THE EFFECTS OF PARENTAL BONDING ON SELF-ESTEEM IN ADULTS

by

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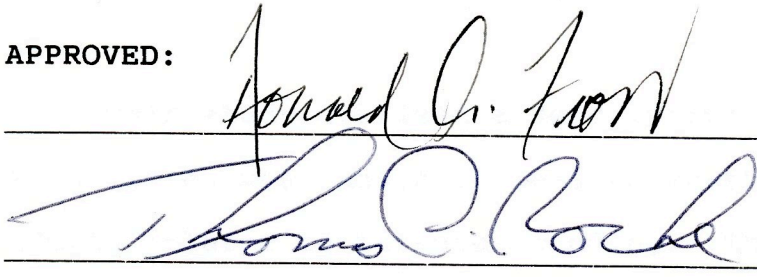

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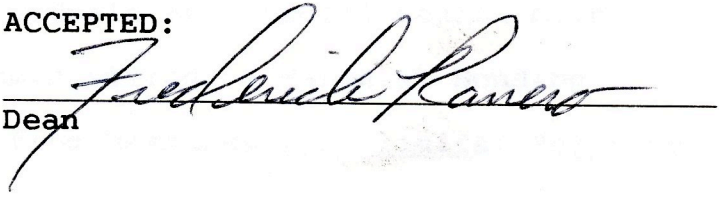

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ABSTRACT

The purpose of this study was to assess the relationship between parent-child attachment and self-esteem in adults. The research question was: what is the relationship between parental bonding and self-esteem in adults?

The literature review in this study covered attachment organization interactional patterns, coping strategies, and self-esteem. Three types of attachment styles were identified and described. Interactional patterns impacting attachment organization such as marital discord, divorce, physical abuse, and psychological maltreatment were explored. Coping strategies were presented including styles of attribution, level of involvement in interparental conflict, and utilization of social support. Lastly, the influence of parental bonding on self-esteem in adults was examined.

This study utilized a descriptive research design. This design was chosen to measure whether self-esteem in adults related to parental bonding. The population studied included males and females between the ages of 19-63. The sample size was 70 individuals at a mental health clinic. Two instruments were administered, a Parental Bonding Instrument (PBI) taken from Measures for Clinical Practice

by Fisher and Corcoran and a Multidimensional Self-Esteem Inventory developed by O'Brien & Epstein.

The results of this study confirmed that there is a correlation between parental bonding and self-esteem in adults. When comparing the parental bonding subscale, care, to global self-esteem and its eight components, all demonstrated a statistically significant correlation with the exception of self-control and personal power. The strongest correlations were between care and global self-esteem ($r=0.29$, $p<.05$), care and lovability ($r=0.43$, $p<.001$), and care and body appearance ($r=0.35$, $p<.05$).

On the contrary, when comparing the parental bonding subscale, overprotection, to global self-esteem and its eight components, no statistically significant correlations were found. All were inverse correlations with the exception of self-control. Therefore, as overprotection was increased, self-esteem was decreased. This is a reasonable assumption, as the opposite extreme of overprotection would be encouragement of autonomy and independence.

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CHAPTER 1

THE PROBLEM

Introduction

There has been minimal research completed on the topic of parent-child bonding and self-esteem in adults. The majority of previous studies have been conducted with children and adolescents.

By not fully knowing and understanding the long-term effects of parent-child bonding on adult self-esteem, professionals in the mental health field may fail to explore this potential factor during intake and assessment, parenting classes, or interventions during the therapeutic process.

Development of the Problem

The exploration of parental-bonding and self-esteem in adulthood is both necessary and valuable as assessment of one's own worth determines the quality of every experience he or she will have. Self-esteem greatly impacts physical and mental health, socio-emotional proficiency, psychological tolerance, behaviors, cognitive schemas, and the quality of all interpersonal relations (Gross & Keller,

1992).

Prior studies have shown that there may be a correlation between inadequate parental bonding and later adjustment difficulties, socio-emotional proficiency, behavior problems including anger and aggression, and difficulties in forming and maintaining attachments. All of these factors negatively impact self-esteem (Gross & Keller, 1992; Tresch Owen, Cox, 1997; Carlson, Cicchetti, Barnett & Braunwald, 1989).

Models or representations concerning self and others are based on an individual's history of transactions with primary caregivers. Insecure attachment relationships become represented mentally as negative internal working models. Implications are formed based on caregiver responsiveness in terms of self, including self-esteem, self-efficacy, acceptability, and lovability. Thus, self-worth is achieved and maintained. Specific patterns of relating over the life span are greatly influenced (Belsky, Spritz & Crnic, 1996).

There are three major variants of attachment organization: secure, insecure-avoidant and insecure-resistant (Tresch Owen & Cox, 1997). Securely attached infants incessantly employ affective sharing with the caregiver and when distressed elicit comfort and are able to be calmed by the attachment figure. Secure attachment seems to evolve out of sensitive nurturant care.

On the contrary, insecure-avoidant infants exhibit an avoidance during interactions with the primary caregiver and present with nominal displays of affect. Insecure-resistant infants present with high proximity seeking and contact with the attachment figure mixed with resistance and, when distressed, an incapacity to be comforted and calmed (Carlson, Cicchetti, Barnett & Braunwald, 1989).

Need for the Study

This study proposes to provide a sound therapeutic basis for intervention with those suffering attachment disorders and low self-esteem.

