PSYCHOLOGICAL IMPACT OF TEENAGE PREGNANCY ON PREGNANT TEENAGERS

by

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DECLARATION

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

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DEDICATION

Dedicated to my family:

From you I derive my inspiration.

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The participants who were willing to share their experiences with me. This study would not have been possible without them.

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My mother who continues to give me strength.

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Thank you!!!

ABSTRACT

The aim of the present study was to investigate the impact of teenage pregnancy on pregnant teenagers. Specifically, the study sought to determine whether or not pregnant teenagers experience psychological distress during pregnancy, and to explore the nature of such distress. Fifty two (52) pregnant teenagers were conveniently sampled to participate in the study. Their ages ranged from 15 to 20 years, with the gestation period ranging from 4 to 9 months. The sample included pregnant teenagers from high schools and tertiary institutions in the Capricorn District (Limpopo Province). Data was collected using triangulation of methods, namely quantitative and qualitative methods. For the quantitative data, a 28-item General Health Questionnaire (GHQ-28) which measures such factors as somatic complaints, anxiety and insomnia, social isolation, and depression was used. For qualitative data, three focus group interviews were conducted with the participants. The results suggested indications of psychological distress during the gestation period. These included experiences of symptoms associated with somatic complaints, anxiety and insomnia, social isolation and severe depression. Furthermore, the study showed themes of distress wherein teenagers react to the realisation of pregnancy with fear and disbelief, and thoughts of termination of pregnancy. Participants gave reports that pregnancy was seen as a shameful event for the teenagers involved. Coping strategies noted included teenagers' resort to avoidance of situations which were perceived to be stressful, and also associating with people they perceived as being more supportive. Based on the findings, the following recommendations were made:

a) Intervention programmes should be put in place so as to help minimise the psychological and social problems experienced by pregnant teenagers, for example, crisis management skills could be offered to help deal with the trauma experienced;
b) Social support structures should be made available to pregnant teenagers; and,
c) Cultural practices should be incorporated in education syllabi that focus on human sexuality and reproduction.

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CHAPTER ONE

GENERAL ORIENTATION OF THE STUDY

1.1. INTRODUCTION

Teenage motherhood is presented in the literature as a problem both internationally and nationally. For example, a review done by Adams, Adams-Taylor and Pittman (1989) on adolescent pregnancy and parenthood in the United States of America showed that this experience is a problem to the society. Whilst the review found teenage motherhood to have been a problem in society for many years, these authors found that this phenomenon was more disruptive in contemporary society than in the past. They attributed the disruptive tendency to the fact that with time changing, teenage pregnancy and motherhood result in few jobs, many academic years lost and teenagers failing to be productive workers in adulthood. Adams et al (1989) indicated that it was not the behaviour that was problematic, but the timing and the implication that teenage pregnancy had on the teenager's future.

In the past few years, several media reports indicated that teenage pregnancy was on the rise in many provinces in South Africa. For example, a survey conducted in 12 schools in KwaZulu-Natal showed that 727 schoolgirls fell pregnant in 2005 compared to 632 in 2004 in the same schools (Govender, 2006). In another newspaper article, it was reported that over 72 000 schoolgirls in South African public schools did not go to school in the year 2005 because they were pregnant (Sosibo, 2007). The same newspaper article further indicated that there were 5 868 incidents of teenage pregnancy that were reported in 2 320 schools in KwaZulu-Natal. Other provinces that were reported to have higher incidents of teenage pregnancy included Limpopo, Gauteng and Free State.

Whilst teenage pregnancy has been presented as a serious challenge facing education authorities in South Africa, the South African Demographic and Health Survey (1998), also indicated that teenage pregnancy was one of the major problems in South Africa. The survey showed that thirty five percent of all nineteen

year-old women who were part of the sample already had children when the study was conducted. Though the survey indicated considerable variation in teenage fertility by region, education and population group, rural teenagers were generally found to start childbearing at an earlier age when compared to urban teenagers. Also interesting in this survey, Limpopo Province was found to have the highest number of teenage pregnancies when compared to all the other eight provinces in the country. Though a follow-up survey conducted in 2003 by the South African Demographic and Health Survey (2004) showed a decline in terms of teenage pregnancies in the country when compared to the findings of the 1998 survey, a concern was still raised about this phenomenon.

1.2. STATEMENT OF THE PROBLEM

There is a growing body of international and national literature which indicates that there are many problems associated with childbearing during the teen years. For example, a study by Bissell (2000) found that women, who become teenage mothers, when compared to those who delay childbearing past the teen years, are more likely to be socio-economically disadvantaged. Similar findings have been reported by other studies (Lehana & Rhyn, 2003; Olausson, Cnattingius, Haglund & Weitoft, 2001). Several other studies have found that women who fall pregnant during the teen years stand the risk of developing some physical problems (Quinlivan, Tan, Steele & Black, 2004; Ehlers, 2003). For example, Trivedi (2000) found that teenagers were more likely to experience obstetric difficulties when compared to adult mothers. The same findings were also reported by Kekesi (1997) who further pointed out that teenage mothers stand the risk of delivering premature babies or giving birth to children with respiratory distress.

Apart from the socioeconomic and medical problems presented, teenage pregnancy has also been found to cause psychological disturbance for some teenagers. For example, Clemmens (2002) reported that teenagers who have normal delivery later report and present with depressive symptoms. Similar findings were earlier reported by Deal and Holt (1998) who used the Centre for Epidemiological Studies

Depression Scale (CES-D) to learn about depressive symptoms among teenage mothers. In another study that examined the levels of depression, self esteem, loneliness and social support and the relationship between these variables among adolescent mothers, Hudson, Elek & Campbell-Grossman (2000) found that depression scores were in the higher ranges (CES-DC > 15) for 53% of the participants. Whilst the study by Hudson et al (2000) and other previous investigations have indicated that teenagers who have delivered babies are likely to have depressive symptoms and other psychological problems, less information is available on the psychological impact of teenage pregnancy on teenagers at the time of pregnancy.

1.3. RESEARCH QUESTIONS

(a) What are the psychological conditions associated with teenage pregnancy?
(b) What are the reactions of teenagers when they discover that they are pregnant?
(c) What happens to relationships during teenage pregnancy?
(d) How do pregnant teenagers cope with pregnancy?

1.4. AIM OF THE STUDY

The aim of the present study was to investigate the psychological impact of teenage pregnancy on pregnant teenagers.

1.5. OBJECTIVES OF THE STUDY

(a) To find out how teenagers experience pregnancy;
(b) To determine the kind of reactions that teenagers experience when they realise that they are pregnant;
(c) To find out the nature of psychological impact that teenage pregnancy has on the teenagers; and,

(d) To find out about coping strategies that teenagers utilise.

1.6. HYPOTHESES

The following hypotheses were focused on:

(a) Pregnant teenagers are likely to report symptoms of somatic nature.

(b) Pregnant teenagers are likely to experience psychological distress in the form of anxiety, insomnia, social isolation and depressive symptoms and these differ according to demographics (age, level of education and gestation period).

1.7. SIGNIFICANCE OF THE STUDY

A study of this nature could:

(a) Provide useful information about the psychological well being of pregnant teenagers;

(b) Also assist mental health professionals in developing appropriate psycho-educational programmes to address the psychosocial challenges associated with teenage pregnancy and motherhood; and,

(c) Furthermore, help to inform public debate that could lead to the development of appropriate policies on how to deal with the challenge of teenage pregnancy and motherhood.

1.8. OPERATIONAL DEFINITIONS

(a) Pregnant teenager

Pregnant girl aged 13 to 20 years.

(b) Psychological distress

In this study, psychological distress refers to the presence of symptoms related to somatic complaints, anxiety and insomnia, social isolation, and depression.

1.9. SCOPE OF THE STUDY

The current study focused on pregnant teenagers who were drawn from Mankweng Township in the Capricorn District municipality (Limpopo province).

1.10. CHAPTER OUTLAY

Chapter one provides a brief overview of the study and its objectives. Chapter two is a review of the literature. In the first part of Chapter two, literature related to teenage pregnancy is discussed. The last part of the chapter focuses on theoretical perspectives that can be advanced to explain the phenomenon of teenage pregnancy. In Chapter three, the research methodology that has been used in this study is discussed. The results of the study are presented in Chapter four. In Chapter five, the results of the study are discussed in relation to previous studies and existing theories. The last part of Chapter five discusses the limitations of the study and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

Several studies that investigated the issues of teenage pregnancy and teenage motherhood suggested that these phenomena present developmental challenges that could have some negative physiological, psychological and social effects on the developing teenager (Mba, 2003; De Jong, 2001; Parekh & De la Rey, 1997). A review of South African literature focusing on the causes and consequences of teenage motherhood found that teenage pregnancy has a disrupting effect on the teenager's education and life in general (Macleod, 1999a & 1999b). The aim of this chapter is to review the literature that focuses on teenage pregnancy. In the first part of the chapter, the focus will be on the prevalence rate and reactions by teenagers when realizing that they have fallen pregnant. The second part will look at physical, social and mental health issues related to teenage pregnancy. The last section of the chapter will focus on the theoretical perspectives in understanding teenage pregnancy.

2.2. PREVALENCE OF TEENAGE PREGNANCY

Literature shows that 13 million children are born to women under the age of 20 worldwide. It is further indicated that more than 90% of these births occur to women living in developing countries (wikipedia, the free encyclopedia (n.d). In South Africa, media reports indicate that in 2006 over 72 000 girls aged between 13 and 19 years did not go to school because they were pregnant (Sosibo, 2007). A Human Sciences Research Council (HSRC) study showed that even though total fertility rates in South Africa have been declining over the past few decades, teenage fertility has, in contrast, increased in all race groups except in the case of Indians (Makiwane & Udjo, 2006). One suggestion here is that overall fertility has been accompanied by a shift in childbearing towards younger women. The high rate of teenage fertility increases the risk of sexually transmitted infections including

HIV/AIDS. For example, the 2007 National HIV and Syphilis prevalence survey conducted by the National Department of Health indicated that 12.9% of young woman attending antenatal clinics were HIV positive. This suggests that teenage girls are likely to have reproductive health problems including HIV infections.

2.3. REACTION TO PREGNANCY

Teenage pregnancy is mostly unplanned; and as a result, people react to the experience differently. The teenager has to come to terms with the unexpected demands of being an adult, and in some cases, she may also have to deal with disapproval and dissatisfaction shown by significant others like parents and relatives. In several studies, teenage mothers reported having felt sad, disappointed, shocked and depressed after their pregnancies were confirmed (De Visser and Le Roux, 1996; Mpetshwa, 2000; De Jong, 2001; Clemmens, 2002). A study conducted by Parekh and De la Rey (1997) found that most teenagers started by denying the pregnancy at first, before they could inform their parents who, in most cases received the news with anger and disappointment.

The following quote from a study by Kaplan (1996) shows some of the typical reactions of parents of teenage mothers:

> She asked me whether I was going to keep it [baby] and who's the father and where were I going to stay. I told her, yeah, I'm going to stay. And she said, how do you know that I want you here? I've already raised my kids. (p.100).

In a study that was conducted at Ga-Rankuwa Hospital, Kekesi (1997) focused on the social and educational background of 70 teenage mothers who had delivered their babies at the hospital between April and September 1995. Data was collected using structured interviews. The study found that even though most of the participants managed to talk to somebody, some were scared to tell others until their families realised that they were pregnant. An investigation done by Mpetshwa (2000) focusing on seven teenage mothers, found that community members tend to have a wide range of negative reactions towards pregnant teenagers. Some members of the

community tended to react with shock whilst others would gossip about the parents of the teenagers. In some churches the members who fell pregnant would even be refused an opportunity to participate in congregational activities. Some of the participants in Mpetshwa's (2000) study reported having experienced a lot of ill treatment from their family members, especially their parents who felt betrayed by their children falling pregnant.

It is evident from the above studies that confirmation of pregnancy in the case of a teenager triggers different negative reactions by the teenagers and their significant others. In most cases the teenager concerned and her family find it difficult to accept the pregnancy. It is these negative responses to the pregnancy that could lead to some health problems being experienced by the teenager.

2.4. CAUSES OF TEENAGE PREGNANCY

A study by Ehlers (2003) found that the majority of teenagers who end up becoming mothers lacked information about contraceptives and emergency contraceptives. Drawing from the results of South African research (both published and unpublished), Macleod (1999b) found reproductive ignorance to be one of the causal factors of teenage pregnancy. She also reported that female adolescents who were poor students with low educational aspirations were more likely to become teenage mothers than were their high-achieving peers (Macleod, 1999b). Maynard (1997) went further to suggest that one third of young women drop out of school before becoming pregnant. Furthermore, early initiation of sexual activity has been reported to be related to teenage pregnancy (Trembly and Frigon, 2004; Coley and Chase-Lansdale, 1998). According to Mba (2003), the youth in sub-Saharan Africa are initiated into sexual activity as early as age 12 (girls) and 13 (boys); and the early initiation into sexual activity was seen to be directly correlated with reproductive health problems including HIV infections and other sexually transmitted diseases.

Life experiences associated with poverty, alienation at school, prevalent cases of unmarried parenthood and unemployment, and lack of educational opportunities and

stable career prospects were reported to lower the perceived costs of early motherhood, resulting in more teenage pregnancies. It has also been reported that girls living in poor socioeconomic condition with an early onset of menarche, will engage early in sexual behaviour (Coley and Chase-Lansdale, 1998). Based on this finding, it can be argued that socioeconomic factors may play a role in influencing teenagers to engage in early sexual behaviour, thus increasing their chances of falling pregnant.

Whilst socioeconomic factors could be seen to encourage adolescent child bearing, a study done by the HSRC in South Africa found no association between teenage pregnancy and Child Support Grant (Makiwane & Udjo, 2006). In this particular study, the authors found that the upsurge of teenage fertility predated the introduction of Child Support Grant. Consequently, the study was concluded by suggesting that Child Support Grant is not an incentive to get teenagers pregnant.

2.5. CONSEQUENCES OF TEENAGE PREGNANCY

Several studies have suggested that teenage motherhood could lead to both physical and mental health risks for the adolescent. What follows is a review of some of these studies.

2.5.1. Obstetric outcomes

The body of a woman has to naturally develop to such an extent that it can comfortably accommodate a developing baby. An underdeveloped body would obviously pose some problems for both the woman and the baby she carries. A teenager would be considered physically underdeveloped to comfortably accommodate a baby. Such underdevelopment is reported to pose a greater health risk to the individual concerned (Mogotlane, 1993). On the SABC 2 House Call programme, Dr Malebane (a gynaecologist) gave a report on the medical complications that could be associated with teenage pregnancy. These included pre-eclampsia, premature births and low birth weight rates (Ramathesele, 2007). In a

study that focused on live births in Mitchell's Plain (Cape Town) during the first 8 months of 1985, Rip, Keen and Woods (1986) found that 11, 9% of infants were born before the expected date. They also found that teenagers delivered a high proportion of low birth neonates, and the average birth weight of the children was very low.

A study conducted by Trivedi (2000) sought to compare the different obstetric parameters of teenage women and adult women in New Zealand. The results indicated that the average birth weight for the two groups had a 100g difference, with the teenage mothers' babies in the lower end whilst adult women's babies weighed at the upper end. Seven in the teenage mothers group had neonatal birth defects when compared to the adult women group who only had one birth defect. The teenage mothers group had fifteen breech deliveries of which eleven were delivered by caesarean section. The adult women group had seven breech deliveries, of which three were delivered by caesarean section. The most common cause for caesarean section in teenage mothers was obstructed labour/poor progress in labour. With regard to pre-eclampsia / gestational hypertension, 26 teenage mothers were found to have the condition when compared to 16 women from the adult group. Based on the findings of this study, it does appear that teenage pregnancy does pose considerable obstetric health problems to the teenager herself and the child.

2.5.2. Socioeconomic difficulties

Socioeconomic difficulties were reported to be experienced by teenagers who become pregnant during their teenage years (De Jong, 2001; Hanna, 2001). For example, literature review done by Bissel (2000) found that women who become teenage mothers were more likely to be socio-economically disadvantaged later in life when compared to women who tend to delay childbearing. The socio-economic disadvantages relating to teenage motherhood have also been widely reported in the developing countries (Mahomed, Ismael and Masona, 1989; Barnette, 1998). A report by Turner (2004) gives a suggestion that teenage pregnancy perpetuates poor socioeconomic background. Her study found that pregnant teenagers from deprived socioeconomic background tended to keep their pregnancies, and their counterparts

from relatively affluent background usually abort their pregnancies. A study conducted by Barnette (1998) reported that one fourth of Brazilian teenagers were mothers. This situation was found to have serious social and health problems as teenagers and their children were likely to be at a high risk for sickness and death.

Olauson et al (2001) found that when teenage mothers were compared with mothers who gave birth at ages 20 – 24, the former had significantly increased dependency on disability pension and welfare grants. Hobcraft and Kiernan (2001) suggested that teenage mothers were more likely to be having no educational qualifications at age 33. This results in the teenagers being in social housing and being recipients of state social grants. If they are employed, they are more likely to work at low-income jobs. Furthermore, these women who became teenage mothers were more likely to experience longer periods of unemployment, single parenthood and higher levels of poverty (Bissel, 2000; Hobcraft and Kiernan, 2001). Thomas and Rickel (2006) reported that pregnant teenagers experience significantly more maladjustment than their non-pregnant counterparts, and were also found to be less likely to manipulate the environment in a positive manner. The implication here is that pregnant teenagers tend to have their identity development interfered with as they find themselves grappling with developmental issues that are not appropriate for their age.

2.5.3. Education disruption

In the majority of cases, teenage mothers are not in a position to go back to school after delivery as they are forced to look after their children. In some cases, these young mothers' physical health conditions do not make it conducive for them to go back to school. Whilst some young women may be prevented from going back to school as a result of these factors, De Jong (2001) found that there are some cases of teenagers who may use their pregnant status to deliberately escape the demands of high school education. A study by Kekesi (1997) identified a number of reasons to explain why teenage mothers dropped out of school. Some were reported to have dropped out because they had to look after their children whilst others discontinued

with their studies due to some financial difficulties. Still, others were reported to have dropped out because their parents refused to pay the school fees. The issue of financial problems being a reason for teenage mothers dropping out of school was also raised by Mpetshwa (2000).

