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COMPARISON OF ADOLESCENT PERCEPTIONS OF FAMILY DYNAMICS IN
FAMILIES WITH EITHER A SUICIDAL, EMOTIONALLY
DISTURBED/NONSUICIDAL, OR NONPROBLEMATIC ADOLESCENT

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FAMILIES WITH EITHER A SUICIDAL, EMOTIONALLY DISTURBED/
NONSUICIDAL, OR NONPROBLEMATIC ADOLESCENT

DISSERTATION

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

By

Marian Stansbury, B.A., M.S.

* * * * *

The Ohio State University
1985

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CHAPTER 1

INTRODUCTION

Demographic Overview of the Problem

Adolescents are attempting and completing suicide at an ever increasing rate. Among persons 15 to 24 years of age, suicide is currently the third leading cause of death, preceded only by accidents and homicides (Holinger, 1978; U.S. Vital Statistics, 1978). Although the nation's overall suicide rate has not varied much in the past 50 years, the rate of adolescent suicide has doubled in the last decade and tripled in the last 20 years (Holinger, 1978). While the overall death rate for the American people dropped by 25% from 1960-1978, it grew by 11% for the age group 15-24 (U.S. Dept. of Health and Human Services, 1980). In 1977, almost 5,000 adolescent and young adults committed suicide, an average of 13 a day (U.S. Department of Health and Human Services, 1980). For every completed suicide, it is estimated that 50-150 suicidal attempts occur (Finch & Poznanski, 1971; McIntire, Angle & Schlict, 1977).

Males outnumber females in completed suicides (3-4:1) and females outnumber males in the number of attempts by an approximately equal margin (Holinger, 1978; Toolan, 1975). Males and females typically
choose different methods of suicide with males opting for more violent and irrevocable methods, e.g., firearms and hangings, whereas females use more passive approaches, e.g., poisoning (Holinger, 1978; Toolan, 1975). It has not yet been determined whether this gender difference is a result in the differences in death intent or in the degree of impulsive and aggressive tendencies (McKenry & Tishler, 1979).

It is believed that statistics tend to underestimate the extent of the problem because of the social stigma, religious taboos, and limitations of insurance policies. It has been estimated that perhaps as much as 50% of the suicidal behavior in young persons is disguised or not reported (Finch & Poznanski, 1971; Mishara, 1975; Weiner, 1970). Therefore, we do not have a truly accurate picture of the frequency, motivations, or dynamics underlying suicidal behavior.

**Theories of Adolescent Suicidal Behavior**

With such large numbers of adolescents attempting and completing suicide, it becomes important to determine what is happening in the lives of young people that leads them to self-destructive behavior. Various theories, although generally lacking in empirical support, have been advanced to explain the dynamics of suicidal behavior.

The psychodynamic theory (Freud, 1925) is perhaps the most widely accepted theory of suicide. According to this theory, the suicidal person is ambivalent -- both hating and loving an object which seems lost to them. As a result of this loss or rejection, the person recognizes feelings of anger and hostility toward the depriving person. The guilt surrounding these negative feelings
turns the aggressive "acting out" toward the self in an attempt to resolve tension.

Developmental theory focuses on the adolescent stage of development as a time of great change -- physically, emotionally, and intellectually. These normal changes result in varying degrees of stress for the adolescent. If additional stressors are present (i.e., environmental change, feelings of entrapment, loss, etc.), they, along with the adolescent's tendency for impulsivity, may precipitate a crisis resulting in suicidal behavior (Gould, 1965; Jacobs, 1971; McIntire, Angle, & Schlicht, 1977).

What meaning the adolescent derives when considering his/her own death is the primary focus of the cognitive theorists. Because of the adolescent level of cognitive development, death to the adolescent may appear to be an unreality, i.e., a reversible process that is not perceived as final, or perhaps the hope of joining a lost loved one. Adolescents may thus perceive suicide as a way to gain love from significant others or to retaliate against those that have mistreated or acted unjustly toward them (Gould, 1965; McIntire, Angle & Schlicht, 1977).

A sociological perspective, as expressed by Durkheim (1950), describes the relationship between societal control and the individual. Durkheim (1950) described the suicidal person as anomic -- lacking ties with his/her community, feeling alienated and therefore experiencing no "pull" from society to live.

Research on Family and Adolescent Suicidal Behavior

The above theories are general attempts at explaining dynamics leading to suicide, but they do not sufficiently offer a comprehensive
explanation of the etiology of suicidal behavior in young people and, as aforementioned, are generally lacking in empirical support. Because suicide is not considered to be a discrete entity, but a symptom which may have multiple causes in varying combinations, it is important to examine systematically a variety of possible precipitating factors (Brown & Sheran, 1972; Gould, 1965). The adolescent's family has been identified as one key factor that might make him/her more susceptible to self-destructive behaviors (McKenry, Tishler & Kelly, 1982; Williams & Lyons, 1976).

The literature on adolescent suicide makes frequent reference to specific, often theoretically unrelated family characteristics. Such family characteristics include the loss of a family member, suicide committed by a family member, marital conflict, economic stress, frequent moves, parent-child conflict, and poor coping mechanisms to handle both intra- and extra-familial stress (e.g., Cantor, 1972; Gould, 1965; McIntire, Angel & Schlicht, 1977; Richman, 1971; Teicher & Jacobs; 1966).

Yet only a few studies have systematically focused on family functioning in relation to adolescent suicidal behavior (e.g., Marks & Haller, 1977; Toolan, 1975). Such studies have investigated how the families have functioned historically so as to gain an understanding of the current situation in the context of the subject's total biography (Teicher & Jacobs, 1966). Some studies have investigated the communication and interaction patterns of families, e.g., passive aggressive (Marks & Haller, 1977), expressed hostility (McIntire, Angle & Schlicht, 1977), response from others to cry for

The studies of family functioning have utilized a variety of methods to obtain data including: secondary analysis of records of adolescents admitted for mental health services (Barter & Swaback, 1968; Cohen-Sandler & Berman, 1982; Toolan, 1962, 1975); clinical interviews (Marks & Haller, 1977; McIntire, Angle & Schlicht, 1977; Rosenbaum & Richman, 1970; Schrut, 1964; Schrut & Michels, 1969; Teicher & Jacobs, 1966; Wenz, 1978); systematic measures of direct observation (Williams & Lyons, 1976); and interviews utilizing standardized measures of self-report (Tishler & McKenry, 1982; Tishler, McKenry, & Morgan, 1981; Wenz, 1978).

Of these studies of family functioning related to adolescent suicidal behavior, only a few have used control or comparison groups (e.g., McKenry, Tishler & Kelly, 1982; Teicher & Jacobs, 1966; Williams & Lyons, 1976). Even fewer studies have included family members of the adolescent (e.g., McKenry, Tishler & Kelly, 1982, Teicher & Jacobs, 1966; Williams & Lyons, 1976). Another weakness in these family studies of adolescent suicide includes the failure to consider the sex of the subject attempting suicide (Triolo, McKenry, Tishler & Blyth, 1984). Many of the studies also have ignored age differences, often failing even to distinguish adolescents from adults.
and children. Clear definitions of suicidal behavior have not characterized previous studies of adolescent suicide. There has also been a lack of research presenting a family interactional or clinical point of view (Warren, 1976).

Considering the significance of the problem of adolescent suicide, it is clear that additional information is needed regarding the etiology of adolescent suicide attempts. It would appear that the role of families is very salient in such behavior. It is also apparent that to obtain this information, more systematic investigations must be undertaken that utilize control or comparison groups, standardized measures, and control for potentially contaminating variables.

Theoretical Orientation to Studying Family Dynamics

The study of the role of family dynamics or functioning in adolescent suicidal behavior implies awareness of family interaction patterns and the way families structure themselves and function as a unit rather than viewing only the social, demographic characteristics of families (or their individual members), which are only a fraction of what makes up or defines a family. In 1926, Ernest Burgess described the family as a unity of interacting personalities. In 1934, George Herbert Mead set forth the framework for the Symbolic-Interaction theory which shifted the focus from social situations or characteristics and intra-psychic struggles to the internal workings (interactions) of a group of people. This approach seeks to discover the symbolic meaning or perceptions of the individuals which precede an act. It asks the question: How does an individual define (or what meaning does the individual give to) a certain situation or event?
It is theorized that the meaning or definition given to a situation determines one's behavior and interactions with others and therefore that man is an actor as well as a reactor. Thus, to truly understand why individuals/groups behave the way they do, it becomes necessary for the investigator to see the world from the point of view of the subject or subjects (Stryker, 1959). For the purpose of this research, it therefore becomes important to know how adolescents within a family unit view their family so that we may better understand the ways in which they are likely to act and react under stress.

Statement of the Problem

Utilizing a symbolic-interactional approach and controlling for sex and age of the adolescent, the purpose of this study was to assess how adolescents who make a suicidal act perceive their family functioning differently from adolescents who do not exhibit suicidal behaviors. This purpose will be carried out by asking three groups of adolescents: (1) suicidal; (2) emotionally disturbed/nonsuicidal; and (3) nonproblematic:

1. How do they perceive the sharing of physical space and time?
2. To what extent do they perceive emotional support and cohesion within the family?
3. To what extent do they perceive their ability to express feelings and concerns within the family?
4. What are their perceptions regarding the level of conflict (expressed anger and aggression) within the family?
5. What perceptions do they have about the actual or potential (threatened) loss of family members?
6. What support and interaction do they receive from sources external to the family?

7. What do they perceive are the families ability to adapt and make changes within the family?

8. To what extent does the adolescent perceive his/her situation as hopeless?

9. Do sex and age of the adolescent influence responses to any of the aforementioned questions?

Hypotheses

1. Adolescents who demonstrate suicidal behavior will describe their families as being more physically bound together than those adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

2. Adolescents who demonstrate suicidal behavior will describe their families as experiencing less emotional cohesion and support than do adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

3. Adolescents who demonstrate suicidal behavior will describe their families as less expressive than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

4. Adolescents who demonstrate suicidal behavior will describe their families as experiencing more conflict than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.
5. Adolescents who demonstrate suicidal behavior will describe their families as having more actual and potential losses than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

6. Adolescents who demonstrate suicidal behavior will describe their families as having less support and interaction with sources external to the family than do adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

7. Adolescents who demonstrate suicidal behavior will describe their families as less adaptable and less likely to make changes than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

8. Adolescents who demonstrate suicidal behavior will describe feeling more hopeless than the adolescent who is emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

9. The above mentioned relationships will vary as a function of the sex of the adolescent.

10. The above mentioned relationships will vary as a function of the age (i.e., older vs. younger) of the adolescent.

**Definition of Terms**

**Adaptability** - The ability of a family system to change its power structure, role relationships and relationship rules in response to situational and developmental stress as measured by the Adaptability Subscale of Family Adaptability and Cohesion Evaluation Scale (Olsen,
Portner, & Bell, 1982) and by the control subscale of the Family Environmental Scale (Moos & Moos, 1981).

Conflict - The extent to which open expression of anger and aggression and generally conflictual interactions are characteristic of the family as measured by the conflict subscale of The Family Environmental Scale (Moos & Moos, 1981).

Emotional Cohesion - The extent to which family members are concerned, helpful, and supportive and leading family members to believe they are loved, cared for, valued, esteemed, and belong as measured by the cohesion subscale of the Family Environmental Scale (Moos & Moos, 1975), the emotional, esteem, and satisfaction subscales of the Multiple Scales of Social Support (Morgan, 1982).

Expressiveness - The extent to which family members are allowed and encouraged to express their feelings openly and directly as measured by the expressiveness subscale of the Family Environmental Scale (Moos & Moos, 1981).

Hopelessness - Feelings of pessimism and discouragement about the future and feeling that one will not get over one's troubles or the situation will not improve and there is nothing to look forward as measured by the Hopelessness Scale (Beck, 1974).

Losses - Actual or potential/threatened loss of family members or significant others through death, divorce or separation or that of prized material possessions.

Physical Boundedness - The pressure within the family to remain physically intact, share time and space, and be intolerant of physical separation, as measured by the selected items from the cohesion subscale
of the Family Adaptability and Cohesion Scale (Olsen, Portner & Bell, 1982) and the Family Environment Scale (Moos & Moos, 1975).

Suicidal Behavior - Behavior which is life-threatening with the intent of jeopardizing his or her life or giving the appearance of such an attempt (McKenry & Tishler, 1981).

Support and Interaction with Sources External to the Family - Those involvements family members have with outside agencies and organizations that provide a normative influence as well as support as measured by the moral-religious, intellectual-cultural and active-recreational subscales of the Family Environmental Scale (Moos & Moos, 1981) and the affiliative style and assistance resources subscale of the Multiple Scales of Social Support (Morgan, 1982).
CHAPTER II

REVIEW OF THE LITERATURE

Historical Context

The phenomenon of suicide has been an issue of consideration by philosophers, theologians, social scientists, and the medical and legal professions for centuries. It is perhaps in understanding the variety of beliefs about suicide in different cultures and throughout history, that the current diversity of theories of adolescent suicide can be best understood.