This study could greatly impact students and professionals interested in the field of Psychology research and application. Research confirming the correlation between parental bonding and self-esteem could enhance therapeutic interventions. Family systems could be greatly impacted by resulting alterations in educational and therapeutic interventions.

By identifying the attachment type of a client, the therapist may be able to more fully understand personality typology and cognitive schemas which have long-term effects on an individual's self-esteem. The influence of parental distortions on psychological and social functioning can be examined (Parker, Tupling, Brown, 1979).

Purpose of the Study

The purpose of this study was to assess the relationship between parent-child attachment and self-esteem in adults.

Research Question

What is the relationship between parental bonding and self-esteem in adults?

Definition of Terms

1. Parental bonding - Level of attachment between parent and child.

2. Attachment - Active, affectionate reciprocal relationship between two persons in which interaction reinforces and strengthens the link (Paplia & Olds, 1995).

3. Secure Attachment - Attachment pattern in which an infant can separate readily from the primary caregiver and actively seeks out the caregiver upon return (Paplia & Olds, 1995).

4. Insecure-resistant attachment - Infants are ambivalent toward the primary caregiver, demanding attention and affection but petulant when receiving it (Wenar, 1994).

5. Insecure-avoidant attachment - The infant ignores the primary caregiver in a kind of psychological armed truce (Wenar, 1994).

6. Self-esteem - An accumulation of all the thoughts, positive or negative, we have about our own worthiness coupled with self-efficacy.

7. Psychological maltreatment - Adult behaviors that undermine self-esteem and social competence in a child (Gross & Keller, 1992).

8. Learned helplessness - The perception, based on subjective experience, that one has no control over one's reinforcements (Comer, 1995, p.G-11).

CHAPTER 2

THE LITERATURE REVIEW

Introduction

In this chapter literature is presented on these specific areas: attachment organization, interactional patterns, coping strategies, and self-esteem.

Attachment Organization

Attachment is a lasting emotional bond between two people such that the individual strives to maintain closeness to the object of attachment and acts to ensure that the relationship continues (Fogel, 1991). There are three comprehensive patterns of attachment organization: secure, insecure-avoidant, and insecure-resistant (Tresch, Owen & Cox, 1997).

Bowlby postulated that attachment behaviors are produced from an evolutionary biobehavioral system. Bretherton stated that a survival advantage is maintained by keeping young children close to caregivers during times of threat and danger. The child's experience of security evolves from this system's psychological set point. Attachment behaviors are activated when feelings of security

are in some way jeopardized. This will ideally promote the reestablishment of close contact with the caregiver who provides protection. Felt security is dependent upon proximity to and responsiveness from the caregiver (Bowlby, Bretherton, cited in Roberts, Gotlib & Kassel, 1996).

Due to its evolutionary significance, it is generally believed that nearly all infants achieve some form of attachment relationship (Bowlby; Hazan & Shaver, cited in Roberts, Gotlib & Kassel, 1996). Different patterns of attachment seem to be dependent upon individual differences in the behavior of primary caregivers (Roberts, Gotlib & Kassel, 1996).

Individuals who are securely attached will show interest in objects and strangers and will get acquainted with the unfamiliar setting by making brief forays, During infancy, the caregiver will be used as a secure base from which to explore (Fogel, 1991).

Secure attachment seems to evolve out of sensitive nurturant care. Securely attached infants often partake in affective sharing with the caregiver. They are able to be calmed and find comfort from the attachment figure when distressed (Carlson, Cicchetti, Barnett, Braunwald, 1989).

Secure children maintain better peer relations, tolerate frustrations well, and are more able to express a full range of emotions (Belsky & Cassidy, cited in

Belsky, Spritz & Crnic, 1996). This is explained by experientially influenced internal, psychological, affective-cognitive processes that correlate components between past and present. Individuals who experienced nurturant and supportive care with their primary caregiver are more inclined to develop secure attachments as adults. They view themselves as lovable and others as caring. They act in ways which are consistent with this view of the world. As a result of this interpersonal style and behavioral response, this worldview is preserved and experienced in accordance with it (Belsky, Spritz & Crnic, 1996).

As infants, individuals with an insecure-avoidant attachment tend not to be upset when left with an unfamiliar person or in a strange setting. During a reunion, they may avoid approaching caregivers for comfort and may actively resist any attempt to be comforted by turning away and squirming to get down if picked up (Fogel, 1991). Insecure-avoidant infants exhibit minimal displays of affect or distress and an avoidance during interactions with the primary caregiver (Carlson, Cicchetti, Barnett & Braunwald, 1989).

Individuals with an insecure-resistant attachment will be more wary of strangers and as infants tend to get more upset when the mother leaves the room. During the reunion, such infants show ambivalent responses to the mother, first

approaching her and then pushing her away (Fogel, 1991).

Insecure-resistant infants present with high proximity seeking and contact with the attachment figure mixed with resistance and when distressed, an incapacity to be comforted and calmed (Carlson, Cicchetti, Barnett & Braunwald, 1989).

Insensitive parental care has been found to predict insecure attachment. Such care often involves unpleasant, and often painful experiences. As a result, children with insecure attachment histories attend more to negative events than positive events and remember these events more accurately (Belsky, Spritz & Crnic, 1996). Previous studies have found a correlation between insensitive care and insecure attachments (Carlson, Cicchetti, Barnett & Braunwald, 1989).

