



Perceived social support and self-esteem in pregnant adolescents choosing to parent
by Nada Derry Scofield

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

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Abstract:

Pregnant adolescents choosing to parent are faced with potential, long-term, negative consequences in the economic and psychosocial arena. The purpose of this study was to examine the relation between perceived social support and self-esteem in pregnant adolescents choosing to parent. A descriptive correlational design was selected; a convenience sample of 36 pregnant adolescents participated in the study. The questionnaire consisted of the Personal Resource Questionnaire 85-Part 2 developed by Brandt and Weinert (1981), the Self-Esteem Questionnaire-3 by Hoffmeister (1988), and demographic questions. Results indicated a positive correlation between perceived social support and self-esteem ($r = .6257$, $p = .001$). No significant findings were found when the study variables were correlated with demographic variables. This positive relationship between social support and self-esteem increases the necessity of nurses to spend more time and give more care to pregnant adolescents. Also, nurses need to assess the psychosocial history, including social support and self-esteem aspects, and use the assessment as a guide to design interventions in the prenatal period for adolescents choosing to parent.

These actions will assist the adolescents in retaining, maintaining, or attaining an adequate social support base and an adequate level of self-esteem.

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PREGNANT ADOLESCENTS CHOOSING TO PARENT

by

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APPROVAL

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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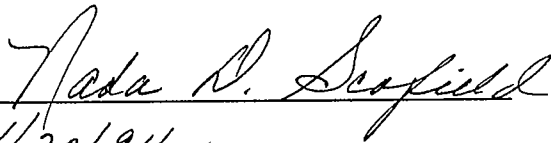
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ABSTRACT

Pregnant adolescents choosing to parent are faced with potential, long-term, negative consequences in the economic and psychosocial arena. The purpose of this study was to examine the relation between perceived social support and self-esteem in pregnant adolescents choosing to parent. A descriptive correlational design was selected; a convenience sample of 36 pregnant adolescents participated in the study. The questionnaire consisted of the Personal Resource Questionnaire 85-Part 2 developed by Brandt and Weinert (1981), the Self-Esteem Questionnaire-3 by Hoffmeister (1988), and demographic questions. Results indicated a positive correlation between perceived social support and self-esteem ($r = .6257$, $p = .001$). No significant findings were found when the study variables were correlated with demographic variables. This positive relationship between social support and self-esteem increases the necessity of nurses to spend more time and give more care to pregnant adolescents. Also, nurses need to assess the psychosocial history, including social support and self-esteem aspects, and use the assessment as a guide to design interventions in the prenatal period for adolescents choosing to parent. These actions will assist the adolescents in retaining, maintaining, or attaining an adequate social support base and an adequate level of self-esteem.

CHAPTER 1

INTRODUCTION

Despite the fact that childbearing and parenting are normal maturational processes and events, potential undesirable consequences are increased with pregnancy and parenting in adolescents. [Adolescents must accomplish certain developmental tasks in order to become healthy, balanced individuals.] When pregnancy and parenting occur, these tasks are interrupted. This interruption can result in dissonance which affects future life events for the adolescents and their children. [A successful outcome for pregnant adolescents choosing to parent and their children depends on many societal factors and personal resources.] Social support is an important societal factor and self-esteem is an important dimension of personal resources.

Problem Statement

For the past two decades pregnant adolescents have shown a significant trend in choosing to keep their babies. [Since 1976, there have been about 1 million adolescent pregnancies every year.] Approximately half of these pregnancies resulted in live births (Hayes, 1987; McLaughlin, Pearce, Mannenen & Winges, 1988). Of the roughly 500,000 annual live births to adolescent mothers between 1976 and 1986, 93-96% chose to keep their babies

(Davis, 1989; Hayes, 1987; McLaughlin et al., 1988; Resnick, 1984).

Pregnant adolescents who chose to parent faced potential detrimental consequences--physical, psychosocial and economic. Maternal morbidity included the following medical problems: pregnancy induced hypertension, placental abruption, amnionitis, and abnormal labor (Hayes, 1987; Zuckerman, Walker, Frank, Chase & Hamburg, 1984). Psychosocial and economic consequences included fewer years in school, decreased opportunities for employment, reduced earnings, large family size, and a high rate of marriage dissolution (Burden & Klerman, 1984; Dillard & Pol, 1982; Hayes, 1987; Kalmuss, Namerow & Bauer, 1992; Mott, 1986).

Children born to adolescent mothers did not escape the potential harmful consequences. [Many studies indicated that these children's medical and psychosocial problems increased.] [The consequences included prematurity, low birth weight, slow rate of growth through childhood, lower IQ, decreased school achievement, behavior problems, and difficulties with interactions] (Hayes, 1987; Kellam, Adams, Brown & Ensminger, 1982; Zuckerman et al., 1984).

Pregnant adolescents, adolescent mothers, and their children affected society, mainly through public expenditures. The costs included numerous support programs, medical expenses, and public assistance. Burden and Klerman (1984) found that half of Aid to Families with Dependent

Children expenditures go to households where the women are teenagers when their first child is born. Hayes (1987) and Herr (1989) reported that welfare-related costs came to \$16.6 billion in 1985.

Adolescents choosing to parent and the resulting consequences have impacted our society. These consequences contributed to loss of national productivity, directly through increased public program costs, and indirectly by individuals not achieving their potential. Adolescent parenting can lead to a less desirable quality of life through continual poverty, lower health status, and lower psychosocial status. The previously mentioned consequences also lead to feeling that one is less successful, less significant, and less worthy, providing a negative effect on self-concept and self-esteem.

Purpose of the Study

The purpose of the study was to investigate the relationship between perceived social support and self-esteem in pregnant adolescents choosing to parent..

Conceptual Framework

The conceptual framework for this study focused on the relationship between two concepts, perceived social support and self-esteem. Both concepts were broadly defined by many scientists and are discussed in this section.

Social Support

Three constructs for social support, based on information (knowledge), were outlined by Cobb (1976). He defined social support as "information leading the subject to believe that 1) he is cared for and loved, 2) he is esteemed and valued, and 3) he belongs to a network of communication and mutual obligation" (p. 300).

Henderson (1977) related social support to attachment theory. He stated "social bonds are the basis for interpersonal interactions, an evolved behavior which has had an essential function in our species history" (p. 186). He felt that social support was a fundamental factor for emotional balance and effective functioning, especially when conflict arose.

Six categories of relational provisions that function with social support for an individual were identified by Weiss (1974) as (a) attachment, (b) social integration, (c) opportunity for nurturance, (d) reassurance of worth, (e) a sense of reliable alliance, and (f) guidance. These concepts were defined as follows.

Attachment was described as a sense of security and a place where one feels comfortable and at home. This is primarily provided in an intimate dyad relationship, such as marriage. Social integration was described as a less intimate sharing of concerns, ideas, and companionship. Opportunity for nurturance was defined as taking

responsibility for another, such as a child; this provision gives meaning to life. Reassurance of worth was described as the sense that one is competent and worthy in a social role, commonly provided by colleagues at work and family members. The sense of reliable alliance was usually derived from kin and was described as continual assistance that is either assumed, expected, or available. Guidance was defined as a trustful and respectful relationship that can provide emotional support (Weiss, 1974).

A social support tool developed in 1981 by Brandt and Weinert strongly emphasized Weiss' (1974) social support model using relational provisions. These two nurse scientists defined perceived social support as "consisting of provision for attachment/intimacy; social integration, that is, being an integral part of a group; opportunity for nurturant behavior; reassurance of worth as an individual and in role accomplishments; and the availability of informational, and material assistance" (Weinert & Tilden, 1990, p. 212).

Researchers defined social support in various ways, yet they basically included the same components: knowledge that one is loved, valued, esteemed, belonging to a group, and given intangible and tangible support when needed within a network of positive relationships.

Self-Esteem

Self-esteem concepts have been addressed in the fields of sociology, psychiatry, and psychology for many years. William James (1950), George Mead (1964), and Charles Cooley (1964) defined self-esteem in the late 19th and early 20th centuries. Each addressed self-esteem by describing the real-self, ideal-self, and the discrepancy between the two. These three scientists considered society and self as integrated. Mead (1964) stated that self was the social process and communication. Cooley (1964) stated that the self was society and that society was the collective of selves.

The early work of these three noted scientists regarding the self and the dimensions of the self formed the building concepts of self-esteem for modern researchers. A plethora of researchers have investigated self-esteem and compiled multiple findings on this dimension of self-concept in the past 40 years. Many terms were used synonymously with self-esteem, such as self-image, self-evaluation, self-regard, self-respect, and self-realization.

Maslow (1954) connected level of security to self-esteem. Whether security and self-esteem were high or low determined actual behavior. He believed people "have a need and desire for a stable, firmly based usually high evaluation of themselves, for self-regard, or self-esteem, and for the esteem of others" (p. 90). Maslow (1942) simply

defined self-esteem as "an evaluation of the self" (p. 260). He believed self-esteem is based on deserved respect from others by merited competence and adequacy, and that high self-esteem developed feelings of self-confidence, worth, strength, capability, and adequacy of being useful and necessary (Maslow 1954).

Self-esteem involves the way in which an individual actually perceives a quality or an ability within oneself and how one evaluates self in that quality or ability. The discrepancy between the perception and evaluation of the two inner selves causes negative or positive feelings, thus, the final step of the concept of self-esteem.

Self-Esteem and Social Support

The concepts of self-esteem and social support, although different, have a significant relationship. Cobb's (1976) concept of social support, with belief that one is loved, is valued, and belongs, and Weiss' (1974) six relational provisions are attributes that appear to be necessary for self-esteem to develop, to change, and to grow. Maslow's (1954) words "deserved respect from others" appear to be an important key for the development of positive self-esteem within oneself. The relationship of self-esteem and social support could be summarized as symbiotic for the development of a healthy, balanced individual.

