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Exploring Psychopathology and Low Self Esteem and its Correlation with Adolescent Substance Abuse Disorders

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by

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"*Let fear be what it is, but do not let fear determine who you are and who you will become"...Get up! Keith L. Marshall 2012*

CHAPTER 1

Personal Statement

I thought well and hard before taking on this thesis research project. I wanted my thesis project to be something that had meaning to me; one that reflected some of my life's experiences, and that would have the ability to affect, inspire, and influence others to want to make behavioral changes. At one period of time in my past life, in what seemed to be a very long chapter, I had some very hard life circumstances and traumatic events that placed me in a seemingly hopeless state of mind, body and spirit. The developmental struggles that I will elaborate on are more about the mental and emotional components of my human development, which, I have discovered, had a powerful effect on my self-esteem, emotional expression, and overall outlook on life.

For a major portion of my early life, I was controlled by low self-esteem, and a maladaptive and twisted belief system, which rendered me a victim to my own feelings. As a young adolescent I can remember being very restless, irritable, and discontented with life and I now realize that my eventual abuse and addiction to drugs can be attributed to those feelings. When I speak of human development struggles I talk about the inability I had to manage my feelings and my emotions for a major portion of my life, and the rigidity I exhibited being stuck in negative attitudes and behaviors. When I speak of human development struggles, I speak of how my self-concept which was driven by fear and low self-esteem influenced every decision I made, and impacted every interpersonal relationship I had, especially with women.

I operated in a mindset that kept me presenting myself in an inauthentic manner for fear of being rejected or not validated. Moreover when I think of struggles I think about how my own ego-defense worked against me for many years keeping me in a state of denial that

prevented me from owning and accepting the truth and more importantly, keeping me from taking full responsibility for my thoughts, feelings and actions.

Based on the aforementioned statements, I have concluded that I had some very powerful and blinding forces working against me that invariably kept me afraid, disturbed and dissatisfied with life. My low self-esteem and mental functioning worked against me by igniting my ego defenses to protect myself so I could continue to act in anti-social ways that quieted my instincts for emotional security and social connectedness. I would always present myself to women in a phony manner by acting like I was doing positive things with my life so I could get them to admire and accept me. But in reality, I feared being discovered because I knew I could not live up to the false image I presented.

I will now continue to put my story in perspective and explain portions of my self-ecology and how my mindset and low self-esteem developed and led me into drug abuse during my adolescence and young adulthood.

I grew up in a low income section of Philadelphia and can remember having many fears as a child that were associated with being rejected, receiving mixed messages (i.e., verbal &nonverbal), being ridiculed and being emotionally, verbally and physically abused. Moreover my primary family had many patterns of intimacy and communication dysfunction. The relationship I had with my mother was very confusing for me during my early childhood and adolescent years. For example my mother would go out of her way to do things for me because I was very picky and particular about things which gave me indication that she cared for me, and in a heartbeat she would compare me to my biological father by saying “you’re just like your father”, whenever she perceived I was lying or not living up to her expectations. The problem with her telling me I was like him were the comments she always made about him-saying he was

a no good for nothing liar, and she could not stand him. Somehow I internalized those messages and figured she meant that I was no good. Moreover my mother smacked me in the face with force on a regular basis whenever she was upset over something I had done wrong even when I felt I did nothing to deserve it. I am sure there were many instances in which I did deserve to be punished, but the way I was smacked in the face or beat with a belt, never felt proper to me and left me feeling so low.

I do want to say that my mother did do a lot for me by instilling in me the values to work hard and never give up, values that have had a chance to manifest in my life today. My mother also worked hard to provide for me even when my stepfather acted in his typical abusive manner towards her or my brothers and me (i.e., verbal, emotional, physical, financial and or mental).

I can remember the time my stepfather beat me until I my body became numb because I failed to refer to him as "dad", something that made me very uncomfortable because I already had a dad. This man would also choke me until I passed out on a regular basis due to my following his orders to fight him back when he would punch on me; stating that he was trying to make me tough. Well after following his orders I got lucky sometimes and landed a good blow to his face, which did nothing but infuriate him to hit me harder and then as I mentioned, choke me until I passed out.

I was stuck in a catch twenty-two situation, if I did not fight back I would get knocked out and when I did fight back I would get knocked out. What made matters worse for me (i.e., my internal thought process) is that I assumed my mother just allowed this man to beat and abuse me, which just added to my fears and feelings of low self-worth. I assumed that my mother never favored or liked me too much so going to her for help was not an option. I do want to add that I later found out that my mother never knew of the abuses that my stepfather inflicted on me.

There were also many times I was beat with a belt and in some cases, an extension cord. The beatings had sort of a ritual to them in that I was told to bend over with my pants down exposing my skin. I was also told not to cover my ass with my hands when the lashes were rendered. In some instances it appeared to me that my stepfather seemed to let off steam when he beat me, which made for harsher lashes that sometimes seemed to go on forever.

The aforementioned accounts of abuse are just a few examples of the environment I grew up in, and there were other traumatic occurrences that I had to endure that were inflicted on me by my stepfather of which my mother was never aware of. Unfortunately for me as a young child, I did not have the cognitive abilities to differentiate and understand the physical and verbal abuse or the mixed messages I received.

Moreover I could not understand the interpersonal, environmental, or social factors that contributed to my mother and stepfather's troubles (e.g., my mother and stepfather constantly fought physically, argued all the time, and constantly stayed angry toward each other). As a result of the confusing, abusive, and dysfunctional environment I lived in during my childhood, I have postulated that my perception of reality became very distorted and maladaptive.

The problems I went through in this socialization process affected my self-esteem and subconscious belief systems. I felt lonely and invalidated; I feared being myself because I believed that Keith was a no good for nothing person and if he expressed anything it would be ridiculed or rejected, which is what happened most of the time.

I remember when I was about thirteen years old and went to my mother upset and feeling hurt about something and she told me that I had no right to feel bad about anything because she provides all of my needs and to get out of her face because she had her own problems. Needless to say I withdrew and never approached her again in an authentic manner. In fact I never

approached anyone in an authentic manner because at that point I had come to the conclusion without knowing, that I was nothing. It never dawned on me as a young person that my mother had very serious issues in her own life to deal with trying to raise three young sons putting them through private school, paying bills most of the time on her own without any help, attending nursing school, working full time, and dealing with my stepfather, who of course did not make life so easy for her most of the time.

The communications in my family most assuredly affected my thoughts, self-worth and outlook on life. If my instincts for emotional security and social connectedness served me right, I probably did what I did as a kid to adapt to the rejection and abuse by playing any role I had to, or acted in ways to win approval and validation.

I also want to make note of the fact that there was a time during my early childhood when I was around seven or eight years old wherein my brothers and I was separated from my mother due to her being in the hospital for a few months while she was being treated for an illness, something that my brothers and I were not aware of at the time.

I thought she had abandoned us and could remember many nights wishing I could see her, especially because I was being treated like crap by an aunt who watched us while our mother was in the hospital. I lived in fear every day and threw extreme temper tantrums on a regular basis. My aunt made it very clear that my oldest brother was her favorite, which is also something that I felt to be true about how my mother felt about him. I could not understand my thoughts and feelings, or the external factors happening in my environment. In light of my aforementioned struggles, there were also many good times that added to the mental confusion I was under because things would change so fast back to unstable, fearful, and dysfunctional.

I have come to the conclusion that my negative early childhood socialization process and my cognitive development incurred twisted thinking patterns which produced negative feelings and emotions, especially fear and shame, both of which affected my self-esteem adversely in all of my interpersonal relationships up until the time I finally discovered my true authentic self. Until that point, I would manipulate and lie in those relationships for fear of being rejected, unapproved, and discovered.

Living a lie, I truly thought that I would be found out to be a phony or that others would find out that I was a loser because after all, that's what I really believed about me especially in my relationships with women. At around the age of fourteen or fifteen, the negative opinion that I had of myself would subtly take over my best intentions to be authentic with others, forcing me to lie about my existence or motives, and destroying any chance of building intimacy with them.

I am happy to say that now, after years of addiction and the negative consequences my behaviors bought me, I finally discovered who I am and learned to love and accept myself. I was able to do this by practicing the spiritual principles of the twelve-step process, which helped me to discover my true authentic self and to take full responsibility for my thoughts, feeling, and actions. Taking that responsibility for my actions invariably helped me to establish healthy interdependent relationships with others.

I remember back in 1974 when I was about fourteen years old; I started experimenting with marijuana and alcohol. Without knowing what I was doing to myself, I discovered that I did not have to feel the hell that I was going through on the inside because both marijuana and alcohol took the pain away. When I got high I could laugh, talk to others with security and feel a sense of confidence in myself that I could never experience left up to my own devises.

Once I started using drugs, I looked to get high whenever I could-- between football and track practice, and especially at parties in the neighborhood. I used marijuana and alcohol exclusively up until the age of around nineteen. It was at that point that I took my first hit of cocaine in a nightclub, and in an instant every fear, doubt about myself, and the low-self-esteem I lived in disappeared like never before.

Marijuana and alcohol no doubt worked to fix those elements of my functioning up until that time but not with the power that cocaine did. I felt like I was on top of the world with a sense of bravery and confidence to socialize like never before. After that first experience with cocaine I had my answer and cure to my low self-esteem; all I had to do was take a hit and instantly I was a new and confident person. Or so I thought. Cocaine became my medicine for any social event whether I was at work, at home, the nightclub, or just being alone to fantasize grandiose plans which never came to be a reality.

The real problems and progression of addiction started to manifest right away because the false sense of confidence cocaine gave me covered up feelings of low self-worth and feelings of inadequacy that I did not realize were part of my mental functioning at the time. I continued to do the cocaine without knowing what was happening to me because I just wanted to feel different than I was feeling at the time. What made matters even worse is the consequences of abusing and becoming addicted to cocaine; it started to exacerbate those aforementioned acquired issues I alluded to all the while creating more negative issues that added to my already low self-esteem.

As I continued through my early adulthood fully addicted to cocaine, I went through some very tragic and harsh situations. I tried desperately to keep employment while using cocaine, which was causing bad results in all of my affairs. The problems of the outer world

were very small considering the perpetual hell I was feeling on the inside. I lacked the ability to manage my feelings and emotions and to control in a positive way my reaction to life's challenges. There I was, a man with very deep intra-personal issues associated with a faulty subconscious belief system that was being driven by fear and low self-esteem, now I was adding something to my life which I could not stop and making things much worse internally and externally.

The many years of drug addiction and living with low self-esteem and a negative intra-psychic thought process had very serious ramifications for me. I could not establish healthy relationship because I could not trust or function at a mature level mentally, emotionally or communicatively. I tended to be in relationships that had all the elements of intimacy dysfunction, which derived from my lack of being honest with my mates or me. I could not maintain employment for any significant periods of time even though my gifts and talents helped me to gain positions in management, which proved very successful when I did work.

My cocaine addiction led me to suffer homelessness on and off for many years; being shot in the head at point blank range but escaping death; being violently stabbed in a crack house numerous times, again escaping death; going in and out of over twenty-five drug treatment centers; going in and out of jails and mental institutions; and experiencing many other life and death situations.

The aforementioned consequences that I suffered as a result of addiction helped me surrender to the process of recovery by using spiritual principles I had learned when I was exposed to the twelve-step program. The spiritual principles I speak of are not religious in orientation but are laws such as honesty, courage, hope, faith, perseverance and forgiveness to name a few.

Before I will acknowledge and attribute my success to overcoming addiction and changing my faulty belief system by practicing spiritual principles, I must give credit to my creator God. I had a very powerful spiritual experience on April 15th 2001 of the year of my freedom from addiction.

That particular day I lay in bed smoking crack cocaine while experiencing what I believed to be demonic forces trying to kill me. I began to cry out to God asking him to please forgive me for all that I had done over the years smoking cocaine. While I was crying out to God I wanted to get out of bed to hit my knees and humble myself before Him but I was too afraid of the demonic forces that I felt around me. After praying again between taking hits of cocaine, I mustered up the faith and bolted out of the bed onto the floor hitting my knees and began to beg God to please protect me from those demonic forces that I had perceived were around me at the time.

Finally I cried out one more time asking God to please free me or kill me because I had lost all hope of overcoming addiction to crack and having a normal life. The next thing I can remember happening to me is nothing short of a miracle and something I will never forget. I immediately fell asleep and woke up the next day feeling very different. I took the rest of the drugs and the crack pipe and flushed them both down the toilet; and I never had another craving or desire for cocaine again.

After throwing the drugs and paraphernalia away something inside of me prompted me to go to a gym the next morning and apply for a job as a personal trainer and I was hired on the spot. From that experience I started a very successful personal training business which I still own today. I also had the inclination to ask a member of the Twelve-Step program to help me go through the Twelve-Step process because I had learned from prior stays in rehabilitation centers

and attendance at Twelve-Step meetings, that the Twelve-Step process would give me clarity about who I really am and teach me how to live. The motivation I had to change my life had now become intentional and intrinsic, and the practice of principles in my life led that change.

I embarked on an intensive and painstaking introspective self-examination to change my perception about myself and become pro-active and responsible for my thoughts, feelings, and emotions. Moreover the work I did to change had given me new confidence and positive self-esteem; something I never experienced in my life.

When I started practicing spiritual principles I came to realize that I had to be intentional in my efforts to practice them. Because of the pain and emotional disequilibrium I would experience trying to break the faulty beliefs that I had become accustomed to operating under, I had to learn to be uncomfortable and practice acceptance when my fears wanted to control my thoughts and not accept people, places, and things as they were.

When I speak of pain I speak about how I had to learn to take responsibility for my selfish, inconsiderate, and self-centered thoughts and behaviors, which challenged me to break my pride and to practice humility. When I speak of pain I talk about how it felt for me to take a look at my ego-defenses and how I used them to continue in anti-social behaviors and addiction. Moreover I speak of pain when I had to learn how to identify and break free from my tendency to get caught in the grip of my low self-esteem.