Childhood attachment styles with the primary caregiver seem to be fairly stable between 12 and 18 months of age, as well as between infancy and early childhood (Main & Weston, Stroufe & Waters; Waters; Main, Kaplan, & Cassidy, cited in Roberts, Gotlib & Kassel, 1996). In terms of continuity across the life span, cross-sectional studies have shown proportions of adult attachment prototypes roughly analogous to those found in infancy (Hazen & Shaver; Mikulincer, Florian, & Tolmatz; Milkulincer, Florian, & Weller; Milulincer & Nachshon, cited in Roberts, Gotlib, & Kassel, 1996). This pattern of results is consistent with the

belief in continuity (Rothbard & Shaver, cited in Roberts, Gotlib, & Kassel, 1996) which is feasible especially if individuals' social environments remain relatively stable (Hazen & Shaver, cited in Roberts, Gotlib, & Kassel, 1996).

Interactional Patterns

Previous studies have shown that parenting in the midst of marital discord (Owen & Cox, 1997), divorce, physical abuse, and psychological maltreatment contributes to a lack of secure-infant-parent adjustment and the probability of many adjustment difficulties in children (Gross & Keller, 1992). On the contrary, positive marital quality is correlated to secure attachment (Owen & Cox, 1997).

Emotional and behavioral difficulties, lowered self-esteem, and impeded adjustment processes may evolve due to exposure to marital conflict, divorce, physical abuse, and psychological maladjustment (O'Brien, Margolin & John, 1995, Owen & Cox, 1997, Shook & Jurich, 1992, Gross & Keller, 1992). Social competence and academic performance are often negatively influenced. Difficulties in forming attachments may also result (Owen & Cox, 1997, Gross & Keller, 1992).

Marital Discord: Exposure to parents' marital discord and violence is stressful for children (Coddington; Colton, Lewis, Siegel & Lewis; Rossman, cited in O'Brien, Margolin & John, 1995). Emotional and behavioral maladjustment may

result due to displays of marital dissatisfaction, conflict, and violence (Cummings & Davies; Emery; Fantuzzo & Lindquist; Fincham; Grych & Fincham, cited in O'Brien, Margolin & John, 1995). Marital conflict seems to be reflected in less sensitive, active, and accepting parenting (Owen & Cox, 1997). "Exposure to angry, discordant marital interactions affects the organization of young children's emotional response to stressful situations" (Owen & Cox, 1997, p. 153).

Disorganized, disoriented infant attachment behavior may be exhibited due to prolonged exposure to frightening parental behavior. During marital conflict, the parent is not available for nurturing or reassurance (Owen & Cox, 1997). According to Owen and Cox (1997), "marital conflict may be an important factor in the development of children's emotional regulation" (p. 164).

Divorce: Family interactional patterns are impeded by the inherently distressful process of divorce (Hess & Camara, cited in Shook & Jurich, 1992). Previous studies have found that parental divorce has detrimental effects on children's self-esteem (Boyd, Nunn & Parish; Parish & Dostal; Parish & Taylor; Parish & Wigle; Rosenberg; Stolberg, Camplair, Currier & Wells, cited in Shook & Jurich, 1992). Qualitative and quantitative differences can be found among children of differing developmental ages (Hetherinton, Stanley-Hagan, & Anderson; Wallerstein &

Kelly, cited in Shook & Jurich, 1992).

Several studies have found that children who are six years old or younger at the time of parental divorce are likely to experience post-divorce adjustment problems (Gardner; Hetherington; McDermott; Rosenberg, cited in Shook & Jurich, 1992). Cognitive immaturity, the inability to construct either concrete or abstract adaptive solutions to problems is evident in younger children. At these ages, fantasy and denial are used to deal with losses (Shook & Jurich, 1992).

Adjustment processes are greatly affected by a continued relationship between the non-residential parent and his or her offspring (Shook & Jurich, 1992). These children are provided with reassurance that the absent parent still cares for them (Walerstein & Kelly, cited in Shook & Jurich, 1992). Quality of relationship between the non-residential parent and offspring has been found to have a significant influence on post-divorce adjustment of children (Shook & Jurich, 1992).

Physical Abuse: Physically abused children often present with passive and withdrawn or provocative and aggressive behavior patterns (Gross & Keller, 1992). They may exhibit low levels of self-esteem, an inability for enjoyment, hypervigilance, and a below-average IQ (Blager & Martin; Elmer; Martin & Beezley, cited in Gross & Keller, 1992). Difficulties in forming attachments and in

socializing with peers are among the psychological consequences of physical abuse (Gaensbauer & Sands; Green; Kinard, cited in Gross & Keller, 1992). Previous research proposes that physically abused clients may tend to experience sadness and depression (Martin & Beezley; Elmer; Farber & Joseph; Steele; Kazdin et al., Kinard, cited in Gross & Keller, 1992).

Psychological Maltreatment: Psychological maltreatment almost always occurs in conjunction with other forms of abuse and is often more subversive in its impact on the lives of children (Hart et al., Garbarino et al. & Hart, cited in Gross & Keller, 1992). Gross and Keller (1992) assert, "psychological maltreatment consists of adult behaviors that serve to undermine self-esteem and social competence in a child" (p. 172). Examples include rejecting, degrading, isolating, terrorizing, corrupting, and exploiting behaviors, as well as behaviors that reject emotional responsiveness (Gross & Keller, 1992).

