

**THE EFFECT OF DEMOGRAPHIC FACTORS AND SOCIAL SUPPORT ON
DEPRESSION AMONG HIGH SCHOOL TEENAGE MOTHERS IN THE MANKWENG
AREA**

**BY
PATRICK MAREDI MOTHAPO**

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SUPERVISOR: Dr. I.M. RAMOKGOPA

DECLARATION

I declare that “*The Effect of Demographic Factors and Social Support on Depression among High School Teenage Mothers in the Mankweng Area*” mini-dissertation hereby submitted to the University of Limpopo, for the master’s degree of clinical psychology has not previously 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.

Mothapo P.M (Mr.)



Date

DEDICATION

This thesis is dedicated to my late younger sister Ngwanamohuba. You will always hold a special place in my heart. Hope to meet you someday in the Kingdom of God.

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ABSTRACT

Adolescent motherhood is a major problem in many societies throughout the world. One of the problems these young mothers have to deal with is depression. Depression often results in the disengagement of mother-child interaction. Adolescent mothers who are identified as depressed are more at increased risk of future psychopathology, with additional effects on their future and infants' lives. The aim of this study investigates the influence of demographic factors (age and marital status) and social support on depression among high school teenage mothers in the Mankweng area in Limpopo Province, South Africa. Two hundred adolescent mothers took part in the study. One hundred of participants were mothers while the others were non-mothers. Their ages ranged between 15 and 19.

A quantitative research design and methodology was employed. Correlation analysis method was also used to associate lack of social support with depression. Correlation analysis indicates that lack of social support was a significant factor negatively affecting teenage mothers' disposition to depression ($r = -0.609$, $p < 0.01$). T-test analysis which was used to compare the experience of depression among teenage mother base on different age group, indicates that age does not play a significant role for teenage mothers to experience depression ($t = 1.409$, $df = 98$; $p > 0.05$). T-test analysis was also used to compare the experience of depression on married teenage mother and unmarried teenage mothers, and indicates that teenage mothers experience depression irrespective of marital status ($t = 1.091$, $df = 98$; $p > 0.05$). It is recommended that professional counseling be provided to teenage mothers before they return to the school system after giving birth. Support from social welfare and family members are also key support system for the young mothers so that these bring psychological and social stability in their lives.

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CHAPTER 1

INTRODUCTION

1.1 OVERVIEW OF THE STUDY

Teenage motherhood is a social problem of teenage girls getting pregnant and becoming mothers, particularly those who are not married (Bloom & Hall, 1999). The consequences of teen parenting are long term. They affect both mother and the child and ultimately the society as a whole. Teenage pregnancy can lead to, among other things, depression, poor school performance and emotional instability. The teenage mother may develop fear of the unknown with regards to abandonment by a boyfriend, deprivation, or reduced family sanction (Bloom & Hall, 1999). A strong relationship between teenage pregnancy and depression can also be assumed. Depression may be associated with impaired decision-making, lack of motivation and low self-esteem (Driscoll, 1997). Amongst girls, pregnancy can reflect an attitude of passivity and of not caring about what happens in their lives.

Studies on the possible social and psychological problems associated with teenage childbearing confirm that lack of social support is a risk factor for the adjustment and development of both young mothers and their children (Driscoll, 1997). Recent concerns about teen pregnancies have centered on the disruption that childbearing causes to the educational and occupational life of young women (Driscoll, 1997). This may consequently maintain and exacerbate poverty, especially when there is a lack of social support.

Social support includes the family, close friends, neighbours, co-workers and professionals. Social support is one of the positive aspects that influence teenager to teenage motherhood (Passino, Whitman, Borkowski, Schellenbach, Maxwell, Keogh, & Rellinger, 1993). Childbirth affects women differently, some feel happy and others feel sad (Hudson, Elek, & Campbell-Grossman, 2000). The demands of motherhood may leave little time or energy for other relationships. As a result, the teenage mother may feel

isolated from her family or peers. Some of the parenting teenage mothers experience a lack of communication, emotional closeness (Rodriquez & Moore, 1995) and support from their parents (Cronin, 2003; Yampolskaya, Brown & Greenbaum, 2002). Although the well-being of teenage mothers appear to be affected by a variety of psychosocial stressors, the stage of adolescence itself is accompanied by a variety of social pressures, such as establishing autonomy, friendship and familial relations and occupational goals (Prodomidis, Abrahs, Field, Scafidi & Rahdert, 1994).

Falling pregnant while still at school or at an educational institution is generally problematic for the teenager. If a young mother decides to carry her unborn baby to full term, she may have to interrupt her studies. Her decision for leaving school or the educational institution may lead to isolation of her peer group and may also reduce her sources of social support (Bezuidenhout, 1998). Tanga and Uys (1996) investigated the social support system of unmarried teenagers in South Africa and found that both parents and peers gave teenagers the support they needed. While Brage, Meredith and Woodward (1993) found a negative relationship between low self-esteem, loneliness, or depression and feelings of disconnection from social support in teenage mother groups, Prodomidis et.al (1994) found that depressed teenage mothers reported poorer functioning in the areas of physical health, mental health, peer relations, family relations and social skills. The lack of support from family or friends and the isolation during pregnancy is likely to negatively affect their mental health. This can be identified as a factor that leads to depression (Clemmens, 2002). Social isolation and the sense of abandonment that many participants experience can deepen depression and emphasise the need to keep these women attached to their families and to their peers.

1.2 BACKGROUND OF THE STUDY

Teenage motherhood is a social problem that needs serious attention because it creates feeling of depression. Many of the teenagers drop out of school as a result of their pregnancies and mothering, others fail and others think of abortion and still others think of committing suicide. Many attempts have been done in trying to reduce teenage

motherhood, but it is still increasing at an alarming rate (Roles, 1991). A study by Turner, and Ascher (1985) indicate that a combination of family, partner, and friend support was related to a decreased incidence of depression among teenage mothers.

The first few months after having had a baby are challenging time for first-time teenage mothers. During motherhood women endure social, emotional and economic changes (Gittins, 1993). During this transitional period, women also experience complex cognitive, affective and behavioural changes. The term 'motherhood', according to Walker (1995), distinguishes between firstly, mothering referring to the practice of motherhood and secondly, the discourse of motherhood, focusing on the ideas about the acceptable role of the 'Good Mother', according to the particular society. With regard to the practice of mothering, Walker (1995) argues that motherhood includes the act of childbirth, the physical care for the baby and the emotional nurturing i.e. looking after the infant. Special abilities and energy are required in performing the new tasks involved in caring for a baby (Pridham & Chang, 1992).

Children that are restless, weepy or easily irritated tend to decrease the mother's coping abilities by increasing her exhaustion and tiredness. If this continues to happen, the mother can easily question her own capacities and capabilities of caring for her infant and become more dependent on the support from family members, friends or professionals (Tarkka, Paunonen, & Laippala, 1996). Many teenagers may also experience feelings of anxiety and confusion, because of their unrealistic expectations of motherhood, especially when they do not get social support (Ex & Janssens, 2000). Therefore, social support helps in preventing depression.

Teenage parenthood is a complex phenomenon that touches the lives of the teenage mother and father, the children born to them, the teenagers' parents, the schools, counseling services and family planning services that have been established to help them cope (Caldas, 1993). Teenage mothers may not be socially and personally mature enough to assume the new roles of parenthood. Young parents may lack parenting skills; they may also be impatient, insensitive, and irritable. Teenage mothers may easily become

overwhelmed with their new burden, and without adequate social support system and positive coping skills, they may become depressed and even contemplate suicide (Cronin, 2003).

Teenage mothers under the age of eighteen are less cognitively prepared for parenting than those over eighteen years, according to Sommer, Whitman, Borkowski, Schellenbach, Maxwell and Keogh (1993). The study by Ex and Janssens (1998) shows that teenage mothers are less informed or less educated about the normal development of infants than the adult mothers. This may lead to teenage mothers being overwhelmed by the role of parenthood. Teenage parenting therefore, presents a challenge to young mothers, and these mothers are often unprepared. This may contribute to high rates of depression, especially if there is no social support.

Partners also form a key source of social support. Several studies have found that when support from a male partner is not available, mothers were more likely to be depressed (Littewood & Mchugh, 1997). Depressed women reported less instrumental and emotional support from their husbands than did their non-depressed counterparts (O'Hara, 1986). Teenagers who are married may experience less depression than those who are not married. Therefore married teenage mothers depend on their partners for social support.

1.3 PROBLEM STATEMENT

Teenage motherhood continues to be a common and complex phenomenon in the world. In South Africa, a study that was conducted in all the provinces revealed that the age for first sexual intercourse for urban women was a slightly older age than rural women because rural women get married earlier (Kaufman, de Wet & Stadler, 2000). This also applied to Limpopo Province. Rural teenagers tend to start childbearing earlier than urban teenagers (21% compared to 13%). Research also shows that more than 35% of South African teenagers became pregnant before they reached the age of 20 (Republic of South Africa, 1998).

