

MENTAL HEALTH AND COPING STRATEGIES OF TEENAGE MOTHERS IN
THE KAVANGO REGIONS

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ABSTRACT

The aim of this study is to assess the mental health, investigate the challenges and coping strategies of teenage mothers in the two Kavango regions, namely Kavango East and Kavango West. The main focus of the study is to investigate, whether young schooling mothers show symptoms of depression, anxiety and stress. Furthermore, the study seeks to explore the extent of these symptoms and any other psychological or social challenges. Finally, the study seeks to explore methods used in coping with these challenges. The population sample consist of teenage mothers aged between 14 to 19 years, a sample size of seventy-two (72) participants. Thirty (30) participants were selected from Kavango East and the other thirty (30) from Kavango West. Three (3) combined and senior secondary schools were selected per region. A process of systematic random sampling was used to select a total number of 10 participants per school. In addition, two (2) focus groups each consisting of six (6) participants were selected in each region. A triangulation method of quantitative (close-ended) and qualitative (open-ended) methods was used to collect the data. For the quantitative data, a self-report 42-item Depression, Anxiety and Stress Scale (DASS) was used to measure symptoms of three variables, namely: depression, anxiety and stress. For the qualitative data, semi structured interviews were conducted with participants in the two focus groups. The results indicate themes of regret, guilt, worry, chronic sadness, symptoms of moderate to severe depression, anxiety and stress, stigma and limited or a lack of financial and emotional support. It is therefore recommended that there is access to psychotherapy and/or counselling services in schools and in communities and teenage mothers' clubs. Furthermore, it is recommended that flexible learning environments are created, moreover, provision of day care facilities to help minimise the varying stress experienced which consequently affect school performance.

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LIST OF ABBREVIATIONS

APA	American Psychiatric Association
DASS	Depression, Anxiety and Stress Scale
DSM	Diagnostic Statistical Manual
HPCNA	Health Professions Councils of Namibia
MDD	Major Depressive Disorder
MOE	Ministry of Education
SPSS	Statistical Package for the Scientific Software
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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DEDICATIONS

I dedicate this thesis to my parents, Monika Kauna Musese and the late Michael Muronga Musese. My values and morals are a reflection of you.

DECLARATION

I, Annastasia Nepemba Musese, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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CHAPTER 1

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The motivation and interest for this study was influenced by the parachuting reported rates of teenage pregnancy and school dropouts in Namibia. Moreover, the study was influenced by the researcher's observations attesting to the official reports during her employment period as a Psychological counsellor in the Kavango regions primarily working with teenagers providing career guidance and counselling. As supported by the literature, Namibia is ranked as one of the countries with the highest learner pregnancy rates in Africa (Ministry of Education, Arts and Culture [MOE], 2010). Particularly in Namibia, Lillian and Mumbango (2015) reported that Kavango regions have the highest percentages of teenage pregnancies of 13.1% followed by four other regions namely; Otjozondjupa (9.1%), Khomas (9.0%), Zambezi (8.5%) and Ohangwena (8.2%). Moreover, Lillian and Mumbango (2015) recommend that interventions should target those regions as adolescent pregnancy is correlated to HIV/AIDS, sexual abuse, child neglect, increased mortality rate, school failure and dropout, poor self-image and limited future career opportunities. Nekongo-Nielsen and Mbukusa (2013) concur that teenage pregnancy rates in Namibia are particularly higher in the Kavango regions and that many learners in these regions drop out of school as a result of pregnancy. Furthermore, according to Nekongo-Nielsen and Mbukusa (2013), out of 131 learners interviewed during the time of their study in the Kavango regions, 60 out of 72 female learners dropped out of school due to pregnancy. In the same vein, Hubbard (2008) reports that in the year 2007 a total of 1,465 learners dropped out of school (96% of them being girls) due to teenage pregnancy with the

highest school dropout rate in the Kavango regions followed by Omusati, Oshikoto, Oshana and the Caprivi region, currently known as the Zambezi Region.

De Villiers and Kekesi (2004) report that teenage pregnancy has a negative impact on the social, educational, cultural and economic development of teenage mothers. Several studies have found that the dual role of parenting and being a learner has consequences on the academic performance of a learner when learners' performance before and after pregnancy was compared (Beesham, 2000; Haufiku, 2014). In a study by Chigona and Chetty (2007), it is reported that teenage mothers were constantly absent from school which subsequently affected their academic performance. The above discussed literature confirms that teenage pregnancy in Namibia is a social problem of great concern, contributing to female learners dropping out of school thus hindering the achievement of gender equality in education.

1.2 STATEMENT OF THE PROBLEM

Literature indicate that high rates of teenage pregnancy, motherhood and school dropout have been a national issue for a substantial time. Media reports indicate parachuting statistics on teenage pregnancy in the country, increased school failure rates and school dropouts, particularly in the Kavango regions. Moreover, the education sector policy (among other measures) addressing concerns relevant to the prevention and management of learner pregnancy are inadequately and unsuccessfully met as the rates of teenage pregnancy and motherhood remain high.

In addition, the researcher has established that there is a vast gap in academic literature on teenage mothers and well-being. It is against this background that the researcher hopes to empower by imparting knowledge on teenage mother's mental health, challenges and coping strategies. Through a top down approach, policy makers are

recommended to implement strategies such as, ongoing and improved psychoeducation programmes in schools and communities envisaged to positively influence teenage mothers to make better and informed decisions and possibly reduce subsequent pregnancies. In addition, implementing and accessibility to improved support services (counselling and psychotherapy). Moreover, creating a flexible learning environment which may motivate teenage mothers to continue their education striving to become productive citizens of Namibia. It is hoped that these measures promote gender equality and empower women, hence, eliminating gender disparities in education and employment sectors in Namibia.

1.3 OBJECTIVES OF THE STUDY

1. To assess the mental health of teenage mothers in the Kavango regions in relation to depression, anxiety and stress.
2. To investigate the experiences, challenges and coping strategies of teenage mothers.

1.4 SIGNIFICANCE OF THE STUDY

As previously stated, teenage pregnancy, a great social problem in Namibia has various consequences for school going teenage learners and mothers. A study of this nature is significant for the following reasons:

- a) The study aims to fulfil the welfare of teenage mothers by focusing on their psychological experiences through the process of assessing their mental health.
- b) Additionally, the study focuses on teenage mothers and motherhood as opposed to the traditional approach of focusing on the pregnant teenagers.

c) Furthermore, this study may aid mental health professionals, amongst others, in developing appropriate intervention programmes to address challenges experienced by teenage mothers.

d) A study of this nature may also inform policy makers and assist further development of research in the discipline.

1.5 DELIMITATION OF THE STUDY

This research was undertaken in the Kavango East and Kavango West regions, situated in the North Eastern part of Namibia. The sample was drawn from the secondary and combined schools in Rundu, Nakazaza, Kayira-yira and Sinzogoro areas. The focus of this study was on the mental health and coping strategies of teenage mothers, moreover, examining the experiences and challenges faced by these teenage mothers and coping strategies used. The rationale for conducting research in these regions is attested by literature and official reports which declare these regions to have the highest rates of teenage pregnancy in Namibia.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The aim of this study was to assess the mental health of teenage mothers in the Kavango regions and to explore their experiences, challenges and coping strategies. This section reviews relevant literature. Various studies have established that teenage pregnancy is a major concern in many countries. Particularly in Namibia, it is a hindrance to eliminating gender disparities and in the attainment of gender equality in education. The National Demographic and Health survey indicate that young people in the Kavango regions are likely to have their first sexual intercourse by and/or before age 15 (Ministry of Health and Social Services [MoHSS], 2008). Moreover, that condom use at first sexual intercourse by women in the Kavango regions is lowest occurring at 37% (HoHSS, 2008). The UNICEF (2006) survey study of 265 teenage girls aged between 15 to 24 in the Kavango, Omaheke and Ohangwena regions, indicated that 19% of the girls reported to already been pregnant and that 40 % of the pregnancies resulted from non-consensual/forced sex. Furthermore, there is indication of teenage mothers utilising methods such as illegal abortions, baby dumping and infanticides as a means of preventing motherhood from interfering with their education. It is against these concerns, that guidelines have been put in place to prevent and manage teenage pregnancies through efforts to minimise challenges experienced by learners that are parents.

2.2 EDUCATION SECTOR POLICY ON THE PREVENTION AND MANAGEMENT OF LEARNER PREGNANCY.

Various legal documents or structures influenced the development of this policy, namely, The Namibian Constitution, the Education Act 16 of 2001, the Vision 2030, UN Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), UN Convention on the Rights of the Child, Charter on the Rights and Welfare of the African Child, Protocol to the African Charter on the Rights of Women in Africa and the Education for All (EFA) policy document.

The policy on the prevention and management of learner pregnancy has an ultimate goal to reduce the rate of teenage pregnancy and teenage motherhood in Namibia. However, in doing so, in the meantime the policy aims to improve measures in place addressing prevention and management of teenage pregnancy (Ministry of Education, Arts and Culture [MOE], 2010). It is applicable to all school going age learners, including those above the age of 18, still attending secondary school. Moreover, it is applicable to all Government and Government subsidised private schools in Namibia. This policy is divided into two sections:

The first section, addresses matters pertaining to the preventative measures of learner pregnancy such as education on sexual and reproductive health. Moreover, it also addresses the ongoing collaborations with non-governmental organisations and other agencies where possible. In addition, the policy addresses the implementation of counselling services, life skills and supplementary programmes in schools and promoting a safe environment and safe leisure activities for all learners. Furthermore, this section ensures that there is gender-specific support and mentoring through learner empowerment, equal opportunities and the attainment of appropriate goals by learners. Lastly, the policy emphasises the importance of family and the community

involvement in all aspects of learners' lives and the educative staff being the positive role models learners need them to be.

The second section of the policy, which looks at management strategies of learner pregnancy, promotes openness (ability to openly express), information sharing, counselling and psychosocial support in the form of encouragement, parenting skills and monitoring and evaluation of learners during pregnancies. Furthermore, this section looks at various ways of providing and availing information pertaining to health, breast feeding and expression of milk education before giving birth, school assignments, education after giving birth and examinations.

The other significant thing is that this policy has placed measures to address educational support (missed school work, tutoring, attendance and information about contraceptives) and fight discrimination against pregnant learners, expectant fathers and learner-parents. In conclusion, according to the Ministry of Education, Arts and Culture (2010) to ensure that this policy comes to life, educative programmes in schools, various stakeholders and government institutions are expected to play their designated roles in the hope of successfully and appropriately implementing this policy.

2.3 PREVALENCE OF TEENAGE PREGNANCY

The United Nations International Children's Emergency Fund (UNICEF) (2008) defines teenage pregnancy as pregnancy usually in girls aged 13-19. Atuyambe, Titilayo and Opatola (as cited in Micah et al., 2003, p. 2) reports that worldwide, an estimate of 16 million girls aged 16-19 give birth every year, 95 per cent of these births occurring in developing countries.

In the Namibian context, MOE (2015) statistics recorded that 1881 learners' dropped out of school as a result of pregnancy nationwide. According to MOE (2015) Kavango West and Kavango East regions had the highest rates of school dropouts countrywide of 405 learners out of the total 1881. Furthermore, the United States Agency for International Development (USAID) (2011), reported teenage pregnancy in the Kavango regions as being tremendously high, estimated at 34%, a rate twice as high as the nation's average rate of teenage pregnancy. Correspondingly, the New Era newspaper "Ohangwena has the highest" (2015), reported that in 2013 there was an estimate of 1553 school dropouts as a result of pregnancies reported by the Ministry of Education, highest numbers occurring in the Northern and North Eastern regions of Namibia.

In addition, a media report by Tashaya (2013) stated that young girls in Ohangwena region were involved in unsafe sexual practices leading to increased rates of teenage pregnancies and sexually transmitted infections (STD's). These reports and statistics confirm that teenage pregnancy rates are tremendously high in the Northern regions.

That being the case, Kapitako (2016) reported a speech by Israel Tjizake of the United Nations Population Fund (UNFPA) at the commemoration of the 'International Day of the Midwife' that teenage pregnancy and motherhood has an impact on learners' future education, career opportunities and chances of attaining employment. Given these points, it is evident that teenage pregnancy is a major social problem in Namibia contributing to high unemployment rates, unskilled workforce and increasing poverty rates hindering development. Consequently, hindering the attainment of Namibia's Vision 2030 goals which are among others to improve the quality of all Namibian people to the level of their counterparts in the developed world (National Planning Commission, 2004).

2.4 TRANSITION TO PARENTHOOD: EXPERIENCES AND CHALLENGES

Transition into parenthood presents a developmental period involving new roles, adjustment, expectations which may all cause stress for the parents and the family as a whole (Motjelebe, 2009). Teenage motherhood, an aftermath of teenage pregnancy, is an adversity that affects many teenagers. It is often experienced as challenging because most teenagers are unemployed and still attending formal school. The empirical finding reported by Micah, Chris and Halimat (2013) state that 80 per cent of teenage mothers are financially dependent on either their parents or their guardians. In the same vein, a study by Yates (2013) suggests that teenage mothers reported challenges namely; financially unable to cater for their children's needs and tension emerging from trying to find a balance between being a teenager and mother simultaneously.

Motjelebe (2009) reports that parenting creates new social roles, demands and responsibilities on the mother, father and grandparents. Moreover, the acquired responsibilities of motherhood can have a significant impairment on an individual's level of functioning thus affecting a teenage mothers' relationship and interaction patterns with her new baby (Motjelebe, 2009).

In addition, a qualitative study by Agunbiade (2009) on pregnant adolescents in two Yoruba communities selected using snow balling technique suggests that pregnant adolescents are stigmatised by their peers, fellow community members and even so, by people close to them which caused them to attempt abortions prior to delivery. To expand on this, Ellis-Sloan (2014) states that even after giving birth, teenage mothers continue to be stigmatised by members of the public, medical professionals and their families. Under those circumstances, teenage mothers are likely to experience feelings

of shame, regret and guilt. According to Micah et al (2013, p. 2) stigma has “emotionally devastating” consequences on adolescent mothers.

In addition, Kaye (2008) avers that teenage motherhood is experienced as stressful and this, coupled with stigma stemming from early childhood conception, burdens teenage mothers, as a result, they feel regretful and overwhelmed. Furthermore, the United Nations International Children's Emergency Fund (UNICEF) (2008) reported that teenage pregnancy and motherhood gives rise to socioeconomic and psychological consequences for the mother, child and the young siblings. Motjelebe (2009) concurs that motherhood impairs the daily functioning of teenagers because they experience various challenges relating to finances, attaining basic needs for their babies, seeking employment and balancing school and parenting. For the above stated reasons, according to UNICEF (2008) teenage mothers are thus likely to prematurely terminate their education and as a consequence remain jobless and experience poor living conditions leading to depression which may gradually progress and cause them to commit suicide.

Nekongo-Nielsen and Mbukusa (2013) suggest that teenage pregnancy poses major challenges to learners in schools, challenges which tend to escalate even more as these adolescents become mothers. It is reported that orphans and learners whose parents live far from schools, experience difficulties in finding caretakers for their babies while attending school. On the other hand, others cannot afford babysitters. Moreover, teenage mothers reported that there is little or no time at all to focus on studies because the majority of their mothers had full time paid employment in farms which required them to work the whole day, as a result they were responsible their babies after school (Nekongo-Nielsen and Mbukusa, 2013).

Chauke (2013) discusses some other challenges experienced by teenage mothers such as undesirable attitudes from peers and educators towards teenage mothers, lack of supportive structures such as counselling services, extra curriculum programmes and educative programmes for teenage mothers. In consequence, a lack of supportive structures and figures to assist teenage mothers with the role of motherhood can contribute to a high absenteeism rate, poor school performance and school dropout.

Nekongo-Nielsen and Mbukusa (2013) concur that school dropout is highly influenced by psychological factors, such as a learner's inability to cope with the new role of motherhood, school work and a lack of support from family members. Similarly, Sibeko (2012) states that learners are faced with a major challenge of trying to cope with the demands of motherhood and schooling simultaneously. For this reason, many opt to drop out of school and continue the poverty cycle in which they become trapped for the rest of their lives. An ethnographic qualitative study by Leese (2016) reported that teenage mothers' transition into motherhood significantly differs from that of older mothers as it is likely to be more stressful. Moreover, that teenage mothers are reluctant to engage with support services, therefore in planning, support services should be appropriately tailored to help facilitate the challenges that they face (Leese, 2016).

2.5 SOCIOECONOMIC DIFFICULTIES

Teenage motherhood may be experienced as overwhelming because many teenagers are unemployed and for that reason, they may experience financial difficulties especially those that come from low socioeconomic households. Agunbiade (2009) in his qualitative study reported that adolescent mothers receive little informal support especially from their mothers, as a result, in order to survive, most of them serve as apprentices, restaurant attendants and engage in profitable economic activities such as

tailoring and hairdressing. This clearly demonstrates some of financial difficulties experienced by adolescents who are economically disadvantaged. The financial pressures and difficulties experienced by teenage mothers are likely influenced by factors such as; high unemployment rate, single parent headed families and a whole family relying on monthly government grant obtained by orphans and the old age. According to MoHSS (2013), the Kavango regions were observed to have the least equitable distribution of wealth (highest Gini coefficient) at 0.51. Such inequalities, moreover, socioeconomic difficulties and poverty may give rise to teenage mothers dropping out of school to seek informal employment in order to sustain themselves and their children, tasks they are developmentally not ready for. A longitudinal study by Gibb, Fergusson, Horwood, and Boden (2015) found that people who conceive before the age of 20 suffer long term financial consequences and/or disadvantages lasting for a period of at least 10 years.

