1995

The family's influence on mental disorders

Melissa S. Rochman
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

Recommended Citation

Rochman, Melissa S., "The family's influence on mental disorders" (1995). *Master's Theses*. 1178.
DOI: <https://doi.org/10.31979/etd.ka32-4wbs>
https://scholarworks.sjsu.edu/etd_theses/1178

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

THE FAMILY'S INFLUENCE ON MENTAL DISORDERS

A Thesis

Presented to

the Faculty of the Department of Psychology
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by

Melissa S. Rochman

December, 1995

UMI Number: 1377269

UMI Microform 1377269

Copyright 1996, by UMI Company. All rights reserved.

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI

**300 North Zeeb Road
Ann Arbor, MI 48103**

© 1995

Melissa S. Rochman

ALL RIGHTS RESERVED

APPROVED FOR THE DEPARTMENT OF PSYCHOLOGY

Greg Feist, Ph.D.

Michael Alessandri, Ph.D.

Laree A. Huntsman, Ph.D.

APPROVED FOR THE UNIVERSITY

ACKNOWLEDGEMENTS

I would like to thank Dr. Gregory Feist for all of his help and support on this project. The correspondence across the miles was a challenge, but Dr. Feist was truly amazing throughout the entire process. He provided his time without measure and his insight without limits. I have learned a great deal by having the honor to work with such a gifted man.

Also, I would like to thank all of my friends and colleagues who assisted in this project: Michael Alexander, Julia Mattingly, Troy Newton, Dr. Laree A. Huntsman, and Dr. Michael Alessandri.

Finally, I would like to thank my family for their unwavering support and love. I dedicate this thesis to my mother, the greatest lady I know.

TABLE OF CONTENTS

SECTION	PAGE
ABSTRACT	1
INTRODUCTION.....	2
METHODS	15
Participants.....	15
Measures	16
Procedures.....	18
RESULTS	20
DISCUSSION	23
REFERENCES.....	29

LIST OF TABLES

TABLE	PAGE
1. Means (M) and standard deviations (SD) for all dimensions of The Children's Report of Parental Behavior Inventory and The Rosenberg Self-Esteem Scale for all groups.....	21
2. Total sample correlation between self-esteem and parenting style	23

The Family's Influence on Mental Disorders

Melissa S. Rochman

San Jose State University

Running Head: FAMILY'S INFLUENCE

Footnotes

**Requests for reprints should be sent to Melissa S. Rochman, Department of Psychology,
San Jose State University, San Jose, California 95192**

Abstract

Previous research has shown that the family plays a critical role in the etiology of mental illness. Using the revised 56-item Children's Report of Parental Behavior Inventory and the Rosenberg Self-Esteem Scale, the present study examined mentally-ill adults' ($n = 47$) perceptions of their parents' childrearing behavior and its effect on subsequent self-esteem in comparison to a college group ($n = 31$) and an adult education group ($n = 26$). It was hypothesized that the mentally ill adults would perceive their parents as having been more rejecting, more controlling, and stricter disciplinarians than individuals in both adult comparison groups. The results supported the hypothesis on the Firm-Control-Lax-Control dimension of the CRPBI, and the differences in the overall levels of self-esteem, but these differences were not in the predicted direction. In addition, all participants who viewed their fathers as more rejecting and controlling had lower self-esteem.

The Family's Influence On Mental Disorders

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating to others (National Alliance for the Mentally Ill (NAMI), 1989). These disorders impair the social and psychological functioning of those afflicted and result in substantially diminished capacities for coping with the ordinary demands of life. In addition to these hardships, those suffering from mental illness continue to endure prejudice and fear from the public surrounding their psychopathologies. While people today disregard the once popularly held belief that those suffering from mental disorders are being controlled by evil, demonic forces, a number of misconceptions continue to abound. Some of the commonly held stereotypes about those with mental illnesses can be summed up in the following descriptive words: dangerous, dirty, unpredictable, and uneducated (NAMI, 1989). In actuality, these stereotypes are due to lack of education on the perceiver's part. Mental illness can affect persons of any race, religion, and age--children, adolescents, adults, and the elderly.

Over the years, many mental disorders have been undiagnosed and continue to be overlooked within society . While these disorders have been a neglected focus in the national health care system, several million people suffer from serious, long term mental illness on a daily basis (Rice, Kelman, & Miller, 1992). These mental illnesses are now imposing a bigger financial and societal burden than in recent history. In 1985, the total economic costs of mental illnesses were \$103.7 billion (Rice, Kelman, & Miller, 1992). These costs were estimated to be on the lower limits of the true cost of mental illness. The cost to society is even higher when one includes lost productivity and pain and

suffering of patients and their family and friends. Patients with mental illness occupy more hospital beds than do persons with any other illness (NAMI, 1989). These figures can no longer be ignored and neither can the mentally ill.

In the DSM-IV (American Psychological Association, 1994), each of the mental disorders is conceptualized as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom....Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual ” (p. xxi). It is important to note in the above definition of mental disorders that the origins of mental disorders are not specified. Thus, the original causes of these disorders continue to warrant exploration in order to derive a more comprehensive view of the factors involved in their emergence.

The role of the family

During the past several decades many investigators interested in the domain of psychopathology have shifted their attention from the individual to the larger interpersonal context in which the individual functions (Jacob, 1973). The family, long referred to as the basic institution, derives its strength from the functions it serves for individuals, for other societal systems, and for society as a whole (Gautman & Kamal, 1986). It makes intuitive sense and there is research to support it, that because the family is the primary learning ground in which children are taught social skills and aspects of self-regulation, at least early in life, that any impairment during this fundamental time

period would have subsequent detrimental effects (Koopmans, 1992). For example, Brown and Harris (1978) postulated that deprivation in a child's social structure leads to feelings of insecurity, which in turn would lead to problems with lifestyle and cognitive sets during adolescence and adulthood. They believed this characteristic path resulted in sustained psychological vulnerability. Other theorists have taken this idea a step further and have sought to identify specific focal points of disruption in the family environment which may be in part responsible in the development of abnormal behavior.