After successfully learning to become proactive and responsible for my life I have been able to attend and graduate junior and undergraduate college maintaining a perfect GPA throughout those years and now as a graduate student, and is close to achieving my goal of starting doctoral studies in the spring of 2013.

I have also become certified as a State Addictions Treatment Counselor and have been working as a Substance Abuse Counselor for the past five years while running my own personal training business on a part time basis. My ability to change my thinking and to gain control of my life and succeed at getting goals completed, has given me a positive self-esteem that is healthy and confident.

It is my intention in this thesis project to explore psychopathology and low self-esteem in adolescents, and how these elements of development correlate with adolescent substance abuse. I also want to explore how early childhood exposure to maltreatment and unhealthy communication patterns within the family system affects the development of psychopathology and self-concept within the child, which has potential to lead adolescent behavior problems. My hope is that the reader will learn and understand that maltreatment of children physically, mentally, emotionally, and communicatively can have adverse effects on the adolescent, which of course will have negative effects on society from the micro-systems (the family) to the macro-systems (societal institutions).

Please take note that psychopathology is a very complex subject matter with both biological and social ramifications associated with it. I want to make clear that there are many negative and positive implications (resiliency) and ramifications of early childhood maltreatment, which may or may not cause internal as well as external issues associated with the development of psychopathology.

My main focus will of course be to get an understanding of how psychopathology and low self-esteem correlates with negative behavior. After all I have postulated that these elements of human development placed me in a position to almost lose my life, and without doubt left me

living a life where I functioned maladaptive and could not be productive as a person for many years.

Background/Problem Statement

According to Newcomb & Bentler (1989) many children and teenagers will become drug users in their lives, whether limited to alcohol, caffeine, cigarettes, marijuana, cocaine, hard drugs, or prescription medications. The age at which initiation and in particular, regular use occurs is quite crucial.

Childhood and adolescence are critical periods for the development of both personal and interpersonal competence, coping skills, and responsible decision-making. Drug use is a manner of coping that can interfere with or preclude the necessary development of these other critical skills if engaged in regularly at a young age. For instance, if a young teenager learns to use alcohol as a way to reduce stress, he or she may never learn other coping skills to ameliorate distress. Thus, teenage drug use may truncate, interfere with, or circumvent essential maturational processes and development that typically occur during adolescence.

According to the Partnership for a Drug-Free America (2010), adolescence is a developmental period in which the brain is still developing, and substance abuse has the potential to inhibit healthy neurological development. Ongoing substance use or abuse can place an individual at greater risk for addiction in adulthood.

The teen years are also a period of significant social, emotional and academic development, and ongoing substance abuse has the potential to disrupt or even prohibit healthy and effective skill development (Bowles, 2010). As one result, teenage drug users enter adult roles of marriage and work prematurely and without adequate socioemotional growth and often experience greater failures in these adult roles (Newcomb & Bentler, 1989). It is very apparent

that teenage drug users have the potential to get caught in adulthood unprepared and unequipped with adequate life skills to handle the basic rigors of life. According to Newcomb & Bentler (1989), regular use of drugs at developmentally critical life periods such as when an individual is very young or has not yet reached puberty can be considered abuse because of the potential for interfering with crucial growth and adjustment task.

Alcohol and drug use is a salient concern during adolescence. National surveys in the United States indicate that alcohol is consistently the drug of choice for teens. By the time teens are in the 12th grade, 4 out of 5 have begun drinking alcohol and 50% have consumed alcohol in the past month (Johnston, O'Malley, Bachman & Schulenberg, 1987).

Increasingly, youth consume alcohol in a particularly hazardous fashion (Brown, McGue, Maggs, Schulenburg, Hingson, Swartz,-Welder, H. S., et al., in press). According to the National Epidemiological Survey of Alcohol and Related Conditions (NESRARC; Grant & Dawson, 1997), adolescents drink alcohol half as often as adults but consume 4.9 drinks per occasion, whereas the mean consumption of adults is 2.6 drinks.

Exposure to other illicit substances is not uncommon among adolescents. Approximately half of high school seniors report lifetime use of a drug other than alcohol or cigarettes (Johnston, O'Malley, Bachman, & Schulenberg, 2006). Marijuana is the most widely used illicit substance by adolescents. Half of high school seniors report lifetime use of marijuana. One in five seniors has smoked marijuana in the prior month.

The greatest increase in use of any substance among adolescents over the last decade has been MDMA (Ecstasy). Seven percent of high school seniors reported use of Ecstasy, in 1997; by 2001 that number increased to 11.7%. Over the last decade, greater access and availability

have been linked with trends for increased use of hard drugs (e.g., opiates, cocaine, and crack), while hallucinogens and inhalants displayed marked decreases (Johnston et al., 2006).

The age at which involvement with psychoactive substances is initiated has important epidemiological and developmental implications. Clearly, not all youth with exposure to psychoactive substances develop substance abuse disorders. However, age of first use is a reliable risk factor for the onset of substance abuse problems and later disorders.

The National Household Survey on Drug Abuse showed that although 11.8% of adolescents who first use marijuana before age 15, only 2.1% of those whose first use of marijuana were after age 17 developed dependence. Early onset of alcohol and marijuana use is also predictive of binge drinking in adolescence (D' Amico, Metrik, Mcarthy, Appelbaum, Friskill, & Brown, 2001). According to the National Longitudinal Survey of Youth (NLSY), the odds of developing dependence decreases by 9% for each year that the onset of drinking is delayed (Grant, Stinson, & Harford, 2001).

Among youth receiving treatment for substance use disorders, age of alcohol initiation has been reported at 11 years with progression to weekly alcohol use by age 13, while other drug use was initiated by age 13.7 years and progressed to regular use within a year (Brown, Gleghorn, Schuckit, Myers, & Mott, 1996). Among substance – abusing adolescents with comorbid psychopathology, the age of onset of drug initiation is earlier, with first use at 12.4 years and weekly use at 13.3 years (Abrantes, Brown, & Tomlison, 2003; as cited in Beauchaine & Hinshaw, 2008).

Both disruptions in family relations and functioning and parental psychopathology are precursors, correlates, and consequences of adolescent substances abuse disorders (Beauchaine et al., 2008). If low self-esteem has been part of a teenager's upbringing, according to Bennett

(2012), they may see themselves as less than everyone else, deficient in one way or another. They may consider their body or looks to be undesirable; they may doubt their ability to participate in sports; or they may tell themselves that their brainpower is insufficient. In either child or adult, low self-esteem can result in feeling stuck, having little or no motivation or energy. Everything becomes drudgery and hence the potential for destructive behavior and escaping (e.g., drug abuse) to a world where judgment is non-existent becomes a very powerful hook.

Florida State University professors John Taylor (2006) and Donald Lloyd (2006), along with University of Miami professor emeritus George Warheit (2006), studied data from a multi-ethnic sample of 872 boys collected over period of nine years and concluded low self-esteem and peer approval of drug use at age 11 predicts drug dependency at age 20 (as cited in About.com Alcoholism, 2012). According to Taylor (2006) low self-esteem is a kind of spark plug for self-destructive behavior, and drug use is one of them.

Taylor (2006) states that it's fundamental to need to have a good sense of self. Without it, people may become pathologically unhappy with themselves, and that can lead to very serious problems. Taylor (2006) also noted that it is important to identify problematic behaviors in children early on so intervention strategies could be implemented to help the children avoid using drugs as a way of coping and starting the cycle of addiction.

According to a longitudinal study done by Jonathan Shedler (1990) and Jack Block (1990) of the University of California, Berkeley it was determined that psychological differences between frequent drug users, experimenters, and abstainers could be traced to the earliest years of childhood and related to the quality of parenting received. The findings indicated that problem drug use is a symptom and not a cause of personal and social maladjustment and the

meaning of drug use could only be understood in the context of an individual's personality structure and developmental history. The study also suggested that current efforts at drug prevention are misguided to the extent that they only focus on symptoms and not on the psychological syndromes underlying the abuse of drugs.

Virginia Satir (1988) defines self-esteem as a concept, an attitude, a feeling, an image; and it is represented by behavior. In the process of exploring how low self-esteem correlates with adolescent drug abuse, it is necessary to understand self-esteem and how the child comes to develop it. According to Satir, the family is the root environment, which will provide stimulus and nurturing for the children to develop the healthy sense of self. She further postulates that,

> Troubled families make troubled people and thus contribute to the devaluing of self, which is linked to crime, mental illness, *alcoholism, drug abuse,* poverty, alienated youth, terrorism, and many other social problems…Giving ourselves full permission to make the family a place to develop people who are more truly human will reflect itself in a safer and more humanly responsible world (Satir, 1988, pg.17).

Self-esteem is the ability to value one's self and to treat oneself with dignity, love, and reality. Integrity, honesty, responsibility, compassion, love, and competence—all flow easily from people whose self-esteem is high. We feel that we matter, that the world is a better place because we are here (Satir, 1988). It is clear to understand and postulate how a child with low self-esteem would have negative outlook on life.

When people feel they have little worth, they expect to be cheated, stepped on, and depreciated by others. This opens the way to becoming a victim. Expecting the worst, these

people invite it and usually get it. To defend themselves, they hide behind a wall of distrust and sink into the terrible feeling of loneliness and isolation (Satir, 1988).

Parental deviance and psychopathology may also confer risk for substance abuse disorders through lack of parental involvement and /or low levels of parent-child affection (Baer & Bray, 1999; Loukas, Zucker, Fitzgerald, & Krull, 2003; Sandava, 1987; Zucker, Wong, Clark, Leonard, Schulenberg & Cornelius, 2006). Inconsistent parental discipline, lower monitoring of behavior, excessive punishment, and permissiveness are all risk factors for substance abuse disorders among adolescents (Brody & Forehand, 1993; Chilcoat & Anthony, 1996; Gilvarry, 2000; Williams and Hine, 2002). In addition, family conflict is predictive of more disruptive behaviors in children, which elevates risk for substance abuse during adolescents (Loukas et al., 2003; Zucker, Fitzgerald, Refior, Puttler, Pallas & Ellis, 2000).

According to Oshri, Rogosch, Burnette, & Cicchetti (2011) child maltreatment is strongly associated with adolescent psychopathology and substance abuse and dependence. However, developmental processes unfolding from childhood into adolescence that delineate this trajectory are not well understood.

Research findings support a transactional—ecological model revealing a developmental sequence in which severity of early childhood maltreatment potentiates less adaptive childhood personality functioning, followed by externalizing problems in preadolescence, and ultimately adolescent cannabis abuse and dependence symptoms.

According to the aforementioned statement there is a strong correlation between the preadolescent's and adolescent's maturation level with respect to their personality functioning (i.e., ability to cope effectively) and the potential for adolescent substances abuse.

Moreover the anxiety produced by the intra-psychic conflict developed in early childhood also implies that the child's early social relationships most notably with parents, as being the antecedent which effects psychopathology, which of course affects the child's self-concept (Oshri et al., 2011).

Significance Statement

To put into perspective why this topic area is so important, it is necessary to consider the levels of impairment and pain linked with child and adolescent psychopathology. Think, for instance, of the hopelessness and despair associated with depression; the personal, family, school, societal, and peer related disruptions incurred by dysregulated attention and impulse control; the havoc wreaked on society by substance abuse and dependency. Overall, the personal and family confusion, grief, emptiness, and all lost opportunities incurred by conditions such as these are deeply felt by all who are affected (Beauchaine et al., 2008).

Furthermore, emotional and behavioral problems in children and adolescents are distressingly prevalent and often lead to serious impairments in such crucial life domains as academic achievement, interpersonal competencies, and independent living skills (Mash & Barkley, 2003). These conditions incur massive pain for individual, families, and communities at large, triggering major economic burdens for caregivers, school districts, and health care systems.

From a developmental perspective, not only are the major child and adolescence disturbances likely to persist across lifespan, but also the majority of mental disturbances experienced by adults have their origins in childhood and adolescence (Kessler, Berglund, Demler, Jin, & Walters, 2005).

Over and above the clinical and policy-related concerns raised by child and adolescent psychopathology, during the past century these conditions have begun to engage serious scientific efforts aimed at understanding their etiology, individual-level and systems-related maintaining factors, and empirically supported prevention and interventions efforts (Beauchaine et al., 2008).

After many years of professional and scientific neglect of childhood psychopathology, we have now entered a time of rapid progress. The study of child and adolescent disorders is a major endeavor, and increasingly sophisticated efforts have begun to bear fruit in terms of scientific advances (Beauchaine et al., 2008).

Child and adolescent development involves substantial changes across systems ranging from biological, cognitive, social-emotional, and behavioral, varying with genetics, community and cultural factors. Changes in any of these systems may influence a variety of aspects of early alcohol and other drug involvement (e.g., onset, escalation, problems).

Exposure to alcohol and other drugs may directly or indirectly influence all-important developmental systems levels of functioning and may delay, promote, or disadvantage important aspects of normal development (Beauchaine et al., 2008). These bidirectional, and in some cases synergistic effects may produce short-term consequences that quickly resolve (hangover). In other cases, such effects may alter developmental trajectories in ways that impact long term adult functioning (e.g., substance abuse disorders, frontal lobe development) (Beauchaine et al., 2008).

Thus understanding youth development and the development of alcohol and drug problems in adolescents requires both an appreciation for the processes and tasks of normative adolescent development, and knowledge of the impact and mechanisms of progression along the continuum of alcohol and drug dependence (Beauchaine et al., 2008).

Regardless of which etiological model of substances abuse disorders applies, core developmental processes and system-specific stages must be considered to account for the complex symptom matrix that youth with substance abuse disorders present. The joint consideration of both mechanisms of development and processes of adolescent addiction progression should facilitate better prediction of risk, optimal research paradigms, and creation of substance interventions for this prevalent adolescent disorder, i.e., substance abuse (Beauchaine et al., 2008).