2.5.4. Teenage motherhood and social relationships

A number of studies have indicated that becoming a mother during adolescence interferes with the manner in which the teenager in question relates to other people. A study by De Visser and Le Roux (1996) found that many teenage mothers felt that their pregnancy upset their parents. Other studies also found that fathers tended to be angered by their daughters' pregnancies. In some cases, this anger would even lead to the fathers threatening to chase their teenage daughters out of the house (Parekh and De la Rey, 1997). In a study by Kaplan (1996), some teenage mothers indicated that mothers were resentful toward them. Some of the teenage mothers even contemplated moving out of the house as a way to resolve the problems that they had with mothers.

Apart from the problematic relationships that teenage mothers develop with significant others, there are also indications to suggest that adolescent motherhood may lead to clashes between the teenager's parents as they try to come to terms with the situation. For example, in the study conducted by Parekh and De la Rey (1997), one of the participants indicated that her father blamed her mother for the pregnancy, whilst her uncles "blamed [her] mother and told her that she was not strict with [the teenager]" (p. 226). The tendency to blame mothers for the behaviour of their teenage daughters seems to perpetuate the patriarchal notions that are prevalent in most African societies.

Relationships with partners were also referred to as being negative as a result of pregnancy. Less than half of teenage mothers in De Visser and Le Roux's (1996) study indicated to be still having some relationship with the fathers of their children.

Mpetshwa (2000) indicated that relationships with partners did not really materialise even though in some families partners assisted in supporting the children.

A South African study conducted by Ritcher and Mlambo (2005) with teenagers found that these young people were not happy about their pregnancies. Most participants in Ritcher and Mlambo's (2005) study also perceived their pregnancies to be a crisis for themselves and their families. It was also reported that having a child did not raise one's social status; instead this experience was perceived as a disgrace in the eyes of parents and the community. The same sentiment was also expressed by participants in the study conducted by Mpetshwa (2000) in which participants reported that the community members tended to have a wide range of negative reactions towards adolescent mothers. Some of the participants in Mpetshwa's (2000) study reported having experienced a lot of ill treatment from their family members, especially their parents who felt betrayed by their children falling pregnant. Participants indicated that they were no longer treated like other members of the family, as was the case before pregnancy. Pregnancy made some of the participants to feel rejected by friends. It is these feelings which may result in severe psychological conditions like depression.

2.5.5. Depression

Depression is one health problem that has been reported in several studies that investigated teenage pregnancy and parenthood. Clemmens (2002) assembled a purposive sample of 20 teenage mothers aged between 16 and 18 who were participating in programmes for adolescent mothers in the North-Eastern cities of the United States of America. The sample comprised of teenage mothers who reported feeling depressed since the birth of their babies. Generally, these teenage mothers had experienced normal deliveries and no complications were reported for both the mother and the baby. All the participants were at school and the age of babies ranged from 1 to 11 months at the time of the interview. Participants in Clemmens'(2002) study reported feeling depressed after the birth of their babies. None of the participants had a history of being treated for depression. Participants

reported feeling scared with the sudden realisation of motherhood. Some felt abandoned and rejected by partners and peers whilst others indicated being overwhelmed with questioning and not understanding the experience of depression and what was happening to them. Some participants reported feeling confused by the experience.

Other studies have also found teenage motherhood to be associated with depressive symptoms. A study conducted in Maseru reported that the transition to motherhood is accompanied by some social and psychological consequences. Participants in this particular study reported feeling robbed of their adolescence, their educational possibilities in the future and their chances for good life socio-economically. The teenagers were reported to be "far from being emotionally, cognitively and socially ready for the prospect of motherhood" (Lehana & Rhyn, 2003, p.35). A prominent South African psychiatrist, Dr Rataemane suggested on House Call programme that pregnant teenagers should not be treated like outcasts; they should rather be supported to achieve success in the future (Ramathesele, 2007).

According to the psychodynamic theory, depression is presented as a disorder that can be linked to real or imagined object loss (Sadock & Sadock, 2003). Holmes (1994) maintains that depressed people are often unjustifiably self-critical and angry with themselves. Psychodynamic's object relations theory maintains that depression is caused by problems that people have in developing representations of healthy relationships. Depression is a consequence of an ongoing struggle that depressed people endure in order to try and maintain emotional contact with desired objects. It involves a person who feels dependent upon relationships with others and who essentially grieves over the threatened or actual loss of those relationships. These people experience intense fears of abandonment and desperately struggle to maintain direct physical contact with the need-gratifying object. Depression can also occur when a person feels that they have failed to meet their own standards or the standards of important others, and that therefore they are failures. The person ultimately turns the anger to the self (Holmes, 1994).

Another prominent theory to explain depression and other psychological problems is the cognitive behaviour theory. This theory is premised on the principle that behaviour results from some kind of a model, the ABC model (Scott, Stradling & Dryden, 1995). According to the ABC model, the interpretation and evaluation of an event (B) is a major influence on an individual's emotional response (C), rather than the event or the stimulus (A). The implication is that it is possible for the individual to control his or her behaviour. Based on this particular theory, depression and other related psychological conditions could thus be explained as maladaptive interpretations of situations resulting in the individual's negative emotional response. (Scott et al, 1995). According to Sadock and Sadock (2003), cognitive theorists postulate that depression result from specific cognitive distortions present in persons. The distortions are cognitive templates that perceive both internal and external data in ways that are altered by early experiences. Depressive symptoms are therefore believed to be mediated by faulty thinking patterns. Individuals prone to depression have a negative view of themselves, they have a tendency to experience the world as hostile and demanding, and they perceive the future as being characterized by expectation of suffering and failure (Sadock & Sadock, 2003). Research has indicated that negative cognitions can serve as both the cause of depression and the maintenance factors (Holmes, 1994).

2.6. CULTURE AND TEENAGE PREGNANCY

Communities across the world have cultural systems and practices that help them to deal with matters related to sex and sexuality during adolescence. For example, Paige and Paige (1981) conducted a global analysis of puberty rites and concluded their investigation by describing cultural female initiation practices as mechanisms for initiating girls into adulthood. In his book entitled "emerging from the chrysalis: Studies in rituals of women's initiation", Lincoln (1981) described puberty rites as women's initiation - a process that marks the attainment of menarche that is an indication of a woman's fertility, sexual and social maturity. Based on this conceptualisation, puberty rites were explained as significant developmental milestone that results in a woman becoming "fertile, productive, experienced and whole" (Lincoln, 1981, p.90). Puberty rites were also described as a platform through

which girls are given education on sexuality, gender and other health related issues through poetry, dances, singing and story-telling.

Different societies in Africa also engage in puberty rites which are seen as an expression of fundamental social values. The focus of such cultural practices is on the institution of marriage. In a study conducted among the Basanga in South Zaire, Persons (1990) found that female puberty rites served as a transition stage that not only leads to acculturation into a new social group, but also results in more responsible behaviour on the part of the initiate.

Ziyane and Ehler (2006) conducted a study with Swazi youths to learn about their attitudes concerning adolescent pregnancy and contraception. The main purpose of the study was to investigate adolescents' perceptions and attitudes in order to help address the continued high adolescent pregnancy rate in Swaziland. Among others, the study found that Swazi youths bear children during adolescence to prove their fertility, and in so doing, prove their marital value. Furthermore, child bearing was found to be important for determining and maintaining social position of a family in the Swazi culture. The study found that the prevalence of adolescent pregnancy was influenced by childbearing practices, cultural values and health practises. The causal factors included the importance of children in cultural terms, barriers to family planning services, and the need to prove ones fertility (Ziyane and Ehler, 2006).

The study by Ziyane and Ehler (2006) seems to suggest that teenage pregnancy is a practice that conforms to societal expectations. In other words, an adolescent girl growing up in a society that has these cultural practices is likely to succumb to the pressure to fall pregnant. Similar finding was reported by Mokwena (2003), who reported that teenage mothers tended to be less anxious when compared to teenage non-mothers. The less anxiety in teenage mothers was attributed to the fact that culturally, "the father of the child may not leave [the teenager]" (Mokwena, 2003, p.88). This gives an indication that the father to the child is culturally expected to accept the pregnant teenager.

In South Africa, different ethnic groups have developed their own puberty rites which serve to prepare young women for acceptable behaviour in their culture. For example, in Limpopo Province, Xitsonga speaking people have evolved an initiation rite that is known as “vukhomba” (‘kgopa’ in Sepedi and ‘vhusha’ or ‘khomba’ in Tshivenda). According to Maluleke (2003a), this particular practice is culturally meaningful and significant as it is intended to encourage acceptable behaviour in young girls after menarche. As Maluleke (2003a) puts it, the “vukhomba” is a period during which the young initiate changes “… from one state of being to another, that is, from childhood to womanhood” (p. 49).

Apart from its social and cultural significance, ‘vukhomba’ was also found to be a traditional sexuality education programme (Maluleke, 2003b). The content of this programme was found to include topics such as personal hygiene, maintenance of virginity, self-control and social morals.

Whilst self-control and maintenance of virginity are supposed to be some of the goals of vukhomba, Maluleke (2003a) found that such a cultural practice does not necessarily reduce the incidence of teenage pregnancy and motherhood in the particular community that she investigated. For example, her findings suggested that there was no significant difference between initiated and uninitiated girls when it comes to the incidents of teenage pregnancy. Furthermore, “initiated women also indicated that teenage pregnancy is a problem in the villages for both initiated and uninitiated girls” (Maluleke, 2003a, p.55). The ‘khomba’ ceremony seems to communicate a message that the initiates are ready for marriage even though some of them could still be in primary schools. Such a message could result in teenage pregnancies that ultimately lead to school drop outs (Chikunda, Marambire & Makoni, 2006).

According to Macleod (1999a), two explanations have been provided to explain the increasing phenomenon of teenage pregnancy. Firstly, sexual control practices like initiation ceremonies and other puberty rites provided for, among others, instruction about sexual matters, vaginal inspection and supervision (and control) of marriage

by kinfolk. These practices are believed to have collapsed due to factors like urbanisation, erosion of the patriarchal structure of the family and formal schooling that has taken away education from the control of parents. Consequently, young people have become sexually permissive when compared to traditional adolescents. Secondly, the great emphasis that is placed on fertility in many African communities is believed to lead to young people being pressurised to conceive so as to escape the reputation of being infertile. In this context, child bearing is perceived as "an essential part of being a woman and achieving success as a woman" (Macleod, 1999a, p.13).

2.7. THEORETICAL PERSPECTIVES

Several theories can be advanced to explain teenage pregnancy and motherhood as the phenomena that can result in significant levels of psychological distress. In this study, two such theories, namely problem behaviour theory (PBT) and Erik Erikson's psychosocial theory of development are presented. Gerald Caplan's crisis theory is presented hereafter as a theoretical framework that informed the current study.

2.7.1. Problem Behaviour Theory

According to Problem Behaviour Theory (PBT), teenage pregnancy is considered as problem behaviour that results in significant levels of psychological distress. This theory asserts that adolescent problem behaviours are developmentally anteceded by social structural variables (Boyer, 2006). The social structural variables include the parent's education, occupation, religion, ideology, family structure, home climate, and peer and media involvement. These social factors "interact and spawn a personality system which is composed of motivational, belief, and self-control factors, and a perceived-environment system, which is composed of perceptions of parental support, peer support and parent-peer interaction" (Boyer, 2006, p. 293). These social structural factors produce the systems that determine problem behaviour engagement, and also trigger the onset of problem behaviour (Boyer, 2006; Babalola, 2004; Tremblay & Frigon, 2004). The decision to engage in problem

behaviour results from the interplay between the personality system and the perceived environmental system. From the perspective of Problem Behaviour Theory, teenage pregnancy could be seen as developing from problem behaviour that adolescents engage in as they negotiate their path towards independence, with the perceived support that social structures provide.

2.7.2. Erik Erikson's psychosocial theory of development

Erik Erikson (1963) proposed that human development is to be understood as a series of eight stages, each of which has significance in and of itself. Erikson argued that the process whereby these stages evolve is governed by the epigenetic principle of maturation which means that:

> Human personality in principle develops according to steps predetermined in the growing person's readiness to be driven toward, to be aware of, and to interact with, a widening social radius; and, that society in principle, tends to be so constituted as to meet and invite this succession of potentialities for interaction and attempts to safeguard and to encourage the proper rate and the proper sequence of their unfolding. (Erikson, 1963, p.270).

Erikson hypothesised that each of the eight psychosocial stages has its task and outcome characterised by contrasting terms, one emphasising the positive need and the positive outcome if the need is successfully met, and the other a possibly negative result. In other words, each of the eight stages is characterised by a 'phase specific' crisis that must be dealt with at that particular time. Erikson understood a crisis in this context to mean a turning point in the individual's life that arises from physiological maturation and social demands made upon the person at a particular stage. For example, during Erikson's first psychosocial stage (known as Infancy: Basic Trust versus Mistrust – Hope) the infant needs to resolve the crisis of trust versus mistrust in order to advance to the next developmental stage. Other psychosocial stages associated with childhood are autonomy versus shame and doubt; initiative versus guilt; and industry versus inferiority.

Adolescence, which is the fifth stage, known as Ego Identity versus Role Confusion – Fidelity, is according to Erikson that critical developmental period which is roughly between the ages of 12 or 13 to about 20. During this stage, the adolescent is confronted with various social demands and role changes that are essential for meeting the challenges of adulthood. The adolescent needs to resolve the crisis of ego identity versus role confusion in order to successfully advance to the next developmental stage. According to Hjelle and Ziegler (1981), many adolescents in the struggle of this age specific conflict "experience a profound sense of futility, personal disorganisation, and aimlessness. They feel inadequate, depersonalized, alienated and sometimes even seek 'negative identity', an identity which is opposite to the one prescribed for them by their parents and peers" (p.127).

Based on the above understanding of the conflict associated with adolescence stage, it can be argued that teenage pregnancy is likely to precipitate a developmental crisis that could lead to role confusion instead of positive self identity. Sadler and Catrone (1983) have in their study on adolescent parent reported that the process of identity formation and role experimentation may be inhibited by maternal identification and role definition. After the stage of adolescence, Erikson postulated that the individual progresses to adulthood which progressively consists of intimacy versus self absorption, generativity versus stagnation, and finally, integrity versus despair. According to Erikson, each of the eight stages is a developmental crisis because in each there is both the opportunity for significant growth and an occasion for the dangers of the failure to grow. Consequently, each of these stages is bound to have its own particular emotional stress. The implication of Erikson's theory is that so long as a person stays alive, there is no possibility of avoiding having to deal with the external and internal situations presented by each stage.

2.8. THEORETICAL FRAMEWORK

In the current study, the crisis theory as elucidated by Caplan (1964) is advanced to conceptualise teenage pregnancy as a crisis whose positive resolution leads to fundamental integrity of the pregnant teenager. According to Caplan (1964), a crisis arises out of some change in a person's life space that produces a modification of his/her relationship with others and/or perceptions of the self. Such a change may come about relatively slowly and as a result of rather normal and inevitable experiences of growing and developing physically and socially or quite rapidly as a result of some unforeseen and traumatic event. Based on this explanation of a crisis, teenage pregnancy could be perceived as an experience that leads to rapid physical, emotional and social changes that are usually unforeseen by the pregnant teenager.

Caplan (1964) outlined four phases of a crisis situation to illustrate how the process takes place:

Phase 1: During this particular phase, there is a rise in tension as a result of the problem stimulus which generates anxiety and perceptions of threat to the self. This anxiety and perceived threat to the self, triggers habitual problem-solving responses which the individual has learnt previously and which might be generalised to this particular situation. In the case of teenage pregnancy, it can therefore be postulated that the teenager will become anxious as soon as she realises that she has fallen pregnant (the problem stimulus). This will then trigger some of the habitual problem-solving responses that the teenager is accustomed to.

Phase 2: Since the problem stimulus and the situation will be of such novelty and intensity, the individual experiencing the crisis will fail to reduce the anxiety in the period of time expected. This perceived failure to apply the usual coping mechanisms will lead to feelings of helplessness and ineffectualness. Similarly, a pregnant teenager may be overwhelmed by her pregnancy to the point of feeling helpless.

Phase 3: It is during this phase, known as the "hitching up the belt" stage that the individual will try to draw from her reserve of strength in order to maintain her ego integrity. The individual may even try to redefine the problem to bring it into the range

of prior experience. Trial and error behaviour may be contemplated, both in thinking and in overt act, to change or remove the problem stimulus. In some cases, the individual may even try to redefine her role in order to accommodate the new situation. The individual may accept the situation and thus integrate it into the self image. Caplan (1964) points out that such acceptance may result in the individual becoming stronger and thus moving farther along the continuum toward mental health. It is this acceptance of the situation that helps the individual to develop new methods of effectively dealing with a new and threatening situation. It can therefore be postulated that a pregnant teenager may, during this stage, try to maintain her ego integrity by associating the experience with her other previous experiences. If the experience is perceived as acceptable, the teenager could become more positive about the pregnancy and thus develop new and positive ways of dealing with it.

Phase 4: If the problem fails to be resolved during the third phase, the tension produced by the anxiety is likely to take the individual beyond the threshold of rational responding. The fourth phase is characterised by personality decompensation (where there are exaggerated distortions of one's identity or of the situation) and other maladaptive behaviour patterns like compulsive and ineffective behaviour, socially unacceptable behaviour and extreme withdrawal. Failure by a pregnant teenager to accept and cope with the new experience, could lead to various forms of psychological distress.

2.9. CONCLUDING REMARKS

The main aim of this chapter was to review literature on teenage pregnancy. A number of problems were found to be associated with teenage pregnancy. The experience was found to impact negatively on the physical, psychological and social functioning of the teenager. Notwithstanding these unpleasant consequences, teenage pregnancy is reported to be on the increase. In the next chapter, the research methodology that has been followed in the current study will be presented.

CHAPTER THREE

METHODOLOGY

3.1. INTRODUCTION

The current chapter focuses on the methodology utilised in the present study. It gives an outline of the research design, the procedure that was followed and the process of data collection and analysis. The ethical issues taken into consideration during the data collection process are also discussed.

3.2. RESEARCH DESIGN

Based on the problem that was investigated, the research design was exploratory and correlational in nature, using quantitative and qualitative methods of data collection.

