine to form an overarching theme. Braun and Clark (2006) described a theme as something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (p. 82). These authors further argued that a thematic analysis could be further identified as inductive (data driven) or theoretical which would tend to be driven by the researcher’s theoretical interest in the area. They asserted that coding for a theoretical approach involved coding to a specific research question and was more explicitly analyst driven.

After carefully considering the data, it was clear that I was analyzing data with a thematic approach as I was coding to my research questions and there was a preconceived theory driving the process. The students were describing or defining wellness, which was my first research question. However, the students also seemed to be repeatedly making reference to “a balance of wellness” or connection between all the different aspects of their lives. Finally, there were many students speaking to the moderating influences (physical, spiritual, psychological and social) of wellness.

Next, I reread my initial themes and I recognized that the themes identified were actually more appropriately categories of data. I then decided to develop three categories in order to organize the themes of this study. The first category of themes included all the codes that referred to a description of wellness and, thus, I decided the label was Understandings of Wellness Themes. All the codes relating to the discussion of the balance or connection of the components of wellness were grouped into the Relationship Between Wellness and Development Themes. Finally, all the codes relating to the influences of wellness were collapsed into the category called Moderating Influences of Wellness Themes.

For the teacher focus group, I followed the same process and two categories of themes were identified and these were: 1) Understandings of Wellness Themes and 2) The Moderating Influences of Adolescent Wellness Themes.

There were several themes and subthemes identified in each category. The first category titled the understandings of wellness resulted in three themes and these were *Wellness Definitions, The Multi-dimensions of Wellness and The Characteristics of a Well Person*. The relationship between wellness and development themes resulted in the *Balancing the Dimensions of Wellness Theme*. Finally, the moderating influencing factors of wellness themes were further divided into sub-categories (physical, spiritual, psychological and social). The resulting themes were Physical (*physical activity, nutrition, smoking/drugs and alcohol, body weight and parent/guardian*), Spiritual (*parent/guardian and school*), Psychological (*parent/guardian, peers and media*) and Social (*parent/guardian, peers and school*) influences of wellness.

The teacher themes were also divided into two categories. The first was titled the understandings of wellness themes which resulted on two themes and these were *Wellness Definitions* and *Characteristics of a Well Adolescent*. The next category was labeled the moderating influences of adolescent wellness and was further divided into sub-categories (physical, spiritual, psychological and social) of themes. There were many themes identified within each of the developmental subcategories and these were Physical (*physical activity, nutrition, smoking/drugs and alcohol, sleep and poverty*), Spiritual (*parent/guardian and school*), Psychological (*parent/guardian, peers and media*) and Social (*parent/guardian, peers and school*) influences of wellness.

Step four involved reviewing at the level of the coded data and reading all the collated extracts for each theme and considering whether they appear to form a coherent pattern (Braun & Clark, 2006). In this step, I reviewed all the data statements in each of the three categories of themes and discarded inappropriate codes from the analysis or moved the codes to an already existing but more suitable category. I also coded additional data within the categories that had been missed during earlier coding stages.

I began Step five by refining the themes for both the student and teacher focus groups. Braun and Clark (2006) further explained:

By ‘define and refine,’ we mean that identifying the essence of what each theme was about. For each individual theme, you need to conduct and write a detailed analysis. As well as identifying the ‘story’ that you are telling about your data. (p. 92)

In this phase, I reconsidered the content of each of the theme and as a result, the analysis moved to interpretation and synthesis rather than paraphrasing.

While refining the themes of the study, I considered whether or not subthemes were appropriate. Braun and Clark (2006) defined subthemes as “a theme within a theme and are useful for giving structure to a large and complex theme and for demonstrating the hierarchy of meaning within the data” (p. 92). Breaking themes into subthemes worked to ensure that the data would cohere and that there would be clear and identifiable distinctions between themes.

After carefully consideration of all these data, it seemed that there were many several meanings presented in the previously identified *influencing of school theme*. Thus, in order to demonstrate the hierarchy of meanings to this complex theme, the *influences of school theme* was further divided into sub themes and these were *influences of teachers, school counselors, the school environment and programs*.

Finally, step six involved writing a detailed analysis or a story for each of themes. Thus, I told the complicated story in a way that illustrated the validity of my analysis. Braun and Clark (2006) suggested that it was important for the analysis to provide a “concise, coherent, logical and non-repetitive account of the story” and the researcher should choose “particular examples of extracts that will capture the essence of the theme” (p. 93).

The analysis examined both the quantitative and qualitative findings, made comparisons with the literature and included several examples of data extracts from the study. During the review of these data, I was cognizant of interpreting the data beyond the level of description. The analysis was framed with the intent to present arguments in relation to each of my research questions.

The analysis included conceptualizations of wellness, the contradictions between the proposed ideal state of wellness and the adolescent's perceptions of wellness, and of each of the developmental dimensions. These conceptualizations were developed with the intent to further the reader's understanding of the analysis. The discussions included plausible explanations for the findings diverging from the expected. Finally, I formulated implications for educational theory, practice, policy and future research.

Trustworthiness

As recommended by Guba and Lincoln (1999), rigor and trustworthiness was established by ensuring credibility, transferability, dependability and confirmability. According to Guba and Lincoln (1999), credibility would be maintained through the following techniques:

- (a) Prolonged engagement at a site to overcome a variety of possible biases and misperceptions and to provide time to identify salient characteristics;
- (b) persistent observation to understand salient characteristics and appreciate atypical meaningful features;
- (c) peer debriefing to test growing insights and to receive counsel about evolving design, discharge personal feelings and anxieties;
- (d) triangulation, whereby a variety of data resources and different perspectives are pitted against one another;
- (e) recordings are collected during the study and archived for later use and
- (f) member checks, whereby data and interpretations are continuously checked with members from various groups from which data were solicited, including overall check at the end of the study. (p. 147)

Transferability was sought by using purposeful sampling in order to maximize the range of information and provide the most stringent conditions for developing theory. I also collected thick descriptive data in order to gather enough information about a context to facilitate naturalistic generalization (Guba & Lincoln, 1999).

Finally, dependability and confirmability was ensured through the use of multiple methods or triangulation. Triangulation was used to facilitate an understanding of how

participants might construct their perceptions and experiences (Fontana & Frey, 2005). Moreover, aggregating the research methods generated a more complete picture of the social world (Atkinson & Delamont, 2005).

As discussed throughout chapter, I employed these techniques in order to increase the trustworthiness and reliability of this study. This approach added rigor, breadth and richness to the qualitative inquiry and, ultimately, to the understanding of wellness within the adolescent population.

Ethics

When implementing case study research, there are many important ethical considerations. Case study research shares an intense interest in personal views and circumstances and puts the participants at risk of exposure and embarrassment (Denzin & Lincoln, 2005). I recognized the importance of being sensitive to responses of concern from the participants, protecting the participant's identity, ensuring accuracy of the data and protecting the participant from emotional and physical harm (Fontana & Frey, 2005). Incorporating these considerations into the process provided protection and safety to the participants of the study.

In order to proceed with the study I received ethical approval from the University Ethics Committee (Appendix E1), and subsequently permission to proceed from the Director of Education from the school district and the principals at both the schools (Appendix B3). The parents, students and teachers were informed of the purpose and procedures of the study, including an explanation of how the focus groups were formed, the make up of each group, and that the participant's written consent that was required prior to participation in the study (Appendices B1 and B2). I also required a signed

consent from each participant in the study (Appendices C1, C2, and C3). Informed consent included voluntary participation, and the agreement was based on full and open information about the nature of the research (Fontana & Frey, 2005).

Summary

In sum, I chose to use multiple methods in order to understand the intricate details of the influences, antecedents and barriers to the ideal state of adolescent wellness. The qualitative methods consisted of focus groups, and the subsequent analysis consisted of a thematic analysis. I also included a survey as a quantitative method. The study was subjected to ethical approval by the University and the School District. The knowledge gained from this study and the unique methodological approach adds to the limited body of knowledge that exists on adolescent wellness.

CHAPTER FOUR

Description of Questionnaire Results

Chapter Four provides a brief description of each of the schools selected to participate in the study. Similar procedures were followed at each school and details of these processes are described in this chapter. Also provided is a presentation of the collective demographics for the participants. Descriptive statistics of the combined survey results are presented. These results were organized to describe the possible relationships between adolescent developmental behaviours and wellness. The results of an inferential statistical analysis, summaries of correlations coefficients between all the items measuring the developmental dimensions and wellness, and an analysis of the variances using ANOVA tests are cited. The chapter concludes with a summary of the results of all the statistical analyses.

Sites Participating in the Study

Schools from both the public and Catholic districts were invited to participate in the study however; the public school district declined. Two mid-sized secondary schools in a Western Canadian city were selected to participate in the study. The pseudonym for the city and the district from which the participants were drawn are “Spirit City” and “John A. MacDonald School District.”

Spirit City has a population that has grown over the last decade and now has well over two hundred thousand people residing within its boundaries. The John A. MacDonald School District serves approximately 15,000 students in over 40 elementary and secondary schools. In addition, all the schools within this district have programs that are rooted in the Catholic Faith which means that the students may seek spiritual

development through prayer, scripture study, liturgical celebrations, retreats and faith instruction.

This study engaged students from two main stream Spirit City High Schools: Labeled Site One and Site Two for the purpose of the study. Each of the schools has its own history and culture and draws its student population from different areas in the city. Both schools enroll students from grade nine to grade twelve, offer a variety of compulsory and elective courses, and include a wide assortment of before and after school club and athletic activities. Students within John A. MacDonald School District have access to a full range of services including counselors, social workers, home-school liaison workers and learning assistance personnel.

The two schools were similar in terms of number of grade eleven students and total enrolment highlighted in Table 4.1. Note that, students were required to be enrolled in at least one grade eleven class to participate in the study.

Table 4.1

Summary of Enrolment for the Two Sites

	Site One	Site Two
Total School enrolment	972	675
Total Grade Eleven Enrolment	225	234

As indicated in Table 4.1, there were over two hundred students enrolled in grade eleven in each school.

Responses to the Adolescent Wellness Survey

During the month of March 2008, 225 consent forms were distributed to the grade eleven students in Site One. As requested by the administrator, the teachers administered a paper copy of the survey during class to the students that had signed the consent form. One hundred and fifty two questionnaires were completed in Site One and had a response rate of 68%.

In Site Two, the administrator organized for all the grade eleven students to complete the survey online. For three days straight, the students came to the computer lab, and I administered the survey. The students entered their responses directly in the computer and one hundred and twenty-eight questionnaires were completed in Site Two and had a response rate of 55%.

Collective Demographic Information

The demographic information provided by the grade eleven students in both sites is provided in Table 4.2.

Table 4.2

Collective Demographic Information

Variable	<i>n</i> (total = 280)	Percentage
Site One	152	54.0%
Site Two	128	46.0%
Gender		
Male	150	54.0%
Female	130	46.0%
Age		
16 years old	160	57.0%
17 years old	101	36.0%
18 years old	16	06.0%
19 years old	2	00.7%
20 years old	1	00.3%

As indicated in Table 4.2, there were 280 participants and an overall response rate of 61%. The sample was comprised of more males than females, and ninety- three percent of respondents were 16 and 17 years old. This information has been provided for the sole purpose of presenting contextual demographic data. There were no further use of gender, age or site variables for this study.

Descriptive Statistical Analysis

The descriptive statistical results are organized with the intention to describe the possible relationships between adolescent developmental behaviours and wellness.

Figure 4.1 is used to illustrate the students perceived level of wellness. There were three possible answers for number four of the questionnaire (Low, Medium and High). Question number four asked the students to respond to the statement “My level of wellness is.”

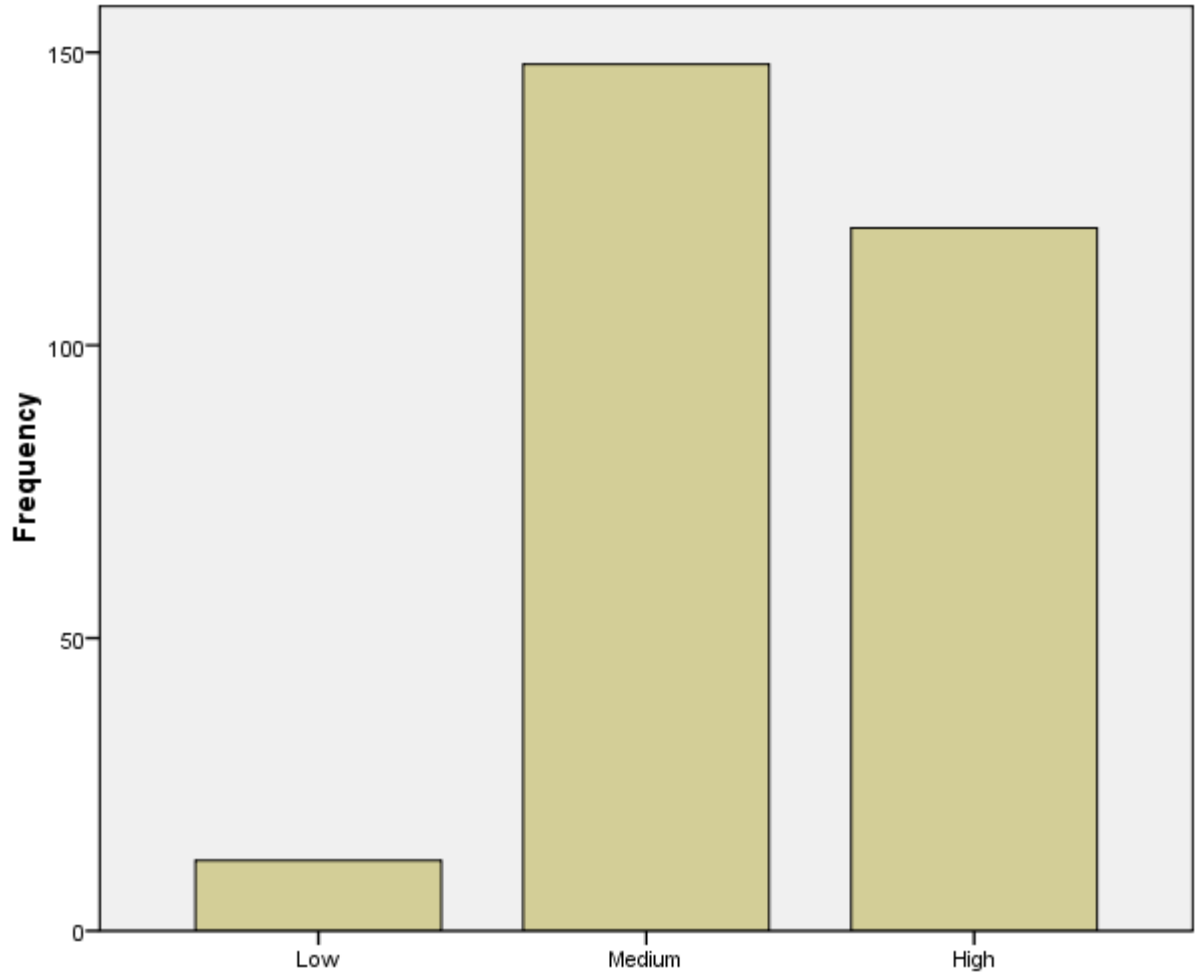


Figure 4.1. Student responses to the statement “my level of wellness is.”

As indicated in Figure 4.1, the majority of the students ($n=148$) indicated a medium-level of wellness. There was a significant number ($n=120$) of student respondents that indicated a high-level-wellness and only a minimal number ($n=12$) with a low-level wellness.

Figure 4.2 is used to illustrate the results of the students’ responses to a second wellness statement “I am well”. There were five possible answers for number three of the questionnaire (Strongly agree, agree, neutral, disagree and strongly disagree).

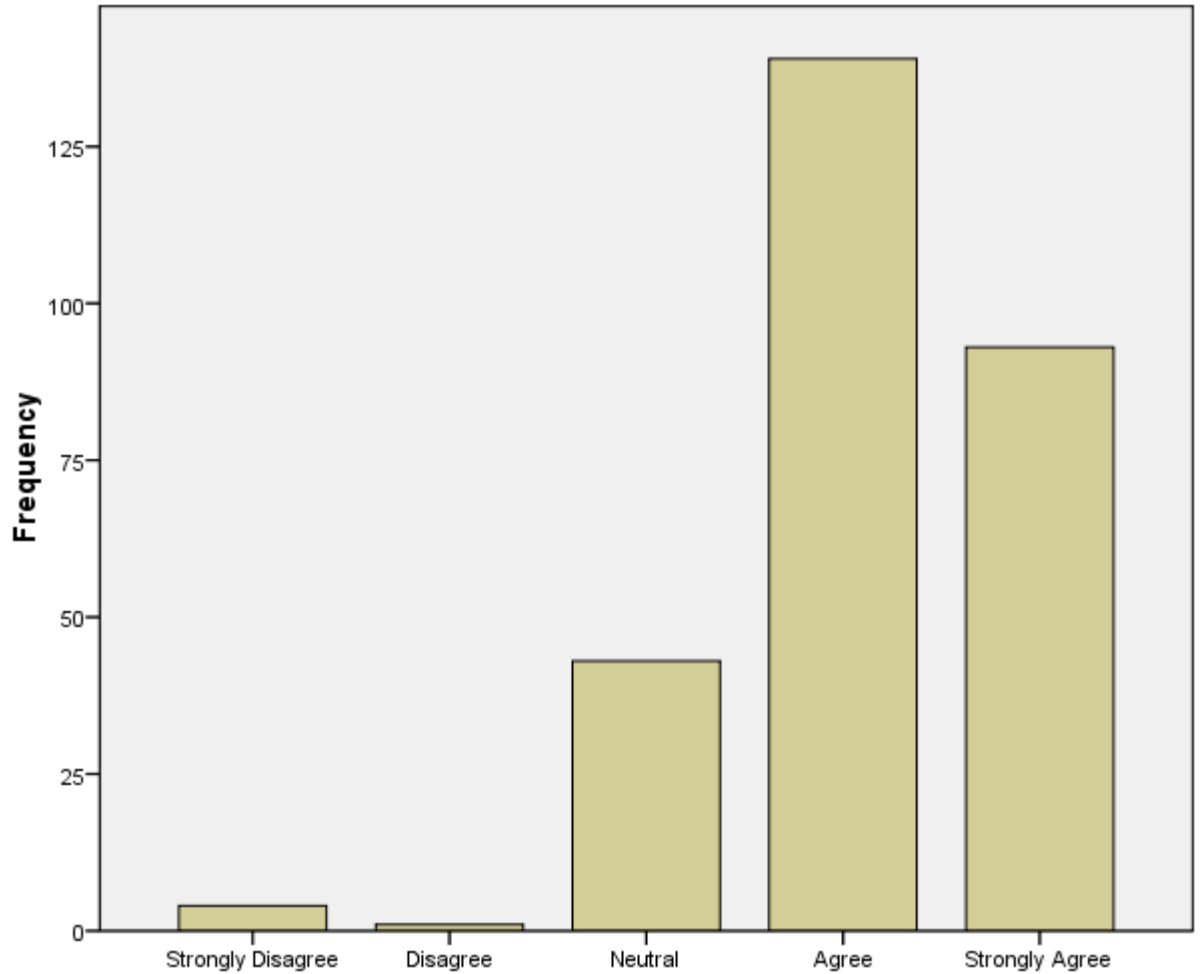


Figure 4.2. Student responses to the statement “I am well.”

As illustrated in Figure 4.2, the majority of students ($n=232$) indicated that they are well. The mean (4.13) response was that the students “agree” with the statement, and there was not a large variation in the student responses ($SD= 0.78$).

Table 4.3 illustrates the students’ perceptions of the contributions of the adolescent developmental dimensions to wellness.

Table 4.3

Student Perceptions: The Contributions of the Developmental Dimensions to Wellness

	Physical Development	Spiritual Development	Psychological Development	Social Development
Percentage	80%	53%	89%	85%
Mean	4.14	3.48	4.29	4.28
Standard Deviation	1.00	1.00	0.70	0.75

Note. Percentage values include the students who “agreed” or “strongly agreed” with the items (physical #19, spiritual #28, psychological #51 and social development #63) affecting their overall sense of wellness, $n = 280$.

As indicated in Table 4.3, the majority of student respondents stated that physical (80%), psychological (89%) and social development (85%) contributed to their overall sense of wellness. However, 53% of the respondents perceived that spiritual development contributed to wellness and the mean that most closely corresponded was a response of “neutral.” The standard deviation for these statements indicated that there was more variability on student responses for physical development (1.00) and spiritual development (1.00) than psychological development (0.70) and social development (0.75).

Table 4.4 illustrates the student’s perceptions of the factors affecting adolescent physical development.

Table 4.4

Student Perceptions: The Contributions to Physical Development

	Drugs/alcohol/smoking	Nutrition	Physical Activity	Body Weight
Percentage	61%	76%	72%	31%
Mean	3.69	3.98	3.96	2.92
Standard Deviation	1.39	0.97	0.98	1.15

Note. Percentage values include the students who “agreed” or “strongly agreed” with the items (drugs/alcohol/smoking #18, nutrition #13, physical activity #11 and body weight #8) affecting their physical development, $n = 280$.

As indicated in Table 4.4, 61% of the students felt that drugs, alcohol and smoking affected their physical development. On the other hand, only 31% perceived that body weight affected their physical development. There was significant variability in the response to these statements with a standard deviation of 1.39 and 1.15 respectively, and the mean most closely corresponded to a response of “neutral.” However, a higher percentage of students stated that nutrition and physical activity affected their physical development. The variability was also lower with these statements, 0.97 and 0.98 respectively, and the mean most closely corresponded to a response of “agree.”

Table 4.5 presents a summary of the results of percentage of the participants’ smoking, drugs and alcohol use.

Table 4.5

Summary of Student Reported Smoking/Drugs/Alcohol Use

	Smoking	Alcohol	Marijuana	Other drugs
Percentage	25%	55%	20%	5%
Mean	1.39	2.25	1.52	1.10
Standard deviation	0.81	1.44	1.28	0.53

Note. Percentage values represent items smoking (#14), alcohol (#15), marijuana (#16) and other drug use (#17), $n = 280$.

As presented in Table 4.5, the percentage and mean indicated that the majority of the student respondents are not smoking, using marijuana and other drugs. On the other hand, only 45% of the students responded that they have never drunk alcohol. There was a large variance in the responses to the statement regarding the use of alcohol (1.44), and the mean most closely corresponded to a response of “about once a month.”

Table 4.6 presents a summary of the students’ beliefs about the contributions to spiritual development and illustrates the percentage, mean and large variability of the responses to all the spirituality statements.

Table 4.6

Student Perceptions: The Contributions to Spiritual Development

	Spirituality assists me to be creative and to develop my values.	Spirituality brings a sense of hope and meaning.	Spirituality brings a sense of connectedness	Spirituality enriches a person's life.	Spirituality is important.
Percentage	46%	56%	57%	57%	58%
Mean	3.32	3.49	3.56	3.56	3.62
Standard Deviation	1.13	1.13	1.08	1.06	1.09

Note. Percentage values include the students who “agreed” or “strongly agreed” with the items (creative #20, hope #21, connectedness #22, enriches life #24 and important #27) affecting their spiritual development, $n = 280$.

As indicated in Table 4.6, over half of the student respondents stated that spirituality brought a sense of hope and connectedness (56%), enriched a person's life (57%), and was important (58%). There were a smaller number of students (46%) who perceived spirituality as assisting them to be creative and to develop values. There was a large variability in the responses to all the spirituality statements, and the mean most closely corresponded to a response of “neutral.”

Table 4.7 illustrates the results of the students' perceptions of self-concept and autonomy, which are contributions that research has shown affect psychological development. As stated in Chapter Two, psychological development is defined as the predictable growth in self-esteem, self-concept and autonomy with each of these concepts contributing to the complexity of human development. In this study, self-concept is defined as the socially constructed personal beliefs about oneself; the individual answers the question “who am I.”

Table 4.7

Student Perceptions: The Contributions to Psychological Development

	Self-Concept “Who am I”	Perceptions of good decision- making skills
Percentage	66%	90%
Mean	3.79	4.29
Standard Deviation	1.07	0.67

Note. Percentage values include the students who “agreed” or “strongly agreed” with item #30 (I can answer the question who am I) and item #50 (I feel like I have the ability to make good decisions), which are factors that research has shown to affect psychological development, $n = 280$.

As illustrated in table 4.7, the majority of the students had a positive self-concept as 66% of the students were able to respond to the statement “who am I.” Moreover, the majority of the student respondents (90%) perceived that they had possessed good decision-making skills.

Table 4.8 presents a summary of the students’ beliefs of the contributions to the psychological developmental variable self-esteem. In this study, self-esteem was measured by the student’s sense of competence, worthiness, pride, positive feelings of life purpose and sense of oneself.

Table 4.8

Student Perceptions: The Contributions to Self-Esteem

	Competent	Worthy	Proud of themselves	Feel their life has purpose	Like them- selves
Percentage	80%	87%	78%	69%	71%
Mean	4.03	4.33	4.12	3.90	3.93
Standard Deviation	0.73	0.74	0.94	0.99	0.96

Note. Percentage values include the students who “agreed” or “strongly agreed” with the items (competent #35, worthy #37, proud #32, life purpose #31 and like themselves #33) influencing self-esteem, which are factors that research has shown to affect psychological development, $n = 280$.

As indicated in Table 4.8, the majority of student respondents indicated a high sense of self-esteem. The mean most closely corresponded to a response of “agree.”

Table 4.9 presents a summary of the students’ beliefs of the contributions to adolescent social development.

Table 4.9

Student Perceptions: The Contributions to Social Development

	Family Connectedness	Peer Connectedness	School Connectedness	Support Available in School	People in School Who Care	Feel Safe in School
Percentage	70%	82%	56%	78%	58%	81%
Mean	3.89	4.05	3.54	4.09	3.64	4.13
Standard Deviation	1.03	0.86	1.02	0.89	0.86	0.77

Note. Percentage values include the students who “agreed” or “strongly agreed” with the items (family #53, peers #56, school #57, support #59, caring people #60, feel safe #58) influencing social development, $n = 280$.

As indicated in Table 4.9, the majority of students felt a strong sense of family (70%) and peer connectedness (81%); however, there were large variations in the student responses (1.03) and (0.86), respectively. A large percentage of students who perceived the school to be safe (81%), and that there was support available from at least one teacher, counselor or administrator (78%). The means for these statements most closely corresponded to a response of “agree.” On the other hand, only 56% and 58%, felt a sense of school connectedness and that there were caring people in the school, respectively. The mean most closely corresponded to a response of “neutral”.

Summary of Descriptive Statistical Findings

These results suggested that the majority of the participants were a medium and high-level of wellness, with the majority of the students perceiving physical, psychological and social development as contributing to their overall sense of wellness. Moreover, over half of the student respondents indicated that spiritual development contributed to their overall sense of wellness.

There were also several statements measuring the factors affecting physical development and these were body weight, nutrition, physical activity, smoking, drug and alcohol. The results of this analysis indicated that 61% of the students felt that drugs, alcohol, smoking affected their physical development. On the other hand, only 31% perceived body weight as an influence on their physical development. However, a higher percentage of students felt nutrition (76%) and physical activity (72%) affected their physical development.

Several statements related to spiritual development and these were a sense of connectedness, purpose in life, a sense of right and wrong, personal values and beliefs.

The results of this analysis suggested that over half of the student respondents perceived spirituality as bringing them a sense of hope (46%) and connectedness (57%), enriching their life (57%) and important (58%). A smaller number of students (46%) perceived spirituality as assisting them to be creative and to develop values.

The psychological development statements related to the students self-esteem, self-concept and independence. The results indicated that the majority of the students felt they had good independent decision-making skills (90%), a positive self-concept (66%) and self-esteem. Perceptions of self-esteem were measured by the students' positive response to being competent (80%), worthy (87%) and proud of themselves (78%).

Finally, the social development statements related to the students perceptions of coping skills, and potential influences of parents, peers and the school. The results indicated that the majority of students felt a strong sense of family (70%) and peer connectedness (82%). The students also felt safe in the school (81%) and that there was support available from at least one teacher, counselor or administrator (78%). On the other hand, only 56% of the students felt connected to their school, and 58% sensed that the people in the school cared.

Inferential Statistical Analysis

This part illustrates the results of an inferential statistical analysis and includes summaries of correlations coefficients between the main variables of the study and wellness and an analysis of the variances using ANOVA analysis.

Correlations Analyses

The next section includes the results of correlational analyses between wellness and the developmental scales, as well as the relationship between wellness and the

individual items measuring each of the four developmental scales. Also included were other relevant correlations in the study. The Pearson product moment correlation coefficient was used as the method by which the relation between two variables was quantified. There were three categories used to describe the correlations between the developmental dimensions and the wellness composite (Minimal: 0-2.5, Moderate: 2.6-6.0 and Strong: 6.1-10).

Table 4.10 outlines the correlations between the physical, spiritual, psychological and social scales and wellness. As previously discussed in chapter three, the items in each of developmental dimensions were combined to form a scale to measure each developmental area, and these scales were then correlated with the wellness composite variable. There were two items measuring wellness (“I am well” and “My level of wellness”) that were combined to form a wellness composite variable. Since the two items have different response scales, each subject’s score on each variable was first converted to a standard z-score¹ and then added to form a composite score. Each item was transformed to a standard z-score to ensure that both items had a $M = 0$ and a $SD = 1$ and then they were added to form a composite wellness measure with a $M = 0$ and $SD = 2$, as is recommended in Cresswell (2002) as a standard procedure for creating a variable composed of items with different response scales.

¹ The procedure for converting to a z-score includes subtracting the subject’s score from the mean of all the scores, and dividing by the standard deviation

Table 4.10

Correlations Between Wellness Perceptions and the Developmental Dimensions Scales

	Wellness Composite
Physical Development Sub-Scale (health)	.54**
Physical Development Sub-scale (substance use)	-.07
Spiritual Development Scale	.19**
Psychological Development Scale	.42**
Social Development Scale	.35**

Note. $n=280$, Correlations are statistical significant at ** $p < 0.01$ (2-tailed).

As illustrated in Table 4.10, the results of the survey suggest that an increased sense of wellness was moderately associated with higher scores on the health ($r = .54, p < 0.0005$), psychological ($r = .42, p < 0.0005$) and social ($r = .35, p < 0.0005$) development scales. Increased wellness was associated with better perceived physical health, psychological well-being and social functioning. The results also imply a minimal relationship between higher student self-reported levels of wellness and the spiritual ($r = .19, p < 0.001$) development scale. There was no relationship between wellness and the substance use subscale.

Table 4.11 presents the correlations between the items related to physical development (nutrition, physical activity, body weight and smoking/drugs and alcohol) and wellness.

Table 4.11

Correlations Between Wellness Perceptions and the Items Related to Physical Development

	Wellness Composite
Nutrition	.18**
Physical Activity	.55**
Body Weight	-.02
Smoking/drugs/alcohol	.03

Note. ** $p < 0.01$ (2-tailed). For each of these variables, the students were asked if nutrition, physical activity, body weight, and smoking, drugs and alcohol affected their physical development, $n=280$.

As indicated in Table 4.11, higher ratings of wellness among students were moderately associated with the belief that physical activity ($r = .55, p < 0.0005$) contributed to adolescent physical development, and was minimally related to the belief that nutrition affected adolescent physical development ($r = .18, p < 0.001$). There were no relationships between body weight, smoking/drugs/alcohol use and wellness.

Table 4.12 illustrates the correlations between items related to smoking, drugs and alcohol and wellness.