The suicidal act has been viewed both as an act of courage and heroism as well as a sin for which one is eternally punished. Throughout Japanese history, the practice of hara-kiri, the ritual of disemboweling oneself, was limited to the Samurai warrior and noble classes and was expected to occur in certain situations to maintain one's honor (Schneidman, 1981). Suicide has always been more accepted in the East than in the West partially because of the Hindu view that the soul never dies (Gehlot & Nathawat, 1983). Carstairs (1955) observed that in the Indian culture "...death is not final but one incident in a long series of existences...". Indian widows during 1526-1857 would frequently join their deceased husbands on the funeral pyre since these women would become outcasts for the rest of their lives if they refused (Gehlot & Nathawat, 1983).
During the classical Greek era, the value placed on life was not how long, but how well one lived according to his/her principles, even if this required the sacrifice of one's life. Likewise, in ancient Roman society, the emphasis was on quality not quantity of life, living as well as one can, not merely as long (Shneidman, 1981). Therefore, suicide was not viewed as negatively in these cultures as it is today.

Views toward suicide began to change with the advent of Christianity. Taking one's life came to be believed as interference with the plan of the Diety (Ray & Johnson, 1983). Suicide was considered as a sin and a crime for which there was an associated punishment. In the Fourth Century, St. Augustine viewed suicide a crime because it violated the Sixth Commandment, and by 693 A.D., the church proclaimed that anyone who attempted suicide was to be excommunicated (Schneidman, 1981).

The propriety of suicide as a means of ending one's life has varied over time and among cultures as has the issue of responsibility or blame. During the late Seventeenth and early Eighteenth Centuries, philosophers such as Locke and Berkeley emphasized the role of the environment in affecting both positive and negative behaviors, while viewing the individual as basically innocent (Aaron, 1971; Tsanoff, 1953), and Rousseau transferred sin from man to society. In 1777, David Hume's essay "On Suicide" did not discuss suicide as a sin, but suggested that it was acceptable if life becomes a burden (Shneidman, 1981).
Whether it is the individual, the family, or society that is responsible for suicidal behaviors continues to be discussed and debated today. The two primary influences in theorizing about suicide in the Twentieth Century have been Emile Durkheim (1897) and Sigumd Freud (1925). Durkheim in his well known work *Le Suicide* (1897) suggested that suicide is the result of the strength or weakness of society's control over the individual. The effect of the society on the individual, he hypothesized, was demonstrated in three types of suicide. The first, "altruistic," occurs when the suicidal action is required by the society and must be completed in order to maintain one's honor, e.g., hara-kiri. The second type, "egoistic," occurs when an individual is an isolate and has so few ties with his community that the encouragement and support to continue living do not reach him. The third type, "anomic," occurs when there is a sudden change of established relationships (e.g., loss of job, death of a significant other) which create alienation and confusion for the individual.

While Durkheim's focus was explaining man and his relationship with society, Freud's focus was man's intra-personal dynamics. Freud returned responsibility to the individual but without the aspect of sinfulness. Freud (1925) explained the act of suicide as the result of an individual's response to feeling both hate and love for what appears to be a lost love and the subsequent guilt about the hostile feelings, which then leads to the suicidal behavior. Freud's ideas about suicide have been further developed by Karl
Menninger in his book *Man Against Himself* (1938). Menninger suggests that the hostile drive in suicide consists of three wishes: (1) the wish to kill; (2) the wish to be killed; and (3) the wish to die. These theories suggest that suicide is not an individual event but involves another in a relationship who is intended to experience harm.

Studies of child and adolescent suicide research, although far less extensively studied, have tended to also be in these two domains, sociological and psychological. In the psychological domain, emphasis has been on the cognitive level of adolescents as they perceive and interpret events in their life, and specifically their comprehension of death. Sociological accounts of child and adolescent suicide have primarily dealt with various environmental stressors facing youth in an increasingly complex society. For adolescents, the majority of the events in their life and their overall development occur in the context of their family and friends. Thus, psychologists and sociologists have focused on relationships with these significant others.

### The Role of the Family in Suicidal Behavior

"Most significant to the proneness for childhood suicidal behavior is the environment in which the child grows up" (Pfeffer, 1981, p. 111). It has become widely agreed that the motives for suicidal behavior among the young cannot be fully understood without a careful consideration of relationships among family members (Barter, Swaback, & Todd, 1968; Haider, 1968; Richardson, 1948; Tishler, McKenry, & Morgan, 1981; Williams & Lyons, 1976). Williams and Lyons
(1976) suggest, "The potential suicidal member does not initiate the pattern of interaction and communication which precipitates the act nor is he the passive victim; he participates in a reciprocal process with other family members" (p. 244). It is also more often that adolescent suicidal gestures, attempts, and completions occur at home with family members nearby (Garfinkel, Froese, & Hood, 1982; Jacobziner, 1965).

In a study by Tishler, McKenry, and Morgan (1981), fifty-two percent of the 108 adolescents studied cited parental problems as the primary reason for suicidal attempts. McKenry, Tishler, and Kelly (1982) emphasize that even if a direct link is established between family functioning and adolescent suicidal behavior "...this should not be interpreted to indicate families are to blame..." (p. 270), but that the family is one key factor that might make the adolescent more susceptible to self-destructive behaviors.

The finding most consistently reported in the literature as a characteristic of suicidal youth is that of family disruption, disorganization, and dysfunction (Cohen-Sandler, Berman & King, 1982; Tishler, McKenry & Morgan, 1981; Topol & Reznikoff, 1982; Walker & Mehr, 1983). Pfeffer (1982) states "...that childhood suicidal behavior is not an impulsive action but rather a symptom that evolves within the context of chronic family dysfunction" (p. 243). Teicher and Jacobs (1966a) have developed probably the most widely accepted model of adolescent suicide. They suggest that suicidal behavior among adolescents represents a "long-standing history of
problems" with parents. They contend that it is only within the context of the adolescents total biography that such events have any significance. Following a long history of problems, there is a period of escalation of the problem that usually revolves around the arrival at the adolescent stage of development. The final stage occurs when the failure to resolve the problems with parents during the first two stages results in the adolescent's feelings of failure and hopelessness. Barter and others (1968) have concluded that "Those adolescents who are unable to achieve adequate family relationships ... have a significantly higher rate of suicidal behavior" (p. 527).

It thus appears that an adolescent's vulnerability to suicidal behavior takes place within the context of the families pattern of interaction (Everstine & Everstine, 1983; Pfeffer, 1981b; Wenz, 1982). Shneidman (1969) described suicide as a "dyadic" pattern that is social and relational in nature and that most suicidal tensions are between two people closely known to each other. Faberow (1968) has suggested that suicidal behavior of an interpersonal nature is more often found among the youth.

Freud (1925) and Smith (1981) content that suicide emerges from an unconscious wish to kill someone other than themselves. Where Freud (1925) concludes that suicidal behavior is the result of guilt, Smith states that "Young people who kill themselves may be symbolically killing their parents" (p. 281). The source of the impulse to suicide, according to Smith, is most likely to be found in the person's relationships with the parents.
"The structural factor of family constellation and its possible consequences on personality and behavior has intermittently been of interest to social scientists for over a century" (Wenz, 1982). Much research and theorizing has been done regarding family dynamics or processes and the outcomes for the child. Broderick and Pulliam-Krager (1979) suggest establishing a typology of child outcomes to which various family styles can be related. The areas most studied at present are the family patterns of schizophrenia (Bowen, 1960; Haley, 1971; Laing, 1964; Lidz et al., 1957; Wynne & Singer, 1963) and delinquency (Glueck & Glueck, 1960; Minuchin, 1974). Lewis (1980) discusses the family patterns of depressed adolescents, and Madden and Harabin (1983) offer a description of the family structures of assultive adolescents.

The specific structure and dynamics of a family that may lead adolescents to risk ending their own life have not as yet been clearly determined. By utilizing the symbolic-interaction theory, this research will attempt to ascertain the manner in which adolescents make interpretations and give meaning to the requirements for physical presence, emotional closeness, expressiveness, conflict, adaptability, and helplessness within the family context which may lead the adolescent to suicidal behavior.

**Physical Bondedness**

Various patterns of family functioning associated with suicidal behavior have been suggested in the clinical literature. Of the fourteen listed by Richman (1971), the primary one discussed is the
intolerance for separation. He suggests, in fact, that the major precipitant of suicidal behavior among the young involves the issue of separation as most suicidal families experience more incidents of loss and separation that non-suicidal families. Cohen-Sandler, Berman, and King (1982) found in their study of suicidal and depressed children that suicidal children usually remain in the parental home intensely involved with family members whereas the depressed and control group children were often separated from their parents. Richman (1971) also describes the suicidal family members as having a "barbed wire exterior;" i.e., when someone gets close they get hurt, but, on the other hand, they cannot tolerate distance.

As previously mentioned, Garfinkel and others (1982) found that adolescent suicide attempts most often occurred "...at home with parents or friends nearby..." (p. 1261). Jacobziner (1965) in a review of 497 adolescent suicide attempts reported that in fifty-two percent "...either one or both parents were present at the time of the occurrence" (p. 9). Teicher and Jacobs (1966b) stated that eighty-eight percent (n=>50) of the adolescent suicide attempts in their study occurred in their home, often with the parents in the next room.

**Emotional Cohesion**

The absence of a warm, nurturing parent with whom to identify has been noted as a characteristic of adolescents who become suicidal (Corder et al., 1974). Glaser (1965) described the parents as "emotionally detached." Teicher and Jacobs (1966b) state that the
biography of an adolescent suicide attemptor is one of progressive social isolation and alienation from meaningful relationships. Thus, a common factor in the history of suicidal adolescents is the perception of not being understood, appreciated, or cared for by their families (Peck & Litman, 1975).

Research on adolescent suicide attempters has substantiated the withdrawal and lack of affection that characterizes the relationship between the suicidal adolescent and his/her parent. Corder and others (1974) compared eleven adolescent suicide attemptors with eleven matched controls who were admitted to a psychiatric unit but with no suicidal behavior and concluded that the suicidal adolescents were more likely to report they did not feel close or warm toward any adults. Marks and Haller (1977), in a study of 830 adolescents who demonstrated suicidal ideations, threats, and behaviors, described the adolescents as lacking in feelings of closeness to their parents. Topol and Reznikoff (1982), in a study of 99 adolescents comparing hospitalized suicidal adolescents with hospitalized nonsuicidal and nonhospitalized coping adolescents, concluded that the suicidal adolescents were least likely to identify themselves as having a family member as a close confident.

Korrella (1972) compared adolescent suicide attempters with adolescents having adjustment problems and concluded that the parents and adolescents who attempted suicide were less affectionate toward each other. McKenry, Tishler, and Kelly (1982), in a study of 46 adolescent suicide attempters and their parents concluded that the
attempters described their relationship with their parents as less satisfactory than a comparison group of non-attempters. Friedrich, Reams, and Jacobs (1982), in a study of 132 junior high school adolescents, concluded that the increasing severity of suicidal ideation was related to the lack of family cohesiveness.

Gehlot and Nathawat (1983) state "All persons with suicidal ideation have an intense underlying sense of deprivation of affection and a deep sense of personal rejection" (p. 275). Gould concluded 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 messages, either nonverbally as well as verbally, and unconsciously as well as consciously, may try to fulfill his/her parents' unconscious (or conscious) wishes and this attempt suicide if this is the only way to gain their approval and love.

Sabbath (1969) discusses the concept of the "expendable child" as "...one who no longer can be tolerated or needed by his family. He ceases to be useful either as an object of affection or as the vicarious fulfiller of the needs of his parents." (p. 282). It is this awareness by the adolescent which may lead to suicidal behavior.

Henden (1975) states that suicidal adolescents perceive their relationships with their parents as dependent on their emotional, if not physical, death. He concluded that the crucial factor was the "quality of feeling" that follows between the adolescent and his parent and that the bond of emotional death was as powerful in suicidal students who had not experienced the active death of a
parent as it was in those who had. Toolan (1962) suggests that the more a child feels rejected or unloved by his/her parents, the greater is his/her need for them.

Richman (1971) identified "symbiosis without empathy" as a pattern in families with a suicidal member. He states that such families maintain a symbiotic relationship in which the suicidal member is exploited by other family members. By not viewing the suicidal member as separate, the needs of the suicidal person go unheeded and s/he therefore receives the communication not to be. A "...polarity between either merging with another or suffering a drastic rejection with no middle ground is characteristic of the unstable, tension-filled...family relationships of suicidal persons" (Richman, 1978). It is clear, as Munichin (1974) has described, that it is the midpoint in the continuum between merging with another (emeshment) and experiencing separation (disengagement) that describes healthy family functioning.

Cantor (1972) concludes that the adolescent by his attempt hopes to alter the family's dynamics. She describes the "...typical attemptor as affiliative..." (p. 254) wanting to bring themselves into association with others. Ray and Johnson (1983) concluded that "...where family ties are close, suicide rates are low, and where families are not close, suicide rates are high" (p. 132). Spainer (1981) predicts that if the family is to meet the challenge of the future, family members will have to more adequately perform the most basic of family functions, i.e., emotional support.
Expressiveness

Poor communication between adolescents and their parents has been cited in the literature as being a characteristic of families with a suicidal adolescent. Fawcett and others (1969) stated that suicidal adolescents frequently were unable to express their needs in a manner which lead to their gratification. Williams and Lyons (1976), in a comparison study of six normal families with six families with an adolescent suicidal member, concluded that the families with an adolescent suicidal member communicated in a less effective, clear, and specific manner in terms of content and interpersonal interaction.