Salvador Minuchin's family systems theory proposes that the emotional boundaries of family members (i.e., cohesion) and family adaptation to developmental and external pressures (i.e., adaptability) are important parameters for evaluating family functioning (Minuchin, 1974). Cohesion has been referred to as the extent to which family members are connected to one another and operate as a cohesive interactive unit, while adaptability has been referred to as the ability of the family to adapt effectively its internal structure to meet environmental demands (Olson, 1983). Furthermore, a study examining family psychosocial functioning and its relation to psychopathology among adolescents with severe emotional disturbance (SED) revealed that these family dimensions of cohesion and adaptability were indeed impaired (Prange, Greenbaum, Silver, Friedman, Kutash, & Duchnowski, 1992).

Prange, et al., (1992) found that on the cohesion dimension of the Family Adaptability and Cohesion Evaluation Scale (FACES-III), both parents and adolescents with SED perceived their family relations as more disengaged and less connected than did normative families. In contrast, on the adaptability dimension, only parents of

adolescents with SED reported less leadership, structure, and control over family activities than did normative families (Prange et al., 1992). These findings were further substantiated when examining families with a wide range of adaptive problems. Both cohesion and adaptability were different in families with adaptive problems, such as schizophrenia, neurosis, substance abuse, juvenile delinquency, etc., when compared to families who functioned adequately (Olson, 1989).

Burgess's conceptualization of the family as a "unit of interacting personalities" initiated the scientific approach to family study (Burgess, 1926). Psychosocial approaches to understanding family factors that influence human behavior are based on the assumption that people do not have problems, but are part of a system that has problems. Today, most family investigators would suggest that there are definable family patterns and processes that are crucial to understanding the etiology, development, and maintenance of abnormal behavior and that identification of such family patterns might lead to more effective methods of treatment and prevention (Jacob, 1987).

Moreover, the family has long been considered the foundation of social order and the current generation is experiencing a relative weakening of this institution particularly with the marked increase in the divorce rate (Marquis, 1992). This trend could have undesirable consequences for future social stability and for the emotionally scarred offspring of such families. Therefore, it is now more essential than ever before to further an understanding of the association between family dynamics and psychopathological development. Through understanding, mental health practitioners can move closer towards intervention, treatment, and ultimately, prevention.

Early clinical studies and theorists often alluded to and implicated the family's role in disordered behavior (Fromm-Reichmann, 1948; Lewis, 1937). Some researchers have continued to explore the links between childhood stressors and adult psychiatric disorders (Brown and Harris, 1978; Rutter & Garmezy, 1983). For example, in a 1992 study, Patterson, Smith, Smith, Yager, and Grant examined whether the effects of experiencing adverse life events during childhood increased vulnerability to physical illness and psychological disorders during adulthood. The results of this study revealed that the elderly male participants who indicated that they grew up in families with harsh climates and whose affiliation needs remained unmet tended to have more psychological and physical symptoms in old age than participants who did not report growing up in such environments.

One of the unique aspects of the above study (Patterson, Smith, Smith, Yager & Grant, 1992) was that it focused on the effects of early adverse life stress on psychological disturbance by utilizing healthy elderly adults rather than those who had already been diagnosed with psychological disorders. In a similar vein, results from a major longitudinal study of medical students indicated that a lack of closeness to parents was associated with cancer, mental illness and suicide later in life (Thomas, Duszynski, & Shaffer, 1979).

Schizophrenia. Due to the fact that general findings attest to the importance of the association between family dynamics and psychopathological development, specific psychiatric disorders have been singled out and researched extensively to explore possible familial origins. Schizophrenia is one of the most serious and disabling of the

mental illnesses (NAMI, 1989). Parent and offspring perceptions of family relationships were examined in a group of children at high risk for schizophrenia (Mednick, Burman, Machon, Parnas, & Schilsinger, 1987). This study was based on the underlying theory that schizophrenics and people with schizotypal personality disorder have a comparable genetic predisposition to schizophrenia, but that environmental factors determine whether the full schizophrenic syndrome will develop (Mednick, Parnas, & Schulsinger, 1986). In other words, the theory takes the form of the diathesis-stress model which suggests that stressful environments will tend to produce schizophrenia in genetically predisposed individuals.

Schizotypal personality disorder is not considered to be as extreme or debilitating as schizophrenia. Persons with schizotypal personality disorder do not suffer from the active auditory hallucinations and/or delusions present in those diagnosed as with schizophrenia, and they are more frequently classified as having what is referred to as pervasive, magical thinking. The results of the above study (Mednick, Burman, Machon, Parnas, & Schilsinger, 1987) supported the hypothesis that the family relationships of high-risk offspring who later developed schizophrenia were perceived to be less satisfactory than the family relationships of high-risk offspring who were later diagnosed as having schizotypal personality disorder or no mental illness. These findings illuminate the interaction between biological and environmental influences in the emergence of schizophrenia by pointing out that people at high risk for schizophrenia (biological base) decompensate in part because of environmental stress associated with unsatisfactory family relationships. Previous work from a longitudinal prospective study of disturbed

adolescents indicated that a number of qualities in parents were associated with an increased risk for schizophrenia spectrum disorder, particularly deviant communication and negative affective attitudes and interaction behavior (Goldstein, 1987).

As a result of the debilitating nature of schizophrenia, it was primarily the focus of early work on the role of the family in the development and course of major psychiatric illnesses. However, this focus has now expanded to include other mental disorders.