Research Question

To investigate the concepts of perceived social support and self-esteem in pregnant adolescents, the following research question was constructed: Is there a relationship between perceived social support and self-esteem in pregnant adolescents choosing to parent?

Definitions of Terms

The following definitions of terms were taken from the instruments that measure perceived social support and self-esteem which were selected for this study.

Perceived Social Support: Functions confirming that one: "a) has indications of being valued, b) is an integral part of a group, c) has provision for attachment/intimacy, d) has an opportunity for nurturance, and e) has availability of information, emotional and material help" (Brandt & Weinert, 1981).

Self-Esteem: "The feeling that a person is capable, significant, successful, and worthy" (Hoffmeister, 1988, p. 2).

Pregnant Adolescent: A young woman who is between the ages of 13 and 18 at the time of conception.}

CHAPTER 2

REVIEW OF THE LITERATURE

Research on the concepts of social support and self-esteem is very extensive; therefore, this literature review was selective. Social support was examined broadly as it relates to disease and well-being, and was followed by a review of social support relating to perinatal issues and adolescent mothers. The review of self-esteem literature focused on adolescents, pregnant adolescents, and adolescent parenting. Finally, social support specifically relating to self-esteem was addressed.

Social Support

The need for social support has been alluded to for generations as a necessity for living because humans are social beings. Social support is a factor in the quality of life starting at birth and ending with death (Antonucci, 1976; Cobb, 1976). In fact, Cobb stated, "Social support begins in utero, is best recognized at the maternal breast and is communicated in a variety of ways, but especially, in the way the baby is held [supported]" (p. 301).

Disease and Well-Being

House, Landis and Umberson (1988) reported on six community longitudinal studies which regarded social support

as a predictive source for mortality. The last five studies basically replicated the first, which was conducted in 1965. It included a sample of 4,776 adults, ages 30-69, living in Alameda County, California. The study was controlled for variables that could impact mortality. Four types of social relationships were included: marriage, contact with extended families and friends, church membership, and other formal and informal group affiliations. The first study, as well as the five studies which replicated it, showed a similar and consistent pattern of the association of social relationships to health. The conclusions of this review were twofold: (a) a broader theory of the biopsychosocial parameters that could affect social support and disease was needed; and (b) the quantity, quality, and content of social relationships must be further studied to understand the beneficial healthy outcomes related to the social support constructs.

In 1976, two authors, Cobb and Cassel, presented separate theoretical concepts regarding the effects of social support affecting well-being, crises, and life changes. These theories were recognized as precursors to current researchers relating social support to healthy outcomes, and social support as a buffer against disease and life stresses.

Cassel (1976) supported the concept of social support as a relevant environmental variable affecting disease by

applying the concept of disease, which encompasses the triad of the host, agent, and environment. A review of many animal and human studies indicated a pattern in which social support was inversely related to chronic illnesses and death. The following examples were cited.

Five North Carolina counties reported a substantial increase in stroke mortality of black men, ages 44-54, during the period 1956-1964. This coincided with a time of high social instability and local government disorganization. Japanese men residing outside Japan, specifically in Hawaii and California, showed a higher incidence of cardiovascular disease than men of the same age in Japan, even when appropriate controls for nutrition, smoking, and high blood pressure were applied. It was speculated that in the process of migrating, the men lost important social support and experienced loss and change in culture. Cassel concluded that social support provided as an intervention and used as a preventative measure could protect society from disease.

Cobb (1976) emphasized social support as a deterrent against unhealthy outcomes in crisis and change. Through investigation in multiple studies, he found patterns that demonstrated social support to be protective against life stresses. One example Cobb presented was the outcome of sanatorium treatment for tuberculosis. All treatment failures were experienced by the group with the lowest

scores on an index of social support and psychological reactions. Another example was the decrease of high steroid doses for asthma patients having high life stress and high social support, compared to asthma patients needing high steroid doses with high life stress and low social support.

Cobb's and Cassel's conclusions that social support had an impact on health outcomes were questioned in an article by House et al. (1988), as the majority of their research studies were cross-sectional, retrospective, or on self-reported data. House et al. stated that earlier studies "could not determine whether poor social support relationships preceded or followed ill health" (p. 540).

Weiss (1974) investigated social support in individuals who had lost a primary relationship. He interviewed participants from Parents Without Partners and expected to find the loneliness resulting from loss of spouse to be ameliorated by the social life and friendship gained within the group. Friendships gained within the group gave the participants a sense of well-being and importance; however, friendships did not diminish the sense of loneliness derived from the loss of their partners. Weiss then studied six couples that had moved many miles away from family and friends. Although the women had emotional support from their husbands, loneliness and severe distress were reported in four of the women due to lack of social activity with friends. He surmised that loneliness could come from two

situations: social isolation or emotional isolation. He concluded that one person or one group could not fulfill all of the social support functions required for an individual's well-being.

The quality and quantity of perceived social support in adolescents were studied by D'Attilio, Campbell, Lubold, Jacobson and Richard (1992). They found that those who were at greater risk for suicide were significantly less satisfied with the quality of their social support. The social support variable accounted for over 52% of the variance in suicide potential.

Turner, Grindstaff and Phillips (1990) found that with high levels of stress, increased family social support was inversely related to decreased levels of a mother's depressive symptomology and the infant's birth weight in a lower socioeconomic group. Turner et al. also reported that socioeconomic background influenced the relationship between social support and a mother's outcomes. As the socioeconomic scale increased, family social support was not significantly related to the mother's psychological status.

Social Support and Perinatal Issues

Psychosocial assets and social stressors in cumulative life changes through the year prior to pregnancy were explored by Nuckolls, Cassel and Kaplan (1972). This study involved 170 army wives who delivered at a military hospital. Data were gathered during the prenatal and

immediate postdelivery periods. The women with high life change stress and high social support had only one-third the complication rate of women who had high life change stress but low social support. No differences were noted in the pregnancy complications of women with low life change stress prior to pregnancy regardless of their levels of social support. Other studies revealed a greater number of premature deliveries were experienced in a certain subgroup of women reporting higher psychosocial stress as compared to women who had full term deliveries (Berkowitz & Kasl, 1983; Newton & Hunt, 1984). The researchers recommended increased assessment for stress and emphasized the value of social support as a buffer against the stress.

Oakley (1985) reviewed studies of social support during pregnancy and concluded that the resultant low birth weights were potentially affected by social relationships of the mother. Oakley stated that there was considerable evidence that social support was a beneficial factor in preventing low birth weight.

O'Hara, Rehm and Campbell (1983) studied the impact of social network variables and the frequency of stressful life events between a group of women (N = 11) experiencing mild to moderate postpartum depression compared to a group of postpartum women (N = 19) who were not depressed and making a successful adjustment. The sample was recruited during the second trimester of pregnancy and followed

longitudinally through the postpartum period. On the first contact, the researchers collected initial data on social network, life stressors, and depression. They measured the same variables through the postpartum period. The social network consisted of spouses, parents, and confidants. Depressed women subjects reported receiving less emotional support from spouses, confidants, and parents; they also reported giving less support to their spouses, confidants, and parents. Subjects reported that there was more support in the postdelivery period than in the prenatal period. Where there were no differences between groups in terms of the numbers in their support networks, the depressed group of women had less weekly contact with the people in their support networks. For both groups, spouses were very important in giving support; however the spouses of the depressed women were seen as less able to give social support. This group of depressed women also reported decreased ability to communicate with spouses, more marital problems, and less emotional support from their parents. O'Hara et al. found that the depressed group of women had a history of depression, averaging two past episodes of depression.

Social Support and Adolescent Mothers

Adolescent mothers and their children are faced with many potential medical and psychosocial problems. [Acceptance of the adolescents' situation and support from immediate families and partners cannot help but improve coping and provide a buffer against additional stressors.]

Many pregnant adolescents choosing to parent appear not to take advantage of or participate in formal nonmedical services that could help decrease their stresses and potential consequences. Bergman (1989) studied this dilemma by interviewing 54 adolescent mothers immediately after delivery. She found that the adolescents, whether they used formal support services or not, had strong informal support systems and relationships. [The most important support source through pregnancy was the teens' parents, followed by the male partner, girlfriends, and other relatives.] Professional support and care providers were never mentioned by the subjects. Bergman concluded that the request for services required the adolescents to admit to a problem. Adolescents who were studied feared that such admission might result in being labeled deviant or unable to function independently. Since premarital pregnancies are still surrounded by cultural shame and stigma, health care providers must be very cognizant of the adolescents' reluctance in asking for help.

Cooper, Dunst and Vance (1990) studied the effect of social support on parent-child interactions with 19 adolescent mothers. The mothers participated in a 20-week model demonstration program working in a preschool classroom with skilled caregivers. The outcome was a significant increase in frequency of response to the child's behavior for mothers 16 years of age and over. No change was noted in the mothers under age 16. The authors concluded that long term intensive one-on-one intervention was necessary to facilitate behavioral changes for this special group of mothers.

Unger and Wandersman (1988) interviewed 19 adolescents during the prenatal period and again 8 months postpartum. Their structured questions focused on perceived social support from family and partner. At the postpartum interview, a structured observation of mother and infant interaction was added. [The adolescents were more satisfied with their lives if they had their parents' support, the fathers of the infants or, if different, current male partners.] At both interviews, the family support was related to financial support and all the aspects of daily living. The majority of the adolescents (74%) were still living with their parents at 8 months postpartum. The adolescent mothers reported more satisfaction with their lives during pregnancy and with their parenting behavior if support was received from significant male partners. Good emotional support from their partners was positively related to the mothers'

practice of less punitive behavior and less rejection toward their babies.

