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PATTERNS OF COMMUNICATION AND REJECTION
IN FAMILIES OF SUICIDAL ADOLESCENTS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Yair Abraham, B.A., M.A.

* * * * *

The Ohio State University
1977

Reading Committee:
Herbert E. Rie
Henry R. Angelino
Malcolm M. Helper

Approved By
Herbert E. Rie
Adviser
Department of Psychology
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VITA

December 15, 1946 ................ Born - Ramatayim, Israel

1970 ............................. B.A., The Hebrew University, Jerusalem, Israel

1971-1972 ........................ Research Assistant, Department of Educational Development, The Ohio State University, Columbus, Ohio

1972-1974 ........................ Teaching Associate, Department of Psychology, The Ohio State University, Columbus, Ohio

1973 ............................. M.A., The Ohio State University, Columbus, Ohio


FIELDS OF STUDY

Major Field: Clinical-Child Psychology

Minor Field: Developmental Psychology
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INTRODUCTION

Suicidal behavior among adolescents has been increasing at a steady rate in recent years. It now ranks as the third leading cause of death of teenagers and there are no signs that the trend may subside in the near future.

Historically, suicide had been perceived as a sinful and immoral act. It was Freud's thinking that marked the beginning of a more humanistic approach, one which treats suicide as an understandable human reaction to stress. However, psychoanalytic explanations emphasized the unconscious, irrational and maladaptive nature of suicide and focused on inner stresses and conflicts. Traditional psychological theories employed intrapsychic constructs such as self-punishment, rebirth and reunion fantasies, object loss, and hopelessness and despair to account for a person's attempt to voluntarily end his own life. Only few concerned themselves with developmental considerations or attempted to account for adolescent suicide rather than suicide in general.

Sociological theories, on the other hand, placed the emphasis on external stresses and social disintegration as the major or even exclusive causes of suicidal behavior.

More recently a few attempts were made to integrate empirical data with learning theories, most notably, the drive reduction theory, avoidance learning, modeling, and operant learning.

Family interaction theories which view the family as a system and the locus of psychopathology, and consider intra-familial patterns of communication, interaction, coalitions, decision-making, cohesiveness, etc., to be crucial for the development of mental health or ill-health, are conspicuous in their absence. They have been repeatedly applied to the study of schizophrenia, psychophysiological disorders and acting-out behavior, but not to suicidal behavior.

Since the early 1960s there has been a growing awareness among clinicians of the scope and severity of the phenomenon, and it has been
reflected in the volume and variety of published reports. Numerous attempts have been made to uncover relationships between adolescent suicidal behavior and demographic variables, season and time of day, facilitating, precipitating and predictive factors, depression and psychopathology, personality dimensions, genetic, constitutional and biochemical factors, etc.

There seems to be a growing concern with the family's contribution to adolescent suicidal behavior. Family constellation and structure (birth order, family size, broken home), and family dynamics and atmosphere (frequency and nature of conflicts, parental personalities and attitudes) have been the focus of many investigative efforts.

A major controversy exists between the claim that the adolescent becomes suicidal when he is actively rejected by his family and wished dead by them, and the claim that he tries to escape from parental responsibilities imposed upon him by parents who desperately cling to him for support and fulfillment of their own dependency needs.

Unfortunately, the present evidence is insufficient to resolve the issue, both because it derives from studies fraught with methodological errors, and because it is based on information provided by the patient alone, or, at best, by him and one of his parents, usually the mother.

Applying Minuchin's concept of boundaries, enmeshment and disengagement, and using research tools developed by family researchers, the present study addresses itself to the controversy mentioned above. It attempts to determine whether families with a suicidal adolescent are disturbed in some characteristic and objectively measurable ways, or are only perceived as such by the suicidal adolescent. The teenager's status, both real and perceived, within the family unit is also of interest for the present research.
The Incidence and Severity of Adolescent Suicidal Behavior

Suicide and attempted suicide have been steadily and alarmingly rising in all age groups in recent years. Yet in no other age group has that increase been greater than in the 15 to 19 years age group. An analysis of official figures reported annually by the U.S. Department of Health, Education and Welfare (Vital Statistics, 1952, 1962, 1972), shows the incidence of death by suicide to have risen from 295 in 1952 to 556 in 1962 and up to 1,384 in 1972, i.e., by 469 percent from 1952 to 1972. That this increase is not due only or mainly to higher numbers of adolescents in the U.S. in recent years is indicated by the parallel increase in the rate of death by suicide per 100,000 teenagers—from 2.8 in 1952 to 3.8 in 1962 and 6.9 in 1972. Furthermore, an increasingly larger proportion of all completed* suicides is committed by adolescents. Whereas in 1952 adolescent suicide accounted for only 1.89 percent of all known voluntary deaths in the U.S., a decade later it accounted for 2.75 percent, and in 1972 for 5.53 percent of all deaths by suicide.

These statistics may appear low, but a comparison of these figures with those of other causes of death, and with the total mortality rates for 15 to 19 year old adolescents, demonstrates their significance. Not only are more teenagers taking their own lives every year, but as the incidence of death from other causes declines (e.g., malignant neoplasms), suicide becomes proportionally more important. It now ranks as the third leading cause of death in the 15 to 19 years age group, surpassed only by accidents and homicide. Thus, in 1952 voluntary death accounted for only 2.48 percent of all deaths of 15 to 19 year olds, in 1962 it accounted for 4.27 percent, and in 1972 it accounted for 6.20 percent of

*The term "successful" suicide, commonly used in the literature, sounds too incongruous with the tragic nature of the phenomenon under consideration and will therefore be avoided.
all deaths in that age group. Although the information available for 1975 and 1976 is still incomplete, what is available indicates, beyond any doubt, a continuation of the same trend.

The figures quoted above are even more alarming when it is realized that they are underestimates of the true rate of adolescent suicide. Most, if not all investigators of suicidal behavior concur that numerous cases are disguised as accidents, whether deliberately by relatives and even well-meaning physicians, or mistakenly by people who are reluctant to accept the fact that young people may be miserable enough to take their own lives.

Shaw and Schelkun (1965) attribute the unreliability of the available statistics to social, religious and legal taboos; to the methods of suicide commonly used by children; to children's characteristic modes of communication; and to the tradition of Western society. The strength of taboos and their effects on individual coroners vary over time and from one community to another. Low availability of lethal weapons or drugs and their inefficiency in using them force children and young adolescents to resort to behaviors which are more readily classified as accidents, e.g., jumping from high places or running into traffic. Children, and to a lesser extent adolescents, are frequently not used to communicating in writing and therefore may not leave suicidal notes. Finally,

Western culture, in general, tends to underestimate the strength of children's emotions and motivations; therefore, suicidal motives in children are usually unthinkable—and therefore uninvestigated—in the majority of cases (Shaw and Schelkun, 1965, p. 18).

Toolan (1968) attributes concealment by parents to their inability "to deal with their own feelings of responsibility" (p. 221). He further states that the phenomenon has been "...either ignored or minimized in children and adolescents because of the erroneous concept that youngsters do not experience depression" (p. 223). Haim (1974) adds that the definition of suicide, which directly affects the reported statistics, is itself affected by many "extra-scientific factors" such as the philosophical and moral attitudes towards death in general and suicide in particular, "the degree of tolerance towards suicide," and hypotheses regarding causality, the relationship between suicidal behavior and psychopathology,
and the degree of consciousness of intention (p. 20). In children and adolescents there are the additional difficulties that arise from adults' tendencies to attribute a youngster's act to "an error of judgment regarding the consequences of the act committed, and the widespread belief that children and adolescents have no knowledge or only incomplete knowledge of death" (pp. 20-21).

A recent survey by Shaffer (1974) confirms that suicide among children and adolescents is an under-reported phenomenon. A thorough investigation of all recorded suicide among children aged 14 or under in England and Wales during a seven year period (1962-1968 inclusive) revealed only 30 cases. But in 1968 alone, when a new category--"undetermined whether accidental or purposefully inflicted"--was introduced for the classification of unnatural death, five cases of children's death were thus classified. The following year this category was used nine times. It is not unreasonable to assume that in the absence of such a category coroners prefer to err on the "safe" side.

Unfortunately, these sources of error are unquantifiable and unstable, i.e., they may change over time within the same society, or from one social context to another. Since the error factors are variable, there can be little confidence in estimates of the true rates of suicide which are based on reported rates. The ratio of true suicide to reported suicide is estimated by the Suicide Prevention Center of Los Angeles to be 2:1, i.e., for every reported case of suicide there is another case disguised as an accident (Toolan, 1975, p. 339). Jacobziner (1964) estimates that 10 percent of motor vehicle accidents and probably 15 percent of home accidents have "a suicidal component" (pp. 2-3), but provides no rationale for these estimates.

If the identification of a completed suicide is fraught with uncertainties, that of a suicidal attempt is almost impossible. The survivor of the incidence may provide an accurate or inaccurate explanation for his act, being motivated by conscious or unconscious reasons at the time. The information obtained from attempters is not always clear, and "...sometimes seems to be at variance with their overt behavior. Suicidal intent is frequently denied...," but the denial is followed by an admission that the attempter did not really care whether he lived or not.
(Stengel, 1968, pp. 171-72). Schrut (1968) observed that at times even the suicide attempter himself is not sure of his true motivation, and McIntire and Angle (1975) probably referred to the same idea with their concept of a "pharmacologic roulette" (p. 339).

It thus comes as no surprise that the true incidence of suicide attempts is unknown and is very difficult to assess. There are no official reports or nation-wide surveys of the frequency of suicidal attempts, so that estimates, usually based on the clinical experience of one worker or a small team in one agency, are extremely varied. Some investigators include threats and gestures in their reports of attempts, while others do not. Estimates of suicidal attempts range from five suicide attempts for every completed suicide (Senseman, 1969) to a ratio of 100:1 (Jacobziner, 1965), and even 120:1 (Tuckman and Connan, 1962). Such discrepancies, if transformed into absolute numbers, imply that in 1972 alone there were anywhere from 6,920 to 166,080 suicidal attempts in the 15 to 19 years age group. Obviously, such a gap renders all estimates of the incidence of suicide attempts useless.

Theories of Suicide

A well-known truth in the social sciences has it that when reliable data are meager, theories proliferate. The professional literature concerning suicidal behavior is no exception to this rule.

Most of the twentieth century theories of suicidal behavior share two characteristics. They fail to make a distinction between suicide and suicide attempts, although there is no evidence that the two are just different manifestations of the same problem; and they attempt to account for the phenomenon without regard to age differences, implicitly assuming that the determinants of suicide in latency, adolescence, adulthood and old age are constant and identical.

These theories can be grouped into three categories: sociological theories, psychodynamic theories, and learning theories.

Sociological theories of suicide.

The most familiar of the sociological accounts of suicidal behavior was advanced by the founder of academic sociology in France, Emile Durkheim, in 1951. It was presented as part of an elaborate attempt to
establish the superiority of the "aetological" over the "morphological" approach, and of sociological over non-sociological (particularly individual or psychological) explanations.

Durkheim proposed that the rate of suicide is both a function and an indicator of the degree of social health of any given social group or category. Suicide rates are high when either social integration or social regulation is high or low; the rate of suicide is low when either is moderate. Each end of the integration and regulation continua represents one of four types of suicide--egoistic, altruistic, anomic, and fatalistic.

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**Social integration.** The level of social integration determines the extent to which individual members of a group act in the service of social rather than individual interests. This determines the degree to which they find meaning in life, which, in turn, determines the rate of suicide. When social integration is low, i.e., when society disintegrates, individuals become increasingly detached from social life; they act primarily or completely in the service of their own selfish interests; they cease serving some transcendent purpose, and therefore no longer find meaning in life. Under such circumstances "the least cause of discouragement may easily give birth to desperate resolutions. If life is not worth the trouble of being lived, everything becomes a pretext to rid ourselves of it" (Durkheim, 1951, p. 213). Suicide under such conditions of social disintegration is termed "egoistic suicide."

Conversely, a well-integrated society provides both sanctions against suicide and support systems to fall back upon in stressful times. To commit suicide in such a society is to evade one's social responsibilities and is strongly condemned. There is also less of a need to take such a desperate step, since the well-integrated society makes the endurance of life's sufferings easier. By placing the group's interest above their own individuals can more readily sustain stresses.
An excessive degree of social integration may also be detrimental and lead to a high rate of "altruistic" suicide. When social integration is high, society is powerful and the individual weak, so much so that individual existence loses its meaning. Social interests take priority over individual interests, and individual members readily sacrifice themselves. They also may view life in a world beyond this one as more meaningful and take their lives in order to enter it sooner.

It is important to note that the level of integration itself is determined by the strength of the collective sentiments, which, in turn, is a direct function of the total amount of social interaction. In other words, when social interaction is extremely restricted or excessively high, the level of social integration becomes low or high accordingly, and the rate of suicide increases. Interestingly, this idea was applied to the family only in part—with regard to low levels of social interaction. According to Durkheim, when the family is large, the level of integration is high, and therefore the collective sentiments are strong and social integration is high enough to prevent suicide. Conversely, when interaction is restricted, collective sentiments are weak, and suicide more likely. He does not discuss the possibility of a family which is so large as to risk a high rate of altruistic suicide.

Social regulation. Assuming that (1) one's happiness is not a direct function of his absolute wealth but rather of the correspondence of his means to his needs; and that (2) one's needs are boundless and insatiable; and that (3) society, the source of one's needs, is the only power that can restrict and regulate these needs, Durkheim argued that when society's regulatory impact is either lessened or heightened, suicide rates increase.

When regulation is lessened, either suddenly (e.g., during acute economic depression) or gradually (e.g., when social norms are eroded over time),

...individuals find themselves in new circumstances to which the old rules are inapplicable. Consequently, they are freed from social restraints, needs increasingly outstrip means, and the resulting disequilibrium creates more unhappiness, which manifests itself in higher suicide rates (Pope, 1976, p. 26).
Suicide resulting from such a process is labeled "anomic."

The logically opposite end of the regulation continuum is that of excessive regulation, which implies the blocking of individual aspirations, desires and attempts to change. The resulting despair leads to increased rates of "fatalistic" suicide.

Durkheim's theory, although inherently logical and historically very influential (in making sociology more widely accepted as an academic and scientific discipline), suffers from a number of shortcomings.

First, Durkheim's theory is not a theory of suicide, but rather a study of "social suicide rates" (Durkheim, 1951, p. 146), i.e., it attempts to explain "why the rate is higher for one group than another, or varies for the same group over time" (Pope, 1976, p. 24). As such it is "of no assistance whatever in explaining, anticipating or preventing the suicide of any particular person" (Jacobs, 1971, p. 1). In this respect it is similar to psychodynamically oriented theories, although for different reasons.

Secondly, while rejecting individual-psychological factors as "secondary," Durkheim fails to explain why under conditions of extreme levels of social integration and regulation (either high or low) not even the majority of the group's members put an end to their lives. Similarly, the question of why a few individuals do commit suicide in well-integrated and regulated groups or societies is also left unanswered by a theory which ignores individual differences.

Thirdly, as Pope observes,

...the overlap between the theory of egoism and that of anomie is virtually complete. Including the latter makes Durkheim's theory of suicide far more difficult to falsify; however, it adds no explanatory power (1976, p. 201).

Finally, the theory suffers also from lack of empirical support. Durkheim's own data, which consists only of official suicide rates reported for various groups, as well as his methods of analysis, are judged, by "contemporary standards," to be inadequate. Research conducted by others by and large undermined his theory by failing to conform to theoretical expectations (Pope, 1976). For example, several studies of the association of family size with adolescent suicidal
behavior show a tendency of suicidal adolescents to come from large rather than small families (see more detailed discussion in a later section).

Later sociological accounts of the phenomenon of suicide followed Durkheim's lead in attempting to explain variations in rates of suicide among social groups and categories, and in using official suicide rates reported by various sources as their empirical data. Some, like Gibbs and Martin (1964), adhered to Durkheim's original sociological approach, while others, like Henry and Short (1954), attempted to reconcile it with psychological explanations.

Gibbs and Martin's contribution was an attempt to operationalize Durkheim's key concept of social integration. Social integration was defined as the stability and durability of social relationships, which are inferred from "observable conditions" such as the relative degree of role and status conflict. According to Gibbs and Martin, when "a large proportion of a population simultaneously [occupies] incompatible statuses" integration is low and suicide rates high (1958, p. 142).

This model assumes that "the actual occupancy of statuses in a society reflects the degree of compatibility among statuses" (p. 142), which, as Jacobs noted, implies that

- everyone has equal access to available statuses and
- that if they are not found occupying them, it is because they have tried and left, having found them incompatible with other statuses they hold (1971, p. 8).

This is obviously not the case since not all statuses are always open to every member of a society.

Furthermore, at least one study (Powell, 1950) found that the "Professional-Managerial" category, the highest on the status integration measure, had more suicides than five of the remaining eight categories, while the "Service" category, next to the lowest, had next to lowest instead of next to the highest suicide rate.

Jacobs (1971) cites a number of sociological studies of suicide rates in various cities which reveal the following: the upper class with the highest rates, the lower class with the highest rates, the upper and lower class with the highest rates
and the middle class with the lowest rates, and the middle class with the highest rates (p. 8).

Other sociologists, e.g., Henry and Short, tried to integrate Durkheim's approach with the frustration-aggression model, arguing that frustration leads to "extreme forms of aggression" (1954, p. 13) that can be directed either outward and result in murder, or inward and result in suicide. The status of the concept of internalized aggression is reviewed in the next section. Suffice it to say at this point that there are growing doubts concerning its usefulness.

**Psychodynamic theories of suicide.**

The most pertinent question to any psychoanalytic theory is how it is possible for the ego, which derives its energy from the life-preserving instincts, to become an instrument of self-destruction, or, to use Freud's own words: "How is it possible for the extraordinarily powerful life instinct to be overcome?" (Freud, 1910).

Freud never systematically organized his clinical observations and views on suicide into a unified and coherent theory. In his early writings the conflicting instinctual drives were thought to be libido and self-preservation, neither of which could be gratified by a suicidal act. Aware of this problem he deliberately restricted himself to suicidal ideation among obsessive neurotics and suicidal behavior among melancholics. Suicidal impulses in the former were perceived to be "self-punishment for wishes for someone else's death" (Freud, 1909). He maintained that "...no neurotic harbors thoughts of suicide which he has not turned back upon himself from murderous impulses against others" (Freud, 1917). Suicidal behavior in melancholics becomes possible when libidinal energy previously invested in a love object is, upon the loss of the love object, relocated in the ego and used to create a "shadow" of or an identification with the abandoned object. This identification with the lost object becomes a permanent and quite independent feature of the self. Thus, through identification, the ego is split and one part, which is never fully integrated into the total personality, may treat the remainder of the ego as an object, and a target of judgment and criticism. Ego-splitting allows a portion of the ego to take action against the interests of the remainder:
The ego can kill itself only if, owing to the return of the object cathexis, it can treat itself as an object—if it is able to direct against itself the hostility which relates to an object and which represents the ego's original reaction to objects in the external world (Freud, 1917).

Later, in 1920, in one of the major revisions of his theory, Freud proposed the existence of a dualistic structure, which consists of an instinctual drive toward death—Thanatos—alongside the life instinct—Eros. This new theoretical construct was introduced in order to account for the phenomena of masochism and suicide. It was felt that the monistic approach (Eros only) could not explain the distribution of energy at times of conflict since a single source of energy must activate opposing behaviors. The dualistic approach (Eros and Thanatos) overcomes such difficulties by postulating that Thanatos provides the energy needed for destructive behavior. Ideally, the two basic instincts are fused so that the destructive quality of the aggressive drive is neutralized and the aggressive impulses are expressed in sublimated ways. Self-destructive activity emerges when the neutralizing mechanism is incomplete or fails to function. Cultural prohibitions of the free expression of aggression may also contribute to the tendency of self-inflicted injuries or death. Extra quantities of aggression which are not tolerated by society are internalized and channeled into the superego and turned against the ego. Feelings of guilt, masochism, a need to be punished, or a general obscure feeling of discontent are the end result.