By creating concrete interventions to facilitate goal generation, negotiation of social context, increased variability in responses, and regulation or response initiation and inhibition, adolescent should have more intrapersonal resources for dealing with the risk they will face.

The key focus of psychopathology is to discover the nature of behavioral and emotional problems, syndromes, and disorders (Hinshaw, 2007). Indeed, it is clear that biological vulnerabilities, psychological handicaps, environmental potentiates, and cultural norms all play a role in defining and understanding behavioral manifestations that are considered abnormal and / or pathological in a particular social context.

Risk factors (and constitutional vulnerabilities) are those antecedents' variables that predict such dysfunction, and the ultimate goal is to discover those risk variables that are both malleable and potentially causal of the disorder in question (Kramer, Kadzin, Offord, Kessler, Jensen & Kupfer, 1997; Kramer, Stice, Kadzin, Offord, & Kupfer, 2001).

A key objective is to bring to life the core tenets and principles of developmental psychopathology for clinicians, parents, and childcare givers to have a deeper understanding of the major forms of child and adolescent behavioral and emotional disturbances. To present this

aim the data will be present and up to date, clinically relevant, and directly inclusive of the many factors attributed to developmental psychopathology.

Purpose Statement

According to Covey,

> When we make deposits of unconditional love, when we live the primary laws of love, we encourage others to live the primary laws of life. In other words, when we truly love others without condition, without strings, we help them feel secure and safe and validate and affirmed in their essential worth, identity, and integrity. Their natural growth process is encouraged. We make it easier for them to live the laws of life—cooperation, contribution, self-discipline, and integrity—and to discover and live true to the highest and best within them. We give them the freedom to act on their own inner imperatives rather than react to our conditions and limitations (Covey, 2007, pg.199).

The purpose and intention of this research is to give clinicians, parents, and child care givers an educated and intelligent understanding of how early childhood maltreatment (mental, emotional, and physical) could potentially lead to negative effects on the mental, emotional and behavioral health of children, which could also manifest negative outcomes in adolescence and adulthood. Moreover this research is intended to help sensitize clinicians, parents, and childcare providers to become *intentional* in their efforts to create a safe and nurturing environment during the child's socialization process, which can attribute to the mental health and self-concept the child, will develop.

Parenting and childcare must be a pro-active and responsible undertaking, not some casual experience where the caregiver just reacts in the environment around the child and to the child,

without being sensitive to the mental and emotional health of the child. The implications, ramifications and manifestations of maltreatment (physical, mental, sexual, communicative, and emotional) can easily go unnoticed, rationalized, justified, and minimized, by caregivers especially when the abuse is not physical in nature.

Childcare providers who become aware conceptually of how early life experiences affect the child's cognitive development and their ability to cope and adjust to their environment and to socialize with others, will be better equipped to give the children the most productive and nurturing experience to help them become healthy and independent people, mentally and emotionally.

This research will explore how children exposed to maladaptive and maltreatment factors in the family system and early childhood relationships have the high potential to produce psychopathology in children, which invariably has the potential to manifest mental and behavioral disorders in the adolescent (e.g., low self-esteem and substance abuse). This information will sensitize and assist caregivers to initiate interventions to stop maltreatment and become intentional in their efforts to establish organized and structured ways to help children gain healthy perceptions of reality, and reduce the risk of them internalizing unhealthy thinking patterns which have the potential to lead to adolescent anti-social behaviors.

CHAPTER 2

Literature Review

A wealth of information has accumulated in recent years about the causes, correlates, and underlying mechanisms of child and adolescent mental disorders (Beauchaine et al., 2008). The major goal of this thesis is to provide up-to-date, conceptually and developmentally derived information about (a) risk factors for child and adolescent psychopathology and (b) the effects of low self-esteem leading to adolescent substance abuse disorders.

Adverse childhood experiences are major risk factor for the leading causes of illness and death as well as poor quality of life in the United States (as cited in the Free Library.com, 2012). That is the finding from The Adverse Childhood Experiences (ACE) Study, one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being. The ACE study is a collaborative effort between the Center for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, Health Maintenance Organization (HMO). HMO members undergoing a comprehensive physical examination provided detailed information about their childhood experience of abuse, neglect, and family dysfunction. According to the Free Library.com (2012) over 17,000 members participated in the study.

Child abuse, neglect, and other traumatic stressors are common occurrences in the United States (Free Library.com, 2012). According to Waldman, H., Perlman, S., and Cinotti, A. (2011) almost two-thirds of the participants reported one ACE and more than one in five reported three or more ACE. The risk for the following health problems escalates with increasing adverse childhood experiences:

- *Alcoholism*
- Health related quality of life
- *Illicit drug use*
- Depression
- Smoking
- Suicide attempts
- Multiple sexual partners
- Unintentional pregnancies

As the number of adverse childhood experiences increases the number of co-occurring or "co-morbid" conditions increases (Free Library.com, 2012).

Low Self Esteem and its Manifestations

According to Yo, E. (2012) parenting style used on a child during the first 3 to 4 years of his or her life is the strongest factor that determines his or her level of self-esteem. Parenting style refers to how parents treat, guide, and nurture their young. It encompasses the messages that parents communicate to their child, verbally and non-verbally, about how lovable, worthy, capable, acceptable, and important he or she means to them (Ezinearticles.com, 2012).

When parents consistently displays affection, love, encouragement, and set proper boundaries, a child has the potential to grow and develop. They feel more confident, secure, and have a higher likelihood to achieve their potential (Yo, E., 2012). On the other hand, when parents neglect the needs, criticizes incessantly, withholds love and affection, places excessive demands, and are overly controlling, the child could end up feeling unworthy, insecure, self-critical, and unimportant. Over time, the child's sense of self and self-esteem becomes distorted and crushed from such emotional abuse (Yo, 2012).

The fact is internalizing a set of truths given to us from emotionally unbalanced people in our childhood causes our low self-esteem. It is important to identify and understand where these untruths come from to recover from low self-esteem (pg.1) (http://EzineArticles.com/?expert=Evelyn_Yeo).

There can be many reasons for turning to drugs to get relief, but low self-esteem is a common one. When someone has a low opinion of himself, he can try to remedy this by self-forgetfulness. The low self-image may have begun when one's parent criticized him, or acted using any other host of negative abusive patterns (Cohen, 2012).

If one feels badly about oneself, trying to fit in or please others is a common route. This can involve doing drugs as that behavior can be seen as the norm for some cliques at school (Cohen, 2012). No one likes to feel like an outsider and with low self-esteem, one measures himself by others people's opinions. Being on the outside creates a deep sense of aloneness and alienation. It is hard to live by one's own standard and make choices without others' approval. This is even more difficult for someone with low self-esteem who was exposed to various forms of abuse and neglect as a child (Cohen, 2012).

Feelings of worth can flourish in a nurturing family atmosphere in which individual differences are appreciated, love is shown openly, and mistakes are used for learning. Moreover the communication patterns are open, the rules are flexible, and responsibility and honesty is practiced as a way of life (Satir, 1988).

Conversely, a child in a troubled family often feels worthless, growing up in a system where the pattern of communications within the family system is often confusing and distorted, the rules are inflexible and rigid, and criticism and punishment for mistakes are the norm. Such

children are highly at risk of developing destructive behavior towards themselves (e.g., substance abuse) and/or others (Satir, 1988).

According to the University of Texas at Austin's Counseling & Mental Health Center (CMHC) (2010), a child's self-esteem develops over time. His successes, failures, the way family members and authority figures treat him, and the way he interacts with his peers can all contribute to his self-esteem levels. Moreover negative childhood experiences may result in low self-esteem. Such catalyst includes verbal and physical abuse, teasing, harsh criticism, and experiencing failures in the classroom (Miller, 2010). Children who face ostracism or are expected to fit a certain mold also are at risk for low self-esteem (Livestrong.com, 2012).

Very young children tend to think all events occurring around them are because of them. That includes both good and bad events. One significant part of teaching self-esteem is to differentiate accurately between those events that belong to the child and those that belong to someone else (Satir, 1988). All events, actions, voices, and the like that occur around infants are registered within them and, at some level have meaning (e.g. the psychic structure) (Satir, 1988).

A child with low self-esteem perceives small or temporary setbacks as permanent and intolerable problems, according to Kidshealth.org (2012). Since a child with low self-esteem consistently deals with feelings of stress and depression, he or she is more likely to have long-term problems forming and maintaining relationship, according to the CMHC. Low self-esteem often impairs a child's academic and job performance, and increases his risk of *alcohol and drug abuse.* If a child's feelings of inadequacy go unchecked, the negative consequences of low self-esteem can reinforce his/her beliefs about themselves. This can result in increasingly self-destructive behaviors, according to the CMHC (Livestrong.com, 2012).

Satir (1988), using hypnosis to regress adults to childhood, validated this claim. Infants often register these events without the context that could adequately explain them. Without understanding these circumstances, the events become foundations for later false conclusions and consequent behaviors (e.g., developmental psychopathology) (Satir, 1988).

According to Aron (2010), we all have an undervalued self-buried deep inside, a part that can make us feel worthless. It may rise to the surface now and then, or for some of us, it may be a constant companion. It makes us doubt ourselves or feel shy, anxious, or even depressed. It often interferes just when we most need to be accurate in our estimation of value. It results in "*low self-esteem*," the most common problem addressed by psychotherapists and self-help teachers and the root of most other psychological issues (e.g. substance abuse) (Aron, 2010).

If a child has experienced negative or perceived failures frequently at a time when they are very impressionable, they have the potential to feel powerless, worthless, ashamed, shy, and unenthusiastic most of the time (Aron, 2010). Feeling that negative events or failures must be entirely their fault, they chronically undervalue themselves. Such feelings are the essences of major mental disorders (most notably substance abuse), which is often the result of the "self-conscious" emotions that arise out of how they view themselves as compared to others (Aron, 2010).

According to Skager (1988) & Keegan (1987) low self-esteem either causes or contributes to neurosis, anxiety, defensiveness, and ultimately alcohol and drug abuse. Self-esteem is indeed involved in addictive substance use. The use of drugs is often used to compensate for low self-esteem and feelings of lack of control over one's life. Those who have a strong sense of self do not have to be sustained at the expense of others. They do not need to control or humiliate other people or resort to substance abuse to compensate for low self-esteem.

Psychopathology Key Concepts and Principles

What characterizes a truly developmental view of psychopathology? Several core points will be mentioned in this literature review (there are more core elements that are not expounded upon in this literature review) and are viewed as central to the Developmental Psychopathology (DP) perspective. These include (a) evaluating evidence across multiple levels of analysis (b) exploring both risk and protective factors and their interplay, so that competence, strength and resilience as well as pathology and impairment could be understood and (c) a neurodevelopmental perspective (Beauchaine et al., 2008).

There are three related principle that bear emphasis. The first is that multiple pathways to pathology exits. Indeed, different routes may lead to a common condition or outcome exemplifying the construct of *"equifinality".* For example, aggressive behavior could result from physical abuse, from coercive parenting interchanges with the developing child, from early experiences of insecure attachment or parental rejection, or from different combinations of these vulnerabilities and risk factors (Raine, Brennan, & Mednick). In other words, separate causal influences may well yield similar end states (i.e., the example of equifinality).

Additionally, the concept of *"multifinality"* pertains when a given risk factor or initial state leads to different outcomes during the course of development across different individuals. For example, abuse may or may not lead to severe maladaptation, depending on a host of intervening factors for one individual but other healthier outcome are also possible for another individual, depending on the presence or absence of additional risk or protective factors (Cicchetti & Rogosch, 1996).

Second, DP models place a strong emphasis on person-centered research designs. Those designs could be defined by personality variables, socialization practices, neighborhoods, or

other key factors and their unique developmental journey across lifespan (Berman, von, Eye, & Magnusson, 2006).

Third, given the rapid growth in recent years of genetic and genomic models as well as brain imaging methods, DP researchers in the twenty-first century must pay increasing attention to the role of the brain in psychopathology. Moreover there are also neuroscientific principles (this approach will be emphasized in this thesis) to account for with a wide range of extant pathologies and their devastating impact (Cicchetti & Curtis, 2006).

The roots of the discipline (DP) can be traced to three theories of development, each of which was influenced by Western philosophy and embryology: Freudian psychoanalytic theory, Wernerian philosophy theory, and Piagetian structural theory (Cicchetti, 1990; Kaplan, 1967). Additionally, developmental psychopathology can trace its history back to research conducted within diverse disciplines, including genetics; embryology; the neurosciences; clinical, developmental, and experimental psychology; psychiatry, psychoanalysis; and sociology (Beauchaine et al., 2008). In an early statement about the science of developmental psychopathology, Cicchetti (1990) asserted that such a perspective "should bridge fields of study…contribute greatly to reducing the dualism that exist between the behavioral and biological sciences and…between basic and applied research" (p. 20).

Developmental psychopathology transcends traditional disciplinary boundaries and emphasizes the criticality of moving beyond descriptive facts to a process-level comprehension of normal and abnormal development. The developmental psychopathology perspective provides a broad, integrative framework within which the contributions of separate disciplines can be fully realized in the broader context of understanding individual development and functioning (Cicchetti, 1984).

In a relatively short period of time, the field has witnessed the occurrence of major advances in understanding the complexity of causality, the interaction of risk and protective factors, the heterogeneity of disorder, and the importance of the developmental processes and mechanisms (Sameroff & Chandler, 1975). According Sameroff & Chandler (1975) individual risk factors seldom are powerful enough to exert sufficient influence to result in psychopathology, and when they appear to have such effects, it is highly likely that they are surrogates for multiple, unobserved influences.

Much more commonly, adequate prediction of either disturbances or resilience necessitates the consideration of multiple risk and protective factors and their interplay. Moreover, the consequences of any risk factor depend on a myriad of other aspects embedded in the developmental context.