Worldwide, more than 10% of all births are to women 15 to 19 years of age. Young mothers are often unprepared for the tasks of parenting (Leadbeater, Bishop, & Raver, 1996), leading the young mother to doubt her own abilities and competence in nurturing her infant (Tarkka, Paunonen & Laippala, 1996). Depression often results in mothers distancing themselves from their infants, because they often experience negative perceptions of themselves or the baby (Heneghan, Silver, Westbrook, Bauman & Stein, 1998). Many teenagers have relatively high rates of depression and experience anxiety and confusion during this period (Ex & Janssens, 2000). One of the reasons that make teenagers drop out of school is pregnancy, especially in the absence of social support.

Teenagers are faced with many challenges. Some of the challenges include transition from childhood to adulthood and scholastic. Being a teenage mother may be even more challenging. These challenges may result into teenagers becoming depressed, especially if they do not get social support.

Little information exists regarding the influence of demographic factors and social support on depression among high school teenage mothers. Therefore, demographic factors and social support and the role that they play in teenage mothers who are depressed are the problems that need to be addressed.

1.4 AIM OF THE STUDY

The aim of the study is to investigate the influence of demographic factors (age and marital status) and social support on depression among high school teenage mothers.

1.5 OBJECTIVES OF THE STUDY

Objectives of this study are as follows:

- To determine whether there is a relationship between social support and depression among teenage mothers.
- To determine whether age difference has an influence on teenage mothers experiencing depression.
- To determine whether marital status has an influence on teenage mothers experiencing depression.

1.6 SCOPE OF THE STUDY

The study was conducted among various high school learners in the Mankweng area in Limpopo Province (Capricorn District), South Africa. Mankweng area is located some 28 km east of Polokwane. Mankweng area has eleven secondary / high schools.

1.7 SIGNIFICANCE OF THE STUDY

The study will contribute positively in understanding the problem of teenage motherhood, and in finding effective ways of offering social support to them. Teenage mothers need support and encouragement so that they perceive life more positively despite their condition.

1.8 HYPOTHESES

Hypotheses of the study are as follows:

- Teenage mothers who lack social support will experience depression.
- Teenage mothers under the age of eighteen will experience more depression than those over eighteen years.
- Married teenage mothers are less likely to experience depression than those who are not married.

1.9 OPERATIONAL DEFINITIONS

1.9.1 Demographics

Demographics are the physical characteristics of a population such as age, sex, marital status, family size, education, geographic location, and occupation. Demographics include sex, race, age, income, disabilities, mobility (in terms of travel time to work or number of vehicles available), educational attainment, home ownership, employment status, and even location (Power & Elliott, 2006). In this study, demographics refer to age and marital status.

1.9.2 Social support

Social support is described as consisting of the personal reactions of at least two individual to a shared social interaction and the shared meaning that these individuals jointly construct and attribute to their interaction (Bad, Aciteli, Duck & Carl, 2001). Furthermore, Gottlieb (1983) defines social support as consisting of “verbal and/or nonverbal information or advice, tangible aid, or action that is proffered by social intimates or inferred by their presence and has beneficial emotional or behavioural effects on the recipient.” Therefore, social support refers to a network of family, friends, neighbours, and community members that is available to give psychological, physical, and financial help, in times of need.

1.9.3 Depression

Depression is a psychological disorder that affects a person’s mood changes, physical functions and social interactions. Depression is characterised by sadness and loss of energy and enjoyment in life (Raulin, 2003). Depression is a "whole-body" illness, involving the body, mood, and thoughts. It affects the way one eats and sleeps, the way one feels about oneself, and the way one thinks about things. Furthermore, depression is a state of low mood and aversion to activity.

Therefore, depression can be defined as deep rooted sadness that affects individual normal mood, psychological and daily functioning.

1.9.4 Teenager

A teenager is a person between 13 and 19 years of age. In this study, a teenager refers to a person between 14 and 19 years of age.

1.9.5 School

A school is an education agency (Guttek, 1992). A school is an institution designed for the teaching of students (or "pupils") under the supervision of teachers. In this study a school is defined as an institution designed to allow and encourage students (or "pupils") to learn, under the supervision of teachers.

1.9.6 Mother

Mother can be defined as a caretaker of infants (Coll, Surrey & Weigarten, 1998). Walker (1995) argues that motherhood includes the act of childbirth, the physical care for the baby and the emotional nurturing. Therefore, in this study "mother" is referred to a biological female parent of an offspring.

Chapter one provided a general overview of the study and the definition of terms to be used have been discussed. The next chapter presents the literature review and theoretical perspectives; which will show the extent of the problem and how it was dealt with in other countries.

CHAPTER 2

LITERATURE REVIEW

2.1 ELEMENTS ASSOCIATED WITH DEPRESSION

Depression as a low mood state can be associated with a variety of elements. These elements may have negative influence on the individual (Littewood & Mchugh, 1997). The following elements are associated with depression, namely; Social Support and Depression, Age and Depression and Marital Status and Depression.

2.1.1 Social Support and Depression

Family support is the most important element in the lives of teenagers. As part of their growth experience, teenagers usually expect a lot of things from their parents. Inadequate support from parents is likely to increase the chance of depression among teenagers. This occurs because teenagers usually become confused when they expect to get plenty of help and positive reinforcement from their parents, but do not receive it (Littewood & Mchugh, 1997).

Higher levels of parent-teenager communication have been associated with low depression and pregnancy rate (Wright, Peterson, & Barnes, 1990). Similarly, poor communication with parents and lack of parental support has been linked to high level of depression and high pregnancy rate among teenagers (Turner, & Ascher, 1985). Both high levels of parental supervision and close relationships between teenagers and their parents were related to low rate of depression and later timing of teenager sexual activity. Parental support of teenage autonomy has been associated with later initiation of sexual intercourse (Turner, & Ascher, 1985). This means that the inclusion of parents in pregnancy prevention programmes may help in reducing teen pregnancy and lower the rate of depression.

Most parents react negatively, expressing anger and disappointment when they hear that their teenagers are pregnant. Parents may also experience embarrassment and shame about their daughter's pregnancy, and worry that there will be added responsibility. South African research shows that very few families actually reject their pregnant daughters (Turner, & Ascher, 1985). In the African community in particular, there are helpful customs and rituals which allow for the "cleansing" of the mother and child and the payment of reparation. Despite the initial reaction toward their daughters being pregnant, most parents provide psychological and economic support and welcome the new baby into their family.

Beside family support, peer support is a very important factor for teenagers. Children expect a lot of support from their friends. Peer support can be considered as an alternative method of getting social support if the teenagers receive inadequate attention from their parents. This social support method is not as reliable as family support, because young children can easily withdraw from their own friends if they become depressed. Another problem is when the depressed teenager isolates herself from public gatherings, thereby making it difficult to receive any social support (Littewood & Mchugh, 1997). Receiving social support is essential for teenagers to become successful and to achieve at school.

It is assumed that motherhood causes resentment and jealousy between teenage mothers and their friends (Littewood & Mchugh, 1997). Having a baby may separate the teenage mother from her former friends. Teenage mothers report missing their friends and having a sense of loss in their social life (Littewood & Mchugh, 1997). This change in social life may be difficult for a teenager to bear, and may lead to depression.

A study by Turner and Ascher (1985) indicates that support from family, partner, and friend was related to a decreased incidence of depression among teenage mothers. Although teenage mothers depended mostly on grandmothers and partners for support, professional support as provided by pediatricians and nurses was also valued. Turner and Ascher (1985) further found that a broad range of social support covering (a) sources of

support (professionals, family, partners, and friends); (b) support functions (affect, affirmation, aid, information); (c) social network properties (number in network, duration of relationships, frequency of contact), was significantly related to the quality of teenage parent-infant interaction.

The socio-emotional problems of teenagers are predicted best by mothers' internalised problems, such as depression, and lack of social support from partner and friends (Turner, & Ascher, 1985). Thus, an increase in network size, including multiple sources of support (professional, family, friends, and partner and social ties), is significantly associated with diminished maternal stress. Social ties to significant others are linkages through which child-rearing information can flow to affect teenagers' parenting behaviour (Turner & Ascher, 1985).

Multiple support sources appear to increase mother's knowledge of child development, improve parent-infant interaction, reduce depression and stress, and improve maternal confidence (Turner, & Ascher, 1985). Optimal adaptation to parenting may be fostered by supporting the relationships between teenage mothers and their own mothers or partners. Knowledge of infant development which may be imparted by professionals or "natural" network members such as family, partners, and friends could play important roles in teenagers' confidence in mothering.

