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Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province

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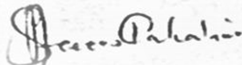
Supervisor: Dr Takalani F.J **Signature:**  **Date: 17 February 2023**

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DECLARATION

I, **Gezani Morris Baloyi of student number 19023394**, hereby declare that the dissertation titled **"Pyschosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province"** submitted by me, has not been submitted previously for a degree at this or any other university, that it is my own work in design and in execution, and that all reference material contained therein has been duly acknowledged.

Signature: **Date: 17 February 2023**

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List of Acronyms and abbreviations

CCLM	Collins Chabane Local Municipality
CEO	Chief Executive Officer
DHP	District Health Plan
DoH	Department of Health
DPRD	Descriptive Phenomenological Research Design
IPA	Interpretive Phenomenological Analysis
HSRC	Human Science Research Council
UEC	University Ethics Committee
UHDC	University Higher Degrees Committee
USA	United States of America
WHO	World Health Organisation

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Table of Contents

Page

Declaration………………………………………..………………………………… i
List of acronyms……………………….……………………………………………. ii
Table of Contents …………………………………………………………………… iii
List of figures(s)……………………………………………………………………… vi
Acknowledgement…………………………………………………………………… vii
Abstract………………………………….…………………………….................... viii

CHAPTER 1: INTRODUCTION

1.1 Background of the study……………………………………………..………….. 1
1.2 Theoretical Framework………………………………………………………….. 4
1.3 Problem statement……………………………………………………………….. 6
1.4 Study purpose and Objectives …………………………………………….….. 7
1.5 Practical Significance…………………………………………………………….. 7
1.6 Operationalised definitions………………………………….…………….......... 8
1.7 Conclusion……………………………………………………………………….. 9

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction………………………………………………………………………….. 10
2.2 Teenage motherhood globally…………………………………………………….. 10
2.3 Psychological distress………………………………………………………………. 14
2.4 Emotional distress…………………………………………………………………... 16
2.5 Social distress………………………………………………………………………. 17
2.6 Psychological experienced by teenage mothers……………………………….... 17
2.7 Emotional distress experienced by teenage mothers……………………………… 21
2.8 Social distress experienced by teenage mothers…………………………………... 21
2.9 Causes of psychological, emotional and social distress among teenage mothers… 22
2.10 Effects of psychological, emotional and social distress among teenage mothers... 24
2.11 Coping strategies used by teenage mothers………………………………………. 27
2.12 Conclusion…………………………………………………………………………… 30

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CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction………………………………………………………………………… 31
3.2 Research approach……………………………………………………………..…. 31
3.3 Research design………………………………………………………………...... 32
3.4 Population and setting……………………………………………………………. 32
3.5 Sampling and procedure…………………………………………………………. 33
3.6 Inclusion and exclusion criteria………………………………………………….. 34
3.7 Data collection and procedure…………………………………………………… 34
3.8 Pre-testing………………………………………………………………………..... 35
3.9 Plan for data management and analysis……………………………………….. 36
3.10 Trustworthiness………………………………………………………………….. 38
3.11 Ethical considerations…………………………………………………………… 40
3.12 Delimitation of the study………………………………………………………… 43
3.13 Plan for dissemination and implementation of results…………………………….. 43
3.14 Conclusion………………………………………………………………………… 44

CHAPTER 4: PRESENTATION OF RESULTS

4.1 Introduction…………………………………………………………………………….. 45
4.2 Theme 1: Psychosocial and emotional distress experienced by teenage mothers.. 45
4.3Theme 2: Causes of psychosocial and emotional distress of teenage mothers…… 54
4.4 Theme 3: Effects of psychosocial and emotional distress on teenage mothers…… 57
4.5 Theme 4: Coping strategies used by teenage mothers……………………………… 61
4.6 Conclusion……………………………………………………………………………… 64

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion on lived experiences of teenage mothers……………………………… 65
5.2 Limitations of the study………………………………………………………………. 80
5.3 Conclusion of the study………………………………………………………………. 81
5.4 Recommendations……………………………………………………………………. 81
5.5 Implications for future research……………………………………………………… 83
5.6 Conclusion……………………………………………………………………………… 83
References……………………………………………………………………………….. 84
Workplan…………………………………………………………………………………. 113

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ANNEXURERS

Annexure 1: University consent form and information sheet……………………………… 114
Annexure 2: Interview guide (English version)…………………………………………… 119
Annexure 3: Demographic profile sheet………………………………………………….. 120
Annexure 4: Letter of permission Department of Health Provincial……………………… 121
Annexure 5: Letter of permission Department of Health District………………………….. 122
Annexure 6: Language editing letter……………………………………………………… 123

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List of Figure(s)

Figure 1: Collins Chabane Local Municipality (CCL) Map within Vhembe District map.... 33

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ABSTRACT

Various studies conducted show that teenage mothers experience adversities such as depression and stigmatization. The main aim of the study was to explore psychosocial distress associated with lived experiences of teenage mothers in Malamulele rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province. The study adopted a qualitative phenomenological research strategy as well as a descriptive phenomenological research design. The population of the study were teenage mothers aged between 15 and 19 years. The researcher used non-probability sampling method to select participants purposively. A total of 15 participants were selected, and, the sample size was determined by data saturation. An interview guide was designed for data collection using semi-structured, face to face interviews. The simplified five step version of Hycner's explicitation process guided the data analysis process. Ethical considerations were employed throughout the study. Four themes emerged from analysing the participants' interview data. These themes include psychosocial and emotional distress, causes of distress, effects of distress and coping resources used by teenage mothers. Recommendations of the study were based on the findings of the study. The study concludes that psychosocial distress among teenage mothers is associated with ill-treatment by healthcare providers.

Keywords: distress, healthcare provider, ill-treatment, teenage motherhood, teenage mother

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CHAPTER 1: INTRODUCTION

1.1 Background of the study

There is an increasing concern that the psychosocial and emotional distress experienced by teenage mothers during their encounter with rude healthcare providers remains a worldwide health issue. This assertion is supported by Bohren et al. (2015) who revealed that negative psychosocial and emotional consequences encountered by teenage mothers are associated with unfriendliness of healthcare professionals globally. Nevertheless, it is also important to consider the transition into teenage motherhood, which is likely to exacerbate distress among teenage mothers. In the context of this study, a teenage mother is a young girl between 15 and 19 years who gave birth to a child at a hospital, confronted with psychosocial challenges as a new mother. A study conducted in Melbourne, Australia by Sawyer et al. (2018), defines a teenage mother as a young girl who gave birth to a child between 13 and 19 years and marks a transition of life from teenage hood to early adulthood.

Teenage mothers tend to be overwhelmed and vulnerable because of negative social evaluation by healthcare providers. It also appears that physical and verbal abuses are forms of ill-treatment teenage mothers are likely to experience. The physical abuse may include threats or actual beatings, hitting or being pushed mercilessly while verbal abuse may include being shouted at, degrading remarks and naming calling. According to McMahon et al. (2014), in Morogoro Region, Tanzania, parenting teenage girls are subjected to acts of physical violence that include clinical neglect, verbal abuse, psychological abuse, and unkindness by health personnel. Furthermore, Malatji and Madiba (2020) in Tshwane District, South Africa, confirm that verbal abuse in the form of scolding, labelling, judging, and rude remarks were common forms of ill-treatment experienced by teenage mothers. They may feel rejected, socially isolated and excluded, and even stigmatized by rude healthcare providers. According to Franjić (2018), teenage mothers often experience poorer social outcomes such as loneliness and feelings of rejection due to unstable relationships.

Unsupportive environment and negative social evaluation perpetrated by healthcare providers may be associated with low self-esteem, worry, lonely life and anxiety among teenage mothers. According to Datta et al. (2017), feelings of loneliness, rejection, stigma, social isolation and worry experienced by new mothers are associated with a lack of healthcare support. Exposure of teenage mothers to harsh treatment from healthcare providers is more likely to increase the risk of psychosocial distress. According to Lucas et

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al. (2019), in London, United Kingdom, distress among victims is associated with disruptive and demeaning interaction with others. Moreover, a person with distress is more likely to manifes with anger, headache, problem with reasoning abilities and concentration (Lucas et al., 2019). Available literature by Arvidsdotter et al. (2015) in Vänersborg, Sweden, argue that distress can affect the way a person thinks, feels, or acts. Teenage mothers experience distress and are vulnerable to ill-treatment from healthcare providers based on certain attributes such as their young ages. Moreover, it seems that teenage motherhood is associated with negative psychosocial consequences. Hodgkinson et al. (2014) in Washington DC, USA, found that teenage mothers ranging from 15 to 19 years experienced postpartum depression at a rate that was twice as high as women aged 25 and older. Teenage mothers are more likely to experience distress, more especially feeling worried, isolated, irritable, and depressed when they are despised and neglected by healthcare providers.

It also appears that teenage mothers are affected negatively by ill-treatment and are likely to react aggressively towards health care providers. According to Mangeli et al. (2017), in Kerman, Iran, teenage mothers tend to be short tempered due negative emotions. They may also think that everyone is judging them negatively because of their situation of being mothers at a young age and eventually develop suicidal thoughts. According to Nkwemu et al. (2019) and Dzotsi et al. (2020), teenage mothers have higher rates of suicidal ideation than their childless adolescent peers and adult mothers. Furthermore, it seems that teenage mothers who are stigmatized and discriminated based on their situation in everyday life are at a higher risk of psychological distress. Exposure to dismissive and abusive interpersonal relationship with healthcare providers contributes to the experience of psychosocial and emotional distress among teenage mothers. According to Van Zyl et al. (2015), social stigma and mistreatment through negative judgmental attitude by others contribute to distress among teenage mothers. In addition, Hodgkinson et al. (2014) revealed that teenage mothers have higher rates of psychological health problems such as anxiety, worry anger, fear and irritability.

Based on the researcher's observation, teenage mothers coming for childbirths at the hospital maternity ward are mostly between 15-19 years old. According to Blum and Gates (2015) in New York, United States of America, around 16 million girls aged between 15 and 19 and 2.5 million girls below 16 years give birth each year globally. This claim is also supported by Darroch et al. (2016) who assert that an estimated 21 million girls aged 15–19 years in developing regions become pregnant every year and approximately 12 million of them give birth. Furthermore, exposure to ill-treatment is likely to be disincentive for teenage

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mothers to seek health services in the health facility due to fear of insensitive treatment of healthcare providers. According to Chadwick et al. (2014) in Pretoria in South Africa, dehumanizing treatment discourages mothers from visiting health facilities for their subsequent healthcare needs. Unfortunately, missed hospital appointments or follow up visits due to fear of ill-treatment will have negative psychosocial health outcomes for both the mother and child. Furthermore, failure to honor scheduled hospital follow up visit is associated with an increased risk of infections and death during postnatal period. According to Islam et al. (2017) in Dhaka, Bangladesh, inadequate access to appropriate care and healthcare support is associated with psychosocial consequences and increased risk for maternal mortality across many countries.

A person with distress seems to struggle to cope with difficult life experiences. It seems that negative consequence of distress is also associated with coping difficulties among teenage mothers because they are psychologically, emotionally and socially immature to deal with adulthood parenting challenges and ill-treatment. According to Lombe et al. (2016), teenage mothers tend to use alcohol and drugs as a way of coping with difficult life experiences. There are also risks that teenage mothers may experience such as severe forms of psychosocial and emotional challenges. This assertion is supported by Nove et al. (2014) who state that a prolonged and untreated distress among teenage mothers put them at higher risk of adverse psychological health complications such as anxiety disorder, major depressive disorders and insomnia.

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1.2 Theoretical framework

Theoretical framework introduces and describes the theory that explains why the research problem under study exists (Gabriel, 2008). This study is guided by Six Dimensions of Psychological Well-being theory developed by Carol Ryff. According to Ryff and Singer (2008), psychological well-being theory acknowledges that attitudes, cognitions, beliefs, and behavior of humans are influenced by situation, setting or relationship they are exposed to.

The six dimensions of psychological well-being theory explained as follows:

- Autonomy (assesses the sense of self-determination and freedom from norms). The dimension implies that an individual tends to be influenced by people with strong opinions or authority.
- Environment mastery (assesses the belief of one's ability to manage life events). The dimension focuses on whether an individual is in charge of the situation in which he or she lives or not.
- Personal growth (assesses one's openness to new experiences and growth). The dimension is interested in whether an individual perceives life as a continuous process of learning, changing, and growth or not.
- Purpose in life (assesses the sense of purpose and meaningfulness in life). The dimension establishes whether an individual enjoys making plans for the future and working to make them a reality or not.
- Positive relations with others (assesses the extent of having satisfying relationships with others). The dimension focuses on an individual's experience of a sense of belonging. This dimension further establishes if an individual often feels lonely because he or she has few close friends with whom to share his or her concerns.
- Self-acceptance (assesses one's attitude towards oneself). The dimension focuses on whether an individual is proud of whom he or she is and the life he or she leads.

Application:

Teenage mothers may tend to experience distress due to negative and degrading encounter with rude healthcare providers in the context of this study. Regarding autonomy, teenage mothers are unable to express their views about the nature of healthcare services they receive because healthcare providers are in control. This means that if these mothers are ill-treated, they may not feel comfortable to say it and is likely to increase the risk of psychosocial consequences. This claim agrees with Cressey et al. (2020) who report that

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undignified treatment from healthcare providers is linked to psychosocial distress experienced by teenage mothers. In the context of environment mastery, teenage mothers seem to be overwhelmed and out of control with their situation. They tend to feel unconfident to handle life challenges because of ill-treatment by healthcare providers. Unfortunately, teenage mothers experience distress if they fail to deal with negative encounter with healthcare providers. According to Sitsofe (2020), distress that manifest with low self-esteem is associated with negative relationship with others. Regarding personal growth, teenage mothers perceive their experiences with healthcare providers as negative and not conducive for learning and for personal development. These mothers seem to be concerned with being disrespected and condemned by healthcare providers. If these mothers remain stagnant because of lack of healthcare support, they are more likely to experience psychosocial distress. Mangeli et al. (2017) reveal that teenage mothers encounter psychological challenges such as depression and anxiety associated with negative interaction.

In the context of purpose in life, teenage mothers seem to feel disempowered to make plans regarding their future because of lack of healthcare support from healthcare providers. Teenage mothers are more likely to experience distress associated with future uncertainities. According to Hodgkinson et al. (2014), feeling of distress among teenage mothers with adverse reactions such as worry and anxiety is linked to unsupportive environment. Regarding positive relations with others, teenage mothers tend to feel lonely and self-isolated because of negative relationship with healthcare providers. Teenage mothers experience distress because they are unable to share their concerns with rude healthcare providers. Sitsofe (2020) indicates that psychosocial problems among teenage mothers are attributed to poor relationship with healthcare providers. Lastly, in the context of self-acceptance, teenage mothers seem to display low self-esteem and not proud about who they are and their lives. They tend to feel unconfident, associated with disapproval and being humiliated by healthcare providers. Teenage mothers are at risk of psychosocial distress if they fail to accept themselves. According to Raj and Boehmer (2013) people without self-trust are more likely to experience distress.

Weaknesses of the theory

Ryff's six dimensions of psychological well-being theory was originally developed to reflect adults' psychological functioning (Ryff & Singer, 2008). Therefore, existing evidence seems insufficient to substantiate its application to teenagers. Therefore, it is reasonable to explore further if the theory can be applied as a sound theoretical framework for investigating teenage mothers' psychological functioning.

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1.3 Problem Statement

Globally, studies suggest that teenage mothers suffer both psychologically and socially. Therefore, it is obvious that psychosocial and emotional problems should be given serious attention because of their devastating effects in the lives of teenage mothers. Based on the researcher's observation half (10 out 20) of teenage mothers between 15-19 years who visited Malamulele hospital did not return for follow up services as per schedule after their initial visits. This tendency was growing rapidly and might lead to serious threat to the psychological and social health of teenage mothers. Teenage mothers do not have necessary experience to care for themselves and their babies, hence the need for regular visits to a health facility for support, check-ups and psychosocial counselling. Moreover, given the nature of public health services, there is a perception that teenage mothers are likely to have an encounter with unfriendly and disrespectful healthcare providers. This kind of negative interaction is likely to expose teenage mothers at higher risk of symptoms of distress such as fear, worry, anxiety, anger and loneliness. According to Mustafa and Mirkhan (2020), negative attitude and hostility of healthcare providers working in maternal and child health care wards are major sources of distress faced by teenage mothers. This claim is also supported by SmithBattle (2013) who indicates that teenage mothers are stigmatized by healthcare providers due to early childbearing.

Moreover, to the best of the researcher's knowledge, there was no available information about the psychological and social problems experienced by teenage mothers who visited Malamulele hospital for maternal health services. In response to this identified gap, the researcher then decided to undertake a research study focusing on the psychosocial distress associated with lived experiences of teenage mothers who visit a hospital for healthcare services. It seemed that if teenage mothers are ill-treated, cause them to feel ashamed and inferior, leading them to live a life withdrawn from other people. The prevalence and severity of distress among teenage mothers is troubling, considering the evidence that distress increases risk of maternal substance use (Chapman & Wu, 2013). If psychological distress is left untreated amongst teenage mothers; their offsprings are also vulnerable to distress and depression (Hamilton, 2009). It also seemed that psychological and social challenges might result in teenage mothers defaulting on treatment, reluctant to seek future healthcare service at the hospital and discouraging others from using the hospital. The researcher argues further that despite the availability of psychological services (private or public); there was still a scarcity of specialised services designed for teenage mothers to deal with their challenges.

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1.4 Study purpose and objectives

1.4.1 Aim of the study

The aim of the study was to explore the psychosocial distress associated with lived experiences of teenage mothers at Malamulele hospital.

1.4.2 Objectives of the study

The study was guided by the following four objectives:

- To explore the psychosocial distress experienced by teenage mothers at Malamulele Hospital.
- To identify causes of psychosocial distress among teenage mothers
- To describe the effects of these experiences on their psychosocial wellbeing.
- To identify the coping strategies used to deal with their lived experiences.

1.5 Practical Significance of the study

The study is important in many ways:

The study findings will be helpful to the healthcare providers working with teenage mothers in providing effective help and encouragement as well as guidance during the pregnancy and parenthood transition period. The feedback from the teenage mothers may assist the healthcare providers to improve the quality of health care practices and lessen complaints from teenage mothers. The hospital management will be informed about unmet needs of the teenage mothers and develop strategies to meet their needs such as emotional, social and psychological needs. The research findings will help the Department of Health (National, Provincial & District level) in dealing with teenage pregnancy and subsequent motherhood in their planning and programming. The study will provide necessary information for policy makers, regarding review and development of policies, programmes and services designed to address and support the psychosocial needs of the pregnant teenagers and motherhood. The study may also contribute to promoting trust for both the teenage mothers and the community in general, to consult and use the hospital for their health needs in future. The study may also benefit the teenage mothers to cope well with their future pregnancy and subsequent motherhood. The study may assist communities with necessary information to

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address the needs such as support resources, physical activity and education for the teenage mothers. The research findings may contribute by uncovering the causes, emotional, social and psychological distress and coping strategies by teenage mothers that need to be addressed. The study may also provide basis for further studies and contribute to the body of scientific knowledge in the field of psychology. Lastly, it is expected that the study will uncover the lived experiences of teenage mothers who use Malamulele hospital for consultation, which may not have been revealed by other studies.

1.6 Operationalised Definitions

Teenage mother: is a young woman, who has given birth before reaching her twentieth birthday, regardless of whether the woman is married or is legally an adult (Save Child Report, 2000).

According to this study, a teenage mother will mean a young woman between 15-19 years who has given birth and is responsible for childcare.

Coping strategies: is to change the cognitive and behavioural efforts in order to manage specific external or internal demands that are exceeding the resources of a person (Lombe et al., 2016).

According to this study, coping strategy means that a teenage mother uses her special means both behavioural and psychological to reduce stressful event.

Distress: is defined as a cognitive health challenge due to disruptive relationship characterized by reasoning challenges and poor focus, hopelessness, sleep disturbance, headache, depression, anxiety and sadness (Lucas et al., 2019).

In this study, distress refers to the negative state of emotional, psychological and social wellbeing that affect the day-to-day functioning of the teenage mothers.

Teenage motherhood: refers to a transition from adolescence to early motherhood in which a young girl between 13 and 19 years old has given birth to a child (Erhunse, 2019).

According to this study, teenage motherhood is the period in which a teenage girl between 15 and 19 years has given birth to a child coupled with parenting responsibilities.

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Healthcare provider: refers to an individual within medicine, nursing professions and allied health employed at a health facility to maintain and provide preventive, curative, promotional, or rehabilitative and psychosocial health care services to individuals, families or communities in a systematic way (Goldblatt et al., 2020).

In this study, healthcare provider refers to nurses, doctors, trauma counsellors and psychologist who provide health interventions in order to address psychosocial and emotional challenges experienced by teenage mothers.

Ill-treatment: refers to a cruel or inhuman treatment, which includes psychological, emotional, social and even physical pain or suffering on teenage mothers, perpetrated by healthcare providers (Bohren et al., 2015).

According to this study, ill-treatment refers to insensitive and harsh practices of healthcare providers against teenage mothers while they seek health services at the hospital.

Batho Pele principle: is an approach to get public servants committed to serving people, accountable for the quality of services provided and to find ways to improve service delivery (Khosa & Du Toit, 2011)

According to this study, batho pele refers to guideline which provide grounding on how healthcare providers should relate and assist patients especially with courtesy and consideration.

1.7 Conclusion

In this chapter, the researcher described the background to the study. The research problem, the aim of the study, objectives of the study, significance of the study, operationalised definitions and theoretical framework of the study were also described.

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CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter explains teenage motherhood and reviews literature related to key aspects of the phenomenon. Literatures of studies conducted in various countries such as in Europe, America, Asia, Oceania, Africa, and South Africa have been reviewed.