Children of psychologically unavailable mothers display severe behavioral problems such as anger, aggression, difficulties in forming/maintaining attachments, and difficulties in school. Previous research has shown that depression and low self-esteem may be significant results of both physical and psychological abuse in children (Gross & Keller, 1992).

Coping Strategies

Coping strategies include styles of attribution, level of involvement in interparental conflict, and utilization of social support. The learned helplessness syndrome endeavors to associate the characteristics of helplessness with feeling depressed and having low self-esteem (Gross & Keller, 1992). Intraindividual factors including cognitive processes and emotional states have been found to be organizers of reactions to interadult anger (Davies & Cummings, 1995).

Individuals strive to understand helpless circumstances by forming attributions about the cause of their helplessness (Gross & Keller, 1992). Numerous studies have tested and sustained the relationship between styles of attribution, helplessness, and depressive functioning in both children and adult subjects (Peterson, Colvin, & Lin, Nolen-Hoeksems, Girgue & Seligman, cited in Comer, 1992).

Attributions are formed based upon three dimensions: internal/external, stable/unstable, and general/specific (Gross & Keller, 1992). "A maladaptive attributional style is characterized by attributing good outcomes to external, unstable, and specific causes and by attributing negative outcomes to internal, stable, and global causes" (Abramson et al., cited in Gross & Keller, 1992). Depression and low self-esteem may be associated with a maladaptive attributional style (Gross & Keller, 1992). Abusive

environments may contribute to feelings of helplessness. (Kinard, cited in Gross & Keller, 1992). Previous studies have found that these symptoms may continue to cause difficulty as some abused children become adults (Gross & Keller, 1992).

Individual differences in the way children cope with marital conflict or violence may impact the connection between marital conflict and children's psychological adjustment. The extent to which children involve themselves in or distance themselves from parental conflict strongly influences their emotional adjustment (O'Brien, Margolin & John, 1995). Family-systems theory proposes that clear boundaries between marital and child subsystems predict healthy child functioning. In contrast, blurred boundaries manifest dysfunction (Minuchin, Rossman & Baker, cited in O'Brien, Margolin & John, 1995).

Children who become involved in interparental conflict increase their exposure to a stressful event over which they have little control (O'Brien, Margolin & John, 1995). These children are more prone to negative physical and psychological effects than are children who avoid or distract themselves from threatening interactions (Miller & Green, cited in O'Brien, Margolin & John, 1995). They report feeling "caught between their parents" and experience greater levels of depression and anxiety, and more behavioral problems (Buchanan, Maccoby, & Dornbusch, cited

in O'Brien, Margolin & John, 1995).

Social learning theory indicates that as children witness conflict between their parents they learn strategies for conflict resolution (Bandura, cited in O'Brien, Margolin & John, 1995). Due to this fact, children who become directly involved in aggressive interparental conflict learn coercive/aggressive behaviors and may have chronic feelings of hostility. When confronted with conflictual interactions with siblings, peers, teachers, and parents they often model inappropriate aggressive behaviors. In contrast, children who shield themselves from their parents' marital conflict avoid high levels of hostility and present with fewer externalizing behavioral problems (O'Brien, Margolin & John, 1995).

Children's emotional adjustment is also effected by the extent to which they utilize social support when exposed to marital discord. Social support is a protective factor when confronted with stressful events (Cohen & Willis, cited in O'Brien, Margolin & John, 1995). By receiving emotional support in handling parental conflict, these children are able to avoid feeling isolated, overwhelmed, or responsible for this stressor (O'Brien, Margolin & John, 1995).

Intraindividual factors, including cognitive processes and emotional states, influence the impact of marital conflict on children (Cummings, Davies, & Simpson, Fincham, Grych, & Osborn, Grych & Fincham, cited in Davies &

Cummings, 1995). Behavioral and instrumental reactions to marital conflict are triggered by children's distress (Emery, cited in Davies & Cummings, 1995). Emotions organize and direct responses to interpersonal events by acting as internal monitoring and guidance systems. Coping responses are formed by the appraisal of events and resulting motivation of behavior (Bretherton, Fritz, Zahn-Waxler, & Ridgeway, Campos & Barret, cited in Davies & Cummings, 1995). Numerous researchers have postulated that prior negative affective states (i.e., sadness, anger, and dysphoria) augment children's antagonistic interpretations and expectations of social circumstances, recall of unpleasant events, and distress and emotional dysregulation (Crick & Dodge; Dodge; Grych & Fincham; Hammen, cited in Davies & Cummings, 1995). Negative mood generalizations have been shown to increase children's awareness to negative aspects of interpersonal events (Davies & Cummings, 1995).

Conversely, pleasant affective states have been assumed to protect children from resulting negative social cognitions and emotional reactivity (Davies & Cummings, 1995). Previous studies have demonstrated that positive mood generalizations heighten prosocial behavior, compliance to parental cues, and positive social assessments (Barden, Garber, Leiman, Ford & Masters; Terwogt, Kremer, & Stegge, cited in Davies & Cummings, 1995).