Menninger (1938) concurs with Freud that a condition of fusion of the death and life-preserving instincts is essential for the prevention of suicide. "In a person who commits suicide it (the self-destructive drive) suddenly bursts its bounds, springs into power, and puts an immediate end to the existence of the individual," i.e., suicide is an impulsive act.

The major weakness of Freud's theory is the concept of death instinct which has been rejected by many, including Freudians themselves, as being too speculative, teleological, and not amenable to direct observations.
Whereas the notion of a biological instinct whose aim is nirvana is largely rejected, the Freudian assumption of an innate-instinctual aggressive drive is still widely accepted among many psychoanalysts. Not unlike libidinal impulses, the aggressive impulses may be subjected to repressive forces which cause the development of defense mechanisms, such as reaction formation, projection, sublimation, and displacement. When aggression is displaced and turned away from the original object and employed on the self, depression and suicide are likely to ensue. Anna Freud discussed this process in her paper on adolescence:

They can displace the libido onto objects outside the family and turn the emotions felt toward them into their opposites. This reversal of affect, e.g., love into hate, may then be projected onto the parents who then become the adolescents' main oppressors and persecutors... Conversely, the full hostility and aggression may be turned away from the objects and employed inwardly against the self. In these cases the adolescents display intense depression, tendency to self-abasement and self-injury, or even carry out suicide wishes (Freud, 1958).

Futterman (1961) also argues that

Aggression may...be turned inward, a process that might be seen in the bodily sphere in the development of somatic complaints or in the mental sphere as a lack of self-possession, excessive severity of superego, depressive states and self-destructive or suicidal tendencies (p. 170).

Similarly, Ackerly (1967) theorizes that latency-age children become suicidal when their primitive rage and aggression against the parents arouse guilt which can be alleviated only by turning the aggression against the self. He emphasizes the hopes such children have that death will bring the pleasures and "the narcissistic satisfactions denied [them] in reality" (p. 242).

However, several studies testing this hypothesis failed to confirm the internalization concept. Tuckman et al. (1959) analyzed the emotional content of 165 suicide notes and found that in only 1 percent was hostility directed inward. West (1965) reported that one third of all murders committed in England and Wales were followed by suicide, and in most cases in very close temporal association. His impression was that
"many of these murder-suicide offenders were actuated by feelings of despair more than hostility" (p. 145). West further found that "In the sample of ordinary murders, the incidence of previous suicidal attempts was as high as in samples of persons who have committed suicide" (p. 146). In still another study only two of 14 suicidal notes, left by pre-adolescents who killed themselves intentionally, were found to contain "inwardly directed hostility," whereas five of the 14 notes contained "outwardly directed hostility" (Shaffer, 1974, p. 279).

Psychodynamically oriented theoreticians and researchers do not only view self-destructive behavior as a deflection of aggressive impulses, they also tend to treat suicide as an unconsciously determined, irrational and impulsive act. Ackerly, for example, is convinced that when a child has attempted suicide "there appears to be a break with reality... A psychotic state prevails" (1967, p. 242).

A contemporary elaboration of Freud's theory is that of the French psychoanalyst André Haim (1974). His systematic analysis is exceptional not only in being the only comprehensive and cohesive theory of adolescent suicide (to be distinguished from general theories of suicide), but also in the successful integration of Freud's basic principles with prevailing ideas on both adolescence and suicide, as well as the empirical data available at the present time. It might well be the only thorough attempt to incorporate clinical and developmental approaches in order to account for adolescent suicide.

Haim accepts the Freudian notions of a thanatogenic tendency and a life tendency which are in a continuous state of conflict or "competition." The degree of integration of the two, equivalent to Freud's concept of fusion, is a major factor in the suicidal process. However, unlike Freud, Haim does not commit himself to an instinctual theory, leaving the issue of their origin deliberately unanswered. He satisfies himself by admitting their existence and significance and defines them loosely.

According to Haim, experiences of early infancy are crucial for the development of a pre-suicidal process. Like all other psychoanalytically oriented theoreticians he views early infancy as a period of intensive
structuring, of developing formations and organizations with long-lasting effects. Thus, for example, the first eight months of life witness

...the establishment of early impulse organization, the development of displeasure from undifferentiated, overall reaction to the appearance of anxiety, mechanisms of introjection and incorporation, and the formation of the maternal Imagos and mechanisms of projection (p. 269).

During the second phase of development,

...the paternal Imagos are integrated and anxiety becomes organized, especially in relation to object losses and defences against anxiety—projection, identification, phantasization—which avoid the fear of fragmentation and disorganizing catastrophic reactions (p. 269).

Such developments are extremely important because "The wrong integration of the thanatogenic tendency into impulse organization gives it an autonomy that facilitates direct expression" (p. 269). When the early organizations are disturbed, subsequent organizations are inevitably affected. Certain disturbances, caused by particular types of parent-child interactions, may affect the "first impulse organization...to the detriment of libidinal impulses, which, in favorable cases, constitute the first anti-thanatogenic defence" (p. 270). As a result, the libidinal investment becomes extremely narcissistic and inadequate. This inadequacy interferes, in turn, with any further organization of the ego, i.e., with the organization of anti-thanatogenic defenses. The end result is a fragile organization that "may eventually lead to a tendency to disorganization" (p. 270). Put differently, the pre-suicidal process, which starts very early in life, leads to the development of an ego whose organization is inadequate and fragile, with a strong narcissistic tendency which is extremely vulnerable to a "catastrophic reaction" and complete breakdown if attacked. The essential nature of the hypothesized "pre-suicidal process" is an interaction of a poorly integrated and highly autonomous thanatogenic tendency with an ego whose organization is quite fragile.

Any personality thus affected by its earliest experiences is characterized by a number of "peculiarities" which contribute to the suicidal
situation during the adolescence years. These peculiarities ante-date both puberty and the suicide situation, but are not necessarily attended to during childhood. These peculiarities are fixed, even during the labile stage of adolescence. The main psychological peculiarities listed by Haim, and said to be present in all suicidal adolescents, are: (1) peculiarities of mood—"...a sort of permanent moroseness and dissatisfaction"; (2) disorder in elaboration—"...inadequate conceptualization and verbalization of emotion and affective experience"; (3) peculiarities in the organization of the ego ideal—"an archaic, megalomaniacal ego ideal" which places absolute demands, is rigid, and cannot be modified when faced with reality, which lead, in turn, to an intolerance of frustration; and most importantly (4) the inadequacy of the usual defense mechanisms, two of which are crucial to the development of the suicidal process: (a) the mobility of investments, which refers to the "inability to disinvest the disappointing or lost object" despite the pain caused by continuous investment in an object that was lost; (b) projective mechanism, which is commonly used by non-suicidal adolescents to bridge the painful gap between their ideal aspirations and the satisfactions offered by reality.

To reach puberty and enter adolescence with such a personality constellation is very dangerous, since adolescence is a period of major reorganizations, accompanied by temporary disorganizations and regressions, and temporarily weakened defenses. It is a phase of many rapid and simultaneous changes—physiological, hormonal, cognitive, emotional and social. All of these changes involve numerous losses. For example, the object loss inherent in the resolution of the Oedipal conflict, the loss of the ego-ideal (i.e., the idealized image of the parents), and the likely disappointment in the first extra-familial love. It is thus a continuous process of investments and disinvestments, which inevitably entails frequent disappointments and narcissistic wounds.

The pre-suicidal personality is poorly equipped to handle all these wounds and losses. When temporary disorganization occurs, which is a necessary corollary of the reorganization implied by the resolution of the Oedipal conflict, archaic motions are reactivated, and pre-suicidal
peculiarities are revived. If the thanatogenic tendency is insuffi-
ciently integrated, it may be freed (because the defenses are undergoing
reorganization and therefore are weakened) and expressed. Because of
the peculiarities of the pre-suicidal personality, the anti-suicidal
forces are nonexistent or are prevented from operating.

Present factors, such as the physical or psychological death of the
father, educational failure, or the occurrence of any other event which
is highly invested by the pre-suicidal adolescent, his parents or the
society, may be a cause of a narcissistic wound and thus contribute to the
suicidal process.

To sum up, the suicidal act is the culmination of a long "suicidal
process" which starts in early infancy with an incomplete integration of
the thanatogenic tendency into impulse organization. The child enters
adolescence with a number of peculiarities which disturb the normal
adolescent process which aims or leads to life; he reaches puberty with
weakened defenses only to find the numerous inevitable narcissistic wounds
and losses, characteristic of the stage, unbearable. An interaction of a
disturbed psychological development with the characteristic crises of
adolescence and present non-specific factors leads to the suicide of ado-
lescents.

The strength of the theory, as already mentioned, lies in its being
limited to one developmental stage, and in the attention given to develop-
mental processes as well as situational factors. It is based on a
thorough familiarity with the empirical findings presently available, as
well as on extensive and direct contact with suicidal and non-suicidal
adolescents (this could not be said about either Freud or Durkheim). The
theory is comprehensive and logically coherent.

Its major weakness is its basic assumption, i.e., the belief in the
existence of a thanatogenic force in every human being. Although we are
freed from the need to accept a biological origin for such a drive, we are
still asked to believe that every youngster is a potential suicide.
Though it is an atypical process which leads to suicide, it is enough for
but a few defenses to be incomplete or shattered at the right time for
suicide to be inevitable.
Haim does not address himself to the issue of the possible reversibility of the damage done in early infancy, nor to the mechanism by which the peculiarities of the pre-suicidal personality are developed. His theory leaves the impression that once started, the process tends to have a fixed and inevitable course. This hypothesis is contradicted by estimates of the ratio of suicide attempts to completed suicides, which, as was mentioned earlier, range from 5:1 to 120:1. Such estimates may indicate that many suicide attempters give up suicidal behavior at some point in time, and do not continue repeatedly until they achieve an early death. Litman (1963) directed attention to the fact that in the majority of cases the attempt causes sufficient changes in the environment to make further attempts unnecessary.

Learning theories of suicide.

In light of the increased popularity of learning theories and their widespread application in the treatment of various forms of psychopathology, it is surprising to find only few systematic attempts to approach suicidal behavior from a learning theory point of view.

One of the earliest attempts to account for suicidal behavior using learning theory principles was that of Graff and Mallin (1969). Theirs was a drive reduction theory, stating that tension reduction contingent upon the act is a reinforcing consequence which may result in the future repetition of the same act. Similarly, Lukianowicz (1972) views the suicidal act as a learned avoidance response to an intolerable situation. As Williams and Lyons (1976) observe, however, both interpretations lack empirical support, and both fail to explain why this particular form of behavior is chosen in the first place.

Two additional learning interpretations are better supported by the available empirical data. One hypothesis attributes the original choice of suicidal behavior to the effects of vicarious learning or modeling. This hypothesis is supported not only by reports of a contagion effect common in the classic as well as the professional literature (e.g., Mathews, 1968), but more so by several studies showing a relatively high rate of suicidal behavior among the parents, siblings and relatives of adolescent suicide attempters (e.g., Paulson and Stone, 1974; Schrut, 1968;
Shaffer, 1974; and Teicher and Jacobs, 1966). The previous occurrence of suicide in the immediate family or in the community make suicidal behavior a meaningful mode of expression and communication. Familiarity with suicide may reduce the fear of it, or may legitimize it as a problem-solving method. Farber has suggested that

...the person in whose family a suicide has occurred carries always in the back of his mind the awareness that there is a way out if necessary, and that it is a way that was taken by a person whom one may have respected or even admired (1975, p. 3).

However, there is at least one study (White, 1974) in which only 8 percent of the subjects knew someone who committed or attempted suicide. Furthermore, the presumed correlation between parents' and children's suicidal behavior does not necessarily indicate cause and effect relationships, even if one was preceded by the other. It is theoretically possible for depression, whether genetically or environmentally determined, to affect parent and child in similar ways.

Finally, the operant learning paradigm was also integrated with data on suicidal behavior. Bostock and Williams (1974; 1975) proposed that the consequences of the suicidal threat or attempt, and the influences they exert on the immediate interpersonal context, serve to reinforce this form of behavior and contribute to its maintenance. Williams and Lyons (1976) analyzed patterns of positive and negative reinforcements in suicidal and normal families and found some support for the operant learning model.

General Empirical Studies of Adolescent Suicidal Behavior

The last 15 years, since the early 1960s, have witnessed a marked increase in the number of published reports about suicidal behavior in children and adolescents. This proliferation may reflect the rise in the prevalence of this phenomenon, a higher degree of awareness among professionals of its existence and severity, and/or a weakening of earlier social, moral, and religious taboos.

There seems to be a gradual shift in the focus of these studies--from an early concern with incidence and the prevalence of certain
demographic variables, to greater attention to personality characteristics and dynamics, and family atmosphere and dynamics in recent years.

Methodological considerations.

Unfortunately, many of the reports amount to nothing more than clinical impressions and most of the studies suffer from serious methodological shortcomings and artifacts, which render usefulness as a source of factual-empirical data questionable. Chief among those methodological defects are: (1) the lack of control groups or the employment of inadequate controls; (2) the use of very small and selective samples; (3) the lack of operational definitions of variables; (4) the almost total absence of objective measures whose reliability and validity have been previously and independently established; (5) the total disregard for possible effects of experimenter biases (in no study was a double-blind technique ever used); and (6) the absence of quantification and statistical interpretation of data.

Furthermore, most reports provide only insufficient information regarding the subjects and procedure employed, thus minimizing the comparability of most studies. As is the case with many other areas of psychological research, there are neither prospective studies nor replications, and only one follow-up study (Stanley and Barter, 1970).

Studies with large samples are usually surveys of already collected information, i.e., they are based on information available in coroners' and police reports, test scores and evaluations found in school records, etc. Valuable as this information might be, it is seldom or never collected with a particular theory of causation in mind or even for research purposes. On the other hand, studies in which the suicide attempter himself, members of his immediate family or significant others provide direct and relevant information are, as a rule, subject to all or most of the methodological criticism cited above.

While some of those limitations (e.g., small and selective samples) might be an inevitable consequence of the nature and scope of the problem under consideration, others, such as the lack of operational definitions of variables and control groups, and the incomplete information provided, are unnecessary and avoidable.
Issues studied.

The various publications concerned with suicide and suicide attempts in children and adolescents deal with a host of issues. It is typical for any one study to concern itself with several questions both because they are interrelated and because of a prevailing belief that suicide is a multiply-determined, or over-determined, behavior.

A detailed discussion of these various issues will not be attempted here because they do not bear directly on the questions of major concern for the present thesis, and in order to contain the present work within reasonable limits. A brief listing of these issues will be followed by a more detailed review of the literature concerning families of adolescent suicide attempters.

Demographic and sociological factors, such as sex, socioeconomic status, race, religion, nationality, and residential area, have been correlated repeatedly with adolescent suicidal behavior (e.g., Bergstrand and Otto, 1962 in Sweden; Haim, 1974 in France; Shaffer, 1974 in England; and Jacobziner, 1965; Lourie, 1967; Shaw and Schelkun, 1965, as well as many others, in the U.S.). It is noteworthy that there is much more consensus with regard to the relationship of these variables to completed suicide than to attempted suicide, and that as a rule each of these variables is studied in isolation and independently of the rest, i.e., possible effects of interaction are ignored.

Conflicting results are reported by investigators attempting to correlate suicidal behavior with seasons of the year or with the weather. Although Shaw and Schelkun (1965) and Jacobziner (1965) found increased incidence in the spring (when studies conducted in California are discounted), Tuckman and Connon (1962) failed to find any seasonal pattern. Shaffer (1974) made the interesting observation that seven of 30 completed suicides in England and Wales were committed within two weeks of birth date, i.e., "nearly three times as often as one would expect by chance" (p. 280). There is much consensus that most attempts in this country take place between 3 p.m. and midnight (Finch, 1971), i.e., after school hours, and the same is true for Sweden (Bergstrand and Otto, 1962).
A large variety of variables is included under the broad title of facilitating, precipitating, and predictive factors. It seems that for every relationship found there is at least one other study failing to find it. Characteristically, studies employing emotionally disturbed adolescents as controls find fewer significant correlations. It is generally accepted that reasons offered by the patient, relatives, or the media are too trivial to account for the drastic act. At best they might explain "triggering factors" but little else (Shaw and Schelkun, 1965). They usually vary from minor rebuffs to serious conflicts with significant others (Ackerly, 1967).

Broken romance, failing grades, arguments with parents over school performance, household chores, dating, etc., are frequently mentioned as precipitating factors (Jacobziner, 1965; Schrut, 1968; Senseman, 1969). Antisocial behaviors such as delinquency, truancy and running away, sexual promiscuity and use of drugs, previous suicidal threats and/or attempts; loss of parent or significant other by divorce, separation but particularly through death and suicide; disorganized home and mental illness in the family; and finally, social rejection or isolation, are frequently considered to be facilitating and predictive factors especially when several of them occur simultaneously (e.g., Finch, 1971; Haim, 1974; Sanborn et al., 1973; Stanley and Barter, 1970). Antisocial behaviors in children and adolescents are perceived by some to be symptomatic manifestations of an underlying depression (Morrison and Collier, 1969; Schrut, 1968; Toolan, 1968), but this approach has been disputed (Rie, 1966) and remains unsolved.

A related issue is whether suicidal behavior is always and necessarily indicative of underlying depression, and whether the suicidal act is pathological in itself (Ackerly, 1967; Haim, 1974; Otto, 1964).

Personality correlates of suicidal behavior include hopelessness (Litman et al., 1961), low self-esteem (White, 1974), sense of incompetence and psychological dependence (Farber, 1975), irritability and resentment (Lester, 1968), low tolerance for disappointments and frustrations (Schrut, 1968), immaturity, impulsivity, and a tendency to overreact (Toolan, 1968), to mention but a few.
The role played by hereditary, constitutional and biochemical factors is, naturally, very controversial. Heredity might be implicated in the degree of susceptibility to depression, temperamental tendencies, and the inheritance of bodily deformity and extreme ugliness (Farber, 1975). Constitutional factors may involve hypersensitivity (i.e., low tolerance for frustration and a tendency to over-react), suggestibility (i.e., elevated responsiveness to death wishes of others, "suicide epidemics" and "anniversary suicides"), related psychological or physical pathology, and developmental disturbances (Shaw and Schelkun, 1965). There are only few twin studies (Kallmann et al., 1949; Kallmann, 1953) and the number of subjects too small to establish any relationship. Fink and Carpenter (1976), Hornykiewicz (1974), Cochran et al. (1976) and others studied the role of various biochemical substances in depression and suicide.

The function as well as the personal and interpersonal consequences of suicidal behaviors receive much attention from many investigators. A cry for help, whether an appeal for long overdue medical and social help (Stengel and Cook, 1958) or for familial-interpersonal help (White, 1974), may be the most frequently mentioned function of suicide attempts, gestures, and threats. Punishment for self, parents, boy or girl friend, or others (Schrut, 1968); reunion with a dead parent or significant other (Ackerly, 1967); "...reactions to feelings of inner disintegration" and "...a response to hallucinatory commands, or a desire for peace and nirvana-like existence" (Toolan, 1968, p. 223), are some of the other frequently mentioned functions. Characteristically, clinicians who attribute some of the above functions to suicidal behaviors are in disagreement with those who view it as an impulsive, uncalculated and irrational act (e.g., Haldane and Haider, 1967; Shneidman and Farberow, 1957; Tuckman et al., 1959).