2.2 Teenage motherhood globally

Prevalence of teenage motherhood seems to be major and a serious challenge around the globe. This assertion is supported by World Health Organization's (2012) revelation that in its recorded report in Geneva, Switzerland sixteen million girls between 15 and 19 years out of 30 million give birth during adolescence annually worldwide. A similar trend was observed by the researcher at Malamulele hospital; that teenage mothers between 15-19 years give birth at an alarming rate. As a result, teenage mothers who gave birth to their first child at a hospital has increased or doubled from 216 to 492 annually in the last three years. This prevalence is a major contributor of an alarming increase in the phenomenon of teenage motherhood amongst teenage girls. Similarly, a study by Blum and Gates (2015) in New York, United States of America, revealed that around 2.5 million girls below 16 years give birth each year globally out of 16 million girls aged between 15 and 19. According to Blum and Gates (2015), teenage motherhood among teenage girls between 15-19 years in the poorest regions of the world is still four times higher than in the high-income regions.

Moreover, the phenomenon of teenage motherhood among teenage girls between 15 to 19 years appears to be a universal challenge irrespective of the economic status of the country. The argument is aligned with Timeus and Moultrie (2015) who state that teenage motherhood is also prevalent in high-income countries such as the USA and Britain, where rates of teenage childbearing in girls between 15 to 19 years are relatively high. Furthermore, 90% of teenage motherhood among 15-19 year occurs within marriage in the African region (Blum & Gates, 2015). Mollborn (2017) further discovered that teenage mothers face unique disadvantages because of their youth, such as a lack of access to some public programs, including health services and the difficulties of getting an education while parenting. It appears that teenage motherhood does not only affect one area but different parts of the world. This claim is in agreement with a study in Nairobi, Kenya by Wado et al. (2019) who state that teenage motherhood in young girls between the ages of

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15 to 19 is also common and with high rates recorded in the Eastern African region, ranging from 18% of teenage mothers in Kenya to 29% in both Malawi and Zambia. It seems that teenage girls between 15 to 19 years who get pregnant are more likely to give birth successfully and ultimately become new teenage mothers. The assertion is supported by a survey conducted by Ghana Statistical Service and Ministry of Health (2018) in Accra, which reveals that 14% of 15-19-years had experienced teenage pregnancy; of these, 12% were teenage mothers with 3% of them having their first baby. Prevalence of teenage motherhood seems to affect teenage girls between 15 to 19 years old. This claim is aligned with a study in Johannesburg, South Africa, by De Villiers and Kekesi (2004) who argue that the phenomenon of teenage motherhood has been seen on the 15 to 19 years old females who engage in unprotected sexual practices, become pregnant and ultimately give birth. Similarly, the Department of Social Development (2013) in Pretoria, South Africa reveals that recent South African statistics show that 12.4% of babies are born to teenage mothers aged between 15 and 19 years old.

2.2.1 Teenage mother's perceptions regarding teenage motherhood

There are teenage mothers who regard motherhood as an opportunity to explore adult roles and having a baby is seen as a gift from God. This assertion is supported by Seamark and Lings (2004) who found that teenage motherhood is perceived in a positive manner by other teenage mothers. In addition, they view early motherhood as something that shape their life, God's blessing and an opportunity to experience adult role and responsibilities (Seamark & Lings, 2004). Although most of these mothers are worried about lack of healthcare support from healthcare providers, they appreciate support from family members more especially their mothers and siblings. According to Anwar and Stanistreet (2015), teenage mothers are not overwhelmed by early motherhood because it contributes to their improved social support, social status and recognition within the communities. Furthermore, the transition is viewed as an enabling factor to promote decisiveness and good decision making and improved reasoning among teenage mothers. According to Jenkins (2013), teenage mothers argue that early motherhood is associated with cognitive abilities and improvements in their psychological and social outcomes.

Furthermore, some teenage mothers view early motherhood as a crucial period to learn and relook at their life for future. The claim is supported by Aparicio et al. (2016) and Smith et al. (2012) who state that teenage motherhood transforms life of teenage mothers. Moreover, teenage mothers argued that early motherhood enables them to reassess the importance of education and future career attainment (Anwar & Stanistreet, 2015). Additionally, some

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teenage mothers felt a sense of maturity, responsibility, and purpose associated with early motherhood (Ngum Chi Watts et al., 2015). Teenage motherhood is regarded as an opportunity to become self-reliant, self-sufficient and worthy, more autonomous and independent by other teenage mothers (Shea et al., 2016). An interesting argument is that some of the teenage mothers view motherhood as an essential part of the social and cultural system in Ghana (Ghana Statistical Service & Ministry of Health, 2018). Also, some teenage girls seem to enjoy the status of motherhood because it is honorable within their communities. According to Ntinda et al. (2016), teenage motherhood in some societies is associated with genuine womanhood.

However, many teenage mothers experience teenage motherhood as burdensome and they tend to encounter psychosocial challenges. According to Haigh (2020), early motherhood is the transitional period which is difficult and overwhelming that brings about major negative psychological changes for teenage mothers. A challenge with coping is more prevalent especially for the new mothers, without necessary knowledge, skill and support or assistance from the people around them. This argument is supported by Haigh (2020) who states that early parenting is problematic because teenage mothers may not be psychologically and socially prepared to become a mother. Teenage mothers seem to abandon their education due to early motherhood. According to World Health Organization (2012), negative consequences of teenage motherhood may lead to reduced educational achievement. It seems that teenage motherhood is more likely to be associated with psychosocial distress among teenage mothers. According to Mollborn (2017), negative consequences of teenage motherhood are psychologically and socially disruptive in nature. Moreover, teenage motherhood is an inevitable common challenge across many countries in which teenage girls, more especially aged 15 to 19 years are the most affected. In addition, the transition of teenage motherhood is occurring at a very important period of a young girl's life where a teenage girl should be a mother while still a teenager. The assertion is supported by Ngum Chi Watts et al. (2015) who revealed that teenage motherhood coincidentally happen during a critical developmental period of teenage mothers' life.

It seems that childcare responsibilities for teenage mothers are challenging experiences associated with psychosocial distress. According to Bah (2016), early parenthood is linked to psychological and social challenges among teenage mothers. Therefore, transition to teenage motherhood requires psychological and social preparedness; but teenage mothers are not ready to become mothers which contribute to feelings of distress. According to De Villiers and Kekesi (2004), teenage motherhood is associated with a higher risk of psychosocial distress as the mother struggles to adapt to the new challenging experience.

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Teenage motherhood in the context of teenage mothers is often marked by negative outcomes because parenting mothers experience the dual transitions of becoming a mother while also adjusting to everyday life as a teenager. According to McMichael (2013), teenage motherhood has a negative effect to the general well being and life of a teenage mother due to multiple demands and roles. Teenage motherhood is associated with many negative outcomes and eventually may lead to feelings of distress such as bitterness, feeling concerned and feeling depressed. The assertion is supported by Sitsofe (2020) who reveals that teenage motherhood is associated with psychosocial consequences among teenage mothers. These mothers seem to experience social rejection from other people, this experience result in lonely life and self-isolation. This argument is supported by Chohan and Langa (2011); Mwaba (2000) and Sekhoetsane (2012) who state that teenage mothers encounter multiple challenges, including being neglected, loneliness and social exclusion.

It appears that early school termination is attributed to early pregnancy and birth. McMichael (2013) and Ngum Chi Watts et al. (2015) further support the argument as they indicate that teenage motherhood is associated with school underachievement and dropouts. It appears that teenage mothers tend to be worried due to failure to finish their education while those who continue with school are concerned with poor performance. This claim is supported by Lotse (2016) who reports that teenage mothers experience distress associated with educational disruption and poor outcome. Transition into motherhood also results in termination of school attendance amongst teenage mothers which then lead to difficulties in finding work in future. According to Wado et al. (2019), teenage motherhood is associated with school interruption, low educational achievement and early school termination and contributes to potential joblessness. A life of a teenage mother is uncomfortable and in distress because she has to juggle her time between going to school, enduring ill-treatment from healthcare providers and taking care of their child without a clear idea about child rearing. In support of the above view, Sitsofe (2020) and Wado et al. (2019) state that teenage mothers are exposed to multiple negative aspects of motherhood and these affect their psychosocial health negatively. Teenage girls between 15 to 19 years who are mothers are more likely to struggle to complete their education while childless teenage girls show positive prospect and are successful in their education. This argument is consistent with Bah (2016); Krugu et al. (2016) and Sedgh et al. (2015) who state that teenage mothers between 15–19 years are less likely to finish high school when compared to their peers who delay childbearing.

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2.2.2 Teenage motherhood associated with problematic relationship

Teenage mothers are stigmatized by rude healthcare providers because of premarital childbearing and early motherhood. This claim is supported by Shea et al. (2016) and Sitsofe (2020) that teenage mothers tend to suffer from humiliation such as negative judgmental attitude, dehuminising remarks, stigma and social exclusion by healthcare providers. Teenage mothers' negative evaluation by healthcare providers contributes to cause these mothers not to return for hospital follow up appointment visits. The assertion is consistent with Krugu et al., (2016); Lotse (2016) and Maly et al., (2017) who state that those healthcare providers' biases and negative attitudes towards teenage mothers also serve as major barriers for new mothers from seeking health services. These mothers are denied healthcare support by healthcare providers to develop their parental competency and to improve their psychosocial health. This argument is further supported by Sekhoetsane (2012) and Sitsofe (2020) who indicate that lack of emotional support from healthcare providers is associated with psychosocial distress among teenage mothers.

2.3 Psychological distress

It appears that teenage mothers between 15 to 19 years are more likely to present with psychological challenges when compared with non-parenting teenagers and older mothers; a claim supported by Lucas et al. (2019) who indicate that distress is more prevalent among teenage mothers between 15 to 19 years than other women. Moreover, it appears that many teenage mothers experience distress and they are easily missed by healthcare providers. The assertion agrees with Arvidsdotter et al. (2013) who reveal that psychological distress often goes unnoticed in a healthcare setting and its prevalence is more likely to be higher than prevalence rates of 10-38% as it is currently recorded. It seems that psychological distress among teenage mothers is as a result of psychosocial stressors. This claim is consistent with Arvidsdotter et al. (2015) and Vingerhoets et al. (2016) who state that psychological distress is a state of psychological and emotional suffering associated with undesirable life experiences and personally unattainable demands. Furthermore, the role of the transition to motherhood also puts teenage mothers at a greater risk for psychological distress because they are socially, cognitively and emotionally immature to cope with the demands of the new experiences. According to Mouzon et al. (2016), early parenthood is an overwhelming experience for the young teenage girls without knowledge and skill regarding motherhood. Furthermore, it seems that distress encountered by teenage mothers is linked to disrespectful and insensitive attitude by healthcare providers. The argument is aligned with Cardozo et al. (2012) and Saima and Muhammad (2014) who confirm that relationship

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challenges between teenage mothers and healthcare providers are associated with psychological distress. Teenage mothers are more likely to experience psychological distress manifesting with anger, fear, anxiety, suicidal thoughts, irritability, depression, sleep deprivation and headache due to ill-treatment. This is further supported by Lucas et al. (2019) and Slavich et al. (2009) who indicate that parenting teenage girls with psychological challenges tend to manifest with sleep problem, headache and sadness.

Psychological distressed teenage mothers tend to display adverse reactions more especially when they are exposed to difficult situation. According Haftgoli et al. (2010), psychosocial stressors were significantly linked with psychological distress and victims are more likely to present with negative symptoms. Therefore, these mothers seem to be anxious about their situation and complain with headache associated with worry. This argument is supported by Arvidsdotter et al. (2013) who state that psychological distress is manifested by depressive symptoms, anxiety, worry and headache. Furthermore, it seems that if these mothers are exposed to persistent strenouos situations are likely to experience suicidal thoughts. According to Arvidsdotter et al. (2013) and Haftgoli et al. (2010), prolong distress is likely to result in racing thoughts and suicidal tendencies for the victim. In addition, teenage mothers with psychological distress tend to present with emotional response such as crying tendencies when they struggle to handle pressures of life. According to Vingerhoets et al. (2016), psychological distress is associated with crying habits due to coping difficulties. Moreover, negative consequences of psychological distress among teenage mothers may include feeling bitter, feeling rejected, loss of self-worth, frustrated and hopeless. This argument is supported by Mouzon et al. (2016) who reveal that increased feeling of distress expose teenage mothers to higher risk of adverse reactions such as reduced hope, low self-esteem and loss of self-trust. Teenage mothers with distress who are still going to school may display poor reasoning abilities, forgetfulness and loss of concentration. The assertion is supported by Drapeau et al. (2012); Kelemu et al., (2020) and Ridner (2004) who argue that teenage mothers tend to struggle to focus, experience loss of memory and indecisiveness while at school associated with psychosocial difficulties.

Teenage mothers with distress seem to be at risk of negative psychological sypmtoms such as being more depressed, anxious and fearful. This claim is aligned to Farrer et al. (2018) who indicate that psychological distress is considered a public psychological health challenge with 14.4% of people who encounter anxiety, 10.1% suffer from fear and 5.4% facing depression. Furthermore, a person who encounters distress seems to have difficulties to establish or maintain meaningful friendship and interactions. This argument is in agreement with Saima and Muhammad (2014) who indicate that psychological distress is

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linked to an emotional problem associated with problematic interpersonal relationships. It appears that negative effect of distress among teenage mothers interferes with their normal functioning. Teenage mothers are also unwilling to participate in the normal habits attributed to decreased hope, feeling discouraged and annoyed. This is supported by various researchers (Drapeau et al., 2012; Haftgoli et al., 2010 & Uddin et al., 2017) who found that teenage mothers in distress are at higher risk of negative behavior such as neglect of self care and decreased desire to do anything important. It seems that teenage mothers are likely to struggle on their own to deal with negative feelings of psychological distress. The assertion is supported by Lucas et al. (2019); Meerwijk and Weiss (2011) and Mouzon et al. (2016) who state that inability to deal with difficult life situation is associated with feelings of distress and reduced sense self-capabilities by teenage mothers. They tend to engage in risk taking behaviour such as substance use as an effort to alleviate distress. The claim is consistent with Uddin et al. (2017) who state that psychological distressed people tend to engage in risk taking behaviours to handle external events or stressful situation. Unfortunately, negative behaviour may in turn be associated with adverse health consequences such as thoughts to commit suicide or to harm others, more especially if it fails to mitigate the distress. According to Farrer et al. (2018), negative outcomes of failure to handle distress may also include racing thougts and suicidal tendencies.

2.4 Emotional distress

Teenage mothers experience emotional distress if they are subjected to hostile and negative judgmental attitude by healthcare providers. This claim is supported by Braniecka et al. (2014) who reveal that emotional distress is an emotional feeling associated with negative interaction. These mothers seem to manifest with low mood, hopelessness and helplessness under difficult situation. According to Braniecka et al. (2014), emotional distressed teenage mothers are at risk of adverse reactions such as unstable mood, loss of hope and intention. It seems that when teenage mothers are exposed to ill-treatment and stigmatized by healthcare providers, they react with aggressive behavior. Moreover, Braniecka et al. (2014) further argue that emotional distress experienced by teenage is linked to negative feelings of aggression as a result of difficult and aversive encounter. It is noted that the negative effect of unfriendly relationship between teenage mothers and healthcare providers tend to cause these mothers to manifest with anger, fear and irritability. According to Brosh et al. (2010) and Heatherton (2015), emotional distress is described as negative emotional experiences with symptoms of fear, rage, annoyance and frustration elicited by disruptive interactions. Moreover, undignified and insensitive treatment from healthcare providers is likely to generate feelings of fear, bitterness, anxiety, worry, doubt, and suicidal thoughts among

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teenage mothers. The findings agree with other literatures (Diamond et al., 2010; Gračanin et al., 2014 & Mendelson, 2013) who indicate that emotional distress is associated with adverse consequences related to undesirable interaction with others.

2.5 Social distress

It seems that social distress faced by teenage mothers is associated with social negative encounter with healthcare providers. This assertion is supported by Dormann and Zapf (2004); Levine (2017); McGuffin (2014) and Wadman et al. (2011) who reveal that social distress is linked to stressful social situations such as negative judgmental attitude. Mothers who feel unaccepted and rejected are likely to be lonely and self-isolate and withdraw from others, more especially from unfriendly healthcare providers. This is supported by McGuffin (2014) who state that social distress is triggered by interpersonal deprivation and manifest with symptoms of depressive reactions, loneliness and socially isolated.

2.6 Psychological distress experienced by teenage mothers

It appears that teenage mothers experience an increased episode of distress linked to rudeness of healthcare providers than other non parenting teenage girls and women. An argument is in line with various literatures (McLeish & Redshaw, 2017 & Thapar et al., 2012) which state that psychological distress is at elevated levels of 56% amongst abused teenage mothers as compared to older mothers at 10–15% and rates below 10% among non-childbearing female teenagers. Moreover, it seems that teenage mothers experience distress because of multiple challenges related to the transition to teenage motherhood. The claim is aligned with other researchers (David et al., 2017; Hammen et al., 2011; Timaeus & Moultrie, 2015 & Waterhouse et al., 2017) who state that early parenthood is associated with distress. It seems that teenage mothers are subjected to ill-treatment practices by healthcare providers such as being stigmatized, called degrading names in front of fellow mothers and negative judgmental attitudes. This assertion is supported by Aparicio et al. (2015) who reveal that teenage mothers are ashamed because of being humiliated by healthcare providers. It is concerning to note that some of the mothers were threatened or beaten while giving birth at the hospital because of being mothers at a young age and perceived to be uncooperative by nurses. Furthermore, Aparicio et al. (2015) argue that teenage mothers suffer physical and emotional abuse perpetrated by healthcare providers. It seems that common psychological adverse reactions faced by teenage mothers seem to include memory loss, reasoning difficulties, being irritable even without provocation, anger, depressive symptoms, racing thoughts, worried and living a distant life. This argument is

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consistent with Chohan and Langa (2011); Nabugoomu et al. (2018) and Turner and Honikman (2016) who indicate that common psychological consequences such as cognitive impairment, forgetfulness, thought to harm self or others, low mood, loss of interest and enjoyment, and reduced energy are reported among teenage mothers.

It is noted that negative experiences of distress encountered by teenage mothers are associated with sadness, feeling depressed, worried and suicidal thoughts. This argument is in agreement with Jenkins (2013); McLeish & Redshaw (2017) and Xu and Chi (2013) who report that the adverse reactions of psychological distress include the symptom of feeling concerned, anger, anxiety, depression and racing thoughts. Furthermore, it seems that when teenage mothers are subjected to physical and emotional abuses, they are at a higher risk of being aggressive toward healthcare providers. This argument is consistent with Falci et al. (2010); Haigh (2020) and Sedgh et al. (2015) who found that teenage mothers are vulnerable to negative social evaluation by healthcare providers that make these mothers to react with bitterness. Their aggressive behaviors appear to be deterrent against further abuse. According to Haigh (2020), aggression displayed by teenage mothers is associated with a means to defend themselves from harsh treatment by healthcare providers. It seems that a distressed mother is more likely to display difficulty in understanding simple instructions such as work. According to Sedgh et al. (2015), psychological distress among teenage mothers is linked to cognitive impairment and reasoning difficulties. A teenage mother who is always alone is at a higher risk of being depressed and more worried in a manner that is likely to disturb their sleep. This argument agrees with Mitchell et al. (2010) who stated that loneliness is associated with sleep deprivation, feeling worried and depressive reactions. Negative feelings of lonely life among teenage mothers cause them to feel excluded, angry, hopeless and helpless about life success. This is further supported by Hodgkinson et al. (2010) and Siegel and Brandon (2014) who indicate that teenage mothers' experience elevated levels of bitterness due to loneliness linked to reduced hope, helplessness and social rejection by healthcare providers.

It seems that the feeling of distress presenting with anger, irritability, moodiness and anxiety is more likely to affect teenage mothers. This argument is consistent with Hodgkinson et al. (2010) who found that teenage mothers experience psychological distress, including feeling concerned, annoyed, sadness, low mood and restlessness than adult mothers and their non-pregnant peers. Moreover, it appears that if a teenage girl between 15 and 19 years becomes a mother, it seems to be a risk factor for multiple negative reactions such as being sad, worried and depressed. This is supported by Hodgkinson et al. (2014) who reveal that the rates of psychological distress with sadness and depression are estimated between 16%

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and 44% among teenage mothers between 15 and 19 years as compared to between 5% and 20% among non-parenting teenage girls and adult women. It is also assumed that if teenage mothers remain distressed without interventions to address their psychosocial and emotional needs, there is likelihood of suicide thoughts and attempts. This is aligned with Fessler (2008); Hodgkinson et al. (2014); Slavin-Spenny et al. (2013) and Wang et al. (2011) who argue that unsupported teenage mothers between 15 to 19 years report having thoughts of suicide at approximately 19% and suicide attempts at 9% but rare among older women and non-parenting teenage girls. Furthermore, it appears teenage mothers in distress are more likely to suffer from negative feelings of distress such as forgetfulness. This argument is consistent with Finsterwald and Alberini (2014) and Giles et al. (2014) who found that people who experience psychological distress are likely to encounter negative reactions that include memory difficulties, poor concentration and indecisiveness.

Teenage mothers are more vulnerable to multiple symptoms of psychological distress. According to Wilson-Mitchell et al. (2014), approximately 42.1% of teenage mothers experienced symptoms of sadness; 36.5% reported feelings of depression and 39.4% reported feeling guilt. This is also supported by Pinheiro et al. (2011) who reveal that teenage mothers suffer from psychological distress that present with depression at 26.3% while non-parenting at 13.6% and anxiety at 43.6% while non-parenting at 28%. Teenage mothers with distress are more likely to display adverse reactions such as being moody, fearfull and angry. This assertion is in agreement with some scholars (Agu et al., 2017; Edberg, 2019; Kim et al., 2018; Wall-Wieler et al., 2016 & Wilks, 2014) who state that teenage mothers in distress due to ill-treatment, tend to display psychological consequences associated with sadness, annoyance and anxiety. Teenage mothers seem to experience self-isolation, suicidal ideation and racing thoughts associated with harshness of healthcare providers. This is further supported by Boden et al. (2008); Erfina et al. (2019); Kaye (2008) and Roberts et al. (2011) who argue that teenage mothers encounter ill-treatment from healthcare providers and tend to be occupied with thoughts to kill themselves or others. It appears that teenage mothers are more likely to suffer from psychological distress manifesting with anxiety and depressive symptoms. According to Awusabo-Asare et al. (2004); Bah (2016); Kelemu et al. (2020) and Yator et al. (2020), that teenage mothers are more prone to psychological distress that present with depression and anxiety with a prevalence rate ranging from 26% to 50% as compared to older women.

