DETERMINANTS OF POST-PREGNANCY PSYCHOLOGICAL ADJUSTMENT OF OUT-OF-SCHOOL TEENAGE MOTHERS IN SOUTH-WEST NIGERIA

BY

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CERTIFICATION

I certify that this research work is carried out by Bolatito Alake Adebisi (Matric No. 148615) in the Department of Guidance and Counselling, University of Ibadan, Ibadan, Oyo State, Nigeria under my supervision.

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Supervisor

DEDICATION

The research work is first and foremost dedicated to the Almighty God, The Father of Light and Knowledge in whom there is no variableness or shadow of turning. Secondly to all women, awake from your slumber, study to make yourselves approved. Update yourselves so as not to be outdated. There is no age limit to education.

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ABSTRACT

Transition to motherhood generally represents a major developmental milestone for all women even though it could be stressful for teenagers; because the basic physiological features for coping with pregnancy are not yet fully developed. Pregnancy, most especially among teenagers, could therefore be psychologically debilitating, physically frustrating and emotionally draining; particularly when the teenager is out-of-school. Although there are related studies on post-pregnancy psychological adjustment of women generally, only few of such studies concentrated on teenagers who are out-of-school. This study, therefore, investigated stigmatisation, social support, family support, peer support, self-esteem, self-concept, sexual debut, depression and socioeconomic status as determinants of post-pregnancy psychological adjustments of out-of-school teenage mothers.

The study adopted descriptive survey design of *ex-post facto* type. The purposive sampling technique was used to select 42 Local Government Areas (LGAs) across Lagos (eight), Ondo (seven), Oyo (seven), Ogun (seven), Osun (seven) and Ekiti (six) where there is high prevalence of out-of-school teenage mothers. Also, the purposive sampling technique was used to select the main health centre in each of the selected LGAs. One thousand, two hundred and ninety two out-of-school teenage mothers attending post-natal clinic across the 42 health centres were purposively selected. Duke-UNC Functional Social Support Questionnaire (r=0.72),Teenage Mothers Post-Pregnancy Psychological Adjustment (r=0.82), Rosenberg Self-esteem (r=0.74), Self-Concept Clarity (r=0.88), Global Depression (r=0.79), Teenage Mother Stigmatisation (r=0.76), Teenage Mother Sexual Debut (r=0.78), Teenage Mother Peer Influence (r=0.72), Family Support (r=0.86) and Socio-Economic Status (r= 0.64) scales were used for data collection. These were complemented with six Focus Group Discussions sessions with selected 72 teenage mothers. Three research questions were answered and nine hypotheses tested at 0.05 level of significance. Data were analysed using descriptive statistics, Pearson product moment correlation, multiple regression and content analysis.

Participants were secondary school drop outs with a mean age of 14 ± 3 years. There was a significant multiple correlation between the independent variables and post-pregnancy psychological adjustments of out-of-school teenage mothers ($F_{(9;1282)}$=29.07; R=0.41) and accounted for 16.4% of its variance. Self-esteem (β=0.296), social support (β=0.13), stigmatisation (β=0.09), self-concept (β=0.08), peer influence (β= 0.06) had positive significance contributions with post-pregnancy psychological adjustments while socio-economic status (β= -0.14), depression (β=-0.13) and sexual debut (β=-0.01) had significant negative contributions but family support had none. Self-esteem (r=0.34), social support (r=0.22), self-concept (r=0.21), stigmatisation (r=0.21), peer influence (r=0.19), sexual debut (r=0.15) and depression (r=0.09) had significant correlations with post-pregnancy psychological adjustments. Teenage-motherhood among the respondents was more of a chain of action, which they imitated from their mothers/sisters and perceived as a way of life.

Self-esteem, social support, stigmatization, self-concept and peer influence were the potent predictors of post-pregnancy psychological adjustment of out-of-school teenage mothers in South-West Nigeria. Counsellors and educational psychologists should integrate these factors into intervention programmes targeting out-of-school teenage mothers.

Keywords: Out-of-school teenage mothers, Post-pregnancy psychological adjustment, Psycho-social variables, South-West, Nigeria

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CHAPTER ONE

INTRODUCTION

Background to the Study

Transition to motherhood is a major developmental milestone for all women, but it is particularly stressful for teenagers. This is premised on the ground that teenagers would struggle to manage their new maternal roles and responsibilities which they are ill-prepared for. However, sexual risk-taking behaviours and experimentation are somewhat expected outcomes of teenage mothers as they strive to manage self with the complex changes occurring at this stage of life as it has been reported that they are usually unproportionately and unfairly over-burdened with the consequences of this developmental process (Uwakwe, Falola, Adeyemo & Osiki, 2012). Coping with the motherhood physical, emotional, affective as well as demands and challenges of adolescence could be chronically stressful. Hence, research works on the immediate and long term adjustment to motherhood among teenage mothers are much emphasized now than before, because it is a source of great psychological challenge negatively impacting the modern world and Nigeria is no exception (Okoiye & Falaye, 2010). More than as expressed by Okoiye and Falaye (2010), motherhood among teenagers could come with social stigma, social alienation and other social-psychological factors. Evidence abounds that teenage childbearing is one 'off-time' transition that is associated with reasonably strong societal norms with negative sanctions for the individuals who violate them (Mollborn,2009).

In Nigeria, out-of-school teenage mothers are often faced with complex psychological challenges due to their inexperience. This, more often than not, could place the mother and child at great risk of maladjustment. Teenage mothers are not knowledgeable in the act of child care due to their ill-preparedness. They have limited

motherhood skills needed for foetus nursing, child care and rearing. This phenomenon could result in feelings of hopelessness, sadness, isolation, worry and withdrawal (Okoiye, Ohizu & Adediran, 2011).

Therefore, lack of psychological adjustment skills by the out-of-school teenage mothers could bring challenges for coping efficacy as they experience the demands of motherhood that require self-acceptability and self-responsibility in almost every dimensions during the motherhood period (Cauce, Mason, Gonzales, Hiraga & Liu, 2005).

Ajuwon (2005) states that reproductive phenomenon is associated with considerable negative health and developmental challenges. Similarly, the United Nations (2004) report cited in (Okoiye, Ohizu & Adediran, 2011) upholds the fact that reproductive health and development of adolescents continue to grow throughout the world and addressing the sexual health information and service needs of this population poses significant challenges for policy makers and service providers. Therefore, to have a clear perspective of the trauma of teenage motherhood in terms of their struggle for psychological adjustment; it is germane to investigate measures of determinants of post-pregnancy psychological adjustment of out-of-school teenage mothers in Southwest, Nigeria which is the focus of this study.

The developmental changes associated with teenage motherhood is characterised by psychobiological and social skills that the teenager should master or to understand the functional capacity and regulations before transiting to motherhood stage of life which is often regarded and described as maturity. Okoiye and Asamaigo (2011), report that the occurrence of teenage motherhood is predicated on some antecedents, including changing family constellations, negative peer influence, economic hardship and exposure to loss of community bonds. In support of this assertion, Awam (2009) reports that teenage mothers in Nigeria face myriads of problems in their bid to assert themselves sexually. This may

be as a result of faulty or inadequate preparation given to the child for effective sexual adjustment.

Teenage mother is becoming more rampant, according to Bimbola and Ayodele (2007), they posit that there is an increasing rate of teenage pregnancy despite the fact that teenage childbearing continues to be seen as an important social and public health problems. In the same token, World Health Organisation's (2011) report that, the proportion of births that take place during adolescence is about 2% in China, 18% in Latin America and the Caribbean and more than 50 % in sub-Saharan Africa and half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India and the United States. Nigeria equally features as one of the countries negatively affected, Therefore, there is the need to carry out the study on the effect.

However, sanctions experienced by teenage mothers could be interpersonal, such as facing explicit disapproval from others. Regardless of the sanctions experienced, it seems possible that teenage parents who violate societal norms about appropriate transitions to parenthood might suffer mental health resulting to psychological distress among the teenage parents (Wooten, 2006).

Consequently, maternal psychological distress is an important concern for researchers because of its problematic outcomes for mothers, which include repeated pregnancies, low parenting competency and poor educational achievements (Eshbaugh, 2006; Holub, Kershaw, Ethier, Lewis, Milan & Ickovics 2007). In addition, maternal distress has detrimental effects for children's normal development, including language development, coping skills, social adjustment, and physical health (Sills, Shetterly, Xu, Magid & Kempe, 2007). Similarly, teenage mothers' psychological distress levels have been found to be high

(Schmidt, Weimann, Rickert & Smith, 2006). This implies that teenage childbearing has the tendency to change the teenage mother's life pattern forever in a negative way (Grant & Hallmark, 2006) as they may leave school and never return because of the need to take care of their children. Pillay (2008) asserts that teenage mother's career and goals are shattered, these factors impact negatively on parent-child interactions with resultant effect of diminished infant development. The teenage mothers' inability to complete school could make them vulnerable to poverty with a long lasting effect on their psychological and socio-economic well-being (Gustafsson & Worku, 2007).

Furthermore, it is of note that teenage childbearing is accompanied by stress in the family, partner disapproval and peer avoidance. These are negative risk factors that undermine the post-pregnancy psychological adjustment and development of both teenage mothers and their children (Richter, Norris & Ginsburg, 2007).

In congruence, Atuyambe, Mirembe, Tumwesigye, Annika, Kirumira and Faxelid (2008) found that teenage mothers were significantly more disadvantaged in terms of health-care-seeking behaviour for reproductive health services and faced more challenges during pregnancy and early motherhood compared to adult mothers. They are also likely to experience disapproval of parents and community stigmatisation.

Asides, premature mothers experience hostility in their dealings with social service institutions, education providers and health care givers (McDermott & Graham, 2005). Collins (2005) reports that the stigmatization of teenage mothers by the society impacts negatively on their psychological well-being and coping ability to adjust to reality of their predicament. Inconsistence with Palacios and Kennedy (2010) establish report, that the effects of stigmatization on the life experiences, adjustment and personality

characteristics of teenage mothers who were Mexican American and African American, reveals that forty-four percent of the respondents report experiencing stigmatization from parents, peers, religious centers and community. Palacios and Kennedy (2010) also report that teenage mothers experiencing stigmatization adjust poorly in the society than those that are not being stigmatized.

Makiwane, Desmond, Ricter and Udjo (2006) found that lack of social support is associated with psychological harm to teenage mothers and their children. Thus, the children of teenage mothers do not develop and progress at optimal level because of growing in a single parent environment (Lassa, 2006). Similarly, McDonald, Conrad, Fairlough, Fletcher, Green, Moore and Lepps' (2008) assert that social supports for teen mothers are related to their psychological, social and emotional well-being, including impulsivity and problem-solving. Therefore, the teenage mothers require significant socio-psychological support not only to cope with the stress of pregnancy, but also the post-pregnancy life.

However, McDonald et al., (2008) posit that teen mothers living with family or close friends have higher levels of social support, educational achievement, self-efficacy, and problem-solving abilities. This is premised on the fact that the mothers and other significant others could play a significant role such as housing, child care and parenting support when the teen and child reside with them, especially within the first twenty four months of their child's life, and may improve thier psychological adjustment to parenting (Oberlander, Shebl, Magder & Black, 2009). Thus, the quality of social support received may influence teen mothers' hopes for the future as well as their perception of themselves as having a productive future (Beers & Hollo, 2009). Similarly, it would reinforce a clear and well established relationship between parents' parental behaviours with their children who are teenage mothers which would in turn strengthen their maladjustment (Jackson,

Pratt, Hunsberger, Pancer, & Anderson, 2005); because parental support has been hypothesized to influence teenage mothers psychological adjustment (Parmar & Rohner, 2005). This is consistent with the assertion of Aremu and Ogbuagu (2005) that parental involvement in the lives of their children correlates positively with their behavioural disposition(s). Thus, parental warmth has been consistently identified as being significantly related to psychological adjustment of teenage mothers (Rohner, Khaleque, & Cournoyer, 2007). Specifically, a meta-analysis of 43 studies worldwide shows that regardless of culture, ethnicity or geographic location, approximately 26% of the variability in youths' psychological adjustment is accounted for by perceived parental warmth (Khaleque & Rohner, 2002).

Rohner et al. (2007) findings indicate that young Korean American teenagers' self-reported lower maternal and paternal warmth were positively correlated with overall poor psychological adjustment and as well as the attributes including hostility, negative self-esteem, negative self-adequacy, emotional unresponsiveness, emotional instability, and negative worldview. These findings support the proposition of parental acceptance and rejection theory (Rohner et al., 2007). Therefore, the teenage mothers' perception of a warm and accepting quality in the relationship with their parents is remarkably important to maintaining their healthy psychological adjustment. However, when teenage mothers perceive their parents as low in warmth, their emotional need for positive responses from the people most important to them (ie, parents) is not met and this results in poor psychological adjustment (Rohner et al., 2007).

Like the other forms of support, Adeyemo and Torubeli (2008) find that positive peer relationship impact positively on the well-being of teenagers. Also, Bunting and McAuley (2004) find that peer support positively impacts the psychological health of a teenage mother. They further posit that there are some evidence to suggest that teen

mothers may be able to receive higher quality support from peers with similar experience. Thus, these support groups for teenage mothers provide a comfortable atmosphere that reinforces peer interaction. Therefore, associating with others who share similar experiences may provide support that one does not receive from non-parenting peers. In support, Breheny and Stephens (2006) discover through series of interviews with health professionals in New Zealand, the importance of peer support above access to health information. These health professionals are aware of the problems of social isolation faced by young mothers and their need for peer support. Hence, Breheny and Stephens (2007) urge that teenage motherhood should not be viewed as a social problem, but rather, as a challenge requiring community support regardless of the mothers' ages and socioeconomic position.

In this same vein, Bunting and McAuley (2004) found that family support has been indicated to improve parenting skills and behaviours. Teenage mothers appear to rely on their mothers most times for material support in the form of childcare. In the same vein, Dennis (2005) states that lack of family support has consistently been predicated for poor mental health among teenage mothers and a source of possible developmental risks in their children. In view of this, family support is recognized as important in reducing depression and improving the general circumstances of teenage mothers (Bunting & McAuley 2004). Though family support can have a significant positive impact on teenage mothers, but families can also be a source of negative impact, depending on the level of family connectedness (Breheny & Stephens 2006).

Furthermore, Meesu (2011) hypothesizes that the internal psychological resources for teenage mothers' self-concept include identity development and vary depending on their environment. Teenage mothers with positive self-concept tend to experience less identity crisis, whereas those with poor self-concept appear to be experience identity

confusion and psychological maladjustment (Schwartz, Mason, Pantin & Szapoczik, 2009). In a study conducted in South Africa by Ritcher and Mlambo (2005) with teenagers, they found that teenagers are not happy about their pregnancies. Most participants perceive their pregnancies to induce crises to them and their families by impacting negatively on their self-esteem. Thus, teenage mothers do not perceive having children as an exalted social status; rather, they perceive it as a disgrace to their parents and community. Thus, Edzisani (2009) states that to boost teenage mothers' self-esteem, they should not be treated like outcasts; they should rather be supported to achieve success in the future. Likewise, it is found that their early life experiences have long-term implications on their self-esteem and psychological well-being throughout life (Ha, Hong, Seltzer & Greenberg, 2008). This implies that the self-esteem of teenage mothers is based on their level of differential exposure to environmental risks and resources around them, which could produce increasing disadvantage for the well-being of some and increasing advantage for others (Kendig, Dykstra, Van Gaalen & Melkas, 2007).

Furthermore, in investigating the sexual debut of teenage mothers in Swazi land, Ziyane and Ehler (2006) find that most Swazi teenage mothers experiment their sexual debut to bear children and to prove their fertility, and in so doing, prove their marital value. The study suggests that early sexual debut and teenage pregnancy are practices that conform to Swazi's societal expectations. Furthermore, child bearing is found to be important for determining and maintaining social position of a family in the Swazi culture. Therefore, the prevalence of early sexual debut in the country is influenced by childbearing practices, cultural values and health practices, as well as barriers to family planning services.

In other words, a teenage girl growing up in a society that has these cultural practices is likely to succumb to the pressure of experimenting sex early, becoming

pregnant and bearing children. Similarly, Mokwena (2003), reports similar findings that teenage mothers tend to be less anxious when compared to teenage non-mothers. The less anxiety in teenage mothers is attributed to the fact that culturally, "the father of the child may not leave [the teenager]" (Mokwena, 2003, p.88). This gives an indication that a father to his child is culturally expected to accept the pregnant teenager.

This phenomenon seems to cut across continents as Rios-Neto and Miranda-Ribbeiro (2009) report that in Latin American countries, most incident of teenage motherhood is as a result of early sexual debut experience among teenagers who are less knowledgeable about their reproductive development, hence do not take necessary steps to prevent pregnancy. In support of this assertion, Emma and Georgina (2010) find that in Latin American countries in 2010, over 2.1 million children were estimated to be born to teenage mothers of between 15 and 19 years of age in the region. They further reveal that teenage mothers who had their first child before turning 18 were on average 15 years of age at the time of their first sexual intercourse. Those who became mothers between 18 and 19 years of age were on average 16 years old at the time of their sexual debut.

This has implication on their psychological well-being considering the fact that more often than not, it impacts negatively on their mental health and stimulate the feeling of depression. Giving credence to this, Nancy (2004) avers that seventy-two percent of teenage mothers reported clinically high levels of stress. Also, Barnet, Arroyo, Devoe and Duggan (2004) posit that teenage mothers experience rapid repeat pregnancy in the short term, depression, parental and peer rejection and school dropout, as well as a reduced probability of future economic independence. Projecting this context further, Margarita, Sonya, Tiffany, Frank, and Elizabeth (2004) contend that depression is a major problem facing teenage mothers. Early sexual activity, pregnancy, childbirth, and motherhood exemplify stressful situations that may trigger or exacerbate depression among teenage

mothers. Limited educational and financial resources, single parenthood, and lack of social support networks could also aggravate depression.

In contrast, Bunting and McAuley (2004) find that covariates, including socioeconomic disadvantage and prior poor performance in school, may also explain negative outcomes of teenage mother's experience. They further report that teenage mothers are more likely to come from more depressed socioeconomic backgrounds; however, this does not mean that teen pregnancy is the result of being raised in a poor household. Some studies suggest that teenage mothers from middle-class backgrounds characterized by intact families, higher incomes, and higher education levels and occupation status tend to choose abortion at a higher rate than teenagers from poor backgrounds. Poor socioeconomic circumstances and factors associated with economic disadvantage also explain the experience of psychological distress in teenage mothers. Thus, teenage mothers of low socioeconomic background have been found to have increased psychological depressive symptoms (Milan, Ickovics, Kershaw, Lewis, Meade, & Ethier, 2004).

It is observed that though the plight of teenage mothers has been reported by diverse authorities, the contextual psychological adjustment problems of out-of-school teenage mothers have not really been given much attention because most research works on teenage childbearing focus on the nature, causes, and prevalence in advance countries such as Europe, America and Asia with scanty ones from Africa and Nigeria in particular. Till date, no study has investigated the combined determinants (stigmatization, social support, family support, peer support, self-esteem, self-concept, sexual debut, depression and socioeconomic status) on the psychological adjustment of teenage mothers in Nigeria. Therefore, this thesis is systematically analysing these factors.Thus, sensitising the society

about the things and facts that could impair or help teenage mothers succeed in their psychological adjustment.

Statement of the Problem

The rate of occurrences of teenage pregnancy and motherhood in Nigeria, most especially in Southwest is worrisome and of great concern to stakeholders. This is because out-of-school teenage mothers could be at a high risk of child bearing with high prenatal risks. The children of teenage mothers are at greater risk of lower intellectual, academic achievement and health complications. Asides, children of teenage mothers more often than not, express social behaviour problems and problems of self-control composed to the children of older mothers, primarily due to the effects of single parenthood, lower maternal education and large family size. These babies are usually associated with birth injuries, serious childhood illness and mental and physical disabilities. These could cause a lifelong psychological challenge in the lives of the teenage mothers.

Other consequences include school interruption, persistent poverty, limited vocational opportunities, separation from the child's father, divorce, repeated pregnancy, stigmatization and abated self-esteem. The children born to single teenage mothers are more likely to drop out of school, to give birth out of wedlock, to divorce or separate and to become dependent on welfare, compared to children with older parents. In addition to their personal impact on the lives of women and children, these factors have negative implications on the security of the societal and national development. These are premised on the fact that most children of teenage mothers, due to poor or no educational attainment, moral or ethical upbringing are not equipped with the necessary skills to make them functional and contribute to the society positively, and as a result, they turn to crime and make the society unsafe.

Negative vices and unrest in Nigerian society with the experience of thuggery, armed robbery, prostitution and human trafficking are traceable to babies born by the teen mothers, because their developmental experience reduce their access to desired development in normal environment which would assist them to develop their own independent self and unique identity. Therefore, this study investigates stigmatization, social support, family support, peer support, self-esteem, self-concept, sexual debut, depression and socioeconomic status as determinants to post pregnancy psychological adjustment of out-of-school teenage mothers in South-west Nigeria.

Purpose of the Study

The purpose of the study is to:

(a) Examine the relationship between the independent variables (stigmatization, social support, family support, peer support, self-esteem, self-concept, sexual debut, depression and socioeconomic status) and the dependent variable (psychological adjustment of out-of-school teenage mothers);

(b) Examine the composite effect of the independent variables on psychological adjustment of out-of-school teenage mothers; and

(c) Examine the relative effect of each of the independent variables on the dependent variable (psychological adjustment of out-of-school teenage mothers).

Significance of the Study

The study is significant in many aspects as summarily enumerated below:

- The findings will better inform the society about the challenges faced by teenage mothers who either by adventure or no fault of theirs became pregnant and eventually resulted to being a mother at a very tender age.

- The study will bring to the awareness of the government the need for establishing counselling services in schools.
- It will help parents to be aware of the developmental challenges and needs of their children.
- It will also aid how parents guide and relate with their children.
- The findings will bring to the knowledge of parents that a girl's childhood must be preserved, cherished, nurtured and protected, so that she can fuily develop her potential in life.
- The findings of this study would be useful to researchers, people in the helping professions, medical practitioners, government, school administrators, parents and others in various fields to better understand teenage mothers' challenges and psychological adjustment problem to life.
- The findings will help the media to project programmes that encourage the development of the girl-child through campaign and advocacy against teenage pregnancy.
- The findings will help the parents to be more responsible for the environment in which the girl-child is going to socialize.

Scope of the Study

This study is centred on the determinants of post-pregnancy psychological adjustment of out-of-school teenage mothers in Southwest Nigeria. The population for the study was made up of one thousand two hundred and ninety two teenage mothers attending post-natal clinic in local government health centres across communities in the six states in the South-Western part of Nigeria. This is comprised of Lagos, Oyo, Ondo, Ogun, Osun and Ekiti States.

Operational Definition of terms

The following terms are defined as used in the study:

Teenage Mother: This is a teenager already bearing children.

Psychological Adjustment: This is defined as a teenage mother's cognitive, perceptual and motivational dispositions to respond to situations of life arising from nursing children at a stage in which she is not emotionally prepared for.

Stigmatization: Stigmatization is an act of labeling a special discrimination against teenage mothers who are out of school.

Self-esteem: This is a teenage mother's self-appriasal of her social worth during pregnancy.

Self-concept: It refers to a teenage mother's perception of "self" in relation to the pregnancy being carried.

Social Support: This is the physical and emotional comfort teenage mothers expect from significant others (parents, guardians and friends) during pregnancy.

Sexual Debut: This refers to the first sexual experience of a teenage mother while in school.

Socio-economic Status: This refers to the economic situation and identity of the teenage mother's family and environment.

Peer Support: This refers to the expected social and psychological supports from teenage mothers' friends.

Family Support: This is defined as the expected family supports to teenage mothers during pregnancy.

Parental Support: This is defined as expected immediate parental supports given to teenage mothers during pregnancy.

Depression: This is a state of emotional distress experienced by teenage mothers during pregnancy and child bearing.

Out-of-School Teeanage Mother:- This is a teenager who because of pregnancy and child bearing is out of school.

Delibitating:- Weak, anything that can stop one from reaching a goal

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CHAPTER TWO

REVIEW OF RELATED LITERATURE

The review of literature for this study is attempted to focus attention on the nature, concept, development, as well as recent theoretical and empirical literature on determinant of post pregnancy psychological adjustment of teenage mothers. However, emphases were made on the following trends:

Theoretical Review

Psychological Adjustment

Teenage Motherhood

Stigmatization

Teenage Sexual Debut

Depression

Self-Esteem

Self-Concept

Social Support

Peer Support

Family Support

Socioeconomic Status (SES)

Theoretical Framework

Health Belief Model

Social Learning Theory

Theoretical Framework of the Study

Review of Empirical Studies

Psychological Adjustment and Teenage Mother Stigmatization

Psychological Adjustment and Teenage Mother Sexual Debut

Psychological Adjustment and Teenage Mother Depression

Psychological Adjustment and Teenage Mother Self-Esteem

Psychological Adjustment and Teenage Mother Self-Concept

Psychological Adjustment and Teenage Mother Social Support

Psychological Adjustment and Teenage Mother Peer Support

Psychological Adjustment and Teenage Mother Family Support

Psychological Adjustment and Teenage Mother Socioeconomic Status

Conceptual Model for the Study

Conceptual Clarification

Psychological Adjustment

Psychological adjustment is defined as an individual's affective, cognitive, perceptual and motivational dispositions to respond to various life conditions. Parental acceptance or rejection, as perceived by teenage mothers has been shown to have consistent effects on their psychological adjustment (Rohner, 1991). Especially, when teenage mothers perceive their parents as low in warmth (ie, rejecting), they tend to develop poor psychological adjustment. Psychological adjustment in this context includes attributes of dependence, hostility or aggression, negative self-esteem, negative self-adequacy, emotional unresponsiveness.

Pregnancy is a major life transition requiring changes, challenges and adaptation of many kinds. According to researchers, parenthood continuous demands and responsibilities leave little or no time for most teenagers' concern; such as, peer relations,

dating, academics and career choices (Coley & Lansdale, 1998). Both unintended and unwanted childbearing among teenagers can have negative health, social and psychological consequences. Health problems include greater chances for illness and death for both the mother and the child. In addition, such childbearing has been linked with a variety of social problems, including divorce, poverty, child abuse and juvenile delinquency. In one study, unwanted children are found less likely to have a secured family life. As adults, they are more likely to engage in criminal behavior; be on welfare; and receive psychiatric services.

Teenage mothers are often found to experience high level of psychological distress and to report low self-efficacy and low self-esteem when compared with their non-parenting counterparts and older mothers. In most studies of teenage mothers, psychological distresses are associated with social and economic stressors, which are results of teenage child bearing (Kalil & Kunz, 2000). Teenage fathers often refuse to accept financial and social obligations of parenthood. There is a tendency to deny paternity to avoid financial responsibility. Often, boys and their families offer 'conditional acceptance of paternity', while the girsl are still pregnant. This means that, even though the boys' families know that their sons were seeing the girls before the pregnancy, the boys and their families will agree to acknowledge their paternity only if the children are born with some resemblance to the family (Kaufman, De Wet & Stadler, 2001). Becoming a teenage mother in Western societies is a phenomenon often associated with various psychological problems. The socioeconomic status of teenage mothers is on the lower average compared with older mothers (Moffitt, 2002). Both teenage mothers and their children have an increased risk of mental health problems. Children of teenage mothers are more likely to be involved with delinquent behaviour and to have problems in school (Henretta, Grundy, Okell & Wadsworth, 2008).