Teicher and Jacobs (1966b) in a study of fifty adolescent suicide attempters and a control group of nonattemptors found that the adolescent suicide attempters were cut off from family members with whom they could discuss problems and concluded, as a result of the breakdown in communication, that "If they don't care, I don't either" (1966a, p. 1255). Richman (1971) described the suicidal family as being unaware or non-receptive to verbal messages from the suicidal member and stated that there was a distinct pattern of hostility communicated both verbally and non-verbally to the suicidal individual. He concluded that the suicidal individual is the recipient of much aggression within the family. Pfeffer (1981) also observed that in families of suicidal children, there is ambivalence, hostility, and little expression of empathy or support.
Suicidal behavior has frequently been referred to as a "cry for help." Walker and Mehr (1983) state that "An adolescent suicide attempt is never an isolated and meaningless act. Rather, it is an act of desperation by a young person who believes that his or her only effective means of expression and communication is a self-destructive one. Often this outcry of suffering is not heard and understood by those persons closest to the adolescent within their own families... The adolescent, by attempting suicide, has tried to communicate dramatically and drastically to others in his or her world" (p. 286). Everstine and Everstine (1983) state that "Suicide is an event which is intended to send a message from one person to another..." (p. 207) and is "...a private message, intended for a private audience..." (p. 212).

Durkheim (1951) stated that suicide is the ultimate expression of alienation, but Henderson (1974) included the expression of suicidal attempts among what he terms care-eliciting behaviors. Stengel (1958) observed that "In most attempted suicides, we can discover an appeal to other human beings" (p. 22). It appears that suicidal adolescents have previously attempted less drastic means of communication but with no avail. "Attempted suicide is seen as an extreme or desperate effort to communicate and is utilized after the more common modes of communication have failed" (Cantor, 1972, p. 253).

As adolescence is recognized as the time when the family system is required to make a major shift in communication patterns allowing
the adolescent more input in decision making (Olson & McCubbin, 1983), positive communication skills enable families to increase family cohesion and adaptability more readily (Olson, Russell & Sprenkle, 1983). If communication skills are lacking as they appear to be in suicidal families, change toward the adolescent's needs being met appears to even be less likely and with increased conflict as a result.

**Conflict**

Conflict with parents frequently becomes heightened during the stressful period of adolescence and, when conflict becomes extreme in families, the rate of attempted suicide in adolescence does appear to increase (Williams & Lyons, 1976). The primary reason given by adolescence for their suicide attempts is some type of arguments or disagreement with their family (Jacobziner, 1965). It has also been noted that adolescence suicide attempts most commonly follow arguments with parents (Walker, 1980). Williams and Lyons (1976) found that in families with an adolescent suicidal member, the suicidal adolescent engaged in conflictual interaction with either or both of the parents but displayed little conflict with siblings.

Corder and others (1974) state that overt parent-child conflict was characteristic of the adolescents in the suicidal group studied and represented one of the major presenting complaints when these families are seen at clinics. Rosenbaum and Richman (1970), through interviews of suicidal and nonsuicidal patients and their families, reported that family members expressed anger at the patient more
often than the patient expressed anger at them. Ray and Johnson (1983) identified the dynamics of high expectations for the adolescent held by the parent and the adolescents tendency to avoid conflict by withdrawal. In a study by Jacobs (1971) comparing adolescent suicide attemptors with a group of normal adolescents, the attemptors were more withdrawn and reported they had parents who were more likely to nag, yell, and physically punish. However, withdrawal is not the only response noted in the literature as Cohen-Sandler and others (1982) report that the majority of suicidal children they studied expressed rage and homicidal behavior toward others; they concluded that this behavior was a good discriminator or suicidal children.

Richman (1971) observed that members of suicidal families alternate between being hurt and hurting others. Even when attempts may be made by the parents to resolve family conflict, their perceptions are frequently based on the adolescent's behavior problem and any attempts at resolving the problem tend to increase the level of conflict, as the adolescent feels that the behavior problem which the parent attributes to him do not exist (Teicher & Jacobs, 1966a).

Walker and Mehr (1983) observed that "When a family system is tumultuous, one member often becomes the identified expression of the family conflict. Most often it is the adolescent who assumes that role" (p. 286). Tishler and others (1981), in a study of 108 adolescent suicide attempters, reported that almost 60% of the adolescents assessed their parents marriage as poor. Pfeffer (1981 & 1982), has
noted that severe spousal conflict and unresolved conflicts with their families of origin were characteristic of parents of suicidal children.

Schaffer (1974) described suicidal adolescents as having a "chip on their shoulder" and being self-critical. It is possible that the more conflict the adolescent experiences in their family, the more they need to defend themselves from threatened and potential loss.

**Losses**

Suicidal adolescents frequently have histories that include a significantly greater number of life stressors and actual or threatened losses of all kinds (Corder, Shorr & Corder, 1974; Cohen-Sandler, Berman & King, 1982). According to Richman (1971), the families of suicidal members are overly sensitive and intolerant of loss and separation and are often preoccupied with death.

Freud (1925) saw the suicidal person as ambivalently hating and loving an object which is lost, or seems lost to him. Gould (1965) also emphasized that the core factor in a "suicidal personality" in children and adolescence is the perceived loss of love. Toolan (1962) hypothesized that "...the common denominator in all depressive reactions is the loss of a desired love object, whether this be in fact or in fantasy" (p. 414).

There are many forms that loss may take. When the adolescent does not perceive his/her dependency needs as being met, this may be experienced as a loss of support, love and intimacy (Gould, 1965; Rosenkrantz, 1978). The adolescence may also experience loss in

The death or loss of a significant person in the life of an adolescent is generally believed to lean toward a predisposition to suicide (Rosenkrantz, 1978). Gould (1965) reported that five times as many adolescents attempted suicide in a home where there was an absence or a death of a family member, and Barter and others (1968) stated that if the adolescent had experienced loss of a parent, they had a higher rate of suicidal behavior. Research by Garfinkel and others (1982) indicated that the majority of the adolescents in their study who attempted suicide did not live with both of their biological parents. In a study of 108 adolescent suicide attempters by Tishler and others (1981), 50% reported that their parents were divorced. Henden (1975) also found a significantly higher proportion of seriously suicidal adolescents had lost a parent through death, divorce, or separation, and Ray and Johnson (1983) concluded that the loss of a parent was one of the main causes of adolescent suicide. Sabbath (1969) described families in which the suicidal adolescent is regarded as "expendable" by parents who consciously or unconsciously wish them dead and for the adolescent "...this is a loss which is tantamount to being abandoned" (p. 282).

Crumley (1979) described the personality traits of the suicidal adolescent as including intense reactions to loss along with poorly controlled rage and impulsivity. When the losses and stresses in an adolescent accumulate, the reaction of the adolescent may also be
that of despair and detachment (Bowlby, 1973). If the adolescent continues to detach from support systems, s/he may have increased feelings of hopelessness and thus little confidence of change.

**External Support**

The main tenet of Durkheim's theory is that suicide rates vary inversely with the degree of social integration (Gibbs, 1971). The literature also contains frequent references to social isolation as a characteristic of adolescent suicide (Rohn et al., 1977; Hemming, 1977).

Teicher and Jacobs (1966b) describe the adolescent suicide attemptor as one who has "...a biography characterized by progressive social isolation from meaningful social relationships" (p. 406). In their study of 68 adolescents who attempted suicide, all of the adolescents were found to be lacking in meaningful social relationships (1966a). Rosenbaum and Richman (1970) and Barter and others (1968) also concluded that suicidal behavior was particularly likely to occur when external support was unavailable or withdrawn.

In a study of 50 adolescent suicide attemptors, Teicher and Jacobs (1966b) found 36% were not enrolled in school and another 23% had no identified peers to turn to when they needed to talk. Marks and Haller (1977) in a study of 830 emotionally disturbed adolescents reported that suicidal boys lacked close relationships with male peers, and the suicidal girls had few or no friends during childhood.

Richman (1971) explained that the closed system of the suicidal family is not tolerant of contact outside the family, and this is
seen as threatening to the established family structure. Teicher and Jacobs (1966a) point out that isolation is the result of a cumulation of other problems and serves to keep the adolescent from any possible solutions to his/her problems. This precludes change and increases the feelings of hopelessness. Garfinkel and others (1982), in a study of 505 children and adolescents who had attempted suicide found that 63.2% had previous contact with psychosocial services. It was suggested that since they later attempted suicide, they were less likely to utilize such interventions when available.

**Adaptability**

The primary feature of suicidal families described by Pfeffer (1982) is the rigidity of structure that serves to inhibit change; as any separation or expression of individuality is perceived as a threat to the survival of the family. Richman (1971) further explains that "Suicidal families are threatened by the ideas of growth, maturity and change since these notions are often equated with loss and separation" (p. 35). He also explains that any role change and conflict between new and old roles tend to precipitate a suicidal crisis in these families. Corder and others (1974) characterized the suicidal adolescent as feeling a lack of control over their environment as a result of rigid parental rules and structure.

Teicher and Jacobs (1966b), in a study of 50 adolescent suicide attemptors, found that the suicidal behavior is chosen only after a series of alternative behaviors have been tried and failed, and the suicidal behavior is then perceived as the only way left. However,
many of those who attempt suicide then discover that this too fails
to gain the needed attention, and they may then become convinced
that death is the only solution to their chronic problems. Topol
and Reznikoff (1982) also agree that a "suicidal mental set" is
frequently the result for adolescents who feel hopeless and impotent
about effecting solutions within their family. Williams and Lyons
(1976), from their comparison of six families with a suicidal
adolescent with six normal families, found that the families with
a suicidal member had greater difficulty making efficient group
decisions and were more rigid in their patterns of interaction.

In a study of 128 suicide attemptors, Bancroft and others (1976)
found that 42% expressed a desire to escape from an impossible
situation. Glaser (1978) suggests that "Most, but not all, suicidal
behavior is manipulative" (p. 260) by "...a person who may see no
other way of extricating himself from an unpleasant situation"
(p. 261).

Miller (1975) contents that suicide is an expression of a
desire to change or end the social environment in which the suicidal
person finds himself. Cohen-Sandler and others (1982) observed that
children who felt incapable of making an impact on their family's
functioning used "...suicide as a means of interpersonal coercion
and retaliation" (p. 184). Beck and others (1974) described suicide
attemptors as gambling with death in order to produce interpersonal
change. It is often that the goal of suicidal behavior is to
change one's life rather than to end it.
Cantor (1972) suggested that what the young suicidal person hoped to achieve by an attempt is to bring themselves into a closer relationship with others and attain the love and attention of the parents. Gould (1965) also suggests that the suicidal adolescent's desire is to make the parents change their ways in relating to the adolescent and to prove their love.

Beavers (1983) describes severely disturbed families as those that "...are like cogwheels that are not in contact, that turn endlessly and never effect change" (p. 88). Eventually, it may be the suicidal behavior of a family member that may elicit family reorganization so members can remain together in a more tolerable manner. If the family is not able (or perceived by the adolescent as not being able) to respond in a way that meets the adolescents needs, increased feelings of hopelessness may develop.

**Hopelessness**

"Depression has been given as a major factor in adolescent suicides. Signs of depression include feelings of hopelessness..." (Smith, 1981, p. 288). Beck and others (1974) found that hopelessness is more highly correlated with suicide intent than is depression.

There is frequent reference in the literature to the suicidal adolescent's feelings of hopelessness. The lack of investment in the future and the absence of future goal orientation was noted by Corder and others (1974) as characteristic of adolescent suicide attempters. Gould (1965) describes the suicidal behavior as "a last cry for help" when the adolescent sees no way to cope and perceives
the parent as depriving him of any hope of support and love. Toolan (1962) referred to suicide attempts as a signal of distress and a "last ditch" effort to call attention to one's problems.

Hemming (1977) described the feeling of utter hopelessness as the precipitating cause of suicidal action. Tishler and McKenry (1983) found that the suicidal adolescents in their study exhibited classical, clinical symptoms of depression. Birtchnell (1983) states that "The suicidal patient is obsessed with the hopelessness of his situation, the meaninglessness of live, and the pointlessness of going on" (p. 32).

Mark and Haller (1977) in their study of 830 emotionally disturbed adolescents described the suicidal adolescents as having more feelings of hopelessness than the nonsuicidal adolescents. Pfeffer and others (1979) found greater feelings of hopelessness, worthlessness, and the wish to die among the suicidal group studied. Crumley (1982) suggested that the adolescent suicide attemptor's feelings of hopelessness were a result of feeling let down by someone on whom they depended. Topol and Reznikoff (1982) suggest that the escalating problems and feeling of lack of control lead to the feelings of hopelessness. In their study comparison of suicidal adolescents with both a nonsuicidal/emotionally disturbed and a normal comparison group of adolescents, they found the suicidal group to be significantly more hopeless than either of the other two groups.