Summary

Perceived social support was documented as a social resource relating to healthy outcomes in persons experiencing many physical and psychosocial stressors. Researchers reviewing previous literature on social support found that methodological problems existed in many of the studies and few were replicated. Yet, overall, the researchers indicated that strong social support appeared to have a positive effect and could change the negative course of stressors. Perceived social support appeared to be related to fewer physical and emotional problems during the perinatal period. The adolescent mothers were more satisfied with their lives and their children if family and partner support were present.

Self-Esteem

Self-esteem is one dimension of the self and enhancement of self-esteem is a primary human need. Self-esteem has dynamic psychological and social aspects and its development is related to the dimension of self-love in infancy and childhood (Symonds, 1951). Adolescence is the last developmental stage of childhood in which an individual progresses from a dependent child to a self-sufficient adult; therefore adolescence is a vulnerable time for development of self-esteem.

Self-Esteem and Adolescents

Adams and Gullotta (1983) summarized important factors that determined levels of self-esteem in adolescents. The primary factor was family. The authors stated, "The very foundation of self-esteem appears to emerge in the family itself" (p.179). Parental interest and support, association with community groups that possess similar values, school setting including academic success, socioeconomic status, and progression through age-developmental tasks are other factors that determine self-esteem.

Self-esteem increases during the adolescent maturational and developmental processes (Bachman & O'Malley, 1977; Mullis, Mullis & Normandin, 1992; Adams & Gullotta, 1983). There is evidence that adolescent girls have a lower self-esteem than adolescent boys (Adams & Gullotta, 1983; O'Malley & Bachman, 1979; Steitz & Owen, 1992; Harper & Marshall, 1991). However, Wylie (1979) reported that gender was not related to self-esteem in general, while Gecas (1971; 1972) found that the girls showed a higher level of self-esteem than boys. These discrepancies in findings among studies may be explained through methodological differences and variations in variables and contexts studied.

At times it is unclear whether self-esteem is the cause of certain social behavior or if it is the effect of social influence. Rosenberg, Schooler and Schoenbach (1989)

investigated self-esteem and its relationship to delinquency, poor school performance, and depression. They reported that delinquent behavior was instigated by feelings of low self-esteem; however actual delinquent behavior raised self-esteem because the adolescents' acts were accepted by peers having the same behaviors. A higher self-esteem was related to better academic performance. Higher self-esteem was inversely related to depression; depression is known to cause decreased self-esteem. Although no concise conclusion as to whether self-esteem was the cause or the effect of certain behavior, the findings provided stronger support for the theory that the level of self-esteem was related to behavior in adolescents (Rosenberg et al.).

Steitz and Owen (1992) studied the relationship of self-esteem with participation in school activities and working part-time outside of school. There was no significant relationship between higher self-esteem and overall participation in school activities. However, working part-time while going to school was significantly related to lower self-esteem, especially in girls. The more hours the girls worked, the lower their self-esteem. The researchers interpreted this to mean increased participation in school activities affirmed or raised their self-esteem. Steitz and Owen reported higher self-esteem as the girls grew older. Girls with higher self-esteem were more likely

to choose a vocational or technical curricular track compared to those who choose the college curricular track.

Self-esteem was identified with such terms as competence, mastery, and feelings of worth and power. Rosenberg and Gaier (1977) used these dimensions in defining self-esteem. They reported that adolescents with learning disabilities had a significantly decreased level of self-esteem compared to adolescents who were not disabled and who were considered average in academic achievement.

It would be most difficult to review all studies that have investigated self-esteem in adolescents. Rosenberg (1989) gave a succinct summary by stating there was

abundant empirical research showing that low self-esteem is associated with depression, somatic and psychological anxiety, self-concept volatility, irritability, resentment, anomia, hypersensitivity, low life satisfaction, loneliness, and other forms of psychological distress (p. xxi).

Self-Esteem and Pregnancy

Self-esteem was considered one of the causal factors in adolescent pregnancy for many years. Overall, it was assumed that pregnancy may be one attempt to overcome low self-esteem.

Patten (1981) collected data using the Tennessee Self Concept Scale, from 37 pregnant adolescents in 1979. He compared the results of this sample to similar samples in two earlier studies, 1963 and 1970. He found no significant differences between the 1979, 1970, and 1963 mean scores of

self-concept and self-esteem. [The pregnant adolescents in all three studies showed lower self-esteem scores in comparison to the norms of the general population.] This was rather surprising as the 15 year span included many societal changes including a rejection of many established societal values, as well as the re-emergence of women's equality.

An extensive review of the literature about pregnant adolescents making their pregnancy resolution decisions and the related social psychological factors was conducted by Olson (1980). [This review revealed that pregnant adolescents choosing to parent demonstrated a poorer self-esteem and a lower feeling of competence and control than adolescents choosing to terminate their pregnancies.] Zongker (1977) studied pregnant adolescents in a longitudinal study of 2 years. The study compared 88 pregnant adolescents to nonpregnant adolescents. The pregnant adolescents reported feelings of inadequacy and unworthiness and less satisfaction with their family relationships. Hall and Taylor (1984) reported similar findings in pregnant adolescents when compared to a group of nulliparous adolescents, but only in the area of self-concept. There appeared to be little difference between either group in terms of evaluating self-esteem.

Kogan, Boe and Valentine (1965) found that pregnant adolescents had poor self-concept and self-esteem in the third trimester, but shortly after delivery showed a

significant increase. Scheller (1974) studied self-esteem in pregnant adolescents before and after a group counseling program. Self-esteem was considerably higher after the program. Both of these studies could be interpreted to mean that the level of self-esteem can be altered with life situational changes and increased educational support.

Over the years an assumption developed that adolescent pregnancy must be due to some underlying problem. Therefore, the majority of studies addressing pregnant adolescents are problem centered. Several authors (McKenry, Walters, & Johnson, 1979; Phipps-Yonas, 1980; Shaffer, Pettigrew, Wolkind, & Zajecek, 1978) questioned this assumption and contended that a significant number of pregnant adolescents are normal and well-adjusted people. Adams and Gullotta (1983) posed the question:

Are all pregnant adolescents emotionally disturbed? We suggest not. There is a growing body of evidence to support ... that often the caring relationship between two people simply ends unexpectedly in pregnancy (p. 341).

Adams and Gullotta's statement was thought provoking. All health care providers might better aid pregnant adolescents if they assumed that their clients included well-adjusted and healthy adolescents who became pregnant. The potential consequences and stressors of pregnancy would be present regardless of the adolescent's emotional state. Therefore, assistance and support need to be provided to all pregnant adolescents.

Self-Esteem and Parenting

There is evidence from the research that adolescent parents display lower self-esteem. Zongker (1977) studied adolescent parents for a 2-year period and found lower self-esteem in adolescent mothers. Comparing the self-esteem of unwed adolescent mothers to nonpregnant adolescents, Thompson (1984) found strong evidence that the mothers had lower self-esteem and a higher external locus of control than the control group.

Many articles reviewed on adolescent mothers concentrated on multiple variables that the mothers were faced with in their life situations. Self-esteem was not directly addressed but was indirectly a component in the conclusions and recommendations of the studies.

Summary

Self-esteem was documented as a personal dimension starting in infancy. Family was the primary factor that determined levels of self-esteem. The literature search noted discrepancies in the levels of self-esteem between gender. Self-esteem appeared to be the basis of behavioral decisions although actions could change the level of self-esteem. Pregnant adolescents and adolescent mothers consistently displayed lower self-esteem than nulliparous or pregnant adolescents choosing to abort, as well as the general population. The research indicated that a higher

level of self-esteem was important for psychological well-being.

Self-Esteem and Social Support

Although there has been extensive research in the areas of social support and self-esteem, there is a paucity of articles specifically relating these two concepts directly, especially in adolescents. The following articles did not specifically concentrate on the adolescent population, but rather provided a summary of the few articles found on the relationship between self-esteem and social support.

Rosenberg (1989) studied parental support, through parental interest, in relation to adolescents' self-esteem in three different life experiences: friends, report cards, and dinner conversations. This study, conducted in 1963, used a stratified random sample from 10 high schools in the State of New York. The sample included 1,684 juniors and seniors. Rosenberg found a direct relationship between teens' low self-esteem and parents showing no interest in the teens' experiences. Teens having punitive responses from their parents demonstrated a higher level of self-esteem than the group of teens having no parental interest displayed. The teens receiving positive responses from the parents had the highest level of self-esteem.

The relationship of parental support and control behavior, to adolescents' self-esteem was studied by Gecas

(1971) using subscales of self-worth and self-power. Parental support was found to be consistently related to the adolescents' self-esteem. Parental control was related to self-esteem but not consistently. This part of his research replicated Rosenberg's (1989) study and supported Rosenberg's findings. Gecas reported that the strongest influence in parental support was seen between the same-sex child and parent. Also maternal support was strongest in the self-worth construct and the paternal support was strongest in the self-power construct.

The effects of social support and self-esteem on adolescent substance abuse treatment outcomes were addressed by Richter, Brown and Mott (1991). Social support was positively related to the abstainers during the year following treatment as compared to the relapsers in the same time frame. During that same posttreatment year higher self-esteem was inversely related to fewer psychological problems.