Teenage mothers tend to experience common psychological adverse reactions which include memory loss, reasoning difficulties, being irritable even without provocation and tend to be isolated. This assertion is consistent with some scholars (Chohan & Langa, 2011;

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Manzi et al., 2018; Nabugoomu et al., 2018 & Turner & Honikman, 2016) who argue that common psychological consequences such as cognitive impairment; forgetfulness and being irritable are reported among teenage mothers. It seems that teenage mothers tend to experience multiple psychological outcomes including feeling embarrassed, inability to accept changes and fear associated with teenage motherhood. This argument is further supported by Yates (2013) and Schmidt et al. (2005) who found that psychological distress linked to teenage motherhood is associated with fear, shame and denial. Teenage mothers in distress tend to develop hatred, distrust and have difficulty in establishing meaningful relationships with healthcare providers. These mothers are also more likely to avoid interaction with unfriendly and arrogant healthcare providers. This argument is supported by Agu et al. (2017); Blum and Gates (2015); Fessler (2008); Jenkins (2013); Slavin-Spenny et al. (2013) and Wang et al. (2011) who mention that teenage mothers in distress tend to live a lonely life because of fear of unkindness of healthcare providers. Teenage mothers experience distress because they are subjected to abusive relationship even by their close family members, more especially their paternal parents. This claim is supported by David et al. (2017); Krugu et al. (2016); Laurenzi et al. (2020); Ntinda et al. (2016) and Yates (2013) who indicate that teenage mothers often experience unhealthy relationships with their fathers and it contributes to the perpetuation of distress among teenage mothers.

Teenage mothers seem to be affected negatively with distress and tend to resort to negative coping resources such as consumption of alcohol to handle negative feeling. This assertion is aligned with some researchers (Agu et al., 2017; Hodgkinson et al., 2014; McLeish & Redshaw, 2017; Mollborn & Morningstar, 2009; Wang et al., 2011 & Yakubu & Salisu, 2018) who state that teenage mothers are more likely to engage in risk taking behavior such as alcohol drinking to alleviate distress. It appears that psychological distress is more likely to affect the educational progress of teenage mothers negatively. According to Manzi et al. (2018); McFarlane et al. (2014) and Wall-Wieler et al. (2016), teenage mothers experience elevated levels of psychological distress with devastating effect of dropping out school. It is assumed that teenage mothers experience distress because they are not given healthcare support by healthcare providers. This argument is consistent with some scholars (Abbott et al., 2014; Eau Claire et al., 2012; Gyesaw & Ankomah, 2013; Krugu et al., 2016 & Osok et al., 2018) who state that if teenage mothers are not supported with parental skills and baby care as first-time mothers, they are more likely to encounter psychological distress. Lack of healthcare support is associated with distress among teenage mothers that present with poor personal hygiene, feelings of loneliness, self-isolation and fear. Cressey et al. (2020); David et al. (2017) and Timaeus and Moultrie (2015) support the argument by stating that

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self-limiting impairments of psychological distress experienced by teenage mothers due to absence of support, include avoidance of interaction with others and feeling afraid.

2.7 Emotional distress experienced by teenage mothers

It seems that both ill-treatment by healthcare providers and strain related to teenage motherhood play a major role in causing emotional distress; a claim supported by Haigh (2020); Hoffman et al. (2013); McLeish and Redshaw (2017); Molaie et al. (2019); Pompili et al. (2015) and Sekhoetsane (2012) who found that teenage mothers are at a higher risk of emotional distress associated with early parenting and harsh treatment. It seems that teenage mothers tend to experience low self-esteem, sleep disturbance and headache associated with arrogance of healthcare providers. An argument is in line with various researchers (Fernandes et al., 2020; Lucas et al., 2019; Martorell-Poveda et al., 2015 & Porr et al., 2012) who state that ill-treated teenage mothers by healthcare providers is associated with emotional distress manifesting with reduced self-trust. Furthermore, teenage mothers are rejected and stigmatized by healthcare providers, and they are likely to experience suicidal thoughts and aggression. According to Molaie et al. (2019); Muehlenkamp et al. (2012) and Sodi and Sodi (2012), negative social evaluation encountered by teenage mothers is associated with aggressive behavior, incidences of attempted suicide and suicidal tendencies.

2.8 Social distress experienced by teenage mothers

It seems that negative encounter with healthcare providers and the strain of the transition of teenage motherhood seem to be associated with social distress among teenage mothers. According to Almeida (2005); Blum and Gates (2015); Ellis-Sloan and Tamplin (2019) and McLeish and Redshaw (2017), social distress among teenage mothers is attributed to the negative effect of both il-treatment and early parenting. It seems that stigmatized treatment from healthcare providers contribute to cause teenage mothers to experience fear, feel unconfident, loose trust, and feel lonely and isolated from their health care providers. Socially distressed people, because of social rejection, are more likely to report a decreased desire for social interaction, low self-esteem, fear and feeling of worthlessness (Hamilton, 2004; Hunter et al., 2015; Jacobson, 2009; Levine, 2017 & McGuffin, 2014). Moreover, teenage mothers are at higher risk of suicidal thoughts because they are overwhelmed with many challenges and distress. The claim is aligned with various studies (Levine, 2017; Mohammadi et al., 2016; Nabugoomu et al., 2018 & Ponsford, 2011) who found that multiple

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demands of life and psychosocial challenges contribute to suicidal tendencies among teenage mothers.

2.9 Causes of psychological, emotional and social distress among teenage mothers.

2.9.1 Causes of psychological distress among teenage mothers

It appears that there are many causes of psychological distress among teenage mothers. This claim is supported by Lucas et al. (2019) who state that psychological distress is associated with various factors. The causes of distress seem to include negative judgemental attitude and rudeness of healthcare providers, stigma and discrimination, social exclusion and rejection, feeling disrespected, witnessing others being ill-treated and lack of emotional, informational and instrumental support. This assertion is consistent with Gonzalez-Castro and Ubillos (2011); Hunter et al. (2015); Lucas et al. (2019) and O'Connor et al. (2015) who reveal that stigmatization, interpersonal challenges, lack of social support by healthcare providers are primary sources of psychological distress among teenage mothers. It seems that negative consequences of teenage motherhood are linked to psychological distress. The argument is further supported by Boath et al. (2013); Cardozo et al. (2012); Copty and Whitford (2005) and Sinnema et al. (2018) who confirm that early parenting is associated with distress and adverse reactions encountered by teenage mothers. However, regarding support, it seems that family support alone is not adequate to mitigate the negative feeling of psychological distress among teenage mothers. Cardozo et al. (2012) and Xu and Chi (2013) indicate that teenage mothers are supported by their family members but still experience psychological distress associated with ill-treatment by healthcare providers. Furthermore, a teenage girl who has a child while she still between 15 to 19 years increases the likelihood of psychological distress due to psychological, emotional and social immaturity. An argument is in agreement with Millborn (2017) and Yimgang et al. (2017) who reveals that a teenage birth had negative implications for psychological distress compared to giving birth after 19 years.

Teenage mothers, do not only experience psychological distress through disrespect and physical abuse from healthcare providers, but they are also affected negatively through seeing fellow women beind ill-treated. This claim is supported by Aparicio et al. (2015); Leplatte et al. (2012); Mitchell et al. (2010) and Yimgang et al. (2017) who say that teenage mothers who are exposed to ill-treatment through direct experience or had witnessed ill-treatment increase the likelihood of psychological distress due to their vulnerabilities. Moreover, teenage mothers who are subjected to any form of verbal and physical abuse

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such as harsh language, beatings, aggression, hitting, and slapping from healthcare providers are more likely to experience distress. Kim et al. (2018); Mustafa and Mirkhan (2020); Porr et al. (2012) and Slavin-Spenny et al. (2013) state that psychological distress among people is associated with interpersonal disruptions and condemnation by others. Furthermore, it appears that negative staff attitudes reflected in behaviors such as abusive language by healthcare providers has an adverse effect on the psychological well-being of teenage mothers. The finding is consistent with other literatures (Boobpamala et al., 2019; Edberg, 2019; Hanna, 2001; Mustafa & Mirkhan, 2020 & Whitley & Kirmayer, 2008) reveal that psychological distress encountered by teenage mothers is attributed to negative attitude and hostility of healthcare providers. Furthermore, motherhood more especially for teenage girls of 15 to 19 years is associated with psychological distress because of early assumption of adulthood activities. Erfina et al. (2019); Kelemu et al. (2020) and Manzi et al. (2018) argue that teenage mothers between 15 to 19 years encounter psychological distress due to many challenges associated with the new transition to motherhood.

2.9.2 Causes of emotional distress among teenage mothers

It seems that negative social evaluation and dehuminizing remarks from healthcare providers are associated with emotional distress among teenage mothers. The argument is supported by other scholars (Brand et al., 2018; Ellis-Sloan, 2014 & O'Connor et al., 2015) who argue that people who encounter negative comments and disapproval by others are more likely to experience adverse effect of emotional distress. It appears that lack of support is related to information defiencies, absence of emotional and physical help for a teenage mother. According to Bylsma et al. (2011); Carr and Umberson (2013) and Yardley (2008), teenage mothers without emotional, informational and tangible support from others are at higher risk of emotional distress. Teenage mothers are more likely to experience emotional distress due to physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment in health facility. This argument is supported by some researchers (Corcoran, 2016; Fernandes et al., 2020; Hallman, 2007; Millborn, 2017; Mollborn & Morningstar, 2009 & Slavich et al., 2009) who confirm that emotional distress encountered by teenage mothers is linked to social exclusion and rejection, stigma and ill-treatment by healthcare providers.

Moreover, feeling of emotional distress is associated with early parenting among teenage mothers and is likely to hamper a person's life and contributes to loss of personhood. Cremonese et al. (2017); Fernandes et al. (2020); Fulford and Ford-Gilboe (2004) and Greenberg (2004) further state that early parenthood and poor self concept among teenage

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mothers are associated with the negative impact of emotional distress. It appears that teenage mothers tend to experience emotional distress associated with name calling by healthcare providers. This argument is consistent with Bain et al. (2020); Coast et al. (2019); Laurenzi et al. (2020) and Turner and Honikman (2016) who found that teenage mothers experience emotional distress attributed to healthcare providers' negative judgmental attitude.

2.9.3 Causes of social distress among teenage mothers

It is assumed that ill-treatment, social exclusion, being undermined, stigma and discrimination pepertrated by healthcare providers are potential sources of social distress among teenage mothers; an assertion is supported by various studies (Birkeland, 2005; Gavin et al., 2011; Gonzalez-Castro & Ubillos, 2011; Hammen, 2011 & Taylor & Turner, 2002) who reveal that people experience social distress due to stigma and ill-treatment and discrimination. Moreover, negative effect of social distress experienced by teenage mothers is linked to avoidance of relationship with healthcare providers. Bos et al. (2013); Coast et al. (2019) and Van Zyl et al. (2015) support the argument as they postulate that teenage mothers are reluctant to associate with unfriendly healthcare providers.

2.10 Effects of psychological, emotional and social distress among teenage mothers.

2.10.1 Effects of psychological distress on teenage mothers

It is assumed that teenage mothers tend to be unhappy because they are ill-treated when seeking healthcare services by healthcare providers. The argument is in line with Arvidsdotter et al. (2015) and Sinnema et al. (2018) who state that the feeling of anger among teenage mothers is linked to rudeness of healthcare providers. However, teenage mothers are overwhelmed by psychological distress and are likely to experience low educational achievement and abandon school linked to loss of concentration and memory. The claim is supported by Vingerhoets et al. (2013) and Yimgang et al. (2017) who maintain that poor school performance and early school termination among teenage mothers are attributed to the effect of psychological distress that manifest with difficulty to focus and forgetfulness. Teenage mothers are overwhelmed with psychological distress and tend to be rebellious and display aggression towards healthcare providers, more especially when they are ill-treated. The argument is aligned with Hipwell et al. (2016); Kalil and Kunz (2002) and Yimgang et al. (2017) who found that aggressive behavior among teenage mothers with psychological distress is associated with dismissive attitude of healthcare providers.

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Moreover, it also seems that the adverse effect of psychological distress among teenage mothers is associated with feeling demovitivated and discouraged, depressive episode, fear, anxiety and suicide thoughts. Studies by researchers (Fessler, 2008; Hammen et al., 2011 & Yimgang et al., 2017) confirm that teenage mothers are overwhelmed with multiple challenges of psychological distress such as symptoms of suicidal tendencies, feeling afraid and hopelessness.

Furthermore, teenage mothers with psychological distress tend to display loneliness, social isolation and withdrawal, poor reasoning, poor concentration and memory loss. This claim is supported by Chaby et al. (2015) and Wilks et al. (2006) who say that negative reactions such as multiple cognitive impairments, distant lifestyle and avoidance of interacting with healthcare providers are linked with psychological distress among teenage mothers. Teenage mothers in distress are more likely to struggle to handle embarrasment attributed to demeaning name calling. They tend to engage in smoking and drinking alcohol to alleviate negative feelings. The argument agrees with De Villiers and Kekesi (2004); Levran et al. (2014); Mohammadi et al. (2016) and Yakubu and Salisu (2018) who state that teenage mothers exposed to humiliating attitude of healthcare providers, are more likely to engage in risk related behaviors such substance use to mitigate distress. Exposure to belittling treatment from healthcare providers is associated with inability to matriculate and early ceasation of schooling among teenage mothers in distress. According to Cremonese et al. (2017); Erfina et al. (2019) and Ganchimeg et al. (2014), poor performance at school and inability to finish education among teenage mothers with distress is related to disruptive social interaction with healthcare providers. It appears that psychological distress among teenage mothers is associated with disturbance in mutual relationship. The assertion is supported by Hakizimana et al. (2019) and Osok et al. (2018) who reveal that problematic interaction encountered by teenage mothers are linked to psychological distress.

2.10.2 Effects of emotional distress on teenage mothers

It appears that teenage mothers with emotional distress linked to negative judgmental attitude of healthcare providers are more likely to be worried, loose trust and be less confident about their abilities. In support of the above-mentioned view, Arvidsdotter et al. (2015); Brand et al. (2018) and Copty and Whitford (2005) state that teenage mothers who suffer from ill-treatment, tend to display low self esteem, feeling of inadequacy, feeling concerned and loss of self belief. These mothers eventually become hopeless and helpless about the future regarding success in education and career opportunities. This argument is aligned with Arvidsdotter et al. (2015); David et al. (2017); Hallman (2007); Jenkins (2013)

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and Maly et al. (2017) who state that distress that manifest with reduced hope, feeling of self worthlessness among teenage mothers is associated with poor school performance, school dropout and low employment rates. Furthermore, it also appears that an angry and depressed mother is more likely to experience negative emotional response that includes a tendency to always cry. This claim is consistent with Balsters et al. (2013); Gračanin et al. (2014); Sharman et al. (2020) and Șipoș and Predescu (2017) who indicate that emotionally distressed mother are more likely to cry as an emotional response associated with harsh treatment of healthcare providers.

2.10.3 Effects of social distress on teenage mothers

It seems that teenage mothers with social distress associated with unfriendly healthcare providers are at a higher risk to experience negative reactions of distress. Negative reactions include being anxious, loneliness, living a distant life due to fear of ill-treatment. The argument is consistent with Agu et al. (2017); Sinnema et al. (2018) and Șipoș and Predescu (2017) who reveal that teenage mothers who are ill-treated are more likely to avoid interaction with healthcare providers because of anxiety and fear. It appears that double pressures of the transition and disrespectful treatment tend to increase risk of social distress. Teenage mothers with distress are more likely to experience low self-esteem, feeling unconfident and aggressive behaviour. This argument is aligned with Agu et al. (2017) and Fulford and Ford-Gilboe (2004) who state that teenage mothers in distress are more likely to display rebellious attitude, bitterness and reduced self trust.

Teenage mothers end up being involved in alcohol consumption and cigarette smoking as an effort to deal with social distress. This claim is supported by Peake et al. (2013) and Torres-Berrio et al. (2018) who indicate that disruptive effects of social distress for individuals with negative encounters are associated with negative coping resources, including smoking to handle distress. Furthermore, teenage mothers seem to struggle to attend school and fail to achieve good results due to the effect of social distress and frustration. Hanson et al. (2014); Hakizimana et al. (2019); Mjwara and Maharaj (2018) and Timeus and Moultrie (2015) argue that socially distressed, confused teenage mothers are more likely to drop out of school. A socially distressed mother is at higher risk of being lonely and self-isolated because of reluctancy to interact with rude and arrogant healthcare providers. According to Gonzalez-Castro and Ubillos (2011); Sekhoetsane (2012) and Yator et al. (2020), the effect of social distress among teenage mothers is associated with unwillingness to interact with unfriendly healthcare providers.

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2.11 Coping strategies used by teenage mothers

The researcher argues that it is important to describe a concept of coping and the types of coping strategies people tend use when confronted with difficult situations. Therefore, coping is the process of using behavioural and cognitive approaches to manage stressful situations and plays an integral role in maintaining both psychological and physical well-being of an individual (Lombe et al., 2016).

2.11.1Types of coping strategies are described as follows:

- Emotion focused: seek to adjust the emotions caused by a stressful event e.g. seeking moral support and encouragement like psychological counselling to mitigate negative emotional responses.
- Problem focused: attempt to modify the environment or situation or finds practical ways to deal with stressful situations e.g. seek concrete advice or assistance
- Avoidance: withdrawing from a situation e.g. tendencies to avoid conversations or interaction with people perceived to be triggers of distress.
- Dysfunctional: stress management approaches which are not beneficial to an individual and have any damaging consequence e.g. drug and alcohol abuse.

It seems that people with distress are more likely to use either positive or negative coping mechanism to deal with life difficulties confronting them. According to the Department of Social Development (2013) and Lombe et al. (2016), positive and negative coping strategies are used by individuals as an effort to mitigate distress associated stressful situations. Furthermore, teenage mothers seem to be subjected to belittling remarks, negative social evaluation, being stigmatized, being undermined and socially excluded by healthcare providers. Moreover, World Health Organization (2012) postulates that teenage mothers are exposed to many forms of ill-treament in their encounter with healthcare providers, such as social rejection, being humiliated, name calling and abused physically and emotionally. These mothers tend to experience worry and fear associated with abusive relationship with healthcare providers. According to Ponsford (2011), rudeness of healthcare providers is linked with adverse reactions such as feeling scared and concerned among teenage mothers.

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2.11.2 Postive coping strategies used by teenage mothers

There are teenage mothers who tend to utilize positive coping strategies (emotion focused and problem focused) to deal with stressful relationships and experiences of life dicussed hereunder.

Family support for teenage mothers

It also appears that family support is a means of positive coping resource linked to empowerment and reduced feeling of distress among teenage mothers. According to Pejner et al. (2012) psychologically distressed people cope with negative feelings through emotional support from their female parents. Moreover, despite lack of support from healthcare providers some teenage mothers are likely to receive support from immediate family members more especially from their parents or mothers and siblings. This assertion is consistent with Jenkins (2013) who acknowledges that teenage mothers express happiness regarding a close and supportive relationship with their own parents especially their mothers. In addition, some teenage mothers engage in positive coping behaviors such as talking to a family member in an effort to alleviate such feelings (Gračanin et al., 2014). For teenage mothers with parental support, they may be supported with supportive childcare or baby keeping while teenage mothers go to school and even be assisted with baby clothes. According to Akella and Jordan (2011); Ko et al. (2013); Morelli et al. (2015) and Ntinda et al. (2016), teenage mothers are given tangible assistance such as supportive childcare from their families as their source of strength during unfamiliar and challenging period of parenting role.

Religious support for teenage mothers

Some teenage mothers are able to solicit support from a church through the sermons and counseling from their pastors which help to handle negative feeling of psychosocial distress. Religious belief such as Christianity has a divine element with the benefits of being supportive and transformative to the thoughts, feelings, and behaviors of the emotional distressed person. This claim is consistent with Horwitz et al. (2011); Lucock et al. (2011) and Turgut Ekşi (2020) state that people with emotional distress tend to seek spiritual and religious intervention such as Christianity to mitigate distress.

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2.11.3 Negative coping strategies used by teenage mothers

There are teenage mothers who tend to utilize negative coping strategies (avoidance and dysfunctional) to deal with stressful relationships and experiences of life dicussed hereunder.

Avoidance behavior by teenage mothers

Teenage mothers are more likely to avoid conservations and live a distant life from people who appear to dislike them, more especially harsh healthcare providers. This argument is in agreement with some scholars (Dolezal & Lyons, 2017; Horwitz et al., 2011; Pejner et al., 2012; Peterson et al., 2007; Ponsford, 2011 & Wadman et al., 2011) who state that problematic relationship is associated with avoidance behavior among teenage mothers as an effort to avoid anything that has potential to trigger feelings of distress.

Aggressive behavior by teenage mothers

Teenage mothers seem to be aggressive if they fail to alleviate negative feelings of distress through avoidance. Researchers who support this claim (Fulford & Ford-Gilboe, 2004; Jeste, 2013; Porr et al., 2012; Șipoș & Predescu, 2017 & Wagner & Heatherton, 2015) postulate that if the use of avoidance as a coping strategy by teenage mothers is ineffective to reduce distress; teenage mothers are more likely to display aggressive behavior. It is prevalent that teenage mothers are more likely to be aggressive towards others, more especially when under the influence of substance use as an effort to mitigate distress. Teenage mothers tend to cope with difficult situtions through aggressive behavior such as shouting at others (Drapeau et al., 2012; Kaye, 2008 & Levran et al., 2014).

