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A Comparison of Self-Esteem Scores for Adolescents Who Have Not Been Pregnant, Have Been Pregnant and Have a Child

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A COMPARISON OF SELF-ESTEEM SCORES FOR ADOLESCENTS WHO HAVE NOT BEEN PREGNANT, HAVE BEEN PREGNANT AND HAVE A CHILD

Bridget Laffleur B.S.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Arts
1997

Abstract

The differences in the average self-esteem scores between adolescents who have not been pregnant, adolescents who are pregnant, and adolescents who have a child was the focus of this study. The subjects were adolescents ranging in age from 12 to 19 who were living in a residential treatment facility. The participants were administered the Rosenberg Self-Esteem Inventory. The results found that self-esteem and pregnancy status were weakly correlated but was unable to find a significance due to the low number of subjects.

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TABLE OF CONTENTS

Chapter I Introduction.....1

Chapter II Literature Review.....4

Chapter III Methodology.....29

Chapter IV Results.....34

Chapter V Discussion.....38

Appendix A.....42

Appendix B.....44

References.....49

Vita Auctoris.....54

LIST OF TABLES

		Page
Table 1	Number of subjects in each group and age range	29
Table 2	Summary of Self-Esteem According to Status of Pregnancy	34
Table 3	Summary of Self-Esteem Scores According to Race and Status of Pregnancy	35
Table 4	Cross-Tabulation of Self-Esteem and Status of Pregnancy	36

Chapter I

Introduction

Teen pregnancy has become an epidemic in our society that has shown no signs of slowing down. Every year one million adolescents become pregnant (Bode, 1992). It has become a growing concern in this country in view of the fact that the U.S. currently is ranked highest in teen pregnancy in the Western World (Braverman & Strasburger, 1993). Adolescents are having babies earlier in life and having more children. Various factors have been found to influence teen pregnancy including: socioeconomic status, family relationships, educational goals, prior sexual abuse, psychological components and race (McCullough and Scherman, 1991).

Racial differences have been found to influence an adolescent's level of self-esteem. According to Braverman and Strasburger (1993), in the African-American community single parenthood is more accepted and there are more support systems for the teen mom. This leads the researcher to speculate that African-American adolescents who are mothers might have higher

levels of self-esteem than Caucasian adolescents (Desmond, 1994). Medora, Goldstein, and von der Hellen (1994) found self-esteem scores for African-American adolescents were higher than Latino, Anglos, and Asians. They also state that the African-American scores increased with age. The issue of racial differences in relation to self-esteem was also looked at in this study.

Statement of Purpose

There is conflicting research regarding self-esteem and its relationship to teen pregnancy. According to a study done by Plotnick and Butler (1991), adolescents who scored high on the self-esteem scale were less likely to become unwed mothers. In contrast a study done by Robinson and Frank (1994) yielded differing results. Their study found that there was no difference in self-esteem scores between pregnant and non-pregnant adolescents. The conflicting research shows that a definite conclusion on whether or not teen pregnancy affects self-esteem has yet to be determined. Further research should continue to be done in this area and this study hopes to help add to the growing number of studies on the subject.

The primary purpose of this study is to look at self-esteem differences in relation to teen pregnancy. Specifically to explore whether there are differences

in self-esteem scores for three groups of adolescents: those who have never been pregnant, those who are pregnant and those who have a child. In addition, race will be examined to see if there are any differences in self-esteem scores between African-American and Caucasian adolescents.

Hypothesis

The null hypothesis for this study is that there is no significant difference in self-esteem scores for pregnant adolescents, adolescent parents, and adolescents who have never been pregnant.

The secondary null hypothesis is that there is no significant difference in self-esteem scores for African-American adolescents and Caucasian adolescents.

Chapter II

Literature Review

Teen Pregnancy

Babies having babies. It is a saying that is becoming very familiar in today's society today. The U.S. has become one of the top countries in the world for teen pregnancies. In the U.S. there are approximately 1 million teen pregnancies each year (Bode, 1992). Of these pregnancies approximately 50% of the adolescents decide to raise their child, 40% have an abortion and 10% decide to give the child up for adoption (Braverman & Strasburger, 1993). According to Planned Parenthood (1994), an American teenager has a baby every minute. Adolescents who become pregnant usually do so within the first three months after becoming sexually active (McCullough & Scherman, 1991). McCullough and Scherman state that approximately 9,490 adolescents between the ages of 13 and 14 have their first baby each year and approximately 4,740 16 years olds have their second child.

The U.S. ranks 7th in the industrialized world in adolescent pregnancies according to Desmond (1994).

According to Robinson and Frank (1994) the U.S. has the highest adolescent pregnancy rate of 15-19 year olds in the developed nations. The authors state that the main difference between pregnant adolescents in the U.S. compared to those in other countries is the number of younger adolescents becoming pregnant. The number of adolescents in the U.S. becoming pregnant each year is increasing in younger adolescents. Due to the large number of adolescent pregnancies, the dilemma cost the U.S. $16.6 billion in 1986 according to Medora, Goldstein, and von der Hellen (1993). One factor contributing to the U.S. having one of the highest adolescent pregnancy rates is that the U.S. provides less education regarding sexuality and contraceptives than most other countries (Braverman & Strasburger, 1993).