A final issue involves the long dispute of whether suicide attempts are to be distinguished from completed suicide or not. Haim (1974), Hendin (1975) and others believe there is no reason to differentiate between the two as (1) some intend to die but survive by accident, and (2) among the attempters are "the majority of those who eventually commit suicide" (Hendin, 1975, p. 329), i.e., most of those who commit suicide
have attempted once or more before finally killing themselves. Others (Barahona Fernandes, 1974; Dorpat et al., 1965; Stengel, 1960) choose to distinguish between suicide attempters and victims of suicide, citing the high ratio of attempted to completed suicide as a proof that most attempters never proceed to take their own lives, and presenting empirical data which show the histories and life experience of the two groups to be different.

**Family Studies**

The available studies of families of adolescent suicide attempters can be classified into two categories: studies of family constellation and formal structure, and studies of family atmosphere and dynamics.

**Family constellation and formal structure.**

Several researchers attribute causal significance to the adolescent's sibling position and find him more likely to be either first or last born and to come from large families or broken homes.

**Birth order.** Toolan (1968), in a review of the statistics of Bellevue Hospital in New York City for 1960, found first children to predominate, probably because they are "especially prone to feel rejected and unloved following the birth of a sibling as it alters their former unique relationship with their parents" (p. 225). Haldane and Haider (1967) reported 13 subjects to be eldest children, and additional 8 to be the youngest, in their sample of 30 Scottish suicide attempters aged 9 to 15 years. Similarly, Shaffer, in his study of 30 completed suicides of 12 to 14 year old children, found 13 to be the eldest, 11 to be the youngest and the other 6 to be "...at least 5 years younger than their next eldest sibling and might therefore be expected to be functioning in some aspects as a special or only child" (1974, p. 284). Lawler et al. (1963), Perlstein (1968), and Jan-Tausch (1963) made similar observations.

A review of the literature dealing with the association between sibling position and suicidal behavior led Lester (1970) to the conclusion that "in spite of considerable inconsistency of results, none of the studies shows an excess of middle-borns among suicidal individuals. Whether first borns or last borns will be in excess appears to be affected
by age, sex of subject, degree of psychological disturbance, alcoholism, criminality, etc." (p. 204). His review included studies of children and adolescents as well as those of adults.

It is unfortunate that none of the reviewed studies involved a comparison group of non-suicidal adolescents suffering from other forms of psychological disturbances, since birth order has been correlated with childhood psychosis (e.g., Bender, 1955; Rimland, 1964; Wolff and Chess, 1964) and delinquency (Burt, 1925) to mention but a few.

Family size. Haider (1968) and Shaffer (1974) found an excess of adolescents from large families in their studies. The latter reports that only three of 30 were only children, 12 had one sibling, 7 had two siblings and 8 had three or more siblings.

Finch (1971) hypothesizes that the one denominator common to first borns, last borns, and children from large families is that they are more likely to be unplanned and unwanted by their parents and therefore less likely to receive "their fair share of love and attention" (p. 22).

Broken home. The prevalence of broken homes among suicidal children and adolescents is reported by many to be higher than their true proportion in the general population. Teicher (1973) reports that 72 percent of a sample of unspecified size "had one or both natural parents absent from home" due to separation, divorce or death (p. 133). In Schrut's group of 14 attempters, nine had lost a parent by divorce prior to the attempt (1968) while 44 percent of the 1,727 teenagers studied by Bergstrand and Otto (1962) in Sweden came from broken homes. This is in agreement with observations made by Jacobziner (1964), Toolan (1968), Richman and Rosenbaum (1970), Dorpat et al. (1966), Levi et al. (1966) and others.

However, not only are there studies which failed to document similar rates of separation, divorce, or death of parents (e.g., Haldane and Haider, 1967; Sanborn et al., 1973), but few studies which, unlike the above, employed appropriate control groups, found no excess of broken homes among suicidal adolescents (e.g., Stanley and Barter, 1970). This is hardly surprising in light of the well-established fact that broken homes are frequently found in many other psychiatrically disturbed
populations--as noted by Rutter, Tizard and Whitmore (1970), Hetherington and Martin (1972), and by Gregory (1958). The only exception to this generalization is Bruhn and McCulloch's well-controlled study of 91 suicide attempters in Edinburgh (1962). They found only 58 percent of the experimental group to have been raised by both parents, versus 75 percent in a control group of psychiatric out-patients matched for sex, age and occupation. However, their sample was predominantly an adult one, with only 11 of the 91 subjects (or 12 percent) in each group being under 21 years of age.

There are some indications that the parental loss occurs earlier in the life of the adolescent suicide attempter. Schrut found that in nine of his 14 cases "the parents were divorced or separated for significant periods of time between the patient's infancy and the time the suicide attempt occurred" (1968, p. 70). Similarly, Stanley and Barter (1970) found their suicidal adolescents to differ significantly from a control group of psychiatric patients in the timing of loss: it was earlier in the suicidal group, usually before age 12. Another comparison of adolescent suicide attempters with non-suicidal psychiatric patients yielded similar results (Stein et al., 1974).

Others, most notably Dorpat et al. (1965), believe that suicidal adolescents are characterized by multiple losses, i.e., that they, more than any other group, lose both parents before the attempt occurs. This observation is confirmed by Bruhn and McCulloch (1962) in their study of adolescents and adults.

The issue under consideration is far from being clear and its contribution to the etiology of suicidal behavior a matter of speculation. The effects of parental loss are probably mediated by the degree of identification with the lost parent, timing of the loss, subsequent changes in life style, the emotional availability of the remaining parent, availability of substitutes, degree of real and fantasized reversibility of loss, parent's image as portrayed and reinforced by the remaining parent, degree of decrease in the child's own sense of worth (due to feelings of being abandoned), sense of guilt, etc.
A few investigators, impressed by the lack of statistically significant and stable differences between suicidal and non-suicidal psychiatrically disturbed adolescents in the frequency of broken homes, concluded that it is neither "broken home" per se, nor the loss of love object which leads to suicidal behavior, but rather the loss of love itself (Hofmann, 1975; Jacobs, 1971). The loss of love may occur in intact as well as in broken families. It is implicated and reflected in a variety of behaviors. It might well be the common denominator of all studies concerned with the home atmosphere and family dynamics.

**Family atmosphere and dynamics.**

The disturbance of the nuclear family of the suicidal adolescent has been variously described as involving some or all of the following: poor intra-family communication, isolation of child, inadequate support system, inappropriate parental attitudes, active rejection of child, etc.

**Communication.** A few investigators (e.g., Hofmann, 1975; Schrut, 1968) were impressed by the minimal amount of communication among family members over differences and difficulties. Although the origin and nature of these profound and long-standing communication difficulties are not accounted for, it is assumed that such a situation is conducive to the arousal of feelings of isolation, lack of support, and being unwanted, especially in the adolescent who is going through a stormy phase of multiple developmental stresses and normal losses. Sabbath (1969) claims suicide to be the inevitable consequence of "a failure in communication between the individual and his meaningful object relationships, together with an inability to cope with the stresses of life" (p. 272).

This lack of meaningful communication may be a consequence of disturbed parental personalities and attitudes, as well as a cause for and result of persisting quarrels and marital conflicts in which the adolescent is caught.

**Parental attitudes.** Parents of adolescent suicide attempters were described as rejecting (Sabbath, 1969); cruel, neglecting and showing very little interest in getting help and preventing recurrence (Tuckman and Connon, 1962); hostile (Rosenbaum and Richman, 1970); ambivalent (Schrut, 1964); demanding and never satisfied with "work their children
found fascinating" because of their own inability "to cope with pleasure and excitement" (Hendin, 1975, p. 329) and suffering a chronic or recurrent physical or mental illness (Haldane and Haider, 1967).

Fathers were portrayed repeatedly as passive (e.g., Glaser, 1965; Grow et al., 1970; Haim, 1974) i.e., as creating difficulties for the normal and healthy processes of psychosexual development and identity formation of their adolescent child. Paternal passivity and disinterest is also said to create a vacuum in the family balance, thus leaving the child to the mercy of a domineering mother and depriving him of opportunities "to gain independence and strength" (Glaser, 1965, p. 224).

However, fathers were also found to be aggressively dominant, unable to affectionately support either wife or children, yet sometimes overindulging though without overt affection (Haldane and Haider, 1967). White (1974) identifies two paternal patterns:

One (three families) involved fathers who were rigid, strict, disciplinarians, displaying marked hostility towards their children. They laid down rules for their offspring behaviour which were so coercive and divorced from the child's experience outside the family as to invite rebellion and hence further recrimination (p. 31).

The other pattern (four families) involved "fathers who were irresponsible, ineffective, habituated to drink and gambling, sporadically violent, but socially indifferent to family needs" (p. 31). Such a pattern causes much turmoil at home leaving mothers with very little time or energy for consistent child rearing. White states clearly that "the father was most often the nuclear problem" (p. 31). It is interesting to note that the only two studies to find dominant fathers were conducted in the United Kingdom.

Mothers were described as "cold, rejecting, and rigid" (Bigras et al. 1966); "angry, depressed, and withdrawn" (Margolin and Teicher, 1968); domineering and exercising rigid control over their children thus denying their independence and freedom (Glaser, 1965); and emotionally labile, prone to depression, struggling with unresolved dependency needs, and disturbed (Krcider and Motto, 1974).
As Finch (1971) noted, such descriptions are applicable to mothers of many non-suicidal psychiatric patients. Furthermore, all the above studies of parental attitudes "are primarily descriptive and impressionistic" (p. 21). Operational definitions of passivity, rigidity, emotional lability, etc., and objective measures of these dimensions have not been used.

Marital disharmony. Several investigators tried to examine the quality and nature of family conflicts and their findings are somewhat contradictory. Stanley and Barter (1970), in one of the few well-controlled studies, using histories which have been recorded by many different observers, found "no significant difference in the recorded amount of fighting, quarreling, or alcoholic abuse" (p. 90) between a group of 38 adolescent suicide attempters and a similar-size group of non-suicidal psychiatrically ill teenagers (matched for age and sex). However, they did find 26 percent of the parents of the experimental group but only 8 percent of the control parents to repeatedly threaten separation or divorce.

Paulson and Stone (1974) concluded from their contacts with 12 suicidal pre-adolescent boys and girls the existence of a high prevalence of chronic marital unhappiness in the homes of those youngsters. Similarly, Sanborn et al. (1973) using the "psychological autopsy" technique ("A narrative report resulting from interviews with the suicide victim's family, relatives, friends, family physicians, and other significant persons in the deceased's life," p. 235), found "a climate of discord and unhappiness" in eight of ten families in which a child committed suicide. In those eight families a major problem appeared to be in communication, but no further information could be obtained about the exact nature of the communication problem.

Schrut (1968) interviewed 14 adolescent girls who attempted suicide, as well as at least one parent of 11 of them, and found "a stormy way of life" marked by, among other things, frequent quarreling between parents, in a "majority" of the 14 cases (p. 70).

Death wish. A few investigators, dissatisfied with a mere description of parental attitudes and marital disharmony examined the
content of the parental communication and identified what they consider to be a unique feature of suicidal families, namely, a recurring message to the child—"kill yourself"!

Schrut (1964), in his study of 19 suicidal children, identified a basic feeling of being a burden that was directed toward the child. In at least ten cases this feeling has been present unconsciously since infancy. Both mother and child were struggling to keep this demand for the child's nonexistence from coming to consciousness.

Gould (1965) believes that

For many reasons the parent(s) may wish the child did not exist...[and] basically feel they would be happier without children. The child who picks up these clues...may try to follow his parents' unconscious (or conscious) wishes and attempt suicide if this is the only way to gain their approval and love (p. 307).

Sabbath (1969) coined the term "the expendable child" to describe

...a parental wish, conscious or unconscious, spoken or unspoken, that the child interprets as their desire to be rid of him, for him to die...
The parent perceives the child as a threat to his well-being, and the child sees the parents as persecutors or oppressors (pp. 272-73).

A child may become expendable under certain circumstances—when he can no longer be tolerated; when "He ceases to be useful either as an object of affection or as the vicarious fulfiller of the needs of his parents" (p. 282); when he is not useful in "maintaining the precarious equilibrium within the family structure" (p. 282); or when he becomes "a positive threat to the sanity, the marital stability, and the very existence of the parents" (p. 283). When this condition develops, feelings of rejection are communicated to the child and then it is only a matter of time until an incident of felt rejection triggers the suicide attempt. In other words, this situation is the necessary and sufficient condition for adolescent suicide.

Interesting as this thesis might be it arouses at least as many questions as it attempts to answer. It is unclear why the child or adolescent becomes expendable at a certain time, i.e., why he stops
fulfilling some or all the functions listed above, and in what ways he may threaten parents' "sanity," "marital stability" or even their "very existence." This is a perplexing issue also because Sabbath states that "the roots of expendability go back at times to birth or even before conception" (p. 283). It is equally unclear how one child is chosen to be the expendable one from among several siblings. Sabbath did not address himself to these questions and since his thesis is based on only three brief case studies, it should be treated as a source of hypotheses rather than established fact.

Richman and Rosenbaum (1970) were also impressed by a strong familial wish for the death of the suicide attempter. They interviewed "over a hundred" suicidal persons, ranging in age from 8 to 86, together with at least one family member. Thirty-six of these patients were subjected to "a more intensive study." The same procedure had been applied to 30 in-patients suffering a variety of severe psychiatric disturbances, including "concealed suicidal behavior or ideation" but whose admission was for non-suicidal reasons (p. 216). They found "much more aggression, hostility, and rejection [being] directed towards the suicidal patient by family members than is returned by him" (p. 217). This pattern is said to distinguish the control from the experimental group. The suicidal family is angry with the patient, fed up with him, and treats him like a burden. The patient himself agrees with the family and confirms that he is a burden, without which everyone would be better off. The suicidal member of the family does not fight back because of both external and internal prohibitions--he is not allowed by the family to express hostility, and he fears the magical effect of his own aggression. He is isolated within his own family, left alone to deal with his own unexpressed aggression as well as with that of the significant others. Interestingly, "the death wish in a suicidogenic situation is communicated by someone who not only is loved by the patient but who also loves the patient in return." The suicidal act often represents "a response to the non-hostile needs of the significant other." The death wish, whether expressed verbally or not, is not "I could kill you" but rather "I can't kill you but we'd all be better off if you were dead" (p. 223).
As Richman and Rosenbaum note, this pattern was recognized by Straker (1958) who argued that serious suicidal attempts reflect a wish to die in order to gratify others' hostile wishes; by Meerloo (1962) who proposed the concept of "psychic homicide"; and by Federn (1910) who is quoted to have said: "Only he who is wished dead by someone else kills himself."

Hendin (1975) draws on his clinical experience and briefly describes five cases to support his thesis that young suicide attempters "are tied to their parents in a kind of death knot [and] become overtly suicidal when life--coming to college, graduating, becoming seriously involved with another person--threatens to unravel this knot" (p. 338). They "see their relationships with their parents as dependent on their emotional if not physical death" (p. 328), and this "bond of emotional death" lasts even after the death of a parent so that parental death per se is less important than the death knot" (p. 329).

However, using a different method, Gehrke and Kirschenbaum (1967) found what might be considered the opposite pattern. In the course of treating 20 families with disturbed adolescents they were struck by the recurrence of three distinct familial patterns of communication and interaction--one characteristic of families with a psychosomatically ill teenager, another characteristic of families having a delinquent adolescent, and finally, a pattern characteristic of families with a suicidal youth. They found the "suicidal family" (i.e., family with an adolescent suicide attempter) to share a survival myth that

No one can function alone, that no member is whole without the others, and that, therefore, the family cannot survive if any member leaves it... Interaction consists of constant consistent, universal disqualification. Coalitions constantly shift depending on who is being threatened... The family system is working against pinning anybody down. The function of the identified patient...is to act out the aggressions of both parents while at the same time providing them with support and reassurance. The Survival Myth implies that neither parent can survive without the other and without the children the parents cannot
survive... In this family system no one is in charge" (pp. 73-74).

The contradiction of Sabbath's "expendable child" is obvious. Here the identified patient is said to be essential for the survival of the family, especially the marriage. His departure is likely to destroy rather than save the family. He provides support and opportunities to relieve emotions, especially aggressions for his parents, and he is an active member of existing coalitions. Also, such a description conflicts with those studies showing at least one parent, usually the mother, to be the dominant figure at home.

Kreider and Motto's analysis of three case studies (1974) lends some support to Gehrke and Kirschenbaum's impression. They found role reversal, initiated and maintained by a parent whose dependency needs were never resolved, to arouse much hostility in the teenager, hostility that is likely to become internalized. Role reversal arouses hostility because it deprives the child of the nurturance he needs; restricts him by placing demanding expectations on him; is an imposed burden; and may arouse severe anxiety in a youngster who "senses his inability to fulfill the parental role adequately" (p. 366). Suicidal behavior is seen not only as a misdirected aggression, but also as a means of escaping from the parental role. Self-destructive behavior may indicate to the parents the child's true needs, may cause the child's removal from home by the parents or others, or may result in his permanent removal-death.

To sum up, it is presently unclear whether an adolescent becomes suicidal because he is actively rejected by his parents and others in the family, or because he collapses under the responsibilities imposed on him as a parental-child. It is also unknown how he compares in these respects to his own siblings. This state of affairs is hardly surprising in light of the methodological shortcomings by which most studies are afflicted.

**Evaluation of family studies.**

The studies reviewed in the last section demonstrate the great importance attributed in recent years by investigators of adolescent suicidal behavior to familial relations. Unfortunately, inconsistencies
of findings are the rule, and due to serious methodological shortcomings there can be only little confidence in the reported findings. Besides the methodological criticisms voiced in an earlier section of all studies of adolescent suicide, studies of intra-familial relations suffer some additional disadvantages. First, almost all of the studies confuse intact and broken families in their samples although there are ample reasons to suspect the dynamics of each to be widely different. Secondly, studies of home atmosphere, intra-familial conflicts, parental attitudes, etc., are primarily descriptive and impressionistic, rarely experimental. Finally, with only two exceptions (Gehrke and Kirschenbaum, 1967; Williams and Lyons, 1976) existing studies are psychodynamically oriented, and as such they concentrate primarily on deviations from normal parent-child relationships. The data that have been gathered were provided by only one or two informants, characteristically, the patient and/or his mother. All other members of the family have been ignored, yet conclusions concerning the whole family have been reached. Such an approach implicitly assumes that any one member is motivated and capable of adequately describing the intricacies of his own family life. Although these studies were successful in associating adolescent suicidal behavior with severe family disorganization, they could not uncover the exact nature of these familial deficiencies, or single out those which distinguish the home life of the suicide attempter from that of adolescents suffering other disorders. As Williams and Lyons (1976) state, the fact that this approach still prevails in this area of research is

...surprising in the light of the research effort in recent years, which has led to a considerable body of knowledge related to normal and disturbed family functioning (p. 243).

In light of the above it seems reasonable to view the clinical and demographic studies as a rich source of valuable hypotheses. These hypotheses can, and have to, be examined experimentally, using some of the more recent techniques developed by family interaction researchers. Furthermore, they may be fruitfully reconceptualized from a systems theory point of view. The present research will be a preliminary step in this direction.
Family Interaction Theory

In the last 20 years several theories have been advanced which attempt to explain the family's role in the emergence of psychopathology in one or more of its members. The various theoreticians share a few fundamental assumptions, some of which are, that (1) the nuclear family is a system which employs certain patterns of interaction repeatedly; (2) every member of the family participates in a reciprocal process with other family members; and (3) the locus of psychopathology is neither intrapsychic nor dyadic nor even triadic, but rather in the system as a whole. Extensive research conducted in the 1960s and 1970s corroborates these assumptions. Comprehensive reviews are available elsewhere (Riskin and Faunce, 1972; Jacobs, 1975) and will not be attempted here. Suffice it to say these theories and studies focus on concepts such as the power structure within the nuclear family, the nature of the intra-familial coalitions, decision-making processes, efficiency of functioning, levels of cohesiveness, and quantity and quality of communications.