Table 4.12

***Correlations Between Wellness Perceptions and Smoking,
Alcohol and Drug Use***

	Wellness Composite
Smoking	-.13
Alcohol	.09
Marijuana	-.11
Other Drugs	-.17**

Note. ** $p < 0.01$ (2-tailed). The variables (smoking, alcohol, marijuana and other drugs) represent the students' actual reported level of use of the substances, $n=280$.

Table 4.12 illustrates that there was no relationship between smoking ($r = -.13, p < 0.01$), marijuana ($r = -.11, p < 0.01$), and alcohol use ($r = .09, p < 0.01$) and wellness. Although this relationship was minimal, these results also indicate that higher ratings of wellness were associated with lower levels of other drugs (crack, cocaine, heroin, ecstasy, crystal meth, sniffing glue and solvents) use ($r = -.17, p < 0.01$).

Table 4.13 illustrates the correlations between the items related to spiritual development and wellness.

Table 4.13

Correlations Between Wellness Perceptions and the Items Related to Spiritual Development

	Wellness Composite
Spirituality assists me to be creative and to develop my values.	.16**
Spirituality brings me a sense of hope, meaning and purpose in life.	.14
Spirituality means having a sense of connectedness to a higher power.	.19**
Spirituality enriches a person's quality of life.	.04
Spirituality guides your decisions about what is right and wrong.	.09
Spirituality is important	.16**

Note. ** $p < 0.01$ (2-tailed). The variables within this table are the factors that research has shown to influence spiritual development, $n=280$.

As indicated in Table 4.13, the results suggest that higher ratings of wellness were minimally associated with the beliefs that spirituality assists a person to be creative and to develop values ($r = .16, p < 0.01$), connectedness to a higher power ($r = .19, p < 0.01$) and finally, the perception that spirituality is important ($r = .16, p < 0.01$). There were no relationships between wellness and the other spirituality factors.

Table 4.14 illustrates the correlations between the items related to psychological development (self-concept and autonomy) and wellness.

Table 4.14

Correlations Between Wellness Perceptions and the Items Related to Psychological Development (Self-Concept and Autonomy)

	Wellness Composite
I have grown up with an affectionate and accepting caregiver.*	.30**
Self-concept (Who am I)*	.22**
I have friends who care.*	.23**
My friends will be there for me.*	.23**
I have at least one best friend.*	.21**
I feel that I have friends to help me make decisions.*	.24**
I have family who cares.*	.20**
My parent/guardian is involved in my life.*	.23**
I feel that I can rely on my parent/guardian to help me make decisions.*	.25**
I feel that I have the ability to make good decisions.	.25**

Note. ** $p < 0.01$ (2-tailed). * Indicates that the variable is a factor that research has shown to influence self-concept, $n=280$.

As indicated in Table 4.14, all the statements associated with psychological development were significantly correlated with wellness. Higher ratings of wellness were moderately associated with the belief that an affectionate caregiver contributed to adolescent wellness ($r = .30, p < 0.0005$). The results also imply a minimal relationship between

higher student self-reported levels of wellness and positive self-concept ($r=.22, p < 0.0005$), good decision making ($r= .25, p < 0.0005$), caring friends ($r= .23, p < 0.0005$) and family ($r=.20, p < 0.001$), peer reliability ($r= .23, p < 0.0005$) and a reliable/ involved parent/guardian. ($r=.25, p < 0.0005$ and $r=.25, p < 0.0005$).

Table 4.15 illustrates the correlations between the items related to psychological developmental (self-esteem) and wellness.

Table 4.15

Correlations Between Wellness Perceptions and the Items Related to Psychological Development (Self-Esteem)

	Wellness Composite
My life has purpose	.27**
I have a lot to be proud of.	.28**
I like myself just the way I am.	.25**
I feel just as good as others.	.32**
I feel competent	.30**
I have a lot of good qualities	.22**
I am worthy of happiness	.30**

Note. ** $p < 0.01$ (2-tailed). The variables in this table represent the factors that research has shown to influence self-esteem, $n=280$.

As indicated in Table 4.15, all the statements associated with psychological development were positively correlated with wellness. The results suggest that higher student self-reported levels of wellness were moderately associated with increased beliefs of life purpose ($r=.27, p < 0.0005$), sense of pride ($r=.28, p < 0.0005$), competency ($r=.30, p < 0.0005$), positive feeling of oneself ($r=.32, p < 0.0005$), and perceptions of worthiness

($r=.30, p < 0.0005$). Higher rating of wellness were minimally related to the belief that good qualities ($r=.22, p < 0.0005$) and liking oneself ($r=.25, p < 0.0005$) contributed to adolescent wellness.

Table 4.16 illustrates the correlations between the items related to social development and wellness. This table provides data on the items related to the social development dimension (parental and peer influences).

Table 4.16

Correlations Between Wellness Perceptions and the Items Related to Social Development (Parental and Peer Support)

	Wellness Composite
I feel that I have the resources to overcome problems.	.27**
I feel connected to my parent/guardian	.22**
My parent/guardian is nurturing, warm and accepting/	.23**
My parent/guardian takes interest in my life.	.07
I feel connected to my peers	.33**

Note. ** $p < 0.01$ (2-tailed). The variables in this table represent the factors that research has shown to influence social development, $n=280$.

As indicated in Table 4.16, higher ratings of wellness were moderately associated with the beliefs that greater resources ($r= .27, p < 0.0005$) and peer connectedness ($r=.33, p < 0.0005$) contributed to adolescent wellness. The results also imply a minimal relationship between higher student self-reported levels of wellness and parent/guardian

connectedness ($r = .22, p < 0.0005$) and familial warmth and acceptance ($r = .23, p < 0.0005$). There was no relationship between parental interest and wellness.

Table 4.17 illustrates the correlations between the items related to social development (school) and wellness.

Table 4.17

Correlations Between Wellness Perceptions and the Items Related to Social Development (School)

	Wellness Composite
I feel connected to my school	.27**
I feel safe in my school	.23**
I feel like there is support available in the school	.20**
I feel the people in the school care about me.	.37**
I feel the school provides opportunities to be healthy	.23**
I feel that the school helps me to be successful.	.20**

Note. ** $p < 0.01$ (2-tailed). The variables in this table represent the factors that research has shown to influence social development, $n = 280$.

As indicated in Table 4.17, higher ratings of wellness were moderately associated with the beliefs that caring people in the school ($r = .37, p < 0.0005$) and school connectedness ($r = .27, p < 0.0005$) contributed to adolescent wellness. The results also suggest a minimal relationship between higher student self-reported levels of wellness and feeling safe and supported in school ($r = .23, p < 0.0005$ and $r = .20, p < 0.001$), and perceptions that

the school provided opportunities for healthy choices ($r=.23, p < 0.0005$) and success ($r=.20, p < 0.001$).

Other Relevant Correlations

While analyzing the relationship between the wellness composite and the developmental dimensions I noted several other important correlations that will now be presented.

Table 4.18 illustrates the correlations between parent and child relationship and the participants' sense of parent connectedness.

Table 4.18

Correlations Between Adolescent/Parental Relationship and Parent Connectedness

	I Feel Connected to my Parent/Guardian
My Parent/Guardian is Nurturing, Warm and Accepting.	.75**
My Parent/Guardian Takes Interest in Where I Am and What I Am Doing.	.54**
I Feel Connected to My Peers	.35**

Note. ** $p < 0.01$ (2-tailed), $n=280$.

As indicated in Table 4.18, the results of the survey suggest a strong relationship between higher student self-reported levels of parent connectedness and increased feelings of familiar warmth ($r=.75, p < 0.0005$). Moreover, higher ratings of parental/guardian connectedness were moderately related to an increased sense of peer connectedness ($r=.35, p < 0.0005$) and parental interest ($r=.54, p < 0.0005$).

Finally, Table 4.19 illustrates the correlations between school connectedness and other influences of school.

Table 4.19

<i>Correlations Between School Connectedness and Other Influences of School</i>	
	I Feel Connected to My School
I Feel Connected to My Peers.	.53**
I Feel Safe in School	.44**
I Feel Supported in School	.44**
I Feel People in School Care About Me.	.57**
My School Assists Me to be Healthy	.43**
My School Helps Me to be Successful in Life.	.48**

Note. ** $p < 0.01$ (2-tailed), $n=280$.

As indicated in Table 4.19, the results of the survey suggest a moderate relationship between higher student self-reported levels of school connectedness and an increased sense of peer connectedness ($r=.53$, $p < 0.0005$), school safety ($r=.44$, $p < 0.0005$) and support ($r=.44$, $p < 0.0005$). Higher ratings of school connectedness were also moderately associated with the beliefs that there are people in the school that care ($r=.57$, $p < 0.0005$), that the school assists to the students to be healthy ($r=.43$, $p < 0.0005$) and successful in life ($r=.48$, $p < 0.0005$).

Summary of the Main Findings in the Correlations Analyses

The results of the correlations analyses suggest that there were statistically significant relationships between the adolescent developmental scales and wellness. This summary highlights the moderate and strong relationships between wellness and adolescent development.

Higher ratings of wellness were moderately associated with the belief that physical activity ($r = .55, p < 0.0005$) influenced adolescent physical development. The results also suggest that higher student self-reported levels of wellness were moderately associated with the belief that an affectionate caregiver contributed to adolescent wellness ($r = .30, p < 0.0005$). Moreover, beliefs of life purpose ($r = .27, p < 0.0005$), sense of pride ($r = .28, p < 0.0005$), competency ($r = .30, p < 0.0005$), positive feeling of oneself ($r = .32, p < 0.0005$), and perceptions of worthiness ($r = .30, p < 0.0005$) were moderately associated with higher ratings of wellness. Finally, the beliefs that caring people in the school ($r = .37, p < 0.0005$), school and peer connectedness ($r = .27$ and $r = .33, p < 0.0005$) and greater resources ($r = .27, p < 0.0005$) were moderately associated with an increased sense of wellness.

ANOVA Analyses

One way ANOVAs were conducted to compare the means for the wellness groups of low ($n=12$), medium ($n=148$) and high ($n=120$). Post-hoc comparisons of means were conducted using Neumann Keuls analyses, which assume homogeneity of variances. The Levene test was used to determine if homogeneity of variances could be assumed. Tamhanes T_2 test was used to test pairwise comparisons of means for variables for which the assumption of homogeneity of variances was not met. A $p < .01$ was considered significant for all the analyses.

Table 4.20 illustrates the differences among the levels of wellness and the adolescent developmental dimensions (physical, spiritual, psychological and social).

Table 4.20

***Analysis of Variance for the Differences
Among the Wellness Groups on Adolescent
Developmental Dimensions***

	<i>F</i> (2, 277)	<i>p</i>
Physical Development	3.10	0.047
Spiritual development	2.91	0.056
Psychological development	3.03	0.050
Social development	2.29	0.103

Note: n = 280.

As indicated in Table 4.20, the ANOVA suggested that there were no significant differences between the wellness groups on perceptions of psychological development ($F(2, 277) = 3.03, p < .050$), physical development ($F(2, 277) = 3.10, p < 0.047$), spiritual ($F(2, 277) = 2.91, p < 0.056$) and social development ($F(2, 277) = 2.29, p < 0.103$).

Table 4.21 presents an analysis of the differences among the wellness groups and the students' perceptions of the items related to physical development (smoking/drugs and alcohol, nutrition, physical activity and body weight).

Table 4.21

Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Physical Development

	<i>F</i> (2, 277)	<i>p</i>	Low-wellness (<i>n</i> =12)	Medium-wellness (<i>n</i> =148)	High-wellness (<i>n</i> =120)
Smoking, drugs and alcohol	.04	0.964			
Nutrition	3.01	0.051			
Physical activity	56.99	0.0005	2.42 _i	3.65 _{ii}	4.50 _{iii}
Body weight	1.99	0.138			

Note. Means with different Roman numeral (*i, ii, iii*) subscripts are significantly different. Newman-Keuls was used for all the post-hoc tests.

As indicated in Table 4.21, the high wellness group ($M=4.50$) was more likely than the medium-level wellness students ($M=3.65$) to state that physical activity affects their physical development, and both the high and medium-wellness groups were more likely than the low-wellness group ($M=2.42$) to state that physical activity affects adolescent physical development ($F(2, 277) = 56.99, p < 0.0005$). There were no significant differences between the wellness groups on perceptions of nutrition, body weight and smoking, drugs and alcohol affecting physical development.

Table 4.22 presents an analysis of the differences among the levels of wellness and the students' perceptions of the items related to physical development (body weight, physical appearance, ability to participate in physical activity and daily activities).

Table 4.22

Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Physical Development (Body Weight, Body Image and Physical Activity)

	<i>F</i> (2, 277)	<i>p</i>	Low-wellness (<i>n</i> =12)	Medium-wellness (<i>n</i> =148)	High-wellness (<i>n</i> =120)
My weight is where it should be.	11.99	0.0005	2.83 _i	3.52 _{ii}	4.02 _{ii}
I am satisfied with my physical appearance.*	13.84	0.0005	2.83 _i	3.56 _i	4.01 _{ii}
I am capable of some sort of physical activity.*	26.04	0.0005	3.67 _i	4.66 _i	4.88 _{ii}
I am able to do daily activities without getting tired.*	27.04	0.0005	3.50 _i	4.26 _i	4.72 _{ii}
I participate in enough physical activity to have healthy physical development.	22.82	0.0005	2.75 _i	3.16 _i	3.98 _{ii}

Note. Means with different Roman numeral (*i*, *ii*) subscripts are significantly different.

*Tamhane's T2 post hoc test was used with these variables due to unequal variances. Newman-Keuls was used for all other post hoc tests.

As indicated in Table 4.22, the high ($M=4.02$) and the medium-wellness groups ($M=3.52$) felt satisfied with their weight more than the low-wellness group ($M = 2.83$). However, the medium ($M= 3.52$) and high-wellness groups did not differ significantly in their perceptions of weight satisfaction ($F (2, 277) = 11.99, p < 0.0005$). Similarly, the high-

wellness group ($M=4.01$, $M=4.88$, $M=4.72$ and $M=3.98$) felt more satisfied with their physical appearance ($F(2, 277) = 13.84$, $p < 0.0005$), more capable of physical activity ($F(2, 277) = 26.04$, $p < .0005$), more able to do daily activity ($F(2, 277) = 27.04$, $p < 0.0005$), and more able to participate in physical activity ($F(2, 277) = 22.82$, $p < 0.0005$) than the medium-wellness group ($M=3.56$, $M=4.66$, $M=4.26$ and $M=3.16$) and the low-wellness group ($M = 2.83$, $M=3.67$, $M=3.5$, $M=2.75$). However, there were no significant differences between the medium and low-wellness groups.

Table 4.23 presents an analysis of the differences among the wellness groups' and the students' perceptions of the items related to spiritual development.

Table 4.23

<i>Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Spiritual Development</i>		
	<i>F (2, 277)</i>	<i>p</i>
Spirituality assists me to be creative and to develop my values.	2.51	0.083
Spirituality brings me a sense of hope, meaning and purpose in life.	2.39	0.093
Spirituality means having a sense of connectedness to a higher power.	2.82	0.061
Spirituality enriches a person's quality of life.	1.60	0.206
Spirituality guides your decisions about what is right and wrong.	2.80	0.063
Spirituality is important	2.27	0.105

Note: n = 280.

As indicated in Table 4.23, the ANOVA analysis suggested that there were no significant differences in the groups' perceptions of the factors affecting spiritual development.

Table 4.24 presents an analysis of the differences among the wellness groups' perceptions on the items related to psychological development (self-concept and autonomy).

Table 4.24

Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Psychological Development (Self-Concept and Autonomy)

	<i>F</i> (2, 277)	<i>p</i>	Low-wellness (<i>n</i> =12)	Medium-wellness (<i>n</i> =148)	High-wellness (<i>n</i> =120)
I have grown up with affectionate and accepting caregiver.*	8.36	0.0005	3.33 _{i, ii}	3.97 _i	4.3 _{ii}
Self-concept (Who am I)*	3.62	0.028			
I have friends who care.	1.67	0.190			
My friends will be there for me.*	1.62	0.200			
I have at least one best friend.	3.45	0.034			
I feel that I have friends to help me make decisions.	1.07	0.344			
I have family that cares.	2.12	0.122			
My parent/guardian is involved in my life.*	5.87	0.003	3.33 _i	4.07 _i	4.28 _i
I can rely on my parent/guardian to help me make decisions.	6.69	0.001	3.17 _i	3.89 _{ii}	4.17 _{ii}
I have the ability to make good decisions.	5.39	0.005	4.00 _i	4.27 _{i, ii}	4.49 _{ii}

Note. Means with different Roman numeral (*i, ii*) subscripts are significantly different.

*Tamhane's T2 post hoc test was used with these variables due to unequal variances.

Newman-Keuls was used for all other post hoc tests.

As indicated in Table 4.24, the high-wellness groups ($M=4.3$) were more likely than the medium-wellness groups ($M=3.97$) to state that they have an affectionate caregiver ($F(2, 277) = 8.36, p < 0.0005$). However, the low-wellness ($M=3.33$) groups did not differ significantly in their perceptions of affectionate caregiver from either the medium and high-wellness groups.² The high-wellness group ($M=4.49$) was also more likely than the low-wellness group ($M=4.0$) to state that they possessed good decision-making skills ($F(2, 277) = 5.39, p < 0.005$), although the medium-wellness group did not differ significantly in its perceptions of making good decisions from either the high or low-wellness group. Similarly, the high ($M=4.17$) and medium- ($M= 3.89$) wellness groups were more likely than the low-wellness ($M=3.17$) group to have a parent/guardian to help make decisions ($F(2, 277) = 6.69, p < 0.001$) although there were no differences between the medium and high-wellness groups on these variables. Moreover, the ANOVA suggested that there were significant differences between the wellness groups on perceptions of parent/guardian involvement ($F(2, 277) = 5.87, p < 0.003$), but the post-hoc analyses did not reveal any significant differences between the groups. Finally, the ANOVA analysis also suggested that there were not any significant differences between the wellness groups for all the other psychological developmental variables.

Table 4.25 presents an analysis of the differences among the wellness groups and students' perceptions on the items related to psychological development (self-esteem).

² Reduced power for the low wellness group due to a small n ($n = 12$) likely contributed to the non-significant findings in some of the comparisons involving the low-wellness group.

Table 4.25

Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Psychological Development (Self-Esteem)

	<i>F</i> (2, 277)	<i>p</i>	Low-wellness (<i>n</i> =12)	Medium-wellness (<i>n</i> =148)	High-wellness (<i>n</i> =120)
My life has purpose.	7.64	.0005	3.75 _i	3.70 _i	4.17 _i
I have a lot to be proud of.	9.20	.0005	3.92 _i	3.91 _i	4.39 _i
I like myself just the way I am.*	7.65	.0005	4.0 _{i,ii}	3.72 _i	4.17 _{ii}
I feel just as good as others.	9.99	.0005	3.07 _i	3.73 _{ii}	4.08 _{ii}
I feel competent in dealing with life challenges.	10.40	.0005	3.75 _i	3.87 _i	4.25 _{ii}
I have a lot of good qualities.*	3.22	.041			
I am worthy of happiness.	9.36	.0005	4.17 _i	4.17 _i	4.54 _i

Note. Means with different Roman numeral (*i*, *ii*) subscripts are significantly different.

*Tamhane's T2 post hoc test was used with these variables due to unequal variances. Newman-Keuls was used for all other post hoc tests.

As indicated in Table 4.25, the high-wellness group ($M= 4.17$) was more likely than the medium-wellness group ($M=3.72$) to like themselves ($F(2, 277) = 7.65, p < 0.0005$).

Although the low-wellness group ($M= 4.0$) did not differ significantly in its perceptions

from either the high or medium-wellness groups.³ The high-wellness group ($M = 4.08$) was also more likely to have a good feeling of oneself ($F(2, 277) = 9.99, p < 0.0005$) than the low-wellness ($M = 3.07$) group, although the medium-wellness ($M = 3.73$) group did not differ significantly in its perceptions from the high-wellness group. Similarly, the high-wellness group ($M = 4.25$) was more likely than the medium ($M = 3.87$) and low-wellness ($M = 3.75$) groups to feel competent although the low-wellness group did not differ significantly from the medium-wellness group in perceptions of competence. Finally, the ANOVA analysis suggested that there were significant differences between the wellness groups on perceptions of being worthy of happiness ($F(2, 277) = 9.36, p < 0.0005$), believing that their life has purpose ($F(2, 277) = 7.64, p < 0.0005$) and pride ($F(2, 277) = 9.20, p < 0.0005$), but the post-hoc analyses did not reveal any significant differences between the groups.

Table 4.26 presents an analysis of the differences among the wellness groups' and the students' perceptions on the items related to social development (family and friends).

³ Reduced power for the low wellness group due to a small n ($n = 12$) likely contributed to the non-significant findings in some of the comparisons involving the low-wellness group.

Table 4.26

Analysis of Variance for Differences Among the Wellness Groups on the Items Related to Social Development (Peer and Family)

	<i>F</i> (2, 277)	<i>p</i>	Low- Wellness (<i>n</i> =12)	Medium- wellness (<i>n</i> =148)	High- wellness (<i>n</i> =120)
I feel that I have the resources to overcome problems.*	5.69	0.004	3.75 _{i, ii}	4.02 _i	4.25 _{ii}
I feel connected to my parent/guardian.	4.61	0.011	3.5 _i	3.75 _i	4.09 _i
My parent/guardian is nurturing, warm and accepting.	3.66	0.027			
My parent/guardian takes interest in my life.	.238	0.788			
I feel connected to my peers.*	7.15	0.001	3.33 _i	3.98 _{i,ii}	4.22 _{ii}

Note. Means with different Roman numeral (*i, ii*) subscripts are significantly different.

*Tamhane's *T*₂ post hoc test was used with these variables due to unequal variances.

Newman-Keuls was used for all other post hoc tests.

As indicated in Table 4.26, the high-wellness group ($M = 4.25$) felt that they had more resources than the low ($M = 3.75$) and the medium wellness ($M = 4.02$) groups although the low-wellness group did not differ significantly in its perceptions of resources from

either the medium or high-wellness group ($F(2, 277) = 5.69, p < 0.004$).⁴ Similarly, the high-wellness group ($M=4.22$) felt a greater sense of peer connectedness than the low wellness group ($M=3.33$) although the medium wellness ($M=3.98$) group did not differ significantly in its perceptions of peer connectedness ($F(2, 277) = 7.15, p < 0.001$) from either the low or high-wellness group. Lastly, the ANOVA suggested that there were significant differences between the wellness groups on perceptions of connectedness to parents ($F(2, 277) = 4.61, p < 0.011$), but the post-hoc analyses did not reveal any significant differences between the groups.

Table 4.27 presents an analysis of the differences among the wellness groups on students' perceptions on the items related to social development (school).

⁴ Reduced power for the low wellness group due to a small n ($n = 12$) likely contributed to the non-significant findings in some of the comparisons involving the low-wellness group.

Table 4.27

Analysis of Variance for the Differences Among the Wellness Groups on the Items Related to Social Development (School)

	<i>F</i> (2, 277)	<i>p</i>	Low-wellness (<i>n</i> =12)	Medium-wellness (<i>n</i> =148)	High-wellness (<i>n</i> =120)
I feel connected to my school.	8.75	0.0005	2.92 _i	3.38 _{i, ii}	3.81 _{ii}
I feel safe in my school.	2.29	0.104			
I feel that there is support available in the school.	3.59	0.029			
I feel the people in the school care about me.*	13.03	0.0005	3.00 _i	3.47 _i	3.91 _{ii}
I feel the school provides opportunities to be healthy.	4.23	0.016			
I feel that the school helps me to be successful.	1.08	0.341			

Note. Means with different Roman numeral (*i, ii*) subscripts are significantly different.

*Tamhane's T2 post hoc test was used with these variables due to unequal variances.

Newman-Keuls was used for all other post hoc tests.

As indicated in Table 4.27, the high-wellness group ($M = 3.81$) felt more connected to its school than the low-wellness group ($M = 2.92$) although the medium wellness ($M = 3.38$) group did not differ significantly in its perceptions of school connectedness from either

the low or high-wellness group ($F(2, 277) = 8.75, p < 0.0005$). Moreover, the high-wellness group ($M=3.91$) was also more likely than the medium ($M=3.47$) and low-wellness ($M=3.0$) groups to feel that there were caring people in the school ($F(2, 277) = 13.03, p < 0.0005$) although there were not any significant differences between the low and medium-wellness groups. There were no statistically significant differences among the wellness groups on the statements regarding the school assisting the students to be successful ($F(2, 277) = 1.08, p < 0.341$), on perceptions of support in the school ($F(2, 277) = 3.59, p < 0.029$) and the school providing opportunities to be healthy ($F(2, 277) = 4.23, p < 0.016$).

Summary of the Analyses of Variance

The results of the ANOVA analyses indicated that there were several significant differences among the wellness groups (low, medium and high) in relation to the physical, psychological and social developmental dimensions. However, the ANOVA analyses did not reveal any significant differences between the wellness groups for the spirituality dimension. Moreover, the statistical analysis suggested that there were certain characteristics that might present in a student who self-identified with a high, medium and low-level wellness and, thus, these data were used to further illustrate the adolescents' perceptions of wellness.

Table 4.28 presents a summary of the characteristics of the high, medium and low-wellness participants.

Table 4.28

Characteristics of High(H), Medium (M) and Low-level (L)-Wellness Adolescents

Body Weight Satisfaction	H>L M>L
Satisfaction With Physical Appearance	H>M H>L
Physical activity affecting physical development.	H>M>L
Capability for Physical Activity	H>M H>L
Ability to do Daily Physical Activity	H>M H>L
Participating enough in Physical Activity to have Healthy Physical Development.	H>M H>L
Affectionate Caregiver.	H>M
Good Decision-Making Skills.	H>L
Liking Themselves	H>M
Feelings of Competence.	H>M H>L
Resources.	H>M
Sense of School Connectedness	H>L
Sense of Peer Connectedness	H>L
Sense that People in the School Care.	H>M H>L

Note. Only the means with significant differences are reported in this table. Low ($n=12$), medium ($n=148$) and high ($n=120$).

Table 4.28 illustrates characteristics that were more likely associated with higher perceptions of wellness. For example, participants in the high-wellness group were more likely to be satisfied with their physical appearance than those in both the medium and low-level wellness group. Also suggested was that students in the medium-level wellness group were more likely to be satisfied with body weight and to perceive that physical activity affected physical development than those in the low-level wellness group. More detailed information, including the means, was presented in Appendix E-4.

Summary of the Results of all the Statistical Analyses.

Chapter four has described the two sites participating in the study. There were 280 completed questionnaires. The results were analyzed collectively to determine the possible relationships between adolescent developmental behaviours and wellness.

The descriptive statistics indicated that the majority of the participants perceived that physical, psychological, spiritual and social development as contributing to their overall sense of wellness. There were also positive correlations that suggested that the developmental dimensions influenced student wellness. However, the ANOVA analyses indicated that there were no significant differences in the wellness groups (high, medium and low) on student perceptions of spiritual development affecting adolescent wellness.

The results of all the statistical analysis indicated that a high percentage of participants perceived that nutrition and physical activity affected their physical development. Higher student self-reported levels of wellness were also related to increased perceptions that nutrition and physical activity affected adolescent physical development. Moreover, the ANOVA analyses suggested that the high-wellness group

was more likely than both the medium and low-wellness group to perceive physical activity affecting their physical development.

Several statements explored the students' understanding of spirituality. The results indicated that approximately half the participants perceived spirituality as bringing a sense of hope, connectedness, enriching their life, assisting them to be creative and that this was important to them. The students' increased perceptions of wellness were positively correlated to the belief that spirituality assists a person to be creative and to develop values, connectedness to a higher power and finally, the perception that spirituality is important. The ANOVA analyses suggested that there were no significant differences between the wellness groups for the spirituality developmental dimension.

The psychological development statements related to the students self-esteem, self-concept and independence. The results suggested that the majority of the students felt they had good decision-making skills, positive self-concept and self-esteem. The positive correlations analyses support the notion that increased perceptions of wellness are connected with positive self-concept, self-esteem and autonomy. Moreover, the ANOVA analyses indicated that the high-wellness group was more likely to perceive that they have reliable/affectionate caregivers, high self-esteem, good decision-making skills and an increased sense of competence.

Finally, the social developmental dimensions statements (i.e., family, peers and school) indicated that the majority of participants felt a strong sense of family, peer connectedness, felt safe in school, and that there was support from at least one teacher or administrator. On the other hand only 58% of the students sensed that the people in the school care. The correlations analyses suggested a relationship between school

connectedness and an increased sense that there are people in the school that care, and that the school is a safe and supportive environment. Finally, the ANOVA analyses indicated that the high-wellness group was more likely to have an increased sense of peer and school connectedness, greater resources and that there were caring people in the school.

CHAPTER FIVE

The Qualitative Findings of the Study: Themes and Subthemes

Chapter Five provides the themes of the study and presents the data as obtained from the students and teachers. The chapter concludes with a summary of the results of all the qualitative data.

Student Experiences and Understandings

The student focus group data were framed into three categories of themes, and these included understanding wellness themes, the relationship between wellness and development theme and the moderating influences of wellness themes.

Table 5.1 provides details of the student focus group participants.

Table 5.1

The Number and Gender of Student Focus Group Participants

Focus	#1	#2	#3	#4	#5
Groups					
Number of students and Gender	4(3f, 1m)	8(8f)	4(4m)	3(3f)	3(3m)

As indicated in Table 5.1, the focus groups were composed of twice as many females perspectives: females=14, male=8. However, the majority of male participants did not hesitate to discuss their perceptions of wellness. This information has been provided for the purpose of presenting demographic data. There were no gender-based comparisons in this study. In order to maintain anonymity, I have referred to the students' responses based on the focus group number in which the student participated.

Understanding of Wellness Themes

In each of the focus group discussions I asked “what does wellness mean to you,” and the themes identified were organized into the category titled Understanding of Wellness Themes. Three themes were identified in this category, and these included *Wellness Definitions*, *The Multidimensions of Wellness* and *The Characteristics of a Well Person*.

Wellness Definitions

Participants in each of the focus group discussions defined the term wellness. This discussion was initially focused on the physical aspects of wellness. However, student comments moved the dialogue beyond the physical component.

Examples of student statements provided to the researcher are:

- Wellness is someone being at peace with himself/herself. (F#1)
- Wellness is health. (F#2)
- Wellness is when your body is well. (F#2)
- Wellness is what you do to keep your body well, like eating healthy and exercising. (F#2)
- Wellness is being comfortable with who you are. I know when we had gym and everyone was like, oh I don't want to go swimming because of my body. You have to be comfortable with who you are to exercise and eat healthy. (F#2)
- Wellness is getting in shape physically or mentally even. (F#3)
- Wellness is a lifestyle, physical exercise and keeping your body in shape. (F#3)
- Wellness is a state of mind. (F#3)
- Wellness is how you feel about yourself and how others feel about you. If you feel good about yourself, then you will feel well. (F#4)
- Wellness is being comfortable with who you are and not having to hide anything or pretend to be something you're not. (F#4)
- Wellness is a fancy way of saying gym. Getting daily exercise and staying healthy. Eating right and staying fit so you don't become a couch potato with a big belly. (F#5)
- Wellness is believing that you are well. (F#5)

Student comments reflected on the physical and psychological aspects of wellness. Wellness was defined as “physical exercise and “eating healthy.” There were also remarks relating to the importance of “keeping the body in shape or healthy.” However, the definition of wellness moved beyond the physical dimensions as students’ expressed that wellness was “feeling good about yourself,” or a “state of mind.” Student perceptions focused on the psychological dimension and there was a prevalent sense that feelings and beliefs were an important factor affecting wellness.