The choice that the adolescent makes to become sexually active can be influenced by many different factors. In one article, Thomas and Rickel (1995), state that:

> Several variables have been identified as influencing early sexuality and experimentation: changing moral climate, religion, education, puberty, and maturational factors, psychological variables, socioeconomic status, family relations, use and/or abuse of alcohol or drugs and degree of sexual knowledge. (p. 200)

This literature review looks at several of these factors stated above along with a few others. There

are also factors that influence the adolescent's decision as to what to do if she becomes pregnant. The three choices she has if she becomes pregnant are to keep the baby, give the baby up for adoption, or have an abortion. The factors that can influence an individuals decision include their socioeconomic status, family relationships (including communication and a cycle of teen pregnancy), education, prior sexual abuse, psychological components, and race.

The first factor is socioeconomic status. Adolescents who come from lower socioeconomic status, according to Thomas and Rickel (1995) are more likely to experiment with their sexuality. Since most households today need both parents to work, this leads to the adolescents having more time to be unsupervised, thus contributing to more time for them to engage in sexual activity if they chose (McCullough & Scherman, 1991). The less adult supervision that an adolescent has the more likely she is to listen to peer pressure and experiment with drugs, alcohol and sex (McCullough & Scherman). The adolescent who grows up in a household where the parents are not around to supervise them or grows up in a one parent household has a higher rate of teen pregnancy. According to Medora et al. (1993), of all the adolescents who become pregnant many of them are from single-parent families.

A second factor is that of family relationships. In a family where an adolescent had a mother who had her as a teen, she will more likely also become a teen parent (Bravermen & Strasburger, 1993). There tends to be a cycle of teen pregnancies in some families. Within the families there is also the issue of communication. McCullough and Scherman (1991) state that communication problems between an adolescent and her family can contribute to her engaging in early sexual activity. Medora et al. (1993) state that many teens had a strained relationship with their mothers prior to the pregnancy. When it comes to making a decision on what to do if an adolescent becomes pregnant, the family's relationship can play a part. Braverman and Strasburger state that pregnant adolescents who grew up in households where there was limited communication and the parents were uninvolved tended to keep their child.

A third factor that influences a teen's decision is that of her education. According to Plotnick (1992), teens who have high educational goals are less likely to become sexually active. Adolescents who are at a high risk for teen pregnancy are usually at a high school with a higher dropout rate and had a mother who did not graduate from high school herself (Braverman & Strasburger, 1993). According to Planned Parenthood

(1994), only 50% of girls who give birth before the age of 17 will complete high school by age 30. An adolescent who has lower educational goals is more likely to engage in early sexual activity and to become pregnant. These adolescents are also less likely to complete high school. A fourth factor is that of prior sexual abuse. According to McCullough and Scherman (1991), many teen pregnancies may be due to unresolved feelings and behaviors which are due to the earlier sexual abuse. In two of the studies that were reviewed, there was a high percentage of pregnant teens who stated they had been previously sexually abused. The first one was a study done by McCullough and Scherman, where they looked at factors related to adolescent pregnancy and used adolescent mothers and adolescents who were pregnant in their sample. They found that 43% of their sample of pregnant adolescents and adolescent parents had been sexually abused as a child or adolescent. According to Planned Parenthood (1994), in a second study of 535 pregnant teens, 55% had at some time been molested, 42% had been victims of an attempted rate and 44% had been raped.

The fifth factor includes the psychological components. With regard to teen pregnancy, when a teenager has a baby she now has something that she considers only hers and something that no one can take

away from her (Hart & Hilton, 1988). The baby according to Hart and Hilton, is there to help the teen compensate for past hurts and losses. The baby could be used as protection for whatever might happen in the future and give her someone to love and care for (Hart & Hilton).

The final factor is that of race. The percentages of girls who will give birth by age 18 are 25% Black, 15% Hispanic and approximately 6% White (Berlfein, 1992). Nathanson's study (as cited in Desmond, 1994) states that:

> Although the ratio of out-of-wedlock to in-wedlock birth has more than doubled among white teenagers and has increased by only 40% among black teenagers, this translates into nearly 90% of black teenager births occurring out of wedlock as compared to 40% of white teenage births. (p.327)

In the African-American community single parenthood is more accepted and there are more support systems for the teen mom (Braverman & Strasburger, 1993). Also Hill stated (as cited in Dore & Dumois, 1990) that the African-American family is less rigid than the Caucasian family and can accommodate a new member more easily. A study done by Dore and Dumois, noted that African-American teens found being a teen mom to be just one aspect of their lives and not all of their life. Finally African-American fathers, are more likely to play an ongoing role in their children's lives whether or not they stay romantically linked with

the mother (Dore & Dumois).

A look at options that the African-American teen would most likely chose if she became pregnant, indicate that she would be likely to keep the baby. African-American adolescents are less likely than Caucasian adolescents to have an abortion according to Furstenberg (Desmond, 1994). African-American teens usually do not chose formal adoption but possibly informal adoption where another family member would take care of the child until the mother was able to (Desmond). According to Hill (as cited in Dore & Dumois, 1990) another reason that African-American adolescents don't chose formal adoption is due to the fact that in the past they have denied these resources.