2.6 EDUCATION DISRUPTION

Education is key to success and a promise to an improved and better future. According to Mangino (2008) teenage mothers are likely to prematurely terminate school when compared to their non-parenting peers. Felton and Haihambo-Muethudana (2002) suggest that Namibian statistics indicate that female and male Namibians are not on the same level in terms of academic qualifications, employment hierarchy and the standards of living. Losper (2004) additionally indicates that school going girls drop out of school more than boys do. Also, according to Felton and Haihambo-Muetudhana (2002) female learners in the Kavango region tend to repeat upper primary more and tend to dropouts out more than their male counterparts. In addition, the official report by the Ministry of Education's Educational Management Information System (EMIS) from 2005-2009 concurs that Kavango region among other two regions in the country

have high rates of school drop outs annually estimated at 17% (EMIS, 2010). Furthermore, Nekongo-Nielsen and Mbukusa (2013) report that Kavango region not only have higher prevalence of teenage pregnancy but also have high rates of school dropouts. In their study, 58 schools were visited and interviews were held with learners (both male and female), teachers, principals and two parents, they found that 46% of the learners dropped out due to pregnancy and the remaining dropped out due to poverty, financial difficulties, poor parental support and factors related to culture and the education system (Nekongo-Nielsen and Mbukusa, 2013). Moreover, teachers reported some other risk factors influencing school dropouts such as learners experiencing challenges in balancing motherhood and schooling simultaneously and lack of assistance from relatives in caring for their children (Nekongo-Nielsen and Mbukusa, 2013). Timæus and Moultrie (2015) in their study further reported that “girls who went on to give birth had twice the odds of dropping out of school and nearly five times the odds of failing to matriculate”.

In an in-depth qualitative study by Theron and Dunn (2006, p. 496-497) on five adolescent South African birth mothers, factors such as “inconsistent support, inability to articulate exactly what support was needed, negative future expectations, disrespect for personal belief systems” were highlighted as being likely to cause deterioration in the academic performance of teenage mothers. Education is not only important in assisting one to attain new knowledge, employment and independence, but also, as suggested in extant literature, education strongly correlates with health. According to Freudenbeg and Ruglism (2007), the more educated one is, the easier access he/she will have to better health care services and therefore, a longer life expectancy (Economist Intelligence Unit, 2012). In addition, according to Bridgeland, DiIulio and Morison (2006) low education attainment not only jeopardises an individual’s future

in relation to health care and social services, but it also has a profound negative impact on local communities and the employment sector due to the loss of prospective productive workers that could potentially help grow the nation's economy.

2.7 THE MENTAL HEALTH OF TEENAGE MOTHERS

Mental health can be defined “as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014). Evidently, as defined, mental health is broad because it looks at various aspects of life. A review article investigating the burden of mental and substance disorders in children and youth aged 0–24 years by Erskine, Moffitt, Copeland, Costello, Ferrari, Patton, and Scott (2015) found that mental disorders, mainly, substance use disorders (classified as a disability) are the primary cause of disability globally among children and the youth estimated at 54.2 million. Moreover, Erskine et al. (2015) reported that the aforementioned statistic is a significant contributor to the disease globally in children and youth.

According to Hodgkinson, Beers, Southammakosane and Lewin (2014), adolescent parenthood is associated with mental health problems which affect parenting such as; depression, substance abuse, and posttraumatic stress disorder. Hodgkinson et al. (2014) further reported that often these mental health problems occurring in adolescent mothers are due to the transition to motherhood, i.e. demands and responsibilities of parenting in relation to finances and social disadvantages. Highet, Stevenson and Coo (2014) concurs with the view that often symptoms of depression and anxiety emerge during the transition period to motherhood which is associated with feelings of loss and frustration. Particularly, this part of the literature discusses mental health in relation to depression, anxiety and stress.

Depression and anxiety are considered as serious health issues during pregnancy, and anxiety during pregnancy which varies from general anxiety, anxiety disorder, or pregnancy related anxiety can be a risk factor for developing depression after birth (Brunton, Dryer, Saliba & Kohlhoff, 2015). Similarly, Rallis, Skouteris, McCabe and Milgrom (2014) are of the opinion that symptoms of depression, anxiety and stress vary across the pregnancy period and that, increased levels of depression is likely to predict high levels of anxiety and stress in pregnant women. Furthermore, literature indicates that the presence of depression, anxiety and stress during pregnancy may influence the likelihood for children to have cognitive impairments, emotional problems and symptoms of Attention Deficit Hyperactivity Disorder (ADHD) (Glover, 2014).

According to O'Hara and Wisner (2014) various risk factors such as the history of mental illness and psychological factors, for example, poor support, stressful life events and conflicts with partner can make one susceptible to perinatal mental illness which is likely to progress to postnatal mental illness. In another study by Leger and Letourneau (2015) it was found that the amount of social support available within the home environment potentially protects mothers from developing depression. In addition, Lindhorst and Oxford; Mollborn and Morningstar (as cited in Easterbrooks, Kotake, Raskin and Bumgarner, 2016, p. 61) opine that mothers that are young are more prone to elevated symptoms of depression thus postpartum depression among adolescents is likely double than in older mothers. Baginsky (2008) further reports that in the United States, postpartum depression among adolescents is particularly shocking. In a study by Kaye (2008) adolescent mothers are reported to have symptoms of anxiety, having low self-esteem, financial difficulties, lacking moral and material support and stigmatisation from community health workers when seeking

health care. All this may actually make one vulnerable and contribute to the development of depression.

Sodi (2009), after exploring various studies on teenage pregnancy and parenthood, reports that there is a correlation between teenage pregnancy, parenthood and depression. A qualitative study involving adolescent mother's aged between 16 and 18 by Clemmens (2002) found that teenage mothers reported feeling depressed as a result of significant abandonment and rejection by their peers after the birth of their babies which also affected their capacity to form and maintain relationships. Furthermore, Nekongo-Nielsen and Mbukusa (2013) suggest another reason for the occurrence of depression among teenage mothers associated with problems finding baby sitters which led to poor academic performance. As a result, the teenage mothers were discouraged to continue with school. In addition, according to Secco, Profit, Kehnedey, Walsh, Letourneau and Stewart as cited in (Baginsky, 2008 p.10) when adolescent mothers are depressed they may neglect their babies for example, they may miss and not notice obvious behaviours such as crying. The above literature evidently shows that depression can be disabling in the sense that it can significantly impair various aspects of our lives. For that reason, it is important to know that clinically, depression is diagnosed as Major Depressive Disorder (MDD) using the Diagnostic Statistical Manual (DSM 5). Particularly in this context of motherhood, depression is clinically diagnosed as Major Depressive Disorder (MDD), with a specifier; peripartum onset because depressive symptoms likely occur during pregnancy and persist after delivery (American Psychiatric Association, 2013).

In addition, while there is a substantial body of knowledge on depression as a phenomenon, less emphasis has been placed on stress, a condition likely to play a critical role in the development and maintenance of anxiety (Yildiz and Akbayrak,

2014). In other words, stress can be viewed as a precipitating factor for anxiety. Rallis et al. (2014) report that stress experienced during the second trimester of pregnancy progress to anxiety. Furthermore, Hans and Thullen, (as cited in Huang, Costeines, Kaufman & Ayala 2014, p. 255) reported that first time teenage mothers experience undesirable emotions and stress as a result of parenting consequently affecting the development of their children. According to Huang et al. (2014) this results suggest that adolescent mental health status is significantly determined by parenting stress, and focusing on ways to minimize stress and maximize support are important to maintain a healthy development of infants and prevent adolescent mothers from developing depression.

2.8 THE IMPORTANCE OF SOCIAL RELATIONSHIPS AND SUPPORT AS COPING STRATEGIES FOR TEENAGE MOTHERS.

The researcher perceives social relations as significant patterns of interaction among close people varying from parents, siblings, extended family members, friends and boyfriends. Theron and Dunn (2006) highlight the importance of teenage mothers receiving consistent support from parents, family and friends which correlates with better school performance and vice versa. According to Huang et al. (2014), increased support to teenage mothers lowers their depression. Edwards et al. (2012) also associated positive mental health (reduction in stress and depression) among teenage mothers with positive relationships with parental figures and the father of the child. Bunting and McAuley (as cited in Huang et al. 2014, p. 256) concur that social support from family and friends play a significant positive role on the mental health of adolescent mothers. According to Hodgkinson et al. (2014) mental health interventions such as paediatric Primary Care, home Visiting and co-parenting are helpful in preventing and reducing the mental health problems experienced by teenage mothers.

Moreover, Sandier (as cited in Barth, 1985, p. 76) stresses the importance of support networks in relieving people from the stress and tension occurring in motherhood. Furthermore, according to Barth (1985), having structured school-based parenting training programs enable adolescent mothers to acquire new set of skills on conflict resolution and also strengthen their social support networks). All in all, as stated in the literature, great emphasis should be placed on social support for teenage mothers for their general and psychological wellbeing.

2.9 THEORETICAL PERSPECTIVE:

2.9.1 Erickson's theory of psychosocial development

The theoretical framework deemed suitable for understanding the points of this research is Erikson's theory of psychosocial development, 1950, 1963. Just like Freud, Erikson postulated that "human development is governed by the epigenetic principle that development occurs in a series of stages which are universal to humankind and that unfold in a predetermined sequence" (Ryckman, 2008, p. 178). Erickson quotes Ryckman (2008) as saying each stage is marked by a psychosocial crisis; in other words, a turning point. Furthermore, according to Erikson (as cited in Ryckman, 2008, p. 178) "Such developmental and normative crises differ from imposed, traumatic and neurotic in that the very process of growth provides new energy even as society offers new and specific opportunities according to its dominant conception of the phases of life". Resolving a crisis positively correlates with ego strength and vice versa (Ryckman, 2008, p. 178).

The eight stages postulated by Erikson in Ryckman (2008) are; basic trust vs mistrust, autonomy vs shame and doubt, initiative vs guilt, industry vs inferiority, identity vs role confusion (stage of emphasis in this study), followed by intimacy vs isolation, generativity vs stagnation and lastly stage ego integrity vs despair. The basic notion

is failure to resolve conflict/crisis at a particular stage leads to stagnation. The fifth stage which is identity versus role confusion will be the stage of emphasis in this study. This stage occurs between the developmental period of ages thirteen to nineteen (Ryckman, 2008). During this period of uncertainty, those youths that are confused try to establish who they are by over-identifying with cliques and crowds (Ryckman, 2008, p. 185). According to Evans (as cited in Ryckman, 2008, p. 184), identity is comprised of things we do not desire to be or what we are prohibited/forbidden to being. Furthermore, according to Hjelle and Ziegler (as cited in Sodi, 2009, p. 30) during this conflicting stage, adolescent “feel inadequate, depersonalised, alienated and sometimes even seek negative identity”, those identities often opposite of what society perceives as acceptable and appropriate.

Taking into account the conflict associated with the adolescent stage, it could be reasoned and hypothesised that teenage pregnancy could arise from the adolescent developmental crisis characterised by role confusion/role diffusion instead of acquiring a positive self-identity (Sodi, 2009). When adolescents successfully resolve crises at this stage it leads to fidelity which according to Erikson (1964, p. 125) refers to “the ability to sustain loyalties freely pledged in spite of the inevitable contradictions of value systems”. On the other hand, failure to successfully resolve their conflicts, adolescents may experience/develop a negative identity in which they violate roles which are socially and morally accepted by their communities (Erikson, 1968, p. 172-173).

2.10 THEORETICAL FRAMEWORK:

2.10.1 Transactional model of stress and coping

In the present study, the transactional model of stress and coping as elucidated by Lazarus and Folkman (1984) is employed to conceptualise teenage motherhood as an

experience perceived as stressful and positive resolution leads to utilisation of inner resources (coping mechanisms). With reference to extant literature, pregnancy possess various stressors on teenage mothers which result in mental health problems, now, in an attempt to explore and understand the nature of the stress experienced by teenage mothers, coping mechanisms and the effect of this stress on their well-being, the researcher looks at the stress and coping model.

Weiten (2014) defines stress as any condition or situation that is perceived as a threat to an individual's wellbeing taxing their abilities to cope. Psychological stress on the other hand is viewed by Lazarus and Folkman (as cited in Mitchel, 2004, p.17) as a relationship that exists between an individual and his/her environment often perceived to potentially endanger his/her wellbeing. According to Weiten (2014, p. 436) there are four major types of stress namely, "frustration, conflict, change and pressure". Frustration is experienced when something prevents us from pursuing our goal and conflict involves getting caught between two or more incompatible motivations (Weiten, 2014). Kurt Lewin (as cited on Weiten, 2014, p. 437) describe and extensively investigates three different types of conflict, namely, (1). Approach-approach conflict in which "a choice must be made between two attractive goals", (2). Avoidance-avoidance conflict, in which "a choice must be made between two unattractive goals" and lastly, (3). Approach-avoidance conflict in which "a choice must be made about whether to pursue a single goal that has both attractive and unattractive aspects". The other two major types of stress include change which can be defined as "noticeable alterations in one's living circumstances that require readjustment and pressure which "involves expectations or demands that behave in a certain way" (Weiten, 2014, p. 438).

Each individual perceives and experiences stress in a unique way based on the appraisal of a stressful situation. There are two processes that mediate the relationship between the person and the environment. (1).The cognitive appraisal - a process in which an individual assesses the extent to what and why a particular person-environment transaction is stressful and (2). Coping: - involves a process in which an individual copes and manages emotions from the stressful situation as a result of the person-environment relationship (Mitchel, 2004).

Lazarus and Folkman (as cited in Weiten, 2014, p. 436) distinguishes between two forms of cognitive appraisals, (a). Primary appraisal as “an initial evaluation of whether an event is (1). Irrelevant to you, (2). Relevant but not threatening or (3). Stressful”, (b) Secondary appraisal on the other hand as “an evaluation of your coping resources and options for dealing with stress”. In other words, the primary appraisal assesses our interpretation of a particular event, whether it is perceived as threatening, stressful or perhaps not and secondary appraisal on the other hand specifically looks into the use of coping mechanisms.

Lazarus and Folkman (as cited in Mitchel, 2004, p. 18) define coping as a process of constantly adjusting/altering our thought patterns and actions as we attempt to manage both our “internal and external demands” perceived as challenges. Coping can be grouped into three categories: (1). Problem-focused coping, (2). Reappraisal and (3). Emotion-focused coping (Kalat, 2011). Problem focused coping is a form of action oriented approach to coping with stress which involves doing something and feeling that one is in control, makes a situation less stressful. According to Kalat (2011, p. 444) “we fear an unpredictable event may grow so intense that it might become unbearable” however “when an event is predictable, we prepare for it at the appropriate time and relax at other times”. Coping by reappraisal on the other hand involves

“reinterpreting a situation to make it less threatening”, lastly, emotion-focused coping involves assisting one manage how he/she reacts emotionally to a stressful event (Kalat, 2011, p. 445). This may involve emotional suppression, social support, relaxation, distraction or exercise (Kalat, 2011).

Overall, the role and responsibility of motherhood is likely to be appraised by teenagers as threatening and stressful evoking frustration, conflict, change in our living circumstances and pressure from society. In attempt to deal with this life transition, various coping strategies are used. However, the unsuccessful attempt to resolve the encountered stress may contribute to the development of mental health problems.

To conclude, the main aim of this chapter was to review literature on the challenges, experiences, mental health and coping strategies of teenage motherhood. Teenage mothers’ experiences were found to significantly impact their mental well-being. Also, a number of challenges were found to contribute to a high rate of school dropout. Noteworthy, is the importance of social support for the general and psychological well-being of teenage mothers. The next chapter will present the research methodology that has been followed in the current study.

CHAPTER 3

RESEARCH METHODS

This chapter focuses on the types of methodologies used in the present study. It outlines the research design, population, sample size, research instruments and the procedures followed in collecting and analysing the data.

3.1 RESEARCH DESIGN

The present study was conducted in the two Kavango regions (West and East) by means of a mixed method; quantitative and qualitative research. Creswell (2014, p.217) defines mixed methods as “the collection of both qualitative (open-ended) and quantitative (close-ended) data in response to research questions or hypotheses”. The quantitative research method involved collecting data using a self-report 42-item measure/instrument, (Depression, Anxiety and Stress Scale-DASS) developed by Lovibond and Lovibond in 1995. Additionally, the qualitative research method, involved collecting data using semi structured interviews. A combination of the quantitative and qualitative research methods allowed the researcher to use the strengths of both research approaches to thoroughly understand the research problem by allowing for the convergence and comparison of the two databases (Creswell, 2014). Furthermore, the use of a mixed method approach in this study helped the researcher understand the data at a more detailed level. In other words, the qualitative data aids to explain the quantitative data, therefore creating more insight into the study.

3.2 QUANTITATIVE PHASE

3.2.1 Population

The target population are teenage mothers in the Kavango regions (East and West) aged fourteen to nineteen years. Statistics by (Ministry of Education, Arts and Culture

[MOE], 2015) concerning Male and female Dropout by Reason, Gender and Region in Namibia indicate that the highest school dropout nationwide is influenced by teenage pregnancy which was estimated at 1881, with 1843 being female and 38 male. Furthermore, MOE (2015) statistics indicate that Kavango West and Kavango East regions have the highest school dropouts influenced by teenage pregnancy, estimated at 405 out of the national figure of 1881.

3.2.2 Sample

A sample of sixty participants was drawn from the Kavango regions, 30 participants from the Kavango East region and the remaining 30 from the Kavango West region. The sample consisted of school going teenage mothers within the age range of 14 to 19 years. Three schools were conveniently selected per region and a process of systematic random sampling was used to select a total number of 10 participants (teenage mothers) per each selected school. Systematic sampling applies similar principals of random selection in which the researcher picks every nth item in a systematic way from a list (Denscombe, 2014). Similarly, in application, based on the fraction of teenage mothers that were present and available at the different schools, the researcher began by choosing a random start and selected every nth participant.

3.2.3 Research Instruments

3.2.3.1 Sociodemographic Questionnaire

The socio-demographic questionnaire, self-designed by the researcher was used to obtain participant's biographical information to be precise; name, date of birth, age, place of birth, nationality, name of the school, grade, place of residence, home language and lastly, number of children. (See Appendix 4).