The Multidimensions of Wellness

The participants’ understanding of wellness broadened when they engaged further into the discussion as students repeatedly referred to wellness as a combination of the developmental dimensions. However, there were varying opinions on the importance and particulars of the combinations.

Examples of student statements provided to the researcher are:

- Wellness is a combination of all the components, not just one. Like when you’re eating healthy and you’re exercising regularly and you have healthy relationships. (F#2)
- Wellness is a combination of physically, emotionally, mentally, all that stuff. Spiritually. (F#3)
- Wellness is a combination of physical and also psychological and stuff. (F#3)
- I think your self-esteem kind of acts as the balance. Cause self-esteem is the thing that’s connected to all of them ‘cause like self-esteem will lead to all. So I think the higher the self-esteem the more those things will be balanced. (F#5)

A few of the students’ comments exemplified the relationship between adolescent development and wellness. For these students, wellness was more than the simplified thought of being physically active and eating well. These remarks suggested that the

adolescents perceived wellness as multidimensional, and these included physical, spiritual, psychological and social.

The Characteristics of a Well Person

As exemplified by the students' statements below, the youth described what a well person would be doing or looks like. Thus, the focus of wellness evolved into the characteristics of a well person.

Examples of student statements provided to the researcher are:

- Well people are happy with what they're doing and who they are. (F#1)
- Well people are healthy and active, but I also think there's a mental sort of spiritual wellness where you are okay with yourself, and you're not afraid to let people know who you are and what you stand for. (F#1)
- Well people are taking good care of him or herself. (F#1)
- Well people are people that have gone through struggles to get to be the person that you are going to be. (F#1)
- Well people are at peace with themselves, kind of a peace of where they are in their life, circumstances they have, their abilities, just being okay with that. (F#1)
- Well people are okay with themselves. (F#1)
- A well person could be anyone, anyone who basically is happy with themselves and with all aspects of their life. (F#1)
- Well people are taking care of their body. They are not overeating or eating junk food. No drugs, smoking, or alcohol. (F#2)
- Well people are people that know themselves, and they do a lot better cause you can tell when people don't know themselves because they might make a choice they didn't want to make just because other people pushed it, and they'll regret it and at least when you know who you are and what you want to do that...shouldn't be a problem for you...and...they'll just be content no matter how things go kind of thing. (F#4).

These student comments reflected many important characteristics of a well person. There was one participant who suggested wellness included a healthy lifestyle of eating nutritious food and regular exercise. However, as the students continued in the discussion, it was clear that there were students who felt that wellness extended beyond the physical dimension. Wellness was described as a combination of factors (physical,

emotional, mental and spiritual), and there were comments reflecting that well people were taking care of their body. The students referred to well people as being okay or happy with themselves and their circumstances. Finally, wellness was understood as simply being at peace with oneself.

The Relationship Between Wellness and Development Themes

The participants reflected on the relationship between wellness and the developmental dimensions. These students' perceptions revolved around the expansion of their understandings of wellness. The prevalent theme that emerged from the data was labeled *Balancing the Dimensions of Wellness*. A student (F#5) stated:

In the end they're all intertwined with like lifestyle or how you eat, how you're physically active. If you're good in one area, it's going to eventually lead you to be good in the other. If you have a good lifestyle or if you eat well, you're going to be healthier, and even if you're not active, and then eventually you'll be more open to being active. ...it's all connected in the end.

This same student elaborated (F#5):

If you're physically fit you might have better self-esteem because you find yourself maybe more attractive then that will lead to being more social. If you're more social then you might have higher self-esteem so you could...maybe become more spiritual, they're all connected, they're all integrated and they'll all kind of level each other out.

For this student, the dimensions of wellness were all connected and self-esteem provided the balance. Higher self-esteem was associated with "being more social, active, eating well and spiritual" (F#5).

Other students articulated their perceptions that wellness was about having *balance in life*. One student stated (F#1):

Wellness is about *balance* with the different parts of your life. Balance in what you eat and a balance in how active you are, and then there is the spiritual and emotional balance there too.

No disagreements were expressed in this focus group that wellness was “a *balance act*,” and each of the developmental dimensions (physical, spiritual, psychological and social) were perceived as equally important. Another student (F#4) expressed:

I think it has to do with all four aspects: physical, emotional, spiritual and social and *balancing* them all out to have a good lifestyle. If you’re too active and your not having enough time for spiritual, then you need to *balance* it out.

Finally, a student agreed (F#4), “I think it’s good to be physically active and to have a *balance* too, because if you’re in too much to any of those sides you can get really stressed and then you’re not well anymore.”

In sum, for several of the participants, wellness involved a *balancing of the dimensions of wellness*. There was an understanding among many of the youth that wellness was more than just physical health since most considered spirituality, psychological and social development as being instrumental to the enhancement of wellness. Moreover, several students agreed that the failure to achieve such *balance* would result in stress and feelings of a lack of wellness.

The Moderating Influences of Wellness Themes

The Moderating Influencing Factors of Wellness Themes were further divided into sub-categories (physical, spiritual, psychological and social) of themes. In each of the focus group discussions I asked the students to define each of the developmental dimensions. Thus, there were four themes identified that were related to the definitions

of the adolescent developmental dimensions (physical, spiritual, psychological and social).

Moderating Influences of Physical Development Themes

Physical development was identified by the majority of student participants as an important dimension of wellness. I asked the question “what is physical development to you” and within this discussion, the theme *understandings of physical development* was identified.

Understanding of Physical Development

The participants in each of the focus group discussions defined the term physical development. Students spoke very openly about their beliefs of what physical development was and what physical development was not. Thus, their responses were organized into two categories which were *Physical Development is* and *Physical Development is not*.

Physical Development Is

As indicated in the statements below, the students’ definitions of physical development were generally focused on what was required to develop and maintain a healthy body.

Examples of student statements provided to the researcher are:

- Physical Development is physical activity that strains you to the point where you grow physically, become stronger and develop stamina. (F#5)
- Physically Development is being physically fit. (F#5)
- Physically Development is eating healthy and exercising. (F#2)
- Physically Development is being healthy and active. (F#1)

These findings suggested that these youth felt physical development was about exercising regularly and healthy eating.

Physical Development Is Not

Students expressed their perceptions of what physical development was not.

Examples of student statements provided to the researcher are:

- Physical Development is not smoking, using drugs and alcohol. (F#2)
- Physical Development is not going to gym class and having to compete. (F#4)

These students further elaborated on their understanding by stating physical development was not smoking, using drugs and alcohol. There were also several participants in focus group #4 who firmly believed that physical development was not enhanced by organized physical education classes.

Influences of Physical Development

Several themes within the physical developmental dimension emerged from the focus group discussions; these were *influences of physical activity, nutrition, drugs/alcohol, body weight and parent/guardian.*

Influence of Physical Activity

Participants felt that physical activity had a significant influence on physical development. A student (F#4) disclosed that physical activity was used as a stress outlet:

I dance for an hour every Friday...and if I'm feeling like really stressed then...like the energy that I put into the dance and like the movement and stuff it calms me and it helps me feel better about myself and the stress just kind of goes away.

Another related (F#4):

Physical activity is a stress relief, I like running long distance so if I'm really stressed...I'll go out for a jog or I'll even go biking if I'm like really upset about something, the first thing I want to do is bike.

Other students expressed the view that sports and physical activities would assist to develop the other adolescent developmental dimensions. For example (F#2):

Most people get into sports and they meet people at sports or you join a team because hey, let's go play ultimate Frisbee together and they have never done it before but they go. So if you have friends there you'll have more fun, you'll like it more and you'll keep doing it.

For these students, physical activity was a good stress relief. The remark, "the energy that I put into the dance and like the movement and stuff it calms me and it helps me feel better about myself", reflected the student's perception that physical activity positively influenced her self-esteem. Furthermore, the last comment revealed that the youth perceived sports and teams as a method of building peer relationships.

Influence of Nutrition

Nutrition was also identified as an influencing factor of physical development.

One student stated (F#5):

Well considering food is a direct influence on how much you weigh and whether that is a healthy weight or not, yeah, there's no way that it doesn't. You get all of your body fat and all of your energy from what you eat and drink...Yeah, I don't get how that could not affect your wellness.

Another expressed (F#4):

Some people like they don't get overweight because like their body can handle all that fat but they're still not in shape and they still don't feel good about themselves so you have to like not only just be active and eat the right foods.

For one participant, there was a sense that poor nutrition affected other adolescent developmental dimensions. One student stated (F#4):

If you go to fast foods and stuff it's just the wrong food to eat because that's when you can get overweight and like for me, if I'm going to be, if I'm not going to be

very active one day and decide to eat some really greasy food then I just...feel bad and I just feel sick so I guess it kind of affects your mental health.

For this student, poor nutrition affected more than her physical health but also her mental wellness.

However, a few voices expressed that nutrition did not really affect wellness or, if so, only momentarily. One student related (F#3):

Depends on the body, it's like temporarily. I notice if I, whatever, eat a greasy burger right before playing hockey I don't play as good but if I regularly, like not regularly but if I have McDonalds Tuesday, Wednesday and then Thursday I eat pasta and have a game I don't notice the McDonalds slowing me down at all.

For this student the effects of fast food were temporary. His comment reflected his belief that as long as he was physically active, he could eat unlimited fast food without any effects to his sporting ability.

Influence of Smoking, Drugs and Alcohol

Several students identified smoking, using drugs and alcohol as an influence on an adolescent's overall sense of wellness. A few students expressed the view that there were not only physical problems from smoking, drugs and alcohol, but there are multiple effects. One youth expressed the view (F#4):

I think marijuana affects like all aspects of wellness because...like all drugs do because you can't feel good about yourself. Cause with drugs it's like they make you feel really good and you can never feel like a normal person would after that so it...like it makes you really low and you can't...seem to feel good about yourself.

Another student shared (F#4):

I definitely think it's negative because like it just seems if you have friends that do it, it's really hurtful to you because you know it doesn't help you and they're spending all this money on this thing that's not helping them with their future and

the funny thing is, its stopping them from accomplishing everything they can so it just seems really pointless to me. I think it hurts so many aspects 'cause it hurts your family and it hurts your health because you probably don't eat as well if you're doing drugs, like you're always thinking about drugs and not food and different things so it's just not positive thing at all to me.

Other students identified the physical effects (F#5), "drugs and alcohol can affect your physical wellness, smoking, it can destroy your lungs which makes it harder to breath, and that'll basically affect their life." A female student (F#1) referred to drugs and alcohol as a "poison."

These findings clearly indicated that the students were cognizant of the effects of smoking and using drugs and alcohol. The students suggested that smoking affected physical wellness by limiting lung capacity and that alcohol was a "poison." Almost all the participants felt the alcohol/drugs affected all aspects of wellness including their peer and family relationships and the youths' feelings of themselves.

A few participants concluded that the effects of smoking, drinking and drugs may not have immediate consequences (F#5):

I think it would be gradual and it wouldn't be like...it wouldn't be as apparent but it would in the long run. If someone starts smoking one day they're not going to just stop running and everything immediately. It's going to be a bit of a process. It is not so much doing them that would affect it but choosing to do them instead of doing a physical activity.

Another student stated (F#2):

The thing about drugs and smoking is I think that you'll start smoking and then you'll play a sport and then you'll keep smoking and gradually you'll lose your, like your wellness, your physical ability to do the sport and then gradually, since it's an addiction, you'll take smoking over the sport.

Two students felt that youth who smoke and do drugs could still be active or participate in physical activity. However, as the student becomes addicted to drugs or smoking then “gradually you’ll lose your wellness or your physical ability to do the sport.”

Similar to nutrition, there were a few students who perceived the effects of smoking, drugs and alcohol as temporary, and therefore, not an influence on their overall sense of wellness. One student stated (F#3):

It kills brain cells but I don’t think it’s brought down my marks or anything either at the same time. If I start drinking like I’ll feel the affects for whatever, three or four hours until I sober up and then it’s kind of right back to normal.

Another student stated (F#5), “depending on how often you do it too. So if you do it casually it’s just like a drink here and there, it’s no big deal.” However, this student expressed the view that drinking excessively could be an influence in the long run. He stated:

If you drink like excessively every week...that’s when it gets worse and worse. It builds up inside you and then you’re starting to hurt yourself inside basically. In terms of your body, yes, and then depending for the reasons that what you started to do it could be mentally as well, emotionally.

The student comment (F#3) “I sober up and then it’s kind of right back to normal’ illustrated that the student was not cognizant of the effects of alcohol. On the other hand, one student reflected on how drinking, “excessively every week...that’s when it gets worse and worse. It builds up inside you and then you’re starting to hurt yourself inside basically,” could affect an adolescent mentally, emotionally and physically.

Influence of Body Weight

It was my bias before beginning this research that the students would identify body weight as a significant influence on adolescent physical development. As the research progressed, it was clear that my opinion was incorrect. With the exception of one student statement, all the students' comments reflected the perception that the participants felt that body weight had little or no influence on a person's sense of wellness. One student stated (F#3), "you could always change it, like either start running more or working out more, to get rid of that body weight." Another student related (F#3):

I think it's more a state of mind or a determination. Because no matter whatever body type you have, if you're born with it or you develop being fat, you can always find like a sport or something that fits with your body type. Like if you're bigger you can play football or if you're really skinny, you can play gymnastics and not play football.

Another participant agreed (F#3), "if you look at linebackers or linemen on football teams, I'd still consider them physically well. They could be heavy and overweight or whatever but they can still be well." One student expressed the view (F#4):

If you're overweight, I mean it doesn't stop you, I see hip hop a lot and I see big people do hip hop and they look just as good as the small people and it doesn't change anything. Like you could dance just as well so I don't think it should affect your physical at all.

However, one male offered his view (F#5):

Being overweight, you wouldn't really have that much energy to more or run, do anything. If you're underweight you like can be moving fast but then you'd have absolutely no energy left after a few moments. You have to basically be in between those two things to have the right amount of energy to get through every day.

The findings of the study suggest that many of the students did not support the notion that body weight affected physical development. There was no mention of the potential complications associated with unhealthy body weights. Only one comment indicated that the youth was concerned that excess weight might hinder his physical performance. Once again, the effects of unhealthy body weights were perceived as temporary or a factor within the control of the adolescent.

However, these students provided insight into the youths' perceptions of wellness. The comment (F#3), "they could be heavy and overweight or whatever but they can still be well," suggested that the youth viewed wellness beyond the physical dimension.

Influence of Parents on Physical Development

Several comments from students related to parental influence on physical development. One student stated (F#5):

It's your parents who buy the groceries. Sure you could go get whatever you want but if they bring in or buy things like fruits and vegetables that will be better for you 'cause its there and what you see everyday and you start it think that the good food is better for you.

Another student related (F#5), "my family influences my wellness because they encourage me to work out, keep in shape and eat healthy." There were also students who spoke of parents as role models for health behaviours such as smoking. One student expressed (F#2), "if your parents smoke then you feel like you're more likely to start smoking." Another student felt that her parents were role models for healthy eating. She stated (F#2):

My family, like my parents are really healthy, like really healthy type people so the food that we eat for supper, like lunch and everything it's...it's all like we have our serving of vegetables, our serving of meat.

For these students, parents were important role models for healthy eating and behaviours such as smoking. The adolescents also articulated that parental encouragement can be an important influence on physical activity levels.

In sum, there were no disagreements expressed by any of the students that physical activity had a significant influence on adolescent physical development. Several youth agreed with the statement that physical activity played a vital role in stress relief and they also stated the physical benefits of exercise, such as growth, strength and stamina. Nutrition was also identified as an important component of physical development as food has a direct influence on body weight and energy balance. Most participants agreed that smoking, drugs and alcohol were harmful. However, only one student stated that body weight may affect an adolescent's sense of wellness. Finally, several students voiced the importance of parental influence on health behaviours such as nutrition, physical activity and smoking.

Moderating Influences of Spiritual Development

Spirituality was identified by the student participants as an important dimension of wellness. I asked the question "what is spirituality to you" and within this discussion, the theme *understanding of spiritual development* was identified. There were three themes within the moderating influences of the spiritual developmental dimension that were recognized, namely *influence of parents/guardians, schools and peers*.

Understanding of Spirituality Development

The participants in each of the focus group discussions defined the term spiritual development. Students spoke very openly about their beliefs of what spirituality was and

what spirituality was not. Thus, their responses were organized into two categories and these were *Spirituality is* and *Spirituality is not*.

Spirituality Is

Although the meanings and experiences of spirituality varied among the participants, many of the students felt strongly that spirituality was individual and was not necessarily associated with religion.

Examples of student statements provided to the researcher are:

- Spirituality is beliefs. For me it means putting your faith into something that you believe is above yourself, even if that doesn't mean God. Whether it be money or anything like that. (F#5)
- Spirituality is different for everybody. (F#2)
- Spirituality is just having something to believe in. If you believe in Karma but don't believe in a higher power or you believe in a higher power but you don't believe in the Ten Commandments, it's just having something to believe in. (F#2)
- Spirituality is motivating. (F#2)
- Spirituality is your outlook in life and what you think of the big picture. (F#3)
- Spirituality is a relationship with God. (F#1)
- Spirituality is something you can't let other people decide. You have to think it through or criticize it before you can accept it. (F#1)
- Spirituality defines who you are and what you believe. (F#1)
- Spirituality is part of you, it's your beliefs and it has to come from you. (F#4)
- Spirituality is being able to believe in something bigger than yourself. (F#4)

As indicated by the above comments, three students perceived spirituality as a person's beliefs. For many of the youth it was important that spirituality was developed from within as the personal belief represented the self-concept of the adolescent. For some students spirituality represented a relationship with God, but for others, spirituality was defined as a 'belief in a higher power.'

Spirituality Is Not

Examples of student statements provided to the researcher are:

- Spirituality is not necessarily believing in God and religion. (F#2)
- Spirituality is not believing in God and following every single rule that is like God and living a perfect Christian. (F#2)
- Spirituality is not totally religious. (F#1)
- Spirituality is not necessarily God, Jesus or religion because you could not have any religion and still be very spiritual and very connected. (F#4)

For these students, spirituality did not represent a relationship with God, and there were no disagreements expressed with the statement that a person could be spiritual and connected without being affiliated with a religion.

Influence of Spiritual Development

The majority of the student participants agreed that spirituality, however defined, affects an adolescent's overall sense of wellness. One student stated (F#5), "people who are spiritually content have increased self-esteem, which would go into the social, and then it gets all together again." Another student related (F#5), "a higher power helps you kind of, gives you something to follow and it kind of helps you live better." Many students simply defined spirituality as believing and expressed that this pattern of thought would enhance their desire to live a healthy life. A student stated (F#5):

Believing is kind of a set of rules you might want to follow. They are there but you don't have to, it's not like you have to use them every single day. If you use them in a good way, you're going to live a good and healthy life.

For some students, spirituality was expressed as religion and beliefs about God. One student related (F#5), "if I didn't believe in God I wouldn't really care about wellness. When I started to believe in God, I started to get my life on track." Finally, a

student shared (F#1), “spirituality defines who you are and what you believe, and ‘cause your wellness is who you are, spirituality is who you are.”

Despite the varying definitions, several students felt that spirituality was an important dimension of wellness. Some youth felt that spirituality leads to increased self-esteem or a set of rules that assisted the adolescent to live a better or healthier life. Other students expressed the view that spirituality or believing in God defined who they were and, once again, significantly affected their sense of wellness.

It is worthy to note that several male participants agreed with the statement that spirituality was not part of their lives and did not affect their perceptions of wellness.

One student stated (F#5):

Spirituality only affects your overall sense of wellness to the extreme, whereas a little bit of physical activity can go a long way, you need to be extremely spiritual before it will start having a direct influence on your overall sense of wellness. Spirituality needs to be a constant, and you need to believe in it whole heartily before it can start to have an affect on your wellness.

Another male student stated (F#3):

When I first hear the word spirituality I think of Jesus and I’m not a Jesus guy. If you’re super religious, you believe that if you lead a good life you’re going to go to heaven, you’re going to be well...or you’re going to think that would make you well but I think that...like I don’t think there’s some...God watching me all the time and protecting me or like I don’t think that there’s really a reason why I was put on earth. I just think I’m here so...and then that’s all that I know.

One participant identified (F#3), “its your outlook on life and like what you really think of as a big picture and I really don’t think about that – I’m just going at it day by day.”

Several of the male focus group participants agreed that wellness was perceived as a state of balance in their lives; however, for the majority of males, spirituality was not included as an essential dimension of wellness. Nonetheless, these same male

participants recognized that spirituality could be important to other people's sense of wellness.

Influence of Parents/Guardians on Spiritual Development

Students spoke of the influence of parents on spiritual development. Several youth expressed the negative influence of parents on spiritual development. One student stated (F#1):

I was forced to go to church by my parents and so they were like oh, you know, you're going to go to church now and I was like, but I'm not comfortable there. I'm trying to figure out what I believe in and, its kind of like...they're in an atmosphere where they're jamming religion. I think both your parents should be open to what you want to believe but you should also be open to what they believe but no one should try to force what they want.

Another student expressed (F#2), "parents that bring their kids to church and throw them in a place that they don't understand and it's hard on them, it turns them away."

Another student felt (F#2):

When you go to church and you're like hey dad, you know what, like was learning about these other religions and hey, karma kind of appeals to me or Buddhism appeals to me...and your dad would be like no, you're a Catholic, blah, blah, blah and you have to stay Catholic, I see like that as being a negative influence.

These student comments reflected the youths' determination to make spiritual decisions independent of their parents. The adolescents' comments reflected their feelings that "parents should be open to what you want to believe" and parents should not be "jamming or forcing religion" on the youth. Clearly, the students had specific expectations of parents in terms of spiritual development.

One student expressed the positive influence of parent/guardian on spiritual development. She disclosed (F#4):

My family's like really spiritual so I guess I've kind of grown up with that but like at the same time they're also really open. Like even though they're really spiritual they told me, being Christian is like totally my choice and like it's not something you can force on someone and like I guess with that I feel pretty balanced with my spirituality.

For this student, the parent's openness to individual decision-making and diversity assisted the adolescent to spiritually develop. Parental communication and role modeling promoted a balance of spirituality.

Influence of School on Spiritual Development

Several students felt that the school environment also influenced their spiritual development. One student stated (F#2):

I think being in a Catholic, in the separate school system is really good. Like students in public school aren't allowed to openly express their spirituality and it's like for us, there's a chapel upstairs. If we want to, we can go up there whenever we want and we have...home room masses so like if your classrooms, our individual classrooms will go up to the chapel and we'll have our own mass with a...local priest and we have school masses and it's like even in Christian Ethics class it's not, we don't just talk about Christianity. Like in Grade 12 Christian Ethics we get to go over different religions but it's all those different things and so...they're not...just restricting it to Catholicism.

Another student agreed (F#2), "at school it's positive, if you're Catholic then you...get it taught to you like through the years what the meaning of it is." Another student expressed (F#1), "I think going to a Catholic school helps you develop spiritually, explore with different like aspects of a religion and make your own decisions." A student stated (F#4), "the school influences my spirituality, like going to a Catholic school even

cause, you always have masses and stuff connected to religion and that helps you to develop spirituality.”

Another student stated (F#4):

The spiritual aspect of the school makes it very easy to be involved because like it will ask you to kind of explore how you feel about religion and stuff and so once you get that figured out it's really easy.

A student related (F#4), “to hear all this Catholic stuff and know there's something out there that's bigger than all this, it helps me to be well.”

A few students expressed their view of how the school environment had a positive influence on spiritual development. The school chapel, local priest and home room masses were identified as positive factors affecting spirituality. One student felt (F#4), “going to a catholic school, having masses and stuff connected to religion,” assisted the youth to develop spirituality.

A few students expressed the negative influences of teachers on spiritual development. One student stated (F#2), “teachers who do...just strictly keep it at Catholicism and...like throw it over your heads and basically push it on you its negative.” This comment reflected the student frustrations of the teachers solely focusing the discussions of spirituality on Catholicism. It can be assumed that the youth expected to learn beyond the confines of Catholicism. Another student stated (F#3), “a negative influence on your spirituality, I think a lot of teachers, like especially Christian Ethics teachers try to push...like being Catholic on you too hard.” Finally, a student expressed (F#1), “I found that a lot of the teachers that I've had for Christian Ethics have...believe that it's their path to convert people.”

Similar to the discussion of parental influence on spirituality, these student findings suggested clear expectations for the school in terms of a supportive role in spiritual development. Many students expressed their view that it was not appropriate for teachers “to convert people” to Catholicism.

The next two comments summarize the youths’ perceptions regarding adolescent spirituality. One student stated (F#2), “I think it’s positive when you’re allowed to believe what you want to believe and...believe as far as you want to believe.” Another student related (F#1):

You need to like think and analyze everything to, like to get your spirituality, you know, and you can’t let other people decide it. You have to like...you have to like think it through or criticize it before you can accept it as your own.

In sum, several of the students felt it was their personal right to make decisions regarding spirituality, and there were many comments that expressed the importance of support and positive influence of parent/guardians and teachers in their journey of spiritual development.

Influence of Peers on Spiritual Development

A few students expressed how their spirituality was influenced by their friendships. One student stated (F#4):

Peers affect your spirituality, like...if you start talking about like what you believe in and then like you hear other peoples point of views, like that can help influence your own. Like you can say oh I really like that...but still, like hold on to your own views and stuff and just kind of like mesh them together and it helps you like grow and understand things more.

Several other students in the group agreed that they felt comfortable talking about spirituality with their peers. Another student expressed (F#1), “friends can influence

spirituality , like say if they're religious and they're like oh well, would you like to explore my religion this week or something or you want to come to church with me.”

On the other hand, a few students felt that spirituality was not a topic that would be discussed among friends. One stated (F#1), “it's not something that you would generally rely on your peers for. Cause like they're still trying to find out what they believe and find a good direction.”

Although the meanings and experiences of peer influence on spiritual development varied among the participants, these findings suggested that for some adolescents, spirituality was a topic of discussion.

Moderating Influences of Psychological Development

Psychological development was identified by the participants as an influence of adolescent wellness. I asked the question “what is psychological development to you” and within this discussion, the theme *understandings of psychological development* emerged.

Understanding of Psychological Development

The participants in each of the focus group discussions defined the term psychological development. Students expressed very openly their perceptions of what psychological development was and what psychological development was not. Thus, their responses were organized into two categories and these were *psychological development is* and *psychological development is not*.

Psychological Development Is

Before beginning this research, I was concerned that the students may not understand the term “psychological development.” However, their definitions clearly

illustrated that the students did indeed understand the term “psychological” as many of their comments related this concept to self-esteem and self-concept.

Examples of student statements provided to the researcher are:

- Psychological Development is growing mature and being understanding. Being aware of how things work, being more aware of why things happen and being more educated in consequences. (F#5)
- Psychological Development is being able to understand the basic things that happen in a person’s everyday life. (F#5)
- Psychological Development is self-esteem and how you feel about yourself. (F#2)
- Psychological Development is your mental, how you are feeling. (F#3)
- Psychological Development is establishing who you want to be, it’s just what everyone goes through when they are teenagers. Everyone goes through an identity crisis; they’re trying to find out who they want to be. You learn from your mistakes the kind of person you want to be. (F#1)
- Psychological Development is questioning who am I? (F#1)
- Psychological Development is establishing who they aren’t because some people try to live up to these expectations of themselves that are not possible and they need to understand that’s not who they are and that not the ability they were given or that not the kind of person they are. (F#1)
- Psychological Development is being comfortable with who you are and how other feel about you. (F#4)
- Psychological Development is your state of mind and what you choose to believe. (F#4)

The findings suggest that the students’ defined psychological development as growing, understanding the basic things of life and being more educated about consequences. In addition, the word psychological was tied to feelings about themselves (self-esteem), and questioning “who am I” (self-concept).

Psychological Development Is Not

Students were also cognizant of what psychological development was not.

Examples of student statements provided to the researcher are:

- Psychological Development is not someone who is depressed. (F#3)
- Psychological Development is not having to hide anything or pretend to be something you’re not. (F#4)

These student comments illustrated that the concept of psychological development was associated with self-esteem and self-concept. In this case, the concept was not linked to negative feelings or false pretenses about oneself.

Influence of Psychological Development

Three themes within the psychological developmental dimension emerged from the focus group discussions, and these were *influences of parent/guardian, peers and the media*.

Influence of Parents/Guardians on Psychological Development

The findings suggest that the participants felt parents/guardians have an important role in psychological development. Several participants commented that parents could positively or negatively affect a student's self-esteem. One student stated (F#5), "just your parent's comments to you everyday, in everyday situations, like say, if you do something really stupid and they just beak at you and basically put you down, then you'll start to feel useless." Some students felt that parents do not influence their feelings about themselves. One related (F#3):

My parents don't really influence my feelings 'cause I make my own opinion at this point. I really don't talk to my parents about feelings or anything like that. I never really have a deep conversation with anyone in my family except for what I'm planning on doing at University.

On the other hand, students felt that parents played an important role in the psychological development of the adolescent. One student stated (F#5), "the people that love you and are the closest to you influence your feelings about yourself and determine how easily you'll be influenced by peers." Another student related (F#1), "your parents

are the people who you spend the most time with, up to lets say after high school, so their actions and beliefs are going to shape your actions.”

These students’ comments illustrate the impact of parental encouragement and loving attitudes, or lack thereof, on adolescent feelings about themselves. The remark (F#3), “I really don’t talk to my parents about feelings or anything like that” suggested a sense of disconnectedness from the parent/guardian.

Influence of Peers on Psychological Development

There were varying opinions of the effects of peers on psychological development. Despite the fact that students identified some negative aspects of peer relationships, there were comments that suggested students placed significant value on the importance of friends.

A few participants voiced that girls have a tendency to be more critical of the female body, and this attitude affects their general self-concept. For example (F#2):

Girls are awful, ‘cause it almost not accepted to be able to say, I accept myself as I am. Its like everybody says, I hate this about my body and its weird it you don’t hate yourself. Some people may say I’m comfortable with myself but there are always people that say, my nose is kind of big.

Another female related (F#2):

I know people that may say they’re comfortable with themselves but I don’t think anyone can fully be 100% comfortable with who you are. Most 16-year girls would say, yes, I’m okay, but I don’t think they would actually believe it.

These two females comments “its weird it you don’t hate yourself” and “I don’t think anyone can fully be 100% comfortable with who you are” spoke of the importance of physical appearance among peers. The remarks confirm that there was a perception, among some peers groups, that it is not cool to feel good about yourself.

Students made reference to the negative effects of peer pressure. One student asserted (F#3), “let’s say you don’t want to drink and you go to a big party, and your friends pressure you to drink which would be a negative influence on your wellness.”

Another student stated (F#1):

I think your friends can bring you down. Like say you trying to establish this belief you have but they break you down and don’t agree with it and then it makes you step back a little and that’s not right because you’re letting other people influence what you want to believe.

A student expressed the view (F#4):

I never made friends easily and that affected my psychological development in a negative way because I didn’t fit in and I was usually alone, like I was the kid who’d sit by themselves at recess and read a book.

On the other hand, a few students suggested that friendships were held in great value, and that there were many positive factors associated with peer relationships. One student expressed the importance of peers in his life (F#3):

If everybody didn’t like me then I wouldn’t be as happy as I am now. But I think overall, I know some people don’t like me but most people do. I guess if I meet someone that doesn’t like I can shrug it off easier. Whereas, if everyone didn’t like me, I’d be what am I doing wrong. I’d be depressed or maybe even angry.

Another student related to the positive influences of peers (F#1), “friendships are positive if they support you in the direction you’re heading and they’re there to talk you through stuff. I have some friends who are really good for me and they just support me.”