One model of family functioning, proposed by Minuchin (1974), seems to converge with the existing literature on families of adolescent suicide attempters, and thus may provide a useful way of conceptualizing the suicidogenic elements in such families from a system point of view. One of Minuchin's key concepts is that of "boundaries" between subsystems within the family. Boundaries are "the rules defining who participates, and how," and their function is

...to protect the differentiation of the system. Every family subsystem has specific functions and makes specific demands on its members; and the development of interpersonal skills achieved in these subsystems is predicated on the subsystem's freedom from interference by other subsystems (Minuchin, 1974, pp. 53-54).

In order to fulfill this function

...the boundaries of subsystems must be clear. They must be defined well enough to allow subsystem members to carry out their functions without undue interference, but they must allow contact between the members of the subsystem and others (p. 54).
The degree of clarity of generational boundaries (i.e., boundaries between the parental subsystem and the children's subsystem) defines a continuum whose two opposing poles are labeled "enmeshment" and "disengagement," with the majority of families falling somewhere between those two extremes. Enmeshment describes a situation of extremely diffused boundaries, and disengagement refers to the other extreme of overly rigid boundaries.

The enmeshed family develops its "own microcosm," where communication is abundant and intra-familial concern at its highest. Extreme closeness and blurry boundaries characterize the enmeshed system. It tends to respond with "excessive speed and sensitivity" under stressful circumstances. "The boundaries that define individual autonomy are so weak that an individual's life space is impinged upon. This may be reflected in lack of privacy, excessive 'togetherness' and sharing" (Minuchin et al., 1974), and, it may be added--role reversal.

The disengaged family, on the other hand, develops very rigid boundaries, to the extent that communication between subsystems becomes very difficult. As a consequence, "the protective functions of the family are handicapped" (p. 54). Members of disengaged families are said to be quite independent of each other to the point that they lack feelings of loyalty and belonging and the capacity for interdependence and for requesting support when needed (p. 55) (emphasis added).

In a disengaged system "...stresses in one family member do not cross over its inappropriately rigid boundaries. Only a high level of individual stress can reverberate strongly enough to activate the family's supportive system" (p. 55) (emphasis added).

The similarity of the enmeshed prototype to Gehrke and Kirschenbaum's and Kreider and Motto's descriptions of the suicidal family is striking. Similarly, the resemblance of the disengaged system to Sabath's and Richman and Rosenbaum's portrayal of the suicidal family is equally striking.

Statement of the Problem

The trio of boundaries, enmeshment and disengagement, both determine and reflect the type of communication and interaction patterns
prevailing in a family. Similar concepts were implicated in existing clinical and demographic studies of families with a suicidal youth, yet with inconsistent results due to major methodological, and even conceptual, limitations.

The present study is a partial attempt to shed some more light on the role played by the nuclear family in the teenager's decision to make an attempt on his life. This may be accomplished by approaching the issue from a family interaction theory point of view, and through the application of reliable and valid measures, and in a direct, controlled and experimental procedure to some aspects of the lives of families with adolescent suicide attempters. By comparing all members of families with adolescent suicide attempters to families of psychosomatic and of non-disturbed adolescents, answers to the following questions will hopefully emerge:

(1) Is there a "suicidogenic family" whose disturbance is discernible in some objective ways, or is it only perceived as disturbed by the adolescent suicide attempter?

(2) If there is a disturbed pattern that can be observed directly by an outsider, toward which end of the enmeshment-disengagement continuum is such a family typically leaning?

(3) How is the suicide attempter's position within the family different from that of his siblings, if indeed it is at all?

(4) Is the family perceived similarly or differently by the various members of the suicidal family?

Hypotheses.

The following hypotheses will be tested:

(1) Closeness, communication of self-revealing information, and sensitivity and responsiveness to members' desires are lowest in families of suicidal adolescents (SU), highest in families of psychophysio logically ill teenagers (PS), and moderate in families with non-disturbed youth (NO).

(2) Family efficiency is lower in SU and PS families than in NO families.

(3) Perceived family effectiveness is lower in SU and PS families than in NO families.
(4) Family satisfaction is lower in SU and PS families than in NO families.

(5) The suicidal identified patient (IP) is subject to rejection and criticism at home while his psychosomatic counterpart is over-protected, and the non-disturbed IP is neither rejected nor over-protected, i.e., is treated like his siblings.

(6) IPs, in all three groups, perceive their families' attitudes toward them quite accurately, so that the SU IP expects his family to reject him more than his siblings; the PS IP expects his family to favor him over his siblings; and the NO IP expects to be treated as one among equals.
CHAPTER II

METHODOLOGY

The hypotheses of the present study were tested by comparing the performance of families with suicidal adolescents with that of families of psychophysiologically ill teenagers, and families of non-disturbed adolescents on three objectively scored tasks. Testing was done with each family individually and was completed in one session in which all family members living at home with the identified patient (IP) participated.

Subjects

Choice of experimental and control groups.

The sample in this study consists of three groups of families—an experimental group of families with adolescent suicide attempters, families with psychophysiologically ill teenagers, and families with non-disturbed adolescents. They will be referred to as SU families, PS families, and NO families, respectively.

The non-deviant, or normal, control group is essential in order to determine the significance of obtained differences (as well as similarities) between the experimental group and the non-suicidal but otherwise disturbed group (PS in the present study). In the absence of a normal control it is impossible to evaluate whether such differences indicate the existence of disturbance in the experimental group, in the control group, or in both. It is possible for the experimental group to differ from the non-normal control on some measures yet to fall within the normal range on these same measures.

The use of a deviant control group is dictated by the need to assess whether differences obtained between the experimental group and the non-disturbed control are uniquely characteristic of the experimental group or are shared by other disturbed groups as well, i.e., whether they are correlates of a specific disorder or of psychological disturbances in general.

The employment of a disturbed control group composed of patients afflicted by the same type of psychopathology, rather than by a variety...
of deviances, is indicated by the fact that theories of psychopathology predict different, rather than similar, antecedents for different forms of pathological behavior. Psychological heterogeneity in a disturbed control group might simply obscure significant similarities and differences between it and the other groups. Yet the use of disturbed controls homogeneous for type and severity of disturbance is rare (Hetherington and Martin, 1972).

The choice of families with psychophysically ill teenagers to serve as a control group in the present study was dictated by both theoretical and practical considerations.

The psychophysically ill patient has been described by several psychodynamically oriented theoreticians in ways which are reminiscent of the description of the suicidal individual, yet the home situation of the two groups may differ greatly. The asthmatic patient was portrayed as one who is unable to express emotions, especially aggression and grief (Herbert, 1965), and the asthmatic attack was viewed as a suppressed cry for help (French and Alexander, 1941). Sperling called ulcerative colitis a "psychosomatic suicide" (Ackerly, 1967). Haim (1974) found the "frequent absence of phantasization and anxiety" and the "tendency to express emotion through the body rather than in verbal communication" (p. 290) to be a common characteristic of both suicidal and psychophysically afflicted patients. He also refers to the phenomenological, if not dynamic, resemblance of suicide and anorexia nervosa.

At the family level, Minuchin and his co-workers have shown in a series of studies (Minuchin, 1974; Minuchin et al., 1973; Minuchin et al., 1974) that psychophysologic disorders are produced in families which are characterized by enmeshment, over-protectiveness, lack of conflict resolution, and rigidity. This pattern was observed in families of asthmatic, diabetic, and anorectic patients, i.e., the model they advocate is a non-specific one.

By comparing SU families with PS families, i.e., families already shown to be disturbed and in a known direction along a dimension which is central to the present work, the psychological significance of differences, if obtained, will be clearer. If the main etiological factors are
familial, and if the SU family tends to be a disengaged one as hypothesized, then the two groups should show significant differences on measures of enmeshment-disengagement.

The decision to use families of psychophysically ill teenagers as the disturbed control was also based on practical considerations. The original design called for the employment of families of runaways to serve as a control group because of the presumed similarities, rather than differences, of the two conditions. Both running away and suicide attempts are considered to be manifestations of acting-out behavior. Both are said to originate in disorganized homes and rejecting families, and, phenomenologically, both are perceived as escapes from an unbearable situation. Indeed, it is not uncommon for adolescent suicide attempters to have a previous history of running away. It may seem that the major difference between the two groups is only a matter of degree or severity. A comparison of the two could help in determining which of the family characteristics are common to families with acting-out teenagers, and which are uniquely characteristic of families with suicidal youth.

However, the existence of such a continuum could not be tested because of the unavailability of intact families of runaways. Of two possible sources in the Columbus area one refused to cooperate for fear of interference with its own work, while the other failed to provide the names promised (claiming, initially, an extremely low incidence of running away during the unprecedently cold winter of 1976-77, and, later, an extremely low rate of intact families among its clientele).

**Definitions.**

**Suicidal attempts.** Following Stengel (1968) and Kirstein et al. (1975) suicide attempt was defined as "any non-fatal act of self-damage inflicted with self-destructive intention, however vague and ambiguous" (Stengel, 1968). "Lack of intent was not assumed merely on the basis of the patient's denial, absence of serious risk to life,...added manipulative elements" (Kirstein et al., 1975, p. 23), or absence of symptoms of depression prior to the attempt.

The above definition is broad and consistent with those of Kiev (1974) and Kessel and Lee (1962). It includes cases commonly referred
to as gestures and apparently harmless acts of self-damage because adolescents' understanding of lethality may frequently be incomplete. This definition excludes behavior patterns which, though self-damaging in the long run, are not undertaken with the intention of self-destruction (e.g., alcoholism, drug addiction). Adolescents who have been known to have used drugs in the past were excluded even if they themselves claimed a suicidal intent since it is not uncommon for a youngster to try to conceal his involvement with drugs by claiming a suicidal intent. Threats and preoccupation with suicidal fantasies and ideation were also excluded; some kind of act was required. Pregnant girls who might have attempted abortion and injured themselves in the process, mentally retarded and psychotic individuals were also excluded, the first because the act could have been directed against the fetus rather than self, and the last two in order to minimize confounding variables and ensure comparability with the two control groups. All the car accident cases brought to the attention of the investigator were screened out because in none was there enough information available to indicate intentionality. Cases in which the adolescent was not a driver were included in the NO group.

Of the 15 suicidal patients included in the present sample all but one attempted suicide by taking an overdose of drugs of varying degrees of lethality. The remaining one shot himself in the abdomen.

**Psychophysiologic disorders.** Psychophysiologic disorders were defined as physical illnesses that are of proven or presumed psychogenic origin (American Psychiatric Association, 1968).

Commonly, medical diagnosis is negative, i.e., there are no known organic causes to account for the onset, severity and frequency of occurrence of the symptomatology. Furthermore, responsiveness to medication is either minimal or short-lived. The only two positive elements contributing to a psychosomatic diagnosis are: (1) association of the onset with known emotional problems or stressful life situation; (2) the success of parentectomy (separation from the family) in alleviating the symptom.

Only four kinds of psychophysiologic disorders—asthma, anorexia nervosa, juvenile diabetes, and abdominal distress including pain and vomiting—were sought for the present study since Minuchin's studies were
conducted primarily with these groups. However, only asthmatic cases were referred and studied. Asthma was defined as follows:

Chronic, severe, relapsing in spite of competent pediatric management. Improvement after separation from the family, followed by a relapse upon returning home. This syndrome—labeled intractable asthma by Peshkin and Tuft—constitutes 10-12% of all children with asthma.

Attacks occur in a specific type of emotional situation (with no known allergen). Otherwise there is no regularity or lawfulness in the occurrence of the attacks.

Referring sources were briefly interviewed, whenever possible, in order to clarify reasons for suspicion of a suicidal attempt or a psychophysiological disorder. Furthermore, parents were asked in a casual and non-intrusive manner about the nature of the recent incident, possibility of previous use of drugs (in SU families), and about the frequency of and circumstances surrounding asthmatic attacks (in PS families). This was done during the initial telephone contact or at the beginning of the testing situation in order to establish the true nature of the problem as clearly as possible. Doubtful cases were excluded.

Normality. Normal families were defined as families in which no member had psychiatric or psychological treatment in the last five years, or had a criminal record. The informants were, by necessity, always the parents.

Recruitment of subjects.

Eleven hospitals and mental health agencies in the Columbus, Ohio, area and four psychiatrists in private practice expressed their willingness to refer appropriate patients after carefully reviewing the proposed study, and after receiving assurances of minimal or no-interference with their diagnostic and therapeutic efforts or their daily routine. Concerns regarding protection of patients' rights and identities were met. The consenting institutions included Children's Hospital, Upham Hall, University Hospital, Harding Hospital, Mt. Carmel Medical Center, Children's Mental Health Center, The House, Doctors Hospital, North Central Community Mental Health Center, Alfred Willson Children's Center, and Worthington Community Counseling Service. Actual referrals were made only
by the first six agencies. Not a single patient of the other five agencies and the four private psychiatrists was ever referred in spite of repeated inquiries. A contact person (physician in charge of emergency room, nurse, social worker or secretary), chosen by the agency, was contacted at least once a week (usually twice a week). With one exception, none of the contact persons ever initiated a referral, in spite of repeated promises to do so. Children's Hospital and University Hospital allowed the investigator direct access to current emergency room records. A few of the agencies required a parent's written permission to release his name, address and telephone number before making a referral.

All hospitals and mental health agencies participating in the project were given a detailed definition of a suicidal attempt together with a checklist to serve as a guideline in making referrals. They were urged to refer even doubtful cases for the investigator to determine whether a case met the criteria used. This was deemed necessary because numerous workers from a variety of agencies and with different orientations and levels of education and experience were involved in making referrals. Since it was impractical to try to train them, it was decided to leave the final decision concerning the appropriateness of a case to the investigator himself.

Names and telephone numbers of normal adolescents were obtained from the emergency room records of Children's Hospital (with the exception of one family which was recruited through friends). Teenagers receiving treatment in the emergency room or hospitalized for accidents or sudden illness may be subjected to traumatic experiences not unlike those experienced by suicide attempters and psychosomatic patients. The same holds true for their families. Thus, they may provide a good control for experiences associated with injury, emergency treatment and/or hospitalization. Furthermore, normal Ss obtained from the same source as the other two groups were more likely to come from similar socioeconomic backgrounds.

Over 200 families were contacted by telephone and were invited to participate in the study. Of 69 SU families thus contacted 54 either refused to participate or failed to meet the criteria set for the sample (definition of suicide attempt, age, intact family). Similarly, 32 of
45 PS families, and 79 of 93 NO families that were contacted could not or did not want to be included in the final sample. Although exact figures were not kept, it is cautiously estimated that two thirds of the exclusions in the SU group and PS group were due to parental refusal and only one third was excluded because of failure to meet the criteria. In the NO group, the frequency of refusal is estimated to have been higher--about 75 percent.

In addition to the definitions of suicide attempt, psychophysiologic disorder and normality used in the present study (which led to the exclusion of a number of families), all participating families had to meet the following criteria: (1) The IP had to be a teenager, i.e., between 13 to 19 years old. The original proposal called for a more narrowly defined age group--15 through 19--but it proved to be too restrictive and was thus expanded downward by two years. (2) The family had to be intact. An intact home was defined as a household containing one adult identified as a paternal figure, and another adult identified as a maternal figure. Thus it was not mandatory for either father or mother to be the natural parent. However, they had to be living together, as one nuclear family, for a minimum of three uninterrupted years prior to the present study. (3) None of the family members was a trained psychiatrist, psychologist, or social worker.

Sample description.

The final sample was composed of 15 SU families, 13 PS families, and 14 NO families, with a total of 176 subjects. Table 1 indicates the composition of this sample in terms of the mean age, age range, sex and sibling position of the IPs. Due to the high rate of family refusal or inability to participate in the study, direct matching of the three groups on variables of major importance could not be attempted. Table 1 shows the PS patient to be slightly, though not significantly, younger than either the SU or NO patient. The PS patient is also more likely to be a female and an only child. None of the suicidal and normal patients in the present study were only children. As in other studies, the suicidal patient in the present sample also tends to be either the oldest or youngest sibling. It may be concluded, then, that not only are the three
### Table 1

**AGE, SEX AND SIBLING POSITION OF THE IDENTIFIED PATIENT IN THREE GROUPS**

<table>
<thead>
<tr>
<th>Variable</th>
<th>SU</th>
<th>Group</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>15</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td><strong>Mean age</strong></td>
<td>15.26</td>
<td>14.76</td>
<td>15.64</td>
</tr>
<tr>
<td><strong>Age range</strong></td>
<td>13-18</td>
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<td><strong>Sex:</strong></td>
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<td></td>
</tr>
<tr>
<td>M</td>
<td>7</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td><strong>Sibling position:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Second</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Third</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Fourth</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Fifth</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sixth</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
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<td>1.46</td>
<td>1.92</td>
</tr>
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<td>Youngest</td>
<td>5</td>
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</tr>
<tr>
<td>Oldest</td>
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<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Only</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>
groups quite similar in IP major characteristics, but they are probably comparable to samples employed in other studies.

The formal structure and major characteristics of the 42 families studied are summarized in Table 2.

As shown in Table 2, the SU families in the present study tend to be slightly larger than NO families, and both are significantly larger than PS families. There is a higher incidence of remarriage in SU families than in either PS or NO families, but the difference does not reach the .05 level of statistical significance. Parents in PS families are somewhat younger than parents in either SU or NO families, but the difference is significant only for fathers. Parental education and socioeconomic status is similar in all three groups, with PS parents being slightly higher on both measures. SES was determined on the basis of father's occupation according to an interval scale of occupations proposed by the U.S. Bureau of the Census (1963). The score assigned to a family may range from 00 to 98 and was derived by averaging scores for the component items of occupation, education, and father's income. The three groups were matched with regard to race, having only one black family each.

The differences found among the three groups of families are consistent with findings reported in earlier studies, thus contributing to the comparability of the present sample.

Instruments

Three family tasks were used: The Unrevealed Differences Technique, The Family Concept Test, and the Statement Game and Guessing Game.

The Unrevealed Differences Technique (see Appendix A).

Task. Family members are instructed to complete a questionnaire referring to a number of "situations." For every situation members are asked to indicate the three choices they like the most and the three choices they like the least or not at all, among ten given alternatives. The questionnaire is completed twice--once individually by each member, and then as a family, i.e., with the understanding that their choices are meant to represent a family decision and as such apply to all members.
# TABLE 2

**FORMAL STRUCTURE AND GENERAL CHARACTERISTICS OF ALL FAMILIES, BY GROUP**

<table>
<thead>
<tr>
<th>Variable</th>
<th>SU</th>
<th>Group</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>15</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Number of children:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
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<td>1</td>
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<tr>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.00</td>
<td>2.30</td>
<td>3.57</td>
</tr>
<tr>
<td>Parents:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural</td>
<td>9</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Step</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Father:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age&lt;sup&gt;b&lt;/sup&gt;</td>
<td>45</td>
<td>40.38</td>
<td>46.35</td>
</tr>
<tr>
<td>Mean educ.</td>
<td>11.73</td>
<td>13.46</td>
<td>13.14</td>
</tr>
<tr>
<td>Mother:</td>
<td></td>
<td></td>
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<tr>
<td>Mean age</td>
<td>41.66</td>
<td>37.46</td>
<td>40.92</td>
</tr>
<tr>
<td>Mean educ.</td>
<td>11.13</td>
<td>12.30</td>
<td>11.42</td>
</tr>
<tr>
<td>SES:&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>69.72</td>
<td>73.90</td>
<td>66.45</td>
</tr>
<tr>
<td>Range</td>
<td>40-96</td>
<td>47-96</td>
<td>34-96</td>
</tr>
<tr>
<td>Race:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
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<td>1</td>
</tr>
<tr>
<td>White</td>
<td>14</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

---

<sup>a</sup> One-way analysis of variance, $F = 5.01$, $p < .01$

<sup>b</sup> One-way analysis of variance, $F = 3.14$, $p < .05$

<sup>c</sup> Based upon father's occupation, according to a classification proposed by the U.S. Bureau of the Census, 1963
The individual choices of each member (first step) are not disclosed to the family.