Quantitative approach allows for presentation of data in a quantifiable manner. According to Neuman (1997), the strength of quantitative measures is their ability to allow the researcher to measure the social world objectively without the researcher adding his/her own impressions or interpretations. In quantitative research, the researcher can generalise research findings beyond the confines of the research location depending on the representativity of the sample.

Qualitative approach is based on the view that the phenomenon being investigated should be addressed in such a way as to make sense of the lived world of the participants. Qualitative researchers seek to present the participant's perspective (Marshall & Rossman, 1995). According to Bryman (1993), qualitative methodology is " an approach to the study of the social world which seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied" (p.46).

Through a qualitative approach, participants are allowed to share their experiences and points of view without the researcher being seen as a judge. Researchers do not include any information that would be seen as bringing some change or different meaning to what the participant has presented. Qualitative approach allows the researcher the opportunity to learn and understand different social and cultural contexts.

3.3. QUANTITATIVE PHASE

3.3.1. Sampling and participants

Non-probability convenient sampling was utilised to secure participants for the study. This type of sampling involves choosing participants on the basis of their availability and some features or process that may be of interest for a particular study (Strydom & Venter, 2002). For the current study, pregnant teenagers who were available and showed their willingness and interest in participating in the study were considered and included. Fifty two (52) such participants availed themselves. The ages of the participants ranged from 15 to 20 years. The pregnancy period ranged from 4 to 9 months. There were no teenagers available for the first trimester of pregnancy.

3.3.2. The instrument

The 28-item General Health Questionnaire (GHQ-28) was administered to assess the psychological well being of the 52 pregnant teenagers. The GHQ-28 is a self-administered questionnaire that assesses somatic symptoms, anxiety and insomnia, social dysfunction/isolation and severe depression. A participant responds by choosing a statement that describes his/her relevant experience in relation to the assessed factor. Four possible responses are available, with values ranging from 0 – 3. The lowest value indicates the absence of the symptom measured, and the highest value indicates the severity of the symptom measured.

The GHQ-28 has been used in previous studies that investigated psychiatric morbidity with pregnant teenagers. For example, the study by Maskey (1991) found that anxiety and insomnia were significantly related to teenagers' pregnant status. The GHQ-28 scale was derived by factor analysis of the original 60-item version and prepared mainly for research purposes. Studies that have investigated internal consistency, validity and the test-retest reliability of the GHQ-28 have found this instrument to have good psychometric properties. For example, the Cronbach's alpha coefficient of reliability of subscales and the internal consistency of the total scale were reported to be around 0,82 and 0,92 respectively when the instrument was psychometrically evaluated (Nagyova, Krol, Szilasiova, Stewart, van Dijk & van den Heuvel, 2000). On the basis of these findings, Nagyova et al (2000) concluded that the GHQ-28 has good psychometric properties. The GHQ-28 was also found to be appropriately correlated with other measures that assess related traits (Kilic, Rezaki, Kaplan, Ozgen, Sagduyu & Ozturk, 1997); Molina, Andrade-Rosa, González-Parra, Blasco-Fontecilla, Real & Pintor , 2006).

Literature also shows that there is no tendency for the GHQ to work less efficiently in developing countries; and that gender, age, language and educational level are shown to have no significant effect on the validity of the measure (Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje & Rutter, 1997; Lopez-Castedo and Fernandez, 2005; and Tait, French & Hulse, 2003).

3.3.3. Procedure

The researcher approached a volunteer community worker who offers educational programmes to the youth to help in identifying participants for the study. The community worker made initial contacts with possible participants who were requested to participate in the present study. After the community worker had secured the participation of 52 participants, the researcher met with the participants in smaller groups to explain the process and the objectives of the study. A total of 52 questionnaires were ultimately filled in and returned. The questionnaires were filled in when the teenagers met with the community worker for their educational

programmes. There was no provision on the questionnaire for the respondent's name. This made it easier for participants to respond without fearing that specific responses will be associated with them.

3.3.4. Data analysis

The Statistical Package for Social Sciences (SPSS) software, 14.0 version was used to analyse the data. The Likert Scale type scoring was used to assign values to possible responses on the GHQ-28 as per scale scoring guidelines. The following values were assigned to responses when scoring:

(a) Values of 0 and 1 were assigned to Responses number 1 and 2 respectively. In terms of the scoring guideline, these two values mean that there is no difference in the experience of the assessed symptom;

(b) A value of 2 was assigned to Response number 3. In terms of the scoring guideline, this response means that the symptom assessed is experienced more than what is usual for the respondent;

(c) A value of 3 was assigned to Response number 4. In terms of the scoring guideline, this response means that the participant experiences the symptom as excessive and beyond what is considered normal.

Items 1 to 7 on the questionnaire assess somatic complaints; items 8 to 14 assess anxiety and insomnia; items 15 to 21 assess social dysfunction (isolation); and items 22 to 28 assess severe depression. A score of 14 and above per factor suggests the presence of the factor assessed (See Appendix B).

The data was then coded accordingly. No values were assigned in cases where the participant gave no response. The values assigned were then used when computing the differences in the experiences of the different conditions. Thus, the mean scores indicated on the different tables (chapter 4) were computed using these values. Participants were categorized in terms of age, level of education and the length of the pregnancy. Since the study was exploratory in nature, descriptive statistics was performed to assess the existence of the measured factors. The analysis of variance was computed to learn about different trends in variables measured.

3.4. QUALITATIVE PHASE

Apart from the quantitative approach, the researcher in the present study obtained additional information through qualitative method of investigation. As was the case with quantitative approach, convenient sampling was used to get participants for the qualitative data. Fifteen (15) of the 52 participants indicated their interest and willingness to take part in the qualitative data. Method of data collection used was the focus group interviews.

3.4.1. Focus group interviews

Focus group interviews were conducted to get the participants to discuss and share their experiences about teenage pregnancy phenomenon. A focus group is defined as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive non-threatening environment (Greeff, 2002). Focus groups create a process of sharing and comparing, and interaction among participants. Participants are found to be likely to self-disclose or share personal experiences in groups with people they perceive to be like themselves, rather than in individual interviews. Focus group interviews stimulate spontaneous exchange of ideas among participants. It is also fairly easier to assess the extent of consistency of shared views by participants in a focus group discussion (Patton, 1990).

3.4.2. Procedure

Three focus group interviews were conducted. The focus of the interviews was mainly to understand the general health of the participants during the gestation period (see appendix C: Interview guide). Participants also shared their experiences that are related to teenage pregnancy. A voice recorder was used to record the interviews. The interviews were conducted in Sepedi and were later transcribed and translated in to English.

3.4.3. Data analysis

The thematic approach as described by Rubin and Rubin (1995) was followed in analysing the interviews. The process involved reading the interview transcripts and coding the descriptive concepts that emerged from the focus group interviews that were conducted. The researcher organised individual ideas into categories that shared similar concepts. This was accomplished by reading through the different interviews and identifying individual ideas that share the same meaning. These ideas were grouped together into themes that were then formulated on the basis of concepts that emerged from the interviews.

3.5. ETHICAL CONSIDERATIONS

The issue of confidentiality and dissemination of information was discussed with the participants before the questionnaires were administered. Participants were made aware that participation in the study was not mandatory, and that they were free to withdraw from participating should they found it necessary. They were requested to complete consent forms to participate in the study (see appendix A). Letters of the alphabet were used on the transcripts to conceal the identities of the participants. For example letters PA, PR, PF, etc. were used to refer to participants.

3.6. CONCLUDING REMARKS

In this chapter, the researcher discussed the methodology that was utilized in conducting the study. Both the qualitative and quantitative approaches were used to explore the phenomenon that was investigated. The rationale for the use of triangulation of methods in the present study was thus to allow for the exploration of the phenomenon in detail. Questionnaire responses were intended to indicate the variance in the experience of psychological distress, whilst focus group interviews, on the other hand, were meant to add depth to the quantitative analysis performed. The next chapter focuses on data analysis and interpretation.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.1. INTRODUCTION

The aim of this chapter is to present the findings that were obtained from both the quantitative and qualitative investigations. With regard to the quantitative investigation, the GHQ-28 was administered to assess the psychological impact of pregnancy on the teenagers using subscales of somatic complaints, anxiety and insomnia, social dysfunction/isolation, and depression. With regard to the qualitative investigation, focus group interviews were conducted to allow participants to share information on their health and their experiences during their pregnancies. The findings from the quantitative measure will be presented first. This will be followed by a presentation of the results from the qualitative investigation.

4.2. QUANTITATIVE DATA

4.2.1. Demographic information

Fifty two participants took part in this study. In line with the phenomenon being investigated, all participants were females and pregnant (between 4 and 9 months of gestation), with ages ranging from 15 to 20 years. All the participants in this study, with the exception of one, were experiencing pregnancy for the first time. Thirty four participants were high school learners whilst 18 were at tertiary institutions. (See table 1 and figures 1, 2 and 3).

Table 1: Demographics

Demographics	Frequency	Percentage
Gender – Female	52	100%
AGE 15 – 16 17 – 18 19 – 20	 3 20 29	 6% 38% 56%
Level of education School Tertiary	 34 18	 65% 35%
Length of pregnancy 4 – 6 Months 7 – 9 Months	 30 22	 58% 42%

Figure 1: Age distribution

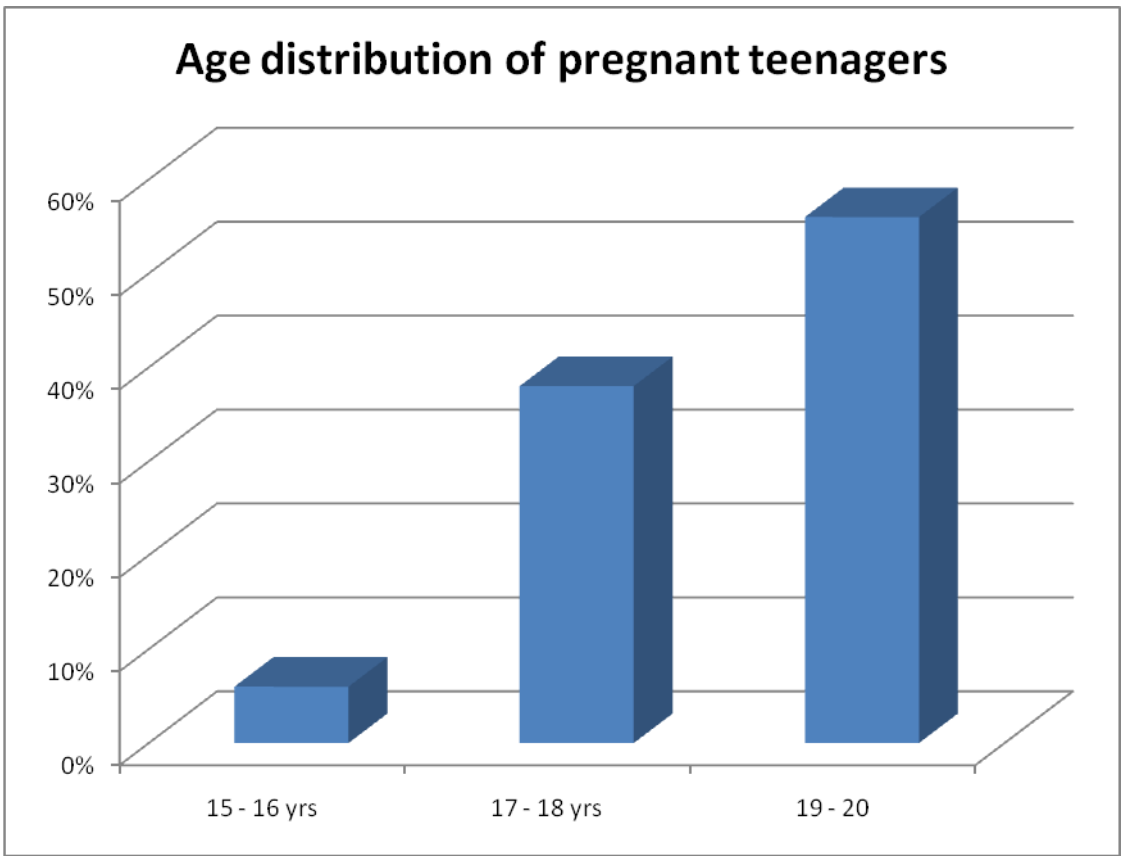


Figure 2: Level of education

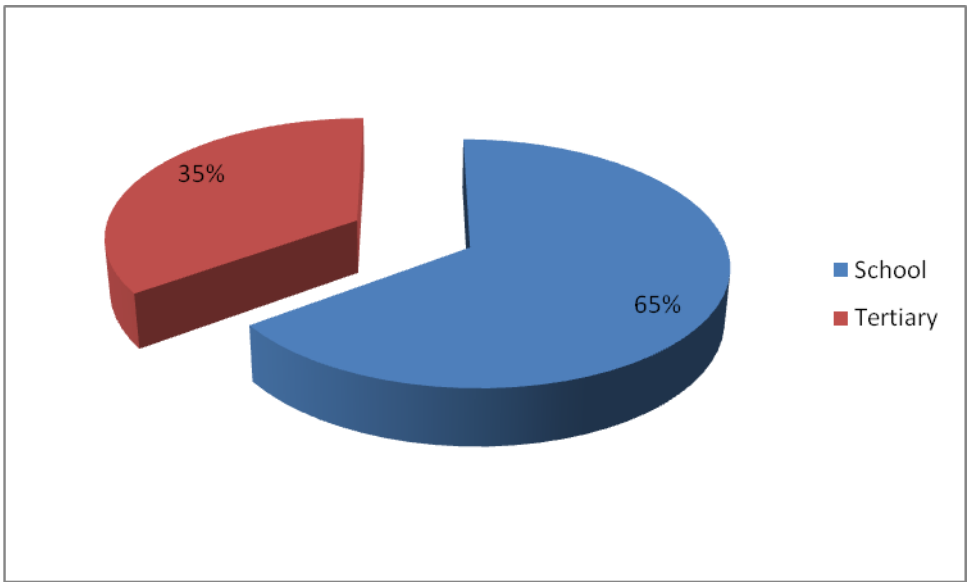
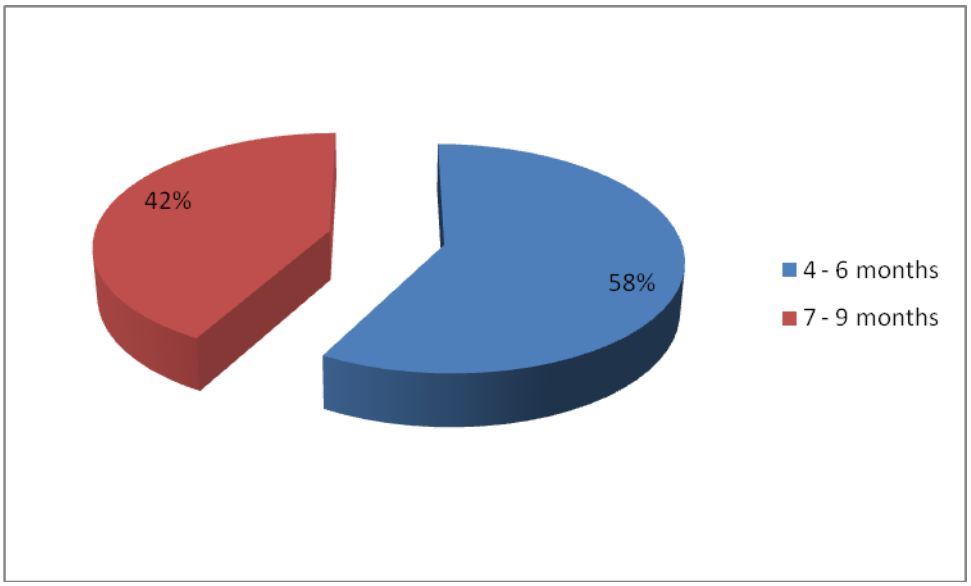


Figure 3: Period of pregnancy



4.2.2. GHQ factors measured and demographic information

Analysis of variance (ANOVA) was computed to determine the mean differences of the various GHQ factors in relation to the demographic information of the participants. What follows is a presentation of the results of the analysis of each GHQ factor in relation to the demographic information of the participants.

4.2.2.1. Reports of somatic complaints by demographics (Age, level of education and length of pregnancy)

(a) Age

ANOVA was computed to determine if there was any significant difference in the reports on the experience of somatic complaints by three age groups (that is, those from 15 to 16 years; 17 to 18 years and 19 to 20 years). There was no significant difference in reports of experience of somatic complaints by the three age groups ($F = 0.33$, $df = 42$, $p = 0.72$). There was, however, an indication to suggest that the older teenagers (19 – 20) tended to report experience of somatic complaints more than the two younger groups (15 to 16, $\bar{x} = 4.50$; and 17 to 18, $\bar{x} = 5.53$). The findings are detailed in table 2.

(b) Level of education

To determine if there was a significant difference in the participants' reports of the experience of somatic complaints in relation to level of education (that is, for those still at school and those in tertiary institutions), ANOVA was used. The findings indicated no significant difference among the groups with regard to the reports of experiencing somatic complaints ($F = 0.35$, $df = 42$, $p = 0.85$). Although the overall findings do not show any significant difference in terms of level of education, the mean scores suggest some difference. Thus, those participants who were at school ($\bar{x} = 5.79$) tended to experience less somatic complaints when compared to participants at tertiary institutions ($\bar{x} = 6.00$) (See table 2).

(c) Length of pregnancy

The difference in the means for the different periods of pregnancy found that there was no significant difference between the 2nd trimester and the 3rd trimester when the ANOVA was computed ($F = 0.10$, $df = 42$, $p = 0.76$). Teenagers in the 3rd trimester of

their pregnancy however, seemed to report experiences of relatively higher levels of somatic complaints ($\bar{x}$ = 6.05) when compared to teenagers in the 2nd trimester of pregnancy ($\bar{x}$ = 5.71). The results imply that participants tend to experience more somatic complaint during the 3rd trimester of pregnancy when compared to the 2nd trimester (See table 2).