3.2.3.2 Depression Anxiety Stress Scale (DASS)

In addition, the DASS was also used to collect quantitative data. Lovibond & Lovibond (as cited in Imam, 2010 p.184) refer to the DASS (42-item) as a reliable measure of depression, anxiety, and stress. Furthermore, according to Lovibond and Lovibond (1995) the DASS has no discriminant validity. Crawford and Henry (2003, p. 128) attest to this in their findings of the psychometric properties of the DASS when assessed on the general adult UK population which showed the reliability measured by Cronbach's alpha for the depression scale as .93, for the anxiety scale .95, and for the stress scales .97. Cross-culturally, the DASS has not been applied on the Namibian population yet, however in Africa, it has been administered to university students in Ethiopia in a cross-sectional study reporting Cronbach's alpha of 0.82 for depression, 0.78 for anxiety and 0.79 for stress (Lemma¹, Gelaye, Berhane¹, Worku & Williams, 2012). In this study, reliability of the instrument was also measured using Cronbach α and it was .796 for depression, .785 for anxiety and .795 for stress indicating good internal consistency between the scale items.

The DASS measures three related negative states classified into three different scales; depression, anxiety and stress. Each of the scales has 14 items, divided into subscales of two to five items with similar content summing up to a total of 42 items. The depression scale items are 3, 5, 10, 13, 16, 17, 21, 24, 26, 31, 34, 37, 38, and 42. The anxiety scale items are 2, 4, 7, 9, 15, 19, 20, 23, 25, 28, 30, 36, 40 and 41. The stress scale items are 1, 6, 8, 11, 12, 14, 18, 22, 27, 29, 32, 33, 35 and 39. Moreover, the DASS uses a four-point Likert scale of severity/frequency of participants' experiences over the past week. The scores range from zero to three, with a score of zero meaning the items do not apply to the participant at all, and a score of three meaning the participant considered the item to apply to them very much, or most of the time. The

average score which is two means the item applies to the participant to a considerable degree or a good part of the time. (See Appendix 4). To calculate a composite score, participant's responses on the 14 items in each sub-scales (depression, anxiety and stress) are summed up. The summed score in each sub-scales is then interpreted using the table below.

Table 1: *Severity rating index for depression, anxiety and stress*

	Depression	Anxiety	Stress
Normal	0 – 9	0 - 7	0 – 14
Mild	10 – 13	8 – 9	15 – 18
Moderate	14 – 20	10 –14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extremely Severe	28+	20+	34 +

3.2.4 Procedure

Prior to carrying out the study, the researcher sought written consent from the Ministry of Education, Arts and Culture. The researcher subsequently sought permission from the Directors of the two Regional education offices in the Kavango regions to visit the different schools in the respective regions. With the assistance of the regional school counsellors, the researchers identified combined and secondary schools with high rates of teenage pregnancy. The identified schools were visited and permission was further sought from the school principals to conduct research in their schools. With the assistance of the school principals and teachers for Life Skills, the researcher met some teenage mothers that were available during the time of the study in groups to explain the process and objectives of the present study. This process allowed prospective participants to ask questions about the study and their participation. Furthermore, this was followed by a process of systematic random sampling used to select ten participants per each selected school. Participant assent and parental informed consent were obtained prior to participation.

A small scale (six participants; 10 percent of the total sample size) preliminary study on the Depression Anxiety Stress Scale (DASS) was conducted to assess feasibility, time and the adequacy of the scale (language comprehension). The feedback from the participants indicated a few comprehension problems on the DASS. For this reason, the researcher, under the guidance of a supervisor improved a few words and statements to basic user friendly language which was easily apprehended by participants. (See Appendix 4) table of changes.

3.2.5 Data analysis

The quantitative data was analysed using the basic statistical process, the Statistical Package for the Social Sciences (SPSS), Version 24.0. The SPSS 24 statistical package is recent and produces valid and reliable data suitable for analysing the data gathered. Participants in the current study were categorised using the demographics; age, grade and number of children. Moreover, because the study was exploratory in nature, SPSS 24 was used to analyse descriptive statistics in the form of (frequencies and percentages) and correlation statistics, to assess the degree of the relationship between depression, anxiety and stress levels.

3.3 QUALITATIVE PHASE

In addition to the quantitative approach, the researcher obtained additional information through qualitative methods.

3.3.3 Sample

A sample of twelve participants was drawn from the Kavango regions, six participants from the Kavango East region and the remaining six from the Kavango West region. This sample was drawn using convenient methods of sampling from the quantitative sample of sixty teenage mothers aged between 14-19.

3.3.2 Research instrument

3.3.2.1 Semi-structured group interviews

In the present study, focus group discussions were conducted using semi-structured interviews. These interviews were designed to elicit participants' experiences, challenges and coping strategies in relation to motherhood as shown in Appendix 4. According to Denscombe (2014) focus groups are composed of a few people, often six to nine individuals gathered by the researcher aiming to explore ideas, feeling, perceptions and attitudes about a certain topic. Morgan (as cited in Denscombe, 2014, p. 189) suggests that members in focus group discussions share individual experiences and thoughts and this allows for a comparison of views and opinions to take place, promoting insight and understanding. In other words, focus group discussions promote identification through the process of interaction, sharing of similar experiences amongst group members.

3.3.3 Procedure

For the two focus groups, semi-structured group interviews were conducted using both English and Rukwangali. Participants were encouraged to express themselves in a language of preference. Prior to the interviews, participants were encouraged to seek psychological help from the researcher who is a registered psychological counsellor with Health Professions Councils in Namibia (HPCNA) in an event where a participant experienced emotional discomfort. The interviews were conducted in a quiet, isolated area to promote a safe and non-judgemental environment. This further promoted self-disclosure and helped establish rapport. Moreover, the interviews were conducted in an objective and neutral manner across the two regions. A digital voice recorder was used with obtained assent from the research participants to capture the content of the interviews which were later translated and transcribed by the researcher.

3.3.4 Data analysis

The Qualitative data was analysed using the ATLAS.ti software by means of coding; categorisation and classification of common themes that exist in the qualitative data. In other words, the interview transcripts were read multiple times and the researcher identified descriptive concepts which were coded as individual ideas. An analysis process of grouping and categorising the identified codes into themes followed. Through this process, the researcher was able to identify themes of significance and those of less significance in line with the research objectives.

3.4 RESEARCH ETHICS

The researcher ensured that all ethical considerations were well thought out before the actual research process. Moreover, the researcher obtained ethical clearance from the University of Namibia's Ethics Committee (UREC) and by all means adhered to the ethical guidelines as stipulated by the University throughout the research period. To begin with, informed consent was obtained from the selected schools. The school principals and research participants were briefed about the nature of the study and provided with information regarding the pros and cons of participating in the study. Thereafter, voluntary participants gave assent and parental informed consent was also obtained. In addition, freewill was given to either take part or otherwise withdraw from the study at any time during the research process. Additional assent was obtained from the participants to use a digital voice recorder. During the study, participants were all treated as equals, with outmost respect and dignity. In order to maintain anonymity, the researcher assigned codes to conceal participant's identities and also used the participants' ages instead of their actual dates of birth. Furthermore, to maintain privacy and confidentiality, all the information gathered during the research was

strictly used for the purpose of this study only. This information will be archived for a period of at least three years before discarding it by means shredding.

In conclusion, this chapter explored the methodology used in conducting the present study. A mixed method of quantitative and qualitative approach was used to explore the research topic in detail. The standardised questionnaire administered (DASS) were intended to show variance in depression, anxiety and stress levels as experienced amongst teenage mothers. On the other hand, the focus group discussions were intended to promote in-depth understanding of the qualitative data and teenage mothers' experiences and coping strategies. Lastly, the researcher outlined the ethical principles considered throughout the study. The next chapter will focus on presenting the results of the study.

CHAPTER 4

RESULTS

This chapter aims to present the findings obtained from the mixed research approach using quantitative and qualitative approaches. In relation to the quantitative approach, the Depression Anxiety and Stress Scale (DASS) was administered to assess levels of depression, anxiety and stress in relation to age, grade and number of children. On the other hand, with regard to the qualitative approach, two focus groups semi-structured interviews were conducted to elicit information regarding teenage mothers' experiences, challenges and current coping strategies. The quantitative results will be presented first followed by the qualitative results.

4.1 QUANTITATIVE DATA

4.1.1 Demographic information

A total of sixty female participants took part in this study. In line with the phenomenon being investigated, the participants were teenage mothers aged between 14 and 19. Their ages were categorised as follow: 14-15, 16-17 and 18-19. The most represented age group of teenage mothers was the 18-19, followed by the 16-17 and lastly the 14-15 year olds. Furthermore, all the 60 teenage mothers were school going, their grades are categorised as 6-7, 8-9 and 10-11. The greatest number of teenage mothers represented in the study making up 53.3% of total sample were in grade 8-9, followed by those in grade 10-11 with 36.7%, and the least representation of 10% was from grade 6-7. In addition, 57 teenage mothers in the study had one child each, two had two children each with the exception of one that had three children. This demographic information is depicted in Table 1 and Figures 1, 2 and 3.

Table 2: Demographic on the characteristics of participants

N=60

Demographics	Frequency	Percentage
Gender-Female	60	100
Age		
14-15	1	1.7
16-17	21	35.0
18-19	38	63.3
Total	60	100
Grade		
6-7	6	10
8-9	32	53.3
10-11	22	36.7
Total	60	100
Number of children		
1	57	95
2	2	3.3
3	1	1.7
Total	60	100

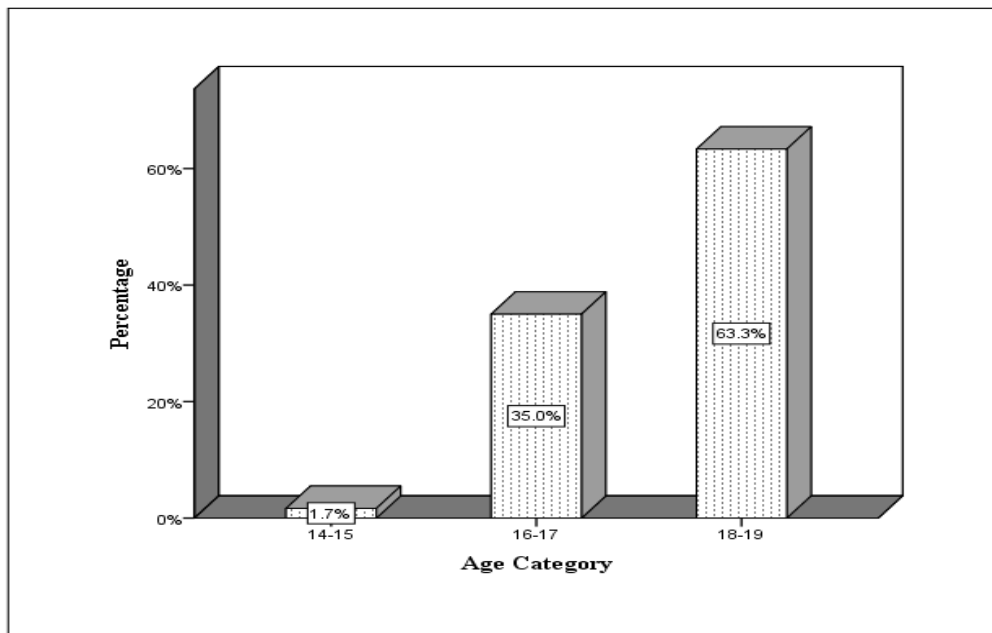


Figure 1: Age Distribution of teenage mothers

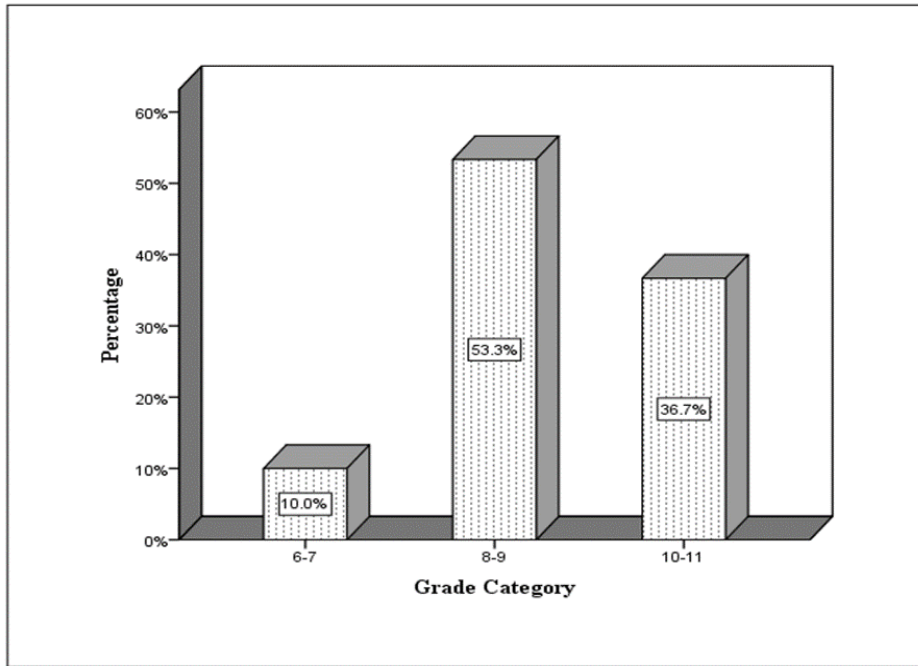


Figure 2: Grade distribution of teenage mothers

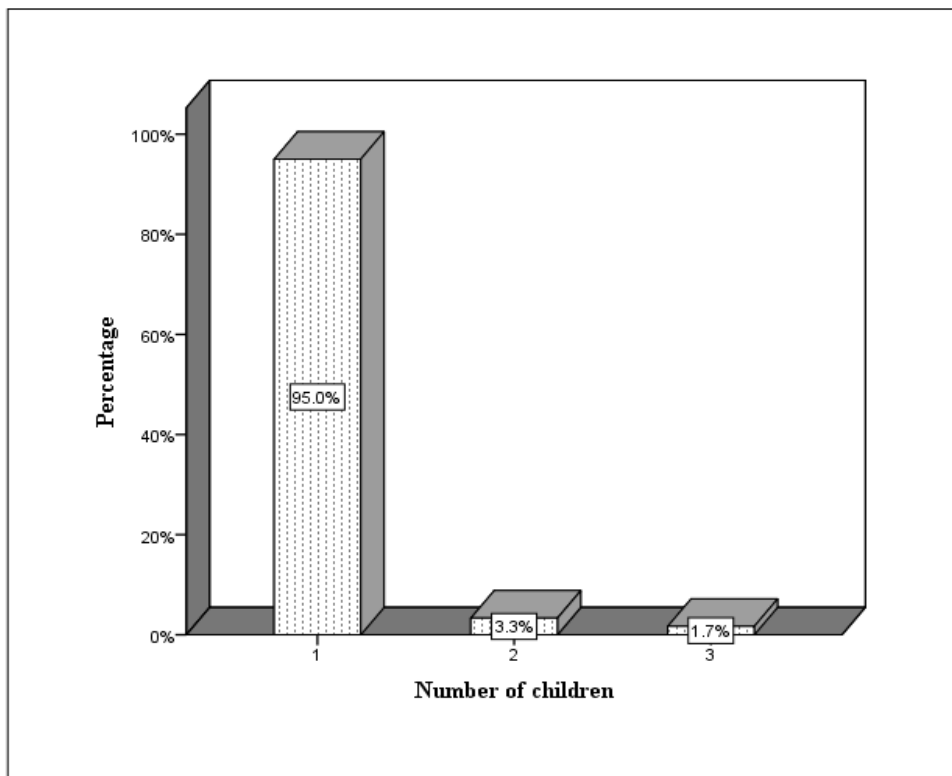


Figure 3: Number of children of teenage mothers

4.1.2 Frequency distribution and percentage of Depression, Anxiety and Stress

Levels

Once the Depression, Anxiety and Stress scale (DASS) were scored, the obtained summed scores were categorised in terms of severity using the DASS severity scoring scale. The results are presented in Table 2 and they indicate the following in relation to the three variables:

a) Depression

Table 2 depicts that 34 (56.7%) teenage mothers reported to experience severe to extremely severe depression levels. Also, that 18 (30%) teenage mothers reported to experience moderate depression levels, three (5%) reported to experience mild depression levels and the remaining five (8.3%) teenage mothers reported to be normal.

Table 3: *Frequency distribution and percentages of Depression, Stress and Anxiety levels*

N=60

Range	Depression Level		Anxiety Level		Stress Level	
	Frequency	%	Frequency	%	Frequency	%
Normal	5	8.3	11	18.3	8	13.3
Mild	3	5.0	3	5.0	12	20.0
Moderate	18	30.0	8	13.3	18	30.0
Severe	18	30.0	13	21.7	19	31.7
Extremely Severe	16	26.7	25	41.7	3	5.0
Total	60	100.0	60	100.0	60	100.0

b) Anxiety

Furthermore, Table 2 depicts that, out of the total 60 participants, 38 (63.4%) teenage mothers, more than half of the total participants reported to experience severe towards extremely severe anxiety levels. Moreover, eight (13.3%) teenage mothers reported to

experience moderate anxiety levels, three (5%) reported to experience mild anxiety levels and 11 (18.3%) teenage mothers reported to be normal.

c) Stress

Lastly, Table 2 shows that out of the 60 participants, 22 (36.7%) teenage mothers reported to experience severe to extremely severe stress levels. Moreover, 18 (30 %) teenage mothers reported to experience moderate stress levels and 12 (20%) reported to experience mild stress levels. The remaining eight (13.3%) teenage mothers reported to be normal.