Measures. (1) Spontaneous Agreement (SA): The number of agreements, i.e., similar choices, among family members. This refers to agreements found to exist prior to any family discussion. SA score is obtained by comparing the individually filled out questionnaires and counting instances in which a positive choice of two family members agrees, and similarly where a negative choice matches a negative choice of other member(s). This measure can be calculated for every possible dyad in the family (SA) and for the family as a whole (FSA). It reflects the effectiveness of inter-member communication and inter-member closeness.

(2) Choice Fulfillment (CF): This is defined as "the number of instances in which the individual's choices (as expressed in the individual's questionnaire) became the family choices (as expressed in the family's questionnaire)" (Ferreira and Winter, 1968, p. 21). Like the SA score, the CF score can be calculated once for each individual member (CF), and once for the family as a unit (FCF). This measure reflects the degree to which the family group meets the wishes of its members, all of them, just one or a few. In other words, it is a measure of power or dominance in the family. The family member whose choices become those of the whole group can be said to have more power over other members. The FCF score is an indicator of family efficiency.

(3) "Crazy" Decisions (CD): The number of instances in which all members indicated a dislike individually but expressed a preference as a family, and conversely, the number of instances in which all members expressed a preference individually yet failed to express it as a family. This measure serves as an index of alienation, disengagement and absence of coalitions.

Two additional family measures, Decision Time (DT) and Index of Normality (IN) could not be used in the present study although they reflect the efficiency of intra-family communication and the balance and quality of family functioning, respectively. Both are based on the amount of time needed by the family to complete the joint questionnaire. Unlike previous investigators who used the test, the present investigator could not leave the family to discuss the questionnaire alone. Thus,
in several families attempts were made by one or more members of the family to involve him in the discussion. Although it could have been a way of avoiding the task or postponing decision-making, and as such indicative of family problems, the precision of the measure could have been affected by other factors and it was therefore rejected altogether.

The Unrevealed Differences Technique was developed by Ferreira and Winter (1965) and has been used repeatedly with families of disturbed and non-disturbed children and adolescents (Ferreira and Winter, 1966 and 1968; Ferreira et al., 1966; Murrell, 1971; and Byassee and Murrell, 1975), revealing statistically significant and stable differences between the two groups in the expected direction of lower SA, FSA, CF, and FCF, and higher CD, DT and IN scores for disturbed families. It is one of the very few objectively scored yet psychologically meaningful tests available in the field of family research.

The Family Concept Test (see Appendix B).

Task. The Family Concept Test is an 80 item multiple-choice questionnaire. Each item describes a social or emotional aspect of the whole family, and is rated from 0 (least like) to 8 (most like). The test is given twice, first under the instruction to describe "your family as it is now," the real family concept, and then to describe "your family as you would ideally like it to be," the ideal family concept.

Measures. (1) Family Effectiveness (FE): FE is a measure of the adequacy of functioning of the family based on the person's real family concept. This measure uses 48 items on which 27 clinicians showed high agreement as being characteristic or uncharacteristic of the "ideal family." An item is scored if the family member places it on the same side of the scale (like or unlike) as it was placed by the professional group. The score assumes that the clinicians' judgments comprise an expert assessment of qualities necessary for effective family functioning. (2) Family Satisfaction (FS): FS is measured by comparing a member's view of his family as it actually is to the way he would ideally like it to be. The measure assumes that when perceived conditions are more similar to desired conditions the person is more satisfied. (3) Family Congruence (FCon): FCon refers to the degree of agreement
between the real family concepts of the father and mother. (4) Family Compatibility (FCom): FCom measures the degree of agreement between the ideal family concepts of the mother and father.

The Family Concept Test was developed by van der Veen et al. (1964) on the assumption that the family concepts of parents and children...play a critical mediating role in the development and alleviation of childhood disturbance.

The family concept is an heuristic construct for conceptualizing and investigating the individual in relation to the family system. Analogous to the self concept, it is a cognitive-emotional "schema" that is composed of a person's perceptions, attitudes, feelings, and expectations regarding his or her family unit.

It is assumed that

...the family concept...develops principally from interaction within the family over an extended period of time...it exerts a potent and lasting influence on behavior, and...it is fluid and subject to change under a variety of conditions including formal intervention such as family therapy (van der Veen, 1975, p. 1).

The Family Concept Test is said to be a reliable and valid measure of the family concept of individual members. The test has been used in numerous studies and significant relationships were found between the family concepts of fathers, mothers and children and the child's adjustment (Novak and van der Veen, 1970), marital adjustment (Kimmel, 1970), school achievement (Strauss, 1970), child's aggression versus withdrawal (Janzen, 1972), to mention but a few.

The test is available in three different response formats—Q sort, multiple-choice, and true-false. The multiple-choice format was selected for the present study because the Q sort is too time consuming and restricts item dispersion, while the true-false format was found to be affected, more than the other two, by social desirability and to yield high scores of somewhat lower stability. The multiple-choice format yields moderate scores, is convenient, and is only slightly affected by social desirability (van der Veen et al., 1970).

Statement Game and Guessing Game (see Appendices C and D). These tasks are my own integration and modification of Ferreira's Flag Task (1963) and Watzlawick's Blame task (1966).
In Ferreira's Flag Task each family member was asked to color eleven flags with eight crayons trying to achieve "the most pleasing color combination." The flags thus colored by one member were given to another member who was then asked to throw away those that he did not like for whatever reason. The family member judging the flag was working in privacy, fully aware of the identity of the family member who colored the cards. This was done for every dyad in the family. The number of cards rejected is considered indicative of the degree of rejection of the painter by the judge. In a second step each family member was asked to guess how many of his or her own flags had been rejected by any other family member. Number of cards believed to have been rejected supposedly indicate perceived rejection. Results show rejection and expectancy of rejection to be greater in pathologic than in normal families, but the difference did not reach statistical significance.

Watzlawick's Blame technique is the last of a five-step structured interview conducted in the course of family therapy for diagnostic purposes. For this task the father is seated on the interviewer's left followed at his left by the mother and then the children from oldest to youngest. Every member is then asked to write the main fault of the person on his left, without identifying him. The interviewer then collects the cards, shuffles them, adds two cards of his own and reads them to the family unaltered, asking each family member, in turn, to whom he thinks the statement applies. Guesses are made aloud in the presence of all family members. Although the cards are shuffled the interviewer always starts with his own two cards (which read--"Too good" and "Too weak") because they are ambiguous enough to produce controversy. Watzlawick felt that this task "reveals highly significant data on scapegoating, favoritism, and self-blame in a family" (1966, p. 263). Since the interview was designed as a clinical rather than a research tool, no attempt was made to quantify the data or compare different groups.

In the present tasks the family is seated together and each family member is handed a 3 x 5 file card on which he is asked to write the main fault of any one person in the family. He is asked to indicate who that person is, and also write his own name on the card. The family
is reassured that no one will ever find out who wrote what about whom, except for the researcher. The cards are then shuffled and read to the group one by one but not before the experimenter added two cards of his own and changed the wording of the original statements so as to eliminate possibility of guessing on the basis of vocabulary or sentence structure while preserving the content of the message. As the statements are read, each family member tries to guess who wrote the statement and about whom it could have been written. Subjects are allowed to guess more than once with regard to the same person or persons and are reminded that two of the statements were written by the experimenter prior to the meeting. The same is repeated with positive statements. The first two cards to be read are always those written by the investigator. The two positive statements are: "That person is warm and loving," and "That person cares about me." The two negative statements are: "It's difficult to get along with that person," and "That person doesn't seem to understand me."

An underlying assumption of the present task is that it is easiest to criticize someone who is disliked or serves as a common target of criticism and scapegoating at home. This is so because derogatory statements concerning such a person are over-rehearsed and readily available, and because the fear of counterattacks by others is minimal. Similarly, it is assumed that under "test conditions" it is easier and safer to make a positive comment about a person who is well-liked and favored by the family. Thus, in the present task, unlike the original two, family members were allowed to select their targets.

The present task tries to utilize the advantages of the original tasks while eliminating some of their shortcomings. As in Watzlawick's Blame task, subjects are asked to make a written statement, which seems to be more directly related and relevant to the variables of concern than the rejection of a product made by someone else. As in Ferreira's Flag Task the results are quantifiable.

A few additional advantages of the modified task are: (1) Positive attitudes, or favoritism, are measured directly instead of being inferred from the absence of negative feelings; (2) accuracy of perceptions can
be examined directly by comparing perception with the actual behavior of others; (3) mutuality of feelings, either positive or negative, can be measured directly in a task which does not restrict one to make a statement regarding the person on his left, or demands that he judge the product of every other member of the family.

The Statement Game and Guessing Game may yield nine interrelated measures (not all of which will be examined in the present study).

**Measures.**

1. **Negative Statements Received (NSR):** Proportion of negative statements each member actually received may indicate scapegoating and real rejection;
2. **Positive Statements Received (PSR):** Proportion of positive statements received may indicate favoritism and real acceptance;
3. **Negative Statements Perceived (NSP):** Proportion of negative statements believed by a member to be directed at him may indicate self-blame, expectancy of rejection, and perceived isolation;
4. **Positive Statements Perceived (PSP):** Proportion of positive statements believed by a member to be directed at him may indicate degree of security and confidence in family support;
5. **Accuracy of Perceived Negative (APN):** Proportion of negative sources and targets accurately perceived by a family member;
6. **Accuracy of Perceived Positive (APP):** Proportion of positive sources and targets accurately perceived by a family member;
7. **Accuracy of Perceived Relationships (APR):** Proportion of correct guesses of dyadic relationships of actual statements. This measure is calculated separately for guesses concerning negative statements (NAPR) and guesses concerning positive statements (PAPR). The four accuracy measures (APN, APP, NAPR, and PAPR) may indicate awareness of intra-familial coalitions, and clarity of boundaries and communications.
8. **Number of Negative Statements Perceived by Others (NPBO):** Proportion of instances in which an individual member was perceived by other members of the family to be the target of negative statements;
9. **Number of Positive Statements Perceived by Others (PPBO):** Proportion of instances in which an individual member was perceived by other members of the family to be the target of positive statements.
Procedure

Each family was contacted by telephone within a few days of the emergency room visit or hospitalization. Attempts were made to see the family quickly before any possible effects of therapy could take place. Unfortunately, this was not always feasible due to one or more of the following reasons: The case was not brought to the investigator's attention within the first week of the most recent incident; the family needed some time to decide whether to participate or not; one family member was temporarily away from home; and/or some of the PS patients were already involved in ongoing psychotherapy.

The purpose of the study was presented to one of the parents during the initial telephone conversation as "a study of patterns of communication and interaction in families with teenagers." Questions regarding source of information about the family, nature of tasks, and duration, timing and location of the experimental session were the most frequent ones. It was emphasized that the family could not expect any diagnostic or therapeutic gains from the study, and their involvement in it was purely for research purposes. Usually, several telephone calls were required before a meeting could be arranged.

As a rule, meetings were held in the hospital or agency in which the teenager was first treated. However, a few families asked not to be seen in the hospital and were therefore visited at home. A deliberate attempt was made to match the three groups in this respect. As a result, three SU families, three PS families and four NO families were seen at home. One additional SU family was seen at The Ohio State University.

All members of the family presently living at home were invited to participate in the study. However, children under 10 years of age were excluded because they found The Family Concept Test incomprehensible and were unfamiliar with many of the alternatives provided for each situation in The Unrevealed Differences Technique. Additionally, one grandparent and one paternal uncle were not included in the study because they had been living with their families for only a few weeks.
At the beginning of the experimental session the purpose of the study and the nature of the various tasks were explained to all family members who were encouraged to ask clarifying questions. These were answered without any mention of the existence of three separate groups. In addition, it was emphasized that they were involved in a research rather than diagnostic or therapeutic project; that all information would remain completely confidential; that the questionnaires were not school tests on which one can excel or fail; and, finally, that they were not to discuss the various tasks while performing them, unless asked to in the family part of The Unrevealed Differences Technique, in order not to influence each other's responses. After signing a consent form (two for patients of Children's Hospital, see Appendices E and F), they were given the questionnaires. Every participant had to complete the first task before the family was given the second set of questionnaires, and so on.

The order in which the questionnaires were given was changed from one family to another in order to counter possible effects of order. However, the order was not completely random since the Ideal Family Inventory and the Real Family Inventory (forming, together, The Family Concept Test) were always given in succession, with the Ideal preceding the Real in 50 percent of the cases in each group, and following it in the other 50 percent. This pair of questionnaires preceded The Unrevealed Differences Technique in every other family in each group, and followed it in the rest. The Statement Game and Guessing Game were always given as a final task for fear that increased tension (which occurred in none of the families) might affect the responses to the other questionnaires. Odd numbered families in each group received Guessing Game No. 1 first, and even numbered families received Guessing Game No. 2 first.

The whole session typically lasted one and one-half hour, with a few families requiring as much as two hours. Following tests administration family members were encouraged to ask further questions and share their feelings with the experimenter. Many commented that they enjoyed the session and found it interesting, yet a few were relieved when it
was over. Only one SU family made a request for further consultation and the case was brought to the attention of the Chief Psychologist of Children's Hospital. All SU families obtained through Children's Hospital received a written statement emphasizing the experimental and non-therapeutic nature of the study, and encouraging them to contact the Psychology Office of the hospital if they desired any help for the problem or problems that brought them to Children's Hospital.
CHAPTER III
RESULTS

The findings of the present study will be presented in order of hypotheses rather than of tasks or measures. Since all three of the tests used yield several measures, each bearing on a different, though related, question, each task will be referred to repeatedly throughout this chapter.

Hypothesis 1--Intra-Familial Closeness, Communication, Sensitivity and Responsiveness

Intra-familial closeness, communication of self-revealing information, and sensitivity and responsiveness to members' needs were hypothesized to be lowest in families of suicidal adolescents (SU families), highest in families of psychophysiologically ill teenagers (PS families), and moderate in families with no disturbed youngsters (NO families). They were measured by means of The Unrevealed Differences Technique and the Statement Game and Guessing Game. Eight measures are relevant to the issue under consideration. These are: Spontaneous Agreement (SA), Family Spontaneous Agreement (FSA), Choice Fulfillment (CF), and Family Choice Fulfillment (FCF)--all obtained from The Unrevealed Differences Technique--and Accuracy of Perceived Negative Statements (APN), Accuracy of Perceived Positive Statements (APP), and Accuracy of Perceived Relationships, both negative (NAPR) and positive (PAPR)--obtained from the guessing phase of the Statement Game and Guessing Game.

SU, PS, and NO families were compared on each of those eight measures through the use of one-way analysis of variance. The statistical significance of the differences between any two group means was determined by t-tests where indicated.

SA scores for each possible dyad in the family were derived by assigning a numerical value of one to the first choice, a value of two to
the second choice, three to the third choice, four to an unselected choice, and five to an option that was crossed off and by calculating the square root of the mean of the square of differences between the choices of the two members \( \sqrt{\frac{\sum(X-Y)^2}{N}} \). This is a traditional measure of similarity to compare psychological variables. Thus computed a set of identical scores would yield a mean similarity score of zero. Such a scoring procedure is considered to be more sensitive than the simple counting of similarities used by Ferreira and Winter in their own studies. Unlike the original scoring procedure the one used in the present study takes into consideration the preferences as indicated by a subject by giving them different weights. Because of the scoring method used in the present study, higher SA scores indicated lower spontaneous agreement, or increased distance in preferences and dislikes.

Means and standard deviations of SA scores for each dyad across families in each of the three groups are reported in Table 3. Similar information is provided for FSA scores.

The number of families or individual subjects involved in each analysis is specified in this and the following tables since not all families nor all family members always completed all tasks. N may thus vary from one comparison to another.

The figures reported in Table 3 show the first hypothesis to be partially supported because in five out of nine dyadic pairs the SU family has the highest SA scores, and in the remaining four it is a very close second. Furthermore, the FSA score of the SU family is significantly higher than those of the PS family and the NO family. The range of SA scores within the SU group is also higher than in the other two groups. However, the PS group, hypothesized to have lowest SA scores, has the highest score in four dyads and is closer to the SU group than the NO group. Although only four of the nine comparisons reach an acceptable level of statistical significance, a consistent pattern of low SA scores in NO dyads versus relatively high SA scores in both groups with a psychologically disturbed adolescent is apparent.

This observation is supported by the results of a series of t-tests which yielded statistically significant t-values only for differences
TABLE 3
MEANS AND STANDARD DEVIATIONS OF DYADIC SA
SCORES AND FSA SCORES FOR EACH GROUP

<table>
<thead>
<tr>
<th>Dyad</th>
<th>SU N</th>
<th>X</th>
<th>S.D.</th>
<th>PS N</th>
<th>X</th>
<th>S.D.</th>
<th>NO N</th>
<th>X</th>
<th>S.D.</th>
<th>F Value</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fa-Mo</td>
<td>15</td>
<td></td>
<td></td>
<td>13</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
<td></td>
<td>1.13</td>
<td>n.s.</td>
</tr>
<tr>
<td>Fa-IP</td>
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<td></td>
<td>13</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
<td></td>
<td>9.05</td>
<td>.0006</td>
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<tr>
<td>Fa-SIBI</td>
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<td></td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td>9.63</td>
<td>.0007</td>
</tr>
<tr>
<td>Fa-AS</td>
<td>17</td>
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<td>12</td>
<td></td>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td>5.75</td>
<td>.0086</td>
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<tr>
<td>Mo-IP</td>
<td>15</td>
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<td>13</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
<td></td>
<td>0.70</td>
<td>n.s.</td>
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<tr>
<td>Mo-SIBI</td>
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<td></td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td>0.08</td>
<td>n.s.</td>
</tr>
<tr>
<td>Mo-AS</td>
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<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td>0.91</td>
<td>n.s.</td>
</tr>
<tr>
<td>IP-SIBI</td>
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<td></td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td>1.73</td>
<td>n.s.</td>
</tr>
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<td>IP-AS</td>
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<td>21</td>
<td></td>
<td></td>
<td>4.36</td>
<td>.02</td>
</tr>
<tr>
<td>FSA</td>
<td>9</td>
<td></td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td>4.29</td>
<td>.02</td>
</tr>
</tbody>
</table>

a. Fa = Father
b. Mo = Mother
c. SIBI = Oldest sibling, whether older or younger than IP
d. ASI = Average sibling, i.e., mean of SA scores of all participating siblings,
excluding IP but including SIBI. Wherever used AS has the same meaning as in this table.
e. Two degrees of freedom for every row
between the NO and SU or NO and PS groups but none for differences between the SU and PS groups. All of the non-significant differences among the three groups remained non-significant in any two group comparison.

Of special interest is the finding that three of the four statistically significant differences involve the father and one child (or the "average sibling"), and two involve the IP. This finding will be discussed in greater detail in a later section.

Choice Fulfillment (CF) scores were calculated in the same manner as SA scores, but involved the comparison of an individual's choice with those of the family as a group. As is the case with SA scores, a high CF score indicates less concordance than a low CF score.