Substance use by teenage mothers

It seems that teenage mothers are more likely to engage in bad habits such as cigarette smoking, alcohol consumption and drug misuse, including treatment overdose in order to handle distress. Bottorff et al. (2014); Chapman and Wu (2013) and Dolezal and Lyons (2017) confirm that people with psychosocial distress are at risk of overdose of medicines, always drinking alcohol, smoking and substance use to handle life challenges. These mothers believe that if they are under the influence of substances it enables them to cope successfully with difficult situations. This argument is aligned with Fernandes et al. (2020); Hipwell et al. (2016) and Torres-Berrio et al. (2018) as they mention that negative lived

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experiences are more likely to increase chances of mothers to engage in smoking and drug use deal with difficulties.

2.12 Conclusion

Literature which focused on exploring teenage motherhood and psychological, emotional and social distress, their causes, effects and coping mechanisms were reviewed in this chapter. Literature illustrated that these psychological, emotional and social distresses have many negative effects on teenage mothers which caused them to utilize various mechanisms to cope with distresses experienced.

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CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The section provides the discussion on the research approach and design, study setting, population of the study, sampling and sample techniques, data collection methods, data analysis, trustworthiness and ethical considerations.

3.2 Research Approach

Epistemologically, the constructivist or interpretative paradigm believes that knowledge is subjective because it is socially constructed and mind dependent (Creswell, 2012). According to Cresswell (2014), understanding the world as others experience it or understanding people's experiences and that truth lies within the human experience is fundamental. Researchers are part of social reality being studied and not detached from the participants they are studying (Patton, 2002). The goal of constructivist or interpretative research is not to discover universal, context and value free knowledge and truth but to try to understand the interpretations of individuals about the social phenomena they interact with (Grix, 2004). Paradigmatically, constructivists believe that there is no single reality or truth and therefore theoretical perspective is that reality needs to be interpreted (Grix, 2004). The paradigm leans more towards qualitative methods to get those multiple realities (Creswell, 2014). Findings in these studies typically rely on in-depth descriptions that help to explain the situation being studied (Cresswell, 2012). According to Cresswell (2014) philosophical underpinning the chosen study methodology and design are phenomenological. Philosophical outlook to investigate a phenomenon was guided by the necessities and requirements of this research study (Patton, 2002). These paradigmatic and epistemological issues informed the researcher's commitment to identify qualitative research approach as the best approach for this study. Qualitative research paradigm was congruent with epistemological and ontological assumptions that multiple realities exist and have unique meanings for the individuals being studied (Cresswell, 2012). This approach was appropriate because it enabled the researcher to gather more information about the topic under study. The approach was used with the purpose of describing and understanding the lived experiences of teenage mothers from their point of view. According to Cresswell (2013), qualitative approach is useful because it enabled the generation of new ideas and assumptions; techniques get developed and can address research questions of all types. This qualitative method employs an inductive approach in which the researcher first collected data and then attempted to derive explanations from those data.

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3.3 Research Design

The study adopted a Descriptive Phenomenological Research Design (DPRD). Through this design the researcher comprehended the universal meaning of the event, situation or experience and arrived at a more profound understanding of the phenomenon (Sousa, 2014). This design enabled the researcher to explore and describe the essence of the participants' experiences, feelings, beliefs and convictions, refraining from any pre-given framework and remaining true to the facts (Rodriguez & Smith, 2018). According to Charmaz (2006) bracketing is a scientific process in which a researcher suspends in abeyance his presuppositions, biases, assumptions, theories and previous experiences to see and describe the phenomenon. Bracketing was achieved through setting preconceptions in abeyance, process of self-discovery facilitated by engaging a colleague or co-researcher. The researcher developed an awareness of preconceptions at the start of the research process when the project was first conceptualized and continuing with the process of bracketing throughout the research. This philosophical underpinning of phenomenology is congruent with the perspective of the study of lived experiences of persons and a view that these experiences are conscious ones (Cresswell, 2014). The participants were teenage mothers who have first-hand knowledge of an event, situation or experience. In this design, teenage mothers were interviewed and given the freedom to give their own views about the psychosocial distress they experienced, the factors that cause it and its effects. This implied that teenage mothers were in a better position to express in detail their lived experiences. The participants were informed about what was expected of them in the study prior to the start of the interview. The participants were requested to respond to all questions and to give their own responses during the interview. They were reassured that there was no wrong or right response; all responses were correct.

3.4 Population and Setting

The population for this study comprised of teenage mothers aged 15-19 years old who visited the hospital for maternal healthcare services. Based on the researcher's observation, complaints were common in the age range mentioned above. The study was conducted at Collins Chabane Local Municipality (CCLM). Collins Chabane Local Municipality is one of the four municipalities (Makhado, Musina, and Thulamela) in Vhembe District Municipality. According to the Vhembe District Health Plan (DHP 2019-20 Final Draft, 2019), CCLM is situated on the eastern side of Vhembe District and the northern part of Limpopo province, South Africa. Collins Chabane Local Municipality has 30 fixed clinics, 3 Community Health Centers, 5 mobile clinics and 1 district hospital. Common health challenges in CCLM as

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recorded in the DHP are high teenage pregnancy and HIV/AIDS prevalence amongst girls between 15-34 years. According to CCLM Integrated Development Plan (2018), girls in CCLM are engaged in various physical and social activities including household chores, traditional dancing, and extramural activities such as netball and soccer. Based on the researcher's observation; alcohol drinking among youth result in negative consequences, such as unprotected sexual behaviour and risk of unwanted pregnancies. According to CCLM Integrated Development Plan (2018), alcohol consumption and unemployment are high amongst the youth between 15-34 years old.

Collins Chabane Local Municipality map below within Vhembe (Vhembe District Department of Health, 2017).

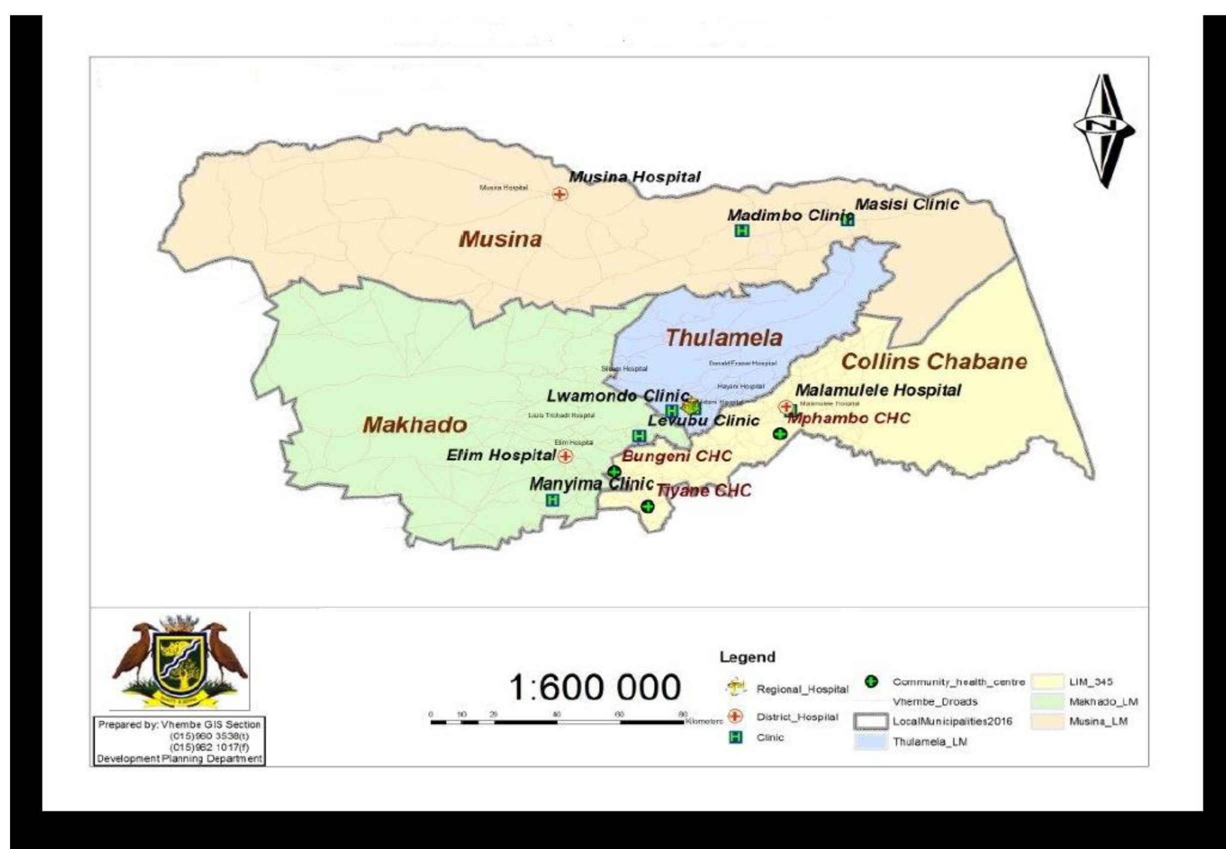

Figure 1. CCLM map on the right side showing the study area within Vhembe district map.

3.5 Sampling and Procedure

Non-probability purposive sampling method was used. A purposive (also known as judgemental) sampling method was used to select the sample (participants) and a site for this study (Etikan et al., 2016). Selection of participants in this study was judgmental, meaning that teenage mothers did not have an equal chance of being included in the sample. The researcher selected participants that were proficient, well informed with a

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phenomenon of interest and willing to provide the information by virtue of their lived experiences (Cresswell et al., 2011). The researcher used this method because it was appropriate for the selection of the participants with specific cases and characteristics such as lived experiences, gender and age of the teenage mothers. For example, theresearcher selected teenage mothers between 15 and 19 years. Participants were recruited through a screening tool designed by the hospital to triage patients when they visited the hospital for healthcare services. Permission was sought from the hospital management for the researcher to participate in the screening process to identify teenage mothers who came for follow up visits to be recruited to participate in a study.

3.6 Inclusion and exclusion criteria

A selection was based on the following criteria: teenage mothers between 15-19 years who visited a hospital for maternal healthcare services. The researcher was able to access teenage mothers when they visited the hospital. The researcher developed a rapport with the participants, to make them feel comfortable enough to respond to questions. A total of 15 participants who met the requirements were selected. A sample size was according to guidelines for actual sample sizes in phenomenological studies which are from 5 to 25 interviews (Cresswell, 2012 & Charmaz, 2006). Sample size was from the larger group of teenage mothers with common characteristics and experiences. Only teenage mothers who had visited Malamulele hospital for maternal healthcare services and who were not satisfied about their lived experiences were included in the study. Inclusion was based on the fact that complaints were often received from the age range indicated above. Teenage mothers who were willing to participate irrespective of their language but most of them speak Xitsonga were included. All adult women and teenage mothers between the ages of 13-14 years consulted in Malamulele hospital were excluded in this study. Exclusion was based on the fact that complaints were rare in the age range indicated above. All teenage mothers who were unwilling to participate in this study were excluded.

3.7 Data collection and procedure

Semi-structured interviews were conducted to collect data from teenage mothers about their lived experiences. Interview guide was used as a guide for research questions. According to Kallio et al. (2016), interview guide is a set of predetermined questions that guide rather than dictate the interview. Semi-structured interviews gave participants freedom to express fully and elaborate their responses (De Vos et al., 2011). All participants were asked the same questions with follow up questions in order to get a clear understanding of the responses

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given. The researcher chose this instrument because of its flexibility in gathering necessary information of participant's views, feelings and experiences about the phenomenon under study, sometimes personal and sensitive issues (Kallio et al., 2016). Permission was sought from the hospital management to utilise a training centre before commencement of the study. A proposed venue was finalised as the researcher agreed with the participants and it was suitable to them. The researcher used Malamulele hospital training centre for data collection from teenage mothers. The Training centre was used because it was free from noise and distractions which helped to maintain confidentiality and privacy. Signed consent forms were sought from teenage mothers' parents or guardians and from teenage mothers because their participation in a study was voluntary and willing. The researcher conducted the interviews by himself. A research assistant with a BA Degree was recruited to assist in data transcription of the audio recordings of the interviews. Each participant was interviewed for a minimum of 60 minutes while the maximum was 90 minutes, using the participants' home language. According to Cresswell (2013), interviews range from one hour to one and half hours in duration, appropriate for phenomenological studies.

Interview questions were translated from English to Xitsonga which was the home language of the participants, in order to maximise the participants' understanding of the questions and instructions. The guardians of the participants were not part of the interviews and they were not allowed to enter the interview room although they were required to sign the consent forms. This was done for the purpose of maximising confidentiality and privacy. Participants were informed that they will be recorded by an audio recorder (Miles et al., 2013). An audio recorder was used to record the participants' responses. An exam pad was used to make notes after each interview in order to make sure that adequate information is captured (Creswell, 2012). The audio recorder was used since it had excellent sound quality. The audio recorder was more reliable than any other recorders because it provided complete confidentiality. The audio recorder was placed on the flat table to record in such a way that it does not distract the researcher and participants.

3.8 Pre-testing

The researcher conducted pre-testing in order to test whether the participants interpreted questions as intended (De Vos et al., 2011). Pre-testing was crucial to determine if there were some elements of the interview guide that needed some adjustment. An Interview guide was used when the researcher was satisfied that it was comprehensive to gather relevant information about the phenomenon under study, clear and understandable to the participants. The same questions used during the pre-testing were also used in the actual

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study (De Vos et al., 2011). Two pre-testing interviews were conducted on two participants before the actual study commenced. It comprised of two teenage mothers who consulted at Malamulele Hospital, who were between 15 and 19 years. These participants met inclusion criteria and were selected by means of non-probability purposive sampling technique. The pre-testing interviews were excluded from the final data corpus.

3.9 Plan for data management and analysis

A simplified version of Hycner's explicitation process was used to analyse data (Hycner, 1999). This strategy is congruent with the philosophical underpinnings of descriptive phenomenology because the process requires consistent bracketing and phenomenological reduction. This explicitation process has five steps which are:

Step 1: Bracketing and phenomenological reduction.

The researcher firstly listened repeatedly to the audio recording and read through transcriptions of each interview to become familiar with the words, expressions and intonation of the interviewee. This process was done with openness to whatever meanings emerged. The claim is supported by Hycner (1999) who referred to this method as phenomenological reduction, an underlying assumption in descriptive phenomenology. The researcher held subjective, private perspectives or beliefs about the experience of a phenomenon in abeyance and allows the essence of this phenomenon to emerge (Hycner, 1999). A conception of bracketing was used in which the researcher made every attempt to suspend his own meanings and interpretations and entered into the world of the participant (Sadala & Adorno, 2001). The researcher was attentive to non-verbal and para-linguistic levels of communication (Hycner, 1999). Sadala and Adorno (2005) describe this as a way in which a researcher adopts an empathic attitude, which aligns with the epistemology of phenomenology (Sadala & Adorno, 2001). This was done in order to develop a holistic sense (Hycner, 1999).

Step 2: Delineating units of meaning.

The researcher then began the rigorous process of explicating the data by extracting those statements that illuminated or depicted a research phenomenon (Hycner, 1999). One transcript was analysed at a time. Statements pertaining to the participants' feelings and thoughts about their preparedness for psychosocial distress and the lived experiences of teenage mothers were underlined. While underlining statements that appeared relevant to

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the interview questions (Hycner, 1999), a researcher was silently posed to each underlined statement. A researcher is required to make a substantial amount of judgement calls while consciously bracketing her/his own presuppositions in order to avoid inappropriate subjective judgements. The list of units of relevant meaning extracted from each interview is carefully scrutinised and the clearly redundant units eliminated (Hycner, 1999). To do this a researcher considered the literal content, the number (the significance) of times a meaning was mentioned and how (non-verbal or para-linguistic cues) it was stated. The researcher described the units of meaning reflecting on the descriptions given by the participant in the interviews. Notes were made next to the units of meaning indicated in the square brackets to draw his attention to attributes of the conversation that were unique or that overlap with descriptions given by the participant (Hycner, 1999).

Step 3: Clustering of units of meaning to form themes.

The researcher maintained bracketing his presuppositions in order to remain true to the phenomenon with the list of non-redundant units of meaning in hand. An inductive approach was employed by the researcher to identify units of meaning that appeared to have a common theme (Cresswell, 2012). The researcher colour-coded units of meaning that shared a similar meaning. These colour-coded units of meaning that corresponded with the similar colours were clustered together under an unlabeled heading. Instead of rewriting the description of the units of meaning, the researcher clustered the assigned numbers (representing the units of meaning) that reflect a topic of similar interest together under an unlabeled heading (Groenewald, 2004). The researcher examined each unlabeled cluster of units of meaning rigorously to elicit the essence of meaning of units within the holistic context (Groenewald, 2004). The researcher identified significant topics, also called units of significance (Sadala & Adorno, 2001). Hycner (1999) emphasizes the importance of a researcher going back to the recorded interview and forth to the list of non-redundant units of meaning to derive clusters of appropriate meaning. Following this activity, the researcher inductively extracted key words with relevant meaning (Hycner, 1999) from each of the unlabeled grouped clusters of units of meaning that best described each grouped cluster of units of meaning. The key words became labeled headings for each cluster of units of meaning. The number of labeled clustered units of meaning varied for each participant. Central themes emerged from further examination or interrogation of the clusters of themes (Cresswell, 2012). Central themes were determined which express the essence of the identified clusters of themes (Hycner, 1999). The researcher listed non-redundant units of meaning, examined list and elicited the essential meaning within a holistic context. Clusters

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of themes were created, by grouping units of meaning together. The final step was to identify significant topics, known as units of significance.

Step 4: Summarise each interview, validate and modify.

A summary of each participant's interviews was done that incorporated all the themes elicited from the data reduction that gives a holistic context (Groenewald, 2004). At this point the researcher conducted a validity check by returning to each participant to determine if the essence of the interview has been correctly captured (Hycner, 1999 & Sadala & Adorno, 2001). No modifications were required because of validity check. Steps one (1) to four (4) were followed for analysis of each participant's interview data. The aim of the researcher during analysis was a reconstruction of the inner world of experience of the participant.

Step 5: General and unique themes for all the interviews and composite summary.

When the processes outlined in step 1 to 4 has been done for all the interviews, a researcher looked for the themes common to most or all of the interviews as well as the individual variations (Hycner, 1999). The researcher was careful not to cluster common themes if significant differences existed. The central themes (Hycner, 1999) common to most of the interviews were called major themes. Themes that were sub sets of the major themes to a single interview or represented in the interviews were called sub themes (Hycner, 1999). Phenomenological reduction throughout this process of explication of the interview data was employed. The main and sub-themes were described in the findings section of the research report and the researcher also concluded the explicitation by writing a composite summary, which reflected the context or horizon from which the themes emerged (Hycner, 1999). According to Sadala and Adorno (2001), the researcher at this point, transformed participants' everyday expressions into expressions appropriate to the scientific discourse supporting the research. Saturation of themes was established after both interviews of each participant were analysed (Sadala & Adorno, 2001). This was an indication that further interviews would have elicited no further central information to the psychosocial distress associated with lived experiences of teenage mothers in an identified rural hospital.

3.10 Trustworthiness of the study

Researcher ensured the trustworthiness of this study by making sure that credibility, transferability and confirmability were established.

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Credibility

Credibility establishes whether the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original views (Korstjens & Moser, 2018). The researcher made sure that the recordings are done. Notes were made after each interview. Non-verbal behaviours were observed because participants' thoughts and feelings were also conveyed through unspoken words. The researcher had ensured credibility through following ethical considerations, and every participant was informed of the right to withdraw from the study. Therefore, the researcher gave accurate information provided by the participants (Shenton, 2004). There was no alteration of the participants' data during the process of interpretation (Fenton & Mazulewicz, 2008). The researcher did not add or reduce the information provided by the participants.

Transferability

Transferability is ensured when the results and findings of qualitative research can be applicable to other contexts with other respondents (Shenton, 2004). Qualitative researchers can use thick description to show that the research study's findings can be applicable to other contexts, circumstances, and situations (Korstjens & Moser, 2018). The researcher provided a detailed and clear discussion of the results of the field work. This enabled the reader to relate or transfer the study results to the one he or she knew. Provision of detailed information assisted in addressing the problem of applicability.

Confirmability

Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but clearly derived from the data (Korstjens & Moser, 2018). The researcher sought confirmation from the participants to ascertain whether his interpretations were a true reflection of their experiences. In this study, the researcher had indicated confirmability by quoting the participants' responses to back up her interpretation, and the findings were also contextualised in literature. That confirmed that the information provided by the researcher was not from his own views, but the participants' responses.

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3.11 Ethical considerations

In this study, the researcher discussed the ethical considerations in order to develop mutual understanding with participants without harm. Punch (2000) defines ethics as a set of moral principles that are suggested by an individual or group, and which are subsequently widely accepted. The study focused on eight ethical considerations or rules, namely, permission to conduct the study, informed consent, anonymity, confidentiality and privacy, nonmaleficence or no harm, beneficence, voluntary participation, and publication of the research results and debriefing of participants. These ethical considerations or rules are discussed below.

Permission to conduct the study

Authorisation to conduct the study was sought from the relevant departments and authorities before data collection commenced. The following process was followed:

- **Internal ethics:**

The researcher presented his research proposal to the Department of Psychology for recommendation and then to the School of Health Sciences for quality assurance. Thereafter it was submitted to the University Higher Degrees Committee (UHDC) for approval. After the approval of the research proposal the researcher applied for ethical clearance from the University Ethics Committee (UEC) at the University of Venda (Ethical clrearance number: SHS/20/PSYCH/22/1111). In the current study, the researcher had obtained ethical clearance from the UHDC University Higher Degrees Ethics Committee at the University of Venda.

- **External ethics:**

Before the study commenced, the researcher sought permission from the provincial Department of Health (DoH) and approved with (Permission reference number: LP_2020_11_036). The researcher presented written permission letters from UEC and Provincial DoH to Vhembe District DoH management. Then the researcher presented written permission letters from DoH Provincial and District DoH and UEC certificate to Malamulele Hospital management. Furthermore, the researcher acquired permission from the parents or guardians and teenage mothers participating in an individual interview; a consent form was signed by all teenage mothers and by their parents or guardians.