Depression. In an overview of family functioning and major depression (Keitner & Miller, 1990), the family was implicated as playing a major role in the development and course of clinical depression. In fact, a number studies suggest that depressive illness is associated with more family distress and impairment than are other psychiatric illnesses and some medical conditions (Keitner & Miller, 1990). These researchers also reported that 43 depressed inpatients and their families were significantly more dysfunctional than 29 nonpsychiatric control families particularly in the area of family communications and problem-solving. These findings are of interest because they show two specific aspects of the family environment, family communications and problem-solving, that may be contributing factors in the manifestation of depressive illness. The researchers caution that there is a danger of losing sight of this broader psychosocial reality with society's increasing focus on the neurochemical, neurophysiological, and pharmacological issues in the understanding and treatment of depressive illness (Keitner, Miller, Fruzzetti, Epstein, Bishop, & Norman, 1987).

Parental rejection has also clearly been one of the child-rearing variables indicated in adult depression. A study of depressed women (Jacob, 1978), reported that both inpatients and outpatients reported a significantly greater history of rejection than did a group of normal women. Similarly, in studies of memories of parental behavior (Raskin, Boothe, Reatig & Schulterbrandt, 1971), depressed patients compared to normal subjects rated both parents higher on rejection.

Suicide. There is an added inherent urgency to identify the connection between family and parental characteristics and depressive illness because depressive illness continues to be associated with high rates of suicide (Clayton, 1985). In reviewing the family studies, a similar theme is suggested, namely, that suicide attempts are strongly related to a disturbed home environment. This pattern of attempted suicide and disturbed home environments also appears in countries other than the U.S. For example, Gehlot and Nathawat (1983) reviewed the history of suicides in India. They noted that the “prime causes of suicide are not unemployment and poverty, but family problems” (p.275).

Suicide ranks as the second leading cause of death among adolescents (National Center for Health Statistics, 1989), and community based surveys suggest there are as many as 200 suicide gestures or attempts for each completed suicide (Angle, O'Brien, & McIntire, 1983). As would be expected, family functioning and suicidal behavior in adolescent inpatients with mood disorders have been examined (King, Segal, Naylor, & Evans, 1993), and revealed a negative pattern of interaction within suicidal adolescents' families. These findings were clear and consistent with past research in empirically

documenting a maladaptive or unhealthy dynamic within the families of these suicidal adolescents with mood disorders (Orbach, 1988).

Past research has also suggested that suicidal adolescents' perceptions of their families are more negative than those of other adolescents (McKenry, Tishler, & Kelley, 1982). More specifically, suicidal patients perceive their family functioning to be worse than other family members. Analysis of the discrepancy between parents and their family members in the above study (King et al., 1993), showed that patients who had attempted suicide were significantly more negative than their families with respect to how well their families functioned, while nonsuicidal patients perceived their families as functioning more positively. This finding extends the current understanding by suggesting that it is actually the discrepancy between how the patient and the family see their functioning that may distinguish suicidal from nonsuicidal behavior.

Multiple Disorders. Overall, the literature consistently reveals that families of specific diagnostic groups differ in their severity and/or type of dysfunction which suggests that the different dysfunction may reflect something about the specific disorder. Few previous studies have compared the functioning of the families of different diagnostic groups within the same study.

The functioning of families of five psychiatric groups with DSM-III disorders (major depression, schizophrenia, alcoholism, adjustment disorder and bipolar disorder (manic)) and a group of nonclinical families was assessed by the Family Assessment Device (FAD) (Miller, Kabacoff, Keitner, Epstein, & Bishop, 1986). Results revealed that all the families of the psychiatric patients reported significantly greater impaired

family functioning when compared to nonclinical families. Furthermore, families of patients with major depression, alcoholism, and adjustment disorders showed the most profound impairments, particularly in the areas of communication and affective involvement, while families of schizophrenics and bipolar patients manifested less significant disturbances.

Similarly, in a 1986 study, Gautman and Kamal examined family typology and family interaction of patients suffering from schizophrenia, manic-depressive psychoses and neurotic disorders. Their findings revealed that the antagonistic type of family interaction (comprising mutual resistance, active opposition, hostility and conflict) were observed statistically more in families of schizophrenic patients, while families of patients of manic-depressive psychoses and patients with neurotic disorders showed indifferent interactional patterns characterized by lack of cohesiveness, apathetic disinterest and lack of general consensus on common objectives. As a result, differences in the severity and/or type of family dysfunction may have important implications concerning what type of treatments may be relevant to which type of patients (Miller, et al. 1986). Yet, causality cannot be inferred from these findings.

Research out in the field acknowledges that the association between family dynamics and mental disorders is complex, and the possibility cannot be ruled out that disrupted family features are in fact an outcome of psychological development, because such development has an adverse effect on the way the family functions. Yet, in a recent study investigating mental disorder in youth and family of origin (Koopmans, 1992), a majority of subjects reported that the symptoms of mental disorder coincided with or

followed instances of role confusion within their families (63%) , and only 18% of the subjects reported role confusion occurring more than a year after the symptoms were already present.

The role of the family on self-esteem

It should be clear from this discussion that the profound impairments that manifest themselves in psychiatric patients may be revealed in a number of ways. One further way is its effect on self-esteem. Self-esteem has recently been defined as “the sense of contentment and self-acceptance that stems from a person’s appraisal of their own worth, significance, attractiveness, competence, and ability to satisfy their aspirations” (Robson, 1988, p.6). Self-esteem is often discussed in the clinical context, both as an explanation for or consequence of psychological disorders (Robson, 1988, pg. 6). In a study that measured the self-esteem of 141 psychiatric out-patients with a variety of DSM-III-R diagnoses, all the patient groups appeared to have lowered self-esteem when compared with scores from normal populations (Silverstone, 1991).