Self-Esteem

Self-esteem is formed within an individual's family of origin and is dependent upon messages conveyed. Feelings of worthlessness or lower self-esteem may be the result of a disruption of the marital bond during childhood or adolescence (Shook & Jurich, 1992). In a recent study conducted by Roberts, Gotlib & Kassel (1996), the hypothesis that insecure adult attachment is associated with dysfunctional attitudes and depleted levels of self-esteem was confirmed. Self-esteem may be defined as the general positive or negative attitude an individual maintains about him/herself (Shook & Jurich, 1992).

> When we speak of high self-esteem...we shall simply mean that 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, he recognizes his limitations and expects to grow and improve (Rosenberg, cited in Shook & Jurich, 1992, p. 159).

For the first five or six years of children's lives, messages of worthiness and unworthiness are primarily given from parents and extended family members. Subsequently, school and various other social agents assist children in forming the attitudes that they maintain about themselves. These agents reinforce feelings of worthiness and unworthiness that were originally created within the home

environment. Family dynamics continue to significantly impact the self-esteem of children even during adolescence (Satir, cited in Shook & Jurich, 1992).

Roberts and Bengtson (1996) found that youths who proclaimed stronger affective ties to parents reported higher self-esteem at baseline and at 17- and 20-year follow-ups. The long-term correlation between baseline affection and subsequent self-esteem was primarily attributed to moderate stability in self-esteem from childhood into adulthood. These findings suggest that quality of affective ties to parents during the transition to adulthood greatly influences self-esteem among offspring.

A child's self-esteem is advanced through close parent-child relations. This evolves into a psychological strength which continues into adulthood. Parental love and emotional closeness produce positive self-evaluations which increases self-esteem (Roberts & Bengtson, 1996).

Psychological health in adulthood seems to be based on the affective environment of one's family of origin during childhood and adolescence (Bachman, O'Malley & Johnston; Block; Roberts & Bengston; Snarey; Wallerstein, cited in Roberts & Bergson, 1996). The formation of self-esteem is primary to healthy psychosocial functioning and lifetime well-being (Bettelheim; Coopersmith; Gecas & Seff; Rosenberg; Wilson, cited in Roberts & Bengtson, 1996).

Roberts & Bengtson (1996) conducted a 20 year

longitudinal study and determined that self-esteem was moderately stable over the transition into adulthood. Effects of parental affection on self-esteem in the family of origin continued to shape the course of subjects' psychological well-being (Roberts & Bengtson, 1996). Commonly hypothesized sources of stability include motivations to preserve consistency of self-concept and to perceive oneself favorably (Allport; James; Kaplan; Rosenberg, cited in Roberts & Bengtson, 1996), inclinations to perform central roles consistently well or poorly over time (Bohrnstedt & Fisher, cited in Roberts & Bengtson, 1996), and enduring self-evaluatory styles formed in the family of origin and brought to adulthood (Bettelheim; Roberts & Bengtson; Satir, cited in Roberts & Bengtson, 1996).

Several recent studies have also identified other results of earlier positive affective ties to parents in adulthood such as socioecomonic achievements (Greene & Reed; Plotnick & Butler, cited in Roberts & Bengtson, 1996), health and heal-promoting behaviors (Holden, cited in Roberts & Bengtson, 1996), and mental health (Olmstead et al., cited in Roberts & Bengtson, 1996).

Theory implies that insecure attachment relationships evolve into negative cognitive internal working models. Models or mental representations concerning the self and others are built from the child's history of interactions

with primary caregivers. These are basically operating rules and expectations relating to the availability of support from caregivers. The caregiver's responsiveness helps to form perceptions regarding self, including self-esteem, self-efficacy, acceptability, and lovability (Bretherton, cited in Roberts, Gotlib, & Kassel, 1996). Working models of the self and others often parallel one another. Thus, an unresponsive caregiver many times contributes to a working model of others as unreliable and to a model of the self as unworthy of support and affection (Rogers, cited in Roberts, Gotlib, & Kassel, 1996). These expectations impact the quality of new relationships and help maintain limited patterns of relating over the life span (Bowlby; Bretherton; West & Sheldon-Keller, cited in Roberts, Gotlib, & Kassel, 1996).

Summary

In summary, the literature review covered attachment organization, interactional patterns, coping strategies, and self-esteem. Theorists have proposed that attachment behaviors have evolutionary significance. Proximity to and responsiveness from the caregiver determine felt security. It is assumed that almost all infants accomplish some type of attachment relationship. This relationship seems to be dependent upon individual differences in the behavior of primary caregivers (Bowlby, Bretherton, Hazen & Shaver,

cited in Roberts, Gotlib & Kassel, 1996). Attachment patterns established during childhood seem to be reenacted in adulthood (Hazen & Shaver; Mikulincer, Florian & Tolmatz; Milkulincer, Florian & Weller; Milulincer & Nachshen, cited in Roberts, Gotlib & Kassel, 1996).

Marital dissatisfaction, conflict, and violence may contribute to emotional and behavioral difficulties (Cummings & Davies; Emery; Fantuzzo & Lindquist; Fincham; Grych & Fincham, cited in O'Brien, Margolin & John, 1995). Parental nurturing or reassurance is impeded. Studies have found that parental divorce has negative effects on children's self-esteem (Boyd, Nunn & Parish; Parish & Dostal; Parish & Taylor; Parish & Wigle; Rosenberg; Stolberg, Camplair, Currier & Wells, cited in Shook & Jurich, 1992).