Means and standard deviations of CF scores for the father, mother, IP, oldest sibling (SIB₁), average sibling (AS), and the family as a unit (FCF score) in each of the three groups are reported in Table 4, together with the results of one-way analysis of variance. FCF scores were derived by averaging the individual CF scores of all participating members.

The same trends observed with regard to the SA scores are discernible in Table 4. Members of SU families consistently received the highest CF scores, members of NO families received the lowest scores, and the CF scores of members of PS families were closer to those of SU families. However, in spite of the consistency of this pattern, only one of the six comparisons was statistically significant. As was the case with regard to SA scores, this single statistically significant difference involved the father.

The consistency of differences between the CF scores of individual members of SU, PS and NO families also accounts for the fact that the composite CF score, or FCF, was highest in the SU group, lowest in the NO group, and intermediate in the PS group.

The various measures of accuracy of perception of sources, targets and relationships in the guessing stage of the Statement Game and Guessing Game, are believed to reflect the level of intra-familial communication and openness (see Chapter II). It has been assumed that in a family system characterized by clear generational boundaries and open communication, members are more aware of the structure of familial coalitions,
TABLE 4
MEANS AND STANDARD DEVIATIONS OF CF AND FCF SCORES BY ROLE AND GROUP

<table>
<thead>
<tr>
<th>Role</th>
<th>SU</th>
<th></th>
<th></th>
<th>PS</th>
<th></th>
<th></th>
<th>NO</th>
<th></th>
<th></th>
<th>F</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>S.D.</td>
<td>N</td>
<td>X</td>
<td>S.D.</td>
<td>N</td>
<td>X</td>
<td>S.D.</td>
<td>Value</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>15</td>
<td>126.66</td>
<td>33.09</td>
<td>13</td>
<td>121.15</td>
<td>28.04</td>
<td>14</td>
<td>95.71</td>
<td>36.31</td>
<td>3.60</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>15</td>
<td>119.60</td>
<td>29.73</td>
<td>13</td>
<td>116.38</td>
<td>44.03</td>
<td>14</td>
<td>109.21</td>
<td>31.00</td>
<td>0.33</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>IP</td>
<td>15</td>
<td>140.93</td>
<td>36.18</td>
<td>13</td>
<td>146.07</td>
<td>42.80</td>
<td>14</td>
<td>116.57</td>
<td>37.57</td>
<td>2.28</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>SIB_I</td>
<td>9</td>
<td>134.77</td>
<td>53.40</td>
<td>8</td>
<td>118.00</td>
<td>38.13</td>
<td>12</td>
<td>109.66</td>
<td>36.12</td>
<td>0.90</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>17</td>
<td>132.63</td>
<td></td>
<td>12</td>
<td>103.12</td>
<td></td>
<td>21</td>
<td>111.69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCF</td>
<td>62</td>
<td>130.04</td>
<td>38.10</td>
<td>51</td>
<td>122.03</td>
<td>38.25</td>
<td>63</td>
<td>108.67</td>
<td>35.25</td>
<td>2.21</td>
<td>n.s.</td>
<td></td>
</tr>
</tbody>
</table>
of each other's feelings toward one another (or mutuality of feelings), etc., and therefore will be more likely to accurately identify the source and target of a negative or positive statement written by another family member.

Table 5 summarizes the information concerning the level of accuracy of perception, as measured by Accuracy of Perceived Negative (APN), Accuracy of Perceived Positive (APP), and Accuracy of Perceived Relationships, both negative (NAPR) and positive (PAPR). The data are reported for each group across the various family roles. Low scores on any of the four measures indicate low level of accuracy and high scores indicate a high level of accuracy.

The figures reported in Table 5 show the three groups not to differ significantly on any of the four measures. No group, role or interaction effects were found, and the t-values for any pair of groups for each measure also failed to reach the .05 level of significance. However, there is at least one detectable pattern, namely, the consistency of low scores in the SU family. On all four measures this group scored lower than either of the other two, as expected. Another possible pattern shows PS families to be more accurate than NO families when guessing the sources and targets of as well as the relationships involved in positive statements, but less accurate when negative statements were judged.

To summarize, the first hypothesis seems to have been at least partially supported by the obtained findings. Although only relatively few of the comparisons yielded statistically significant differences among the three groups, all of the significant differences and most of the non-significant ones show SU families to score lower than either of the other two groups on measures of meaningful communication, responsiveness to others' needs, and awareness of familial patterns of communication. On the other hand, PS families failed to score higher than the NO group on most of the measures, usually falling in between the SU and NO groups, closer to the SU.
### TABLE 5

GROUP MEANS AND STANDARD DEVIATIONS FOR FOUR MEASURES
OF ACCURACY OF IDENTIFICATION OF STATEMENTS
MADE BY FAMILY MEMBERS

<table>
<thead>
<tr>
<th>Variable</th>
<th>SU</th>
<th></th>
<th>PS</th>
<th></th>
<th>NO</th>
<th></th>
<th>F (^a/)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>(\bar{X})</td>
<td>S.D.</td>
<td>N</td>
<td>(\bar{X})</td>
<td>S.D.</td>
<td>N</td>
</tr>
<tr>
<td>APN</td>
<td>60</td>
<td>42.88</td>
<td>16.25</td>
<td>39</td>
<td>47.84</td>
<td>21.14</td>
<td>38</td>
</tr>
<tr>
<td>APP</td>
<td>60</td>
<td>36.65</td>
<td>19.79</td>
<td>39</td>
<td>43.71</td>
<td>18.02</td>
<td>41</td>
</tr>
<tr>
<td>NAPR</td>
<td>60</td>
<td>50.48</td>
<td>19.81</td>
<td>39</td>
<td>58.41</td>
<td>20.25</td>
<td>38</td>
</tr>
<tr>
<td>PAPR</td>
<td>60</td>
<td>53.93</td>
<td>22.71</td>
<td>39</td>
<td>64.20</td>
<td>20.41</td>
<td>41</td>
</tr>
</tbody>
</table>

\(^a/\) df = 2
Hypothesis 2--Family Efficiency

Family efficiency, an accepted indicator of the system's soundness and health, was hypothesized to be lower in both SU and PS families than in NO families. Disengaged and enmeshed families share in common the inappropriateness of generational boundaries. Whether these are overly rigid or almost non-existent, one of the consequences might be impairment of the decision-making processes, leading to decisions which are not as gratifying as they might have been.

Two measures were used in the present study to test this hypothesis. These were the frequency of "Crazy" Decisions (CD) and Family Choice Fulfillment (FCF) scores, both derived from The Unrevealed Differences Technique.

CD proved not to be usable due to the rarity of its occurrence in the present sample. Of 2,940 decisions made by the families participating in the present study (42 families x 7 situations x 10 choices per situation), less than one dozen could be classified as "crazy" decisions. Such a small number of CD scores could be obtained by chance alone and cannot be subjected to any statistical analysis. Furthermore, a review of these few instances of CD failed to show any consistent pattern.

FCF scores for each of the three groups are reported in Table 4 (p. 62). Once again, although the differences among the three groups are not statistically significant they are in the hypothesized direction, with the PS group having a mean FCF score which is closer to that of the SU than the NO group.

Hypothesis 3--Perceived Family Effectiveness

It was hypothesized that members of SU and PS families would score lower on a measure of perceived family effectiveness than members of NO families, thus reflecting their awareness of the hypothesized inefficiency of disturbed families. Assuming that given the opportunity and appropriate means of expression family members may describe their families more or less accurately, a measure of perceived family effectiveness may also be related to Hypothesis 2 above, i.e., how the three types of families compare on efficiency.
One measure, the family effectiveness (FE) score, was used to test Hypothesis 3. The FE score reflects the degree of agreement of one's rating of his own family on 48 items on The Family Concept Test with the ratings of the same 48 items by a group of trained professionals. A high score indicates a high level of perceived family effectiveness, whereas a low score indicates a low level of perceived effectiveness.

As indicated by the data provided in Table 6, Hypothesis 3 cannot be rejected since there is a main effect of the group variables (columns): $F(2) = 35.25, p < .0001$. Members of SU families, regardless of role, rate their own families as ineffective, while members of PS families perceive their families as moderately effective, and members of NO families view their families as the healthiest.

Hypothesis 4--Family Satisfaction

Satisfaction with one's own family (FS) was hypothesized to be lower for every member in SU and PS families than in NO families, reflecting the fact, not always consciously realized by family members, that the problem is at least as much a familial problem as it is an intra-psychic one. FS scores were derived by correlating the Real Family Concept of a subject with his Ideal Family Concept. Pearson product-moment correlations were used. The obtained coefficients of correlation were then transformed into Fisher's Z scores for better equalization of scale intervals. The higher the correlation coefficient, the higher the Z score, and the higher the Z score, the greater the degree of satisfaction with one's own family. Table 7 presents the results of a two-way analysis of variance for the Z values of correlations between Real and Ideal concepts of the family.

Hypothesis 4 is corroborated by the data provided in Table 7. Not only are the group means across roles significantly different in the hypothesized direction, but the same trend in a similar magnitude is maintained for every single role (except that Ns for the second sibling are too small to be trusted).
### TABLE 6

MEANS AND STANDARD DEVIATIONS OF FE SCORES BY ROLE\(^a\) AND GROUP\(^b\)

<table>
<thead>
<tr>
<th>Role</th>
<th>SU</th>
<th>PS</th>
<th>NO</th>
<th>(F) Value</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N)</td>
<td>(\bar{X})</td>
<td>S.D.</td>
<td>(N)</td>
<td>(\bar{X})</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>29.93</td>
<td>8.59</td>
<td>13</td>
<td>31.38</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>28.20</td>
<td>6.34</td>
<td>13</td>
<td>34.69</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>20.80</td>
<td>9.71</td>
<td>13</td>
<td>28.92</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>23.60</td>
<td>8.14</td>
<td>8</td>
<td>22.25</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>23.20</td>
<td>7.20</td>
<td>8</td>
<td>24.75</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>25.53</td>
<td>8.28</td>
<td>51</td>
<td>29.50</td>
</tr>
</tbody>
</table>

\(^a\) Main role effect: \(F(5)=16.61\), \(p < .0001\)

\(^b\) Main group effect: \(F(2)=35.25\), \(p < .0001\)

\(^c\) Interaction effect: n.s.
### TABLE 7

MEANS AND STANDARD DEVIATIONS OF FS
SCORES BY ROLE AND GROUP

<table>
<thead>
<tr>
<th>Role</th>
<th>SU</th>
<th></th>
<th>PS</th>
<th></th>
<th>NO</th>
<th></th>
<th>F</th>
<th>Value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>( \bar{X} ) S.D.</td>
<td>N</td>
<td>( \bar{X} ) S.D.</td>
<td>N</td>
<td>( \bar{X} ) S.D.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>13</td>
<td>.47 .34</td>
<td>13</td>
<td>.63 .48</td>
<td>12</td>
<td>.86 .25</td>
<td>3.31</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>14</td>
<td>.27 .34</td>
<td>12</td>
<td>.67 .42</td>
<td>12</td>
<td>1.04 .43</td>
<td>11.93</td>
<td>.0001</td>
<td></td>
</tr>
<tr>
<td>IP</td>
<td>13</td>
<td>.11 .44</td>
<td>13</td>
<td>.52 .45</td>
<td>12</td>
<td>.60 .55</td>
<td>3.66</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>SIB_I</td>
<td>8</td>
<td>.17 .41</td>
<td>8</td>
<td>.17 .74</td>
<td>10</td>
<td>.70 .54</td>
<td>2.58</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>SIB_II</td>
<td>5</td>
<td>.40 .25</td>
<td>4</td>
<td>.73 .44</td>
<td>6</td>
<td>.72 .34</td>
<td>1.45</td>
<td>n.s.</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>.29 .38</td>
<td>50</td>
<td>.54 .52</td>
<td>53</td>
<td>.79 .45</td>
<td>12.53</td>
<td>.0001</td>
<td></td>
</tr>
</tbody>
</table>

Note: Figures for SIB\_III were omitted because of small Ns in each cell.
Hypothesis 5--IP's Position Within His Own Family

IP was hypothesized to be rejected in the SU family, over-protected and favored in the PS family, and not to be singled out in either direction in the NO family. This hypothesis was tested by six measures: Spontaneous Agreement (SA), Choice Fulfillment (CF), Negative Statements Received (NSR), Positive Statements Received (PSR), Negative Statements Perceived by Others (NPBO) and Positive Statements Perceived by Others (PPBO). The first two are derived from The Unrevealed Differences Technique and the latter four from the Statement Game and Guessing Game. Within group and between groups comparisons of IP's scores on these six measures were used to test this hypothesis. The scoring procedure of The Unrevealed Differences Technique to obtain SA and CF scores was detailed earlier in this chapter and will not be repeated here. NSR and PSR were calculated as the proportion of negative or positive statements actually directed by others at an individual member, and NPBO and PPBO were calculated as the proportion of negative and positive statements guessed by the other family members to be directed at an individual.

Analysis of IP's SA scores with every other member of the family fails to support the hypothesis under consideration. When the SA scores of the suicidal adolescent are compared to those of his parents or siblings, no consistent pattern emerges, and the highest scores (i.e., greatest distances) do not necessarily involve IP. His overall SA score is not different from that of either the oldest sibling or the average of all the siblings. The ranking of the dyads within the SU group according to the magnitude of their mean SA score, from lowest to highest (i.e., in order of decreasing spontaneous agreement), is presented in Table 8 to illustrate this conclusion.

Furthermore, a between groups comparison shows the SU IP to fare better in this respect than the PS IP who, within his own family, has the highest SA scores, contrary to what was hypothesized. The ranking order of the SU IP within his own family is quite similar to that of the NO IP. However, when absolute values, rather than the relative standing within the family, are considered, the SU IP resembles the PS IP very closely, and the two are significantly different from the NO IP in two out of four
### TABLE 8

**IP's RELATIVE POSITION WITHIN HIS FAMILY**

**IN TERMS OF HIS SA SCORES,**

**FOR EACH GROUP**

<table>
<thead>
<tr>
<th>Rank</th>
<th>SU Order</th>
<th>Dyad</th>
<th>Mean SA</th>
<th>PS Order</th>
<th>Dyad</th>
<th>Mean SA</th>
<th>NO Order</th>
<th>Dyad</th>
<th>Mean SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fa-Mo</td>
<td>175.86</td>
<td></td>
<td>Mo-SIB₁</td>
<td>176.37</td>
<td></td>
<td>SIB₁-Fa</td>
<td>151.83</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>SIB₁-Mo</td>
<td>184.11</td>
<td></td>
<td>Mo-Fa</td>
<td>180.30</td>
<td></td>
<td>IP-Fa</td>
<td>157.00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>IP-Mo</td>
<td>192.13</td>
<td></td>
<td>Mo-AS</td>
<td>181.31</td>
<td></td>
<td>Mo-Fa</td>
<td>158.78</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>IP-SIB₁</td>
<td>199.88</td>
<td></td>
<td>Fa-SIB₁</td>
<td>188.37</td>
<td></td>
<td>IP-AS</td>
<td>159.72</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>IP-Fa</td>
<td>208.93</td>
<td></td>
<td>Fa-AS</td>
<td>190.43</td>
<td></td>
<td>Fa-AS</td>
<td>161.05</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mo-AS</td>
<td>212.38</td>
<td></td>
<td>IP-Mo</td>
<td>195.69</td>
<td></td>
<td>IP-SIB₁</td>
<td>162.50</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>IP-AS</td>
<td>218.72</td>
<td></td>
<td>IP-AS</td>
<td>200.31</td>
<td></td>
<td>Mo-SIB₁</td>
<td>179.08</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Fa-SIB₁</td>
<td>219.00</td>
<td></td>
<td>IP-SIB₁</td>
<td>200.62</td>
<td></td>
<td>IP-Mo</td>
<td>180.64</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Fa-AS</td>
<td>234.38</td>
<td></td>
<td>IP-Fa</td>
<td>210.92</td>
<td></td>
<td>Mo-AS</td>
<td>182.30</td>
<td></td>
</tr>
</tbody>
</table>
comparisons (see Table 3, p. 60). In addition, IP's spontaneous agree-
ment with SIB\textsubscript{1} and with AS is lower (i.e., the score is higher) in both
SU and PS groups than in the NO group.

In summary, when only SA scores are considered the SU IP's relative
position within his family fails to indicate rejection, yet his distance
from other family members is systematically greater than that of the NO
IP, but not the PS IP.

Choice Fulfillment (CF) scores (see Table 4, p. 62) show a somewhat
reversed trend. Within his own family the SU IP ranks the last (i.e., he
has an elevated CF score compared with those of the other members), but
a between group comparison shows him to share this position with both the
PS and NO IPs. However, as is the case with regard to SA scores, when
absolute values of CF scores are compared between groups, the SU IP proves
to be quite distant from his NO counterpart, and slightly surpassed by the
PS IP. Yet the differences fail to reach an acceptable level of statisti-
cal significance.

The proportions of negative and positive statements written by other
family members about IP (NSR and PSR, respectively) also lend only partial
support to the hypothesis under discussion.

As can be seen in Table 9 the SU IP is indeed a common target of
criticism, second only to his father. He is the least likely member to
be complimented by others. However, he is not alone in this position.
Within his own family the PS IP also ranks second as a target of negative
statements, and last as the choice of positive remarks. Interestingly
enough, the NO IP is even in a worse situation—he tops the list of fam-
ily members when they are ranked by NSR, and he closes the list when they
are ranked by PSR.

The differences among the means of the three types of IP (on both
measures), as well as the t-values for all three pairs (on both measures),
are not statistically different. Of the three IPs, the suicidal one
receives the fewest negative statements and the most positive ones, rather
than the reverse as was hypothesized. Although the differences between
IP's mean scores and the composite means for all siblings together fail
to reach an acceptable level of statistical significance in each of the
## TABLE 9
MEANS AND STANDARD DEVIATIONS OF NSR AND PSR SCORES BY GROUP AND ROLE

<table>
<thead>
<tr>
<th>Role</th>
<th>NSR</th>
<th>PSR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>S.D.</td>
<td>N</td>
</tr>
<tr>
<td>Father:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSR</td>
<td>15</td>
<td>35.00</td>
<td>10</td>
</tr>
<tr>
<td>PSR</td>
<td>15</td>
<td>22.40</td>
<td>10</td>
</tr>
<tr>
<td>Mother:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSR</td>
<td>15</td>
<td>19.40</td>
<td>10</td>
</tr>
<tr>
<td>PSR</td>
<td>15</td>
<td>45.86</td>
<td>10</td>
</tr>
<tr>
<td>IP:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSR</td>
<td>15</td>
<td>26.20</td>
<td>10</td>
</tr>
<tr>
<td>PSR</td>
<td>15</td>
<td>11.06</td>
<td>10</td>
</tr>
<tr>
<td>SIB_{I}</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSR</td>
<td>9</td>
<td>22.77</td>
<td>6</td>
</tr>
<tr>
<td>PSR</td>
<td>9</td>
<td>20.66</td>
<td>6</td>
</tr>
<tr>
<td>All SIBs:</td>
<td></td>
<td></td>
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<tr>
<td>NSR</td>
<td>17</td>
<td>16.76</td>
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<tr>
<td>PSR</td>
<td>17</td>
<td>14.11</td>
<td>9</td>
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<tr>
<td>Total:</td>
<td>62</td>
<td>24.09</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>62</td>
<td>23.06</td>
<td>39</td>
</tr>
</tbody>
</table>

Note: SIB_{II} and SIB_{III} are not listed separately because of small Ns in each cell. None of the comparisons involving IP yielded statistically significant differences.
three groups, the trend is for smaller differences in the NO group. It might be that the NO IP, in spite of being frequently criticized and seldom complimented, is less distressed by this state of affairs because he is not singled out from all the other children in this respect.