Pfeffer (1982) acknowledged that "Suicidal tendencies may be diffused as soon as the child can conceptualize alternative means of
coping with adversity, when he gains hope, and when he begins to recognize the shortcomings and psychological problems of his parents" (p. 246).

Overall, it appears from a review of the literature, that if an adolescent feels physically bound to his family without feeling emotionally close or able to express him/herself, there is likely to be more conflict, and sense of loss. And in addition, if the adolescent does not experience some sense of support from sources external to his family or feel that change is possible within his/her family, he/she may feel helpless. The more helpless the adolescent feels, the more likely he/she is to manifest suicidal behavior for the purpose of ending his/her life (thereby escaping the family situation) or more dramatically, attempting to induce change within the family system.
CHAPTER III

METHODOLOGY

The purpose of this study was to assess differences in adolescent perceptions of family functioning in families with an adolescent who demonstrates suicidal behavior as compared to families where the adolescents (a) are emotionally disturbed but not acting in a suicidal manner and (b) have no history of psychiatric problems. The areas of family functioning assessed included physical boundedness, emotional cohesion and support, expressiveness, conflict, actual and potential losses, support and interaction with external resources, adaptability and hopelessness. The independent variable was thus the mental status of the adolescent. The dependent variables were various measures of family functioning. This study is part of a larger study, "Comparison of Family Dynamics in Emotionally Disturbed Families," under the direction of Dr. Patrick McKenry, Associate Professor, Department of Family Relations and Human Development and funded by The Ohio Department of Mental Health.

Sample Selection

Adolescents who had demonstrated suicidal behavior (e.g., intentional drug overdoses, slashed wrists) within the past month and who came from two-parent families (may have included step-parents)
were purposively identified and selected from local community mental health centers and hospitals serving emotionally disturbed adolescents. This group did not include any adolescents with a diagnosis of schizophrenia or a major affective disorder in which the suicidal behavior may have been a factor in the client's psychotic symptomatology rather than that of family dynamics. Any clients with a diagnosis of organicity or a biological causation were also excluded to avoid contamination of the variable being studied. Adolescents in this group were asked to complete the questionnaires according to how they felt at the time they made the suicidal gesture.

The second group consisted of adolescents who were identified as having emotional problems and who were in counseling but had demonstrated no suicidal tendencies or signs of organicity. These adolescents may have had a diagnosis of schizophrenia or a major affective disorder. These adolescents were purposively identified and selected from local community mental health centers and hospitals serving emotionally disturbed adolescents. These adolescents were asked to complete the questionnaires regarding how they were feeling at the present time.

The comparison group of nonproblematic adolescents were purposively selected through reputation sampling procedure. They were asked to complete questionnaires based on how they were feeling at present.

Only those adolescents (12-17) coming from two-parent households (may have included step-parents) were included in the study. Each of three groups (suicidal, emotionally disturbed/nonsuicidal and
the nonproblematic group) were sub-divided by age and sex. Each group included twenty (20) adolescents with a total sample size of sixty-one (61) adolescents (one additional nonproblematic adolescent was sampled). The demographic data for each of the three adolescent mental status groups are presented in Table 1 for adolescent suicide group.

Data Collection Procedures

After Human Subjects approval was obtained (Appendix A), local community mental health agencies and hospitals serving suicidal and other emotionally disturbed adolescents were invited to participate in this study. Those agencies consenting to participate (Appendix B) were asked to make available a consent form (Appendix C) to families who met the criteria of the study. Families were contacted by phone and an appointment scheduled for the completion of the assessment instruments. This appointment was scheduled at a time that was of convenience to the families but at a time that did not interfere with the treatment program of the agency. Nonproblematic families were similarly contacted through a neighborhood reputational sampling technique.

Questionnaires were administered by the researcher and five research assistants who were trained by the researcher. All the research assistants had prior experience in the area of mental health interviewing.

The questionnaires were simultaneously administered to the three family members (father, mother and adolescent child), and each member independently responded to their questionnaires. Prior to the administration of the questionnaires, the research was explained to each subject as outlined in the consent form (Appendix D). (For the purpose of this phase of the investigation, only adolescent responses were used.)
# TABLE 1
Demographic Profile of Adolescents and Their Parents by Mental Status Groups

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<tr>
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<th>Suicidal</th>
<th>Emotionally disturbed/nonsuicidal</th>
<th>Nonproblematic</th>
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<td>0</td>
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<tr>
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<tr>
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<td>6</td>
<td>1</td>
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<tr>
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<td>4</td>
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<tr>
<td>Semi-professional</td>
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<tr>
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<tr>
<td>Major professional</td>
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<td><strong>Mean age</strong>*</td>
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<tr>
<td>Boy</td>
<td>15.4 (SD=1.8)</td>
<td>15.2 (SD=1.7)</td>
<td>15.4 (SD=1.3)</td>
</tr>
<tr>
<td>Girl</td>
<td>15.1 (SD=1.5)</td>
<td>14.6 (SD=1.3)</td>
<td>14.9 (SD=1.6)</td>
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<td><strong>Mean Educational Level of Mother</strong>*</td>
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<tr>
<td></td>
<td>43.3 (SD=8.4)</td>
<td>41.9 (SD=7.2)</td>
<td>45.9 (SD=6.8)</td>
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<tr>
<td><strong>Mean Educational Level of Father</strong>*</td>
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<tr>
<td></td>
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<td>39.5 (SD=4.2)</td>
<td>44.9 (SD=10.8)</td>
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<td><strong>Mean Number of Individuals in Household</strong>*</td>
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<tr>
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<td>4.8 (SD=1.5)</td>
<td>4.0 (SD=1.2)</td>
<td>4.4 (SD=1.3)</td>
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</tbody>
</table>

* Nonsignificant
** p = <.05
*** p = <.01
**** p = <.001
**Instrumentation**

Data were collected from family members through paper and pencil questionnaire. These questionnaires consisted of standardized instruments as well as a demographic background sheet and an assessment of loss scale devised by the author. The adolescent questionnaire consisted of the demographic background sheet, The Family Adaptability and Cohesion Evaluation Scale II (FACES II), Family Environmental Scale (FES), The Multiple Scale of Social Support (MSSS), The Hopelessness Scale, and the assessment of losses scale (Appendix E). Time needed for completion of the questionnaire by each subject was approximately one hour.

**Family Adaptability and Cohesion Evaluation Scale II**

The Family Adaptability and Cohesion Evaluation Scale II (FACES II) was developed by Olson, Portner, & Bell (1982) for the purpose of assessing family cohesion and adaptability so that families may be classified according to perceived level of current functioning on both these dimensions. The scale consists of a total of 30 items measuring both dimensions. The family cohesion subscale contains 8 factors (as the result of factor analysis): (1) emotional bonding, (2) family boundaries, (3) coalitions, (4) time, (5) space, (6) friends, (7) decision making, (8) interests and recreation. The family adaptability subscale contains 6 factors: (1) assertiveness, (2) leadership (control), (3) discipline, (4) negotiation, (5) roles, and (6) rules.

All items were administered to the adolescents and parents in the study. The reading level is such that children as young as
12 can understand the items. Items are answered on a Likert-type scale ranging from 1 (almost never) to 5 (almost always). The variable of physical bondedness was, in part, measured by selected items (which have face validity) from the cohesion subscale. The variable of adaptability was measured, in part, by the adaptability subscale.

Reliability was measured by internal consistency and test-retest. The internal consistency for the cohesion subscale was .87, for the adaptability subscale .78, and for the total scale .90. The test-retest study used a 50 item version of the scale with a time lapse of 4 to 5 weeks between the first and second administration of the test. The Pearson correlation for the total scale was .84, .83 for cohesion and .80 for adaptability.

Validity was assessed through factor analysis on the 30 item scale. Cohesion items loaded on Factor I and adaptability items loaded primarily on Factor II. Factor loadings on the cohesion subscale ranged from .34 to .61 and on the adaptability subscale from .10 to .55.

**Family Environmental Scale (FES)**

The Family Environmental Scale (FES) was developed by Moos and Moos (1981) to measure the social-environmental characteristics of all types of families and is a measure of individual's perceptions of their current family environment.

The FES consists of 10 subscales which assess three underlying dimensions: (1) relationship, (2) personal growth, and (3) system maintenance. The relationship dimension is measured by the subscales
of cohesion, expressiveness and conflict. The personal growth dimension is measured by the subscales of independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation and moral-religious orientation. The system maintenance dimension is measured by the subscales of organizations and control.

Although all subscales were administered (consisting of 90 true/false statements), only 7 were scored for the purpose of this study. The variables of cohesion, expressiveness, and conflict were measured by the corresponding subscales. The perceptions family members have of support from external sources were assessed in part by the intellectual-cultural, active-recreational, and moral-religious subscales. The perceived ability of their family to adapt and make changes was measured in part by the control subscale.

Reliability measures of the 10 subscales are of two types: (1) internal consistency and (2) test-retest. With the use of Cronbach's Alpha for each of the 10 subscales, the internal consistencies were all in the acceptable range, varying from moderate to substantial. The test-retest was measured at 8 week, 4 and 12 month intervals. The 8 week correlations were all in the acceptable range varying from .68 to .86. The mean for the 4 month interval was .78 and for the 12 month interval, .71. Intercorrelations of the 10 subscales "indicated that the subscales measure distinct though somewhat related aspects of family social environments." (p. 5).

In order to further assess validity, subscales were correlated to family size, length of marriage, age, education, and occupation, and stress level of families. Consistent differences were found on
the subscales between the normal and distressed families. Distressed families were found to be lower on cohesion, expressiveness, independence, intellectual, and recreational orientation and higher on conflict and control. Relationships between the subscales and family background factors demonstrated consistent patterns in regard to age, length of marriage, family size education, and occupation.

**The Hopelessness Scale**

A.T. Beck and his associates (1974) developed the Hopelessness Scale to measure what they considered the most important factor in suicide and the one that may explain the link between suicide and depression. Hopelessness is defined as negative expectancies concerning oneself and one's future.

The scale consists of 20 true-false statements. Reliability was assessed by measuring internal consistency which was .93 and by correlations between each item and the total score which ranged from .39 to .76.

Validity was assessed by clinical ratings of the severity of the patient, comparing scores with other tests designed to measure negative attitudes about the future (concurrent validity with scores significant at the p < .001 level), and by construct validity and factor analysis. Construct validity was measured by testing various hypotheses related to hopelessness in several studies which confirmed the relationships, i.e., depression and suicidal intent. Factor analysis revealed three factors being assessed: (1) feelings about the future, (2) loss of motivation, and (3) cognitive aspects. It was concluded that validity was sufficient to justify the use of the scale (Beck et al.; 1974).
**Multiple Scales of Social Support (MSSS)**

The Multiple Scales of Social Support (MSSS) was developed by Morgan (1982) to measure perceived social support. Support was demonstrated by Morgan to mediate the impact of stress and thus promote physical and mental health as persons with high levels of social support had significantly less physical illness and psychiatric symptoms.

The scale contains five, 10-item subscales. Emotional resources, esteem resources, and satisfaction subscales were used to assess the cohesion variable. The subscales, assistance resources and affiliative style, were used to assess the variable of support and interaction with sources external to the family.

Reliability for the scale by means of internal consistency for the total scale was .926, whereas the range of subscale correlations was from .741 to .862. Thus, it was concluded to have an acceptable degree of reliability.

Validity was assessed by correlating the MSSS with personality measures which revealed support for the construct validity of the MSSS. Morgan (1982) cautions that further studies of the reliability and validity of the scale are important.

The scale consists of five variables that assess risk and five variables that assess rescue. The risk factors include (1) agent - what the person did, (2) level of impaired consciousness, (3) severity of the lesion or toxicity, (4) degree of reversibility anticipated, (5) level of therapy required. The rescue factors include (1) location of the act, (2) person initiating rescue, (3) probability of discovery.
by a rescuer, (4) accessibility to rescue, and (5) time delay until discovery.

Each of the factors is rated on a scale of 1 to 3 points and the total points for both risk and rescue are converted to a scale ranging from 1 (low risk, least rescuable) to 5 (high risk, most rescuable). The Risk-Rescue Rating is determined by the formula - Risk score/Risk score + Rescue score x 100 resulting in low of 17 (for a low risk and high rescue score) to a high rating of 83 (for a high risk and low rescue score).

The effectiveness of the scale was evaluated by administering it to 100 cases of suicidal behavior. Ratings scored by the sample ranged from 17 to 83 with a mean rating of 40. It was found that the R-R rating correlated significantly with the level of treatment received, i.e., first aid to intensive care. The inter-rater reliability coefficients revealed that the scale "...is not subject to the vagaries of overall clinical judgements and the idiosyncrasies of different clinicians." (p. 209). The authors concluded that the scale has face validity and correlates with other clinical and empirical judgements.