There are three options a teen has when she becomes pregnant. She can keep the baby, put the baby up for adoption or have an abortion. Adolescents who chose each option can be described with similar characteristics. The first option is that of keeping the baby. In the research there were two different views on the adolescent's own traits. According to Furstenberg and Crawford (as cited in Cervera, 1993) adolescents who decide to raise their child have a greater risk of lower educational achievement, more emotional difficulties, higher rates of poverty, and lower-paying jobs than adolescents who give their baby

up for adoption. In contrast, in an article by Thomas and Rickel (1995), the authors state that adolescents who decide to keep their babies are not psychologically maladjusted and are less distressed by their circumstances than many had once believed.

The next available option for an adolescent who becomes pregnant is that of adoption. This option, as stated previously in this review, is not utilized very frequently. It seems that very few adolescents choose to give their child up for adoption today. According to Berlfein (1992), in the 1950's approximately 80% of babies born to teen mothers were put up for adoption, but today with abortion and society's acceptance of single parents this number has dropped dramatically to only approximately 5 to 10%. According to deAnda and Becarra (as cited in Cervera, 1993) 80-90% of adolescents who originally say they are going to give their child up for adoption change their minds and keep the baby. According to Backrach (as cited in Cervera) some of the variables that affect whether or not an adolescent decides on adoption are: their age, race, ethnicity, family income, religion, employability, vocational/educational goals, boyfriend's involvement with pregnancy, and the family's feelings about the pregnancy.

The final option to be reviewed is that of

abortion. According to Braverman and Strasburger (1993), 42 out of every 100 adolescent pregnancies in 1987 ended in an abortion. In approximately 30 states there is a law that a teen has to at least tell her parents that she is going to have an abortion (Berlfein, 1992). In approximately 19 states there is a law that requires consent from at least one of the teen's parents in order for them to have an abortion. (Berlfein). The adolescents who choose abortion tend to have the following personal characteristics and factors involved in the pregnancy: more independence, academic goals, higher economic status, easy access to abortion facilities, family and peer approval, higher self-esteem and have been using some sort of contraceptive (Braverman & Strasburger).

Self-Esteem

Self-esteem is an aspect of a person's being that depends on many internal and external factors in his/her life. Coppersmith (as cited by Medora et al., 1993) described self-esteem as the extent to which persons believe themselves to be capable, significant, successful and worthy. Self-esteem is also considered to be a positive or negative attitude towards the self (Rosenberg, 1989). In researching adolescent's self-esteem, Medora et al. defined self-esteem, for the purpose of their study, as the emotional evaluation

teenagers make about themselves. Which, according to Medora et al. is generally in the form of approval or disapproval for themselves. Maslow (as cited by Rosenberg, Schooler & Schoenbach, 1989) stated that self-esteem was a "prepotent" of human needs. These needs were part of a self-esteem motive, which according to Maslow, is part of the basic human motive.

According to Rosenberg (1989) a person with high self-esteem has the following qualities:

> The individual respects himself, considers himself worthy; he does not necessarily consider himself better than others, but he definitely does not consider himself worse; he does not feel that he is the ultimate in perfection, but on the contrary, recognizes his limitations and expects to grow and improve. (p. 31)

According to Thorne and Michaelieu (1996), adolescents with high self-esteem have an inner and outer self-confidence. On the other side, low self-esteem is considered to imply rejection, self-dissatisfaction, and self-contempt (Medora et al. 1993). According to Rosenberg, low self-esteem is self-rejection, self-dissatisfaction, self-contempt. The person does not respect him or herself and wishes that it could be different. According to Heatherton and Ambady (as cited by Bratter, Bratter & Bratter, 1995), "Individuals with low self-esteem attempt less challenging goals for themselves because they are concerned with protecting themselves from the image-damaging consequences of failure" (p.61). Low self-

esteem is also thought of as causing delinquency (Rosenberg et al., 1989).

There are many different factors that could affect an individual's self-esteem. Self-esteem in relation to teens is affected by their feelings of attractiveness, peer acceptance, academic competence, athletics, and conduct (Petersen, Leffert, & Graham, 1995). In a review of the literature some of the prominent factors that affect self-esteem are: success/failures, acceptance, personal memories, sexual abuse, if they have had an abortion, and parental attachment (Baldwin & Sinclair, 1996; Thorne & Michaelieu, 1996; Medora et al., 1993; Rice & Cummins, 1996). The first factor to be looked at is that of a person's successes and failures. When a person has a success or failure it can affect his or her self-esteem by increasing or decreasing it (Baldwin & Sinclair). This is linked to a person's expectations of being accepted or rejected by others (Baldwin & Sinclair). The researchers found that persons with low self-esteem link success with acceptance and failure with rejection.

This idea of wanting to be accepted by others is a second factor that affects self-esteem. According to Baldwin and Sinclair (1996), contingent acceptance, which is highly conditional acceptance, can affect a

person's self-esteem. If a person is continually experiencing contingent acceptance, Harter stated (as cited by Baldwin & Sinclair) they could have low self-esteem compared to a person who is not experiencing contingent acceptance. This is due to the idea, according to Harter (as cited by Baldwin & Sinclair) that the individual feels he or she is not doing what others want him or her to do. In one article by Thorne and Michaelieu (1996), the researchers show a difference between men and women's, self-esteem and their concern with being accepted. According to Throne and Michaelieu, females who have high self-esteem are concerned with connecting with others while males with high self-esteem are more concerned with getting ahead of others.