Lohr and Gillmore (1991) reported lower stress and higher self-esteem in adolescent mothers (N = 119) with supportive friends. These adolescent mothers, aged 17 and under were interviewed during pregnancy and 6 months postpartum. The young mothers indicated having less friends at 6 months postpartum than during pregnancy. The network of friends had also changed; there were more friends who were also parenting than during the prenatal period. The

participants experienced decreased stress and higher self-esteem if there were supportive friends present and a sharing of feelings with these friends. The most significant change between the prenatal and postpartum periods was the increase of friends who were also parenting. Friendship was a necessary part of psychological well-being during one's lifespan; friends usually tended to change to those having similar characteristics and activities (Lohr & Gillmore).

Koeske and Koeske (1990) investigated social support as a buffer for normal parental stress. They contended that demands placed on parents by the child caused strain which resulted in continued stress. If the strain continued, the mother had increased physical and psychological symptoms, lowered self-esteem, and increasing dissatisfaction with the parenting role. Koeske and Koeske found that continued parental stress resulted in negative consequences such as lower self-esteem, more parental dissatisfaction, and more physical and psychological symptoms. Social support had a buffering effect against parental stress. The spiraling negative effects due to stress were significantly related to the lack of social support; thus, adequate social support had an indirect positive relationship to self-esteem.

Head Start, a program for preschool children, was viewed as being a form of social support for mothers whose children participated in the program. Parker, Piortrkowski

and Peay (1987) used a pretest/posttest design and reported that the more mothers participated in Head Start the greater their feelings of mastery, life satisfaction, and psychological well-being. Parker et al. concluded that besides Head Start having a positive effect on preschool children (well documented), this program also benefited the mothers. This study did not directly assess self-esteem but the constructs of mastery, satisfaction and well-being are terms which often are used in addressing self-esteem.

Self-esteem and social support relating to positive health practices in 98 men and women were studied by Muhlenkamp and Sayles (1986). Their results indicated a positive association between self-esteem, social support, and a healthy life-style.

Thompson and Peebles-Wilkins (1992) examined informal, formal, and societal support in relation to mental health, through self-esteem, depression, and general distress. A total of 170 black adolescent mothers were interviewed. The mothers' increased psychological well-being in self-esteem was significantly related to the support of the male partners. Also, support from male partners was significantly related to less depression and general distress. The only significant formal support person was the caseworker. The frequency of the caseworker's contact was associated with lower levels of depression and general distress. A pattern of increased social support from the

maternal grandmother and other relatives was inversely related to general distress, depression, and self-esteem; however, the findings were not significant.

Summary

Social support and self-esteem are two psychological concepts that can make a difference in healthy outcomes and psychological well-being for pregnant adolescents choosing to parent. Extensive research documented the positive effects of both variables.

However, the review also documented differences and conflicts in the effects of social support and self-esteem. The relationship of social support to self-esteem has not been clearly documented in the available literature, specifically, to pregnant adolescents choosing to parent. The findings of this study added to the body of knowledge about the relationships between perceived social support and self-esteem in this particular group of adolescents.

CHAPTER 3

METHODOLOGY

The research methodology utilized in this study is presented in this chapter. Design, instrumentation, sample, data collection procedure, human subjects protection, and statistical analysis are addressed.

Design

A descriptive correlational design was used to investigate the relationship between perceived social support and self-esteem in pregnant adolescents choosing to parent. This design was chosen because (a) the researcher's intent was to survey a population with a specific interest, i.e., adolescents choosing to parent and (b) to relate two variables, self-esteem and social support, to one another in the designated group (Woods & Catanzaro, 1988).

The assessment of perceived social support and self-esteem was measured once in the prenatal period. Participants completed a questionnaire packet that included the Personal Resource Questionnaire 85-Part 2 (PRQ85-Part 2) (Brandt & Weinert, 1981) and the Self-Esteem Questionnaire (SEQ-3) (Hoffmeister, 1988). Demographic and background data also were collected.

Instrumentation

Social Support Instrument

The PRQ85 is a two-part instrument designed by Brandt and Weinert in 1981 and modified by them in 1985 (Brandt & Weinert, 1981; Weinert, 1987). Only the PRQ85-Part 2 was used for this study. It was chosen because of its clarity, readability, simplicity, and demonstrated reliability and validity in measuring social support. PRQ85-Part 2 measured the level of perceived social support based on the five dimensions of relational provisions of social support described by Weiss (1974). These dimensions included intimacy, nurturance, worth, assistance, and social integration. It is a 25-item questionnaire. Participants responded to each item using a 7-point rating scale, 1 (strongly disagree) to 7 (strongly agree). Scale scores ranged from 25 to 175; the higher score indicated higher levels of perceived social support (see Appendix A). One statement for each of the five dimensions was worded negatively to reduce response bias (Brandt and Weinert, 1981).

Weinert (1987) reported a Cronbach's alpha reliability of .89 for the total scale and the subscales' reliabilities ranged from .61 to .77 indicating internal consistency. The PRQ85-Part 2 scores were similar to the PRQ82-Part 2 indicating construct validity. There was a significant moderate correlation between the scores of the PRQ85-Part 2

and the scores of the instruments measuring related constructs.

Weinert (1987) stated that the 5 years of psychometric testing on the earlier version (PRQ82) gave strong evidence to support the validity and reliability of the Personal Resource Questionnaire. Construct and criterion validity of the PRQ85-Part 2 were supported in studies of adults and adolescents (Weinert & Brandt, 1981; Weinert, 1987; Yarcheski, Mahon & Yarcheski, 1992). Permission to use the PRQ85-Part 2 was obtained from Dr. Weinert (see Appendix B). The alpha coefficient was .91 for this study.

Self-Esteem Instrument

Hoffmeister's (1988) SEQ-3 was used to measure self-esteem. This 21-item scale, published in 1971, was designed using the cluster analysis procedure. All items fell into two distinct subscales, self-esteem (SE) and self-other satisfaction (SOS). Items were answered with a Likert scale ranging from 1 (not at all) to 5 (yes, very much). The lower scores denoted lower SE and less SOS (see Appendix A). A 4th grade reading level was required to be able to complete the SEQ-3 (Hoffmeister, 1988; McCarthy, 1985). The SEQ-3 tool was chosen for its low reading level and simplicity. The two variables, SE and SOS, are interspersed throughout the instrument; therefore, the complete questionnaire was used in data collecting, but in the analysis only the SE items were analyzed.

Reliability and validity were established at the time the instrument was developed (Hoffmeister, 1988). A test-retest reliability with a 2-week interval resulted in Pearson correlations of .70 for both measures from a grade school sample ($N = 250$) and .94 in an adult sample ($N = 100$). Cronbach's alpha ranged from .80 to .95 on SE and .85 to .96 on SOS. For testing criterion validity, the SEQ-3 and the Coopersmith Self-Esteem Questionnaire showed a moderate correlation between the two instruments. Construct validity was established using the Otis-Lennon Mental Ability Test and the correlation coefficient was .20 for SE and .10 for SOS (Hoffmeister, 1988). McCarthy (1985) stated that the SEQ-3 was empirically developed to measure the construct of self-esteem, and believed it to be an appropriate test for children, adolescents, and adults. Permission to use the SEQ-3 was been obtained from Dr. Hoffmeister (see Appendix B). Hoffmeister's computerized program for scoring the questionnaires does not provide for the Cronbach alpha reliability reading.

Demographic and Background Questionnaire

The demographic data form contained two types of questions. Items included to describe the sample consisted of age, marital status, length of marital status, level of education, type of residence, and ethnicity. The remaining questions were developed to gain insight regarding the obstetrical background of the participants. The adolescents

were asked about the estimated date of delivery, pregnancy status (planned or unplanned), initiation of prenatal care, previous pregnancies and children, and any medical problems related to the pregnancy. Two other questions elicited information regarding the birth of the first child born to the adolescents' mothers and sisters (see Appendix A).

Sample

The sample was a nonrandom convenience sample of 36 pregnant adolescents choosing to parent. Solicitation continued until 36 adolescents agreed to participate. Researcher access to the population was arranged through the agencies that administered the Women, Infants, and Children (WIC) program and alternative schools. [WIC is a federally subsidized program providing food and nutrition education to pregnant women, infants, and children up to age 5.] Alternative schools are part of the public school system, designed for unique students who are not fitting well into the traditional school system. [Pregnant adolescents and adolescent mothers enter alternative schools for apparent reasons.] The sample was obtained in Montana and Idaho. Letters of support from these agencies were obtained (see Appendix C).

The sample size of 36 was determined utilizing feasibility factors recommended by Woods and Catanzaro (1988). Hoffmeister (1988) developed a specific computer

program that provided scoring for the SEQ-3. The scoring was programmed to discard any questionnaire that has over 70% of inconsistent responses. "A score is computed only if the person has responded in a reasonably consistent fashion to the items used to measure that factor" (Hoffmeister, p. 2). Crandall (1978) and McCarthy (1985) stated the maximum numbers rejected are 10-15% and 1-5%, respectively. Therefore, 36 participants provided a minimum number of 30 for adequate data analysis.

Criteria for inclusion in the study were as follows: the pregnant adolescent was planning to parent, between 13 and 18 years of age at the time of conception, and between 20 and 40 weeks gestation. Existing medical problems that were pregnancy induced were acceptable (*i.e.*, urinary tract infections, pregnancy induced hypertension). Pregnant adolescents who had an underlying chronic disease (*i.e.*, diabetes, epilepsy) were excluded. Marital status was not a criterion for participation in the study.