Attachment disorders, low self-esteem, depression, and socialization difficulties have been noted as consequences of physical and psychological abuse (Blager & Martin; Elmer; Martin & Beezley; Gaensbauer & Sands; Green; Kinard, cited in Gross & Keller, 1992 Children of psychologically unavailable caregivers exhibit severe behavioral problems such as anger, aggression, and academic difficulties (Gross & Keller, 1992).

Numerous studies have confirmed the correlation between styles of attribution, helplessness, and depressive functioning in both children and adults Peterson, Colvin &

Lin, Nolen-Hoeksems, Girgue & Seligman, cited in Comer, 1992). Maladaptive attributional styles are associated with depression and low self-esteem (Gross & Keller, 1992).

Protective factors which produce a negative correlation between marital conflict and child maladjustment include the extent to which children exercise coping strategies that distance them from their parents' marital conflict (O'Brien, Margolin & John, 1995), and seeking support from peers or adults when confronted with marital conflict (Cohen & Willis, cited in O'Brien, Margolin & John, 1995).

Cognitive processes and emotional states also influence the impact of marital conflict on children (Cummings, Davies & Simpson, Fincham, Grych & Osborn, Grych & Fincham, cited in Davies & Cummings, 1995). Emotions function as internal monitoring and guidance systems. The appraisal of events and subsequent motivation of behavior shape coping responses (Bretherton, Fritz, Zahn-Waxler & Ridgeway, Campos & Barret, cited in Davies & Cummings, 1995).

Self-esteem is formed from messages of worthiness and unworthiness primarily given in an individual's family of origin, school and various other social agents (Shook & Jurich, 1992). Previous research suggests that quality of affective ties to parents during the transition to adulthood greatly influences self-esteem (Roberts & Bengston, 1996).

CHAPTER 3

METHODOLOGY

Purpose

The purpose of this study was to assess the relationship between parent-child attachment and self-esteem in adults.

Research Design

A descriptive research design was employed in this study. Descriptive designs examine facts about people and draw attention to the degree two events are correlated.This design was chosen to measure whether self-esteem in adults related to parental bonding. This study utilized causal/comparative research. Results will indicate a relationship that may indicate cause. Statistical explanation and analysis will be used for comparison of data (Merriam & Simpson, 1995).

Population and Sample

The population studied included males and females between the ages of 19-63. The sample size was 70 individuals randomly chosen. The sample was selected from clients and their families at a mental health clinic. The

ethnicity of the respondents included Anglo-American, Mexican-American, African American, and Asian-American subjects.

Assumptions and Limitations

An assumption of this study was that a correlation does exist between parental bonding and self-esteem in adults. A second assumption was that therapeutic interventions with adults experiencing attachment disorders and low self-esteem could be advanced.

One limitation of this study was the apparent lack of predictive ability. A second limitation was the utilization of statistics in the interpretation of research findings. This method of reporting often frustrates researchers and research consumers (Merriam & Simpson, 1995). A third limitation was the purposeful selection of participants from a mental health clinic. Results gathered from clients and family members could influence results due to identified and existing mental health difficulties. Respondents could have answered questions in a manner they thought was expected instead of answering honestly.

Procedure

Data gathering techniques included a demographic survey and parental-bonding and self-esteem assessments. A consent form was included which assured confidentiality and

explained that all information gathered would be used for the sole purpose of this study and reported in summary form only.

Instruments were administered in private offices within a mental health clinic. Initially, respondents were asked to complete the demographic survey. Secondly, instructions for the Parental Bonding Instrument (PBI) and the Multidimensional Self-Esteem Inventory (MSEI) were reviewed to insure that respondents understood the rating procedures and response options. Lastly, administrators instructed respondents to rate all items, using a check for each item on the PBI and a circle for each item on the MSEI. Respondents were informed that if they wished to change a rating, they should not erase but should make an "X" through the incorrect rating and check or fill in the circle for the correct response.

Instrumentation

The demographics survey was developed by this researcher to determine gender, ethnicity, age, highest level of education, marital status, employment status, and whether respondents were receiving counseling services or taking mental health medications at the time of administration.

A Parental Bonding Instrument (PBI) taken from Measures for Clinical Practice by Fisher and Corcoran was used to

measure parental behaviors and attitudes as perceived by participants. The PBI was structured on the basis of two variables: caring (with the opposite extreme being indifference or rejection), and overprotection (with the opposite extreme being encouragement of autonomy and independence) (Fischer & Corcoran, 1994).

The Multidimensional Self-Esteem Inventory (MSEI) was employed to measure global self-esteem and its 8 components: Competence, Lovability, Likability, Personal Power, Self-Control, Moral self-Approval, Body Appearance, and Body Functioning. The MSEI is constructed on a coherent model of self-concept and self-esteem (O'Brien & Epstein, 1988).

According to Fischer & Corcoran (1994), "the PBI has good to excellent internal consistency, with split-half reliability coefficients of .88 for care and .74 for overprotection. The PBI also has good stability, with three-week test-retest correlations of .76 for care and .63 for overprotection. The PBI has good concurrent validity, correlating significantly with independent rater judgments of parental caring and overprotection." (p.379).

The MSEI was normed on 785 college students. All scales demonstrated internal consistency reliability coeffients of .80 or higher. All of the MSEI scales exhibited substantial test-retest reliabilities. Most of the scales had reliabilities equal to or greater than .85 with only one scale slightly under .80 (O'Brien & Epstein,

1988).