A third factor that also relates to wanting to be accepted by others is that of a person's personal memories. A study done by Thorne and Michaelieu (1996), looked at an adolescent's personal memories to see how they affected his or her current self-esteem. The study found that the memories of high self-esteem males focused on wanting to assert themselves with male friends, while females with high self-esteem focused on memories where they wanted to help their female friends. Females had more memories that dealt with the concern of others than did the males (Thorne &

Michaelieu). Similar to what was stated above in relation to acceptance, a person's memories of past acceptance can affect his or her self-esteem.

A fourth important factor affecting self-esteem is that of sexual abuse. A study done by Medora et al. (1993), looked at self-esteem in pregnant teenagers. The researchers found that sexual abuse greatly affected the subject's self-esteem. In the study the mean self-esteem score of those subjects who had been sexually abused was significantly lower than those who had not been abused. The reasons given for the lower self-esteem scores in teenagers who have been sexually abused is that they have more difficulty with choices involving trust, control, commitment and sexual involvement. According to Mennen and Meadow (1993), adults who were sexually abused as children had higher rates of depression, anxiety and lower self-esteem than those adults who were not abused.

A fifth factor is that of whether or not the pregnant teenager had had an abortion in the past. In the study done by Medora et al. (1993) the researchers looked at this factor and found that the 28 subjects who had stated that they had had a previous abortion had a higher self-esteem score than did the other 93 subjects who did not have a previous abortion. Medora et al. stated reasons for the higher self-esteem scores

may be due to adolescents who are better at goal setting, more future oriented and have the ability to plan ahead.

A sixth and final factor is that of parental attachment. Rice and Cummins (1996) published a study that dealt, in one aspect, with parental attachment and an adolescent's self-esteem. They found that the more attachment there is with the parents the better the adolescent's self-esteem. Adolescents who had parents who were caring and encouraging tended to have higher self-esteem. According to Ryan and Lynch (as cited in Patterson, Pryor & Field, 1995) the adolescent's idea of the quality of attachment to parents and psychological wellbeing does not change through the adolescent years. Rice and Cummins, also looked at parental gender differences in relation to the adolescent's self-esteem. They found that the father's sensitivity to the attachment bond didn't make much difference in the self-esteem score. This was compared to the mother's sensitivity to the attachment bond which did make a difference in the adolescent's self-esteem. Ainsworth (as cited in Paterson et al., 1995) found similar results in that the quality of the adolescent's attachment to her mother will be a better predictor of self-esteem than the attachment to her father.

Self-Esteem and Teen Pregnancy

Throughout the research on teen pregnancy and teen pregnancy there have been differing results of whether or not teen pregnancy affects self-esteem. The following three studies show some of the differing results.

The first study was conducted by Robinson and Frank (1994). They examined self-esteem and its relationship to teen pregnancy, among other factors. Through the research of other studies, Robinson and Frank found mixed results on the relationship between self-esteem and adolescent pregnancy. Thus they conducted their own study by using the hypothesis, "Pregnant females will report higher levels of self-esteem than nonpregnant females" (p. 28). The study found that there were no significant differences between the self-esteem scores in the two groups. The study also went on to state that they did not find any self-esteem differences based on race, gender, virginity, sexual activity or pregnancy.

In a second study conducted by Medora et al. (1994), similar results were found. Results indicated that there were no significant differences in the self-esteem scores of the pregnant teens, teen mothers and the control group (nonpregnant, nonparenting teens). The researchers did find that the self-esteem scores

for the pregnant teens and the teen mothers was slightly higher than the control group, but these were considered insignificant.

The third study was conducted by Plotnick and Butler (1991) to look at adolescent nonmarital childbearing and self-esteem. This study, in contrast to the above mentioned ones, was able to find significance in the self-esteem scores. The study found that adolescents who scored high on the self-esteem scale were less likely to become unwed mothers (Plotnick & Butler). It was also found that 20% of those adolescents who were in the lowest fifth of the self-esteem scores became unwed mothers compared to only 12% of the top fifth of the self-esteem scores.

There has been research done to see how to increase self-esteem in pregnant adolescents. One such study was conducted by Koniak-Griffin (1994), where aerobic exercise was utilized to see the effect on the pregnant adolescent's self-esteem. It was thought that an exercise program might be good for the adolescents because they tend to experience low self-esteem (Koniak-Griffin). In her study, Koniak-Griffin found that adolescents who had higher self-esteem would usually not have depressive symptoms. Also the subjects who had good social support had significantly higher self-esteem scores at both the pre- and

posttesting. The aerobic exercise was found to be able to help increase the adolescent's self-esteem by reducing depression and minor discomforts in the pregnancy (Koniak-Griffin). Adolescents may have also felt an increase in self-esteem due to their feelings of accomplishing this activity.

According to Hepfer (as cited in Robinson, 1994) adolescents are at an age where developing a good self-concept is very important, so programs should be developed to help focus on increasing an adolescent's self-esteem. Robinson states that in order to work towards prevention, families and communities should be involved. According to Thomas and Rickel (1995), intervention programs that are focused on teens who are at risk for pregnancy should be utilized. These programs could focus on sexuality and contraceptive use in a very fact-based manner. According to Hart & Hilton (1988):

> If we are to eliminate untimely pregnancies among teenagers, perhaps the best education we can offer is not only contraceptive advice but education in self-awareness, understanding of one's personal values and goals, self-regulation, and awareness of the needs, feelings, differences, and separateness of others. (p. 131)

In order to help the adolescent who is at risk for teen pregnancy, it is good to work on what is inside of them first. It is helpful to help them build their self-confidence and self-esteem, then to give them the best

possible sex education possible.