2.1.2 Age and Depression

According to Rice (1992), early motherhood creates stresses in the lives of teenagers. Teenage mothers are more likely to drop out of school and unemployed. They may experience loneliness and feelings of isolation from friends, with little time for themselves. Many teenage mothers cope through assistance from family members and community agencies. McWhitter and McWhitter (1993) point out that when a teenage girl becomes pregnant; her physical, social, educational, and career development is significantly altered. An unwanted child may have consequences for the mother's socio-

economic status, her educational attainment, her health, and her family development. From the above arguments, it is noted that teenage parenting is a serious problem, which affects not only the teenager, but family members as well. The problem tends to change the future expectations of teenage mothers. Thus her educational, social, physical and job opportunities tend to be drastically affected.

Sparks (1998) indicates that problems of teenage girls usually do not include motherhood. When a 14 year-old discovers that she is pregnant, the issues of shopping and sleepovers are eclipsed by the need to make decisions that will affect her for the rest of her life. She may ask herself questions such as: - “Is there anyone she can tell? Should she keep the baby? How long does she have to decide?” With regard to age, teenage mothers under the age of eighteen may experience more depression than those over eighteen years. The reason for this is because; teenage mothers over the age of eighteen may have better cognitive development, and therefore can cope better with motherhood than those under eighteen years. Thus, the younger the age, the more likely the depression. Teenage mothers, who are unprepared for responsibilities of parenthood, often live below the poverty level in disadvantaged environments and have higher levels of stress, less education, and fewer psychological resources than do women who delay childbearing (McWhitter & McWhitter, 1993). Early childbearing presents a developmental crisis for teenage parents, who must face the task of parenting before completing the developmental phase of adolescence. Adolescent mothers are less likely to receive child support from biological fathers, less likely to complete their education or to work, and less likely to be able to provide themselves and their children without outside assistance (McWhitter & McWhitter, 1993).

2.1.3 Marital Status and Depression

Partners (husbands of teenage mothers) are a key source of social support. Littewood and Mchugh (1997) found that when partner support was not available, mothers were more likely to be depressed. Depressed teenage mothers reported less instrumental and

emotional support from their husbands than did their non-depressed counterparts (O'Hara, 1986).

After their mothers, teenage mothers rated their child's father as the second most valuable source of social support. Living in a nuclear family (teenager mother and her husband) has been associated with stronger social support and more positive child-rearing attitudes (O'Hara, 1986). Partner support has also been associated with greater responsiveness to infants and greater maternal satisfaction with life. Social support from the infant's father enhances adjustment to parenting and the quality of teenager mother-infant interaction.

Little support from a partner after birth is associated with anger and punitive behaviour by teenage mothers toward their toddlers. Littewood and Mchugh (1997) reveal that partner support was correlated with the mother's psychosocial well-being and favorable developmental outcomes for the infant. The relationship between enhanced child development outcomes and partner support may be explained, in part, by the increased likelihood of teenage mothers with partners to seek preventive health care for their children and to remain involved in support programmes. Unfortunately, the relationship between the teenage mother and the father of the child is often short-lived.

Although partners of teenage mothers are much less likely to be negative in their reaction than their parents, up to half are said to be unhappy with the pregnancy (O'Hara, 1986). This implies that despite being unhappy about the pregnancy, partners of teenage mothers often offer support.

2.2 THEORETICAL PERSPECTIVES

Social Support theory, Appraisal Theory, Social Support Networks and Depression Theory and Cognitive theory of Depression, are theories that attempt to explain the relationship between depression and social support. These theories will be examined in detail.

2.2.1 Social Support Theory

Motherhood has a negative impact on teenagers. Teenagers who are mothers are likely to become shameful and abandon many of their dreams, especially due to lack of social support. This lack of social support negatively affects their psychological wellbeing (Cohen & Wills, 1985).

According to Cohen and Wills (1985), teenage mothers with social support are unlikely to experience mental health problems. Buffering hypothesis generally put forward two ways in which social support mediates the causal sequence linking stress to illness. First, social support may prevent a stress appraisal response. The perception that others will help to provide the necessary resources to combat stress may bolster one's perceived ability to cope with the situation, and consequently prevent a particular stressor from being appraised as highly stressful. Second, adequate social support may intervene to suppress the stress reaction. Support may reduce the impact of stress by facilitating healthful behaviour, providing a solution to the problem, or inhibiting the neuroendocrine system (Cohen & Wills, 1985).

Furthermore, in Main Effects Hypothesis, Cohen and Wills (1985) assign positive main effects of social support to its provision of positive effect, a sense of stability and recognition of self-worth. Involvement in a social support network may also directly promote avoidance of stressful or negative life experiences, and the absence or removal of social support constitutes a source of stress in itself (Gottlieb, 1983., Turner, 1983).

The buffering and main effect models of social support are not mutually exclusive. This view postulates that social networks serve as both active support systems, furnishing the satisfaction of day to day expressive and instrumental needs, and as reactive support systems, available to respond to typical stressors (Dean & Ensel, 1983).

Oritt, Paul and Behrman (1985) propose that in the Perceived Social Support Model individuals appraise their current support network through recollections of past

supportive interactions and outcomes. The elements of perceived social support comprise those variables that are reviewed by the individual when recollecting past supportive encounters. These variables possess at least one quality in common- all are subjective in that they are modified by an interpretive memory and the passage of time. It is the interpretation of the impact of past events that is presumed to play a crucial role in determining current perceptions of social support (Oritt, Paul & Behrman, 1985). Thus, if the appraisal process concludes that interaction with the support network is likely to reduce stress for the individual, the model assumes that the individual will engage in support-seeking behaviours.

A number of perceived social support variables can be viewed as falling within the subjective experience of the individual: the perception of how readily available network members are for providing support during times of stress; the personal gratification resulting from the perceived effectiveness of the support in reducing stress; the number and types of support an individual believes he or she might expect to receive from a network member; the extent to which an individual believes reciprocity of support exists between him or her and the support network, and the extent to which an individual believes conflict exists between oneself and members of the support network (Oritt, Paul & Behrman, 1985). Thus, the presence of social support in the lives of teenage mothers helps them maintain their psychological wellbeing.

2.2.2 Appraisal Theory

One of the cornerstones of the transactional framework is appraisal theory. Lazarus and Folkman (1984) state that a specific event or stressor influences individual cognitions of an event termed, appraisal. Appraisal theory examines the process by which emotions are elicited as a result of an individual's subjective interpretation or evaluation of important events or situations; hence, it is the evaluation of events to determine one's safety in relation to his or her place in the environment (Lazarus, 1999). Therefore, an event, irrespective of its importance, may or may not be perceived as stressful or harmful by an individual (Regehr & Bober, 2005).

Appraisal theory posits that there are two levels of appraisal: primary appraisal and secondary appraisal (Lazarus & Folkman, 1984). Primary appraisal is the individual's evaluation of an event or situation as a potential hazard to his or her well-being. Primary appraisal is also defined as when an individual concentrates on the magnitude of an event or situation possibly for harm (Lewis, 2002). Secondary appraisal is the individual's evaluation of his or her ability to handle the event or situation. This estimation of the range of coping skills in the individuals' repertoire occurs in relation to, not necessarily after, a primary appraisal of a situation (Lazarus, 1999). Thus, the evaluation is dependent on the subjective interpretation of whether or not the event poses a threat to the individual (i.e., primary appraisal) and whether or not the individuals perceive they have the resources (inner and outer) to cope with it (i.e., secondary appraisal) (Regehr & Bober, 2005).

According to Lazarus and Folkman (1984), there are also three types of primary appraisal: (a) irrelevant, where the individual has no vested interest in the transaction or results; (b) benign positive, in which the individual assumes that the situation is positive with no potential negative results to his or her wellbeing; and (c) stressful, where the individual only perceives negative results or that the circumstances are detrimental to his or her wellbeing. In order to determine the magnitude of an event or situation using secondary appraisal (Lazarus & Folkman, 1984), an individual focuses on one of three perceptions: harm or loss, threat, or challenge (Lewis, 2002). Harm or loss is the belief that one has endured a physical or emotional loss with the temporal nature of the loss in the past. Threat is an anticipation of future harm or loss. Lastly, challenge is marked by positive events that have a risk of future negative outcomes that are laced with mastery (of event) and risk (from the challenge). Challenge also can be defined as the potential for positive personal growth by applying coping skills to mitigate the stressful event or encounter (Lazarus & Folkman, 1984).

Because secondary appraisal is purely a cognitive process, coping efforts have not been instituted at this point. Depending on the nature of the primary appraisal, the secondary

appraisal can be influenced by contextual-level factors such as demands, constraints, and opportunities. The resulting appraisal then generates an emotion, or meaning, attributed to the particular event or situation. The individual is now able to move from thinking to action (Lazarus, 1999).