Table 2: Reported experiences of somatic complaints

Age		N	Mean ($\bar{x}$)	Standard deviation	F	p value	df
	15 – 16	2	4.50	2.12	0.33	0.72	42
	17 – 18	17	5.53	3.06			
	19 – 20	24	6.21	3.96			
Education	School	28	5.79	3.45	0.35	0.85	42
	Tertiary	15	6.00	3.80			
Length of pregnancy	4 – 6 months	24	5.71	3.68	0.10	0.76	42
	7 – 9 months	19	6.05	3.42			

4.2.2.2. Reports of anxiety & insomnia by demographics (Age, level of education and length of pregnancy)

(a) Age

ANOVA was used to determine mean differences in the experience of anxiety and insomnia within the different age groups, no significant difference was found among the three age groups in the experiences that they reported of anxiety and insomnia (F = 0.24, df = 43, p = 0.79). There was however an indication to suggest that the younger teenagers (15 – 16) tend to experience less anxiety and insomnia ($\bar{x}$ = 4) when compared to older teenagers (17-18, $\bar{x}$ = 4.29) and those of 19 – 20 years ($\bar{x}$ = 5.08). The findings suggest that even though there is no significant difference in

terms of anxiety and insomnia experienced, there is however an indication that older teenagers report experiences of more anxiety and insomnia when compared to younger teenagers (See table 3).

(b) Level of education

There was no significant difference in the reports of experiencing anxiety and insomnia in relation to participants' level of education when the ANOVA was calculated ($F = 1.44$, $df = 43$, $p = 0.24$). Although the overall findings do not show any significant difference in terms of one's level of education and the experience of anxiety and insomnia symptoms, the mean scores suggest some difference whereby those participants who were still in school reported more symptoms of anxiety and insomnia ($\bar{x} = 5.25$) than participants who were at tertiary institutions ($\bar{x} = 3.81$)(See table 3).

(c) Length of pregnancy

To determine the differences in the experience of anxiety and insomnia within the different periods of pregnancy, ANOVA was used. No significant difference was found between the 2nd trimester and 3rd trimester with regard to anxiety and insomnia ($F = 0.60$, $df = 43$, $p = 0.44$). Participants in the 2nd trimester however reported having experiences of more symptoms of anxiety and insomnia ($\bar{x} = 5.12$) than those in the 3rd trimester ($\bar{x} = 4.21$) (See table 3).

Table 3: Reported experiences of anxiety and insomnia

Age		N	Mean ($\bar{x}$)	Standard deviation	F	p value	df
	15 – 16	2	4	2.83	0.24	0.79	43
	17 – 18	17	4.29	4.09			
	19 – 20	25	5.08	3.83			
Education	School	28	5.25	4.33	1.44	0.24	43
	Tertiary	16	3.81	2.66			
Length of pregnancy	4 – 6 months	25	5.12	4.26	0.60	0.44	43
	7 – 9 months	19	4.21	3.26			

4.2.2.3. Reports of social isolation by demographics (Age, level of education and length of pregnancy)

(a) Age

When determining if there was any significant difference in the experience of social isolation by the three age groups, ANOVA revealed no significant difference in the reports by the three age groups of their experiences of social isolation (F = 0.95, df = 47, p = 0.40). There was however an indication to suggest that both groups of older teenagers (17 – 18 and 19 – 20) reported having experienced more social isolation ($\bar{x}$ = 7.95 and $\bar{x}$ = 7.81) than younger teenagers (15-16, $\bar{x}$ = 5) (See table 4).

(b) Level of education

The difference in means for the different levels of education showed that there was no significant difference in terms of social isolation across the participants' level of education (F = 0.83, df = 47, p = 0.37). The analysis shows that the school going

teenagers reported having experienced more social isolation ($\bar{x}$ = 8.03) than teenagers at tertiary institutions ($\bar{x}$ = 7.24) (See table 4).

(c) Length of pregnancy

ANOVA was used to find differences in experience of social isolation within the different periods of pregnancy. The results showed no significant difference in the reports of experiences of social isolation for teenagers in different gestational periods (F = 1.85, df = 47, p 0.18). Participants in the 2nd trimester ($\bar{x}$ = 8.21) reported experiencing more social isolation than participants in the 3rd trimester ($\bar{x}$ = 7.05) (See table 4).

Table 4: Reported experiences of social isolation

Age		N	Mean ($\bar{x}$)	Standard deviation	F	p value	Df
	15 – 16	2	5	2.83	0.95	0.40	47
	17 – 18	19	7.95	2.97			
	19 – 20	27	7.81	2.86			
Education	School	31	8.03	3.20	0.83	0.37	47
	Tertiary	17	7.24	2.25			
Length of pregnancy	4 – 6 months	29	8.21	2.76	1.85	0.18	47
	7 – 9 months	19	7.05	3.05			

4.2.2.4. Reports of severe depression by demographics (Age, level of education and length of pregnancy)

(a) Age

The mean difference showed no significant difference in the reports of depressive symptoms experienced by the three age groups when ANOVA was computed (F = 0.16, df = 47, p = 0.85). There was however an indication that both groups of older teenagers (17 – 18, with $\bar{x}$ = 4.21 and 19 – 20, with $\bar{x}$ = 4.62) reported experiencing fewer symptoms of severe depression when compared to younger teenagers (15-16 with $\bar{x}$ = 5.33) (See table 5).

(b) Level of education

There was no significant difference found on the reports of depressive symptoms in relation to level of education when the ANOVA was computed (F = 0.18, df = 46, p = 0.67). There were however some variations in the experiencing of depressive symptoms. The means for the school going teenagers and those in tertiary institutions were 4.67 and 4.22 respectively. The findings seem to suggest that school going teenagers are likely to report more symptoms of severe depression when compared to teenagers at tertiary institutions. (See table 5).

(c) Length of pregnancy

ANOVA was used to determine the differences in experience of symptoms of severe depression in the different periods of pregnancy, no significant difference was found in the reported experiences of symptoms associated with severe depression during the different periods of pregnancy (F = 0.50, df = 47, p = 0.48). There was however an indication that participants in the 3rd trimester (f = 0.50, p = 0.48) tended to report experiences of more symptoms of severe depression ($\bar{x}$ = 7.05) than those in the 2nd trimester ($\bar{x}$ = 4.90) (See table 5).

Table 5: Reported experiences of severe depression

Age		N	Mean ($\bar{x}$)	Standard deviation	F	p value	Df
	15 – 16	3	5.33	5.51	0.16	0.85	47
	17 – 18	19	4.21	3.39			
	19 – 20	26	4.62	3.44			
Education	School	30	4.67	3.66	0.18	0.67	46
	Tertiary	17	4.22	3.23			
Length of pregnancy	4 – 6 months	27	4.90	4.12	0.50	0.48	47
	7 – 9 months	21	7.05	3.05			

4.2.2.5. Summary of quantitative results

The results suggest that there are reports of the experiences of symptoms that are associated with psychological distress. According to the reported experiences, older teenagers (19 – 20) tend to experience more symptoms of somatic complaints when compared to the groups of younger participants. With regard to the level of education, participants who were at school reported experiencing less somatic complaints than participants at tertiary institutions. The results also imply that teenagers who are in the 3rd trimester of pregnancy tend to experience more somatic complaints when compared to those in 2nd trimester.

When it comes to anxiety and insomnia, the results suggest that older teenagers experience more anxiety and insomnia when compared to younger teenagers. Those participants who were still at school also experienced more anxiety and insomnia symptoms when compared to participants who were at tertiary institutions. Teenagers in the 2nd trimester of pregnancy were found to experience more symptoms of anxiety and insomnia when compared to those in the 3rd trimester.

Reports on the experiencing of social isolation were elevated in both groups of older teenagers. The findings also show that the school going teenagers are more likely to experience social isolation when compared to teenagers at tertiary institutions. Participants in the 2nd trimester tend to experience social isolation more than participants in the 3rd trimester. Social isolation seems to be evident during the second trimester of pregnancy. This is the time during which the pregnancy is beginning to be visible, and the participants may find it difficult to carry on with their daily activities and to interact with other people.

The results suggest that younger teenagers are likely to experience more symptoms of severe depression. School going teenagers reported more symptoms of severe depression. Participants in the 3rd trimester were found to experience more symptoms of severe depression when compared to those in the 2nd trimester.

Overall, quantitative findings suggest that teenage pregnancy tend to be associated with symptoms of somatic complaints, anxiety and insomnia, social isolation and severe depression.

4.3. QUALITATIVE DATA

Focus group interviews were conducted with three groups of pregnant teenagers. The questions addressed focused on the teenagers' reactions following the confirmation of pregnancy, the meanings that they attach to teenage pregnancy, emotional and behavioural experiences, sexuality, relationships, child support grant and coping with teenage pregnancy. The interviews were audio-taped and transcribed. These transcripts were then read many times in order to identify and document the descriptive concepts that emerged from the focus group interviews. These descriptive concepts were grouped into ideas which were later developed into psychological themes that included; fear of the unknown, denial, ambivalence, fear associated with HIV/AIDS, planning abilities, pregnancy as a sudden stumbling block, pregnancy as a shameful event, and achievement of a developmental stage. The themes also included anxiety and irritability, suicidal ideation, discomfort

associated with being sexually active, avoidance, perceiving no link between teenage pregnancy and child support grant, and the role played by a support system.

4.3.1. Reaction to pregnancy

On the question of the participants' first reaction to pregnancy, the following themes emerged:

(a) Fear of the unknown

Most participants expressed intense fear and disbelief on first discovery that they were pregnant. Some expressed shock and others became anxious and could not believe that they were indeed pregnant. Some also expressed that they also got confused and uncertain about what to do. Such fear, disbelief and uncertainties can be attested from the extracts hereunder:

> PR: "I did experience fear, and it was for the first time that I had such an experience. In all my life I had never missed a menstrual period, that was the first time it happened. The thing that happened to me is that I slept with my boyfriend for the first time, thereafter I used the 'morning after pill', and again for the second time I used it but it was not pleasant. I just took it that I was experiencing the menstrual changes because of the 'morning after pill'. For me it was very stressful".
> PG: "When you do not know whether you are taking the right decision or not. Eish!, it has to be quick decisions, you do things quick, quick, you have to think fast"

(b) Denial

Discovering that one is pregnant was perceived as a shocking experience that led to denial in most participants. They indicated that they did not think that they were pregnant even when they had missed their menstrual periods. Statements by one of the participants confirm the extent of the shock and subsequent denial and wishful thinking that the pregnancy should not be the case.

> PS: "With me the first time I saw, I did not know that I was pregnant- you cannot see that you are pregnant because you cannot see menstruation on the same date; you can menstruate maybe around the 5th and next month may be around the 10th, so I thought that I was still going to menstruate. The date that I knew that I menstruate around it had passed, and I was afraid to tell them at home".

PS: “Also, I did not know how many months pregnant I was. One month passed without menstruating, and I told myself that maybe the next month I would see the menses. Then the next month I did not see anything, it was then that I told him”.

(c) Ambivalence or perceived complications about continuing with or terminating the pregnancy

Furthermore, on realisation of pregnancy, some participants thought about hiding the pregnancy and committing abortion secretly. The issue of abortion seemed to be the very first thing that some participants thought about, although complications around logistics of such a process were of great concern for them. Extracts such as the ones below attest to the feelings of most participants:

PC:” I told my elder sister and she gave me some guidance. I did not want to hear anything about the guidance because I was frightened. When I was alone I thought about doing abortion because only my sister and I knew”.
PG: “The first thing that comes to mind when you realise that you are pregnant, is to do abortion. When you think about how your parents are, everyone knows how their parents are. Even with me, when I found out that I was pregnant, I told my sister and because she knew how our parents are, she told me that it will not be possible to keep the pregnancy, I have to do abortion – there was no any other way. I then decided that I was going to do abortion”.
PR: “I was having sleepless nights, thinking that the issue of abortion could not be possible. I then called my aunt who is in Gauteng to tell her that I was coming; so that she could give me the money to do abortion”.
PS: “Yes, even with him, I told him that I was going to do abortion, but he told me that I should wait for a while”.

The thought of committing abortion and the indecisiveness also show that teenagers found the pregnancy to be an overwhelming experience. They found it to be beyond their capabilities.

(d) Fear of ill-preparedness for HIV/AIDS status disclosure

The realisation of pregnancy was also accompanied by fear associated with the possible discovery of HIV/AIDS status and the implications thereof. The fear associated with HIV/AIDS is suggested by the following participant’s response:

PG: “I was just confused not knowing what to do, also afraid because I did not know my status. I had never tested [for HIV/AIDS] and I was thinking that I might be positive. And obviously if I were positive I will have to do abortion and if negative I have to find a way of telling them at home. I was just thinking about a lot of things, doing things secretively, making appointments to do HIV test, I was just confused”.

Based on the above information, it does appear that teenage pregnancy comes with a wide range of psychological distress that include fear, denial and a lot of other emotionally laden experiences for the teenagers. Participants also experience ambivalence when it comes to having to take decisions about keeping the pregnancy or terminating it. There is also some kind of fear that some participants experience in relation to discovering and disclosing of HIV/AIDS status.

4.3.2. Meanings attached to pregnancy

The following themes emerged when participants were asked about their understanding of the pregnancies:

(a) Questioning of own planning capabilities

Some participants found their pregnancy to be a confusing experience that they consider to have happened without having planned for it. The indication is that teenage pregnancy happens when the teenagers involved do not even think about pregnancy as a possibility. The following extract indicates that pregnancy happen without it being planned:

> PF: “It is just a mistake. You just forget that I am still a child and there is a possibility of being pregnant and my life may be shattered. You just forget and the boys become wiser. We just forget and not think that we have to keep our lives and go to school. We forget ourselves and go to the boys and they impregnate us, and we start thinking thereafter”.

(b) Pregnancy as a sudden stumbling block

Some of the participants saw pregnancy as a burden that interferes with developmental processes and educational opportunities. The indication was that the pregnancy happened at the time that it was not expected, and as a result retard progress on activities that the teenager needs to accomplish. The following statements attest to this problem:

> PG: “Especially when you had never thought that you can be pregnant, not now.”
> R: “It looks like you feel burdened when you say, not now”.
> PG: “Yes, it is”.

PG: “The other thing is when you are pregnant and you are still studying, you are no longer able to handle your school work the way you did before being pregnant. You just see that you have a lot of work; you get stressed, you are always sleepy and you do not have the time to study. When you fail you think that you have to complete your studies early because you have already brought another person to the world you have to care for. And when you think that you are failing, every time you have to study, you are sleepy, it becomes a problem”.

(c) Pregnancy as a shameful event

Teenage pregnancy was seen by some participants as an embarrassment. They see it as an event that inhibits and restricts them, making it difficult for them to interact with others freely. The following extracts illustrate this point:

PR:” It embarrasses me sometimes. I ask myself: Am I going to be a parent? Is there going to be a person who calls me mother? That’s the thing I keep on asking myself. I am no longer going to be my mother’s baby, there is somebody going to call me mother, I will be having somebody to take care of”.
PR: “Yes, she is telling the truth. Like, even when you are with parents watching the TV and they start talking about teenage pregnancy (P2: “You get embarrassed”), you even feel like you can change the channel. There is one pamphlet that I saw, it was on teenage pregnancy, I could not read it – the way teenage pregnancy bothers me. When you are seated with parents it’s difficult” (laughter by all).
PS: “Yes, like when you are watching the TV with parents, and they show a picture of somebody who is pregnant, and maybe you are all quite; when I see that pregnant person and knowing that I am also pregnant, I stand up and leave the room or act as if I am busy doing something until the person disappears from the screen”.

(d) Achievement of developmental stage

Some participants tend to interpret their pregnancy as a developmental reality that should be embraced. Teenage pregnancy is seen as an experience that allows transition to womanhood. This interpretation seems to be reinforced by the kind of information that they get from their families. The following statements support this point:

PS: “I went home then she told me that I should not do abortion because even with ‘me (participant’s mother) I got you when I was a teenager’. She told me not to do abortion. My grandmother told me that she had realised that I was pregnant but she was not that sure and she just thought maybe I was just a child and there was nothing. My aunt also called and told me not to do abortion, telling me that everybody has passed the stage, and for one to have a child, the person has to be pregnant. So my worries were reduced”.
PR: “Thereafter they spoke to me and my mother suggested that because I am still a student and will not be able to care for the baby, how will it be if I do abortion? My father is the one who disagreed, he mentioned that I was not the first one to get pregnant - people have got pregnant before”.
PS: “ My mother responded, she told her that there is no problem as to when a woman bears children; if she is pregnant and we do abortion and it happens that that was the only baby she could have do you see what it would mean? Now she does not talk too much”.

The extracts presented above suggest that different meanings are attached to the experience of teenage pregnancy. In some cases, teenage pregnancy is perceived as an embarrassing mistake that retards one's progress whilst in other cases the same experience is interpreted as a developmental reality that should be accommodated.

4.3.3. Emotional and behavioural problems

The following themes emerged from the reports on emotional and behavioural problems:

(a) Anxiety and irritability

A number of participants reported experiencing feelings that are associated with anxiety. There was also an indication that some participants get easily irritated and impatient for no reason. They attributed these experiences to pregnancy. The following statements support the emotional experiences encountered:

> PG: "The other thing is easily getting emotional, minor things get one very angry. When you are alone you just feel like crying, it feels like you are in this alone there is no one to help you. You feel helpless".
> PC: "You will just feel irritated by people, and when you later think about it, you realise that they did not do anything to you; but you will have felt fed up and also start shouting at children for no reason".
> PD: "I get impatient with boys. I just see myself being impatient with them. I am able to sit with girls and talk nicely, but with boys, I shout at them.
> Laughter (all participants). I just find myself shouting at them".
> PC: "Sometimes is due to lack of tolerance when one is pregnant. When you have tolerance, you cannot be impatient".
> PF: "Sometimes you feel frightened without knowing why".

(b) Thought preoccupation and suicidal ideation

There were reports that participants do at times think about committing suicide. Suicide ideation was reported to be also accompanied by the need to alone, and some sleep problems. The following extracts illustrate some of the thought preoccupations and suicide ideation experienced:

> PF: "Yes, like people you were close to, you no longer want them next to you; you want to lock yourself alone and just keep on thinking".

PE: “I find that I do not want to be with other people, I want to be alone and you find that I will be thinking a lot and get easily irritated”.
PR: “It is because you are going to have a child. The thought that ‘I am going to have a child’ (nodding by others). If there was nothing about it, I would not be like that”.
PD: “It happens when you think a lot”.
PR: “It was possible for me to stay in bed, convincing myself that I was sleeping. I am staying with two other girls, one is doing BSc. When she would be studying, I would be tossing in bed, keep on turning to different sides, thinking about the baby, asking myself how the baby will be, what kind of a child without a father. Like at home I am still a child, now they will be stressed by my child and it would be the end of my future. I often feel that I want to be alone”.
PR: “I even thought that I could kill myself”.