**Data Analysis**

The purpose of this study was to determine differences among three groups, but because assumptions surrounding parametric statistics could not be met, non-parametric procedures were employed. Huck and others (1974) contend non-parametric statistical procedures are preferrable when the researchers cannot assume that the samples came from populations that are normally distributed and when the researcher has a relatively small sample size. Specifically, in
this study, the Kruskal-Wallis One-Way Analysis of Variance of Ranks was used to determine differences in the dependent variables as a function of adolescent mental status. In addition, age and sex subgroup analyses were also performed using the Kruskal-Wallis One-Way Analysis of Variance of Ranks. The Kruskal-Wallis One-Way Analysis of Variance of Ranks post-hoc multiple comparison tests (i.e., Mann-Whitney U tests; see Marascvio & McSweeney, 1977) were performed when significant differences were found between groups. A probability level of .05 was used to test hypotheses. Measures of central tendency and frequency were also performed. SAS User's Guide: Statistics (1985) computer package was used for all data analyses.
CHAPTER IV

RESULTS

Introduction

The purpose of this study was to determine adolescent perceived differences in family functioning among suicidal adolescents, emotionally disturbed/nonsuicidal adolescents, and nonproblematic adolescents. The independent variables were the three adolescent mental status classifications. The dependent variables were those descriptors of family functioning including physical boundedness, emotional cohesion, expressiveness, conflict, losses, external support, adaptability, and helplessness. Because the sample size was small and cannot be assumed to be normally distributed, the Kruskal-Wallis One-Way Analysis of Variance of Ranks was used to determine the differences in the dependent variables as a function of adolescent mental status. The Kruskal-Wallis One-Way Analysis of Variance of Ranks was also used to assess group differences by age and sex. When the Kruskal-Wallis proved significant, Mann-Whitney U tests were performed as post-hoc analyses to determine differences between each set of groups (e.g., Suicidal vs. Emotionally Disturbed, Emotionally Disturbed vs. Nonproblematic, Suicidal vs. Nonproblematic).
Data Analysis

The data analysis that follows utilizes nonparametric and cross-categorical analyses. There are several reasons for the use of these particular tests, to analyze these data. First, if one considers the major purpose of this study (the determination of differences among the three different mental status groups on each of the dependent measures), the usual parametric data analysis technique of choice is the one-way analysis of variance. However, this test requires that the data meet several assumptions, among them that the data are normally distributed and have equal variances. In the current investigation, these assumptions seem dubious based on the types of individuals from which the dependent measures were taken (e.g., suicidal and emotionally disturbed adolescents). Of equal concern is the relatively small sample size for each group (21 or less). Although these sample sizes themselves are probably adequate for conducting parametric analyses, when the samples are broken down by sex and age group (as they are in the findings section), the sample sizes become smaller than the recommended 10 subjects per group. Therefore, in the case where parametric test assumptions of normally distributed data and when relatively small sample sizes are employed, nonparametric tests become the tests of choice. Indeed, nonparametric tests have been called "assumption-freer" because they do not require that the data meet as many nor as stringent assumptions as their parametric counterparts (Marascuilo & McSweeney, 1977).

Based on the arguments above, the use of a nonparametric technique to determine differences among the three groups on each of the
dependent measures seem in order. When one is choosing a nonparametric test, it is necessary to decide exactly what procedure is needed.

In the case of the current study, there is a need for determination of differences in something called location. That is, the present study asks the question if there is a difference among the measures of central tendency (e.g., means, medians, modes) for each dependent measure among the three groups (CF, Daniels, 1978; Hollander & Wolfe, 1973; Marascuilo & McSweeney, 1977). The nonparametric test for determining differences in "location" is the Kruskal-Wallis One-Way Analysis of Variance by Ranks. This procedure requires that the samples are random, the observations are independent, the measures to be tested are continuous and at least ordinal, and that the populations are relatively similar in the shape of their distributions. The Kruskal-Wallis procedure is designed to determine if there are differences among the medians of three or more groups (versus the parametric analysis of variance's focus on means). It does so by ordering all the observations, assigning ranks to each observation, and then determining mean ranks for each group. If there are no differences among the medians of the groups, then these mean ranks are expected to be relatively similar, but if there are differences among the medians, then the mean ranks will be different. Thus, the Kruskal-Wallis test determines if the differences among the means ranks are significantly different (see Daniels, 1978, pp. 200-205, for a discussion of the Kruskal-Wallis procedure). Based on these reasons, location differences in the current study will be determined by the use of the Kruskal-Wallis technique.
It should be noted that it may not be adequate to assume that the distributions among the three groups are similar in shape. At one time, it was feared that violation of this assumption could damage the tests' ability to reject the null hypothesis when it should have been rejected (this property is called power). However, Marascuilo & McSweeney (1977, p. 305) report that the power of the procedure does not suffer significantly if the location differences exist and that "Power was not restricted by variation in the shapes of the distributions."

It is equally helpful to determine among which groups location differences exist if the Kruskal-Wallis test is significant. That is, in this study, there are three groups being compared, so that is there is a significant difference, between which two groups does that difference exit? Often in parametric procedures these follow-up tests are called post-hoc comparisons. Two options exist for conducting such comparisons in the present study: Testing differences among two groups using the Mann-Whitney U test (a nonparametric equivalent to the T test) or the use of the Dunn procedure (see Daniels (1978) and Maraschilo & McSweeney (1977) for a detailed discussion of these options). When conducting a moderately large number of comparisons, the Dunn procedure is more appropriate; however, in the present purposes, there are only three possible post-hoc comparisons which can be made in each analysis (i.e., nonproblematic group versus suicidal group, nonproblematic versus emotionally disturbed, and suicidal versus emotionally disturbed). When such a small number of comparisons are to be made, one can use the Mann-Whitney U,
as long as there is control for the possibility for chance significant results due to the number of simultaneous tests being run (this is sometimes termed experiment-wise error). In the current results, a significance level of alpha less than .05 was used for reporting results of the Mann-Whitney test, however, the controlled alpha level taking into account the possibility for experiment-wise error is alpha less than .02. Therefore, when reviewing the results, the reader should note that post-hoc tests which are significant at a less than .05 level are most-likely truly significant, and that results at an alpha level less than .02 are significant accounting for the possibility for experiment-wise error.

A last note should be made concerning the use of a nonparametric analysis of variance simultaneously on several dependent measures. If using the parametric procedure in the current study, one would in all likelihood conduct a multiple analysis of variance (MANOVA). This procedure controls for the interrelatedness of the dependent measures, since such interrelatedness could cause several analyses to appear to be significant when in fact they appear so due to a high interrelatedness among the dependent measures. That is, if analyses on measure A and measure B were significant, but measure A and B were highly interrelated, then the results of the analysis on measure A could be significant because it reflects the differences in variance found on measure B. Thus, one of the analyses in this hypothetical case is a spurious finding since it exists only by virtue of the relationship between measures A and B. In nonparametric techniques, there are no currently available reliable tests equivalent to the
MANOVA. Therefore, it is necessary to be aware that several of the dependent measures in the current study are relatively highly interrelated and thus could create spurious findings among the Kruskal-Wallis tests due to this interrelatedness. The reader is advised to note that those correlations above .30 (see Table 2) indicate both significant and meaningful correlations, since such correlations show two variables sharing at least 10% of their variances. Therefore, when considering results of the Kruskal-Wallis tests on variables which are intercorrelated above .30, the reader is cautioned that similar Kruskal-Wallis results on these interrelated variables could represent real differences for each variable or could be the product of high levels of interrelatedness.

Findings

Eight Kruskal-Wallis One-Way Analysis of Variance of Ranks tests were performed to determine if each of the eight dependent measures differed as a function of three mental status groups. Eight additional Kruskal-Wallis One-Way Analysis of Variance of Ranks tests were performed for the mental status/sex subgroup, and eight for the mental status/age subgroup. Post-hoc analyses (Mann-Whitney U) were performed to identify specific group differences if a significant difference was found among any of the three mental status groups. (For means of dependent measures, see Appendix F).

Overall Mental Status Group Comparisons

The Kruskal-Wallis One-Way Analysis of Variance of Ranks test indicated that only the measures of emotional cohesion, expressiveness, external support, helplessness, and losses differed significantly by
<table>
<thead>
<tr>
<th></th>
<th>Physical bondedness</th>
<th>Emotional cohesion</th>
<th>Expressiveness</th>
<th>Conflict</th>
<th>Adaptability</th>
<th>External support</th>
<th>Helplessness</th>
<th>Losses</th>
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<td>-.254</td>
<td>.534*</td>
<td>.538*</td>
<td>.355*</td>
<td>.047</td>
<td>-.264</td>
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<td>.396*</td>
<td>.452*</td>
<td>.401*</td>
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* significant at p < .05
the three mental status groups (see Table 3). The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated emotional cohesion differed significantly by the three mental status groups ($X^2=9.22$, $df=2$, $p.<.01$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($X^2=8.62$, $df=1$, $p.<.003$) and between the emotionally disturbed/nonsuicidal and nonproblematic group ($X^2=4.20$, $df=1$, $p.<.041$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that expressiveness differed significantly by the three mental status groups ($X^2=7.79$, $df=2$, $p.<.02$). The post-hoc tests revealed that the difference occurred between the suicidal and nonproblematic groups ($X^2=7.04$, $df=1$, $p.<.008$). However, the difference between the emotionally disturbed/nonsuicidal and the nonproblematic groups approached significance ($X^2=3.01$, $df=1$, $p.<.08$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that external support differed significantly by the three mental status groups differed ($X^2=9.01$, $df=2$, $p.<.01$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($X^2=8.14$, $df=1$, $p.<.004$) and between the emotionally disturbed/nonsuicidal and nonproblematic group ($X^2=5.13$, $df=1$, $p.<.02$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that helplessness differed significantly by the three mental status groups ($X^2=26.16$, $df=2$, $p.<.0001$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($X^2=16.16$, $df=1$, $p.<.0001$) and between the emotionally disturbed/nonsuicidal and nonproblematic groups ($X^2=23.16$, $df=1$, $p.<.0001$).
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<td>3</td>
<td>21.36</td>
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* No significant differences
** $p < .05$
*** $p = .01$
**** $p < .001$
The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that losses differed significantly by the three mental status groups ($\chi^2=10.87$, df=2, $p<.004$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($\chi^2=4.68$, df=1, $p<.002$).

**Sex/Mental Status Group Comparisons**

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that the measures of emotional cohesion, expressiveness, external support, helplessness, and losses differed significantly by sex/mental status groups (see Tables 4 and 5).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that emotional cohesion differed significantly by the three female/mental status groups ($\chi^2=9.71$, df=2, $p<.008$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($\chi^2=7.80$, df=1, $p<.005$) and between the emotionally disturbed/nonsuicidal group and the nonproblematic group ($\chi^2=4.91$, df=1, $p<.03$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that external support differed significantly by the three female/mental status groups ($\chi^2=7.96$, df=2, $p<.02$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($\chi^2=8.10$, df=1, $p<.004$) and between the emotionally disturbed/nonsuicidal and nonproblematic groups ($\chi^2=3.78$, df=1, $p<.05$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that helplessness differed significantly by the three female/mental status groups ($\chi^2=12.77$, df=2, $p<.002$). The post-hoc tests revealed
TABLE 4

Results of the Kruskal-Wallis Tests: Mental Status/Female Subgroup

<table>
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* No significant differences
** p < .05
*** p < .01
**** p < .001
### TABLE 5
Results of the Kruskal-Wallis Tests: Marital Status/Male Subgroup

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
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<td>7.94**</td>
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</tr>
</tbody>
</table>

* No significant difference

** $p < .05$

*** $p < .01$

**** $p < .001$
that the differences occurred between the suicidal and nonproblematic groups ($\chi^2=7.75$, df=1, $p<.005$) and between the emotional disturbed/nonsuicidal group and the nonproblematic group ($\chi^2=11.55$, df=1, $p<.0007$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that expressiveness differed significantly by the three male/mental status groups ($\chi^2=8.64$, df=2, $p<.013$). The post-hoc tests revealed that the difference occurred between the suicidal and nonproblematic groups ($\chi^2=7.15$, df=1, $p<.008$) and approached significance between the suicidal and emotionally disturbed/nonsuicidal groups ($\chi^2=3.53$, df=1, $p<.06$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that helplessness differed significantly by the three male/mental status groups ($\chi^2=13.73$, df=2, $p<.001$). The post-hoc tests revealed that the difference occurred between the suicidal and nonproblematic groups ($\chi^2=8.28$, df=1, $p<.004$) and between the emotional disturbed/nonsuicidal and nonproblematic groups ($\chi^2=11.87$, df=1, $p<.0006$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that losses differed significantly by the three male/mental status groups ($\chi^2=7.94$, df=2, $p<.02$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($\chi^2=5.17$, df=1, $p<.02$) and between the emotional disturbed/nonsuicidal groups and the nonproblematic groups ($\chi^2=6.32$, df=1, $p<.01$).

**Age/Mental Status Group Comparison**

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that only the measures of expressiveness, external support, losses and
and helplessness differed significantly by age/mental status groups (see Tables 6 and 7).