4.1.3 Levels of depression, anxiety and stress by demographics

In the following section the levels of these variables i.e. depression, anxiety and stress are reported in relation to age, grade and number of children.

4.1.3.1 Levels of depression by age, grade and number of children

Table 3 shows that participants within the 18-19 years age category reported to experience severe and extremely severe levels of depression at 35%, followed by participants in the age category 16-17 at 21.6%. Lastly, lower levels of depression were reported by participants in the age category 14-15.

Severe and extremely severe levels of depression were reported by participants in the grade 8-9 category, occurring at 28.3%, followed by participants in the grade 10-11 category at 20%. Lastly, participants in the grade category 6-7 reported the least severe and extremely severe levels of depression at 8.4%.

Table 4: *Depression levels in relation to demographics*

N=60

Levels Categories		Normal		Mild		Moderate		Severe		Extremely -severe		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Age	14-15	0	0	1	1.7	0	0	0	0	0	0	1	1.7
	16 -17	1	1.7	1	1.7	6	10	8	13.3	5	8.3	21	35
	18-19	4	6.7	1	1.7	12	20	10	16.7	11	18.3	38	63.3
Total		5	8.8	3	5	18	30	18	30	16	26.7	60	100
Grade	6-7	0	0	0	0	1	1.7	4	6.7	1	1.7	6	10
	8-9	3	5	2	3.3	10	16.7	8	13.3	9	15	32	53.3
	10-11	2	3.3	1	1.7	7	11.7	6	10	6	10	22	36.7
Total		5	8.3	3	5	18	30	18	30	16	26.7	60	100
Number of children	1	5	8.3	3	5	18	30	17	28.3	14	23.3	57	95
	2	0	0	0	0	0	0	1	1.7	1	1.7	2	3.3
	3	0	0	0	0	1	1.7	0	0	1	1.7	1	1.7
Total		5	8.3	3	5	18	30	18	30	16	26.7	60	100

Table 3 also reveals that the highest severe and extremely severe levels of depression were reported by participants with only one child occurring at 51.6%, followed by participants with two children occurring at 3.3%. Lastly, the one and only participant with three children also reported extremely severe levels of depression.

4.1.3.2 Levels of anxiety by age, grade and number of children

Corresponding to depression, participants within the 18-19 years age category reported to experience severe and extremely severe levels of anxiety at 43.4 %, followed by participants in the 16-17 age category at 20%. Lastly, lower levels of severe and extremely severe anxiety were reported by participants in the age category 14-15 (table 4).

It is clear from table 4 that severe and extremely severe levels of anxiety were reported by participants in the grade 8-9 category occurring at 33.4%, followed by participants

in the grade 10-11 category, occurring at 21.6%. Lastly, participants in the grade 6-7 category reported the lowest anxiety levels at 8.4%.

Table 5: *Anxiety levels in relation to demographics*

Category \ Levels		Normal		Mild		Moderate		Severe		Extremely-severe		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Age	14-15	1	1.7	0	0	0	0	0	0	0	0	1	1.7
	16-17	3	5	3	5	3	5	3	5	9	15	21	35
	18-19	7	11.7	0	0	5	8.3	10	16.7	16	26.7	38	63.3
Total		11	18.3	3	5	8	13.3	13	21.7	25	41.7	60	100
Grade	6-7	0	0	0	0	1	1.7	1	1.7	4	6.7	6	10
	8-9	6	10	2	3.3	4	6.7	7	11.7	13	21.7	32	53.3
	10-11	5	8.3	1	1.7	3	5	5	8.3	8	13.3	22	36.7
Total		11	18.3	3	5	8	13.3	13	21.7	25	41.7	60	100
Number of children	1	10	16.7	3	5	7	11.7	13	21.7	24	40	57	95
	2	0	0	0	0	1	1.7	0	0	1	1.7	2	3.3
	3	1	1.7	0	0	0	0	0	0	0	0	1	1.7
Total		11	18.3	3	5	8	13.3	13	21.7	25	41.7	60	100

Highest severe and extremely severe levels of anxiety were reported by participants with only one child occurring at 61.7%. In addition, only one of the two participants with two children reported extremely severe levels of anxiety. On the other hand, the participant with three children reported to be normal.

4.1.3.3 Levels of stress by age, grade and number of children.

Table 5 envisages that participants within the age 18-19 and 16-17 years category experienced similar levels of severe and extremely severe stress with a variance of only 1 at 18.4% and 18.3%. Lastly, lower levels of severe and extremely severe stress were reported by participants in the age category 14-15 years.

In relation to grade category table 5 reveals that severe and extremely severe levels of stress were reported by participants in the grade 8-9 category occurring at 23.3%,

followed by participants in the grade 10-11 category occurring at 10%. Lastly, participants in the grade 6-7 category reported the lowest severe and extremely severe stress levels at 3.3%.

Table 6: *Stress levels in relation to demographics*

N=60

Levels Categories		Normal		Mild		Moderate		Severe		Extremely-severe		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Age	14-15	0	0	1	1.7	0	0	0	0	0	0	1	1.7
	16-17	2	3.3	5	8.3	3	5	10	16.7	1	1.7	21	35
	18-19	6	10	6	10	15	25	9	15	2	3.3	38	63.3
Total		8	13.3	12	20	18	30	19	31.7	3	5	60	100
Grade	6-7	1	1.7	1	1.7	2	3.3	2	3.3	0	0	6	10
	8-9	6	10	6	10	6	10	12	20	2	3.3	32	53.3
	10-11	1	1.7	5	8.3	10	16.7	5	8.3	1	1.7	22	36.7
Total		8	13.3	12	20	18	30	19	31.7	3	5	60	100
Number of children	1	8	13.3	11	18.3	18	30	17	28.3	3	5	57	95
	2	0	0	0	0	0	0	2	3.3	0	0	2	3.3
	3	0	0	1	1.7	0	0	0	0	0	0	1	1.7
Total		8	13.3	12	20	18	30	19	31.7	3	5	60	100

Higher severe and extremely severe levels of stress were reported by participants with only one child occurring at 33.3%, followed by participants with two children occurring at 3.3%. Lastly, the only participant with three children reported to be normal.

In summary, participants with only one child, moreover those aged 18-19 years and those in the grade 8-9 category reported to experience severe and extremely severe levels of depression, anxiety and stress. Lowest levels of these variables were experienced by participants with two and three children, and those aged 14-15 years

and lastly those in the grade 6-7 category. This could be due the mere fact that participants within these categories were the least represented in the study.

4.1.4 The correlation of the DASS variables measures

The Pearson's correlation coefficient (r) was used to determine the strength and direction of the relationship between depression, anxiety and stress as reported and experienced by teenage mothers. The closer the value is to +1 or -1 indicate the strength of the relationship. The correlation matrix of the results as presented in Table 6, indicate that there was a statistically significant positive strong correlation between depression and, anxiety $r=0.698$, $n=60$, $p < .001$. Moreover, there is also a statistically significant positive strong relationship between depression and stress $r=0.737$, $n=60$, $p < .001$. Lastly, the results on the correlation matrix show that there is a statistically significant positive moderate relationship between anxiety and stress, $r=0.658$, $n=60$, $p < .001$. These findings indicate that higher scores on one variable are associated with higher scores on the other variable. Figure 4, 5 and 6 illustrates the results of the scatter plots.

Table 7: *Correlation analysis between depression, anxiety and stress*

		N=60		
		Depression Level	Anxiety Level	Stress Level
Depression Level	Pearson Correlation	1	.698	.737
	Sig. (2-tailed)		.000	.000
	N	60	60	60
Anxiety Level	Pearson Correlation	.698	1	.658
	Sig. (2-tailed)	.000		.000
	N	60	60	60
Stress Level	Pearson Correlation	.737	.658	1
	Sig. (2-tailed)	.000	.000	
	N	60	60	60

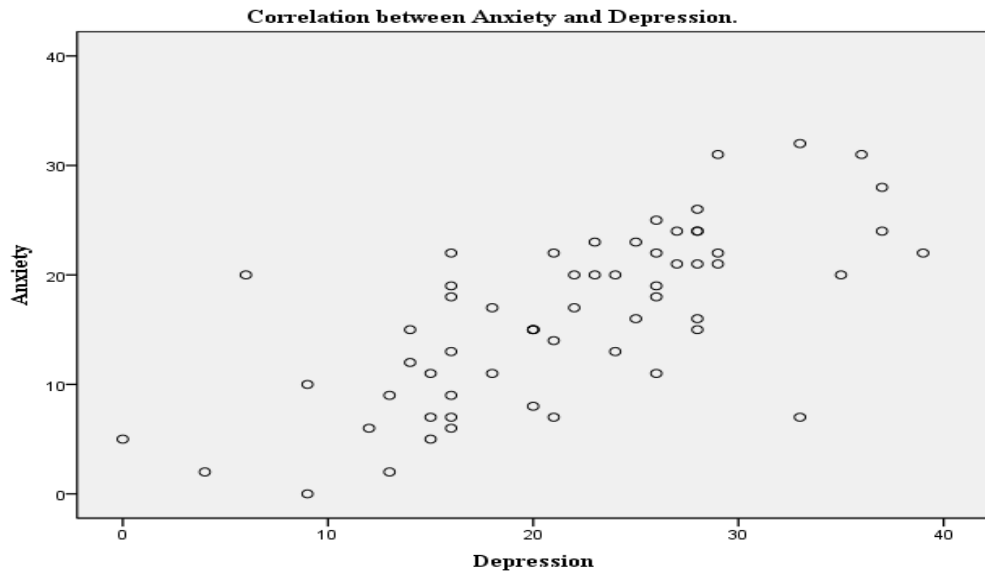


Figure 4: Correlation between anxiety and depression

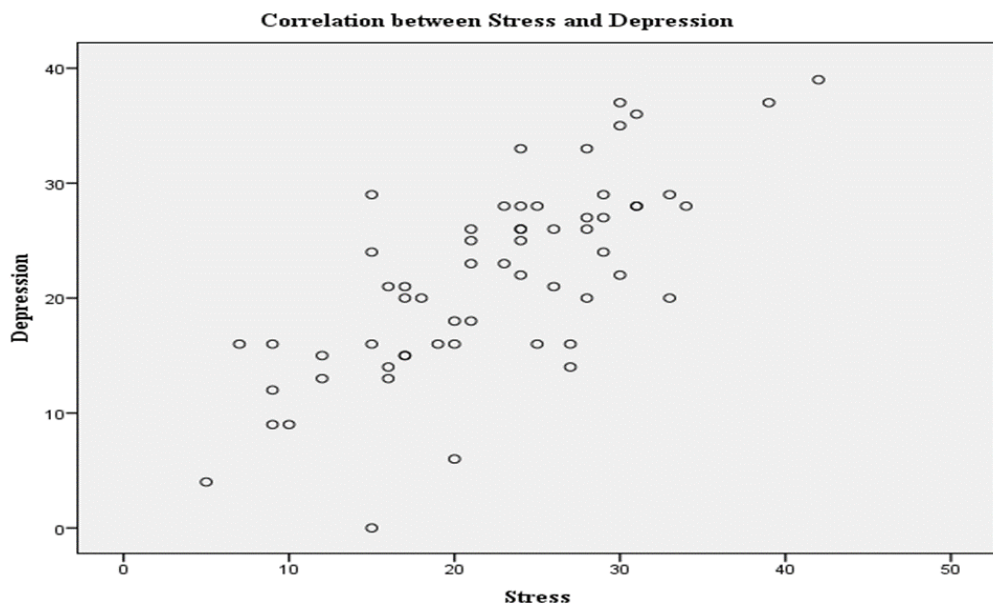


Figure 5: Correlation between stress and depression

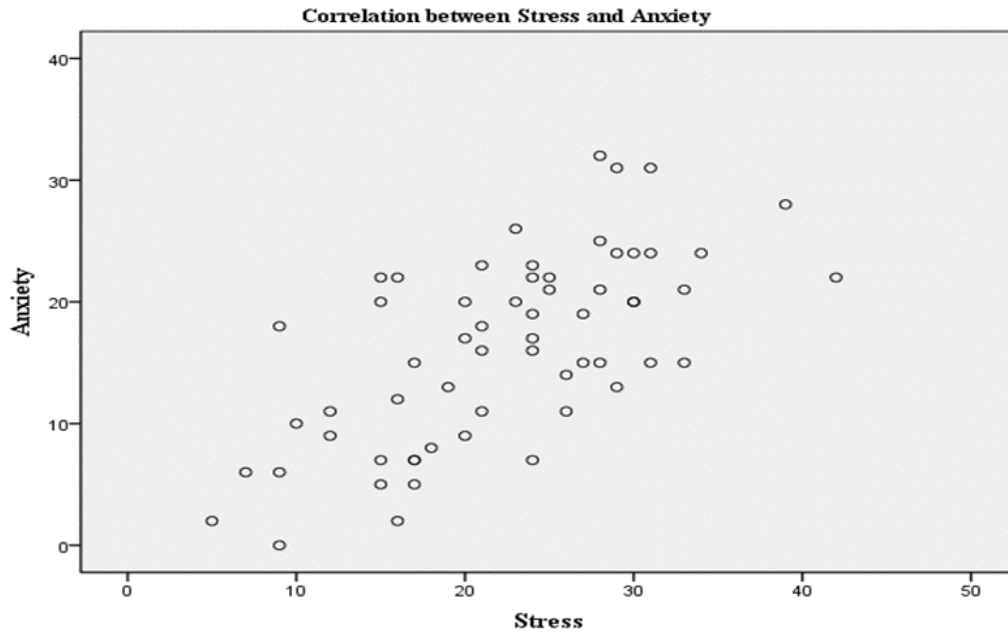


Figure 6: Correlation between anxiety and stress

In summary this section outlined the participants’ demographic information, the frequency and percentage distribution of depression, anxiety and stress levels. Furthermore, the levels of depression, anxiety and stress are broken down in relation to age, grade and number of children. Lastly, the section looks at the correlations between the three levels. The next section presents the qualitative findings of the study achieved through semi-structured group interviews.

4.2 QUALITATIVE DATA

In addition to the Depression, Anxiety and Stress Scale (DASS) administered, the researcher conducted two focus group discussions, one in Kavango East region and the other in the Kavango West region by means of semi-structured interviews. The interview questions assessed for depression, anxiety and stress as an attempt to validate the first objective of the study. To assess for depression, anxiety and stress, the interview questions explored teenage mothers’ daily activities, their goals in life, their current eating and sleeping patterns/habits and lastly examined their moods (assessing for feelings of sadness, worry and guilt). In addition, the semi-structured interviews

were designed to elicit responses relating to the experiences of teenage mothers, the challenges they face and their coping strategies. The themes that emerged from the group interviews are presented below:

Table 8: *Themes and sub-themes of teenage mother's experiences, challenges and coping strategies*

<p>4.2.1 Experience of teenage motherhood</p>
<p><i>a) Stress and worry</i></p> <p>Teenage motherhood is experienced as stressful and challenging, mainly due to unemployment and lack of support from family members and the fathers of the babies/children.</p>
<p><i>b) Regret and guilt</i></p> <p>For falling pregnant while still young and in school, denoted as a “mistake”. Wish they had waited and listened to their parents.</p>
<p>4.2.2. Reports on depression, anxiety and stress</p> <p>To assess for symptoms of depression, anxiety and stress, questions relating to teenage mother’s activities, goals, hobbies and interests were asked.</p>
<p><i>a) Normal day like</i></p> <p>Generally involves going to school, caring (preparing formula milk or soft porridge) and spending time with their children.</p>
<p><i>b) Goals in life</i></p>

To develop and improve in life, complete secondary school, continue with tertiary education and become professionals one day.

c) A decreased interest in previous pleasurable activities

Limited time, parenting responsibilities, mockery and negative perceptions of selves are all factors that have influenced the loss of hobbies and interest in previous activities.

d) Poor eating patterns and disrupted sleeping patterns

Decrease or change in eating and sleeping patterns mainly attributed to worries concerning their children's health and well-being.

e) Sadness and decreased mood

- i. Sadness attributed to arguments, misunderstandings with parents and rejection/abandonment by parents.

Insensitive remarks from parents/elders/members of the community, feelings of abandonment and rejection by their parents all contribute to changes in mood.

f) Persistent worries and stress

Attributed to:

- i. Unemployment and limited/lack financial support
- ii. Wellbeing and health of their children
- iii. Overwhelming experience of motherhood

g) Persistent guilt

Teenage mothers experience feelings of guilt mainly attributed to their inability to provide for their children. Additionally, those in boarding schools feel guilty for leaving their children at home in pursuit of their education.

4.2.3 Challenges

a) Lack of support and ill treatment by extended family members

Participants reported to receive minimal support and/or lack of financial support from family members. Moreover, maltreated by their extended family members (example, by not given food and sometimes not permitted to switch on lights at night to study).

b) Poor school attendance

Mainly because they are children are often sick and sometimes hospitalised.

c) Poor relationships with parents

It was reported that parents (elders) are disappointed. Moreover, that their attitudes, affection and attention towards them have changed. Some teenage mothers expressed feeling like orphans.

d) Stigmatisation and mockery by members of society

Participants are stigmatised and mocked by the members of society, peers and educators. Some feel so ashamed to the extents of wanting to prematurely terminate their education.

4.2.4 Coping mechanisms

a) Cope financially by means of assistance from supportive structures

Many parents and guardians are unemployed. Participants cope financially by means of small scale businesses involving selling sweets and during weekends/school holidays selling traditional brewed beer. Moreover, most of them rely on the old age grant and orphan grant from government.

b) Coping by means of emotional support

Primary emotional support systems for many participants are their grandparents and to some degree life skills teachers and boyfriends.

c) Dependence on ongoing motivation and encouragement

From their loved ones, especially when they feel overwhelmed, wanting to give up (dropout of school).