Meaning and emotions are usually generated after the acute event has been appraised by the individual. Then a behaviour called coping ensues. Coping involves the decision of which behaviours are utilised to handle the event. It is an interaction between the person's internal resources and external environmental demands (Lazarus & Folkman, 1984). It is also defined as constantly changing cognitive and behavioural efforts to manage specific demands that are appraised as potentially taxing or exceeding a person's resources. Coping includes attempts to reduce the perceived discrepancy between situational demands and personal resources (Lazarus, 1999).

Lastly, an individual employs coping strategies in one of two ways, by problem-focused coping, which is actively or behaviourally altering the external person–environment relationship, or emotion-focused coping, which is altering the personal or internal meaning or relationships (Lazarus, 1999). Problem-focused coping is also defined as channeling efforts to behaviourally handle distressing situations, gathering information, decision making, conflict resolution, resource acquisition (knowledge, skills, and abilities), and instrumental, situation-specific, or task-oriented actions (Folkman & Moskowitz, 2000). This type of coping allows the individual to focus attention on situation-specific goals and allows for a sense of mastery and control in working toward attaining that specific goal. Alternatively, emotion-focused coping involves positive reappraisal. This process of cognitively reframing typically difficult thoughts in a positive manner impacts deeply held values that become apparent when certain conditions occur and are needed to assist in coping (Lazarus, 1999). Therefore, the more the teenage mother has positive appraisals about important situations, the less she will experience depression.

2.2.3 Social Support Networks and Depression Theory

Individuals with a healthy social support network, find it easier to handle major stressors (Wade & Kendler, 2000). A proper support network consists of a reinforcing family and friends who can help the affected individual to work through any problems, such as the death of a family member, loss of a job, major injury, or any of a number of other stressors that can contribute to psychological illnesses, such as depression. For individuals with an undeveloped social network, or those with a negatively reinforcing social network, these major life events can cause greater harm to the individual because of a lack of support that most individuals have. An individual with underdeveloped social network cannot handle the pressure of an individual looking for support, and a negatively framed social network can actually reinforce thoughts of hopelessness, failure, and worthlessness. Without this support, it is more likely for that individual to develop symptoms of depression (Wade & Kendler, 2000).

When a parent is depressed, children may end up being depressed too (Wade & Kendler, 2000). Depression can be attributed to many things, such as marital problems, difficulty adjusting to a new family member, and poor social connections being formed with depressed family members. In normal conditions, a healthy social support network that is found in many families can help a depressed individual cope with the problems that he or she is experiencing. The absence of such a network can cause the individual facing a difficult situation to be unable to cope with the problem (Billings & Moos, 1983).

When a parent is depressed, the children in the family, experiencing problems of their own as children often do, can further depression in the parent by getting in trouble with the law, performing poorly in school, or any number of other things that a non-depressed parent would normally be able to cope with. If that parent is depressed, it may not be possible for the parent to help the child face his or her problems, which increases the likelihood of the development of depression in children. The lack of social support from a parent can be a factor in the development of childhood depressive symptoms, or in clinical childhood depression (Billings & Moos, 1983).

In other circumstances, an otherwise normal family can increase the chances of children becoming depressed by creating a negative social dynamic within the family. Kenney-Benson and Pomerantz (2005) found that parents' heightened use of control especially that of the mother, caused perfectionistic traits in children, which led to heightened depressive symptoms when the child was not able to achieve highly.

It is not unusual to find that in the community some of the brightest individuals are affected by depression. The more intelligent a girl is, the more likely that she will be depressed. Studies on social causes of depression in highly intelligent individuals revealed that highly intelligent and creative individuals have poor social networks (DeMoss, Milich, & DeMers, 1999). This depressive style has been shown to negatively affect other social relationships in a person's life. A study conducted to determine the relation between social support and depression found that individuals who are mildly depressed often end up creating situations where friends can no longer take the constant assurance-seeking and cut off the relationship with the individual, leading to more serious depression (Wade & Kendler, 2000). The more intelligent the girl is, the more she is susceptible to depression. This applies to teenage mothers as well. Thus, the proper social support from family and friends may help teenage mothers to be less depressed.

2.2.4 Cognitive theory of Depression

Beck (1976) believes that people become depressed because they feel responsible for every negative life event that has happened to them. He stated that people with depression learn a negative schema from which they view the world. When they encounter similar situation later, this negative schema is reactivated. They expect to fail, they magnify their failures, and they minimize their success (Atkinson, 1983). They feel that they can do nothing about their own helplessness and thus become victims of it.

Beck's main argument was that depression was instituted by one's view of oneself, instead of one having a negative view of oneself due to depression. This has large social

implications of how we as a group perceive each other and relate our dissatisfactions with one another.

Abela and D'Alessandro's (2002) study on college admissions found that the student's negative views about their future strongly controlled the interaction between dysfunctional attitudes and the increase in depressed mood. The research clearly backed up Beck's claim that those at risk for depression due to dysfunctional attitudes who did not get into their college of choice then doubted their futures, and these thoughts lead to symptoms of depression. Therefore, the students' self-perceptions became negative after failing to get into college, and many showed signs of depression due to this thinking. Individuals who are depressed misinterpret facts and experiences in a negative fashion, limiting their focus to the negative aspects of situations, thus feeling hopeless about the future, especially in the absence of social support.

2.3 THEORETICAL FRAMEWORK

The researcher identified this study to be inclined to social support theory. Social support is a crucial factor for teenage mothers. Buffering hypothesis stipulates that social support mediates the causal sequence linking stress to illness. Social support may prevent a stress appraisal response. The perception that others will help to provide the necessary resources to combat stress may bolster one's perceived ability to cope with the situation, and consequently prevent a particular stressor from being appraised as highly stressful. Adequate social support may intervene to suppress the stress reaction. Support may reduce the impact of stress by facilitating healthy behaviour and providing a solution to the problem.

The next chapter presents the methodology employed in this study.

CHAPTER 3

RESEARCH METHODOLOGY

This section details all the methods that were employed in this study. It provides explanations about samples, numbers of participants, method of data collection, methods of data analysis and ethical considerations.

3.1 RESEARCH DESIGN

The quantitative research approach was utilised for the purposes of this study. Quantitative research methodologies are enquiries into a social or human problem, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures (De Vos, Schurink, & Strydom, 1998). The aim of quantitative research is to measure the social world objectively, to test the hypotheses, and provide information necessary to predict and control human behavior (Cresswell, 1993).

The study utilised experimental research design. The aim of the experimental research is to investigate the possible cause-and-effect relationship by manipulating one independent variable to influence the other variable(s) in the experimental group, and by controlling the other relevant variables, and measuring the effects of the manipulation by some statistical means (Bless, Higson & Smith, 1995). The researcher's aim in this study was to explain the influence of demographic variables and social support on depression among teenage school mothers.

3.2 VARIABLES

Variables can be defined as a way of systematically relating change in one thing to another (Welman, Kruger & Mitchell, 2005). There are two types of variables, which are dependent and independent variables. Dependent variable is the effect to be explained (changes that occur due to independent variables). The independent variable is the causes of change in the dependent variable (Welman, Kruger & Mitchell, 2005). In this study,

the dependent variable is teenage motherhood while the independent variable is social support and depression.

3.3 SAMPLE

A sample is the part of a statistical population which is observed or the selected part of a population, and which represents all organisms of a specific area. The sample of the study comprised registered female learners from Mankweng area. It consisted of two groups, namely the experimental and the control group.

The experimental group comprised teenage mothers who had babies before completing their secondary school and who returned to school after the birth of their babies. They temporarily stopped going to school due to pregnancy. The control group comprised teenagers who did not have child/children. Teenage mothers with post-partum depression were excluded from the study. The sample of the study was between the ages of 15 and 19. The sample size was one hundred control group and one hundred experimental group.

3.4 SAMPLING METHOD

The researcher used probability sampling for the purposes of the study. In particular, random sampling technique was used. According to Welman, Kruger and Mitchell (2005), random sample is one chosen by a method involving an unpredictable component. Different units in the population had equal probabilities of being chosen.

The schools were selected from a list of high schools in the area that have exclusively African learners (Blacks). The participants were sampled by choosing an equal number of names (odd numbers) from the list of teen mothers provided by the principal of the schools. A control group was sampled conveniently by selecting haphazardly an equal number of participants from each classroom equivalent to the experimental group.

3.5 RESEARCH INSTRUMENT

The following questionnaires were used as instruments to collect data, namely; Biographical Information, Duke-UNC Functional Social Support and Beck Depression Inventory Scale.

3.5.1 Biographical Information Questionnaire (BIQ)

Biographical information questionnaire was used to collect participants' information such as age, place of residence, educational level, number of children, and marital status (See Appendix A).