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Informed consent

The participants were informed about what was required of them. Each participant has the right to give informed, un-coerced consent to participate or not and may withdraw their consent (Alase, 2017). Participants may cease participation at any point during the research process, without this negatively impacting on them (Alase, 2017). Research topic and purpose of the study, time of interviews and notes taking were explained clearly. The researcher informed the parents or guardians and the participants about the research topic, the purpose of the research and the time that the research took. The researcher introduced himself to the participants (the particulars of who he is, where he comes from). The participants were also informed about their rights, for example, they have the right to participate or not to, and to withdraw if they felt that they were no longer interested or for other reasons. Consent to interview the participants was sought from their parents or guardians and the participants themselves. Parents or guardians gave consent for the teenage mothers since the participants to be interviewed were teenagers. Consent was in a written form (Trochim, 2006).

Anonymity

Participants' identity and their names will not be divulged to anyone during interviews and at any stage of the study (Alase, 2017). The names of the participants were not provided in writing to maintain anonymity. The researcher used pseudonyms such as Teenage mother 1 for participants' real names.

Confidentiality and privacy

The participants will be protected from risk of her personal information becoming available without her consent and such personal information will be kept private and confidential (Alase, 2017). The responses on the audio recorder will be kept in a locked cupboard for 24 months after data analysis. Then after two years, transcribed data will be discarded through shredding. Information given by the participants remained confidential. It was not revealed to anyone, whether relatives, friends, or strangers. It was used for the purpose of completing the researcher's Masters' degree at the University of Venda. The interviews were conducted at Malamulele hospital training center in order to maintain confidentiality and privacy. Every participant was interviewed individually in the absence of their peers and guardian. The interviews were semi-structured. Training on ethical considerations such as confidentiality for research assistant was arranged and conducted by hospital trauma counsellor. The

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researcher ensured compliance to the POPI Act (Protection of Personal Information) which sets out the minimum standards regarding accessing and processing of any personal information belonging to another (Dronammraju et al., 2020). The Act defines "processing" as collecting, receiving, recording, organising, retrieving, or the use, distribution or sharing of any such information (Dronammraju et al., 2020).

Nonmaleficence or no harm

No harm should come to the participants and the risks to the participants should be very minimal (Alase, 2017). The researcher avoided conducting research in an unsafe environment. Participants should be protected from unwarranted physical and or mental discomfort, distress, harm, danger or deprivation (De Vos et al., 2011). In order to avoid psychological and emotional harm, the asking of sensitive questions about participants' past or sexual conducts that added more harm to the participants was avoided. A study was conducted in a safe place, in the hospital training center, to avoid physical harm. It was low risk because it involved danger free voice recording.

Beneficence

The findings of a study will be made accessible to the participants because this has implication to increase use of the services by teenage mothers in the surrounding communities. This also includes making the findings accessible to the hospital management and it has implications for improved service delivery.

Voluntary participation

The participants should be allowed, if any so choose to be excused from participation in the research study all together; or refuse to answer questions that they may not be comfortable with (Alase, 2017). They were not coerced or bribed into participating (Trochim, 2006). Participation in the study was voluntary and based on participants' willingness without coercion or incentives given to the participants to influence them to participate in the study.

Publication of research results

When reporting the study results, the ethical issues include continued protection of the rights of, and honouring promises made to participants, reporting findings truthfully, accurately and completely (Alase, 2017). Falsification or alteration of results was avoided.

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Debriefing of participants

The participants were offered debriefing sessions in an effort to deal with feelings that might have been evoked during the interview and throughout research process. The contact details of the researcher and research assistant were given to ensure further contact should it be necessary (Jantjie, 2009).

3.12 Delimitation of the study

This research however is subjected to delimitation factors that limit the scope of one study so that the aims and objectives of the study do not become impossible to achieve (Theofanidis & Fountouki, 2019). In this study, the researcher consciously chose the problem itself, purpose, objectives, the research questions, theoretical perspectives, target population and the geographical location covered.

3.13 Plan for dissemination and implementation of results

The study findings will be returned to the participants and management where the study was conducted for implementation activities (Wilson et al., 2010). Soft and hard copies of the study results will be made available in the university library for access by other researchers. The study findings will be presented to both international and national conferences and articles published.

University of Venda library

The researcher will submit three copies of the research report to the library of the University of Venda for use by fellow-students and academics. Other three copies will be submitted to the examination section for records purposes. This information and or literature could assist future researchers who would like to pursue this topic further.

Malamulele Hospital

The researcher will take a copy of this research report to Malamulele hospital where the study was conducted. The hospital management together with healthcare providers could use this data to improve provision of healthcare services for teenage mothers. Policies and protocols would be guided by the findings of this study that have indicated clearly the psychological, emotional and social distress (the causes, its effects and coping resources)

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among teenage mothers consulting at Malamulele hospital. This study report could also assist in providing awareness to the general hospital staff in understanding the psychological, emotional and social difficulties encountered by teenage mothers.

The Department of Education

One copy will be submitted to The Department of Education in the Limpopo Province. The Department of Education could develop new strategies that can maximize attendance among teenage mothers. These findings could assist in the development and improvement of new policies and rules used in schools to mitigate school dropouts and underperformance among teenage mothers.

Journal articles

Articles will be published with the approved and registered publishers. This will be done to increase the accessibility of my research results to the people all over the world. These should include teenage mothers encountering psychological, emotional and social distress and other researchers who would need literature on the topic related to this one.

Presentation of findings at conferences

The findings of the study will be presented in conferences. This should include the national and international conferences; different researchers would be available for questions and comments on my study findings.

3.14 Conclusion

The researcher focused on the following aspects: research design and procedures; introduced the whole planned process of what was done in the field work. The study is qualitative and interpretative in nature. Non-probability purposive sampling procedure was used to select the participants. The researcher used semi-structured interview guide consisting of four main open-ended questions as an instrument to collect data and sub-questions were used to get more data.

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CHAPTER 4: PRESENTATION OF RESULTS

4.1 Introduction

In this chapter, the researcher presents the major themes that emerged from the study conducted at Malamulele Hospital in Collins Chabane Local Municipality. The major themes that emerged were psychosocial and emotional distress experienced by teenage mothers, causes that contributed to psychosocial and emotional distress among teenage mothers, effects of psychosocial and emotional distress on teenage mothers and coping strategies used by teenage mothers.

4.2 Theme 1: Psychosocial and emotional distress experienced by teenage mothers

Twelve sub-themes emerged from the study. These sub-themes include depression, sleep disturbance, worried, headache, anxiety and fear of ill-treatment, anger and irritability, hopelessness and helplessness, loneliness, social isolation and withdrawal, stigmatisation, suicidal thoughts, trouble with memory and concentration. The sub-themes are presented below.

4.2.1 Sub-theme 1: Depression

Some of the particpants felt disinterested in doing things they used to excel in life. They felt overwhelmed and sad even when they were at home, due to ill-treatment by healthcare providers. Some showed diminished sense of self-care (poor personal hygiene and loss of appetite). Some preferred to be left alone because they were easily provoked to anger when they talked with others. Some also showed a sense of distrust to healthcare providers. The participants had the following to say:

I'm frustrated and felt lonely due to ill-treatment. I don't like the nurses. Every small thing makes me sad [frowning]. (T.mother 1)

Erm, I experienced unkind attitude, this make me to feel <u>bitter</u> all the time. I lost interest to things I used to enjoy. I don't like company of others [Throat clearing]. (T.mother 2)

Eish…It's difficult to relax and to be happy. I'm always irritable and I don't want to be disturbed. I think I failed to do the right thing. I don't like food or bathing either…I'm not sure.

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I'm still sad by the rough manner I was treated when I deliver my baby. One of the nurses said to me "we don't have time for devils". (T.mother 4)

Hey! Not good, I'm very sad because I was called with humiliating names like stupid, devil and irresponsible girl. (T.mother 7)

One of the nurses said to me "don't bother us, we're not responsible". Hey, I'm always angry and moody. I feel guilty all the time when I think about how the nurses ill-treat us. I'm very suspicious that they can also give us wrong medications. I hate them…surely. (T.mother 8)

Erm… nurses are so rough. I hate to interact with them or other women. I have no desire to get up and do something for myself, and I have lost interest to bath and have no appetite. I'm always so sad and prefer to be left alone in my room always. (T.mother 13)

Eish… I don't have enough time about myself. I have no desire to meet with friends or shopping. I'm so angry all the time and experience challenges with headache always. It's very difficult. (T.mother 15)

4.2.2 Sub-theme 2: Sleep disturbance

Some participants reported that they had difficulties in falling asleep particularly at night during their admission at the hospital and even after being discharged. The difficulty to sleep is worsened when they thought of the suffering they encountered from the healthcare providers. The finding is supported by the following statements:

I always stay awake even at night while I was at the hospital because I was afraid that they might harm me and my child. I'm very worried that even at home I struggle to have a proper sleep even when I'm tired. (T.mother 1)

I don't sleep well nowadays since I visited the hospital I don't know why…may be is being a teenage mother, I'm not sure. (T.mother 2)

I will try to sleep but I experience difficulty in sleeping nowadays. (T.mother 4)

I'm scared and worried about their attitude… the nurses are unfriendly. I'm also afraid to sleep at night because I don't know what they may do to me or my baby. (T.mother 7)

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You know what... nurses will sit there talking bad about us and even laughing at you when you pass by; I have difficulty to fall asleep when I think about this… (T.mother 8)

Hm… I don't know where to start because I'm very disturbed about the negative attitude of nurses. I don't sleep at night; I don't know why.... (T.mother 10)

I,I,I… like to sleep but sometimes it's difficult to sleep when you're not happy. (T.mother 11)

I have challenges falling asleep since I became a mother. I don't understand because I used to sleep a lot in the past. (T.mother 15)

4.2.3 Sub-theme 3: Worried

In the analysis of the responses given by the teenage mothers it was found that many of them (teenage mothers) were worried about the rudeness displayed by healthcare providers. Some teenage mothers were worried about how they were humiliated and name calling as young and inexperienced mothers.

Do you want to know.., one of the nurses told me that "don't you see that you're young, ugly and shapeless to be a mother" I feel overwhelmed and worried about these words even when I'm at home. (T.mother 3)

I'm worried and feel rejected because of how they treat us like dustbin. (T.mother 5)

I'm worried because I don't know how to hold the baby and instead of getting help, nurses insult and embarrass me in front of other women. (T.mother 7)

To tell you the truth…I'm so disturbed to talk about it because I'm worried about everything. Health care providers are not kind. Eish, I don't know what to say… (T.mother 9)

Hey, I'm always worried about how they treat us as if we're dogs. (T.mother 14)
I was called with degrading names like devil, cheap and filthy girl. I'm worried when I think about my experience at the hospital; it was horrible as a teenage mother. (T.mother 15)

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4.2.4 Sub-theme 4: Headache

Other participants indicated that they had persistent and unexplained headaches. They often thought about how harsh it felt when they were called degrading names by healthcare providers. The participants had the following to say:

I sometimes experience headache more especially when I think a lot about the uncaring attitude of the health care providers. (T.mother 1)

I always experience constant headache since I got my child which doesn't respond even with treatment. (T.mother 3)

Sometimes my head pains a lot at night when I remember the harsh treatment I suffered from nurses. (T.mother 4)

I always have trouble with headache every time I remember how I was humiliated [shakes head to show disgust]. (T.mother 9)

You know honestly speaking…nurses treat us like nothing and useless people, I usually have problem with my head the moment I start thinking about this… (T.mother 11)

I have unexplained headache at night more especially when I remember how I'm humiliated by nurses. I feel very bad actually… (T.mother 12)

As I kept on thinking every day about the rudeness of healthcare providers, I have problems with headache. (T.mother 14)

4.2.5 Sub-theme 5: Anxiety and fear of ill-treatment

Some of the participants were anxious and afraid of ill-treatment. Some were afraid that they could be victimised and harassed like valueless people by heartless healthcare providers. The finding is supported by the following statements:

Erm, I feel very anxious and terrified when I remember how nurses were so rude to me from the moment I arrived at the hospital until the time I was discharged. (T.mother 1)

I'm so afraid and anxious because of this rudeness by health care providers. (T.mother 4)

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I'm very scared and hurt [Shakes head with show bitterness] because I was treated like a rag or useless person. (T.mother 7)

Hm…I'm scared and anxious how they will treat me when they see me again at the hospital. They don't smile but always shouted at me like a little thing, I hate [Frowning face to show disgust] them. (T.mother 8)

Erm…I think they (health care providers) must be changed. When they talk with us, they always shout and threaten us, I'm afraid of them. (T.mother 9)

I always live in fear because they will shout at you even for little thing. (T.mother 10)

You may not like to be assisted at the hospital even if your condition needs hospital care because of fear of ill-treatment and not being sure what you're likely to experience. (T.mother 12)

I'm so afraid of them because they will always show us angry faces without any wrong we did against them; I don't understand why they are like this… (T.mother 14)

4.2.6 Sub-theme 6: Anger and irritability

The results of the study indicated that many teenage mothers were frequently provoked to get angry and felt irritable towards healthcare providers. The anger and irritability were likely to be triggered when teenage mothers were insulted or offended by the healthcare providers.

I'm so irritated [shakes head to show disgust] to visit this hospital for services because I don't know what they will do to me this time. (T.mother 1)

I feel irritated and anxious to receive services at the hospital because I was beaten when I was delivering my baby at this hospital. (T.mother 2)

I usually feel angry and irritated [shakes head to show disgust] about their negative attitude, I don't know why they hate us so much; I don't know [Looking up to show concern]. (T.mother 9)

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Is okay, I will tell you if you want to know… I was beaten [Looking with eyes wide open to show concern] during the time I gave birth, I'm very angry about this kind of humiliation. (T.mother 15)

4.2.7 Sub-theme 7: Hopelessness and helplessness

As a result of ill-treatment experienced by teenage mothers, some participants became hopeless and helpless about seeking health care services in future. The hope for seeking health care services was threatened by the loss of trust between them (teenage mothers) and the healthcare providers. The finding is supported by the following statements:

They (nurses) call us names like "Satan" I feel hurt and helpless when I think about this… (T.mother 2)

I feel helpless because I'm treated as nobody by the nurses…it's very bad. (T.mother 3)

The healthcare providers were very harsh at me; I'm very offended and helpless and hopeless to be pregnant again. (T.mother 7)

I feel hopeless about my future as young girl with a child. Nurses don't talk with us in the right way, always criticizing, blaming and discouraging us. (T.mother 11)

Erm, I'm not sure how I will make it while being ill-treated and motherhood demands. I still have to learn to accept it but it's not easy, maybe I will or not, I don't know… (T.mother 13)

4.2.8 Sub-theme 8: Loneliness

Some of the participants felt lonely due to lack of emotional support from healthcare providers. They felt inferior and worried to talk with fellow mothers and the healthcare providers thinking that they may be rejected. This finding is supported by the following participants' responses:

Well, yeah… that's something, people talk too much. I prefer to be alone. (T.mother 1)

I feel lonely and worried most of the time because I don't know how to care for the child. Nurses shout at me that make me feel socially excluded. (T.mother 2)

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4.2.9 Sub-theme 9: Social isolation and withdrawal

Some teenage mothers were embarrassed because of they gave birth at a young age and revealed that they never felt comfortable to associate with others. This was as a result of the stigma attached to teenage motherhood and the negative attitude shown to them by healthcare providers. The finding is supported by the following statements:

Hm, I keep a distant life because people like to ridicule you. They often ask too many silly questions such as how will I raise the child; I don't like such embarrassment so… (T.mother 8)

… I don't want people to laugh at me because of my situation. I'm worried that nurses don't interact with us. I'm also afraid to seek for help because they shout at us. (T.mother 9)

Okay…I, I, I like to be left alone because I don't want to be disturbed more… (T.mother 10)

I have no desire to talk with others; people make fun out of you when you're in this situation, it's better to be alone. (T.mother 13)

I'm tired and feel reserved; the nurses don't treat us like human beings. They don't engage or talk with us. I'm afraid of them because… they don't like us. (T.mother 13)

Hey…nurses show rejection and disapproval towards us. It's better to be left alone; I don't want any trouble. (T.mother 14)

4.2.10 Sub-theme 10: Stigmatisation

Some participants felt that healthcare providers treated them with disrespect and shame because they were seen as too young to be mothers. They also felt that healthcare providers would not talk to them with humility but usually shout or call them using degrading names: The finding is supported by the following statements:

I think, we deserve to be treated with respect although we made a mistake of being mothers at a very young age. We are not objects but human beings with feelings like them (health care providers). (T.mother 1)

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Erm, nurses shout, belittling and shaming us as teenage mothers, this is horrible experience and worrisome. Hm… nurses will call you names like Satan, devil and careless young girl. (T.mother 5)

Nurses are always angry and yelling at us more especially against young parenting mothers. We… don't know why, may be because of our young age. (T.mother 9)

…Hey, They don't treat us good, belittle us. I remember one of the nurses said to me "Am I the one who impregnated you, we don't want to be bothered by lazy kids". (T.mother 10)

Well, I regret why I came to be assisted to this hospital. One of the nurses said to me "You are too young and ugly to be pregnant". I'm not fine about… They talk to you in a disrespectful manner. (T.mother 11)

If you're young and have a child you're in trouble in this hospital, everyone take advantage of you, it's disturbing. (T.mother 13)

It's better for older women at least they are respected. If you're a teenager, they ridicule and shout at us when they talk to us. (T.mother 14)

4.2.11 Sub-theme 11: Suicidal thoughts

Some of the participants indicated that they had thoughts of killing themselves because they saw no value in life of suffering and shame. They felt disregarded and unhappy due to social exclusion perpetrated by healthcare providers. The finding is supported by the following statements:

Everyone see you as an irresponsible young girl or an outcast. Sometimes I feel I'm not a valuable person and… better to poison myself to death. Maybe I will find some rest. (T.mother 5)

I sometimes think what the importance of living is when I'm hurt. I don't enjoy, may be is better to end my life, I don't know… (T.mother 8)

I feel discouraged, may be life is hell to be a teenage mother. I think of ending my life if I get a chance to close the chapter of my anguish, I don't know… (T.mother 9)

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I'm concerned [shaking her head to show disgust] about ill-treatment… for your information. I see no value to live. I sometimes think it's better to finish myself up; I'm tired to be embarrassed. (T.mother 11)

Sometimes I thought of taking my life… I had no peace inside me because no one seemed to care about me anymore; I'm on my own, it's better to end it. (T.mother 13)

4.2.12 Sub-theme 12: Trouble with memory and concentration

Some participants were concerned that they forget things they used to remember with ease. They often responded inappropriately in conversations with others. They struggle to understand things even when explanations are given in details or when they are being taught. The finding is supported by the following statements:

I always forget things easily nowadays I don't understand, why? (T.mother 3)

One of the nurses said to me "Are you a baby making machine". I can't concentrate well when I remember these words. (T.mother 4)

Erm, I wasn't treated with respect. I'm still scared and sometimes feel like losing my focus [scratching forehead to show concern]. (T.mother 8)

I can't focus sometimes when I'm at school and at home. I'm slow to learn nowadays but not sure why and worry a lot of time… (T.mother 9)

I struggle to think about important things and forget easily [scratching head to show concern] nowadays, I'm worried about this… (T.mother 10)

Since I got the child I find it difficult to focus. I sometimes unable to remember familiar things or events… I don't understand. Hm… it's so strange to me. (T.mother 12)

Eish… I can't concentrate about everything like before; I don't understand why… things have changed badly. (T.mother 14)

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4.3 Theme 2: Causes of psychosocial and emotional distress among teenage mothers

Five sub-themes emerged from the study. These sub-themes include experiencing and witnessing rudeness of healthcare providers, lack of social support, lack of knowledge regarding teenage motherhood, poor treatment received and unfriendly healthcare providers.