Residential Centers and Adolescent Self-Esteem

Kazdin (as cited in Cates, 1991) states that there are approximately 12 million (19%) children in the U.S. who may need mental health treatment due to emotional problems. Some of these children would need to go into a residential treatment center or a foster care home. The Select Committee on Children, Youth, and Families (as cited in Friman, Osgood, Smith, Shanahan, Thompson, Larzelere and Daly, 1996) states there are not enough foster families to take care of the 840,000 children who needed out-of-home placement in 1995. The children not able to go into foster care may be put into residential treatment centers. According to Wells (as cited in Edwards, 1994) at the end of 1983 there were 19,215 children in residential treatment facilities and in 1990 there was an increase of 32% to 25,334 children.

According to Edwards (1994) when adolescents are placed in residential treatment it can be for a variety of reasons. Three main reasons stated in the research were family situations, no where else to put them and a mental health disorder. According to Edwards they might have been placed in a residential center due to so many children and adolescents needing placement and not enough foster care resources. If they did have a

mental health reason Pfeiffer (as cited in Edwards) states that the most frequent diagnoses for adolescents who enter residential treatment centers are: conduct disorders, schizophrenia/psychosis, depression, and personality disorders. Adolescents who are in a residential setting compared to those in a non-residential setting are more likely to show a greater psychopathology including a variety of behaviors, attitudes and perceptions (Cates, 1991).

Family is a vital factor that influences why the adolescent is in the residential center, how they progress in the center and what happens when they leave. According to Gray-Little, Williams, and Hancock (1997) a main reason why a child or adolescent enters a residential center is due to a dysfunctional family environment. Due to this dysfunction with the family the child or adolescent may not be able to function in a family environment so a foster home would not be a viable option (Gray-Little et al.). Instead they would need to be placed in a residential center. According to Bratter, Bratter, and Bratter (1995), adolescents in residential treatment may have low self-esteem due to parental neglect and parental absences, either emotionally or physically. The length of stay in a residential center may not be due to a psychiatric status but rather an adolescent's family situation or

lack there of (Edwards, 1994). A child or adolescent many times will not be returned home until the family is ready. Family also plays role in the adolescent's progress after discharge. According to Cates (1991) the less stable a family is when the adolescent is discharged the more likely the adolescent will have a poor adjustment.

The way residential centers are "supposed to be" has been an issue throughout the research. According to Friman et al. (1996) during the past 20 years many residential treatment centers have changed from the traditional training school format to a more intimate group-home format. Rivlin and Wolfe (as cited in Shennum & Carlo, 1995) contend that residential centers are supposed to be home-like but they usually do not meet this criteria. They state that instead they take away the adolescent's privacy and have rigid schedules that they have to adhere to which is more like a traditional training school. In regards to improving residential treatment centers the research has focused on staff relations with residents, parental involvement, case management, and specialized services.

According to Brown and Hill (1996) one way to improve residential treatment centers is to focus more on case management, individualized services and parental involvement. Stroul and Friedman (as cited by

Brown and Hill, 1996) state that case management:

> Involves brokering services for individual youngsters, advocacy on their behalf, insuring that an adequate treatment plan is developed and is being implemented, reviewing client progress and coordinating services. Case management involves aggressive outreach...to ensure that all needed services and supports are in place. (p.38)

Case management is very involved and time-consuming but beneficial to the progress of the child. Case management is working to meet the needs of the child. Through individualized services the staff looks at each resident and sees what their needs are and tailors the appropriate services. Parental involvement also helps to meet the child's need by helping with family relationships. A parent's involvement is also important in helping to obtain the best possible and appropriate services for that child.

The relationship between staff and residents can affect the resident's self-esteem. For example, staff and residents may have two different ideas on what the residents need in the residential center. In a study conducted by Shennum and Carlo (1995) they focused on how residents felt about their residential center and what they wanted from the staff. The study found that kids stated that what they needed from the staff at the residential center was love. When the staff was asked what they thought the kids needed they responded that they needed consistency, safety, limits and

socialization. When asked what they believed the purpose of the therapy sessions were the residents responded to help them talk about their feelings and find out about their family. Kids also stated that their stay at the residential center was only temporary until they could go home. The resident's answers focused on family.

Another study done to look at resident's self-esteem and staff was done by Shiendling (1995). The study states that when a resident exhibits a negative behavior the way in which the staff reacts affects the way the resident thinks about him or herself and the world. When staff becomes frustrated with residents due to the negative behaviors than they are less able to effectively do their job (Shiendling). If a negative pattern of behaviors between the staff and resident continues then the self-esteem of the resident may be affected in a negative manner. Shiendling describes a healthier manner of dealing with the resident for the staff member. According to Shiendling:

> Those working in residential settings must, while imposing discipline, fervently protect the self-esteem of the children in their care and allow for healthy verbal expression. Behavior can be controlled while at the same time, the child's self-esteem is preserved and protected and the relationship between staff and child enhanced. (p.47)

Shiendling developed a model of communication called

the Therapeutic Diamond Model to help develop healthier relationships between residents and staff. Communication is defined as, "communication which either facilitates client behavioral change, enhances the therapeutic alliance, promotes insight, conveys necessary information, diminishes client distress, or enhances resident self-esteem" (Shiendling, p.47). The basic premise of the model is for the staff to look at both negative and positive behaviors of a resident and not just the negative behaviors. The model states that the staff should be as encouraging as possible and try to always maintain a therapeutic focus. The staff should also set limits and give consequences whenever needed but to always follow up with a positive reinforcement. This model, according to Shiendling, if used correctly by staff should help increase self-esteem in residents.

