THE PSYCHOLOGICAL HEALTH OF TEENAGE MOTHERS FROM SELECTED SECONDARY SCHOOLS IN SESHEGO TOWNSHIP, LIMPOPO PROVINCE

by

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Declaration of Originality

I declare that the dissertation hereby submitted to the University of Limpopo for the degree of Masters of Arts has not been previously submitted by me for a degree at this or any other university; that it is my own work in design and execution, and that all material contained therein has been duly acknowledged.

_____ _____

Ms H.L Maleka Date

Dedication

This work is dedicated to my daughter, Tehila, my mother, Itumeleng, my late father, Lazarus, my sisters, Kerileng, Tebogo, Thabiso and Refiloe, and my only brother, Gabriel, for their motivation, love and continuous support during my studies.

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- To the teenage mothers and teenage non-mothers who so willingly participated in my study.

Abstract

Early motherhood has been associated with negative biological and social outcomes in the developing world of the teenage mother and child. The study sought to explore the psychological health of teenage mothers from selected secondary schools in Seshego Township, Limpopo Province. Generally, the study makes use of a comparative design and 120 participants were selected for the study consisting of 60 teenage mothers and 60 teenage non-mothers. The psychological health of teenage mothers was compared to the psychological health of teenage non-mothers. The study made use of the 28-item General Health Questionnaire (GHQ) with only three demographic questions, which was given to both teenage mothers and teenage non–mothers.

The results of the study show that there was no significant difference in the psychological health of teenage mothers and teenage non–mothers. Results also showed that there was no significant difference on the sub-scales of somatic symptoms, anxiety and insomnia, social dysfunction and depression. Results of teenage mothers were compared to one another, and this comparison also showed that there was no significant difference within this group. Also results on age, grade and family structure showed no significant difference between the two groups compared to one another. Given the literature that exists worldwide showing that teenage motherhood can have negative impacts on mothers, particularly social and economic, but also physical and psychological health, it is clear that further research in this area needs to be conducted.

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Chapter 1: Introduction

1.1 Background to the Study

One major social problem faced by most countries in the world is teenage pregnancy (Meadows, 2012; Gyan, 2013). A study conducted by Willan (2013) found that approximately 30% of female teenagers in South Africa were reported to have been pregnant with the majority of them stating that their pregnancies were unplanned. This, in Moses-Europa's (2005) view, poses a serious developmental crisis to the teenagers. The economic and social conditions in which most teenage mothers are forced to live and the emotional stresses associated with these conditions, as well as with child-bearing, can be a heavy burden (Dilworth, 2006; Moses-Europa, 2005; Shrestna, 2012). Meadows (2012), suggests that teens are unprepared for parenting, and are likely to struggle socially and economically due to limited education and employment.

Early motherhood has been associated with negative biological and social outcomes in the developing world of the teenage mother and child (Malahlela & Chireshe, 2013; Meadows, 2012). According to Dilworth (2006), teenagers who have children are frequently criticised and blamed for causing adult poverty, welfare dependence, and other social problems. Furthermore, children born from teenagers often suffer from low birth weight, which is associated with physical and behavioural problems. In addition, children of teenage mothers may receive less medical care, are at higher risk of poor parenting, and may become victims of abuse or neglect. Consequently, these challenges may predispose teenage mothers to psychological challenges which may affect their attitude towards parenting their own children.

1.2 Research Problem

Literature has suggested that teenage motherhood predisposes teenagers to psychological distress in the absence of a supportive environment and counselling (Asian-Pacific Resource and Research Centre for Women, 2006; Domings, Merighi, Jesus & Oliveira, 2013). Research conducted on teenage motherhood outside South Africa (e.g., Ntinda, Moagi, Bender & Mpofu, 2015; Vo, 2008) has found that teenage mothers reacted differently to the responsibility of caring for their children. On one hand, some received support from family, and this helped them to have a positive outlook on parenting (Vo, 2008). On the other hand, Ntinda et al. (2015) found that younger teenage mothers felt that attention was given to older teenagers and this created psychological distress for them.

In South Africa, studies appear to have had contradictory results. Maphoti, Kgole and Tladi (2014) as well as Mokwena, Govender and Setwaba (2016), for example, have found that teenage mothers have been found to experience less psychological distress than teenage non-mothers. However, Sodi (2009) and Sodi and Sodi (2012) found that teenage mothers experienced psychological challenges such as depression among others (Sodi 2009; Sodi & Sodi, 2012). The current study attempts to shed light on this apparent contradiction by exploring some of the factors associated with the psychological health of teenage mothers from selected secondary schools in Seshego Township, Limpopo Province.

1.3 Aim of the Study

The aim of this study was to compare the psychological health of teenage mothers and teenage non-mothers from selected schools in Seshego Township.

1.4 Objectives of the Study

The objectives of the study are to:

- Compare the psychological health of teenage mothers with teenage non-mothers.
- Assess if the age of the teenage mothers affects their psychological health.
- Investigate if the current grade of the teenage mother influences the psychological health of teenage mothers.
- Measure if the family structure of the teenage mother influences the psychological health of the teenage mother.

1.5 Hypotheses

1.5.1 Hypothesis 1

H_0: There will be no significant difference in the psychological health between teenage mothers and teenage non-mothers.

H_1: There is a significant difference in psychological health between teenage mothers and teenage non-mothers.

1.5.2 Hypothesis 2

H_0: There will be no significant difference in psychological health between younger and older teenage mothers.

$H_{1:}$ There is a significant difference in psychological health between younger and older teenage mothers.

1.5.3 Hypothesis 3

H_0: There will be no significant difference in psychological health between teenage mothers in lower grades and those in Matric.

H_1: There is a significant difference in psychological health between teenage mothers in lower grade and those in Matric.

1.5.4 Hypothesis 4

H_0: There will be no significant difference in the psychological health of teenage mothers who are living with both parents and those living with single parents.

H_1: There will be a significant difference in the psychological health of teenage mothers who are living with both parents and those living with single parents.

1.6 Significance of the Study

Dlamini (2016) suggests that it is important that research on teenage motherhood should provide insight and shed light into the lived experiences of teenage mothers. Also, teenage mothers are often unprepared or too immature to care for a child; therefore their choices in all aspects of life may be restricted (Pitso, Kwheswa, Nekhwevha & Sibanda, 2014). Furthermore, it is hoped the results of this study will contribute to the existing knowledge on teenage motherhood in general. Findings will also bring about an understanding of the characteristics of the psychological health of teenage mothers in Seshego Secondary Schools. Furthermore, finding out about teenage mothers' psychological health will assist in targeted interventions for both the teenage mother and the child. This knowledge will therefore help in the

integrated approach (individual, family, community, school) to supporting the teenage mother.

1.7 Operational Definition of Concepts

1.7.1 Psychological health

This is a level of psychological well-being, or an absence of mental illness (Barry & Jenkins, 2007). In the context of the present study, psychological health is understood to mean the overall mental well-being and stability of the teenage mother.

1.7.2 Teenage mother

A teenage mother refers to a young woman who has reached puberty with an age ranging between 13-19 years who has a child (Maputle, 2006). This is the definition adopted by the current study.

1.7.3 Teenage non-mother

A teenage non mother refers to a young woman who has reached puberty with an age ranging between 13-19 years who does not have a child. This is the definition adopted by the current study.

1.8 Chapter Outline

Chapter 1 provides an introduction to the study, as well as the background and the research problem. Chapter 2 is a review of the available literature on teenage mothers. Chapter 3 is the discussion of the methodology that was used in this study.

Chapter 4 consists of results of the study displayed in table form. Chapter 5 provides a discussion of results. Lastly, Chapter 6 gives a summary of the findings, and addresses the limitation of the study and the recommendations thereof.

1.9 Summary of the Chapter

The current chapter introduced the background of the study and the research problem as well as the significance of the study. The aim and objectives along with operational definitions were stated. Chapter 2 focuses on a review of the literature which is relevant to the present study.

Chapter 2: Literature Review

2.1 Introduction

In this section, some of the key psychological health challenges associated with teenage motherhood will be reviewed. In this regard, psychological problems such as depression, anxiety and insomnia, somatic symptoms and social dysfunction will be discussed. Other topics that will be covered in this section include family characteristics and cultural issues. The theoretical orientation underpinning experiences of teenage mothers such as the stigma theory, coping mechanisms and the six-factor model of psychological wellbeing will also be discussed.

2.2 Teenage Motherhood and Somatic Symptoms

Several difficulties related to the transition to parenthood have been studied, particularly in adolescent mothers (Dlamini, 2002). Psychological adjustment during the transition to parenthood seems to be more difficult for teenage mothers (Figueiredo, Tendais, & Dias, 2013), and an increase in both somatic symptoms such as fatigue or sleep disruption and psychological symptoms such as anxiety or depression has been documented (Mitchell, Bennett & Stennett, 2014). Teenage mothers seem to be particularly at risk of experiencing somatic and psychological symptoms during pregnancy and the post-partum period. There is evidence that early childbearing may hold a risk of delaying emotional development, as a result of high stress and potentially abusive environments, and consequently reduce life opportunities for both mother and child (Fredericton, 2006). Additional evidence on psychological distress amongst teenage mothers was found by Willson-Mitchell,

Bennett and Stennett (2014) who conducted a case-controlled study to compare the psychosocial and psychological health of 110 teenage mothers and 110 teenage non-mothers. The findings indicated that teenage mothers suffered more from low levels of social support, depression, traumatic life events and other psychosocial difficulties.

While the literature mentioned above focuses on the negative impact of childbearing on the teenage mother, a study by Mokwena et al. (2016) found, in contrast, that teenage mothers experienced less somatic symptoms compared to teenage non-mothers. In addition, Sodi (2009) found no significant difference in somatic symptoms among pregnant teenagers. Thus, upon these contradictory findings, there exists a need to investigate factors associated with the presence or absence of somatic symptoms in teenage mothers.

In contrast to the findings suggesting adverse health consequences for teenage mothers, there is evidence that teenage mothers do not suffer from higher levels of psychological disturbance or worse physical health than teenage mothers. Research by Iring, Bradley, Cupples and Booltan (1997) found that pregnant teenagers compared with a peer group who were sexually active but not pregnant and a peer group who were not sexually active, did not differ from the others in physical health, but they, together with the sexually active group, had higher rates of mental health problems and symptoms of conduct disorders. This evidence suggests that teenagers mental health problems may be associated with early sexual activity, rather than with pregnancy and motherhood during the teenage years. Sodi (2009) found that, in terms of somatic complaints, older teenage mothers were found to experience more symptoms of somatic complaints when compared to younger teenage mothers.

2.3 Teenage Motherhood, Anxiety and Insomnia

There are different views on the experience of insomnia and anxiety among teenage mothers. A study conducted by Sodi (2009) on teenage mothers found that the majority of the participants in her study experienced higher levels of anxiety. On the other hand, a comparative study of teenage mothers and teenagers by Mokwena et al. (2016) reported low anxiety among teenage mothers. It may be that there are factors that contribute to different levels of anxiety. For example, Sodi (2009) found that there were differences in anxiety levels between students at high school and those who were at tertiary institutions, with participants who were still at school being found to experience more anxiety and insomnia symptoms compared to participants who were at tertiary institutions. Sodi (2009) found that older teenage mothers experienced more anxiety and insomnia compared to younger teenage mothers.

2.4 Teenage Motherhood and Socialisation

There is evidence that a mother's ability to cope with the transition to motherhood and her well-being are influenced by the extent of her socialisation and the intensity in which she receives various forms of support. However, Moses-Europa (2005), found that many younger teenage mothers feel lonely after childbirth and the demands of motherhood leave little time or energy for other relationships. As a result, the adolescent mother may feel isolated from her family or peers. Therefore, teenage mothers may experience a lack of communication, emotional closeness and support from their parents and her peers. Teenage mothering is thus often a cause and a consequence of social exclusion of which she may experience social isolation from her peers (Dilworth, 2006; Chauke, 2013; Gyan, 2013, Pitso, et al. 2014). Certainly, in a study conducted by Sodi and Sodi (2012), participants indicated that

their intra and interpersonal relationships had adversely been affected after pregnancy and giving birth. In addition, Meadows (2012) viewed that the lack of support from family or friends can lead to isolation during pregnancy and motherhood. This is likely to negatively affect the mental health of the teenage mother. Moreover, Iring et al. (1997) found that there are links in social ties to behaviour and health.