A range of antecedents of teenage pregnancy have been identified in the literature. Among the strongest and most persistent associations are measures of social disadvantage, inequality and social exclusion (Woodward, Fergusson & Horwood, 2001). A pattern of intergenerational transfer has also been observed with daughters of teenage mothers being at high risk to become teenage mothers themselves, which has been associated with the transfer of disadvantage between generations and with an association with childhood aggressive behaviours (Meade, Kershaw & Ickovics 2008). Aggressive and antisocial behaviour have also been independently associated with teenage pregnancy. Dysfunctional family relationships; family breakdown and sole parent family structures are associated with higher rates of teenage pregnancy (Woodward, Fergusson & Horwood, 2001).

Adolescent pregnancy is one of the main issues in every health care system. The reason is that an early pregnancy can have harmful implications on girls' physical, psychological, economic and social status (Tsai & Wong 2003), and it has been found that teenage mothers have poor antenatal care, as they do not attend their antenatal appointments, they tend to deliver low birth weight babies, premature babies and babies who die during the first year of their life. Additionally, the infant mortality and morbidity rates are higher for infants delivered by teenage mothers than infants delivered by older women (Limmer, 2005). Also, it is more likely that these children are raised in single-parents families and to live in poverty (Limmer, 2005). Early motherhood is associated with low educational achievement, long term benefit receipt, low or no income, low occupational status, or unemployment and therefore, it can affect teenage girls' wellbeing (Tsai & Wong, 2003).

Most teenage mothers continue to struggle with completing the developmental tasks of adolescence while facing the challenges of parenting a young infant (Coley & Chase-Lansdale, 1998). Past research has shown that many do not finish their schooling (East &

Felice, 1996), and often their efforts to do so are thwarted by difficulties with child care arrangements, unstable romantic relationships, and subsequent pregnancies. In the past, many struggled to maintain employment and often were forced on welfare to help navigate this difficult period in their lives (Coley & Chase-Lansdale, 1998). Many mothers in early adulthood become depressed, which in turn impacts their abilities to nurture their children effectively; further their education and maintain upward momentum on the job ladder (Leadbeater & Linares, 1992). In contrast, several long-term studies found that, by midlife, many former teenage mothers manage to become economically self-sufficient, gainfully employed, complete high school and limit their fertility (Werner & Smith, 2001).

The establishment of clear and persistent associations between early childbearing and later problematic outcomes for mothers and their children have led to an increased interest in the risk factors and life processes associated with teenage pregnancy and parenthood. Knowledge about the developmental risk factors that contribute to teenage pregnancy risk is important for at least two reasons. First, it is now generally accepted that many of the adverse outcomes associated with teenage pregnancy and early motherhood may at least reflect the effects of antecedent selection factors that are correlated with teenage pregnancy (Woodward et al., 2001). Specifically, there is mounting evidence to suggest that the developmental timing of a young woman's transition to parenthood is quite strongly influenced by her previous life experiences and behavioural adjustment, while young women who are perhaps the least well equipped for parenting, both socially and psychologically tend to become pregnant at a younger age (Woodward et al., 2001).

Teenage Motherhood

Teenage childbearing is associated with many unfavorable consequences for the teen mothers, their families and children. For teenage mothers and their children, the prospects for a healthy and productive life are significantly reduced. Teenage mothers in the absence of adequate nutrition and appropriate prenatal care are at a heightened risk of experiencing pregnancy complications and poor birth outcomes. Ryan (2004) suggests that children do best when two parents who have a healthy marriage raise them. Ryan (2004) again finds that only 20 percent of teen births occur within marriage, and teen pregnancy itself is associated with lower likelihood of marriage. Teen mothers are unlikely to marry the fathers of their children, and those teenage mothers who do wed often end up in unstable marriages (Lichter, 2001). In the process of assisting teenagers to reach adulthood before childbearing, one would help more children grow up in families with healthy marriages and improve their wellbeing.

Unmarried teenage mothers are at a greater risk of poverty. Teens that give birth outside of marriage have lower education attainment; seven out of ten will drop out of high school. Equally, teenage mothers who have lower incomes earning are more likely to receive public assistance and their children are significantly poorer than the adult counterparts (Ryan, 2004). Children born to teen mothers are more likely to be born prematurely and 50 percent are more likely to be low-birth weight babies, which increase the likelihood for chronic respiratory problems, mental retardatio, and cerebral palsy. Also, children of teen mothers perform significantly worse on test of their cognitive development, as only 77 percent of the children of teenage mothers earn their high school diplomas by early adulthood, compared with 89 percent of the comparison group (Maynard, 1997). Maynard (1997) again posits that sons of teenage mothers are 2.7 times

more likely to land in prison than the sons of mothers who delayed childbearing until early twenties.

Stigmatization

Social stigma is a severe social disapproval of personal characteristics or beliefs that are perceived to be against cultural norms. Sources of existing or historical social stigmas include: mental illness, physical disabilities, teenage pregnancy and diseases such as leprosy, as well as illegitimacy, skin tone or affiliation with a specific nationality and religion.

Social stigmas can occur in many different forms. Many people who have been stigmatized feel as though they are transforming from a whole person to a tainted one. They feel different and devalued by others. This can happen even in their own family (Major & O'Brien, 2005). Stigma may also be described as a label that associates a person to a set of unwanted characteristics that form a stereotype. It is also affixed (Jacoby, 2005). Once people identify and label an individual's difference, others will assume that it is just how things are, and the person will remain stigmatized until the stigmatizing attribute is undetected. A considerable amount of generalization is required to create groups, meaning that you put someone in a general group regardless of how well they actually fit into that group. However, the attributes that different societies select differ according to time and place. What is considered out of place in one society could be the norm in another. When a society categorizes individuals into certain groups, the labeled person is subjected to status loss and discrimination (Jacoby, 2005).

Stigma may affect the behaviour of those who are stigmatized. Those who are stereotyped often start to act in ways that their stigmatizers expect of them. It does not only change their behaviour, but it also shapes their emotions and beliefs (Major &

O'Brien, 2005). Members of stigmatized social groups often face prejudice that causes depression (ie deprejudice). This stigma put a person's social identity in threatening situations like “low self-esteem”. Members of stigmatized groups start to become aware that they are not being treated the same way and know they are probably being discriminated against. Studies have shown that "by 10 years of age, most children are aware of cultural stereotypes of different groups in society, and children who are members of stigmatized groups are aware of cultural types at an even younger age." (Major & O'Brien, 2005).

The right or wrong perception or attribution about teenage motherhood carries a strong social stigma. Stigma is generally based on stereotypical and uninformed impressions or characterizations of a given subject. Although, the specific social categories that become stigmatized can vary across times and places, the three basic forms of stigma (physical deformity; poor personal traits,and tribal out group status) are found in most cultures and time periods, leading some psychologists to hypothesize that the tendency to stigmatize may have evolutionary roots (Collins, 2008).

Bruce and Jo-Phelan (2008), propose that stigma exists when four specific components converge in the like of: individual differences and human variations; prevailing cultural beliefs; tying of labelled individuals to adverse attributes. Also, categorizing some labelled individuals in distinguished groups that serve to establish a sense of disconnection between "us" and "them" and experiencing "status loss and discrimination" that lead to unequal circumstances.

Teenage Sexual Debut

Teenage sexual and reproductive behaviour is a critical public health concern across the world. Their sexual debut has attracted increasing scholars' attention (Wellings 2006). Giving the trends of sexual experimentation among teenagers, teens are less likely to remain abstinent until marriage and are increasingly sexually active during their adolescent years (Wellings 2006). Without using contraceptive to offset the risks associated with an early transition to sexual activity, teens can face the hazards of unintended pregnancy and unwanted childbirth. Engaging in sexual activity at an early age significantly enhances exposure to sexually transmitted infections (STIs). Ultimately, STIs, HIV/AIDS and teenage childbearing which can incur significant consequences for young women and public health costs for the society. (Regnerus, 2007).

Early sexual intercourse is serious in adolescent risk behaviour and early initiation of sexual intercourse.It is associated with other behaviours that increase risk of frequent intercourse and greater numbers of sexual partners (Moore, Miller & Glei, 1995) and lowers the probability of contraceptive use during the adolescent years (Seidman, Mosher & Aral 1994). Thus, individuals who initiate into sexual intercourse relatively early in their adolescence are at high risk to sexually transmitted disease and early pregnancy. Psychosocial theories of health behaviour as well as previous empirical research suggest that the timing of first sexual intercourse is influenced by a broad array of socio-environmental and personal factors. Among the most powerful sources of social influence are: parents, siblings, sexual partners and friends (Kirby, 1997). In regard to parental influences, a recent review of empirical research highlights the aspects of parent-child relations that are particularly relevant to adolescents' sexual risk behaviours. Key relationship factors include: parent-child closeness and connectedness: parents' values about teen sex, and parent-child communication about sex (Kirby, 1997).

The effects of early sexual activity may resemble those of other risk behaviours viewed collectively as a 'problem behaviour syndrome' (Jessor & Jessor 1975). Engaging in risk behaviours is thought to mark 'transition proneness' and early adoption of adult roles (Udry & Billy, 1987). Early sexual activity within a romantic relationship could increase expectations of cohabitation, marriage and childbearing. Also, early sexual activity and other risk behaviours often accompany adolescent employment (Bozick, 2006), a transitional role that might tempt an adolescent to forgo investment in tertiary education.

Interactional theories of development (Thornberry, 1987) suggests a causal basis between involvement in risk behaviour and the development of a less conventional outlook. Engagement in risk behaviour antagonizes relations with conventional supports such as: family and school, and it strengthens ties with unconventional peer groups (Jessor & Jessor, 1975). This model is supported by longitudinal research, linking sexual debut with subsequent changes over time, including poorer relationships with parents; lower religious attendance; stronger affiliation with deviant peers and increased likelihood of delinquency (Armour & Haynie, 2007; Ream & Savin-Williams, 2005). Such changes might foster a shift in a teenager's mindset with less value placed on education. Effects of sexual debut on diminished school affiliation could lead more directly to lower academic performance and aspirations (Ream, 2006).

There are some evidence that early sexual debut has negative associations with academic outcomes at secondary school, that are not explained by prior confounding influences. A few studies found longitudinal associations between sexual debut and depressed academic aspirations or achievement in US secondary school pupils, after taking account of initial levels of these academic outcomes (Schvaneveldt, Miller, Berry & Lee, 2001).

Recently, negative effects of sexual debut on school attachment and performance were found after adjusting for a much wider range of prior confounders, as well as for changes in some of these, over the 12-month period studied (Sabia, 2007). Recent US research has also investigated effects on education persisting beyond secondary school. Sexual debut before age 16 is associated with decreased early adulthood participation in tertiary education after adjusting for confounders measured 6–7 years previously. These include: academic achievement; family and neighbourhood factors; college expectations and aspirations and substance use (Spriggs & Halpern, 2008). The study suggests that childbearing accounts for much of the negative associations between sexual debut and educational participation, but does not explore the contribution of changes in teenagers' social environment and attitudes over the study period.

Depression

Depression is one of the most pervasive mental health disorders affecting teenage mothers during the child-bearing years. A clinical diagnosis of depression is based on the presence of a depressed mood and/or loss of interest in activities along with other symptoms including: fatigue, feelings of worthlessness and recurrent thoughts of death. Few studies have examined depression among pregnant teenagers, even though published reports suggest that. Compared with pregnant adults, teen mothers are at proportionately higher risk for developing depression (Huang, Wong & Ronzio, 2007).

Prevalence rates of depression are much higher among pregnant teens with rates estimated between 16% and 44% than the lifetime prevalence of major depression among non-pregnant adolescents, which is reportedly between 5% and 20%, depending on the sample. Prevalence estimates of depression may vary because of minor differences in sample composition (eg, urban versus rural) and how depression is operationalized.

Estimates of lifetime risk of depression among pregnant adult women also vary with rates between 6% and 17% (Dopheide, 2006). Research has identified a number of significant risk factors that predict onset of major depression, including family history; childhood adversity; social isolation and exposure to stressful life experiences (eg, trauma, abuse, loss). Exposure to stressful events is greater among people with a history of depression than among individuals without such a history. The lives of teenagers who become teen mothers differ from those of non-pregnant teens. Teenage mothers are disproportionately more likely to have a history of physical and sexual abuse; live in impoverished communities; be exposed to community violence and have restricted access to quality health care resources (Dopheide, 2006).

One of the most obvious concerns related to depression during pregnancy is the potential worsening of the pregnancy condition. Untreated depression may lead to suicidal ideation and attempts. Although, completed suicides are rare among pregnant women. According to available reports in Nigeria in 2004, rates of suicidal ideation range from 3% to 18% (Bonari, Pinto & Ahn, 2004). Suicidal ideation and attempts are common among youth with depression. Approximately, 19% of 15- to 19-year-olds have thought about suicide, and 9% of teens have attempted suicide (Dopheide, 2006). Depression is a serious mood disorder that can take joy from a teenage mother's life. It is normal for a teenage mother to be moody or sad from time to time. These feelings are expected after the experience of stigmatization or disappointment in a love relationship. But if these feelings last for weeks or months, they may be a sign of depression. Experts used to think that only adults could get depressed, now it is known that even a young child can be depressed and will need treatment to improve (Graves 2000).

Teenage mothers' depression is a disorder occurring during the teenage years, marked by persistent sadness, discouragement, loss of self-worth,and loss of interest in

usual activities. The National Mental Health Association (1996) in the report of its study gave credence to this view, as it indicates that about 5 percent of teenage mothers has a major depressive disorder and further contends that this is a very serious depressive condition, not the moodiness of adolescence. The findings of the study further provide guidelines for recognizing core symptoms of depression among teenage mothers like: social withdrawal; irritability, decreased concentration and sleep disturbance. True depression in teens is often difficult to diagnose because normal teenage behaviour is marked by both up and down moods, with alternating periods of feeling 'the world is a great place' and 'life sucks.' These moods may alternate over a period of hours or days. Postpartum (or postnatal) depression is very common among young mothers. Research indicates that over half of adolescent mothers exhibit depressive symptoms within the first 3 months of motherhood (Logsdon, Birkimer, Simpson, & Looney, 2005).

Self-Esteem

The term self-esteem as a concept is used to describe a person's overall sense of self-worth or personal value. Self-esteem is often seen as a personality trait which could be stable and enduring. It involves a variety of beliefs about oneself, such as the appraisal of one's own appearance, beliefs, emotions and behaviours. Self-esteem is the ability to value oneself. It is slightly different from self-confidence, which refers to our sense of being able to do something successfully. Self-esteem is the overall opinion people have about themselves (Brown & Marshall, 2006). Thus, self-esteem reflects a person's overall emotional evaluation of his or her own worth, a judgment of oneself as well as an attitude towards self assessment. Self-esteem encompasses beliefs, for example, "I am competent"; "I am worthy") and emotions such as: triumph, despair, pride and shame (Hewitt, 2009). Smith and Mackie (2007) define it by saying , self-concept is what we think about the self;

self-esteem is the positive or negative evaluations of the self, as in how we feel about it. Self-esteem is also known as the evaluative dimension of the self that includes feelings of worthiness, pride and discouragement. One's self esteem is also closely associated with self-consciousness.

Self-esteem is the disposition a person has, which represents his or her judgment of his or her own worthiness. Morris Rosenberg and Social-learning theorists in the mid-1960s define self-esteem as a personal worth or worthiness. Nathaniel Branden (1969) defines self-esteem as "the experience of being competent to cope with the basic challenges of life and being worthy of happiness." According to Branden (1969), self-esteem is the sum of self-confidence; a feeling of personal capacity and self-respect; a feeling of personal worth. It exists as a consequence of the implicit judgment that every person has of their ability to face life's challenges to understand and solve problems, and their right to achieve happiness and be given respect (Olsen, Breckler & Wiggins, 2008).

As a social psychological construct, self-esteem is so attractive that researchers have conceptualized it as an influential predictor of relevant outcomes, such as academic achievement or exercise behaviour. In addition, self-esteem has also been treated as an important outcome due to its close relation with psychological well-being. Self-esteem can apply specifically to a particular dimension for example, "I believe I am a good writer and I feel happy about that" or a global extent for example, "I believe I am a bad person and feel bad about myself in general". Psychologists usually regard self-esteem as an enduring personality, characteristic trait or self-esteem, though normal,short-term variations ("state" self-esteem) also exists. Synonyms or near-synonyms of self-esteem include: self-worth, self-regard, self-respect and self-integrity (Greenberg, 2008).

Experiences in a person's life are a major source of self-esteem development. The positive or negative life experiences one has, creates attitudes towards the self which can

be favourable and develop positive feelings of self-worth, or can be unfavourable and develop negative feelings of self-worth. In the early years of a child's life, parents are the most significant influence on self-esteem and the main source of positive and/or negative experiences a child will have. The emphasis of unconditional love in parenting, represents the importance of a child developing a stable sense of being cared for and respected. These feelings translate into later effects of self-esteem, as the child grows older (Olsen, Breckler & Wiggins, 2008).

During the school years, academic achievement is a significant contributor to self-esteem development. Individual self-esteem of students who consistently achieve success or consistently fail will strongly be affected. Social experiences are another important contributor. As children go through school, they begin to understand and recognize differences between themselves and their classmates. Using social comparisons, children assess whether they do better or worse than their classmates in different activities. These comparisons play important roles in shaping the children's self-esteem and influencing the positive or negative feelings they have about themselves. As children go through adolescence, peer influence becomes much more important, as adolescents make appraisals of themselves based on their relationships with close friends. Successful relationships among friends are very important to the development of high self-esteem for children. Social acceptance brings about confidence and produces high self-esteem, whereas rejection from peers and loneliness brings about self-doubts and produce low self-esteem (Olsen, Breckler & Wiggins, 2008).

Childhood experiences that contribute to healthy self-esteem include: being listened to and being spoken to respectfully. Receiving appropriate attention and affection and having accomplishments recognized and mistakes or failures acknowledged and accepted also develop self-esteem. Experiences that contribute to low self-esteem include:

being harshly criticized, being physically, sexually or emotionally abused, being ignored, ridiculed or teased or being expected to be "perfect" all the time (Erol & Orth, 2011).

Self-Concept

According to Beheshtifar and Rahimi-Nezhad (2012), self-concept refers to the totality of a complex, organized and dynamic system of learnt beliefs, attitudes and opinions that each person holds to be true about his or her personal existence. Self-concepts represent knowledge structures that consist of beliefs about the self, including one's attributes, social roles and goals. The main factors determining the formation of the self-concept of an individual are the environment and the people with whom the individual lives. Research into self-concept has attracted considerable attention (Green, Nelson, Martin & Marsh, 2006). Self-concept is a person's combined view of one's self (Doherty, 2011). In other words, self-concepts are cognitive structures that can include content, attitudes or evaluative judgment and are used to make sense of the world; focus attention on one's goals and protect one's sense of basic worth. It is self-concept that gives rise to possible selves, and it is possible selves that create the motivation for behavior" (Yahaya & Ramli, 2009). There is no shortage of ways to define self-concept. Perhaps, the simplest one is found in Longman Dictionary of Language Teaching & Applied Linguistics, which says that self-concept is the image a person has of himself or herself. A measure of a person's self-concept sometimes is included in the study of affective variables (Jing, 2007).

The main factors determining the formation of the self-concept of an individual are the environment, the people with whom the individual lives and the one who plays a very crucial role in the mould of the self-concept. The term describes a given individual in terms of various personality traits and when these traits are consistently applied, the

person often accepts them as descriptions of him or her (Kimani, Cheboswony, Kodero & Misigo, 2009). It is important to note that self-concept is not restricted to the present. It includes "past selves" and "future selves". Future selves or possible selves represent individuals' ideas of what they might become. Possible selves may function as incentives for future behavior and they also provide an evaluative and interpretative context for current view of self (Adetoro, 2011).

The self-concept of different people across life endeavors has been found to impact on their behaviour (Adetoro, 2011). There are several different components of self-concept: physical, academic, social and transpersonal. The physical aspect of self-concept relates to that which is concrete; what we look like; what kind of car we drive and so forth. Academic self-concept relates to how well we do in school or how well we learn. There are two levels: a general academic self-concept of how good we are overall and a set of specific content-related self-concepts that describe how good we are in Mathematics, Science, Language arts and Social science. Social self-concept describes how we relate with other people, while transpersonal self-concept describes how we relate with the supernatural or unknown (Beheshtifar & Rahimi-Nezhad, 2012; Yahaya & Ramli, 2009).

Social Support

Social support is broadly defined as the resources provided by other persons and can be conceptualized as the function of one's network. Social support is considered as one of the mechanisms through which social networks affect health. Social support is not a uni-dimensional fixed set of resources, rather it is situation-issue and context-specific (McDowell, 2006). There is a need to operationally define the concept of social support in a way that adheres to meanings prescribed by people with direct experience of the phenomena. Social support is increasingly identified as helping people adjust to a stressful life. However, despite the large amount of empirical research on such support conducted in health care in the last 20 years, the findings remain inconsistent. This inconsistency can be attributed to the use of different measures and different operational definitions of the term "social support" from one study to another (Nausheen, Gidron, Peveler & Moss-Morris, 2009).

Finfgeld-Connett (2005) conducted a study to clarify the concept of social support, by using findings from three linguistic concept analyses and 44 qualitative studies. The concept analyses revealed that a common way for nurses to view social support is as emotional and instrumental support. Emotional support consists of comforting behaviour, which is intended to alleviate uncertainty, anxiety, hopelessness and depression. Instrumental support consists of providing tangible goods and services such as transportation and assistance with household tasks. Another way of defining social support, commonly used outside of the caring context, is to make a distinction between structural and functional support. Structural support implies a network of interpersonal relationships, involving relatives, friends and co-workers, through which the person is attached to his or her community. Functional support is usually described in terms of the

provision of information, tangible support and emotional support (Nausheen, Gidron, Peveler & Moss-Morris, 2009).

Besides inconsistencies in descriptions of social support, the similarities between caring and social support can also be confusing in literature. Caring and social support have comparable attributes and both concepts are characterised as dynamic interpersonal processes directed towards improved mental well-being. In contrast, physical well-being is commonly only an outcome of caring when social support is connected mainly with the non-professional area (Finfgeld-Connett, 2007). A support network can be a resource for family members in a time of crisis (Madsen & Poulsen, 2011). There is a need for further research regarding the presence of social support networks for the families of persons in the early stage of treatment for advanced lung or gastrointestinal cancer. Such research will contribute to a better understanding of the family members' need for support in a drastically changing life situation. There is at the same time a need to investigate what the term "social support" is taken to imply.

Despite ubiquitous use of the term by both lay people and professionals, there is still a lack of clarity about its meaning, and social support is easily confused with, for instance, caring (Finfgeld-Connett, 2005).

An additional aim is to validate the study's empirical findings by means of the Finfgeld-Connett conceptual model for social support. The intention is to investigate whether these findings are in accordance with previous research in nursing. The term "family" is taken to include more than just biological relatives or people related by marriage, as it also refers to people identified by the patients as playing a key role in their lives (Sjolander, Rolander, Järhult, Mårtensson & Ahlstrom, 2012).

Peer Influence

Adolescence is a time when peers play an increasingly important role in the lives of youth. Teens begin to develop friendships that are more intimate, exclusive and more constant than in earlier years. In many ways, these friendships are essential components of development. They provide safe venues where youth can explore their identities, where they can feel accepted and where they can develop a sense of belonging. Friendships also allow youth to practice and foster social skills necessary for future success. Nevertheless, parents and other adults can become concerned when they see their teens becoming preoccupied with their friends. Many parents worry that their teens might fall under negative peer influence or reject their families' values and beliefs, as well as be pressured to engage in high-risk and other negative behaviour (Brown & Klute, 2006).

In actuality, peer influence is more complex than the stereotype of the negative influences from friends. First, peer influence can be both positive and negative. While we tend to think that peer influence leads teens to engage in unhealthy and unsafe behaviors, it can actually motivate youth to study harder in school; volunteer for community and social services and participate in sports and other productive endeavors. In fact, most teens report that their peers pressure them not to engage in drug use and sexual activity. Also, peer influence is not a simple process where youth are passive recipients of influence from others. In fact, peers who become friends tend to already have a lot of things in common. Peers with similar interests, similar academic standing and enjoy doing the same things tend to be intimate with each other. So, while it seems that teens and their friends become very similar to one another through peer influence, much of these similarities were present to begin with (Brown & Klute, 2006).

Previous research has found evidence for the importance of peer relations in a variety of areas of adolescent functioning. Allen, Porter, McFarland, Marsh, and

McElhaney (2005) reports that adolescents who are well-liked by many peers display higher levels of ego development and secure attachment, as well as have better interactions with their mothers and best friends (p.747). Popularity is also linked to "minor levels of…delinquency" (p. 747), but less hostile behaviour towards peers (Allen et al., 2005, p.757). Furthermore, adolescents' susceptibility to peer pressure from their close friends predicts future responses to negative peer pressure; decreases popularity and increases depressive symptoms. Susceptible teens also rate themselves as less competent in their close friendships (Allen, Porter, & McFarland, 2006). Peer pressure susceptibility is also cross-sectionally correlated with deviant behavior and substance use, especially if a close friend experimentss such (Allen et al., 2006). In addition, attachment style influences the link between friendship and negative outcomes. Non-dismissing attachment style has been found to moderate the link between general friendship quality and a teen's delinquency (McElhaney, Immele, Smith, & Allen, 2006).

Peer support or social interactions effects refers to externalities in which the actions or characteristics of a reference group affect an individual's behaviour. Such effects are possible in a huge variety of social contexts with recent studies exploring areas, including educational performance and criminal behaviour (Pattachini & Zenou, 2008). Adolescent peer groups provide support as teens assimilate into adulthood. Major changes include: decreasing dependence on parents, increasing feelings of self-sufficiency and connecting with a much larger social network. Adolescents are expanding their perspective beyond the family and learning how to negotiate relationships with others in different parts of the social system (Steinberg, 2010). Peers, particularly group members, become important social referents. Peer groups also influence individual members' attitudes and behaviour on many cultural and social issues, such as: drug use, violence and

academic achievement and even the development and expression of prejudice (Aboud, 2005).

Peer groups provide an influential social setting in which group norms are developed and enforced through socialization processes that promote in-group similarity. Peer groups' cohesion is determined and maintained by such factors as: group communication, group consensus and group conformity concerning attitude and behavior. As members of peer groups interconnect and agree on what defines them as a group, a normative code arises. This normative code can become very rigid, such as when deciding on group behavior and clothing attire (Aboud, 2005). Peer support can help individuals form their own identity. Identity formation is a developmental process where a person acquires a sense of self. One of the major factors that influence the formation of a person's identity is his or her peers. Studies show that peers provide normative regulation, and they provide a staging ground for the practice of social behaviours. These allow individuals to experiment with roles and discover their identities. Identity formation process is an important role in an individual's development. Erik Erikson emphasizes the importance of identity formation, and he illustrates the steps one takes in developing his or her sense of self. He believes this process occurs throughout one's entire life (Friedman, 2011).