Data Collection Procedure

Permission to conduct the study and solicit participants at each of the WIC agencies and alternative schools was obtained prior to initiating data collection (see Appendix C). The actual data collection process was a collaborative effort between each agency and the researcher. The adolescent was contacted during a scheduled appointment

or in school. The researcher or trained assistant met with each potential participant, discussed the study, and asked for her consent to participate. If the adolescent was interested, a written consent form was given to her explaining the purpose of the study, the individual's role in the study, the estimated length of time for participation, the benefits, risks, assurance of confidentiality, and the right to refuse. The researcher assured each adolescent that there was no risk of lost services for refusal to participate. The researcher answered any questions the prospective participant posed. After reading the informed consent letter, a signature from the participating adolescent was requested and obtained (see Appendix D). This signed consent form was retained by the researcher and a copy of the letter was given to the participant for her to retain.

The time estimated to complete the questionnaire packet was 30 minutes. Recommendations were taken from Brandt and Weinert (PRQ85-Part 2) and Hoffmeister (SEQ-3). Time to complete the demographic data also was considered. The actual time needed for filling out the questionnaire varied from 10 to 20 minutes. If the adolescent wished a report of the summary be sent to her, she indicated by writing her address on the consent form.

Protection of Human Subjects

The research proposal was submitted and approved by the Montana State University Human Subjects Review Committee. The researcher began data collection after approval by the committee (see Appendix E).

Statistical Analysis

Descriptive statistics included frequency, means, range, and standard deviation procedures to analyze the demographic data, PRQ85-Part 2 results, and the SEQ-3 results. The Pearson correlation coefficient and analysis of variance were used to analyze the relationship between perceived social support, self-esteem, and demographic variables.

Sample Description

The sample in this study was composed of 36 young adolescent women who met the stated criteria. A total of 42 subjects completed the questionnaire. It was determined that six subjects did not meet the criterion of 20 or more weeks gestation, and these participants' responses were not included in the sample. The two sparsely populated states represented in the sample were Montana (92%) and Idaho (8%). Ninety-two percent of the participants lived in a town/suburb. The participants had various living

arrangements, but the majority (67%) lived with one or both of their parents/stepparents.

The age of the sample ranged from 14 to 19 with a mean of 16.7 years. Sixty-seven percent were Caucasian, 19% were Native Americans, 3% were Hispanic, and the remaining 11% indicated some other ethnicity. The participants' years of education ranged from 8 to 12 years with a mean of 9.9 years; 64% ($n = 23$) are currently attending school. Thirty-two participants (89%) were single. The four marriages represented in the group ranged in length from less than 6 months to less than 18 months. A more detailed description of the sample can be found in Appendix F.

CHAPTER 4

RESULTS

The purpose of this study was to investigate the relationship between perceived social support and self-esteem in pregnant adolescents choosing to parent. The results from the data analysis are presented in three sections: the relationship between self-esteem and perceived social support, relationships of perceived social support, self-esteem, and demographic variables, and additional demographic descriptions. The sample description was outlined in the previous chapter. A .05 significance level was used for all statistical tests.

Relationship Between Concepts

The research question explored in this study was, is there a relationship between perceived social support and self-esteem in pregnant adolescents choosing to parent? The PRQ85-Part 2 (Brandt & Weinert, 1981) was used to determine perceived social support for this sample. It has 25 items and was a 7-point Likert response scale. It has a potential score range of 25-175; higher scores indicate higher perceived social support. In this sample, 32 participants' scores fell between the scores of 99-175; the mean was 137.50 (SD = 20.74).

The SEQ-3 tool (Hoffmeister, 1988) was used to determine the level of self-esteem. It has 12 self-esteem items and uses a 5-point Likert response scale. Hoffmeister (1988) established categories to denote high, situational, and low levels of self-esteem for the SEQ-3. In this sample, 35 participants' scores in self-esteem fell in the high level ($n = 17$) or within the situational level ($n = 18$) and one participant's score fell into the low self-esteem category. In this sample the self-esteem scores mean was 3.78 ($SD = .673$).

The Pearson product moment correlation coefficient (Pearson r) was used to identify the relationship between perceived social support and self-esteem in the sample. A positive correlation between the two concepts ($r = .6257$, $p = .001$) resulted.

After the sample scores mean from SEQ-3 was computed, it was compared to the normative data from Dr. Hoffmeister for the SEQ-3 instrument. The reported mean for the SEQ-3 instrument for junior high and high school students was 3.85. While this sample had a lower scores mean (3.78) compared to the normative data for adolescents, both of the normative and this sample means scores fell within the high self-esteem level (3.75-5.00).

The scores mean of the PRQ85-Part 2 was also compared to the mean from previous studies (see Table 1). Unfortunately, there were no mean or SD reported for the

Yarcheski (1992) study, the only study with an adolescent sample. As compared to the reported means from studies consisting of adult samples this study had the lowest mean.

Table 1. Comparison of PRQ85-Part 2 Scores to
Reported Mean of Sample.

Sample	<u>n</u>	Mean Age	PRQ85 Part 2 Mean	<u>SD</u>
Catanzaro	45	47.9	139.0	19.0
Mulenkamp	132	69.5	141.9	13.9
Weinert	66	49.0	142.0	17.4
Gibson/Weinert	120	40.7	149.2	18.1
Yarcheski/Mahon/ Yarcheski	325	16.2	Not Reported	Not Reported
Scofield	36	16.7	137.8	20.7

Perceived Social Support, Self-Esteem,
and Demographic Variables

The relationship of perceived social support and self-esteem to demographic variables was analyzed to better understand this sample. No statistically significant correlations were obtained; however, trends were identified in two of the demographic variables, age and living arrangements.

Ages of the pregnant adolescents were not correlated to perceived social support ($r = -.12$, $p = .50$) or self-esteem ($r = -.68$, $p = .694$) in this sample. Because the correlations between age, perceived social support, and self-esteem were negative, this indicated that the younger the adolescents the higher the scores in perceived social

support and self-esteem. Neither of these results were statistically significant.

The 11 categories within the living arrangements item were collapsed into three groups. Group 1 included parents, only one parent (mother or father), and a mother or father with a stepparent. Group 2 included husband or male partner, and Group 3 encompassed relative (grandmother), friend, and alone categories. Analysis of variance revealed no statistically significant difference in the means of perceived social support to the three groups of living arrangements. Although not statistically significant, the social support means were lowest in Group 1 and highest in Group 3, suggesting that the participants living outside of the primary family perceived they had more social support (see Table 2).

Table 2. Comparison of Perceived Social Support by Living Arrangements Using Analysis of Variance.

Variable	<u>n</u>	Mean	<u>SD</u>
Living Arrangement			
Group 1 - Parental Setting	21	134.29	22.33
Group 2 - Husband/Partner	5	138.20	10.26
Group 3 - Other	6	149.50	19.27
Arrangements			

$F = 1.28, p = .29$

Self-esteem data were analyzed using the same procedure of collapsing the living arrangements categories into three groups. Again, there was no significant difference in the means of self-esteem in the three living arrangement groups,

but the lowest mean was found in Group 1 and the highest mean in Group 3. As with perceived social support, and displayed in Table 3, this may suggest that the participants living outside of the primary family have higher self-esteem.

Table 3. Comparison of Self-Esteem by Living Arrangements Using Analysis of Variance.

Variable	<u>n</u>	Mean	<u>SD</u>
Living Arrangement			
Group 1 - Parental Setting	24	3.67	.68
Group 2 - Husband/Partner	6	3.85	.57
Group 3 - Other Arrangement	6	4.16	.68

F = 1.37, P = .27

Additional Demographic Description

The sample description reported 31 pregnancies (89%) as unplanned. The range of ages in the unplanned pregnancy group was 14-18. Only four participants reported an intended pregnancy; their ages ranged from 16-19 years. Two of the four married participants reported that the pregnancies were planned; their ages were 16 and 17. Twenty-three of the participants reporting unplanned pregnancies lived with parents or in a parental setting (see Table 4).

Table 4. Frequency of Living Arrangements and Pregnancy Intent.

Variable	Unplanned	Planned
Parents	7	1
Mother Only	10	
Father Only	1	
Mother/Stepfather	4	
Father/Stepmother	1	
Husband	1	2
Male Partner	2	
Relative (Grandmother)	1	
Friend	1	
Alone	3	1
Missing	1	

[Data related to obstetrical history revealed that nine of the participants (25%) had previous pregnancies, with one reporting two previous pregnancies.] [Currently, seven participants, ages ranging from 15-19 years, have one child.] [Only two out of the nine having previous pregnancies reported the current pregnancy as planned.]

Prenatal care for 54% ($n = 19$) of this sample began before the beginning of the third month and for 69% ($n = 24$) of the sample prenatal care began before the end of the third month. Eleven percent ($n = 4$) waited until the fifth month of pregnancy before initiating prenatal care. The sample mean for initially seeking prenatal care was 2.75 months. Only three participants identified complications related to their pregnancies. The complications were anemia (1), lower urinary tract infection (1), and hypertension (1).

Data obtained on the participants' mothers' ages when their first child was born revealed the following information. The mothers' ages at the time of the birth of their first child ranged from 14-30 years. The mean age for the mothers of the participants was 18.9 years while the mean age for this sample was 16.7 years, a difference of 2.2 years. Ten of the participants' mothers were 17 years of age or younger when they gave birth to their first child.)

The same question was asked about sisters that had a child or children. Thirteen participants did not respond to the question about age of sister(s) with first delivery. Ten participants had a sister with a child. The ages of sisters ranged from 14-25 years; five sisters were under the age of 20 when they had their first child. This item in the questionnaire did not include the category "do not have a sister," therefore, it was difficult to discern an accurate summation of the responses.