The evidence is not entirely negative, however. In a study conducted by Mokwena, et al. (2016), the researcher reported that there were no significant differences on social dysfunctions between teenage non-mothers and teenage mothers. In addition, Ackard, Neumark-Sztainer, Perry and Story (2006) discovered that most teenage mothers viewed their families as an important anchor for information and guidance, especially their parents.

2.5 Teenage Motherhood and Depression

Depression can become especially evident during adolescence with a lifetime impact on teenagers (Conklin, 2011). According to Moses-Europa (2005), depression in mothers has extensively been studied during the last few decades. The transition to parenthood is associated with biological, psychological, and social changes, particularly in a woman's identity, responsibilities, concerns, and significant relationships (Elisabeth & Eva, 2012; Figueiredo et al., 2013; Moses-Europa, 2005; Willan, 2012; Corcoran, 2016). Although these changes contribute to personal growth, they can also result in mental disorders, for example, postnatal depression. In fact, many women have relatively high rates of depression and experience anxiety and confusion during this period (Aufseeser, Jekielek & Brown, 2006).

Depression is much more prevalent among teenage mothers than their older women who have children at a more mature age or teenage non-mothers in general. Having a child as a teenager may have a long-lasting adverse effect on mental health that is only partly explained by socioeconomic status (Marino, Lewis, Bateson, Hickey, & Skinner, 2016). There is evidence to suggest that teenager mothers are at higher risk for psychological distress, particularly in the absence of supportive counselling (Ntinda et al., 2014). Emotionally, younger teenage mothers have been found to struggle with higher levels of maternal depression compared to older adult mothers (Figueirodo, Bifulco, Pacheco, Magarinho, & Costa, 2006; Brown, 2011). Sodi and Sodi (2012), for example, found depression scores to be higher in 53% of the teenage mothers, and they also found that there was an increased risk of depressive symptoms for pregnant teenagers and teenage mothers who had participated in the study (Sodi & Sodi, 2012). In another study of African American teenage mothers, Brown (2011) found that younger mothers tend to have higher rates of maternal depression than older adult mothers. Postpartum depression is considered to be the most common type of depression experienced by teenage mothers (Figueirodo, at el. 2006). Adolescents also face many developmental changes and emotional challenges as they adapt to being a mother.

Sodi and Sodi (2012) found that higher levels of depression among teenage mothers were accompanied by lower levels of self-esteem. Teenage mothers are in most cases unprepared for the tasks of parenting which may lead them to doubt their own abilities and competence in nurturing their infants (Moses-Europa, 2005; Malahlela & Chireshe, 2013; Meadows, 2012). This type of depression often results in the teenage mothers distancing themselves from their infants, because they often

experience a negative perception of themselves and/or the baby (Maputle, 2006; Aufseeser et al., 2006).

The depression of teenage mothers is also associated with social, economic, and developmental challenges including financial support, staying out of school, and obtaining child care while trying to care for an infant. A study conducted by Dlamini (2016) found that some teenagers from relatively deprived backgrounds might enter into motherhood in order to enter into the phase of adulthood with the aim to be independent. Thus, meeting these challenges is likely to be more difficult for the adolescent mother compared to more mature, and often more financially stable adults who have already completed their education (Martin, 2009). Martin (2009), reports that depressive symptoms increased among postpartum adolescents if there was conflict with the infant's father and decreased if there was support from him.

In contrast to this evidence, a comparative study conducted by Mokwena et al. (2016) in the Mankweng area of Limpopo, South Africa, including a total number of 112 teenage participants, 56 of whom were teenage mothers and 56 of whom were teenage non-mothers, reported that teen mothers in this study did not differ from teenage non-mothers on the level of depression and coping strategies. Similarly, Moses-Europa (2005) found that teenage mothers experienced similar depressive symptoms compared with adult mothers. The current study may help in part to resolve this apparent contradiction.

2.6 Teenage Motherhood, Age and Psychological Health

A number of studies have suggested that age differences among teenage mothers may be associated with psychological health. Study conducted by Pitso et al. (2014)

found that difficulty found in teenage mothering could lead to disappointment, anger, depression, feelings of being trapped, loneliness, anxiety and insecurity. For example, a cross-sectional study on teenage mothers by Biello, Sipsma and Kershaw (2010) found that younger teenage mothers experienced greater depression than older teenage mothers. Similar results were found by Brown (2011), from African Americans where younger mothers were found to have higher rates of maternal depression than older adult mothers. A study conducted by Sodi and Sodi (2012) in the lower Limpopo province in South Africa also found that younger teenagers are likely to experience more symptoms of severe depression. School-going teenagers reported more symptoms of severe depression Young parents can face isolation, negative social attitudes, stress, anxiety and low self-esteem (Biello et al., 2010).

In contrast to this, Sodi (2009) found no significant difference in the age of pregnant mothers in relation to somatic complains, anxiety and insomnia, social dysfunction and depression. Despite this, means tests showed that older pregnant teenagers experienced more psychological distress than their younger counterparts.

2.7 Teenage Motherhood and Family Structure

Family structure, income, and where a family lives are also related to the risk of teen pregnancy (Cancian & Reed, 2009; Simigiu, 2012). Bojuwoye and Sylvester (2011) stated that, in South Africa, approximately a third of families are single parent households. Teenagers living in a large or father absent family may receive less parental guidance and supervision (Mkhize, 1995). It is estimated that about 40% of 18 million children are being raised by single mothers. In study conducted by Mothiba and Maputle (2012) conducted in the Capricorn District of the Limpopo

Province, found that 44% of teenage mothers' depended on their single mothers income to support their children. Marino et al. (2016) are of the view teenage motherhood is intergenerational in that the daughters of adolescent mothers are more likely to become teenage mothers themselves.

According to Bah (2016), family dysfunction has also been identified in some studies as the underlying factors that predict teenage childbearing. Those teens living in neighbourhoods that are faced with issues such as poverty, unemployment, and high crime rates are more likely to start having sex early, fail to use contraceptives, and become pregnant (Cancian & Reed, 2009; The National Campaign to Prevent Teenage Pregnancy, 2004; Thobejane, 2015). Two parent homes are reportedly likely to be better off financially than one-parent homes (Hoskins, 2014; Oyserman, Radin, & Saltz, 1993). Kellam, Adams, Brown and Ensminger (1982) found that, teenage mothers were less likely to be living in families with both their mother and father. They discovered that teenage mothers came from homes where they lived with either their mother, grandmother or a mother and a step-father.

Certain aspects of family composition can heighten the risk of somatic complains amongst the youth at different developmental levels, as a result, adolescents use somatic symptoms as a means of coping with family problems (McDermott, Graham, & Hamilton, 2004). Thobejane (2015) stated that family disorganisation may prompt family members to engage in deviant acts. For example, if there is little or no love offered to the offspring in such households, they tend to seek love and affection elsewhere. Teenage motherhood can also be influenced by the rejection of children by their parents. Parents who fail to provide for their children also contribute to the situation of teenagers falling pregnant at an early age. In this context teenagers may try to attain a sense of self-worth by becoming involved in sexual relationship at an

early age because this is where they feel loved. On the other hand Dlamini (2016) found that teenage mothers who come from supportive families, and who get support from teachers and friends often do better and cope better than those who lack support.

Adolescent mothers commonly grow up in single-parent families (Brown, 2011). This may contribute to their psychological distress. However, Pietrowski (2006) found no evidence that maternal support reduces the teenage mother's maternal stress or increases a sense of general well-being. Moreover, she found that those who reported receiving support from sisters and other relatives (including aunts, uncles and cousins) reported more parenting difficulties and stress than those adolescents who did not receive support from relatives. A study by Bah (2016) revealed that teens with supportive family relationships, who live with both parents, and who have better educated parents are less likely to initiate sex at a young age. It can be assumed that parents play an important role in the lives of their children.

2.8 Teenage Motherhood and Culture

Traditionally children are born inside wedlock and parenthood is a joint responsibility of both parents who are adults (Mkhize, 1995). In every society there is a culturally recognised and approved way in which a man and woman may live together and procreate (Mkhize, 1995). Communities across the world have cultural systems and practices that help them to deal with matters related to sex and sexuality during adolescence (Sodi, 2009). In most cultures, bearing a child is the most essential part of being a woman and being considered a success as a woman (Kanku & Mash, 2010; Nkwanyana, 2011). According to Nkwanyana (2011), within certain cultures, the value placed on fertility is believed to encourage teenage mothering. Some

cultures support a more tolerant attitude towards the phenomenon of pregnancy at a very early age (Simigiu, 2012).

2.9 Teenage Motherhood and School Performance

Teenage pregnancy in South Africa is growing rapidly among school-going pupils and it leads to school drop-out as the teenage mothers have to leave school to care for their babies (Thobejane, 2015). A study conducted by Chauke (2013) found that the number of school-girls birth rates jumped from 1,169 in 2005 to 2, 336 in 2006 in the Gauteng Province. Therefore, teenage mothers are less likely to complete the education necessary to qualify for a well-paying job, and only 41% of mothers who have a child before age 18 ever complete high school (Schuyler Centre for Analysis and Advocacy, 2008). Such mothers' career prospects are severely restricted, as a result limiting the teenager to lower socio-economic status (Mwaba, 2000). Significantly for this study, according to Pietrowski (2006) the age at first childbirth and background variables contribute to future academic success in teenage mothers.

The challenges faced by teenage mothers may be increased by financial pressures. The costs of teenage motherhood are enormous not only for the teenage mothers but also for their families, their children and for the society as well (Mkhize, 1995; Chigona & Chetty, 2008).

2.10 Teenage Mothers' Attitude Towards Parenting

Teenagers have a complex variety of attitudes about motherhood (Shefer, Bhana & Morrell, 2013; Vo, 2008). This may be influenced by whether the pregnancy was

planned or not as those having a planned pregnancy have been found to have a more positive attitude towards parenting. Nevertheless, findings by Sodi and Sodi (2012) on teenage pregnancy found that motherhood was unplanned, and teenagers were unprepared for the experiences of early motherhood which may lead to negative attitude towards parenting by teenage mothers.

However, positive attitudes towards parenting are also influenced by other. For example, Vo (2008) found that some teenage mothers viewed their baby as giving them the opportunity to provide the kind of love and life they themselves did not have as a child. Teenage mothers in Vo's study viewed the experience of motherhood as an opportunity to start their lives again.

Apart from these traditional characteristics, younger women saw mothers as being independent and being "an individual" outside the home. Participants' perception of mother roles seemed to be a reflection of their observation of their own mother (Vo, 2008). Furthermore, 80% teenage mothers that participated in Sodi and Sodi (2012) study mentioned that they were not fully aware of the responsibilities of early motherhood as their families took care of their children, while they were still able to play with their friends.

2.11 Other Influences on Teenage Motherhood

There is a substantial body of evidence indicating that one of the most consistent risk factors for early pregnancy is lower socio-economic status and poverty. Several studies conducted in developing countries indicated that adolescent mothers are more likely to have been brought up in a less-advantageous social environments, come from poor families and experience pre-existing disadvantage that results from

poorer economic circumstances (Mkhize, 1995). Other factors include child grants, sibling influence and peer influence.

In South Africa, some observers have suggested that the child support grant provided by the state was an incentive to young girls to fall pregnant. However, Nkwanyana (2011) pointed out that the number of pregnancies among girls between 15 and 19 years peaked in 1996, two years before the grant was introduced, and had been declining slightly since, although they remained high (Nkwanyana, 2011). Similarly, Sodi (2009) found that the participants in her study did not consider their pregnancies to be a strategy to access the government child support grant. Instead, the participants saw the grant as too little to meet the basic needs of a child.