Litovsky and Dusek (1985) investigated the relationship between aspects of child rearing and adolescent self-concept in 130 male and female adolescents. The researchers found that low self-esteem adolescents compared to high self-esteem adolescents perceived their parents as less accepting, as using more psychological control, and as being overly firm in making and enforcing rules and regulating the adolescents’ behavior. In a study of adolescent female identity development , Adam and Jones (1983) reported that girls with more advanced identity statuses perceived their mothers as not being controlling or regulating and as encouraging free and independent behavior, and they

perceived their fathers as fair disciplinarians. On the other hand, girls who perceived their mothers as controlling and their fathers as using unfair disciplinary practices, had lower identity statuses (i.e., self-esteem) (Adams & Jones, 1983).

Purpose of present study

In conclusion, the influence of the family in the etiology of a number of different psychopathologies and in the development of self-esteem has been clearly documented within the literature. The present study explores familial influence on both psychiatric disorders and self-esteem, whereas previous studies have focused primarily on singular dimensions of familial influence. Also, a majority of the research in the area examines adolescents' perceptions of their parents' childrearing behavior and its effects on child psychopathology. The current study focuses on adults' perceptions of their parents' childrearing behavior and adult psychopathology. In addition, there have been a number of methodological flaws noted in the past research on familial influence and the emergence of mental disorders, such as the lack of control groups and lack of classification of mental disorders according to Diagnostic and Statistical Manual of Mental Disorders criteria (DSM-II, DSM-III, DSM-III-R, or DSM-IV). The present study utilizes two adult comparison groups to serve as controls and all mentally-ill adults' diagnoses are based on DSM-IV criteria. It is hoped that further investigation into the association between family interaction and the role it plays in the etiology of mental illness and subsequent self-esteem will expand current knowledge by illuminating and promoting heightened awareness of the social context in which they evolve.

The present study is modeled after research on the family perception of sex offenders (i.e., rapists and pedophiles) (Bass & Levant, 1992). These researchers attempted to clarify the childhood experiences of sex offenders by focusing on the retrospectively recalled communication within the offender's family as reported by the sex offender himself. The researchers predicted that rapists and pedophiles would perceive their parents as (1) having been more rejecting, (2) as having exerted more control while encouraging less autonomy, and (3) as having provided stricter discipline than individuals in comparison groups. They used a revised version the Children's Reports of Parental Behavior Inventory, (CRPBI), a self-report inventory (Schaefer, 1965), which measures participants' reports of parental attitudes of acceptance versus rejection, psychological autonomy versus psychological control, and firm versus lax discipline. Bass and Levant used the CRPBI revised version 90-item inventory (Boothe, Odle, Raskin, & Reatig, 1971). Results comparing pedophiles to college students supported the above hypotheses. Similar perceptions were noted for the rapists, with one exception: the rapists' fathers were not perceived as being more rejecting. However, this research did not find perception of parental discipline (firm versus lax) for either mother or father to differ significantly among the groups.

The purpose of the present study was to compare perceptions that a group of mentally ill adults' had of their parents' childrearing behaviors with a college undergraduate population and an adult education population. In addition, this study compared the self-esteem levels of all three groups: psychiatric, college, and adult education. Based on the research by Bass and Levant (1992), the hypotheses were as

follows: the mentally ill adults would perceive their parents as 1) having been more rejecting, 2) as having exerted more control while encouraging less autonomy and 3) as having provided stricter discipline than individuals in both adult comparison groups. It was also hypothesized that there would be differences between the three groups in overall level of self-esteem. More specifically, the psychiatric group was predicted to have the lowest self-esteem of the three groups.

Furthermore, based on the existing literature (Adam & Jones, 1983; Coopersmith, 1967; Leahy, 1981; Litovsky & Dusek, 1985; Rosenberg, 1979), it was hypothesized that participants who see their parents as being most rejecting would have the lowest self-esteem, while participants who see their parents as granting psychological autonomy and utilizing lax control (i.e. discipline) would have higher self-esteem.

Methods

Participants

The participants were ($n = 48$) males and ($n = 56$) females between the ages of 18-59 years old. The psychiatric group was comprised of ($n = 33$) males and ($n = 14$) females with a mean age of 34.13 years old. The college group was comprised of ($n = 10$) males and ($n = 21$) females with a mean age of 22.93 years old. The adult education group was comprised of ($n = 5$) males and ($n = 21$) females with a mean age of 32.30 years old. All participants in the psychiatric group were residents living at one of the Avenues to Mental Health's residential programs ($n = 47$). The participants for the adult comparison groups were those enrolled in 1) adult education classes at Independence Adult Center (adults working on GEDs/ high school diplomas) ($n = 26$)

and 2) undergraduates at San Jose State University (SJSU) ($n = 31$). Two comparison groups were used because the psychiatric group was demographically heterogeneous. The main ethnic constellations of the three groups were as follows: psychiatric-56.5% Caucasian; college-38.7% Asian and 32.3% Caucasian; and the adult education-42.3% Asian and 23.1% Mexican American. Finally, the main educational levels of the groups were as follows: psychiatric-44.7% had high school diplomas, 19.1% were currently attending college and 23.4% had college degrees; college-100% were currently attending college; and adult education-80.8% were currently working on high school diplomas and 11.5% had college degrees. It is an important consideration that some participants in the adult education group were English as a second language students who had already completed college degrees in foreign countries.

The adults in the psychiatric group had psychopathologies classified according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These diagnoses were made by qualified clinical psychiatrists based on the criteria specified within the DSM-IV along with extensive patient histories and interviews. All participants were asked to voluntarily participate.

Measures

The revised 56-item Children's Report of Parental Behavior Inventory (CRPBI) (Margolies & Weintraub, 1977) was administered to all 104 participants. The revised version is less cumbersome than the 260-item original (Schaefer, 1965). The revised 56-item measure assessed participants' reports of parental attitudes on three dimensions: acceptance versus rejection, autonomy versus control, and firm versus lax discipline.

These three dimensions emerged from factor analyses of American and Belgian grade school children (Schaefer, 1965) and college students (Cross, 1968) on the 260-item original CRPBI. The abbreviated 56-item CRPBI used in this study has the same factor structure as the original measure (Margolies & Weintraub, 1977).