4.2.5 Suggested measures by teenage mothers to prevent teenage pregnancy and assist teenage mothers

a) Support groups such as “teen mothers club”

There is a reported need to affiliate with a peer establishment where teenage mothers can have the platform to openly and freely express themselves without fear of judgment, providing a sense of belonging.

b) Implementation, availability and accessibility to school counsellors

Teenage mothers requested and suggested that having counselling services in schools and communities will assist them to cope better with their negative emotions resulting from their experiences and challenges.

c) *Financial assistance from the government and day care facilities*

d) *Non-discrimination, fair and just system*

4.2.1 Experience of teenage motherhood

On the question of the participants' experiences of teenage motherhood (how life is like for them as teenage mothers) the following themes emerged:

a) Stress and worry

The participants expressed that being a teenage mother was quite challenging because most of them still relied on their parents (of which most are unemployed) to sustain both their basic needs and that of their children. Teenage motherhood is experienced as stressful, also accompanied by chronic worries partially induced by a lack of support and rejection (denial of the baby) by the children's fathers. Moreover, the stress and worry is induced by concerns relating to the health and wellbeing of their children and the inability to afford their basic needs. Such stress and worry can be attested from the extracts hereunder:

Participant 10: "Life is extremely difficult for me because I left my child at home in order to come to school and whenever I am informed that my child is not well it really affects my performance because I am unable to pay attention at school".

Participant 8: "My grandmother is unemployed and the father of the baby only gives his child money when he remembers him. This is a challenge especially when the baby's milk is finished because I get stressed and I worry for my grandmother".

Participant 9: "When I was pregnant the father of the baby and his family denied my pregnancy apparently because their son is too young to have

impregnated me so my child is fatherless and now my parents no longer trust me and every time I go out they fear that I will come back pregnant”.

The above extracts clearly indicate that teenage mothers are likely to perform poorly academically because most of the time their attention is drawn to matters of motherhood.

b) Regret and guilt

Many teenage mothers expressed guilt and regret for falling pregnant while still young and in school, denoted it as a “mistake”. They wished it could have been better if they had waited and listened to their parents. The following statements support this point:

Participant 8: “I feel bad and I constantly have thoughts about why I didn’t wait to get a bit older and then only have a child”.

Participant 10: “I feel really bad because I am a child and I also have a child and I also feel old among my peers at school”.

Participant 2: “I do feel guilty because all my cousins and my sisters do not have children. In fact, I am the first youngest to have a child in the family”.

Guilt was also expressed in the form of having shamed or disgraced their families and being the youngest in the family to be mothers. Nonetheless, most of them have accepted it as a mistake which may be an indication of a lesson learnt.

4.2.2. Reports on depression, anxiety and stress

Primarily, to assess for symptoms of depression participants were asked to describe their normal day in relation to activities they are involved in, their interests and hobbies. Additionally, the researcher explored their goals in life.

a) Normal day like

Bearing in mind that most of their children are in the care of their mothers and grandmothers, participants reported that every day before going to school they prepare their children's food (formula milk or soft porridge). In relation to hobbies and interests, they reported they do not have as many interests and hobbies as before they became teenage mothers. The following extracts describes how their normal days are like:

Participant 2: "During school days I wake up early in the morning to prepare my baby's milk usually two bottles because my grandmother doesn't know how to make the formula milk, she always forgets. Lunchtime I go back home to eat and I come to school for extra classes, after that when I return home I have to go and prepare dinner".

Participant 5: "When I wake up, because my child also wakes up early, first I clean the house and help my mother with house chores and when I am at home I make sure that my mother rests from looking after my child. Usually starting Fridays after school throughout the weekend I am busy with almost everything that needs to be taken care of/done at home, I make sure that my mother only resumes her daily chores on Mondays to Friday afternoon".

Participant 1: "School days, I wake up, bath and go to school and for lunch, I remain at school because home is far, so I only leave after study. When I arrive home which is usually around 17h00 or 18h00 I start preparing dinner because my mother goes to the market every day with my child to sell things and because the market is far she doesn't always arrive on time to prepare dinner. During weekends, I am still the one that does most of the house chores so that my mother can get some rest".

There is a clear reflection of maturity and responsibility because many teenage mothers reported that apart from attending school, their days revolve around daily house chores

and taking care of their children more especially during weekends. It is also clear that motherhood has taken away their freedom to be children or teenagers enjoying normal teenage activities. The few hobbies they have are deliberately tailored to suit their roles and responsibilities as teenage mothers, for example, staying at home and watching television.

b) Goals in life

Some participants reported almost prematurely terminating school, however, they were encouraged to return to school by their peers. Their goals right now are to complete secondary school and continue with tertiary education in order to become professionals one day. They want to serve as examples to others in the near future, below is the evidence to prove that:

Participant 1: "I also want to pass my grade 10 so that I am able to go as far as grade 12 and complete my education. Moreover, I want to be an example to those that are teenage mothers and school dropouts, that despite being a teenage mother you can still become someone and achieve your goals and dreams".

Participant 11: "When I fell pregnant I used to get teased a lot by boys at school and I almost dropped out of school. I remember a time when I was at home the whole week and my friends came to visit me, they encouraged me to return to school, thereafter, I made a decision to continue and complete my education and become an important person in society one day. In fact, I no longer want to get involved with boys".

Participant 8: "When I fell pregnant I wanted to drop out of school however, my grandmother encouraged me to continue and she promised that she would take care of my baby. After I delivered, I left my baby with her. My goal right now is to get educated so that one day I can take care of my child and my grandmother".

Most of these teenage mothers' goals are influenced by their social circumstances and environments. Many have demonstrated determination and resilience as they are trying and willing to move forward. In further assessing for symptoms of depression, anxiety and stress, the following themes emerged:

c) A decreased interest in previous pleasurable activities

In relation to interests and hobbies, many participants reported either not having time or having lost interest in activities and interest they had before. This is due to mockery by others and also because they are conscious about their bodily changes. Others, demonstrated a perceptual fear from society if they were to still pursue their previous pleasurable interests and activities prior to becoming mothers. The following extracts illustrate this point:

Participant 4: "As for me I used to sing, I also used to go clubbing everyone knew me as a singer and dancer, in fact they respected and loved my talent but now I feel old and incapable of singing and dancing. Also, I fear what people will say about me if they were to ever see me singing and dancing again".

Participant 1: "My hobby has always been playing netball, even now I still like it but whenever I want to play usually people mock me and make insensitive comments like I am a mother and this often discourages me".

Participant 11: "My current hobby is staying home and just watching TV".

Researcher: And why is that?

Participant 11: "Because I no longer have time, I always have to look after my child".

Persistent mockery and/or being ridiculed have influenced the loss of hobbies and interest in activities for many teenage mothers.

d) Poor eating patterns and disrupted sleeping patterns

A decrease or no appetite is mostly due to worries about their children's health. Participants reported that their appetite was often affected when their children were crying, feeling sick and not eating. Moreover, since most of them did not live with their children, general worries relating to the wellbeing of their children also affected their appetite.

Participant 3: "I have access to food where I am currently staying, however, whenever I think of my child that is living with my mother, my appetite is often affected".

Participant 2: "Sometimes one may feel like eating, however, as soon as you hear the baby crying you stop to attend to the baby, when you get back to your food, the appetite is gone".

Participant 4: "My appetite is not really fine because my child doesn't really eat, even during the time I was breast feeding. Also, my child only likes eating nice food like rice or meat and not porridge or traditional food. This worries me a lot because we can't always afford the type of food she likes".

In relation to sleep, some participants reported that there is sleep disruptions to some extent as demonstrated below:

Participant 1: Because my parents are unemployed life is really difficult especially when the baby cries a lot for whatever reason or when he is sick, for me it becomes really difficult. I cannot even study no matter how much I try; I often have to leave everything I am doing to attend to him, it really affects me.

Researcher: Okay, so what you are saying is that, when the baby is sick it affects your sleep?

Participant 1: Yes

Participant 4: “As for me I don’t have a room of my own, I share with my grandmother. My baby often wakes up at night and cries throughout especially when he hasn’t eaten and this interrupts my sleep. Moreover, when it is time to prepare for school he follows me around even to bathroom requesting for the food he wants to eat”.

On the contrary, two participants reported that they sleep well because they receive a lot of assistance from their parents with their children. The extracts below attest to this:

Participant 5: “I sleep quite well because my child often sleeps well too when I give him breast milk but, when he is not feeling well he often cries a lot at night which interrupts my sleep. However, my mother assists by taking him for the night so that I am able to wake up in time for school the next day”.

Participant 2: “I sleep very well because I recently got a big new bed where I can sleep with my baby and when he cries a lot there is always milk or my grandmother takes him for the night”.

As demonstrated in the extracts above, assistance from parents is important because it helps young mothers to attend school.

e) Sadness and decreased mood

Participants reported that their mood is often low and they feel sad due to the following reasons:

Sadness attributed to arguments, misunderstandings with parents and rejection/abandonment by parents.

The insensitive remarks made by either elders or members of society made participants feel sad thus contributing to their low mood. Some other participants felt sad because

they longed for motherly love following rejection or abandonment by their parents. On the other hand, others felt sad because they did not have a good relationship with their parents. The extracts below support these emotional experiences:

Participant 6: "My mood is often low because my mother abandoned me and I remember there is a day she even called me to tell me she is not my mother and I had to call my father to ask who my mother really is".

Researcher: I am so sorry to hear this. When was this?

Participant 6: "It was just last week I called her, she even insulted me and I just ended up crying because it really hurts. Sometimes I just feel lonely, to make matters worse, sometimes my grandmother scolds me and says things like "this is not your father's house".

Participant 3: "As for me my current low mood is probably attributed to the fact that I never grew up with my biological mother and father, this sometimes makes me feel sad. My father recently moved into a family home where I am also living and sometimes we have misunderstandings. The other day I asked for money to buy a T-shirt at school, an argument just started, I feel like an orphan".

Participant 1: "I also feel bad and my mood is low because sometimes parents say insensitive things as a means of punishment. Also, because they are unemployed and I am the first child and only girl sometimes when I ask for money to buy basic things they tell me that they do not have. They also ask me who will provide for my child if they provide for me, such things contribute to my low mood".

In addition, irrational thoughts that participants may have bring them sadness and continuous worries. Below is an extract attesting to this:

Participant 2: "As for me I always feel sad because sometimes my thoughts are very bad. I sometimes think I won't make it, I won't be the top of the class, I fear I will have anxiety especially when I have a test the next day".

f) Persistent worries and stress

The worries and stress are due to the following reasons:

i) Unemployment and limited/lack financial support

Many of the participant's worries and stress are due to a lack of finances. Most of them come from low socio-economic households with no or limited access to good sanitation, water and electricity. Moreover, they rely on subsistence farming for survival because their parents are unemployed. In addition, the majority of their children's fathers are either unemployed or not supportive. The following extracts elaborates their financial struggles:

Participant 1: "Worries are definitely there; I worry about the situation at home if there is food or not because my parents are unemployed. Another worry or challenge is, where I stay there isn't electricity and sometimes when I ask for money to buy batteries for my torch which enables me to study, my parents tell me or make comments such as "if we buy those batteries for you, who will take care your child's basic needs", this makes me feel so sad. This also makes me stress because if they are unable to provide for me as my parents, who else or where else am I supposed to get the money to buy batteries for example, such things really worry me".

Participant 10: "I worry a lot especially during school holiday because, I have to make a plan and find something to sell so that I can have hostel fees. During out weekends I make sure to leave the school and hostel premises early. For example, I leave on a Tuesday or Wednesday that way I can have a bit of time to look for money to afford my basic needs such as cosmetics and transport back to school. Also, when I have tests I worry a lot about my performance as I am always preoccupied with thoughts that may negatively affect my studies".

Participant 5: "..... things are difficult because sometimes we sleep with hunger, even my child sleeps with hunger...".

The above extracts reveal the financial difficulties experienced by teenage mothers. It clearly demonstrates how some of them are living in poverty as they do not have access to basic needs such as water, food and electricity.

ii) Wellbeing and health of their children

Many participants are preoccupied with negative thoughts concerning the wellbeing of their children because many times, their children have been neglected. They often also worry about their children's health whenever they are informed that their children are sick. The following statements attest to this and illustrates some of the thought preoccupations:

Participant 12: "Sometimes especially when I am alone I worry a lot about my child's wellbeing at home, I worry whether people at home are caring and providing for him".

Participant 5: "I used to worry and I was constantly preoccupied with negative thoughts because my grandmother, who used to look after my baby was very old and crippled while my mother used to cultivate. So it was my responsibility to make sure that I prepared enough milk and remove the mattress from inside the house to the outside, where they would spend the whole day. This really used to worry me and I always felt anxious to return home".

Participant 3: "My child lives with my mother because my parents are separated so my mother took the responsibility of looking after my child while I, on the other side, live with my father. However, sometimes I doubt the kind of support my child is receiving from my mother because she drinks a lot and many times I have found my child neglected".

Moreover, many participants felt overwhelmed with their roles as mothers as discussed below.

iii) Overwhelming experience of motherhood

A few participants expressed that they felt stressed and overwhelmed with their experience of motherhood. The support and assistance received is not sufficient. The following statements support this point:

Participant 2: "I am always stressed, especially when the baby is crying a lot, which mostly happens at night and I don't know how to keep the baby quiet. When this happen I always call my grandmother or my sisters when they are here for holidays, to assist me with keeping him quiet because I don't know how to keep the baby quiet".

Participant 5: "Especially when the child is sick or when it is time for the immunisation or follow up clinic injection, the child usually cries a lot at night and it can really stress one".

Participant 4: "I worry a lot because my mother no longer shows me the love she used to show me before I had a child. I fell pregnant when I was in grade 8 and my performance before I had a child was good, now I am in grade 9 and I am not doing so well in school because I am often distracted by my child. A contributing factor is, that when I go back home after school there is usually no one to assist with the child in order for me to study".

As a consequence, the persistent worries and stress affect their concentration and performance in school.

g) Persistent guilt

In addition to the guilt reported earlier under experiences, teenage mothers felt guilty for leaving their children at home when returning to school (in town or village school hostels). Others felt guilty because they were unable to provide for their children.

Extracts below support this:

Participant 7: “I always feel guilty for leaving my child at home with my parents because sometimes she may fall sick as she needs my attention. For example, right now she needs my attention but I am far as I am at school”.

Participant 10: “I often feel guilty especially when I cannot afford things for my child, I feel that I am disappointing him. I also feel guilty when I ask money from my elders because I feel that they are still angry with me for falling pregnant”.

Participant 9: “I feel guilty because I fell pregnant at an early age and also because my parents are raising my child on my behalf. Sometimes, parents are unable to provide the child’s needs and wants. I also feel that my child may likely fall sick as he longs for his mother’s love that is absent”.

Participants perceived leaving their children at home to return to school as abandonment or neglect, moreover, others felt that it was a burden to their parents.

4.2.3 Challenges

The following themes emerged as challenges often experienced by teenage mothers.

a) Lack of support and ill treatment by extended family members

In addition to financial stress and worries discussed earlier, teenage mothers reported that they received minimal support if not a lack of support from their family members. Also, they reported being mistreated by their extended family members whom most of them live with them. This is demonstrated in the extracts below:

Participant 6: “When my father has no money to send, I expect no one else to assist. I live with my aunt and she really doesn’t care about me and the other extended children at home, she mistreats us. I wish my mother was a part of my life, perhaps things would have been better”.

Participant 6: "Often times we look for our own food. Like I have mentioned my aunty really doesn't take care about us. She makes comments such as, we are not her children and we have to find ways to look for our own food. Also, there are times she switches off the light to prevent us from studying, however, when uncle is around she pretends as if we are just fine. We have tried reporting this to our granny but she doesn't believe us".

Researcher: So, what I pick up is that the home environment also plays a role in your studies because some of you live with relatives who mistreat you. In your case it sounds to me like the uncle is your relative that is why the aunty only treats you well when he is around.

Participant 6: "Yes".

Researcher: Otherwise, when the light is switched off early it gets really difficult to study right?

Participant 6: "Yes, sometimes I use my phone's torch light to study".

The occurrence of maltreatment may often result in a no sense of belonging, furthermore, affecting concentration in school.

b) Poor school attendance

School attendance is often affected when children are sick. Many teenage mothers reportedly choose and sacrifice to accompany their children to the hospitals when they are sick. They reported that it is difficult to leave home and go to school knowing your child is sick. According to them, attending school during such circumstances is not productive as their attention and concentration in reduced. The extracts below prove how their motherly responsibilities contribute to poor attendance at school:

Participant 2: "So far for me, I have only been absent from school when I take my baby to the hospital for immunisation".

Participant 4: "I do not have a choice, if my child is sick I cannot come to school because I have to take him to the hospital. All elderly people in the house have commitments, for example, my grandmother goes to cultivate, my mother on the hand remains at home with other children and my aunt goes to work. So, it is my responsibility to take him to the hospital every time he is sick".

Participant 11: "When my child is sick it is difficult to leave him at home and come to school, because sometimes as I am leaving the house I hear him cry, often that troubles me".

Researcher: So does that mean that you are sometimes absent from school?

Participant 11: "Yes, usually on my way to school I just turn back".

This clearly demonstrates how children's ill health can cause a decrease in school performance.

c) Poor relationships with parents

Based on the observations made by participants, they reported that their parents' attitudes, affection and attention towards them has been reduced. Moreover, they reported that their parents were disappointed, as a result some have set ultimatums. In addition, others reported feeling like orphans although their parents are still alive. The following statements give an indication of how their relationships with their parents have changed:

Participant 1: "As for me, our relationship has really changed. Before I had a child my parents always assisted me financially but now my child comes first, also, I feel like they despise me for falling pregnant at a young age which I have somehow accepted and made peace with".

Researcher: Hmmm, okay. Do you perhaps feel they love you different compared to when you didn't have a child?

Participant 1: "Yes"

Researcher: And how does that make you feel?

Participant 1: "It makes me feel really sad, I feel like an orphan even though my parents are still alive".