Peer influences among siblings have been shown to play an important role in the risky behaviours of teenagers. A teenager might mimic a sibling's behaviour if they admire their older sibling or desire the same attention and engage in riskier sexual actions to get it (Ryan, Claessen, Markowitz, 2013). Similar influence is seen with siblings, particularly older siblings, who play a central role in the onset of sexual activity. Younger sisters of parenting teens, in particular, have higher rates of sexual activity (Bah, 2016; Hoskins, 2014). Girls may see their older sisters gain attention from the family and an adult status in the community through parenthood. Thus, it is not surprising that the younger sisters of teenage mothers are more accepting of early non-marital childbearing, perceive younger ages as appropriate for marriage and birth, are pessimistic about school and career (Sturgeon, 2008; Hoskins, 2014; Usakli, 2013).

Young people are affected by the influence and pressure of peers but those are not as large and negative as might be anticipated (Simigiu, 2012). Like siblings, friends are considered to be socialising agents who set standards of conduct and can serve

as role models, therefore shaping the development of sexual attitudes and norms. A study conducted by Barber and Eccles (1992) amongst minority adolescents, for example, found that the number of sexually active girlfriends was positively associated with permissive sexual attitudes, intentions for future sexual activity, and non-marital childbearing. Other risk behaviours have an impact as well. When a teen's friends are not attached to school, have poor grades, abuse drugs or engage in delinquent behaviours, there is a greater likelihood that the teen will become sexually active at an early age.

A study conducted by Thobejane (2015) found that 100% of the respondents had friends who played an important part in their lives. About 80% of them indicated that their friends did influence them to have children. Close to 20% did not agree with this, saying that it was their decision to have children. This suggests that peer pressure may, in some instances, indeed be a major factor in teenage pregnancy.

According to Hoskins (2014) and Usakli (2013), it is not only the actual behaviour of peers, but the assumption of certain behaviours by peers, that influences adolescent sexual activity.

2.12 Theoretical perspectives

Several theories can be used to explain why teenage motherhood may result in significant intensity of psychological distress. In the current study, two such theories, namely, the social stigma theory and coping theory are presented. The six factor psychological wellbeing theory will be presented henceforth as the theoretical framework within which teenage motherhood is conceptualised.

2.12.1 Stigma Theory

According to the stigma theory, teenage motherhood can be stigmatised, resulting in psychological distress. The social stigma theory was developed by Goffman (1963) who posited that stigma is an illuminating excursion into the situation of individuals who are unable to conform to standards that society calls normal, and viewed it as a process based on the social construction of identity (Frost, 2011.). According to Goffman (1963), stigma is referred to as an attribute that is deeply discrediting. Stigma has far-ranging effects on its targets and social stigma has been associated with poor mental health, physical illness, academic underachievement, infant mortality, low social status, poverty, and reduced access to housing, education, and jobs (Crosby, 2015; Pescosolido & Martin, 2015).

According to Frost (2011), stigma is socially constructed, and varies from setting to setting. In addition, individuals and groups react differently to the stigmatising process. Labelling, stereotyping, separation, status loss, and discrimination can all occur at the same time and are considered components of the stigma. Society teaches its members to categorise persons by common defining attributes and characteristics. One's social identity may include: (1) physical activities, (2) professional roles, and (3) the concept of self. Anything that changes one of these, such as a disability, changes the individual's identity and, therefore, potentially creates a stigma. Thus, a teenager becoming a mother changes her identity and this could predispose her to some levels of stigma. Goffman (1963) used the idea of social identity to expand previous work done on stigma. His theory defined stigma as something that disqualifies an individual from full social acceptance.

According to Frost (2011), there are special circumstances in which stigma can be perceived with enhanced distinction. Individuals who lack a fully-developed sense of

personal identity and who are reliant upon external sources to reinforce their internal sense of worthiness may be uniquely prone to a sense of stigma. Whenever a stigma is present, the devaluing characteristic is so powerful that it overshadows other traits and becomes the focus of one's personal evaluation. Teenage mothers are likely to stigmatised because the behaviour or difference could be considered to be self-inflicted and, therefore, less worthy of help. The social stigma theory will be used to view teenage motherhood outside of the stigma it has been given for many years.

When looking at teenage mothers and the extensive research that has been done on teenage pregnancy, stigma is an issue that comes up repetitively, and could impact the teenage mother even after giving birth to her child. It could be that the teenage mothers are stigmatised and viewed differently by the community which could in turn impact the teenage mother psychologically, causing her to experience problems in her psychological health.

2.12.2 Coping Theory

Lazarus and Folkman developed approaches designed to measure and study coping as a process and examine its consequences for adaptation (Lazarus, 1993). Most of the research on an individual's stressful life circumstances had focused only on their potential to negatively affect that individual's ability to function mentally, physically, and socially, and only later were the positive aspects recognised as well. Under normal circumstances, disasters do not result in psychological and social issues. In fact, they may be viewed as resulting in a positive outcome and, as a result, concepts such as resilience and competence became increasingly important (Krohne, 2002; Zaumseil and Schwarz, 2014). According to Krohne (2002),

psychological coping models can be seen as one specific way of looking at the process of handling strain and stress.

The coping methods help with the basic motivation of human beings to move toward goals while avoiding threats. From the very beginning, one of the strengths of the psychological coping models was the fact that the outcome was to yield both positive and negative results. Coping models address both successful and unsuccessful attempts to manage challenges or threats (Krohne, 2002; Zaumseil & Schwarz, 2014). Another strength of these models is that they attempt to draw a connection between internal and external elements. In coping models, according to Krohne (2002), internal and external challenges and threats (for example, sickness or an earthquake), and internal or external personal resources (for example, a high perceived self-efficacy and a resource-rich social environment) are viewed as interrelated factors.

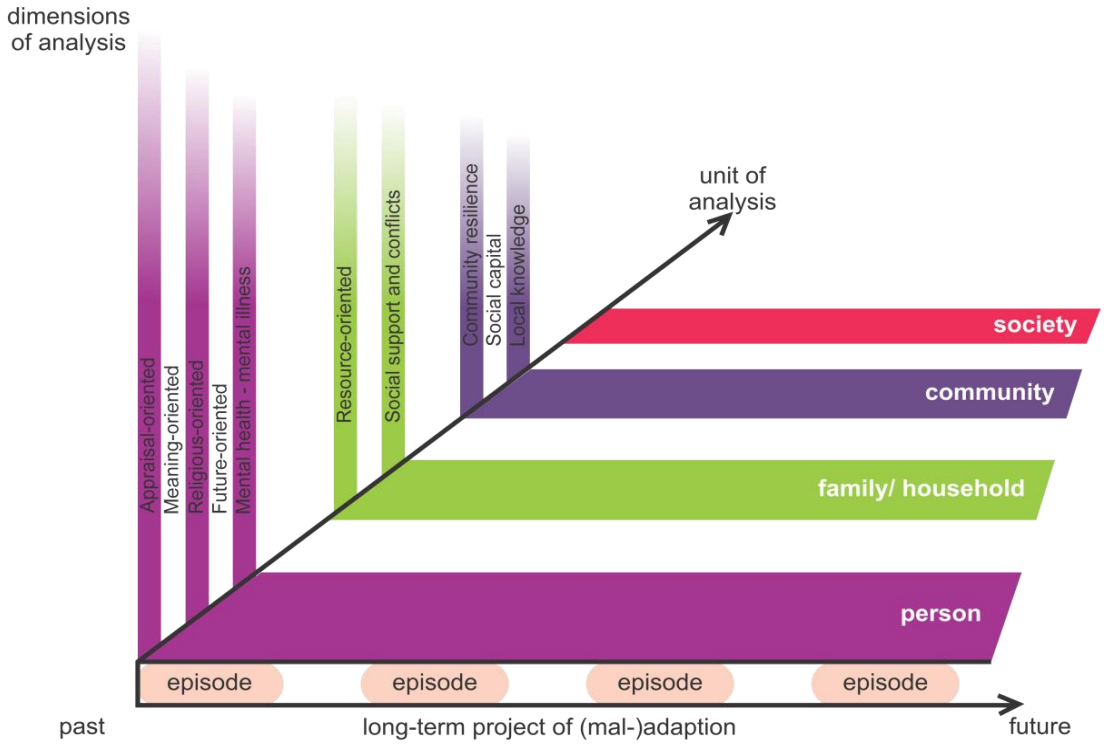

Figure 1. Dimensions and Units of Analysis for Psychological and Sociological Approaches to Coping (DUPS).

Source: Zaumseil and Schwarz (2014, p 47).

The diagram above provides an overview of the numerous perspectives and dimensions covered by the approaches to coping developed in both psychological and social science contexts. The diagram displays the past or prior history of stressful and overwhelming experiences (Krohne, 2002). A coping episode can also be selected as a unit of analysis for a particular individual. In newer approaches in developmental psychology, coping is viewed as an adaptive process associated with a potentially long-term series of interactions with a potentially challenging environment (Krohne, 2002; Zaumseil and Schwarz, 2014). These approaches take into account the fact that a series of stressful episodes can lead to changes both in the individual and in the environment itself (Krohne, 2002). The coping theory will

help understand how teenage mothers have adapted to teenage motherhood and how teenage mothers have coped psychologically with their stressful situations of becoming a mother, while parenting and dealing with other life stressors.

Teenage motherhood and coping with the adjustment of becoming a mother can be a very stressful event. In this study the results show that teenage mothers coped better when compared to teenage non-mothers. Teenage mothers may be applying coping strategies better than teenage non- mothers. Hence the adjustment into motherhood is not as stressful as some would think it could be.

2.13 Theoretical Framework for the present study: The Six Factor Psychological Well- Being Theory

In the current study, the Six Factor Psychological Well-Being as expounded by Ryff and Keyes, (1995), is adopted in order to conceptualise teenage motherhood as a context of which positive fortitude could lead to authentic notions of motherhood. Psychological well-being is associated with positive mental health (Henn, Hill, & Jorgensen, 2016; Opree, Buijzen, & van Reijmersdal, 2018; Ryff & Keyes, 1995). Carol Ryff investigated psychological well-being in relation to development and growth and developed a model consisting of six core dimensions of psychological well-being (van Dierendonck, Diaz, Rodriguez-Carvajal, Blanco, & Jimenez, 2007). In this model, psychological well-being is attained by achieving a state that is balanced by both challenging and rewarding life events. To the teenage mother, parenthood can be challenging and rewarding depending on how the mother handles the transition.

Carol Ryff's six categories of psychological wellbeing are:

1) *Environmental mastery*—Environmental mastery pertains to the competence to manage one's environment and the ability to choose and create contexts suitable for one's needs. For the teenage mother, managing their environment entails making small decisions in everyday matters.
2) *Personal growth*—Personal growth refers to one's feelings of continued personal development. It closely relates to self-actualisation, which has been defined as 'the process of discovering the true self'. At the heart of personal growth is one's openness to new experiences. This happens when the teenage mother embraces the new experience of being a teenage mother.
3) *Purpose in life*—Purpose in life relates to one experiencing a sense of directedness and having goals in life. For example, purpose in life is measured with items like "I enjoy making plans for the future and working to make them a reality" and "I live life one day at a time and don't really think about the future".
4) *Self-acceptance*—Self-acceptance entails having a positive attitude towards oneself. It is closely linked to self-esteem, which is the extent to which people take pride in themselves. For example, self-acceptance may be measured with items like "In general, I feel confident and positive about myself" and "I like most parts of my personality". This measures the capacity with which the teenage mother will embrace her role as a mother.
5) *Autonomy*—Autonomy consists of one's desire and ability to make independent decisions. For example, autonomy is measured with items like "My decisions are usually not influenced by what everyone else is doing" and "It is difficult for me to voice my opinions on controversial matters".