The integrative nature of the developmental approach to psychopathology was articulated by Eisenberg (1977), who stated that development "constitutes the crucial link between psyhsiogenic and psychogenic causes" (p. 225). Development thus encompasses " not only the roots of behavior in prior maturation as well as the residual of earlier stimulation, both internal and external, but also modulations of that behaviors by the social fields of the experienced present" (p. 225).

Gottlieb's (1992) conceptualization is one of a fully interrelated coactional system in which the activity of genes themselves can be affected through the cytoplasm of the cell and by events originating at any other level of the system, including the external environment. For example, external environmental factors, such as social interactions (e.g., parenting), traumatic experience such as domestic violence and child maltreatment, and the like, can cause hormones to be secreted. Those hormonal secretions can now result in the activation of DNA transcription

inside the nucleus of the cell (i.e., "turning genes on"). Environmental conditions may interact with an individual's genetic make-up to alter processes such as the timing of the initiation of transaction for a specific gene, the durations for which it does, or whether the gene will ultimately be translated or expressed. The probabilistic perspective thus implies those individual are neither unaffected by earlier life experiences nor immutably controlled by them (Beauchaine et al., 2008, & Gottliebs, 1992).

Thus, a developmental analysis presupposes change and novelty, high-lights the critical role of timing in the appearance and organization of behaviors and underscores multiple determination and causations against expecting invariant relations between causes and outcomes across the life course (Capcioppo & Tassinary, 1990; Cairns, 1998, Cicchetti, 1990; Kaplan, 1967, Sroufe, 1997).

All of the issues, terms, concepts, and principles described in the previous paragraphs have been stated and restated across a large number of articles, chapters, and books that promote and explicate Developmental Psychopathology models. Indeed, detailed discussion of anyone one of them could easily fill a book unto itself. Because of this, full coverage immediately following this paragraph will not emphasize many topics associated with DP, although integrating across multiple levels analysis is essential to all work in DP.

Overall, progress in understanding pathological behavior will require multidisciplinary efforts in which investigators ranging from geneticists and biochemist, scientist focusing on individual pathology, experts on family and neighborhood process, examiners of clinical services systems, and public health officials must work collaboratively and in increasingly diversified ways (Beauchaine et al., 2008). The phenomena under consideration are too complex, too dynamic, and too multifaceted to be understood by an exclusive focus on psychobiological

processes, family factors, peer processes, or cultural factors in isolation. Moreover performing the necessary kinds of investigations will often mandate large-scale, complex, and interdisciplinary work, negotiating collaborations across traditional disciplinary boundaries (Beauchaine et al., 2008).

Resilience-From a Multidisciplinary Approach

Undoubtedly any research, study, or experiment which points out negative outcomes associated with elements of human development and functioning related to pathology, disturbances, trauma or emotional disequilibrium, must also consider the dichotomous responses and factors (e.g., resiliency).

Understanding how individuals overcome significant adversity and function adaptively has been a wonder to the imagination of many throughout the ages; however, it has been only a little more than three decades since systematic empirical study of the phenomenon that is today known has *resilience* began. The roots of the work on resilience can be traced back to prior research in diverse areas, including investigations of schizophrenia, poverty, and responses to trauma (e.g., child abuse) (Luthar, Cicchetti, & Becker, 2000; Masten, 2001).

Before the early 1970s, scientific investigation of children from high-risk environments, as well as those with mental disorders, portrayed the developmental course of such individuals as deterministic, inevitably eventuating in maladaptive and psychological outcomes (Luthar et al., 2000). As researchers discovered that not all high-risk children developed the negative consequences that existing theories of psychopathology predicted, comprehending the processes through which children at risk did not develop psychopathology became viewed as important for informing theoretical viewpoints on the development of pathology (Cicchetti & Garmezy, 1993).

Resilience is a dynamic developmental process that has been rationalized as an individual's attainment of positive adaptation and competent functioning despite the experience of chronic stress or traumatic circumstances, or prolonged exposure to detrimental circumstances (Cicchetti & Garmezy, 1993; Luthar et al., 2000). Resilience is multidimensional in nature; exemplified by findings that high-risk individuals may manifest competence and positive perseverance in some domains and contexts, whereas they may exhibit problems in others (Beauchaine et al., 2008).

Despite the growing attention paid to discovering the processes through which individuals at high risk do not develop maladaptive, the empirical study of resilience has focused primarily on detecting the psychosocial aspects of the phenomenon (Curtis & Cicchetti, 2003). For research on resilience to grow it must incorporate a multidisciplinary approach, which includes constructs to understand underlying processes. Research of this nature would entail the consideration of biological, psychological, and environmental / contextual processes from which varied pathways to resilience (equifinality) might eventuate, as well as those that result in a variety of outcomes among individuals who have achieved resilient functioning (multifinality)(Beauchaine et al., 2008).

The role of biological factors in resilience is suggested by evidence on neurobiological and neuroendocrine function in relation to stress reactivity (Gunner & Vazquez, 2006), by behavior-genetics research on non-shared environmental effects (Rende & Waldman, 2006), and by molecular genetic research that may reveal the genetic elements that serve a protective function for individual experiencing significant adversity or trauma (Cicchetti & Blender, 2004).

Children who develop resiliency despite having experienced significant adversity play an active role in constructing, seeking, and receiving the experiences that are developmentally

appropriate for them. To date, research investigations that search for mechanisms of genetic and environmental interaction have yet to address the role that genetic factors may play in influencing how children who are developing in a resilient fashion have actively transformed their social environment (a process known as evocative gene-environment correlation according to Rende & Waldman, 2006; Scar & McCartney, 1983).

At the neurobiological level, different areas of the brain may attempt to compensate; on another level, individual may seek out new experiences in areas where they have strength (Black, Jones, Nelson, & Greenough, 1988; Cicchetti & Tucker, 1994). Thus, neither neurobiological anomalies alone nor aberrant experiences alone should be considered as determining the ultimate fate of the individual (Beauchaine et al., 2008).

The Role of Trauma and Neglect in Psychopathology-Neurodevelopmental Perspective

How can maltreatment—abuse or neglect—contribute or lead to psychopathology? The neurodevelopmental "lens" provides significant insight into the sometimes-confusing interrelationships between psychopathology, DSM-IV diagnosis, and maltreatment. A neurodevelopmental perspective is meant to compliment other theoretical and experimental views (Beauchaine et al., 2008).

Maltreatment in childhood increases risk for virtually every DSM-IV disorder, from symptoms related to autism-spectrum conditions to Schizophrenia, major depression, substance abuse disorders and Posttraumatic Stress Disorder (Rutter, 2004). Although many of the aforementioned condition are heritable, maltreatment can nevertheless contribute to the symptom expression and the severity of disorder. The developmental psychopathology perspective underscores the notion that all psychiatric conditions—even those with large genetic components—are shaped and maintained by the interaction of genetic vulnerabilities and

environmental risk factors, and few such risk factors are as powerful as maltreatment in children (Rutter, 2004).

The primary reason and premise of examining the neurodevelopmental perspective is that the human brain mediates *all emotional, social, cognitive, and behavior functioning*. Psychopathology therefore must involve altered functioning of systems in the brain (Beauchaine et al., 2008). The specific nature of dysfunction (e.g., anxiety versus inattention versus affect regulation versus thought disorder) is determined by which neural networks and brain areas are altered—and by a host of environmentally mediated consequences of trauma or neglect. Simply stated, neglect results in dysfunctions in the neural systems that do not receive appropriately timed and patterned stimulation, and abuse/trauma (emotional/physical) results in alterations in the brain systems that mediate the stress response (Beauchaine et al., 2008).

As just stated, the two major forms of maltreatment that are emphasized in this section of the thesis are neglect and trauma. Although often co-occurring, these two types of maltreatment are distinctively different in the impact they have on the developing brain and on the development of psychopathology.

Defined from neurodevelopment perspective *neglect* is the absence of an experience or a pattern of experiences required to express underlying genetic potential in a key neural system. In contrast, *trauma* is an experience or pattern of experiences that activate the stress-response systems in such an extreme or prolonged fashion as to cause alterations in the regulation and functioning of these systems (Beauchaine et al., 2008). Both neglect-and trauma-related abnormalities in neurodevelopment may potentiate psychopathology, although the specific types and their severity will depend on a host of interacting neural and environmental events (Beauchaine et al., 2008).

According to Beauchaine et al, (2008), maltreatment can have a negative impact on development in several ways. It may be the primary mediator of psychopathology when abnormal experience directly alters developing neural systems. For example neglect may precipitate an attachment disorder and trauma may yield posttraumatic stress disorder (e.g. a child being choked and beat on a continuous basis… *Doesn't this example ring a bell…*)?

Neurodevelopment

The brain develops extremely rapidly in utero and in the first years of life. During this time important molecular processes are taking place that, if disrupted, can result in abnormal organization and function. Depending upon the nature, timing, and frequency of maltreatment (e.g., being choked on a continuous basis as a child), all of these processes can be influenced by chaos (e.g., watching and hearing physical and verbal abuse) and neglect (e.g., being ignored and rejected) (Hinshaw, 2007).

Molecular Processes of Neurodevelopment

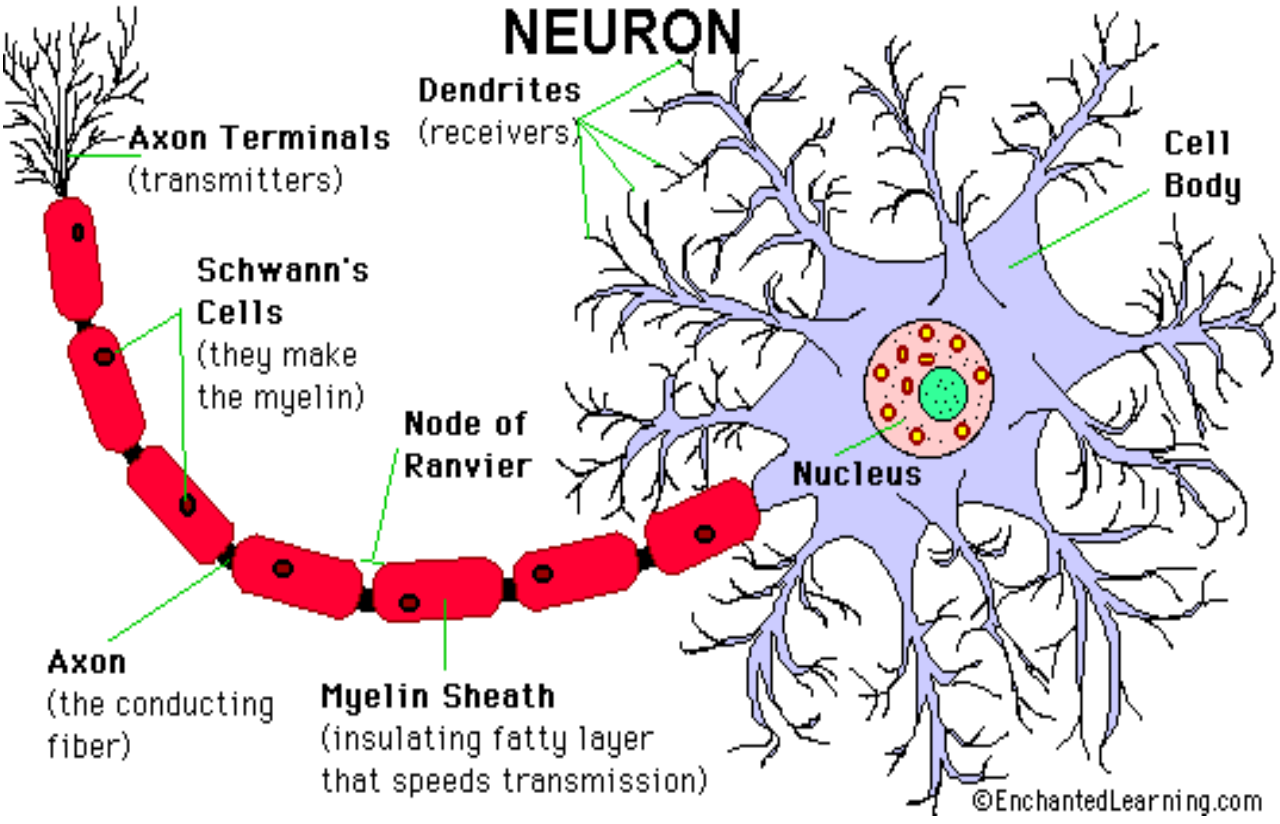
Below are eight molecular processes that take place in neurodevelopment and will be expounded upon individually according to their human function. Each molecular process must be examined in context of their physiological process in order to give meaning and understanding of the impact of neglect and abuse on the neural system, which regulates all human functioning:

- Neurogenesis
- Migration
- Differentiation
- Apoptosis
- Arborization

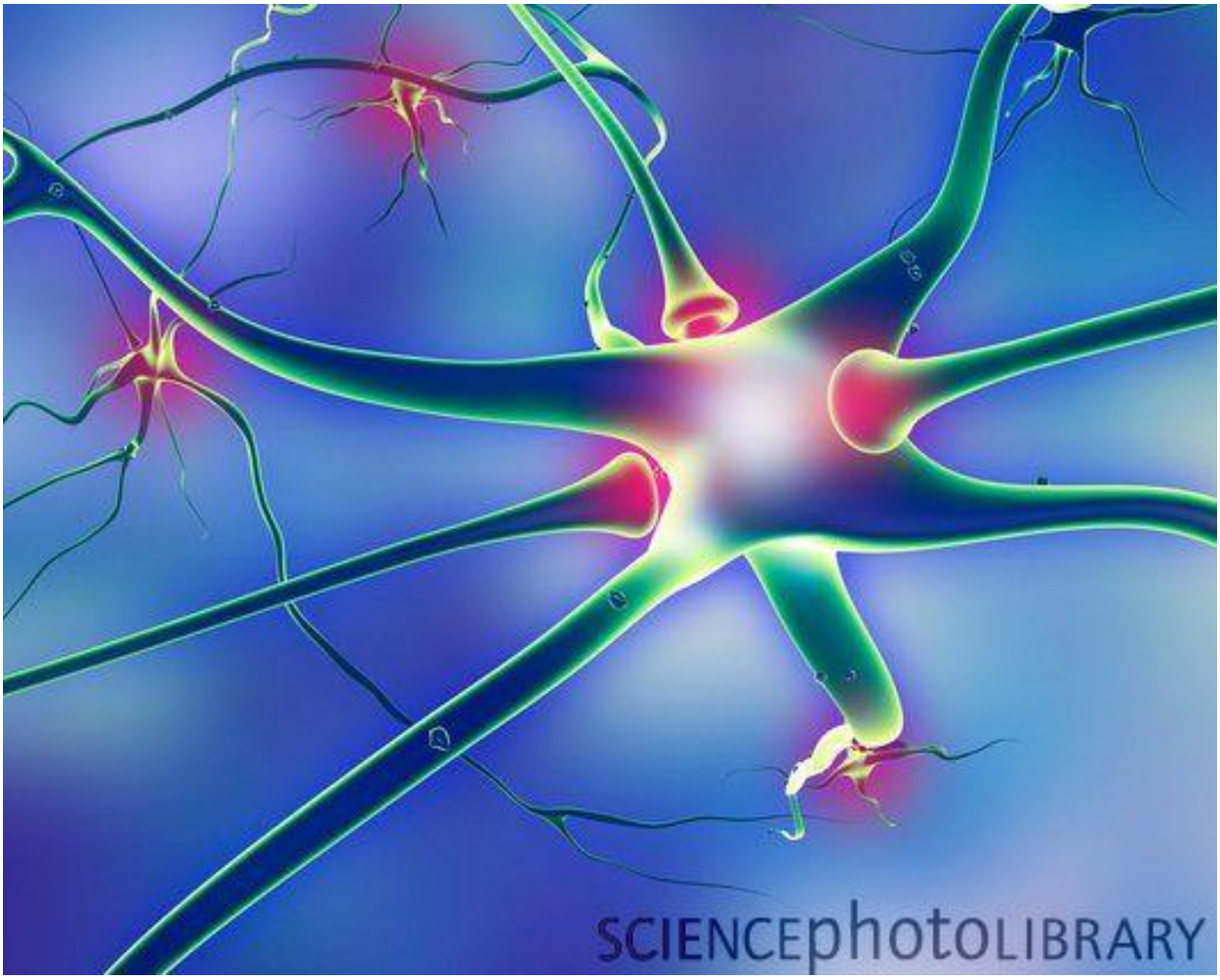
- Synaptogenesis
- Synaptic sculpting
- Myelination

Each of the terms stated have specific function and are interrelated. *Neurogenesis* (i.e., cell birth) takes place while the fetus is developing in the mother's uterus. Relatively few neurons (nerve cell, see item 1 & 2) are created after birth, although some research has demonstrated Neurogenesis in the mature brain (Gould, Reeves, Graziano & Gross, 1999).

Here is an example of what a nerve cell looks like:



Item.1 Description of the makeup of a nerve cell
Retrieved: www.manypap.com/nerve-cells



Item. 2 Actual example of a nerve cell
Retrieved from: www.sciencephoto.com/media/209328/enlarge

Migration is the process of neurons moving. It is clear that both genetic and environmental factors play an important role in determining a neuron's final location (Rakic, 1981, 1996). According to Rakic (1981, 1996) migration of neurons takes place primarily in the intrauterine and immediate perinatal period around the time of birth and continues throughout childhood and, to a much lesser degree, into adulthood. A host of intrauterine and perinatal insults (e.g., traumatic experiences) such as lack of oxygen, infections, and exposure to alcohol and various psychotropic drugs (e.g., the pregnant mother being an alcoholic) could alter the migration of

neurons and have a profound impact on the expression of genetic potential for a host of functions(Perry, 1988).

Neurons can mature to thousands of unique structures producing hundreds of neurotransmitters (e.g., dopamine, norepinephrine, and serotonin). Developing neurons *differentiate* in response to chemical, often neurochemical signals. Therefore, any experience that alters neurochemical, hormonal or micro-environmental signals (e.g., extreme activation of the stress response, as in trauma from abuse) during development can change the ways in which certain nerve cells differentiate, thereby altering the functional capacity of the neural networks in which these cell reside (Rutledge, Wright, & Duncan, 1974).

In the human system more neurons are born than are required to make a functional system. In the process of apoptosis the body will take redundant neurons, when unable to adequately "connect" them into active neural networks and eliminate them (Kuan, Roth, Flavell, & Rakic, 2000). The neurons that make synaptic connections with other neurons and have adequate levels of stimulation survive, whereas neurons with little activity are reabsorbed. This is an example of the important principle of activity-dependent development. This clearly shows how under stimulation from neglect (e.g., malnutrition) could increase apoptosis, or cell death, beyond normative levels (Kuan, et al., 2000).

As neurons differentiate, they send out short, fiber-like receptive processes called dendrites. These are the "receiving" sites of neurotransmission from presynaptic neurons. The density of these dendrite branches is related to the frequency and intensity of incoming signals. *Arborization* allows neurons to receive, process, and integrate complex patterns of input. Dendrite density may be one of the most *experience-sensitive* physical features of a neuron (Diamond, Prevor, Callender, & Druin, 1997).

The most experience-sensitive feature of a neuron is the synapse (i.e., the point at which nerve impulses pass from one neuron to another). Developing neurons generate projections that become *axons* (a usually long and single nerve cell process that usually conducts impulses away from the cell body), which form synaptic junctions with the dendrites of other neurons. A continuous dynamic of synaptic neurotransmission regulates the activity chain of neurons that allow all brain function.

During development, neurons "find" and connect with appropriate target neurons. This process is guided by certain growth factors and cellular adhesion molecules that attract or repel a specific growth cone to appropriate target neurons. Furthermore, this process is influenced by the transmission of nerve impulses across a synapse (i.e., neurotransmission). Due to the rapid and important neural changes taking place in the first year, this is also a time of remarkable vulnerability to trauma and neglect (Huttenlocher, 1979, 1994; as cited in Beauchaine et al., 2008).

The synapse, which constitutes the region of interconnection between a presynaptic neuron's axon terminal and the postsynaptic neuron's dendrite, is a dynamic structure. A key determinant in this synaptic sculpting is the activity of neurotransmission. When there is a consistent, active process of neurotransmitter release, synaptic connections are strengthened through physical changes that make the pre-and postsynaptic neurons grow more tightly interconnected. This powerful activity-dependent process appears to be the molecular basis of learning and memory and is therefore at the *core of neurodevelopment* (Beauchaine et al., 2008). *Myelination* occurs when specialized *glial cells* (supporting tissue intermingled with the essential elements of nervous tissue) wrap around axons and thereby create more-efficient electrochemical transduction down the neuron. This process allows a neural network to function more rapidly

and efficiently, thereby providing for more complex functioning (e.g., walking depends upon myelination of neurons in the spinal cord for efficient, smooth regulation of neuromotor functioning). This process may be affected by abuse and neglect. Experience, good and bad, shapes the nueroarcheology of the individual's brain (Perry, 2001a). The effects of maltreatment are therefore extremely dependent upon the state of development of the child and the stage of neurodevelopment (Beauchaine et al., 2008).

Nature and Nurture

According to research conducted by Caspi, Mclay, Moffit, Mill, Martin, Craig, et al. (2002); and Capsi, Sudgen, Moffitt, Taylor, Craig, Haarington, et al., (2003), neurodevelopment is the product of genetic potential and how potential is expressed as a function of the timing, nature, and pattern of experience. The genetic differences in key neural factors are related to the functioning of the stress-response system. For example, the ways these genetic vulnerabilities are expressed remain sensitive to the developmental experiences of trauma. In other words, trauma (e.g., physical abuse) has the potential to dramatically affect the sequence of normal molecular events thus contributing to developmental psychopathology (Caspi, et al., 2002, 2003).

The impact of experience on neurodevelopment shifts across the lifespan. In the just-fertilized ovum, chemical processes driving development are genetically determined sequences of molecular events. By birth, however, the brain has developed to the point where environmental cues, mediated by the senses, play a major role in differentiation, arborization, and synaptogenesis, thus helping to create functional neural networks (Caspi, et al., 2002, 2003). By adolescence, the majority of the changes that are taking place in the brain are determined by experience and not by genes. The cultural practices and complex cognitive and emotional

functioning (e.g., self-esteem) by this age are largely experienced based (Caspi, et al., 2002, 2003).

Disruption of experience-dependent neurochemical signals during early life may lead to major abnormalities or deficits in neurodevelopment (remember, from a neurodevelopment perspective, it is the brain that mediates all emotional, social, cognitive, and behavior functioning) (Beckett, Maughan, Rutter, Castle, Colvert, Groothues, et al., 2006; Perry 2001a, 2001b). Disruption of critical neurodevelopmental signals can result from a lack of neglect (e.g., malnutrition, social contact). Moreover, all important molecular signals that need to regulate at normal functioning could also become irregular from the effects of trauma (e.g., physical abuse), which of course gives theorist a basis for understanding psychopathology related to child abuse and neglect(Beckett et al. 2006; Rutter & O'Conner, 2004).

According to Beckett et al. (2006) and Rutter & O'Conner (2004), in the development of socio-emotional and cognitive functioning early life nurturing is critical. If such nurturing is absent for the first 3 years of life but the child is then adopted and begins to receive attention, love and affection, these positive experiences *may not be sufficient* to overcome already acquired disorganization of the neural systems, mediating socio-emotional and cognitive functioning. If the period of deprivation persists, there is a stronger chance for later maladaptation (such as adolescent substance abuse disorder, post-traumatic stress disorder, etc…), although individual resiliency factors could potentiate other outcomes (Beckett et al. 2006; Rutter & O'Conner, 2004).

The primary implication is that early childhood trauma or maltreatment has a disproportionately large capacity to cause dysfunction in comparison with trauma or neglect later in life (Rutter, English, & Romanian Adoptees Study Team, 1998; Rutter, Anderson-Wood,

Beckett, Bredenkamp, Castle, Grootheus, et al., 1999). The younger the child is the more likely he or she is to have enduring and pervasive problems following trauma and neglect. Neglect in the early years of life can have a devastating impact even if a child is removed from the neglectful environment (Perry, 2002, Perry 2006). The longer a child remains in a neglectful environment, the more vulnerable he or she becomes (Rutter et al., 1998, O'Conner et al., 2000; Perry 2006)

A major consequence of these principles is that the organizing brain of a child is more malleable than a mature brain. For example, a traumatic situation has the potential to alter the behavior of an adult wherein the child with a developing brain may internalize the external in a particular framework. This process is due to the fact that the child's brain is plastic (i.e., capable of being molded) and is most sensitive to good and bad (Rutter et al., 1998, O'Conner et al., 2000; Perry 2006).

In conclusion, the human brain is continually sensing, processing, storing, perceiving, and acting in response to information from the external and internal environments. This continuous monitoring process is especially sensitive to input that may indicate threat (e.g., anticipated and acted physical abuse). Our physiology and neurophysiology are characterized by continuous modulation, regulation, compensation, and activation, all designed to keep our body's systems in a state of equilibrium or homeostasis. Whatever information or stimuli from either inside or outside the body that alters this homeostasis or indicates similar previous perceived threat (as in a child fearing the inevitable beating which may have become the norm), the brain will initiate compensatory adaptive responses to re-establish homeostasis or take action necessary to survive(Perry, 2001b; Perry & Pollard, 1998).

Summary

Many people who have experienced a number of defeats, patterns of abuse, and separations, especially in early childhood, suffer from some forms of mental/emotional disorders. The more damaging the defeats and patterns of abuse the child is repeatedly exposed to the more these early life experiences have the potential to lead to feelings of worthlessness and subsequent mental disorders.

Addiction is not always in pursuit of pleasure. Many addicts are dissatisfied and frustrated with who they think they are and what they feel about themselves. When the pain of living with oneself becomes hard to bear, addictions are born to drown the pain.

While it is already known that low self-esteem is correlated with adolescent substance abuse disorders, as this research and literature has stated, this thesis project is important because it suggest that early, measurable factors (low self-esteem) can identify future risk for drug dependence. Early intervention and prevention efforts could now target potential at risk youth before they reach their teens, when experimentation with drugs is most likely to begin. Parents, teachers, and childcare givers can be on the lookout for signs of low self-esteem.

When referring to mental disorders, the literature review clearly indicates the manifestations of psychopathology as it is related to abuse and maltreatment. All of the major molecular processes involved in brain development can be negatively influenced by abuse, maltreatment, and neglect.

With either trauma or neglect, the timing (the earlier in life the more the impact), intensity, pattern, and duration of maltreatment can alter virtually every brain system and brain area. The result is that in any given child, the individual history of maltreatment produces a unique pattern of altered neural systems, which control all emotional, social, cognitive, and

behavior functioning, and resulting psychopathology. As a result, maltreatment may be the "great imposter". Depending on the age, nature, and pattern of maltreatment, a child may develop symptoms that mimic DSM-IV diagnosis from PTSD to substance abuse disorders.

This complexity poses a fundamental challenge to any attempts to create simple over-inclusive descriptive categories of psychopathology. The hope and the promise is that understanding the mechanism underlying psychopathology will lead to more effective interventions, and ultimately to more changes in practice, program, and policies that will help prevent the development of abuse-related psychopathology.

CHAPTER 3

Methodology

Study Design

This study examines adolescents and adults who are in drug treatment programs to discover if there is a direct correlation with their substance abuse issues to childhood maltreatment and low self-esteem. There were two research methods (qualitative & quantitative) that this researcher decided to use to help the reader understand this thesis.

The qualitative research design was determined to be an effective approach for this topic because it asked the participants of the study questions about their perceptions, opinions, beliefs, and attitudes toward their early life social experiences (Fossey, Harvey, McDermott and Davidson, 2002,). This method also helped the researcher draw out conclusions and determine if they substantiated or ruled out the hypothesis. The qualitative data collection methods chosen were interviews and focus groups (e.g., mini focus group with 11 members; one with adults and one with adolescents).