3.5.2 Duke-UNC Functional Social Support Questionnaire (FSSQ)

Duke-UNC Functional Social Support Questionnaire measures individual's perception about the amount and type of personal social support. In Duke-UNC Functional Social Support Questionnaire, Test-retest reliability was evaluated over a 2-week time period, and a correlation coefficient of .66 was found. Item-remainder correlations were used to assess internal consistency and ranged from .50 for useful advice, to .85 for help around the house (Broadhead, Gehlbach, DeGruy, & Kaplan, 1988). Internal consistency, as measured by Cronbach's Alpha was .81-.92 across racial groups and study and data points (See Appendix B).

3.5.3 Beck Depression Inventory Scale (BDIS)

Beck Depression Inventory Scale for depression consists of 21 item self-report rating inventory measuring characteristic attitudes and symptoms of depression (Beck, 1961).

In Beck Depression Inventory Scale, with regard to construct validity, the convergent validity of the BDI-II was assessed by administration of the BDI-1A and the BDI-II to two sub-samples of outpatients (N=191). The order of presentation was counterbalanced and at least one other measure was administered between these two versions of the BDI, yielding a correlation of .93 ($p < .001$) and means of 18.92 (SD = 11.32) and 21.888 (SD =

12.69) the mean BDI-II score being 2.96 points higher than the BDI-1A (See Appendix C).

3.6 PROCEDURE OF DATA COLLECTION

The first step in commencing with this research was by obtaining permission from the University of Limpopo (Turffloep Campus) Ethics Committee. After that, permission was sought from Limpopo Province's Department of Education to collect data from selected government/public schools. The topic, aim, participants, names of selected schools and time frame were stipulated. Once this was done, the researcher approached the selected schools in which teenage mothers were identified with the assistance of the school principal. Participants were randomly sampled by choosing an equal number of names from the list of teen mothers provided by the principals of the schools. Teen mothers and non-teen-mothers were invited to participate in the study. They were all asked for their consent. The researcher informed the participants that participating in this study was voluntary and that their identity would be confidential. Participants from each group were then randomly selected and a total number of 100 were selected. Thirty-three learners were selected from each school; with the exception of the sixth school in which thirty-five learners were selected. The participants were given the questionnaires to fill in and these were collected when they were completed. The questionnaires were in English to accommodate all the participants. The researcher had an assistant who helped in collecting the questionnaires from the participants. The research assistant was a masters student with knowledge of human behavioural science procedures. Collection of data was completed in two weeks in six high schools in the Mankweng area.

3.7 DATA ANALYSIS

The data were analysed by the researcher using Factor analysis, Correlation analysis, T-test analysis and analysis variance, using the Statistical Package for Social Sciences (SPSS).

3.7.1 Factor analysis

This is a statistical method used to describe variability among observed variables in terms of fewer unobserved variables called factors (Gorsuch, 1983). The observed variables are modeled as linear combinations of the factors, plus "error" terms. The information gained about the interdependencies can be used later to reduce the set of variables in a dataset.

3.7.2 Correlation analysis

Correlation analysis determines the extent to which changes in the value of an attribute is associated with changes in another attribute. In particular, Pearson correlation analysis was used to reflect the degree to which the variables are related.

3.7.3 The t-test (or student's t-test)

The t-test gives an indication of the separateness of two sets of measurements, and is thus used to check whether two sets of measures are essentially different (and usually that an experimental effect has been demonstrated). The typical way of doing this is with the null hypothesis, that means of the two sets of measures are equal. In particular, unpaired or "independent samples" *t*-test was used to analyse data.

3.8. ETHICAL CONSIDERATIONS

Ethical guidelines are essential in research since they serve as a standards and the basis upon which each researcher out to continuously evaluate his or her own condition (Strydom, 1998). Strydom defines several ethical issues that need to be considered if research is to be undertaken.

The study doesn't involve physical activity such as running, and there is no medical risk associated with this it. Though the participants might have experienced stress during the interview, the stress was acknowledged and minimised.

The researcher asked for consent from the participants before proceeding with the interview. The participants had to sign a consent form which indicated that if a participant felt uncomfortable before or during the interview, the researcher would terminate the interview immediately.

The subjects were given detailed explanation of what the research aimed to achieve through their involvement. This helped the participants to understand their role in the study and to alleviate any fear that the subjects might have had.

The participants were assured that their identities would not be disclosed. The information gathered was dealt with confidence. The results of the study will be made available to the participants should they request them. If required by the participants, the researcher will offer a debriefing session after the data collection phase.

This chapter discussed the methodology that the study employed and discussed data analysis procedures. The next chapter presents the results of the study.

CHAPTER 4

RESULTS PRESENTATION

This chapter focuses on the findings of the study. The overall results are presented in this format: frequency tables of demographic variables, performance on scales, factor analysis of Duke-UNC functional social support questionnaire, correlation between depression and social support, *t*-test independent samples of teenage mothers under the age of eighteen and above, *t*-test independent samples of married and unmarried teenage mothers and summary of the results.

4.1 FREQUENCY TABLES OF DEMOGRAPHIC VARIABLES

Participants in the study were drawn from six high schools in the Mankweng area. Demographic variables presented below are for both teenage mothers and non-mothers. The frequency distribution of the participants is presented according to age, marital status, grades, ethnicity, number of children and residential area.

4.1.1 Distribution of participants by age

Table 1

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 15 years	22	11.0	11.0	11.0
16 years	22	11.0	11.0	22.0
17 years	53	26.5	26.5	48.5
18 years	62	31.0	31.0	79.5
19 years	41	20.5	20.5	100.0
Total	200	100.0	100.0	

The study indicates that 22 % ($n = 44$) of the participants were between ages of 15 – 16 years, while 78 % ($n = 156$) were 17 - 19 years old. The majority of the participants were

of the ages between 17 and 19 years. However, there are also participants between the ages of 15 and 16 years (See Table 1).

4.1.2 Distribution of participants by marital status

Table 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never married	196	98.0	98.0	98.0
Married	4	2.0	2.0	100.0
Total	200	100.0	100.0	

The study indicates that the majority of participants were not yet married (98 %, n = 196). It further indicates that neither of them is a widow nor divorced (See Table 2).

4.1.3 Distribution of participants by grades

Table 3

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Grade 10	16	8.0	8.0	8.0
Grade 11	80	40.0	40.0	48.0
Grade 12	104	52.0	52.0	100.0
Total	200	100.0	100.0	

The table indicates that the majority of the participants (92 %, n = 184) were in grades 11 and 12 (See Table 3).

4.1.4 Ethnic distribution of the population

Table 4

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Ped	177	88.5	88.5	88.5
Tsonga	15	7.5	7.5	96.0
Venda	5	2.5	2.5	98.5
Zulu	3	1.5	1.5	100.0
Total	200	100.0	100.0	

The study indicates that majority of participants were Pedi speaking (88.5 %, n = 177) (See Table 4).

4.1.5 Distribution of participants by number of children

Table 5

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	100	50.0	50.0	50.0
One	98	49.0	49.0	99.0
Two	2	1.0	1.0	100.0
Total	200	100.0	100.0	

The study shows that 50 % (n = 100) of the participants have no child/ren. While 49 % (n = 98) have one child and only 1 % (n = 2) has two children (See Table 5).

4.1.6 Distribution of participants by residential areas

Table 6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Semi-rural	79	39.5	39.5	39.5
	Township	121	60.5	60.5	100.0
	Total	200	100.0	100.0	

The majority of participants (60.5 %, n = 121) were from the township (See Table 5).

4.2 PERFORMANCE ON SCALES

4.2.1 Beck Depression Inventory Scale

T-test indicates that overall performance on Beck Depression Inventory Scale is a mean of 26.8000 (n = 100) for the experimental group. The mean score for control group on Beck Depression Inventory Scale is 1.1200 (n = 100) (refer to Appendix G).

4.2.2 Duke-UNC Functional Social Support Questionnaire

T-test further indicates that the overall performance on Duke-UNC Functional Social Support Questionnaire for experimental group is a mean of 29.7100 (n=100). The mean score for control group on Duke-UNC Functional Social Support Questionnaire is 46.8100 (n = 100) (refer to Appendix H).