The proportion of instances in which an individual member was believed by other members of his own family to be the target of negative or positive statements may also be indicative of the extent of his rejection or acceptance by them. NPBO and PPBO scores for each family member, for each group across roles, and for each role across groups are reported in Table 10.

Again, only a few of the F and t-values are statistically significant, but the pattern of differences and relationships are strikingly similar to those described in Table 9. The SU IP and the PS IP rank second within their respective families on both measures, while the NO IP is judged by others to be the most frequent target of criticism. Unlike Table 9, though, the NO IP is believed to receive more positive statements than his closest sibling (SIB₁). A comparison of Tables 9 and 10 indicates that not only is the SU IP the recipient of fewer negative and more positive statements than his PS and NO counterparts, but his status as perceived by others closely resembles his actual standing within his family as indicated by his NSR and PSR scores.

In summary, the hypothesis that the PS IP is over-protected and favored over his siblings is not supported by the findings of the present study. Similarly, the hypothesis that the NO IP occupies a mid-point between the SU and PS IPs is also rejected. However, several measures concur in indicating a greater rejection of the disturbed IP, regardless of disorder, than the non-disturbed IP. Within group comparisons show that on five out of six measures--CF, NSR, PSR, NPBO and PPBO--both SU and PS IPs rank higher on rejection than other members of their families. The PS IP receives high rejection scores on the sixth measure--SA--as well. But between group comparisons show the NO IP to be rejected as often or more on all measures derived from the Statement Game and Guessing Game, yet not on the two measures derived from The Unrevealed Differences Technique.
### TABLE 10
MEANS AND STANDARD DEVIATIONS OF NPBO AND PPBO SCORES BY GROUP AND ROLE

<table>
<thead>
<tr>
<th>Role</th>
<th>NPBO</th>
<th>PPBO</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>SU</td>
<td>S.D.</td>
</tr>
<tr>
<td>Father:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPBO</td>
<td>15</td>
<td>34.66</td>
<td>22.54</td>
</tr>
<tr>
<td>PPBO</td>
<td>15</td>
<td>27.46</td>
<td>19.29</td>
</tr>
<tr>
<td>Mother:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPBO</td>
<td>15</td>
<td>17.53</td>
<td>13.65</td>
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<tr>
<td>PPBO</td>
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<td>19.82</td>
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<td>12.80</td>
<td>11.89</td>
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Note: SIBII and SIBIII are not listed separately because of small Ns in each cell.

None of the comparisons involving IP yielded statistically significant differences.
**Hypothesis 6--Perception of One's Own Status**

The final hypothesis referred to IP's perception of his own status within his family. It was hypothesized that such perceptions are accurate and reflect the real situation (which, as shown in the preceding section, proved to be somewhat different from the hypothesized one). The proportion of negative and positive statements believed by IP to have been directed at him (NSP and PSP, respectively) were used to test this hypothesis.

As within group comparisons of the data provided in Table 11 indicate, the SU IP is surpassed only by his father in NSP, and the difference is small. Similarly, SU IP believed that only 13.78 percent of all positive statements made were directed at him. He may thus be said to perceive himself as rejected by his family. However, a comparison with his own siblings' scores show them to feel even more rejected. Furthermore, a between group comparison proves the magnitude of both negative and positive scores of IP to be very similar across the three groups. Also, the relative position of the PS IP within his family is practically identical to that of the SU IP, and the NO IP ranks even higher on rejection in his own family.

The similarity of the patterns observed in Table 11 to those summarized in Tables 4, 9 and 10 are striking. These similarities may reflect not only the interrelationships of the various measures but also their validity.

Hypothesis 6 has two parts, one of which has to be rejected, whereas the other is supported by the findings. The hypothesis that the SU IP feels himself to be rejected while the PS IP perceives himself to be favored (with the NO IP falling in between) gains no support from the findings. But the hypothesis concerning the accuracy of perceptions is supported, as indicated by the comparison of real and perceived patterns.
TABLE 11
MEANS AND STANDARD DEVIATIONS OF NSP AND PSP SCORES BY GROUP AND ROLE

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<th>Role</th>
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Note: SIB II and SIB III are not listed separately because of small Ns in each cell.

None of the comparisons involving IP yielded statistically significant differences.
CHAPTER IV
DISCUSSION

The present study was a preliminary attempt to examine some intra-familial patterns of communication and interaction which could play a role in the etiology of adolescent suicidal behavior. The available literature on adolescent suicide attempters suggests the existence of positive correlations between various kinds of disturbed parent-child relationship and home atmosphere, on the one hand, and suicidal behavior in adolescence, on the other. However, these were not studied from a system theory point of view and most of the studies are fraught with too many methodological shortcomings to render them useful as sources of empirical data. Reconceptualizing some of the problems believed to be characteristic of families with suicidal adolescents from a structural family theory point of view, and applying objectively scored measures developed by family theoreticians and researchers, the present study attempted to determine whether the family of the suicide attempter is actually suicidogenic or is only perceived as such by the adolescent.

To study the hypotheses that the adolescent suicide attempter comes from a disengaged family, and that within such a system he finds himself isolated and even rejected by others, a group of 15 intact families of adolescent suicide attempters was compared to two control groups--a group of 13 intact families with psychophysiologically ill adolescents and a group of 14 intact families with non-disturbed teenagers. The three groups were studied through the use of three objectively scored family tasks which yielded both familial and individual scores.

Although many of the findings reported in the previous chapter failed to reach an acceptable level of statistical significance, a number of trends and patterns emerged frequently and consistently enough to posit the following tentative conclusions and to entertain them as tenable hypotheses for further research.
Several independently scored measures concur in showing the family of the suicidal adolescent (SU family) to be more disengaged than the family of the psychophysically ill adolescent (PS family) and the family of the non-disturbed adolescent (NO family). SU families demonstrated repeatedly reduced levels of spontaneous agreement, choice fulfillment, and accuracy of identification of communications made by family members. Intra-familial communication and closeness, sensitivity to the needs of individual members, and responsiveness to their desires are much more restricted in SU than in NO families. Not surprisingly, families thus characterized proved also to be less efficient than NO families. When inter-member communication is lowered and awareness of others' likes and dislikes limited, family members may require more time and effort to realize their differences and work out an acceptable compromise. Even then they are less likely to reach such a solution. When initial or spontaneous agreement is low, the final group decision cannot be expected to satisfy every member equally. This indicates the existence of a vicious cycle previously noted by Ferreira and Winter (1968): Restricted communication leads to reduced spontaneous agreement which, in turn, interferes with decision-making processes and the achievement of a family consensus. This may cause frustration, dissatisfaction and increased intra-familial tension which may, in turn, foster a tendency to retire and give up (i.e., to disengage), and an even greater reluctance to try to communicate, and so on.

That this is the case is supported by the fact that members of SU families evaluated their own families as the least effective ones. It is hardly surprising, then, to find the highest degrees of dissatisfaction with one's family among members of SU families. The gap between the evaluation of the present home situation and the ideal situation was significantly wider for the SU group than for the control groups across roles, and for every individual role.

However, such a pattern is not uniquely characteristic of the SU family. In the present study, the PS group came very close to the SU group on most if not all of the measures indicating disengagement. Although the differences between SU and PS families were quite consistent across
measures, and in the hypothesized direction of less disengagement in PS than in SU families, they were, as a rule, smaller than those between PS and NO families. In other words the PS families of the present study did not deviate toward the enmeshed end of the enmeshment-disengagement continuum, but rather toward the disengaged pole.

Two separate explanations can be advanced in an attempt to account for the apparent contradiction between the relatively high level of disengagement found in PS families in the present study and the consistent pattern of enmeshment found by Minuchin and his team (Minuchin, 1974; Minuchin et al., 1973; Minuchin et al., 1974).

It may be argued that enmeshment and disengagement are actually two pathological adaptations used by families suffering severe communication problems. The latter, rather than the former, was measured in the present study. According to this explanation, families may react to the threat implied in the relative absence of meaningful communication in one of two ways—by reducing all forms of communication to a minimum, or by over-reacting and "communicating" excessively, even if these communications are still quite meaningless. The difference between the SU and the PS families is then not in the underlying problem (i.e., lack of meaningful communication), but rather in their reaction to the underlying problem (i.e., disengagement versus enmeshment). Thus, the apparent gap between Minuchin's findings and the findings of the present study may stem from the fact that while Minuchin and his co-workers studied disengagement and enmeshment, the present study examined the quality of the intra-familial communications.

However, an alternative explanation, one which attributes the differences between Minuchin's findings and the present ones to the instruments used, is also plausible. It is quite likely that the instruments used here tap the consequences of enmeshment and disengagement more than the disengaged and enmeshed patterns themselves. Put differently, low levels of spontaneous agreement and choice fulfillment, reduced communication and knowledge of others, and dissatisfaction with one's own family, may all be the end result of disturbed familial patterns, regardless of their exact nature, rather than an indication of degree of disengagement. The
enmeshed system is characterized by abundance of communication, extreme
closeness and blurry inter-generational boundaries, all of which imply a
continuous infringement on an individual's privacy and autonomy. Although
Minuchin does not state so clearly, it may be concluded that the enmeshed
and disengaged systems are distinguishable more in terms of the quantities
and the apparent content of their communication than the effects such
communications have. They share in common the fact that whatever pattern
of communication does exist it leads nowhere, i.e., it fails to solve the
particular problems of individual members as well as those of the family
unit itself. In the disengaged family problems are not attended to and
solutions are not found because of dearth of communication, whereas in the
enmeshed family the same consequences occur because the excessive communi-
cation is meaningless and is used mainly to divert attention from real
problems and to detour important conflicts.

This explanation becomes even more plausible when it is realized that
the measures used in the present study are outcome measures whereas those
used by Minuchin were process measures. It may be added that the study of
the outcomes of disengagement and enmeshment is important because the con-
sequences of these disturbances are likely to cause a further intensification
of the family's problems.

The similarities observed between the SU and PS groups in the present
study and their distance from the NO group may, therefore, indicate that
the first two are indeed disturbed. This conclusion is supported by the
findings showing that all family members, and not just the IP alone, in the
SU and PS groups tend to differ systematically from their counterparts in
the NO group on almost all of the measures used. The exact nature of the
disturbance of each group could not be uncovered with the instruments used
in the present study. They proved to be sensitive measures of family
pathology yet incapable of detecting the finer differences between differ-
ent forms of psychopathology, if in fact such differences exist at all.

There are no indications in the present study that generational bound-
daries are clearer in the NO group, or that they are very flexible in the
PS group and very rigid in the SU group. All three groups show a
relatively high degree of stability in parental position and status across
measures, and the same applies to children's status and to parent-child relationships. Confusion of generational boundaries could be indicated in the present study by: (1) a higher degree of concordance between parent-child scores than between both parents, in the SU and PS groups, but not in the NO group; and (2) a wider gap between siblings' scores than between parent-child scores, in the disturbed groups but not in the non-disturbed group. None of these conditions appears to occur systematically in the present study. However, these measures were not constructed to identify impairments of generational boundaries and thus may not be directly applicable to this issue.

Although no particular hypotheses were advanced with regard to parent-child relationships, the findings of the present study bear on the issue.

The father in the SU group was found to be systematically and repeatedly rejected by all family members and to lack in dominance, whereas the PS father was sometimes rejected and sometimes favored, and the NO father was quite consistently liked. This finding supports earlier studies which have shown fathers of suicidal adolescents to be passive (Glaser, 1965; Grow et al., 1970; Haim, 1974) and fathers of normal children to be dominant (Jacobs, 1975). The SU father in this study is especially remote from his children in general, and IP in particular. This may cause difficulties for the psychosexual development and processes of identity formation of the adolescent, and may also leave the teenager with a domineering and overburdened mother (Glaser, 1965).

The origin as well as the effects of such paternal passivity were not examined directly by the present study and can be only speculated upon. It may be safe to assume that paternal passivity is not independent of the maternal role, which, in turn, is not likely solely to result from the paternal role. Factors affecting spouse selection are very likely to be involved. Whatever these are, this finding also indicates a disturbance at the family level, and underlines the need for further exploration of the paternal role in both normal and disturbed families.

The SU mother, on the other hand, proved to be at least as dominant as the PS mother and almost as dominant as the NO mother. Her dominance is not necessarily a by-product of her husband's passivity since the tests
used allowed for both parents to be either passive or dominant. It is interesting to note that in the two kinds of disturbed families IP was closer to his mother than his father, while the opposite was true in the NO group. This may be a function of the father's distance more than the mother's closeness, i.e., the teenager cannot be said to be replacing his father.

The findings of the present study show the SU IP to be only somewhat more rejected than his PS and NO counterparts. Within his own family the SU IP is consistently the most rejected person. However, the PS and NO IPs rank the same way quite frequently. It is conceivable that the two major differences are the extent of rejection as measured by absolute rather than relative scores, and the distance from other siblings. The findings seem to indicate that the SU IP is not only the most rejected member of his family, but the degree of satisfaction and support he could expect from his family is far lesser than that of the PS and NO IPs. Furthermore, more often than not the SU IP falls far behind his own siblings on measures of acceptance, whereas the NO IP comes very close to his own siblings, and the PS sometimes surpasses them and sometimes falls behind on these measures. Sibling support is another neglected area which deserves more intensive and extensive exploration.

The SU IP also resembles the PS IP and the NO IP in the feeling of being rejected. Such a subjective feeling, partly at least based on their real home experiences, may be a corollary of the normal changes of adolescence which frequently entail a sense of being misunderstood. Such a feeling is distressing enough for every adolescent experiencing it. It may be many times as distressing when it occurs in a disengaged context. In a normal context there are likely to be some corrective mechanisms and feedback processes which may sooner or later ameliorate the youngster's feelings of being isolated, rejected or misunderstood. These processes may be absent, minimal or ineffective in the disengaged home.

A final finding deserving some mention concerns the Statement Game and Guessing Game. The small number of families which participated in this stage of the experimental procedure does not allow any definite conclusions to be drawn. However, the consistency of scores obtained from
the various measures, and their similarity to the other two tests used, exceeded all expectations. The usefulness of the instrument is indicated by the following: (1) Although the positive and negative statements were made, read, and scored independently of each other, they proved to be complementary, so that a subject scoring high on Positive Statements Received (PSR), for example, also scored low on Negative Statements Received (NSR); (2) with few rare exceptions subjects were very accurate in identifying their own statements even after they were rephrased by the investigator (in the guessing phase of the test). The few who missed their own statements usually confused them with very similar, sometimes identical statements made by other family members. This proves that the rewording of statements by the experimenter achieved its goal at least partially; (3) the high degree of overlap between the perception by others (NPBO and PPBO) and the actual statements directed at a person (NSR and PSR) also indicates that guessing was not randomly made, but was rather based on familiarity with the family; (4) the level of congruence among the various measures derived from the Statement Game and Guessing Game and scores derived from The Unrevealed Differences Technique and The Family Concept Test was high enough to suggest validity, yet not too high as to suggest redundancy.

These indicators are encouraging enough to warrant further investigation of this new tool. Administration proved to be short and simple, and, contrary to some preliminary worries, the idea of the task was well accepted by all but one subject.

One difficulty relates to the fact that a statement may be phrased as either positive or negative, in conformity with the instructions, yet be qualified in such a way as to render it opposite in meaning. This was observed more frequently in the positive than in the negative statements. A "positive" statement written by one father about his wife may illustrate the point: "[M]y wife does a good job of cooking, when she cooks." Another "positive" statement, this one written by a mother, read: "The best thing about my husband is that he gave me wonderful children."
Evaluation and Implications

The major contribution of the present study is the confirmation of the disturbance in the suicidal family. The disturbance is not limited to any single individual or even to a dyad or a triad, but rather involves the functioning of the whole system. This finding concurs with Williams and Lyons' (1976) finding of disturbance at the family level. This finding, coupled with the other major finding, namely, the one showing IP not to be much more rejected within his family than other children are within their own families, calls for a shift in the focus of both research and treatment. In light of the present findings researchers and therapists might be advised to concentrate on the family unit rather than on the symptom bearer alone. One of the goals of the therapeutic process may be to decrease inter-member distances and especially encourage father's involvement and active participation in family affairs. The latter implies that the father has to be helped in re-entering the system while the family has to be urged to make room for him. Special emphasis should be placed on improving communication between children and father, IP included.

However, this study cannot claim to provide conclusive answers to the questions raised. In spite of the consistency of certain trends across independent measures, a consistency which lends support to the findings and increases the confidence in their reliability, the study suffers a few shortcomings which urge caution in the interpretation of the findings.

The most obvious limitations of the present study concern the sample used. The small number of families in each of the three groups may be responsible for the relative rarity of statistically significant differences. It also raises questions as to the representativeness of the sample, and the generalities that may be safely drawn. Furthermore, as mentioned in Chapter II, the three groups employed could not be matched on a number of variables such as birth order of IP, family size, and father's age. The possible effects of such variables are unknown. Analysis of covariance was not performed since its use in adjusting for initial differences among groups has been questioned (Lord, 1969).

The final sample of 42 families was composed, by necessity, of volunteer families only, and they accounted for 20 percent or less of those
contacted. The motivation for their cooperation is an unknown factor, the effects of which are equally unknown. It is felt that a sizable proportion in each group consented because of a hope of gaining some insights into their problems, or even free consultation. Families actively seeking help, or those trying to take advantage of what they consider to be an opportunity to get help, cannot be said to represent the families which refused to participate. This applies to NO families as well. In other words, it is quite likely that some of the NO families have problems for which they have not sought help so far. This may also account for the lack of more statistically significant differences between the groups. It could be corrected by recruiting only families whose members score high on tests of psychological adjustment in the NO group.

The generalization of the present findings and conclusions to non-intact suicidal families is unadvisable. This is a major limitation of the study since the incidence of broken homes in the population of adolescent suicide attempters is high, even if not higher than in other psychopathological groups.

One advantage of the present sample is its comparability to those used in other studies, as mentioned in Chapter II.

The present study, as all other studies of adolescent suicidal behavior, is a retrospective one. It is therefore impossible to weed out the effects of the traumatic experience from its causes. The inclusion of normal controls who were treated for non-self-inflicted traumas and illnesses was a partial attempt to solve this problem, but is insufficient.

A further limitation concerns the measures chosen for the present study. A major problem in the field of family research concerns the relationship between measures used and concepts studied. Objectively scored measures yield relatively reliable scores but they are usually only remotely related to the theoretical concepts which are of interest to the investigators. Measures more directly related to theoretical concepts, and as such requiring less inference, on the other hand, are usually less reliable and therefore less valid. The measures chosen for the present study were selected because of the objectivity of the scoring procedure and their proven usefulness in previous studies (except for the Statement
Game and Guessing Game). Yet a certain gap between scores and concepts, or between behaviors actually observed and behaviors of interest, had to be bridged by making some inferences.

**Suggestions for Further Studies**

The review of the literature (Chapter I) suggests a general need for better controlled and better designed studies of all aspects of adolescent suicidal behavior. However, a few areas of research have been neglected more than others and deserve special attention.

The present study indicates a need for more studies of the family as a functioning and interacting system. Studies of the functioning of the siblings sub-system and the father-children sub-system may throw light on important relationships that were identified but unexplored in the present study.

Studies of processes rather than outcomes may clarify the true nature of the family disturbance and suggest possible entries for therapy.

The role played by the interaction between the adolescent suicide attempter's personality and developmental level and his family's disturbance in the development of suicidal tendencies is another neglected but promising area of research.

One strategy that may be used to study the role of family variables is to examine the effects of the modification of certain known patterns of interaction and communication, induced in the course of therapy, on the suicidal tendencies of the suicidal adolescent.