4.3.1 Sub-theme 1: Witnessing rudeness of healthcare providers

Some participants revealed that experiencing and witnessing the rudeness by healthcare providers triggered the psychosocial distress that they experienced. Some participants were overburdened by negative judgemental attitude of healthcare providers. The following responses support the finding:

Like I said health care providers are very rude. They don't treat us in a good way. We are so afraid of them. (T.mother 1)

Nurses don't show us respect but instead they are rude and arrogant. They talk bad and laugh at you when you pass the nurses' station or ask for some help. (T.mother 3)

Eish…nurses treat us like we don't exist. They will call us names like "Prostitute, little rat, illiterate girl and even calling you a baboon. They are very rude and heartless. (T.mother 4)

Eish…I felt disgusted on how fellow women were also humiliated or called with embarrassing names like Satan, baby making machines … they didn't care about us. (T.mother 9)

They will <u>laugh</u> at you as if you're stupid; it's disturbing and offending in front of others (teenage mothers). (T.mother 11)

Hm… nurses have negative attitude and hard. They called me with degrading names like Sathan in front of others, it's humiliating and hurting. We are so irritated about their rudeness. (T.mother 12)

4.3.2 Sub-theme 2: Lack of healthcare support

Some participants felt helpless and hopeless due to unsupportive healthcare providers. They always shouted at them (teenage mothers) instead of assisting or giving advice on proper

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motherhood. Participants were not taught about taking care of the baby; like feeding or bathing but left to struggle on their own. The following responses support the finding:

Hm…I did not know much about the care of child such as breastfeeding and how to hold the baby and what position I should. I expected health care providers to guide me, but they did not. They would instead shout and insult me, you know… (T.mother 3)

Nurses are always shouting and talking in bad way to me even when I struggle to feed the baby, I don't know how to…I, I, I mean caring for the baby… no help. (T.mother 7)

It's tough to be…I mean I was afraid even to ask them (nurses) for any help because of their attitude to us. They will leave you to struggle with baby care and instead of helping us, they just shout at us. (T.mother 9)

I see the nurses like my parents because most of them are of my mother's age or even older, I expect support from them not this [Frowning faces to show concern]. (T.mother 10)

The nurses always shout at me when I struggled to bath and breastfeed my baby. No one is willing to help us… it's bad. (T.mother 12)

I felt bad because the nurses don't teach us how to feed our babies but shout at us for nothing. One of the nurses said to me "If you know how to make a baby, you must know how to care for him, and you should stop bothering us". (T.mother 13)

4.3.3 Sub-theme 3: Lack of knowledge regarding teenage motherhood

Most of the participants were concerned that they do not have any idea about motherhood such as holding, feeding and bathing the baby because it is their new experience to be mothers. Healthcare providers ill-treated and made fun of them instead of being helpful. The finding is supported by the following statements:

I always needed their guidance about parenting skills, but they will ignore me or didn't answer my questions. It's very frustrating. (T.mother 7)

Eish, it's very bad because nurses are so impatient with us. We need their assistance because it's a new experience to most of us. We are still young… we don't know what to do. (T.mother 8)

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Hey, I'm still young to be a mother; I don't know how to care for the baby. I feel embarrassed about this because people laugh at me instead of helping me. They look at me with a sense of disgrace. (T.mother 9)

I don't have any idea about being a mother; nurses called me stupid when I struggle feed the baby. It's very disturbing and frustrating. (T.mother 12)

4.3.4 Sub-theme 4: Poor treatment received

Some participants reported that they were threatened while some were actually physically assaulted by healthcare providers. They felt belittled and hurt because healthcare providers are inconsiderate and harsh. The finding is supported by the following statements:

You know what... [Throat clearing], on arrival at the maternity ward, nurses looked at me with an angry face. One of them said to me "Hey, devil, we beat people here if they don't cooperate". They will laugh at you, more especially if you are a young mother. They will shout at you like a child… (T.mother 1)

I was threatened and also beaten when giving birth [shakes head to show disgust]. One of the nurses said to me "We don't play with child mothers here but we punish you so that you can learn a lesson" (T.mother 5)

They (nurses) just shout at us instead of helping us; we don't have any idea about motherhood. We feel more disturbed about this, you know… (T.mother 7)

It's not good to get a child at Malamulele hospital [Frowning face to show anger]. Nurses will make you feel small, embarrass you, shout and even beat you. (T.mother 10)

4.3.5 Sub-theme 5: Unfriendly healthcare providers

Some participants revealed that they were teased and despised by healthcare providers. The healthcare providers always show frowned faces that made it difficult for teenage mothers to ask for any help when they needed it. This kind of unfriendly gesture contributed to the negative experience of psychosocial and emotional distress amongst teenage mothers. This finding is supported by the following responses:

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I, I, I mean… they (nurses) were very unfriendly. I'm still hurt…um, health care providers are unkind and aggressive. (T.mother 1)

Actually.., I'm not okay and it's hell to be admitted at that hospital. The nurses weren't friendly at all. (T.mother 3)

It's hard.., the nurses instruct you like a child. They are so aggressive, shout and unfriendly; something as that… (T.mother 4)

I'm very disgusted… They often laugh at me when I pass anywhere they are seated or if I ask them to help me with anything. (T.mother 7)

The health care providers more especially nurses always show serious faces; very rude [shakes head to show disgust]. They don't seem to like us, it's not fair… (T.mother 10)

…Hey, They (nurses) are unkind, shout at us; it's not acceptable [Shakes head to show disgust]. (T.mother 13)

4.4 Theme 3: Effects of psychosocial and emotional distress on teenage mothers

Six sub-themes evolved from discussions on the effects of psychosocial and emotional distress on teenage mothers. These sub-themes were negative emotional responses, aggressive behaviour, low self-esteem, dropping out of school and low educational performance, racing thoughts and problematic interpersonal relationship.

4.4.1 Sub-theme 1: Negative emotional responses

It emerged from the study that some of the participants reacted emotionally through crying when they recalled how harsh they were treated by healthcare providers. Some of them indicated that they were annoyed as they felt ill-treated and neglected by healthcare providers. The finding is supported by the following statements:

Erm…I don't know what to say… I cry all the time because I feel bad to be called devil by the nurses. I was also called a small rat as a teenage mother. I'm not happy… surely. (T.mother 1)

Y-a-a-h…I can't help myself but I always cry because nurses don't tolerate us as human beings. They treat us like useless things as teenage mothers, I feel very annoyed... (T.mother 2)

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I always cry a lot when I think about name calling by the healthcare providers. (T.mother 7)

I feel irritable and cry usually when I think of the brutality of nurses. I was exploited, insulted and called with degrading names like senseless prostitute [Shakes head to show disgust]. (T.mother 10)

Hm… I kept on crying most of the time when I think about negative judgemental attitude and name calling by nurses. (T.mother 13)

Erm… they (nurses) don't care about us; they are always on their phones, laughing at us. (T.mother 15)

4.4.2 Sub-theme 2: Anger and aggressive behaviour

Some participants become aggressive in retaliation to the perceived ill-treatment perpetrated by healthcare providers. They resisted taking medications and always react with bitterness when healthcare providers tried to talk to them (teenage mothers). The finding is supported by the following statements:

I was so angry [Frowning face to show being disturbed] that I felt like fighting them but I couldn't as I was pregnant and feeling weak. (T.mother 2)

Yeah…if someone offends me; I confront a person violently the same way he or she did to me, and then I will be satisfied. I don't like it seriously. (T.mother 5)

I'm overwhelmed with anger to fight back when I'm provoked in order to feel better. (T.mother 10)

4.4.3 Sub-theme 3: Low self-esteem

The study results revealed that some of the participants felt incompetent in what they do because healthcare providers often referred to them (teenage mothers) as useless people. Some avoided bathing their babies due to fear that they will be humiliated in front of fellow teenage mothers if they didn't bath their babies well. The finding is supported by the following statements:

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Y-a-a-h, nurses undermines us and are rude, I feel small and unimportant. I blame myself for this situation. I'm not sure if I can do anything right you know… (T.mother 5)

I always think about how nurses embarrassed and belittle me. I don't believe I can able to do something meaningful. (T.mother 12)

Nurses are harsh and they will make you feel like nothing. (T.mother 15)

4.4.4 Sub-theme 4: Dropping out of school and low educational performance

It emerged from the study that some of the participants felt discouraged and ashamed to go back to school. However, some teenage mothers dropped out of school because of loss of confidence to succeed with their education when they recalled their memories of being called fools by healthcare providers. Some were unable to concentrate due to recurrent thoughts of ill-treatment and added responsibility of baby care. The participants had the following to say:

I have to stop going to school, you know because I can't cope, and you know…it's very hard. (T.mother 6)

I lost interest and struggled with my school work, I would often fail dismally in all my tests. I finally decided to drop from school because I was not coping. (T.mother 11)

I dropped from school because I felt ashamed as a young mother. (T.mother 12)

I always struggle with school activities. I can't understand… when I'm taught. I get low marks all the time. When I think of how I was ill-treated and called a fool by healthcare providers; I felt demotivated and discontinued schooling, you know… (T.mother 13)

Hm, nurses are rude to me… I have quitted with schooling because it's hard for me in this situation. (T.mother 14)

I, I, I mean, I keep on thinking on how I left school. It is very tough for me. I feel disappointed [Shakes head to show disgust] b'cos I couldn't continue with my education. (T.mother 15)

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4.4.5 Sub-theme 5: Racing thoughts

Some of the participants felt like hurting or fighting back when they thought of the ill-treatment they suffered from healthcare providers. They expressed hatred against healthcare providers. Whereas some of the participants always thought that healthcare providers were bad people and deserved to be harmed. The finding is supported by the following statements:

I'm telling you… if they continue to provoke me [Shaking her head to show anger]; I will teach someone a lesson not to forget. Hm…they don't know me; I'm not their child. (T.mother 4)

I'm always thinking of hurting someone. I'm not intimidated or afraid of them…I can teach them a lesson. I'm so sad I can tell you. (T.mother 7)

Erm…I'm always thinking to harm them if I can get a chance. Nurses treated me like a bad person who deserves nothing.... (T.mother 10)

It's not easy though with the child and….ill-treatment. I don't like nurses, I hate them. They think they are special people, yet they are wicked [Frowning her face with disgust]. (T.mother 11)

4.4.6 Sub-theme 6: Problematic interpersonal relationship

Some participants struggle to associate or form meaningful interpersonal relationships with others. They felt judged and rejected because they had babies at a young age and as new teenage mothers. Some have fear that other people will shame, ridicule and be provoked to anger. The participants have the following to say:

Erm…I don't feel motivated to associate with others. I'm so disturbed about the negative judgemental attitude of nurses. I don't like them… (T.mother 3)

I have nothing to do with others because I'm always thinking of the rudeness of the nurses. (T.mother 5)

I don't feel comfortable to keep any company; I'm very bitter and humiliated by nurses. (T.mother 7)

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I dislike interacting with others because people will add more problems for me. I'm… trying to deal with my own challenges. (T.mother 12)

Hey… I feel ashamed and reserved to establish a mutual relationship because nurses make jokes about me, I feel bad to tell you the truth… it's very frustrating. (T.mother 15)

4.5 Theme 4: Coping strategies used by teenage mothers

The participants used mixed resources to cope with psychosocial distress experienced as the result of ill-treatment by healthcare providers. Some of the participants used positive while others used negative coping resources. The positive coping resources used included seeking religious intervention, and adequate social support received. The negative coping resources used by other teenage mothers included abuse of illegal substances, and avoidance of negative stimuli.

4.5.1 Sub-theme 1: Seeking religious intervention

Some participants indicated that they were actively involved in religious activities as a positive coping resource. They were inspired and encouraged by the sermons that were shared by pastors at church. They confirmed that they enjoyed singing and being part of youth committees in the church. The finding is supported by the following quotes from the participants:

I feel some comfort [Nodding the head] when I attend church services. I love our pastor… he encourages us with his teachings. He doesn't judge us negatively and is very supportive to everyone. (T.mother 2)

Hm, I keep myself busy at the church because I'm in a committee, I feel strong and well. (T.mother 12)

I [Smiling]… I engage in church commitments and feel lifted with my pastor's teachings, that are good and comforts me. (T.mother 13)

Of course, I attend church services and involved in church activities such as choir and cleaning at least I feel occupied. I also feel comforted and motivated with my pastor's sermon and counselling. (T.mother 15)

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4.5.2 Sub-theme 2: Adequate social support received

Some participants were encouraged by the support they have been receiving from their own siblings or sisters and female parents who listened to their concerns without judging them negatively. This kind of support significantly helped them cope with the psychosocial distress that the participants experiencded. The participants have the following to say:

Yeah... I only talk my sister because she always gives me her listening ear. She is so caring and sometimes she buys clothing for my baby. She spends time with me and encourages me not to give up but to see the situation as a lesson. I love my sister because her support makes me to feel as important person despite the mistake I committed of being a mother at a young age. (T.mother 3)

I get support from my mother; she encourages me to be positive and not to give up. She assists me with bathing, feeding and holding my baby when I'm cleaning the house. (T.mother 7)

Hm… I think my sister is my number 1 in my life and attentive to my problems. She give me support in everything such as buying clothing for my child or feeding him. Yes [Smiling] if… I talk to my sister; she understands me and keeps my secrets. (T.mother 9)

Seriously [Laughing], I'm not proud to have a child because I'm very young and still at school. My mother is my pillar of strength, she always give me attention, advices and care. (T.mother 12)

4.5.3 Sub-theme 3: Use of illegal substances

Some participants used negative resources to cope with psychosocial distress. The study revealed that there were participants who engaged in alcohol consumption, use of illegal substances and smoking to mitigate the distress. The finding is supported by the following statements:

I prefer…just to have bit of drink containing something [laughing], I think you understand me, y-a-a-h…I mean some alcohol to feel better. (T.mother 1)

Ya-a-h, when I feel overwhelmed. I drink alcohol or something like cigarettes that will make me sleep or feel okay at least… (T.mother 3)

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I will use a strong drink that will cause me to forget my problems. May be…or not. (T.mother 4)

I prefer to have a crazy drink like alcohol, which will cause me to feel alright. (T.mother 7)

…I desire to smoke something to make me cool, I don't know…but it's fine with me. (T.mother 8)

…hey, if I can have at least two cigarettes my anger will usual subside a bit. Sometimes I should add up some drink containing some stuff to forget my sufferings. (T.mother 11)

4.5.4 Sub-theme 4: Avoidance of negative stimuli

Some of the participants were reluctant to interact with people who hurt them and preferred to avoid a place where they had a bad experience in the past to avoid triggering their psychosocial and emotional distress. The finding is supported by the following statements:

Hm…I'm so afraid to visit the hospital in future to avoid an exposure to the hostility of the nurses that will provoke my anger. (T.mother 1)

Nurses <u>shout</u> at me that make me to avoid interacting with them, maybe I will get better...I don't know. (T.mother 2)

…I feel discouraged to return to the hospital for health services unless if it's very serious and I will have no other choice. (T.mother 3)

You may not want to return at the hospital to go through the bad experience again more especially if you're a teenage mother. (T.mother 4)

I'm always feeling reluctant to receive services at the hospital with the fear that I will receive the same harsh and aggressive attitude from nurses. (T.mother 5)

…I was humiliated; I'm not happy and eager [Frowning face to show anger] to receive health services in this hospital if the nurses are not changed. (T.mother 10)

I feel unmotivated and will refrain to come to the hospital for assistance, nurses are very rude. (T.mother 15)

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4.6 Conclusion

The chapter presented the study results as directed by the participants' responses during the interviews. The next chapter discusses the findings of the study, provides conclusion based on the study findings and gives recommendations.

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CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter discusses the findings, and the limitations of the study, and gives conclusions based on the findings of the study and recommendations as directed by the findings of the study; the implications for the future research which are guided by the participants' responses during the interviews are also given. The researcher sees a need for research to be conducted in future after analysing data from different participants. Based on the responses by teenage mothers, it was found that teenage mothers experience different psychosocial and emotional distresses. These distresses are associated with relationship challenges with others. Eventually, teenage mothers become overwhelmed and resort either to negative or positive coping resources to alleviate distress.

5.1 Discussion on lived experiences of teenage mothers

5.1.1 Psychosocial and emotional distress experienced by teenage mothers

The main findings highlight negative experiences and perceptions of early motherhood among most of the teenage mothers. The researcher is of the view that the lived experiences of teenage mothers during this transition of early parenting as directly examined in this study, is characterized by many worries and future uncertainties. It emerged from the current study that teenage mothers experience symptoms of distress such as depression, feelings of anger, irritability and frequent headache. This finding is in agreement with Agu et al. (2017) and Lucas et al. (2019) who found that teenage mothers with psychological distress display cognitive health challenges associated with negative interaction. The current study also found that teenage mothers experience significantly higher depressive symptoms as a result of strain of teenage motherhood, ill-treatment and lack of healthcare support from healthcare providers. The finding is consistent with various studies (Boobpamala et al., 2019; Edberg, 2019 & Osok et al., 2018) which argue that early parenting, the exposure to stigmatization, and rudeness of healthcare providers contribute to psychological negative symptoms faced by teenage mothers. Depressive symptoms manifested by teenage mothers following their negative encounter with healthcare providers include bad temper, always sad and being easily offended.

Teenage mothers were disinterested to interact with anyone and preferred to be left alone even when they are at home. Moreover, most of them express lack of trust and suspicion towards healthcare providers, loss of interest and unmotivated to engage in activities they used to find pleasure in the past since they became mothers. The findings are aligned with

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Arvidsdotter et al. (2013) and Siegel and Brandon (2014) who agreed that teenage mothers with psychological distress show distrust and concern towards health personnel when they are ill-treated. Based on the findings of the current study, elevated levels of distress among teenage mothers may also be linked to stigma, negative judgmental attitude and rude healthcare providers. According to Jenkins (2013), teenage mothers report negative experiences and being stigmatized in an encounter with healthcare providers which seem to contribute to distrust and lead to psychosocial distress. The researcher is of the view that if teenage mothers struggle with adaptation and coping with the challenges posed by the transition of early motherhood, they will eventually experience increased levels of distress. The current study also found that teenage mothers experience irritability and constant anger during interaction with rude healthcare providers. The findings are consistent with Coast et al. (2019) who reveal that teenage mothers suffering from psychological distress are more irritable and always angry when stigmatized and undermined. Negative judgemental attitude and degrading name calling such as being called stupid, devil and irresponsible girl by healthcare providers seem to be serious causes of irritability and anger among teenage mothers. The finding is consistent with Edberg (2019) and Hammen et al. (2011) who reveal that negative social evaluation and being humiliated are sources of annoyance and bitterness experienced by teenage mothers in distress.

The researcher postulates that teenage mothers are more likely to be provoked and sad, associated with experience of threats or physical abuse such as being beaten by healthcare providers when they had their babies at hospital. The findings of this study revealed that teenage mothers are overwhelmed and felt upset which ultimately discourage them so seek healthcare services in future. The findings are supported by Cressey et al. (2020) and Ganchimeg et al. ((2014) who further note that psychologically distressed teenage mothers presenting with short temperedness due to multiple interaction difficulties, contribute to make them to be reluctant to visit health facilities. Unfortunately, missed appointments or hospital follow up visits or defaulting of hospital treatment by teenage mothers due to fear of ill-treatment may result in adverse psychological consequences for new mothers. It emerged from the current study that ill-treatment and lack of healthcare support by healthcare providers contributed to psychological distress which manifests with frequent headache. Feeling unhealthy and always sick is associated with lack of desire to participate in daily activities such as childcare, going to school and honoring hospital visits. Elevated feeling of headache among teenage mothers is also attributed to being worried about the unfriendliness and rudeness of healthcare providers. The findings are consistent with Haftgoli et al. (2010) who reveal that strenuous interpersonal relationships and dismissive

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attitude from healthcare providers faced by teenage mothers contribute to feeling of constant worry which eventually led to headache.

The researcher notes that teenage mothers suffer from headache which does not respond to medication, associated with difficulties of teenage motherhood and negative encounter with healthcare providers. Moreover, when teenage mothers are exposed to harsh and diminishing treatment and stigma from healthcare providers, they are at higher risk of experiencing recurrence headache. The claims are aligned with Hammen et al. (2011) and Sekhoetsane (2012) who confirm that teenage mothers suffer from symptoms of headache due to many challenges such as belittling comments, condemnation, social exclusion and rejection. The researcher is of the view that teenage mothers seem to think a lot about the ill-treatment and name calling by healthcare providers and therefore are more likely to experience increased levels of headache. The researcher further argues that lack of sleep among teenage mothers, more especially at night, may also contribute to headache problem due to fatigue. The current study revealed that teenage mothers experience psychological distress with adverse reactions such as trouble with memory and concentration and suicidal thoughts. The findings agree with Kelemu et al. (2020) who indicated that the problem of forgetfulness, inability to concentrate, reasoning difficulties and headache are major causes of concern for teenage mothers in distress. It emerged from the current study that teenage mothers with psychological distress tend to forget things they used to remember with ease in the past. The current study also found that exposure to stigma, negative judgmental attitude, social exclusion and rejection by healthcare providers were major sources for trouble with memory and concentration among teenage mothers. The observations made by Chaby et al. (2015); Giles et al. (2014) and Marchand et al. (2012) note that individuals suffer from cognitive difficulties characterized by inability to focus, learning difficulties and forgetfulness linked to negative social evaluation and disruptive relationships. The researcher acknowledges that the challenges of memory experienced by teenage mothers seem to be linked to being occupied with negative thoughts of ill-treatment and effects of humiliation by healthcare providers.

Based on the observation of the current study, problems of memory and concentration experienced by teenage mothers may not be resolved until the triggers of psychological distress are mitigated. Fergusson et al. (2008) revealed that psychological consequences experienced by teenage mothers are likely to persist for long period if ill-treatment by healthcare providers is not addressed. The researcher is of the view that focusing on negative past experiences of ill-treatment is likely to distract teenage mothers and eventually lead to trouble with memory and concentration. The current study revealed that teenage

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mothers experience distress linked to many challenges which contribute to suicidal thoughts. This finding is in agreement with various studies (Hammen et al., 2011; Molaie et al., 2019 & Muehlenkamp et al., 2012) which argue that incidences of attempted suicide and suicidal tendencies among teenage mothers are triggered by difficult life situations. Early motherhood and ill-treatment by healthcare providers are associated with negative outcomes of suicidal tendencies. This finding is supported by Erfina et al. (2019); Jenkins (2013) and Roberts et al. (2011) who noted that teenage mothers suffer from suicidal thoughts and racing thoughts associated with unsupportive judgmental healthcare providers and the transition of early parenting. The researcher argues that teenage mothers seem to explore different means and decide on the effective way of ending their lives when they are overwhelmed by psychological distress. Increased levels of suicide thoughts experienced by teenage mothers may be associated with feelings of anger and worry. The findings are consistent with Wall-Wieler et al. (2016) who acknowledged that bitterness and being worried most of the times are potential causes of suicidal ideation faced by teenage mothers.

This study revealed that an increased sense of hopelessness and helplessness among teenage mothers are more likely to aggravate suicidal tendencies. This negative sense of suicide thoughts may also be associated with feeling of discouragement. These mothers perceive themselves as failures and therefore being unable to mitigate distress. Suicidal thoughts are also triggered and may be linked to ill-treatment, stigma and the inability to deal with life challenges. The above mentioned findings are consistent with various scholars (Hodgkinson et al., 2014; Pinheiro et al., 2011; Sedgh et al., 2015 & Wilson-Mitchell et al., 2014) who argued that teenage mothers tend to feel discouraged and reserved due to negative social evaluation and ultimately suffer from suicidal thoughts. The researcher acknowledged that the thoughts of suicide seem to be an indication that teenage mothers feel resourceless to deal with psychological distress. It emerged in the current study that teenage mothers suffer from psychological and emotional distress and tend to display adverse reactions such as worry, sleep disturbance, anxiety and fear. This finding is in agreement with some researchers (Bain et al., 2020; Hoffman, 2013; Jenkins, 2013; Kelemu et al., 2020 & Martorell-Poveda et al., 2015) who state that people are more likely to be scared, anxious, experience sleep deprivation and concerned while in distress triggered by undesirable situation.