From the above presentation, teenage pregnancy appears to be a source of some emotional and behavioural problems that include suicidal thoughts, anger, sadness, anxiety, insomnia and loneliness.

4.3.4. Support and relationships in pregnancy

Participants emphasised support as a factor that made some of them to cope better with the otherwise distressing experience. It was indicated that parents and other people should be supportive towards the pregnant teenagers, as support was perceived to minimise the distress. The following themes emerged:

(a) Support reduces distress

Most participants indicated that they found support to play a significant role in minimising the distress that they experienced during pregnancy. Participants also tried to show how important it was for their families to be supportive towards them, as they see support to be directly related to less distress. The following extracts indicate the expectation that teenagers have, as they perceive support to be significant in reducing distress:

PF: “There is a need for support from parents and other members of the family; and people that we spend time with should support us telling us that it is not for the first time with you. There should be advice to tell us on what to do after giving birth so that in the future we should not experience the same problems”.
R: “Can we then say that the support you have helps to make you to feel alright”?
PS: “Yes”
PF: “Maybe you find that you are pregnant at this age and you are still at school. You find our parents shouting at us indicating that you are still at school and you are pregnant, who do you think is going to feed the child? Or maybe your boyfriend does not care any longer about you. You find that you start getting stressed. And also when you do not get any support from any person. When you request things from parents they tell you to go to the person who

impregnated you. The painful thing is that you are still their child, you are not saying ma, do this for my child, you are saying ma, buy me some clothes or something that I desire; they tell you that your boyfriend will do it for you because he impregnated you. These are the things that cause one to be stressed. You find that you desire something and if they cannot buy for you when you are still pregnant, where are you going to get support".

(b) Experience of selective provision of support

The participants reported that they found some people to be supportive and some not supportive. They were reports that own families were perceived as being supportive. Some participants reported that their partners were supportive. There were however reports that some friends were not supportive. The indication is that there has been support availed, and on the other hand, some people, including members of the community were perceived to be not supportive. The following extracts attest to provisioning of support:

All: "Yes, it's fine, relations are fine at home".
PD: "They will not be impatient with you because they understand what you are going through".
PS: "I see that I am alright; they ask me how I am doing and also how the baby is doing".
PC: "When my boyfriend heard that I was pregnant, he went back home to Johannesburg to work so that he can afford things that may be required. His family has invited me, they want to see me so that they know the person who is carrying their grandchild. I will be going there in December; they are supportive".
PG: "My relationship with my boyfriend is supportive. He completed his studies and is looking for a fulltime job, currently he is working part time to cover the expenses and his family is also supportive".
PG: "My friends are supportive, but they terminated their pregnancies. They support me and they are happy for me. I just do not know if they regret having terminated theirs, but they support me".
PC: "My friend does not talk to me anymore. She tells herself that I am not careful; I jumped to things that are done by older people. But she has a lot of boyfriends, she does not realise that it may happen to her one day. She does not talk to me because I am pregnant. She does not visit me anymore; I spend my time with my family now".
PC: "She is not supportive".
PC: "No…, from others; all others do is to gossip. When you pass they talk and laugh at you, they also mention that - we told her long ago!".
PS: "With some, other no. in my community there is a woman who does not have children. So, sometime back she told my mother that your daughter made you an old lady when it is still early".

Participants found their families and partners to be supportive. For example, in terms of instrumental support, one of the participants indicated that the boyfriend had to go to work in order to provide financial assistance. Apart from instrumental support, there are also indications from the above extracts that some of the participants were given emotional support by families and friends.

4.3. 5. Discomfort about connection of pregnancy to being sexually active

Some participants reported that they found their pregnancy to be a confirmation that they were involved in sexual intercourse, the idea they face with discomfort. It appears from the discussions that participants consider themselves to be children who are not suppose to be sexually active. They see themselves as having done something that, according to their communities, should be done by adults. The extracts below show the kind of discomfort and dissatisfaction that the teenagers seem to encounter:

PR: “Every time when I think about my pregnancy was that, do my parents think that I was involved in sex? They expect me to be involved in love relationships, but not to that extent. When they see the big stomach they ask themselves if I was involved in sex, what was she doing to end up this way”?
R: “It means it brings the thought to you that they think until they reach a point of you having sex”.
PR: “Yes, I think it is understandable that a child of 15 years can be involved in intimate relationship, but not to the extent of having sex”.
R: “You are saying that they did not think that you were involved in sexual activity, but the pregnancy is a sign to show them that you were involved”.
PR: “Yes. You see I get to a point that I think that my parents are saying it means that this person was having sex”.
R: “So this seems to be one of the concerns that you keep thinking about”.
PR: “Our African people think that sex is for older people. And even when they see it on TV, they ask themselves if the child can do it”.
R: “It appears like it is something that is a question”.
PS: “Yes”
PR: “Yes, it is only that they avoid it”.
PC: “She tells herself that I am not careful; I jumped to things (referring to sex) that are done by older people”.

The above extracts show that sex is not something that is discussed with children in the families even though parents may be aware that their children may be involved in intimate relationships with boys. Participants also referred to African cultural practises which seem to be silent when it comes to offering guidance to teenagers on matters relating to sexuality.

4.3.6. Dissociation with plan to receive government child support grant

During the interviews, some of the participants also spoke about the government child support grant. It was clear from the discussions that the availability of the child support grant was not a driving force behind their pregnancies. They see the grant as an allocation that cannot cover all the needs of a child. The following extracts show how the grant is perceived:

> PC: "The worst part is that they tell us that we become pregnant because we want grant money".
> PF: "No, you cannot go and sleep with a young man to have a child so that I can, no, the money is R200.00, and it cannot afford a person. If you think that a child needs clothes, feeding milk and this or that. And milk is expensive. You can only buy milk with that R200.00, the child needs nestum, purity and other things. You will find that the money cannot satisfy the child's needs, it's nothing. Even now if you go and say you are going to buy bread, you will find that you have bought a few things that you will just eat for one day and not have for other days. There is no one who can say I am going to be pregnant, I need a grant, that money (PB: R200.00 is not enough) is not enough. Even if you tell yourself that I want it, my parents will support my child and I will buy clothes with it, you cannot buy pants, a T-shirt and shoes. You buy a pair of pants is R200.00 a pair, a T-shirt is R100.00, a pair of shoes cost more than R200.00, you have to add more money, or else you buy a pair that will not last for a longer period. R200.00 cannot do anything. There is no one who can be pregnant to get a grant".
> PB: "No, it's not the money".
> PF: "Of course you cannot just say I will not go for the grant because I am afraid of what people will say. Not that I want it because I am poor, or I became pregnant because I wanted it. No, you may find that your man is supporting you financially and your child is well cared for. So you can just use the grant money on your own things. The child's father or your parents will be caring for the child. The R200.00 you just spend on what you want, because you cannot just leave it".

Participants seem to suggest that the availability of child support grant cannot be seen as a reason for teenage pregnancy. They consider the money to be too little to meet basic needs of a child.

4.3.7. Coping with pregnancy

The following themes emerged on the question of coping with pregnancy

(a) Coping by avoidance

In order to cope with pregnancy, some participants resolved to avoiding those interactions / situations that were found to cause distress. There was an indication

that relationships with partners and other people were also avoided where necessary as a way of coping. The following statements give an indication of how some participants utilised avoidance to cope better:

> PB: “I do not care. He stays far away from me”.
> R: “What is it that makes you not to care?”
> PB: “Wherever he is, he may be having other girlfriends; so I do not care”.
> PB: “If you rely on him, you will stress yourself”.
> PC: “Yes, you just have to be on your own. Because if you think about him and also the pregnancy, so is better if you do not think about him”.
> PB: “He may seem to be close, but when he leaves you, he changes because you do not see him”.
> PD: “You find that you hear from your friends that your boyfriend is doing other things”.
> PB: “I do not care about people”.
> PC: “If you are afraid of what people will say, you will not do anything. You should not care about people”.
> PB: “Yes, because others when you do good things they are not happy”.
> PB: “Some people may change. Like maybe in class, the teachers may start not talking to you in a good manner”.

The above extracts indicate that some of the participants did not want to think about issues which may cause them problems. Instead, they resort to avoidance as a way to cope with these distressing situations.

(b) Minimization of stress brought by teenage pregnancy

Some participants engaged in other activities as a way of taking their attention away from pregnancy which was found to be stressful. The following statement illustrates how one participant kept herself busy by doing other things instead of worrying about the pregnancy:

> PR: “With me I often feel that I want to be alone. The thing that keeps me busy is the computer. When I feel like being alone, I go to the computer laboratory and spend the whole day there and come back in the evening; I share a room with two other people, so it was not going to be easy for me to be alone. I often spend the whole day at the laboratory, and when I come back I feel better”.

(c) Dependence on selected support systems

As a way of coping with the pregnancy, some participants associated more with those people who were seen to be supportive.

> PC: “I spend my time with my family now”.
> PS: “I feel alright spending time with my friend because we talk about different things, and we would not be talking about pregnancies. We would spend the time laughing together”.

When interacting with the participants, it was evident that their experiences of pregnancy were characterised by symptoms of psychological distress. Different strategies were used by the participants to cope with the challenges. These included sticking to relationships which were perceived to be supportive, and engaging in activities which took them away from thinking about the pregnancy.

4.3.8. Summary of qualitative results

The results suggest that pregnant teenagers display a wide range of unpleasant reactions upon realising that they are pregnant. These responses gave the researcher the impression that the experience can be equated to a crisis. In a crisis situation, the individual is exposed to life events that are usually outside the range of usual experience. This results in a range of unpleasant symptoms that may include anxiety, fear and depression. Similarly, the researcher in the current study observed that the accounts presented by the participants were of such a nature and magnitude that they could be considered to have constituted a crisis. There were also indications to suggest that denial is a common psychological reaction that the teenagers show upon realisation that they are pregnant. Some of the participants would even continue to entertain some hope that they will menstruate even after some months of not going through this experience. There were also some experiences of ambivalence arising from the uncertainties of whether one should keep or terminate the pregnancy. In some cases, there was also fear experienced in relation to the readiness to go for HIV testing and to receive the results.

As is usually the case in a crisis situation, victims' problem solving capabilities tend to be compromised. For example, individuals finding themselves in a crisis situation may question their own abilities to plan effectively. In the present study, the researcher found the tendency to question one's planning abilities to be evident. Some participants even saw their experience as an embarrassing mistake that retards their progress. Whilst this leads to the conclusion that teenage pregnancy may lead to feelings of despair, there were however indications that the same experience was, for some participants representing a developmental reality that

needed to be accommodated. In other words, there was recognition by some participants that teenage pregnancy provides an opportunity to grow and face new challenges.

In the current study, some participants showed discomfort in having to accept that teenage pregnancy suggests that they are sexually active. It was further indicated that issues relating to sex are not easily discussed in the context of an African family. Some participants expressed appreciation regarding the support that they received from their families. Partners were also reported to be supportive even though they would not be physically available in most cases. The provision of support was reported to be playing a significant role in minimising the distress that some participants experienced. It is therefore not surprising to find the participants expressing a need to associate more with those who were perceived to be supportive. It is this support system that strengthens the individual by minimising unpleasant emotional and behavioural experiences that may include suicidal thoughts, anger, sadness, anxiety, insomnia and loneliness. Whilst families and partners were reported to be supportive, there were also indications that some friends terminated their friendship with the pregnant teenagers. Community members were reported to be less tolerant of teenage pregnancy. In other words, it can be argued that the particular community from where the sample for this study was drawn, tend to have relatively conservative views when it comes to teenage sexuality and pregnancy.

One of the finding of the current study related to the issue of child support grant. In recent months, this matter has been receiving so much media attention to the extent that the Human Sciences Research Council conducted a study to determine if there was any link between child support grant and teenage pregnancy. The study found no link between these two phenomena (Makiwane and Udjo, 2006). Similarly, the present study found that the participants did not consider their pregnancies to be a strategy to access government child support grant. Instead, the participants were found to be seeing the grant as too little to meet the basic needs of a child.

Participants embarked on different strategies to cope with teenage pregnancy. These included avoidance of distressing situations, minimising stress by engaging in other activities and being dependent on support systems.

4.4. SUMMARY OF FINDINGS

A total of 52 pregnant teenagers, aged from 15 to 20 years with gestation periods ranging from 4 to 9 months were selected for this study. Sixty five percent (65%) of the sample (n = 34) comprised of secondary school learners whilst the remaining thirty five percent (35%), (n = 18) was made up of students from tertiary institutions. The analysis of variance performed on each of the four GHQ factors shows some mean differences with regard to the demographic information of the participants.

The results show that teenage pregnancy is a psychologically stressful experience that is associated with conditions like anxiety, insomnia, depression, social isolation and somatic symptoms. Whilst teenage pregnancy was generally found to be a stressful condition for all teenagers, it does appear that variables like age, gestation period and level of education do play a role in how the psychological symptoms are experienced. For example, the results show that older teenagers tend to experience more symptoms of anxiety and insomnia when compared to younger teenagers. In terms of educational level, participants who were still at school were found to experience anxiety and insomnia symptoms more than those in tertiary institutions. Anxiety and insomnia symptoms appeared to be more evident during the 2nd trimester of pregnancy. In terms of somatic complaints, older teenagers were found to experience more symptoms of somatic complaints when compared to younger teenagers. Those participants who were still at school experienced fewer symptoms of somatic complaints when compared to those in tertiary institutions. The other indication was that more symptoms of somatic complaints tend to be experienced during the 3rd trimester of pregnancy. Looking at teenage pregnancy and depressive symptoms, younger teenagers were found to be more likely to experience symptoms of depression when compared to older teenagers. More symptoms of severe depression were found to be experienced during the 3rd trimester of pregnancy.

The results of the current study indicate that teenage pregnancy does lead to some degree of social isolation. For example, teenagers in their 2nd trimester were found to experience more symptoms of social isolation when compared to those in the 3rd trimester. One could argue that the symptoms of social isolation tend to manifest at the time when the pregnancy becomes noticeable, that is, during the second trimester. In the third trimester, one could further argue that the teenager is more accustomed to the bodily changes, hence the fewer symptoms of social isolation. Older teenagers were also found to be more likely to experience symptoms of social isolation when compared to younger teenagers. School going teenagers were found to experience more symptoms of social isolation when compared to those in tertiary institutions. One explanation for this difference could be that teenagers in tertiary institutions are away from their parents. On the other hand, school going teenagers are likely to worry about the reaction of their parents since they still stay with them in the same house.

On realisation of pregnancy, participants reacted with fear and denial. They also thought about committing abortion as they considered teenage pregnancy to be a shameful event. There was also an indication that teenage pregnancy was seen as part of development. For some participants, the support that they got from their families and boyfriends was perceived as very crucial in minimising the psychological distress associated with teenage pregnancy. Various strategies employed by the participants to cope with their pregnancies were found to include actions like associating with those considered supportive and also engaging in activities that kept their minds away from their pregnancies. Child support grant was found to play no role in motivating teenagers to be pregnant.

4.5. CONCLUDING REMARKS

The focus of this chapter was to present the findings of both the quantitative and qualitative investigations. The findings seem to suggest that teenage pregnancy is associated with distressing psychological experiences like somatic complaints, anxiety and insomnia, social isolation and severe depression. In order to cope with

these distressing symptoms, participants were found to employ different strategies that included avoidance and depending on supportive relationships.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1. INTRODUCTION

In this chapter, the findings of the study are discussed in relation to the literature and hypotheses outlined.

5.2. REACTION TO TEENAGE PREGNANCY AS A CRISIS SITUATION

Caplan's (1964) crisis theory maintains that a crisis occurs when the individual encounters what is perceived as threatening and challenging to the individual's manner of coping. The theory further maintains that failure to integrate the challenge to be part of the self, may result in maladaptive behaviour and cause psychological distress. The current study suggests that pregnant teenagers find themselves in a situation that can be equated to a crisis. Participants indicated that their pregnancies were unexpected and traumatic. This was found to generate feelings of being overwhelmed. The news of being pregnant was received with shock and fear. Most participants found themselves confronted with a need to take, within a short period of time, far-reaching decisions like having to decide whether or not to keep or terminate a pregnancy. The reactions of the participants were found to be consistent with those explained by Kübler-Ross regarding the five- stage experience of grief (Chapman, 2006). Kübler-Ross' model points that people can experience emotional upsets that are similar to those experienced during grief when dealing with other of life's challenges, more especially when one is confronted with something that is difficult for the first time. Teenage pregnancy was found to impose emotional upsets that resulted in some of the participants experiencing the behavioural problems suggested in Kübler-Ross' model.

According to Kübler-Ross, the first stage in the grief process is characterised by people denying the existence of the situation. Denial becomes a conscious or unconscious defense mechanism that helps the experiencing individual to refuse accepting the facts, information or reality relating to the situation concerned. It's a defence mechanism that is natural. Some people may become locked in this stage and thus find themselves unable to effectively deal with the traumatic event. Some of the participants in the current study denied the existence of the pregnancy at first. They kept on hoping that their menstrual cycles would resume. Using Kübler-Ross' model, it can be suggested that some of the participants found pregnancy at their age to be a life challenging experience that triggers a denial response.

The second stage in terms of Kübler-Ross' grief model is anger. During this stage the individual concerned tends to feel emotionally upset. As a result of this anger, some people may end up feeling embarrassed and ashamed. In the current study, some participants reported being easily irritable, angry and embarrassed. By dealing with the anger that is associated with the second stage, the individual moves to the third stage which is known as bargaining. In other words, a person facing a crisis situation may bargain or seek to negotiate a compromise. In the current study, some participants expected their families and partners to be supportive to them.

The fourth stage in Kübler-Ross' model is depression. During this particular stage, people tend to experience emotions like sadness, regret, fear and uncertainty. The person going through this stage will have begun to accept the reality of their situation. In the present study, some participants reported feeling depressed and even suicidal. The fifth and final stage in Kübler-Ross' model is known as acceptance. The experience of this stage depends on the person's situation, although broadly it is an indication that there is some emotional detachment and objectivity. This is when individuals begin to realise that what has happened is real. The fact that most participants in the present study began to adopt different coping mechanisms could be an indication that they could have reached the stage of acceptance in terms of Kübler-Ross' model.