Method of Analysis

The demographic survey was used to determine gender, race, marital status, employment status, if respondents were receiving mental health services or medication at time of administration, and to calculate mean age and level of education. The PBI was scored on a likert-type scale ranging form 0 ("very like") to 3 ("very unlike"). Items 1,5,6,8-13,17,19,20 were reverse-scored (Fischer & Corcoran, 1994). The MSEI was scored using MSEI rating and profile forms. Ratings of global self-esteem and its 8 components were compared to parental-bonding subscales of care and overprotection using Pearson's correlation.

CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Demographics

Figure 1 below includes frequency and percentage distributions for gender, race, age, education level, marital status, and employment status. It also identifies if respondents were receiving counseling services and or taking mental health medications at the time of distribution.

Figure 1. Respondent Demographics

Survey Respondents-n=70	Frequency	Percent
Gender:		
Male	39	56
Female	31	44
Race:		
Caucasian	58	83
Mexican American	8	12
African American	3	4
Asian American	1	1
Age:		
-21	4	6
21-25	10	14
26-30	11	16
31-35	14	20
36-40	17	24
41-45	6	8
46-50	4	6

Figure 1. cont.

	Frequency	Percent
+50	4	6
Education:		
<Elementary	1	1
Elementary	6	9
High School	38	54
College Degree	19	27
Post Graduate	6	9
Marital Status:		
Single	32	46
Married	19	27
Separated	3	4
Divorced	15	22
Widowed	1	1
Employment Status:		
Employed	55	79
Unemployed	15	21
Receiving Counseling:		
Yes	48	69
No	22	31
Taking Mental Health Medication:		
Yes	9	13
No	61	87

There were 56 percent male and 44 percent females respondents. The majority of respondents were Caucasian (83 percent) and between the ages of 21 and 40 (74 percent). Fifty four percent of the subjects had completed high school and 27 percent were college graduates. Forty six percent of the participants were single, 27 percent were married, and 22 percent were divorced. Seventy nine percent of respondents were employed and 21 percent were unemployed. Sixty nine percent of participants were receiving counseling services at the time of administration and thirteen percent were taking mental health medication.

Findings and Results

Figure 2 contains means and standard deviations for the following variables: care, overprotection, global self-esteem, competence, lovability, likability, self-control, personal power, moral self-approval, body appearance, and body functioning.

Figure 2. Means and Standard Deviations

	Mean	Standard Deviation
Care:	20.16	8.13
Overprotection:	18.27	8.02
Global Self-esteem:	32.44	8.52
Competence:	37.87	6.71
Lovability:	34.01	7.89
Likability:	34.63	6.44
Self-control:	33.89	6.59
Personal Power:	35.20	7.04
Moral Self-approval:	36.71	5.79
Body Appearance:	31.00	7.67
Body Functioning:	33.04	7.76

The mean scores for the parental bonding instrument were 20.16 for care and 18.27 for overprotection. It is important is note that on the care subscale, one respondent scored 0, while sixty four percent of respondents scored between 12 and 28. Average self-esteem scores were between 26 and 40.

Figure 3 exhibits Pearson r and probability correlation scores between the first component of parental bonding, care, and global self-esteem, competence, lovability, likability, self-control, personal power, moral self-

approval, body appearance, and body functioning.

Figure 3. Pearson r Correlations (Care)

	Pearson r	Probability
Global Self-esteem:	0.29	0.02
Competence:	0.24	0.04
Lovability:	0.43	0.00
Likability:	0.27	0.02
Self-control:	0.16	0.19
Personal Power:	0.10	0.41
Moral Self-approval:	0.28	0.02
Body Appearance:	0.35	0.00
Body Functioning:	0.25	0.04

When comparing the parental bonding subscale, care, to global self-esteem and its eight components, all demonstrated a statistically significant correlation with the exception of self-control and personal power. The strongest correlations were between care and global self-esteem ($r=0.29$, $p<.05$), care and lovability ($r=0.43$, $p<.001$), and care and body appearance ($r=0.35$, $p<.05$).

Figure 4 displays Pearson r and probability scores between the second component of parental bonding, overprotection, and global self-esteem, competence, lovability, likability, self-control, personal power, moral self-approval, body appearance, and body functioning.

Figure 4. Pearson r Correlations (Overprotection)

	Pearson r	Probability
Global Self-esteem:	-0.02	0.84
Competence:	-0.04	0.26

Figure 4. Pearson r Correlations (Overprotection) cont.

	Pearson r	Probability
Lovability:	-0.02	0.89
Likability:	-0.09	0.44
Self-control:	0.05	0.64
Personal Power:	-0.06	0.61
Moral Self-approval:	-0.07	0.55
Body Appearance:	-0.08	0.48
Body Functioning:	-0.13	0.29

When comparing the parental subscale, overprotection to global self-esteem and its eight components, no statistically significant correlations were found. All were inverse correlations with the exception of self-control. Therefore, as overprotection was increased, self-esteem was decreased. This is a reasonable assumption, as the opposite extreme of overprotection would be encouragement of autonomy and independence. As demonstrated, the parental bonding scale, care, has a much stronger affect on self-esteem than the parental bonding scale, overprotection.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to assess the relationship between parent-child attachment and self-esteem in adults. A more comprehensive understanding of this relationship may be a significant factor in the therapeutic process.