Participant 12: "Yes, the love is not the same, it is less. It is more like our children have replaced us, they have taken our places in terms of care and support from our parents".

Out of all the participants, one expressed the opposite that her relationship with mother had not changed as illustrated below:

Participant 5: "My relationship with mother hasn't really changed because I am the only child and my mother has taken my child as her second child".

d) Stigmatisation and mockery by members of society

Participants reported being stigmatised and mocked by the members of society, peers and educators. Moreover, they reported that these people made insensitive comments towards them. To a certain extent, some felt so ashamed that they almost prematurely terminated their education. The following extracts attest to this:

Participant 11: "When I fell pregnant I used to get teased a lot by boys at school and I almost dropped out of school. I remember a time when I was at home the whole week and my friends came to visit me, they encouraged me to return to school, thereafter, I made a decision to continue and complete my education and become an important person in society one day. In fact, I no longer want to get involved with boys".

Participant 10: "Yes, people usually refer to us as old because we have given birth".

Participant 5: "...for instance in Life Science class when we discuss topics relating to sex or the reproductive system, people in class often laugh and tease us and the teachers do not defend us".

The persistent mockery and insensitive remarks made by others to teenage mothers is seen to contribute to the decreased mood and feelings of sadness and to an extent, others may have become self-conscious.

4.2.4 Coping mechanisms

Teenage mothers reported that they cope in the following ways:

a) Cope financially by means of assistance from supportive structures

The main source of financial support for many teenage mothers are their grandparents, parents (especially their mothers) and siblings. One out of 12 participants is financially dependent on her boyfriend and another one relies on a monthly orphan grant she received from the government (Ministry of Gender Equality and Child Welfare). Moreover, participants cope financially through means of small scale business such as selling sweets and/or selling traditional beer during school holidays to make an income. The following statements illustrate how participants cope financially:

Participant 4: "As for me, I am just thankful to God for giving me a responsible and respectful boyfriend, without him I could have been really suffering... the father of the baby tries and makes sure to send money for his child every month..".

Participant 9: "During holidays I usually sell things to make some money for school. An example would be traditional beer that my mother sells, sweets and sausages. So from the little money I make, I often take some to use for hostel registration and leave the rest for my child".

Participant 11: “I get a monthly poverty grant of N\$250 from the ministry of Gender and that is the money I practically survive on. However, I also rely on my mother because she has a small business of selling fat cakes and sweets”.

On the contrary, two participants expressed that they are financially content as illustrated in the extracts below:

Participant 2: “As for me it is not that difficult because all the people, my cousins, those not in school are employed. My aunts and uncles support me financially.

Participant 12: “I don’t really have as many challenges because my child who previously lived with his father, now lives with my mother in Windhoek, so I only get to speak to him during out weekends and that’s if he feels like speaking to me...laughs...furthermore when I go home during out weekends my older siblings at home try by all means to give me money, a N\$100 or so”.

b) Coping by means of emotional support

As demonstrated in the extract below, many participants rely on the emotional support mainly from their family members (mainly grandparents), life skills teachers and with an exception of one participant relying on her boyfriend.

Participant 12: “I have two sources of emotional support, my grandmother and the father of my baby, they are the two people I feel most free to discuss my problems with”.

Participant 9: “I normally discuss my emotional problems with my grandmother because she has lived long enough, I also feel she is wise enough to assist me overcome my problems”.

Participant 7: “When I was having problems last year, I talked to Ms S, a Life Skills teacher, she gave me some advice on how to deal with those problems and how to ignore people, yah”.

It needs to be mentioned that not all participants have emotional support, there is an absence of emotional support for some participants as proven below:

Participant 1: "...to be honest I do not have someone to talk to. I bottle everything that happens to me and I try to deal with it on my own, in the best way I know how".

Moreover, some participants reported on having fear of disclosing their problems to others due lack of trust. This fear and lack of trust is illustrated in the extracts hereunder:

Participant 5: "You know one may have a friend they love dearly and can disclose anything to, but, one day she may disappoint you and share your secrets leading to regret. So, it is difficult to really be open even to your best friend".

Participant 4: "It is actually just better to share with your relatives".

Participant 5: "It's true, for example, you may have a disagreement with relatives but they will never disgrace you publicly unlike with friends".

Researcher: Okay, those who have emotional support continue expressing yourselves because sharing our emotions makes us feel so much better, okay. It can provide a lot of relief and who knows, you may also just get great guidance and encouragement from others just from sharing. As for those who do not have people to openly talk to, you can approach social workers at the Ministry of Gender or a psychological counsellor at the Ministry of Labour to share your problems and experiences. These people are guided by professional ethics, in other words they made an oath of confidentiality meaning whatever you discuss with them shall be kept private okay.

Consequently, this fear hinders emotional support.

c) Dependence on ongoing motivation and encouragement

Participants further expressed that ongoing motivation and encouragement from their loved ones helps them cope better with stress that comes with being a teenage mother, especially during times they feel so overwhelmed and want to give up, dropout of school.

Participant 1: “My parents are also the ones that help me cope...Their ongoing motivation and advice also further encourages me to work hard”.

Participant 5: “As for me, my mother and her younger brother have accepted the situation because they try to provide for me, also, they really motivate me to continue with my education. Without them I would probably have been a school dropout by now. Their support, their ongoing assistance really motivates me to pull myself up”.

Participant 8: “When I fell pregnant I wanted to drop out of school however, my grandmother encouraged me to continue and promised that she would take care of my baby. After I delivered, I left my baby with her. My goal right now is to get educated so that one day I can take care of my child and my grandmother”.

In addition, academic wise, participants cope by means of continuous support and assistance from their grandparents and mothers who help with caring and raising their children. As demonstrated in the extract below, their assistance somehow enables them to concentrate on their school work.

Participant 5: “As for me, no, even though my baby is sick, my mother makes sure I go to school”.

Participant 5: “During examinations, my mother looks after my child on a full time basis, in fact during this time I am usually exempted from household duties just so that I am able to pay full attention to my studies”.

Participant 12: “When my child is sick, people at home normally do not inform me because they feel it will distract me and affect my studies, they also do not want me to excuse myself from school”.

It is also noteworthy to state that there was a sense of identification reported by one participant as demonstrated below:

Participant 12: “Just like they have all mentioned, I feel the same way too. I actually thought I am the only one that felt that way but I just learnt that we actually all feel the same way”.

Researcher: How does it now make you feel to know you have common experiences which you are able to identify with one another?

Participant 12: “Now that they were honest enough to openly discuss their problems I feel I shouldn’t worry that much and preoccupy myself with negative thoughts that in the end will affect my studies”.

The process of sharing experiences during the interview made this participant identify with others and feel a sense of belonging as she was able to relate to the stories narrated by others.

4.2.5 Suggested measures to prevent teenage pregnancy and assist teenage mothers

a) Teen mothers club

Participants reported an interest and need to belong to a peer group establishment such as clubs where they can freely express themselves without fear of judgment, also, where they can relate to others. Moreover, these clubs can serve as supportive

structures and can be used as educative platforms to empower teenage mothers. The following verbal quotes support this:

Participant 12: "I think there should be clubs which can assist teenage mothers to openly discuss preventative measures. These clubs could also promote psychoeducation on HIV/AIDS related topics and perhaps also get external people to help encourage us".

Participant 5: "There should be platforms like clubs that would allow us to express our feelings, problems and what is happening daily at home, for example arguments with our parents".

Participant 1: "As mentioned by her, I would also like to be part of a group where I can feel a sense of belonging. I think this will help as opposed to dealing with something alone".

In addition, as previously discussed there were participants who lacked emotional support, moreover, others had no one to trust and openly discuss their problems with. The next theme addresses access to professional counselling services.

b) Availability and accessibility to school counsellors

Having professional counselling services in schools and communities may help these teenage mothers cope better with their emotions. Some participants reported previously having exposure to such services before and confirmed that it helped them.

The quotes below attest to this:

Participant 2: "I think it is better for counsellors to come and counsel those teenage mothers who are having problems at home, emotional, physical and academic challenges. This would help them avoid negative thoughts and have a better and positive outlook on life".

Participant 6: “I also agree to what she just said, because I remember there were some counsellors that came to our school in 2015 and there was a girl I was talking to, she encouraged me when I was pregnant, how to be and how to avoid people who were teasing me”.

Participant 12: “For example, we have two teachers here at school that help us with our problems and it is really difficult to approach them because most of us are shy. However, it will be better to have a club where we can all just meet and openly discuss our problems”.

Furthermore, Participants reported that they would appreciate assistance from the government to cope better with teenage motherhood as demonstrated below.

c) Financial assistance from the government and day care facilities

Financially, many teenage mothers are struggling as a result they are often worried and stressed about the basic needs of their children. Therefore, they are requesting for assistance from the government in forms of money or provision of formula milk, nappies and day care facilities where they can leave their children while they attend school.

Participant 9: “I would like our children to get financial assistance from the government that can assist with obtaining their basic needs”.

Participant 11: “When I was young I lived with my father and step mother in the south and they were both employed. I remember they used to leave me at a day care facility with my basic needs for the day and only fetch me after work. So, I would really appreciate it if we had such a service in this village”.

d) Non-discrimination, fair and just system

Lastly, despite the actions or principles defined in the education sector policy on the prevention and management of learner pregnancy, teenage mothers continue to feel

that the education system is not fair and just. The quotes below demonstrates their frustrations:

Participant 7: "I think the government or the school must put up rules like if a boy impregnated a girl they must both go home and seat until the girl gives birth and they should return to school the same year"

Participant 7: "Yes, the boy should also experience how it feels just sitting at home while others are attending school".

To conclude, this qualitative section reported various experiences, challenges, coping strategies as narrated by teenage mothers. Moreover, assessed for symptoms of depression, anxiety and stress. In the next chapter, the results of both quantitative and qualitative analysis will be discussed in relation to literature.

CHAPTER 5

DISCUSSIONS OF THE RESULTS

In this chapter, the findings of the study are discussed in relation to the objectives of the study and the relevant literature. To logically integrate these findings, this chapter will begin by looking at the reported experiences and challenges of teenage motherhood. In sequence, followed by exploring the mental health of teenage mothers and lastly, the chapter will address various coping strategies used by teenage mothers.

5.1 EXPERIENCES OF TEENAGE MOTHERHOOD

The present study involves teenage mothers, which are theoretically characterised as adolescents. Erickson's theory of psychosocial development explains that the adolescent stage is marked by a psychosocial crisis, in other words a developmental stage involving resolutions of conflicts. According to Erickson as cited in Rykmann, (2008, p. 185) adolescents are likely to experiment and explore by associating with crowds and cliques in attempting to search for their identities. Consequently, in relation to the area of focus in the present study, some fall pregnant and become teenage mothers, henceforth the experiences as discussed below.

The results of the study reveal that teenage motherhood has taken away young mothers' freedom to be normal teenagers enjoying teenage activities. They expressed feelings of regret because motherhood forces them to mature fast. Moreover, the findings of the study reveal that their current lives are routine like primarily centred on responsibilities involving daily house chores and caring for their children apart from attending school. For this reason, teenage mothers no longer had hobbies.

In addition, the study reveals that teenage mothers are guilty of disappointing their parents. They also experience the role of motherhood as challenging, often accompanied by feelings of worry and stress surrounding unemployment, rejection by the children's fathers and the wellbeing of the children. This finding is consistent with Motjelebe (2009) who postulates that the developmental period of transitioning into motherhood is often accompanied by stress, moreover, that teenage mothers are confronted with various challenges relating to parenting, finances, attaining basic needs for their babies and balancing school which impairs their daily functioning. Therefore, it can be argued that the regret and guilt reported and experienced by teenage mothers may have stemmed from their negative experiences of motherhood, for example, the loss of freedom as teenagers coupled with the inability to provide for their children.

5.2 CHALLENGES

It emerged from this study that teenage mothers experienced various challenges such as socio-economic difficulties, ill treatment by extended family members, poor relationships with parents, guardians and other members of society, stigmatisation and mockery and poor school attendance: factors likely to contribute to school dropout. These challenges are discussed below.

a) Socio-economic difficulties

In the current study, it is revealed that many schooling teenage mothers do not have access to basics such as good sanitation, electricity and sometimes food. Moreover, it emerged from this study that most of them came from low socio-economic households where parents were either unemployed/relied on subsistence farming or were involved in a small scale business such as selling snacks or traditionally brewed beer. The results of the study further reveal that due to the limited or lack of financial assistance

received, some teenage mothers were involved in small scale businesses such as selling sweets and traditional beer after school/weekends and during holidays to make an income that would enable them to sustain some of their children's basic needs. This finding relates to the results of a Nigerian study by Agunbiade (2009) stating that teenage mothers receive limited support from parents, as a result, most of them engage in profitable economic activities such as tailoring and hair dressing and are employed as restaurant attendants in order to survive. The aforementioned clearly demonstrates socioeconomic difficulties experienced by pregnant teenagers and mothers. In the same vein, The United Nations International Children's Emergency Fund (UNICEF) (2008) states that motherhood increases socioeconomic and psychological concerns for the mother. Similarly, Bissel (2000) established that socioeconomic wise, teenage mothers were likely to be disadvantaged later in life as opposed to women who delayed childbearing. This literature is consistent with the findings of the present study stating that the teenage mothers indeed face financial challenges which manifested into financial burdens as they not only had obligations to sustain their needs but also that of their children.

b) Ill treatment by extended family members

It emerged from this study that teenage mothers were mistreated by their extended family members whom they lived with. Some of them originally resided in villages and in search for better education, they moved to town to live with extended family members. One participant reported an incident where her uncle's wife would switch off the lights while she was busy studying. Moreover, mistreatment occurred in the form of not being given food/being deprived of food. The researcher perceives such factors as being likely to lead teenage mothers into unexpected behaviours or actions such as dating as a means of making a living, leading to subsequent pregnancies.

c) Poor relationships with parents, guardians and other members of the society

It is revealed through the study that teenage mothers were disappointed by having shamed and or disgraced their families since most of their relatives were disappointed in them too. Similarly, Ritcher and Mlambo as cited in Sodi, (2009, p. 23) reveal that having a child at a young age was perceived as a disgrace to the community and their families. Findings of this study indicate that the emotional relationships between teenage mothers and their parents have changed and this is reflected in the reported attitudes and behaviours of their parents and guardians. Moreover, in support of these findings, teenage mothers revealed conflicts between them and their parents in the form of verbal arguments, disagreements and poor communication. A similar sentiment was expressed by participants in a study by Mpetshwa (2000) who reports that since falling pregnant they felt rejected by their parents because falling pregnant was perceived as a form of betrayal which resulted in hostile treatment by the parents.

d) Stigmatisation and mockery

The present study concurs with other studies reporting that adolescent mothers were stigmatised and mocked by their peers, community members and to a minimum extent, by some educators. According to Ellis-Sloan (2014) there is some stigma towards teenage mothers by members of the public, medical professionals and in rare cases their family members. In addition, Micah et al. (2013) suggests that stigma has emotionally devastating consequences on teenage mothers. This study reveal that stigma and mockery are factors that are likely to influence premature termination of education.

e) Poor school attendance: a factor likely to contribute to school dropout

Felton and Haihambo (2002) suggest that there is gender disparity between male and female Namibians in terms of education, employment opportunities and the standard

of living. Moreover, according to Sibeko (2012) teenage mothers are faced with major challenges as they simultaneously try to cope with the demands of motherhood and schooling. As a result, most of them prematurely terminate their education thereby continuing the poverty cycle. Similarly, Chigona and Chetty (2008) aver that the challenges teenage mothers face, prevents them from completing their education. In relation to the present study, teenage mothers revealed two main reasons contributing to their poor school attendance. Firstly, their children's ill health and secondly, not having reliable persons to care for their children. In contrast, they reported times when they attend school despite their children falling sick, however during such moments their concentration and attention at school is often reduced resulting in poor performance.

A number of studies concur with these findings, for instance, Malahlela (2012) maintains that those teenagers that were pregnant and teenage mothers generally perform poorly academically due to dual responsibilities, lack of support and poor health status as opposed to those that are not pregnant and teenage mothers. Similarly, Duncan (2011) suggests that teenage mothers perform poorly academically as opposed to their non-parent peers because of the dual responsibility they are faced with. In addition, Nekongo-Nielsen and Mbukusa (2013) report of similar findings that school dropout is highly influenced by psychological factors, such as a learner's inability to cope with the new role of motherhood, school work and a lack of support from family members.

The findings of this study reveal that there are teenage mothers who report of almost dropping out of school to seek employment and care for their children. However, such thoughts were discouraged. This finding concurs with the literature above which has established that lack of support from family members is likely to influence teenage

mothers to drop out of school. In addition, despite the measures set by the policy on prevention and management of learner pregnancy in Namibia, the present study reveal that teenage mothers continue to experience difficulties in managing the dual role of motherhood and learning. More so, measures such as psychosocial support (encouragement & provision of parenting skills) and counselling programmes as stipulated in the policy, are not accessible and available to all learner mothers especially those in remote areas. In addition, the present study revealed there were some teenage mothers who were determined to succeed in life. They reported of trying by all means to work hard in order to pass and complete their secondary education. Some of them demonstrated that they had goals they wanted to achieve. At face value, this demonstrated resilience to the researcher because these mothers were trying to overcome the various challenges they faced, although doing so to a lesser extent. Moreover, this determination is perceived by the researcher as the reason they haven't yet dropped out of school despite the challenges they encountered.