6) *Positive relations with others*—Positive relations with others refer to one's warm and satisfying relationships with other people. For example, positive relations with others is measured with items like "I know I can trust my friends, and they know they can trust me" and "Maintaining close relationships has been difficult and frustrating for me" (Opree et al, 2018; Henn et al. 2016; van Dierendonck et al., 2007). Positive relations are associated with the mental health of the teenage mother.

Opree et al. (2018) stated Carol Ryff's model of psychological well-being provides a powerful framework through which to analyse and organise one's life, and to generate ideas about how to live better.

2.14 Summary of the Chapter

The literature review shows that teenage motherhood can be a psychologically stressful experience that is associated with conditions like anxiety, insomnia, depression, social isolation and somatic symptoms. It does appear that variables like age, family structure and grade do play a role in how the psychological symptoms are experienced. The chapter briefly discussed studies that were conducted on teenage mothers and some of the key psychological problems associated with teenage motherhood. This chapter also focused on the role of the theories used in this study. The theoretical framework provided insight that teenage mothers may be handling the stressors of motherhood positively making use of the psychological model mentioned by Ryff. The following chapter will focus on the methodology used in the study.

Chapter 3: Research Methodology

3.1 Introduction

In the previous chapter, literature relevant to this study was reviewed. The present chapter will specifically address methodological issues, such as the research design, sampling issues, method used to collect data and methods of data analysis. The quality criteria that guided the researcher, as well as the ethical considerations, will also be presented.

3.2 Research Design

The current study adopted a quantitative comparative design (de Vos, Delport, Fouche, & Strydom, 2011; Fielding & Pillinger, 2008). Quantitative research is broadly defined as a formal, objective, systematic process in which numerical data are used to obtain information about the world (Fielding & Pillinger, 2008; Sibanda, 2009). A comparative analysis used in research was used to search for similarity and variance amongst two groups with a view to discovering something about one or both groups being compared (Mills, van de Bunt & de Bruijn, 2006). In the current study, the researcher compared a group of teenage mothers to a group of teenage non-mothers.

3.3 Sampling

3.3.1 Area of study

The area of this study was in Seshego which is a growing township located in South Africa in the Limpopo province and in the Polokwane local municipality of the Capricorn District. In the 1970s, Seshego was known as the capital of the non-independent Bantustan of Lebowa which was abolished in 1994. Seshego was integrated into Polokwane during the transition period between the apartheid and democracy eras. Seshego is divided into eight zones, with a population size based on the census collected in 2011 of 974043 (Cloete & Massey, 2016; South African Cities Network, 2015).

Figure 2. The map of Polokwane where Seshego Township is located

Source: https://www.viamichelin.ie/web/Maps/Map-Seshego-Limpopo-South_Africa

3.3.2 Population and sample

Participants for the present study were sampled from four secondary schools in Seshego Township. A simple random sampling technique (by ballot system) was used to select the four secondary schools from the 11 secondary schools in the township. Afterwards, a stratified sampling technique was used to select 120 participants (60 teenage mothers and 60 teenage non-mothers) from the selected schools. A stratified sampling technique is a method used to divide a population into different subgroups called strata (Alvi, 2016). Teenage mothers were identified through the assistance of the guidance teacher that knew teenage mothers.

3.3.3 Procedure

On the dates agreed with the schools, the guidance/ life orientation teachers arranged all participants into one classroom where questionnaires were distributed amongst them. The research assistant was given the periods/classes usually used for guidance to avoid disrupting lessons and causing disorganisation among the learners. Participants' guardians and/or parents consented to the study. Participants provided informed consent to participate. Data was collected during normal school hours. Participants were selected by the information provided to the research by the guidance teachers from grades 8 to 12. In each of the selected classes, all the teenage mothers and non-teenage mothers were appealed to by the researchers to participate in the study.

After the teenage mothers who were willing to participate in the study had indicated their consent, a request was also made of each of those classes for a corresponding number of teenage non-mothers to participate in the study. Each of those participating students were then given a consent form to sign (if she was 18 years or

older) or to give to any of her parents or guardians to sign. Follow up dates were arranged with guidance teachers on when consent forms signed by parents would be returned from teenage mothers and non-mothers that were younger than 18 years of age. After consent forms were returned, the researcher administered the General Health Questionnaire for participants to fill in.

3.4 Data Collection

Data was collected through the use of a demographic questionnaire and the General Health Questionnaire (GHQ) as discussed below.

3.4.1 Demographic questionnaire

Demographic data was collected using a self-report instrument consisting of the following variables: age, current grade, and family composition (see Appendix 1A).

3.4.2 The General Health Questionnaire (GHQ)

The 28-item General Health Questionnaire used to collect data (see Appendix 1B) was developed by Goldberg and Hillier (1979) to assess the participants' level of general health. The GHQ-28 incorporates four subscales, being somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. There are four possible responses with values of 1 to 4, where the highest value indicates severe symptoms and the lowest value indicates an absence of symptoms. The GHQ-28 is coded according to the intensity felt by participants, for example, 1= Not at all, 2= No more than usual, 3= Rather more than usual, 4= Much more than usual.

The GHQ is described as a tool designed to be a self-administered screening test which is aimed at detecting psychiatric disorders in a community and a non-clinical

setting (Gibbons, Arevalo, & Monico, 2003; Sodi, 2009; Sterling, 2011; Kumaranayake & Srimatni, 2016). The GHQ-28 version is the only version that provides sub-scale measures of more specific domains of psychopathology. The General Health Questionnaire (GHQ) was validated to be used in South Africa, Limpopo Province's population of chronic condition by Maepa and Idemudia (2014) and its Cronbach alpha was 0.94. It was further utilised in a comparative study on teenage mothers and teenage mothers by Mokwena et al. (2016). The Cronbach's alphas for scores from the scales among the participants were as follows: somatic symptoms (0.61), anxiety and insomnia (0.67), social dysfunction (0.50) and severe depression (0.75). The overall Cronbach's alpha for scores from the GHQ for the study was 0.81.

3.5 Data Analysis

The purpose of data analysis is to reduce, organise, and give meaning to the raw data. This is done by addressing the aim and objectives. Data was analysed using the Statistical Package for the Social Sciences (SPSS) version number 25. Demographical variables are presented in the form of frequencies and percentages. Independent *t*-tests were used to analyse and compare the means scores of the two groups of participants (teenage mothers and non-teenage mothers) on the 28 item-GHQ. For the purpose of this study, the confidence interval was set at 95% and the statistical significance was assumed at $P < 0.05$.

3.6 Reliability of the study

The Cronbach Alpha for the social dysfunction scale was very low so the results on the sub-scale would not be reliable. Thus, there exists a need to customise the scale for students.

3.7 Ethical Considerations

3.7.1 Permission for the study

Ethical clearance was sought and obtained from the University of Limpopo's Research Ethics Committee. In addition, gatekeeper's permission was obtained from the Limpopo Provincial Department of Education before gaining access to the schools in Seshego Township (see Appendix 5: Permission letter to Limpopo Provincial Department of Basic Education).

3.7.2 Informed consent

According to Bulger (2002), informed consent is the process in which a participant consents to participate in a research project after being informed of its procedures, risks, and benefits. In this study, participants whose age was above 18 were asked to consent to the study and parents/guardians of those who were below 18 years of age were provided with all the details of the study to be conducted. Thereafter, they were asked to give written consent for the teenager they were responsible for to participate in the present study (see Appendix 2: Informed consent and Appendix 3: Informed consent form and Appendix 4: Informed consent for parents).

3.7.3 Confidentiality and anonymity

According to Brett and van den Eynden (2010), the researcher should aim to assure participants that every effort will be made to ensure that the data they provide cannot be traced back to them in reports and presentations. Confidentiality was ensured by making sure that none of the participant's personal information was discussed with anyone besides the guidance teacher who would have identified the students to the researcher.

3.7.4 Avoidance of harm to participants

The fundamental ethical rule of social research is that it must bring no harm to participants, regardless of whether they participate voluntarily or not, because subjects can be harmed emotionally in the course of a study. The researcher has an ethical obligation to protect participants within all possible reasonable limits from any form of physical or emotional discomfort that may emerge from the research project (de Vos et al., 2011; Brett & van den Eynden, 2010), and the researcher kept this in mind when undertaking the study. The participants, who displayed adverse emotional reactions as a result of the study were referred for psychological intervention at the nearest hospital.

3.8 Summary of the Chapter

The above chapter summarised the research design and quantitative approach to the investigation, which included the method of sampling, the data collection procedure, and data analysis. Lastly, ethical issues which the researcher considered were also addressed.

Chapter 4: Results

4.1 Introduction

In this section, results of the study are presented in line with the aims and objectives of the study. Demographical information of participants will be displayed followed by the presentation of the quantitative data through the use of tables, and the hypotheses will be tested.

4.2 Non-Response to Questionnaires

This research had a sample size of 120 participants. The response rate was 100%. The research handed out questionnaires to participants and waited for participants to complete the questionnaire (thus a response rate of 100%).

4.3 Approach to Data Analysis

Data was analysed using the Statistical Package for Social Sciences version 25 (SPSS 25). Demographic data is presented in the form of frequencies, percentages and tables. *T*-tests were used to compare the differences between teenage mothers and teenage non-mothers' psychological health.

4.4 Reliability Testing

Table 4.1 is a presentation of the internal consistency of the questionnaire completed by teenage mothers only.

Table 4.1: Internal consistency of all variables (teenage mothers)

Items	Cronbach's Alpha	N of items
General Health Questionnaire	0.70	28

Based on the above table, the Cronbach's Alpha for the scale for teenage mothers is 0.70.

Table 4.2 is a presentation of the internal consistency of the questionnaire completed by teenage non- mothers.

Table 4.2: Internal consistency of all variables (teenage non–mothers)

Items	Cronbach's Alpha	N of items
General Health Questionnaire	0.70	28

Based on the above, the Cronbach's Alpha for scale for the teenage non–mothers is 0.70.

Table 4.3 is the presentation of the overall internal consistency of the questionnaire completed by both teenage mothers and teenage non-mothers.

Table 4.3: Internal consistency of all variables

Items	Cronbach's Alpha	N of items
General Health Questionnaire	0.81	28

Based on the above table, the Cronbach Alpha of the scale for both teenage mothers and teenage non-mothers is 0.81.

4.4.1 Reliability testing of each sub-scale within the GHQ

Table 4.4 is a presentation of the presentation of the internal consistency of the sub-scales for teenage mothers

Table 4.4: Internal consistency of each sub-scale for teenage mothers

Items	Cronbach's Alpha	N of items
Somatic symptoms	0.66	7
Anxiety and insomnia	0.70	7
Social dysfunction	0.25	7
Depression	0.71	7
Overall	0.76	28

Based on the table above, the Cronbach Alpha for the questionnaire completed by teenage mothers only is 0.76, with the lowest of the scales being social dysfunction at 0.25, and the highest scale being depression with a Cronbach Alpha of 0.71..

Table 4.5 is a presentation of the presentation of the internal consistency of the sub-scale for teenage non- mothers.

Table 4.5: Internal consistency of each sub-scale for teenage non-mothers

Items	Cronbach's Alpha	N of items
Somatic symptoms	0.53	7
Anxiety and insomnia	0.60	7
Social dysfunction	0.50	7
Depression	0.76	7
Overall	0.70	28

Based on the table above, the Cronbach Alpha for the questionnaire completed by teenage non-mothers only is 0.70, with the lowest scale being social dysfunction with

a Cronbach Alpha of 0.50, and the highest scale being depression with a Cronbach Alpha of 0.76.

Table 4.6 is a presentation of the presentation of the internal consistency of the sub-scale for both teenage mothers and teenage non-mothers.

Table 4.6: Internal consistency of the sub-scale for both teenage mothers and non-mothers.