**TABLE 6**
Results of the Kruskal-Wallis Tests Groups: Mental Status/Younger Age Subgroup

<table>
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</table>

*No significant difference

**p < .05

***p < .01

****p < .001
Table 7

Results of the Kruskal-Wallis Tests: Mental Status/Older Subgroup

<table>
<thead>
<tr>
<th>Variable</th>
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<td>3.21*</td>
<td>2</td>
</tr>
</tbody>
</table>

* No significant difference
** p < .05
*** p < .01
**** p < .001
The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that external support differed significantly by the three younger/mental status groups ($X^2=9.11$, df=2, $p<.01$). The post-hoc comparison revealed that the differences occurred between the suicidal and emotionally disturbed/nonsuicidal groups ($X^2=5.36$, df=1, $p<.02$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that losses differed significantly by the three younger/mental status groups ($X^2=6.84$, df=2, $p<.03$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($X^2=4.36$, df=1, $p<.04$) and between the emotionally disturbed and nonproblematic groups ($X^2=5.65$, df=1, $p<.02$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that expressiveness differed significantly by the three older/mental status groups ($X^2=9.20$, df=2, $p<.02$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic groups ($X^2=7.21$, df=1, $p<.007$) and between the emotionally disturbed/nonsuicidal and nonproblematic groups ($X^2=5.80$, df=1, $p<.02$).

The Kruskal-Wallis One-Way Analysis of Variance of Ranks indicated that helplessness differed significantly by the three older/mental status groups ($X^2=22.74$, df=2, $p<.0001$). The post-hoc tests revealed that the differences occurred between the suicidal and nonproblematic
groups \( (X^2=15.57, df=1, p.<.0001) \) and between the emotionally disturbed/nonsuicidal and the nonproblematic groups \( (X^2=17.73, df=1, p.<.0001) \).

Additional subgroup analyses, i.e., sex/age/mental status comparisons, were unable to be performed because of diminishing cell size. For example, the younger, male suicidal group consisted of only two subjects.

**Testing of Hypotheses**

Based on the analysis of these data, each hypothesis will now be addressed.

Hypothesis One -- Adolescents who demonstrate suicidal behavior will describe their families as being more physically bound together than those adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

No significant differences in physical boundedness were found between the suicidal, emotionally disturbed/nonsuicidal, and the nonproblematic group. Therefore, the hypothesis was rejected.

Hypothesis Two -- Adolescents who demonstrate suicidal behavior will describe their families as experiencing less emotional cohesion and support than do adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

A significant difference in emotional cohesion was found between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. Therefore, the hypothesis was partially accepted.
Hypothesis Three -- Adolescents who demonstrate suicidal behavior will describe their families as less expressive than adolescents who are emotionally disturbed/nonsuicidal adolescents and who are nonproblematic.

A significant difference was found in expressiveness between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and the nonproblematic groups. Therefore, the hypothesis was partially accepted.

Hypothesis Four -- Adolescents who demonstrate suicidal behavior will describe their families as experiencing more conflict than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

No significant differences in conflict were found between the suicidal emotionally disturbed/nonsuicidal, and the nonproblematic groups. Therefore, the hypotheses was rejected.

Hypothesis Five -- Adolescents who demonstrate suicidal behavior will describe themselves as having more actual and potential losses than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

A significant difference was found in losses between the suicidal, the nonproblematic and the emotionally disturbed/nonsuicidal and the nonproblematic groups. Therefore, the hypothesis was partially accepted.

Hypothesis Six -- Adolescents who demonstrate suicidal behavior will describe their families as having less support and interaction with sources external to the family than do adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.
A significant difference in external support was found between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and the nonproblematic groups. Therefore, the hypothesis was partially accepted.

Hypothesis Seven -- Adolescents who demonstrate suicidal behavior will describe their family as less adaptable and less likely to make changes than adolescents who are emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

No significant differences were found in adaptability between the suicidal, emotionally disturbed/nonsuicidal, and nonproblematic groups. Therefore, the hypothesis was rejected.

Hypothesis Eight -- Adolescents who demonstrate suicidal behavior will describe feeling more hopeless than the adolescent who is emotionally disturbed/nonsuicidal and adolescents who are nonproblematic.

A significant difference was found in hopelessness between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. Therefore, the hypothesis was partially accepted.

Hypothesis Ten -- The above mentioned relationships will vary as a function of the sex of the adolescent.

A significant difference was found in emotional cohesion among females between the suicidal and nonproblematic groups and between the emotionally disturbed and nonproblematic groups. A significant difference was found in external support among females between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. A significant
difference was found in helplessness among females between the suicidal and nonproblematic groups and the emotionally disturbed/nonsuicidal groups.

A significant difference was found in expressiveness among males between the suicidal and nonproblematic groups. A significant difference was found in helplessness among males between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. A significant difference was found in losses among males between the suicidal and nonproblematic groups. Therefore, the hypothesis was partially accepted.

Hypothesis Ten -- The above mentioned relationships will vary as a function of age of the adolescent.

A significant difference was found in external support among the younger adolescents between the suicidal and emotionally disturbed/nonsuicidal and between the suicidal and the nonproblematic groups. A significant difference was found in losses among younger adolescents between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups.

A significant difference was found in expressiveness among the older adolescents between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. A significant difference was found in external support among the older adolescents between the emotionally disturbed and nonproblematic groups. A significant difference was found in helplessness among the older adolescents between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups. Therefore, the hypothesis was partially accepted.
CHAPTER V

DISCUSSION, RECOMMENDATIONS, AND IMPLICATIONS

Summary of Findings

Comparisons were made among three groups of adolescents: (a) adolescents who had demonstrated suicidal behavior; (b) adolescents who were emotionally disturbed but nonsuicidal; and (c) nonproblematic adolescents to determine perceived differences in family functioning. Information was gathered by questionnaire, including standardized measures, a losses checklist, and a demographic background sheet developed by the author.

The Kruskal-Wallis One-Way Analysis of Variance of Ranks was used to determine adolescent perceived differences in eight dependent variables: family physical bondedness, emotional cohesion, expressiveness, conflict, losses, external support, adaptability, and helplessness, as a function of the independent variable, mental status of the adolescent. Sex and age subgroups were also included in the analyses.

Data analysis revealed that there were no overall significant differences in adolescent perceptions of physical bondedness, conflict, and adaptability as a function of adolescent mental status. Significant differences were, however, found in emotional cohesion, expressiveness,
losses, external support, and hopelessness as a function of adolescent mental status, but only between the suicidal and emotionally disturbed/nonsuicidal groups and between the suicidal and nonproblematic groups. In the female subgroups, significant differences in the variables of emotional cohesion, external support and hopelessness were found between the suicidal and nonproblematic and between the emotionally disturbed/nonsuicidal and the nonproblematic groups. In the male subgroups, significant differences in losses, and hopelessness were found between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups and in expressiveness between the suicidal and nonproblematic groups. In the younger age groups, significant differences were found in losses between the suicidal and nonproblematic and between the emotionally disturbed/nonsuicidal and nonproblematic groups and in the variable of external support between the suicidal and the emotionally disturbed/nonsuicidal groups. In the older groups, significant differences were found in the variables of expressiveness and hopelessness between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and nonproblematic groups and on the measure of external support between the emotional disturbed/nonsuicidal and nonproblematic groups. The dependent measures did not, as anticipated, differentiate the adolescents who were suicidal from those that were emotionally disturbed but nonsuicidal except for the younger adolescents on the measure of external support.

Discussion

It has often been suggested by clinicians and researchers alike, but never systematically assessed, that there might be a continuous
sequence of family and individual factors that would lead an adolescent to choose suicidal behavior as a means to resolve an intolerable situation. Teicher and Jacobs (1966a) have suggested that suicidal behavior in adolescence unfolds as a result of a long history of problems within the family. The author's research attempted to discern what some of the specific dimensions of these problems might be that distinguish suicidal adolescents from other adolescents based on their perceptions of their family's functioning.

It has been recognized by clinical practitioners as well as researchers that diagnosis of suicidal tendencies among adolescents is difficult as symptoms of depression and hopelessness in adolescence may vary in expression. Many adolescents do demonstrate the classical symptoms of depression, i.e., insomnia, change in appetite, depressed mood as well as acting-out behaviors that primarily reflect feelings of anger and mask feelings of hurt, depression, and hopelessness. Yet these behaviors have also been acknowledged to vary by age with the younger adolescent being less expressive of feelings and more likely to behaviorally demonstrate feelings through "acting out" behaviors (McKenry & Tishler, 1979). In addition, there are others, including Glasser (1967), and Crumley (1979), who contend that suicidal and emotionally disturbed adolescents present no clearly defined symptoms as do adults.

Although a specific pattern was not found in this research, suicidal adolescents and emotionally disturbed/nonsuicidal did significantly differ from nonproblematic adolescents (but not from each other) on five of the eight dependent measures. These results
stand in contrast to those of Cohen-Sandler and others (1982) who found that suicidal children (ages 5-14) did vary from depressed and a psychiatric control group in the amount of stress experienced and from Topol and Reznikoff (1982) who found that suicidal adolescents varied from hospitalized nonsuicidal and nonhospitalized adolescents in feelings of closelessness with a family member. The results of this research, however, were in agreement with Marks and Haller (1977) who found little difference between adolescents who made suicide attempts and other problematic adolescents who reported suicide ideations but exhibited no behaviors. The findings of this study also support those of Tishler & McKenry (1982) and Williams & Lyons (1976) who found significant differences between suicidal attemptors and nonproblematic adolescents in overall family functioning.

The remaining discussion centers on those specific variables of family functioning hypothesized to be related to three adolescent mental status groups. The extent to which this study supports other resource literature will be examined, and possible explanations for discrepancies in findings will be offered.

Physical bondedness was intended to determine the adolescents perception of the need within their families to remain physically intact. It was, however, one of the variables on which the three adolescent mental status groups failed to differ regardless of sex or age. Although there were no other studies identified that specifically utilized this variable, there are numerous references in the literature that suggest that families with suicidal members have an intolerance for separation (Richman, 1971). For example, Cohen-Sandler and others
(1982) found in a comparison of suicidal and depressed nonsuicidal adolescents that the suicidal adolescents tended to be far less likely to leave home. The lack of significant difference in physical bondedness among the three adolescent mental status groups in this study could be related to the fact that all the adolescents in this study came from intact two-parent, family structures which might be assumed to be more stable than that of many suicidal adolescents. Studies have clearly shown that a disproportionate number of suicidal adolescents come from single parent families (McIntire, Angle & Schlict, 1977; Teicher & Jacobs, 1966b; Tishler, McKenry & Morgan, 1981). Many of the parents of both suicidal and emotionally disturbed in this study brought their adolescent in for treatment and participated in the treatment themselves; this itself may indicate that these families are more physically bonded than other disturbed adolescents who have less parental involvement. It is possible that the families of the two disturbed adolescent groups were more likely to be midrange or emeshed families which tend to be more physically bonded than the disengaged families (Minuchin, 1974).

The measure of emotional cohesion was designed to assess the adolescent's perception of the love and support they experience within their families. This variable did discriminate between the suicidal and nonproblematic groups as well as between the emotionally disturbed/nonsuicidal and the nonproblematic groups, when comparing all the adolescents and when comparing females alone in the three groups, but not when comparing the mental status groups within the male subgroup or within the two age subgroups. Yet other researchers have found
differences in feelings of closeness and cohesion that adolescents have for their family between groups that are suicidal and groups that are problematic but not suicidal (CF, Corder, Shorr & Corder, 1974; Korrella, 1972; and Topol & Reznikoff, 1982).

These findings support, in part, those studies which have found nonproblematic adolescents to describe their relationships with their parents as significantly better than suicidal adolescents (McKenry, Tishler & Kelly, 1982). The suicidal and emotionally disturbed/nonsuicidal adolescents may not have differed on emotional cohesion as both groups may have viewed themselves as equally estranged from the family since both have likely been identified by other family members, if not also by counselors, as "the problem" or the "identified patient" and thus viewed as separate from other family members (Satir, 1967). The subjects in the suicidal group were judged to be generally low in the level of lethality in their suicidal behavior and therefore may not have been as different emotionally from the emotionally disturbed/nonsuicidal group as anticipated and originally hypothesized. Also, it must be remembered that the emotionally disturbed/nonsuicidal group represented a variety of emotional disorders wherein suicidal tendencies could easily have been masked.

In terms of sex differences and emotional cohesion, Marks and Haller (1977), in their study of 830 emotionally disturbed adolescents, described suicidal boys as having mothers who drank alcohol excessively and were close to their father, and suicidal girls as viewing their parents as passive and feeling cold and fearful toward their fathers.
This research did support Marks and Haller's conclusion that suicidal adolescent girls are different from other adolescent girls in feelings of closeness but did not support their findings that suicidal and emotionally disturbed males differed from nonproblematic males. Perhaps families treat adolescent girls with emotional disorders differently than nonproblematic girls, whereas boys are treated in a more similar manner regardless of the presence of identified problems (Douvan, 1966). Also, parents generally are less nurturant of adolescent boys than girls (Douvan, 1966; McKenry, Price-Bonham, & O'Bryant, 1981).