Traditional interviews and focus groups can provide accurate information and produces data and insights that would be less accessible without interaction. In addition to the focus group, there were two self-esteem questionnaires (see appendix) used as a part of this research and they were (a) the "Rosenberg self-esteem scale" (RSES) which provided information about themes associated with self-worth and is considered a reliable and valid quantitative tool for self-esteem (Rosenberg, 1965), and (b) the "Self Esteem Questionnaire developed by Marilyn Sorensen, Ph.D., consisting of a survey design that was expounded upon in her book "Breaking the Chain of Low Self Esteem" (2006). Both questionnaires are unique in their design and were used to determine the probability of low or high self-esteem in the individual.

In the social sciences, focus groups allow interviewers to study people in a more natural setting than one-on-one interviews. In combination with participant observation, it will raise unexpected issues for exploration. For the qualitative purpose of this research, two focus groups were conducted; one involved speaking with adults and the second focus group involved adolescent participants.

The group and interview process for adults consisted of open-ended questions that addressed issues related to specific memories in early childhood about how they felt, were there issues of abuse, did they experience low self-esteem growing up, and what were their early childhood family dynamics.

The group and interview process for teens consisted of open-ended questions of how they presently felt about themselves. This research process is important because discussion produces data and insights that would be less accessible without interaction in a group setting—listening to others' verbalized experiences stimulates memories, ideas, and experiences in participants (http://en.wikipedia.org/wiki/Focus_group).

Participants

The participant pool was comprised of emancipated adolescents (14-18 years of age) and adults, who are both currently in drug and alcohol treatment (all have been in treatment for about 3 to 6 months). The adult participants have past life experiences, which had powerful implications in understanding their present feelings of worth. Moreover there were common themes of maltreatment and neglect in their childhoods, which gave indication of a correlation to their present drug and alcohol disorders. The adolescents provided information about their current feelings of worth and the impact of early childhood maltreatment. Another important factor that helped this research process (due to the trust level that has been built) is the fact that

this researcher is a drug and alcohol counselor and works with the entire participant population in this study.

Procedure

The focus groups and interview were conducted during normal treatment hours. This researcher works for two separate drug and alcohol treatment organizations with both adults and adolescents. This presented a unique opportunity to conduct focused groups with both demographics over a period of six weeks. This researcher conducted two focus groups (1 adult & 1 adolescent) with 12 participants in each group. The meetings lasted one and a half hours each and every member was given time to expound upon the topic presented as discussed early on.

There were also two self-esteem questionnaires presented to both adults and adolescents on separate occasion. The questionnaires were done within the confines of this researcher's work hours over the course of six weeks during the psycho-education portion of their respective treatment modalities. The adolescent participants were given the questionnaire under a more controlled type setting wherein the questions were read out loud by this researcher so he could give contextual meaning of each question to assure the authenticity of their responses. Each participant in each program was assured anonymity by not revealing names on questionnaires or being referred to in the discussion of finding section of this paper (also to assure authenticity).

Data Analysis

All questionnaires were tabulated and checked for themes and commonalities. The focus groups and interview analysis also helped the researcher to extrapolate as much authentic data from each participant to discover or uncover themes related to low self-esteem, maltreatment and neglect in their early childhood years. Quotes, coding for themes, and comments, were then

integrated into the following chapter to illustrate the results and to provide examples that allow the reader to fully understand the scope of this research.

CHAPTER 4

Results of Research

In order to put the results in perspective this researcher will give the results in a systematic order before using the discussion portion of this paper to correlate the themes and data. The hope and conclusion of this researcher's work is to provide evidence and information from his research subjects who gave clear indication that substantiate the hypothesis that early childhood maltreatment and neglect and low self-esteem have high correlation with substance abuse disorder. Moreover the intention was also to point to the origins of psychopathology and low self-esteem, which is indicated in the early childhood relationships (most notably with parents and caregivers).

The results are being documented in the following order:

- 2 Questionnaires –Adolescents
- Adolescent individual interviews
- Adolescent focus group
- 2 Questionnaires -Adults
- Adults individual interviews
- Adult focus group

The results and pertinent data of the questionnaires were very easily obtained. As stated in the methodology, the adolescents were asked the questions by this researcher so he could put in context the terminology in the questionnaire for the adolescent to understand before each participant documented their response. Moreover, each questionnaire (see appendix) has

language that is different in its construct and verbiage as to extrapolate pertinent information from the participants, which gave indication of their level of self-esteem.

Further, the participants who answered the questionnaires were also the same participants (i.e., 12 of them) who participated in the focus groups. This procedure was intentional as to give strong correlation to the what, where, when, or why factors that could have attributed to their self-esteem. The focus group was an open discussion in which all factors related to each participant's lives and development were accounted and used for the development of this researcher's conclusion.

Adolescent research results

Adolescent Questionnaires:

In the first questionnaire the "*Rosenberg self-esteem scale***"** (which asked participants to choose from 1 of 4 responses) there were 21 adolescent participants between the ages of 16 and 17. There were 8 Hispanic males, 6 Hispanic females, and 6 African American males, all of whom come from low socio-economic backgrounds. 10 of these males, 5 Hispanic and 5 African American, are currently emancipated living in the foster care system.

Once the answers were tabulated, 16 of the 21 participants showed very low self-esteem; 3 showed moderate low-self-esteem (90% showed low self-esteem); and 2 showed very high self-esteem. This researcher postulates that there is a strong possibility that these 2 finding may not be accurate due to the nature of the questions and the differences in the verbiage of each questionnaire. In the second questionnaire there was a 100% reported rate of low self-esteem from the same pool of participants.

In the second questionnaire **"***Self Esteem Questionnaire***"** developed by Marilyn J. Sorensen, Ph.D. (which asked 50 questions) the same adolescent participant pool of 21 adolescents

participated and the same method of reading the questions to the participants was done by this researcher to assure that each question was understood contextually by participants before they documented their answers.

After the questionnaire was completed the answers were tabulated according to the questionnaires process for obtaining answers. Of the 21 adolescent participants 14 showed *severe* low self-esteem and 7 showed moderate low self-esteem (100% showed low self-esteem). Results of adolescent questionnaires-indicate:

- All adolescents are in drug and alcohol rehabilitation suffering substance abuse disorders
- 95% of adolescent participant pool present with low self-esteem

Adolescent interviews:

There were three separate interviews conducted with three 16- year old adolescent males (2 Hispanic and 1 African American). Each participant has been in drug and alcohol treatment suffering from a substance abuse disorder for approximately 4 to 5 months, and all have developed intimacy, trust, and a therapeutic alliance with this researcher, who is their drug and alcohol counselor. Since this researcher works as a counselor to these participants there is always the possibility that the participants will disclose very sensitive matters, which may or may not derive from early childhood experiences. This researcher and the participants have developed a therapeutic alliance built on trust, and because of these alliances, the participants' information provided strong, relative, and reliable information from which to draw conclusions.

The interviews were conducted in a private office with all three participants being interviewed separately. Each interview lasted approximately one hour in duration. This researcher explained to the participants the definition of self-esteem and all its implications so they could give their narratives based on how they view themselves. This researcher also asked

each participant during their interview if they felt comfortable enough to discuss their early childhood relationships with their parents, siblings, and families which may or may not expose elements of all forms of neglect and maltreatment. This researcher explained the definition of abuse and all its implications and functions in human development. This approach was taken due in part to be able to deal with the feelings that could be incited within each participant because of the possibility that some disclosure might violate cultural norms for the participants (e.g., the Hispanics cultures idea of secrecy about family matters being discussed outside the family is seen as taboo).

Adolescent interview #1:

In the first interview with participant number 1(Hispanic male) there was no resistance by him to disclose some very sensitive information about his early childhood relationships. Participant #1 discussed how he realizes that he does have low self-esteem and that he used drug and alcohol to feel better or to escape how he felt. The Participant stated that he has been using marijuana and cocaine (since age 9) and alcohol (since age 7). The participant stated that he walked through childhood in fear because he was verbally abused and physically abused often (from ages 4-10). The participant stated that his stepfather beat him often with a belt and told him he would amount to nothing. The participant also stated that his older sister would allow her boyfriend to smack him around and tell him he was no good and a half-breed (referring to him having a different father). The participant stated that he was a very angry child and was seen by his mother (who did not know of the abuses) as a troubled child. He disclosed many acts of physical, mental, and emotional abuse during his early childhood up to, and including his early adolescent years. The participant also felt very sad and wondered why his paternal father would not come to his rescue after noticing bruises, scars, and swelling on the participant's body.

This researcher wants to point out that during the interview there was a lot more information disclosed by this participant, which would indicate to this researcher that there was a lot of early childhood neglect and maltreatment. Furthermore, this adolescent exhibits strong elements of low self-esteem.

Adolescent #1 interview results-indicate:

- Strong evidence of early childhood emotional neglect
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Strong evidence of parental emotional and physical neglect (particularly the father)
- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Diagnosed substance abuse disorder
- Low self-esteem and low self-worth
- Early childhood use of drugs and alcohol
- Verbal abuse
- Rejection
- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others

Adolescent interview # 2:

Participant # 2 is a 16 year old African American adolescent male. The participant stated that he could remember back when he was age 5 up until the age of about 9 that his mother was a chronic crack addict and his paternal father (who did not reside in his home) was a drug dealer.

The participant stated that he remembered going days without food in his early childhood because his mother would not have money, due to smoking crack. The participant stated that he

would witness his mother and stepfather physically fighting often, which confused and scared him. The participant stated that his mother would curse at him and tell him he would amount to nothing. He also stated that his mother would put him down over and over, which made him feel like he was worthless. The participant states that his stepfather emotionally, physically, and verbally abused him on a regular basis. For example, the stepfather would yell and curse at him on a regular basis telling him he was a "little bitch" and would tell him and his siblings "f…ck all of you".

The participant remembered that, due to his mother's drug abuse and reported child abuse, when he was about 8 years of age that he and his sibling were taken out of the home by the Department of Social Services and placed in a foster home. The participant stated that he felt scared and experienced poignant feelings associated with grief and loss due being separated from his mother and sibling. The participant stated that he was confused and did not understand why they were separated.

Participant #2 stated that his aunt eventually took him and his sibling out of the foster care system and placed them in her home. He noted that the aunt would beat them violently on a regular basis and verbally abuse them. The participant stated that he felt angry and fearful much of his life and could not understand why his paternal father would not protect him or show any affection towards him. The participant stated that he spent lots of time in therapy as a small child because he was angry and termed a troubled child.

Participant #2 stated that at age13 years he started experimenting with marijuana, which made him forget his troubles and the feelings he could not understand. This researcher wants to point out that during the interview there was a lot more information disclosed by this participant,

which would indicate to this researcher that there was a lot of early childhood neglect and maltreatment. Furthermore this adolescent exhibits strong elements of low self-esteem.

Adolescent #2 interview results indicate**:**

- Strong evidence of early childhood emotional neglect
- Grief and loss
- Early childhood physical, emotional, and mental neglect and maltreatment
- Low self-esteem and low self-worth
- Early childhood use of drugs and alcohol
- Diagnosed substance abuse disorder
- Strong evidence of parental emotional and physical neglect (particularly the father)
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Verbal abuse
- Rejection
- Constant witnessing and experiencing verbal, mental, emotional, and physical abuse of others

Adolescent interview #3:

Participant #3 is a 16 year old Hispanic male. The student stated that he was ok with disclosing information about his childhood because he felt safe with this researcher. The student states that at the age of six his mother and father separated, which left him feeling very sad and confused. The participant stated he would witness his mother and father physically fighting on a

regular basis, which kept him frightened as a child. The participant stated that his father would beat his mother violently while he watched.

Participant #3 stated that his mother would hit him from time to time but it would only be in the torso and that he felt he deserved it because his behaviors were bad sometimes. The participant stated that his father (who is an alcoholic) would beat him with cables, brooms, and sticks on a regular basis as a child for no reason at all. The participant remembered that his father would never show or display affection or emotions towards him. He stated that when his mother and father separated he feared going to his father's house, which he had to do on a regular basis because he knew he was going to get beat.

The participant stated that his father and mother reconciled after sometime, which prompted his father to move back in the house. The participant stated that the beatings he got from his father got worse when he moved back in the house. He stated that his father cut his hair off one day and made him stand outside the house while all the kids in the neighborhood watched and laughed at him. Participant #3 stated that he felt like a worthless person and stayed very angry during his early childhood. The participant stated that he had to see a therapist for many years because he was termed a troubled and problems child.

Participant #3 stated that he started using cigarettes at age 13, alcohol at age 14 and marijuana at age 15. He stated that drugs, alcohol, and cigarettes made him feel different and removed the bad feelings he had about himself and his life.

Adolescent #3 interview results indicate**:**

- Grief and loss
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Low self -esteem and low self-worth

- Early childhood use of drugs and alcohol
- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Early childhood physical, emotional, and mental neglect and maltreatment
- Diagnosed substance abuse disorder
- Rejection
- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others

Adolescent Focus Group:

The focus group consisted of 11adolescents between the ages of 15 to 18. The participants' demographics consisted of 8 Hispanic males, 1 African American male, and 2 Hispanic females, all of whom are in an alternative high school for adolescents with negative behavioral problems. Additionally, each adolescent is a client in the school's drug and alcohol program. The group process went on for 2 hours and took place in a closed conference room with a round table discussion.

This researcher is the drug and alcohol counselor who has been working with these adolescents for approximately 4 months, and has established a trusting therapeutic alliance with them. This researcher explained to the participants how the group process would function and what subjects he would like them to focus on. This researcher also informed the participants the importance of the research and the importance of honest self-disclosure if they were to participate. Each participant was given the opportunity to leave the group at any time without explaining why.