Family Support

Family support is a relationship-focused principle that strengthens the ever-evolving journey of family members. One of the primary functions of the family is to produce and reproduce persons, biologically and/or socially. This can occur through the sharing of material substances such as: semen and food; the giving and receiving of care and nurture; natural ties of rights and obligations and moral and sentimental ties. Thus, one's experience of one's family shifts over time. From the perspective of children, the

family is a "family of orientation"; the family serves to locate children socially and plays a major role in their enculturation and socialization (Dunst & Trivette, 2005).

Families are perhaps the most critical component of an early childhood system dedicated to promoting optimal development for young children. Even before the first day of life, families set the stage for babies' development, beginning with accessing pre-natal care and promoting healthy pregnancies. Families are primarily responsible for ensuring that their young children receive adequate food, shelter, medical attention, nurturing relationships at home and the full measure of opportunities for social, emotional and cognitive development that shape the children's eventual success in school and in life (Dunst & Trivette, 2005).

Family support is often the term used to define the practices that ensure the holistic nature of the process, for families are sustained through the timelines and varying entities that they encounter. The definition for individual families of what has supported them through the process is unique to each family. The distinctive nature of families' configuration, cultural considerations, beliefs, values, emotional reactions, coping styles, family dynamics and other issues play a role on how effective a family will be able to navigate its system.. Family support comes from a wide variety of sources. Thus, families require different types of support based on their unique needs. This process takes time and involves many things including: mutual respect; honesty, clear communication, understanding and empathy. Professionals who develop active listening skills help to create positive connections with families (Jackson, 2009).

The goal of family support as a factor in family integration helps to ensure that families' members are been able to meet their needs and overcome stressors that impair effective quality of life. By helping family members to provide a nurturing environment, family support plays a critical role in fostering the healthy development of family

members. Additionally, family support is seen as a crucial early intervention strategy for children who are at risk or those with special needs. The concept of family support while initially encompassing only income support has evolved over time to include a more comprehensive and often integrated set of care (Thompson, Uyeda, Wright & Halfon, 2005).

Socioeconomic Status (SES)

Socioeconomic status (SES) is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education and occupation. When analyzing a family's SES, the household income, earners' education and occupation are examined, as well as combined income, versus with an individual when their own attributes are assessed. Socioeconomic status is typically broken into three categories: high SES, middle SES, and low SES to describe the three areas a family or an individual may fall into. When placing a family or individual into one of these categories any or all of the three variables (income, education and occupation) can be assessed. Additionally, low income and little education have shown to be strong predictors of a range of physical and mental health problems. Low income families focus on meeting immediate needs and do not accumulate wealth that could be passed on to future generations, thus increasing inequality. Families with higher and expendable income can accumulate wealth and focus on meeting immediate needs while being able to consume and enjoy luxuries and weather crises (Boushey & Weller, 2005).

Education plays a major role in skill sets for acquiring jobs, as well as specific qualities that stratify people with higher SES from lower SES. Research shows that lower SES students have lower and slower academic achievement as compared with students of

higher SES (American Psychological Assoication 2012). When teachers make judgment about students based on their class and SES, they are taking the first step in preventing students from having an equal opportunity for academic achievement. Educators need to help overcome the stigma of poverty. A student of low SES and low self-esteem should not be reinforced by educators. Teachers need to view students as individuals and not as a member of an SES group. Teachers looking at students in this manner will help them to not be prejudiced towards students of certain SES groups. Raising the level of instruction can help to create equality in student achievement. Teachers relating the content taught to students' prior knowledge and relating it to real world experiences can improve achievement (Gollnick, 2013).

Occupational prestige as one component of SES, encompasses both income and educational attainment. Occupational status reflects the educational attainment required to obtain job and income levels that vary with different jobs and within ranks of occupations. Additionally, it shows achievement in skills required for the job. Occupational status measures social position by describing job characteristics; decision making ability and control and psychological demands on the job (Scott & Leonhardt, 2005). Occupations are ranked by the census (among other organizations) and opinion polls from the general population are surveyed. Some of the most prestigious occupations are physicians, surgeons, lawyers, chemical and biomedical engineers and communications analysts. These jobs considered to be grouped in the high SES classification provide more challenging work and greater control over working conditions, but require more ability. The jobs with lower rankings include: food preparation workers, counter attendants, bartenders and helpers, dishwashers, janitors, maids and housekeepers, vehicle cleaners, and parking lot attendants. The jobs that are less valued also offer significantly lower

wages and often are more laborious, very hazardous and provide less autonomy (Scott & Leonhardt, 2005).

Occupation is the most difficult factor to measure, because so many exist and there are so many competing scales. Many scales rank occupations based on the level of skill involved, from unskilled to skilled, and from manual labour to professional, or they employ a combined measure, using the education level needed and income involved. Thus, majority of researchers agree that income, education and occupation together best represent SES, while some others feel that changes in family structure should also be considered. With the definition of SES more clearly defined, it is now important to discuss the effects of SES on students' cognitive abilities and academic success. Several researchers have found that SES affects students' abilities (Milne & Plourde, 2006).

SES is measured based on out of pocket expenses for prescription medications (Manitoba has an income based deductible for the provincial Pharmacare programme) and median neighbourhood income quintile (from Statistics Canada census files). Prescription drug users are divided into three groups, as follows: Lower income: individuals in the lowest and second lowest median neighbourhood income quintile; Higher income: individuals residing in the neighbourhoods with the three highest median neighbourhood income quintiles; and Income unknown: individuals who cannot be assigned a neighbourhood income from the census data. This category includes individuals residing in facilities such as personal care homes, psychiatric facilities, prison or wards of the public trustee and child and family services (Raymond, Metge, Alessi-Severini, Dahl, Schultz & Guenette 2010).

Theoretical Framework

The Health Belief Model

The Health Belief Model (HBM), a well-tested, comprehensive social cognitive framework by Rosenstock (1974) was one of the first models used to predict and explain variations in contraceptive behavior among women in the 1970s and 1980s (Eisen, Zellman & McAlister 1992). HBM has seldom been applied in family planning. In a recent review of 14 studies testing theory-based contraceptive behaviour interventions, none was found to use the HBM (Lopez, Tolley, Grimes & Chen-Mok 2009).

Theory-driven strategies to prevent unintended pregnancy are currently needed. Along with decades of research on unintended pregnancy prevention, knowledge about poor contraceptive behaviour has evolved. People are more aware of the complexities of contraceptive behaviour, which may support enhanced application of the HBM to help identify and predict factors that influence successful contraception in current population and settings. The purpose of this conceptual and integrated review is to examine the suitability of the HBM as a framework for explaining and predicting modern contraceptive behaviour (Lopez, Tolley, Grimes & Chen-Mok 2009). The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt the behaviour.

The HBM derives from psychological and behavioural theories with the foundation that the two components of health-related behaviour are: 1) the desire to avoid illness, or conversely get well if already ill; 2) the belief that a specific health action will prevent or cure illness. Ultimately, an individual's course of action often depends on the person's perception of the benefits and barriers related to health behaviour. There are six

constructs of the HBM. The first four constructs were developed as the original tenets of the HBM (Abraham & Sheeran 2005):

1. Perceived Susceptibility - This refers to a person's subjective perception of the risk of acquiring an illness or disease. There is a wide variation in a person's feelings of personal vulnerability to an illness or disease.
2. Perceived Severity - This refers to a person's feelings on the seriousness of contracting an illness or disease or leaving the illness or disease untreated. There is wide variation in a person's feelings of severity, and often, a person considers the medical consequences (eg, death, disability) and social consequences (eg, family life, social relationships) when evaluating the severity.
3. Perceived Benefits - This refers to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease or to cure illness or disease. The course of action a person takes in preventing or curing illness or disease relies on the consideration and evaluation of both perceived susceptibility and perceived benefit, such that the person will accept the recommended health action if it is perceived as beneficial.
4. Perceived Barriers - This refers to a person's feelings on the obstacles to perform a recommended health action. There is a wide variation in a person's feelings of barriers or impediments, which lead to a cost or benefit analysis. The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous (eg, side effects), unpleasant (eg, painful), time-consuming or inconvenient.
5. Cue to Action - This is the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal (eg, chest

pain, wheezing, etc.) or external (eg, advice from others; illness of family members, newspaper article etc.).

6. Self-efficacy - This refers to the level of a person's confidence in his or her ability to successfully perform a behavior. This construct was added to the model most recently in mid-1980. Self-efficacy is a construct in many behavioural theories, as it directly relates to whether a person performs the desired behaviour.

Over time, the model has been expanded to include other factors such as the inclusion of self-efficacy. This concept asserts that whether or not people undertake a task or health behaviour, their judgment will depend on their own ability to organise and execute the actions or steps required to complete the task. Connor and Norman (2005) believe that self-efficacy would provide a more powerful approach in understanding health-related behaviour. According to Abraham and Sheeran (2005), a number of studies have tested the predictive utility of including self-efficacy in the HBM, and generally confirm that 'self-efficacy is a useful additional predictor'.

A number of uses have been outlined for the HBM. According to Abraham and Sheeran (2005), there are numbers of studies prior to the early 1970s which indicate that the key health beliefs underlying the threat and behavioural evaluations provide a useful framework for understanding individual differences in health behaviour and for designing interventions to change behaviour (Abraham & Sheeran 2005).

Social Learning Theory

The social learning theory emphasizes the importance of observing and modelling the behaviour, attitudes and emotional reactions of others. It focuses on learning by observation and modelling. The theory originally evolved from behaviourism, but now includes many of the ideas that cognitivists also hold; as a result, it is sometimes called

social cognitive learning**.** Thus, social learning theory talks about how both environmental and cognitive factors interact to influence human learning and behaviour. It focuses on the learning that occurs within a social context**.** It considers that people learn from one another, including such concepts as observational learning, imitation and modelling (Bandura 2007).

Learning theories attempt to explain how people think and what factors determine their behaviour. Social Learning Theory (SLT) is a category of learning theories which is grounded in the belief that human behaviour is determined by a three-way relationship between cognitive factors, environmental influences and behaviour. In the words of its main architect, Albert Bandura, social learning theory approaches the explanation of human behaviour in terms of a continuous reciprocal interaction between cognitive, behavioural and environmental determinants (Bandura, 1977).

The social learning theory according to Bandura (1977) emphasizes the importance of observing and modelling the behaviour, attitudes and emotional reactions of others. Bandura (1977) states: "Learning would be exceedingly laborious, not to mention hazardous, if people have to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour are learnt observationally through modelling; from observing others, one forms an idea of how new behaviour is to be performed, and on later occasions this coded information serves as a guide for action." (p22). Social learning theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural, an environmental influences. The component processes underlying observational learning are: (1) Attention, including modelled events (distinctiveness, affective valence, complexity, prevalence, functional value) and observer characteristics (sensory capacities, arousal level, perceptual set; past reinforcement); (2) Retention, including symbolic coding; cognitive organization; symbolic rehearsal; motor

rehearsal); (3) Motor Reproduction including: physical capabilities; self-observation of reproduction; accuracy of feedback and (4) Motivation, including external, vicarious and self-reinforcement (Bandura 2007).

SLT is a valuable and effective tool for health educators who want to assist their students in gaining new health supporting skills. SLT can help educators determine why certain learning activities work, and why other activities aren't very effective. Many health educators feel that SLT is consistent with their own experience and "hunches" of what works in prevention programmes. But SLT has more than "hunches" to back up its efficacy. Many prevention programmes based on SLT and other theories have undergone rigorous research-based evaluations to determine if they have been effective in positively changing health behaviour (Bandura 2007).

Social learning theorists share many assumptions with behaviourists, particularly the belief that people are shaped in fundamental ways by their environment through learning processes. Social learning theorists also acknowledge that classical and operant conditioning are important influence on human behaviour. However, they add to these learning processes a third observational learning. They believe people learn by observing others and therefore that other people (the social environment) are particularly important as an influence on behaviour. With the emphasis on observational learning comes a belief that it is impossible to explain human behaviour without considering the role of internal; mental processes in human behaviour; something that behaviourists reject (Bandura 2007).

Observational learning involves a number of cognitive and behavioural processes. In order to learn the behaviour of another, the person must first pay attention to what the other person (calls a model) is doing. They must then encode and form a memory of the behaviour the model performs. At a later time, this memory must be translated back into behavior, so that the observer may imitate it. In order to imitate the behaviour effectively,

the observer may need to practise it. Whether or not the observer actually makes use of the behaviour they have learnt, depends on whether they are motivated to do so. The observer's motivation may be affected by several factors, principally, if they believe that reinforcement is available if they imitate. Their beliefs may be influenced by the consequences of their past behaviour (as in behaviourism), but also by the observed consequences of the model's behaviour. If the model is observed to be reinforced for their actions, then imitation becomes more likely, assuming that the observer values the reinforcer that the model is observed to get (Bandura 2007).

Conversely, if the model is observed to be punished, then imitation becomes less likely (these processes are called vicarious reinforcement and punishment). A number of factors besides reinforcement and punishment influence whether a particular person is likely to be selected as a model and imitated. Models are more likely to be imitated if the observesr perceive them to be similar to themselves. Imitation is also more likely when the model has high status and is attractive and when the observer has low self-esteem. Social learning theorists share with behaviourists a commitment to the scientific method. They favour objective, quantitative approaches to research and use the experimental method if possible. Unlike behaviourists, they do not study animal learning. They conduct research in any context in which learning occurs, particularly favouring research using children, whose behaviour is more obviously influenced by the people around them than adults' (although adults also learn through observation). Social learning research therefore may include observation of children and adults in school and family settings. However, the laboratory setting is favoured by many researchers because of the opportunities it gives to isolate and examine the causal effects of different influences on observational learning (Bandura 2007).

This research work is anchored on Rosenstock (1974) Health Belief Model. This model helps explain why individual patients may accept or reject preventative health services or adopt healthy behaviours. Social psychologists originally developed the Health Belief Model to predict the likelihood of a person taking recommended preventative health action and to understand a person's motivation and decision-making about seeking health services. The Health Belief Model proposes that people will respond best to messages about health promotion or disease prevention when the following four conditions for change exist: the person believes that he or she is at risk of developing a specific condition; the person believes that the risk is serious and the consequences of developing the condition are undesirable; the person believes that the risk will be reduced by a specific behaviour change and the person believes that barriers to the behavioural change can be overcome and managed. Therefore, knowing what aspect of the Health Belief Model patients accept or reject can help one design appropriate interventions. For example, if a patient is unaware of his or her risk factors for one or more diseases, one can direct teaching towards informing the patient about personal risk factors. If the patient is aware of the risk, but feels that the behavioural change is overwhelming or unachievable, one can focus one's teaching efforts on helping the patient overcome the perceived barriers.

Review of Empirical Studies

Psychological Adjustment and Teenage Mother Stigmatization

Though many studies have shown that teen-childbearing is statistically associated with mental morbidity in early adulthood, theories put forth to explain that these findings vary considerably (Schmidt & Wiemann, 2006). Steinberg (2008) reports that the adverse

outcomes of teen childbearing are related to adolescent specific brain maturation processes that predispose youth to risky behaviours (eg unprotected sex) and that account for their neurological and cognitive inability to cope with parenting demands. Thus, stigmatisation is more likely to occur where teen childbearing is widely regarded to be a violation of socially sanctioned norms that have been created through: (1) the age-based institutionalisation of life-cycle from the completion of education to full psychological maturation and to financial independence, and only then to marriage and parenthood (Mollborn & Morningstar, 2009; Whitley & Kirmayer, 2008); (2) the rapid production of scientific knowledge on what it means to violate life-transition norms and to be at risk of violating them and how such violations and potential violations should be treated and prevented. In societies where this institutionalisation is inequitable, individuals experience a chasm between their reality and the ideal espoused and a difference that has a considerable detrimental effect on well-being (Wilkinson & Pickett, 2009).

Kramer and Lancaster (2010) find that in cultural settings where young motherhood is an expected social norm that occurs within the context of avowal from society as a whole, teen motherhood is a largely unproblematic experience that does not lead to any health squeal. However, Dressler and Balieiro (2007) posit that in settings where institutions posit teen childbearing as a key constraint to economic and personal well-being and where teen pregnancy has become a potent symbol of immaturity and developmental deviance, the experience itself is more likely to have negative psychological, biological and social effects. These dynamics are likely to be exacerbated when individuals feel the pressures of and strive to comply with normative values. So strong are these stigmatizing pressures that some marginalised communities in the US have developed protective responses by nurturing a secluded pre-natalist minority culture

much like the women in our study who eventually opted to withdraw from normative society altogether.

Esparza (2006) in examining the incidence and effects of stigmatization on the life experience, adjustment and personality characteristics of teenage mothers who are Mexican American and African American, reveals that forty-four percent of the respondents are reported experiencing stigmatization from parents, peers, religious centers and community. Also in another study, Esparza (2006) reports that teenage mothers experiencing stigmatization adjust poorly in the society than those that are not being stigmatized. These findings suggest that stigmatization may be related to vulnerability for teenage motherhoods to be experiencing psychological stress and dysfunction in the society. Along this projection, Logsdon and Davis (2003) report that stigmatization experienced by teenage mothers affect their self-concept negatively especially when teenage mothers do not have dependable social support network. Clements (2003) notes as well that relationship between teenage mothers and their own mothers, fathers of the newborn or peers can negatively influence teenage mothers' self-concept. If the relationship with their own mothers is not positive and their peers no longer provide them with needed support, teenage mothers will often seek support from the fathers of the newborns, only to find them neither dependable nor reliable (Gee & Rhodes, 2003).

In the same vein, Gold and Jones (2005) empirical research consistently show a strong correlation between teenage motherhood and many social negative outcomes. They express that whether these correlations are actually causal, remains unclear. However, a large literature on the consequences of teen childbearing seeks to unpack these concerns. A central problem in this research is to separate the effects of individual, family and community characteristics from those of early childbearing itself. The factors that lead some teenage girls to bear children may have some disadvantages on the children and have

negative effects on them fundamentally, economically and educationally. More subtly, early childbearing is likely to have different effects on different outcomes, and if teen parenting causes social hardship, childhood outcomes that are especially sensitive to social relationship will show strongest effects. If, however, the dominant impact of early childbearing is on parenting skills and behaviours, one might observe its large effects on childhood outcomes that are especially sensitive to parenting skill.

Psychological Adjustment and Teenage Mother Sexual Debut

There is a long tradition of research examining the relationships between education, teenage sexual initiation and childbearing in developing countries (Lloyd, 2005) and research has typically found adolescent school enrollment and schooling to be negatively associated with the probability of sexual initiation and early childbearing (Lloyd & Mensch, 2008). Evidence reports in the National Academy of Sciences on transitions to adulthood in developing countries that adolescent girls attending school are half as likely as their unmarried peers who are out of school to have ever had sex (Lloyd, 2005). One explanation of this association is that success in negotiating sexual initiation and parenthood is more likely to be ensured if other transitions occur prior to sexual debut and parenthood. There has also been empirical evidence in Sub-Saharan Africa showing that girls appear vulnerable to dropping out of school once they become sexually mature and engage in premarital sex (Biddlecom, Gregory, Mensch & Lloyd, 2006).

Early sexual debut of adolescents has been viewed as problem behaviour alongside behaviour such as: drug use, being a fugitive, stealing, vandalism and school failure or drop out. Although, research has illustrated an association between early sexual intercourse and negative psychosocial factors (Kirby, Lepore, & Ryan, 2005). Armour and Haynie (2007) utilize a longitudinal design to examine the direction of the relationship

between early intercourse and delinquency. They find early sexual intercourse to be associated with delinquency one year later (Armour & Haynie, 2007).

Early sexual debut has been linked with a number of detrimental health consequences. Young age of first sexual intercourse is correlated with unintended pregnancy due to reduced use of contraception (Raine, Minnis & Padian, 2003). Therefore, early initiation of sexual intercourse has long been an area of interest to developmental psychologists, health and sex researchers. Evidence suggests that the timing of sexual intercourse and sequences of sexual trajectories (eg, pace and sequence at which adolescents progress from less intimate to more intimate behaviour) are related to health outcomes (de Graaf, Vanwesenbeeck, Meijer, Woertman, & Meeus, 2009). Research focusing on U.S. samples has found evidence of a relationship between sexual intercourse during early adolescence (commonly defined as before age 16) and future problem behaviour (Woodward, Fergusson, & Horwood, 2001).

More recently, there has been a few studies linking education to sexual and reproductive behaviour in developing countries considering both the timing of events and additional variables characterizing the educational process. These studies focus on how experiences with school are related to adolescent reproductive outcomes. Lloyd and Mensch (2008) find that adolescents with slower school progress in four West African countries have higher probability of a teen birth. Using information from the South African province of KwaZulu-Natal, Grant and Hallman (2006) find that prior school progress measured by temporary school withdrawal and grade repetition are significant predictors of both the likelihood of pregnancy and dropping out of school after pregnancy. Similarly, Marteleto, Lam, & Ranchhod (2006) find that having repeated a high proportion of grades prior to the start of the reproductive years is associated with teen childbearing as well as with a smaller probability of returning to school after birth.

Psychological Adjustment and Teenage Mother Depression

Teenage maternal distress is an important concern for researchers, because it has been linked to problematic outcomes for teenage mothers, including repeated pregnancies; low parenting competency and poor educational outcomes (Eshbaugh 2006). In addition, teenage maternal distress has detrimental effects on children's outcomes, including: language development; coping skills; social adjustment and physical health (Sills, Shetterly, Xu, Magid & Kempe 2007). The prevalence and severity of teenage mothers' distress have spawned a considerable research enterprise examining its correlation and effects on teenage mothers' psychological adjustment to life (Brown, Woods, Buman, Harris & Cox 2007; Eshbaugh, 2006). Thus, teenage mothers' psychological distress levels have been found to be high in samples of varying sizes (Schmidt, Weimann, Rickert & Smith, 2006).

Past research on teenage mothers and depression has frequently presented information specific to teenage mothers without introducing comparisons with other groups such as: adult mothers and non-pregnant teens (Eshbaugh 2006; Schmidt, et, al. 2006). However, Falci and Mortimer (2007) find that teenage mothers have higher levels of depression than other young women who have children later if at all. Also, postpartum depression (PPD) and its associated mood swings have been shown to present an incapacitating mental struggle for a new mother. The symptoms of PPD usually begin within one month postpartum and can last up to one year (Abrams & Curran, 2007), and the incidence of PPD is higher among adolescents than among adult women (47 percent as compared to 28 percent) (Logsdon, Birkimer, Simpson & Looney, 2005).

According to Abrams and Curran, (2007) the symptoms of PPD are feelings of worthlessness, sadness and uncontrollable crying, as well as fatigue, changes in appetite; and sleep problems. Research on utilization of mental health services find that depression

is prevalent in adolescent mothers, but they are least likely to report symptoms to doctors or health professionals (Kahan, 2010). In a review by Reid and Meadows-Oliver (2007) that integrates 12 research-based articles, their results show that increased family conflict; fewer social supports and low self-esteem all contribute to PPD in teenage mothers. Depression for teenage mothers can last well into the child's toddler years. One study identifies adolescent mothers at a higher risk for depression at 36 months after the delivery of their babies, and also finds a relationship between ethnicity and depression (Kahan 2010; Eshbaugh, 2007).

As cited in Kahan (2010) the multi-site National Early Head Start Research and Evaluation Project use three scales: the Pearlin Mastery scale, the Knowledge of Infant Development Inventory (KIDI) and the Parenting Stress Index scale to investigate predictors of depression in three specific ethnic groups. The sample is comprised of 278 African-American, 206 European-American and 122 Hispanic teen mothers. The findings indicate that mothers who show signs of parenting–related stress at 14 months are likely to show depression at 36 months. This study also finds that at three years of age there are ethnic differences in depression with research showing increased depression among European-Americans, but notes that significant resilience is found in particular, in Hispanic teen mothers. Eshbaugh (2007) notes several weaknesses in this study, including that psychometric information is limited due to a slight modification of measurement instruments, and that there is an exclusion of teen mothers from many other ethnic groups.

Stress factors in the adolescent mothers'environment are found to sometimes affect their preparedness to becoming parents and are also compounded, as teen mothers begin to face the reality of the huge responsibility of raising their children (Holub, Kershaw, Ethier, Lewis, Milan & Ickovics, 2007). Crises that thrive because of developmental delays, both in the young mother and the baby could be further compounded by the lack of cognitive

readiness to parent a child (Reid & Meadows-Oliver, 2007). In a study, Holub et al. (2007) measures the effects of adolescent pre-natal stress and parenting stress on the maternal adjustment and the emotions of the mother, it shows that both high pre-natal and post-natal stress in adolescent mothers could result in less time spent in caring for their infant, suggesting the need for health services that target this group. . Adolescent girls are at risk to experience violence during pregnancy in the form of sexual, emotional or physical abuse, such as being hit by their boyfriends or being forced to have sex. Maladjustment stemming from the domestic violence they have experienced can lead to the use of harsh parenting behaviour by adolescent mothers increasingly (Kahan 2010).

Furthermore, Kahan (2010) reports that two studies utilize the same data collected from 20 U.S. cities in a national, longitudinal study known as the Fragile Families and Child Well-Being (FFCW) study (Huang & Lee, 2008; Lee, 2009). Researchers used stratified random sampling between 1998 and 2000 with a final sample of 3087 mothers. In the first, a descriptive study measured the engagement activities and the use of spanking in teen mothers (Huang & Lee, 2008). The use of spanking was shown to be infrequent at first, but was more likely to increase as their children grew older and behaved badly.

The second study looked at the role of maternal human, social and cultural capital in the relationship between early motherhood and harsh parenting behaviour (Lee, 2009). Findings using multivariate analyses showed that young teen parenthood had a significant impact on the incidence of harsh parental violence towards their children. Both of these studies uncovered a complexity of factors associated with teenage parenting and suggested in their findings that the current welfare policy on marriage and work is lacking in its efforts to support good parenting (Huang & Lee, 2008; Lee, 2009). They recommended more social work and intervention programs in the schools in order to avoid or reduce the tendency for adolescents to resort to punishing their young children and urged that

practitioners become more informed about the importance of cultural factors and social capital on parenting behaviour (Huang & Lee, 2008; Lee, 2009).

Psychological Adjustment and Teenage Mother Self-Esteem

Teenage mothers may be particularly vulnerable to the psychosocial challenges of pregnancy because of developmental immaturity; low self-esteem and limited resources (Ickovics, Meade, Kershaw, Milan, Lewis & Ethier, 2006). Though, regardless of age or circumstance, parenting is a challenge. However, it is found that teenage mothers are faced with multiple obstacles to effective child rearing. Among these risk factors are higher levels of mental health disorders; low self-esteem,; lower levels of educational attainment; increased levels of economic disparities and employment difficulties (Boden, Fergusson & Horwood, 2008). Thus, teenage mothers are at high risk of developing mental health problems (ie, low self-esteem, depression and anxiety). Therefore, it is of note that mature and psychologically healthy parents develop a feeling of high self-esteem, competency or self-efficacy in their abilities to nurture their children. In general, teen mothers are at an increased risk of developing low self-esteem and depression due to multiple risk factors in their lives. These include: financial challenges, work and school obligations, and the integration of the potentially unexpected role as a mother along with other life roles (Birkeland, Thompson, & Phares, 2005).

Teenage mothers more often experience low self-esteem, and low self-esteem among teenage mothers lead to many problems while they suffer from lack of confidence and hopelessness. Self-esteem refers to self-worth, self-respect and how one regards or feels about oneself. Simply, it is an individual's feeling about various convictions of themselves as a capable and competent person who has worth. The symptoms of low self – esteem vary for every teenage mother. This corroborates Cox, Buman, Valenzuela, Joseph,

Mitchell and Woods' (2009) research report conducted in Nigeria on the effect of self-esteem on parent among teenage mothers attending a Teen Tot programme. They found that low self-esteem is associated with decreased maternal confidence in their ability to parent.