The participants completed the CRPBI self-report inventory by indicating whether the item specified on the CRPBI was very true (i.e., very true = 3), somewhat true (i.e., somewhat true = 2), or not true at all (i.e., not at all true = 1) of their parents. Mothers and fathers were rated separately, but on the same form. The participant's responses were summed to yield scores on the individual factors. According to the revised 56-item CRPBI (Margolies & Weintraub, 1988), Factor 1 of the CRPBI was the Acceptance vs. Rejection dimension and it was comprised of 24 items. A higher score on this factor was associated with perceptions of parents as having been more accepting as opposed to rejecting. Factor 2 of the CRPBI was the Psychological Autonomy vs. Psychological Control dimension and it was comprised of 16 items. Higher scores on this factor were associated with perceptions of parents as providing more psychological autonomy opposed to psychological control. Factor 3 of the CRPBI was the Firm Control vs. Lax Control dimension and it was also comprised of 16 items, and higher scores on this factor were associated with perceptions of parents as having provided lax discipline opposed to firmer discipline (due to the reverse scoring for a number of items on this dimension). Test-retest coefficients (ranging from .66 to .92 for a one-week interval, and from .77 to .93 for a five-week interval, for mother and father) indicate the scale has suitable reliability (Margolies & Weintraub, 1977).

The Rosenberg Self-Esteem Scale (RSES), is a 10-item Guttman scale with a Coefficient of Reproducibility of 92% and a Coefficient of Scalability of 72% and was used to measure the adults' global self-attitude (Rosenberg, 1979). The RSES yielded an overall self-esteem score measuring positive self-esteem or negative self-esteem. The reliability and validity of measure is adequate (Rosenberg, 1965). Participants were asked whether they strongly agreed, agreed, disagreed, or strongly disagreed with the items, on a 1-4 likert-like scale.

Procedures

Prior to the actual execution of this study, experimenter provided the clinical director of Avenues to Mental Health with a proposal of the present study delineating nature and purpose of study along with guidelines to ensure patient confidentiality in undertaking study. An additional proposal was also submitted to the director in charge of mental health services for the Santa Clara County. Permission to undertake study was granted by both agencies.

All participants completed informed consent releases prior to their participation in the study. They were also offered incentives for their participation (e.g., soda, candy, gum, etc.). All participants were recruited for the study individually. Residents of the ATMH programs were run in different sessions at different placements in order to acquire an adequate sample size. Diagnoses for the mentally ill participants were based on the criteria specified in the DSM-IV (1994). The experimenter in charge of this project (an employee of ATMH) had access to the residents' confidential files which contained their diagnoses. Permission was granted to the experimenter to access these

files in order to document participants' DSM-IV diagnoses; however, all identifying information was destroyed once diagnoses were accessed.

The comparison subjects were recruited from local adult education classes at Independence Adult Center and from the SJSU undergraduate subject pool. Prior arrangements were made with an adult education teacher to visit her classrooms after experimenter was granted permission to utilize the adult education students by the principal of the school. College students were recruited on open subject pool today at San Jose State University. Questionnaires were administered to the mentally ill population at their residences and to the comparison populations in designated classrooms.

To safeguard the privacy of the participants, each was assigned a code number. Only the experimenter had access to the participant's identification. All raw data from the questionnaires were kept in a locked file drawer and available only to the experimenter. Code sheets with the mentally ill population's diagnoses were destroyed as soon as identification codes were matched with their CRPBI and self-esteem questionnaires. Participants were informed of all the safety precautions being used in the study to ensure their anonymity. Experimenter stressed to participants that all identifying information would be destroyed as soon as identification code numbers were matched with correct questionnaires.

After completing consent to participate forms, all participants were asked to complete a short form requiring demographic information such as age, gender, ethnicity, and years of education completed. Participants were then asked to complete the two instruments, the CRPBI first, followed by the Rosenberg Self-Esteem Measure.

After the participants completed both measures, they were debriefed on the nature of the experiment. It was explained that the experimenter was examining the perceptions held by mentally-ill adults in comparison to other adult populations regarding their parents' child-rearing behavior. Additionally, the participants were informed that the experiment was also examining whether or not this child-rearing influenced subsequent self-esteem among the populations.

Results

Statistical analyses were conducted using the statistical software package SPSS. Because of incomplete data for some participants, analyses conducted were based on 104 participants. Table 1 presents the means and standard deviations of the three groups on all of the dimensions (i.e., factors) of the CRPBI and for total self-esteem scores on the RSES.

Six analyses of variance were conducted to determine whether the psychiatric group ($n = 47$) represented a unique group distinct from the two specified comparison groups, college ($n = 31$) and adult education ($n = 26$), in their perceptions of their parents' childrearing behavior as measured by the Children's Report of Parental Behavior Inventory.

There was a significant difference between the three groups only on their perception of their father's control ($F(2, 101) = 7.61, p < .001$). Simple planned comparisons revealed that the above significant differences were due to the differences

Table 1

Mean and Standard Deviations for All Dimensions of the Children's Report of Parental Behaviors Inventory and The Rosenberg Self- Esteem Scale for All Groups

Inventory	Scale	Group	<u>M</u>	SD
CRPBI	Father Factor 1	Psychiatric	48.40	12.40
		College	53.87	12.29
		Adult Education	49.19	11.57
	Father Factor 2	Psychiatric	31.09	7.27
		College	28.90	8.42
		Adult Education	32.73	7.95
	Father Factor 3	Psychiatric	26.96	5.71
		College	32.00	5.59
		Adult Education	28.23	5.59
	Mother Factor 1	Psychiatric	52.19	13.11
		College	55.81	12.37
		Adult Education	56.23	9.84
	Mother Factor 2	Psychiatric	32.60	7.43
		College	32.39	8.10
		Adult Education	33.27	6.85
	Mother Factor 3	Psychiatric	27.83	6.07
		College	29.10	5.80
		Adult Education	28.42	5.86
RSES	Overall Self-Esteem	Psychiatric	28.23	5.48
		College	32.39	4.87
		Adult Education	25.85	8.00

CRPBI= Children's Report of Parental Behavior Inventory; RSES= Rosenberg Self-Esteem Scale;

Factor 1 = Acceptance vs. Rejection Dimension; Factor 2 = Psychological Autonomy vs. Psychological

Control; Factor 3 = Firm Control vs. Lax Control

between the psychiatric group and the college group ($F(1,101) = 14.90, p < .000$), not between the psychiatric group and the adult education group ($F(1,101) = 2.61, n.s.$). In other words, the psychiatric group viewed their parents as having provided stricter control than individuals in both adult comparison groups, at least for fathers.