Items	Cronbach's Alpha	N of items
Somatic symptoms	0.61	7
Anxiety and insomnia	0.67	7
Social dysfunction	0.50	7
Depression	0.75	7
Overall	0.81	28

Based on the table above, the Cronbach Alpha for the questionnaire is 0.81. The depression sub-scale is the highest 0.75 and the lowest of the scale is social dysfunction with a Cronbach Alpha of 0.50.

4.5 Demographic Characteristics

Section A is the demographic section of the questionnaire that inquired about the, age, grade and family characteristics of the participants. The results below will be presented in the form of frequency tables.

Table 4.7 below shows the age of teenage mothers who participated.

Table 4.7: Age of teenage mothers

Age of Participants	Percent
16	6.7
17	18.3
18	33.3
19	41.7
Total	100

The above table indicates that, out of 60 teenage mothers, the largest group were 19 years of age with a percentage of 41.7%, while only a few participants were 16 years of age years old with a percentage of 6.7%.

Table 4.8 below shows the age of teenage non-mothers who participated.

Table 4.8: Age of teenage non-mothers

Age of Participants	Percent
15	13.3
16	11.7
17	25.0
18	33.3
19	16.7
Total	100

The above table indicates that, out of 60 teenage non-mothers, the largest group were 18 years of age with a percentage of 33.3%, while only a few participants were 16 years of age with a percentage of 11.7%.

Table 4.9 shows the age of both teenage mothers and teenage non- mothers who participated.

Table 4.9: Age of all participants

Age of Participants	Percent
15	6.7
16	9.2
17	21.2
18	33.3
19	29.2
Total	100

The table above indicates that out of 120 participants, the largest number were 18 years of age with a percentage of 33.3%, and the smallest group of participants were 15 years of age with a percentage of 6.7%.

Table 4.10 shows the grade of teenage mothers

Table 4.10: Grade of teenage mothers

Participants' grade	Frequency	Percent
Grade 10	9	15.0
Grade 11	26	43.3
Grade 12	25	41.7
Total	60	100

The table above indicates that, out of 60 teenage mothers, the largest number of the participants were from grade 11 with a percentage of 43.3%, and the smallest group of participants were from grade 10 with a percentage of 15.0%.

Table 4.11 presents the grade of teenage non-mothers.

Table 4.11: Grade of teenage non-mothers

Participants grade	Frequency	Percent
Grade 10	28	46.7
Grade 11	5	8.3
Grade 12	27	45.0
Total	60	100

The table above indicates that, out of 60 teenage non-mothers, the largest number of participants were from grade 10 with a percentage of 46.7%, and the smallest number of teenage non-mothers were from grade 11 with a percentage of 8.3%.

Table 4.12 presents the grades of both teenage mothers and teenage non- mothers.

Table 4.12: Grade of both teenage mothers and teenage non-mothers

Participants grade	Frequency	Percent
Grade 10	37	30.8
Grade 11	31	28.8
Grade 12	52	43.3
Total	120	100

The above table shows that, out of 120 participants, the highest number of participants were in grade 12 with a percentage of 43.3%. The second highest were from grade 10 with a percentage of 30.8%, followed by grade 11 with a percentage of 28.8%.

Table 4.13 presents the family characteristics of teenage mothers.

Table 4.13: Family characteristics of teenage mothers

Living with	Frequency	Percent
Both biological parents	20	13.3
Mother and step-father	8	13.3
Father and step-mother	0	0
Mother only	23	38.3
Father only	1	0.7
Other	8	13.3
Total	60	100

The above table shows that the largest number (38.3%) of teenage mothers were living with their mother only, while there was no participant (0%) living with a father and step-mother.

Table 4.14 presents the family characteristics of teenage non- mothers.

Table 4.14: Family characteristics of teenage non-mothers

Living with	Frequency	Percent
Both biological parents	20	33.3
Mother and step-father	7	11.7
Father and step-mother	1	0.7
Mother only	18	30.0
Father only	0	0
Other	14	23.3
Total	60	100

The above table shows that the largest number (33.3%) of teenage non-mothers were living with both biological parents, while no participants (0%) were living with a father only.

Table 4.15 presents the family characteristics of both teenage mothers and teenage non-mothers.

Table 4.15: Family characteristics of both teenage mothers and teenage non- mothers

Living with	Frequency	Percent
Both biological parents	40	33.3
Mother and step father	15	12.5
Father and step mother	1	0.8
Mother only	41	34.2
Father only	1	0.8
Other	22	18.3
Total	120	100

The above table shows that the largest number (34.2%) of participants were living with a mother only, while the lowest number of participants (0.8%) were living with a father and step-mother.

Table 4.16 Mean comparison of all the major variables of the study

	Teen status	n	x̄	SD	t	df	p-value	Cohens' d
Somatic symptoms	Mother	60	14.15	3.73	2.02	118	0.47	0.32
	Non-mother	60	12.85	4.35				
Anxiety and Insomnia	Mother	60	13.18	4.80	1.42	118	0.33	0.33
	Non-mother	60	14.63	4.00				
Social dysfunction	Mother	60	16.11	3.69	4.21	118	0.67	0.94
	Non-mother	60	19.46	3.46				
Depression	Mother	60	13.38	4.86	2.80	118	0.53	0.51
	Non-mother	60	15.95	5.17				
OVERALL GHQ	Mother	60	56.16	13.30	3.72	118	0.47	0.66
	Non-mother	60	64.80	12.78				

Table 4.16 explains the differences between the teenage mother and non-mother for the study variables. Cohen effect size (d) was used to determine differences. Cohen (1988) described effect sizes as follows: d = 0.2 indicates a small effect, d = 0.5 indicates medium effect and d = 0.8 and higher is indicative of a larger effect. Generally the effect size for GHQ between teenage mothers and teenage non-mothers was within medium level (d = 0.66). When disaggregated the standard deviations units by sub-scales, the effect size was found to be small for somatic symptoms (d = 32) and for anxiety and insomnia (d = 0.33). On the other hand, the effect size was however extremely large for the social dysfunction (d = 94) and medium (0.51) for depression subscales, respectively. Therefore, it can be assumed that there was no significant difference on the between the teenage mothers ad teenage non-mother with regards to their general health.

4.6 Hypothesis of Participants Responses on the General Psychological Health Questionnaire (GHQ)

This section is the presentation of the participants' results based on the hypothesis that were tested. The researcher used independent *t*-tests to compare teenage mothers and teenage non-mothers' general health. Teenage mothers were also compared in terms of their age, grades, and their family characteristics. The following hypothesis will be tested as follows:

4.6.1 Hypothesis 1

There are no significant difference in psychological health between teenage mothers and teenage non–mothers.

Table 4.17 shows the results of the *t*-test comparison between teenage mothers and teenage non-mothers.

Table 4.17: T-test of the general health of teenage mothers and teenage non-mothers

	Mean				
	Mother	Non-Mother	p-value	df	t
Somatic symptoms	13.18	14.75	0.47	118	2.02
Anxiety and insomnia	13.48	14.63	0.33	118	1.42
Social dysfunction	16.11	19.46	0.67	118	4.21
Depression	13.38	15.95	0.53	118	2.80
Over all GHQ	56.16	64.80	0.47	118	3.72

Based on the table above, the *t*-test comparison results indicate no statistically significant difference on general health between teenage mothers (Mean = 56.16 SD = 13.30) and teenage non- mothers (Mean = 64.80, SD = 12.78), $t = 3.72$, $p = 0.48$.

The p-value is > 0.05, therefore, we accept H_o. Furthermore, there was no significant difference between the general health sub-scales.

4.6.2 Hypothesis 2

There are no differences in psychological health between younger and older teenage mothers

Table 4.18 shows the *t*-test results comparing older and younger teenage mothers.

Table 4.18: T-test of the general health of older and younger teenage mothers

	Mean				
	Older	Younger	p-value	Df	t
Somatic symptoms	12.16	13.34	0.18	58	1.04
Anxiety and insomnia	13.56	13.42	0.56	58	-.10
Social dysfunction	13.84	14.20	0.63	58	0.40
Depression	13.28	13.45	0.47	58	0.12
Over all GHQ	52.84	54.42	0.99	58	0.48

Based on the table above, the *t*-test comparison results indicate no statistically significant difference in general health between of older teenage mothers (Mean = 52.84, SD = 12.56) and younger teenage mothers (Mean = 54.42, SD = 12.43), t = 0.48, p = 0.99. The p-value is > 0.05, therefore, we accept H_o. Furthermore, there was no significant difference between the general health sub-scales.

4.6.3 Hypothesis 3

There will be no significant difference on the psychological health between teenage mothers in lower grades and those in matric.

Table 4.19 shows the results of the *t*-test comparison between teenage mothers in a lower grade and matric.

Table 4.19: T-test of the general health of teenage mothers in lower grades and matric

	Mean				
	Lower Grade	Matric	p-value	Df	t
Somatic symptoms	13.80	11.52	0.45	58	2.05
Anxiety and insomnia	13.48	13.48	0.66	58	0.01
Social dysfunction	14.20	13.84	0.45	58	0.40
Depression	13.62	13.04	0.19	58	0.45
Over all GHQ	55.11	51.88	0.26	58	0.99

Based on the table above, the *t*-test comparison results indicate no statistically significant difference in general health between teenage mothers in lower grades (Mean = 55.11, SD = 13.22) and teenage mothers in matric (Mean = 51.88, SD = 11.15), $t = 0.99$, $p = 0.26$. The p-value is > 0.05, therefore, we accept H_o. Furthermore, there was no significant difference between the general health sub-scales.

4.6.4 Hypothesis 4

There will be no significant difference in the psychological health of teenage mothers that are living with both parents and those living with single parents.

Table 4.20 Indicates whether there is or isn't a significant difference between teenage mothers that are living with both parents or single parents.

Table 4.20: T-test of the general health of teenage mothers living with both parents and single parents

	Means				
	Both parents	Single parent	p-value	Df	T
Somatic symptoms	12.96	12.75	0.48	58	0.18
Anxiety and insomnia	12.89	14.00	0.08	58	-0.88
Social dysfunction	14.53	13.62	0.23	58	1.03
Depression	13.50	13.28	0.24	58	0.17
Over all GHQ	53.89	53.65	0.68	58	0.07

Based on the table above, the *t*-test comparison results indicate no statistically significant difference in general health between teenage mothers living with both parents (Mean = 53.89, SD = 12.03) and teenage mothers living with single parent (Mean = 53.65, SD = 13.00), $t = 0.07$, $p = 0.68$. The p-values is > 0.05, therefore, we accept H_o. Furthermore, there was no significant difference between the general health sub-scales.

4.7 Summary of the Chapter

In this section, results of the study were presented in line with the aims and objectives of the study. Demographic information for the participants was displayed followed by the presentation of the quantitative data through the use of tables, and the tested hypotheses.

Chapter 5: Discussion

5.1 Introduction

In the previous chapter, the data collected for the study were presented. This chapter will focus on explaining and discussing the results obtained in relation to the literature reviewed earlier. Comparative findings of teenage mothers and teenage non-mothers' overall psychological health as well as subscales (anxiety and insomnia, somatic symptoms, social dysfunction and depression) will be discussed. This will be followed by analysis of teenage mothers' demographic variables such as age, level of education and family characteristics.

5.2 Psychological Health of Teenage Mothers versus Teenage Non-Mothers

5.2.1 Overall psychological health

The findings of the study show no significant difference in the general psychological health between teenage mothers and teenage non–mothers. Despite the lack of a statistically significant difference, an overall mean score on the General Health Questionnaire (GHQ) of 56.18 was obtained for teenage mothers while a score of 64.80 was obtained for teenage non–mothers. Therefore, the general tendency appears to be that teenage mothers have less psychological distress than teenage non-mothers. This is contrary to much of the literature that has suggested that teenage mothers are more likely to have higher levels of psychological distress when compared to teenage non–mothers (e.g., Biello et al., 2015; Figueredo et al., 2013; Mitchell et al., 2014), or that their levels of psychological distress do not differ (e.g., Biello et al., 2010). However, a review of studies by Singh and Hamid (2015) found

that pregnant teenagers and teenage mothers in South Africa perceived their motherhood in a positive light and reported that it enhanced their lives.