The report of NIHFW (2005) research reveals that teenage mothers due to the psychological trauma they experience are conditioned to suffer low self-esteem and inferior status. Self-esteem is also viewed both as a personal trait and a psychological state. People have a typical level of self-esteem that is consistent across time. Also, NIHFW (2005) report further reveals the fact that teenage mothers' self-esteem has negative correlation with their psychological well-being and adjustment to life challenges. The report emphasizes that as teenage mothers grow old, because of maturity in thinking and expanding experiences, they try to evaluate themselves in a rigid manner; the results are: a lower self-esteem; disturbed psychological state and poor adjustment to life. This also can be due to failure to fulfil their expectations in life.

Harter (2006) explains how self-esteem coupled with other factors might be involved in teenage mothers' sense of worthlessness and suicide. In one recent study, high narcissism; low empathy and being sensitive to rejection combined with low-esteem are linked to teenage mothers' violent thoughts (Harter & McCarley, 2004). In another study, teenage mothers who are engaged in violent thinking show: fluctuating self-esteem; have more conduct problems and have histories of humiliating events that threaten their egos (McCarley & Harter, 2004).

Psychological Adjustment and Teenage Mother Self-Concept

Children's Report Card, (2008) highlights the fact that teenage pregnancies impair teenagers' self-concept; interfere with their completion of high school and successful entry into the job market, both of which are pathways to economic self-sufficiency. The report further indicates that teenage pregnancy and parenting have been seen to be significant social problems that present substantial health, economic and societal impediments for families and communities. Also, Social Work Speaks, (2006) finds that with an impaired self-concept, teenage mothers are more likely to be unmarried and more likely to choose to deliver and bring up their children themselves, rather than give them up for adoption. Again, research shows that due to the development of low self-concept, most teenage mothers have been shown to go without early pre-natal care and suffer birth complications, such as premature labour and low infant birth weight (McKenzie, Pinger, & Kotecki, 2005).

Consequently, the development of low self-concept causes traumatic experience(s) in the lives of teenage mothers for which Zastrow and Kirst-Ashman, (2007) assert that the transition to motherhood affects teenage mothers mentally, emotionally and sometimes, physically, considering the fact that becoming mothers require self-sacrifice and the understanding that personal needs must often be put aside and identity formation marred. Therefore, in view of its negative impact on their self-concept formation, it is found that teenage mothers often feel isolated and vulnerable to conflict, distress and frustration (Reid & Meadows-Oliver, 2007). Thus, postpartum depression has been shown in studies to be prevalent for many teenage mothers (Reid & Meadows-Oliver, 2007), but teen mothers can also be at-risk for depression well into their infants' toddler years (Eshbaugh, 2007).

Saleebey (2006) reports that teenage mothers need to be cared for through beneficent relationships that revive their self-concept, hopes and dreams and build upon ability, assets and competencies in the face of adversity. Thus, teen childrearing has been linked with the development of low self-concept; long-term family poverty; school interruption and medical complications to mother and child (Klein, 2005). Also, several risk factors have been found to adversely contribute to the problems of teenage childbearing and affect low birth outcomes, examples of which include: growing up from poor or low-income families; being exposed to a harmful social environment and exhibiting high-risk behaviour involving substance abuse (East, Khoo & Reyes, 2006). With poor concept formation, teenage mothers have been found to be at a high risk for depression and are often unprepared for the stresses and tests that lie ahead (Eshbaugh, 2007).

Teenage motherhood is typically an experience that depletes the self-concept and self-esteem of teenagers in diverse cultural settings and this makes them to be at the receiving end, as it is found among them: higher rate of unstable marriages; feelings of isolation; stress, or guilt. In view of this, teenage pregnancy represents a big problem for the society and National Health System (NHS). One year medical cost of teenage pregnancy is estimated to be £63 million coupled with the social benefits for one teenage mother, which is between £19.000 and £25.000 during the first year (Teenage Pregnancy & Sexual Health Strategy, 2009). However, Harden Brunton, Fletcher and Oakley (2009) identify three main themes associated with early parenthood such as: dislike of school; unhappy childhood and poor material circumstances. Allen, Bonnell, Strange, Copas, Stephenson, Johnoson & Oakley (2007) support their conclusion by stating that 'easy communication with parents or guardians as well as education at school reduce risk of teenage pregnancy'.

Psychological Adjustment and Teenage Mother Social Support

Kaye (2008) posits that in many developing countries especially in sub-Saharan Africa, teenage pregnancy is readily identified as one of the pressing social and reproductive health issues. However, this perception is rarely translated into programmes of support that will effectively reach adolescents' needs. This may be due to lack of awareness of their specific needs. Thus, Kaye (2008) study's report shows that teenage pregnancy and parenthood may be socially accepted as a source of identity and status and may be prestigious to some teenagers. While they may be undesirable and strongly resented, but tolerated in some teenagers, they may markedly reduce the quality of life of some others affected. Kaye (2008) further asserts that healthcare providers and significant others need to recognize that pregnant adolescents and adolescent mothers have varying needs in order to provide them necessary support.

Teenage mothers with positive social support functioning tend to experience less identity confusion, whereas chaotic social support functioning appears to be mutually exclusive with identity confusion (Schwartz, Mason, Pantin & Szapoczik, 2009). As cited in VanDenBerg (2012) in one longitudinal study of mothers, 59% of women who are mothers of the age of 18 achieve no educational qualifications (ie, a high school or college diploma) at the age of 25 (Boden et al., 2008). Although, teen motherhood is stressful, greater developmental maturity and non-maternal support can serve as protective factors against negative effects (Kramer & Lancaster, 2010). Thus, McDonald et al. (2008) assert that social supports for teen mothers are related to their social and emotional well-being, including impulsivity and problem solving.

The role of social support in teen mothers' lives is often examined in relation to their sense of competence or self- efficacy. The majority of literature emphasizes the role of self-efficacy for typically aged mothers. Teen mothers lie outside what is considered

'normal parenthood' and thus often rely on two resources to which they have the most access: their families and own personal capacities for support (McDermott & Graham, 2005). Therefore, support rendered by mothers of teen mothers can play a significant role when the teen and child reside with them. Supports such as: housing, child care and parenting support are beneficial to them especially within the first 24 months of their child's life, and can improve the teen mothers' adjustment to parenting (Oberlander, Shebl, Magder & Black, 2009). However, the mother of a teen mother can be intrusive by acting as her grandchild's parent, resulting in the teen mother developing low parental self-efficacy (Culp, Culp, Noland, & Anderson, 2006).

When a teen mother has a less supportive relationship from her mother, the teen mother is more likely to leave the home, resulting in decreased financial and educational support and uncertainty for the future (Oberlander et al., 2009). Thus, teen mothers may face a situation where too little support from her own parents may compromise her competence as a parent and emerging adult, but too intrusive support may also undermine her autonomy and effective rearing. VanDenBerg (2012) contends that emotional support and social expectations are two aspects of social support. These types of support influence not only the teen mothers' mental health and parental competence (Ensor & Hughes, 2010); they might also be implicated in another process that is important to a teen mother's development and future orientation (Breen & McLean, 2010).

As revealed in VanDenBerg (2012), the quality of emotional support may influence the teen mothers' hopes for the future as well as their view of themselves as having a productive future (Beers & Hollo, 2009). In addition, social expectations may influence teen mothers' ability to see what their expected future will be in terms of possible selves (Oyserman & James, 2009). Research reveals that the development of teen mothers' future orientation is fostered by social support. This include family members,

peers and community members. Specifically, many teen mothers feel inspired by older female mentors who are able to achieve professional careers, despite having been teen mothers (Klaw, 2008).

Psychological Adjustment and Teenage Mother Peer Influence

Herrman (2008) finds that peer relationships play a key role in the social development of teenagers, but may be altered significantly in the context of pregnancy and motherhood. Thus, studies of new teenage mothers have noted an overall negative impact of parenting on the lives of adolescent teen mothers. Among other things, these mothers experience feelings of social stigma and loss of friendships. At the same time, however, teen mothers may experience increased support from peers, especially from those who are also pregnant or parenting. Herrman (2008) further asserts that quantitative data suggest that these relationships may also facilitate repeated teen pregnancy even though social support from teenage mothers' peers may provide psychosocial benefits. Also, in a study by Raneri and Wiemann (2007) they find as regards to peer relationships among teenage mothers that; some want to hold on to their past relationships and their social image among peers, while others accept the change in their peer interactions and even prefer to become more detached from potentially negative influences. However, some teenage mothers maintain relationships with peers who provide emotional and material support.

Likewise, Resnick, Blum, Bauman, Harris, Jones, Tabor, Beuhring, Sieving, Shew, Ireland, Bearinger and Udry (2007) find that peer influence and state of communication are strong predictors of early sexual debut and teenage pregnancy. They contend that sexual relationship and alcohol use are associated with higher rate of early sexual debut. Also, in their reviews of previous research highlight on the aspects of adolescents' friendships that are key influences to their sexual risk behaviour, they find out that friends'

sexual behaviours; adolescents' perceptions of friends' behaviour and level of involvement with friends are among the key determinants of sexual behaviour. The perceptions of gaining the respect and acceptance of friends and the curiosity of doing what others are doing can impair adolescent's good judgment and fuel risk taking behaviour. Moreover, alcohol consumption has been reported to diminish risk perception and judgment, causing not only to engage in sexual activities, but also other risky behaviour (Masatu, Kazaura, Ndeki & Mwampambe, 2009).

Thus, attachment to peers becomes increasingly important during the challenging experience of motherhood among teenagers (Smetana, Campione-Barr & Metzger, 2006), and some have argued that peer attachment figures become more influential than parent attachment figures during this time. While parents are found to influence adolescents' values and moral issues, adolescents' social behaviours are more influenced by their peers (Smetana et al., 2006). Peer influence has been found to strengthen the effects of peer beliefs about sex on adolescent sexual behaviour (Smetana et al., 2006). In relating with peers, (Steinberg & Morris, 2001) find that teenage mothers evaluate themselves along several distinct dimensions, and the emergent self-concepts and self-worth serve as important factors for positive development (Steinberg & Morris, 2001). For example, Williams, Connolly and Cribbie (2008) find that non support from peer has negative effect on the self-concept of teenage mothers. Also, teenage mothers due to isolation experience from peers have been found to express low self-worth (Crockett, Moilanen, Raffaelli, & Randall, 2006).

Dilworth (2000) also finds that teenage women who become pregnant and have children are frequently criticized by their peers and their pregnancies get blamed for causing adult poverty; welfare dependence and other social problems. Thus, this research supports the widespread belief that peers play an important role in adolescents' sexual

lives. Teenagers with sexually active friends are more likely to have sex themselves (Dilworth, 2000). In view of this assertion, Lee (2004) reports that even after being pressurized by peers into sexual act leading to pregnancy, friends abandon teen mothers; stigmatize them and let them live in a state of psychological frustration, stress and disillusionment.

Psychological Adjustment and Teenage Mother Family Support

For teenage mothers, family support is the most important element in their lives. As part of their growth experience, they usually expect a lot of things from their parents. Inadequate support from the parents will likely increase the chance of getting depression among teenage mothers who get into unfortunate situation with their parents. This occurs because they usually become confused when they expect to get plenty of help and positive reinforcement from their parents, but they do not happen (Stice, Ragan, & Randall, 2004).

Besides family support, peer support also is a very important factor for teenage mother's psychological adjustment. They tend to expect a lot from their friends. Peer support can be considered as an alternate method of getting social support if teenage mothers receive inadequate attention from their parents. This social support method is not as reliable as family support, because teenage mothers could easily withdraw from their own friends if they become depressed. Another problem arises in this area when depressed teenage mothers isolate themselves from public gatherings. This could prevent them from getting any social support at all (Stice et al., 2004). Receiving social support is very essential for them to become successful and achieve satisfactory level of emotional and psychological stability in life.

Baumrind in Berger (2005) states that the developmental experience of teenage mothers in their immediate family differs along the dimension of three parental child

rearing practices: authoritarian, authoritative and permissive parenting, which influence their psychological wellbeing and adjustment to motherhood challenges. Furthermore, Baumrind in Berger (2005) affirms that authoritarian parenting is not only a restrictive and punitive style that insists on rigid adherence to rules, respect for work and effort, it also lacks warmth. Parents use physical punishment for offenders to enforce obedience and emphasize the power of their roles as parents. Authoritarian parenting places firm limits and control over the teenage mothers and allows little verbal exchange. Consequently, teenage mothers from such homes acquire socially incompetent behaviours. Authoritative parenting is marked by parental warmth; use of rules and reasoning or induction to promote obedience and keep discipline. Such parents use verbal and non-physically punitive measures to correct a child than physical punishment; they are equally consistent in their words and actions over time. Authoritative parenting allows extensive verbal give-and- take with their teenage mothers. Thus, teenage mothers from such homes are self-reliant, socially responsible and have socially competent behaviour.

Baumrind in Berger (2005) further notes that permissive parents may be indifferent or indulgent to their teenage mothers. Permissive- indifferent parents exhibit inconsistency in their use of rules. They are generally uninvolved in the lives of their children who are teenage mothers. Permissive indifferent parenting develops in teenage mothers socially incompetent behaviour, especially lack of self-control. The permissive indulgent parents are highly involved with their children who are teenage mothers, but place few demands or control on them. The parents allow their children who are teenage mothers to do what they want and every request of the child is met by the parents who relate with them more like peers. This type of parenting can lead to socially incompetent behavior, such as lack of self-control. In this kind of family environment, teenage mothers could be self-indulgent; have few friends and never learn to abide by rules and regulations.

Psychological Adjustment and Teenage Mother Socioeconomic Status

Sociological researchers are often interested in psychological distress (often framed as depression) as both cause and effect of social phenomena. Extensive research focuses on the links between socioeconomic status (SES) and mental health to examine whether low SES causes depression or whether those who are depressed are more likely to end up with low SES. Thus, it is found that teenage mothers and their children, especially those living in impoverished and under-resourced communities are at increased risk of adjustment problems including psychological distress (Barrett & Turner, 2005) and behaviour problems (Simons, Chen, Simons, Brody, & Cutrona, 2006).

In the specific realm of research on teenage childbearing, acknowledgement of the bi-directional nature of the relationship between mental health and adolescent motherhood has been slower to blossom. Instead, studies of socioeconomic consequences of teenage childbearing have led the way on this issue. Selection bias has been a persistent concern in the research of socioeconomic effects on teenage parenthood, because many of the perceived problematic "consequences" of adolescent childbearing are largely functions of problems that plague these teens before they have children, increasing their likelihood of becoming young parents. Studies of teenage parents' socioeconomic outcomes are prominent examples for which research has worked to disentangle selection effects from teenage childbearing effects (Hotz, McElroy & Sanders 2005). Also, Frost and Driscoll (2006) find that socioeconomic status is a predictive predictor of teenage reproductive health outcomes among Latinas and lower socioeconomic status or position has been shown to be associated with earlier initiation of sexual intercourse and with adolescent pregnancy and childbirth among Blacks and Whites (Rose, Koo, Bhaskar, Anderson, White & Jenkins 2005) and that Latinas in the United States in general have lower levels

of education (US Census Bureau 2005) and other socioeconomic indicators than non-Latina Whites (US Census Bureau 2006).

Parental educational level is an important predictor of the children's educational and behavioural outcomes (Davis-Kean, 2005). The majority of research on the ways in which parental education shapes child outcomes has been conducted through cross-sectional correlational analyses or short-term longitudinal designs in which parents and children are tracked through the children's adolescent years. Furthermore, Davis Kean (2005) finds direct effects of parental education on European American children's standardized achievement scores, as he states that 'both parental education and income exert indirect effects on the parents' achievement-fostering behaviour, and subsequently, exert educational achievement on their childdren'.

In line with longitudinal studies spanning a shorter time frame (eg, into adolescence), it is found that parental education affects children's aspirations for their own education as well as their actual educational achievement through adolescence. Because of the long interval between childhood and adolescent assessments (age 8 and 19). (Davis-Kean, 2005) is unable to examine the proximal processes that might account for the effects of parental education on the child's developing aspirations and achievement. Other research (Davis-Kean, 2005) shows that parental education is linked to the parents providing a more stimulating physical, cognitive and emotional environment in the home, and more accurate beliefs about their children's actual achievement. These proximal processes likely affect the developing child's achievement-related aspirations and actual achievement behaviour.

Summary of Literature Review

The review of literature reveals that the transition to motherhood represents a major developmental milestone for all women, but could be particularly stressful for teenagers. This is because they might be struggling to negotiate their new maternal roles and responsibilities, coping with the physical, emotional and cognitive challenges of adolescence simultaneously. Teenage mothers could also face additional 'adversities' stemming from stigmatization, depression, low self-esteem; poor self-concept; poor parental and environmental social support, dejection and economic hardship arising from their new found mother status. Thus, the experience of teenage mothers could be complex. For example, the developmental changes associated with the teenage stage of life is characterized with immense psychobiological and social activities, which emphasizes that teenagers must master and maintain full functional capacity and regulations before transiting to the next stage of life and then be described as mature individuals.

However, sexual risk-taking behaviour and experimentation are somewhat expected outcomes of teenage mothers, as they strive to manage selves with the complex changes occurring at this stage of life, as it has been reported that they are usually unproportionately and unfairly over burdened with the consequences of this developmental process (Uwakwe, Falola, Adeyemo & Osiki, 2002). Thus, maternal psychological distress is an important concern for researchers because it has been linked to problematic outcomes for mothers, including repeated pregnancies; low parenting competency and poor educational outcomes (Eshbaugh, 2006; Holub, Kershaw, Ethier, Lewis, Milan & Ickovics 2007.). In addition, maternal distress has detrimental effects for children's outcomes, including language development; coping skills; social adjustment and physical health (Sills, Shetterly, Xu, Magid & Kempe, 2007). Also, teenage mothers' psychological distress levels have been found to be high in samples of varying size

(Schmidt, Weimann, Rickert & Smith, 2006), sometimes with more than half of teenage mothers meeting the criteria for clinical depression.

Research Hypotheses

The following hypotheses were tested at 0.05 margin of error.

1. There is no significant relationship between teenage mothers' stigmatization and their psychological adjustment to life.
2. There is no significant relationship between sexual debut experience of teenage mothers and their psychological adjustment to life.
3. There is no significant relationship between depression experienced by teenage mothers and their psychological adjustment to life.
4. There is no significant relationship between the self-esteem of teenage mothers and their psychological adjustment to life.
5. There is no significant relationship between the self-concept of teenage mothers and their psychological adjustment to life.
6. There is no significant relationship between social support experienced by teenage mothers and their psychological adjustment to life.
7. There is no significant relationship between the experience of peers support by teenage mothers and their psychological adjustment to life.
8. There is no significant relationship between the experience of family support by teenage mothers and their psychological adjustment to life.
9. There is no significant relationship between socio-economic status of teenage mothers and their psychological adjustment to life.

Research Questions

The following research questions were answered in the study:

1. What is the relationship between the independent variables (social support, sexual debut, peer support, parental support, socioeconomic status, family support, stigmatization, self-esteem, depression and self-concept) and the dependent variable (psychological adjustment of teenage mothers)?
2. What is the composite effect of the independent variables on psychological adjustment of teenage mothers?
3. What is the relative effect of each of the independent variables on the dependent variable (psychological adjustment of teenage mothers)?

CHAPTER THREE

METHODOLOGY

This chapter presents the methodology for this study under the following sub-headings: research design, population and sampling procedure; sampling procedure; research instruments,procedure for data collection and analysis.

RESEARCH DESIGN

This study adopted descriptive survey design of ex-post facto type. It is a type of design that the researcher usually has no control over the variables of interest being investigated and therefore cannot manipulate them. Usually, data were collected after the event or phenomenon under investigation has taken place. Hence, the name ex-post facto; Kerlinger and Lee (2000) defined ex-post facto as a systematic empirical inquiry in which the researcher does not have direct control of the independent variable because their manipulations have already occurred or because they are inherently not manipulable.

STUDY POPULATION

Out-of-school teenagers who are mothers from the Southwest states in Nigeria constituted the population of the study. Southwest states comprise Ekiti, Lagos, Ogun, Ondo, Osun and Oyo. There are about thirty thousand senior secondary schools in the six states with a population of about three hundred and fifty thousand. While it was difficult to ascertain the population of out-of-school mothers in the Southwest due to poor records and withdrawal from schools which is not always documented, the researcher relied on data obtained from state hospitals, clinics and government health centers in the six states.

SAMPLING PROCEDURE:

The purposive sampling technique was used to select forty-two local government areas (LGAs) across Lagos (8), Ondo (7), Oyo (7), Ogun (7), Osun (7) and Ekiti (6) where there is high prevalence of out-of-school teenage mothers. The participants were out-of-school teenage mothers attending postnatal and immunization programmes in local government health centres and state hospitals across the communities in the six states of South West Geographical region of Nigeria. Also, the purposive sampline technique was used to select the main health centres in each of the selected LGAsAbout one thousand two hundred and ninety-two (1,292) out-of-school teenage mothers attending post-natal clinic across the forty-two (42) health centers were purposively selected. The researcher and trained research assistants went to six states in South West Nigeria namely: Ekiti, Lagos, Ogun, Ondo, Osun and Oyo.

Due to financial constraints, selected local government areas were reached in each state. For instance, seven local government areas were visited in each state. Questionnaire was distributed to each of the out-of-school teenage mothers who attended postnatal clinic and immunization programmes through the help of the nurses, midwives and nurse assistants.

In Ekiti States, the seven local government areas visited were: Ado Ekiti, Efon Alaaye, Aramoko, Igede, Ikere and Oye. About 228 participants were present, only 215 participated fully. About 237 participants took part in the exercises in Lagos State with the eight local government areas namely: Alimosho, Akowonjo, Agege, Apapa, Sango, Victoria Island, Badagry and Mushin, 217 questionnaires were retrieved.

Also, seven local government areas were touched in Ogun State namely: Odeda, Ijebu-Ode, Ifo, Ado-Odo/Ota, Abeokuta South, Ipokia and Shagamu. 225 participated and 211 questionnaires were recovered. Likewise Ondo State, 240 were in attendance, only

215 questionnaires were rightly filled and collected. The names of local government areas visited were: Akure south, Ifedore, Ondo West, Owo, Akure North, Ile Oluji/Idanre and Owena. Osun State was visited with seven local government areas namely: Iwo, Ayedaade, Isokan, Boripe, Ifelodun, Atrakumosa West and Ife East. 242 participants were in place to take part in the exercise only 221 participants submitted their questionnaire correctly.

Lastly, Oyo State was not an exception because Oyo is part of South West. Seven local government areas were visited namely: Lagelu, Ido, Oyo North, Ibarapa North, Ogbomoso North, Afijio and Akinyele. 228 participants were in attendance, 213 questionnaires were retrieved. The nurses and midwives intervention gave us the achievement we attained. This is because they did not normally attend any programme slated for them except it is embedded with entertainment and incentives. That was why we could not get more than what we got because they were hard to reach clients or patients as being tagged by the nurses. Lastly, the average age of the participants was 16 during the visit.

INCLUSION CRITERIA

To ensure proper representation of the participants in the study, the following inclusion criteria were used:

- Participants were teenage mothers who were out of school.
- Participants were residing in one of the South-Western States in Nigeria as at the period of the study and;
- Participants were willing to participate in the study.

RESEARCH INSTRUMENT

Teenage Mothers Post-Pregnancy Psychological Adjustment Scale: This is a self-constructed instrument by the researcher and the supervisor. It was validated through a pilot study and used to measure the psychological adjustment of teenage mothers to life situations and challenges. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.79. It is a ten-item scale modified of a four -likert point of :strongly agree, agree, disagree and strongly disagree. It has items such as: 'I am happy being a mother; Inu mi dun wipe mo je iya olomo, I would have done an abortion; Toba se wipe mo mo, mi o bati se oyun omo na'. Items of the instrument were translated to Yoruba language for easy understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Rosenberg Self-Esteem Scale (Rosenberg, 1965): This was used to measure the self-esteem of teenage mothers. The scale is a ten-item modified likert scale with items responded to on a four point scale from strongly agree to strongly disagree. Scoring: SA=3, A=2, D=1, SD=0. The higher the score, the higher the self-esteem. It has reliability coefficient of 0.85. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.74. It has items such as: 'On the whole, I am satisfied with myself; Ni ti temi, inu mi dun ni ipo ti mowa leni; At times, I think I am no good at all; Nigbami, mo man ro wipe mi o dara leniyan'. Items of the instrument were translated to Yoruba language for ease of understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Self-Concept Clarity Scale (Campbell, Trapnell, Heine, Katz, Lavallee & Lehman, 1996: This scale was used to measure the self-concept of teenage mothers. It is a 12-item measure of the degree to which individuals rate a clear notion of who they are. An example item is: ‘‘In general, I have a clear sense of who I am and what I am.’’ The scale is a 4-point scale. Higher scores reflect higher self-concept clarity. The alpha reliability coefficient is 0.88. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.82. Items of the instrument were translated to Yoruba language for the participants’easy comprehension. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Global Depression Scale (GDS) (David, 2000)**:** The GDS was used to measure depression of teenage mothers. The scale has a yes or no response pattern and with a maximum score of 15. It could be interpreted as thus, 0-4 normal, depending on age, education and complaints: 5-8 mild, 8-11 moderate and 12-15 severe. The internal consistency is 0.79. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.73. Items of the instrument were translated to Yoruba language to ease the understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Teenage Mother Stigmatization Scale: This was self-constructed by the researcher and the supervisor. It was validated through a pilot study and used to measure the experience of stigmatization by teenage mothers. It is a modified ten-item scale with a four likert

point of strongly agree, agree, disagree and strongly disagree with a reliable coefficient of 0.76. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.72. It has items such as: 'As a teenage mother, my friends make fun of me; Gege bi eni to bimo lomode awon ore mi maan fi mi se yeye. My friends isolate me; Awon ore mi ma n takete si mi'. Items of the instrument were translated to Yoruba language for easy understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Duke-UNC Functional Social Support Questionnaire (Gehlbach, DeGruy & Kaplan, 1998) was used to measure the level of social support received by teenage mothers. The scale has thirteen items and it is a modified four point likert with a reliability coefficient of 0.82. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.76. It has items such as 'Your friends really try to help you; Awon ore re gbiyanju lati ran e lowo'. Items of the instrument were translated to Yoruba language for ease of understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Teenage Mother Sexual Debut Scale. It has six items and it was self-constructed by the researcher and the supervisor. It was validated through a pilot study and use to determine the age at which teenage mothers had their first sexual experience and the circumstance at which they had it. It has items as 'I willingly had sex the first time, I was between the age of ten and fifteen then; Mo momo ni ibasepo fun igba akoko nigbati mo wa laarin omo

odun mewa si meedogun'. It is a modified four point likert scale of strongly agree, agree, disagree and strongly disagree with an internal consistency of 0.88. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.76. Items of the instrument were translated to Yoruba language for the participants' easy comprehension. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Teenage Mother Peer Influence Scale. It has eight items and it is self-constructed by the researcher and the supervisor. It was validated through a pilot study and use to determine the pattern and measure of peer influence that made teenage mothers indulge in sexual activities. It is a four point modified likert scale of strongly agree, agree, disagree and strongly disagree with an internal consistency of 0.82. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social, culture and religion ways of life with other states in the Southwest. The pilot test measure of the instrument was 0.74.It has items such as 'My friends influence me to have sex; Awon ore mi lo je kin bere sini ni ibalopo pelu okunrin'. Items of the instrument were translated to Yoruba language for the participants to easily comprehend. The translation was carried out by Yoruba experts from the Department of Linguistics University, of Ibadan.