Whilst Kübler-Ross' model is presented in terms of the five stages, it is important to note that people do not necessarily experience these stages in a linear fashion. In other words, transition between the stages does not necessarily happen as a progression. In some cases, people do not always experience all of the five 'grief cycle' stages. Some stages might not even be experienced at all. Kübler-Ross acknowledges that there are individual patterns of reactive emotional responses which people feel when coming to terms with death, bereavement, great loss or trauma (Chapman, 2006).

5.3. PSYCHOLOGICAL DISTRESS IN TEENAGE PREGNANCY

The results of the current study suggest that teenage pregnancy is associated with distressing psychological symptoms like loneliness, feeling stressed and inadequate. Similar findings are reported by Barth, Schinke & Maxwell (1983). These authors reported that adolescent mothers and pregnant teenagers experienced psychological distress. In another study, Hudson, Elek and Campbell-Grossman (2000) examined levels of depression, self-esteem, loneliness, and social support, and the relationships between these variables, among adolescent mothers. A depression scale, self-esteem scale, loneliness scale and the social support questionnaire were administered to participants during the ninth month of pregnancy and three months after delivery. Hudson et al (2000) found the depression score to be in a high range for 53% of the teenage mothers. Depression was associated with increased feelings of loneliness and decreased social support. Good self-esteem was correlated to social support. Loneliness on the other hand increased as a result of poor social support.

5.4. SPECIFIC EMOTIONAL AND BEHAVIOURAL CHALLENGES

Participants reported having experienced fear and denial on realisation of pregnancy. These experiences are in line with what is reported in the literature. For example, a study by Parekh and de La Rey (1997) reported that teenagers' first reactions when they learned about their pregnancies included shock and denial.

Also, thoughts about abortion were found to have preoccupied some of the participants in the present study. This finding is consistent with findings from previous studies. In an earlier study that investigated the experiences of pregnant teenagers, Sodi (1999) found that pregnant teenagers thought about performing illegal abortions when they discovered that they were pregnant. The results also suggested that some pregnant teenagers tend to perceive their pregnancies as a shameful event and a form of social isolation. For example, some participants reported feeling that they were not comfortable when they were in the company of other people. Some studies have reported that members of some communities regard teenage pregnancy as a shameful event for the families of the teenagers (Mpetshwa, 2000). These findings give an indication that teenage pregnancy is generally considered a shameful encounter.

Whilst teenage pregnancy was considered a shameful event, there was also a sense by some participants of having achieved developmental expectations. Teenage pregnancy was seen as a developmental stage that leads to womanhood. According to Zabin, Astone & Emerson (1993), teenage girls may see pregnancy as a means of achieving adulthood, finding a purpose in life, having someone to love, or strengthening the relationship with their sexual partners. The need to strengthen relationship can also be seen in the context of developing some kind of bonding with others.

5.5. PSYCHOLOGICAL CONDITIONS ASSOCIATED WITH TEENAGE PREGNANCY

Feelings of anxiety and insomnia were found to be experienced by the participants. Psychological problems like intense feelings of ambivalence, uncertainty and confusion were reported. School going participants were found to experience high levels of anxiety and insomnia when compared to participants who were at tertiary level. Accounts of anxiety are consistent with the finding by Maskey (1991) who reported that pregnant teenagers experience uncertainty that makes them anxious. With these feelings of uncertainty and anxiety, one could expect pregnant teenagers

to be hampered in their development when compared to teenagers who are not pregnant.

The study also showed that teenage pregnancy is associated with some depressive symptoms. Sad feelings, suicidal thoughts and irritability were some of the experiences encountered. This finding lends support to previous findings by Lehana and Rhyn (2003) who found that unmarried pregnant adolescents experience depressive symptoms. Kalil and Kunz (2002) also found that unmarried teenage child bearers displaced higher levels of depressive symptoms that were also evident in young adulthood. A study by Clemmens' (2002) also reported feelings of depression by teenagers after the birth of their babies. In their study on depressive symptoms among adolescent mothers, Deal and Holt (1998) concluded that adolescents aged between 15 and 17 years were more than twice as likely as adult mothers to be depressed. Also, for the current study, younger teenagers (15 – 17 years) reported more symptoms of severe depression than older group (19 – 20). The indication is that school going teenagers and younger teenagers tend to experience more symptoms of psychological distress.

5.6. COPING WITH TEENAGE PREGNANCY

In the current study, support from others was found to be useful in assisting some teenagers to cope with their pregnancies. As a result, participants coped by avoiding those situations, including people who were perceived to be unsupportive, and associating more with those that they perceived as being supportive. This finding lends support to previous studies that found a positive relationship between emotional support and good psychological well being during teenage pregnancy. In an earlier study, Lehana and Rhyn (2003) found that pregnant teenagers tend to display increased emotional problems if they receive little support from significant others. In a television interview, Dr Rataemane, a South African psychiatrist, appealed to society not to treat pregnant teenagers as outcasts (Ramathesele, 2007). He attributed some psychological problems to lack of support during teenage pregnancy.

Some participants reported feeling stressed when they receive less support from their families and boyfriends. These reports are consistent with a study by Figueredo, Bifulco, Pacheco, Costa and Magarinho (2006) who reported that poor partner support resulted in depression for the pregnant teenagers. Another investigation conducted with teenage mothers and their mothers found that teenagers who perceived their mothers to be supportive were found to experience fewer symptoms that are associated with depression (Caldwell, Antonucci & Jackson, 1998). Barth et al (1983) reported that social support and socioeconomic status predicted psychological well-being of pregnant teenagers and teenage mothers. The same finding was also reported by Turner, Grindstaff & Phillips (1990) who found that family support, friend support and partner support were significant for the psychological well-being of pregnant teenagers. Previous studies and the findings of the current study seem to suggest that pregnant teenagers value the association that they have with supportive family members and friends as they find this to be assisting them to cope better.

5.7. SOCIO-CULTURAL CONTEXTUALISATION

The current study found that teenagers were unable to link their pregnancies to any specific situation. Currently in South Africa, the government provides child support grant which has been generally perceived to be motivating teenagers to fall pregnant (Makiwane & Udjo, 2006). Participants in the current study indicated that child support grant was not the reason for their pregnancies. National and international studies have also found no direct link between government support grants and teenage pregnancy. For example, a South African study by Makiwane and Udjo (2006) found that there was no proof to suggest that teenagers fall pregnant so that they can access the government child support grant. In an international study by Hanna (2001), participants indicated that government grant was not enough money to care for the child. Consequently, falling pregnant could not be associated with a government support grant.

Some participants were found to be worried by the fact that their pregnancy implies that they are sexually active. The discomfort was believed to be brought by the fact that matters relating to sexuality were not easily discussed in families. This difficulty in addressing matters relating to sexuality could possibly be explained in the context of African culture which tends not to encourage debate on matters related to sex and sexuality between parents and their children. According to Maluleke (2003b), African culture assigns such responsibility of addressing sex and sexuality matters to initiation schools. For example, a sexual education programme, 'vukhomba' is intended to address topics such as personal hygiene, maintenance of virginity, self-control and social morals (Maluleke, 2003b). Whilst self-control and maintenance of virginity are supposed to be some of the goals of vukhomba, Maluleke (2003a) found that such a cultural practice does not necessarily reduce the incidence of teenage pregnancy and motherhood in the particular community that she investigated. For example, her findings suggested that there was no significant difference between initiated and uninitiated girls when it comes to incidents of teenage pregnancy. On the other hand, some African cultural practices were found to encourage pregnancy by putting emphasis on proving fertility and declaring teenagers ready for marriage after initiation (Chikunda et al, 2006; Ziyane and Ehler, 2006).

5.8. SUMMARY AND CONCLUSION

The aim of the current study was to investigate the psychological impact of teenage pregnancy on pregnant teenagers. Data was collected using the GHQ-28 and focus group interviews. The results show that teenage pregnancy is a psychologically stressful experience that can be experienced as a traumatic event. The availability of social support by family and partners was found to minimise these problems. The results also revealed that some participants tend to view teenage pregnancy as a developmental experience that they go through. The implication here is that teenage pregnancy is a crisis that teenage girls experience in their developmental journey.

5.9. LIMITATIONS OF THE STUDY

(a) The current study was exploratory. The sampling method used and the size of the sample would therefore not allow for generalization of the findings to the broader society.

(b) Possible chances of random responding may have happened when the participants responded to the questionnaires. There may have been incidents where participants responded to the questionnaires without paying attention to the items.

(c) The use of focus group interviews may have made the inhibited participants to conform to the ideas voiced by the active participants, thereby narrowing the explorative nature of the study.

5.10. IMPLICATIONS AND RECOMMENDATIONS OF THE STUDY

The current study found that teenage pregnancy generates a wide range of unpleasant emotional and behavioural experiences that include denial, fear, anxiety, feelings of shame and ambivalence. This means that teenage pregnancy constitutes a great challenge to pregnant teenagers and it is experienced as a traumatic situation. Consequently, there is a need for intervention programmes to be put in place so as to help minimise the psychological and social problems experienced by pregnant teenagers. For example, crisis management skills could be offered when teenage pregnancy is confirmed to help the teenager understand the situation and to explore coping mechanisms.

Some of the teenagers perceived the experience as a developmental challenge. For this group, teenage pregnancy afforded them an opportunity to cross over to womanhood. Since this ‘opportunity’ is accidental, there is a need for education syllabi in schools to incorporate human sexuality and reproduction. In developing such educational programmes, attention should also be given to the cultural realities

of the communities concerned. Furthermore, such programmes will need to be introduced in grades that will coincide with the onset of puberty in both boys and girls.

It was clear from the results of the current study that supportive relationships were seen to be minimising psychological distress. This implies that more effort should be given to providing social support structures for pregnant teenagers both at home and in the learning environment. Facilities like student counselling centres and peer support groups could probably be made available to this group of individuals.

Since teenage pregnancy was presented in the literature as a problem nationally and internationally, there is a need to develop programmes that will empower teenagers to cope with the challenges that they face during their pregnancy. Developers of such intervention programmes will need to involve the teenagers themselves if such interventions are to be effective.

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Appendix A

CONSENT FORM

UNIVERSITY OF LIMPOPO
ETHICS COMMITTEE

PROJECT TITLE: Psychological well-being of pregnant teenagers

PROJECT LEADER: Edzisani Sodi

CONSENT FORM

I, _____*name of participant*_____ hereby voluntarily consent to participate in the following project:

I realise that:

1. The study deals with psychological functioning

2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage;

3. The Ethics Committee has approved that individuals may be approached to participate in the study.

4. The experimental protocol, ie. the extent, aims and methods of the research, has been explained to me;

5. The protocol sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage;

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation;

7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research;

8. Any questions that I may have regarding the research, or related matters, will be answered by the researchers;

9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the research team;
10. Participation in this research is voluntary and I can withdraw my participation at any stage;

11. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor;

12. I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

SIGNATURE OF RESEARCHED PERSON SIGNATURE OF WITNESS

SIGNATURE OF PERSON THAT INFORMED THE RESEARCHED PERSON

SIGNATURE OF PARENT/GUARDIAN (where necessary)

Signed at _____ this _____ day of 2007

Appendix B

General Health Questionnaire-28 (GHQ28)

We would like to know if you have had any medical complaints and how your health has been in general, over the last few weeks. Please answer ALL the questions by ticking the answer which best applies to you. Remember that we want to know about PRESENT and RECENT complaints, not those that you have had in the past. It is important that you try to answer ALL questions.

Have you recently…..

		Response 1	Response 2	Response 3	Response 4
1.	**Been feeling well and in good health?**	Better than usual	Same as usual	Worse than usual	Much worse than usual
2.	**Been feeling well in need of a good tonic?**	Not at all	No more than usual	Rather more than usual	Much more than usual
3.	**Been feeling run down and out of sorts?**	Not at all	No more than usual	Rather more than usual	Much more than usual
4.	**Felt that you are ill?**	Not at all	No more than usual	Rather more than usual	Much more than usual
5.	**Been getting pains in your head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
6.	**Been getting a feeling of tightness or pressure in the head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	**Been having hot or cold spells?**	Not at all	No more than usual	Rather more than usual	Much more than usual
8.	**Lost much sleep over worry?**	Not at all	No more than usual	Rather more than usual	Much more than usual
9.	**Having difficulty staying asleep once you are off?**	Not at all	No more than usual	Rather more than usual	Much more than usual
10	**Felt constantly under strain?**	Not at all	No more than usual	Rather more than usual	Much more than usual
11.	**Been edgy and bad tempered?**	Not at all	No more than usual	Rather more than usual	Much more than usual
12.	**Been getting scared and panicky for no good reason?**	Not at all	No more than usual	Rather more than usual	Much more than usual
13.	**Found everything getting on top of you?**	Not at all	No more than usual	Rather more than usual	Much more than usual
14.	**Been feeling nervous and strung-up all the time?**	Not at all	No more than usual	Rather more than usual	Much more than usual
15.	**Been managing to keep yourself busy and occupied?**	More so than usual	Same as usual	Rather less than usual	Much less than usual
16.	**Been taking longer you over things you do?**	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
17.	**Felt on the whole you were doing things well?**	Better than usual	About the same	Less well than usual	Much less well
18.	**Been satisfied with the way you carry out a task**	More satisfied	About the same as usual	Less satisfied than usual	Much less capable
19.	**Felt that you are playing a useful part in things?**	More so than usual	Same as usual	Less so than usual	Much less useful

20.	**Felt capable of making decisions about things?**	More so than usual	Same as usual	Less so that usual	Much less capable
21.	**Been able to enjoy your day -to –day activities?**	More so than usual	Same usual	Less so than usual	Much less usual
22.	**Been thinking of yourself of yourself as a worthless person?**	Not at all	No more than usual	Rather more than usual	Much more than usual
23.	**Felt that life is entirely hopeless?**	Not at all	No more than usual	Rather more than usual	Much more than usual
24.	**Felt that life is not worth living?**	Not at all	No more than usual	Rather more than usual	Much more than usual
25.	**Thought of the possibility that might make away with yourself?**	Definitely not	I don't think so	Has crossed my mind	Definitely have
26.	**Found at times you couldn't do anything because your nerves were so bad?**	Not at all	No more than usual	Rather more than usual	Much more than usual
27.	**Found yourself wishing you were dead and away from it all?**	Not at all	No more than usual	Rather more than usual	Much more than usual
28.	**Found that the idea of taking your own life kept coming into your mind?**	Definitely not	I don't think so	Has crossed my mind	Definitely has

Appendix C

Interview guide for the researcher to be used in focus group interviews.

1. Facilitate discussions on pregnant teenagers' experiences of teenage pregnancy.

2. Ask questions to get information about their reactions, and entertain discussions on feelings of anxiety, insomnia and depressive symptoms that may be experienced.

3. Explore on the meaning of pregnancy for the participants.

4. Get participants to talk about interpersonal relationships and their participation in social activities.

Appendix D

Transcripts of focus group interviews

Focus group 1

R: I will start from the beginning, introducing myself and the purpose of our meeting. The reason I am meeting with you is that I am doing research that on the psychological wellbeing of pregnant teenagers. I would like us to start by discussing the physical experiences that we are encountering. Health wise, physically, what is happening? I am aware that there are members of the group who have just given birth after we started with the process of data collection, you are welcome to share your feelings and opinions.

PC: Yes, you feel some changes in the body, also vomiting. For example, with me now my legs are swollen, it's part of it. These are the changes that I have observed. You also get anxious, even when you are sleeping, you get anxious. Sometimes you get emotional, just feel like you can cry. It's just changes, funny ones.

R: You mentioned that even when you are sleeping you feel anxious without knowing what is happening, with funny changes. Can we discuss these as a group?

PE: With me I get tired easily, even when I am working on something, I have to rest and continue later. I find that I do not want to be with other people, I want to be alone and you find that I will be thinking a lot and get easily irritated.

R: She talks about not wanting to be with other people, she would prefer to be alone thinking a lot..

PF: Yes, like people you were close to, you no longer want them next to you; you want to lock yourself alone and just keep on thinking. Sometimes you feel frightened without knowing why.

R: You indicate that you feel frightened and get tired without understanding what is happening.

PF: Without having done anything.

R: Earlier it was indicated that people get irritated without anything bothering you.

PC: You will just feel irritated by people, and when you later think about it, you realise that they did not do anything to you; but you will have felt fed up and also start shouting at children for no reason.

R: These are some of the things that happen. I see others are smiling, what is happening, just to talk about things that happen we may not follow a specific structure, but just how you want to talk about this experience. (silence). These discussion ends among us, as I indicated earlier about the confidentiality of the information. The reason we did it in this fashion is that we all share something in common, it's unlike if we had invited somebody who is not pregnant. When such a person leaves, she goes out and talk about what was discussed because she does not share the experience with you. I indicated earlier that I have three children meaning that I have gone through more or less the same experience in the past.

PG: Your immune system changes, it's no longer strong. If you get flu, you become weak. You are even heavy on yourself.

R: You are heavy on yourself as a person. What other things do you experience.

PE: With me I have a problem of smell, get nauseated and start vomiting .