In sum, the concept of peers seemed to evoke both positive and negative responses from the participants. A few students perceived that peers could “break you down” or exclude you, and this resulted in negative feelings of self-worth and loneliness. The “pressure to drink” was also viewed as a negative influence. However, there were

students who suggested peers were supportive, promoted feelings of happiness and an adolescent's ability to work through the many issues facing youth. Finally, friends could influence an adolescent's life path or future "directions."

Influence of Media on Psychological Development

One unexpected influence that emerged from the student focus group discussions was the effects of media on adolescent self-esteem and self-concept. The students' findings reflected the view that the media images were idealized or not real but, for several participants, the media seemed to affect the adolescent. One stated (F#4):

Media affects your wellness just the way you think about yourselves, because the one time that you start feeling bad about yourself and as soon as you compare yourself to someone that's, that's when you start feeling bad and often people compare themselves to girls in the media because they want to be like them and...I think that's why a lot of girls may feel bad about themselves because of a couple random girls on the media but really, it doesn't even make up a lot of the world and everyone's different. I do know some people who are very much into what the media says and they think like a whole bunch of people look funny or do something weird and they'll tell me that and I'm wondering how they can see so many bad things in so many people, it doesn't make sense to me. But it's because that's how they've, they've allowed it to control their views on what's pretty, what's not, what's beautiful, what's...important I guess so media can affect...the way you think.

For this student, the media contributed "to bad feelings about herself." This adolescent furthered the discussion by disclosing her lack of understanding as to why so many adolescents allowed the media to "control" his/her thinking and views of body image.

Another female related (F#4):

You look at the pictures of these models that are like modeling makeup and stuff and you think wow, I wish I could look like that and then you start to feel bad about yourself because you don't, so you have to remind yourself that like...these girls are wearing makeup and the pictures have been like digitally touched up and stuff.

A student in a different group expressed a similar thought (F#2), “it’s like if they’re your idol you want to be exactly like them so you’re going to pick up their habits. It’s like America’s Next Top Model.” Another student related (F#2), “you see them smoking on TV and...getting drunk on weekends when they’re underage, stuff like that and pre-marital sex., it’s just, it kind of...feeds into what you believe is cool.” Finally, a student agreed (F#2), “magazines, they’re like picture perfect and everyone’s supposed to look like.”

These students’ words “I wish I could look like that and then you start to feel bad about yourself” and “you want to be exactly like them so you’re going to pick up their habits” illustrated the potential effects of media on adolescent self-concept and behaviours. The remark “magazines, they’re like picture perfect and everyone’s supposed to look like” is representative of the pressure on adolescents to conform to the ideals as presented in the media.

In sum, several students felt that parents/guardians, peers and the media have the potential to influence adolescent psychological development. Loving and caring parent/child relationships resulted in positive feelings for many of the adolescents. On the other hand, there were participants who clearly were disconnected emotionally from their parents. In this case, the students’ expressed that parent/guardian relationships were no longer an influence on self-esteem and self-concept. The effects of peer pressure on decision-making, health behaviours and self-concept were evident to most of the participants. A few students expressed the importance of supportive friendships as these relationships enhanced the adolescents’ happiness. Finally, there were female

participants who felt the media was an influence on adolescent psychological development.

Moderating Influences of Social Development

Many students within the focus groups agreed that social development affects adolescents' overall sense of wellness. I asked the question "what is social development to you", and within this discussion the theme *understanding of social development* emerged.

Understanding of Social Development

Participants in each of the focus group discussions defined the term social development. Students expressed their perceptions of what social development was and thus, their responses were organized into the category labeled Social Development Is.

Social Development Is

The term social was understood by most students as the development of relationships. An elaboration of this concept included details of what was important in a "healthy" peer relationship.

Examples of student statements provided to the researcher are:

- Social Development is being able to go up to someone and talk to them. (F#5)
- Social Development is being able to interact with people. (F#5)
- Social Development is having healthy relationships with people. (F#2)
- Social Development is the ability to make friends I guess or just to be comfortable around everybody. (F#3)
- Social Development is knowing how to react to people. It is being able to know how you respond in a relationship and how to develop them kind of thing. (F#1)
- Social Development is about developing relationships with everyone around you. (F#1)
- Social Development is being yourself and still be able to make friends. Not pretending to be something like an athlete to be friends with certain people. You can just be who you are and they'll still like you. (F#4).

Social development was defined as the growth of personal relationships. Students felt that “feeling comfortable” and “understanding how to react and respond” to people were important factors to include in the development of relationships.

Influence of Social Development

Several themes within the social developmental dimension emerged, and these were *influences of parents/guardians, peers and school*. The influences of schools theme was further divided into sub themes, which were *influences of teachers, school counselors, the school environment and programs*.

Influence of Parents/Guardians on Social Development

There were varying perceptions regarding the influence of parents/guardians on adolescent social development. However, students felt that parents/guardians did indeed play an important role in the development of relationships. There were students who expressed the importance of parents/guardians as role models. One student stated (F#1):

Your parents and your family are supposed to be the ones to teach you to have the social development, so you need to form a relationship with them. It is that kind of basis that is needed so you know how to start other relationships.

Another student felt (F#5):

The more social your parents are, the more socially you will be, and it will be easier to do that with other people. You're watching how your parents interact, you're kind of in a way taking in how they are with people and you take that away with yourself.

These students identified that parents were role models for the development of relationships. The comment “you need to form a relationship with them” reflected the idea that social development was also dependent on parent/child connectedness.

The topic of parental love and warmth resulted in an explosion of comments regarding the importance of familial connectedness, love and support. One student related (F#4):

It is the strong love of my parents, it's just helped me. It just had a positive influence on the way I see things in life and just gets me motivated to do stuff and just try my best in everything I do.

Several students stated that feeling close or connected to a parent/guardian was an important influence on the adolescent. One student stated (F#4), "my mom and I we share stuff and we talk about everything. So it's really easy to connect and feel good about myself." Another student related (F#4), "the love of my parents motivates me because just spending time with us and just all the time and energy they put into us, it's just like you know, you just feel like you want to do more." One more student stated (F#2) "a happy relationship with your parents just makes you happier and make you feel better." Finally, a student felt (F#4):

I think if you can talk to your parents and they'll listen and give you advice and even if they don't know what you're going through, they just give you a hug then that can make you feel good about yourself. You will know everything is going to be okay and they reassure you without even having to say anything.

These student comments spoke to the importance of parental love and support on the development of positive feelings for the youth. For the youth, a sense of parent-connectedness promoted feelings of happiness and motivation.

Other students felt that parental/guardian interactions negatively affected adolescent social development. One student stated (F#4), "parents wouldn't be a big influence on your social development because they're older, they're a different generation and most of the time they're not exactly current." For this student, parents

could not relate to youth and therefore, could not assist in the development of relationships. Another student expressed (F#3):

If I get up in the morning and first thing my dad does is yell at me or something, like it might take a couple hours later I might completely forget about it but...you know, I won't be as happy or as social.

In sum, parents' love and acceptance of their adolescent was reassuring and promoted positive feelings. Moreover, a strong sense of parent-connectedness was motivating and "makes you happier and feels better." One student also suggested that a lack of connectedness would have the opposite effects. Finally, students acknowledged parents as role models for the development of relationships.

Influence of Peers on Social Development

Several students suggested that peers were an important influence in the adolescents' lives. There were a few youth who expressed that there were many positive, but also potentially negative, aspects of friendships. One student stated (F#2), "if your best friends with someone who eats McDonald's three times a day and they're big into pot something like that, like that's going to influence you, it's going to affect the choices that you make." Another student expressed (F#2):

Like people that are in the wrong crowd or whatever, if you've ever seen Mean Girls when they used her...and people can like use people or say hey, your dad owns a company so, and you have a nice car so hey, let's be friends. People make friends for the wrong reasons.

Finally, a student offered insight into the effects of peer groups (F#2):

It's like as a teenager and I know that I do this but, we tend to ostracize people that aren't like us. Like you always see like the kid, out by the staffroom. There's this one person who just sits in the corner every lunch hour. He stares at me all the time, and it's like, like he's not, like he doesn't fit into any of our

crowds, like nobody really makes an effort to go talk to him about include him just because he's different and we all do it.

I wanted to clarify her statement so I asked if ostracizing was affecting her ability or just the student's ability to do well? She responded, "I'm sure it's affecting our ability too because we are putting boundaries on what is normal, what is right and what should be accepted."

It is fair to say that peers have a direct impact on adolescent decision-making. The students felt that peers were role models and provided reinforcement for acceptable social behaviours such as adolescents' willingness to be inclusive and respectful of others.

A few students articulated the positive influence of peers. One student expressed the view (F#5):

If you're always alone though, in a way, it would be tougher to get out there, like you've got no friends you're basically going to be by yourself somewhere. You've got your family I guess but then, eventually you're going to get to a point where it's just going to be...not good.

Participants felt that it did not matter with whom the relationship was as long as the adolescent has someone to engage socially. One student stated (F#1):

I think everyone needs to have a close relationship with someone just so someone they can like talk about to anything cause if you don't have that you just kind of feel like alone, alone and all in one spot.

Another student related (F#1), "the teenagers that feel alone, they're not as well."

Finally, a student expressed (F#5):

Friends do affect your overall sense of wellness, because, it will affect your self-esteem and then it gets back to that the better you feel about yourself, then you'll

be able to do other things which will result in you being healthy overall – mentally, physically, and emotionally.

The students felt that people generally needed at least one person to engage socially, and peers could provide the relationship that would prevent the feelings of being “alone, alone and all is one spot.” Peer relationships were understood by almost all the students as affecting wellness. Friendship was viewed as a significant influence on self-esteem that was identified as the driving force in the development of the adolescent.

Influence of the School on Social Development

Students felt the school was an important influence on the adolescents’ sense of wellness and social development. The influences of school themes were further divided into sub themes and these were *influences of teachers, school counselors, the school environment and programs.*

Influence of Teachers. Most students perceived teachers as a positive influence on adolescent social development. One student stated (F#5):

The teachers will increase your self-esteem somewhat, all depending on the circumstances but it will increase it and then that can lead to once again a group social life, you feel better about yourself, it can help your spirituality, you then you feel good about yourself, you’ll feel good, when you feel good about yourself psychologically and mentally, that will naturally lead to you eating healthier and working out more. It might happen gradually but it will affect it.

Another student related (F#4), “I know lots of my teachers have inspired me and had a really good influence on me.” A student furthered the thought by stating (F#4):

The teachers can affect you just by the way like they present themselves to you and just like how they receive you. But if they’re like good teachers they can inspire you to do so many things.

A student expressed the view (F#4):

The teachers like they encourage you to do good and to study hard and like to get somewhere in life and when you do and your teachers actually, they seem to be proud of you and like you can tell that they are because like they know that they push you and that you did it for them. Like it can make you feel really good. Like you just made somebody else, like, happy with you.

Finally, another student disclosed (F#2), “the gym teachers here really push you, and they really try to influence you into healthy eating and working out regularly, like they’re really push that on you.”

All these student comments were reflective of the potential of teachers to positively influence youth. These statements suggested that teachers were inspiring, motivating and role models for health behaviours. Moreover, educators impacted an adolescent’s self-esteem and assisted with the development of spirituality. Finally, the encouragement and acceptance from teachers increased the students’ sense of pride and happiness.

On the other hand, one student perceived a lack of interest from teachers as a negative influence on wellness. She stated (F#4):

Our teacher didn’t actually teach us anything so it kind of made us feel like we weren’t good enough so she just didn’t bother and some teachers in high school are like that. Like they don’t tell you you’re doing a good job or they kind of like look at you and they’re like you’re not worth their time and then so you start thinking like maybe it’s because I’m not smart enough or because I don’t do good enough work and that can really affect your wellness in a negative way.

This student’s remark was reflective of the emotional impact of teachers on students.

The perceived lack of interest from the educator clearly disturbed the youth’s sense of self-esteem.

In sum, with the exception of a few students’ comments, the youth perceived educators as fundamental to the adolescents’ feelings of competence, worthiness and

pride. Teachers were instrumental in the development of adolescent spirituality and relationships.

Influence of School Counselors. A few students commented on the influence of the school counselors. One student expressed the view (F#2), “school counselors are useless.” Two other students stated (F#3), “I really don’t talk to school counselors”, and (F#1), “I went to one counselor and he just told me, like made me feel like I was wasting his time.”

Other students agreed that the school counselors assisted with the development of their class schedule. One student stated (F#1):

The one I go to or whatever, she’s like good and I’m like even if I’m just having a bad day or like I help, or she like helped me pick all my classes and she had these books, like reference, like every topic you could ever think of. Like she just like tailored your schedule like specifically for your needs.

Another student felt the school counselor assisted her to feel good about herself. She stated (F#4):

Counselors help you so you can all go to them and talk to them and they can help you sort of whatever problems you have and if they can’t help, then they try their best to make you feel better.

There were several views relating to the role of the school counselors. A few students felt the school counselors only assisted with the scheduling of classes and were not able to relate socially or emotionally. On the other hand, one student spoke openly how the counselor was able to connect with and assist the adolescent with her problem. This student perceived a positive impact from her interactions with the school counselor.

Influence of the School Environment. There were comments from the students regarding the influence of the school environment on the students’ sense of wellness.

Once again, I had a bias that the candy and drink machines in the school would have negative effects on the adolescents because the machines offered several poor health choices such as chocolate bars and sugary drinks and juices. However, as my research progressed, I realized that my opinion was incorrect.

When I asked the students about the candy and pop machines, they agreed that the vending machines were not an influence on their health and wellness. One student stated (F#1), “they have healthy choices in the vending machines, like they have stuff with hearts on it or the checkmark and you can make your own choice of what you pick.” Another student made reference to the healthy food available for purchase in the cafeteria. She stated (F#2), “the cafeteria is a positive influence on my wellness because it’s all homemade food and it’s really good.”

The view was expressed that the school environment provided the students with the opportunity to be healthy. All the adolescents’ comments were reflective of appreciation for the different food options in the school and for the responsibility of making the decision regarding their personal health.

Influence of the School Programs. The last subtheme that was identified from the focus group discussions was the positive effects of school programs such as sporting activities. One student expressed the view (F#2):

Sports help with wellness because you meeting people who are doing the same thing and friends are also there, like they encourage you to, like I know that when people talk about working out they always have like a workout person/friend, to motivate you and encourages you.

Another student related (F#2):

The gym class is a really big part of wellness. Like...I know that a lot of people join gym, like after it’s required – it’s only required until you complete your

Grade 10 course and so in Grade 11 and 12 a lot of people join Special Physical Education and a lot of people don't get exercise other than that.

The focus group discussion suggested that there were multiple influences within the school affecting wellness. Students acknowledged that supportive teachers had inspired the youth to work harder and to succeed. Beyond the teacher's impact on the students' sense of wellness was a supportive school environment that included the school counselors and programming.

In sum, multiple influences were acknowledged as factors affecting adolescent social development. Parents/guardians were identified as role models for developing healthy relationships, and there were participants who strongly voiced the importance of familial warmth and love in the development of the adolescent. A few students disclosed that peer support was related to the enhancement of adolescent wellness and that friends were definitely influential in adolescents' decision making. Finally, students expressed the positive influence of teachers, school counselors and the school environment and programming.

Teacher Experiences and Understandings

These data were organized into two categories of themes, and these were Understandings of Wellness Themes and The Moderating Influences of Adolescent Wellness Themes.

There was one adult focus group held that was comprised of teachers and one administrator. I believe all the participants eagerly shared their perceptions of adolescent wellness. Although there was a limited number of participants in the adult focus group discussion: 6(5F, 1M), and despite the fact that adult perceptions were not a major focus

in this study, I felt it was important to share their perspective as all these professionals work closely with the students and had clear opinions on adolescent wellness.

Teachers' Understanding of Wellness

Similar to the student focus groups, I asked the teachers the question “What is adolescent wellness”, and the themes were organized into the category titled *Understanding of Wellness Themes*. Two themes were identified in this category, and these included *Wellness Definitions* and *The Characteristics of a Well Adolescent*.

Wellness Definitions

As indicated in the statements below, the teachers felt that there were many important components of wellness and clearly articulated the definition beyond the physical dimension.

Examples of teacher statements provided to the researcher are:

- Wellness is when a child comes to school refreshed and feeling ready to face the day. By having a...you know, a good night sleep, enough food and is not over stimulated by caffeine and other products like that. And has a good healthy esteem. All those things all wrapped together to me means wellness.
- Wellness is four compartments – emotional, physical, spiritual and mental. If those are at a *good balance*, each one of them, then you have a well person.
- Wellness is more on the physical...and the spiritual/mental.

These participants suggested that wellness was multidimensional and included adequate sleep, healthy nutrition and self-esteem. An elaboration of the concept resulted in the description of wellness as a balance of the adolescent dimensions (emotional, physical, spiritual and mental).

The Characteristics of a Well Adolescent

The teachers described what a well adolescent would be doing or look like. The focus of the discussion became the behaviours of the adolescents.

Examples of teacher statements provided to the researcher are:

- Well Adolescents are, I think for me is if they all got a good night sleep. I think sleep deprivation is, is rampant. It is, they're exhausted most of the time and maybe right along with that is what kind, maybe their eating, but whatever they're eating isn't fueling them, it's not nourishing them.
- Well Adolescents are involved in physical activities and they're eating properly and they're probably getting most of the sleep.

The teachers furthered the definition of wellness by including a description of a well adolescent, and this was a youth who was physically active, eating adequate nutrition and receiving enough sleep.

The Moderating Influences of Adolescent Wellness

The Moderating Influencing Factors of Wellness Themes were further divided into sub-categories (physical, spiritual, psychological and social) of themes.

Influences of Adolescent Physical Development

Several themes within the physical developmental dimension were identified from the focus group discussions, and these were *influences of physical activity, nutrition, smoking/drugs/alcohol, sleep and poverty*.

Many teachers felt that there were multiple factors affecting adolescent physical development. One teacher stated, "a stressor for some of those kids is the drug activity that they're involved in, and I think that dope and alcohol are still very prevalent."

Another teacher agreed, "smoking, drugs, drinking, I mean that all affects physically. Physical activity and back to your nutrition, sleep."

One unexpected influence that the teachers identified was poverty. One stated:

Poverty affects their physical development. Poverty, inconsistent food, inconsistent nutritional food, inconsistent medical health, and care, attention, medical and dental care. Health care, like seeing the same health care provider, you know, instead of not just seeing numerous and sporadic. Prescriptions for glasses and things like that.

Several teachers agreed with the view that drugs and alcohol use was prevalent in this population. As the educators expanded on their thoughts, nutrition, sleep and physical activity emerged as factors affecting adolescent physical development. Finally, poverty emerged as a theme as low socioeconomic status was associated with inconsistent food and health care such as dental and eye care.

Influences of Adolescent Spiritual Development

Spirituality was identified by the teacher participants as an important dimension of wellness. There were three themes within the moderating influences of spiritual developmental dimension that were identified, and these were *influences of parents/guardians, peers and the school*.

Influence of Parents/Guardians on Adolescent Spiritual Development

Many teachers agreed that parents/guardians were an important influence on the adolescents' spirituality. One teacher stated:

Family is a big influence on your spirituality. My parents are gone, but it's still there. I always have it, but had they not given it to me, I would never have anything. I would have had to find it on my own, and I don't know if I would've but just having that...basic behind you, I, you know...and I think that's what these kids need. At least think about it, at least be subjective to it.

Another teacher agreed:

I think if you move in family, if you move in a circle of friends where most of them have a strong spiritual background I think that is a good influence on somebody who maybe doesn't have a strong spirituality.

These teacher comments reflected the importance of parents/guardians as role models for development of adolescent spirituality. The remark "had they not given it to me...I would never had anything" implied that students would not develop without parents to provide "the basics" of spirituality.

Influence of Peers on Adolescent Spiritual Development

Only one teacher expressed the opinion that peers were an influence on adolescent spirituality. She stated, "friends with strong spirituality might influence another student to become spiritual."

Influence of School on Adolescent Spiritual Development

The teachers felt the school influenced student spirituality. However, this discussion moved beyond the influence of teachers to include multiple supportive networks within the school. The discussion was as follows. One teacher stated:

Even in the Christian Ethics classes and such...a student that's maybe never had any experience with Catholic Christian faith whatsoever, it just opens them up to that but not just Christian faith, the Christian Ethics classes look into all other faiths so it just gives...kind of that introduction some student may not have at all.

Another teacher agreed:

We have a real advantage, you know, we live the gospel values and that's something that we profess all the time and our guiding. The staff walks the walk and the kids, they follow along. Sometimes, you know, they're, they're teenagers and they're still going to rebel at times 'cause they don't really agree with what they're seeing, and they want to find their own route and so forth but for a lot of our students...the, it just makes so much sense, you know, when...a lot of it boils down to respect in a lot of ways, you know, and a lot of the gospel values get down to that too but it's, it's about the mutual care, mutual respect, you know, the kids have for each other, and then it's the teachers, students, and back and forth.

There's a lot of innate spirituality that happens because people look for it, that they often look for it in other people then too so it just sort of, they just expect it to be there, and they find it here.

Finally, a teacher related:

Spiritually, we have access to a priest who is very visible, in our school and the kids, I think, really know and respond to them very well. We also have a full-time chaplain who is very available to the students and I know personally of quite a few students who have gone to see him, you know, over spiritual, various spiritual concerns.

The comment "the staff walks the walk and the kids, they follow along" reflected how the teachers felt they were role models for the development of spirituality. The educators argued that the feelings of mutual care and respect offered in the school facilitated the students to further their understanding of spiritual development. Finally, there were teachers who felt educators provided the basics for spirituality; however, other important services were offered in the school, and these included access to a priest and a full-time chaplain.

Influences of Adolescent Psychological Development

Psychological development was identified by the teacher participants as an important dimension of wellness. There were three themes within the psychological developmental dimension that were identified, and these *were influences of parent/guardian, peers and the media.*

One teacher felt strongly about the positive and negative influence of parents/guardians as role models. She stated:

I think some of the models that these children have in their home, in their homes and they're not effective, or...they're not good models on, on how to cope and how to handle and how to live life so they see these, inadequate models around them, and that's what they've learned to internalize, and that's how they deal with

their relationships even though it's not very functional. I think the kids with good wellness...have positive role models and, you can see that in their decision making and...and the types of decision they make. The types of positive decisions that they make about their life whereas...some of the other ones that I don't consider healthy, and I see as barriers are these models, there really inefficient models that they're trying to duplicate or just lean to or go to...and they don't really have the...the skills or the awareness to realize that there's a better way of life.

This teacher expressed that a good parent role model would facilitate the development of relationships and social skills for the youth. Moreover, this teacher felt that adolescents did not have the ability to recognize their parents as inadequate models, and thus the cycle of poor decision-making would be passed to the youth.

Another teacher spoke about role models in terms of gangs. The view was expressed that psychological development was dependent on feelings of connectedness either with a friend and/or the school, and that a lack of support results in reliance of a gang for friendship and a sense of belonging. The teacher stated:

The community in the sense of gangs because that's definitely behaviour that is modeled and emulated by some students. I mean, they want to belong to something because they're not connected either at school, at home, and they need a family and that turns into it and that's very negative models, but also something that they want to emulate.

Finally, a teacher spoke about the negative influence of media on adolescent development. She stated:

I think popular culture out there has a tremendous influence on these kids. There are all sorts of idols that are out there – music idols or movie stars, fashion idols, and the magazines. I mean you get somebody who's on television screaming and yelling and whatever else, and it's always in the news. Like, you know, Brittany's gone nuts, well so should I then. There isn't anybody out there with this so called healthy attitude out there to be a mentor so that's who they pick.

This final teacher comment was reflective of the importance of positive role models for adolescents. The concern expressed was that, for many adolescents, there was a lack of “healthy attitude out there to be a mentor.”

In sum, the teacher participants felt role models were an important influence on adolescent psychological development. Parents/guardians teach adolescents how to cope, make decisions and develop relationships. Students who perceive a lack of support from school and parents/guardians may choose to emulate behaviours and connect with peers from a gang. Finally, a few educators felt that the students who lacked positive role models in their lives were influenced from the mentors portrayed in the media.

Influences of Adolescent Social Development

Social development was identified by the teacher participants as an important dimension of wellness. There were several themes within the social developmental dimension, and these were *influences of parents/guardians, peers and school*.

Teachers felt that parents/guardians were important influences on adolescent social development. One stated:

Parents promote wellness in the family. Parents who know how to parent and, what doesn't promote it, are parents who don't know how to parent. I mean...That you love your children that you let them know that you want them, and you have enough parenting skills I guess to know how to discipline without being abusive.

Another teacher spoke about the importance of parents/guardians' support and how familiar love can influence decision-making. She stated:

I think the kids need to know their parents have expectations for them too in terms of their future. Like passing Grade 12. They seem almost to have a bit of a role there in encouraging them and supporting them in the decisions that they're making. Whatever role that might be. And not necessarily college, it could be training, it could be the family farm.

Similar to the students, the teachers felt that parental love, encouragement and support enhanced adolescent wellness. There were teachers who felt parental expectations and appropriate parenting skills for discipline promoted positive behaviours for the youth

All the teachers' agreed with the statement that peers influence social development. The discussion suggested that there were both positive and negative effects of peer relationships. One teacher expressed the view, "some of the kids have some very good positive peer relationships that influence them, and you can tell through the discussions in the classroom. They support each other with making the right moral decisions." Another related the negative effects of peer pressure. She stated, "there's definitely a culture I think in every school, of kids who encourage other students to skip, to smoke to, you know, do whatever. So for sure there's peer pressure with some choices."

Similar to the students, the teachers spoke of how peers could provide assistance and support in the development of healthy relationships and personal morals. Peers were also identified as contributing to the "culture" of negative health behaviours such as smoking and drug use.

The topic of the school facilitating student wellness resulted in several comments about all the programs available to students. The discussion was as follows. One teacher stated:

I'm going to say it's the breakfast program or there's always fruit available if you're talking from a nutritional end. From the physical aspect, the food part, there is breakfast made available for students in the morning if they don't have breakfast. There is fruit available at various places in the school. No questions asked, kids just pick it up. There are lunch tickets available if...they cannot afford to bring a lunch – there's that program there too so nutrition wise there are

some things open to them if they want to take advantage. I think the school recognized how important that is that someone needs to be fed before they can learn.

Another teacher spoke of the changes within the school that were directed at promoting wellness. He stated:

Another positive thing though we're getting rid of them, all of the pop and junky food. The school is definitely working on nutrition kind of policy. And that comes out too in the Grade 9 and 10 wellness is mandatory or health gym class, phys. ed. They definitely address nutrition and the importance of physical exercise and our Grade 9, phys. ed. runs all year. So every second day they get that hour of physical activity for the full year, which is good.

One teacher spoke of the other programs available for the students that are designed to promote wellness. She stated:

The school is trying to encourage healthy choices. We have an addiction's counselor here at the school who is open and has been in classrooms talking about addictions and, you know, smoking and drug use and alcohol use and that kind of thing. Another perspective for the kids, she also sees students herself, but she definitely is available to go into classrooms for teachers who wish to address that.

Finally, a teacher expressed her sentiment, "I think we're a great school. It's there for the taking, all you have to do is accept it."

For these teachers, the school was actively making changes to promote wellness. I found it quite interesting that the teachers' responses were similar to my bias of research as they indicated that the pop and candy machines were being removed to "encourage healthy choices." Then, the discussion moved beyond nutrition and physical activity to include an account for the services offered in the school such as the addictions counselor. The final comment "it's there for the taking, all you have to do is accept it," suggested that from this teacher's perspective, the school was meeting the needs of the students.

In sum, there were several important social influences identified by the teachers, and these were parents/guardians, peers and the school. Teachers expressed the importance of having supportive and loving parents/guardians who have clear expectations for their children. Also identified were the positive and negative effects of peer relationships. Finally, all the teachers agreed that the school offered programs that assisted with the enhancement of student wellness.

Summary of Qualitative Findings

There were several themes and subthemes identified in this study. Table 5.2 will be used to present an overview of the student themes.

Table 5.2

Overview of Student Themes

Understandings of Wellness Themes	Balancing the Dimensions of Wellness Theme	Moderating Influences of Wellness Themes
Wellness Definitions	Balancing the Dimensions of Wellness	Understandings of Physical Development
The Multidimensionality of Wellness		Influences of Physical Development (physical activity, nutrition, smoking/drugs/alcohol, body weight and parents/guardians).
Characteristics of a Well-person		Understandings of Spiritual Development
		Influences of Spiritual Development (parents/guardians, school and peers).
		Understandings of Psychological development.
		Influences of Psychological development (parents/guardians, peers and media).
		Understandings of Social Development.
		Influences of Social Development (parents/guardian, peers and school). Subthemes of school: influences of teachers, school counselors, school environment and programs.

As illustrated in Table 5.2, the themes were divided into understanding of wellness themes, the balancing the dimensions of wellness theme and the moderating influences of wellness themes. In the latter category, the themes were further divided into subcategories of the previously identified developmental dimensions (physical, spiritual, psychological and social).

The major teacher themes were also divided into categories and these were understandings of wellness themes and the moderating influences of adolescent wellness themes. An overview of the teacher themes were presented in Table 5.3.

Table 5.3

Overview of Teacher Themes

Understandings of Wellness Themes	Moderating Influences of Adolescent Wellness Themes
Wellness Definitions	Influences of Physical Development (physical activity, nutrition, smoking/drugs/alcohol, sleep and poverty).
Characteristics of a Well-student	Influences of Spiritual Development (parents/guardians, school and peers).
	Influences of Psychological development (parents/guardians, peers and media).
	Influences of Social Development (parents/guardians, peers and school)

As illustrated in Table 5.3, there were several teacher themes within the two categories of understanding of wellness themes and the moderating influence of adolescent wellness themes.

Summary of Chapter Five

Chapter five provided the data as presented by the students and teachers. The responses to each of the focus group questions were cited in this chapter. The main themes of this study were divided into three categories, and these included understandings of wellness themes, the relationship between wellness and development theme and the moderating influencing of wellness themes.

CHAPTER SIX

Reflections of the Study

Chapter Six restates the research questions, examines both the quantitative and qualitative findings and makes comparisons with the literature. The initial conceptualization of wellness is revisited throughout the discussion of each of the developmental dimensions. Key findings of the study are cited and implications for future research, educational theory, policy and practice are suggested. The chapter concludes with final thoughts.

The Research Questions

Due to notable interest of educational and health professionals to foster the health and well-being of future generations, I felt it was timely to explore the definition, conceptualization and influences of adolescent wellness from students' and teachers' perspectives. To reiterate the research questions from Chapter One:

1. What are adolescents' perceptions of wellness?
2. What is the perceived relationship between the adolescent developmental dimensions and wellness?
3. What are the perceived social, physical, spiritual and psychological developmental influences on adolescent wellness?
4. What influences do teachers have on adolescent wellness, from the perspective of students?

A Comparison of the Findings with the Literature

This section presents a discussion of the findings in relation to extant literature. This discussion is organized to answer each of the four research questions driving the

inquiry process. The conceptual framework was revisited in the discussion of wellness and in the exploration of the moderating influences of adolescent wellness.

Adolescent Perceptions of Wellness

I begin by comparing the wellness literature with the findings of this study with the intent to address the first research question of this study “what are adolescent perceptions of wellness?” Then, I present a reconceptualization of the wellness phenomenon. Throughout the following discussion, I have italicized and labeled the data into the previously identified categories (*physical, spiritual, psychological and social*) in order to illustrate the notion that wellness was the aggregate of the adolescent developmental dimensions.