Family Support Scale. It has ten items and it is self-constructed by the researcher and the supervisor. It was validated through a pilot study and used to determine the impact of family members on the developmental life course of teenage mothers. It is a modified four point likert scale of strongly agree, agree, disagree and strongly disagree with a reliability

coefficient of 0.86. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social and culture and religion with other states in the Southwest. The pilot test measure of the instrument was 0.72. It has items such as 'My father always give me support; Baba mi maan se iranlowo fun mi'. Items of the instrument were translated to Yoruba language for ease of understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Socio-Economic Status Scale (SESS)

The Socio-Economic Status Scale developed by Salami (2000) was used as a measure of Socio-Economic Status of the participants. The SES scale asked for information on the educational qualifications and occupational status of the participants' parents (mother and father or guardians). The parents' educational qualification (14 points) and occupational status (10 points) were summarized to indicate the participants' socio-economic status. The highest score obtained when the parents' education was combined with their occupational status score was 24 while the least was 4. On the basis of the scores, the respondents were classified into lower socio-economic status (1-8), middle socio-economic status (9-16) and higher socio-economic status (17-24). The test-retest reliability of the SES scale was 0.73 with an interval of three weeks. The internal consistency Cronbach's alpha was 0.83. The instrument was validated by correlating the scores on the SES scale with scores of SES by 1paye (1977). The correlation coefficient obtained between the two scores on the two SES scales was 0.64. The instrument was pilot-tested on teenage mothers from Kwara State before the actual field work. The choice of Kwara State was due to the similarity in social, culture and religion ways of life with other states

in the Southwest. The pilot test measure of the instrument was 0.72. Items of the instrument were translated to Yoruba language for easy understanding of the participants. The translation was carried out by Yoruba experts from the Department of Linguistics, University of Ibadan.

Procedure for Administration

1. The instruments were given to teenage mothers willing to participate in the six states in the South West geographical region of Nigeria on individual basis.

2. Permission was obtained from the health centres and maternity authorities and the participants themselves.

3. The teenage mothers were approached on post-natal clinic days usually held on Tuesdays and Thursdays across health centers in the Southwestern States.

4. They were instructed that their responses were for research purpose and the researcher will treat it confidentially.

5. Instruments were read aloud and the purpose of the research was made clear to the participants. Research assistants were trained and used for the study.

6. The administration of the instrument lasted close to four months.

7. Thereafter, questionnaires were collected for scoring.

DATA ANALYSIS

Data was analysed using Pearson Product Moment Correlation and Multiple Regression Analysis at 0.05 level of significance. Multiple regressions were used to find out the combined and relative contribution of the independent variables on the dependent variable (psychological adjustment of teenage mothers). PPMC was used to determine if

the relationship between the variables are statistically significant to warrant rejection or acceptance of the hypotheses.

CHAPTER FOUR

RESULTS

In this chapter, the data would be analysed and interpreted. The test of statistics would include Multiple Regression Analysis and Pearson Product Moment Correlation. Each of the research questions and hypotheses would be tested for significance at 0.05 levels. A summary of the findings would be presented at the end of the chapter.

The results of the findings are thus presented in the tables below:

Research Question 1: What is the relationship between the independent variables (social support, sexual debut; peer support; socioeconomic status; family support; stigmatization, self-esteem; depression and self-concept and the dependent variable (psychological adjustment of teenage mothers)?

DATA ANALYSIS AND INTERPRETATION OF RESULTS

Table 4.1: Descriptive Statistics and Correlation Matrix of Relationship between the Variable

Variables	N	Mean	Std Dev	1	2	3	4	5	6	7	8	9	10
Psychological adjustment of teenage mothers	1292	33.26	7.066	1.000									
Self-esteem	1292	30.48	8.418	.342	1.000								
Self-concept	1292	36.37	3.86	.208	.400	1.000							
Depression	1292	22.06	4.68	0.98	.435	.405	1.000						
Stigmatization	1292	30.10	8.11	.205	.361	.364	.468	1.000					
Social support	1292	35.27	11.75	.215	.273	.209	.303	.273	1.000				
Sexual debut	1292	18.84	5.92	.148	.396	.394	.434	.484	.236	1.000			
Peer influence	1292	24.25	7.75	.186	.431	.415	.432	.404	.252	.710	1.000		
Family support	1292	23.64	9.97	-0.056	-0.098	-0.052	-0.047	-0.061	0.058	0.030	0.007	1.000	
Socio Eco Status	1292	13.31	2.95	-0.062	.199	.174	.471	.178	.101	.344	.333	.246	1.000

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

* Correlation is significant at the 0.05 level (2-tailed)

Table 4.1 shows the mean, standard deviation and zero order correlation among the variables. It is observed that there is significant relationship between the independent variables and the dependent variable (psychological adjustment of teenage mothers) in the following order of magnitude: self-esteem (R=0.342, p<0.05), social support (R=0.215, p<0.05), self-concept (R=0.208, p<0.05), stigmatisation (R= 0.205, p<0.05), peer influence (R=0.186, p<0.05), sexual debut (R=0.148, p<0.05), depression (R=0.098, p<0.05), socio-economic status (R=-0.062, p<0.05), and family support (R=-0.056, p<0.05).

Research Question 2: What is the composite effect of the independent variables on psychological adjustment of teenage mothers?

Table 4.2: Joint Effect of the Independent Variables on the Dependent Variable

R	R Square	Adjusted R Square	Std.Error of the Estimate
0.412	0.169	0.164	6.4619

ANOVA

	Sum of Squares	Df	Mean Square	F	P	Remark
Regression	10922.949	9	1213.661	29.066	0.00	Sig
Residual	53530.763	1282	41.756			
Total	64453.712	1291				

Table 4.2 shows that there are joint effect of the independent variables (social support, sexual debut, peer support, socioeconomic status, family support, stigmatization, self-esteem, depression and self-concept) on the dependent variable (psychological adjustment of teenage mothers) R=0,412, P<0.05. The table further reveals 16.4% (adjusted R square = 0.164) of the variance on the psychological adjustment of teenage mothers are accounted for by the linear combination of the independent variables. The ANOVA results from the regression analysis shows that there is a significant effect of the independent variables on the dependent variable: F (9, 1291) =29.066, p<0.05.

Research Question 3: What is the relative effect of each of the independent variables on the dependent variable (psychological adjustment of teenage mothers)?

Table 4.3: Relative Effect of the Independent Variables on the Dependent Variables

Variable	Unstandardised Coefficient		Standardised Coefficient	Rank	T	P	Remark
	B	Std. Error	Beta				
Constant	25.200	1.179	-		21.379	.000	Sig
Self-esteem	.249	.026	.296	1st	9.616	.000	Sig
Self-concept	5.557E-02	.022	.077	4th	2.560	.011	Sig
Depression	-.156	.053	-.103	8th	-2.942	.003	Sig
Stigmatisation	7.798E-02	.027	.089	3rd	2.918	.004	Sig
Social support	7.657E-02	.017	.127	2nd	4.611	0.00	Sig
Sexual debut	-1.68E-02	.045	-.014	7th	-.374	.708	NS
Peer Influence	5.074E-02	.035	.056	5th	1.456	.146	NS
Family Support	1.069E-03	.019	.002	6th	.056	.956	NS
Socio-economic	-.308	.074	-.129	9th	-4.134	.000	Sig

Table 4.3 reveals that self-esteem makes the highest contribution to the psychological adjustment of the teenage mothers (β=0.296), followed by social support (β=0.127), then stigmatisation (β=0.089), self-concept (β=0.077), peer influence (β= 0.056), family support (β= 0.002), sexual debut (β=- 0.014), depression (β= -0.103) and socio-economic status (β= -0.129) makes the least contribution.

Ho1: There will be no significant relationship between the self-esteem of teenage mothers and their psychological adjustment to life.

Table 4.4: PPMC Summary Table Showing Significant Relationship between Self-Esteem of Teenage Mothers and Their Psychological Adjustment to Life

Variables	N	Mean	SD	R	Df	P
Psychological Adjustment to Life	1292	33.26	7.066	0.342	1290	Sig
Self-esteem	1292	30.48	8.418			

Table 4.4 shows that the variable self-esteem significantly correlates with teenage mothers psychological adjustment to life, r (1290) = 0.342, p<.05, the mean and standard deviation for self-esteem are 30.48 and 8.418 respectively. With this result, the Ho: is thus rejected.

Ho2: There will be no significant relationship between the self-concept of teenage mothers and their psychological adjustment to life.

Table 4.5: PPMC Summary Table Showing Significant Relationship between Teenage Mothers Self-Concept and their Psychological Adjustment to Life

Variables	N	Mean	SD	R	Df	P
Psychological Adjustment to Life	1292	33.26	7.066	0.208	1290	Sig
Self-concept	1292	36.37	9.805			

Table 4.5 shows that the variable self-concept correlates significantly with psychological adjustment to life of teenage mothers, r (1290)= 0.208, p<.05. The mean and standard deviation for self-concept are 36.37 and 9.805 respectively. With this result, the Ho: is thus rejected.

Ho3: There will be no significant relationship between depression experienced by teenage mothers and their psychological adjustment to life.

Table 4.6: PPMC Summary Table Showing Significant Relationship between Teenage Mothers Depression and their Psychological Adjustment to Life

Variables	N	Mean	SD	R	Df	P
Psychological adjustment to life	1292	33.26	7.066	0.094	1290	Sig
Depression	1292	22.06	4.681			

Table 4.6 shows that the variable depression correlates significantly with teenage mothers' psychological adjustment to life, r (1290) = 0.094, p<.05. The mean and standard deviation for depression are 22.06 and 4.681 respectively. With this result, the Ho: is thus rejected.

Ho4: There will be no significant relationship between stigmatisation experienced by teenage mothers and their psychological adjustment to life.

Table 4.7: PPMC Summary Table Showing Significant Relationship between Stigmatization of Teenage Mothers and Their Psychological Adjustment to Life

Variables	**N**	**Mean**	**SD**	**R**	**Df**	**P**
Psychological Adjustment to Life	1292	33.26	7.066	0.205	1290	Sig
Stigmatisation	1292	30.10	8.106			

Table 4.7 shows that the variable stigmatisation correlates positively with psychological adjustment to life of teenage mothers, r (1290) = 0.205, p<.05. The mean and standard deviation for stigmatization are 30.10 and 8.106 respectively. With this result, the Ho: is thus rejected.

Ho5: There will be no significant relationship between social support experienced by teenage mothers and their psychological adjustment to life.

Table 4.8: PPMC Summary Table Showing Significant Relationship between Social Support Experienced by Teenage Mothers and their Psychological Adjustment to Life

Variables	N	Mean	SD	R	Df	P
Psychological adjustment to life	1292	33.26	7.066	0.215	1290	Sig
Social support	1292	35.27	11.75			

Table 4.8 shows that the variable social support significantly correlates with the psychological adjustment to life of the teenage mothers, r (1290) = 0.215, p<.05. The mean and standard deviation for social support are 35.27 and 11.75 respectively. With this result, the Ho: is thus rejected.

Ho6: There will be no significant relationship between sexual debut experience of teenage mothers and their psychological adjustment to life.

Table 4.9: PPMC Summary Table Showing Significant Relationship between Teenage Mother's Sexual Debut and Their Psychological Adjustment to Life

Variables	N	Mean	SD	R	Df	P
Psychological Adjustment to Life	1292	33.26	7.06	0.148	1290	Sig
Sexual Debut	1292	18.84	5.92			

Table 4.9 shows that the variable sexual debut significantly correlates with psychological adjustment to life of the teenage mothers, r (1290) = 0.148, p<.05. The mean and standard deviation for sexual debut are 18.84 and 5.92 respectively. With this result, the Ho: is thus rejected.

Ho7: There will be no significant relationship between the experience of peers influence by teenage mothers and their psychological adjustment to life.

Table 4.10: PPMC Summary Table Showing Significant Relationship between the Experience of Peer Influence and the Psychological Adjustment to Life of the Teenage Mothers

Variables	N	Mean	SD	R	df	P
Psychological Adjustment to Life	1292	33.26	7.066	.186	1290	Sig
Peer Influence	1292	24.25	7.748			

Table 4.10 shows that the variable peer influence correlates with the psychological adjustment to life of the teenage mothers, r (1290) = -0.186, p>.05. The mean and standard deviation for peer influence are 24.25 and 7.748 respectively. With this result, the Ho: is thus rejected.

Ho8: There will be no significant relationship between the experience of family support by teenage mothers and their psychological adjustment to life.

Table 4.11: PPMC Summary Table Showing the Significant Relationship between the Experience of Family Support and the Psychological Adjustment to the Life of Teenage Mothers

Variables	**N**	**Mean**	**SD**	**R**	**Df**	**P**
Psychological Adjustment to Life	1292	33.26	7.066	-0.056	1290	Ns
Family Support	1292	23.64	9.966			

Table 4.11 shows that the variable family support does not significantly correlate with the psychological adjustment to the life of teenage mothers, r (1290) = -0.061, p>.05. The mean and standard deviation for family support are 23.64 and 9.966 respectively. With this result, the Ho: is thus accepted.

Ho 9: There will be no significant relationship between the socio-economic status of theteenage mothers and their psychological adjustment to life.

Table 4.12: PPMC Summary Table Showing Significant Relationship between Teenage Mothers' Socio-economic Status and their Psychological Adjustment to Life.

Variables	N	Mean	SD	R	df	P
Psychological Adjustment to Life	1292	33.26	7.066	-0.062	1290	n.s
Socio-economic Status	1292	13.31	2.954			

Table 4.12 shows that the variable teenage mothers' socio-economic status does not correlate with their psychological adjustment to life, r (1290) = -0.062, p>.05. The mean and standard deviation for socio-economic status are 13.31 and 2.954 respectively. With this result, the Ho: is thus accepted.

SUMMARY OF THE FINDINGS

The summary of the findings of this research is as follows:

1. The measures of association revealed that there was significant relationship between the independent variables (social support, sexual debut, peer support, socioeconomic status, family support, stigmatization, self-esteem, depression and self-concept) and the dependent variable (psychological adjustment of teenage mothers)

2. It was found that the independent variables (social support, sexual debut, peer support, socioeconomic status, family support, stigmatization, self-esteem, depression and self-concept) made significant joint contributive effect of 16.4% on the psychological adjustment of teenage mothers.

3. The result revealed significant composite effect of the independent variables to the psychological adjustment of the lives of teenage mothers in this order of magnitude: self-esteem (β=0.296); made the highest contribution followed by social support (β=0.127), then stigmatisation (β=0.089), self-concept (β=0.077), peer influence (β= 0.056), family support (β= 0.002), sexual debut (β=- 0.014), depression (β= -0.103) and socio-economic status (β= -0.129) made the least contribution.

4. There was significant correlation between self esteem and teenage mothers' psychological adjustment to life, r = 0.342, p<.05. The mean and standard deviation for self-esteem was 30.48 and 8.418 respectively.

5. The study revealed that the independent variable self-concept correlated significantly with the psychological adjustment of the lives of the teenage mothers,

r (1290) = 0.208, p<.05. The mean and standard deviation for self-concept was 36.37 and 9.805 respectively.

6. It was found that depression correlates significantly with teenage mothers' psychological adjustment to life, r (1290) = 0.094, p<.05. The mean and standard deviation for depression was 22.06 and 4.681 respectively.

7. Also, the result of the study shows that the variable stigmatisation correlates positively with the psychological adjustment to life of teenage mothers, r (1290) = 0.205, p<.05. The mean and standard deviation for stigmatisation were 30.10 and 8.106 respectively.

8. Likewise, it was found that social support significantly correlated with the psychological adjustment to life of tenage mothers; r (1290) = 0.215, p<.05. The mean and standard deviation for social support were 35.27 and 11.75 respectively.

9. The result of the study also showed that the variable sexual debut significantly correlated with psychological adjustment to life of teenage mothers, r (1290) = 0.148, p<.05. The mean and standard deviation for sexual debut were 18.84 and 5.92 respectively.

10. Also, the result showed that the variable peer influence correlated with the psychological adjustment to life of teenage mothers, r (1290) = -0.186, p>.05. The mean and standard deviation for peer influence were 24.25 and 7.748 respectively.

11. Similarly the result shows that the variable family support did not significantly correlate with psychological adjustment to life of teenage mothers, r (1290) = -0.061, p>.05. The mean and standard deviation for family support were 23.64 and 9.966 respectively.

Furthermore, it was found that the variable teenage mothers socio-economic status did not correlate with their psychological adjustment to life, r (1290) = -0.062, p>.05. The mean and standard deviation for socio-economic status were 13.31 and 2.954 respectively.

CHAPTER FIVE

DISCUSSION

This chapter contains the discussion of the study's findings, summary and conclusion,; implications of the findings; recommendations as well as suggestions for further research.

Discussion of the Findings

Hypothesis One

This hypothesis states that there is no significant relationship between the self-esteem of teenage mothers and their psychological adjustment to life.

The findings show that self-esteem significantly correlates with teenage mothers' psychological adjustment to life, r (1290) = 0.342, $p<.05$. The mean and standard deviation for self-esteem was 30.48 and 8.418 respectively. With this result, the Ho_i was thus rejected. This implies that due to the negative consequences attached with this development in a typical Nigerian society, teenage mothers always develop low self-esteem as the society see them as irresponsible, carefree and promiscuous individuals, as such, they are often cited as bad examples and use them as points of reference who impact negative influence on other teenagers and should be avoided. This associated relationship makes teenage mothers feel rejected and frustrated. Therefore, the life experiences of teenage mothers are major source of their self-esteem development. Their positive or negative life experiences make them create attitudes toward themselves, which can be favourable, resulting in positive feelings of self-worth, it could also be unfavourable, giving rise to negative feelings of self-worthlessness. This is in congruence with Hewitt (2009) that self-esteem reflects a person's overall emotional evaluation of his or her own worth. It is a judgment of oneself as well as an attitude towards self. Self-esteem encompasses beliefs for example, "I am competent", "I am worthy" and emotions such as:

:triumph, despair, pride and shame. Teenage mothers more often experience low self-esteem and low

Self-esteem among teenage mothers lead to many problems while they suffer from lack of confidence and hopelessness. Self-esteem refers to self-worth, self-respect and how one regards or feels about one self. Simply, it is an individual's feeling about various convictions of themselves as a capable or competent person who have worth. The symptoms of low self –esteem vary for every teenage mother. This corroborates Cox, Buman, Valenzuela, Joseph, Mitchell and Woods (2009) research report conducted in Nigeria on the effect of self-esteem on parenting among teenage mothers attending a Teen Tot programme. They found that low self-esteem is associated with decreased maternal confidence in their ability to parent. Furthermore, the report of National Institute of Health and Family Welfare (NIHFW), (2005) research reveals that teenage mothers due to the psychological trauma they experience are conditioned to suffer low self-esteem and inferior status. Self-esteem is also viewed both as a personality trait and a psychological state. People have a typical level of self-esteem that is consistent across time. Also, National Institute of Health and Family Welfare (NIHFW), (2005) report further reveals the fact that teenage mother's self-esteem has negative correlation with their psychological well-being and adjustment to life challenges. The report emphasizes that as teenage mothers grow old, because of maturity in thinking and expanding experiences, they try to evaluate themselves in a rigid manner; the results are lower self-esteem; disturbed psychological state and poor adjustment to life. This can also be due to failure to fulfil their expectations in life.

Hypothesis Two

This hypothesis states that there is no significant relationship between the self-concept of teenage mothers and their psychological adjustment to life.

The result of the study reveals that the variable self-concept correlates significantly with psychological adjustment to life of teenage mothers, r (1290)= 0.208, p<.05. The mean and standard deviation for self-concept was Ẍ=36.37 and 9.805 respectively. With this result, the HO_2 was thus, rejected. The reason for this could be that due to the way and manner significant individuals relate or treat teenage mothers negatively, they tend to develop low self-concept. This makes them most times withdraw from associating with other people and also express self-verbalisation and regret. Thus, evidence point to the fact that teenage childbearing is one "off-time" transition that is still associated with reasonably strong societal norms and negative sanctions for the individuals who violate them (Mollborn, 2009). These sanctions can be interpersonal, such as facing explicit disapproval from others or institution. Regardless of the sanctions experienced, it seems possible that teenage parents who violate societal norms about appropriate transitions to parenthood might suffer mental health consequences. And experiencing everyday interpersonal or institutional sanctions cause psychological distress among teenage parents (Wooten, 2006).

Furthermore, the development of poor self-concept by teenage mothers holds to the fact that teenage childbearing is accompanied by stress in the family; partner disapproval and peer avoidance. These serve as negative risk factors that undermine the post-pregnancy psychological adjustment and development of both teenage mothers and their children (Richter, Norris & Ginsburg, 2007). These results are also consistent with the view of Kimani, Cheboswony, Kodero and Misigo (2009) that the main factors determining the

formation of the self-concept of an individual is the environment as well as people with whom the individual lives, who play a very crucial role in the mould of the self-concept. However, it is important to note that self-concept is not restricted to the present. It includes "past selves" and "future selves". Future selves or possible selves represent individuals' ideas of what they might become. Possible selves may function as incentives for future behaviour and they also provide an evaluative and interpretative context for current view of self (Adetoro, 2011). Consequently, the development of low self-concept causes traumatic experience(s) in the lives of teenage mothers for which Zastrow and Kirst-Ashman, (2007) assert that the transition to motherhood affects teenage mothers mentally, emotionally and, sometimes, physically,considering the fact that becoming a mother requires self-sacrifice, and the understanding that personal needs must often be put aside and identity formation marred. Therefore, in view of its negative impact on the self-concept formation, it is found that teenage mothers often feel isolated and vulnerable to conflict, distress and frustration (Reid & Meadows-Oliver, 2007).

Hypothesis Three

This hypothesis states that there is no significant relationship between depression experienced by teenage mothers and their psychological adjustment to life.

The result of the study shows that depression correlates significantly with teenage mothers' psychological adjustment to life, r (1290) = 0.094, p<.05. The mean and standard deviation for depression were (Ẍ=22.06) and (r^2=4.681) respectively. With this result, the HO_3 was thus rejected. This indicates that the incident of teenage child bearing impacts negatively on the mental wellbeing of teenage mothers. This more often than not makes teenage mothers feel disillusioned, angered, self-agitated and confused. In addition, teenage maternal distress has detrimental effects on children's outcomes, including: language development, coping skills, social adjustment and physical health (Sills,

Shetterly, Xu, Magid & Kempe 2007). The prevalence and severity of teenage mothers' distress have spawned a considerable research enterprise examining its correlates and effects on teenage mother's psychological adjustment to life (Brown, Woods, Buman, Harris & Cox 2007; Eshbaugh, 2006). Thus, teenage mothers' psychological distress levels have been found to be high in samples of varying size (Schmidt, Weimann, Rickert & Smith, 2006). However, Falci and Mortimer (2007) find that teenage mothers have higher levels of depression than other young women who had children later if at all. Also, postpartum depression (PPD) and its associated mood swings have been shown to present an incapacitating mental struggle for a new mother. The symptoms of PPD usually begin within one month postpartum and can last up to one year (Abrams & Curran, 2007), and the incidence of PPD is higher among adolescents than among adult women (47 percent as compared to 28 percent) (Logsdon, Birkimer, Simpson & Looney, 2005). According to Abrams and Curran (2007), the symptoms of PPD are feelings of worthlessness, sadness and uncontrollable crying, as well as fatigue, changes in appetite and sleep problems. Research on utilization of mental health services finds that depression is prevalent in adolescent mothers, but that they are least likely to report symptoms to doctors or health professionals (Kahan, 2010).

Hypothesis Four

This hypothesis states that there is no significant relationship between teenage mother's stigmatization and their psychological adjustment to life. The result of the study shows that the variable stigmatisation correlates positively with psychological adjustment to life of teenage mothers, $r\ (1290) = 0.205$, $p<.05$. The mean and standard deviation for stigmatisation were 30.10 and 8.106 respectively. With this result, the HO_4 was thus rejected. The reason for this development could be that in Nigeria, when a teenager gets

pregnant and bears the child, such teenager is often stigmatised as wayward and promiscuous and as such, other teenage girls would be ask to avoid possible association with the teenage mother. These developments do cause lot of disaffection, regret and frustration. In congruence, Atuyambe, Mirembe, Tumwesigye, Annika, Kirumira and Faxelid (2008) find that teenage mothers are significantly more disadvantaged in terms of health care seeking for reproductive health services and face more challenges during pregnancy and early motherhood compared to adult mothers. They contend that teenage mothers are more likely to drop out of school due to pregnancy and less likely to earn salary. They are also more likely to experience violence from parents and to be stigmatized by the community and this places unfathomed psychological, emotional and economic burden on them with compelling consequences on their well-being and quality of life. Additionally, young parents often face substantial social stigma. For example, many young mothers report experiences of judgment or even hostility in their dealings with social service institutions, education providers and health care facilities (McDermott & Graham, 2005). Also, Collins (2005) reports that the stigmatization of teenage mothers by the society impacts negatively on their psychological well-being and coping ability to adjust to reality of their predicament. This is consistent with Palacios and Kennedy (2010) establish report after examining the incidence and effects of stigmatization on the life experiences, adjustment, personality and characteristics of teenage mothers who are Mexican American and African American, their report reveals that forty-four percent of the respondents report experiencing stigmatization from parents, peers, religious centers and community. Palacios and Kennedy (2010) further report that teenage mothers experiencing stigmatization adjust poorly in the society than those that are not being stigmatized. These findings suggest that stigmatization may be related to vulnerability of teenage mothers to experiencing psychological stress and dysfunction in the society

Hypothesis Five

This hypothesis states that there is no significant relationship between social support experienced by teenage mothers and their psychological adjustment to life.

The study reveals that the variable social support significantly correlates with psychological adjustment to life of teenage mothers, r (1290) = 0.215, p<.05. The mean and standard deviation for social support were 35.27 and 11.75 respectively. With this result, the HO_5: was thus rejected. This implies that teenage mother most times do not get the desired social support from significant others in the society. The reason for this could be associated with the measures of social disadvantage, inequality and social exclusion they are made to experience. Thus, teenage mothers with positive social support functioning tend to experience less identity confusion, whereas chaotic social support functioning appears to be mutually exclusive with identity confusion (Schwartz, Mason, Pantin & Szapoczik, 2009). As cited in VanDenBerg (2012) in one longitudinal study of mothers, 59% of women who are mothers by the age of 18 achieve no educational qualifications (ie., a high school) or college diploma by the age of 25 (Boden et al., 2008). Although, teen motherhood is stressful, greater developmental maturity and non-maternal support can serve as protective factors against negative effects (Kramer & Lancaster, 2010). Thus, McDonald et al., (2008) asserts that social supports for teen mothers are related to their social and emotional well-being, including impulsivity and problem solving. Furthermore, as revealed in VanDenBerg (2012), the quality of emotional support may influence the teen mothers' hopes for the future as well as their view of themselves as having productive future (Beers & Hollo, 2009). In addition, social expectations may influence the teen mothers' ability to see what their expected future will be in terms of possible selves (Oyserman & James, 2009). Research reveals that the development of the teen mothers' future orientation is fostered by social support. This include family

members, peers and community members. Specifically, many teen mothers feel inspired by older female mentors who are able to achieve professional careers, despite having been teen mothers (Klaw, 2008).