The participants were asked to discuss anything that they wanted about their childhood that pertained to how they felt, what it is like now in their life, how they feel now, and whatever they deemed important enough to disclose. This researcher assured the participants that their anonymity would be protected.

During the group process every participant was involved in the discussion and bought up very disturbing revelations about their childhood and how they currently view themselves. For starters' the question of low self-esteem and low feelings of worth seemed to apply to every participant. Each participant unanimously agreed that they felt less than or not good enough. Furthermore, each of the eleven participants stated that their drug and alcohol use is directly related to how they feel about themselves and that using drugs seems to make uncomfortable feelings and shyness go away.

All the participants seemed to get angry and upset during the discussion about their fathers. The participants talked about how their fathers were mostly unaffectionate and verbally and physically abusive towards them. The unanimous element about their fathers is the lack of affection or lack of emotional contact that their fathers have established with them during their early childhood and in their present adolescent stage.

All the participants agreed that they were emotional and verbally abused or neglected during their early childhood and in some of their present situations. The discussion on physical abuse bought up a very angry discussion about how they were hit or beat as children; all had various stories about how and when the abuse took place and what they were hit or beat with. The overwhelming response was that they were all hit with objects at various times, with most of the participants stating they were hit on a consistent basis. Seven of the participants disclosed that they were suffering co-occurring disorders and each has been or is in the foster care system.

Many of the participants discussed witnessing their mothers being abused by either a father or some other male figure in their lives. There was also a strong association with each participant having a parent or caregiver as an alcoholic or drug addict. Some of the participants stated that they were left sometimes lacking basis needs as a result of their parent or parents' drug and alcohol abuse (e.g. proper food and nutrition and adequate clothing).

Each participant talked about how they tended to put up a facade or false persona in fear of being rejected when in social situations especially with peers. Participants discussed how they all have felt shame most of their lives for various reason but mostly because of who they are.

Each participant gave a comment on anger and discussed how anger seems to be the overriding feeling especially towards their fathers and themselves. Each participant has stated how they would be scrutinized and put down much of the time by their parents, most notably their fathers.

In conclusion, each participant made reference to the fact that they had experienced beatings, being hit, being pushed, and being smacked around on a regular basis by some adult during their early childhoods and that they will never forget those experiences.

Adolescent focus group results indicate**:**

- Strong and poignant negative feelings associated with their fathers
- Lack of emotional attachment with their fathers
- Diagnosed with substance abuse and other mental disorders
- Growing up in environments that were verbally and emotionally abusive
- Early childhood neglect and maltreatment (emotional, physical, and mental)
- Low self-esteem and self-worth
- Strong feelings of anger and being seen as angry children

- Strong connection with each other to physical abuse
- Strong connections with parents or a parent being a substance abuser
- Strong connection to feeling shameful about who they are
- Fear of rejection Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others

Adult questionnaires results:

In the adult population there were ten adults who took part in the process. There were 3 Caucasian men, 4 Caucasian women, 1 Hispanic male, 1 African American woman, and 1 African American man. All of the adults were in a high-end drug and alcohol program, with most of the participants coming from middle and upper socioeconomic class. Each adult was asked to remember how they felt as adolescents and to answer the questions from that perspective. The first questionnaire that was used was the "*Rosenberg self-esteem scale*". Of the 10 participants, 8 out of 10 of them that reported low self-esteem (80% showed low self-esteem). In the second questionnaire the "*Self-Esteem Questionnaire*" by Marilyn J. Sorensen, Ph.D., 9 out of 10 reported low self-esteem (90% showed low self-esteem).

Results of adult questionnaires indicate:

- Diagnosed substance abusers
- 85% of adults presenting with low self-esteem as adolescents and adults

Adult interview #1:

The interview with Adult #1 took place in a private setting at this researcher's house. The adult participant #1was assured that the interview would be kept confidential. The adult participant is a 57 year old African American male who has been recovered from a chronic cocaine addiction for 13 years and has done intensive work in the Twelve-Step process. This

adult participant mentors people in the Twelve-Step process and has a very good sense of who he is as a result of having done years of psychotherapy.

This researcher explained to Adult Participant #1 what the interview would cover and ask him to expound upon events and relationships in his early childhood and also how he felt as a child and adolescent. This researcher asked the adult participant to expound upon any neglect, trauma, or maltreatment in his early childhood and adolescents if it is relevant and pertains to his life. Adult Participant #1 agreed to be totally transparent and to disclose all that he could about his life.

The participant stated that he started using marijuana and alcohol at the age of 13 and eventually started using cocaine at the age of 21. He stated that he felt lonely, deserted and unprotected as a child and adolescent. The participant stated that he was neglected emotionally, always denied authentic emotional expression, never felt validated, never felt important, and never felt that he mattered as a child or an adolescent.

Adult Participant #1 stated that when he was age 7 his father died and that he felt very angry, afraid, and deserted by the death. The participant stated that his uncle then became the primary male figure in his life which, for him, was a nightmare situation. The participant stated that his uncle beat him with switches and belts on a regular basis. He remembered that he felt very confused and afraid during his childhood because he would get beat by his uncle whenever he was hurt while playing. The participant stated that he could not come in the house with injuries from play because that would prompt a beating from his uncle. He noted that his uncle would cuss and use very abusive language while telling him he would never amount to nothing as a person.

Adult Participant #1 would witness his mother and sister getting beat up violently at times from their male counterparts when he was around the age 10. He stated that there were many times during his childhood wherein he was hungry and would take bread, sugar, and diluted evaporated milk and fry it on the stove. The participant stated that his stepfather was a drug addict and would leave marijuana lying around the house, which sparked interest and curiosity within him to use it.

In conclusion, the participant stated that as a young child and especially in his adolescent years his self-esteem was very low and that drugs quieted the pain he felt as a youth. The participant stated that drugs were a way to escape his feelings, which for him were always confusing and angry.

Adult #1 interview results indicate:

- Grief/loss
- Strong and poignant negative feelings associated with his father
- Early childhood use of drugs and alcohol
- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Early childhood physical, emotional, and mental neglect and maltreatment
- Diagnosed substance abuse disorder
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Low self-esteem and low self-worth
- Lack of emotional attachment with father
- Neglect associated with malnutrition and protection

- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others
- Diagnosed substance abuse disorder

Adult #2 interview:

The interview with Adult Participant # 2 took place in a private group room at a rehabilitation center. The interview was conducted after the regular Saturday morning family education group, which is facilitated by this researcher.

Adult Participant #2 is a 35 year old Hispanic gay male who has been clean from drugs for about 60 days. The adult participant has also been a client of this researcher and has stated that he felt comfortable and safe to discuss sensitive early childhood and adolescent issues with him due to their therapeutic alliance.

Adult Participant #2 stated that his father was a military man who moved the family constantly. The participant stated that he felt very angry and fearful much of his youth because whenever he would get to make new friends they would have to move, which would cause him a lot of grief/loss issues throughout much of his early childhood and adolescent years. The participant stated that he often felt different and out of place because many times they would move to other cities where there were language barriers (e.g., the participant moved to Mexico but did not speak his native language which made him uncomfortable to assimilate into his environment). Participant #2 remembered that as an adolescent he also felt ashamed because of his skin color and the fact that he was a short Mexican boy with lots ugly pimples. He stated that he hated himself as an adolescent and because of that, he started using drugs in early adolescent and it made him feel good and took away the pain he experienced on a daily basis.

Adult Participant #2 stated that matters got worse for him when some of his gender expression became noticeable to others and indicated that he was gay. He stated that his family's strong religious orientation and participation in church made things very hard for him due to the teachings against being gay. Participant #2 stated that he felt lonely, angry, and fearful throughout much of his youth and adulthood due to being gay and feeling alienated by people, especially his family.

Adult Participant #2 stated that his father did not show any affection or emotion and never accepted him being gay. He remembered that he also got called names by his brother and others who found out about his gender association (the participant would be called a "faggot" a lot by his brother).

Participant #2 stated that during his childhood he did get beatings by his mother with switches and belts but thought that he deserved to get beat because he was bad at times. The participant stated that he watched his mother cry often due to his father's infidelities with other women. The participant stated that there was constant fighting between his parents over his father's adulterous relationships with other women.

In conclusion the participant stated that he hated himself as an adolescent and that drug use seemed to be the only relief he had to escape the feelings of loneliness, fear, anger, and self-hate.

<u>Adult #2 interview results indicate</u>:

- Grief/loss
- Strong and poignant negative feelings associated with his father
- Early childhood use of drugs and alcohol

- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Low self-esteem and low self-worth
- Neglect associated with emotional and mental health
- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others
- Diagnosed substance abuse disorder
- Lack of emotional attachment with father

Adult #3 interview:

The interview with Adult Participant #3 took place in a private group room at a rehabilitation center. The interview was conducted after the regular Saturday morning family education group, which is facilitated by this researcher.

Adult Participant #3 is a 37 year old African American male who has been clean from drugs for about 60 days. This participant has also been a client of this researcher and has stated that he is comfortable and felt safe to discuss sensitive early childhood and adolescent issues with him due to their therapeutic alliance.

The participant started talking about the relationship that he had with his mother. He stated that he felt ok about his mother but feared her also; and that he got beat frequently with belts, power cords, and switches. The participant stated that what made the beatings horrific for him was the fact that he had to pull his cloths down and expose his skin.

Adult Participant #3 stated that he witnessed lots of gambling, drinking, and smoking marijuana by adults in his house that would come over to play cards with his parents. The

participant stated that both his parents drank abusively and would fight violently with each other especially after they became intoxicated. The participant stated that they would cuss each other out and that verbal and emotional abuse was the norm for him and the household.

The participant stated that his father was very withdrawn and unaffectionate with him. He felt that his environment was very fearful and dangerous because of all the shooting and gang violence he was witnessing. Participant #3 stated that he felt angry, fearful, ashamed, and confused all of his childhood and adolescent years.

Participant #3 remembered that he started drinking alcohol from the glasses of drinks that were left by the adults during their gambling and drug using events. He felt that alcohol took away all his fears and anxiety about life and that he knew that he found the answers to his "troubles" with alcohol. The participant stated that as an adolescent he felt like he was unimportant as a person so he did drugs to medicate his felling of low self-worth.

This participant decided to end the interview early stating that the feelings were getting to him and that he wanted this researcher to understand that as a youth and adolescent he just did not like himself and feared people and rejection by them. The participant went on to say that getting beat as a child hurt and kept him in fear of his mother and father who he felt never seemed to care.

Adult #3 interview results indicate:

- Low self-esteem and low self-worth
- Neglect associated with emotional and mental health
- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others

- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Strong and poignant negative feelings associated with their fathers
- Early childhood use of drugs and alcohol
- Diagnosed substance abuse disorder
- Lack of emotional attachment with their fathers

Adult focus group:

The adult focus group consisted of 11 adult participants, 3 Caucasian females between ages 34 and 72, 1 Hispanic female age 35, 6 Caucasian men between the ages of 29 to 55, and 1 gay Hispanic male age 33. The participants are all clients who have built a trust and alliance with this researcher who also happens to be a Substance Abuse Counselor working with each of them in a drug and alcohol treatment program.

The participants were assured that their confidentially would be kept and were asked to explain and disclose any information related to neglect, maltreatment, and negative relationships in their childhood and adolescents years. During the focus group the participants talked about many issues related to maltreatment. One of the participants discussed how she felt afraid during her early childhood years because she had a nanny who constantly beat her and verbally abused her from the age of 4 thru 17 at which time she was able to move away. The participant talked about how she resented her mother and father who she states new of the abuse but never intervened to stop it.

Another participant discussed how he was constantly beat and put down by his father who was always angry and hateful towards him and his mother. The participant stated that his father

always displayed displeasure with everything he did and would not approve of any of his efforts to accomplish positive things like sports or good grades. In fact the participant stated that when he tried to do something like run track his father would state that he was never going to be good enough to go anywhere in the sport so he might as well quit the team so he does not make a fool of himself during competition. The participant stated that he hated his father and wondered why his mother stuck with him.

One of the participants discussed how he felt so lonely during his childhood and adolescents years because he knew he was different than all the other boys in the neighborhood because he liked feminine play activities like dressing dolls and putting on makeup. The participant stated that he would get beat violently when he was around age 4 stating that his father and mother were trying to toughen him up. The participant stated that drug use at age 9 took away his loneliness and gave him false confidence.

As stated in the adolescent focus group each of these adults' participants unanimously agreed that they felt less than or not good enough. Furthermore, each of the eleven participants stated that their drug and alcohol use is directly related to how they feel about themselves and that using drugs seems to make uncomfortable feelings and shyness go away.

There was a lot of reference to seeing and witnessing physical, verbal, and emotional abuse of their mothers committed by their fathers or the mother's significant other. During the interview all of the adults stated that drug use gave them feelings of power and confidence that they would continuously seek to fix and cover internal hurt, fear, and feelings of low self-worth.

Many of the adult participants discussed getting beat and hit with objects, being neglected emotionally ignored or invalidated, and feeling no one really cared how they felt.

To sum up the process it was apparent that the participants in the group had themes and disclosures which were sounding familiar and interrelated. The group process ended with some of the participants notably upset and tearful about their childhood and adolescent years, especially in the area of neglect, low self-esteem, and maltreatment.

Adult focus group results indicated:

- Strong evidence that participant experienced the persistent feelings of fear, anger, ambivalence, and ambiguity during early childhood and adolescents
- Strong evidence of early childhood physical and emotional abuse resulting in trauma
- Strong and poignant negative feelings associated with their fathers
- Early childhood use of drugs and alcohol
- Diagnosed substance abuse disorder
- Lack of emotional attachment with their fathers
- Low self-esteem and low self-worth
- Neglect associated with emotional and mental health
- Constant witnessing and experiencing verbal , mental, emotional, and physical abuse of others

To sum up the findings it was very clear for this researcher to see high correlations and elements of human functioning from both research populations (adolescents and adults) which give substantial empirical data that indicates implications and ramifications of early childhood maltreatment in their lives. Moreover this research also gives overwhelming data that indicates that early childhood maltreatment leading to psychopathology and low self-worth, are indeed major precursors that lead to adolescent drug dependency (and many other mental disorders not mentioned).