There are several examples of studies that have evaluated various domains of wellness. One of the most commonly used models in the literature, developed by Myers, Sweeney and Witmer (2000), proposed a holistic model of wellness and prevention over the life span. The assessment tool (*Wellness Evaluation of Lifestyle*) was used with youth and corresponded to the concepts of the wheel of wellness: spirituality, self- direction, love, friendship and work/leisure. Many other researchers have identified the importance of exploring the multiple aspects of wellness (Ardell, 1996; Chandler et al., 1992; Hartwig & Myers, 2003; Hettler, 1980).

Similar to the literature, the findings suggest that wellness was multidimensional. Figure 6.1 is used to illustrate the contradictions between the proposed ideal state of wellness and the adolescent’s perceptions of wellness. As stated in Chapter Two, the ideal state of wellness was defined as the predictable growth of the four developmental

dimensions. In addition, I had conceptualized wellness as the aggregate of all four developmental dimensions of life.

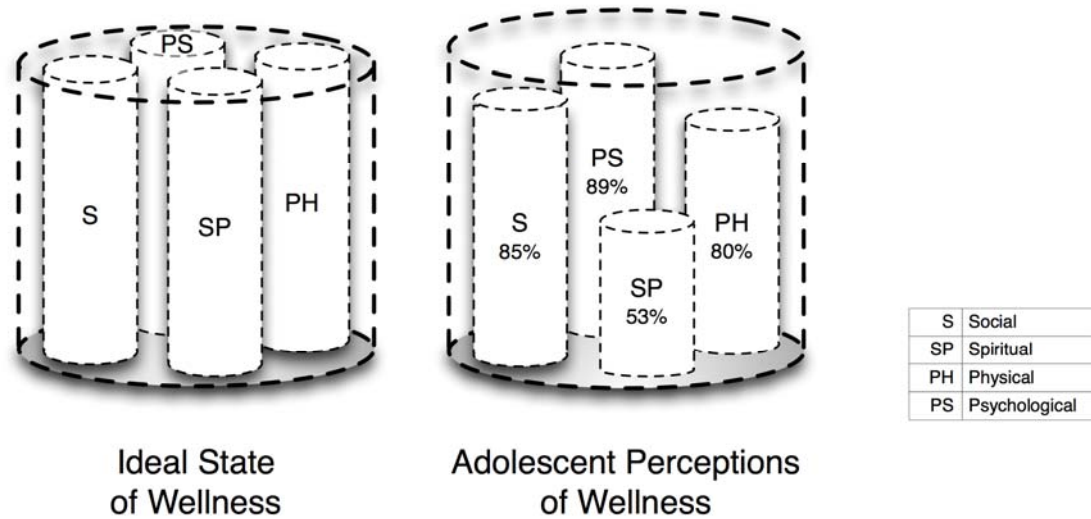


Figure 6.1. Adolescent perceptions of wellness.

As illustrated in Figure 6.1, the students suggested that wellness was multidimensional but, different from the ideal state of wellness, for many participants the dimensions were not equally important. Slightly over half the students felt that spirituality (53%) contributed to the youths' sense of wellness. The majority of students suggested that psychological (89%), social (85%) and physical (80%) development made the most significant contribution to adolescent wellness.

Moreover, throughout the focus group discussions several students spoke of the various components of wellness. Many students suggested that wellness included a healthy lifestyle of nutritious food and exercising regularly (*physical*). Wellness was also described by one student as a combination of factors (*physical*, emotional, mental and *spiritual*). Similar to this student, a teacher described wellness as being comprised of

four compartments (emotional, *physical*, *spiritual* and mental). The emotional and mental component would fit into the researcher's previously identified *psychological* dimension. One student suggested that wellness included healthy relationships (*social*).

I found these data interesting as I would have thought that the students would define wellness as nutrition, physical activity or factors within the physical dimension. However, the students' cognitive maturation was evidenced in their ability to think about possibilities, hypothesize and think abstractly, all which Piaget (1972) would identify as the emergence of formal operational thought. Clearly this level of cognitive development allowed many of the students to view the concept of wellness symbolically and holistically. Although this opinion could not be generalized to all the student participants, it is a reasonable assertion that the adolescents' understood wellness as multidimensional.

The Relationship Between the Adolescent Developmental Dimensions and Wellness

This discussion addressed the second research question "what is the perceived relationship between the developmental dimensions and wellness" and further illustrated the convergence of the literature with the findings of this study.

As indicated, Dunn (1977), defined wellness as "an integrated method of functioning which is orientated toward maximizing the potential of which the individual is capable, it requires that the individual maintain a continuum of *balance* and purposeful direction within the environment in which he is functioning" (p. 5). There are many other prominent theorists who suggested wellness was a complex state of *balance* among certain dimensions in life (Chandler et al., 1992; Morris & Devane, 1994; Powers, 1994; Robbins et al., 1999; Sweeney & Witmer, 1991). Several studies have explored

adolescent wellness from a holistic perspective (Deiner, 2000; Dixon, 2002; Dixon Rayle, 2005; Hartwig & Myers, 2003; Hatfield & Hatfield, 1992; Hattie et al., 2004; Myers et al., 2003; Rayle & Myers, 2004). Although many of these researchers used different conceptual models, similar to this study, a wellness-orientated, strengths-based approach was used to explore wellness.

Both the adolescent and adult wellness literature asserted that wellness involved a balance of certain life dimensions. In this study there were positive correlations between the developmental dimensions and general wellness. The results of the survey suggested that an increased sense of wellness was moderately associated with higher scores on the health ($r = .54, p < 0.0005$), psychological ($r = .42, p < 0.0005$) and social ($r = .35, p < 0.0005$) development scales. Increased wellness was associated with better perceived physical health, psychological well-being and social functioning. The results also imply a minimal relationship between higher student self-reported levels of wellness and the spiritual ($r = .19, p < 0.001$) development scale.

The focus group discussions supported the notion that the developmental dimensions were related to the students' sense of wellness. Repeatedly, students and teachers referred to wellness as a balance in life. A few students perceived the dimensions of wellness to be integrated or connected and equally important. Students described the balance of wellness using terms such as nutrition, physical activity, spirituality, emotions and mental.

The conversation on wellness was not limited to any specific dimension but rather included logical arguments supporting Dunn's (1977) assertion that a well individual must maintain a continuum of *balance* and purposeful direction within his/her

environment. Although there were varied perceptions of importance of the dimensions required to maintain a state of *balance*, it was clear that the students perceived a relationship between the adolescent developmental dimensions and wellness.

The Moderating Influences on Wellness

I now present a comparison of the literature with the Moderating Influencing on Adolescent Wellness that addresses the third research question “what are the perceived social, spiritual, psychological and physical influences on adolescent wellness?” Similar to earlier chapters, I have decided to organize this part according to the previously identified adolescent developmental dimensions (physical, spiritual, psychological and social). Also included were conceptualizations of the moderating influences on wellness.

The Moderating Influences on Physical Development

This discussion begins with a comparison of the literature with each of the moderating influences of physical development, and these include physical activity, healthy eating, health habits such as smoking, alcohol or drug use and body weight. Plausible explanations for the findings diverging from the expected are discussed.

The Influence of Physical Activity

There is a vast amount of literature documenting the positive effects of participation in physical activity on adolescent functioning. Regular physical activity enhances physical development such as reducing risk for cardiovascular disease and high blood pressure, promotes healthy emotional development, reduces risk of depression, and promotes healthy sleep patterns (Brien & Katzmarzyk, 2006; Hockenberry & Wilson, 2007; Katzmarzyk et al., 2003; McKinney et al., 2005).

This study found that many students felt that physical activity positively affects adolescent physical development. For example, the descriptive statistics indicated that 72% of participants perceived physical activity affecting their physical development. There was also a moderately positive correlation that suggested increased perceptions of wellness were associated with the belief that physical activity ($r = .55, p < 0.0005$) contributed to physical development. The ANOVA confirmed that students in the high-level wellness group ($M = 4.50$) were more likely than the medium-level wellness students ($M = 3.65$) to state that physical activity affects their physical development. Both the high and medium-level wellness groups were more likely than the low-level wellness group ($M = 2.42$) to state that physical activity affects adolescent physical development ($F(2, 277) = 56.99, p < 0.0005$).

The focus group discussions supported the statistical results as all the students agreed that physical activity was essential to health growth and development. Although a few students expressed their disappointment in organized activities such as gym class, several adolescents repeatedly referred to physical activity affecting every part of their life. Being physically fit contributed to their ability to develop peer relationships, was a stress relief and improved adolescent self-esteem. Clearly, the findings suggested that physical activity was an important influence on physical development.

The Influence of Healthy Eating

Research indicated that nutrition is a vital component of healthy growth and development (Hockenberry & Wilson, 2007; London et al., 2007), and the study's findings strongly supported this theory. The descriptive statistics indicated that 76% of students felt that nutrition affected their physical development. There was also a

significantly positive correlation that suggested increased perceptions of wellness were minimally associated with the belief that nutrition ($r=.18$, $p<0.001$) contributed to physical development.

The focus group data also supported the belief that nutrition positively influenced adolescent development. There were a few student comments that reflected the youths' understanding of the effects of fast foods and the importance of maintaining energy balance. However, there were a few voices that expressed that nutrition did not really affect physical development or, if so, only temporarily. One student (F#3) stated that he could eat fast food everyday, and he did not perceive any effects. He stated, "I don't notice the McDonalds slowing me down at all." In other words, the student felt his performance in sports was not influenced by the regulation ingestion of fast food.

In sum, the students perceived that healthy nutrition could positively affect a person's physical and emotional sense of oneself. However, there were a few students who expressed that the effects of fast food on physical development were non-existent or temporary.

The Influence of Drugs, Alcohol and Smoking

The literature clearly indicated the harmful effects of drugs/alcohol and smoking on adolescent physical development. Hedberg, Bracken and Stashwick (1999) found that "behaviours such as smoking were established in adolescence and could continue into adulthood, and the cumulative effects of ongoing health-compromising behaviour contributed to adult-onset disease" (p. 137). Health Canada (2004a) found that nearly one-quarter of current and former drinkers reported that their drinking had caused harm to themselves or to someone else in their lives. Health Canada (2004a) found that:

Alcohol is the substance most commonly used by Canadians. In the past 12 months before the survey, 79.3% of people aged 15 years or older consumed alcohol. At least 70% of young people between the ages 18-24 have reported using cannabis at least once in their lifetime. (p. 48)

Similar to the Health Canada study, the prevalence rates in this study indicated that many students were smoking, using drugs and alcohol. Specifically, 25% of students were smoking and, 55% and 20% respectively, were using alcohol and marijuana. Only 5% of the students indicated that they were using other drugs. Moreover, the descriptive statistics in this study suggest that 61% of student participants felt that drugs, alcohol and smoking affected their physical development.

The focus groups discussion also supported the notion that smoking, using drugs and alcohol influences an adolescent's overall sense of wellness. Several students expressed the view that there were not only physical problems from smoking, drugs and alcohol, but that there were multiple effects. Smoking and drugs were referred to as a "poison", and a few adolescents expressed the view that marijuana affects all aspects of wellness, "because you can't feel good about yourself," and "it hurts your family and it hurts your health."

It is worthy to note that there were a few students who felt that the effects of drinking were temporary and voiced the opinion that alcohol did not affect wellness. One student (F#3) stated, "if I start drinking like I'll feel the effects for whatever, three or four hours until I sober up and then it's kind of right back to normal." Similar to the comments relating to nutrition, the student remarked that he could drink alcohol without any long-term physical effects. These words are reflective of the student minimizing the potential long-term effects of alcohol.

In sum, 61% of students were cognizant of the effects of smoking and using drugs and alcohol, yet one quarter of the participants were smoking and over half had drunk alcohol. Although these results are similar to the Health Canada study, one begins to question why the students are continuing to drink and smoke despite their knowledge of the harmful effects.

The Influences of Body Weight on Physical Development

There are many research studies documenting the effects of body weight on physical development. Obesity poses both immediate and long-term implications for adolescents. Although complications from obesity are more frequently seen in adults, children and adolescents are experiencing significant health consequences as well (Hockenberry & Wilson, 2007). For example, evidence suggested that Type Two Diabetes Mellitus (T2DM), hyperlipidemia and hypertension were not restricted only to adults but are also becoming increasingly common among children (Katzmarzyk et al., 2004). Furthermore, overweight and obesity during childhood were strong predictors of obesity and cardiovascular disease in young adulthood (Janssen et al., 2005). Clearly, the research indicates the many physical effects of overweight and obesity.

However, the findings of this study did not support these ideas. Only 31% of the student participants perceived that body weight affected physical development. The correlations and ANOVA analyses were non-significant.

The focus group discussions also diverged from the evidence presented in the literature. In fact, with the exception of one student comment, all the adolescents perceived body weight as temporary or a factor within the control of the adolescent. As

the student participant (F#3) noted, “you could always change it, like either start running more or working out more, to get rid of that body weight.”

Despite the research documenting the effects of unhealthy body weight, the findings confirm that the students did not support the notion that body weight affected physical development. There was no mention of the potential complications associated with unhealthy body weights. The comment (F#5), “being overweight, you wouldn’t really have that much energy to move or run, do anything” indicated that the youth was concerned that excess weight might hinder his physical performance. The focus for this student was that he needed to have enough energy to perform in sports, but there was no indication that he was concerned about the physical effects of an unhealthy body weight.

However, the students’ reflections provided insight into the participants’ understanding of wellness. The comment “they can be heavy and overweight but they can still be well” contributed to the understanding of wellness being more than a healthy weight.

Discussion of the Influences of Physical Development

The students’ responses illustrated great insight into the contributing influences on physical development. The relationship between student wellness and the items measuring physical development, as identified in the results of the descriptive statistics, can be explained by the heuristic presented in Figure 6.2.

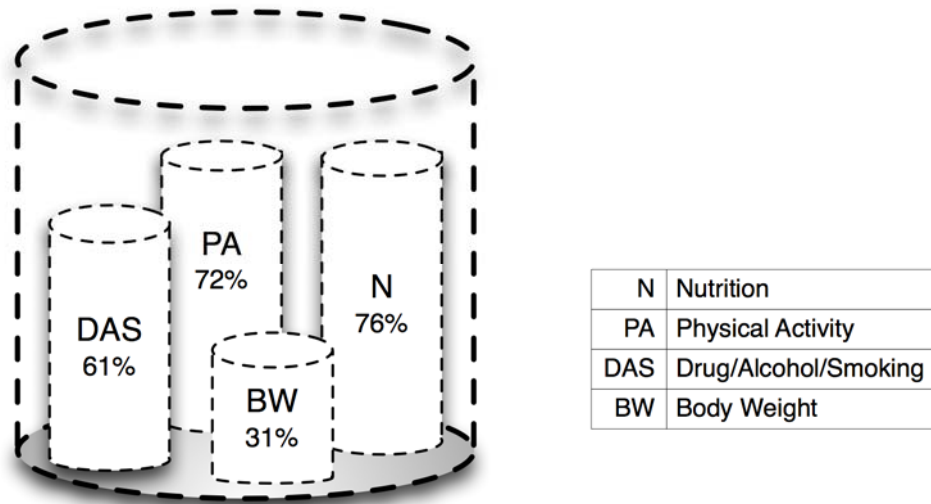


Figure 6.2. Adolescent perceptions of the factors contributing to their physical development.

As illustrated in Figure 6.2, the students' responses reflected their feelings that physical activity and nutrition had a significant influence on physical development. The findings also illustrated a strong knowledge base regarding the harmful effects of smoking, drug and alcohol use. However, only 31% of the students perceived body weight as an influence on physical development.

As stated earlier, it was my bias that the students would be knowledgeable of the influences on physical development and, specifically, body weight. However, the results suggested that the students did not speak to or did not recognize the potential health issues associated with unhealthy body weights. In addition, the prevalence rates of smoking, drugs and alcohol were notable.

The students strongly expressed their beliefs regarding the harmful effects of smoking and using drugs and alcohol, yet there are many students choosing these harmful health behaviours. As a researcher and nurse educator, one begins to question why an

adolescent chooses a health-compromising behaviour when, clearly, the data illustrated that many of the students are educated and knowledgeable as to the multiple health problems associated with ongoing use.

There are many plausible explanations that might be used to describe the high prevalence rates of smoking, alcohol and drug use. Peer pressure, challenging authority and a sense of being infallible are three reasons for why an adolescent would choose a health compromising behaviours. There are also several theorists that could be used to understand the students' behaviours. This discussion was delimited to Piaget as I believe, with similar perspective taken by Hockenberry and Wilson (2007), that this theory provides a logical explanation for adolescent cognitive development, and it describes how these changes have important implications for understanding the health risks to which adolescent are exposed, and the risk-taking behaviours in which they engage. Piaget's theory provided an excellent guide to make sense of, and assess the adolescents' cognitive development and decision-making abilities.

Piaget (1972) described the shift from childhood to adolescence as a movement from concrete to formal operational thought. Formal operational thinking allows the individual to think in abstract terms; thus, he/she can symbolically associate behaviour with abstract concepts. The speed of development varies from one individual to another and also from one social environment to another (Piaget, 1972). Thus, some children might quickly develop, but others might not.

Piaget's theory (1972) may explain why many adolescents are acknowledging the harmful effects of smoking, drugs and alcohol, and others are not. Using Piaget's theory, I suggest that the students who are speaking to the harm of smoking were cognitively

developed. Thus, these adolescents had developed the ability to have organized and logical thinking and associated the use of smoking, drugs and alcohol with physical harm.

Piaget's framework also offers potential reasoning for the high prevalence rates of smoking and alcohol use despite the vast knowledge of the harmful effects. Piaget (1972) suggested those adolescents who have developed formal operational thoughts have the ability to think abstractly and outside the present; thus, they can symbolically associate behaviours with abstract concepts and are able to imagine possibilities such as a sequence of events. The findings confirm that, when discussing the effects of smoking, drugs and alcohol, some of the students are solely thinking in the present and have not developed formal operational thinking. The statement "it kills brain cells but it does not bring down my grades" reflected the student's inability to associate the health problems with compromising health behaviours such as smoking/drugs or alcohol.

Piaget (1972) also described the development of hypothesized reasoning. This reasoning was defined as the ability to think about possibilities and explanations and to compare what he/she actually observed to what he/she believed is possible. Moreover, Piaget (1972) stated that, "hypothetical reasoning changes the nature of discussions: a constructive discussion means that by using hypothesis the adolescent may be able to adopt the view of the adversary and draw the logical consequences that may be applied" (p. 4).

Student comments reflected Piaget's theory of hypothesized reasoning as the data suggested that many adolescents have developed the ability to foresee the consequences of health-compromising behaviours. Through the several student comments it was clear that many adolescents understood the multiple consequences of drug use.

However, there were student comments that suggested that they had not developed hypothesized reasoning and, thus, would be more likely to choose to drink and smoke. For example, another student stated (F#5), “depending on how often you do it too. So if you do it casually it’s just like a drink here and there it’s no big deal.” This statement supports Piaget’s theory that the students choosing the health-compromising behaviour may have not begun to use abstract reasoning and, thus, lack the ability to view the consequences of the smoking and drug/alcohol use.

Another concern was the students’ lack of insight into the effects of unhealthy body weights. The students acknowledged that an overweight and obese adolescent can still be well; however, there was only one student comment identifying the health implications of an unhealthy body weight. An apparent understanding among many of the students was that body weight was within the control of the adolescent, something the youth could change and, thus, was not a factor influencing physical development or wellness.

The literature not only has documented the multiple effects of overweight and obesity, but there are also many studies reflecting the increased rates of unhealthy body weight in the adolescent population. Specifically, over a 15-year period in Canada, “rates have increased from 11% to 33% in boys and from 13% to 27% in girls for overweight, and from 2.0% to 10% in boys and from 2% to 9.0% in girls for obesity” (Tremblay et al., 2002, p. 538). The prevalence of overweight and obesity has tripled among boys and doubled among girls. Tremblay’s (2002) study suggested that not only have children become more overweight in the past few decades, but also that overweight children have been getting heavier.

Obesity is a serious problem among children and adolescents. The fact that the students did not support this view illustrates the urgent need to further develop this health knowledge in our youth. These results also raise an important question about how to address the promotion of healthy body weights while being conscious of the potential harm to body image and indicate an area that clearly warrants future research.

The Moderating Influences of Spiritual Development

Spiritual development has been previously identified as an important influence on adolescent wellness. This discussion presents an illustration of the moderating factors of spiritual development, and these include perceptions of spirituality as being important, bringing a sense of hope and connectedness, enriching life, assisting creativity and developing values. Then, I present explanations for the varied student responses to the importance of spirituality as a component of wellness.

Over time, spirituality and spiritual development have remained an important area of inquiry; however, there has not been a consensus within the literature as to how to define these concepts. Fowler and Dell (2006) argued:

Faith is universal and can exist within and outside of religious traditions. Faith is a person's way of responding to transcendent value and power in such a way that the trust in, and loyalty to, the source of transcendence integrate our identity and give our lives unity and meaning. (p. 7)

The findings of this study support the above conclusion as the meanings and experiences of spirituality varied among the students. For many students, spirituality represented a relationship with God or simply "beliefs." For other participants, spirituality was not representative of a relationship with God. Figure 6.3 presents adolescent perceptions of the factors contributing to spiritual development.

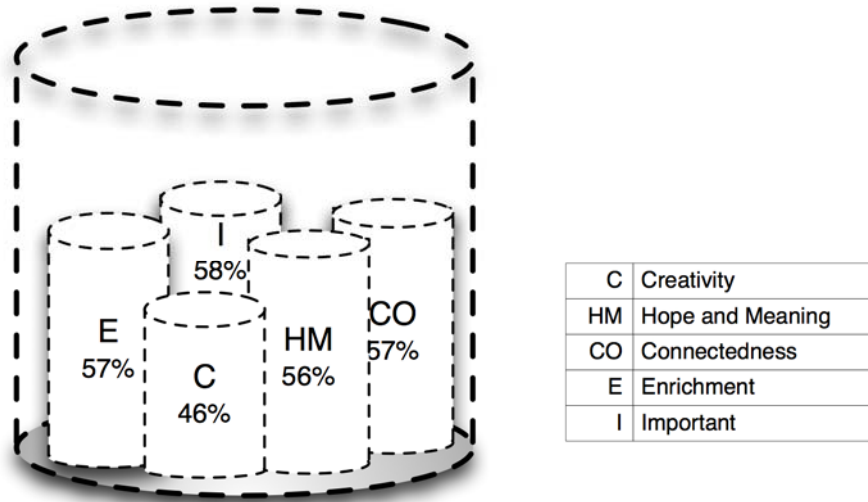


Figure 6.3. Adolescent perceptions of the factors contributing to their spiritual development.

As illustrated in Figure 6.3, the students' responses were consistent among all the factors affecting spiritual development. The results of this analysis suggested that over half of the student respondents perceived spirituality as bringing them a sense of hope (56%) and connectedness (57%), enriching their life (57%) and being important (58%). There were a smaller number of students (46%) who perceived spirituality as assisting them to be creative and to develop values.

Roehlkepartain, Ebstyn King, Wagener, & Benson (2006) suggested that spiritual development is a vital process and resource in the adolescents' developmental journey. The findings of this study supported the above conclusion. For example, the descriptive statistics illustrated that 53% of the participants perceived that spiritual development contributed to their overall sense of wellness. The correlation analyses also suggested that increased perceptions of wellness were minimally associated with the

beliefs that spirituality assists a person to be creative and to develop values ($r = .16, p < 0.01$), connectedness to a higher power ($r = .19, p < 0.01$) and finally, the perception that spirituality is important ($r = .16, p < 0.01$).

The focus groups' results were congruent with the survey as there were several students who felt that spirituality was a component of wellness. One student stated (F#1), "spirituality defines who you are and what you believe, and 'cause your wellness is who you are, spirituality is who you are." This expression illustrated the general sense that spirituality contributed to the beliefs and meanings in the students' lives.

It is worthy to note that the findings of this study did not fully concur with Roehlkepartain, Ebstyne King, Wagener, & Benson's (2006) assertion that spiritual development is a vital resource in adolescent development. There were a few focus group students who noted that spirituality was not part of their life, and that they never thought about God or spirituality.

There are several theories that explain the process of spiritual development. Lerner, Alberts, Anderson and Dowling (2006) argued that cognitive, emotional and behavioural characteristics that operationalize spirituality are characteristics that develop over a lifespan. Kohlberg (1984b) proposed a six-stage theory of development that involved a progression from pre-conventional to principled moral decision making. The stages of moral development were presented as structures of thinking about rules or principles obliging one to act because the action was seen as morally right (Kohlberg, 1984a). In each level of moral thinking, thinking became individual, and behaviours were based on personal moral standards. Principled moral decision making emerged in later adolescence. This level of reasoning involved adolescents beginning to question

absolute standards and rules. Personal values and morals were separated from the standards held by authority figures (Kohlberg, 1984b). Finally, adolescence was a period of transition where the youth begin to question and are conflicted about their values, beliefs and morals (Coles, 1990).

After reflecting on these theories, I now present explanations for the varied student responses to the importance of spirituality as a component of wellness. Perhaps the students who lacked insight into the spirituality dimension have not developed the cognitive and emotional ability to respond to and understand spirituality. On the other hand, the students may be forming individual beliefs, values and morals and are questioning their spirituality. One student (F#3) stated, "I don't think there's some...God watching me all the time and protecting me or like I don't think that there's really a reason why I was put on earth. I just think I'm here so...and then that's all that I know." This remark supports the above notion that the participants were questioning the standard beliefs and values held by authority figures.

Another possible reason for their response is that the adolescent is emerging into what Kohlberg (1984b) referred to as the principled moral decision-making. One student (F#2) commented, "parents that bring their kids to church and throw them in a place that they don't understand and it's hard on them, it turns them away." In this case, the youth may be separating themselves from the standards or spirituality held by their parents. Furthermore, the words "throwing them in a place" illustrated that the adolescent is developing his/her own personal values and morals that are clearly not congruent with the parent/guardian.

Verma and Sta. Maria (2006) argued that the changing global context and the widespread societal changes are affecting adolescent attitudes towards religion and spirituality development. They stated, “urbanization has facilitated the increased contact between diverse cultures and religious groups. Youth are now required to operate in multicultural settings and to be culturally pluralistic” (p. 125). Also, Inglehart and Baker (2000) have written about the effects of globalization. They stated that youth are exposed to a variety of spiritual beliefs and practices, and this may result in a secure grounding of traditional values, or the exposure may produce a wide variance in meanings and experiences (Inglehart & Baker, 2000).

The comments by students supported the above research as there were several statements relating to the importance of accepting the multiple variances of spirituality. For example, one student stated (F#2), “you could still think like...the earth wasn’t actually made by God but you know that there’s some kind of God there.” Clearly this student was cognizant of the multiple options for religions and spiritual beliefs and strongly felt that it was important to accept and/or explore the different options.

In summary, there were varying definitions and perceptions of spirituality affecting wellness. Plausible explanations for the diversity in responses may be the lack of cognitive development or the transitioning to principled moral decision-making. Finally, the changing global context has influenced adolescent spiritual development that resulted in multiple experiences and meanings. Despite the varied responses, the study’s findings suggested that there were many students engaging in dialogue and/or reflecting about spirituality in relation to their overall sense of wellness.

The Moderating Influences of Psychological Development

Psychological development (self-concept and self-esteem) has been identified by many as an important dimension of wellness. The following discussion illustrates the many factors affecting psychological development, and these include feelings of worthiness, competence, pride, self-worth and self-appreciation.

Self-esteem has been well researched in relation to positive psychological well-being. For example, Baumeister, Campbell, Krueger and Vohs (2003) correlated high self-esteem with happiness, enhanced initiative, good personal adjustment, internal sense of control and good coping mechanisms. Harter (1990) argued that “self-esteem serves as a buffer against stress and is typically associated with a wide range of coping strategies. In addition, it is clearly linked to enhanced motivation and positive emotional states” (p. 354).

These data echo the above assertions. The descriptive statistics illustrated that 89% of students felt that positive psychological development contributed to their overall sense of wellness. Figure 6.4 is used to present the students’ perceptions of the factors contributing to psychological development.

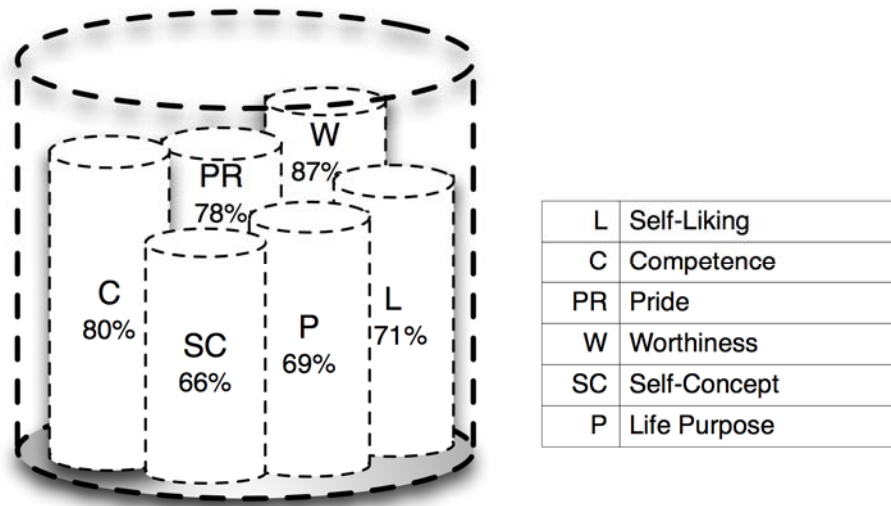


Figure 6.4. Adolescent perceptions of the factors contributing to their psychological development.

As indicated in Figure 6.4, over three quarters of the student participants perceived themselves to be competent, proud and worthy, and over 66% of the adolescents stated that they liked themselves, felt that their life had purpose and had a positive self-concept.

Similar to Harter's and Baumeister's conclusions on self-esteem, all the items measuring psychological development were positively correlated with wellness. The results suggest that higher student self-reported levels of wellness were moderately associated with increased beliefs in life purpose ($r=.27, p < 0.0005$), sense of pride ($r=.28, p < 0.0005$), competency ($r=.30, p < 0.0005$), positive feeling of oneself ($r=.32, p < 0.0005$), and perceptions of worthiness ($r=.30, p < 0.0005$). Increased perception of wellness were minimally related to the belief that good qualities ($r=.22, p < 0.0005$) and liking oneself ($r=.25, p < 0.0005$) contributed to adolescent wellness.

The student focus group discussion also supported the above conclusion. One student provided excellent insight into the relationship between self-esteem and wellness.

He stated (F#5), “I think you’re self-esteem kind of acts as the balance. Because self-esteem is the thing that’s connected to all of them ‘cause like self-esteem will lead to all. So I think the higher the self-esteem the more those things will be balanced.” For this student, feeling good about himself was the key to maintaining balance in his life.

The statistical data and the students’ comments seem to lead to the conclusion that self-esteem was at the center of wellness. However, to merely state that psychological development is a central component of wellness is to beg the question, what causes an adolescent to like himself/herself while others do not? In other words, what factors enhance an adolescent’s self-esteem? As the research progressed, it was clear from the student and teacher experiences that there are many potential factors. This analysis now turns to focus on the effects of media on body image satisfaction and self-esteem, in order to shed light on findings related to body image.

The Effects of Media on Body Image Satisfaction

Piaget’s (1972) developmental stages involved transitioning from concrete descriptions of oneself to more abstract self-portraits. Thus, as the adolescent develops, he/she is able to formulate a sense of his/her true self. Harter (1990) argued:

Although abstractions illustrate that the adolescent is developmentally advanced, the teenagers are removed from concrete thoughts and therefore more susceptible to distortion. The adolescent’s self-concept becomes more difficult to verify, is often unrealistic and puts the teenager at risk for developing inaccurate self-concepts. (p. 355-6)

Thus, during this period of transition, the adolescent may be vulnerable to powerful socializers, such as normative standards and opinions of others (Harter, 1990).