An elevated level of worry experienced by teenage mothers is associated with ill-treatment of healthcare providers when seeking healthcare services. According to Atuyambe et al. (2008) harsh treatment such as unpleasant questions and being rejected by healthcare providers contribute to distress faced by teenage mothers. The researcher argues that feeling of worry

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among teenage mothers seems to be triggered by defaming and inconsiderate attitude from healthcare providers. Humiliation by healthcare providers in front of fellow mothers such as being called ugly or devil is a source of worry mentioned by teenage mothers. The finding is supported by Marchand et al. (2012) who argue that individuals who are exposed to name calling in the presence of others is linked to feeling of concern. The current study revealed that ill-treatment and lack of healthcare support by healthcare providers contribute to psychological distress presenting with anxiety and fear. This argument is aligned with other authors (Drapeau et al., 2012; Fessler, 2008; Giles, et al., 2014; Haigh, 2020 & Lucas et al., 2019) who confirm that teenage mothers with distress are always afraid and anxious because of rude behaviours of healthcare providers.

Increased level of anxiety among teenage mothers is associated with fear of the possibility to be subjected to ill-treatment during future consultation. This finding is supported by Sekhoetsane's (2012) assertion that previous exposure to ill-treatment creates fear of recurrence on the victim. The current study found that teenage mothers are at higher risk of suffering from anxiety and fear due to their vulnerabilities as young girls who are expected to adjust quickly to adult roles. The assertion is supported by Finsterwald and Alberini (2014) and Slavin-Spenny et al. (2013) who argued that anxiety and fear are also attributed to a rushed transition of motherhood during critical developmental period of adolescence. The negative experiences of fear and anxiety among teenage mothers are compounded by witnessing other fellow mothers being ill-treated. This finding is in line with Cressey et al. (2020) and Yimgang et al. (2017) who reported that teenage mothers who saw other people humuliated are more likely to develop fear and anxiety. The current study found that unfriendliness and rudeness of healthcare providers are sources of hopelessness and helplessness with distressing effect; this was according to the report given by teenage mothers. The finding is supported by various studies (Atuyambe et al., 2008; Chohan & Langa, 2011; Fernandes et al., 2020; Hanna, 2001; Jenkins, 2013 & Wall-Wieler et al., 2016) which revealed that teenage mothers are hopeless and helpless associated with ill-treatment by healthcare providers.

The current study reveals that teenage mothers encounter social distress as a result of various factors. This finding is in line with other researchers (McGuffin, 2014; Porr et al., 2012 & Van Zyl et al., 2015) who argued that multiple social challenges such as ill-treatment, stigma, lack of healthcare support and social exclusion are potential causes of distress with social withdrawal among teenage mothers. Teenage motherhood is a devastating transition with unfamiliar expectations and demands which seems to contribute to distress with negative reactions. Bah (2016); McLeish and Redshaw (2017) and Sitsofe (2020) revealed

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that teenage mothers suffer from social distress with negative consequences such as stigma, loneliness and social isolation during the early motherhood period. Lack of emotional support from healthcare providers for these mothers was a major contributory factor for the experience of symptom of loneliness. This argument is consistent with various literatures (Chohan & Langa, 2011; Ellis-Sloan & Tamplin, 2019; Erfina et al., 2019; Mohammadi et al., 2016 & Ngum Chi Watts et al., 2015) who confirmed that teenage mothers encounter elevated levels of social distress depicted by feeling of isolation and loneliness associated with unsupportive and rude healthcare providers. A prolonged feeling of loneliness among teenage mothers is likely to exacerbate negative consequences such as anger, irritability and suicidal tendencies. Erfina et al. (2019); Hunter et al. (2015); Levine (2017) and Maly et al. (2017) state that unresolved social distress linked to hostile interaction contributes to more bitterness, negative thoughts to end ones life and being easily provoked.

5.1.2 Causes of psychological, emotional and social distress among teenage mothers

Based on the findings of the current study the distress experienced by teenage mothers is exacerbated the assumption of new adult roles, routines and changed relationship. In addition, teenage mothers are exposed to ill-treatment, negative judgmental attitude, stigma, social exclusion and rejection by others such as healthcare providers. The above mentioned findings are in agreement with Turner and Honikman (2016) and Waterhouse et al. (2017) who confirm that new demands of teenage motherhood are potential causes of negative consequences such as worry anxiety and depression. Sitsofe (2020) further acknowledged that negative social evaluation, rejection, teased and dehumanizing name calling are associated with elevated risk of distress among teenage mothers. The current study found that witnessing rudeness of healthcare providers contributed to psychological, emotional and social distress amongst teenage mothers. This claim is supported by Mitchell et al. (2010) who found that the likelihood of feeling of distress is increased through seeing others treated with demeaning attitude.

Based on the observation of the current study, teenage mothers are at higher risk of suffering from psychological, emotional and social distress associated with witnessing fellow mothers being ill-treated by healthcare providers. The kinds of ill-treatment experienced by fellow mothers include degrading name calling such as being called prostitute, little rat, illiterate girl, baboon and devil worshippers; this was according to a report given by teenage mothers. The findings are consistent with Yimgang et al. (2017) who indicated that that indirect experience of ill-treatment and humiliation leads to distress. The current study reveals that if healthcare providers are rude to others, teenage mothers suffer from

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psychological health problems through indirect experience. Teenage mothers who had witnessed fellow mothers being ill-treated reported adverse feelings of distress such as anger, worry, anxiety, moody and depression. The findings are aligned with other authors (Bylsma et al., 2011; Cressey et al., 2020 & Osok et al., 2018) who confirmed that psychological distress experienced by teenage mothers with symptoms of sadness, depression and suicidal tendencies is linked with seeing others being ill-treated. An encounter with arrogant and rude healthcare providers is a serious cause of social isolation and lonely life which contribute to social distress. This finding is in line with Krugu et al. (2016) who reported that mothers tend to self-isolate and be alone when they are despised by others and overwhelmed with distress. Increased levels of anxiety and worry experienced by teenage mothers is associated with not knowing what will happen to them after seeing others being ill-treated. The finding is supported by Laurenzi et al. (2020) who argued that teenage mothers exposed to stigma, discrimination, social exclusion and blame, increased the risk of worry regarding future encounter with others. The researcher argued that teenage mothers feel helpless and more depressed because there is nothing they can do to advocate or protect fellow mothers from being ill-treated.

It emerged in the study that, when teenage mothers are treated unfriendly and stigmatized by healthcare provide may contribute to being moody. This finding is in aligned with Manzi et al. (2018) who noted that negative social interaction is likely to lead to adverse emotional reaction such as being moody among teenage mothers. Persistent negative judgmental attitude, social exclusion and rejection by healthcare providers seem to affect teenage mothers negatively and may eventually lead to suicidal thoughts. According to Manzi et al. (2018) further indicated that negative comments and evaluation from others such as peers and healthcare providers are sources of suicidal tendencies among the distressed teenage mothers. The current study revealed that lack of healthcare support for teenage mothers during the devastating transition of early motherhood is a source of distress. The finding is in line with Hunter et al. (2015) found that if teenage mothers are not supported, they suffer from distress with negative symptoms. The researcher is of the view that support in the form of social, emotional, informational and tangible is necessary in order to enable teenage mothers deal with negative effects of psychological distress. Based on the observation of the current study, if these mothers are not supported by others more especially by informed healthcare providers, they are more likely to experience worry and anxiety. Negative feelings of worry and anxiety experienced by teenage mothers may be exacerbated by lack of knowledge and skill about baby care. The above mentioned findings are consistent with Sekhoetsane's (2012) confirmation that significant lack of support for teenage mothers by healthcare providers contribute to emotional distress such as anxiety. According to Bah

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(2016) teenage mothers are concerned due to knowledge deficiency and multiple demands of early motherhood. It emerged in the current study that teenage mothers require support in order to adapt to the new experience of teenage motherhood and likely to prevent negative feelings of distress. The finding is in agreement with various scholars (Cremonese et al., 2017; Gavin et al., 2011; Kim, et al., 2018 & Wang et al., 2011) who noted that adequate support is associated with successful coping abilities for distress.

It seems that lack of knowledge and skills about proper parenting tend to cause feelings of helplessness and hopelessness among teenage mothers. These mothers seem to be uncomfortable to hold, feed or bath their babies because they do not know how it is done in a correct and safe manner. In addition, most of them it is their first experience as mothers which contribute to depression. This finding is supported by other researchers (Gyesaw & Ankomah, 2013; Sitsofe, 2020 & Xu & Chi, 2013) who revealed that teenage mothers feel discouraged without parental skills and in taking care of the baby alone and eventually at higher risk of symptoms of distress. It emerged from the study that teenage mothers become hostile as a way of coping when they continue to be humiliated such as being shouted at and insulted instead of being assisted or supported. An elevated level of bitterness will in turn trigger distress among teenage mothers. The finding agrees with Hodgkinson et al. (2014) who stated that ill-treatment is a cause of aggressive behaviour displayed by teenage mothers and tends to exacerbate distress. The researcher is of the view that teenage mothers are more likely to report less social distress if they are given proper guidance about proper motherhood such as breastfeeding, bathing and holding their babies. An elevated level of distress experienced by teenage mothers is also linked to fear of being judged negatively when they try to seek for help and healthcare providers who are not receptive. The finding is in agreement with Lucas et al. (2019) who reported that teenage mothers are more reserved to solicit help due to stigmatization and interpersonal challenges.

It emerged in the current study that teenage mothers are more likely to encounter poor treatment from healthcare providers. Poor treatment received was reported to be a source of psychological, emotional and social distress on teenage mothers. The above mentioned findings are in line with Agu et al. (2017) and Leplatte et al. (2012) who found that teenage mothers are at higher risk of distress because they are likely to be stigmatized and victimized by healthcare workers as compared to adult mothers. The current study revealed that teenage mothers were worried and disturbed by social exclusion and name calling from healthcare providers. Some teenage mothers indicated that it was very distressing to be called devil, fool, little rat and Satan by healthcare providers. This finding is supported by McLeish and Redshaw (2017) who argued that teenage mothers who are humiliated and

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rejected by others tend to suffer from worry and nervousness. Teenage mothers tend to experience distress because of ridiculous comments made by healthcare providers when they seek guidance regarding proper holding position of the baby to breastfeed. A feeling of distress among teenage mothers is exacerbated by negative remarks made in front of fellow mothers. According to Turner and Honikman (2016) being embarrassed and stigmatized by others lead to distress encountered by teenage mothers. The current study findings also revealed that teenage mothers reported to be worried and unhappy because they were viewed as failures and troublesome by healthcare providers. Some teenage mothers reported that they were humiliated and labeled as baby making machines. This kind of lived experience was the source of anger and irritability; this was according to report given by teenage mothers. The findings are consistent with Bah's (2016) observation that teenage mothers treated with disrespect are easily annoyed and always sad. Aparicio et al. (2015) revealed that negative social evaluation is a cause of bitterness. It emerged from the current study that stigma and social exclusion of teenage mothers by healthcare providers may lead to depression. This finding is aligned with Abbott et al. (2014) assertion that depressive reaction encountered by teenage mothers is due to an exposure to negative judgmental attitude by healthcare providers.

Based on the observation of the current study feelings of anxiety, fear, worry and depression are more likely to be worse for teenage mothers with first hospital experience who had no knowledge of proper baby care. This finding is consistent with Carr and Umberson (2013) who argued that an exposure to negative new life experiences characterized by unfamiliar demands is a potential cause of distress. It emerged from the study that teenage mothers experienced more anger and moody associated with threats while others reported to have been physical assaulted by healthcare providers during child birth. The findings are supported by Corcoran (2016) who revealed that ill-treatment and abuse were most strongly associated with sadness and unstable moods. An exposure to ill-treatment is a major source of aggressive behaviour displayed by teenage mothers towards rude healthcare providers. Most of the mothers felt discouraged from visiting the hospital for future consultations in order to avoid rude healthcare providers. The findings are in agreement with Krugu et al. (2016) and Lotse (2016) who revealed that unfriendliness of healthcare personnel contributes to creating fear of stigma and limits teenage mothers' access to and utilization of health services. The elevated feelings of depression worry and suicidal thoughts are exacerbated by unsupportive healthcare providers such as withholding information regarding proper baby care. The findings are supported by other studies (Boath et al., 2013; Braniecka et al., 2014 & Chohan & Langa, 2011) who reported that lack of information and recommendations about motherhood is also associated with depression and eventually

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result in suicidal tendencies. Teenage mothers were always suspicious, afraid and worried that healthcare providers would harm or do something bad to them such as being given wrong medications. The findings are supported by Wadman et al. (2011) who revealed that lack of trust towards others is a source of fear and worry.

Teenage mothers tend to display aggressive behaviour such as shouting back or refusal to take instructions and always bitter in response to the perceived rude healthcare providers. The finding is aligned with Millborn (2017) and Sinnema et al. (2018) who reported that dismissive and unfriendly relationships are potential sources of rebellious conduct and sadness displayed by teenage mothers. Some teenage mothers resorted to living a lonely life in order to avoid troubles and distress from hostile healthcare providers. This finding is consistent with Mendelson (2013) who noted that negative interpersonal relationship with other contributes to loneliness and social isolation. It seems that the negative impact of relationship challenges with healthcare providers cause these mothers to drop-out of school while some of them struggled with low educational performance. According to Uddin et al. (2017) disruptive interaction is associated with school underachievement and early school termination. Furthermore, unabated relationship problems have the most devastating impact on psychosocial health and eventually lead to depression. This finding is supported by Cardozo et al. (2012) who found that depression on teenage mothers might have been resulted from strained relationship and intolerant attitude of healthcare providers. Based on the observation of the current study, teenage mothers are more likely to experience low mood and low self-esteem linked to being despised and teased by healthcare providers. Slavin-Spenny et al. (2013) state that that lack of confidence and being reserved is liked to interpersonal disruptions and condemnation by others.

5.1.3 Effects of psychosocial and emotional distress on teenage mothers

It emerged from the study that teenage mothers experienced different effects of psychological, emotional and social distress. The current study found that the effects include negative emotional response, aggressive behaviour, low self-esteem, dropping out of school and low educational performance, racing thoughts and problematic interpersonal relationships. According to Hodgkinson, et al. (2014) the impact of distress among teenage mothers results in multiple challenges that affect their daily functioning negatively. The current study revealed that teenage mothers were emotionally affected to an extent that they always cry when they think about how they were ill-treated by healthcare providers. This finding is align with Gračanin et al. (2014) who reveal that emotionally distressed people cry all the time as an emotional response associated with diminishing negative encounter with

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others. Constant anger and irritability experienced by teenage mothers are associated with negative emotional response of crying a lot. This finding is supported by Balsters et al. (2013) who found that susceptibility to crying among emotional distressed people is attributed to sadness and annoyance. Some teenage mothers are worried about the diminishing effect of humiliating name calling which resulted in frequent crying when they think about it. They also felt that their personhood was crushed through this kind of disrespectful conduct of healthcare providers. Consistent with the above finding, Sharman et al. (2020) revealed that people with emotional distress characterized by worry are associated with crying triggered by thoughts of negative social evaluation.

Based on the observation of the current study symptoms of depression and crushed hope faced by teenage mothers may exacerbate crying tendencies. According to Vingerhoets et al. (2013) negative emotional response through crying experienced by people in distress is associated with negative feelings such as hopelessness. An exposure to stigma and name calling such as being called prostitute, being insulted and neglected by healthcare providers triggers negative emotional response of crying. This finding is aligned with Vingerhoets et al. (2016) who indicate that individuals exposed to social exclusion and negative judgmental attitude are more likely to cry more frequently. The current finding was that teenage mothers tended not to cooperate with healthcare providers and spent most of their time indoors or inside own hospital ward or room alone refusing to talk to anyone. Thus, some healthcare providers' negative judgmental attitude against teenage mothers contributed to crying. Consistent with the above findings, Wall-Wieler et al. (2016) indicated that ill-treatment is a main cause of aggressive behaviour and loneliness among teenage mothers with diminishing effects such as crying alone. An unsupportive healthcare provider is the reason for teenage mothers to show negative emotions of crying and ultimately lead to increased level of distress. The finding agrees with Bylsma et al. (2011) who indicated that lack of emotional, informational and tangible support from others is a source of crying tendencies among female teenagers.

Teenage mothers seem to display aggressive behaviour towards healthcare providers. They often dislike speaking with healthcare providers and are usually filled with thoughts to retaliate for the ill-treatment they experienced. These mothers tend to display anger and irritability and eventually start to shout back at healthcare providers. Aggressive behaviour was reported to be displayed at the period more especially when being insulted, threatened to be beaten or actual beaten by healthcare providers for no valid reason. The findings are consistent with other literatures (Dolezal et al., 2017; Fulford & Ford-Gilboe, 2004; McLeish & Redshaw, 2017 & Porr et al., 2012) who reported that unhappy teenage mothers are more

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likely to be bully towards others as a defensive mechanism in order to handle distress. The researcher is of the view that psychosocial distress experienced by teenage mothers is associated with the negative effect of physical and verbal abuses. The current study found that depressed teenage mothers are at higher risk of negative consequence of suicidal thoughts because they are overwhelmed with ill-treatment. According to Roberts et al. (2011) suicidal ideation among teenage mothers is associated with unsupportive and judgmental healthcare providers. The current study found that teenage mothers tend to be moody and irritable when they interact with arrogant healthcare providers. This finding is in agreement with various researchers (Hodgkinson et al., 2014; Molaie et al., 2019; Sinnema et al., 2018 & Wall-Wieler et al., 2016) who noted that adverse reactions such as annoyance and bad temper are associated with distress due to condemnation by others. The current study revealed that when teenage mothers are ill-treated by healthcare providers they are more likely to doubt themselves on everything they do which contribute to social distress. The finding is supported by Osok et al. (2018) who confirmed that teenage mothers feel incapacitated attributed to disruptive interpersonal relationships.

It emerged in the study that teenage mothers showed low self-esteem associated with lack of healthcare support and social exclusion by healthcare providers. This claim is consistent with other authors (Levine, 2017; McGuffin, 2014; McLeish & Redshaw, 2017 & Sodi & Sodi, 2012) who reveal that a person who does not receive support from others and rejected becomes less confident. Teenage mothers reported that they did not feel confident to do tasks alone due to fear of failure and being criticised by healthcare providers. They were afraid to try bath their babies on their own. They resorted to just wiping their babies' faces with a wet towel and cover the other parts of the baby's body with clean blanket as a disguise. The findings are supported by other scholars (Bah, 2016; Peake et al., 2013; Bos et al., 2013; Fernandes et al., 2020; Haigh, 2020; Lucas et al., 2019 & Sitsofe, 2020) who indicate that self-blame and lack of knowledge on proper baby care among new mothers result in self-doubt and decreased self-worth. It emerged in the current that psychological, emotional and social distress experienced by teenage mothers is associated with poor educational performance and school dropout. According to Turner and Honikman (2016) teenage mothers with distress are also less likely to finish their education and struggle to get pass marks in their studies. Moreover, substandard educational achievement and early school termination among teenage mothers with distress is attributed to ill-treatment by healthcare providers. Some teenage mothers felt uncomfortable and stigmatized to continue with school because of embarrassment of being mothers while still young. The findings agree with other researchers (Cremonese et al., 2017; Hanson et al., 2014; Kelemu et al., 2020; Maly et al., 2017 & Yator et al., 2020) who found that school dropout among

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distressed teenage mothers is as a result of effects of negative social evaluation and early motherhood. An experience of anger and irritability affected teenage mothers to an extent that they encounter learning difficulties at school such as lack of concentration. The findings are in line with various authors (Chaby et al., 2015; Hakizimana et al., 2019; Marchand et al., 2012 & Wado et al., 2019) who reported that annoyance and sadness is associated with learning and concentration problems among the people in distress.

Researcher's view is that teenage mothers are discouraged to continue with their education attributed to adverse psychological effects of name calling such as being called stupid by healthcare providers. Factors such as assumption of new adult roles, routines and extra demands of caring for the baby interfere with educational attendance and accomplishment of teenage mothers. These challenges are related to teenage motherhood experienced by teenage mothers have far-reaching consequences such as failure to matriculate. The findings are supported by various studies (David et al., 2017; Ganchimeg et al., 2014; McMichael, 2013; Sedgh et al., 2015 & Timeus & Moultrie, 2015) early motherhood among teenage mothers between 15-19 years is a major contributor to poor educational attainment and potential educational disruptions. Inability to complete grade 12 among teenage mothers is compounded when it happen concurrently with being stigmatized by other people such as their peers and healthcare providers. This finding is consistent with Mjwara and Maharaj's (2018) assertion that life challenging realities confronting teenage mothers and early parenthood hinder their educational and future aspirations.

In the current study it was found that teenage mothers were seriously affected and often had racing thoughts. They often had negative thoughts to kill or hurthealthcare providers when they think how they were being ill-treated. They expressed hatred towards healthcare providers and felt that the government had employed wrong people with no passion to help others. The findings are supported by other researchers (Abbott et al., 2014; Erfina et al., 2019; Falci et al., 2010 & Kaye et al., 2008) who indicated that people have thoughts to end their lives or others when they are unhappy with negative attitude of others. It emerged in the current study that teenage mothers were exposed to problematic interpersonal relationship. This resulted in their unwillingness to interact with healthcare providers due to fear of ill-treatment and being judged negatively. The findings agree with other literatures (Haftgoli et al., 2010; Jenkins, 2013; Mitchell et al., 2010; Romeo, 2015 & Yator et al., 2020) who revealed that psychological distressed teenage mothers are always reluctant to associate with others. Based on the observation of the current study, ill-treated teenage mothers by healthcare providers are more likely to experience distress with adverse reactions of loneliness, social isolation and withdrawal. This finding supported by various studies (Hunter

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et al., 2015; McLeish & Redshaw, 2017; Osok et al., 2018 & Saima & Muhammad, 2014) who argue that social isolation and lonely life are linked to condemnation and being stigmatized by others.