CHAPTER 5

Discussion and Conclusion

In my attempt to gain understanding and awareness of how and why I ended up using and becoming dependent on drugs, I decided to do a research project which could help me understand how I developed the origins of my thought process and my self-esteem which led me to using drugs. In the process of this research it became evident to me that the trauma and neglect I experienced in my early childhood had powerful implications and ramifications on my human development.

FSU professors John Taylor(2006) & Donald Lloyd(2006) , along with University of Miami professor emeritus George Warheit(2006) studied data from a multiethnic sample of 872 boys collected over a period of nine years and concluded low-self-esteem and peer approval of drugs use at age 11 predicts drug dependency at age 20.

In my sample study of adult and adolescent participants I decided to use three different methodologies to determine if psychopathology and low self-esteem were predictors or indicators of adolescent substance abuse disorders and if there was also a correlation to my hypothesis about how I came to use and become dependent on drugs. The findings were startling and compelling.

During my early childhood years I experienced neglect and maltreatment on a regular basis and suffered the ramifications of low self-esteem which I have learned and concluded based on this research, attributed to my subsequent drug dependency. During my research I was also able to correlate some common themes with my research participants, the literature review and what other experts who have researched this subject matter have expounded on, and my own life experiences.

The two prevalent themes or major themes are father/mother issues, such as the mother not being able to protect the child from the father or father figure, and mother/child communication which many times is grounded in negativity and emotional abuse. Out of these two themes, all of these other things happen: a) persistent feelings of fear, anger, ambivalence, and ambiguity, b) early childhood use of drugs and alcohol, c) strong and poignant negative feelings associated with their fathers, d) the lack of emotional attachment with the father, e) constant witnessing and experiencing verbal, mental, emotional, and physical abuse, and) persistent neglect associated with emotional and mental health

As research from Bennett (2012) shows, the feelings of low self-esteem and low self-worth were all common themes amongst the research population; as such, they may see themselves as less than everyone else, deficient in one way or another. Moreover some of my own life experiences and what the experts (Beauchaine et al., 2008; Johnston, O'Malley, Bachman & Schulenberg, 1987; Rutter et al., 1998, O'Conner et al., 2000; Perry 2006)

have determined as being negative human development issues and symptoms that derive from early childhood experiences also became very apparent correlations among the research population.

"The way a role is lived out in the family seriously affects the self-worth of the individual involved" (Satir, 1988, pg.206). Troubled families make troubled people and thus contribute to the devaluing of self, which is linked to crime, mental illness, *alcoholism, drug abuse,* poverty, alienated youth, terrorism, and many other social problems (Satir, 1988).

The fact that I have been able to identify a group of people who are at risk (adolescent's participants) or who have already suffered from problematic behaviors (adult participants) is

very important. If interventions on groups of people can be conducted before they embark on a cycle of addiction it could have huge health benefits.

I have been able to conclude that simple questionnaires such as the ones I used (see appendix) could help parents, clinicians, and teachers to identify at-risk kids. If you are a parent, clinician or teacher and you notice that a child has very low self-esteem that should be a warning sign that the child needs some attention or perhaps some professional counseling.

In my conclusion this research has helped change my paradigm about what methodology I will use when counseling or providing therapy to adolescents and adults who are in drug and alcohol treatment. The conclusions of my research have indicated profound connections to negative early childhood treatment, low self-esteem, and subsequent substance abuse disorders.

As such it is now my intention to use psychodynamic theory (e.g., to explore early childhood experiences that have potential to attribute to distorted thinking, psychopathology and low self-esteem) and cognitive therapeutic approaches (e.g., which help clients to examine present perceptions leading to anti-social behaviors), as an integrative therapeutic strategy to better understand and help my clients.

This research has taught me the importance of exploring the past (i.e., with clients in drug and alcohol treatment) and how it can attribute to present distorted beliefs and feelings of worth which lead to anti-social behaviors, most notably substance abuse and dependency.

Several limitations should be noted. First my sample of adolescents represented a high risk sample of economically disadvantaged youth, and the findings may not generalize to normative samples of youth from higher socioeconomic status levels. Second, peer and parental substance use are strongly associated with adolescent substance use and abuse; however, I did not have this data available in the current study.

I am encouraged by the findings of (Hinshaw, 2007) which showed that depending upon the nature, timing, and frequency of maltreatment and neglect molecular processes have potential to be disrupted which can lead to abnormal organization and function. This finding helps me to understand how important it is to evaluate and gain understanding of the clients early childhood experience because it could have powerful implications associated with current presenting mental disorders.

Another potential limitation is my focus on early childhood maltreatment and neglect; subsequent maltreatment during adolescence was not incorporated or focused on in this research. Maltreatment during adolescents may bear additional maladaptive effects above and beyond that explained by maltreatment in early childhood.

The current findings suggest an unfolding process that may guide a robust pattern of associations with this literature on maltreatment and substance abuse disorders. If replicated it further indicates the need to develop early interventions. Specifically, for children exposed to maltreatment, it would be beneficial to implement early preventative interventions aimed at improving parenting skills for both mother and father and indirectly fostering more adaptive personality development.

During preadolescents, tailored prevention interventions could focus on strengthening social skills and improving emotional and behavioral regulations to reduce externalizing behaviors.

Interventions developed to treat adolescents with comorbid use and other problem behaviors might be appropriate for maltreated youth. For example brief strategic family therapy (Kurtines, Hervis, & Szapocznik, 1989; Szapocznik & Hervis, 2003) uses a family systems perspective that includes fathers and mothers to address dysfunction in child-parent relations.

Future studies should be aimed at replicating this research, as well as evaluating whether they map onto successful intervention strategies that build resiliency strategies for the family (Luthar, Cicchetti, & Becker, 2000; Masten, 2001). Overall, this current study provides further knowledge regarding the complex developmental pathways spanning from the origins of psychopathology and low self-esteem, to the emergence of adolescent substance abuse disorders.

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APPENDIX 1 Letter of Introduction

Hello, my name is Keith Marshall and I am a graduate student in Human Development at Pacific Oaks College in Pasadena, CA. I am working on completing my graduate thesis project on Exploring Psychopathology and Low Self Esteem and its Correlation with Adolescent Substance Abuse Disorders. I am researching whether or not there is a correlation between how participants were treated in early childhood and their substance abuse disorders that are present in their adolescence and adulthood.

I am asking you to participate in this study because you have been through many of these issues and either are in treatment, or are in active recovery. Your experiences will be a valuable part of this research and will also contribute to studies in Human Development and will help clinicians understand the complexity of early childhood maltreatment and neglect. I want to develop intervention strategies to help young adolescents to overcome low self-esteem and to help them develop a healthy sense of self. I believe this would help reduce their possibility of abusing chemicals in order to cope with their feelings of low self-worth.

Your participation in this study is strictly voluntary and you may withdraw from it at any time without repercussions.

If you decide to participate in this research project, you will sign an informed consent letter, of which you will receive a copy and the original will be kept on file in the researcher's possession. You will also be given questionnaires that will measure self-esteem and are to be filled out anonymously, thus allowing you to give the most honest answer possible. You will also be interviewed by the researcher to talk about your childhood experiences. This interview will be audio taped and reviewed solely by the researcher and no parts of it will contain self-identifying information. You will also select a pseudonym to further protect your identity.

The study asks about concerns and experiences that may be unpleasant to discuss or recall. The potential risk of your participation is that it may bring up some unresolved childhood issues that you may have repressed. If this does happen, I have a list of therapist I can refer you to in order to work through those unresolved conflicts. Additional risks associated with your participation in this study are: having confidential information collected, being asked personal questions, being taped using an audio recording device, and being inconvenienced by the time spent in the interview (approximately two hours).

You may request a copy of the completed results and they will be sent to you within 2 months of the completion date. You may also request to see the conclusion and implications for further research by contacting the researcher.

Thank you for your time and information.

Keith Marshall

(626) 584-9502

APPENDIX 2 Letter of Consent

Exploring Psychopathology and Low Self Esteem and its Correlation with Adolescent Substance Abuse Disorders

Authorization for Participation: I understand as a participant in this research study:

- My participation is voluntary. I am not required to participate. I can choose to quit at any time.
- The confidential research interview will be recorded using an audio recording device.
- My identity will not be revealed in any publication or document resulting from this study, or to anyone other than the research interviewer and his project advisor.

I have read or had read to me the above, and I have decided that I will participate in the research interview. Its general purposes, the particulars of the involvement and possible risks and benefits have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form. If I am a participant who is under the age of 18 years, it also confirms that I am an emancipated minor and am able to give my informed consent without further need of a guardian's signature.

Research Participant's Name (Print):_____

Research Participant's Signature: _____

Date: _____

Appendix 3

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

The scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State.

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

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

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self esteem.

The scale may be used without explicit permission. The author's family, however, would like to be kept informed of its use:

The Morris Rosenberg Foundation
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2112 Art/Soc Building
College Park, MD 20742-1315

References

References with further characteristics of the scale:

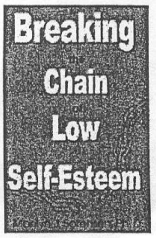
Crandal, R. (1973). The measurement of self-esteem and related constructs, Pp. 80-82 in J.P. Robinson & P.R. Shaver (Eds), **Measures of social psychological attitudes. Revised edition**. Ann Arbor: ISR.

The Self-Esteem Institute
www.getesteem.com

Self-Esteem Questionnaire

By Marilyn J Sorensen, PhD, Clinical Psychologist & Author
Adapted from her book, *Breaking the Chain of Low Self-Esteem*

Do you think you may suffer from low self-esteem? This questionnaire will help you find out. Low self-esteem (LSE) is often misunderstood, and it is even misdiagnosed by many therapists as being a secondary concern. Rather than being merely a symptom, LSE is frequently the root cause of many psychological, emotional, personal and relationship issues. Treatments that do not focus on recovery from LSE may not be be effective, because they are not dealing with the core issue.



INSTRUCTIONS: Click to place a check next to the number of each statement that you find to be true. Your score will be displayed and explained at the bottom of the second page.

RESET

1. ___ I generally feel anxious in new social situations where I may not know what is expected of me.
2. ___ I find it difficult to hear criticism about myself.
3. ___ I fear being made to look like a fool.
4. ___ I tend to magnify my mistakes and minimize my successes.
5. ___ I am very critical of myself and others.
6. ___ I have periods in which I feel devastated and/or depressed.
7. ___ I am anxious and fearful much of the time.
8. ___ When someone mistreats me I think that I must have done something to deserve it.
9. ___ I have difficulty knowing who to trust and when to trust.
10. ___ I often feel like I don't know the right thing to do or say.
11. ___ I am very concerned about my appearance.
12. ___ I am easily embarrassed.
13. ___ I think others are very focused on—and critical of—what I say and do.
14. ___ I fear making a mistake which others might see.
15. ___ I often feel depressed about things I've said and done, or things I failed to say or do.
16. ___ I have avoided making changes in my life because I was fearful of making a mistake or failing.
17. ___ I often get defensive and strike back when I perceive I am being criticized.
18. ___ I have not accomplished what I am capable of due to fear and avoidance.
19. ___ I tend to let fear and anxiety control many of my decisions.
20. ___ I tend to think negatively much of the time.
21. ___ I have found it difficult to perform adequately or without embarrassment when involved in sex.
22. ___ I'm one of the following: The person who reveals too much personal information about myself or the person who seldom reveals personal information.
23. ___ I often get so anxious that I don't know what to say.
24. ___ I often procrastinate.
25. ___ I try to avoid conflict and confrontation.
26. ___ I've been told I'm too sensitive.
27. ___ I felt inferior or inadequate as a child.

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28. I tend to think that I have higher standards than others.

29. I often feel like I don't know what is expected of me.

30. I often compare myself to others.

31. I frequently think negative thoughts about myself and others.

32. I often feel that others mistreat me and or take advantage of me.

33. At night, I frequently review my day, analyzing what I said and did or what others said and did to me that day.

34. I often make decisions on the basis of what would please others rather than on what I want or without even considering what I want.

35. I often think that others don't respect me.

36. I often refrain from sharing my opinions, my ideas, and my feelings in groups.

37. I sometimes lie when I feel that the truth would result in criticism or rejection.

38. I'm fearful that I will say or do something that will make me look stupid or incompetent.

39. I do not set goals for the future.

40. _____ I am easily discouraged.

41. I am not very aware of my feelings.

42. ____ I grew up in a dysfunctional home.

43. I think life is harder for me than for most other people.

44. I often avoid situations where I think I will be uncomfortable.

45. I tend to be a perfectionist, needing to look perfect and to do things perfectly.

46. I feel too embarrassed to eat out alone or to attend movies and other activities by myself.

47. I often find myself angry or hurt by the behavior and words of others.

48. At times I get so anxious or upset that I experience most of the following: heart racing or pounding, sweating; tearfulness; blushing; difficulty swallowing or lump in my throat; shaking; poor concentration dizziness, nausea or diarrhea; butterflies.

49. I am very fearful of criticism, disapproval, or rejection.

50. I rely on the opinion of others to make decisions.

YOU'RE

0

If you checked: 00-04 Statements ..... You have fairly good self-esteem
05-10 Statements .....You have mild low self-esteem
11-18 Statements .....You have moderately low self-esteem
19-50 Statements .....You have severely low self-esteem

It's important to realize that your score on this questionnaire in no way indicates that you are not a quality person. Instead what it does is to measure how you view yourself. If you have a healthy view of yourself, your score will be low. If your view of yourself is unhealthy, your score will be high.

Be aware that it will be difficult to raise children with healthy self-esteem, if you yourself suffer from low self-esteem. Without realizing it, you will pass on the attitudes, fears, and thinking that accompany low self-esteem.