Current research indicates that the media is obsessed with body stereotypes and encourages normal standards for body height and weight, and these body image

depictions are not attainable for most human kind, including adolescents. Fuller and Damico (2008) studied the influence of media use and health behaviours and found that the surveyed adolescents believed that media had a direct impact. Specifically they found “a positive relationship between gender representation and subsequent risks for body image disturbance” (p. 325). Herbozo, Tantleff-Dunn, Gokee-Larose and Thompson (2004) suggested that repeated exposure to media can lead young people to feel pressure to conform to the ideal. Hawkins, Richards, Granley and Stein (2004) also found that women exposed to thin-ideal magazine images had increased body dissatisfaction, negative mood states and decreased self-esteem.

The experiences of the students and teachers support the above conclusions as there were several statements from female students made in reference to the influence of the media on self-esteem. To reiterate one student comment (F#4), “I think that’s why a lot of girls may feel bad about themselves because of a couple random girls on the media.” There were also a few comments from the teachers. One stated, “I think popular culture out there has a tremendous influence on these kids. There isn’t anybody out there with this so-called healthy attitude out there to be a mentor so that’s who they pick.” Of note, the male focus participants did not speak of the media as an influence on self-esteem.

These student and teacher comments reflected the powerful impact of media on adolescent self-esteem and self-concept. Before beginning this study, I suspected that there were many young girls feeling pressure to lose weight or actively dieting and that in general, many women are not satisfied with their personal body image. I speculated that the pressure to conform to the ideal body would be due to peer pressure. I did not expect

that the adolescents would compare themselves with models and touched up magazine pictures. The words, “I wish I could look like that and then you start to feel bad about yourself” provided evidence that the media images have positioned this adolescent for body-image disturbance. The remark, “magazines, they’re like picture perfect and everyone’s supposed to look like” was representative of the pressure to conform to the unattainable ideal. Although I appreciate the students’ honesty, I am saddened that the media has such an influence over our youth.

I speculate that there are many possible reasons for the teachers and students commenting on the influence of media on adolescent self-esteem. Teacher statements reflected a sense of protectiveness for the students combined with a frustration of the unrealistic expectations presented by the media. Moreover, teacher remarks may have been provoked due to a lack of educational strategies to address the influence of media on health behaviours.

For the students, the comments seemed to reflect the pressures of media to conform to societal stereotypes. Harter (1990) asserted that the teenager is at risk for developing inaccurate self-concepts and are vulnerable to powerful socializers, such as normative standards. Similarly, I suggest that the adolescents in this study were comparing themselves to the unattainable stereotypes in the media and, thus, their developing self-image was at risk for distortion. Clearly, the students and teachers were cognizant of the powerful images presented in the media, and their comments reflected the direct impact of these stereotyped ideals on adolescent psychological development.

The Moderating Influence of Social Development

Social development has been identified by many as an important influence on adolescent wellness. This discussion now turns to an examination of the factors influencing social development, and these include student perceptions of support, feeling safe, peer, school and family connectedness, and finally, a sense that there are caring people in the school. The influence of parents and peers on social development is also discussed.

This study identified that there were several moderating influences within the social developmental dimension. Figure 6.5 is used to illustrate the students' perceptions of the factors contributing to social development.

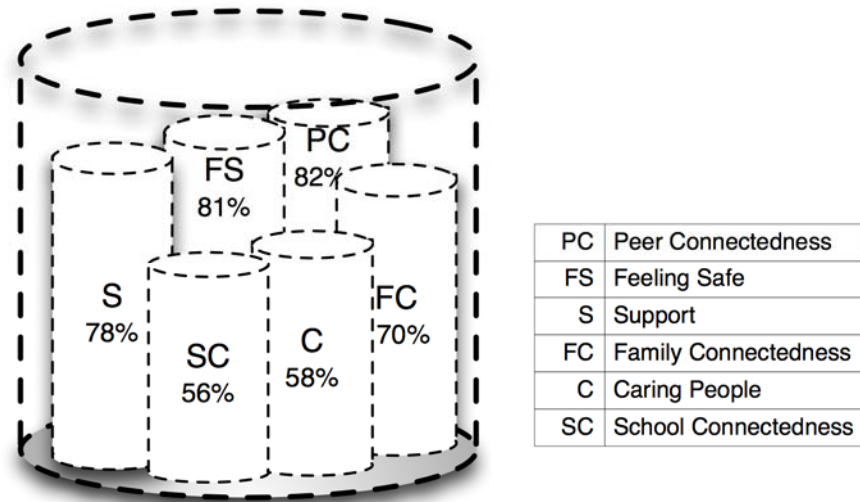


Figure 6.5. Adolescent perceptions of the factors contributing to their social development.

As illustrated in Figure 6.5, 70% of the students felt connected to their family and 82% to their peers. Over three quarters of the adolescents perceived that they had support and

felt safe in the school. On the other hand, only 56% and 58% respectively felt a sense of school connectedness and that there were caring people in the school.

Influence of Parents

There are many family characteristics that have been identified as potential influences on adolescent social development. Throughout the following discussion of the role of parents in adolescent development, I italicized and labeled the data into the previously identified categories (*physical, spiritual, psychological and social*) in order to illustrate the notion that parents affect all the dimensions of wellness.

Irwin (1987) argued, “a supportive environment with parents/guardians that give guidance not only seems to act as a buffer against negative social influences but also as promoter of prosocial behaviours and skills” (p. 3). Resnick, Bearman and Blum (1997) also found that adolescents who felt close to their parents showed more positive psychological development and were less susceptible to negative peer pressure. Santorum (2005) summarized the effects of positive connections by stating, “parents who set high expectations, who make those expectations clear, who talk often and about serious as well as casual matters, monitor their kids’ activities, and set clear rules and limits are the parents whose adolescents feel connected” (p. 98). Finally, McLaren (2002) argued that a nurturing parenting style is more likely to result in good developmental outcomes such as educational achievement, emotional and psychological well-being.

These above assertions provide evidence of the influence of parents on adolescent *social* development and the findings of this study support their conclusions. Specifically, the results suggest a minimal relationship between higher student self-reported levels of

wellness and parent/guardian connectedness ($r = .22, p < 0.0005$) and familial warmth and acceptance ($r = .23, p < 0.0005$). Moreover, higher student self-reported levels of parent connectedness were moderately related to increased feelings of familial warmth ($r = .75, p < 0.0005$) and parental interest ($r = .54, p < 0.0005$).

The comments made by students and teachers also supported the theory that parents are an important influence on adolescent development. A few students spoke of the importance of parental warmth and love and how these feelings increased the youths' sense of happiness and motivation. The teacher confirmed the students' assertions as several felt that parental love was associated with the development of positive feelings for the youth.

Also emerging from this study was evidence that parents influence adolescent *spiritual* development. Boyatzis, Dollahite and Marks (2006) argued:

Parents influence adolescent spiritual development through verbal communication and induction and indoctrination of beliefs and behavioural modeling. Families also engage in activities that promote spirituality such as saying mealtime prayers, engaging in devotions at home and performing religiously motivated charity for others. (p. 299)

The student and teacher comments seem to support the above comments as a few students engaged in dialogue about parents as positive role models for spiritual development. One student expressed (F#4) the view that a parent's openness to individual decision-making and diversity assisted the adolescent to spiritually develop. Parental communication and role modeling promoted a balance of spirituality.

Parents buy groceries and are role models for healthy eating and behaviours such as smoking, drinking and alcohol consumption (Hockenberry & Wilson, 2007). There were several comments from students supporting the previous researcher's assertion. The

youths' discussion offered insight into the effects of role-modeling of health behaviours such as nutrition, physical activity and smoking. For example, one student logically explained that it is your parents who bring in the groceries, and this practice will ultimately affect what kind of nutrition will be available for the family. Another student expressed (F#2), "if your parents smoke then you feel like you're more likely to start smoking." This student articulated how the actions of a parent can negatively affect the health behaviour of their offspring. Finally, Harter (1990) argued that "adolescents who feel supported and positive regard by significant others such as parents will express positive regard for the self in the form of high-self-esteem" (p. 367).

The student comments supported Harter's conclusion that parents are an important influence on adolescent *psychological* development. Parental interaction, such as a simple display of affection or a slighting negative comment, was understood by the adolescents as a significant influence on the adolescents' self-esteem. Clearly, parental encouragement and loving attitudes, or lack thereof, significantly impact adolescents' feelings about themselves.

The relative parental influence on the dimensions of adolescent wellness, as identified in the results of the qualitative analysis, can be explained by the heuristic presented in Figure 6.6.

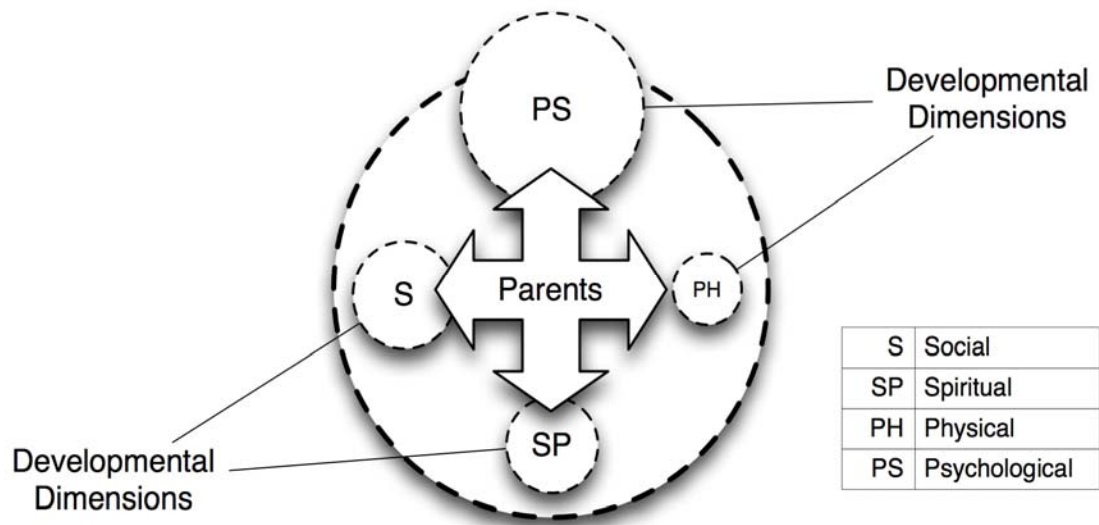


Figure 6.6. Parental influence on dimensions of adolescent wellness.

As illustrated in Figure 6.6, the depicted size of each developmental circle approximates the proportion of the student responses, and positive parenting was perceived to have a relationship to each of the adolescent developmental dimensions (physical, spiritual, psychological and social) to varying degrees. In the focus groups, psychological development was most frequently emphasized by students as an area influenced by their parents. In fact, there were more than twice as many comments relating to the positive influence of parents on psychological development as compared to the other dimensions, which reiterates the importance of parental love and support in the development of adolescent self-esteem and self-concept.

Influence of Peers

There are many peer characteristics that have been identified as potential influences on adolescent social development. Beginning in adolescence, the peer group becomes increasingly important. A study from the Canadian Institute of Health Information (2005) found that “peers who reported a high level of peer connectedness

also tended to report high levels of self-worth and very good health” (Canadian Institute for Health Information, 2005, p. 48). Peer connectedness was defined as whether or not adolescents have many friends, the ease with which they get along with others their own age and whether other youth their own age like them and want to be their friend” (p. 47-8).

The results of this study were congruent with the Canadian Institute’s findings. Increased perceptions of wellness were moderately associated with the beliefs that peer connectedness ($r=.33, p < 0.0005$) contributed to adolescent wellness. Moreover, the ANOVA analysis suggested that the high-level wellness ($M=4.22$) group felt a greater sense of peer connectedness than the low-level wellness group ($M=3.33$). Although the medium-level wellness group did not differ significantly in its perceptions of peer-connectedness ($F(2,277) = 7.15, p < .001$) from the high and low-level wellness groups.

There was also a student comment that supported the Canadian Institute’s research. For example, one stated (F#1), “the teenagers that feel alone, they’re not as well.” There was a general consensus among the students in this focus group that peer relationships enhanced the adolescents’ sense of wellness.

Mclaren (2002) suggested that adolescent friendships provide a space in which to develop social and emotional skills. Peers serve as credible sources of information, role models of social behaviours and sources of social reinforcement (Hockenberry & Wilson, 2007). Harter (1990) argued that after physical appearance, peers are the most important factor contributing to self-esteem.

The findings of the study supported the previous conclusion regarding a positive relationship between peer groups and psychological development. One student

articulated how peers influenced his self-esteem and feelings about himself. As the student continued to reflect, he suggested that peers could potentially affect many components of wellness (mentally, physically and emotionally).

Research has suggested that peers influence adolescent *social* development.

Harter (1990) argued that “the peer group looms large as a source of values, directives and feedback and *social* comparisons” (p. 353). Verma and Sta Maria (2006) found:

New patterns of peer relationships on the World Wide Web are leading to opportunities for learning and sharing a broad variety of social skills, including skills for relationships with people different from oneself. These opportunities will enhance young persons’ abilities to navigate multiple worlds and develop a sense of purpose and self-worth. (p. 129)

The student and teacher comments supported the previous assertion. One student (F#1) reflected on how peer supports positively affected her ability to work through the many issues facing an adolescent today. Her words were reflective of how friends can influence an adolescent’s life path or future “directions.”

Peers encourage learning about different types of religion and spiritual values and beliefs and play an important role in religious tolerance (Verma & Maria, 2006). There were adolescents who reflected on the influence of peers on *spiritual* development. To reiterate a student comment (F#4), “peers affect your spirituality, like...if you start talking about like what you believe in and then like you hear other peoples’ points of view, like that can help influence your own.” The teachers’ discussion suggested that peers were assuming a supportive role in moral decision making. These comments were reassuring as it confirmed that spirituality was a topic of discussion for some adolescents. It was comforting to realize that, in a time when peers are becoming independent from

parents/guardians, peers are intellectually engaging in spiritual dialogue and evaluating multiple world views.

Evidence suggests that, when youth interacted with peers who modeled positive behaviours, these relationships contributed to positive outcomes. For example, an adolescent who associates with friends with good grades is also more likely to abstain from using tobacco, drugs and alcohol (Omen et al., 2004).

The findings of this study diverged from Omen et al. findings in that the student discussion did not suggest that adolescent friendship was precluded by a pact of no drinking/drug use or negative health behaviours. In other words, from the discussion I understood that the adolescents were open to developing relationships regardless of health behaviours. However, the students were very cognizant of the issue of peer pressure and its negative impact on the development of self. There was a student comment that reflected the pressure on adolescents to drink and smoke (*Physical*). Another student related (F#4) to the difficulty of witnessing a friend who was addicted to drugs because “it’s stopping them from accomplishing everything.” Further interpretation of the latter comment is that the adolescents were questioning their peers’ decision to drink and that the student was cognizant of the effects of the negative health behaviours.

Clearly, peers have the ability to validate acceptable social behavior, and as adolescents develop greater independence from their parents, they are susceptible to peer pressure. However, the statistics in this study suggest that 61% of student participants were cognizant that drugs/alcohol/smoking affected their physical development and with

the exception of only a few focus group students, the adolescents demonstrated the ability to rationalize and view the negative consequences of alcohol and drug use.

Similar to the literature, the findings of this study suggested that peer groups potentially impact all four dimensions of adolescent development. Figure 6.7 is used to illustrate the relative influence of peers on the dimensions of adolescent wellness, based on the perceptions of students.

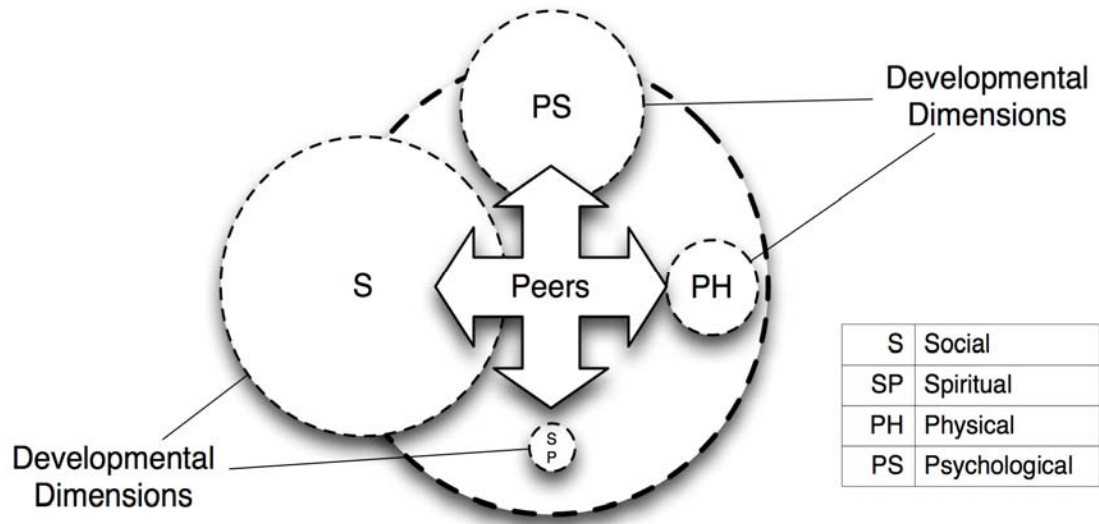


Figure 6.7. Peer influence on the dimensions of adolescent wellness.

As illustrated in Figure 6.7, the depicted size of each developmental circle approximates the proportion of the student responses, and peers were perceived to have a relationship to each of the adolescent developmental dimensions (physical, spiritual, psychological and social) to varying degrees. In the focus groups, the social and psychological developmental dimensions were significantly more emphasized by students as an area of influence by their peers than the physical and spiritual dimensions. Similar to McLaren

(2002), this study's findings suggest that peers have a significant influence on adolescent relationships and self-esteem.

Influence of Teachers on Adolescent Wellness

This last section addresses the final research question “what influences do teachers have on adolescent wellness”, and illustrated the convergence of the results with the literature. Also presented are other factors within the school environment influencing student wellness.

Evidence has shown that teachers are instrumental to the enhancement of student wellness. *The Saskatchewan Education Indicators Report (2008)* identified that, along with parents and the community, educators create a safe, non-discriminating environment to support learning. Teachers have a responsibility to engage students in active learning and use a variety of high quality resources (Saskatchewan Learning, 2008). Epstein (1995) also argued that teachers provide important guidance and encouragement to their students. As support from the school accumulates, significantly more students feel secure and cared for, understand the goals of education, work to achieve their full potential and build positive attitudes and school behaviours (Epstein, 1995).

The results of the study supported the previous assertions. Higher self-reported levels of wellness were minimally associated with perceptions that there was support from at least one teacher in the school ($r=.20$, $p < 0.001$). There were also several comments made by students that supported the notion that teachers are instrumental to the enhancement of adolescent wellness. The adolescents identified that teachers can inspire students to excel to the best of their abilities. A few students concluded that teachers can influence a student's ability and decision to be physically active, eat

healthily and to develop spiritually. It was also suggested that teachers can assist with social relationships and, finally, it was confirmed that educators assist students to feel good about themselves.

These student and teacher comments reflected the important role of teachers in students' lives. Figure 6.8 is used to illustrate the relative influence of teachers on the dimensions of adolescent wellness, based on the perceptions of students.

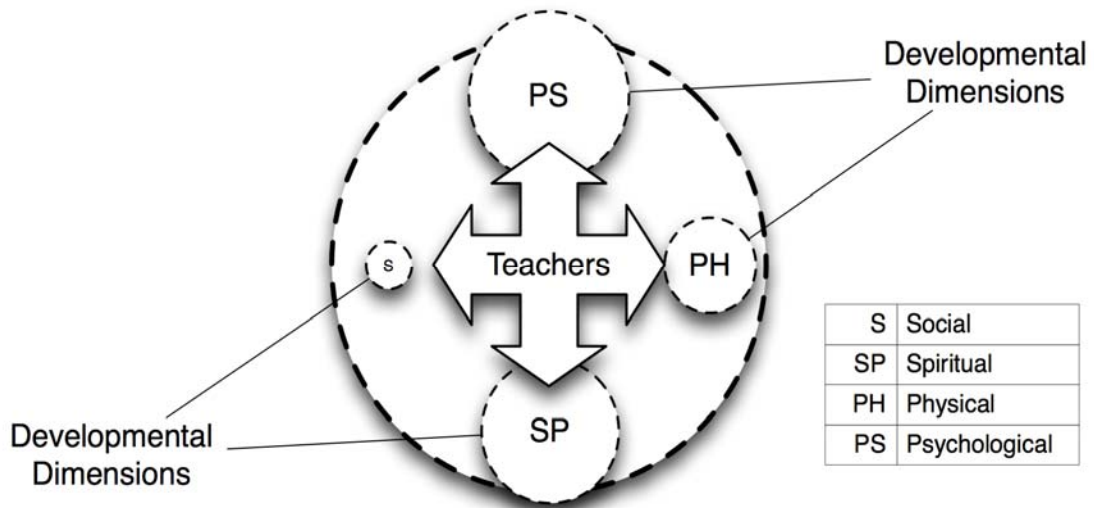


Figure 6.8. Teacher influence on the dimensions of adolescent wellness.

As illustrated in Figure 6.8, the depicted size of each developmental circle approximates the proportion of the student responses, and teachers were perceived to have a relationship to each of the adolescent developmental dimensions (physical, spiritual, psychological and social) to varying degrees. In the focus groups, the spiritual and psychological developmental dimensions were significantly more emphasized by students as an area influenced by their teachers than the physical and social dimensions. Similar

to Epstein (1995), this study's findings suggested that supportive teachers can influence students to develop spirituality, and self-esteem.

As presented in my original conceptual framework, I predicted that as the number of available educational resources and support systems increase, so do perceived levels of wellness. The additional support available to the students created a barrier or lines of defense protecting the student from the imposing stressors in life. The greater the number of lines of defense, the more likely the adolescent was able to maintain a state of balance between the developmental dimensions of life. However, as the research progressed, I realized that adolescent wellness was influenced by more than the previously predicted educational resources and support systems. The students suggested that there were several potential factors within the school environment affecting adolescent wellness.

The Canadian Association for School Health (2007) argued that *supportive school environments* that foster resilience and asset building, safety and social connectedness all work to promote the healthy development of youth. The Canadian Institute for Health Information (2005) found "students who reported feeling engaged or connected with their school were more likely to report high self-worth, excellent or very good self-rated health status" (p. 42-43).

Similar to the previous assertions, the results of the study suggested that there were many factors within the *school environment* affecting student wellness. Increased perceptions of wellness were moderately associated with the beliefs that caring people in the school ($r=.37, p < 0.0005$) and school connectedness ($r=.27, p < 0.0005$) contributed to adolescent wellness. The results also suggest a minimal relationship between higher

student self-reported levels of wellness and feeling safe ($r=.23, p<0.0005$), and perceptions that the school provided opportunities for healthy choices ($r=.23, p < 0.0005$) and success ($r=.20, p < 0.001$).

May and Katzenstein (2004) found that youth who were highly connected to school reported better health than those who reported moderate to low school connectedness. Mcneeley, Nonnemaker and Blum (2002) also presented evidence that positive health behaviours were associated with adolescents' perceptions of caring people at their school and school connectedness. This study's findings support the above conclusions. The relationship between student wellness and sense of school connectedness, as identified in the results of the ANOVA, can be explained by the heuristic presented in Figure 6.9.

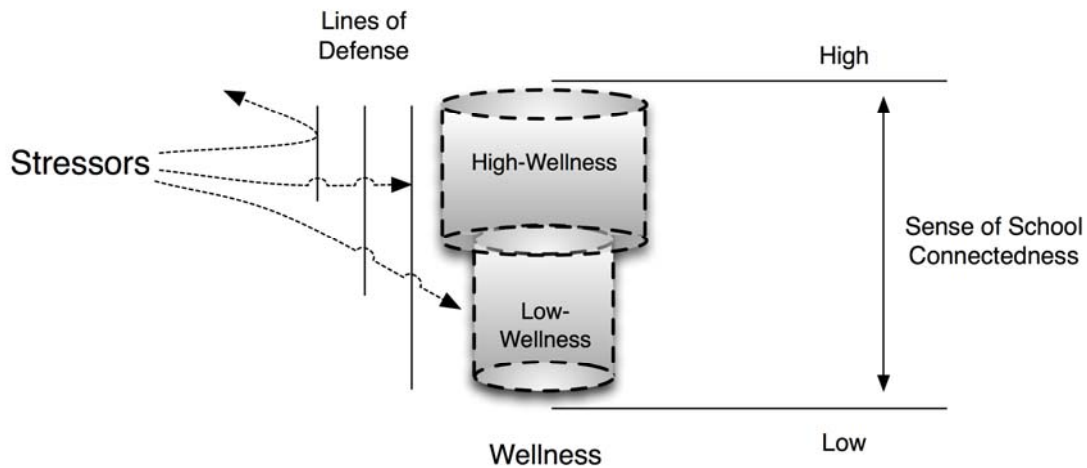


Figure 6.9. Wellness and students' sense of school connectedness.

As illustrated in Figure 6.9, the high-level wellness group felt more connected to its school than the low-level wellness group. An explanation for these results is that the increased sense of school connectedness may have created additional or a stronger lines of defense protecting the student from the imposing stressors in life. In short, the greater

the number or stronger lines of defense, the more likely the adolescent was able to maintain a state of balance among the developmental dimensions, and to rate their level overall wellness as high. On the other hand, the students with a low-level wellness felt a lesser sense of school connectedness, and this may have resulted in fewer barriers or lines of defense from the imposing stressors. Thus, the stressors were able to penetrate their lines of defense, negatively influencing their self-rated level of wellness

The relationship between student wellness and sense of caring people in the school, as identified in the results of the ANOVA, can be explained by the heuristic presented in Figure 6.10.

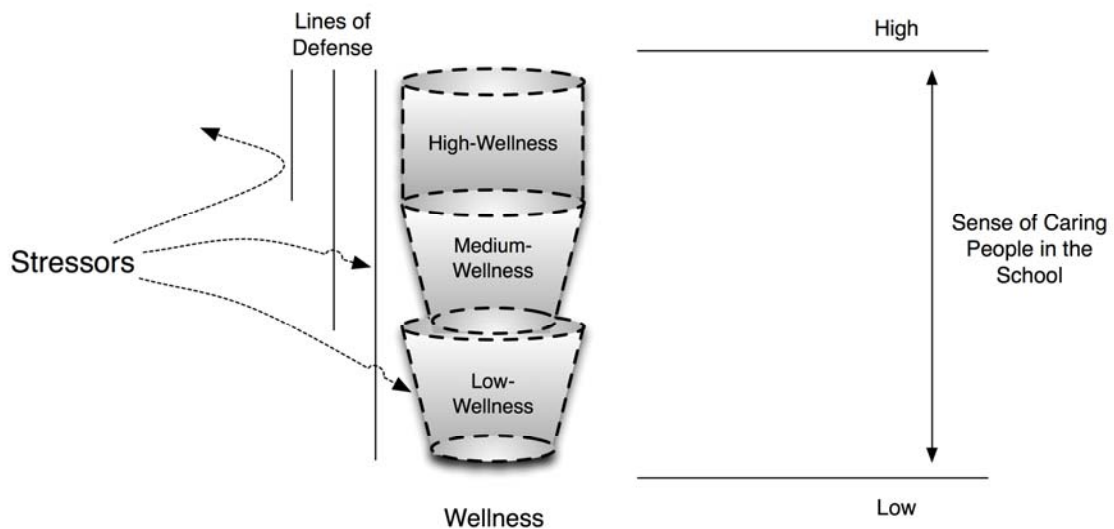


Figure 6.10. Wellness and students' sense of caring people in the school.

As illustrated in Figure 6.10, the high-wellness group was more likely than both the medium and low-wellness groups to feel that there were caring people in the school. An explanation for these results is that the increased sense of caring people may have increased the number or strength of the student's lines of defense and provided protection from the imposing stressors in life. The greater the strength and number of lines of

defense, the more likely the adolescent was able to maintain a state of balance among the developmental dimensions, and to rate their level of overall wellness as high. On the other hand, decreased perceptions of caring people may have resulted in fewer barriers or lines of defense from the imposing stressors. Thus, the stressors were able to penetrate their lines of defense, negatively influencing their self-rated level of wellness

In sum, most students felt strongly that teachers affected student wellness. Other influences on healthy youth development identified in this study were school connectedness, caring people, supportive and safe environment and perceptions that the school assists students to be successful in life. Clearly, a supportive school environment, with teachers having a central role, had a significant impact on student wellness.

Key Findings or Results of this Study

Wellness is more than regular physical activity and eating healthily. It is a complex and multifaceted phenomenon. This study suggested that at least four dimensions were contributing to the balance of wellness (physical, psychological, spiritual and social). For many students, the dimensions were not considered equally important, but wellness involved maintaining a *balance* in life. Finally, factors contributing to wellness were examined.

Wellness

Wellness was described as multidimensional but, for many participants, the dimensions were not equally important. The majority of students suggested that psychological (89%), social (85%) and physical (80%) development made the most significant contribution to adolescent wellness. Moreover, slightly over half the respondents perceived that spiritual development (53%) contributed to wellness.

The Relationship between Adolescent Development and Wellness

Wellness involved a *balancing* of the developmental dimensions of wellness. There was an understanding among the students and teachers that wellness was more than just physical health. Wellness was seen as a balance of the physical, spiritual, psychological and social dimensions of life.

The Moderating Influencing Factors of Wellness

The physical dimension revolved around the common notion that physical activity and healthy nutrition promoted wellness. However, the students did not speak to or did not recognize the potential health issues associated with unhealthy body weights. The prevalence rates of smoking, drugs and alcohol among the student respondents were notable.

The spiritual aspect of wellness was evidenced in the youth descriptions. However, many students voiced that spirituality was not part of their life, and a few youth expressed that they never thought about God or spirituality.

The psychological dimension was exemplified through one student who stated that self-esteem was the center of wellness. Many of the students and teachers reflected on the powerful impact of media on self-esteem and self-concept. The pressure for the adolescent to conform to the unattainable physical ideal was evident.

Flowing from the psychological dimension is social development. Parental love and support promoted positive feelings for the youth. Additionally, higher perceptions of wellness were associated with friendships. Specifically, peer support was perceived to assist the youth to confront the many contemporary issues facing adolescents.

Influence of Teachers on Adolescent Wellness

This study suggested the obvious: teachers have an influential role in students' lives. Teachers inspired the youth to be physically active and eat healthily. Through a supportive role, teachers assisted the youth to develop the cognitive and emotional ability to respond and interpret spirituality and through their interactions with students, educators promoted positive self-esteem. School connectedness and a sense of caring people in the school also influenced student wellness. A supportive school environment, with teachers having a central role, contributed to student wellness.

Implications for Educational Theory, Practice, Policy and Research

The literature and the findings of the study suggested that there are many influences on adolescent wellness. Thus, through educational transformation, the potential exists to enhance the promotion of wellness in schools.

Implications for Theory

This study provided beginning evidence for the construct of wellness and a comprehensive theoretical approach for exploring adolescent wellness. As illustrated in Figure 2.1, wellness was defined as the predictable growth of the four developmental dimensions. I predicted that, in order to achieve wellness, the adolescent must predictably develop in all four developmental dimensions of life, and the students must achieve certain developmental milestones in order to realize wellness. The study revealed that there were varying degrees of emphasis on the four dimensions contributing to wellness: physical (80%), psychological (89%), spiritual (53%) and social (85%). The construct of wellness presented in this study affirmed the importance of in-depth,

comprehensive adolescent wellness research rather than the prevalent problem-based approach.