5.1.4 Coping resources used by teenage mothers

The current study revealed that when teenage mothers experience psychological, emotional and social distresses associated with ill-treatment by healthcare providers tend to utilize mixed coping resources which can be positive or negative. According to Department of Social Development (2013) people use two types of coping resources to mitigate negative symptoms of distress which can be positive or negative. A tendency to seek religious intervention by teenage mothers is perceived as a way of positive coping with distress. Based on the observation of the current study, some teenage mothers found it to be useful and inspiring to participate in Christian-religious activities. The present study also found that church activities such as singing, cleaning the church and being members of the youth committee provided a sense of joy and comfort. All the activities were perceived as a way of praising and worshiping God. Christian-religious orientation of the teenage mothers appeared to foster teenage mothers' psychological well-being. The findings are consistent with Turgut and Ekşi (2020) who state that people engage in various church activities as a way to find happiness, contentment and improve psychological functioning. In addition, teenage mothers expressed their appreciation of their pastors' sermons which has also been a source of inspiration and psychological counseling; this is according the report given by teenage mother. This finding is supported by Lucock et al. (2011) who found that spiritual intervention and teachings are more comforting and helpful in dealing with different life challenges and distress. Based on the finding of the current study, religious belief such as Christianity has a divine element with the benefits of being supportive and transformative to the thoughts, feelings, and behaviours and alleviates distress; this was according to the report given by teenage mothers. According to Horwitz et al. (2011) Christian-religious worship is helpful and supportive in handling negative feelings of psychological, social and emotional distress.

It also emerged from the current study teenage mothers are likely to get encouragement to deal with psychological distress through adequate support received from others. The finding is aligned Gračanin et al. (2014) who found that support through talking with a family member is necessary to deal with distress. Teenage mothers reported satisfaction regarding adequate social support from their close family member more especially their female parents and siblings such as their sisters. Some teenage mothers indicated that their biological

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parents and sisters were very supportive and not judgmental regarding their situation of being mothers while still young. Furthermore, their sisters and female parents will listen at them, buy their babies' clothing and advise them positively on any issue as another way utilised by teenage mothers to cope with psychosocial and emotional distress. The findings are consistent with various scholars (Jenkins, 2013; Morelli et al., 2015; Ntinda et al., 2016 & Pejner et al., 2012) who found that social and emotional support of female parents promotes psychosocial well-being among people in distress.

The current study revealed that there are teenage mothers who tend to resort to negative coping means to alleviate adverse consequences of distress. When these mothers are overwhelmed with distress they engage in illegal substance use to mitigate the negative feelings of distress. The findings are supported by other researchers (Boobpamala et al., 2019; Corcoran, 2016; Finsterwald & Alberini, 2014; Jeste, 2013; McDermott et al., 2004; Romeo, 2015; Torres-Berrio et al., 2018 & Wagner & Heatherton, 2015) who found that individuals in distress engage in risk taking behaviour such as alcohol intake, cigarette smoking and substance use to alleviate negative feelings of distress. Moreover, adverse reactions of distress these mothers experience include racing thoughts, moody, fear, crying all the time, hopelessness and helplessness that require coping resources. The findings are in agreement with Lucas et al. (2019); Martorell-Poveda et al. (2015) and Romeo (2015) who indicated that negative consequences such as feeling scared, demotivation and thoughts to harm or kill someone are associated with psychological challenges. Regarding social distress, negative consequences experienced by these mothers include loneliness, low self-esteem, social isolation and withdrawal that require coping resources. The findings are consistent with various studies (McGuffin, 2014; Nabugoomu et al., 2018; Van Zyl et al., 2015 & Yakubu & Salisu, 2018) who asserted that people suffering from social distress are at higher risk of decreased self-trust and dislike interacting with others. Moreover, teenage mothers who engaged in alcohol consumption could not get their expected result of comfort but in turn experience elevated levels of distress. This study finding is supported by Dolezal and Lyons (2017) and Kaye (2008) who noted that engaging in risk taking behaviour does not eliminate distress but complicate the situation.

Based on the finding of the current study illegal substances used by teenage mothers to mitigate negative feelings of distress also include overdose of hospital prescribed medications. This finding is in line with other authors (Bottorff, et al., 2014; Fernandes et al., 2020; Hipwell et al., 2016; Hodgkinson et al., 2014; Levran et al., 2014 & Martorell-Poveda et al., 2015) who found that teenage mothers with psychological distress tend to be intoxicated with treatment prescriptions to alleviate the negative feeling. Teenage mothers

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cited ill-treatment and name calling by healthcare providers as contributory factors for their excessive alcohol drinking and smoking habits to feel better. They also added that they are always troubled by negative thoughts of being called stupid and feel depressed and eventually engage in substance use in order to feel aroused and relieved. The findings agree with various literatures (Horwitz et al., 2011; McFarlane et al., 2014; Siegel & Brandon, 2014; Sitsofe, 2020 & Turner & Honikman, 2016) who noted that ill-treatment is a potential cause of substance abuse, smoking and intake of alcohol among depressed people as an effort to handle distress. Moreover, teenage mothers with distress seem to avoid interaction with people or places where they had bad experience in the past to prevent elevated levels of psychological, emotional and social distress. They were keen to avoid association and lived distant life with healthcare providers. The findings are supported by various studies (Coast et al., 2019; Peterson et al., 2007; Porr et al., 2012 & Șipoș & Predescu, 2017) who found that teenage mothers refrain from seeking health services and dislike interaction with rude healthcare staff.

5.2 Limitations of the study

This research however was subjected to weaknesses or imposed restriction that were out of the researcher's control and were associated with geographical location covered, data collection method, research questions and ethical concerns (Theofanidis & Fountouki, 2019). This qualitative study explored lived experiences of teenage mothers in one Local Municipality under Vhembe District Municipality. Therefore, the transferability of findings from this qualitative work should be considered with caution. The instruments used in data collection which was semi-structured interviews affected the study in a way that some participants might have decided not to give full information during the interviews and others might have provided false information. Nevertheless, the researcher probed for clarity and also reminded the participants about confidentiality which the researcher had to maintain. That was a way of making them feel free to explain more about their experiences. Because some of the participants did not feel comfortable to provide information through talking, even though the issues of privacy and confidentiality had been explained to them, others might have feared that the information they provided could be disclosed. Some answers might have been given that suited them and that were socially acceptable and gave them a good picture, more especially to questions that required responses on how the psychosocial and emotional distress affected their behaviours.

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5.3 Conclusion of the study

In this study, the psychosocial and emotional effects and coping resources among teenage mothers were found to have been experienced and to be a major challenge among teenage mothers at Malamulele hospital. There were various signs of psychosocial and emotional distress indicated by the participants during the interviews. These included depression, sleep disturbance, worried, headache, anxiety and fear of ill-treatment, anger and irritability, hopelessness and hopelessness, loneliness, social isolation and withdrawal, stigmatization, suicidal thoughts, trouble with memory and concentration. Many participants experienced negative feelings of distress associated with ill-treatment of healthcare workers. The psychosocial and emotional distresses experienced by teenage mothers were found to be as a result of new transition to teenage motherhood, witnessing rudeness of healthcare providers, lack of healthcare support, poor treatment received and unfriendly healthcare providers. There were various effects of psychosocial and emotional distress revealed by teenage mothers during the interviews. These included negative emotional responses, aggressive behaviour, low self-esteem, dropping out of school and low educational performance, racing thoughts and problematic interpersonal relationship. Various ways of coping with the psychosocial and emotional distress are explained which are positive and negative depending on the teenage mothers' temperaments and internalizing of the problem. The Christian religion or church activities that teenage mothers were involved in were singing, and being members of youth committee. Some teenage mothers reported appreciation social support from family more especially from their mothers and sisters which helped them to cope with distress. Another way of coping with distress perceived by these teenage mothers was the use of substance such as alcohol to mitigate distress. Some teenage mothers found it helpful to deal with distress by avoiding interacting with people who hurt them or avoid going to places that were perceived to trigger their distress; they reported that they were unwilling to associate with healthcare providers or visiting the hospital for future consultations.

5.4 Recommendations

Based on the study findings, the researcher made the recommendations of minimising psychosocial and emotional distress, its effects and to maximize productive coping resources in future for teenage mothers. There is a need of intervention by the following stakeholders: The Department of Health (DoH) more especially Malamulele hospital, The Department of Education (DoE), and The Tribal Councils in all communities within Collins Chabane Local Municipality and beyond.

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Recommendations for The Department of Health (Malamulele hospital)

The quality assurance should be easily accessible to educate healthcare providers such as nurses on the consequences of ill-treating teenage mothers. This can also assist in reducing psychosocial and emotional distress on teenage mothers, because psychosocial services and support will be provided appropriately by the healthcare providers. During the monitoring system teenage mothers can be given an opportunity to express their perceptions on the standard of service they will be receiving in the hospital. The researcher recommended training of nurses caring for teenage mothers for primary prevention. In addition, clinical psychologists, counselors, and psychometrists should develop programmes on psychosocial and emotional support for teenage mothers for secondary prevention and intervention. Since many teenage mothers indicated the signs of psychosocial and emotional distress regardless of other supports provided. Psychometrists can also assist in assessing teenage mothers for a placement to relevant school subjects and schools. On the basis of the comments given by the teenage mothers there is a dire need for psychosocial services for teenage mothers consulting at the hospital and other areas.

Recommendations for the Department of Education

The researcher recommends that more educational psychologists should be trained to assist in providing psychotherapy and awareness to vulnerable learners, specifically teenage mothers. The Department of Education should employ educational psychologists/registered counsellors in schools. The service can assist in the reduction of school dropouts and maximize school performance amongst school going teenage mothers.

Recommendations for all Royal Councils in communities within Collins Chabane Local Municipality and beyond

The researcher recommends that all communities through their royal councils within Collins Chabane Local Municipality and beyond should strengthen awareness campaigns and develop programmes that will assist to restore the personhood and community receptiveness of teenage mothers. The above-mentioned mandate will be carried by community groups of experienced senior mothers and grandmothers. The community should provide proper support to teenage mothers and avoid prejudice and negative labeling of teenage mothers. Any persons who can be found or reported to have humiliated teenage mothers due to their situation or for any other reason should be sanctioned.

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5.5 Implications for future research

The current study focused on psychosocial distress experienced by teenage mothers. Therefore, the researcher recommends that future studies should focus on developing and implementing programmes that can reduce the causes and effects of the distress.

5.6 Conclusion

In this chapter the researcher discussed the findings of the study, the conclusion and the limitations of the study. The recommendations based on the findings of the study were also presented that included The Department of Health (Malamulele Hospital), The Department of Education, specifically in the Limpopo Province, and The Tribal councils in communities within Collins Chabane Local Municipality and beyond specifically in the field of Psychology.

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2.14 Work plan

The process of writing a research proposal, data collection, analysis, interpretation, writing up the report will happen from the months of April 2019 to December 2021. After analysing and report writing the months of January 2022 to September 2022 will be allocated for editing and proof reading, evaluation, spiral binding and submission for external examination. The detailed schedule is indicated below.

Table 1: Illustration of the work plan

YEAR 2019												
	JAN	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Research proposal writing												
YEAR 2020												
Present to the Department												
Present to School												
Submission to Executive School Higher Degrees Committee												
Submission to University Higher Degrees Committee												
Apply for ethical clearance												
YEAR 2021												
Seeking permission to conduct the study												
Data Collection												
Data analysis												
Report writing												
YEAR 2022												
Submission of first draft to supervisor												
Submission of final draft to external examiner												

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ANNEXURES

Annexure 1: University consent form and information sheet

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

LETTER OF INFORMATION

Title of the Research Study: *Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local municipality, Vhembe District in Limpopo province*

.

Principal Investigator/s/ researcher: *Mr GM Baloyi, BA Honours in Psychology.*

Co-Investigator/s/supervisor/s: *Dr FJ Takalani, PhD and Mrs B Koko, Master.*

Brief Introduction and Purpose of the Study: *Teenage mothers are subjected to emotional and psychological problems attributed to various factors according to studies conducted in range of countries worldwide. It was found that the common attributing factors include early childhood challenges, stress of parenting, economic hardships, intimate partner violence, and the stigma of early childbearing. It was also found that teenage mothers suffer from social distress as it relate to multiple factors such as inability of teenage mothers to develop trusting relationships, the lack of support from the family and professionals. Based on the findings, it is obvious that psychosocial and emotional problems should be given serious attention because of their devastating effects in the lives of teenage mothers. The purpose of the study seeks to explore the lived experiences of teenage mothers seeking mental health care services in a selected rural hospital in Collins Chabane Municipality, Vhembe District.*

Outline of the Procedures: *The researcher will first gain consent from the gate keepers after obtaining ethical clearance at the University of Venda. The effective informed consent for the participants under 18 years (teenage mothers) to participate in the study will be given by their parents or guardians. The study will be conducted in Malamulele training centre where the selected hospital of the study is based. The training centre will be used as a way*

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of maintaining confidentiality and privacy. The researcher also wants to avoid the disturbance of services in the hospital. Only the selected hospital in Collins Chabane Municipality, Vhembe District will be included in the study. All teenage mothers between the ages of 15-19 years old who visit Malamulele Hospital for consultation, and who are not satisfied about their experiences at the hospital will be included in this study. Teenage mothers who are willing to participate will be included. All adult women and teenage mothers between the ages of 13-14 years old who visit Malamulele Hospital for consultation will be excluded. All teenage mothers who are unwilling to participate in this study will be excluded.
The researcher will use an interview guide in semi-structured face to face interviews to collect data from participants for a minimum of 60 minutes for each participant. Participants who will appear to be disturbed psychologically will be arranged for counselling and or debriefing. The researcher will provide counselling as she has counselling skills as a psychology graduate. Those with social needs will be referred to the social workers in their local areas for assistance.

Risks or Discomforts to the Participant: *It may happen that the participants feel uncomfortable about the questions being asked and talking about their lived experiences. Some questions may provoke their feelings and emotions depending on individuals. Some questions may make them feel angry and or cry. The researcher will try by all means to avoid asking questions that will lead to them feeling depressed psychologically. If the participant cries the interviews will pause and arranged for another day.*

Benefits: *The feedback from the teenage mothers may assist the healthcare providers to improve the quality of health care practices and lessen complaints from teenage mothers. The study findings may provide necessary information for policy makers regarding review and development of policies, programmes and services designed to address and support the needs of the pregnant teenagers and motherhood. The study may also provide basis for further studies and contributes to the body of scientific knowledge in the field of psychology. The research findings of the proposed study may contributes by uncovering the causes, emotional, social and psychological distress and coping strategies by teenage mothers that need to be addressed. The research results will be shared with public in the form of presentation to international and national conferences, published articles, and hard copies of the dissertation will be made available to the Limpopo Department of Health Provincial, Vhembe District and the Collins Chabane sub-district (Malamulele hospital). Participants will be given feedback after the completion of the study.*

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Reason/s why the Participant May Be Withdrawn from the Study: *If they feel uncomfortable about the questions asked, if they feel like withdrawing at any time for any reason. Reason for withdrawal can be given or not given to the researcher and that cannot affect the participants. Participants' withdrawal will not affect them negatively in any way.*

Remuneration: *Participants will be given refreshments after the interviews.*

Costs of the Study: *No, there will be no costs to be covered by the participants.*

Confidentiality: *The study will be conducted in the training centre where the hospital is based. The training centre will be used as a way of maintaining confidentiality and privacy. Every participant will be allocated a time to meet with the researcher. The responses given by the participants will not be disclosed to anyone in any way (written and or verbal) without the participants' consent. Research results will be shared with Health care providers for the purpose of providing awareness about the challenges faced by teenage mothers and the solution to a problem. Personal information of the participants will not be published in any way and will be replaced with pseudonyms. Audio recorded interviews will be stored in a locker for a period of two year for the reason of completing my Master and publication.*

Research-related Injury: *The nature of the study does not have risks like injuries. There is no budget allocated for any injuries. The study will be conducted in hospital training centre in order to avoid physical harm, for maintenance of privacy and confidentiality. Participants who will be psychologically affected will get counselling and debriefing. Counselling and debriefing services will be provided by the researcher as he has counselling skills as a psychology graduate.*

Persons to Contact in the Event of Any Problems or Queries:

(Supervisor and details: Dr FJ Takalani) Please contact the researcher (tel no. 0737278202), my supervisor (tel no. 0829793035) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:
Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population

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CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (*Mr Gezani Morris Baloyi*), about the nature, conduct, benefits and risks of this study – Research Ethics Clearance Number: _,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

I, ……………………. …………… ………… ……………

(*Mr GM Baloyi*) herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Gezani Morris Baloyi

……………………. Date………………. Signature…………………

Full Name of Witness (If applicable)

……………………. Date ………………. Signature…………………..

Full Name of Legal Guardian (If applicable)

………………… Date……………… Signature……………………

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Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

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Annexure 2: Interview guide (English version)

Interview no………………. Date……………..…..
Time started………………. Time finished……….
Introduction; welcome participant
Introduction of the researcher
Explain the purpose of the interview and discuss issues of confidentiality
Thank participant for deciding to take part in the study

- Would you please share with me your feelings about how you have been treated as a teenage mother in Malamulele Hospital?

Probe: Tell me more what comes to your mind when you think of receiving health services in Malamulele Hospital?

What are your thoughts of being a teenage mother?
May you please tell me how well you are able to associate with others?
Probe for: what do others say or think of what being teenage mother in Malamulele Hospital is?
Family members,
Friends;
Community.

- May you please share with me what you think may be the cause of the way you are feeling?

Probe for: What are the things you encountered, and you are encountering while seeking healthcare services as a teenage mother in the hospital?

- May you share with me the ways utilised by you to deal with the emotional, social and psychological experiences you are facing?

Probe for: What do you normally engage yourself in, to deal with such experiences?

- May you please share with me the psychosocial services provided to you?

- Do you think there is a need for specific services to be provided to you to cope with emotional, social and psychological problem you face?

If so, may you please explain to me the reasons for that?

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Annexure 3: Socio-demographic information (key participants)

Table 3: Illustrating (key) participants' socio-demographic information

RESEARCH PROJECT: "Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province."

Project Leader: Baloyi G.M
NAME OF RESEARCHER: Baloyi Gezani Morris

DEMOGRAPHICS PROFILE SHEET

Participant Number.	Age	Area (Rural or Urban)	Marital status	No of years in marriage	Occupation	Level of Education	No. of children	Date of seeking health services	Duration of interview
1.	16yrs	Rural	None	None	unemployed	Grade 9	one	24/03/2021	60 min
2.	18yrs	Rural	None	None	unemployed	Grade 10	one	24/03/2021	60 min
3.	16yrs	Rural	None	None	unemployed	Grade 10	one	25/03/2021	60 min
4.	19yrs	Rural	None	None	unemployed	Grade 11	one	25/03/2021	60 min
5.	15yrs	Rural	None	None	unemployed	Grade 10	one	26/03/2021	60 min
6.	18yrs	Rural	None	None	unemployed	Grade 12	one	26/03/2021	60 min
7.	18yrs	Rural	None	None	unemployed	Grade 10	one	29/03/2021	60 min
8.	17yrs	Rural	None	None	unemployed	Grade 11	one	29/03/2021	60 min
9.	15yrs	Rural	None	None	unemployed	Grade 9	one	30/03/2021	60 min
10.	16yrs	Rural	None	None	unemployed	Grade 10	one	30/03/2021	90 min
11.	17yrs	Rural	None	None	unemployed	Grade 9	one	31/03/2021	60 min
12.	18yrs	Rural	None	None	unemployed	Grade 10	one	31/03/2021	60 min
13.	16yrs	Rural	None	None	unemployed	Grade 11	one	07/04/2021	60 min
14.	18yrs	Rural	None	None	unemployed	Grade 12	one	07/04/2021	90 min
15.	17yrs	Rural	None	None	unemployed	Grade 10	one	08/04/2021	60 min

Total number of hours spent	16 Hours

Researcher's Full Names:…………………… Signature:…………… Date:…………..

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Annexure 4: Letter of Permission

Enq: Baloyi G.M
Cell: 073 727 8202
Email:gezanimorris@gmail.com

P.O Box 3151
MALAMULELE
0982
05 November 2020

THE MANAGEMENT
PROVINCIAL DEPARTMENT OF HEALTH
POLOKWANE
0700

Dear Sir/Madam

RE: Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province.

I, **Baloyi Gezani Morris,** a Master's Degree candidate in the department of Psychology at the University of Venda, hereby request your permission to conduct a research study in Malamulele Hospital of Collins Chabane Local Municipality in Vhembe District. I also request the hospital management to allow me gain the access to the participants in order to locate the participants for consent to participate in the study. The topic of the research is: **Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province.** The main purpose of this study is to explore the emotional, social and psychological distress experienced by teenage mothers and develop strategies to be used to address the experiences. Data collection will be done through semi-structured interviews with teenage mothers.

I hope that my request will receive a favourable response.

Yours faithfully
Gezani Morris Baloyi

Researcher's Signature:……………………. **Date ………….............**

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Annexure 5: Letter of Permission

Enq: Baloyi G.M
Cell: 073 727 8202
Email: gezanimorris@gmail.com

P.O Box 3151
MALAMULELE
0982
18 March 2021

MANAGEMENT
THE DEPARTMENT OF HEALTH
VHEMBE DISTRICT
THOHOYANDOU
0950

Dear Sir/Madam

RE: Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province.

I, **Baloyi Gezani Morris,** a Master's Degree candidate in the department of Psychology at the University of Venda, hereby request your permission to conduct a research study in Malamulele Hospital of Collins Chabane Local Municipality in Vhembe District. I also request the hospital management to allow me gain access to the participants when they visit the hospital in order to locate the participants for consent to participate in the study. The topic of the research is: **Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province.** The main purpose of this study is to explore the emotional, social and psychological distress experienced by teenage mothers and develop strategies to be used to address the experiences. Data collection will be done through semi-structured interviews with teenage mothers.
I hope that my request will receive a favourable response.

Yours faithfully
Gezani Morris Baloyi

Researcher's Signature:………………………….. **Date …………….........**

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PO Box 738

Sibasa

0970

29 Aug. 22

To whom it may concern

Re: Confirmation of editing and proof reading

This is to confirm that a **Master of Arts (Psychology)** dissertation, entitled ***Psychosocial distress associated with lived experiences of teenage mothers in a selected rural hospital in Collins Chabane Local Municipality, Vhembe District in Limpopo province***, submitted to me for editing and proof reading by **Gezani Morris Baloyi, Student Number: 19023394** was edited and proofread for glaring language errors.

Sincerely.

Dr LMP Mulaudzi

Director: CHETL

University of Venda

Private Bag x5050

Thohoyandou

0950

Tel: (27) 15 962 8347

E-mail: Lindiwe.Mulaudzi@univen.ac.za

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