Education level is an important determinant of future socioeconomic status for pregnant adolescents in society; therefore, the items "how many years of schooling completed?" and "currently attending school?" were included in the study questionnaire. Sixty-four percent ($n = 23$) were currently attending school. Eighteen of these participants were living with parent(s) or in a similar parental setting. Two of the four participants living alone were attending school, and the remaining three lived with a

grandmother ($n = 1$) or their male partners ($n = 2$). The four married participants were not currently attending school. In this sample only one participant had completed the 12th grade.

Summary

In summary, a positive correlation was found between perceived social support and self-esteem in pregnant adolescents choosing to parent. Demographic variables were analyzed in relation to perceived social support and self-esteem with no significant correlations. The mean age of 16.7 years for the sample is less than the participants' mothers' mean age of 18.9 years when their first child was born. The majority (69%) of the sample started prenatal care during the first trimester, most (89%) of the pregnancies were unplanned, only four (11%) were married, and 64% are currently attending school.

CHAPTER 5

DISCUSSION

This study was conducted to explore the relationship of perceived social support and self-esteem in pregnant adolescents choosing to parent. A correlational design was used with a convenience sample of 36 pregnant adolescents who were in their last 20 weeks of pregnancy. This chapter will contain a discussion of the findings in relation to the research question and conceptual framework, including the strengths and limitations and the findings in relation to existing literature. A discussion of the nursing implications and recommendations for future studies will conclude the chapter.

Adolescence is the stage when specific maturational tasks need to be accomplished allowing the transition from a dependent child to a self-sufficient adult. Pregnancy and parenthood are major adult events that can be overwhelming to an adolescent and cause dissonance in achieving adolescent developmental tasks, thus setting the stage for negative consequences in future life directions!

Research Question and Conceptual Framework

The conceptual framework was based on two concepts, perceived social support and self-esteem. Self-esteem is a self-evaluation in response to the reactions of others. The

self-esteem dimension varies in situations and in life stages, yet it is believed that a central global level of self-esteem is present in individuals. Rosenberg (1989) succinctly summarized the multitude of studies showing an association between low self-esteem and psychosocial problems. Social support is the knowledge that one is loved, esteemed, and able to obtain material assistance from others when necessary. It has been recognized as a buffer against life's stressors and conflicts and as a fundamental need for a healthy life.

A positive correlation was found between perceived social support and self-esteem in pregnant adolescents choosing to parent. Social support and self-esteem were also analyzed with the demographic variables; no correlations were found. Interestingly, when living arrangements were compared to social support, a trend developed indicating that participants living outside of the primary family setting reported levels of perceived social support which were similar to the means for adult samples. An identical trend was suggested when living arrangements were compared to self-esteem; the participants living outside of the primary family setting reported a higher level of self-esteem. These findings suggest that the adolescents living outside of the primary family setting have achieved more of the adolescent developmental tasks and thus feel more adept in facing adult responsibilities.

A positive relationship between social support and self-esteem was expected. Previous literature demonstrated that social support enhances self-esteem (Rosenberg, 1989; Gecas, 1971; Lohr & Gillmore, 1991; Koeske & Koeske, 1990; and Thompson & Peebles-Wilkins, 1992). The finding of a positive relationship adds more emphasis to the importance of taking and maintaining a psychosocial history when providing care to adolescents. The higher levels of perceived social support may reflect the decreased social stigma and shame attached to adolescent pregnancy and single parenthood. Perhaps society's increased acceptance of adolescent sexual activity and pregnancy allows parents, partners, and others to provide the needed support without portraying a shameful and condescending attitude toward the adolescents; this would certainly contribute to positive self-esteem.

The high level of self-esteem found in most of the clients was unexpected. In past research, low self-esteem in pregnant adolescents choosing to parent has been reported (Barth, Schinke & Maxwell, 1983; Olson, 1980; Patten, 1981; and Zongker, 1977); yet, a more recent study reported that the majority of pregnant adolescents surveyed felt good about themselves (McCullough & Scherman, 1991). Perhaps the higher level of self-esteem in this study is reflecting the global feelings that surround pregnancy. For many, pregnancy is considered a miracle representing the ability

to reproduce and create life, providing a link to immortality.

Although not a statistically significant finding, the suggested trend when living arrangements were related to perceived social support and self-esteem needs to be investigated further. This trend is similar to Streetman (1987) who reported higher measures of self-esteem in unwed mothers who lived alone. It is not unusual for adolescents to presume family support as constant and ever-present without much thought, whereas adolescents living in other arrangements had to, at one time, look at the choices of where to live, using some form of family and self evaluation.

Strengths and Limitations

The findings of this study demonstrated that self-esteem and perceived social support had a strong positive relationship. While this sample study was small, the participants resided in six different areas in Western Montana and Eastern Idaho. The PRQ85-Part 2 (Brandt & Weinert, 1981) and the SEQ-3 (Hoffmeister, 1988) tools, measuring perceived social support and self-esteem, respectively, have well established validity and reliability, thus giving strength to this study's findings.

Caution must be used when generalizing the results of this study to the target population. A correlational design and a convenience sample make such generalizations

impossible for the following reasons. Perhaps the participants who volunteered to participate in this study were feeling good about themselves and, therefore, less vulnerable, making them more willing to participate. The data collection procedure reflected only the feelings of the participants at the time the questionnaire was completed. It is known that the developmental stage of adolescence is a time of volatile and changeable feelings. The sample was small, consisting of only 36 participants, and sample size can distort the weight of findings.

Findings in Relation to Existing Literature

Most of the participants reported (an unplanned pregnancy} which certainly reflects the national trend. In fact, the percentage in this study was higher than the national percentage of unintended pregnancies (Association of Reproductive Professionals, 1994; Trussell, 1988). The finding that seven of the nine participants who had previous (pregnancies reported the current pregnancy as unplanned certainly supports previous research that recommends} contraceptive education and making services more accessible to adolescents (Adams, Adams-Taylor & Pittman, 1989; Chilman, 1990; McKenry et al., 1979; Trussell, 1988). Most of the participants were single; this also mirrors the national trend in pregnant adolescents choosing to remain single (Adams et al., 1989; McKenry et al., 1979; Trussell, 1988). The majority of the participants lived in a primary

family setting. Previous researchers have found many basic needs of pregnant adolescents are met by the parents (Giblin, Poland & Sachs, 1987; Wasserman, Rauh, Brunelli, Garcia-Castro & Necos, 1990; Panzarine, 1986; Unger & Wandersman, 1988).

Pregnancy did not appear to be a barrier to continuing education for the majority of the participants. In years past, many pregnant adolescents were not allowed in school and there were few alternative schools available. This situation has gradually changed since the 1970s, indicating society's increasing acceptance of pregnant adolescents. Accessibility to education is one area where society is making responsible and positive decisions to assist pregnant adolescents instead of ignoring, or avoiding, their impact on society (Burt, 1986; Barth et al., 1983; Stafford, 1987; Trussell, 1988; Zimmerman, 1988).

Nursing Implications

Nurses deal with pregnant adolescents in many social and health settings, such as schools, medical offices, hospitals, and public health departments. Neuman's (1989) goal for nursing can be appropriately applied when caring for pregnant adolescents choosing to parent. The goal for care in this model is "to assist the client in creating and shaping reality in a desired direction ... directed at mitigation or reduction of stress factors and adverse

conditions that could affect optimal client functioning at any point in time" (Neuman, p. 72).

A full term pregnancy causes profound changes, psychologically, physiologically, and socially. Rubin (1984) outlined four maturational tasks to be achieved during pregnancy for a more optimal healthy and long-term outcome. Because adolescents are involved with developmental tasks to achieve adulthood, these additional tasks can cause potential conflict and stress. For example, one of the tasks of adolescence is learning to be at ease with one's body; a constantly enlarging abdomen with a growing fetus may make it difficult to work through this task.

During prenatal visits, nurses must provide the time and care necessary for the pregnant adolescent to feel supported and feel good about herself. Perinatal nursing practice must be cognizant of the adolescent's needs. This can be accomplished by building a trusting relationship, taking and maintaining a thorough psychosocial history, and helping the adolescent to vocalize and identify conflicts through active listening skills and providing education about the developmental stages and maturational tasks. Other nursing measures include helping decrease the adolescent's fears by allowing time for the client to express the "what" and "why" of such feelings, referring the adolescent for further counseling or socioeconomic resources

if necessary, encouraging the adolescent to attend prenatal classes and parenting classes, and being an advocate for the adolescent.

Nurses should be aware of the significant person(s) in the adolescent's support network. Nursing actions should include building an open relationship with the adolescent's support system, encouraging involvement of a significant family member in prenatal visits and classes, and assessing the economic status of the primary family as well as husband or partner (families may need more support when they choose to support their daughters). It is important to recognize that the family members may have to work through conflicting feelings that emerge due to the pregnancy. If the main support person(s) is unable to come to the health care facility, procedures should allow for a home visit; a home visit would provide a more accurate psychosocial assessment.

These actions will assist the adolescent in retaining, maintaining, or attaining an adequate social support base and an adequate level of self-esteem. The majority of these measures are currently being attempted by many nurses and health care providers; yet in reality, assessing, planning, implementing, and evaluating psychosocial issues are more often curtailed, or delayed, than physical concerns due to lack of time and work stressors.

Nursing education must continue to provide sound, up-to-date knowledge regarding maternity care. Since

adolescent pregnancy is a fact in our society, emphasis on the extra stressors and psychosocial needs in this special group need to be emphasized more in basic nursing education. Nursing education can take a more proactive role by providing continuing education for practicing nurses who want to remain current on new findings and research in all aspects of adolescent health care.