Hypothesis Six

This hypothesis states that there is no significant relationship between sexual debut experience of teenage mothers and their psychological adjustment to life.

The result shows that the variable sexual debut significantly correlates with psychological adjustment to life of teenage mothers, r (1290) = 0.148, p<.05. The mean and standard deviation for sexual debut were 18.84 and 5.92 respectively. With this result, the HO_6: was thus rejected. This implies that teenage childbearing is associated with teenage early sexual debut. Therefore, giving the trends of sexual experimentation among teenagers, teens are less likely to remain abstinent until marriage,considering the fact that they are increasingly sexually active and with the tendency of involving in sex without the use of contraceptive to offset the risks associated with unintended pregnancy and unwanted childbirth. Even with effective and consistent use, engaging in sexual activity at an early age significantly enhances exposure to sexually transmitted infections (STIs). Ultimately, STIs, HIV/AIDS and teenage childbearing can incur significant consequences for young women and public health costs for society (Regnerus, 2007). Thus, early sexual debut during early adolescence has been mainly viewed as problem behaviour (Ream, 2006) alongside behaviours such as: drug use, being a fugitive; stealing, vandalism and school failure or drop out.

Although, research has illustrated an association between early sexual intercourse and negative psychosocial factors (Kirby, Lepore, & Ryan, 2005). Armour and Haynie (2007) utilize a longitudinal design to examine the direction of the relationship between early

intercourse and delinquency. They find early sexual intercourse to be associated with delinquency one year later (Armour & Haynie, 2007). Also, early sexual debut has been linked with a number of detrimental health consequences. Young age of first sexual intercourse is correlated with unintended pregnancy due to reduced use of contraception (Raine, Minnis & Padian, 2003). Therefore, early initiation of sexual intercourse has long been an area of interest to developmental psychologists, health and sex researchers. Evidence suggests that the timing of sexual intercourse and sequences of sexual trajectories (eg, pace and sequence at which adolescents progress from less intimate to more intimate behaviour) are related to health outcomes (de Graaf, Vanwesenbeeck, Meijer, Woertman, & Meeus, 2009) Research focusing on U.S. samples has found evidence of a relationship between sexual intercourse during early adolescence (commonly defined as before age 16) and future problem behaviour (Woodward, Fergusson, & Horwood, 2001).

Hypothesis Seven

This hypothesis states that there is no significant relationship between the experience of peers influence by teenage mothers and their psychological adjustment to life. The result shows that variable peer influence correlates with psychological adjustment to life of teenage mothers, r (1290) = -0.186, p>.05. The mean and standard deviation for peer influence were 24.25 and 7.748 respectively. With this result, the HO_7 is thus rejected. This suggests the fact that most teenage mothers are induced into sexual activity by peer influence. Thus, susceptibility to peer pressure from their close friends predicts future responses to negative peer pressure; decrease in popularity and increased depressive symptoms. Susceptible teens also rate themselves as less competent in their close friendships (Allen, Porter, & McFarland, 2006). Peer pressure susceptibility is also cross-

sectionally correlated with deviant behaviour and substance use, especially if a close friend had experimented them (Allen et al., 2006). However, Herrman (2008) finds that peer relationships play a key role in the social development of teenagers, but may be altered significantly in the context of pregnancy and motherhood. Thus, studies of new teenage mothers have noted an overall negative impact of parenting on the lives of adolescent teen mothers. Among other things' these mothers experience feelings of social stigma and loss of friendships. However, teen mothers may experience increased support from peers, especially from those who are also pregnant or parenting. Herrman (2008) further asserts that quantitative data suggest that these relationships may also facilitate repeated teen pregnancy, even though social support from parenting peers may provide psychosocial benefits. Also, in a study by Raneri and Wiemann (2007) they find as regards peer relationships among teenage mothers, that while some want to hold on to past relationships and their social image among peers, others accept the change in their peer interactions and even prefer to become more detached from potentially negative influences. However, some teenage mothers maintain relationships with peers who provide emotional and material supports.

Hypothesis Eight

This hypothesis states that there is no significant relationship between the experience of family support by teenage mothers and their psychological adjustment to life.

The result shows that the variable family support did not significantly correlate with psychological adjustment to life of teenage mothers, r (1290) = -0.061, p>.05. The mean and standard deviation for family support were 23.64 and 9.966 respectively. With this result, the HO_8: is thus accepted. The reason for this development could be that teenage childbearing is unacceptable in a typical Nigerian family. Thus, when a teenager

bears a child, such teenager is often not supported by most members of the family who might see the development as an embarrassment to the family. This also has negative implication on the mental and psychological well-being of teenage mothers. Thus, it is of note that inadequate support from the parents will likely increase the chance of getting depression among teenage mothers who get into unfortunate situation with their parents. This occurs because they usually become confused when they expect to get plenty of help and positive reinforcement from their parents, but it does not happen (Stice, Ragan, & Randall, 2004). In the same vein, Dennis (2005) states that lack of family support has consistently been identified as an important contributor to poor mental health among teenage mothers and a source of possible developmental risks in their children. In view of this, family support is recognized as important in reducing depression and in improving the general circumstances of teenage mothers (Bunting & McAuley 2004). Family support can have a significant positive impact on teenage mothers, but families can also be a source of unsolicited interference and can have a negative impact, depending on the level of family tension (Breheny & Stephens 2006).

Hypothesis Nine

This hypothesis states that there is no significant relationship between socio-economic status of teenage mothers and their psychological adjustment to life.

The result of the study shows that the variable teenage mothers' socio-economic status did not correlate with their psychological adjustment to life, r (1290) = -0.062, p>.05. The mean and standard deviation for socio-economic status were 13.31 and 2.954 respectively. With this result, the HO_9 was thus accepted. This indicates that teenagers of both high and low socio-economic status can be teenage mothers. However, in contrast, Bunting and McAuley (2004) finds that covariates, including socioeconomic disadvantage

and prior poor performance in school may also explain negative outcomes of teenage mothers' experience(s). They further report that teenage mothers are more likely to come from more depressed socioeconomic backgrounds, however, this does not mean that teenage pregnancy is the result of being raised in a poor household. As one explanation, some research suggest that teenage mothers from middle-class backgrounds characterized by intact families, higher incomes and higher education levels/ higher status and occupation tend to choose abortion at a higher rate than teenagers from poorer backgrounds. Poor socioeconomic circumstances and factors associated with economic disadvantage also explain the experience of psychological distress in teenage mothers. Thus, teenage mothers of low socioeconomic background have been found to have increased psychological depressive symptoms compared to adolescent norms (Milan, Ickovics, Kershaw, Lewis, Meade, & Ethier, 2004).

Furthermore, Bimbola and Ayodele (2007) posit that there is an increasing rate of teenage pregnancy despite the fact that teenage childbearing continues to be framed as an important social and public health problem. Therefore, according to World Health Organisation (2011) report, the proportion of births that take place during adolescence is about 2% in China, 18% in Latin America and the Caribbean and more than 50% in sub-Saharan Africa and half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Nigeria and the United States. This makes teenage motherhood a developmental, social, economic and moral catastrophe.

Research Question One

What is the relationship between the independent variables (social support, sexual debut, peer support, socioeconomic status, family support, stigmatization, self-esteem, depression and self-concept) and the dependent variable (psychological adjustment of teenage mothers)?

The result reveals that there was significant relationship between the independent variables and the dependent variable. The possible reason for this development could be that the Nigerian society has detestation against teenage pregnancy and motherhood. The society considers it improper considering the fact that teenage mothers are still children trying to take care of their born child. The society sees this development as being overbearing on the developmental lifespan of teenage mothers. Also, it is of note that the incidence of teenage motherhood would cut short developmental potentials in the likes of teenage mothers dropping out of school, as it will have economical and social disadvantage on them at the long run. In view of this, Nigerian society see it as counterproductive on the wellbeing of teenage mothers and the society at large. Also, considering the fact that transition to motherhood represents a major developmental milestone for all women, it is on the other hand stressful particularly for teenagers, as they tend to struggle to negotiate their new maternal roles and responsibilities, which they are ill-prepared for and cope with the physical, emotional and cognitive challenges of adolescence attached to it at the same time. In support of this point of view is Okoiye and Falaye (2010), who assert the fact that the immediate and long term adjustment to motherhood among teenage mothers is stressful considering the fact that the development is a source of great psychological challenge(s), as it is commonly represented negatively in the modern world and Nigeria is no exception. Also, Uwakwe, Falola, Adeyemo and

Osiki (2002) contend that sexual risk-taking behaviour and experimentation are somewhat expected outcomes of teenage mothers, as they strive to manage self with the complex changes occurring at this stage of life, as it has been reported that they are usually unproportionately and unfairly over-burdened with the consequences of this developmental process.

Research Question Two

What is the relative effect of each of the independent variables on the dependent variable (psychological adjustment of teenage mothers)?

The result of the findings reveals that self-esteem made the highest contribution to psychological adjustment of teenage mothers (β=0.296) followed by social support (β=0.127), then stigmatisation (β=0.089), self-concept (β=0.077), peer influence (β= 0.056), family support (β= 0.002), sexual debut (β=- 0.014), depression (β= -0.103) and socio-economic status (β= -0.129) made the least contribution. This implies that the independent variables have impact on the dependent variable and the reason for this development could be that the incidence of teenage child bearing is frowned at in Nigerian society, such that families that are involved are covered with shame of irresponsibility. Also, the development has associated risks that are detrimental not only to the wellbeing of the teenage mother, but also to the entire society. Thus, unwanted childbearing among teenagers can have negative health, social and psychological consequences. Health problems include greater chances for illness and death for both mother and child. In addition, such childbearing has been linked with a variety of social problems, including: divorce, poverty, child abuse and juvenile delinquency. In support of this point of view, Okoiye, Ohizu and Adediran (2011) assert that it is of note that in Nigeria, out of school teenage mothers are often faced with complex psychological challenges to contend with due to their immature developmental state. This tends to place mother and child at great

risk of maladjustment and dysfunctional development. This is against the backdrop of the fact that teenage mothers are disadvantaged in the act of child care due to their lack of knowledge of child development, unrealistic expectations and limited repertoire of skills for attending to the needs of the child. This phenomenon is basically characterized by more extreme feelings of hopelessness, sadness, isolation, worry and withdrawal.

Research Question Three

What is the composite effect of the independent variables on psychological adjustment of teenage mothers?

The findings of the study reveals that the independent variables had a joint contributing effect of 16.4% and ANOVA results from the regression analysis.It shows that there was significant effect of the independent variables on the dependent variable: $F(9, 1291) = 29.066$, $p<0.05$. This implies that the joint impact of the independent variables on the dependent variable is significantly high and this is possibly responsible in the negative reservation of the society towards teenage mothers in Nigeria. This result is a confirmation that teenage childbearing is associated with many unfavorable consequences for teen mothers, their families and children. For teenage mothers and their children, the prospects for a healthy and productive life are significantly reduced. Teenage mothers in the absence of adequate nutrition and appropriate prenatal care are at a heightened risk of experiencing pregnancy complications and poor birth outcomes. Furthermore, teenage mothers are often found to experience high levels of psychological distress and report low self-efficacy and low self-esteem when compared with their non-parenting counterparts and older mothers. Consequently, in most studies of teenage mothers, psychological distresses are associated with social and economic stressors, which are results of teenage child bearing (Kalil & Kunz, 2000). Giving credence to the above point of view, Okoiye and Asamaigo (2011) report that the occurrence of this phenomenon is based on the

premised that teenagers are faced with many challenges including: changing family constellations; negative peer influence; economic hardship; exposure to violence; taking of drugs and alcohol; development of low-self-esteem and a general loss of community bonds. In support of this assertion , Awam (2009) reports that teenage mothers in Nigeria face myriads of problems in their bid to assert their sexuality. This is owing to faulty or inadequate preparation given to the child for effective sexual adjustment.

Summary

The findings of this study have brought to the consciousness of Nigerian families, the developmental challenges of teenage mothers; the stress they pass through as mothers at immaturity considering the fact that motherhood is a major life transition which requires changes, hardness, psychological and chronological maturity. Therefore, it is of note that both unintended and unwanted childbearing among teenage mothers could have negative health, social and psychological consequences. The health problems include: chances of illness and death for both mother and child.

Conclusion

From the findings it can be concluded that there is significant relationship between the dependent and independent variables. The independent variables have composite effects on psychological adjustment of teenage mothers. Though, the independent variables have composite effects, they vary in degrees in the relative effects. The self esteem has the highest effect while family support has the lowest among others. In addition self esteem, social support, stigmatization, self concept and peer influence were depotent predictors of post-pregnancy psychological adjustment of out-of-school teenage mothers in shout-west Nigeria.

Implication of the Study

1. The findings of this research provide beneficial information that teenage motherhood is stressful and hazarduous, and it is a condition that should be given the attention it deserves, so that it would not result in life damage of the teenage mothers.

2. Similarly, it is realized through the study that teenage motherhood necessitates the social, family and peer support to reinforce the self esteem of the mother so as to acquire and sustain the desired psychological adjustment.

3. The awareness of the stakeholders widened by the finding that with professional handling of teenage motherhood by counselors and health care givers, the teenage mother's future could be brigthened.

Therefore, maternal psychological distress is an important concern for researchers, because it has been linked to problematic outcomes for mothers including: repeated pregnancies, low parenting competency and poor educational outcomes (Eshbaugh, 2006; Holub, Kershaw, Ethier, Lewis, Milan & Ickovics 2007.).

In addition, maternal distress has detrimental effects for children's outcomes, including language development; coping skills; social adjustment and physical health. Therefore, the period should be managed with care and expertise.

Recommendations

Based on the findings of this study, the researcher wishes to make the following recommendations:

- The family and significant others should take time to appreciate the value of teenage mothers and understand their developmental task and challenges so as to device methods of relating with them and not castigate them or label them as spoilt children and treated as lepers. This is necessary to maintain and sustain pleasant social relationship with them so as to facilitate permissible environment where they can express themselves freely.
- Psychological intervention programmes should be put in place that will guide and lead teenagers in the path of self-rediscovery,; identity formation and psychosocial adjustment to life challenges.
- Government must through different sectors address the various barriers to girls development. Facilitation of girls' access to education through flexible hours and scholarship will help to reduce interference.
- Sex education should be taught compulsory in schools to teenagers so that lack of information would no longer facilitate ignorance as a factor that contributes to the manifestation of the stage of teenage motherhood.
- The society should be made to understand the ills associated with stigmatization and its resultant consequences on the developmental nature of teenage mothers and their children.
- Government should encourage the media by projecting programmes that encourage the development of the girl-child and campaign against teenage pregnancy by advocacy.

- Counsellors and educational pshychologists should integrate self esteem, social support, stigmazation, self concept and peer influence into intervention programs targeting out-of-school teenage mothers.
- The government should ensure that functional guidance and counselling centres are established in schools as a leverage to support the adjustment of teenagers to academic and life challenges.
- Parent should realize that a girl's childhood must be preserved, nurtured, cherished and protected so that she can fully develop her potentials in life.
- Parent and teachers should be supportive of the developmental needs of teenagers by listening to them and offer solutions to their problems.
- Government should organize a forum where out-of-school teenage mothers will be rehabilitated ie, by sending them back to school or empowering them with jobs and trades.

Contribution to Knowledge

Through this study, a strong basis for bridging the gap of past research on factors that could influence the psychological adjustment of out-of-school teenage mothers has being established.

The findings of this study serve as a platform for the orientation and awareness of parents and significant others that teenage mothers are often faced with complex psychological challenges due to their immature developmental state which tend to place mother and child at great risk of maladjustment and dysfunctional development.

Through the help of counselling intervention, teenage mothers can still go back to school. The study can add to the cognitive disposition of parents by knowing how to handle girl-child.

The study shows that stigmatization, social support, family support, peer support, self-esteem, self-concept, sexual debut, depression and socioeconomic status could impact on the psychological adjustment of out-of-school teenage mothers, and misuse of girl-child could lead to young motherhood.

Suggestions for Further Research

An important study of this nature should cover a wider scope than what the researcher covered in this study due to constraints. Therefore, it is suggested that a closely replica of this study be carried out after a few years to confirm the results obtained in this study. The study should also be extended to further examine adolescent motherhood and its implication on national development.

It is also suggested that the study could be done in other states of Nigeria to know whether the problem in question is a national issue. Also, research should be conducted among the teenage mothers and teenage fathers.

REFERENCES

Aboud, F. E. 2005. The development of prejudice in childhood and adolescence. In J. F.Dovidio, P.Glick, & L. A.Rudman (Eds.), On the nature of prejudice: Fifty years after.

Abraham C, & Sheeran P. 2005. The Health Belief Model. In: Conner M, Norman P, Eds. *Predicting Health Behaviour*. Maidenhead: Open University Press; 2005:28-80.

Abrams, L., & Curran, L. 2007. Not just a middle-class affliction: crafting a social work research agenda on postpartum depression. *Health & Social Work, 32*(4), 289-296.

Adetoro, N., 2011. "Undergraduate Self-Concept and Use of Information: A Correlative Study". *PNLA Quarterly, the official publication of the Pacific Northwest Library Association* 75 (2), P. 2.

Adeyemo, D. A., & Torubeli, V.A. 2008. Self-efficacy, self-concept and peers influence as correlates of achievement among secondary school students in transition. *Pakistan Journal of Social Sciences,* 5(1), 10-16.

Afable-Munsuz A., Speizer, I., Magnus, H, & Kendall, C. 2006. A positive orientation toward early motherhood is associated with unintended pregnancy among New Orleans youth. *Maternal and Child Health Journal,* 10(3), 265-276.

Ajuwon, A. J. 2005. Attitudes, norms and experiences of sexual coercion among young people in Ibadan, Nigeria. In: *Sexwithout consent*: Young people in developing countries (Ed Jejeebhoy SJ, Shah, I & Thapa, S), 96-104. Zed Book, ISBN: 1184277.

Akers, R. & Jensen, G. 2006. The empirical status of social learning theory of crime and deviance: The past, present, and future. In F. T. Cullen, J. P Wright, & K. R. Blevins, (Eds.) *Taking Stock: The Status of Criminological Theory. Advances in Criminological Theory*, Vol. 15. (pp. 37-76). New Brunswick, NJ: Transaction Publishers.

Allen E, Bonnell C, Strange V, Copas A, Stephenson J, Johnoson A,& Oakley A 2007. Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomised trial of sex education and their implications for policy. *J Epidemiol Community Health.* 61(1): 20–27.

Allen, J. P., Porter, M. R., & McFarland, F. C. 2006. Leaders and followers in adolescent close friendships: Susceptibility to peer influence as a predictor of risky behavior, friendship instability, and depression. *Development and Psychopathology*, 18, 155-172.

Allen, J. P., Porter, M. R., McFarland, F. C., Marsh, P., & McElhaney, K. B. 2005. The two faces of adolescents' success with peers: Adolescent popularity, social adaptation, and deviant behavior. *Child Development*, 76(3), 747-760.

American Psychological Assoication. 2012. "Education & Socioeconomic Status. Retrieved from http://www.apa.org/pi/ses/resources/publications/factsheet-education.aspx

American Academy of Pediatrics Committee on Substance Abuse. 2001. Alcohol use and abuse: A pediatric concern. *Pediatrics*, 108, 185–189.

Anderson, G. 2005. Family relations, adjustment and well-being in a longitudinal study of children in care. *Child and Family Social Work, 10*, 43-56.

Arai, L. 2009. *Teenage pregnancy: the making and unmaking of a problem*. Policy Press.

Aremu, A. O. & Ogbuagu, V. E. 2005. Correlates of parental influence, school environment, learners' interest and self-efficacy on academic performance of police children in Ibadan, Nigeria. *African Journal for the Psychological Study of Social Issues*, 8, 1, 42-57.

Armour S., & Haynie D.L. 2007. Adolescent sexual debut and later delinquency. *Journal of Youth and Adolescence*;36(2):141–152.

Asmussen, K. & Weizel, K. 2006. *Evaluating the evidence: what works in supporting teenage parents*. National Academy for Parenting Practitioners.

Atuyambe, L, Mirembe, F, Tumwesigye, N, Annika, J, Kirumira, E & Faxelid, E. 2008. Adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood in Wakiso district, central Uganda: *Reproductive Health Journal* 5: 13.

Awam, S. 2009. Problems of teenage sexuality, sex education in Nigerian Secondary Schools as a way out, *Nigerian Journal of Humanities and social sciences*, Vol. 3. PP 121-123.

Bandura, A. 1977. *Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. 2007. Much ado over faulty conception of perceived self-efficacy grounded in faulty experimentation. *Journal of Social and Clinical Psychology*, 26(6), 641-758. [see Cahill et al.'s problematic piece]

Barnet B, Arroyo C, Devoe M, Duggan AK. 2004.Reduced school dropout rates among adolescent mothers receiving school-based prenatal care. *Arch Pediatr Adolesc Med.*;158(3):262–268.

Barrett, A. E., & Turner, R. J. 2005. Family structure and mental health: The mediating effects of socioeconomic status, family process, and social stress. *Journal of Health and Social Behaviour*, 36, 156–169.

Beers, L. S., & Hollo, R. 2009. Approaching the adolescent headed family: a review of teen parenting. *Current Problems in Pediatric Adolescent Health Care, 39,* 219-233. doi:10.1016/j.cppeds.2009.09.001.

Beheshtifar, M & Rahimi-Nezhad, Z. 2012 Role of Self-Concept in Organizations *European Journal of Economics, Finance and Administrative Sciences* ISSN 1450-2275 Issue 44.

Berger, K. S. 2005. *The developing person through the life span.* New York; Worth Publishers.

Biddlecom, A, Gregory, R, Mensch B, & Lloyd C, 2006. Premarital sex and schooling transitions in four sub-Saharan countries. Paper presented at the *IUSSP Seminar "Sexual and Reproductive Transitions of Adolescents in Developing Countries";* Cholula, Puebla, Mexico. 6-9.

Bimbola, K.O., & Ayodele, J.C. 2007. The menace of teenage motherhood in Ekiti State. *Middle-East Journal of Scientific Research*, 2(3-4): 157-161.

Birkeland, J., Thompson, J. K., & Phares, V. 2005. Adolescent motherhood and postpartum depression. *Journal of Clinical Child and Adolescent Psychology, 34*(2), 292-300.

Boden, J., Fergusson, D., & Horwood, J. 2008. Early motherhood and subsequent life outcomes. *Journal of Child Psychology and Psychiatry, 49,* 151-160.

Bonari L, Pinto N, & Ahn E, 2004. Perinatal Risks of Untreated Depression During Pregnancy. *Can J Psychiatry*: 49:727.

Borcherding, K. SmithBattle, L. & Schneider J. K. 2005. A preliminary investigation of the grandparent support scale for teenage mothers, in *Journal of Family Nursing*, Vol. 11(3):289-306.

Boushey, H, & Weller, C, 2005. Inequality Matters: The Growing Economic Divide in America and its Poisonous Consequences.. *"What the Numbers Tell Us."* Pp 27-40. Demos.

Bozick R. 2006. Precocious behaviors in early adolescence – employment and the transition to first sexual intercourse. *Journal of Early Adolescence*;26(1):60–86.

Breen, A., & McLean, K., Eds. 2010. Constructing resilience: adolescent motherhood and the process of self-transformation. In McLean, K. C., & Pasupathi, M. (Eds), *Narrative development in adolescence (*pp. 151-168). New York: Springer.

Breheny, M. & Stephens, C. 2006. "Strengthening Social Support: Health Professionals' Views of the Health Care Needs of Adolescent Mothers." *Australian Journal of Rehabilitation Counselling* 12(2): 63-72.

Breheny, M. & Stephens, C. 2007. "Irreconcilable Differences: Health Professionals' Constructions of Adolescence and Motherhood." *Social Science and Medicine* 64(1): 112-24.

Brown, B. B. & Klute, C. 2006. Friendships, cliques, and crowds. In G. R. Adams & M. D. Berzonsky (Eds.). *Blackwell Handbook of Adolescence* (pp. 330-348). Malden, MA: Blackwell Publishing.

Brown, J. D., & Marshall, M. A. 2006. The three faces of self-esteem. In M. Kernis (Ed.), *Self-esteem: Issues and answers* (pp. 4-9). New York: Psychology Press.

Brown. J. D, Woods E. R, Buman M, P, Harris .S. K, & Cox J. E. 2007. Depression and Social Support over Time in Adolescent Mothers. *Journal of Adolescent Health*;40:S44–S44.

Bruce G. & Phelan-Jo C.2008 "Conceptualizing Stigma". *Annual Review of Sociology*. p.363.

Bunting, L., & McAuley, C. 2004. Research review: Teenage pregnancy and motherhood: The contribution of support. *Child and Family Social Work, 9*, 207-215.

Campbell, J. D., Trapnell, P. D., Heine, S. J., Katz, I. M., Lavallee, L. F., & Lehman, D. R. 1996. Self-concept clarity: Measurement, personality correlates, and cultural boundaries. *Journal of Personality and Social Psychology, 70*(1), 141-156.

Carl P, 2011. Parents must support adolescents and start reducing support. http://www.psychologytoday.com/blog/surviving-your-childs adolescence/201101/adolescence-and-parental-support.

Cauce, A. M., Mason, C., Gonzales, N., Hiraga, Y, & Liu, G. 2005. Social support during adolescence: *Methodological and theoretical considerations*. In: K, Hurrelmann, S. F. Hamilton (eds). *Social problems and social contexts in Adolescence*: Perspectives Across Boundaries. New York, NY: Aldine de Gruyter; 131-151.

Chassin L, Flora D. B, & King K. M. 2004. Trajectories of alcohol and drug use and dependence from adolescence to adulthood: The effects of familial alcoholism and personality. *Journal of Abnormal Psychology*;113:483–498.

Children's Report Card. 2008. Population trends and profiles: Sacramento County children's coalition. Retrieved November 9, 2009.

Clements D. 2003. Adolescent motherhood: A meta-synthesis of qualitative studies. *MCN: The American Journal of Maternal Child Nursing*: 28(2):93–99.

Coley, R. L., & Chase-Lansdale, P. L. 1998. Adolescent pregnancy and parenthood: Recent evidence and future directions. *American Psychologist, 53*, 152–166.

Collins, B.A. 2005, *Missing voices: Teenage pregnancy and social policy*, Thesis (PhD), Victoria University of Wellington.

Collins, P. Y. 2008. Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science & Medicine, 67*(3), 389-397.

Connor M, & Norman P. 2005. Predicting Health Behaviour: A Social Cognition Approach. In: Conner M, Norman P, Eds. *Predicting Health Behaviour*. Maidenhead: Open University Press.

Cox, E., Buman,M. Valenzuela, J., Joseph, P., Mitchell, A & Woods, E. 2009. "Depression, parenting attributes, and social support among adolescent mothers attending a teen Tot Programme," *J Pediatr Adolesc Gynecol* vol. 21, no. 5, 275-281.

Crockett LJ, Moilanen KL, Raffaelli M, Randall BA. 2006. Psychological profiles and adolescent adjustment: A person-centered approach. *Development and Psychopathology*. 18:195–214.