4.3 FACTOR ANALYSIS OF DUKE-UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE

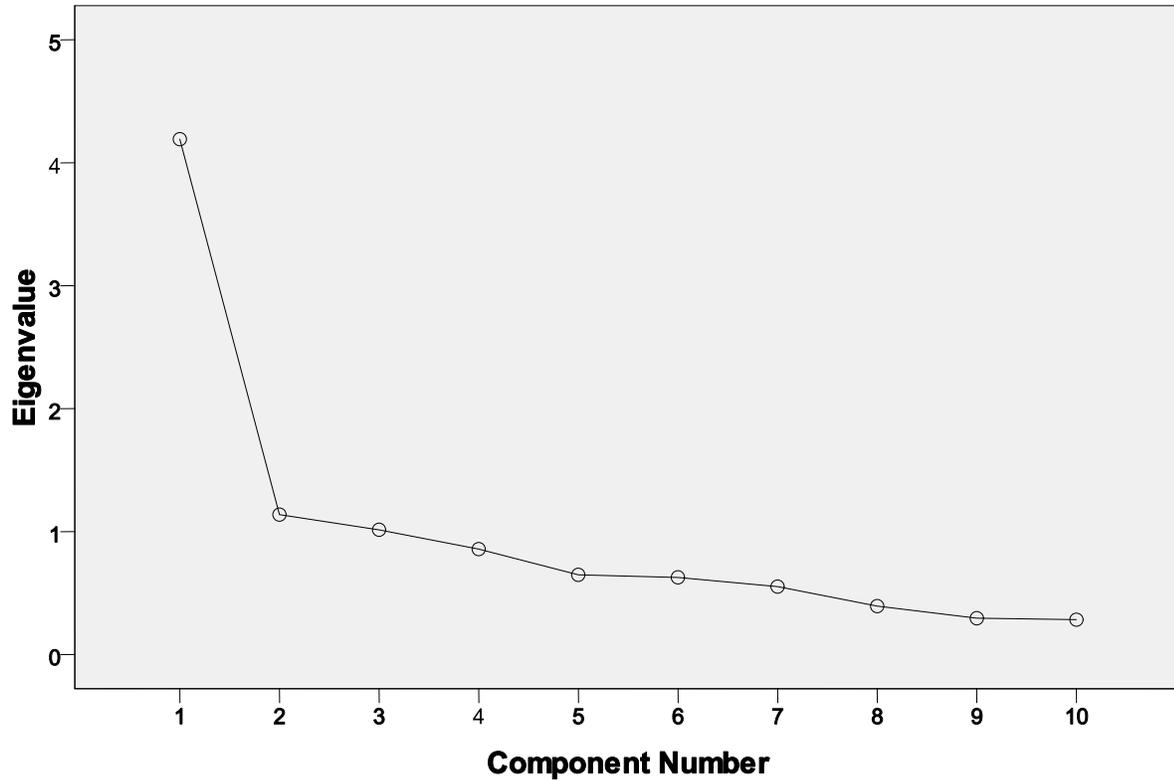
The original social support scale used in this study was constructed on the basis of factor analysis (Gorsuch, 1983). Factor analysis is used to describe variability among observed variables in terms of a potentially lower number of unobserved variables called factors. Factor analysis was conducted for the present sample to investigate what the structure of the scale in this sample would be. The analysis was conducted separately for each of the

two groups (namely, mothers and non-mothers), and then the two groups were combined in the final analysis.

The results of the factor analysis for Duke-UNC Functional Social Support Questionnaire are presented as follows:

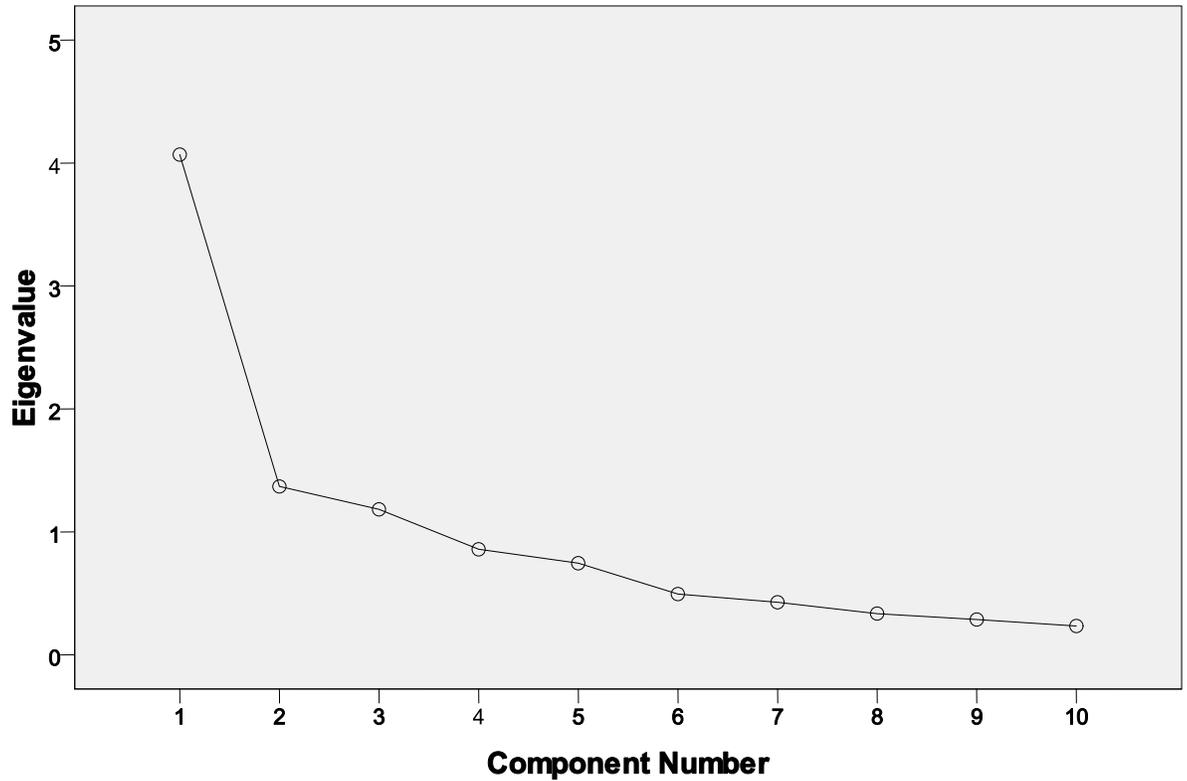
- The Kaiser-Meyer-Olkin (0.816) indicates that the sample size was adequate to allow further analysis on teenage mothers (refer to Appendix D).
- The Kaiser-Meyer-Olkin (0.778) indicates that sample size was adequate to allow further analysis on non-mothers (refer to Appendix E).
- The Kaiser-Meyer-Olkin (0.934) reveals that sample size for both teenage mothers and non-mothers was adequate to allow further analysis (refer to Appendix F). Scree Plot of Duke-UNC Functional Social Support Questionnaire for experimental group is reflected in figure 1 below.

Figure 1: Scree Plot of Duke-UNC Functional Social Support Questionnaire for experimental group



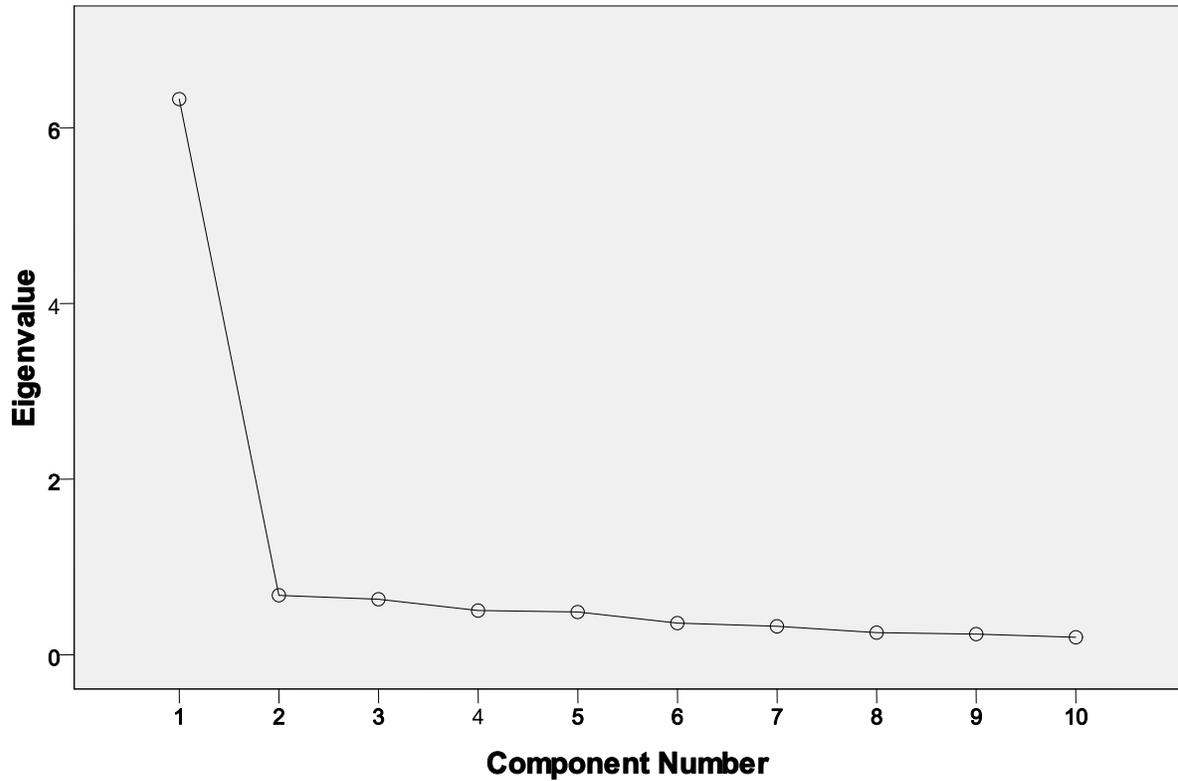
4.3.1 The scree plot for mothers is not clear in terms of reflected variables (refer to figure 1), explaining 63.435% of total variance. Scree Plot of Duke-UNC Functional Social Support Questionnaire for control group is reflected in figure 2 below.