5.2.2 Somatic symptoms of teenage mothers and teenage non-mothers

Disintegrating findings by subscales, there was no statistically significant difference in the somatic symptoms of teenage mothers and teenage non-mothers. However, the means test revealed that teenage mothers experienced less (Mean = 13.18) somatic symptoms than teenage non-mothers' somatic symptoms (14.75). This seems to confirm Mokwena, et al (2016) and Sodi (2009) who also found that teenage mothers experienced fewer somatic symptoms as compared to teenage non-mothers. However, it runs contrary to Figueiredo et al. (2013) who reported that teenage mothers seemed to be at risk of experiencing both somatic and psychological symptoms. Therefore, it would suggest that teenage non- mothers experienced more somatic symptoms when compared to teenage mothers.

5.2.3 Anxiety and insomnia of teenage mothers and teenage non-mothers

Results of comparison tests on anxiety and insomnia show no statistically significant difference between teenage mothers and teenage non-mothers. This is in line with Mokwena et al. (2016); however, it stands in contrast to Sodi's (2009) study on teenage mothers which found that the majority of the participants in her study experienced higher levels of anxiety. The difference between the two can be explained by the age, grade and family characteristics of the teenage mothers as discussed below.

5.2.4 Social dysfunction of teenage mothers and non-mothers

The Cronbach Alpha for the social dysfunction scale was very low, thus, the results on this sub-scale would not deemed be reliable. However the findings on social dysfunction in the current study show a significant difference between teenage mothers (Mean = 16.11) and teenage non-mothers (Mean = 19.46). Teenage mothers seem to experience more social dysfunction than teenage non- mothers. This is in line with Sodi and Sodi (2012), in which participants indicated that their intra and interpersonal relationships had adversely been affected after pregnancy and giving birth. However, it runs contrary to a study conducted by Mokwena et al. (2016) which reported that there were no significant differences on social dysfunctions between teenage non-mothers and teenage mothers.

5.2.5 Depression among teenage mothers and teenage non-mothers

Results for the depression subscale show no statistically significant difference between teenage mothers (Mean = 13.38) and teenage non-mothers (Mean = 18.95). Despite this, non-mothers appeared to report more symptoms of depression compared to teenage mothers. This latter finding contradicts much of the literature that has found that teenage mothers were more predisposed to depression (Figueirodo et al., 2006; Sodi & Sodi, 2012). It also apparently contradicts Mokwena et al. (2016) finding that teenage mothers in their study did not differ from teenage non-mothers on the level of depression and coping strategies. However, with regards to this study it is observed that teenage mothers scored lower than teenage non-mothers, which could suggest that teenage non- mothers experienced slightly higher levels of depression when compared to teenage mothers.

5.3 Teenage Mothers' Psychological Health in Relation to their Demographic Variables (Age, Grade and Family Composition)

5.3.1 Teenage mothers' psychological health in relation to age

The results obtained in this study revealed that there was no significant difference between younger teenage mothers and older teenage mothers in general psychological health in relation to age. Despite the lack of a statistically significant difference, older teenage mothers scored slightly lower (Mean = 52.84) in terms of general health while younger teenage mothers scored slightly more (Mean = 54.42). On the contrary Biello et al. (2010) found that the data suggested that the mental health of adolescents improves as they transition into adulthood. This difference may be due to the impact on other factors that influence teenage mothers' psychological health. For example, Ntinda et al. (2015) found that attention was often given to older teenagers and this created psychological distress to younger teenage mothers.

5.3.2 Somatic symptoms and the age of teenage mothers

Results for the somatic symptom subscale show that there was no statistically significant difference between older teenage mothers (Mean = 12.16) and younger teenage mothers (Mean = 13.34). However, means testing indicated that younger teenage mothers exhibited lightly more or higher somatic symptoms than teenage older mothers. There are few or no recent studies known to the researcher on somatic symptoms of teenage mothers in relation to age, except the two studies in the last decate. For example, Chigona and Chetty (2008) found no significant difference according to age at pregnancy in terms of somatic symptoms. On the other hand, Sodi (2009) reported older teenagers to experience more symptoms of somatic complaints compared to the groups of younger teenage mothers.. It should

be noted that the above literature is dated, and it would seem that future studies would need to be conducted on age differences and somatic symptoms among teenagers in general and teenage mothers in particular in order to help resolve these apparent contradictions.

5.3.3 Anxiety and insomnia and the age of teenage mothers

Findings on anxiety and insomnia show that there was no statistically significant difference between older teenage mothers (Mean = 13.56) and younger teenage mothers (Mean = 13.42), with older teenage mothers tending to be only slightly less anxious than younger teenagers. However, in a study conducted by Sodi (2009), the researcher found that older pregnant teenagers experienced more anxiety and insomnia when compared to younger pregnant teenagers. Young parents can face isolation, negative social attitudes, stress, anxiety and low self-esteem (Biello et al., 2010). However in this study there were no significant differences between the older teenage mothers and younger teenage mothers, this may be due to the fact that they have learnt to cope with teenage motherhood as opposed to being pregnant.

5.3.4 Social dysfunction and the age of teenage mothers

Findings on social dysfunction show no statistically significant difference between older teenage mothers (Mean = 13.84) and younger teenage mothers (Mean = 14.20). Nevertheless, it appears that older teenage mothers tend to struggle slightly more in social relationships than younger teenage mothers. This may be explained by the fact that younger teenage mothers may be receiving more support from family especially during birth. For example, in a traditional African family, aunts and grandmother would provide support and usually they would have someone senior to assist in raising the children (Chigona & Chetty, 2008). This is inconsistent with the

study by Sodi (2009) that revealed that, even in an African context, both young pregnant teenagers and older pregnant teenagers experienced higher levels of social isolation than teenage non-mothers.

5.3.5 Depression and the age among teenage mothers

Results on depression show that there was no statistically significant difference between older teenage mothers (Mean = 13.28) and younger teenage mothers (13.45). Similarly, a study conducted by Moses-Europa (2005) found that teenage mothers experienced similar depressive symptoms compared with adult mothers. However, several studies have suggested that, in contrast to this finding, younger teenage mothers are likely to experience more symptoms of severe depression (e.g., Biello et al., 2010; Brown, 2011; Sodi, 2009; Sodi & Sodi, 2012). Corcoran (2016) mentioned that the occurrence of adolescent pregnancy is multi-factorial, and depression may present one influence that might contribute to early pregnancy in the presence of other risk compared pregnant teenagers to pregnant adults. In relation to teenage mothers and age, a study by Brown (2011) found that younger mothers tend to have higher rates of maternal depression than older adult mothers. However, in this study there are no significant differences in depression between older teenage mothers and younger teenage mothers.

5.4 Teenage Mothers' General Health and Grades

5.4.1 Overall psychological health in relation to grades

The results of this study indicate no statistically significant difference in psychological health between teenage mothers in lower grade (Mean = 55.11) and teenage

mothers in matric (Mean = 51.88). However, means testing revealed that teenage mothers in lower grades generally scored higher on general health symptoms than their non-mother counterparts. One might assume that those in Matric could be experiencing more psychological distress than those in lower grade. A study conducted by Pietrowski (2006) similarly found that teenage mothers who achieved at minimum a high school degree experienced fewer symptoms of psychological distress, fewer depressive symptoms, and greater self-esteem than those who did not.

5.4.2 Somatic symptoms and grades of teenage mothers

The current study found no statistically significant difference in somatic symptoms between teenage mothers in lower grades (Mean = 13.80) and teenage mothers in matric (Mean = 11.52). Despite this, it does appear that teenage mothers in Matric scored slightly lower than those teenage mothers in lower grades. This could be explained by the fact that teenage mothers at Matric would have learned better coping strategies that would enable them to face challenges. However, a study conducted by Chigona and Chetty (2008) found that pregnant women with a higher level of education presented more somatic symptoms than pregnant teenagers with lower education.

5.4.3 Anxiety and insomnia and the grades of teenage mothers

Findings on anxiety and insomnia in the current study showed no statistically significant difference between teenage mothers in lower grades (Mean = 13.48) and teenager mothers in Matric (Mean = 14.48). Despite this, it seems that teenager mothers in Matric experienced more anxiety and insomnia than those at lower grades. This may be explained by the fact that teenage mothers in Matric could be

strained by internal pressure to complete high school on one hand, and the probable amount of work that could be expected for them to complete.

5.4.4 Social dysfunction and the grades of teenage mothers

Results of the current study show no statistically significant difference in terms of social dysfunction between teenage mothers in a lower grade (Mean = 14.20) and teenage mothers in Matric (Mean = 14.00). This is in contrast to a significant number of studies which have found that many younger teenage mothers feel lonely after childbirth and the demands of motherhood leave little time or energy for other relationships, leaving them socially isolated (e.g., Chauke, 2013; Dilworth, 2006; Gyan, 2013; Moses-Europa, 2005). As a result, the adolescent mother may feel isolated from her family or peers. The teenage mothers may experience a lack of communication, emotional closeness and support from their parents. This is probably as a result of adjustment to motherhood and going back to school as well. The findings in this study show that the Cronbach Alpha for the social dysfunction scale was very low so the results on the sub-scale would not be seen as reliable. Thus, there exists a need to develop a culturally appropriate subscale for teenage mothers and teenagers in general.

5.4.5 Depression and the grades of teenage mothers

Results obtained on depression subscale indicate no statistically significant difference between teenage mothers in a lower grade and those teenage mothers who are in Matric, although there was a slight difference (Mean for lower grades = 13.62; Mean for Matric = 13.04). Comparatively, teenage mothers in Matric were found to have slightly lower levels of depression. Chigona and Chetty (2008) also report that teenage mothers face difficulties with keeping up with school work and

take home tasks and the teenage mothers experience pressure from parents, peers and teachers. It would seem that those teenage mothers in matric seem to be coping better than teenage mothers at lower grades. This could result in teenage mothers' resilience to pressure placed on them. Although the study did not focus on secondary school, Kiptanui, et al. (2015), similarly found that teenage mothers in lower grades performed poorer in school when compared to mothers who were studying at tertiary institutions.

5.5 Teenage Mothers' General Health in Relation to Family Structure

5.5.1 Overall psychological health and family structure

According to this study's findings, there was no statistically significant difference in psychological health between teenage mothers living with both parents and teenage mothers living with a single parent. Despite the lack of a significant difference, an overall mean score of 53.89 was obtained for teenage mothers living with both parents and a slightly lower mean score of 53.65 was obtained for teenage mothers living with a single parent. This is contrary to the study that was conducted by Adams et al. (1982) who found that teenage mothers were less likely to be living in families with both their mother and father. They discovered that teenage mothers came from homes where they lived with either their mother, grandmother or a mother and a step-father. A study conducted by Pietrowski (2006) found that there was no evidence that found that maternal support reduces the teenage mother's maternal stress or increases a sense of general well-being. On the other hand, those who reported receiving support from other relatives than a mother or father, and sisters

also reported more parenting difficulties and stress than those adolescents who did not receive support from relatives.

5.5.2 Somatic symptoms and family structure

Disintegrating findings by subscales, there was no significant difference in the somatic symptoms of teenage mothers living with both parents and teenage mothers living with a single parent. However, teenage mothers living with both parents showed a slightly higher (Mean = 12.96) level of somatic symptoms than teenage mothers living with a single parent (Mean = 12.75). A study by McDermott et al. (2004) found that certain aspects of family composition such as the absence or little support from family can heighten the risk of somatic complaints amongst teenage mothers. It would be assumed that as a result, teenage mothers tend to use somatic symptoms as a means of coping with family problems.