Culp, A., Culp, R., Noland, D., & Anderson, J. 2006. Stress, marital satisfaction and child care provisions by mothers of adolescent mothers: considerations to make when providing services. *Children and Youth Services Review, 28,* 673-81.

David, H. C. 2000. Global Depression Scale (GDS) http://www.oscarcanada.org/oscar-users/emr-resource/templates/GDS

Davis-.Kean P. E. 2005. The influence of parent education and family income on child achievement: The indirect role of parental expectations and the home environment. *Journal of Family Psychology*: 19:294–304.

de Graaf H, Vanwesenbeeck I, Meijer S, Woertman L, Meeus W. 2009. Sexual trajectories during adolescence: Relation to demographic characteristics and sexual risk. *Archives of Sexual Behaviour*;38:276–282.

Dennis, C. 2005. "Postsocial and Psychological Interventions for Prevention of Postnatal Depression: *Systematic Review*." BMJ 331(7507): 15.

Dilworth, K. 2000. Appendix A: Literature review. *Pro-action, postponement, preparation and support: a framework for action to reduce the rate of teen pregnancy in Canada*. Ottawa: Canadian Institute of Child Health.

Dopheide J. A. 2006. Recognizing and treating depression in children and adolescents. *Am J Health Syst Pharm*;63:233.

Dressler W.W., & Balieiro M.C. 2007. A prospective study of cultural consonance and depressive symptoms in urban Brazil. *Social Science & Medicine*: 65(10):2058–2069.

Dunst, C. J. & Trivette, C. M. 2005."Measuring and Evaluating Family Support Programme Quality." *Winterberry Press Monograph Series* (Winterberry Press).

East, P. L., & Felice, M. E. 1996. Adolescent pregnancy and parenting: Findings from a racially diverse sample. Mahway, NJ: Lawrence Erlbaum Associates.

East, P. L., Khoo, S., & Reyes, B. T. 2006. Risk and protective factors predictive of adolescent pregnancy: A longitudinal, prospective study. *Applied Developmental Science, 10*(4), 188-199. doi: 10.1207/s1532480xads1004_3

Edzisani E, S, 2009. *Psychological Impact Of Teenage Pregnancy On Pregnant Teenagers*: Research Dissertation Submitted in partial fulfilment of the requirements for the degree of Master Of Arts In Clinical Psychology In the Faculty Of Humanities (School of Social Sciences) at the University Of Limpopo.

Eisen M, Zellman G, L, & McAlister A, L. 1992. A Health Belief Model-Social Learning Theory approach to adolescents' fertility control: findings from a controlled field trial. *Health Ed Behav*. 1992;19:249-262.

Elder G, H, & Shanahan M, J. 2006. The Life Course and Human Development. In: Lerner RM, Damon W, editors. *Handbook of Child Psychology* Vol 1, Theoretical Models of Human Development. Hoboken, NJ: John Wiley & Sons; pp. 665–715.

Emma, L., & Georgina, F.L. 2010. *Sex, contraception and childbearing among high-risk youth:* Do different factors influence males and females Family Planning Perspectives, 30, 163–169.

Erol, R. Y., & Orth, U. 2011. Self-Esteem Development From Age 14 to 30 Years: A Longitudinal Study. *Journal of Personality and Social Psychology*. Advance online publication.

Eshbaugh E. M. 2006. Predictors of Depressive Symptomatology among Low-Income Adolescent Mothers. *Archives of Women's Mental Health*;9:339–42.

Eshbaugh, E. M. 2007. Adolescent mothers and depression: Predictors of resilience and risk through the toddler years. *Journal of Family Social Work*, *10*(3), 13-29. doi: 10.1300/J039v10n03_02

Esparza, M. 2006. *Adolescents and Their Music*: If it's Too Loud, You're Too Old. New York: Garland Pub.

Falci C & Mortimer. J. 2007. *Teenage Parents and Depressed Mood in Adulthood: Gender, Selection, Stressors and Resources*. Presented at the annual meeting of the American Sociological Association; August 11; New York, NY.

Finfgeld-Connett D, 2007. Concept comparison of caring and social support**.** *Int J Nurs Terminol Classif* , **18:**58-68.

Finfgeld-Connett D, 2005. Clarification of social support**.** *J Nurs Scholarsh* 2005, **37:**4-9

Friedman, H. 2011. *Personality: Classic theories and modern research*. Boston, MA: Allyn & Bacon. pp. 131–135.

Frost, J. J., & Driscoll, A. K. 2006. Sexual and reproductive health of U.S. Latinas: A literature review. *Occasional Report*. New York: Guttmacher Institute, No. 19.

Gee C, & Rhodes J. 2003. Adolescent mothers' relationship with their children's biological fathers: Social support, social strain, and relationship continuity. *Journal of Family Psychology*;17(3):370–383.

Gehlbach, S.H., DeGruy, F.V., and Kaplan, B. H. 1998. The Duke-UNC Functional Social Support Questionnaire: Measurement of Social Support in Family Medicine Patients *Medical Care, 26*(7), 709-723.

Gold, D. & Jones, R. K., 2005. "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception." *JAMA,* 293(3), 340–348.

Gollnick, C, 2013. Multicultural Education in a Pluralistic Society.

Grant, M. & Hallmark, K. 2006."*Pregnancy–related school dropout and prior school performance in South Africa, Policy Research Division Working Paper* no. 212, Population Council, New York.

Green, J., Nelson, G., Martin, A.J. & Marsh, H., 2006. "The causal ordering of self-concept and academic motivation and its effect on academic achievement". *International Education Journal*. 7(4), P. 535.

Greenberg, J. 2008. Understanding the vital human quest for self-esteem. *Perspectives on Psychological Science*, *3*, 48-55.

Guilamo-Ramos V, Jaccard J, & Dittus P. 2010. *Parental Monitoring of Adolescents: Current Perspectives for Researchers and Practitioners.* New York: Columbia University Press.

Guilamo-Ramos, V., Jaccard, J., Turrisi, R., & Johansson, M. 2005. Parental and school correlates of binge drinking among middle school students. *American Journal of Public Health, 95*(5): 894-899.

Gustafsson, S. & Warku, S. 2007. *Teenage motherhood and long- run outcomes in South Africa.*University of Amsterdam, Netherlands.

Ha JH, Hong J, Seltzer MM, & Greenberg JS. 2008. Age and gender differences in the wellbeing of midlife and aging parents with children with mental health or developmental problems: Report of a national study. *Journal of Health and Social Behaviour*;49:301–316.

Hair, E., Moore, K., Garrett, S., Kinukawa, A., Lippman, L. & Michelson, E. 2005. The parent adolescent relationship scale. In K. Moore & L. Lippman (Eds.) *What do children need to flourish* (pp.183-202). New York: Springer Science.

Harden A, Brunton G, Fletcher A, & Oakley, A. 2009. Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies. *British Medical Journal 339:* b4254.

Harter, S. 2006. *The construction of the self*. New York: Guilford.

Harter, S., & McCarley, K. E. 2004, April. *Is there a dark side to high self-esteem leading to adolescent violence?* Paper presented at the meeting of the American Psychological Association. Honolulu, Hawaii.

Henretta JC, Grundy EM, Okell LC, & Wadsworth ME (2008) Early motherhood and mental health in midlife: a study of British and American cohorts. *Aging Ment Health* 12:605-14.

Herrman JW. 2008. Adolescent perceptions of teen births. *J Obstet Gynecol Neonatal Nurs*;3:42-50.http://www.plosone.org/article/findcited/5281135

Hewitt, J, P. 2009. *Oxford Handbook of Positive Psychology*. Oxford University Press. pp. 217–224.

Holub C, Kershaw T, Ethier K, Lewis J, Milan S & Ickovics J. 2007. Prenatal and Parenting Stress on Adolescent Maternal Adjustment: Identifying a High-Risk Subgroup. *Maternal and Child Health Journal*;11:153–59.

Hotz V .J, McElroy S. W, & Sanders S. G. 2005.Teenage Childbearing and Its Life Cycle Consequences: Exploiting a Natural Experiment. *Journal of Human Resources*:40:683–715.

Huang, C., & Lee, I. 2008. The first three years of parenting: Evidence from the fragile families and child well-being study. *Children and Youth Services Review*, *30*(12), 1447-1457.

Huang ZJ, Wong FY, & Ronzio CR, 2007. Depressive symptomatology and mental health help-seeking patterns of U.S.- and foreign-born mothers. *Matern Child Health J*:11:257.

Ickovics J. R, Meade C. S, Kershaw T. S, Milan S, Lewis J. B, & Ethier K. A. 2006. Urban teens: Trauma, posttraumatic growth, and emotional distress among female adolescents. *Journal of Consulting and Clinical Psychology*. 2006;74:841–850.

Jackson, L. M., Pratt, M. W., Hunsberger, B., & Pancer, S. M. 2005. Optimism as a mediator between perceived parental authoritativeness and adjustment among adolescents: Finding the sunny side of the street. *Social Development, 14*, 273–304.

Jacoby, A. 2005. "Epilepsy and Social Identity: the Stigma of a Chronic Neurological Disorder." *The Lancet Neurology* 4.3:171-178.

Jackson, C. W. 2009. Family support and resources for parents of chiildren who are deaf or hard of hearing. Jacksonville: Florida State University.

Jessor S.L., & Jessor R. 1975. Transition from virginity to nonvirginity among youth: a social-psychological study over time. *Developmental Psychology*;11(4):473–484.

Jing, H.E., 2007. "Analysis on the Relationship among Test Anxiety". *Self-concept and Academic Competency*. 5 (1), P. 48.

Kalil, A. & Kunz, J. 2000. '*Long Term Effects of Teenage Childbearing on Mental Health in Young Adulthood*'. University of Chicago and Joint Centre for Poverty Research.

Kahan D, G. 2010. Current voices of former teen mothers: challenges and supports to parenting: *Unpublished Master of social work project of california state university, sacramento.*

Kaufman, C.E., De Wet, T. & Stadler, J. 2001. *Adolescent Pregnancy and Parenthood in South Africa* 3 2(2):147-160.

Kaye, D, K. 2008. Negotiating the transition from adolescence to motherhood: Coping with prenatal and parenting stress in teenage mothers in Mulago hospital, Uganda: *BMC Public Health*, **8**:83.

Kendig, S. M. 2010. Adolescent Girls' Ambivalence towards Pregnancy: *The Role of the Self-Concept and Race/Ethnic and Class Locations:* University of Maryland Population Association of America Annual Meeting Dallas, TX.

Kendig H, Dykstra PA, van Gaalen RI, & Melkas T. 2007. Health of aging parents and childless individuals. *Journal of Family Issues*;28:1457–1486.

Khaleque A, Rohner R. 2002. Perceived parental acceptance-rejection and psychological adjustment: A meta analysis of cross-cultural and intracultural studies. *Journal of Marriage and the Family*;64:54–64.

Kimani, C.G., Cheboswony, M., Kodero H. M. & Misigo B.L., 2009. "The self-concept and academic performance of institutionalized and non-institutionalized HIV/AIDS orphaned children in Kisumu municipality". *Educational Research and Review*, 4 (3), P. 107.

Kirby, D. 1997. No easy answers: *Research findings on programs to reduce teen pregnancy.* Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

Kirby D, Lepore G, & Ryan J. 2005. Factors affecting teen sexual behavior, pregnancy, childbearing and sexually transmitted disease: Which are important? Which can you change? Washington, DC: *The National Campaign to Prevent Teen Pregnancy*.

Klaw, E. 2008. Understanding urban adolescent mothers' visions of the future in terms of possible selves. *Journal of Human Behavior in the Social Environment, 18,* 441.

Klein, J. D. 2005. Adolescent pregnancy: current trends and issues. *Pediatrics, 116*(1), 281-286.

Kramer K., Lancaster J. 2010. Teen motherhood in cross-cultural perspective. *Annals of Human Biology:* 37(5):613–628.

Lassa, L. 2006. *Discursive Struggles Within Social Welfare: Restaging Teen Motherhood.* National Health Council. USA.

Leadbeater, B. J., & Linares, O. 1992. Depressive symptoms in Black and Puerto Rican adolescent mothers in the first three years postpartum. *Development and Psychopathology, 4,* 451–468.

Lee, J. 2004. Pregnant and parenting teens and poverty. *Woman View*, 8(5), 1-2.

Lee, Y. 2009. Early motherhood and harsh parenting: the role of human, social, and cultural capital. *Child Abuse & Neglect, 33*, 625-637.

Limmer M. 2005. Keeping the needs of teenage parents at the heart of services *The Journal of The Royal Society for the promotion of Health* **125** (5), pp 214.

Lloyd C, 2005. Growing Up Global: The Changing Transitions to Adulthood in Developing Countries. Washington: *National Academies Press*.

Lloyd C, & Mensch B, 2008. Marriage and childbirth as factors in school dropout: An analysis of DHS data from sub-Saharan Africa. *Population Studies*;62(1):1–13.

Logsdon, M. C., Birkimer, J. C., Simpson, T., & Looney, S. 2005. Postpartum depression and social support in adolescents. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 34*(1), 46–54.

Logsdon M, & Davis D. 2003. Social and professional support for pregnant and parenting women. *MCN: The American Journal of Maternal Child Nursing*: 28(6):371–376.

Lopez LM, Tolley EE, Grimes DA ,& Chen-Mok M.2009. Theory-based strategies for improving contraceptive use: *A systematic review.* Contraception. 2009*;*79*(*6*):*411-417.

Madsen K, & Poulsen HS: 2011. Needs for everyday life support for brain tumour patients' relatives: systematic literature review**.** *Eur J Cancer Care (Engl)*, 20**:**33-43.

Major, B, & O'Brien, L. 2005. *Annual Review of Psychology*, Vol.56 Issue 1, p393-421, 29p, 1.

Makiwane, M., Desmond, C., Richter, L. & Udjo, E. 2006. *Is the child support grant associated with an increase in teenagers fertility in South Africa.* Human Science Research Council, Pretoria.

Margarita, D. Sonya, G. Tiffany, Frank, J. & Elizabeth, N. 2004. Sexual Risk and Protective Factors: Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing, and Sexually Transmitted Disease: Which are Important? Which Can you change? Washington, DC: The National Campaign to Prevent Teen Pregnancy.

Markham C. M, Lormand D, & Gloppen K. M, 2010. Connectedness as a predictor of sexual and reproductive health outcomes for youth. *Journal of Adolescent Health* 2010 Mar;46(3 Suppl):S23-41.

Marteleto L, Lam D, & Ranchhod V, 2006. Schooling and early childbearing in urban South Africa. *PSC Research Report* No 06-610.

Masatu MC, Kazaura MR, Ndeki S, & Mwampambe R 2009. Predictors of risky sexual behavior among adolescents in Tanzania. *AIDS and Behaviours* 13: 94–99.

McDermott, E., & Graham, H. 2005. Resilient young mothering: Social inequalities, late modernity and the "problem" of "teenage" motherhood. *Journal of Youth Studies, 8(1),* 59-79.

McDonald, L., Conrad, T., Fairlough, A., Fletcher, J., Green, L., Moore, L., & Lepps, B. 2008. An evaluation of a group work intervention for teenage mothers and their families. *Child and Family Social Work, 14,* 45-57. doi: 10.1111/j.1365-2206.2008.00580.x

McDowell I. 2006. Measuring health: *A guide to raing scales and questionnaires*. 3rd ed. New York, NY: Oxford University Press, 768 p.

McElhaney, K. B., Immele, A., Smith, F. D., & Allen, J. P. 2006. Attachment organization as a moderator of the link between friendship quality and adolescent delinquency. *Attachment and Human Development*, 8(1), 33 – 46.

McKenzie, J. F., Pinger, R. R., & Kotecki, J. E. 2005. *An introduction to community health* (5th ed.). Sudbury, MA: Jones and Bartlett Publishers.

Meade CS, Kershaw TS, & Ickovics JR: 2008. The intergenerational cycle of teenage motherhood: an ecological approach. *Health Psychol*, **27:**419-429.

Meeus, W. 2011. The study of adolescent identity formation, 2000-2010: a review of longitudinal research. *Journal of Research on Adolescence, 21,* 75-94. doi: 10.1111/j.1532-7795.2010.00716.x.

Milan, S., Ickovics, J. R., Kershaw, T., Lewis, J., Meade, C., & Ethier, K. 2004. Prevalence, course, and predictors of emotional distress in pregnant and parenting adolescents. *Journal of Consulting and Clinical Psychology, 72*(2), 328-340.

Milne, A., & Plourde, L. A. 2006. Factors of a Low-SES Household: What Aids Academic Achievement?

Mishra, S.K., 2007. "Emotional labor as a means of influencing the self-concept of consumers in service organization". *International Marketing Conference on Marketing & Society*, 8-10 April. P. 598.

Moffitt TE, E-Risk Study Team 2002 Teen-aged mothers in contemporary Britain. *J Child Psychol Psychiatry* 43:727-42

Mokwena, J. P. 2003. *The general health and coping strategies of teenage mothers.* Unpublished master"s dissertation, University of Limpopo, Polokwane.

Mollborn, S. 2009. American Adults' Norms about Nonmarital Pregnancy and Their Influence on Willingness to Provide Resources to Parents. *Journal of Marriage and Family.* 2009;71:122–34.

Mollborn S., & Morningstar E. 2009. Investigating the relationship between teenage childbearing and psychological distress using longitudinal evidence. *Journal of Health and Social Behaviour:* 50(3):310–326.

Moore, K. A., Morrison, D. R., & Greene, A. D. 1997. Effects on the children born to adolescent mothers. In R. A. Maynard (Ed.), *Kids Having Kids* (pp. 145-180). Washington, D.C.: Urban Institute Press.

Nancy, B. 2004. Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review*, 21, 1-38.

National Mental Health Association. 1996. *American Attitudes about Clinical Depression and its Treatment: Survey Implications for Women*. Alexandria, VA.

Nausheen B, Gidron Y, Peveler R, & Moss-Morris R, 2009. Social support and cancer progression: a systematic review. *J Psychosom Res*, 67**:**403-415.

Newsom, J. T., Rook, K. S. & Nishishiba, M. 2005. Understanding the relative importance of positive and negative social exchanges: examining specific domains and appraisals. *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, 60B, 304–312.

NIHFW 2005: Women's Empowerment and development are vital for achieving reproductive health goals. NIHFW news letter VII: 3-4.

Oberlander, S. E., Shebl, F. M., Madger, L. S., & Black, M. M. 2009. Adolescent mothers leaving multigenerational households. *Journal of Clinical Child and Adolescent Psychology, 38,* 92-104. doi: 10.1080/15374410802575321.

Okoiye, O, E & Asamaigo, S, E. 2011. Family factors, Self-esteem and Peer involvement as predictors of dyscaculia among students with learning disabilities in Ikeja, Lagos State Nigeria: *Journal of Research in Education and Society* Volume2, Number2, pp96-106.

Okoiye, O. E, & Falaye, O. 2010. Self-appraisal of pregnant adolescents: The predictive effect of some psychological variables: *International Journal of Research in Education:* Vol 2, Number 9, pp 127-133.

Okoiye, O. E, Ohizu, E. C, & Adediran, I. A, 2011. Measured influence of sexual debut, social support and privacy preference on perceived level of depression among in-school adolescents in Abeokuta, Ogun State, Nigeria: *African Journal of Studies in Education* Vol, 8 No. 1&2, pp. 239-251.

Olsen, J.M., Breckler, S.J., & Wiggins, E.C. 2008. *Social Psychology Alive*(1st ed.) Canada:Nelson.

Oyserman, D., & James, L. 2009. Possible selves: From content to process. In K. Markman, W. M. P. Klein, & J. A. Suhr (Eds.), *The handbook of imagination and mental stimulation* (pp. 373-394). NY: Psychology Press.

Palacios, J & Kennedy, H, 2010. Reflections of Native American Teen Mothers: *J Obstet Gynecol Neonatal Nurs*. 39 (4): 425-434.

Parmar, P., & Rohner, R. P. 2005. Relations among perceived intimate partner acceptance, remembered parental acceptance, and psychological adjustment among young adults in India. *Ethos, 33,* 402-413.

Patacchini, E. & Zenou, Y. 2008. 'The strength of weak ties i7n crime.' *European Economic Review*, 52, 209-36.

Pillay, I. 2008. *Teenage pregnancy*. Newspaper 26 May, Satyagraha.

Raine T, Minnis A. M, & Padian N. S. 2003. Determinants of contraceptive method among young women at risk for unintended pregnancy and sexually transmitted infections. *Contraception*;68:19–25.

Raneri L. G, & Wiemann C. M. 2007. Social ecological predictors of repeat adolescent pregnancy. *Perspect Sex Reprod Health*;39:39-47.

Raymond C, Metge C, Alessi-Severini S, Dahl M, Schultz J, & Guenette W.2010. Pharmaceutical Use in Manitoba: *Opportunities to Optimize Use*. Winnipeg, MB: Manitoba Centre for Health Policy.

Ream G.L. 2006. Reciprocal effects between the perceived environment and heterosexual intercourse among adolescents. *Journal of Youth and Adolescence.* 2006;35(5):771–785.

Ream G.L., & Savin-Williams R.C. 2005. Reciprocal associations between adolescent sexual activity and quality of youth-parent interactions. *Journal of Family Psychology*;19 (2):171–179.

Regnerus M. 2007. *Forbidden Fruit: Sex and Religion in the Lives of American Teenagers*. New York, New York: Oxford University Press.

Reid, V., & Meadows-Oliver, M. 2007. Postpartum depression in adolescent mothers: An integrative review of the literature. *Journal of Pediatric Health Care*, *21*(5), 289-298.

Resnick MD BP, Blum RW, Bauman KE, Harris KM, Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, & Udry JR 2007 Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *JAMA* 278: 823–832.

Richter, L.M., Norris S.A. & Ginsburg C. 2007. *The silent truth of teenage pregnancy-Birth to Twenty cohort's next generation.* School of Psychology, University of Kwa-Zulu Natal, Durban.

Rios-Neto, E., & Miranda-Ribbeiro, L. 2009. "Questões Emergentes na Demografia Brasileira" *Revista Brasileira de Estudos da População* 22 (2): 371-480.

Rohner R. 1991. *Handbook for the study of parental acceptance and rejection.* University of Connecticut; Storrs, CT.

Rohner R, Khaleque A, & Cournoyer DE. 2007. Parental acceptance-rejection theory, methods, evidence, and implications: http://vm.uconn.edu/~rohner.

Rose A, Koo HP, Bhaskar B, Anderson K, White G, & Jenkins RR. 2005. The influence of primary caregivers on the sexual behavior of early adolescents. *The Journal of Adolescent Health*:37:135–144. doi: 10.1016/j.jadohealth.

Rosen, A. 2009. Fear of negative evaluation and the reluctance to transmit bad news. *Journal of Communication*, 22, 124–141.

Rosenberg, M. 1965. Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Rosengard, C., Phipps, M & Pollock., L. 2006. Concepts of the advantages and disadvantages of teenage childbearing among pregnant adolescents: A qualitative analysis. *Journal of Adolescent Health, 38(2).*

Rosenstock IM. 1974. The Health Belief Model and preventive health behavior. *In:* Becker MH, *ed. The Health Belief Model and Personal Health Behavior. Thorofare , NJ : Slack;* 1974.

Sabia J.J. 2007. Early adolescent sex and diminished school attachment: selection or spillovers? *Southern Economic Journal*;74(1):239–268.

Salami .O. 2000. *Socio-Economic Status Scale (SESS)* Department of Guidance and Counselling University of Ibadan.

Saleebey, D. 2006. *The Strengths perspective in social work practice.* (4th ed.). Boston, MA: Pearson/Allyn & Bacon.

Schmidt R. M, & Wiemann C. M, 2006. Moderate to severe depressive symptoms among adolescent mothers followed four years postpartum. *Journal of Adolescent Health*: 38(6):712–718.

Schmidt RM, Weimann CM, Rickert VI, & Smith EO. 2006. Moderate to Severe Depressive Symptoms among Adolescent Mothers Followed Four Years Postpartum. *Journal of Adolescent Health*. 2006;38:712–18.

Schvaneveldt P.L., Miller B.C., Berry E.H., & Lee T.R. 2001. Academic goals, achievement, and age at first sexual intercourse: longitudinal, bidirectional influences. *Adolescence*.;36(144):767–787.

Schwartz, S., Mason, C., Pantin, H., & Szapoczik, J. 2009. Longitudinal relationships between family functioning and identity development in Hispanic adolescents: Continuity and change. *Journal of Early Adolescence, 29*, 177-211. doi: 10.1177/0272431608317605.

Scott, J, & Leonhardt, D, 2005."Class Matters: A Special Edition." New York Times 14 May 2005. http://www.nytimes.com/2005/05/14/national/class/15MOBILITY-WEB.html.

Seidman, S. N., Mosher, W. D., & Aral, S. D. 1994. Predictions of high-risk behaviour in unmarried American women: Adolescent environment as a risk factor. *Journal of Adolescent Health,* 15, 126–132.

Shanok, A & Miller, L. 2007. Stepping up to motherhood among inner-city teens. *Psychology of Women Quarterly, 31(3),* 252-261.

Shek, D. 2005. Paternal and Maternal Influences on the Psychological Well-Being, Substance Abuse, and Delinquency of Chinese Adolescents Experiencing Economic Disadvantage. *Journal of Clinical Psychology, 61(3), 219–234.*

Sills M. R, Shetterly S, Xu S, Magid D, & Kempe A. 2007. Association between Parental Depression and Children's Health Care Use. *Pediatrics*.119:E829–E836.

Simons, L. G., Chen, Y., Simons, R. L., Brody, G., & Cutrona, C. 2006. Parenting practices and child adjustment in different types of households: A study of African-American families. *Journal of Family Issues*, 27, 803–825

Sjolander C, Rolander B, Järhult J, Mårtensson J, & Ahlstrom G, 2012. Health-related quality of life in family members of patients with an advanced cancer diagnosis: A one-year prospective study. *Health and Quality of Life Outcomes*.

Smetana, J. G., Campione-Barr, N., & Metzger, A. 2006. Adolescent development in interpersonal and societal contexts. *Annual Review of Psychology, 57*(1), 255-284.

Smith E, R & Mackie, D, M *Social Psychology* 2007: p. 107.

Smits, I., Soenens, B., Luyckx, K., Duriez, B., Berzonsky, M. & Goossens L. 2008. Perceived parenting dimensions and identity styles: Exploring the socialization of adolescents' processing of identity-relevant information. *Journal of Adolescence, 31*, 151–164.

Social Work Speaks. 2006. *National association of social workers policy statements.* (7th ed.). Washington, DC: NASW Press.

Spencer, M. S., Kalil, A., Larson, N. C., Spieker, S. J., & Gilchrist, L. D. 2000. Multigenerational coresidence and childrearing conflict: Links to parenting stress in teenage mothers across the first two years postpartum. *Applied Developmental Science*, *6*(3), 157-170.

Spriggs A.L., Halpern C.T. 2008. Timing of sexual debut and initiation of postsecondary education by early adulthood. *Perspectives on Sexual and Reproductive Health*;40(3):152–161.

Steinberg, L. 2010. *Adolecence*. New York: McGraw Hill. pp. 1–434.

Steinberg L. 2008. A social neuroscience perspective on adolescent risk-taking. *Development Review*. March;28(1):78–106.