5.3 MENTAL HEALTH OF TEENAGE MOTHERS

Hodgkinson et al. (2014) established that the occurrence of mental health problems in teenage mothers is centred on the disadvantages and problems they face as they transition to motherhood. Highet et al. (2014) concurs that the symptoms of depression and anxiety emerge when adolescents transition to motherhood which is often associated with feelings of loss and frustration. According to Yildiz and Akbayrak (2014) there is substantial literature on depression, however, stress as a phenomenon which plays a critical role in the emergence and maintenance of depression and anxiety has been less emphasised. Hans and Thullen, (as cited in Huang et al. 2014, p. 255) report that first time teenage mothers experienced undesirable emotions and stress as a result of parenting consequently affecting the development of their children. In a

similar vein, Lindhorst and Oxford; Mollborn and Morningstar (as cited in Easterbrooks et al. 2016, p. 61) suggest that there is an increase in postpartum depression in young mothers than in older mothers. In concurrence with the above literature, the quantitative results of the present study indicate that teenage motherhood is associated with increased levels of depression, anxiety and stress. Severe and extremely severe levels of depression experienced by 56.7% participants and severe and extremely severe levels of anxiety experienced by 63.4% participants. Lastly, 36.7% participants experienced severe and extremely severe levels of stress and 30% experienced moderate levels of stress. The qualitative results of the current study demonstrate the likely causal factors of the reported depression, anxiety and stress levels by teenage mothers, more so validate the presence of these levels as discussed below:

It emerged from the study that teenage mothers experienced persistent worries and stress and this is attested by the above stated quantitative results. Lazarus and Folkman (as cited in Mitchel, 2004, p.17) view psychological stress as a relationship that exists between an individual and his/her environment often perceived to potentially endanger his/her wellbeing. Furthermore, according to Weiten (2014) stress in general is a result of change (readjustments) and pressure from society in the form of demands and expectations. The findings of the study reveal that 51.6% of participants with only one child experienced severe and extremely severe levels of depression. According to the qualitative findings the experienced stress and worries are due to unemployment and limited/lack of financial support. Moreover, that teenage mothers were overwhelmed with the dual responsibility of motherhood which shows that they experiencing difficulties in coping with the demands of school and that of parenting.

In addition to the stress and worry due to financial difficulties, teenage mothers further expressed persistent worries and stress centred on lack of reliable persons to care for children, wellbeing and ill health of their children. It is revealed from the study that some of their children had previously been neglected by their caregivers hence their worries. This result is consistent with the findings of Nekongo-Nielsen and Mbukusa (2013) who uphold that teenage mothers' depression is centred on the inability to find appropriate caretakers for their babies which led to a decrease in academic performance and discourages some of them continue with their education. According to literature, the stress and worry experienced by teenage mothers may lead to depression. In relating grade to stress and depression, the results of this study further indicate that 60% participants in grades 8-11 showed moderate to extremely severe levels of stress. Furthermore, that 86.6% participants in grade 8-11 showed moderate to extremely severe levels of depression. These statistics give evidence of the presence of these negative states which are likely to contribute to school dropout.

In a similar vein, a quantitative study by Hudson, Elek and Campbell-Grossman (2000) found that more than half of the teenage mothers experienced high levels of depression mainly associated with limited social support and feelings of loneliness. Another qualitative study by Clemmens (2002) on teenage mothers aged between 16 to 18, who were asked to describe and reflect upon their thoughts, feelings, and perceptions about being depressed after giving birth reported that they were depressed due to abandonment and rejection by their peers which consequently affected their ability to establish and maintain relationships. The results of the current study concur with the aforementioned findings declaring that teenage motherhood is associated with persistent feelings of sadness and decreased mood. The sadness is attributed to arguments, misunderstandings with parents and for some, rejection/abandonment by

parents. Moreover, more than half of the participants in the study 56.7% reported severe to extremely severe levels of depression and 35% reported mild to moderate levels of depression. This further proves and concurs with literature that teenage motherhood is associated with depression.

The present study additionally reveals the presence of guilt as expressed by teenage mothers. The guilt was centred on leaving their children at home and not being able to provide for them. Based on these findings, the guilt is rooted in the perceptions of themselves as irresponsible and neglectful parents. Also, the findings reveal that teenage mothers have a decreased and/or loss of interest in previous pleasurable activities mainly due to their role and responsibilities of motherhood. Moreover, persistent mockery from society coupled with worry and fear emerging from others' perception of them, are factors discouraging them to participate in social activities and contributing to their decrease and/or loss of interest in previously pleasurable activities. Furthermore, self-esteem issues in the form of consciousness about bodily changes for example, one mentioned that "my breasts are heavy" and low self-efficacy emerged from the results of the study although not initially assessed. The findings of the study established that some of the participants have a sense of doubt in their general abilities to perform and/or succeed in life due to societal pressures, expectations and in some cases a decreased confidence in them.

Lastly, the results of the study also reveal poor eating patterns and disrupted sleeping patterns centred on the overwhelming experience of motherhood, children's ill health and worries about the wellbeing of children (those who do not live with their children). As a final point, it is evident that teenage mothers experienced severe levels of depression, anxiety and stress, although there was lack of literature supporting the experienced anxiety. In reference to the general population, the mental health findings

in the present study are consistent with a systematic review by Cortina, Sodha, Fazel, and Ramchandani (2012) reporting that there is existence of psychopathology in children and adolescents. In their review on the prevalence of child mental health problems in sub-Saharan Africa, it was found that “one in 7 children and adolescents have significant difficulties, with 1 in 10 (9.5%) having a specific psychiatric disorder” (Cortina et al., 2012). To conclude, based on the findings there is statistically significant positive relationships among these three variables, $r = .698$ between depression and anxiety, $r = .737$ between depression and stress, lastly, $r = .658$ between stress and anxiety. Noteworthy, this finding shows that stress and depression strongly influence one another. Meaning high stress levels causes an increase in depression levels as attested by the findings of the present study.

5.4 COPING MECHANISMS

The Transactional model of stress and coping by Lazarus and Folkman (as cited in Mitchel, 2004, p. 18) defines coping as a process of constantly changing our cognitions and behaviours/actions by reinterpreting threatening situations that exhaust or wear us out. As evidently reflected in this discussion, motherhood is appraised by teenage mothers as a stressful and shameful experience. Moreover, the stress is interpreted to arouse feelings of frustrations emerging from conflict and change in their lives and environments.

Bearing in mind the experiences and challenges discussed above, the present study reveal various coping mechanisms used by teenage mothers in attempting to cope with those challenges. According to Kalat (2011, p. 445) coping can be grouped into the following three categories; Problem-focused coping, Reappraisal and Emotion-focused coping. The present study established that teenage mothers use emotion-focused coping strategies and to an extent reappraisal. Financial support and emotional

support serve the function of emotion-focused coping strategy. It emerged from this study that teenage mothers cope financially by means of assistance from supportive structures and more so, cope emotionally by means of emotional support from some of their family members. The researcher perceives social relations as significant patterns of interaction among close people varying from parents, siblings, extended family members, friends and boyfriends. Theron and Dunn (2006) emphasise the importance of teenage mothers receiving consistent support from parents, family and friends which correlates with better school performance and vice versa. In a similar vein, Huang et al. (2014) reports that increased support to teenage mothers lowers their depression levels. According to Huang et al. (2014) focusing on ways to minimize stress and maximize support are important to maintain a healthy development of infants and prevent adolescent mothers from developing depression.

In addition, another coping mechanism revealed in this study is dependence on ongoing motivation and encouragement which serves as a reappraisal. The result of this study indicate that through measures of ongoing motivation and encouragement, teenage mothers become hopeful and are able to reinterpret their situations by viewing them as less threatening. Complimentary to these findings, Kalat (2011) suggests various ways viewed as successful in assisting teenage mothers manage their reactions to stressful events namely, relaxation, exercise, distraction or suppression of emotions. This study also revealed lack of emotional support by some teenage mothers as a significant factor. On the other hand, others feared to disclose their problems due to a lack of trust which was rooted in previous disappointments. The researcher perceives the trust issue emerging from the study causing a hindrance to some teenage mothers from receiving emotional support. The implication is a chain reaction, which is as follows, failure to unsuccessfully resolve challenges (stressors) may lead to the

development or increase of mental health problems such as depression, anxiety and stress. This causes a negative impact on the academic performance of teenage mothers, more so it increases the rate of school dropouts. As a consequence, increasing the existing gender disparity between male and female in relation to the attainment of education and employment.

CHAPTER 6

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

This chapter summarises and gives conclusions about the experiences, challenges and coping strategies of teenage mothers and recommendations on how best to assist teenage mothers cope with the challenges experienced. Lastly, limitations of the present study are also highlighted.

6.1 CONCLUSION

The objective of the present study was to assess the mental health of teenage mothers in the Kavango regions in relation to depression, anxiety and stress. Moreover, the study aimed to investigate the experiences, challenges and coping strategies of teenage mothers. Data was collected using the Depression Anxiety and Stress Scale (DASS) and focus group interviews. The current study reveals that teenage motherhood an aftermath of teenage pregnancy, is a result of a psychosocial crisis involving experiments and exploration during the adolescent period. The results indicate that teenage mothers are overwhelmed by stress and other challenges they experienced. Moreover, the results reveal that the stress and challenges experienced are centred on their dual role and/or responsibilities as teenage mothers. The availability of financial assistance, emotional support and ongoing motivation and encouragement from either parents, peers or educators was found to minimise the experienced stress and challenges. The implication thereof is that teenage motherhood as already demonstrated disrupts education or learning even more so, it may lead teenage mothers to prematurely terminate their schooling.

6.2 RECOMMENDATIONS

The present study found that teenage motherhood is commonly experienced as overwhelming. The new role of motherhood and the mere fact of caring for another human being whilst the person doing so is a child that lacks experience in raising a child, who also has academic obligations, makes it even more challenging. A wide range of negative emotional setbacks are experienced by teenage mothers such as; feelings of sadness, worry, stress, regret, guilt, stigma and/or mockery from society, lack of emotional and financial support. All these affect teenage mother's academic performance and their role to be good mothers. Therefore, based on these summarised findings, this study draws the following recommendations for teenage mothers inclusive of those that are not schooling:

a) It is evident from the study that support minimises the burden and the psychological distress experienced by teenage mothers. This places great significance on the availability of supportive structures. Taking into consideration suggestions made by the teenage mothers, there is great need for varying intervention programmes to be put into place in order to address these social problems and psychological needs. For example, there should be a teenage mothers support groups in schools and in communities where voluntary teenage mothers can all get together to discuss and share experiences promoting openness, identification with one another and also, creating a sense of belonging. These support groups can alternatively be used to empower these mothers through psychoeducation on preventative measures, health related topics and ongoing motivation and encouragement.

b) In addition, some teenage mothers expressed fear of disclosing their problems to parents, teachers or peers and others reported an absence of emotional support. This coupled with the different emotional setbacks experienced point towards the need for

psychological and psychosocial interventions both in schools and in communities. For this reason, the availability and accessibility to psychotherapy and counselling services (especially in remote areas) is recommended to assist teenage mothers address and manage their emotional needs and setbacks.

c) Furthermore, there is a great need for involving teenage fathers in caring for their children and implementation of a flexible learning programme for teenage mothers through means of financial assistance (provision of nappies & formula milk) and government Day Care facilities in schools and/or in communities. Teenage mothers expressed ongoing worry and stress about their children's basic needs, of which most of them can hardly afford. Moreover, some of them lacked reliable persons to care for their children, in most cases those available were old. These worries and financial burdens affects their attention, concentration and performance in school, as a result there is increased failure rates and school dropouts. Adopting ideas similar to the Bostwana "Diphilana project" may assist in reducing the burden and stress experienced by teenage mothers. Furthermore, decreasing the overall rate of school dropouts and improving school performance eliminates gender disparities in the education and employment sectors in Namibia. Success of such intervention programmes is dependent and guaranteed only if teenage mothers are involved throughout the process. All in all, it is recommended that the above suggestions are taken into consideration in order to help teenage mothers cope better with the dual role of being a scholar and a mother at the same time.

d) Although there is vast literature on teenage pregnancy which is acknowledged and appreciated by the researcher, there is some information gaps on teenage motherhood, especially, on their mental health. It is against this reality that it is recommended that more research should be conducted in this area to fill this gap.

6.3 LIMITATIONS OF THE STUDY

The present study had the following limitations:

- a) The study was preliminary limited due to the small sample size and a restricted choice of ethnicity which does not allow for the findings to be diversified and generalised to broader groups/contexts.
- b) The questionnaire used in the study was written in English, a second and non-dominant language to the participants. Consequently, despite the fact that the standardised questionnaire used was pilot tested, there may still have been comprehension challenges which likely caused participants to guess and randomly respond to the questions.
- c) Furthermore, reserved participants likely held back some of their true opinions and conformed to opinions expressed by others (active and dominant participants), hence narrowing the exploratory nature of the study. A possible improvement to the study therefore could have been to additionally conduct individual interviews in order to elicit participant's true expressions and experiences, undoubtedly obtaining greater depth and varying information.
- d) Finally, this study is limited because it only focused on teenage mothers and not mothers in general.

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APPENDICES

APPENDIX 1: ETHICAL CLEARANCE CERTIFICATE



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /342/2017 **Date:** 20 October, 2017

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy And Guidelines. Ethical Approval Is Given In Respect Of Undertakings Contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Mental Health And Coping Strategies Of Teenage Mothers In The Kavango Regions

Researcher: Annastasia N Musese

Student Number: 200918800

Supervisor(s): Dr Poonam Dhaka

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
- (d) The UREC retains the right to:
 - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
 - (ii) Request for an ethical compliance report at any point during the course of the research;

UREC wishes you the best in your research.

Prof. P. Odonkor: UREC Chairperson

A handwritten signature in black ink, appearing to be "P. Odonkor", written over a horizontal line.

Ms. P. Claassen: UREC Secretary

A handwritten signature in black ink, appearing to be "P. Claassen", written over a horizontal line.

APPENDIX 2

RESEARCH PERMISSION LETTERS



REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION, ARTS AND CULTURE

Tel: +264 61 -2933200/2
Fax: +264 61 - 2933922
Enquiries: C. Muchila/ J. /G. Munene
Email: Cavin.Muchila@moe.gov.na/gm12munene@yahoo.co.uk

Luther Street, Govt. Office Park
Private Bag 13186
Windhoek
Namibia

File no: 11/1/1

Ms. Anastasia Nepembe Musese
P O Box 935
Rundu
Cell: 081 625 8537
Email: anmusese@gmail.com

Dear Ms. A. N. Musese

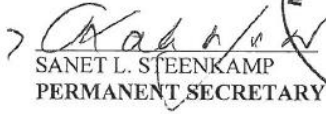
SUBJECT: PERMISSION TO CONDUCT RESEARCH IN KAVANGO REGION

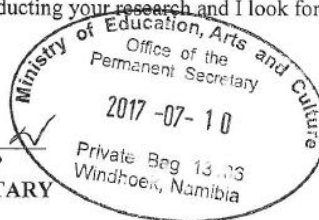
Kindly be informed that permission to conduct research for your Postgraduate Degree in "*Mental Health and coping strategies of teenage mothers*" in Kavango region is herewith granted. You are further requested to present the letter of approval to the Regional Director to ensure that research ethics are adhered to and disruption of curriculum delivery is avoided.

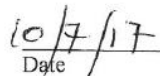
Furthermore, we humbly request you to share your research findings with the ministry. You may contact Mr C. Muchila/ Mr. G. Munene at the Directorate: Programmes and Quality Assurance (PQA) for provision of summary of your research findings.

I wish you the best in conducting your research and I look forward to hearing from you soon.

Sincerely yours


SANET L. STEENKAMP
PERMANENT SECRETARY




Date

All official correspondences must be addressed to the Permanent Secretary



REPUBLIC OF NAMIBIA
KAVANGO EAST REGIONAL COUNCIL

DIRECTORATE OF EDUCATION, ARTS AND CULTURE

Telephone Number : 066 – 258 9000 / 258 9212
Fax Number : 066 – 255 404 / 267 070
Enquiries : **C.S. Shilima**
File No. : 12/3/10

Private Bag 2134
RUNDU
NAMIBIA

Date : 17 July 2017

Ms. Anastasia Nepemba Musese
P.O. Box 935
RUNDU
Cell: 081 625 8537
Email: anmusese@gmail.com

Dear Ms. A.N. Musese

SUBJECT: PERMISSION TO CONDUCT RESEARCH IN KAVANGO EAST REGION

Kindly be informed that approval has been granted to you to conduct research for your Postgraduate Degree in "*Mental Health and coping strategies of teenage mothers*" in Kavango East Region.

The normal teaching and learning activities should **NOT** be disrupted in the process.

Yours sincerely,


F. Kapapero
DIRECTOR: KAVANGO REGIONAL COUNCIL
KAVANGO EAST REGION

17/7/2017
Date



All official correspondence must be addressed to the Chief Regional Officer



**KAVANGO WEST REGIONAL COUNCIL
DIRECTORATE EDUCATION ARTS AND CULTURE**

Private Bag 6193 Nkurenkuru, Namibia Tel. 264 66 264976

Enquiries: **Mr. H. Karapo**

Email: kavangowesteac@yahoo.com

Dear: Ms. A.N. Musese

RE: PERMISSION TO CONDUCT RESEARCH IN KAVANGO WEST REGION

1. Your letter dated 20 July 2017 bear reference.
2. The Directorate of Education, Arts and Culture, hereby grant permission to Ms. A.N Musese to conduct Research in identified schools in Kavango west.
3. The principals are urged to accord her their usual support and corporation in this regard.

Yours Sincerely,



Teopolina N.L. Hamutumua

Director of Education, Arts and Culture

Kavango west Region

<p>KAVANGO WEST REGIONAL COUNCIL Office of the Director Directorate of Education, Arts & Culture</p> <p style="text-align: center;">2017 -07- 26</p> <p>Tel: 066-256090 - Private Bag 6193 Nkurenkuru Email: kavangowesteac@yahoo.com</p>
--

26/07/2017

Date

APPENDIX 3

INFORMATION LEAFLET, ASSENT AND CONSENT FORMS

Dear **participant**,

My name isa University of Namibia Masters of Arts Clinical Psychology student. I am currently doing a research on the mental health and coping strategies of teenage mothers in the Kavango regions. I would like to invite you to take part in a research study.