This study adds to the growing body of knowledge on school connectedness theory. Similar to May and Katzenstein (2004), this study found that youth who were highly connected to school reported higher levels of wellness. The heuristic presented in Figure 6.9 illustrated the explanation that an increased sense of school connectedness may have created additional or stronger lines of defense protecting the student from the imposing stressors in life. In short, the greater the number or stronger lines of defense, the more likely the adolescent was able to maintain a state of balance among the developmental dimensions and to rate their level overall wellness as high. This theory provided insight into the relationship between school connectedness and wellness and may be useful to teachers, administrators and educational partners as they seek evidence as to how to promote the well-being of their students.

Implications for Practice

The results of the study and the related literature indicated that modifications to particular areas of educational practice should be considered when working to promote adolescent wellness. Some of the suggested change areas include: professional development, school programming and committing to school partnerships with health care professionals such as nurses.

Professional Development

Although this study identified many potential areas for professional development, this discussion will be delimited to the development of educational methods to address

spiritual development, school health education, the influence of media on self-concept, and promoting school connectedness.

The results of the study suggested that there were varying perceptions relating to the importance of spirituality as a dimension of adolescent wellness. However, evidence suggests that spiritual development is a vital process and resource in the adolescents' developmental journey (Roehlkepartain, Ebstyne King, Wagener, & Benson, 2006). Developing appropriate educational strategies may be one method of addressing the divergence of the results from the literature. Professional development that is focused on developing spirituality within the different levels of cognitive development may assist adolescents to grow spiritually. Fowler and Dell (2006) argued:

Evaluating the students' stage of cognitive and spiritual development and matching these competencies with methods of teaching at different levels of reflective inquiry and complexity can have a tremendous impact on the perceptions, motives, visions and actions of students. (p. 43)

The above suggestion may be viewed with skepticism by some readers as the counter argument would be that, regardless of the educational methods, adolescents' perceptions of spirituality will not change. However, it might also be argued that educators with this mind-set are more prepared to teach at different age and stage levels and to match their methods and communicative practices with the groups' range of stages (Fowler & Dell, 2006). Thus, teachers who are prepared to address spirituality within the various stages of adolescent cognitive development could potentially have an impact on adolescent values, spiritual beliefs and meanings.

The findings of this study illustrated that there were many students who lacked basic health knowledge such as the effects of overweight and obesity. Kann, Telljohann

and Wooley (2007) found that school health education has the potential to assist students to maintain and improve health and reduce health-related risk behaviours. Professional development directed to the advancement of teaching materials and strategies would assist educators to provide accurate and age appropriate health education (Kann et al., 2007). Moreover, teachers would be more prepared to address the physical, social, and cultural contributions to overweight and obesity in children and youth. A commitment to providing teachers with the supports needed to deliver health education that is designed to build knowledge, skills and attitudes would enhance student learning and contribute to more positive health behaviour decisions (Kann et al., 2007).

The results of this study also suggested a link between media and distorted adolescent self-concept. Thus, another important professional development area to consider is the effects of media on the development of adolescent sense of true self. Although there are many methods of addressing the influence of media, Fuller and Damico (2008) suggested:

Practitioners should allow students to explore and discuss media preferences as this information allows the teacher to develop a better understanding of current and popular media and the role that media plays in students' lives. Educators should ask questions about the health behaviours that media texts present that are potentially problematic. Educators can also ask students to record the frequency and source of body stereotypes and then explore how this image affects perceptions of self and relationships with others. (p. 328)

Appropriate teaching methods in the classroom could assist educators to understand how youth view media content and develop strategies to effectively address the potential impact of media on adolescent self-concept.

A final suggestion is for professional development that is designed to increase youth engagement or school connectedness. *The Canadian Institute for Health*

Information (2005) found:

School engagement or connectedness is defined as the degree of importance that a youth may place on doing well academically, learning new things, making friends, participating in extracurricular activities, getting involved in activities such as school council and expressing opinions in his/her class. (p. 42)

May and Katzenstein (2004) found that youth who were highly connected to school reported better health and fewer risky behaviours than those who reported moderate to low school connectedness. Mcneeley, Nonnemaker and Blum (2002) also presented evidence that positive health behaviours were associated with adolescents' perceptions of caring people at their school and with school connectedness. "Positive classroom management climates, participation in extracurricular activities and tolerant discipline strategies were associated with increased school connectedness" (p. 138). Finally, Henderson, Ecob, Wright and Abrahan (2008) found that the quality of teacher-student relationships, pupils' attitudes to school and the school's focus on caring and inclusiveness influenced the rates of adolescent smoking in school.

Evidence suggested that school connectedness and focusing on a caring school environment promoted student wellness. However, the results of this study indicated that only half of the students felt that the people in the school cared and that they felt connected to their school. High levels of wellness were also positively correlated with an increased sense of school connectedness and feelings that there were caring people in the school.

In-school leaders should consider professional development directed to promoting connectedness in the school. Establishing strategies for teachers to foster connections, competence and social skills (communication) could assist to promote a sense of belonging in the school (Kann et al., 2007; May & Katzenstein, 2004; McNeeley et al., 2002). Moreover, professional preparation focused on fostering a caring and trusting school environment could also increase students' perceptions of school connectedness and overall sense of wellness.

School Programming

Students have many needs that can be appropriately addressed through school programming. This discussion was delimited to the development of educational programs that promote self-esteem, increase physical activity and school health education.

Schools are settings where health is created, supportive environments are built, partnerships are made and many skills are learned (St Leger, 2004). School communities have a responsibility to help students acquire the knowledge and skills necessary to establish and maintain lifelong healthy behaviours. School wellness programs have been shown to positively influence an adolescent's health (Canadian Association for School Health, 2007).

The research presented above illustrated the positive outcomes associated with school programming. The results of this study suggested that the schools have successfully educated many of the students regarding the effects of smoking, drugs and alcohol. However, these students continue to engage in health compromising behaviours such as smoking, drugs and alcohol. As a nurse I could relate to these adolescents as I

have had similar experiences working with pediatric clients who were admitted for cellulitis related to IV drug injection. When I spoke with these clients, they could recite all the effects of drugs but clearly had no intention of quitting this behaviour. It is my belief that the issue was not a lack of knowledge about the drug use, but rather low self-esteem and feelings that the youth were not worthy of healthy behaviours.

While working with youth, I have found that these adolescents have internalized feelings that they are “bad” and lack a feeling of competence. The adolescents may also be using drugs or alcohol to escape the pain and hurt in their lives. Thus, they have knowledge of the effects of alcohol and drug use, but do not feel worthy to protect themselves or think of their future. Their lives are filled with feelings of hopelessness, and thus, they continue to practice health compromising behaviours.

Although the findings of this study indicated that there were many students who had high levels of self-esteem, it is important to develop programming to address the needs of the students who did not perceive themselves as worthy (13%) and competent people (20%). Programming is needed within the schools to address comments such as, “it’s almost not accepted to be able to say, I accept myself as I am. It’s like everybody says, I hate this about my body and it’s weird if you don’t hate yourself.” Although there are current initiatives to address self-esteem, I believe there is still a need to further address this concept in adolescents and in all schools.

Pateman (2006) argued that school-based education has been proven as an effective method of assisting adolescents to develop the knowledge, motivation and support they need to choose health enhancing behaviours. Kann, Telljohann and Wooley (2007) also found that school health education has the potential to assist students to

maintain and improve health. This study's findings provided evidence of the need to increase students' knowledge regarding the effects of smoking, drugs and alcohol, the effects of media and unhealthy body weights. Thus, I suggest that school leaders commit to identifying and providing educational programming that addresses the health knowledge gaps of our youth.

Finally, I would like to address the need to promote healthy body weights and physical activity in adolescence. As previously stated, one of the study's finding suggested that the majority of student participants did not perceive body weight as an influencing factor of physical development. There were also no comments or concerns from students related to the health problems associated with overweight and obesity.

There are studies that illustrate the increasing rates of obesity in adolescents (Katzmarzyk et al., 2004; Tremblay et al., 2002). Tremblay and Willms (2003) presented evidence that supported the link between physical inactivity and obesity of Canadian children. The positive health effects of regular physical activity are also well-documented in the literature. Regular physical activity enhances physical development such as reducing the risk for cardiovascular disease and high blood pressure, promotes healthy emotional development, reduces the risk of depression and promotes healthy sleep patterns (Brien & Katzmarzyk, 2006; Hockenberry & Wilson, 2007; Katzmarzyk et al., 2003; McKinney et al., 2005). Furthermore, there have been several studies that have reported a positive association between participation in physical activity and academic achievement (Crosnoe, 2001; Marsh & Kleitman, 2003; McHale et al., 2001).

Despite the well-known positive effects of physical activity, there has been a general decline in physical activity. For example, "In 2003, 76% of 12-14 year old males

and 71% of 12-14 year females were moderately active in physical activity; among youth aged 15-19, rates decreased slightly in males to 74% and decreased significantly in females to 61%” (Canadian Institute for Health Information, 2005, p. 30).

School programming can be instrumental in addressing this decline in physical activity. Lee, Burgeson, Fulton and Spain (2007) argued that a comprehensive approach is necessary to increase physical activity levels of adolescents. A greater effort is needed to improve the quality of physical activity programming. Flynn, Mcneil, Maloff, Mutasingwa, Ford and Tough (2006) argued, “schools are a critical setting for programming where health status indicators, such as body composition, chronic disease risk factors and fitness, can all be positively impacted. Engagement in physical activity emerged as a critical intervention in obesity” (p. 7).

Similar to the previous assertions, I suggest that in order for schools to successfully promote physical activity and healthy body weight in adolescents, school professionals and administrators consider changes to the physical education programming. It is time to envision physical education as a commitment to promoting daily physical activity for all students every school day. Gordon-Larsen, McMurray and Popkin (2000) found that participation in daily physical education programs was associated with increased likelihood of engaging in high-level moderate to vigorous physical activity. Modifying the physical education programs can result in changes to activity patterns of adolescents.

One suggested change relates to the amount of unorganized physical activity offered within schools. More non-competitive, skill or strength building opportunities could assist to increase physical activity in students who are not active in the current

school sports programs. Another recommendation is to develop daily physical activities for all high school students. This would involve setting a daily time for each class to be in motion, and the activity could be as simple as a 30 minute vigorous walk. Although these changes may seem simplistic, I am very aware that this commitment to promoting physical activity would result in many scheduling issues. Thus, school leaders must truly ask themselves, is the health and wellness of students a priority? If so, then the positive results of promoting physical activity and healthy body weights significantly outweigh the scheduling issues. Changes to physical education programming will promote daily physical activity into the lifestyle of the youth, and thus, will assist in the development of positive lifelong health behaviours.

Committing to Partnerships

Schools have been proven to have a significant influence on the health and well-being of children and youth. However, evidence suggests that there are other important influences on adolescent development that school leaders should consider. Specifically, I suggest that partnerships between schools, parents and communities that are designed to enhance school programming and the overall supports available to teachers, students and families.

Current evidence illustrates the many positive effects of community and school partnerships. For example, the Canadian Association of School Health (2007) stated “schools and communities working in partnerships create and foster health-promoting schools” (p. 1). Moreover, Comprehensive School Health was defined as “a multifaceted approach that includes teaching health knowledge and skills in the classroom, creating health-enabling social and physical environments and facilitating links with parents, local

agencies and the wider community to support optimal health and learning” (Canadian Association for School Health, 2007, p. 1). Epstein (1995) argued that partnerships (school, family and community) can work together to coordinate and implement programs and activities designed to increase the well-being of students.

One important partnership for school professionals and administrators to consider is that of nursing. Nursing has an important part to play in health promotion, assessment and intervention related to school health and this study’s findings may provide some warrant for hiring nursing as the results suggested the need for more education and wellness promotion in all of the developmental dimensions (physical, spiritual, psychological and social).

Youngblade, Theokas, Schulenburg, Curry, Huang and Novak (2007) found that youth who were involved in contexts that provided positive resources from important sources (parents, schools) not only were less likely to exhibit negative outcomes, but also were more likely to show evidence of positive development. Epstein (1995) argued:

Partners recognize their shared interests in and responsibilities for children and youth, and they work together to create better programs and opportunities for students. There are many reasons for developing school, family, and community partnerships. They can improve school programs and school climate, provide family services and support, increase parents' skills and leadership, connect families with others in the school and in the community, and help teachers with their work. However, the main reason to create such partnerships is to help all youngsters succeed in school and in later life. (p. 701)

This quote summarizes all the positive effects of school partnerships. School partnerships enhanced school programming and the overall supports available to teachers, students and families that resulted in educational and lifelong success.

Hence, I suggest that school leaders commit to partnerships with parents and community members, including health professionals such as nurses. This obligation goes beyond supporting the theory of a partnership, but rather, moves towards an obligation of developing positive resources and supports within the school. An example of this initiative would be to contract nursing into the school system. A collaborative effort between families, nursing, education and other community members could assist to enhance optimal adolescent wellness.

Implications for School Health Policy

School health policies have the potential to promote the well-being of children and youth. This discussion has been delimited to the development of educational policies that are supportive of professional development related to health education, policies that promote the hiring of school health nurses, and policies that are reflective of adolescent developmental stages.

Adolescence can be characterized by experimentation with activities that may be beneficial or harmful to health (Canadian Institute for Health Information, 2005). Lifelong behavioural patterns, which can become protective factors for many chronic health conditions, may be established or strengthened (Hedberg et al., 1999). In order to enhance positive health behaviours such as physical activity, a comprehensive approach supported at all levels of administration is necessary. Policies that support comprehensive staff development at the local and provincial levels might enable schools by providing the supports required for students to develop wellness and success in life.

Kann, Telljohann and Wooley (2007) found that school health education helped reduce the prevalence of health risk behaviours and promoted wellness. Therefore,

school policies that require instruction on specific health topics may assist students to maintain or enhance their personal level of wellness. I suggest that certain health education topics should no longer be optional as this study's findings indicate that there is a need to address students' health knowledge and the potential link with risk-taking behaviours. The list of required topics could be developed based on evidence and in collaboration with a school health nurse. Developing policies that require educators to deliver curriculum regarding certain health topics such as the healthy body weights will assist to empower youth with the knowledge to make healthy decisions and enhance wellness behaviours.

Brenner, Wheeler, Wolfe, Vernon-Smiley and Caldart-Olson (2007) found that increasing the number of school nurses is a critical step to enabling schools to provide more services. Health screening, infectious disease reporting, verification of immunization and wellness promotion were a few examples of services that were enhanced with the employment of a school nurse. Whitehead (2006) argued that nurses can evolve broad-based health promotion and move beyond the traditional reliance of limited health education. Finally, Bonny, Britto, Klostermann and Hornung (2000) asserted that school nurses are an excellent resource for identifying disconnected youth.

It is becoming the norm for health professionals to be contracted for services within the school system (e.g. psychologists, speech and language therapists, occupational and physical therapists). It is time for administrators to consider the inclusion of nursing in the regular school staffing patterns in the future. Nurses and nursing students could work with the various disciplines to develop appropriate wellness programming. Callaghan (2006) argued that nurses could assess appropriate adolescent

support, and when deficits in social support are identified, nurses could intervene through referral or working with the student to establish support systems. Nursing would also contribute to the current educational goal of promoting wellness by assisting to address the many health issues facing adolescents today.

Finally, school leaders should commit fiscally to policies that are reflective of all the adolescent developmental dimensions of life. Weller-Clark (2006) argued:

Youths need awareness of their own strengths and appropriate knowledge and education related to how to foster their strengths. This developmentally appropriate approach should be delivered in a nonjudgmental and highly salient format, which emphasizes their choices, responsibilities, and consequences. All youths need to acquire a set of skills to promote healthy relationships. They need to develop peer supports and feel connected to their family, friends, schools, and communities. This sort of connection requires a commitment to building on everyone's capacity. It requires the perception that each adolescent is a person, rather than a potential problem. (p. 9)

Weller-Clark's argument spoke to the importance of viewing adolescence from a different lens, one that is not focused on the problems associated with an adolescent transitioning into adulthood, but rather one that fosters the strengths of the youth. This developmental approach requires a commitment to holistic policies that build school capacity and explores the multiple influences on the health and well-being of adolescents.

Despite the many obligations of school leaders to schools, I would encourage a commitment to the development of more effective and sustainable educational wellness policies. Policies supportive of professional development and health education, policies that consider adolescent growth and development and include nursing in the regular school staffing plan all can result in an environment that promotes optimal wellness for adolescents.

Implications for Future Research

The topic of wellness is one that is open to many areas of future research. Results from this study suggest that wellness is a complex phenomenon that is in a constant state of motion. Thus, longitudinal studies are needed to study this concept over time. Longitudinal research would allow for further exploration of the conceptualization of wellness, and its validity beyond this study.

This study discovered the need to further the definition and understanding of wellness. Because this study's findings were limited to participants in the study, I cannot generalize the findings to all adolescents. There may be significant value in replicating the results of this study, preferably with a larger sample and more refined survey items. Specifically, improving the psychometric properties of the developmental scales used in the questionnaire and the construct validity of the items could be examined.

In a qualitative sense, it would be important to understand wellness in adolescents of all ages and in schools across Canada. This study was delimited to students and teachers; therefore, there is a need to add the voice of parents/guardians. There is also a need to explore other variables, such as culture and socio economics, which were not included in this study's wellness construct.

This study revealed the necessity to further explore the relationship between wellness and adolescent development (physical, spiritual, psychological and social). Further qualitative studies are needed to explore the extent that wellness influences certain developmental behaviours and visa versa.

One topic for potential research could be to explore the relationship between spirituality and wellness, from student perspectives. Using in-depth interviews, this study

would delve into the students' understanding of spirituality. This topic would explain why some students view spirituality as important and others do not. It would address how the school, parents and peers can foster spiritual development in youth.

A second topic to examine could be the effects of media on self-esteem and wellness. This study would explore student perceptions of ideal body image, and it would examine how media affects self-esteem. This study could explore how to successfully incorporate and critically think about media in the students' lives.

A third topic could explore the effects of smoking, alcohol and drugs on an adolescent's sense of wellness? The study identified that students were knowledgeable of the effects of drugs/alcohol and smoking, and yet the prevalence rates for each of these health behaviours remain high. Future research is needed to explore the rationale for this divergence. A survey would examine the health knowledge and prevalence rate in a larger number of participants than this study could offer. An in-depth qualitative study would explore the understandings and meanings of these compromising health behaviours.

A fourth potential study could examine if body weight is a contributing factor to adolescent wellness?" Surveys would be appropriate to examine students' knowledge of health, and in-depth interviews would be needed to explore the students' understanding related to healthy body weight. Furthermore, research is warranted that would examine the best approach to the promotion of healthy body weights while being conscious of harm to the adolescent's body image.

Parents, teachers and peers were all identified as important influences of all the developmental dimensions, and these findings are congruent with the literature. Further

studies are needed to explore the degree to which parents, teachers and peers affect each of the developmental dimensions. This study would delve deeply, using phenomenology methods, into how these relationships are understood by the students, and the meanings they hold for the youth.

Lastly, although school connectedness was minimally explored in this study, a question that emerged was “what is the extent of the relationship between school connectedness and wellness?” Furthermore, what are appropriate strategies to increase student connectedness to school and the sense that people in the school care? These topics of research deserve more thought as Mcneeley, Nonnemaker and Blum (2002) clearly suggested that positive health behaviours were associated with adolescents’ perceptions of caring people at their school and school connectedness. Understanding this influence may provide appropriate policy direction to ensure that all students have the supports to experience well-being.

Clearly, there is significant need to explore adolescent wellness. Future research into wellness could benefit the school and, equally important, the students and their families.

Final Thoughts and Concluding Comments

Adolescence has been labeled by experts and parents as a period of transition characterized by rebellion and turbulence. This population has been associated with complex problems such as drugs, alcohol abuse and pregnancy. In addition, there seems to be significant pressure on parents/guardians and school to foster healthy development as, without this optimal growth, the adolescent will be destined for future struggles and lifelong despair. As a pediatric nurse and parent, I felt an urgent need to understand the

truth of adolescence from students' and teachers' perspectives. I believed it was timely to further explore the definition, conceptualization and influences of adolescent wellness.

Adolescents have been typically described by adults as irrational, self-centered and lacking foresight, and thus my expectations for the students was prejudiced by negative ideations of youth. In addition, many adults defined wellness as physical activity and healthy eating, and I expected similar beliefs from the youth. However, contrary to my preconceived view, the most profound revelation of this study was the students' insight into defining wellness. The students affirmed that wellness was multidimensional and moved beyond physical to include healthy relationships, emotional stability and spirituality. For many students, the dimensions were not considered equally important, but wellness involved maintaining a *balance* in life. These findings illustrated the students' capacity to understand, develop opinions and think abstractly. Moreover, the students illustrated intense cognitive maturity, and the truth emerged: adolescents are not all selfish, confused and destined for the depths of despair. In fact, I finish this study with a sense of pride and anticipation for our future generations.

The findings related to adolescent spirituality were also worthy to note. Once again it seems that there is a general notion that the secular society of the 21st century has had an effect on the spirituality and religious practices of youth. It may be a common belief that many youth reject spirituality or do not practice any form of organized religion. However, this study challenges these perceptions as over 50% of the adolescents felt spirituality influenced wellness and that spirituality was indeed an important resource in their developmental journey. Several students spoke of the importance of spirituality in relation to wellness and I now understand that despite the

complexity and ambivalence of adolescence, there are spiritual leaders among our youth who are capable of reasoning, thinking about, and entering into dialogue about spirituality.

There was an important revelation relating to the effects of media on body image. Particularly disturbing was the female participants' suggestion that they were affected by the message to conform to the idealistic views of bodyweight. As a parent of two daughters, I often wondered how a child perceives the messages as presented by the media. From my perspective, magazines, radio and television all relate the message that beauty is a direct reflection of body weight. For example, a person cannot walk through a grocery aisle without passing by the magazines presenting visuals of the latest model/superstar who has gained weight. The focus of the message is not on the happiness of the individual but rather the undesirable weight gain. This study confirmed my apprehension; adolescents are feeling pressure to conform to the ideal body image. Moreover, the findings established the need to further explore how media affects the youth perceptions of self and relationships with others.

Another unexpected finding was that most of the students did not speak to or recognize the potential health issues associated with unhealthy body weights. Prior to this study, I assumed that due to the prevalent messages in the media, most adolescents were cognizant of the multiple effects of overweight and obesity. The advances in technology and the competence of students to obtain and navigate the information led to the incorrect assumption of knowledge. This new understanding will be used as a guide for the future development of content for my pediatric nursing course. In addition, this

knowledge will be used to direct future high school recommendations and their delivery of health programming.

On the other hand, the findings suggested that the students were knowledgeable of the effects of smoking, drugs and alcohol, yet the prevalence rates were remarkable. This information leads one to question whether the lack of congruency is due to the adolescents' sense of being infallible or, once again, the pressure to conform. Regardless of the reason, this knowledge illustrates the urgent need to further address this health issue in our youth.

In closing, although the movement towards a well society began almost fifty years ago, there is still a considerable need to address the promotion of adolescent wellness. While this study offered insight into defining the concept, the findings also identified many influencing factors on a high school student's sense of wellness. It was suggested that wellness is a multifaceted and complex phenomenon, and the need to further understand the balancing forces still exists.

Caldwell (2006) outlined his view:

Imagination lies at the heart of all that is best in education. The great social movements that have freed the human spirit and lifted people out of material deprivation have required heroic efforts by those who have imagined a better world, and done something about it. (p. 3)

The promotion of adolescent wellness requires educational leaders to imagine transformation of schools. The administrators are working proactively to promote wellness; however, this study acknowledged the importance of considering the meanings and experiences of youth in the vision for transformation. The adolescents' insight coupled with a collaborative approach, including parents and multiple disciplines, can

lead to an educational environment that supports students to experience well-being, learning and life-long success.

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APPENDIX A

A-1 Moderator's Guide (Student Focus Group)

A-2 Moderator's Guide (Teacher and Administrator Focus Group)

A-3 Final Version of the Wellness Survey

A-1 Moderator's Guide (Student Focus Group)

Introductions and greetings

Welcome everyone and thank you for joining us today for this discussion group. My name is Shelley Spurr and I am a student at the University of Saskatchewan and I will be guiding the group discussion today. There are no right or wrong answers. I am here today because I want to learn about your experiences and beliefs.

Statement of the Purpose of the Focus Group

You all attend high school throughout these years you have all had varying experiences with wellness. Some of these experiences may have been positive and others negative. I ask that you describe these experiences and the meaning that you attach to them.

The primary purpose of the focus groups is to explore the knowledge, attitudes and beliefs of high school students about wellness. The second purpose of this study is to evaluate the support systems available to the students in the high school.

Guidelines for the Focus Group

Being that all your experiences are important to me, it will be essential that all people be respectful to each other. No person is here to judge another student, therefore interrupting and disrespectful comments will not be tolerated.

The purpose of the tape recording is to help me be as accurate as I can with the answers that are given and that if I were to write things down, I might miss something. Your names will not be mentioned in the report that will eventually be written from this discussion. Your words are important to me, and I will assure you that no one will listen to the tape except for me and the person doing the transcribing.

Lastly, I would like to ask you that the experiences that are shared within this room be kept confidential. This will mean that out of respect for your peers, no one will share the words and experiences of the people in this room without their consent. I would like to assure you that this a safe place to discuss your experiences.

Opening Questions

To begin, I would like to know a little about each of you.

1. What are your names?
2. What do you enjoy about your school?
3. What do you find challenging about your school?

Focus Group Questions

Wellness

1. What does wellness mean to you?
2. What would a well person be doing?
3. Think about your school. What is there about your school that makes it easy or hard for you to be well? Are there any support systems within the school for example teachers, administrators, school counselors? Talk about programs and resources in the school (lunch programs, support groups)
4. Think about your family. What is in your family that makes it easy or hard for you to be well? Talk about levels of support within the family (parent/guardian, sisters/brothers, aunts/uncles, cousins).

Physical Development

5. What is physical development for you?
6. Are there positive or negative influences on your physical development?

7. Does physical development contribute to your overall sense of wellness? If so, how?

Psychological Development

Think about your feelings about yourself.

8. What is psychological development for you?
9. Are there positive and negative influences on your psychological development?
10. Does psychological development contribute to your overall sense of wellness. If so, how?

Social Development

11. What is social development for you?
12. Are there positive or negative influences on your social development?
13. Does social development contribute to your overall sense of wellness. If so, how?

Spiritual Development

14. What is spirituality to you?
15. Are there positive or negative influences on your spiritual development?
16. What is spiritual development for you?
17. Does spiritual development contribute to your overall sense of wellness. If so, how?

Summary Questions

18. Is there anything that I missed today?
19. Is there anything that you would like to add to this discussion today?

Closing Comments

I would be pleased to answer any questions that you may have before closing this session. Thank you again for your participation...

A-2 Moderator's Guide (Teacher and Administrator Focus Group)

Introduction

Welcome everyone and thank you for joining us today for this discussion group. My name is Shelley Spurr and I am a doctoral student at the University of Saskatchewan, College of Education, and I will be guiding the group discussion today. There are no right or wrong questions or answers. I am here today because I want to learn about your experiences.

The Purpose of the Focus Groups

You have been asked to participate in this study because of your diverse understanding and experiences with high school students. You have knowledge and expertise on adolescent development and wellness. It is these experiences that will be the focus of today's discussion and my dissertation. I ask that you share these experiences and meanings today.

The purpose of the focus groups is to explore your knowledge, perceptions and beliefs about the antecedents, barriers, and influences on adolescent wellness. The second purpose is to identify the support systems available for the students in the school.

Guidelines for the Focus Group

Being that all your experiences are important to me, it will be essential that all people be respectful and courteous to each other throughout the discussion. No person is here to judge another colleague and therefore I will ask you all to reframe from interrupting or making disrespectful comments.

The purpose of the tape recording is to help me be as accurate as I can with the answers that are given and that if I were to write things down, I might miss something.

Your names will not be mentioned in the report that will eventually be written from this discussion. Your words are important to me, and I will assure you that no one will listen to the tape except for me and the person doing the transcribing.

Lastly, I would like to ask you that the experiences that are shared within this room be kept confidential. This will mean that out of respect for your colleagues, no one will share the words and experiences of the people in this room without their consent. I would like to assure you that this a safe place to discuss your experiences.

Opening Questions

To begin, I would like to know a little about each of you.

1. What are your names?

Focus Group Questions

Wellness

1. What do you think wellness means?
2. What would a well person be doing?
3. Think about your school. What is there about your school that makes it easy or hard for the students to be well? Are there levels of support within the school for examples teachers, administrators, school counselors. What programs and resources are available in the school (lunch programs, support groups).
4. Think about the student's family. What is in the student's family that makes it easy or hard for them to be well? Talk about levels of support within the family (parent/guardian, sisters/brothers, aunts/uncles, cousins).

Physical Development

5. What is physically development for you?
6. Are there barriers and/or influences on the student's physical development?

7. Does physical development contribute to a person's overall sense of wellness.

Psychological Development

8. What is psychologically development for you?
9. Are there barriers and/or influences on adolescent psychological development?
10. Does psychological development contribute to a person's overall sense of wellness.

Social Development

11. What is socially development for you?
12. Are there barriers and/or influences on social development?
13. Does social development contribute to a person's overall sense of wellness.

Spiritual Development

14. What is spirituality to you?
15. Are there barriers and/or influences on adolescent spiritual development?
16. What is spiritual development for you?
17. Does spiritual development contribute to a person's overall sense of wellness.

Summary Questions

18. Is there anything that I missed today?
19. Is there anything you would like to add to this discussion today?

Closing Comments

I would be pleased to answer any questions that you may have before closing this session.

Thank you again for your participation.

A-3 Final Version of the Wellness Survey

Student Survey

Choose the response that most says how you really feel or think. If you cannot decide, choose the best answer. Please mark only one answer for each statement.

1. I am:

Male

Female

2. I am:

16 years old

17 years old

18 years old

19 years old

20 years old

3. I am well.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

4. My level of wellness is.

Low

Medium

High

Adolescent Physical Development

5. My weight is where it should be.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

6. I am satisfied with my physical appearance.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

7. My weight affects my physical development.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

8. I am capable of doing some sort of physical activity.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

9. I am able to do daily activities without getting too tired.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

10. In the past week, I participated in physical activity:

Not at all

Once a week

2-3 times a week

4-5 times a week

6-7 times a week

11. I participate in enough physical activity to have healthy physically development.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

12. In the past week, I consumed how many fruits and vegetables:

1-2 a day

3-4 a day

5-6 a day

7-8 a day

13. The food that I eat affects my physical development.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

14. In the last month , I smoked cigarettes.

Not at all

Once in a while

1-5 cigarettes a day

1/2 pack a day

1 pack a day

15. In the past month, I drank anything with alcohol such as beer, wine or liquor.

Never

About once a month

2-3 times a month

Once a week

2-3 times a week

Everyday

16. In the past month, I have smoked marijuana.

- Never
- About once a month
- 2-3 times a month
- Once a week
- 2-3 times a week
- Everyday

17. In the past month, I have used drugs such as Cocaine, Crack, Heroin, Ecstasy, Crystal Meth, Sniffing glue or Solvents.