Figure 2: Scree Plot of Duke-UNC Functional Social Support Questionnaire for control group



4.3.2 The scree plot for non-mothers is also not clear (refer to figure 2), explaining 66.205% of total variance. Scree Plot of Duke-UNC Functional Social Support Questionnaire for both control and experimental group is reflected in figure 3 below.

Figure 3: Scree Plot of Duke-UNC Functional Social Support Questionnaire for both control and experimental group



4.3.3 The scree plot for the combined group (mothers and non-mothers) shows that there is only one factor (refer to figure 3), explaining 63.282% of total variance. This means that the scale cannot be divided into different types of social support.

Based on the results of the factor analysis, it was decided that the total score of the scale would be used for further analysis.

4.4 TABLE 7: CORRELATION BETWEEN DEPRESSION (BDI) AND SOCIAL SUPPORT (FSSQ)

		BDI	FSSQ
BDI	Pearson Correlation	1	-.609**
	Sig. (2-tailed)		.000
	N	100	100
FSSQ	Pearson Correlation	-.609**	1
	Sig. (2-tailed)	.000	
	N	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Correlation analysis was used to determine the extent to which changes in the values of social support are associated with changes in the report of depression. There was a negative relationship between depression and social support ($r = -0.609$, $p < 0.01$) (See Table 7).

4.5 TABLE 8: T-TEST INDEPENDENT SAMPLES OF TEENAGE MOTHERS UNDER THE AGE OF EIGHTEEN AND ABOVE

	Levene's Test for Equality of Variances		t-test for Equality of Means						
								95% Confidence Interval of the Difference	
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
BDI Equal variances assumed	.204	.653	1.409	98	.162	4.15366	2.94780	-1.69616	10.00348
Equal variances not assumed			1.410	98.000	.162	4.15366	2.94541	-1.69140	9.99873

T-test analysis was conducted and it was found that teenage mothers experience depression irrespective of age ($t = 1.409$, $df = 98$; $p > 0.05$). Therefore, teenage mothers are affected by depression across all age groups (See Table 8).

4.6 TABLE 9 : T-TEST INDEPENDENT SAMPLES OF MARRIED AND UNMARRIED TEENAGE MOTHERS

	Levene's Test for Equality of Variances		t-test for Equality of Means						
								95% Confidence Interval of the Difference	
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
BDI Equal variances assumed	1.111	.294	1.091	98	.278	11.53061	10.56785	-9.44095	32.50218
Equal variances not assumed			2.023	1.154	.265	11.53061	5.70090	-41.59871	64.65993

T-test analysis was conducted and it was found that there is no significance difference between married teenage mothers and those who are not married in terms of experiencing depression ($t = 1.091$, $df = 98$; $p > 0.05$). Thus, teenage mothers experience depression irrespective of their marital status (See Table 9).

4.7 SUMMARY OF RESULTS

This chapter focused on presentation of study results, which included results from frequency tables of demographic variables, Factor analysis, correlation analysis and *t*-test analysis results. Most participants were between the ages of 17-19 and were not married. The results further indicate that most of the participants at the time the research was conducted were in grade 11 and 12, and the majority of them were Pedi speaking individuals residing in township.

Correlation analysis results indicate that teenage mothers who lack social support will experience depression. The results from *t*-test analysis indicate that teenage mothers experience depression irrespective of age. Furthermore, *t*-test analysis shows that there is

no significance difference in terms of experiencing depression between married teenage mothers and those who are not married.

CHAPTER 5

DISCUSSION AND CONCLUSION

The following chapter discusses the results in relation to the existing literature, integrating and placing these within the theoretical framework of this study. Limitations are pointed out, and recommendations and conclusion given.

5.1 DISCUSSION OF THE RESULTS

Before embarking on the discussion of results, hypothesis formulated are revisited.

- Teenage mothers who lack social support will experience depression.
- Teenage mothers under the age of eighteen will experience more depression than those over eighteen years.
- Married teenage mothers are less likely to experience depression than those who are not married.

5.1.1 Social Support and Depression

The first hypothesis states that teenage mothers who lack social support will experience depression. Correlation analysis associates lack of social support with depression. The study reveals that teenage mothers who lack social support will experience depression. Thus, the results are in accordance with the stated hypothesis. Lack of social support increases the likelihood of depression. Social support is a key component to most adolescent mothers. Social support appears to be a protective factor with higher levels of social support associated with lower depressive symptoms. These findings confirm past studies which showed that positive social support of teen mothers correlate with psychological well-being, feelings of love towards the infant, and gratification in the maternal role (Jacobson & Frye, 1991). The quality of social support provided to teenage mothers may influence their infants' attachment security. Social support may also contribute to infant attachment security by buffering the infant-mother attachment relationship from stresses (Jacobson & Frye, 1991). Supportive social relationships can

play an important role in buffering the stresses experienced by teenage mothers, thus positively influencing their psychological wellbeing and mothering ability (Thompson & Peebles-Wilkins, 1992). Within the context of this study, it was indicated that social support may prevent a stress appraisal response.

A study by Turner and Ascher (1985) indicates that a combination of family, partner, and friend support was related to a decreased incidence of depression among teenage mothers. Although teenage mothers counted most on grandmothers and partners for support, professional support as provided by pediatricians and nurses was also valued. In another study, primary sources of support for teenage mothers were their families, and few relied on local social services. Ultimately, Turner and Ascher (1985), found that a broad range of social support covering (a) sources of support (professionals, family, partners, and friends); (b) support functions (affect, affirmation, aid, information); (c) social network properties (number in network, duration of relationships, frequency of contact), was significantly related to the quality of teenager parent-infant interaction. Furthermore, the study by Cox, Buman, Valenzuela, Joseph, Mitchell and Woods (2008), reveals that in the 168 teen mothers, mean age 17.6 ± 1.2 years, the prevalence of depressive symptoms was 53.6% ($P < 0.001$). This is in accordance with the findings of this study that revealed $-.609^{**}$ correlation between lack of social support and depression ($p < 0.001$).

5.1.2 Age and Depression

The second hypothesis states that teenage mothers under the age of eighteen will experience depression more than those over the age of eighteen years. However, the study indicates that teenage mothers will experience depression irrespective of age. This might mean that the level of maturity between teenage mothers under the age of eighteen and those over eighteen years is not significant. Early childbearing presents a developmental crisis for teenage parents, who must face the adult task of parenting before completing the developmental task of adolescence. According to Rice (1992), early motherhood creates stresses in the lives of teenagers. Teenage mothers experience loneliness and

isolation from friends, with little time for themselves. This is similar to the sentiments by McWhitter and McWhitter (1993).

5.1.3 Marital Status and Depression

The third hypothesis states that married teenage mothers are less likely to experience depression than those who are not married. However, the study indicates that married teenage mothers appear to suffer from depression as much as unmarried teenage mothers. Even though their partners might provide social support, getting married comes with its own responsibilities that might be too much for the teenage mother. The married teenage mother must play her role as a mother and a wife. Although social support is generally associated with positive outcomes for adolescent mothers, living with a boyfriend or husband is closely correlated with dropping out of school (Warrick, Christianson & Walruff, 1993). In another study by Roye and Balk (1996), early marriage or living with a partner was associated with lower levels of maternal education and school dropout. It appears that the partners of many teen mothers do not support their girlfriends' or wives' success in high school. This might be that married teenage mothers are expected to play their primary role of being wives and education is viewed as less important.