Steinberg L. 2001. We know some things: Parent–adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence* 2001;11(1):1-19.

Steinberg L, & Morris A. S. 2001. Adolescent development. *Annual Review of Psychology*;52:83–110.

Stice, E., Ragan, J., & Randall, P. 2004. Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology, 113,* 155-159.

Stolz, H., Barber, B. & Olsen, J. 2005. Toward disentangling fathering and mothering: An assessment of relative importance. *Journal of Marriage and Family, 67,* 1076-1092.

Teenage Pregnancy & Sexual health Strategy 2009. Department of Health and Department of Children, Schools and Families. Retrieved from http://www.nhs.uk/sexualhealthprofessional/Documents/Sexual_Health_Strategy_2009.pdf

Thompson, L, Uyeda, K, Wright, J, & Halfon, N, 2005. Family support: Fostering leadership and partnerships to improve access (Building State Early Childhood Comprehensive Systems Series No. 14). Los Angeles: University of California, National Center for Infant and Early Childhood Health Policy. *A discussion of the critical role of family support*

Thornberry T.P. 1987. Toward an interactional theory of delinquency. *Criminology*;25(4):863–891.

Tsai Y. F. & Wong T.K. 2003. Strategies for resolving aboriginal adolescent pregnancy in eastern Taiwan *Journal of Advanced Nursing* **41** (4), pp 351-357.

Udry, J. R., & Billy, J. O. G. 1987. Initiation of coitus in early adolescence. *American Sociological Review,* 52, 841–855.

United Nations Programmes on AIDS 2004. *Report of the Global AIDS Epidemic* Geneva, Switzerland.

U.S. Census Bureau. (2005). Available at http://www.census.gov/Press-Release/www/releases/archives/04eductableA.xls. Accessed on November 10, 2007.

US Census Bureau. (2006). Available at http://www.census.gov/hhes/www/poverty/poverty06/table3.pdf. Accessed on November 10, 2007.

Uwakwe, C.B.U., Falola, Y., Adeymo, D. & Osiki, J. 2002. Assertive training and cognitive restructuring programs on the self concept of female Nigerian adolescents forced out of school by unplanned pregnancy. *African Journal of Educational Planning and Policy Studies*. 2: 1; 177-192.

VanDenBerg, M, P. 2012: Protective factors for teen mothers: relations among social support, psychological resources, and child-rearing practices: *Unpublished Masters of Science Thesis in the Department of Human Development and Family Studies* Colorado State University Fort Collins, Colorado.

Wellings, K. 2006. Sexual Behaviour in Context: A Global Perspective. *Lancet* 368:1706-1728.

Werner, E. E., & Smith, R. S. 2001. *Journeys from Childhood to Midlife: Risk, Resilience, and Recovery.* Cornell University Press: Ithaca, NY.

Whitley R., & Kirmayer L.J. 2008. Perceived stigmatisation of young mothers: an exploratory study of psychological and social experience. *Social Science & Medicine*: 66(2):339–348.

WHO 2011, Making Pregnancy safer http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.ht

Wilkinson R., & Pickett K. 2009. Bloomsbury Press; London: The spirit level: Why greater equality makes societies stronger.

Williams T, Connolly J, & Cribbie R. 2008. Light and heavy heterosexual activities of young Canadian adolescents: Normative patterns and differential predictors. *Journal of Research on adolescence*;18:145–172.

Woodward L, Fergusson D, & Horwood J. 2001. Risk factors and life processes associated with teen pregnancy: Results of a prospective study from birth to 20 years. *Journal of Marriage and Family*;63:1170–1184.

Wooten D. B. 2006. From Labeling Possessions to Possessing Labels: Ridicule and Socialization among Adolescents. *Journal of Consumer Research*;33:188–98.

Yahaya, A. & Ramli, J., 2009. "The Relationship between Self-Concept and Communication Skills towards Academic Achievement among Secondary School Students in Johor Bahru". *International Journal of Psychological Studies*. 1 (2), PP. 25-26.

Zastrow, C., & Kirst-Ashman, K. K. 2007. *Understanding human behavior and the social environment* (7th ed.). Australia: Thomson Brooks/Cole.

Ziyane, I.S. & Ehlers, V.J. 2006. Swazi youths" attitudes and perceptions concerning adolescent pregnancies and contraception. *Health SA Gesondheid*, 11 (1), 31 – 42.

APPENDIX "A"

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

Dear Respondents,

This questionnaire is designed basically for a research purpose. It seeks to know how you would react to these statements. All information provided would be treated confidentially. Please, be honest in your Responses.

SECTION A

Demographic Information

1 Age

2 Father's educational qualification……..(PRIMARY SCH) (SECONDARY SCH) (OND) (NCE) (Bsc) (Masters) (OTHERS)……

3 Mothers educational qualification……..(PRIMARY SCH) (SECONDARY SCH) (OND) (NCE) (Bsc) (Masters) (OTHERS)……

4 Father's occupation……

5 Mother's occupation……

Teenage Mothers Post Pregnancy Psychological Adjustment Scale

NO	ITEMS	SA	A	D	SD
1	I am happy being a mother				
2	I would have done an abortion				
3	I regret not being in school				
4	I made a mistake in life				
5	My inability to take care of my child makes me unhappy				
6	Taking care of myself and the child is a big problem				
7	When I see my friends going to school I feel sad				
8	I feel lonely as my friends in school no longer play with me				
9	Without education I feel my future is bleak				
10	Most times I see myself as a failure				

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

No	ITEMS	SA	A	D	SD
1	On the whole, I am satisfied with myself.				
2	At times, I think I am no good at all.				
3	I feel that I have a number of good qualities.				
4	I am able to do things as well as most other people.				
5	I feel I do not have much to be proud of.				
6	I certainly feel useless at times.				
7	I feel that I'm a person of worth, at least on an equal plane with others.				
8	I wish I could have more respect for myself.				
9	All in all, I am inclined to feel that I am a failure.				
10	I take a positive attitude toward myself.				

Self-Concept Clarity Scale
By
(Campbell, Trapnell,Heine,Katz,Lavallee & Lehman,1996).

No	**ITEMS**	**SA**	**A**	**D**	**SD**
1	My beliefs about myself often conflict with one another				
2	On one day I might have one opinion of myself and on another day I might have a different opinion				
3	I spend a lot of time wondering about what kind of person I really am				
4	Sometimes I feel that I am not really the person that I appear to be				
5	When I think about the kind of person I have been in the past, I'm not sure what I was really like				
6	I seldom experience conflict between the different aspects of my personality.				
7	Sometimes I think I know other people better than I know myself.				
8	My beliefs about myself seem to change very frequently				
9	If I were asked to describe my personality, my description might end up being different from one day to another day				
10	Even if I wanted to, I don't think I could tell someone what I'm really like				
11	In general, I have a clear sense of who I am and what I am.				
12	It is often hard for me to make up my mind about things because I don't really know what I want				

Global Depression Scale (GDS) David, H .C (2000)

NO	ITEMS	YES	NO
1	Are you basically satisfied with your life?		
2	Have you dropped many of your activities and interests?		
3	Do you feel that your life is empty?		
4	Do you often get bored?		
5	Are you in good spirits most of the time?		
6	Are you afraid that something bad is going to happen to you?		
7	Do you feel happy most of the time?		
8	Do you often feel helpless?		
9	Do you prefer to stay at home, rather than going out and doing new things?		
10	Do you feel you have more problems with memory than most?		
11	Do you think it is wonderful to be alive now		
12	Do you feel pretty worthless the way you are now		
13	Do you feel full of energy?		
14	Do you feel that your situation is hopeless?		
15	Do you think that most people are better off than you are?		

Teenage Mother Stigmatization Scale

NO	ITEMS	SA	A	D	SD
1	As a teenage mother my friends make fun of me				
2	Most parents discourage their children to play with me saying I will corrupt them				
3	My friends isolate me				
4	At church girls do not play with me				
5	At mosque girls do not play with me				
6	My neigbours call me names				
7	I am always used as negative example to other children				
8	Since I dropped out of school people regard me as a bad child				
9	My parents call me names				
10	My siblings call me a failure				

Duke-UNC Functional Social Support Questionnaire (1998)

NO	ITEMS	SA	A	D	SD
1	There is a special person who is around when you are in need.				
2	There is a special person with whom you can share joys and sorrows.				
3	Your family really tries to help you.				
4	You get the emotional help and support you need from your family.				
5	You have a special person who is a real source of comfort to you.				
6	Your friends really try to help you.				
7	You can count on your friends when things go wrong.				
8	You can really talk about your problems with your family.				
9	You have friends with whom you can share your joys and sorrows				
10	There is a special person in your life who cares about your feelings				
11	Your family is willing to help you make decisions.				
12	You can talk about your problems with your friends				
13	Your spouse/partner supports (or would support) your efforts be happy.				

Teenage Mother Sexual Debut Scale

NO	ITEMS	SA	A	D	SD
1	I willingly had sex the first time				
2	I had sex the first time because I was curious to have it				
3	I was between age ten to fifteen years when I first had sex				
4	I was between age sixteen to nineteen years when I first had sex				
5	I became pregnant through my first sexual experience				
6	I was raped				

Teenage Mother Peer Influence Scale

NO	ITEMS	SA	A	D	SD
1	My friends influence me to have sex				
2	My friends made me belief I cannot get pregnant				
3	My friends use to tell me how they have sex with their boyfriends				
4	My friends made my to have a boy friend				
5	I had sex so as to be like my friends				
6	Because my friends make jest of me as a virgin I decided to have sex				
7	I watch sexual films with my friends				
8	My friends talk a lot about sex				

FAMILY SUPPORT SCALE

S/n	Items	SA	A	D	SD
1	The presence of my father at home makes me happy				
2	The presence of my mother at home makes me happy				
3	My father is always give me support				
4	My mother is always at home to support me				
5	My parents care about my success in life				
6	My parents encourage me to forge on with life				
7	My parents are helping with my decision to acquire a skill				
8	My father encourages me to go back to school				
9	My mother encourages me to go back to school				
10	The support of my parents motivate me to live a better life				

SOCIO-ECONOMIC QUESTIONNAIRE

NO	ITEMS	YES	NO
1	My father has just one wife		
2	My father has more than one wife		
3	My parents educational qualification is below OND		
4	My parents are graduates		
5	My parents are divorced		
6	We are more than four in the family		
7	I have finished my secondary school education		
8	I only attended primary school		
9	I have learnt a trade		
10	I have acquired a skill		

APPENDIX "A"

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

Dear Respondents,

Iwe pelebe yi wa fun lati sewadi nipa idahun yin si awon ibeere ti o wa nisale yi. Gbogbo idahun yin ni a o ko ni je ki elomiran mo nipa re.

SECTION A

Demographic Information

1 Ojo ori

2 Imo eko ti baba mi ni ……..(Ile eko alako beree) (Ile eko girama) (OND) (NCE) (Bsc) (Ile eko alako giga) (OTHERS)……

3 Imo eko ti mama mi ni ……..(Ile eko alako beree) (Ile eko girama) (OND) (NCE) (Bsc) (OND) (NCE) (Bsc) (Ile eko alako giga) (OTHERS)……

4 Ise ti baba mi n se……

5 Ise ti iya mi n se ……

TEENAGE MOTHERS POST PREGNANCY PSYCHOLOGICAL ADJUSTMENT SCALE

NO	ITEMS	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Inu mi dun wipe mo je iya olo omo				
2	Toba se wipe mi mo mi o bati se oyun omo na				
3	Odunmi wipe mi olo si ilewee mo				
4	Mo mowipe mo ti se asise				
5	ayi maletoju omo mi komu inumi dun				
6	Ati se itoju arami ati omo isoro nla ni funmi				
7	Ti ba ti re awon oree mi to losi ilewe inu mi man bajee				
8	Mo man da wa nitori wipe awon oree mi obami seree mo				
9	Ai losi lewe mumi ro wipe ojowaju mi lay masan				
10	Ni gabami mo man re ara gegebi ani ti orise				

ROSENBERG SELF-ESTEEM SCALE (ROSENBERG, 1965)

No	ITEMS	**Mo ni fee si gan gan**	**Mo ni fee si**	**Mi o ni fee si**	**Mi o ni fee si rara**
1	Ni ti temi inu mi dun ni ipo ti mowa leni				
2	Nigbami mo man ro wipe mi o dara leniyan				
3	Mo moo daju wipe mo ni awon ebun to dara				
4	Odami luju wipe mo lese nkan ti awan elomiran lese				
5	Mo lero pe n ko ni ohun afiyangan kankan				
6	Nigbami mo man ri ara mi bi eni yeye				
7	Mo mo wipe emi na je eniyan pataki laarin awon elegbe mi				
8	Owumi ki n le bowo fun ara mi ju bayi lo.				
9	Mo ma nni lokan wipe motikuna				
10	Mo man ri ara mi gegebi olorire				

SELF-CONCEPT CLARITY SCALE

BY

(CAMPBELL, TRAPNELL,HEINE,KATZ,LAVALLEE & LEHMAN,1996).

No	**ITEMS**	**Mo ni fee si gan gan**	**Mo ni fee si**	**Mi o ni fee si**	**Mi o ni fee si rara**
1	Igbagbo mi nipa ara mi ma n mu ariyanjiyan dani ninu okan mi				
2	Nigbamiran mo ma nsiyemeji nipa iru eniyan ti moje.				
3	Opo igba ni mo ma nronu nipa iru eniyan ti mo je.				
4	Igba miran mo ma nro pe nko ki se iru eniyan ti mo ma npe ara mi				
5	Nigba ti mo ba ti ro iru igbe aye mi atehinwa, nko ki n leso iru eniyan timoje.				
6	Okan mi ma nporuru nitori orisirisi ero ti mo ma nro nipa ara mi.				
7	Nigbamiran mo ma nro wipemo mo npa elomiran ju bi mo se mo arami lo.				
8	Ero ti mo ma nro nipa ara mi ko duro soju kan .				
9	Ti won ba ni ki nsoro nipa ara mi. ohun ti no so loni le yato si eyi ti n o so lola				
10	Bi mo ba tie fe so nipa ara mi ‘ nko lero wipe mo le so gege bi mo se ri fun elomiran				
11	Mo le so gege bi mo se ri				
12	O ma nnira fun mi se ipinnu nipa ohun ti mo fe nitori emi pelu ko le so nipa ohun ti mo fe pato				

GLOBAL DEPRESSION SCALE (GDS) DAVID, H .C (2000)

NO	ITEMS	Beeni	Beeko
1	N je igbe aye re te o lorun ?		
2	O ti gbagbe nipa awon ohun kan ti o ma n wu o se.		
3	Nje o ma nro wipe agba ofifo ni o bi?		
4	Nje nkan tete ma n su o bi ?		
5	Nje okan re ma nbale ni gbogbo igba bi ?		
6	Nje o nberu ajalu buruku bi ?		
7	Nje inu re ma ndun ni gbogbo igba bi ?		
8	Nje oma nri ara re bi eni ti ko si iranlowo fun		
9	Se o ma n te o lorun lati da duro sinu ile dipo ki o lo se ohun titun lo		
10	Nje o lero wipe oni isoro lati ranti ohun kan ju elomiran lo		
11	N je o lero wipe dara lati wa laaye bayi		
12	Nje oro wipe igbe yae re wuyi bayi.		
13	Nje oni agbara		
14	Nje o ro wipe owa nipo ainireti		
15	N je o ro wipe ipo ti awon miran wa dara ju o lo.		

Teenage Mother Stigmatization Scale

NO	ITEMS	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Gege bi eni to bimo lomode awon ore mi ma n fi mi se yeye				
2	Opo awon obi ni kin fe kin ba omo won sere ni tori won rope nkowon nikokuko				
3	Awon ore mi ma n takete si mi				
4	Ni ile ijosin awon obirin ki bami sere				
5	Ni mosalasi awon obirin ki bami sere				
6	Awon aladugbo ma n pemi loruko buruku				
7	Apere buburu ni won ma n fi mi se fun awon omo iyoku				
8	Lati igba ti nko ti losi ilewe mo ni awon eniyan ti npemi lomo buruku				
9	Awon obi mi ma n pemi ni awon oruko buruku				
10	Awon aburo mi ma n pemi ni alai rise				

DUKE-UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (1998)

NO	ITEMS	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Eni kan wa ti o ma nba aini re pade				
2	Eni kan wa ti o ma so edun okan re fun				
3	Awon ebi re gbiyanju lati ran o lowo				
4	Awon ebi re ma n ba gbogbo aini re pade				
5	O ni enikan ti o je alabaro re				
6	Awon ore re gbiyanju lati ran e lowo				
7	O le fokan tan awan ore re nigba ti nkan badojuru				
8	O le ba awon ebi re jiroro nipa isoro re				
9	O ni awon ore ti ole ba so nipa ayo ati isoro re				
10	Eni kan wa to se pataki ti o fe ma nmo nipa isoro re				
11	Awon ebi mi ma n ran mi lowo lati se ipinnu				
12	Mo le ba awon oremi soro nipa isoro mi				
13	Oko mi ma n gbiyanju lati riwipe inumi dun				

TEENAGE MOTHER SEXUAL DEBUT SCALE

NO	ITEMS	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Mo ni ibalopo ni gba akoko nitori ti oti okan mi wa				
2	Mo ni ibalopo akoko pelu okunrin intori wipe mo fee mo bo sen ri lara				
3	Mo ni ibalopo akoko laarin odun mewa si meedogun				
4	Mo ni ibalopo akoko laarin odun merindinlogun si odun mokandinlogun				
5	Igba akoko ti mo ni ibalopo pelu okunrin lo doyun				
6	Okunrin fi tipatipa bamilopo ri				

TEENAGE MOTHER PEER INFLUENCE SCALE

NO	ITEMS	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Awon ore mi lo je kin bere sini ibalopo pelu okunrin				
2	Awon ore mi fi ye mi wipe mi ole loyun timo ba ti ni ibalopo pelu okunrin				
3	Awon ore mi ma n so bi won se ma ni ibalopo pelu ore won okunrin				
4	Awon ore mi lo timi si ati ni ore okunrin bi ololufe				
5	Mo ni ibalopo lati dabi awon ore mi iyoku				
6	Mo ni ibalopo pelu okunrin nitori awon oremi ma n fi mi se yeye pe mi oti mo okunrin ri				
7	Mo ma n wo faran ere ife pelu awan ore mi				
8	Gbogo igba ni awon ore mi ma n fi oro ibalopo okunrin pelu obirin tomi leti				

S/N	Items	Mo ni fee si gan gan	Mo ni fee si	Mi o ni fee si	Mi o ni fee si rara
1	Ti baba mi ba wan le enu mi man dun				
2	Ti iya mi ba wan le enu mi man dun				
3	Baba mi man se ironlowo fun mi				
4	Iya mi man se ironlowo fun mi				
5	Awon obi mi fee kin rese layi				
6	Awon obi mi man fun mi ni moron bi ma seni ilosi waju				
7	Awon obi mi man fun mi ni moron bi ma selo kose				
8	Baba mi fe si kin gbada si lewe				
9	Iya mi fe sinkin gbada si lewe				
10	Iranlowo ti awom obi mi fun mi jekin lese atunse se aye mi				

FAMILY FACTOR SCALE

SOCIO-ECONOMIC QUESTIONNAIRE

NO	ITEMS	Beeni	Beeko
1	Iyawo kan ni baba mi ni		
2	Baba mi ni ju iyawo kan lo		
3	Awon obi mi o kaju ilewe girama lo		
4	Awon obi mi ni iwe eri ti yunifasiti		
5	Awon obi mi ti koranwan le		
6	Aju merin lo ninu ebi walo		
7	Mo ti jade ile iwe girama		
8	Mi o kaju ilewe alakobere lo		
9	Mo ti ko ise owo		
10	Mo mo nipa ise owo		

APPENDIX II

Regression

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.412[a]	.169	.164	6.4619

a. Predictors: (Constant), SOCIO-ECONOMIC, SOCIAL SUPPORT, FAMILY SUPPORT SCALE, SELF CONCEPT, TEENAGE MOTHER STIGMATIZATION, SELF ESTEEM, SEXUAL DEBUT, GLOBAL DEPRESSION, PEER INFLUENCE

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	10922.949	9	1213.661	29.066	.000[a]
	Residual	53530.763	1282	41.756		
	Total	64453.712	1291			

a. Predictors: (Constant), SOCIO-ECONOMIC, SOCIAL SUPPORT, FAMILY SUPPORT SCALE, SELF CONCEPT, TEENAGE MOTHER STIGMATIZATION, SELF ESTEEM, SEXUAL DEBUT, GLOBAL DEPRESSION, PEER INFLUENCE

b. Dependent Variable: TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	25.200	1.179		21.379	.000
	SELF ESTEEM	.249	.026	.296	9.616	.000
	SELF CONCEPT	5.557E-02	.022	.077	2.560	.011
	GLOBAL DEPRESSION	-.156	.053	-.103	-2.942	.003
	TEENAGE MOTHER STIGMATIZATION	7.798E-02	.027	.089	2.918	.004
	SOCIAL SUPPORT	7.657E-02	.017	.127	4.611	.000
	SEXUAL DEBUT	-1.68E-02	.045	-.014	-.374	.708
	PEER INFLUENCE	5.074E-02	.035	.056	1.456	.146
	FAMILY SUPPORT SCALE	1.069E-03	.019	.002	.056	.956
	SOCIO-ECONOMIC	-.308	.074	-.129	-4.134	.000

a. Dependent Variable: TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ

Correlations

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SELF ESTEEM	SELF CONCEPT	GLOBAL DEPRESSION	TEENAGE MOTHER STIGMATIZATION	SOCIAL SUPPORT	SEXUAL DEBUT	PEER INFLUENCE	FAMILY SUPPORT SCALE	SOCIO-ECONOMIC
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.342**	.208**	.094**	.205**	.215**	.148**	.186**	-.056*	-.062*
	Sig. (2-tailed)	.	.000	.000	.001	.000	.000	.000	.000	.043	.026
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
SELF ESTEEM	Pearson Correlation	.342**	1.000	.400**	.435**	.361**	.273**	.396**	.431**	-.098**	.199**
	Sig. (2-tailed)	.000	.	.000	.000	.000	.000	.000	.000	.000	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
SELF CONCEPT	Pearson Correlation	.208**	.400**	1.000	.405**	.364**	.209**	.394**	.415**	-.052	.174**
	Sig. (2-tailed)	.000	.000	.	.000	.000	.000	.000	.000	.060	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
GLOBAL DEPRESSION	Pearson Correlation	.094**	.435**	.405**	1.000	.468**	.303**	.434**	.432**	-.047	.471**
	Sig. (2-tailed)	.001	.000	.000	.	.000	.000	.000	.000	.091	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
TEENAGE MOTHER STIGMATIZATION	Pearson Correlation	.205**	.361**	.364**	.468**	1.000	.273**	.384**	.404**	-.061*	.178**
	Sig. (2-tailed)	.000	.000	.000	.000	.	.000	.000	.000	.029	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
SOCIAL SUPPORT	Pearson Correlation	.215**	.273**	.209**	.303**	.273**	1.000	.236**	.252**	.058*	.101**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.	.000	.000	.036	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
SEXUAL DEBUT	Pearson Correlation	.148**	.396**	.394**	.434**	.384**	.236**	1.000	.710**	.030	.344**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.	.000	.274	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
PEER INFLUENCE	Pearson Correlation	.186**	.431**	.415**	.432**	.404**	.252**	.710**	1.000	.007	.333**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.	.815	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
FAMILY SUPPORT SCALE	Pearson Correlation	-.056*	-.098**	-.052	-.047	-.061*	.058*	.030	.007	1.000	.246**
	Sig. (2-tailed)	.043	.000	.060	.091	.029	.036	.274	.815	.	.000
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292
SOCIO-ECONOMIC	Pearson Correlation	-.062*	.199**	.174**	.471**	.178**	.101**	.344**	.333**	.246**	1.000
	Sig. (2-tailed)	.026	.000	.000	.000	.000	.000	.000	.000	.000	.
	N	1292	1292	1292	1292	1292	1292	1292	1292	1292	1292

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

*. Correlation is significant at the 0.05 level (2-tailed).

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SELF ESTEEM	30.4845	8.4181	1292
SELF CONCEPT	36.3692	9.8053	1292
GLOBAL DEPRESSION	22.0611	4.6812	1292
TEENAGE MOTHER STIGMATIZATION	30.1981	8.1058	1292
SOCIAL SUPPORT	35.2693	11.7506	1292
SEXUAL DEBUT	18.8390	5.9204	1292
PEER INFLUENCE	24.2546	7.7482	1292
FAMILY SUPPORT SCALE	23.6378	9.9663	1292
SOCIO-ECONOMIC	13.3127	2.9540	1292

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SELF ESTEEM	30.4845	8.4181	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SELF ESTEEM
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.342**
	Sig. (2-tailed)	.	.000
	N	1292	1292
SELF ESTEEM	Pearson Correlation	.342**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SELF CONCEPT	36.3692	9.8053	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SELF CONCEPT
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.208**
	Sig. (2-tailed)	.	.000
	N	1292	1292
SELF CONCEPT	Pearson Correlation	.208**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
GLOBAL DEPRESSION	22.0611	4.6812	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	GLOBAL DEPRESSION
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.094**
	Sig. (2-tailed)	.	.001
	N	1292	1292
GLOBAL DEPRESSION	Pearson Correlation	.094**	1.000
	Sig. (2-tailed)	.001	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
TEENAGE MOTHER STIGMATIZATION	30.1981	8.1058	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	TEENAGE MOTHER STIGMATIZATION
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.205**
	Sig. (2-tailed)	.	.000
	N	1292	1292
TEENAGE MOTHER STIGMATIZATION	Pearson Correlation	.205**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SOCIAL SUPPORT	35.2693	11.7506	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SOCIAL SUPPORT
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.215**
	Sig. (2-tailed)	.	.000
	N	1292	1292
SOCIAL SUPPORT	Pearson Correlation	.215**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SEXUAL DEBUT	18.8390	5.9204	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SEXUAL DEBUT
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.148**
	Sig. (2-tailed)	.	.000
	N	1292	1292
SEXUAL DEBUT	Pearson Correlation	.148**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
PEER INFLUENCE	24.2546	7.7482	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	PEER INFLUENCE
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	.186**
	Sig. (2-tailed)	.	.000
	N	1292	1292
PEER INFLUENCE	Pearson Correlation	.186**	1.000
	Sig. (2-tailed)	.000	.
	N	1292	1292

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

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
FAMILY SUPPORT SCALE	23.6378	9.9663	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	FAMILY SUPPORT SCALE
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	-.056*
	Sig. (2-tailed)	.	.043
	N	1292	1292
FAMILY SUPPORT SCALE	Pearson Correlation	-.056*	1.000
	Sig. (2-tailed)	.043	.
	N	1292	1292

*. Correlation is significant at the 0.05 level (2-tailed).

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	33.2554	7.0658	1292
SOCIO-ECONOMIC	13.3127	2.9540	1292

Correlations

		TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	SOCIO-ECONOMIC
TEENAGE MOTHERS POST PREGNANCY PSYCHO ADJ	Pearson Correlation	1.000	-.062*
	Sig. (2-tailed)	.	.026
	N	1292	1292
SOCIO-ECONOMIC	Pearson Correlation	-.062*	1.000
	Sig. (2-tailed)	.026	.
	N	1292	1292

*. Correlation is significant at the 0.05 level (2-tailed).