Due to the difficulty of finding adequate comparisons groups for a clinical population, the researcher conducted a post-hoc analysis to determine whether there were differences within the psychiatric group on the various factors of the CRPBI. The psychiatric group was comprised of people with the following disorders: bipolar disorder ($n = 19$), schizoaffective disorder ($n = 9$), schizophrenia ($n = 13$), and other ($n = 5$). Results were negative: there were no statistically significant differences found on any of the dimensions of the CRPBI comparing different categories of illness.

To test the hypothesis regarding self-esteem, an analysis of variance was calculated and revealed that there were statistically significant differences between the three groups in their total self-esteem scores, ($F(2,101) = 8.75, p < .001$). Two simple planned comparisons revealed that the above significant differences in self-esteem were between the psychiatric group and the college group ($F(1,101) = 8.81, p < .004$) and between the college group and the adult education group ($F(1,101) = 16.54, p < .000$). Therefore, the hypothesis stating that there would be differences between the three groups in levels of self-esteem was supported. However, the specific hypothesis stating that the psychiatric group would have the overall lowest self-esteem was not supported.

It was further hypothesized that scores on the Acceptance-Rejection dimension of the CRPBI would be positively correlated with self-esteem while scores from the

Psychological Autonomy -Psychological Control and Firm Control-Lax Control dimensions of the CRPBI would be negatively correlated with self-esteem for all participants. Table 2 shows the correlations between the father and the mother dimensions of the CRPBI and total self-esteem score. Perceptions on the Acceptance-Rejection and the Psychological Autonomy-Psychological Control dimensions for fathers were consistently related to participant self-esteem. In other words, participants who perceived their fathers as warm and accepting and as allowing autonomy had higher self-esteem scores. Fathers' Firm Control-Lax Control dimension of the CRPBI did not relate to self-esteem nor did any of the three specified Mother dimensions.

Table 2

Total Sample Correlation Between Self-Esteem and Parenting Style

Self-Esteem	Father			Mother		
	F1	F2	F3	F1	F2	F3
Total Score	.25*	-.27*	.12	.16	-.12	.04

* $p < .01$ F1 = Factor 1=Acceptance vs. Rejection Dimension

N=104 F2 = Factor 2=Psychological Autonomy vs. Psychology Control

F3 = Factor 3=Firm Control vs. Lax Control

Discussion

The purpose of the present study was to examine mentally ill adults' perceptions of their parents' childrearing behavior and its effects on subsequent self-esteem in comparison to two other adult populations. The Children's Report of Parental Behavior Inventory (CRPBI) was used to measure all participants' perceptions of their parents' childrearing behavior on the following three dimensions: Acceptance/Rejection,

Psychological Autonomy/Psychological Control, and Firm Control/Lax Control.

It was hypothesized that the psychiatric group would perceive their parents 1) as having been more rejecting, 2) as having exerted more control while encouraging less autonomy and 3) as having provided stricter discipline than participants in both adult comparison group. The results of the analyses revealed no significant differences between the groups for mothers on any of the dimensions of the CRPBI.

However, there were significant differences between the groups on the Firm Control/ Lax Control dimension of the CRPBI reported for fathers. The psychiatric group reported that their fathers had provided stricter discipline than those in the college group. This finding on the Firm Control\Lax Control dimension for fathers may have been due to the variations in participants' ages. For example, in a 1971 study, Raskin, Boothe, Reating, Schulterbrandt, and Olde examined patient and normal samples memories of parental behavior and they did not find any differences between the samples on the Firm/Lax Control dimension of the CRPBI. They found that neither the patients nor the normal sample perceived their parents as being especially lax in discipline. However, as a guide for future study, these researchers suggested that differences on the Firm/Lax Control dimension may be more likely to emerge when the adult samples were divided into younger and older age groups if the reported trend of their time was true. The trend these researchers were referring to suggested that parents were beginning to take a more permissive attitude toward childrearing and disciplinary tactics.

In the present study, there were significant age differences between the groups.

This potential confound of age emerges when interpreting the results. The psychiatric was the oldest age group of the three while the college sample was the youngest. Therefore, we are not sure whether perceived stricter punishment by fathers reported by the psychiatric group was related to their mental illness or to their age. There were a few other differences between the three groups' demographics that served as possible confounds. For example, the ethnicity of the participants was not evenly distributed among the groups. The psychiatric group was 56.5% Caucasian, while the college group was 32.3% Caucasian and 38.7% Asian and the adult education group was 42.3% Asian, 23.1% Mexican American, and only 3.8% Caucasian. Also, a large percentage of the adult education group were English as a second language students. A challenge of future research lies in finding a control group that is comparable to a clinical population.

The present study failed to show significant differences between the groups on the first two dimensions of the CRPBI. One explanation for the lack of significant findings on these two dimensions may be due to the nature of the CRPBI as it measures adults' perceptions of their parents' childrearing behavior. Retrospectively recalled perceptions of their parents' childrearing behavior may be inaccurate and colored over the years as relationships changed and matured.