Summary

The issues of adolescent pregnancy, residential centers and self-esteem are complex. The relationships of these variables has been generally unexplored to date. Adolescent pregnancy is a growing concern in our country. Researchers have looked at factors involved in adolescent pregnancy to see how to deal with this epidemic. Factors including socioeconomic status, family relationships (including communication and a

cycle of teen pregnancy), education, prior sexual abuse, psychological components, and race (McCullough and Scherman, 1991) have all been explored. Each factor influences the adolescent's decision to become sexually active and, if they become pregnant, what to do about the pregnancy (abortion, adoption or keeping the baby).

Adolescents who live in residential treatment centers have their own issues with self-esteem. These adolescents may have come from a dysfunctional family and now have to deal with living in a new environment different from what they knew. Reasons why an adolescent might be placed in a residential center, according to the research are: family situations, no where else to put them and a mental health disorder (Edwards, 1994). Family situations are very important in determining the self-esteem of adolescents. Throughout the research on both teen pregnancy, residential treatment and their effects on self-esteem family has played a major role in predicting low self-esteem in adolescents.

Self-esteem has been described as how an individual feels about him or herself and as a basic human need. Throughout the research self-esteem has been shown to be affected by factors including success/failures, acceptance, personal memories, sexual

abuse, abortion, and parental attachment. Each of these factors influences an individual's self-esteem and in return may influence whether or not they become pregnant as an adolescent. Studies that have been done on the subject of teen pregnancy and self-esteem have had differing results. In studies involving self-esteem of adolescents who have not been pregnant, are pregnant, or have a child results have varied from significant to not significant. In addition self-esteem and teen pregnancy have yet to be explored in a residential treatment setting.

Chapter III

Methodology

Participants

The subjects consisted of female adolescents from three residential treatment centers throughout the St. Louis Area. One of the residential centers (residential center A) only accepts adolescents who are pregnant or have a child. The other two residential centers (residential centers B & C) accept adolescents regardless of their pregnancy status. Table 1 shows a breakdown of the total number of adolescents in each group and their age range.

Table 1

Number of Subjects in each group and their age range

Status of Pregnancy	Number of subjects	Age Range
Never been pregnant	16	12 to 18
Pregnant	15	13 to 19
Have a child	15	14 to 18

The total number of subjects were 46, with 16 in the never been pregnant group, 15 in the pregnant group,

and 15 in the has a child group. The age range was from 12 to 19, with a mean age of 15.46. The adolescents in the never been pregnant group, had an age range of 12 to 18 years old. The adolescents who were pregnant ranged in age from 13 to 19 years old. Finally, the adolescents who had a child ranged in age from 14 to 18 years old. The adolescents were from different racial backgrounds with 16 participants being Caucasian, 29 participants African-American and 1 Hispanic.

Instrument

The instrument used for this study was the Rosenberg Self-Esteem Inventory (RSE) (Rosenberg, 1989) which measures an individual's self-esteem. The Inventory is based on a Guttman scale, which contains 10 questions divided into 5 positive statements and 5 negative statements. According to Gray-Little, Williams, and Hancock (1997), the Rosenberg Self-Esteem Scale is a practical scale to use due to the fact that the reading level is fifth grade, it only takes a few minutes to administer and the item content is obviously related to the construct. To insure face validity, only items that dealt directly with the "dimension under consideration" were used (Rosenberg).

According to Gray-Little et al. research done on the RSE shows an acceptable to high level of

reliability and that the questions on the RSE define and provide information "across the self-esteem continuum" (p. 450). Thus the questions on the RSE are testing for what was intended to be tested for: self-esteem. This shows that the RSE has internal validity. Fleming and Courtney (as cited in Gray-Little et al.) found a test-retest coefficient of .82 after one week. A six month test-retest interval done by Byrne found a coefficient of .63. According to Rosenberg, the reproducibility score is .93, scalability for items is .73, and scalability for individuals is .72 for this inventory. Overall Rosenberg states that the scale is internally reliable and has face validity. Gray-Little et al. agree with Rosenberg, stating that "the RSE deserves its widespread use and continued popularity; this scale provides a highly reliable and internally consistent measure of global self-esteem" (p. 450).

For this study a Likert scale was used instead of a Guttman scale (Nickels, 1989). The respondents answer if they strongly agree, agree, disagree, or strongly disagree with each statement. Each question was looked at individually and given a rating from 0 to 3, with 3 correlating with high self-esteem and 0 correlating with low self-esteem. After the data was run, the values were then combined as 0 to 1 equals 1, 1 to 2 equals 2 and 2 to 3 equals 3. These combined

values created three categories of self-esteem, high, moderate, and low.