5.5.3 Anxiety and insomnia and family structure

The anxiety and insomnia sub-scale in this study shows no statistically significant differences in psychological health between teenage mothers living with both parents (Mean = 12.89) and teenage mothers living with a single parent (Mean = 14.00). Despite this, teenage mothers who live with single mothers seem to have slightly higher levels of anxiety and insomnia than teenage mothers who live with both parents. This is somewhat similar to findings of a study conducted by Mitchell et al. (2014) which found that teenage mothers from both parent families experienced less anxiety and insomnia compared to teenage mothers from single parent families. It would seem that investigations need to conducted in the in the African context to explore factors associated with anxiety and insomnia among teenage mothers within single parent families.

5.5.4 Social dysfunction and family structure

According to the results obtained, there was no statistically significant difference in social dysfunction between teenage mothers living with both parents (Mean = 14.53) and teenage mothers living with a single parent (Mean = 13.64). Teenage mothers who are staying with both parents do, however, show a slightly increased level of social dysfunction than those who stay with single parent. A study conducted by Sodi and Sodi (2012) reported a negative impact of teenage motherhood on social relationships. In some cases, teenage motherhood was found to bring considerable tension in the families. They also reported that teenage mothers experienced some ill treatment from their families. Mokwena et al. (2016) reported that teenage mothers who were satisfied with their social support and had strong supportive family networks are most likely to be associated with successful teenage motherhood. However, in this study the results show that social dysfunction in teenage mothers was slightly higher than teenage mothers living with a single parent, suggesting that teenage mothers that lived with both parents are most likely to be successful at teenage motherhood.

5.5.5 Depression and family structure

The depression sub-scale showed no statistically significant difference between teenage mothers living with both parents (Mean = 13.50) and teenage mothers living with a single parent (Mean = 13.28). This is in contrast to Sodi and Sodi (2012) who found that teenagers' mothers reported having poor relationships with family and experienced depression symptoms even years after they had given birth. A study from Botswana by Ntinda et al. (2015), however, found that that those who are living with both parents seemed to be at risk of depression than those teenage mothers

who are living with a single parent. Therefore, there exists a need to research the levels of depression amongst teenage mothers living with both parents and those living in single parent households to try and resolve these apparent contradictions.

The current findings would suggest that expectations are consistent with this actual outcome cited in the extant literature. In addition, when the types of social support were all high in the vignettes (parent, teacher, and peer), education professionals rated the highest global expectations for both teenage mothers and non-mother adolescents, with no significant difference between the two groups. These results seem to suggest that education professionals seem to consider not only parenting status when determining how successful a student might be, but also how much social support one receives, particularly when social support is at either extreme of the spectrum.

Furthermore, it appears that the receipt of social support is more strongly associated with expectations than whether one is a teenage mother, as social support demonstrated a moderate effect size and parenting status only a small effect size. This finding begs the question of whether with high levels of social support teenage mothers may be able to achieve higher levels of success, even in excess of non-parenting adolescents who have less social support. Thus, additional research should examine whether a high level of multiple sources of support ameliorates the negative effects of teenage motherhood on future outcomes.

5.6 Reflection of Findings in Relation to Study Problem and Theoretical Framework

Literature suggests that teenage motherhood predisposes teenagers to psychological distress in the absence of a supportive environment and counselling (Domings et al., 2013). Research that has been conducted in South Africa has found that teenage mothers reacted differently to the responsibilities of caring for their children (Ntinda et al., 2015; Vo, 2008). Sodi (2009) and Sodi and Sodi (2012) found that teenage mothers experienced psychological challenges such as depression, whereas Maphoti et al. (2014) and Mokwena et al. (2016) found that teenage mothers experienced less psychological distress than non- teenage mothers. With this study it sought to shed light on the apparent contradictions by exploring some of the factors associated with the psychological health of teenage mothers.

This study found that there were no significant differences when teenage mothers were compared to teenage non-mothers. In the context of these findings, it seems that the theory by Ryff (1995) may be relevant from a positive stance. The theory consists of 6 core dimensions of psychological wellbeing that explain psychological wellbeing in this context as being associated with positive mental health. Findings from this study may suggest that teenage mothers have to some extent established a state of balance, making what could be a very negative situation of mothering a child a positive one. There is no suggestion in this study that there is a complete absence of psychological issues, just that they are not significant enough when compared to teenage non-mothers. With use of this study it can be seen that the 6 dimensions are being used and applied to their daily lives as positive stressors rather than negative ones.

Stigma is an issue that comes along with when the female teenager becomes pregnant. Teenage mothers become stigmatised and generalised as teenagers that come from disadvantaged backgrounds and from homes headed by single parents. The stigma is premised around amongst others, them receiving child support grant as Dlamini (2016) mentioned in his study that teenage mothers are stigmatised and more often shamed and punished in schools and their communities. However, this would seem that the ability of the teenager mothers to cope with motherhood would serve as a buffer against stigmatising behaviours that would have had an impact on their psychological well- being as this was evidenced in the current study.

5.7 Summary of the Chapter

This chapter focused on explaining and discussing the results obtained in relation to the literature reviewed in the study. Comparative findings of teenage mothers and teenage non-mothers' overall psychological health as well as subscales (anxiety and insomnia, somatic symptoms, social dysfunction and depression) were discussed. This was be followed by an analysis of teenage mothers' demographic variables such as age, level of education and family characteristics.

Chapter 6: Summary and Conclusion

6.1 Summary of the Findings

The study sought to explore the psychological health of teenage mothers from selected secondary schools in Seshego Township, Limpopo Province. Generally, the study makes use of a comparative design; 120 participants were selected for the study consisting of 60 teenage mothers and 60 teenage non-mothers. The psychological health of teenage mothers was compared to the psychological health of teenage non-mothers. The study made use of the 28-item General Health Questionnaire (GHQ) which was given to both teenage mothers and teenage non-mothers.

The results of the study show that there was no statistically significant difference in the psychological health of teenage mothers and teenage non-mothers. Results also showed that there were no statistically significant differences on the sub-scales of somatic symptoms, anxiety and insomnia, social dysfunction and depression. Results of teenage mothers were compared to one another in terms of age, grade and family structure, and these comparisons also showed no statistically significant differences. This is in contrast to much of the existing literature that has suggested that there is a significant difference in the psychological health of teenage mothers and teenage non-mothers.

The results of this study will contribute to the existing body knowledge on teenage motherhood in general, as well as finding out about the teenage mother's psychological health which will assist in targeted interventions for the teenage

mother. This knowledge will therefore help in an integrated approach to supporting the teenage mother.

6.2 The Study Contribution

The current study contributes towards the baseline understanding of the psychological health, not only for teenage mothers, but also for teenage non-mothers. It also gives an overview to mental health practitioners on aspects that they will need to focus on as they intervene at school.

6.3 Limitations of the study

Though this study revealed significant findings, there were several limitations:

- The study relied upon the self-report method of data collection, which is subject to intentional distortion.
- The sample used was limited to 60 participants each of teenage mothers and teenage non- mothers in secondary schools in Seshego only. Consequently, the findings cannot be generalised to teenage mothers based outside of Seshego Township.
- The study lacked a qualitative component, which may have provided more data regarding the psychological health of both teenage mothers and teenage non-mothers.
- The study lacked focus on the interplay of family factors (e.g., parenting styles, communication styles and family cohesion) that may influence the psychological of both teenage mothers and non-mothers.

- Since being a teenage mother may be seen as embarrassing, the participants may have given normative answers and may not have been entirely honest when answering the questionnaires, seeking to give answers that were socially desirable, to give a different impression of their real self.
- The Cronbach Alpha for the social dysfunction scale was very low so the results on the sub-scale would not be reliable. Thus, there exists a need to customise the scale for students.
- This study can be seen as homogenous as the results cannot be generalised to all teenage mothers in the Seshego Township, as the sample size does not allow for large generalisation.

6.4 Recommendations

Based on the above findings, the following recommendations are made:

- More studies should be done on the psychological health of teenage mothers. These studies may utilise a mixed method approach to gather rich data.
- Future studies on the interplay of family factors (e.g. parenting styles, communication styles and family cohesion) that may influence the psychological well-being of both teenage mothers and teenage non-mothers need to be conducted.
- A study that looks at the psychological health of teenage mothers can be conducted from a larger sample of teenage mothers in the entire province.

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Appendix 1: Data Collection Tool

Section (A): Biographical Data

Are you: A mother: A □ **Or** Non-mother: B □

Place a mark (or fill) in the blank space next to your answer.

1. Age (in numbers):

---

2. Grade (in numbers):

---

3. Who do you currently live with?

a. Both biological parents
b. Mother and step farther
c. Father and step mother
d. Mother only
e. Father only
f. Other? Please Specify

Section (B): The General Health Questionnaire

REPLY THE FOLLOWING BY CROSSING THE ANSWER.

To what intensity would you rate yourself recently (For the past <u>one-month</u>) on a four scale?

Have you recently

1= Not at all, 2= No more than usual, 3= Rather more than usual, 4= Much more than usual.				
5. Been feeling perfectly well and in good health?	1	2	3	4
6. Been feeling in need of a good tonic?	1	2	3	4
7. Been feeling run down and out of sorts?	1	2	3	4
8. Felt that you are ill?	1	2	3	4
9. Been getting any pains in your head?	1	2	3	4
10. Been getting a feeling of tightness or pressure in your head?	1	2	3	4
11. Been having hot or cold spells?	1	2	3	4
12. Lost much sleep over worry?	1	2	3	4
13. Had difficulty in staying asleep once you are off?	1	2	3	4
14. Felt constantly under strain?	1	2	3	4
15. Been getting edgy and bad-tempered?	1	2	3	4
15. Been getting scared or panicky for no good reason?	1	2	3	4
16. Found everything getting on top of you?	1	2	3	4
17. Been feeling nervous and strung-up all the time?	1	2	3	4
18. Been managing to keep yourself busy and occupied?	1	2	3	4
19. Been taking longer over the things you do?	1	2	3	4

20. Felt on the whole you were doing things well?	1	2	3	4
21. Felt satisfied with the way you have carried out tasks?	1	2	3	4
22. Felt that you are playing a useful task past in things?	1	2	3	4
23. Felt capable of making decisions about things?	1	2	3	4
24. Been able to enjoy your normal day-to-day activities?	1	2	3	4
25. Been thinking of yourself as a worthless person?	1	2	3	4
26. Felt that life is entirely hopeless?	1	2	3	4
27. Felt that life is not worth living?	1	2	3	4
28. Thought of the possibility that you might make a way with yourself?	1	2	3	4
29. Found yourself you could not do anything because your nerves were too bad?	1	2	3	4
30. Found yourself wishing you were dead and away from it all?	1	2	3	4
31. Found that the idea of taking your own life kept coming to you?	1	2	3	4

KOKETŠO/ SENGWALWA SA TLALELETŠO 1 (B): SEDIRIŠWA SA KGOBOKETŠO YA DATA/ TSHEDIMOŠO

KOKETŠO/ SENGWALWA SA TLALELETŠO 1 (A): DATA YA TŠA BOPHELO

O mme □ goba ao mme □

Swaya (goba tlatša) karabo mo sekgobeng sa kgauswi le karabo ya gago.

1. Mengwaga (ka nnomoro) :

---

2. Grata (ka nnomoro) :

---

3. Ga bjale o dula le mang?

a. Batswadi ba babedi ba madi

b. Bomma le tate yo e se go wa madi

c. Tate le mma yo e se go wa madi

d. Mma a le noši

e. Tate a le noši

f. Yo mongwe? (Hlaloša ka kgopelo)

KAROLO (B): LENANEOPOTŠIŠO KA KAKARETŠO KA MAPHELO.

Araba tšeo di latelago ka go thala karabo

Ke kgonthišišo ye kaakang yeo o ka iphago yona ga bjalo (Mo kgweding e tee yeo e fitilego) godimo ga nne.