Gautam and Kamal (1986) found different family dysfunctions were associated with different mental illnesses. Their findings revealed that schizophrenics most often were from antagonistic family interactional patterns (comprising mutual resistance, active opposition, hostility, and conflict), whereas manic-depressive psychoses and neurotic disorders most often had indifferent family interactional patterns characterized

by lack of cohesiveness, apathetic disinterest and lack of general consensus on common objectives. Due to the difficulty of finding adequate comparison groups for the clinical population in the present study, researcher decided to examine whether breaking down the psychiatric group by diagnosis would reveal differences within this group on the factors of the CRPBI for fathers and mothers. The results were negative: there were no statistically significant differences found on any of the dimensions of the CRPBI comparing different categories of illness. It seems a measure which examines family dimensions and/or interactional styles other than those specified on the CRPBI is necessary to reveal differences within different categories of illness.

Significant differences were found however, in the total self-esteem scores between the groups. The college group reported the highest level of self-esteem, followed by the psychiatric group and adult education group. While it was hypothesized that the psychiatric group would have had the lowest self-esteem, the adult education group had the lowest overall self-esteem scores. These results must be interpreted with educational level and ethnicity in mind, because the adult education group had the lowest educational level of all three groups which may have contributed to a lowered self-esteem. The adult education group was also comprised of predominately Asian and Mexican American students, some of whom acquired English as a second language, and they may have had difficulty interpreting the questions asked.

Further hypotheses of this study specified that scores on the Acceptance\Rejection dimension of the CRPBI would be positively correlated with self-esteem while scores from the Psychological Autonomy\Psychological Control and Firm Control\Lax Control

dimensions would be negatively correlated to self-esteem for all participants. No significant differences were found for any of the dimensions of the CRPBI when correlated with self-esteem for mother ratings. It is unclear why the result occurred. Perhaps, the lack of significant findings for the mother ratings may have been due to of the larger number of females in the study, and females report more satisfactory relationships with their mothers.

Two significant correlations were found for the first two dimensions of the CRPBI when correlated with self-esteem for father ratings that offered partial support for hypotheses. Participants who perceived their fathers as warm and accepting and as allowing autonomy had higher self-esteem scores. These results support previous research that found that acceptance and warmth convey a feeling of value (Schludermann & Schludermann, 1983) that is the basis of positive self-esteem (Coopersmith, 1967). While the current results were partially supportive of the idea that the use of high levels of psychological control and firm control both act to discourage independent exploration and convey a sense of the self as incompetent and perhaps ineffective (Adam & Jones, 1983; Schaefer, 1965).

The present study sought to further an understanding of the family influence on mental disorders and its subsequent effect on self-esteem. Through studies focusing on the family influence on mental disorders, some of the negative stereotyping of mentally-ill persons can be eliminated because the blame is gradually taken off the identified person for the manifestation of these disorders. However, the burdens the mentally-ill person must carry are far from lifted.

Overall, the emotional consequences to a person suffering from a serious mental illness are many: diminished self-esteem and confidence, embarrassment and shame, and often a deep sense of personal loss at not being able to go on with life the way siblings and friends are doing (NAMI, 1989). Recent surveys have documented the high prevalence of mental illness in the general population: 12.6 percent of the population 18 years of age and older reported mental disorders during a one-month period, 14.8 percent during a six-month period, and 22.1 percent during their lifetime (Rice, Kelman, & Miller, 1992).

These figures are growing at alarming rates and patients with major psychiatric illnesses are spending more time with their families because of shorter hospital stays for acute episodes and deinstitutionalization policies have forced patients to rely more heavily on available family members (Keitner & Miller, 1990). Since the causes of long-term mental illness are little understood, there is no effective prevention at this time; more research is needed to determine causes and strategies of prevention. If dysfunctional family patterns and processes can be discerned than perhaps, the revolving door syndrome may be eliminated and improvement may arise within the home environment. Therefore, it is now more crucial than ever to further our understanding of the etiology, development, and maintenance of such abnormal behavior. The results of the present study suggest that the disciplinary tactics utilized by parents may be one such avenue that warrants further attention in the emergence and development of mental illness.

References

- Adam, G., & Jones, R. (1983). Female adolescents' identity development: Age compliation and perceived childrearinfg experience. Developmental Psychology, 19, 249-256.
- Alexander, P., & Lupfer, S. (1987). Family characteristics and long-term consequences associated with sexual abuse. Archives of Sexual Behavior, 16, 235-245.
- American Psychological Association. (1994). Diagnostic And Statistical Manual of Mental Disorders-Fourth Edition. Washington, D.C. : APA.
- Angle, C., O' Brien, T., & McIntire, M. (1983). Adolescent self-poisoning - a nine year follow-up. Deviant Behavior Pediatrics, 4, 83-87.
- Bass, B. A., & Levant, M. D. (1992). Family perception of rapists and pedophiles. Psychological Reports, 71, 211-214.
- Brown, G.W., & Harris, T. (1978). Social origins of depression. London: Tavistock.
- Burgess, E. W. (1926). The family as a unity of interacting personalities. Family, 7, 3-9.
- Clayton, P. J. (1985). Suicide. Psychiatric Clinics of North America , 8, 203-214.
- Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco, CA.: Freeman.
- Cross, H. (1968). College students' memories of their parents: A factor analysis of the CRPBI. Journal of Consulting and Clinical Psychology, 33 (3), 275-278.
- Fristad, M. A., & Karpowitz, D. H. (1988). Norms for the Children's Report of Parental Behavior Inventory Modified Form. Psychological Reports, 62, 665-666.
- Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. Psychiatry, 11, 263-273.
- Gautam, S., & Kamal, P. (1986). Family typology and family interaction in psychiatric disorders. International Journal of Social Psychiatry, 32 (4), 27-31.
- Gehlot, P.S., & Nathawat, SS (1983). Suicide and family constellation in India. American Journal Of Psychotherapy, 37, 273-279.