Social support and self-esteem are dimensions which will change and vary throughout life due to situations and circumstances. It would be prudent if nursing policy makers and program administrators would consider long-term, follow-up visits to be included as part of standards of care for pregnant adolescents as they become adolescent parents. The concerns and potential problems do not go away after the last postpartum visit.

Recommendations for Future Studies

The finding of a positive relationship between perceived social support and self-esteem stimulated further questions regarding this population. Who and what type of social support systems are involved? Was the high level of self-esteem and the level of perceived social support present prior to the pregnancy and will it continue? What came first, social support or the higher level of self-esteem? Will school attendance continue after the child is born? Further studies should examine the components of

social support, such as who makes up the social support network, what types of formal and informal systems are involved and what types of behaviors are considered supportive for pregnant adolescents. A random descriptive, comparative, longitudinal study could be undertaken beginning at age 13, or 7th grade, and extending to age 20, to investigate perceived social support and levels of self-esteem in pregnant and nonpregnant adolescents. Important demographic variables should also be included. This type of study might help determine which concept was first present, if the amount of support and a positive level of self-esteem are basically the same throughout the perinatal period, and if these adolescents continue their education. Such a study would generate multiple helpful findings; it might, for example, shed more light on the trend noted in adolescents who live outside of a family setting, i.e., perceiving better social support and a higher self-esteem. A qualitative study might help to generate other theories that might be applicable to this special group of adolescents.

The positive relationship between perceived social support and self-esteem found in this study only emphasizes the importance of continually assessing psychosocial issues while caring for pregnant adolescents. It is recommended that a nursing tool be developed which is applicable to practice settings and that can succinctly and clearly elicit and maintain necessary psychosocial information, including

social support and self-esteem. Such a tool would be part of the adolescent's health record.

[Adolescent sexual activity, pregnancy, and parenthood have multifaceted causes, have no simple explanations, and continue to perplex and impact our society.] This study has provided additional evidence that adequate social support and a positive self-esteem are important to the health and well-being in this population. The importance of psychosocial issues cannot be denied in attempting to provide quality health care for pregnant adolescents choosing to parent.

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APPENDICES

APPENDIX A
QUESTIONNAIRE

Below are general questions asking about your background. There are three questions that will need a date or number, and the remaining questions will require you to check one of the responses. Ignore numbers on far right, they are for coding purposes only.

Background Information

1. Birthdate _____ [1] Age _____ [2]
2. Estimated date of delivery _____ [1]
3. Was this a planned pregnancy?
 ___ yes [1]
 ___ no [2]
4. How many months pregnant were you before you saw your doctor/midwife?
 ___ month. [1]
 ___ no doctor/midwife care [2]
5. How many pregnancies have you had prior to this pregnancy?
 ___ none [1]
 ___ one [2]
 ___ two [3]
 ___ three or more [4]
6. How many children do you have now?
 ___ none [1]
 ___ one [2]
 ___ two [3]
 ___ three or more [4]
7. Marital status:
 ___ single [1]
 ___ married [2]
 ___ separated [3]
 ___ divorced [4]
8. If married, how long?
 ___ 0-6 months [1]
 ___ 7-12 months [2]
 ___ 13-18 months [3]
 ___ 19-24 months [4]
 ___ more that 2 years [5]
9. How many years of schooling have you completed?
 ___ 6 or less [1]
 ___ 7 [2]
 ___ 8 [3]
 ___ 9 [4]
 ___ 10 [5]
 ___ 11 [6]
 ___ 12 [7]

Turn Over to Reverse Side

10. Are you currently attending school?

- ☐ yes [1]
☐ no [2]

11. Place of residence?

- ☐ farm/ranch [1]
☐ town/suburb [2]
☐ other Please specify _____ [3]

12. Who are you living with now?

- ☐ parents [1]
☐ mother only [2]
☐ father only [3]
☐ mother/stepfather [4]
☐ father/stepmother [5]
☐ husband [6]
☐ male partner [7]
☐ relative Who? _____ [8]
☐ friend [9]
☐ alone [10]
☐ other Please specify _____ [11]

13. Race:

- ☐ White/Caucasian [1]
☐ Native American [2]
☐ Hispanic [3]
☐ African American [4]
☐ Asian American [5]
☐ Other [6]

14. Do you have any health problems caused by your pregnancy
 (such as: high blood pressure, bladder infection)?

- ☐ yes Please specify problem _____ [1]
☐ no [2]

15. What age was your mother when she had her first child?

- _____ years [1]

16. If you have a sister(s), at what age did she have her first child?

- ☐ years (Sister #1) [1]
☐ years (Sister #2) [2]
☐ years (Sister #3) [3]
☐ years (Sister #4) [4]
☐ sister(s) do not have children [5]

- Q-11. Below are some statements with which some people agree and others disagree. Please read each statement and **CIRCLE** the response most appropriate for you. There is no right or wrong answer.

1 = STRONGLY DISAGREE
 2 = DISAGREE
 3 = SOMEWHAT DISAGREE
 4 = NEUTRAL
 5 = SOMEWHAT AGREE
 6 = AGREE
 7 = STRONGLY AGREE

STATEMENTS

- a. There is someone I feel close to who makes me feel secure 1 2 3 4 5 6 7
- b. I belong to a group in which I feel important 1 2 3 4 5 6 7
- c. People let me know that I do well at my work (job, homemaking) 1 2 3 4 5 6 7
- d. I can't count on my relatives and friends to help me with problems 1 2 3 4 5 6 7
- e. I have enough contact with the person who makes me feel special 1 2 3 4 5 6 7
- f. I spend time with others who have the same interests that I do 1 2 3 4 5 6 7
- g. There is little opportunity in my life to be giving and caring to another person 1 2 3 4 5 6 7
- h. Others let me know that they enjoy working with me (job, committees, projects) 1 2 3 4 5 6 7
- i. There are people who are available if I needed help over an extended period of time 1 2 3 4 5 6 7
- j. There is no one to talk to about how I am feeling 1 2 3 4 5 6 7
- k. Among my group of friends we do favors for each other 1 2 3 4 5 6 7

- 1 = STRONGLY DISAGREE
 2 = DISAGREE
 3 = SOMEWHAT DISAGREE
 4 = NEUTRAL
 5 = SOMEWHAT AGREE
 6 = AGREE
 7 = STRONGLY AGREE

STATEMENTS

- l. I have the opportunity to encourage others
 to develop their interests and skills 1 2 3 4 5 6 7
- m. My family lets me know that I am important
 for keeping the family running 1 2 3 4 5 6 7
- n. I have relatives or friends that will help me
 out even if I can't pay them back 1 2 3 4 5 6 7
- o. When I am upset there is someone I can be
 with who lets me be myself 1 2 3 4 5 6 7
- p. I feel no one has the same problems as I 1 2 3 4 5 6 7
- q. I enjoy doing little "extra" things that make
 another person's life more pleasant 1 2 3 4 5 6 7
- r. I know that others appreciate me as a
 person 1 2 3 4 5 6 7
- s. There is someone who loves and cares
 about me 1 2 3 4 5 6 7
- t. I have people to share social events and
 fun activities with 1 2 3 4 5 6 7
- u. I am responsible for helping provide for
 another person's needs 1 2 3 4 5 6 7
- v. If I need advice there is someone who
 would assist me to work out a plan for
 dealing with the situation 1 2 3 4 5 6 7
- w. I have a sense of being needed by another
 person 1 2 3 4 5 6 7
- x. People think that I'm not as good a friend
 as I should be 1 2 3 4 5 6 7
- y. If I got sick, there is someone to give me
 advice about caring for myself 1 2 3 4 5 6 7



Below are some statements of which people have different levels of thoughts in their lives. There is no right or wrong answer. Please read each statement and circle the response most appropriate for you. Mark only one response for each question.

Answer choices are:

- 1 = Not at all
- 2 = Only a little
- 3 = Depends or not sure
- 4 = Pretty much
- 5 = Yes, very much

1. I feel sure of myself. 1 2 3 4 5
2. Most of my friends accept me as they accept other people. 1 2 3 4 5
3. Does the situation described in No. 2 upset you? 1 2 3 4 5
4. Most people who are important to me, who know me, think I do most things well. 1 2 3 4 5
5. Does the situation described in No. 4 upset you? 1 2 3 4 5
6. Most persons my own age seem to be able to do things better than I. 1 2 3 4 5
7. Does the situation described in No. 6 upset you? 1 2 3 4 5
8. I'm usually a lot of fun to be with. 1 2 3 4 5
9. Does the situation in No. 8 upset you? 1 2 3 4 5
10. Most persons who I want to do things with really want me to do things with them. 1 2 3 4 5
11. Does the situation in No. 10 upset you? 1 2 3 4 5
12. I'm satisfied with the way I handle most situations. 1 2 3 4 5
13. I'm popular with most people. 1 2 3 4 5
14. Does the situation described in No. 13 upset you? 1 2 3 4 5
15. Most people my own age seem to be able to do things easier than I. 1 2 3 4 5
16. Does the situation described in No. 15 upset you? 1 2 3 4 5
17. Other people who are important to me really accept me 1 2 3 4 5
18. Does the situation described in No. 17 upset you? 1 2 3 4 5
19. Most people my own age are more satisfied with themselves than I am with myself 1 2 3 4 5
20. Does the situation described in No. 19 upset you? 1 2 3 4 5
21. How self-confident do you usually feel? 1 2 3 4 5

APPENDIX B
PERMISSION TO USE PERSONAL RESOURCE

NADA D. SCOFIELD
805 W. Villard, No. 3
Bozeman, Montana 59715

July 14, 1993

Clarann Weinert, S.C., Ph.D., R.N.
Associate Professor
College of Nursing
Montana State University
Bozeman, MT 59717-0356

Dear Dr. Weinert:

Thank you for the copy of the PRQ85 and the additional material. The PRQ Part 2 that measures the level of perceived social support was the reason for my interest and I have decided to use the PRQ Part 2 in my research project.