E ka ba ga bjale

1= Le ga tee, **2=** E se go ka mehla, **3=**Go ena le ka mehla, **4=** Go feta ka mehla.				
4. O ikwa o phela gabotse e bile o na le bophelo bjo bo botse?	1	2	3	4
6. O ikwa o duma go nwa sematlafatši?	1	2	3	4
7. O ikwa o gakanegile?	1	2	3	4
8. O kwele o babja?	1	2	3	4
9. O ikwa o na le dihlabi ka bjokong/ O ikwa o opa ke hlogo?	1	2	3	4
10. O ikwa o na le kgatelelo ya monagano o lapile?	1	2	3	4
11. O ikwa o fiša goba o tonya?	1	2	3	4
12. O feletšwe ke boroko ka lebaka la go tšhwenyega/ balabala?	1	2	3	4
13. O palelwa ke go robala ge o ka phafoga?	1	2	3	4
14. O kwa o lapiša ditšhika ka mehla?	1	2	3	4
15. O ikwa o lefelela batho pelo?	1	2	3	4
16. O kwa o tšhoga goba o tlalelwa go se na lebaka?	1	2	3	4
17. O ikwa o imelwa ke dilo ka moka?	1	2	3	4
18. O ikwa o e ba le letšhogo ka mehla e bile o se na nako ya go khutša?	1	2	3	4
19. O kgona go itshwarelela ka mošomo	1	2	3	4
20. O tšea sebaka se setelele go dira dilo	1	2	3	4

21.O ikwele o dira dilo gabotse?	1	2	3	4
22. O ikwa o kgotsofetše ka tsela yeo o dirago mešomo ka gona?	1	2	3	4
23. O ikwa o tšea karolo ya mohola go fetiša dilo tše dingwe?	1	2	3	4
24. O ikwa o le maleba go tšea dipheto go dilo tše dingwe?	1	2	3	4
25. O kwa o ipshina ka mešongwana ya ka mehla?	1	2	3	4
26. O nagana go re o motho wa hloka mohola?	1	2	3	4
27. O ikwa e ka re ga o sa na le tshepo bophelong?	1	2	3	4
28. O ikwele e ka re ga o tsebe go re o phelela eng?	1	2	3	4
29. O bona go ka ba le tšwelopele ka wena?	1	2	3	4
30. Ka lebaka la letšhogo o ile wa ikhwetša o sa tsebe seo o ka se dirago?	1	2	3	4
31. O ile wa ikhwetša o bona bokaone o hlokofetše o efogile mathata ka moka?	1	2	3	4
32. O ile wa ikhweditše monagano wa go ipolaya o etla gantši?	1	2	3	4

Appendix 2: Participants Consent Letter

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date: _____

Dear participant

Thank you for agreeing to take part in this study which focuses on the general health of teenage mothers at Seshego Secondary Schools. The aim to this study is to identify factors contributing to teenage mothers' psychological health.

Kindly answer all questions as honesty as you can. Your responses will remain strictly confidential. You are free to answer any question. Participation is voluntary and you are therefore free to withdraw from this study at any time. Thank you for your cooperation.

Kind regard

_____ _____

Ms H.L Maleka (Masters Student) Date

_____ _____

Dr J. P Mokwena Supervisor Date:

KOKETŠO / SENGWALWA SA TLALELETŠO 2 (A): LENGWALO LA TUMELELO LA MOTŠEAKAROLO

Department of Psychology
Unibesithi ya Leboa
Private X1106
Sovenga
0727
Date: _____

Thobela Motšeakarolo

Ke lebogile kudu ge o dumetše go tšea karolo go thutwana ya go lebelelana le maphelo kakaretšo a baswa bao ba šetšego e le batswadi dikolong tša sekontari tša Seshego. maikemišetšo a thutwana ye, ke go hwetša mabaka ao a hlolago maphelo a menagano go baswa bao ba šetšego e le batswadi.

Ka kgopelo araba dipotšišo ka moka ka mo o ka kgonago ka botshepegi. Dikarabo tša gago di tla ba sephiri. O dumeletšwe go araba potšišo yeo o e ratago. Botšeakarolo ga se kgapeletšo, ka fao o na le tokelo ya go tlogela ka nako ye ngwe le yengwe mo thutwaneng ye. Ke leboga go ba le tirišano le lena.

Wa lena

_____ _____

Ms H.L Maleka (Moithuti wa Mastase) Letšatšikgwedi:

_____ _____

Dr J. P Mokwena Molekodi Letšatšikgwedi:

Appendix 3: Participants Consent Form

I _____ hereby agree to participate in a Masters study that focuses on the **psychological health of teenage mothers from selected secondary schools in Seshego township, Limpopo Province**.

The purpose of the study was fully explained to me and I understand that my participation in this study is voluntary and that I am not forced to participate. Furthermore, I understand that I can withdraw from participating in this study at any time. I also understand that my responses will be kept strictly confidential.

I insist that this research project is not necessarily going to benefit me personally.

Signature: _____ Date: _____

KOKETŠO/ SENGWALWA SA TLALELETŠO 3(A): FOROMOTUMELELO YA MOTŠEAKAROLO

Nna _____ ke dumela go tšea karolo go thutwana ya Mastase yeo e lebelelanego le maphelo a monagano a baswa bao e šetšego e le batswadi, bao ba kgethilwego dikolong tša disekontari tša motsesetoropong wa Seshego, Profenseng ya Limpopo.

Ke hlaloseditšwe maikemišetšo a thutwana yeo ka botlalo gomme ke kwešišitše le go re botšeakarolo ga se kgapeletšo nka tlogela ge ke nyaka. Go feta fao, ke kwešišitše go re nka tlogela nako efe goba efe go botšeakarolo ka gare ga thutwana ye. Ke kwešišitše gape le go re dikarabo tšaka e tla ba sephiri.

Ke gatelela go re protšeke ye ya resetšhe/nyakišišo ga e tlo mohola go nna.

Tshaeno: _____ Letšatšikgwedi: _____

Appendix 4: Letter to Parents for Permission

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date: _____

Dear Parent

Your daughter has volunteered to participate in a research study, TOPIC: The Psychological health of teenage mothers from selected secondary schools in Seshego township, Limpopo Province.

This study will be conducted by the researcher H.L Maleka and supervised by Dr J.P Mokwena. During this study your child will be given a questionnaire in which they will be asked to tick the most correct response, your child will also be asked to provide us with necessary demographical information. Each child has the right to withdraw if they wish to discontinue with the study. All personal information gathered from the study will remain anonymous and will be locked away after use.

Kind Regards

_____ _____

Ms H.L Maleka (Masters Student) Date

_____ _____

Dr J. P Mokwena (Supervisor) Date

I give _____ permission to take part in the study.

_____ _____

Parent Signature Date

KOKETŠO/ SENGWALWA SA TLALELETŠO 4(A) LENGWALO LA MOTSWADI LA TUMELELO

Department of Psychology

Unibesithi ya Leboa

Private X1106

Sovenga

0727

Letšatšikgwedi: _____

Thobela Motswadi

Morwedi wa gago o ithaopile go ba motšeakarolo ka gare ga thutwana ya resetšhe, HLOGO: Boitekanelo bja tša monagano go baswa bao e šetšego e le batswadi bao ba kgethilwego dikolong tša disekontari motsesetoropong wa Seshego, profenseng ya Limpopo.

Thutwana ye e dirwa ke moretšha/ monyakišiši H.L Maleka le molekodi Ngk. J.P Mokwena. Ka nako ya thutwana ye, ngwana wa gago o tlo fiwa lenaneopotšišo leo a tlo go kgetha karabo ya nnete, gomme o tlo kgopelwa go fa tshedimošo ya maleba ya naga. Ngwana yo mongwe le yo mongwe o na le tokelo ya go tlogela thutwana ge a sa nyake go se sa tšwela pele ka yona.Tshedimošo ka moka ya gagwe yeo e kgobokeditšwego mo thutwaneng e tla dula go sa tsebege mong wa yona gomme e tla notlelelwa ka morago ga go šomišwa

Wa lena

_____ _____

Ms H.L Maleka (Moithuti wa Mastase) Letšatšikgwedi

_____ _____

Dr J. P Mokwena (Molekodi) Letšatšikgwedi

Ke fa _____ tumelelo go tšea karolo ka gare ga thutwana ye.

_____ _____

Tshaeno ya Motswadi: Letšatšikgwedi

Appendix 5: Letter to Provincial Department of Education

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

0720

Date: _____

The Head of Department

Limpopo Provincial Department of Education

Polokwane

0700

Dear Sir/Madam

I H.L Maleka, a student at the University of Limpopo (Turfloop Campus) hereby apply for approval for research on: **The psychological health of teenage mothers from selected secondary schools in Seshego township, Limpopo Province.**

I am fully aware of the guidelines and regulations relating to a study of this nature and undertake to abide by ethical rules as outlined.

Kind regards

_____ _____

Ms H. L Maleka (Masters Student) Date

_____ _____

Dr J. P Mokwena (Supervisor) Date:

KOKETŠO/ SENGWALWA SA TLALELETŠO 5 (A): LENGWALO LA GO YA GO LEFAPHA LA THUTO LA PROFENSE

Department of Psychology

Unibesithi ya Leboa (Turfloop Campus)

Private Bag X1106

0720

Letšatšikgwedi: _____

Hlogo ya Kgoro

Limpopo Provincial Department of Education

Polokwane

0700

Thobela Morena

Nna, H.L Maleka, moithuti mo Yunibesithing ya Limpopo (Khamphaseng ya Turfloop) ke kgopela tumelelo go dira resetšhe/nyakišišo: ka: Boitekanelo bja tša monagano go baswa bao e šetšego e le batswadi bao ba kgethilwego dikolong tša disekontari motsesetoropong wa Seshego, profenseng ya Limpopo.

Ke tloga ke kwešiša ditlhahli le melawana ya mabapi le thutwana ye gomme ke ithaopa go obamela melao ya go amogelega ka mokgwa wo a laeditšwego.

Wa lena

_____ _____

Ms H. L Maleka (Moithuti wa Mastase) Letšatšikgwedi

_____ _____

Dr J. P Mokwena (Molekodi) Letšatšikgwedi:

Appendix 6: TREC Approval Letter

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
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TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: 07 February 2018

PROJECT NUMBER: TREC/21/2018: PG

PROJECT:

Title: The psychological health of teenage mothers from selected secondary schools in Seshego Township, Limpopo Province.

Researcher: HL Maleka
Supervisor: Dr JP Mokwena
Co-Supervisors: Prof T Sodi
School: School of Social Sciences
Degree: Masters in Psychology

PROF TAE MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Appendix 7: Approval Letter from the Department of Education

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
EDUCATION

Ref: 2/2/2 Enq: MC Makola PhD Tel No: 015 290 9448 E-mail:MakolaMC@edu.limpopo.gov.za

Maleka HL
University of Limpopo
Private Bag X1106
Fauna Park
0720

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

1. The above bears reference.
2. The Department wishes to inform you that your request to conduct research has been approved. Topic of the research proposal: **"THE PSYCHOLOGICAL HEALTH OF TEENAGE MOTHERS FROM SELECTED SECONDARY SCHOOLS IN SESHEGO TOWNSHIP, LIMPOPO PROVINCE".**
3. The following conditions should be considered:

3.1 The research should not have any financial implications for Limpopo Department of Education.

3.2 Arrangements should be made with the Circuit Office and the schools concerned.

3.3 The conduct of research should not in anyhow disrupt the academic programs at the schools.

3.4 The research should not be conducted during the time of Examinations especially the fourth term.

3.5 During the study, applicable research ethics should be adhered to; in particular the principle of voluntary participation (the people involved should be respected).

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Tel: 015 290 7600. Fax: 015 297 6920/4220/4494

3.6 Upon completion of research study, the researcher shall share the final product of the research with the Department.

4 Furthermore, you are expected to produce this letter at Schools/ Offices where you intend conducting your research as an evidence that you are permitted to conduct the research.

5 The department appreciates the contribution that you wish to make and wishes you success in your investigation.

Best wishes.

Ms NB Mutheiwana
Head of Department

09/04/15
Date

REQUEST FOR PERMISSION TO CONDUCT RESEARCH: MALEKA HL

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