The measure of expressiveness assessed the extent to which adolescents perceived they could express their feelings openly within their family. The findings in this study revealed differences in expressiveness between the suicidal and nonproblematic groups and between the emotionally disturbed/nonsuicidal and the nonproblematic groups when comparing all the adolescents and when comparing older adolescents alone and when comparing males alone between the suicidal and nonproblematic group. Younger adolescents and females did not demonstrate a significant difference in expressiveness as a function of mental status groups.

Both Teicher and Jacobs (1966b) and Williams and Lynch (1976), in comparing suicidal adolescents with nonproblematic adolescents, concluded that there was a difference between these groups in their degree of expressiveness within the family. The findings in this study support differences in expressiveness but suggest this difference is more likely to be found among males and older adolescents as compared to females and younger adolescents respectively. As previously
mentioned, perhaps parents are less likely to maintain the same level of open, supportive relationships with males and older adolescents because of role definitions prescribed by society. Likewise, males and older adolescents are more likely to have peer groups with whom to share feelings as opposed to talking with their parents when disturbed by a stressor event; whereas females and younger adolescents are more likely to need the family structure and family members as support (Horrocks, 1976).

The measure of conflict was intended to measure the extent to which the adolescent perceived an open expression of anger and aggression within the family. However, the three adolescent mental status groups including sex and age subgroups, did not differ on this measure. It is generally agreed that adolescence is a period of some conflict with parents. Corder and others (1974), Rosenbaum and Richman (1970), and Cohen-Sandler and others (1982) in their studies comparing suicidal adolescents with emotionally disturbed/nonsuicidal adolescents found differences in expressed conflict between the two groups. Williams and Lyons (1976) and Jacobs (1971) found differences between suicidal adolescents and nonproblematic adolescents in the degree of conflict expressed in the family. Perhaps this measure was not appropriate in this study since many adolescent emotional disturbances, including suicidal behavior, are the result of unexpressed anger or the inability to assert oneself with parents (Teicher & Jacobs, 1966a). In fact, depression is often defined as anger turned inward (e.g., Gould, 1965), and thus not expressed as conflict. Also, adolescent perceptions may not have
reflected the reality of the range of conflict that actually existed in their families.

The suicidal and the emotionally disturbed/nonsuicidal adolescents, including male and younger subgroups, significantly differed on the measure of actual or potential/threatened loss of family members or significant others in their lives. These findings are, however, not consistent with those of Corder and others (1974) and Cohen-Sandler and others (1982) who found that suicidal adolescents had experienced significantly more losses than a comparison group of emotionally disturbed/nonsuicidal adolescents.

Again, perhaps the emotionally disturbed/nonsuicidal and the suicidal groups suffered from some overlap since suicidal behavior among adolescents is often difficult to identify (Corder et al., 1974; Glasser, 1967; McKenry & Tishler, 1979). Some contend that adult reasons for self-destructive behavior are not always applicable to adolescents. Thus, perhaps because of these reasons, suicidal adolescents could not be clearly distinguished from adolescents with other serious emotional disorders. Also, some research has indicated that losses can be related to a variety of emotional reactions, not necessarily suicidal. The precise nature of the loss needs to be known to ascertain the role of this factor in adolescent suicidal behavior (Glasser, 1968). Younger adolescents undoubtedly contributed more to the difference between suicide and emotionally disturbed/nonsuicidal and nonproblematic groups because they would be supposed to be more vulnerable than their older counterparts to loss in general. The fact that the male subgroup was more likely to differ in losses than
females as a function of mental status is perhaps related to the
greater emotional support typically given females in our society
to deal with any such loss (Bem, 1975).

The suicide and the emotionally disturbed/nonsuicidal including
the females and both age subgroups significantly differed from the
nonproblematic group in external support, i.e., the involvement
adolescents have with influences outside of the family. For the
younger group, a significant difference was found between the
suicidal and emotionally disturbed/nonsuicidal groups, with the
suicidal group perceiving less support.

These findings would be consistent with several other studies.
Teicher and Jacobs (1966b), when comparing suicidal adolescents with
nonsuicidal adolescents, concluded that suicidal adolescents experi­
enced more social isolation. Barter and others (1968), Garfinkel
and others (1982), and Rosenbaum and Richman (1970) also found
suicidal adolescents to be less involved with outside groups and
more likely to be suicidal when external support was not available.

This research fails, however, to demonstrate that this is more
true for the suicidal adolescent than the emotionally disturbed/
nonsuicidal adolescent, except for the younger adolescent. Perhaps
the younger adolescent group would have more tenuous ties to contacts
outside the family that could not as readily serve as means of
support (Stone, 1975).

Also, suicidal and emotionally disturbed/nonsuicidal groups
evidenced rather low levels of participation and thus little vari­
tion in external support. As previously mentioned, females perhaps
differed more in the importance of external support as a function of mental status as a result of the greater need for social approval as opposed to that of males (Bem, 1975; Douvan, 1966).

The ability of the family to make changes in their structure or functioning, i.e., adaptability, was found not to be significantly different among the three adolescent groups studied including the sex and age subgroups. Although Corder and others (1974), Pfeffer (1982), Richman (1971), and Williams & Lyons (1976) found families of suicidal adolescents to be more rigid and less likely to make changes than their comparison groups, this was not supported by this research. As parents of both the suicidal and emotionally disturbed/nonsuicidal groups were usually involved in their adolescents' regimen, this may have resulted in more of an ability to adapt than would typically be expected in such families. Perhaps differences in adaptability would have been found if the adolescents had been interviewed prior to treatment.

The suicidal and the emotionally disturbed/nonsuicidal groups significantly differed from the nonproblematic groups in hopelessness, i.e., the adolescents' perception of pessimism about the future. This was true of the two sex subgroups as well as the older adolescents. Beck and others (1974) found hopelessness to be more highly correlated with suicide than depression. Corder and others (1974) described lack of investment in the future and future goals as being more characteristic of suicidal adolescents than other emotionally disturbed/nonsuicidal adolescents. Marks and Haller (1977) also concluded that adolescent suicide attemptors described themselves as
feeling more hopeless than adolescents with suicidal ideation but no suicidal behavior. Although this research revealed differences between the suicidal and nonproblematic adolescent, there were no significant differences indicated between the suicidal and emotionally disturbed as the literature suggests. Perhaps adolescents in treatment would evidence less variation in hopelessness. Then, too, if the emotionally disturbed/nonsuicidal group evidenced depression and self-destructive feelings in masked ways as suggested by many clinicians, comparable levels of hopelessness between these two groups might be expected.

**Implications for Research and Intervention**

Although this study was designed to eliminate some of the weaknesses in other research studies of factors related to adolescent suicide, i.e., use of comparison groups, control of sex, age, and family structure, use of standardized measures, and utilization of adolescent perceptions of their family functioning, there still remain some weaknesses that researchers should consider in future study of the etiology of adolescent suicidal behaviors. Also, some tentative implications for intervention are posited.

1. A larger sample size would possibly reveal greater differences or even different patterns of difference in the variables studied. A larger sample size, more normally distributed, would allow for the use of the more powerful parametric tests. Also, a larger sample size would allow for the use of more controls, e.g., the degree of lethality and social class.

2. Control for social class is recommended in future studies. Since this study did not control for social class, social class may
have affected measures studied. Some authors have noted variations in suicidal behavior by social class (e.g., U.S. Vital Statistics, 1979). Controlling for social class would thus enhance the specificity and generalizability of the research findings.

3. A more precise definition and specific diagnosis of "emotionally disturbed" is needed when this is used as a point of comparison. It is recommended that future studies might compare suicidal adolescents to groups of adolescents with specific diagnosis, e.g., schizophrenia, delinquency, depression, conduct disorder. This research did not differentiate the specific nature of the emotionally disturbed/nonsuicidal group and thus there may have been overlap in the diagnosis between this group and the suicidal group. Comparison of adolescents with specific diagnoses would also facilitate family theorists attempts at differentiating family interaction patterns according to child outcomes.

4. Measures for this study included only adolescents perceptions about their family. Future research might include information from both the parents and siblings. Other methodological approaches to family study should be considered. For example, clinical interviews and observational techniques might have gleaned more valid findings. It is not uncommon for adolescents to minimize family problems or to otherwise be unresponsive to survey approaches (Conger, 1977; Tishler, McKenry & Kelly, 1982).

5. More specificity in the definition of suicidal behavior by assessing severity or degree of lethality and the likelihood of rescue is recommended. Such an assessment might distinguish between
those adolescents considered to have made suicidal gestures (low lethality/high probability of rescue) from those who make serious suicidal attempts (high lethality/low likelihood of rescue). It may be found that the suicidal attemptors might differ on the variables studied from those that make suicidal gestures or from those who are emotionally disturbed/nonsuicidal. Those individuals expressing suicidal ideation might also be distinguished from other emotionally disturbed/nonsuicidal adolescents.

6. It is also recommended that assessment of the mental status of a suicidal individual be made as soon as possible following the suicidal act (Shneidman, 1981). The subjects in this research were assessed within one month following the suicidal behavior and were asked to respond according to how they felt at the time of the suicidal behavior; however any period of intervening time may have allowed defenses to develop and thus cloud the responses of the adolescents.

7. The importance of applying a theoretical approach to suicide research is also sorely needed. Research on suicide, in general, has tended to be atheoretical and thus of limited benefit to clinicians and to the development of any generalizations about suicide behavior. Research should be theoretically grounded to provide information that would support further theoretical development and thus increase our understanding of this phenomenon. This study represents one attempt to use theory as an integrating framework for studying adolescent suicidal behavior.
8. Future research might also take into consideration the importance of race, religious affiliation, and birth order in their designs. These are variables traditionally neglected in family research (McKenry & Price-Bonham, 1984).

9. It is recommended that future research explore younger age groups. Too often, both clinicians and researchers are typically skeptical of the existence of self-destructive and/or depressive behavior in younger adolescents and children and therefore have refrained from the study of these groups.

10. Although this research did not distinguish the suicidal group from the emotionally disturbed/nonsuicidal group on the family variables studied, it did indicate differences between the two emotionally disturbed groups and the nonproblematic group in terms of several family measures. This would indicate the importance of utilizing a family history in diagnosis and treatment of this population.

11. Clinicians need to provide training and education to others, (e.g., teachers, coaches, clergy, peers, pediatricians, parent groups), who are in frequent contact with adolescents, regarding danger signals of suicide and how to get the adolescent in need of counseling to such a setting. The fact that the suicidal and emotionally disturbed/nonsuicidal groups failed to differ on most of the family measures suggests the possibility of undetected suicidal tendencies.

12. Emphasis in an interdisciplinary approach to intervention recommended with the emotionally disturbed youth. To adequately diagnose adolescents suicide and depression, both medical and social science knowledge is required.
APPENDIX A
BEHAVIORAL AND SOCIAL SCIENCES
HUMAN SUBJECT REVIEW COMMITTEE
THE OHIO STATE UNIVERSITY

Research Involving Human Subjects

ACTION OF THE REVIEW COMMITTEE

With regard to the employment of human subjects in the proposed research protocol:

84B0042 COMPARISON OF FAMILY DYNAMICS IN FAMILIES WITH EITHER A SUICIDAL DEPRESSED OR NON-PROBLEMATIC ADOLESCENT, Patrick C. McKenry, Family Relations & Human Development

THE BEHAVIORAL AND SOCIAL SCIENCES REVIEW COMMITTEE HAS TAKEN THE FOLLOWING ACTION:

X APPROVED _____ DISAPPROVED

_____ APPROVED WITH CONDITIONS* _____ WAIVER OF WRITTEN CONSENT GRANTED

Conditions stated by the Committee have been met by the Investigator and, therefore, the protocol is approved.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subject Review Committee for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the Review Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date April 5, 1985 Signed

HS-025B (Rev. 3/85)
APPENDIX B
Ms. Dee Roth, Chief  
Office of Program Evaluation and Research  
State Office Tower, Room 134Q  
30 East Broad Street  
Columbus, Ohio 43215  

Dear Ms. Roth:  

The Central Ohio Adolescent Center is approving and supporting the research on COMPARISON OF FAMILY DYNAMICS IN FAMILIES WITH EITHER A SUICIDAL, EMOTIONALLY DISTURBED/NONSUICIDAL OR NON-PROBLEMATIC ADOLESCENT. It is our understanding that adolescents who are in the first two groups and who are clients at C.O.A.C. and their parents will be involved in the study.  

Sincerely,  

C. Dan Miller  
Acting Superintendent  

/je
February 29, 1984

Ms. Marian Stansbury, M.S.
Central Ohio Adolescent Center
1952 West Broad Street
Columbus, Ohio 43223

Dear Ms. Stansbury:

The Research Committee of the Central Ohio Adolescent Center is supportive of your efforts to conduct a comparative study of family dynamics in families with either a suicidal, depressed or non-problematic adolescent. We will be glad to offer our assistance and support in conducting this study.

Sincerely,

Wisam Owais, M.D.
Chairman
Clinical Committee
Central Ohio Adolescent Center

An Equal Opportunity Employer
OMH-2430
To: Betty Nantwich, Administrative Secretary, Human Subjects Review

From: Ian Gregory, M.D., Chairman, Department of Psychiatry

Subject: Research Proposal by Patrick McKenny, Ph.D., Marian Stansbury, M.S.,
          Alfred Clarke, Ph.D., and Thomas Milburn, Ph.D.