Finally, prospective studies can, more than any retrospective study, provide answers to questions of etiology. The accomplishment of such an endeavor may prove easier than generally believed if a high-risk population of latency-age or pre-adolescence children can be identified.
APPENDIX A

The Unrevealed Differences Technique
INSTRUCTIONS

In this booklet a number of situations are described. For each situation you have 10 possible choices. Now -

(1) Make believe the situation is real and actually happening.

(2) Of the available choices, cross off the three that you would not want or that you want the least. Draw a line through these three choices to cross them off.

(3) Then mark the three choices you would want the most. Write the number "1" next to the choice you want the very most. Then write a "2" next to your second choice, and a "3" next to your third choice.

(4) Check your sheet to make sure you have lines drawn through the three choices you do not want, and your three favorite choices are marked "1", "2", and "3".

(5) Go on to the next situation until you have finished them all.
O. The Situation:

Which of the following new TV series would you prefer to watch tonight?

(1) Cross out the three programs you would not want to watch or would least prefer to watch.

(2) Mark your favorite choices "1", "2", and "3".

a. ____ Commentary on the News (news)
b. ____ Sports Hi-lights (sports)
c. ____ The Neighbors (situation comedy)
d. ____ Orchestras of the World (music)
e. ____ The Great Men (biographies)
f. ____ The Vampires of Outer Space (thrilling fantasy)
g. ____ Our Changing World (science)
h. ____ Murder & Co. (crime stories)
i. ____ Comedy Hour (musical variety)
j. ____ Bedtime Stories (love stories)
B. The Situation:

Tomorrow night you are having supper out. Below are the foods you might find on the menu.

(1) Cross out the three foods you would not like to eat, or want to eat the least.

(2) Mark with numbers "1", "2", and "3" the three foods you would most like to eat, with "1" being your favorite, "2" your second choice, and "3" your third choice.

a. _____ Meat loaf
b. _____ Spaghetti and meatballs
c. _____ Beef stew
d. _____ Pork chops
e. _____ Fried Oysters
f. _____ Ham
g. _____ Macaroni and Cheese
h. _____ Fried prawns
i. _____ Fillet of Sole
j. _____ Cheeseburgers
C. The Situation:

You are going to a movie this weekend. Below are the films you might be seeing.

(1) Cross out those three movies you would not be interested in seeing.

(2) Mark your first, second, and third choices, "1", "2", and "3".

a. _____ A western with John Wayne
b. _____ An adventure story with Kim Novak
c. _____ A comedy with Jerry Lewis
d. _____ A love story with Rock Hudson
e. _____ A western with Sandra Dee
f. _____ A comedy with Tuesday Weld
g. _____ A love story with Brigitte Bardot
h. _____ An adventure story with Gregory Peck
i. _____ A drama with Susan Hayward
j. _____ A drama with Paul Newman
D. The Situation:

You are going to live for a year in a foreign country. Below are the countries where you might go.

(1) Cross out the three countries you would not especially want to live in or want the least to live in.

(2) Mark your first, second, and third choices, "1", "2", and "3".

a. Ethiopia
b. Brazil
c. China
d. Greece
e. Russia
f. Argentina
g. Spain
h. India
i. South Africa
j. West Germany
E. The Situation:

You are going to a championship sports event this weekend.

Below is a list of the sports you might see.

(1) Cross out the three you would want the least to see, or don't want to see at all.

(2) Mark your three favorite choices, "1", "2", "3".

a. _____ Baseball

b. _____ Boxing

c. _____ Ice Hockey

d. _____ Horse racing

e. _____ Bowling

f. _____ Skiing

g. _____ Auto racing

h. _____ Basketball

i. _____ Wrestling

j. _____ Football
F. The Situation:

You are going to subscribe to a magazine. Below are the magazines you might subscribe to.

(1) Cross out the three you would want the least to subscribe to or don't want at all.

(2) Mark your three favorite choices, "1", "2", "3".

a. ______ Vogue
b. ______ Sports Illustrated
c. ______ Hot Rod
d. ______ Seventeen
e. ______ Field and Stream
f. ______ Playboy
g. ______ Modern Screen
h. ______ Ladies Home Journal
i. ______ True Detective
j. ______ True Confessions
0. The Situation:

You are going to choose the color of your next car. Below is a list of choices you might have.

(1) Cross out the three color combinations you do not like, or like the least.

(2) Mark your favorite choices "1", "2", and "3", as before.

a. ______ Maroon and white
b. ______ Black and gold
c. ______ White and blue
d. ______ Blue and cream
e. ______ Red and white
f. ______ Yellow and black
g. ______ Blue and gray
h. ______ Green and cream
i. ______ Red and black
j. ______ Black and gray
PLEASE

GO BACK NOW TO THE BEGINNING

AND QUICKLY CHECK EVERY PAGE.

MAKING SURE THAT FOR EVERY "SITUATION"

YOU HAVE MARKED

THREE MOST LIKED CHOICES (1, 2, and 3)

AND CROSSED OFF

THREE LEAST LIKED ONES

Thank you.
APPENDIX B

The Family Concept Test: Real and Ideal
Family Unit Inventory

Instructions:

For each of the items, circle the number that shows how true the item is for your family as it is now.

You can circle any number, from "0" to "8". At one end, "0" means the item is completely false for your present family. At the other end, "8", means it is very true for your family as it presently is.

Circle one number to the right of each item. Please make no other marks on the paper.

For example, if your family is now very active, you would score the sample item in this way:

<table>
<thead>
<tr>
<th>Least like present family</th>
<th>Most like present family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMPLE: We are an active family.</td>
<td>0 1 2 3 4 5 6 7 8 (S)</td>
</tr>
</tbody>
</table>

If your family was not at all active, you would have circled the "0". If it was neither active nor inactive, you would have circled the "4".

Use the various numbers in all of the positions, whichever best fits your answer, from "0", completely false, to "8", very true.

Please ask any questions if it is not clear what to do. Fill in your complete name at the bottom of this page, and go ahead and answer each item according to how well it fits your family as it actually is now. Answer every item and be as careful and as accurate as you can.

Thank you.

Name______________________________________________________________

Date______________________________________________________________

Family Unit Inventory

Instructions:
For each of the items, circle the number that shows how true the item is for your family as you would ideally like it to be. It does not matter what your family is actually like, only what you most want it to be like.

You can circle any number from "0" to "8". At one end, "0" means the item is completely false for your ideal family. At the other end, "8" means it is very true for your ideal family.

Circle one number to the right of each item. Please make no other marks on the paper.

For example, if you would want your family to ideally be somewhat active, you would mark the sample item in this way:

<table>
<thead>
<tr>
<th>Least like</th>
<th>Most like</th>
</tr>
</thead>
<tbody>
<tr>
<td>ideal family</td>
<td>ideal family</td>
</tr>
</tbody>
</table>

SAMPLE: We are an active family. 0 1 2 3 4 5 6 7 8 (S)

If you would strongly like your ideal family to be very active, you would have circled the "8". If you did not want it to be either active or inactive, you would have circled the "4". If you did not want it to be active at all, you would have circled the "0".

Use the various numbers in all of the positions, whichever best fits your answer, from "0", completely false, to "8", very true.

Please ask any questions if it is not clear what to do. Fill in your complete name at the bottom of this page, and go ahead and answer each item according to how well it fits your family as you would most like it to be. Be as careful and accurate as you can and answer all the items.

Thank you.

Name________________________________________

Date________________________________________

Family Unit Inventory

Present Family

<table>
<thead>
<tr>
<th>Least like</th>
<th>Most like</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We like to do new and different things.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>2. We can usually depend on each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>3. We have a number of close friends.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>4. We often do not agree on important matters.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>5. Each of us tries to be the kind of person the others will like.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>6. Good manners and proper behavior are very important to us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>7. We feel secure (safe) when we are with each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>8. We want help with our problems.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>9. We do many things together.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>10. Each of us wants to tell the others what to do.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>11. There are serious differences in our beliefs about what is right and important.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>12. We feel free to express any thought or feeling to each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>13. Our home is the center of our activities.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>14. We are an affectionate family (show our love for each other).</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>15. The difficulties that we have in the family are not our fault.</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
</tbody>
</table>

(Continue to next page)

<table>
<thead>
<tr>
<th>Present Family</th>
<th>Least like</th>
<th>Most like</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Little problems often become big ones for us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(16)</td>
</tr>
<tr>
<td>17. We do not understand each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(17)</td>
</tr>
<tr>
<td>18. We get along very well in the community.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(18)</td>
</tr>
<tr>
<td>19. We often praise or compliment each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(19)</td>
</tr>
<tr>
<td>20. We avoid talking about sexual matters.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(20)</td>
</tr>
<tr>
<td>21. We get along much better with persons outside the family than with each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(21)</td>
</tr>
<tr>
<td>22. If we had more money most of our present problems would be gone.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(22)</td>
</tr>
<tr>
<td>23. We are proud of our family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(23)</td>
</tr>
<tr>
<td>24. We do not like each other's friends.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(24)</td>
</tr>
<tr>
<td>25. There are many conflicts (disagreements) in our family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(25)</td>
</tr>
<tr>
<td>26. We are usually calm and relaxed when we are together.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(26)</td>
</tr>
<tr>
<td>27. We are not a talkative family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(27)</td>
</tr>
<tr>
<td>28. We respect each other's privacy.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(28)</td>
</tr>
<tr>
<td>29. Accomplishing (actually getting done) what we want to do seems to be difficult for us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(29)</td>
</tr>
<tr>
<td>30. We tend to worry about many things.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(30)</td>
</tr>
<tr>
<td>31. We often upset each other without meaning to.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(31)</td>
</tr>
<tr>
<td>32. Nothing exciting ever seems to happen to us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(32)</td>
</tr>
</tbody>
</table>

(Continue to next page)
<table>
<thead>
<tr>
<th></th>
<th>Present Family</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Least like</strong></td>
<td><strong>Most like</strong></td>
<td></td>
</tr>
<tr>
<td>33. We are a religious family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(33)</td>
</tr>
<tr>
<td>34. We are continually getting to know each other better.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(34)</td>
</tr>
<tr>
<td>35. We need each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(35)</td>
</tr>
<tr>
<td>36. We do not spend enough time together.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(36)</td>
</tr>
<tr>
<td>37. We do not understand what is causing our difficulties.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(37)</td>
</tr>
<tr>
<td>38. Success and reputation are very important to us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(38)</td>
</tr>
<tr>
<td>39. We encourage each other to develop in his or her own individual way.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(39)</td>
</tr>
<tr>
<td>40. We are ashamed of some things about our family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(40)</td>
</tr>
</tbody>
</table>

(Continue to next page)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Do not write on this space)</td>
<td></td>
</tr>
<tr>
<td>Card number</td>
<td>1</td>
</tr>
<tr>
<td>Test form</td>
<td>1</td>
</tr>
<tr>
<td>Occupation of Father</td>
<td></td>
</tr>
<tr>
<td>Education of Father</td>
<td></td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
</tr>
<tr>
<td>Rank of rater</td>
<td></td>
</tr>
<tr>
<td>Age of rater</td>
<td></td>
</tr>
<tr>
<td>Sex of rater (1-male; 2-female)</td>
<td></td>
</tr>
<tr>
<td>Test stage</td>
<td></td>
</tr>
<tr>
<td>Test date</td>
<td></td>
</tr>
<tr>
<td>Missing data</td>
<td></td>
</tr>
<tr>
<td>Test code</td>
<td>MC1</td>
</tr>
<tr>
<td>Group code</td>
<td></td>
</tr>
<tr>
<td>Rater Identity (F1-fa; M2-mo; C3-chi)</td>
<td></td>
</tr>
<tr>
<td>Family ID code</td>
<td></td>
</tr>
<tr>
<td>Deck number</td>
<td></td>
</tr>
<tr>
<td>Present Family</td>
<td>Least like</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
</tr>
<tr>
<td>41. We have warm, close relationships with each other.</td>
<td>0 1 2 3 4 5 6 7 8 (1)</td>
</tr>
<tr>
<td>42. There are some things which we avoid talking about.</td>
<td>0 1 2 3 4 5 6 7 8 (2)</td>
</tr>
<tr>
<td>43. Together we can overcome almost any difficulty.</td>
<td>0 1 2 3 4 5 6 7 8 (3)</td>
</tr>
<tr>
<td>44. We really do trust and confide in each other.</td>
<td>0 1 2 3 4 5 6 7 8 (4)</td>
</tr>
<tr>
<td>45. We make many demands on each other.</td>
<td>0 1 2 3 4 5 6 7 8 (5)</td>
</tr>
<tr>
<td>46. We take care of each other.</td>
<td>0 1 2 3 4 5 6 7 8 (6)</td>
</tr>
<tr>
<td>47. Our activities together are usually planned and organized.</td>
<td>0 1 2 3 4 5 6 7 8 (7)</td>
</tr>
<tr>
<td>48. The family has always been very important to us.</td>
<td>0 1 2 3 4 5 6 7 8 (8)</td>
</tr>
<tr>
<td>49. It is hard for us to please each other.</td>
<td>0 1 2 3 4 5 6 7 8 (9)</td>
</tr>
<tr>
<td>50. We are considerate of each other.</td>
<td>0 1 2 3 4 5 6 7 8 (10)</td>
</tr>
<tr>
<td>51. We can stand up for our rights if necessary.</td>
<td>0 1 2 3 4 5 6 7 8 (11)</td>
</tr>
<tr>
<td>52. We are all responsible for family problems.</td>
<td>0 1 2 3 4 5 6 7 8 (12)</td>
</tr>
<tr>
<td>53. There is not enough discipline in our family.</td>
<td>0 1 2 3 4 5 6 7 8 (13)</td>
</tr>
<tr>
<td>54. We have very good times together.</td>
<td>0 1 2 3 4 5 6 7 8 (14)</td>
</tr>
<tr>
<td>55. We are sometimes frightened of each other.</td>
<td>0 1 2 3 4 5 6 7 8 (15)</td>
</tr>
</tbody>
</table>

(Continue to next page)
<table>
<thead>
<tr>
<th>Present Family</th>
<th>Least like</th>
<th>Most like</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. We often become angry at each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(16)</td>
</tr>
<tr>
<td>57. We live largely by other people's standards and values (what is right and important.)</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(17)</td>
</tr>
<tr>
<td>58. We are not as happy together as we might be.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(18)</td>
</tr>
<tr>
<td>59. We are critical of each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(19)</td>
</tr>
<tr>
<td>60. We are satisfied with the way in which we now live.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(20)</td>
</tr>
<tr>
<td>61. Usually each of us goes his own separate way.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(21)</td>
</tr>
<tr>
<td>62. We resent each other's outside activities.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(22)</td>
</tr>
<tr>
<td>63. We have respect for each other's feelings and opinions even when we differ strongly.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(23)</td>
</tr>
<tr>
<td>64. We sometimes wish we could be an entirely different family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(24)</td>
</tr>
<tr>
<td>65. We are sociable and really enjoy being with people.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(25)</td>
</tr>
<tr>
<td>66. We are a disorganized (mixed up) family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(26)</td>
</tr>
<tr>
<td>67. It is important to us to know how we appear to others.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(27)</td>
</tr>
<tr>
<td>68. Our decisions are not our own, but are forced upon us by things beyond our control.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(28)</td>
</tr>
<tr>
<td>69. We have little fondness for each other.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(29)</td>
</tr>
<tr>
<td>70. We are a strong, competent (able) family.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(30)</td>
</tr>
</tbody>
</table>

(continue to next page)
**Present Family**

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Least like</th>
<th>Most like</th>
</tr>
</thead>
<tbody>
<tr>
<td>71. We avoid telling each other our real feelings.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(31)</td>
</tr>
<tr>
<td>72. We are not satisfied with anything short of perfection.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(32)</td>
</tr>
<tr>
<td>73. We forgive each other easily.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(33)</td>
</tr>
<tr>
<td>74. We are usually somewhat reserved with each other</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(34)</td>
</tr>
<tr>
<td>75. We hardly ever hurt each other's feelings.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(35)</td>
</tr>
<tr>
<td>76. We like the same things.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(36)</td>
</tr>
<tr>
<td>77. We usually reach decisions by talking it over and some give and take.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(37)</td>
</tr>
<tr>
<td>78. We can adjust well to new situations.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(38)</td>
</tr>
<tr>
<td>79. We are liked by most people who know us.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(39)</td>
</tr>
<tr>
<td>80. We are full of life and good spirits.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td>(40)</td>
</tr>
</tbody>
</table>

**Please Fill In:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>2</td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td>Occupation of father (please describe)</td>
<td></td>
</tr>
<tr>
<td>Education of father (years &amp; highest degree)</td>
<td></td>
</tr>
<tr>
<td>Occupation of mother</td>
<td></td>
</tr>
<tr>
<td>Education of mother</td>
<td></td>
</tr>
<tr>
<td>Number of children in family</td>
<td></td>
</tr>
<tr>
<td>Your rank in your family of origin (oldest child, youngest, middle)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Thank you.</td>
<td></td>
</tr>
</tbody>
</table>

(Do not write in this space)

- Card number: 2 (47)
- Test form: 1 (48)
- Occupation of father: (50)
- Education of father: (51-52)
- No. of children: (53-54)
- Rank of rater: (56)
- Age of rater: (57-58)
- Sex of rater: (59)
- Test stage: (60)
- Test date: (61-66)
- Missing data: (67)
- Test code: MC (68-70)
- Group code: (71)
- Rater Identity (F1-fa; M2-mo; C3-chi) (72-73)
- Family ID code: (74-77)
- Deck number: (78-80)
APPENDIX C

The Statement Game: Negative and Positive
On the card you were just given I would like you to write your name, the WORST thing about any one person in your family, and that person's name. You may choose anyone but make sure you choose only one person, and that person must be present here in this room. Make your statement as brief as possible, and don't forget to write that person's name. When you have finished hand your card directly to me. Don't let anybody read it.

Your statement, as well as those made by everyone else, will never be revealed to anyone but me. Later I will collect all statements, shuffle them and read them to the family. But I will not mention who wrote a statement and to whom it applies. This will remain completely confidential and will be used only for the purpose of the present research project.

Do you have any questions? I'll be glad to answer them now.
On the card you were just given I would like you to write your name, the **BEST** thing about any one person in your family, and that person's name. You may choose anyone but make sure you choose only one person, and that person must be present here in this room. Make your statement as brief as possible, and don't forget to write that person's name. When you have finished hand your card directly to me. Don't let anybody read it.

Your statement, as well as those made by everyone else, will never be revealed to anyone but me. Later I will collect all statements, shuffle them and read them to the family. But I will not mention who wrote a statement and to whom it applies. This will remain completely confidential and will be used only for the purpose of the present research project.

Do you have any questions? I'll be glad to answer them now.
APPENDIX D

The Guessing Game
GUESSING GAME

INSTRUCTIONS

As everyone else in your family you have just written a confidential statement about someone in your family. I, the Investigator, collected the cards, shuffled them, and added two of my own. So there is no way you can tell for sure who wrote what about whom. You may guess, of course, and that's exactly what I would like you to do when I read these statements one by one.

For each statement I read please indicate, on the bottom part of this page, who you believe to be the source of that statement (=who wrote it), and its target (=about whom it was written). For each statement guess only one source and only one target. But you may guess as often as you wish about the same person (s).

Needless to say, your guesses will be completely confidential and will be revealed to no one but this Investigator. They will be used only for the purpose of the present research project.

Please PRINT the names.

YOUR GUESSES

WHO WROTE IT

ABOUT WHOM

Statement # 1: Source _________________ Target __________________

Statement # 2: Source _________________ Target __________________

Statement # 3: Source _________________ Target __________________

Statement # 4: Source _________________ Target __________________

Statement # 5: Source _________________ Target __________________

Statement # 6: Source _________________ Target __________________

Statement # 7: Source _________________ Target __________________


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