PC: There are also some people who when they are pregnant, they do not eat. You find that they will say I do not eat eggs, I do not eat this or that; I eat everything. And I get hungry often, there is nothing I do not eat.
R: she talks about what other people experience, but for her she says there is nothing she does not eat and also feeling hungry more often. Earlier there was also an indication getting anxious and irritable, what are the things that make one experience these symptoms?
PF: You find that maybe you are with people and they just do funny things, maybe talking about how pregnant people behave and they do not know that you are pregnant, you get irritated. Also when somebody says something and I do not understand the person, I get impatient and not attend to the person. I feel that I need space where I can be alone and think, I need peace in my soul.
R: There is an indication that when you are with people they talk about things that you do not like, you need your own space.
PG: Yes, sometimes you just see that the place is dirty and some people seem not to realise and you are the only one who see it and they do not help you. You just get impatient and irritated.
R: When I am listening it's like there is a need to get assistance, and if that is not available there are problems. It sounds like there is a need for support which seems not to be available.
PG: Yes, it's like you are the only one who see things at home, others seem not to notice.
PF: You also need special attention. If you want something, you want somebody to drop whatever the person is doing, and attend to you. You expect the person to help you first and can later proceed with what he or she was doing.
R: I hear that there is a need for immediate attention, things need to happen immediately. What happens to others when we look at this.
PG: The other thing is easily getting emotional, minor things get one very angry. When you are alone you just feel like crying, it feels like you are in this alone there is no one to help you. You feel helpless.
R: You feel helpless and emotional. Maybe if we can look at this, what it is it that brings in the helpless feeling.
PF: Maybe you find that you are pregnant at this age and you are still at school. You find our parents shouting at us indicating that you are still at school and you are pregnant, who do you think is going to feed the child? Or maybe your boyfriend does not care any longer about you. You find that you start getting stressed. And also when you do not get any support from any person. When you request things from parents they tell you to go to the person who impregnated you. The painful thing is that you are still their child, you are not saying ma, do this for my child, you are saying ma, buy me some clothes or something that I desire; they tell you that your boyfriend will do it for you because he impregnated you. These are the things that cause one to be stressed. You find that you desire something and if they cannot buy for you when you are still pregnant, where are you going to get support.
R: It looks like you are concerned about support. Indicating that parents are no longer….
PF: Yes, maybe you tell yourself that it is fine I am pregnant and I made a mistake because I am still at school, even though I may be old, my boyfriend has not yet married me and he is not working; it means whatever I get is from my parents, so

instead of them giving you support and love even though you broke the law and make a child when you are still a child we love you. Not that I am looking at having my parents buying me this or that, but the way they supported me before I got pregnant, should be the same. I am not saying that they should buy the child things, but they should look at me as their child. Not that I want bananas, she buys, I want an apple, she buys, ma give me R50.00, she gives me; not like that, but if I say ma, would you please buy me some clothes as my clothes no longer fit me, there should be an indication that she will buy me when the money is available; it should not be to be told that you should go to the person who impregnated you to buy you, I am not the one who impregnated you. She is your parent, it's December time now, everyone is talking about buying children clothes. It should not be that because you are pregnant, go to so and so to buy you clothes. No they should know that our child is pregnant we should accept it, it is a mistake that can be done by any child. They should not be stressing you because you will feel that it can be better to kill yourself or drink some poison to kill the baby, and kill yourself. There is a need for support from parents and other members of the family, and people that we spend time with should support us telling us that it is not for the first time with you. There should be advise to tell us on what to do after giving birth so that in the future you should not experience the same problems. At least to know that if I had the first child still being at home, the next one should be when I am married or doing something. Even if your boyfriend can forsake you, you know that the second one you will have when you are at your own and you can feed the child.

R: When I listen I hear you talk about even other people that they should support you. If we look at your situations, do you get support in the community?

PC: No…, from others; all others do is to gossip. When you pass they talk and laugh at you, they also mention that "we told her long ago". Others do call you and guide you, telling you what to do given the situation; and others seem to enjoy when you despair.

R: It looks like the issue of support is not adequate, and it was also mentioned that sometimes the boyfriend does not care. Generally, what is happening with boyfriends?

PC: hen my boyfriend heard that I was pregnant, he went back home to Johannesburg to work so that he can afford things that may be required. His family has invited me, they want to see me so that they know the person who is carrying their grandchild. I will be going there in December; they are supportive.

R: So for you see that there is support from the boyfriend and his family.

PC: Yes

R: With the others, what is happening with the relationships with boyfriends?

PG: My relationship with my boyfriend is supportive. He completed his studies and is looking for a fulltime job, currently he is working part time to cover the expenses and his family is also supportive.

PA: My boyfriend was supportive during the first few months of pregnancy. Thereafter he was just not available, but currently he is supportive.

R: It looks like different situations happen.

PF: My boyfriend accepted it when I told him that I was pregnant, it's something that he was expecting. It is only that parents do not know yet that I am pregnant. I just do not know how is it going to be with our parents. But with him, he has accepted it.

R: it means in your situation, people have not as yet noticed.

PF: My elder sister knows and she has accepted that the person she stays with is pregnant. I just do not know if my boyfriend has already told his parents; but I have not yet told my parents.
PC: With me one of my parents is deceased, the other one does no longer stay at home, he lives in town. He has another partner and he does not care about us, is my father. I take it that he does not care, he is gone, he only sends us money. He does not care as to what happens at home, so even with me, there is no importance that I should tell him because he does not care. We just heard a roamer that his partner is pregnant. So there is no need for me to tell her because he does not care, what he will do will just be to scold me. He will just shout at me even though he does not stay with us, he does not even know what is happening at home now because he does not come.
R: There is an indication that support varies also showing the kind of issues that we encounter. Earlier there was an indication that people experience fear without knowing what brings it. I would like us to focus on the fear, what is it that happens?
PC: My fear was due to the fact that I realised that I was pregnant and I was no longer going to school. I missed my menstruation dates and I started thinking that I might be pregnant because I was seeing some changes on my body. For example, my breasts, and I began to think that it was going to be tough for me, there were going to shout at me at home. I called my elder sister, I stay with my elder sisters and other younger siblings. My elder brother is working and does not stay with us any longer. I told my elder sister and she gave me some guidance. I did not want to hear anything about the guidance because I was frightened. When I was alone I thought about doing abortion because only my sister and me knew. I did not know how to tell my sister that I wanted to do abortion. I then decided to tell my boyfriend, telling him that they were going to kill me at home, and that I did not want people to know. What are people going to say, I am famous everywhere, at school with poems, I am just famous. Staff members know me, in my class it's me. I then decided that abortion was the solution. When in told me boyfriend he was angry with me. He stopped talking to me. He then realised that not talking to me will make me continue with my thought, he started advising me and he also called his mother and told her. His mother told me not to do abortion, she even scared me by telling that I might do abortion and end up not being able to bear children in the future. She told me that I was not the only one, many people went through the same thing (I used to feel lonely). That made me to understand that abortion was not a solution. I used to be scared, thinking Mary the mother but I understand that I am not the only one.
R: There seem to be a concern about people looking at 'me'….
PC: Yes, mostly at school.
R: And the question that me the mother? What about the others, what things do we ask ourselves?
PG: The first thing that comes to mind when you realise that you are pregnant, it to do abortion. When you think about how your parents are, everyone knows how their parents are. Even with me, when I found out that I was pregnant, I told my sister and because she knew how our parents are, she told me that it will not be possible to keep the pregnancy, I have to do abortion – there was I no any other way. I then decided that I was going to do abortion; but it was not possible to do it without telling my boyfriend. My boyfriend told me that it will not be possible to do abortion; there should be an alternative. He also indicated that my parents were not angels in such

a way that it cannot happen that their child make mistakes, I should find a way of telling them the truth. I was just confused not knowing what to do, also afraid because I did not know my status. I had never tested [for HIV/AIDS] and I was thinking that I might be positive. And obviously if I were positive I will have to do abortion and if negative I have to find a way of telling them at home. I was just thinking about of a lot of things, doing things secretively, making appointments to do HIV test, I was just confused.
R: I hear that people talk about being confused. The confusion seems to be brought by uncertainties about what to do.
PG: When you do not know whether you are taking the right decision or not. Esh, it has to be quick decisions, you do things quick, quick, you have to think fast
R: It's like when something unexpected happen calls for an action, you have to do something .
PG: Especially when you had never thought that you can be pregnant, not now.
R: It looks like you feel burdened when you say, not now.
PG: Yes, it is.
R: What about sleeping, are we able to have restful sleeps?
PC: Sometimes, sometimes you will experience some stomach aches and you will not sleep well. Sometimes you experience headaches, you get restless at night. You feel hot, you want to sleep without blankets. But sometimes it becomes a very good night.
R: Ok. I just want to check. Earlier some of you indicated that you keep busy thinking a lot. What are the things that you think about?
PF: Sometimes is rely thinking that by the way, I am pregnant. But sometimes you just tell yourself that I am not the first one and I will not be the last one. Sometimes you ask yourself if the boyfriend's support will only be available before the birth of the child, and when the child is born, there will be no support. You also think about finding yourself happy before the child's birth thinking that the child will have clothes to wear, will have formula milk. You think that there are situations where you tell your boyfriend that you are pregnant and he tells you that it is not his fault; he will tell you if you did not know that you had to prevent. When you see that there seems to be support, you tell yourself that my child will have a better life. So when you do not get support, you just think that your child is going to live a life full of sufferings, without any support. At least when there is support, you know that your child will live better and I will also be better. And also when the child is sick you can take the child to the doctor for a consultation. It should not be that you get stressed, because you end up thinking about wrong things.
R: what are the other things that happen when we think and ask ourselves questions? Some of the things that present as problems when we are pregnant.
PG: I spend all the time stressed. You get frightened that if you keep on getting irritated, you raise your blood pressure, you may lose the child. Every month you pray that you should be 'sharp'.
R: So this concern is one of the things that preoccupy your thoughts. You are always not sure of what will happen. You are always thinking that the child should be fine, and I guess that in its self makes you worried. You are worried about worrying that the child should be alright.
PG: The other thing is when you are pregnant and you are still studying, you are no longer able to handle your school work the way you did before being pregnant. You

just see that you have a lot of work; you get stressed, you are always sleepy and you do not have the time to study. When you fail you think that you have to complete your studies early because you have already brought another person to the world you have to care for. And when you think that you are failing, every time you have to study, you are sleepy, it becomes a problem.
R: It looks like there are things that happen that makes it impossible for us to do things that we would like to do. Other things that we think about?
PC: It's when you switch on the radio, they say teenage pregnancy; in class they teach you, teenage pregnancy; on TV, teenage pregnancy. You end up feeling guilty, you will be guilty because everywhere they say; hey, teenage pregnancy. You end up feeling guilty too much. So we end up understanding that we violate rules on earth. When you get to the TV, they talk about us; radio, it's us; newspapers, is teenagers' pregnancy.
R: It looks like every where people talk about teenage pregnancy, and you end up feeling guilty. I wonder as to what is it that this session is doing. I mean that we have gathered here because of teenage pregnancy.
PC: No, not like that. I am referring to the fact that on radio they talk about it, everywhere. At least better you when you (referring to self) talk about it, you will feel better.
R: It is better when you get the opportunity to talk about it yourself. I guess like what is happening now.
PC: At least you talk about it. More so that it's among people who you know that you are not the only one, you will feel better.
R: She earlier indicated that she experiences guilt feeling because on the radio, TV and newspapers they ….
PC: The worst part is that they tell us that we become pregnant because we want grant money.
R: What is happening with pregnancy and grant? She is bringing in another issue that we get pregnant because we want grant money. When you look at it, is it the reason that things happen this way?
PF: No, you cannot go and sleep with a young man to have a child so that I can, no, the money is R200.00, and it cannot afford a person. If you think that a child needs clothes, feeding milk and this or that. And milk is expensive. You can only buy milk with that R200.00, the child needs nestum, purity and other things. You will find that the money cannot satisfy the child's needs, it's nothing. Even now if you go and say you are going to buy bread, you will find that you have bought a few things that you will just eat for one day and not have for other days. There is no one who can say I am going to be pregnant, I need a grant, that money (PB: R200.00 is not enough) is not enough. Even if you tell yourself that I want it, my parents will support my child and I will buy clothes with it, you cannot buy pants, a T-shirt and shoes. You buy a pair of pants is R200.00 each, a T-shirt is R100.00, a pair of shoes cost more than R200.00, you have to add more money, or else you buy one that will not last for a longer period. R200.00 cannot do anything. There is no one who can be pregnant to get a grant.
R: It means the grant is not the thing that is encouraging people to be pregnant.
PF: It is just a mistake. You just forget that I am still a child and there is a possibility of being pregnant and my life may be shattered. You just forget and the boys become wiser; you do not say I am going to sleep with a boy so that I can be

pregnant and get a grant. We just forget and not think that we have to keep our lives and go to school. We forget ourselves and go to the boys and they impregnate us, and we start thinking thereafter. Of course you cannot just say I will not go for the grant because I am afraid of what people will say. Not that I want it because I am poor, or I became pregnant because I wanted it. No, you may find that your man is supporting you financially and your child well cared for. So you can just use the grant money on your own things. The child's father or your parents will be caring for the child. The R200.00 you just spend on what you want, because you cannot just leave it.
R: The way she explains it looks like it is not even sufficient to buy a pair of shoes. So even if you may want to buy clothes, it may not be enough. The way it is it's like it is not the thing that encourages becoming pregnant.
PB: No, it's not the money.
R: Trying to capture on some of the things discussed, there was an indication of fear and guilt feelings. I would like to know about relationships with friends. I guess you are not friends; you met because there is something common about you. What is happening with your friends?
PC: My friend does not talk to me anymore. She tells herself that I am not careful; I jumped to things that are done by older people. But she has a lot of boyfriends, she does not realise that it may happen to her one day. She does not talk to me because I am pregnant. She does not visit me anymore; I spend my time with my family now.
R: It looks like the pregnancy makes friends not to want to be associated with you.
PC: She is not supportive.
PG: My friends are supportive, but they terminated their pregnancies. They support me and they are happy for me. I just do not know if they regret having terminated theirs, but they support me.
R: With the others, what is happening with our friends?
PC: Mine does not talk to me anymore; but my boyfriend's younger sister, she is also a teenager and she is pregnant, two years older than me. At the moment she is the person who is supportive, every time she makes sure that she spends time with me. When her parents send her money she buys fruits and other things she shares with me. Even things like pregnancy magazines, we are sharing.
R: It means there is support from somebody who has the same experience as you.
PC: Yes, and her friends spend time with her.
R: Ok. It looks like there are differences, some friends are available, and some do not want to be associated with you. Other things that you can think of when looking at relationships with friends, other people, earlier there was an indication that some will gossip about you? Are there any other things that you experience and would like us to talk about?
PC: It is when other girls who have been through the same experience say it is difficult in the hospital when one is in labour, you get scared because they tell you about what you are still going to experience and they just want to scare you because they exaggerate. And they will say if you do not want to hear, you will shut your ears but they talk in front of you and they talk too much. And it scares.
R: I heard earlier you spoke about pregnancy magazines, if you have access to such things, they can help because they give information, you can know what to expect. It can be a good thing if you can access such things because sometimes people talk , I can talk about my own experience or what other people experience; but the other

thing is that we are different individuals, and when we are different, you find that at times our experiences may not be the same. But if there are facts, have access to information to help understand what happens. I think the fear may be coming because we do not know; they may be saying it is difficult in the hospital, it may be, but if you have information, you expect it. You get information to help you prepare yourself for that experience. I remember that even in the Bible they say labour pain is different, but individuals are not the same. We experience it differently, but getting information, getting the facts could be a good thing, to help one understand. You may find that for someone it was not really an outstanding experience, or it was a very painful experience. But if we get facts from different sources, wherever, just to help ourselves to be prepared for the experience.

Other things that we may want to share that we experience. If there is nothing, I just want to indicate that getting information will be helpful and also, talking about how you feel. At times if we do not get the opportunity to share our feelings, we end up putting a lot of stress on ourselves. This is because we are not sure, we keep on thinking without getting any answers. You ask yourself a lot of questions and they end up being heavy on our feeling. So it is a good thing to share if there are people who are available to listen and these should be people we trust; people who are supportive. You do this for your health, you are stressed because of the things you keep on thinking about. Also get information to help you understand the pregnancy itself, the other thing is that pregnancies are not the same, but if you get information it will help you understand what happens and what to expect.

Anything that you may want to tell me or ask me. If there is nothing, it will mean we have come to the end of our time together.

Focus group 2

I would like to start with indicating that I appreciate that you agreed to be part of this research project. I did introduced myself earlier and indicating that the reason we are meeting is that I am conducting research that looks at the psychological well-being of pregnant .I know that you went through the first phase of filling in the questionnaire; and agreed to be part of the focus groups. Our discussion will be in a form of a follow up to the statements that comprised the questionnaire. I would like us to talk about the physical experiences, what is happening to the body.(silence). Or we could start at a point which you would like us to focus on

PR: I started realising that I was gaining weight and complexion, somewhere in April; and I also started disliking my boyfriend; but I did not know that I was pregnant. I also started sleeping a lot, and I was not a sleeping type. I knew I was pregnant, but I was in denial. My menstruation had stopped and I told myself that it was because of the morning after pill. My boyfriend changed, he stopped visiting me and previously he kept visited me regularly. I decided to go to the clinic to do abortion. The nursing sister at the clinic was very rude; she asked me how do I know if the child I was carrying was not going to be a Mandela or Mbeki, or the child was going to get the cure for AIDS. And my reason for wanting to do abortion was because of the boyfriend. And also my parents are very strict.

R: Before you started talking, she wanted to say something (referring to P2)

PS: No, it's the same

R: You realised that it affected the relationship with your boyfriend (referring to P1)

PR: Yes, on that day I called him, I did the pregnancy test on my own with my friends. The first test we did not do it well, so I did not show anything. I went to the health clinic and they told me to bring the pregnancy test so that they could do. I did not go with the test to the clinic, I decided to do it for the second time with my friends, this time it indicated that I was pregnant. The other thing that made me wanted abortion was that one of the friends I was with was pregnant, and she was lucky that her parents are educated people, they took her to do abortion. With me my mother did not understand this thing of doing abortion.

R: nhmm…so for others, what happened when you realised that you were pregnant, what happened?

PS: I knew that when one was pregnant there would be changes on the breasts and there would be morning sickness. I started experiencing vomiting after meals and I began to avoid eating as a way of controlling the vomiting. I used to eat when there was no one at home, during the day. I would prepare meals earlier than usual so that I could eat before my parents came back home.

R: earlier there was an indication of sleepiness which was not the usual tendency

PR: the other thing that happened to me was that I could no longer finish my meals. That was one of the changes I observed.

R: It means that your intake of food was reduced, no longer eating as much as you used to (silence), what are the other things that are experienced?

PR: Menstruation or….

R: any other thing, I remember in another group it was indicated that some people experience fear which they cannot account for, without understanding why.