Please take some time to read the information presented here, which will explain the details of this research study. Please ask me any questions about any part of this research study information that you do not fully understand and may need clarity on. It is very important that you are fully satisfied, that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

What is this research study all about?

- a) *Where will the study be conducted; are there other sites; total number of participants to be recruited at your site and altogether.*

This research study will be conducted only in the Kavango West and Kavango East regions. A sample of sixty participants will be drawn from the Kavango regions, 30 participants from the Kavango East region and the remaining 30 from the Kavango West region. The sample will consist of school going teenage mothers within the age range 14 to 19 years. In addition the researcher will have two focus groups with six participants selected in each region, summing up to 12 participants in both regions.

b) Research aims

This research study aims to understand the different experiences of teenage mothers. To investigate their challenges and also how they cope with these challenges as teenage mothers. In addition, through expression the study aims to identify and explore resilient factors, the negative feelings/emotions of teenage mothers and assess the severity of these feeling/emotions on teenage mothers' mental health. Moreover, assess the impact these feelings/emotions have on the life of a teenage mother.

c) Procedures.

Permission to conduct this research study was sought from the following: the Permanent Secretary of the Ministry of Education, Arts and Culture, from the Kavango West and East Regional Director and from the selected schools principals. Permission for children below the age of 18 whom are minors to participate in this research study is sought from parents and assent is sought from prospect participants. Once actual data collection have begun, during the different forms of assessments involved, participants are given freewill to withdraw from the study at any time.

Why have you been invited to participate?

a) Explain this question clearly.

You have been selected to participate in this study because you meet the targeted population of this study. You are a teenage mother aged 14-19 and you are currently schooling.

What will your responsibilities be?

As a participants your responsibilities are as follow:

- To Read the consent form and ask the principal researcher (person in charge of the study) any questions you may have.
- To understand what will happen to you during the study before you agree to participate.
- To know the dates when your study participation starts and ends.
- To careful weigh the possible benefits (if any) and the risk of being in the study.
- To contact the principal researcher and/or the University of Namibia Ethics Board with complaints and concerns about your participation in the study.
- To report immediately to the principal researcher any/all problems you may have with the study/procedure/assessment.
- To ask for the results of the study, if you want them.
- To keep a copy of the consent form for your records.

a) *Duration of your participation*

Participation in this study will involve three procedures. Firstly, there will be a briefing session concerning the nature of the study; participants will be provided with information regarding the pros and cons of participating in the study. Freewill will be given to either take part or otherwise withdraw from the study any time during the research. In addition, assent will be obtained from participants and informed consent will be obtained from parents in the native language will also be obtained. The first session is expected to run for fourty five minutes to an hour. Secondly, the Depression

Anxiety Stress Scale (DASS) will be administered and this is expected to be completed in 45 minutes. Lastly, the focus group discussion is expected to run from an hour to two hours and a half. The expected duration of participants in the study is estimated at approximately four hours.

Will you benefit from taking part in this research?

There is no direct benefit for your child in this study. Information from this research study will be available to you and no information about your child will be given to anyone. Confidentiality will be maintained throughout the research process and afterwards. Additionally, information from this study may help other teenage mothers nationwide.

Are there any risks involved in your taking part in this research?

None of the assessments that will be used are harmful and dangerous, for this reason it can be assured to you as a parent that your child will not suffer any physical pain. However, if your child experiences emotional distress or discomfort, counselling will be offered by the principal researcher who is a registered psychological counsellor.

If you do not agree to take part, what alternatives do you have?

Participant should feel free to communicate to the researcher that he/she does not wish to take part in the study. This decision will be respected by the researcher at any time during the research study with no penalty or any sort of punishment.

Who will have access to your medical records?

To maintain privacy and confidentiality, all the information gathered during the research will be strictly used only for the purpose of the study. A digital voice recorder will be used with assent from participants. All collected data will be archived for a

period of three years before discarding them through shredding. To maintain anonymity, pseudonyms will be used for the selected schools. Furthermore, to conceal participant's identities, codes made up of first letter of participants names, surnames and date of birth will be used.

What will happen in the unlikely event if some form injury occurring as a direct result of your taking part in this research study?

The risks of taking part in the study are very low. However, the University of Namibia (UNAM) undertakes that in the event of your child suffering emotional distress from any unexpected sensitivity that is caused by participation in the study, counselling/therapy will be provided.

Will you be paid to take part in this study and are there any costs involved?

Participants will not be paid to take part in this study and the data collection process will be take place in the afternoon, after school during study time. However, transport fare will be provided to the parents of prospect research participants to come to the school for the information session and parental consent.

If there is anything else that you should know or do?

If you have any questions or concerns about this study or if any problem arise, please contact Annastasia Nepemba Musese at cell: +264 816258537/ email: anmusese@gmail.com.

Additionally, you can contact the Health Research Ethics Committee at **+264 61 2063061**.

NB: You will receive a copy of this information and consent form for your own records.

Declaration by participant (ASSENT)

By signing below, I agree to take part in a research study entitled Mental Health and coping strategies of teenage mothers in the Kavango regions.

I declare that:

- a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- b) I have had a chance to ask questions and all my questions have been adequately answered.
- c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- d) I realize that the study is of a psychological nature
- e) I agree to take a psychometric assessment; the Depression Anxiety Stress Scale (DASS)
- f) I agree that I may be referred to other services if I need extra help.
- g) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- h) I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*)2017.

.....
Signature of participant

.....
Signature of parent/guardian

Declaration by researcher

I *Annastasia Nepemba Musese* declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use an interpreter.

Signed at (place).....

on (date).....

.....
Signature of researcher

.....
Signature of witness

Declaration by interpreter

I (*name*) declare that:

- a) I investigator (*name*)explained the information in this document to (*name of participant*) using the language medium of (English and/or Rukwangali)

Signed at (place)..... on (date).....

.....

.....

Signature of interpreter

Signature of witness

CONSENT FORM FOR PARENTS/GUARDIAN

Dear parent/guardian

Your child is invited to take part in a research project and we would like to ask for your consent. Please take some time to read the information presented here which will explain the details of the project. Please ask me any questions about any part of this research study information that you do not fully understand and may need clarity on. It is very important that you are fully satisfied, that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

DECLARATION BY PARENT/GUARDIAN

By signing below, I agree to take part in a research study entitled Mental Health and coping strategies of teenage mothers in the Kavango regions.

I declare that:

- i) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- j) I have had a chance to ask questions and all my questions have been adequately answered.
- k) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- l) I realize that the study is of a psychological nature
- m) I agree to take a psychometric assessment; the Depression Anxiety Stress Scale (DASS)
- n) I agree that I may be referred to other services if I need extra help.
- o) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- p) I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*)
2017.

.....

Signature of parent/guardian

Relation to child

.....

Signature of witness

NON-DISCLOSURE FORM

I, (transcriber's name), hereby declare that I shall maintain the confidentiality of the data collected from or about the research participants through the transcription process. I shall maintain security procedures for the protection of privacy and will not disclose any information regarding the participants of the study or the study itself.

.....

Signature of transcriber

.....

Date

PERMISSION LETTER TO CONDUCT RESEARCH

Cover letter to the Permanent Secretary of the Ministry of Education, Arts and Culture to sought permission to conduct research and collect data from school learners (teenage mothers) the schools.

Ms. Sanet Steenkamp

The Permanent Secretary

Ministry of Education, Arts and Culture

Private Bag 13236

WINDHOEK

Dear Madam,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I'm writing this letter to officially seek permission from your esteemed office to conduct academic research at six combined and secondary schools in the two Kavango Regions that are yet to be identified.

I am a Masters of Arts: Clinical Psychology student in the department of Human Sciences, Psychology section at the University of Namibia (UNAM) under the supervision of Dr. Poonam Dhaka (Senior Lecturer).

The proposed and approved topic of my research is: Mental Health and Coping strategies of teenage mothers in the Kavango regions.

The objectives of the study are:

1. To assess the mental health of teenage mothers in the Kavango regions in relation to depression, anxiety and stress.
2. To investigate the challenges and coping strategies of teenage mothers.

The information obtained will be treated confidential, the estimated duration of data collection is 14 working days. I have attached to this letter, a copy of my approved proposal, an ethical clearance certificate issued by the UNAM and a copy of the research instrument I intend on using in my research.

My supervisor and my contacts are in the table below, to provide further information.

My supervisor	Myself
Dr. Pooman Dhaka	Ms. Annastasia Nepemba Musese
pdhaka@unam.na	anmusese@gmail.com
+264 61 206 3800	+264 81 625 8537

Upon completion of the study, I undertake to provide your esteemed office with a bound copy of the dissertation.

Madam, accept for your highest consideration,

Yours Sincerely,

Annastasia Nepemba Musese

APPENDIX 4

DATA COLLECTION INSTRUMENTS

1. DMOGRAPHIC QUESTIONNAIRE

Date of interview: Duration: to

Participant number/code:

1. Demographic profile of participant

1.1 Name..... 1.2 Date of birth.....

1.3 Age 1.4 Place of birth

1.5 Nationality..... 1.6 Name of the school

1.7 Grade..... 1.8 Place of residence

1.9. Home language..... 2.0 Number of children.....

2. RESEARCHER'S INTERVIEW GUIDE

My name is Annastasia N Musese, a Masters of Arts in Clinical Psychology student at the University of Namibia (UNAM). I have come to meet with you today because I am doing a research on the mental health and coping strategies of teenage mothers in the Kavango regions. Have all of you gone through the first phase of filling in the questionnaire. Do you all agree to be part of the discussion we are about to have. Remember, feel free to terminate your participation in this research if you feel you can no longer continue. In addition, if you feel distress (emotional pain) during or after the group interview, I will be available to offer counselling.

This discussion is a follow up to the questionnaire you have all filled in. I would like to encourage you to please feel free to share your experiences in the group. Everything that is going to be discussed today should remain here and it will be kept confidential. Meaning, all the information gathered during the research will be strictly used only for the purpose of the study and your identities will be concealed using codes, your real names will not be used.

I would like us to start by briefly introducing ourselves, tell the group your name, age, how many children (babies) you have, their ages and the sex of the baby. Thank you all for sharing.

1. **How is life as a teenage mother?** Probe to obtain their experiences.

2. **What does it feel like to be teenage mothers?**

- Identify emotions/ feelings and reflect them.

Assessing for symptoms of depression

- How often is your mood low?
- What are your goals and dreams in life?
- What is your normal day like?

Example, activities you do, your eating and sleeping habits.

- What are your hobbies? Things you like to do and enjoy doing in your free time.
- Do you prefer to stay at home and do nothing rather than going out and doing things?

If yes, how often?

Assessing for symptoms of anxiety

- How often do you feel sad?
- How often do you feel guilty?
- How often do you find yourself worrying too much just about anything? Example, worrying about finances, your baby or school.
- Does worrying affect your school work or perhaps your role as a mother?

Assessing for symptoms stress

- How often do you feel stressed (overwhelmed) with your role as young mother? Tell me more?

3. **What are some of the struggles (challenges) that you face as teenage mothers?**
4. **How do you as teenage mothers cope with difficulties of raising a child?**
5. **As teenage mothers how often do you get bullied or teased by others (members of society, family, friends, and teachers)?**
6. **How are you coping with school as teenage mothers?**
7. **How has your attendance at school been affected as teenage mothers?**
8. **How has teenage motherhood affected your relationship with your parents, family members, friends and the father of the baby?**
9. **Who is your source of support?** Financially or emotionally (someone you are able to openly talk to and express your feelings to).
10. **How are they supporting you?**
11. **What social activities are you actively involved in?**

- Are these activities similar to the activities you were involved in before you became teenage mothers?

12. Is there anything you wish to be in place to assist teenage mothers in Namibia?

- Example, counselling services in schools or communities, financial assistance, day care facilities or clubs for teenage mothers.

13. Any additional comments or is there perhaps anything you would us to talk about that we left out?

3. DEPRESSION ANXIETY STRESS SCALES (DASS)

The DASS is a 42-item self-report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress.

DASS	<i>Name:</i>	<i>Date:</i>
<p>Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all 1 Applied to me to some extent, or some of the time 2 Applied to me to a great amount of extent, or a good part of time 3 Applied to me very much, or most of the time</p>		
1 I found myself getting upset over small/little things	0	1 2 3
2 I was aware of dryness of my mouth	0	1 2 3
3 I couldn't seem to experience any positive feeling at all	0	1 2 3
4 I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness when not involved in any physical activity)	0	1 2 3
5 I just couldn't motivate myself to do anything	0	1 2 3
6 I tended to over-react to situations	0	1 2 3
7 I had a feeling of shakiness (e.g., legs going to give way)	0	1 2 3
8 I found it difficult to relax	0	1 2 3

9	I found myself in situations that made me so nervous I felt relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of fainting	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was moody, had a bad-temper	0	1	2	3
19	I sweat so much (e.g., sweaty hands) even when it is not hot and I am not involved in any physical activity	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Reminder of rating scale:

0 Did not apply to me at all

1 Applied to me to some extent, or some of the time

2 Applied to me to a great amount of extent, or a good part of time

3 Applied to me very much, or most of the time

22	I found it difficult to relax or calm down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of what was happening to my heart (e.g., heart rate increase, missing a heartbeat) when I was not doing anything physical requiring force/effort	0	1	2	3
26	I felt sad and my mood was low	0	1	2	3
27	I found that I was easily irritated/annoyed	0	1	2	3
28	I felt I was close to losing my breath (heart skipping) due to a sudden feeling of nervousness/fear	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would get frightened by some small but unfamiliar task	0	1	2	3
31	I was unable to get excited about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3

34	I felt I was pretty worthless	0	1	2	3
35	I couldn't stand anything that prevented/stopped me from completing my tasks/activities	0	1	2	3
36	I felt frightened/scared	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting nervous/stressed	0	1	2	3
40	I was worried about situations in which I might panic (experience loss of breath/heart skipping) and make a fool of myself	0	1	2	3
41	I experienced shakiness (e.g., in the hands)	0	1	2	3
42	I found it difficult to get myself to start doing something	0	1	2	3

4. DEPRESSION ANXIETY AND STRESS SCALE (CHANGES)

DASS (item) Original

DASS (item) Changes

changes to the rating Scale	
1. Applied to me to some degree, or some of the time	1. Applied to me to some extent, or some of the time
2. Applied to me to a considerable degree, or a good part of time	2. Applied to me to a great amount of extent, or a good part of time
Changes to the scale statements	
1. I found myself getting upset by quite trivial thing	1. I found myself getting upset over small/little things
4. I experienced breathing difficulty (e.g., excessively rapid breathing,	4. I experienced breathing difficulty (e.g., excessively rapid breathing,

Breathlessness in the absence of physical exertion)	breathlessness when not involved in any physical activity)
5. I just couldn't seem to get going	5. I just couldn't motivate myself to do anything
9. I found myself in situations that make me so anxious I was most relieved when they ended	9. I found myself in situations that made me so nervous I felt relieved when they ended
15. I had a feeling of faintness	15. I had a feeling of fainting
18. I felt that I was rather touchy	18. I felt that I was moody, had a bad-temper
19. I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion	19. I sweat so much (e.g., sweaty hands) even when it is not hot and I am not doing any physical activity
22. I found it hard to wind down	22. I found it difficult to relax or calm down
25. I was aware of the actions of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	25. I was aware of what was happening to my heart (e.g., heart rate increase, missing a heartbeat) when I was not involved in doing anything physical
26. I felt down-hearted and blue	26. I felt sad and my mood was low
27. I found that I was very irritable	27. I found that I was easily annoyed
28. I felt I was close to panic	28. I felt I was close to losing my breath (heart skipping) due to a sudden feeling of nervousness/fear

30. I feared that I would be “thrown” by some trivial but unfamiliar task	30. I feared that I would get frightened by some small but unfamiliar task
31. I was unable to become enthusiastic about anything	31. I was unable to get excited about anything
35. I was intolerant of anything that kept me from getting on with what I was doing	35. I couldn’t stand anything that prevented/stopped me from completing my tasks/activities
36. I felt terrified	36. I felt frightened/scared
39. I found myself getting agitated?	39. I found myself getting nervous/stressed
40. I was worried about situations in which I might panic and make a fool of myself	40. I was worried about situations in which I might panic (experience loss of breath/heart skipping) and make a fool of myself
41. I experienced trembling (e.g., in the hands)	41. I experienced shakiness (e.g., in the hands)
42. I found it difficult to work up the initiative to do things	42. I found it difficult to get myself to start doing something

APPENDIX 5

LETTER FROM THE EDITOR



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erfect

roofreading, copyediting, rapporteuring & academic
consulting services



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23 October 2017

TO WHOM IT MAY CONCERN

**REF: COPYEDITING AND PROOFREADING OF ANNASTASIA N MUSESE'S MINI THESIS
FOR THE MASTERS OF ARTS (CLINICAL PSYCHOLOGY) DEGREE**

This letter serves to confirm that I copyedited and proofread ANNASTASIA N. MUSESE's Mini Thesis for the Masters of Arts (Clinical Psychology) Degree titled: **(MENTAL HEALTH AND COPING STRATEGIES OF TEENAGE MOTHERS IN THE KAVANGO REGIONS)**.

I declare that I professionally copyedited and proofread the Mini thesis and removed mistakes and errors in spelling, grammar and punctuation. In some cases, I improved sentence construction without changing the content provided by the student. I also removed some typographical errors from the thesis. I also declare that I am a professional copyeditor & proofreader and that I have edited many Masters and Doctoral theses here in Namibia, Botswana, Zimbabwe and South Africa.

It was a pleasure proofreading and copyediting your student's Mini Thesis.

Please contact me should you need some clarification.

Yours Sincerely,

Archford Musodza (LLB)(Ph.D.).

Academic Writing Consultant
Copyeditor & Proofreader
Blackford Centre (U.K.)