The literature review covered attachment organization, interactional patterns, coping strategies, and self-esteem. Three types of attachment styles were identified and described. Interactional patterns impacting attachment organization such as marital discord, divorce, physical abuse, and psychological maltreatment were explored. Coping strategies were presented including styles of attribution, level of involvement in interparental conflict, and utilization of social support. Lastly, the influence of parental bonding on self-esteem in adults was examined.

This study utilized a descriptive research design. This design was chosen to measure whether self-esteem in adults related to parental bonding. The population studied included males and females between the ages of 19-63. The sample size was 70 individuals agreeing to complete

questionnaires at a mental health clinic. Two instruments were administered, a Parental Bonding Instrument (PBI) taken from *Measures for Clinical Practice* by Fisher and Corcoran (1994) and a Multidimensional Self-Esteem Inventory (MSEI) developed by O'Brien & Epstein, 1988.

This study found a statistically significant correlation between one component of parental bonding, care, and global self-esteem in adults. Conversely, no correlation was found between the second component of parental bonding, overprotection, and self-esteem in adults.

Conclusions

The results of this study confirmed that there is a correlation between parental bonding and self-esteem in adults. When comparing the parental bonding subscale, care, to global self-esteem and its eight components, all demonstrated a statistically significant correlation with the exception of self-control and personal power. The strongest correlations were between care and global self-esteem ($r=0.29$, $p<.05$), care and lovability ($r=0.43$, $p<.001$), and care and body appearance ($r=0.35$, $p<.05$). Previous studies also confirmed a long-term correlation between baseline parental affection and subsequent self-esteem in adulthood. Psychological health in adulthood seems to be based on the affective environment of one's family of origin during childhood and adolescence (Bachman,

O'Malley & Johnston; Block; Roberts & Bengston; Snarey; Wallerstein, cited in Roberts & Bergson, 1996).

On the contrary, when comparing the parental subscale, overprotection, to global self-esteem and its eight components, no statistically significant correlations were found. All were inverse correlations with the exception of self-control. Therefore, as overprotection was increased, self-esteem was decreased. This is a reasonable assumption, as the opposite extreme of overprotection would be encouragement of autonomy and independence.

Recommendations

The findings of this study clearly demonstrate that parental bonding effects self-esteem in adults. This study should be repeated using a larger sample. Due to the lack of statistically significant correlations between the parental bonding subscale, overprotection, and self-esteem, a different instrument may prove more beneficial.

Prevention programs should be implemented that concentrate on potentially inadequate mothers. Counselors should work with at-risk mother from the last trimester of pregnancy through the first postnatal year. Professionals should assist the mother in interacting with her baby and providing appropriate stimulation. Individual, group, or family therapy may also be warranted. Group therapy can offer education, guidance and support in

addition to psychotherapy (Reid & Balis, 1997).

Hospitalization should be seriously considered if an attachment disorder is severe, with failure to thrive. Recommended interventions include nutritional habilitation, stimulation, and attention to emotional care. Follow-up care by clinic staff and visiting nurses may also be provided. "An infant who is responding to treatment increases somatic growth and affect responses" (Reid & Balis, 1997, p. 473).

Other treatment recommendations noted in the *Infant Mental Health Project Research Summary* include: developmental day care, early periodic screening, diagnosis and treatment, Head Start/Preschool, preventive health and other supportive services, continuing parenting and family life education throughout elementary and secondary school years, parent preparation classes, multimedia educational campaigns, family resource programs (1994).

Therapists' should be knowledgeable about of representational models of self and the attachment figure. This insight can guide the assessment and change of the client's interpersonal schemata. These representational models may be inferred from abnormal patterns of attachments. Therapists should assist the client in reflecting on his/her beliefs concerning vulnerability, dependency, and attachment. Liotti notes, "when the patient sees how a counterproductive model of the self-other

relationship has been constructed stemming from past transactions with the caregivers (in which context beliefs that now appear irrational and detrimental might have seemed quite plausible and adaptive), his/her confidence in the basic efficiency of his/her mind is likely to be preserved" (Liotti,1989 cited in Liotti, 1991). Through this process, the client's history of attachment can be reconstructed (Liotti, 1991).

Future research should repeat this study using a larger sample size to confirm the results compiled. Utilization of a different parental bonding instrument may also be beneficial due to the lack of correlation between the parental bonding component, overprotection, and self-esteem.

Future research should investigate whether the self-report measures of adult attachment accurately assess the attachment construct. Questionnaire measures of adult attachment assume that respondents can accurately report these styles (Gotlib & Kassel, 1996). In contrast, the standard interview approach for adult attachment does not assume that respondents can necessarily accurately report such matters (George, Kaplan & Main, cited in Gotlib & Kassel, 1996). Utilizing a laboratory paradigm, attachment ratings based on behavioral responses could also be measured (Ainsworth et. al., cited in Gotlib & Kassel, 1996). Prior research has found that the rules and underlying cognitive models concerning attachment are at least partially non-

conscious (Bowbly, Brewin, cited in Gotlib & Kassel, 1996).

Future research should also examine whether the effects of parental bonding are specific to self-esteem or applies to other forms of disorder. For example, negative representations of self, including dysfunctional conditions of worth and low self-esteem , might demonstrate a relationship between parental bonding and depression or anxiety (Gotlib & Kassel, 1996).

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