- Never
- About once a month
- 2-3 times a month
- Once a week
- 2-3 times a week
- Everyday

18. Smoking, drugs and drinking alcohol affect my physical development.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

19. Physical development (body weight, nutrition, physical activity, smoking, drugs and alcohol) contributes to my overall sense of wellness.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Adolescent Spiritual Development

20. Spirituality assists me to be creative, and to develop my values.

- Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

21. Spirituality brings me a sense of hope, meaning and purpose in life.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

22. Spirituality means having a sense of connectedness to a higher power.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

23. Spirituality is expressed as religious behaviours and beliefs.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

24. Spirituality enriches a person's quality of life.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

25. Who guides your moral decisions about right or wrong?

Parents or Guardians
Teachers

School Counselor

I make moral decisions on my own.

My parent/guardian and I make moral decisions together

26. Spirituality guides your decisions about what is right and wrong.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

27. Spirituality is important.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

28. Spiritual development (sense of connectedness, purpose in life, a sense of right and wrong, personal values and beliefs) contributes to my overall sense of wellness.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

Adolescent Psychological Development

29. I have grown up with an affectionate, accepting and loving caregiver and this relationship helps me to feel confident when coping with challenges in life.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

30. I can answer the question "Who am I".

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

31. I believe my life has purpose right now.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

32. I have a lot to be proud of.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

33. I like myself just the way I am.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

34. I feel just as good as other people.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

35. I feel competent in dealing with life challenges.

Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

36. I have a lot of good qualities.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

37. I am worthy of happiness.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

38. When I have a problem I am able to learn from the experience.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

39. I feel that I have something to offer other people in my family.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

40. I feel that I have something to offer other people in my school.

Strongly Agree
Agree

Neutral

Disagree

Strongly Disagree

41. I feel that I have friends that care about me.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

42. My friends will be there for me when I need them.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

43. I have at least one best friend.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

44. I feel like I can rely on my friends to help me make decisions.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

45. I feel that participating in sports helps me feel good about myself.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

46. I feel that my family cares about me.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

47. My parent/guardian is involved in my life.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

48. My parent/guardian sets reasonable expectations, and let me know that certain behaviours are acceptable and others are not.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

49. I feel like I can rely on my parent/guardian to help me make decisions.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

50. I feel like I have the ability to make good decisions.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

51. Psychological development (self-esteem, self-concept and independence) contributes to my overall sense of wellness.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

Adolescent Social Development

52. I feel like I have the resources and ability to overcome problems.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

53. I feel connected to my parent/guardian.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

54. My parent/guardian is nurturing, warm and accepting.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

55. My parent/guardian takes interest in where I am, whom I am with, and what I am doing.

Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

56. I feel connected to my peers.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

57. I feel connected to my school.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

58. I feel safe in my school.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

59. I feel like there is support available from at least one teacher, school counselor and/or principal in the school.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

60. I feel that the people in my school care about me.

Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

61. I feel that my school provides opportunities for me to be healthy and well. For example, after school activities and healthy lunches.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

62. I feel that my school helps me to be successful in life.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

63. Social development (coping skills, parents, friends and school) contributes to my overall sense of wellness.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

A-4 Summary of the Modified Survey Questions

1. My weight is where it should be.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

2. I am satisfied with my physical appearance.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

3. I am capable of doing some sort of physical activity.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

4. I am able to do daily activities without getting tired.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

5. I believe my life has purpose right now.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

6. When I have a problem I am able to learn from the experience.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

7. My friends will be there for me when I need them.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

8. I have at least one best friend.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

9. I feel my family care about me.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

10. I feel that I have the ability to make good decisions.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

APPENDIX B

B-1 Letter to Parents and Students

B-2 Letter to Teachers

B-3 Letter to the Director of Education

B-1 Letter to Parents and Students

Dear Parents

I write this letter to you both as a parent and to your child.

To you as parents, I ask permission for your child to participate in a study which has been authorized by both the Greater Catholic School System, by the College of Graduate studies and Research at the University of Saskatchewan and the University of Saskatchewan Advisory committee on Ethics in Behavioural Science Research. The study, my PhD dissertation, is titled Adolescent Wellness: The Case of Students' Perceptions in Two Mid-Sized Western Canadian High Schools.

The primary purpose of this study is to explore adolescent perceptions of wellness in a high school setting. This study is timely as future research into wellness could assist adolescents to develop physically, spiritually, psychologically and socially.

Your son/daughter has been chosen because he/she is 16 years old or older, is in grade eleven and attends school in one of the sites chosen for the study. The focus group which is planned for the students will be composed of four- eight participants from grade eleven. A series of questions related to the topic of wellness and development will be presented during the focus group discussion. There will be both males and females participating in the focus group and the discussion will be held in the school that the student attends, and will be 1-2 hours long. The survey will be administered in the school and will take approximately 20 minutes to complete. Similar to the focus groups, the survey will use a series of questions focused on wellness and development. The students may choose to participate in both the survey and focus group. The student can choose to participate in the either the survey or the focus group and visa versa.

The focus group will be audio-taped with access to the tape being restricted to myself, my academic supervisor and my dissertation committee at the College of Education, University of Saskatchewan. The tapes will be transcribed for research purposes but the names of the participants will not be used. The results of the survey will be analyzed but the names of the participants will not be included in the analysis.

Immediately following the focus groups, the students will be asked if the researcher (moderator) summary accurately reflects their comments. The student may ask to withdraw, at any time, any comments made during the focus group and he/she is

not obligated to answer all questions during the focus group. The student can also choose to withdraw from the study at anytime.

Each student participant will be eligible for a draw for an Ipod. Participation in the survey will result in one entry into the draw and participation in the focus group discussion will result in three entries into the draw. The winner will be drawn at the end of the data collection period. The focus group participants will also be provided with food and drink during the session.

Prior to the writing of the final report, I plan to return to the school to meet as a general, to present the combined findings of the sessions and opportunity will be provided at this time to comment on the findings.

A copy of the summary of the findings of the final report will be sent, at no cost, to any parent who requests a copy. A copy of the same document, at no cost, will be sent to any student participant that may request a copy. All material will be stored for a minimum of five years from the date of the completion of the study.

Nowhere in any writing, including the summary report and final report, will any student names be mentioned.

I will ask your child to complete the STUDENT CONSENT FORM (in duplicate) on the day of the focus group and or the survey.

If you have any questions concerning the research project, please feel free to contact myself or my academic supervisor. The relevant information for contact is

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

B-2 Letter to Teachers

Dear Teachers and Administrators

I write this letter to ask permission for you to volunteer to participate in a study which has been authorized by the Greater Catholic School Board, by the College of Graduate studies and Research at the University of Saskatchewan and the University of Saskatchewan Advisory committee on Ethics in Behavioural Science Research. The study, my PhD dissertation is titled Adolescent Wellness: The Case of Students' Perceptions in Two Mid-Sized Western Canadian High Schools.

The primary purpose of this study is to explore adolescent perceptions of wellness in a high school setting. This study is timely as future research into wellness could assist adolescents to develop physically, spiritually, psychologically and socially.

You have been asked to volunteer because you are a teacher or administrator at the school chosen for the study. The focus group which is planned for the teachers/administrators will be composed of 5-8 teachers and both male and female participants. The focus group will be held in the school and will present a series of questions related to the topic of wellness and development.

The focus group will be audio-taped with access to the tape being restricted to myself, my academic supervisor and my dissertation committee at the College of Education, University of Saskatchewan. The tapes will be transcribed for research purposes but the names of the participants will not be used.

Immediately following the focus groups, you will be asked if the researcher's (moderator) summary accurately reflects your comments. You may ask to withdraw, at any time, any comments made during the focus group or you may refuse to answer questions during the focus group discussion. You can also choose to withdraw from the study at anytime.

Prior to the writing of the final report, I plan to return to the school to meet as a general, to present the combined findings of the sessions and opportunity will be provided at this time to comment on the findings. All material will be stored for a minimum of five years from the date of the completion of the study.

Prior to the writing of the final report, I plan to return to the school and meet with all the participants once again, to present the combined findings of the sessions and opportunity will be provided at this time to comment on the findings.

A copy of the summary of the findings of the final report will be sent, at no cost, to any teacher or administrator who requests a copy.

No where in any writing, including the summary report and final report, will any teacher or administrator names be mentioned.

Should you consent to participate in this research study I ask that you complete the attached TEACHER and ADMINISTRATOR CONSENT FORM (in duplicate). I will collect the consent prior to commencing the focus group.

If you have any questions concerning the research project, please feel free to contact me or my academic supervisor. The relevant information to contact us is

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

B-3 Letter to the Director of Education

Dear Mr _____

I am asking permission to conduct my proposed dissertation research. This research has been authorized by the College of Graduate studies and Research at the University of Saskatchewan, and the University of Saskatchewan Advisory committee on Ethics in Behavioural Science Research. Here is an outline of the proposed research.

Topic: Adolescent Wellness

Purpose: To explore adolescent perceptions of wellness in two Mid- Western Canadian high schools. A second purpose is to apply a theoretical framework to better understand and describe a) the relationship between wellness and the developmental dimensions of adolescent lives, b) the antecedents, stressors and positive influences on adolescent wellness, c) the relationship between professional support (teachers, counselors, and administrators) and students' perceived levels of wellness (low, medium and high-level wellness).

Method: Qualitative methods will consist of focus groups. The focus groups will be comprised of student volunteer from grade eleven. I intend to hold up to five focus groups with both female and male participants. Each focus group will meet in the school for up to a two hour discussion. The sessions will be audio taped and later transcribed for research purposes. The principal will also provide a list of up to 10 teachers and/or administrators to participate in a focus group. These participants will meet either in the school or on campus and this discussion will not take place during school hours. This session will be audio taped and later transcribed for research purposes. I also plan to return to the school after the analysis has been completed to present the combined findings of the sessions and opportunity will be provided at this time to comment on the findings.

I also intend to administer a survey to all the grade eleven students. The survey will be completed online and will be held in the computer lab of the school. The survey will take approximately 20 minutes to complete.

Issues of student, teacher and administrator informed consent are addressed in the letter to the parents, students and teachers, and in the student, parent and teacher consent forms. Copies of all these forms and letters are attached.

Issues of student, teacher, and administrator confidentiality are also addressed in those documents.

The logistics of data collection will be arranged in consultation with the administrators from the school as approved by your office.

Research into wellness has grown over the last decade; however, a thorough exploration has yet to occur in the adolescent population. There are many studies on adolescent problems; however, wellness research is limited and has not taken a holistic approach. I hope that my research will contribute to this limited body of knowledge and that the findings will be of value to education in Saskatchewan.

Should you or the board have any questions I would be pleased to attend at your request. Please feel free to contact me or my academic supervisor at the numbers below.

Yours truly,

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

APPENDIX C

C-1 Consent Form for Student Participants (Focus Group)

C-2 Consent Form for Student Participants (Survey)

C-3 Consent Form for Teacher Participants

C-1 Consent Form for Student Participants (Focus Group)

I _____, a student at _____ high school consent to participating in the focus group proposed by Shelley Spurr under the following conditions and after have been advised of:

1. The topic of the research is Adolescent Wellness: The Case of Student's Perceptions in Two Mid-Sized Western Canadian High Schools.
2. The primary purpose of this study is to explore adolescent perceptions of wellness in a high school setting. A second purpose is to better understand and describe a) the relationship between wellness and the developmental dimensions of adolescent lives, b) the antecedents, stressors and positive influences on adolescent wellness, c) the relationship between professional support (teachers, counselors, and administrators) and students' perceived levels of wellness (low, medium and high-level wellness).
3. The research method will be a focus group. Some focus groups will be composed of males and females and there will be some focus groups with only males or only females. Each focus group will be composed of five-eight students from grade eleven. The focus groups will be held in the school for up to two hour sessions, and will be audio taped.
4. Your name will not appear in any transcription of the audiotape or in any writing resulting from this research study.
5. I agree that I shall keep all conversation, which arises in the focus group that I attend, confidential, and I shall not discuss the conversation with others except the researcher and the other members of the focus group that I attend.
6. I have been advised that although all conversation that takes place within the focus group session is meant to be confidential and that all participants will be advised and will have agreed to that requirement. However, the researcher is unable to guarantee that such will be the case and I am dependent of the participants acting in good faith.
7. I have been advised that the only people that will have access to the results from the focus group, wherein you participate, will be the researcher, her faculty advisor and the member's of the researcher's dissertation committee.

8. Following completion of the study, I may request from the researcher, at the expense of the researcher and at her phone number below, a written copy of the summary of the findings which the researcher produces from her research.
9. You will have the opportunity to comment on the preliminary findings at a meeting to be held, subsequent to the completion of the data collection, where all participants from the focus groups, will be invited to be presented with the researcher's preliminary findings.
10. At any time prior to the focus group, or during the focus group session in which I participate, I may withdraw my consent. Further, you may at anytime withdraw from this study or, while participating, refuse to answer questions or withdraw comments made during the focus group discussion. Moreover, should you withdraw during a focus group, your data will not be transcribed. Any action by you will have no bearing upon your academic standing or on your access to services at the school.
11. I understand and consent to the dissemination of the results of this study to the: a) University of Saskatchewan, b) Greater Saskatoon Catholic School Board, and c) the researcher for use in scholarly papers, publications and presentations. All material will be stored for a minimum of five years from the date of the completion of the study.
12. I have been informed that there is no risk to my participating in this research study and that the benefit of publishing the findings will provide the readers of the study, a greater of understandings of adolescent perceptions of wellness. Each student participant will be eligible for a draw for an Ipod. Participation in the focus group discussion will result in three entries into the draw. The winner will be drawn at the end of the data collection period. The focus group participants will also be provided with food and drink during the session.
13. I have acknowledged that I have received this consent form and that I understand it.
14. I acknowledge that I have herby been informed that the research proposal in which I will be a participant has been approved on ethical grounds by the

University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research on the December 19th, 2007.

Dated this _____ day of _____, 2008

Signature of Student

Signature of Researcher

Should you have any questions I would be pleased to attend at your request.
Please feel free to contact me or my academic supervisor at the numbers below.

Yours truly,

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

C-2 Consent Form for Student Participants (Survey)

I _____, a student at _____ high school consent to participating in the survey proposed by Shelley Spurr under the following conditions and after have been advised of:

1. The topic of the research is Adolescent Wellness: The Case of Student's Perceptions in Two Mid-Sized Western Canadian High Schools.
2. The primary purpose of this study is to explore adolescent perceptions of wellness in a high school setting. A second purpose is to better understand and describe a) the relationship between wellness and the developmental dimensions of adolescent lives, b) the antecedents, stressors and positive influences on adolescent wellness, c) the relationship between professional support (teachers, counselors, and administrators) and students' perceived levels of wellness (low, medium and high-level wellness).
3. The research method will be a survey. The survey will be administered to all grade eleven students who meet the inclusion criteria. The survey will take approximately 20 minutes to complete.
4. Your name will not appear in any writing resulting from this research study.
5. I have been advised that the only people that will have access to the results from the survey, wherein you participate, will be the researcher, her faculty advisor and the member's of the researcher's dissertation committee.
6. Following completion of the study, I may request from the researcher, at the expense of the researcher and at her phone number below, a written copy of the summary of the findings which the researcher produces from her research.
7. At any time prior to the survey, or during the survey in which I participate, I may withdraw my consent. Moreover, should you withdraw during the survey, your data will not be transcribed. Any action by you will have no bearing upon your academic standing or on your access to services at the school.
8. I understand and consent to the dissemination of the results of this study to the: a) University of Saskatchewan, b) Greater Saskatoon Catholic School Board, and c) the researcher for use in scholarly papers, publications and presentations. All

material will be stored for a minimum of five years from the date of the completion of the study.

9. I have been informed that there is no risk to my participating in this research study and that the benefit of publishing the findings will provide the readers of the study, a greater of understandings of adolescent perceptions of wellness. Each student participant will be eligible for a draw for an Ipod. Participation in the survey will result in one entry into the draw. The winner will be drawn at the end of the data collection period.
10. I have acknowledged that I have received this consent form and that I understand it.
11. I acknowledge that I have herby been informed that the research proposal in which I will be a participant has been approved on ethical grounds by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research on the December 19th, 2007.

Dated this _____ day of _____, 2008

Signature of Student

Signature of Researcher

Should you have any questions I would be pleased to attend at your request.

Please feel free to contact me or my academic supervisor at the numbers below.

Yours truly,

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

C-3 Consent Form for Teacher Participants

I _____, a teacher/administrator at _____, high school consent to participating in the proposed focus group research proposed by Shelley Spurr under the following conditions and after being informed of the following:

1. The topic of the research is Adolescent Wellness: The Case of Student's Perceptions in Two Mid-Sized Western Canadian High Schools.
2. The primary purpose of this study is to explore adolescent perceptions of wellness in a high school setting. A second purpose is to better understand and describe a) the relationship between wellness and the developmental dimensions of adolescent lives, b) the antecedents, stressors and positive influences on adolescent wellness, c) the relationship between professional support (teachers, counselors, and administrators) and students' perceived levels of wellness (low, medium and high-level wellness).
3. The research method will be focus group research. The focus group will be composed of five to seven teachers or administrators. The focus group will be held in the school conference room and will be one to two hours long. The focus group session will be audio taped.
4. Your name will not appear in any transcription of the audiotape or in any writing resulting from this research study.
5. I agree that I shall keep all conversation, which arises in the focus group that I attend, confidential, and I shall not discuss the conversation with others except the researcher and the other members of the focus group that I attend.
6. I have been advised that although all conversation that takes place within the focus group session is meant to be confidential and that all participants will be advised and will have agreed to that requirement. However, the researcher is unable to guarantee that such will be the case and I am dependent of the participants acting in good faith.
7. I have been advised that the only people that will have access to the results from the focus group, wherein you participate, will be the other members of my focus

group, the researcher, her faculty advisor and the member's of the researcher's dissertation committee.

8. Following completion of the study, I may request from the researcher, at the expense of the researcher and at her phone number below, a written copy of the summary of the findings which the researcher produces from her research.
9. You will have the opportunity to comment on the preliminary findings at a meeting to be held, subsequent to the completion of the data collection, where all participants from the focus group, will be invited to be presented with the researcher's preliminary findings.
10. At any time prior to the focus group, or during the focus group session in which I participate, I may withdraw my consent. Further, you may at anytime withdraw from this study or, while participating, refuse to answer questions or withdraw any comments made during the focus group discussion. Moreover, should you withdraw during the focus group, your data will not be transcribed.
11. I understand and consent to the dissemination of the results of this study to the: a) University of Saskatchewan, b) Greater Saskatoon Catholic School Board, and c) the researcher for use in scholarly papers, publications and presentations. All material will be stored for a minimum of five years from the date of the completion of the study.
12. I have been informed that there is no risk to my participating in this research study and that the benefit of publishing the findings will provide the readers of the study a greater understandings of adolescent perceptions of wellness. The teacher/administrator participants will be entered in a draw for a \$50 gift certificate for a restaurant. I have acknowledged that I have received this consent form and that I understand it.
13. I acknowledge that I have herby been informed that the research proposal in which I will be a participant has been approved on ethical grounds by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research on the December 19th, 2007.

Dated this _____ day of _____, 2008

Signature of Teacher/Administrator

Signature of Researcher

Should you have any questions I would be pleased to attend at your request.
Please feel free to contact me or my academic supervisor at the numbers below.

Yours truly,

Shelley Spurr: 966-8663

University of Saskatchewan, College of Education, University of Saskatchewan

Keith Walker: 966-7623

University of Saskatchewan, College of Education, University of Saskatchewan

This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (December 19th, 2007). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.”

APPENDIX D

D-1 Summary of Student Responses

D-2 Summary of Smoking/Drugs/Alcohol Use

D-3 Summary of Other Questions

D-4 Summary of the ANOVA Analysis

D-1 Summary of Student Responses

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
I am Well	1-5	83%	4.13	.784
My weight is where it should be.	1-5	64%	3.71	1.083
I am satisfied with my physical appearance.	1-5	64%	3.72	.954
My weight affects my physical development.	1-5	31%	2.92	1.147
I am capable of some sort of physical activity.	1-5	97%	4.71	.621
I am able to daily activities without getting too tired.	1-5	91%	4.43	.739
I participate in enough physical activity to have healthy physical development.	1-5	72%	3.96	.975
The food that I eat affects my physical development.	1-5	76%	3.98	.974
Smoking drugs and alcohol affect my physical development.	1-5	61%	3.69	1.386
Physical development (body weight, nutrition, physical	1-5	80%	4.14	1.001

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
activity, smoking, drugs and alcohol) contribute to my overall sense of wellness.				
Spirituality assists me to be creative and to develop my values.	1-5	46%	3.32	1.131
Spirituality brings me a sense of hope, meaning and purpose in life.	1-5	56%	3.49	1.126
Spirituality means having a sense of connectedness to a higher power.	1-5	57%	3.56	1.079
Spirituality is expressed as religious behaviours and beliefs.	1-5	54%	3.48	1.098
Spirituality enriches a person's quality of life.	1-5	57%	3.56	1.061
Spirituality guides your decisions about what is right and what is wrong.	1-5	58%	3.57	1.039
Spirituality is important.	1-5	58%	3.62	1.091
Spiritual Development (sense of connectedness, purpose in life, a	1-5	53%	3.48	.996

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
sense of right and wrong, personal values and beliefs) contributes to my overall sense of wellness.				
I have grown up with an affectionate, accepting, and loving caregiver and this helps me to feel confident when coping with life challenges.	1-5	78%	4.09	.948
I can answer the question "Who am I".	1-5	66%	3.79	1.074
I believe my life has purpose right now.	1-5	69%	3.90	.999
I have a lot to be proud of.	1-5	78%	4.12	.941
I like myself just the way I am.	1-5	71%	3.93	.963
I feel just as good as other people.	1-5	66%	3.85	.922
I feel competent in dealing with life challenges.	1-5	80%	4.03	.734
I have a lot of good qualities.	1-5	86%	4.18	.714
I am worthy of happiness.	1-5	87%	4.33	.736

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
When I have a problem I am able to learn from the experience.	1-5	88%	4.28	.714
I feel that I have something to offer other people in my family.	1-5	81%	4.06	.818
I feel that I have something to offer other people in my school.	1-5	70%	3.88	.864
I feel that I have friends that care about me.	1-5	92%	4.43	.747
My friends will be there for me when I need them.	1-5	89%	4.35	.747
I have at least one best friend.	1-5	89%	4.49	.816
I feel I can rely on my friends to help me make decisions.	1-5	76%	4.49	.915
I feel that participating in sports helps me feel good about myself.	1-5	74%	4.04	1.033
I feel my family cares about me.	1-5	87%	4.40	.895
My parent/guardian	1-5	79%	4.13	.980

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
is involved in my life.				
My parent/guardian sets expectations, and let me know that certain behaviours are acceptable and others are not.	1-5	77%	4.11	.948
I feel I can rely on my parent/guardian to help me make decisions.	1-5	75%	3.98	1.016
I feel like I have the ability to make good decisions.	1-5	90%	4.35	.669
Psychological development (self-esteem, self-concept, and independence) contributes to my overall sense of wellness.	1-5	89%	4.29	.701
I feel I have the resources to overcome problems.	1-5	84%	4.11	.679
I feel connected to my parent/guardian.	1-5	70%	3.89	1.034
My parent/guardian takes interest in where I am, whom I am with, and what I am doing.	1-5	73%	4.04	.994
I feel connected to my peers.	1-5	82%	4.05	.864

Percent Agreement and Strongly Agree, Means and Standard Deviations for the Two Sites Combined.

Questions	Score	Percent Agreement and Strong Agreement	Mean	Standard Deviation
I feel connected to my school.	1-5	56%	3.54	1.022
I feel safe in my school.	1-5	81%	4.13	.772
I feel there is support from at least one teacher, school counselor, and/or administrator.	1-5	78%	4.09	.888
I feel the people in the school care about me.	1-5	58%	3.64	.864
I feel the school provides opportunities for me to be healthy and well. For example, after school activities and healthy lunches.	1-5	70%	3.84	.939
I feel that my school helps me to be successful in life.	1-5	75%	3.94	.891
Social development (coping skills, parents, friends and school) contributes to my overall sense of wellness.	1-5	85%	4.28	.749

Table E-1 presents the means and standard deviations of the student responses for each of the 53 statements where there was a possibility of five choices: 1 (Strongly Agree), 2 (Agree), 3 (Neutral), 4 (Disagree), 5 (Strongly Disagree).

D-2 Summary of Smoking/Drugs/Alcohol

Table E-2

Summary of Smoking (n=280)		
	Frequency	Percentage
Not at all	210	75.0%
Once in a while	42	15.0%
1-5 cigarettes	16	5.7%
½ pack a day	8	2.9%
A pack a day	3	1.1%

Summary of Alcohol use (n=280)		
Never	125	44.6%
About once a month	51	18.2%
2-3 times a month	49	17.5%
Once a week	20	7.1%
2-3 times a week	29	10.4%
Everyday	5	1.8%

Summary of Marijuana use (n=280)		
Never	223	79.6%
About once a month	25	8.9%
2-3 times a month	8	2.9%
Once a week	2	0.7%
2-3 times a week	10	3.6%
Everyday	12	4.3%

Summary of Other drug (Cocaine, Crack, Heroin, Ecstasy, Crystal Meth, Sniffing glue or Solvents) (n=280)		
Never	266	95%
About once a month	6	2.1%
2-3 times a month	4	1.4%
Once a week	1	0.4%
2-3 times a week	0	0.0 %
Everyday	2	0.7%

D-3 Summary of Other Questions

Table E-3

Level of Wellness (n=280)		
	Frequency	Percentage
Low	12	4.3%
Medium	148	52.9%
High	120	42.9%
Participated in Physical Activity (n=280)		
Not at all	16	5.7%
Once a week	39	13.9%
2-3 times a week	79	28.2%
4-5 times a week	83	29.6%
6-7 times a week	63	22.5%
I consumed how fruits and vegetables (n=280)		
1-2 a day	82	29.3%
3-4 a day	126	45.0%
5-6 a day	58	20.7%
7-8 a day	14	5.0%
Who guides your moral decisions about right and wrong? (n=280)		
Parents or guardian	71	25.4%
Teachers	8	2.9%
School Counselors	5	1.8%
I make moral decisions on my own.	141	50.4%
My parents and I make moral decisions together.	55	19.6%

D-4 Summary of the ANOVA Analysis

Summary of ANOVA Statistical Analyses					
	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
My weight is where it should be.	11.99	0.0005	2.83 _i	3.52 _{ii}	4.02 _{ii}
I am satisfied with my physical appearance.*	13.84	0.0005	2.83 _i	3.56 _i	4.01 _{ii}
My weight affects my physical development.*	1.99	0.138			
I am capable of some sort of physical activity.*	26.04	0.0005	3.67 _i	4.66 _i	4.88 _{ii}
I am able to do daily activities without getting too tired.*	27.04	0.0005	3.50 _i	4.26 _i	4.72 _{ii}
I participate in enough physical activity to have healthy physical development.	22.82	0.0005	2.75 _i	3.16 _i	3.98 _{ii}
Physical activity affects my physical development.	56.99	0.0005	2.42 _i	3.65 _{ii}	4.50 _{iii}
The food that I eat affects my physical	3.01	0.051			

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
development.* Smoking drugs and alcohol affect my physical development.	0.04	0.964			
Physical development (body weight, nutrition, physical activity, smoking, drugs and alcohol) contribute to my overall sense of wellness.	3.1	0.047			
Spirituality assists me to be creative and to develop my values.	2.51	0.083			
Spirituality brings me a sense of hope, meaning and purpose in life.	2.39	0.093			
Spirituality means having a sense of connectedness to a higher power.	2.82	0.061			
Spirituality is expressed as religious behaviours and	5.43	0.005	2.75 _i	3.38 _{ii}	3.68 _{ii}

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
beliefs.					
Spirituality enriches a person's quality of life.	1.60	0.206			
Spirituality guides your decisions about what is right and what is wrong.	2.80	0.063			
Spirituality is important.	2.27	0.105			
Spiritual Development (sense of connectedness, purpose in life, a sense of right and wrong, personal values and beliefs) contributes to my overall sense of wellness.	2.91	0.056			
I have grown up with an affectionate, accepting, and loving caregiver and this helps me to feel confident when coping with life challenges.*	8.36	0.0005	3.33 _{i,ii}	3.97 _i	4.30 _{ii}
I can answer the question "Who	3.62	0.028			

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
am I'*. *					
I believe my life has purpose right now.	7.64	0.0005	3.75 _i	3.70 _i	4.17 _i
I have a lot to be proud of.	9.20	0.0005	3.92 _i	3.91 _i	4.39 _i
I like myself just the way I am.*	7.65	0.0005	4.0 _{i,ii}	3.72 _i	4.17 _{ii}
I feel just as good as other people.	9.99	0.0005	3.07 _i	3.73 _{ii}	4.08 _{ii}
I feel competent in dealing with life challenges.	10.40	0.0005	3.75 _i	3.87 _i	4.25 _{ii}
I have a lot of good qualities*.	3.22	0.041			
I am worthy of happiness.	9.36	0.0005	4.17 _i	4.17 _i	4.54 _i
When I have a problem I am able to learn from the experience.	2.81	0.062			
I feel that I have something to offer other people in my family.*	4.93	0.008	3.67 _{i,ii}	3.97 _i	4.23 _{ii}
I feel that I have something to offer other people in my school.	6.71	0.001	3.75 _i	3.72 _i	4.10 _i

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
I feel that I have friends that care about me.	1.67	0.190			
My friends will be there for me when I need them.	1.62	0.200			
I have at least one best friend.	3.45	0.034			
I feel I can rely on my friends to help me make decisions.	1.07	0.344			
I feel that participating in sports helps me feel good about myself.	16.20	0.000	2.92 _i	3.88 _{ii}	4.36 _{ii}
I feel my family cares about me.	2.12	0.122			
My parent/guardian is involved in my life.*	5.87	0.003	3.33 _i	4.07 _i	4.28 _i
My parent/guardian sets reasonable expectations, and let me know that certain behaviours are acceptable and others are not.	2.75	0.065			

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
I feel I can rely on my parent/guardian to help me make decisions.	6.69	0.001	3.17 _i	3.89 _{ii}	4.17 _{ii}
I feel like I have the ability to make good decisions.	5.39	0.010	4.00 _i	4.27 _{i,ii}	4.49 _{ii}
Psychological development (self-esteem, self-concept, and independence) contributes to my overall sense of wellness.	3.03	0.050			
I feel I have the resources to overcome problems.*	5.69	0.004	3.75 _{i,ii}	4.02 _i	4.25 _{ii}
I feel connected to my parent/guardian.	4.61	0.010	3.50 _i	3.75 _i	4.09 _i
My parent/guardian is nurturing, warm and accepting.	3.66	0.030			
My parent takes interest in where I am, whom I am with, and what I am doing.	.234	0.790			

Summary of ANOVA Statistical Analyses

	F (2, 277)	P (0.01)	Low- wellness	Medium - wellness	High- wellness
I feel connected to my peers.*	7.15	0.001	3.33 _i	3.98 _{i ii}	4.22 _{ii}
I feel connected to my school.	8.75	0.0005	2.92 _i	3.38 _{i ii}	3.81 _{ii}
I feel safe in my school.	2.29	0.100			
I feel there is support from at least one teacher, school counselor, and/or administrator.	3.59	0.030			
I feel the people in the school care about me.*	13.03	0.0005	3.00 _i	3.47 _i	3.91 _{ii}
I feel the school provides opportunities for me to be healthy and well. .	4.23	0.020			
I feel that my school helps me to be successful in life.	1.08	0.340			
Social development contributes to my overall sense of wellness.	2.29	0.100			

Note. Means with different roman numerals subscripts are significantly different.

*Tamhane's T2 post hoc test was used with these variables due to unequal variances.

Newman-Keuls was used for all other post hoc tests.

APPENDIX E

E-1 University Ethics Approval

E-2 External Audit Report