Procedure

Residential center A was selected due to the fact that the researcher was currently working there. Residential centers B & C were selected due to the researcher's knowledge of their programs. The researcher was able to ask the director of residential center A in person about participating in the study. A phone call was placed to residential centers B & C to explain the purpose of the study and to ask permission to administer the inventory to the adolescents in their centers. In order to gain approval from each director of the residential centers, the researcher had to submit a letter requesting the participation from the residents of that facility (see Appendix A). The researcher also sent a copy of the Demographic questions and the Rosenberg Self-Esteem Inventory (SES) to each director for their approval (see Appendix B). Each center requested that the resident's identity remain confidential. One of the centers asked that they remain anonymous. The researcher informed this center that the research would not reveal the names of any of the centers that participated in the research.

The residents were administered the RSE by the researcher at residential center A and by employees of

residential centers B & C. All residents who attended the study hour or quiet time at each center were administered the inventory. Employees of residential centers B & C, who were to administer the inventory, were given specific instructions on how to do so. These instructions mirrored how the researcher administered the inventory at residential center A. The employees were informed that they should not tell the adolescents the purpose of the study. They were asked to please explain to the residents to not put their names on the inventory and that the information they were filling out would remain confidential. The inventory took approximately 15 minutes for the residents to complete.

Data Analysis

A summary was run of the adolescent's self-esteem scores by their pregnancy status to detect any differences between the subject groups. A cross-tabulation of self-esteem scores by status of pregnancy was used to compare the three groups of adolescents. A summary of self-esteem by race was done to examine any differences in scores between races.

Chapter IV

Results

The total number of subjects for this study was 46. There were 16 adolescents who had not been pregnant, 15 who were pregnant, and 15 who had a child. The mean score for the entire sample was 18.76 which is the average of all the self-esteem scores. There was a standard deviation of 5.49, for the scores of the entire sample, as seen in Table 2.

Table 2

Summary of Self-Esteem according to Status of Pregnancy

Status of Pregnancy	Mean	Std Dev.	Cases
For entire population	18.7609	5.4861	46
Never been pregnant	18.2500	7.1787	16
Pregnant	17.2667	3.8816	15
Has a child	20.8000	4.3948	15

The highest mean self-esteem scores were for adolescents who had a child (20.80), followed by adolescents who were never pregnant (18.25) and adolescents who were pregnant (17.27).

A comparison was done to show the self-esteem differences in Caucasians and African-Americans according to their status of pregnancy. Due to the fact that their was such a small number of Hispanic subjects (N=1), they were excluded from this analysis.

Table 3

Summary of Self-Esteem According to Race and Pregnancy Status

Race	Mean	Std Dev.	Cases
Caucasian	17.8125	5.8790	16
Never been pregnant	17.2857	7.4546	7
Pregnant	16.0000	3.8079	5
Has a child	21.0000	4.7610	4
African-American	19.2667	5.2976	29
Never been pregnant	19.0000	7.3144	8
Pregnant	17.9000	3.9567	10
Has a child	20.7273	4.4965	11

According to the results, African-American adolescents had higher overall mean self-esteem scores (19.27) than Caucasian women (17.81). When broken into the pregnancy status groups, African-American adolescents who had never been pregnant or were

pregnant had higher self-esteem scores than Caucasian adolescents. Caucasian adolescents who had a child did have a slightly higher mean self-esteem score (21.00) than African-American adolescents (20.73) who had a child.

Due to the small size of the total number of participants, a cross tabulation was utilized to obtain statistical results.

Table 4

Cross-Tabulation of Self-Esteem and Status of Pregnancy

	Status		
Esteem	No Pregnancy	Pregnant	Has Child
Low	2	1	0
	12.5	6.7	0
Moderate	8	12	8
	50.0	80.0	53.3
High	6	2	7
	37.5	13.3	46.7

This table shows the count of each cross-tabulation and the column percentage. The table shows that the majority of the adolescents fall in the moderate self-esteem scores section, with very few in the low self-esteem section. From the table, it can be shown that there are more adolescents who have a child

with higher self-esteem (46.7) than both the adolescents who have not been pregnant (37.5) and those who are pregnant (13.3). The results showed that not one of the adolescents who had a child scored low on the self-esteem inventory.

A chi-square analysis was run on the data and the overall relationship between self-esteem and pregnancy status was weakly correlated (Gamma = .21). This relationship could not tell significance, only the strength of the relationship. It was difficult to determine the validity of the Null Hypothesis due the low number of subjects. However the data was determined to be weakly correlated.

Chapter V

Discussion

The present study looked at whether there would be self-esteem differences in adolescents who had not been pregnant, are pregnant now, and those who have a child. It also examined any differences in self-esteem scores between African-American and Caucasian adolescents. The first null hypothesis for the study stated that there would be no difference in self-esteem scores for pregnant adolescents, adolescent parents, and adolescents who have never been pregnant. The secondary null hypothesis stated there would be no significant differences in self-esteem scores for African-American and Caucasian adolescents.

According to the results that were obtained the first null hypothesis could neither be accepted nor rejected due to the low number of subjects in the study. It did however find that there was a weak relationship between self-esteem and pregnancy status. In the research presented previously in this paper, two studies (Robinson et al., 1994; Medora et al., 1994) both stated that they were unable to find significant differences between self-esteem and pregnancy status.