Several studies have found that when partner support is not available, mothers are more likely to be depressed (Littewood & Mchugh, 1997). After family, teenage mothers rated their child's father as the second most valuable source of social support. Living in a nuclear family (teenage mother and her husband/boyfriend) has been associated with stronger social support and more positive child-rearing attitudes and mother-infant play interactions. Partner support has also been associated with greater responsiveness to infants and greater maternal satisfaction with life. Social support from the infant's father enhances adjustment to parenting and the quality of teenager mother-infant interaction. Littewood and Mchugh (1997) reveal that partner support was correlated with the mother's psychosocial wellbeing and favourable developmental outcomes for the infant. The reason for such a result might be that the research was conducted in different country and a deferent residential area.

5.2 LIMITATIONS OF THE STUDY

This study focused mainly on the effects of demographic variables (age and marital status) and social support on depression among high school teenage mothers in the Mankweng area. Factors such as monthly income in the family and race which could also have same effects on depression were not explored.

5.3 CONCLUSION

The study reveals that lack of social support anticipate the experience of depression on teenage mothers. However, age and marital status seem not to have an effect on teenage mothers experiencing depression. Early motherhood creates stress in the lives of teenagers. They are likely to abandon their dreams about the future, something which may lead to financial constrains to their families. They are more likely to leave school early and later on in their lives become unemployable with no specific skill. Mothers with higher levels of knowledge about infant development and social support were found to have greater confidence in providing care for their babies (Ruchala & James, 1997). It is important for the mother to surround herself with a support system before the baby is born. The findings of Nicols and Zwelling (1997) show that when the baby is happily anticipated, the mother's anxiety of the baby's arrival tends to minimise and the mother's relationship with her newborn seems to be more positive.

5.4 RECOMMENDATIONS

Based on the findings of the study the following recommendations are made:

- It is recommended that social welfare should regularly visit schools and their families to provide the necessary assistance to teenage mothers and their family members.
- Professional counseling should be provided to teenage mothers before they return to school.

- Teenagers should attend parenting classes to help them better their parenting skills that will help them to cope with challenges of being both mothers and learners.
- It is further recommended that identified limitations of study be investigated, using a broader research science.

The problem of the teenage mothers is a worldwide problem and South Africa is not exempt. It is necessary that a support system is created for these mothers so that they do not feel abandoned. Their being acknowledged will give them the confidence to continue with life in a more positive light and this will reduce the chances of them falling into depression.

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APPENDIX A

SOCIO-DEMOGRAPHIC DATA.

1 Gender:

Female	
--------	--

2 How old are you?

--

3. Number of children you have:

--

4. Where is your home based?

Rural Area/ Village	Township	Suburb
---------------------	----------	--------

5. Ethnic group:

Tsonga		Sotho		Venda		Other	
--------	--	-------	--	-------	--	-------	--

6. Highest level of education:

Grade	
-------	--

7. Marital status:

Single

--

Cohabiting

--

Married

--

Separated

--

Divorced

--

Widowed

--

	As much as <u>I would like</u>			Much less than <u>I would like</u>	
I GET...	5	4	3	2	1
1. LOVE AND AFFECTION	5	4	3	2	1
2. CHANCES TO TALK TO SOMEONE I TRUST ABOUT MY PERSONAL AND FAMILY PROBLEM	5	4	3	2	1
3. INVITATION TO GO OUT AND DO THINGS WITH OTHER PEOPLE	5	4	3	2	1
4. PEOPLE WHO CARE WHAT HAPPENS TO ME	5	4	3	2	1
5. CHANCES TO TALK ABOUT MONEY MATTERS	5	4	3	2	1
<hr/>					
5. USEFUL ADVICE ABOUT IMPORTANT THINGS IN LIFE	5	4	3	2	1
6. HELP WHEN I NEED TRANSPORTATION	5	4	3	2	1

8. HELP WHEN I'M SICK IN BED 5 4 3 2 1

**9. HELP WITH COOKING AND
HOUSEWORK** 5 4 3 2 1

**10. HELP TAKING CARE OF MY
CHILD(REN)** 5 4 3 2 1

APPENDIX C

BECK'S DEPRESSION INVENTORY

Instructions

This questionnaire consists of 21 groups of statements. **Please** read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (change in sleep pattern) or Item 18 (change in appetite).

1. Sadness

0. I do not feel sad.
1. I feel sad
2. I am sad all the time and I can't snap out of it.
3. I am so sad and unhappy that I can't stand it.

2. Pessimism

0. I am not particularly discouraged about the future.
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel the future is hopeless and that things cannot improve.

3. Past Failure

0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. As I look back on my life, all I can see is a lot of failures.
3. I feel I am a complete failure as a person.

4. Loss of pleasure

0. I get as much satisfaction out of things as I used to.
1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

5. Guilty Feeling

0. I don't feel particularly guilty
1. I feel guilty a good part of the time.

2. I feel quite guilty most of the time.
3. I feel guilty all of the time.

6. Punishment Feeling

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self-dislike

0. I don't feel disappointed in myself.
1. I am disappointed in myself.
2. I am disgusted with myself.
3. I hate myself.

8. Self-criticalness

0. I don't feel I am any worse than anybody else.
1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

10. Crying

0. I don't cry any more than usual.
1. I cry more now than I used to.
2. I cry all the time now.
3. I used to be able to cry, but now I can't cry even though I want to.

11. Agitation

0. I am no more irritated by things than I ever was.
1. I am slightly more irritated now than usual.
2. I am quite annoyed or irritated a good deal of the time.
3. I feel irritated all the time.

12. Loss of Interest

- 0. I have not lost interest in other people.
- 1. I am less interested in other people than I used to be.
- 2. I have lost most of my interest in other people.
- 3. I have lost all of my interest in other people.

13. Indecisiveness

- 0. I make decisions about as well as I ever could.
- 1. I put off making decisions more than I used to.
- 2. I have greater difficulty in making decisions more than I used to.
- 3. I can't make decisions at all anymore.

14. Worthlessness

- 0. I don't feel that I look any worse than I used to.
- 1. I am worried that I am looking old or unattractive.
- 2. I feel that there are permanent changes in my appearance that make me look unattractive.
- 3. I believe that I look ugly.

15. Loss of Energy

- 0. I can work about as well as before.
- 1. It takes an extra effort to get started at doing something.
- 2. I have to push myself very hard to do anything.
- 3. I can't do any work at all.

16. Change in Sleeping Pattern

- 0. I can sleep as well as usual.
- 1. I don't sleep as well as I used to.
- 2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3. I wake up several hours earlier than I used to and cannot get back to sleep.

17. Irritability

- 0. I don't get more tired than usual.
- 1. I get tired more easily than I used to.
- 2. I get tired from doing almost anything.
- 3. I am too tired to do anything.

18. Changes in Appetite

- 0. My appetite is no worse than usual.
- 1. My appetite is not as good as it used to be.

2. My appetite is much worse now.
3. I have no appetite at all anymore.

19. Concentration Difficulty

0. I haven't lost much weight, if any, lately.
1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

20. Tiredness or Fatigue

0. I am no more worried about my health than usual.
1. I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2. I am very worried about physical problems and it's hard to think of much else.
3. I am so worried about my physical problems that I cannot think about anything else.

21. Loss of Interest in sex

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.

APPENDIX D

The Kaiser-Meyer-Olkin for teenage mothers

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.816
Bartlett's Test of Sphericity	Approx. Chi-Square	330.710
	df	45
	Sig.	.000

APPENDIX E

The Kaiser-Meyer-Olkin for non-mothers

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.778
Bartlett's Test of Sphericity	Approx. Chi-Square	371.141
	df	45
	Sig.	.000

APPENDIX F

The Kaiser-Meyer-Olkin for both teenage mothers and non-mothers

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.934
Bartlett's Test of Sphericity	Approx. Chi-Square	1362.460
	df	45
	Sig.	.000

APPENDIX G

T-test for Beck Depression Inventory Scale

Group Statistics

Scales		N	Mean	Std. Deviation	Std. Error Mean
BDI	Experiment	100	26.8000	14.80922	1.48092
	Control	100	1.1200	2.30187	.23019

APPENDIX H

T-test for Duke-UNC Functional Social Support Questionnaire

Group Statistics

Scales		N	Mean	Std. Deviation	Std. Error Mean
FSSQ	Experiment	100	29.7100	8.55912	.85591
	Control	100	46.8100	3.85519	.38552

APPENDIX I

UNIVERSITY OF LIMPOPO ETHICS COMMITTEE

PROJECT TITLE: The Effect of Demographic Factors and Social Support on Depression among High School Teenage Mothers in the Mankweng Area.

PROJECT LEADER: Mothapo P.M

CONSENT FORM

I, _____ hereby voluntarily consent to participate in the following project: *(it is compulsory for the researcher to complete this field before submission to the ethics committee)*

I realise that:

1. The study deals with _____ (eg. effect of certain medication on the human body) *(it is compulsory for the researcher to complete this field before submission to the ethics committee)*
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

Signed at _____ this ____ day of _____ 2010