PR: I did experience fear, and it was for the first time that I had such an experience. In all my life I had never missed a menstrual period, that was the first time it happened. The thing that happened to me is that I slept with my boyfriend for the first

time, thereafter I used the 'morning after pill', and again for the second time I used it but it was not pleasant. I just took it that I was experiencing the menstrual changes because of the 'morning after pill'. For me it was very stressful; and I was having sleepless nights thinking that the issue of abortion could not be possible. I then called my aunt who is in Gauteng to tell her that I was coming; so that she could give me the money to do abortion. What she did was to call my grandmother and told her that I was having a problem. My grandmother then called my mother and also told her that I was having some problems. On the phone my aunt did not ask me what the problem was. My parents came in the evening, when they arrived they asked me what the problem was, they then called my grandmother; it was my grandmother who I told that I am pregnant.
R: So you had sleepless nights thinking that….
PR: I even thought that I could kill myself .The real reason was the boyfriend because he changed; one time when I had called him he told me that I knew that it was other people who impregnated me, but know he has changed.
R: should we say he did not want to be held responsible?
PR: Yes, the only time that he listened was when I brought a picture of the baby from the sonar scan, when I showed him the picture. With me the time I heard that I was pregnant, I used to feel some hard thing in the tummy, I think it was the head.
R: Other members of the group, what have been your experiences having heard this?
PS: With me the first time I saw, I did not know that I was pregnant- you cannot see that you are pregnant because you cannot see menstruation on the same date; you can menstruate maybe around the 5th and next month may be around the 10th, so I thought that I was still going to menstruate. The date that I knew that I menstruate around it had passed, and I was afraid to tell them at home. I told my boyfriend that my menstrual date had passed; he told me that he felt something that made him wonder after having slept with me. He told me that may be I was indeed pregnant because he felt something. I then told him that I wanted to do abortion. He told me that he could not accompany me, so I should talk to my mother. I told him that I would not want my mother to know because I want it to be a secret. He took my mother's phone number and called to tell her that I wanted to do abortion. My mother told him that I should come home before I could do abortion. I went home then she told me that I should not do abortion because even with me I got you when I was a teenager. She told me not to do abortion. My grandmother told me that she had realised that I was pregnant but she was not that sure and she just thought maybe I was just a child and there was nothing. My aunt also called and told me not to do abortion, telling me that everybody was passed the stage, and for one to have a child, the person has to be pregnant. So my worries were reduced and I stopped thinking about abortion. Somebody I told before telling the boyfriend, she gave me something, I do not know what it was, it was a stinky substance, I got afraid; but after telling my mother I showed her the substance. She told me not to use the substance, and she told me to consult a medical practitioner. I went with her for the consultation, the doctor examined me and I found that serious I was indeed pregnant. We then went back home.
R: would you say you get support from your family?
PS: When I was with siblings, you see I have a younger sibling who is a boy, he used to hurt me, but my mother spoke to him.

R: was he talking about things related to you being pregnant?
PS: He would shout at my boyfriend when he sees him, but he later went and apologise to my boyfriend and things are fine now.
R: when looking at the idea of the abortion……
PS: Yes, even with him, I told him that I was going to do abortion, but he told me that I should wait for a while. Also, I did not know how many months pregnant I was. One month passed without menstruating, and I told myself that maybe the next month I would see the menses. Then the next month I did not see anything, it was then that I told him, he said I should not do abortion. He then told his mother, who came to me to tell me that I should not do abortion. Abortion sometimes they say it is dangerous.
R: So you were able to get support from both your family and the family of your boyfriend. At the moment, what is happening in terms of support?
PS: At the moment?
R: nhmm….
PS: I see that I am alright, they ask me how I am doing and also how the baby is doing.
R: Can we then say that the support you have helps to make you to feel alright?
PS: Yes
R: Earlier, you spoke about your parents coming and that they did not know. So at the moment, what is happening?
PR: Thereafter they spoke to me and my mother suggested that because I am still a student and will not be able to care for the baby, how will it be if I do abortion? My father is the one who disagreed, he mentioned that I was not the first one to get pregnant - people have got pregnant before.
R: so there is some support to help you to go forward.
PR: Yes, I can go forward. Like for June exams felt that I could not even study and we were approaching the exams.
R: You say you could not study, and earlier you were said it was stressing you. When you said it was stressing you, what are the things that made you to get to a point of saying I am getting stressed.
PR: It was possible for me to stay in bed, convincing myself that I was sleeping. I am staying with two other girls, one is doing BSc. When she would be studying, I would be tossing in bed, keep on turning to different side, thinking about the baby, asking myself how the baby will be, what kind of a child without a father. Like at home I am still a child, now they will be stressed by my child and it would be the end of my future.
R: The father, is he no longer interested in you, the child or the relationship, what is going on?
PR: Now there is no problem.
R: We have been touching on a number of things, what is going on with the other members of the group?
PT: with me at home they are supportive. It is only that at first I did not tell them, my mother used to ask me if I was pregnant, and I would say no. She then asked as to when was my last menstruation date, and I would tell her lies. I spent most of the time quite. The other day she asked me if I did not want to go to the doctor with her; I refused and we ended up going to the clinic.
R: Ok, I would like us to look at things like feeling down, or not being interested in doing things, or any other things that were happening. For example, other people

have indicated that they preferred being alone without company of others, others indicate being irritable, impatient or just feeling unusual, do such things happen?
PR: With me I often feel that I want to be alone. The thing that keeps me busy is the computer. When I feel like being alone, I go to the computer laboratory and spend the whole day there and come back in the evening; I share a room with two other people, so it was not going to be easy for me to be alone. I often spend the whole day at the laboratory, and when I come back I feel better.
R: What about the others?
PS: I feel alright spending time with my friend because we talk about different things , and we would not be talking about pregnancies. We would spend the time laughing together. But when I go home I would get irritated easily. They would send me to do things and when you are moving around they will see you. When you stand up the pregnancy may be visible.
R: So the issue of getting irritated was because you did not want them to see the pregnancy.
PS: Yes.
R: You mentioned that you would spend most of your time with your friend. I would like us to look at our relationships with our friends. How are the relationships with friends?
PR: Mine was good. The problem was that I have many friends, the people I live with in the same accommodation facility. You would find that as we are talking, one will say I missed my periods and I would think that she is talking about me; the other one will say my boyfriend did not use a condom yesterday, maybe I am pregnant. So I would think that they are talking about me and this would bore me, and when they talk about this I feel that they do not support me, but there was nothing they could do.
PS: My friends have babies. The one I spend most of the time with once had a miscarriage, she the one who offers me support.
R: So it means there are no changes in terms relationships with friends – they are still there. There is somebody who mentioned that her friend does not speak to her any more. Some friends are reported to be supportive, some would not want to be associated with you when they realise that you are pregnant. In terms of other community members, are you in a position to feel free and interact meaningfully with them?
PS: With some, other no. in my community there is a woman who does not have children. So, sometime back she told my mother that your daughter made you an old lady when it is still early. When my mother responded she told her that there is no problem as to when a woman bears children; if she is pregnant and we do abortion and it happens that that was the only baby she could have do you see what it would mean? Now she does not talk too much.
R: There were also indications from another group that people would like gossiping about you.
PS: Yes, like I have a cousin who is older than me, and she does not have a child. They would ask me why I am going to have a child before my cousin could have a child.
R: It looks like it is not expected that way.
Yes (all).

R: What about other things, earlier we were talking about sleeping problems, finding yourself tossing without falling asleep. What is it that makes it difficult to sleep when you want to.
PR: It is because you are going to have a child. The thought that I am going to have a child (nodding by others). If there was nothing about it, I would not be like that.
R: So it means there is a preoccupation
PR: Yes in the mind, and I just start turning in the bed.
R: Somebody mentioned that I feel guilty now that wherever you go, they talk about teenage pregnancy, when I switch on the radio, it's teenage pregnancy, when I switch on the TV it's teenage pregnancy and when I open a newspaper, they report on teenage pregnancy. She then said this thing make her feel like she has committed crime.
PR: Yes, she is telling the truth. Like, even when you are with parents watching the TV and they start talking about teenage pregnancy (P2: You get embarrassed), you even feel like you can change the channel. There is one pamphlet that I saw, it was on teenage pregnancy, I could not read it – the way teenage pregnancy bothers me. When you are seated with parents it's difficult (laughter by all).
PS: Yes, like when you are watching the TV with parents, and they show a picture of somebody who is pregnant, and maybe you are all quite; when I see that pregnant person and knowing that I am also pregnant, I stand up and leave the room or act as if I am busy doing something until the person disappears from the screen.
R: I am just listening to what you say and it's like you look at yourselves as people with big stomachs, so you would like to excuse yourselves.

PS: Yes, because I am already thinking that they are thinking about me, and when I look at the person on the screen I find that our stomachs are not of the same size. I will be looking at the family members thinking that they are looking at me, and they will be looking at the TV and their minds not at me but at that person.
R: It looks like there is an indication that when you hear people talking, they are talking about you.
PS: Yes, I no longer trust myself. I just think that they are referring to me. And also, when maybe I pass people and they look at me, I will be surprised, asking myself why do they look at me, what do they see.
PR: Every time when I think about my pregnancy was that do my parents think that I was involved in sex? They expect me to be involved in love relationships, but not to that extent. When they see the big stomach they ask themselves if I was involved in sex, what was she doing to end up this way?
R: It means it brings the thought to you that they think until they reach a point of you having sex.
PR: Yes, I think it is understandable that a child of 15 years can be involved in intimate relationship, but not to the extent of having sex.
R: You are saying that they did not think that you were involved in sexual activity, but the pregnancy is a sign to show them that you were involved.
PR: Yes
R: Ok, so it keeps on coming to you, also that when we look at the issue of sex in our communities it is not something that is publicly discussed, even with our parents.
PR: You see I get to a point that I think that my parents are saying it means that this person was having sex.

R: So this seems to be one of the concerns that you keep thinking about.
PR: Our African people think that sex is for older people. And even when they see it on TV, they ask themselves if the child can do it.
R: It appears like it is something that is a question.
PS: Yes
PR: Yes, it is only that they avoid it.
R: For you I guess that you have accepted the pregnancy, you are waiting to have babies. That in itself, what does it mean to you?
PR: It embarrasses me sometimes. I ask myself: Am I going to be a parent? Is there going to be a person who calls me mother. That's the thing I keep on asking myself. I am no longer going to be my mother's baby, there is somebody going to call me mother, I will be having somebody to take care of.
R: Any other thing, or something you want to ask me.
Concluding remarks: there is basically nothing from my side, but as we were talking I realised that there is support. It could just be a word of encouragement. What needs to happen now I think it will be to continue with your lives being in this kind of a situation…….one needs to accept that this is the experience that I have had, and I need to continue with my life unlike having to blame oneself, because that in itself does not bring good health, it makes one to feel depressed and tired most of the time, a lot of complaints. What I can say is that have that spirit of wanting to continue with my life. There was an indication that if I could kill myself for this child. With such a feeling, you will be killing two people for basically nothing, you are not the first one to be pregnant at this age. It is one of the things that happen in life.
For one's good health, I need to accept what has happened to me and continue with my life looking at the future. There may be difficulties here and there but there are things that I can still make happen. Earlier there was an indication that one parent indicated that she was also a teenager when she conceived, if she had decided to kill herself because of the pregnancy, you would not be here. These are some of the things to encourage you to continue with life. There may be challenges and you may ask yourself as to what is happening, but having that courage to continue.
PR: I think we also have options, we can make the babies available for foster care or for adoption; and for foster care if I work, I can claim the child back, and for adoption it means I cannot have the child back.
R: It means options are there, and it is not necessary to kill oneself. There are people who do not have children , they have lodged applications with social workers. For that person if she can get a child, that will make a difference in her life…. It's better to think about what next. Yesterday in one of the groups somebody mentioned that one thing that makes her unhappy is that here in South Africa teenagers are getting pregnant to get child support grant.
PR: It's not all of us who are looking to receive grants. There are some who are. Somebody I know is making children to get the grant. She has two already and she has indicated that she wants to have another one next year.
R: Ok, I think for now we can end here.

Focus group 3

I would like us to start from the beginning where I will introduce myself and to tell you about the purpose of our gathering. I am doing research on the psychological well being of pregnant people, specifically looking at people who are in their teen years. Things that we are going to talk about focus on feelings when one is pregnant. The way I would want us to do it is not like I will say now is this one's turn to speak or that one; it will be to put down an issue for discussion and we share how we see it or how does it affect us looking at the experiences we have. That is what I would like us to talk about. And also, we are all women and pregnant, so it cannot be that I do not want to talk because I am afraid of what they are going to say, we all have something in common. I would like us to first talk about the physical changes that we observed when we realised that we were pregnant. Some people would talk about getting tired, etc. Or even now, what is happening?

PD: I experience dizziness and nausea.

PA: I also feel dizzy most of the time.

R: The things that we are talking about are those that did not happen before. They are starting now since pregnancy.

PB (just had a baby): I used to experience a lot of bleeding through the nose. But since the birth of the baby, I no longer experience bleeding.

R: Before pregnancy, were you experiencing it often?

PB: No, it would be maybe once a year.

PD: I get impatient with boys

R: Is there something that makes get impatient with boys?

PD: I just see myself being impatient with them. I am able to sit with girls and talk nicely, but with boys, I shout at them.

Laughter (all participants). I just find myself shouting at them.

R: What are the things that brings such things, she ….

PB: For me they told me that it is because I will have a baby boy, and I gave birth to a baby boy.

R: When we think of getting impatient, what are the other things that cause it?

PD: Sometimes you find that things just smell bad for you, and this makes you impatient.

PC: Sometimes is due to lack of tolerance when one is pregnant. When you have tolerance, you cannot be impatient.

R: Why does it happen like that, do we ask ourselves why?

PD: It's the pregnancy.

Laughter (all participants). All these things it's because of it.

R: What about sleeping, are you able to sleep well, without being unable to maintain sleep?

PA: I sleep well

PC: I sleep.

PD: I sleep well.

R: So you do not experience problems of being unable to sleep. Earlier there was an indication that you are impatient with boys, can we look at relationships. How are the relations with our friends?

PD: You mean the relationship?

R: Yes, let's say for example I have a friend and she is not pregnant, does the friendship still exist?

PD: There is no one who has changed, they are still my friends. If you find someone changing, it means the person was not a true friend.
R: It means you are able to continue with the friendships. When I ask like this is because others would say that their friends no longer speak to them and would not like to associate with them anymore. They will say it's all because of the pregnancy. How are the relationships at home, other members of the family?
PD: They will not be impatient with you because they understand what you are going through.
R: So, on their part they understand what you are going through. Are we able to continue like before, before pregnancy?
All: Yes, it's fine, relations are fine at home.
R: Somebody mentioned that she feels guilty because when she listens to a radio, they talk about teenage pregnancy; when she looks at the newspapers, they report on teenage pregnancy; she watches the TV, they talk about teenage pregnancy. She mentioned that this worries her as the one who is pregnant and she is not afforded the opportunity to talk for herself as a teenager who is pregnant. She said it makes her feel guilty because all over they talk about it, which makes her to think that she has committed a crime. I would like to check with you if the issue of teenage pregnancy being discussed brings you any thoughts.
PC: You listen, others give advice. You cannot switch it off when they give advice. They talk about it all this time, you cannot switch off; you just have to listen. They will guide here and there.
R: What about the others, how do we see it?
PD: It's better to listen and get some advice.
R: The other thing that I want us to talk about is what other people refer to as feeling down and not having any happiness. Do you experience something like this?
PC: I experience fear and I do not understand what is happening.
R: Is it something that just happens without anything?
PD: It happens when you think a lot.
PC: You see I had a child before, and the child died in September when she was 2 years old. I often get scared and think that maybe the same thing will happen. I keep on thinking and I get frightened *(R suggested to the participant to seek professional intervention looking at grief and the pregnancy).*
R: There is an indication that fear is brought in by thinking a lot. Some mentioned that when they think about their relationships with their boyfriends, they get frightened. What is happening with the relationships with boyfriends?
PB: I do not care. He stays far away from me.
R: What is it that makes you not to care?
PB: Wherever he is, he may be having other girlfriends; so I do not care.
R: There is an issue of maybe he has other girlfriends; what is happening with others?
PB: If you rely on him, you will stress yourself.
PC Yes, you just have to be on your own. Because if you think about him and also the pregnancy, so is better if you do not think about him.
R: So think that a better way of continuing with your life if the boyfriend seems not to care is also not to care about him, and just continue with life. Are our boyfriends close to us at the moment?

PB: He may seem to be close, but when he leaves you, he changes because you do not see him.
R: In other words you do not trust what he does out there.
PB: Yes, because now I have a child I no longer get time to go out there, and I cannot see what he does.
PD: You find that you hear from your friends that your boyfriend is doing other things.
R: In our communities, how are the relations. Do we feel like people think otherwise about us, or there is no difference?
PB: I do not care about people.
R: Ok, is it something you tell yourself that you will just do as you please?
PC: If you are afraid of what people will say, you will not do anything. You should not care about people.
PB: Yes, because others when you do good things they are not happy.
R: So you decide that you will not worry about other people, you will do what you decide on. Are there other things that you realise that you experience and I did not ask you about?
PB: Some people may change. Like maybe in class, the teachers may start not talking to you in a good manner.
R: You feel like they do not treat you like other learners?
PB: Yes, you find them shouting at you, telling you that you make other learners to sleep in class.
R: How does that make you feel when you are told that you make other learners sleep in class?
PD: It is painful
PB: I once cried in class. There was a new teacher, so the other day I had to write on the board, I was wearing a dry-mag jacket, when I stood up I folded it and she just looked at me. The other day when I was going to the toilet, she called me. When I got to her she said: hey, why does it look like you are pregnant? I said yes I was pregnant. And she said why are you pregnant, and she started talking in a different manner and she told me that she was going to tell my classmates. I told her to tell them. And I just said whether you tell them or not, that does not need me. And she said I will tell them in class. I just thought maybe she was joking and I proceeded to the toilet. When I got back to class, after break it was her period. And when I was seated in class she told the class. She just said, I told you that you had problems. I cannot remember her exact words but she was telling my class mate how I was. My friends just looked at me asked me if she that I was pregnant. I just said I did not know, I was hurt and I started crying. My friends went to her to tell her that what she did was not appropriate. She came and asked me to forgive her; the way she had done, it was not good. She alerted a lot of people about my situation. She should have just called me and we talk about it, like she did; but she then continued with it in class.
R: You feel that she should not have mentioned it in class.
PB: Yes, they would see me on their own, not her alerting them.
R: What other reaction did we receive from other people?
PD: With me I had to quit singing at school because I would always be blamed for any mistakes.
R: It shows that even things that you used to do, you could not do any more. I think we can end here if there are no more things to focus on.