Goldstein, M. (1987). The UCLA high risk project. Schizophrenia Bulletin, 13, 505-514.

Hoagwood, K., & Stewart, J.M. (1988). Family structural factors in cases of child sexual abuse. Paper presented at the 96th Annual Convention of the American Psychological Association, Atlanta, GA.

Jacob, T. (1973). Family Interaction in Disturbed and Normal Families: A Methodological and Substantive Review, 82 (1), 33-65.

Jacob, T. (1987). Family interaction and psychopathology. New York, NY: Plenum Press, Corp.

Keitner, G. I., Miller, I. W., Fruzzetti, A. E., Epstein, N. B., Bishop, D. S., & Norman, W. H. (1987). Family functioning and suicidal behavior in psychiatric inpatients with major depression. Psychiatry, 50, 242-254.

Keitner, G.I. , & Miller, I.W. (1990). Family functioning and major depression: An overview. American Journal of Psychiatry, 149 (9), 1128-1137.

King, A., Segal, H.G., Naylor, M., & Evans, T. L. (1993). Family functioning and suicidal behavior in adolescent inpatients with mood disorders. Journal of American Academy of Child Adolescent Psychiatry, 32 (6), 1198-1206.

Koopmans, M. (1992). Mental disorder and perception of family characteristics: An assessment of the relationships in childhood and adolescence. Psychological Reports, 71, 1163-1169.

Leahy, R. (1981). Parental practices and the development of moral judgements and self-image disparity during adolescence. Developmental Psychology, 17, 580-594.

Lewis, M. (1937). Alcoholism and family casework. Family, 18, 39-44.

Litovsky, V. G., & Duske, J. B. (1985). Perceptions of child rearing and self-concept development during the early adolescent years. Journal of Youth and Adolescence, 14 (5), 373-387.

Margolies, P. J., & Weintraub, S. (1977). The revised 56-item CRPBI as a research instrument: Reliability and factor structure. Journal of Clinical Psychology, 33 (2), 472-474.

Marquis, P. (1992). Family dysfunction as a risk factor in the development of antisocial behavior. Psychological Reports, 71, 468-470.

Mednick, S. A., Burman, B., Machon, R.A., Parnas, J., & Schulsinger, F. (1987). Children at high risk for schizophrenia: Parent and offspring perceptions of family relationships. Journal of Abnormal Psychology, 96, 364-366.

Mednick, S.A., Parnas, J., & Schlesinger, F. (1986). The Copenhagen High-Risk Project: 1962-1986. Schizophrenia Bulletin.

McHenry, P.C., Tisher, C.L., & Kelley, C. (1982). Adolescent suicide: A comparison of attempters and nonattempters in an emergency room population. Clinical Pediatrics, 21, 266-270.

Miller, I.W., Kabacoff, R.I., Keitner, G.I., Epstein, N.B., & Bishop, D.S. (1986). Family functioning in the families of psychiatric patients. Comprehensive Psychiatry, 27(4), 302-312.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Nash, M. R., Hulse, T. L., Sexton, M. C., Harralson, T. L., & Lambert, W. (1993). Long-term sequelae of childhood sexual abuse: Perceived family environment, psychopathology, and dissociation. Journal of Consulting and Clinical Psychology, 61(2), 276-283.

National Alliance for the Mentally Ill. (1989). Mental Illness Is Everybody's Business. Arlington, VA.

National Center for Health Statistics. (1989). Advance report of final mortality statistics, 1987. Monthly Vital Statistics, 38, (5th Suppl.). Hyattsville, MD.

O'Grady, T. J. (1988). Community psychiatry - A changing locus of rejection? Community Psychiatry, 31(3), 325-339.

Olson, D.H., & McCubbin, H.I. (1983). Families: What makes them work. Beverly Hills, CA: Sage Press.

Orbach, I. (1988). Children who don't want to live. San Francisco: Josey Bass.

Patterson, T. L., Smith, L. W., Smith, T. L., Yager, J., & Grant, I. (1992). Symptoms of illness in late adulthood are related to childhood social deprivations and misfortune in men but not in women. Journal of Behavioral Medicine, 15(2), 113-125.

Prange, M.E., Greenbaum, P.E., Silver, S.E., Friedman, R.M., Kutash, K., & Duchnowski, A.J. (1992). Family functioning and psychopathology among adolescents with severe emotional disturbance. Journal of Abnormal Child Psychology, 20 (1), 83-101.

Raskin, A., Boothe, H.H, Reating, N.A., & Schulterbrandt, J.G. Factor Analyses of Normal and Depressed Patients' Memories of Parental Behavior. Psychological Reports, 29, 871-879.

Rice, D. P., Kelman, S., & Miller, L. S. (1992). The economic burden of mental illness. Hospital and Community Psychiatry, 43 (12), 1227-1232.

Robson, P.J. (1988). Self-esteem- A psychiatric view. British Journal of Psychiatry, 153, 6-15.

Rosenberg, M. (1965). The measurement of self-esteem. Society and the adolescent self-image. Princeton, NJ. Princeton University Press.

Rosenberg, M. (1979). Conceiving the self. New York, NY: Basic Books, Inc.

Rutter, M. & Garnezy, N. (1983). Developmental psychopatholgy. In Heterington, E.M. (ed.), Socialization, Personality and Social Development, Vol.4, Handbook of Child Psychology, 4th ed., New York : Wiley.

Schaefer, E. (1965). Children's report of parental behavior: An inventory. Child Development, 36, 413-424.

Silverstone, P.H. (1991). Low self-esteem in different psychiatric conditions. British Journal of Clinical Psychiatry, 30, 185-188.

Thomas, C. B., Duszynski, K. R., & Shaffer, J. W. (1979). Family attitudes reported in youth as potential predictors of cancer. Psychosomatic Medicine, 41(4), 287-301.