The research project I am developing concerns the pregnant adolescents choosing to parent. The title gives a brief description and is as follows: Perceived Social Support and Self-Esteem in Pregnant Adolescents Choosing to Parent.

This study will be a descriptive correlational design with a convenience sample of 36 participants, strictly voluntary, accessed through the WIC Program in the western region of Montana. I am fortunate to have Connie Hansen, Great Falls Campus, as my research chairperson.

Be assured that I will abide by your request of no changes, including sequencing and no deletions. Proper identification and authorship will be given. I will be glad to share the demographic data with you.

Enclosed is \$3.00 to help cover expenses of the questionnaire. Thank you for giving permission for use of the PRQ Part 2.

Sincerely,



NADA D. SCOFIELD, R.N.C./N.P.

Enclosure

NADA D. SCOFIELD
805 W. Villard
Bozeman, MT 59715

March 26, 1993

Dr. James Hoffmeister
2400 Park Lake Drive
Boulder, CO 80301

Dear Dr. Hoffmeister:

This letter is to confirm our March 26, 1993, telephone conversation regarding the Self-Esteem Questionnaire (SEQ-3). Enclosed is a \$10.00 check for the manual describing the development and interpretation of the SEQ-3.

Thank you for giving me permission to use your tool for my thesis, investigating the relationship between perceived social support and self-esteem among pregnant adolescents choosing to parent. I thoroughly enjoyed our conversation.

Sincerely,

A handwritten signature in cursive script, reading "Nada D. Scofield".

Nada D. Scofield

Enclosure

APPENDIX C
LETTERS OF SUPPORT

September 20, 1993

To: Joan Bowsher
WIC Director
1980 9th Avenue
Helena, Mt. 59601

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing, Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels of self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered as arranged by your agency.

The potential clients will be asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the questionnaire. It is understood that the adolescents who chose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program:

Joan Bowsher
Authorized signature

12-15-93
Date

September 14, 1993

To: Richard Carlson, Director
Abraham Lincoln Alternative School
1050 South Montana
Butte, Montana 59701

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing, Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master's thesis project.

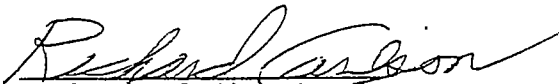
The study focuses on levels of self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered as arranged by your agency.

The potential clients will be asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the questionnaire. It is understood that the adolescents who chose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program:


Authorized signature

10/6/93
Date

December 15, 1993

To: Lila Stanger,
Director of Nursing
Health District VII
254 E Street
Idaho Falls, Idaho 83403

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing, Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels of self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered as arranged by your agency.

The potential clients will be asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the questionnaire. It is understood that the adolescents who chose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program:

Jenny Watson BSW.
Authorized signature

1-11-94.
Date

September 14, 1993

To: Sherry Loney, Health Officer
1130 17th Avenue So.
Great Falls, Montana 59405

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing, Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels of self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered as arranged by your agency.

The potential clients will be asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the questionnaire. It is understood that the adolescents who chose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program:

Sherry Loney
Authorized signature

9-15-93
Date

To: Peggy Conwell, Director
WIC Program
Courthouse, 331 W. Main
Bozeman, Montana 59715

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing at Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels on self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered by myself after a WIC appointment of the participant.

The potential clients will be approached and asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the instrument. It is understood that the adolescents who choose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Nada Scofield R.N.
Graduate Student

Consent of Program to participate.

Peggy Conwell
Authorized signature

9.2.93
Date

To: Doris Biersdorf, Executive Director
WIC Program
3312 4th Avenue N.
Billings, Montana 59101

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing at Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels on self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered by myself, as arranged by your agency, after a WIC appointment of the participant.

The potential clients will be approached and asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the instrument. It is understood that the adolescents who choose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program to participate.

Doris Biersdorf
Authorized signature

8/23/93
Date

To: Valerie Pengelly R.N.
Director, WIC Program

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing at Montana State University, requests permission to utilize your agency for location and identifying potential participants for participation in a master thesis project.

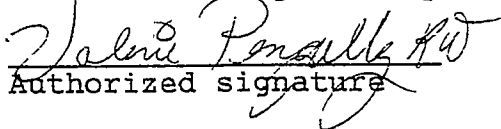
The study focuses on levels on self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered as arranged by your agency and myself after a WIC appointment of the participant.

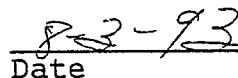
The potential clients will be approached and asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the instrument. It is understood that the adolescents who choose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program to participate.


Authorized signature


Date

To: Diane Lithander, Executive Director
Young Families
1320 Grand Avenue
Billings, Montana 59101

From: Nada Scofield R.N.

Topic: Request for conducting research project.

Nada Scofield R.N., graduate student in the College of Nursing at Montana State University, requests permission to utilize your agency for an avenue to access potential participants to participate in a master thesis project.

The study focuses on levels on self-esteem and social support in pregnant adolescents choosing to parent. A questionnaire will be used to assess levels of social support and self-esteem. The questionnaire will be administered by myself, as arranged by your agency.

The potential clients will be approached and asked if they might be interested in filling out the questionnaire. If they agree, they will be assured that they may withdraw at anytime, without coercion, while completing the instrument. It is understood that the adolescents who choose to participate are strictly voluntary. Confidentiality will be maintained throughout the study, including names and the questionnaire responses.

Your agreement to support this project, by allowing access to adolescents, is deeply appreciated.

Nada Scofield R.N.
Graduate Student

Consent of Program to participate.

Diane Lithander
Authorized signature

8-23-93
Date

APPENDIX D
SUBJECT CONSENT FORM FOR
PARTICIPATION IN HUMAN RESEARCH

1

Subject Consent Form for Participation in Human Research

Montana State University

Dear Expectant Mother:

You are being asked to participate in a study of the experiences of young mothers-to-be. The results of this study will help nurses and others involved in your care to obtain a better understanding in meeting the needs of pregnant adolescents choosing to parent. I understand that you are an adolescent choosing to keep your baby.

If you agree to participate, you will be asked to complete a questionnaire, taking 30 minutes (or less time). There will be no other expectations of you in the future; no other questionnaires will be needed. Most questions only require that you indicate your best response with an X or circling a number. Three questions ask for a date or a number. There is no writing. You are free to ask questions now and during the time you are completing the questionnaire. You may withdraw from the study at any time.

If you agree to participate there are no physical risks involved. There may be an anxious feeling when answering the questions as the subject is about you and your thoughts. If by chance you should need assistance with your anxious feelings, appropriate counseling referrals will be given. There will be no financial or other compensation in payment. This study is of no benefit to you.

Your participation is strictly voluntary. There will be no change in your status as a student, or a WIC client, if you choose not to participate. Confidentiality will be maintained. A code number placed on the questionnaire will be used only for transferring information into the computer for analysis. This signed consent form will be kept separate from the questionnaire and both will be stored in a locked file.

If you want a summary of the study's findings, please write your address beside your name on the consent form. Further questions or information may be obtained by calling Nada Scofield at (406)-585-7481. Thank you.

Nada Scofield, R.N.
Graduate Student
MSU College of Nursing

Authorization: I have read the above and understand the reason for this study and what is expected of me. I agree to participate in this study. I understand that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: _____

Witness: _____ Date: _____

APPENDIX E

MONTANA STATE UNIVERSITY HUMAN SUBJECTS
REVIEW COMMITTEE APPROVAL OF RESEARCH PROPOSAL

5



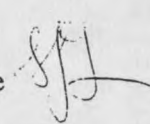
WAMI Medical Program

326 Leon Johnson Hall
Montana State University
Bozeman, MT 59717-0308

Telephone 406-994-4411
FAX 406-994-4398

September 21, 1993

TO: Nada Scofield

FROM: Stephen Guggenheim
Chair, Human Subjects Committee 

SUBJ: "Perceived Social Support and Self-Esteem in Pregnant Adolescents
Choosing to Parent"

Thank you for submitting the revisions to the above proposal as requested by the Human Subjects Committee. This proposal is now approved for a period of one year. At the end of this period you will receive a followup form which will be used to evaluate this proposal for renewal. Please remember that subjects should receive a copy of the consent form. If there are any changes in the research protocol or if there are any adverse effects of the research on the subjects, the committee should be informed as soon as possible.

APPENDIX F

DESCRIPTION OF THE SAMPLE IN TERMS
OF ETHNICITY, COMPLETED SCHOOL YEARS,
MARITAL STATUS, RESIDENCE, AND LIVING ARRANGEMENTS

<u>Variable</u>	<u>Frequency</u>	<u>Percent</u>
<u>Ethnicity</u>		
Caucasian	24	67
Native American	7	19
Hispanic	1	3
Other	4	11
<u>Completed School Years</u>		
8	6	17
9	7	19
10	10	28
11	12	33
12	1	3
<u>Marital Status</u>		
Married	4	11
Single	32	89
<u>State of Residence</u>		
Montana	33	92
Idaho	3	8
<u>Place of Residence</u>		
Town/Suburb	33	92
Farm/Ranch	2	6
<u>Living Arrangement</u>		
Parents	8	22
Mother Only	10	28
Father Only	1	3
Mother/Stepfather	4	11
Father/Stepmother	1	3
Husband	4	11
Male Partner	2	6
Relative (Grandmother)	1	3
Friend	1	3
Alone	4	11

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