According to Thomas et al. (1995), adolescents who decide to keep their baby are not psychologically maladjusted and are less distressed by their circumstances. This coincides with the results that were found in this study, where none of the adolescents who decided to keep their baby scored low on self-esteem but rather all in the moderate to high category.

For this study 30 of the participants were a person of color (29 African-American and 1 Hispanic) and 16 were Caucasian. Due to the small amount of Hispanic subjects the comparison done was between the African-American and Caucasian adolescents. The African-American adolescents had a higher overall self-esteem score (19.27) than the Caucasian adolescent (17.81). Significance was unable to be determined due to the the low number of subjects in the study. According to Braverman et al. (1993) adolescent pregnancy is more accepted and there are more support systems in the African-American community for a teen mom. Interestingly though in this study, African-American adolescents who had a child had a slightly lower self-esteem score than Caucasian adolescents.

Limitations

The most important limitation in this study is that of the number of respondents. If a larger number

of respondents had been utilized then better results could have been obtained. Another limitation is that the author was unable to find out more demographic information about the adolescents due to wanting to keep the questions to a minimum since adolescents have such short attention spans. For example, it would have been very informative to have know about their family history and their socioeconomic status prior to coming to the residential center. This information could have helped to look at more factors that are related to teen pregnancy and could affect self-esteem.

The study was also limited due to the fact that all the adolescents were in a residential setting. In addition, the participants were not a random sample of the population. Therefore, the results are not able to be generalized to the general population. A major limitation of this study is that the participants all lived in a residential center. Adolescents who live in residential centers have their own unique self-esteem issues as previously stated in the literature review of this study. Therefore, this prohibits the results of this study to be generalized to the general population.

Recommendations

For future research it would be interesting to be able to interview the adolescents each individually in order to gain more background information. It would

help to also include other variables such as: socioeconomic status, family history for teen pregnancy and communication, sexual abuse history, and education. Each of these variables would help produce a more thorough study into what effects an adolescents self-esteem in relation to teen pregnancy. A future study might include participants from residential settings and non-residential settings in order to generalize to the general population. Future studies should also include more participants. Since there were not a large number of adolescents who were pregnant or had children in the residential treatment centers, it would be helpful to look at other avenues for obtaining participants. Future research might also want to include both residential and non-residential adolescents in the study in order to generalize the results to the general population.

Appendix A

Dear _______,

Per our conversation today, I am sending you a copy of the Rosenberg self-esteem inventory and the demographic sheet that I would like to administer to your residents. My reason for doing this research is that I am a graduate counseling student at Lindenwood College and part of the requirement for graduation is to write a thesis. I have decided to do my thesis on teen pregnancy and it's effects on self-esteem.

I would like to ask your permission to use the residents at _______ as participants in my research. The research will be completely confidential, no names are needed for the study. All the residents would need to do is fill out the short demographic information form and the self-esteem scale. I have enclosed copies of both of these for your approval. If requested, I will provide you a final copy of my thesis.

Please review the enclosed information and I will call you on ______ to see if you have any further questions and to find out your decision. If you need to reach me prior to ____, you can feel free to call me at XXX-XXXX. Thank you very much for taking the time to consider this and for giving me this opportunity.

Sincerely,

Bridget Laffleur

Appendix B

Rosenberg Self-Esteem Inventory

Demographic Questionnaire

1. AGE______________________________________

2. RACE_____________________________________

3. HAVE YOU EVER BEEN PREGNANT?___________

IF NO, PLEASE GO TO THE NEXT PAGE

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS

4. ARE YOU PREGNANT NOW?_________________

5. IF YOU ARE NOT PREGNANT NOW, BUT WERE IN THE PAST, DID YOU HAVE THE CHILD?______________________

6. IF YOU HAVE CHILDREN HOW MANY DO YOU HAVE?___________

7. DOES YOUR CHILD(REN) LIVE WITH YOU?__________________

RSE

1. I feel that I'm a person of worth, at least on an equal plane with others.

1______Strongly Agree

2______Agree

3______Disagree

4______Strongly Disagree

2. I feel that I have a number of good qualities.

1______Strongly Agree

2______Agree

3______Disagree

4______Strongly Disagree

3. All in all, I am inclined to feel that I am a failure.

1______Strongly Agree

2______Agree

3______Disagree

4______Strongly Disagree

4. I am able to do things as well as most other people.

1______Strongly Agree

2______Agree

3______Disagree

4______Strongly Disagree

5. I feel I do not have much to be proud of.

   1______Strongly Agree

   2______Agree

   3______Disagree

   4______Strongly Disagree

6. I take a positive attitude toward myself.

   1______Strongly Agree

   2______Agree

   3______Disagree

   4______Strongly Disagree

7. On the whole, I am satisfied with myself.

   1______Strongly Agree

   2______Agree

   3______Disagree

   4______Strongly Disagree

8. I wish I could have more respect for myself.

   1______Strongly Agree

   2______Agree

   3______Disagree

   4______Strongly Disagree

9. I certainly feel useless at times.

   1______Strongly Agree

   2______Agree

   3______Disagree

   4______Strongly Disagree

10. At times I think I am no good at all.

1______Strongly Agree

2______Agree

3______Disagree

4______Strongly Disagree

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