Adolescents and their families, identified through The Ohio State University Department of Psychiatry, are among 160 subjects in a proposed study by the above named, entitled "Comparison of Family Dynamics in Families with Either a Suicidal, Depressed or Non-Problematic Adolescent."

I note that an abbreviated (different) title was used in the proposed consent form, and believe that these two titles should be the same.

I presented a summary of this proposal at a regular weekly meeting of the Department of Psychiatry Attending Staff (physicians with regular faculty appointments) held on Monday, April 16, 1984. The majority of child psychiatrists present expressed the opinion that Upham Hall would be in a position to supply a very small proportion of the large numbers in each of the two relevant categories (suicidal or depressed). Questions were also raised about the appropriate mechanisms for access to adolescents and their parents.

The proposal has therefore been referred to the Child Psychiatry Research Committee, following which I believe Dr. Arnold will be in a position to let you know the extent of any possible collaboration our faculty can provide.

IG/gh

cc: L. Eugene Arnold, Chief, Division of Child Psychiatry
    Kitty Soldano, Ph.D., Chairperson, Child Psychiatry Research Committee
    Patrick McKenny, Ph.D., Associate Professor, Dept. of Fam.Rel. & Hum.Dev.
    Marian Stansbury, M.S.
    Herman A. Tolbert, M.D., Division of Child Psychiatry

College of Medicine
Ms. Marian Stansbury  
2846 Indianola Avenue  
Columbus, Ohio 43202

Dear Marian:

I'm writing to confirm our interest in working with you on your Dissertation "Family Patterns of Adolescents who make Suicidal Acts." We will be able to help identify adolescents who meet the criteria for your research and link them up with you.

Thank you very much for involving us in this interesting project and I look forward to seeing your results.

Sincerely,

John T. Clark, Jr., A.C.S.W.  
Director of Out-Patient Services

JTC/kw
Dear Parent:

We would like to invite you to participate in a research project on problems related to adolescents and how family members perceive their family relationships. This is to include both the parents (and/or step-parent) and one adolescent child (12-18). Participation in this study will require 1 hour - 1-1/2 hours to complete a paper and pencil questionnaire on family and personal matters. Your help is needed. You are, of course, free to not participate, or to cease participating at any point in the study and any information given would be destroyed.

If you are willing to participate, please sign your name, address and phone number below, and you will be contacted by phone to schedule an appointment at your convenience. All information will be held in the strictest of confidence, and discussed with you and your family if you so choose.

If you are in agreement, the information gained will be shared with the treatment team of the mental health facility by which you are currently being served. If so, please indicate by placing an "X" in the box below and signing your name.

Sincerely,

Marian Stansbury, MS
Doctoral Student

Patrick C. McKenry, Ph.D.
Associate Professor and Advisor

Place X here if you are willing to participate in this study

Signature

Address

Telephone

College of Home Economics
APPENDIX D
CONSENT TO SPECIAL TREATMENT OR PROCEDURE

Harlan Stansbury or Patrick McMenay

1. Purpose of the procedure or treatment: To obtain knowledge about adolescents and their families

2. Possible appropriate alternative method of treatment: None

3. Desirable and risks reasonably to be expected: Minor amount of stress

4. Possible benefits for subject/interest: To increase our understanding of parent-adolescent relationship and to assist the development of programs or intervention techniques to help families of adolescent children.

5. Anticipated duration of subject's participation: 4-4.5 hours

I hereby acknowledge that the information provided in the procedure described above, about my rights as a subject, has been reviewed all questions to my satisfaction. I understand that I may receive further information about any additional questions. My health and education and I will receive all information about any additional questions. I also understand that the information obtained from me, or from the person I am authorized to represent, will remain confidential and I will not be asked about my inclusion here.

I understand that I am free to withdraw my consent and participation in this project at any time without prejudice to me. I do not have any current knowledge of any research that will affect my health or the health of others.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

I certify that I have personally completed all blanks in the form and explained them to the subject or another representative before requesting the subject or another person to sign it.

Signature: ____________________________ Date: ____________________________
**BACKGROUND DATA**

1. Age? _______ 2. Sex? Male ___ Female ___

3. Who are you living with? 4. With whom have you mostly lived while growing up?
   - Father & Mother _____
   - Father ______
   - other ______
   - Grandparent(s) _____
   - Step-parent _____
   - Other _____

5. Number of people living in your home? _______

6. Are your parents? Married _____ Divorced _____ Separated _____

7. Number of Brothers? ____  Sisters? _____

8. What street drugs have you used? ___________________________

9. When were they last used? __________________________________

10. How many times have you moved in your life? ______

11. Where have you lived most of your life?
    - Big city _____
    - Surburbia _____
    - Small town _____
    - Farm _____

12. What grade are you in school? _____

13. What grades do you get most often in school? _____

14. What is your religion?
    - Protestant (specify denomination) _______ Catholic _____
    - Jewish ____  Atheist ____  Agnostic ____
    - Other (specify) __________________________________

15. How religious are you? (Check one)
    - Very religious _____  Somewhat religious _____
    - not very religious _____  Not religious at all _____
Multiple Scale of Social Support

Instructions: After each of the following statements, ask yourself: How true is this about me? Select the answer below which best applies to you and mark its corresponding number in the space to the left of the statement.

<table>
<thead>
<tr>
<th>Definitely not true</th>
<th>Usually not true</th>
<th>I am not sure</th>
<th>Usually true</th>
<th>Definitely true about me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. The love and support of my family enriches my life nearly every day.
2. I think my family regards me as very good at what I do.
3. Sometimes I just don't feel I can turn to my family for help.
4. I socialize with a wide variety of people.
5. I am involved in a wonderful love relationship with my family.
6. I feel respected by my family.
7. I attend a variety of clubs, church and civic activities.
8. My responsibilities for those with whom I work are an important source of meaning in my life.
9. Sometimes I doubt that members of my family really care about me.
10. I feel my family values my opinion.
11. I tend to solve my problems by myself without seeking the advice of others.
12. I have the opportunity to talk with my closest friends frequently.
13. I feel really loved by my family.
14. If I wanted to learn about something, I am likely to attend a workshop, lecture or meeting about it.
15. One thing I enjoy in life is meeting new people.
16. I feel very close to my family.
17. I think asking for help or advice is really a sign of weakness.
18. Compared to most people, I don't have many close friends.
19. I feel a responsibility toward my family.
20. Throughout my life there has usually been special caring and love in my family.
21. My family seems to think I am a capable person.
22. Family members have given me much helpful advice and guidance.
23. Not many people really know me well.
24. I don't give compliments to others very often.
25. My relationship with my parents is loving and accepting.
26. In my community, there aren't many people who can help me out.
27. For my family, I'd do most anything.
28. My co-workers don't really appreciate the work I do.
29. I am best described as a "loner".
30. My family seem to think I have good ideas and abilities.
31. I shy away from consulting a professional about a specific problem.
32. I am close to many relatives outside of my immediate family (grandparents, aunts, uncle, cousins).
33. I am often helpful to my family when they need me.
34. I don't know where to call for public assistance.
35. I make it a point to learn about various helping services in my community.
36. I am the kind of person who does not get close with others.
37. I would be willing to help a good friend in a financial bind.
38. I have a strong commitment to the people with whom I work.
39. I am not really sure that my spouse or special friend truly loves me.
40. Whenever I need help, I discover where it is available to me.
41. I don't socialize much with other people.
42. I believe it helps me to help others.
43. The love and support of my family is indispensable in my life.
44. My family seems to regard me as an upstanding and honorable person.
45. I know how to get assistance from church and governmental agencies.
46. My life is enriched by the variety of friends with whom I can share both work and good times.
47. I wish I felt closer to my family.
48. I wish my family thought better of me.
49. I would feel better if I had more confidence in the advice I get from my family.
52. Though I hate to say so, I feel rejected by my family whose respect I want most.

53. I wish I had more friends from other "walks of life".

54. Unfortunately, I think my good qualities are often overlooked by my family.

55. I often feel like I need more advice and information than I'm getting from my family.

56. I wish I could have a family in which I could confide.

57. I feel my family respects me for the work I do.

58. My family seem proud to introduce me to their friends.

59. I usually feel my family is glad I am one of them.
Losses -- Actual or Threatened

<table>
<thead>
<tr>
<th>Event</th>
<th>TRUE (age)</th>
<th>FALSE</th>
<th>POSSIBLE</th>
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</thead>
<tbody>
<tr>
<td>Parents divorced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents separated</td>
<td></td>
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<tr>
<td>Not living with parents</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Serious illness or injury of a family member</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Increase in arguments between parents</td>
<td></td>
<td></td>
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<tr>
<td>Death of a family member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensive use of alcohol by parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase arguments with brother/sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother/sister leaving home</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Increased absence of a parent from home</td>
<td></td>
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<tr>
<td>Parent in jail</td>
<td></td>
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<tr>
<td>Parents marriage is poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents spend little time together</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Frequent moves</td>
<td></td>
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<tr>
<td>Severe problems with money</td>
<td></td>
<td></td>
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<tr>
<td>Recent break-up or conflict with boy/girl friend</td>
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</table>
APPENDIX F
<table>
<thead>
<tr>
<th></th>
<th>Suicide</th>
<th>Emotionally disturbed/ Nonsuicidal</th>
<th>Nonproblematic</th>
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<tbody>
<tr>
<td>Physical Bondedness</td>
<td>24.1 (S.D.=3.49)</td>
<td>23.55 (S.D.=3.65)</td>
<td>24.71 (S.D.=4.0)</td>
</tr>
<tr>
<td>Emotional Cohesion</td>
<td>106.4 (S.D.=24.71)</td>
<td>100.05 (S.D.=25.59)</td>
<td>83.19 (S.D.=21.68)</td>
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<tr>
<td>Expressiveness</td>
<td>14.9 (S.D.=1.94)</td>
<td>14.3 (S.D.=1.53)</td>
<td>13.1 (S.D.=2.3)</td>
</tr>
<tr>
<td>Conflict</td>
<td>14.05 (S.D.=2.11)</td>
<td>13.9 (S.D.=2.61)</td>
<td>13.71 (S.D.=2.7)</td>
</tr>
<tr>
<td>Adaptability</td>
<td>53.05 (S.D.=12.1)</td>
<td>59.05 (S.D.=11.88)</td>
<td>54.52 (S.D.=8.95)</td>
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<tr>
<td>External support</td>
<td>39.6 (S.D.=8.3)</td>
<td>40.4 (S.D.=4.76)</td>
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<tr>
<td>Losses</td>
<td>25.05 (S.D.=5.17)</td>
<td>26.95 (S.D.=4.78)</td>
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<td>Hopelessness</td>
<td>30.0 (S.D.=7.18)</td>
<td>28.35 (S.D.=6.03)</td>
<td>21.14 (S.D.=1.11)</td>
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<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
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<td><strong>Physical Bondedness</strong></td>
<td>24.0 (S.D.=3.84)</td>
<td>24.25 (S.D.=3.15)</td>
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<td><strong>Emotional Cohesion</strong></td>
<td>104.42 (S.D.=25.99)</td>
<td>109.38 (S.D.=24.05)</td>
<td>102.67 (S.D.=30.43)</td>
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<td><strong>Expressiveness</strong></td>
<td>14.5 (S.D.=2.11)</td>
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<td>14.5 (S.D.=1.73)</td>
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<tr>
<td><strong>Conflict</strong></td>
<td>13.5 (S.D.=2.28)</td>
<td>14.88 (S.D.=1.64)</td>
<td>14.83 (S.D.=2.04)</td>
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<tr>
<td><strong>Adaptability</strong></td>
<td>52.42 (S.D.=11.28)</td>
<td>54.0 (S.D.=14.0)</td>
<td>62.83 (S.D.=10.14)</td>
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<tr>
<td><strong>External Support</strong></td>
<td>42.0 (S.D.=3.28)</td>
<td>36.0 (S.D.=12.06)</td>
<td>41.0 (S.D.=5.08)</td>
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### Means of Dependent Measures by Sex and Mental Status Groups

<table>
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<tr>
<th></th>
<th>Younger Suicidal</th>
<th>Older Suicidal</th>
<th>Younger Emotionally Disturbed/Nonsuicidal</th>
<th>Older Emotionally Disturbed/Nonsuicidal</th>
<th>Younger Nonproblematic</th>
<th>Older Nonproblematic</th>
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<tbody>
<tr>
<td>Emotional Cohesion</td>
<td>110.43 (S.D.=26.61)</td>
<td>104.23 (S.D.=24.46)</td>
<td>90.86 (S.D.=28.0)</td>
<td>105.0 (S.D.=23.85)</td>
<td>77.17 (S.D.=24.02)</td>
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<td>14.57 (S.D.=2.76)</td>
<td>15.08 (S.D.=1.44)</td>
<td>13.43 (S.D.=1.99)</td>
<td>14.77 (S.D.=1.01)</td>
<td>12.67 (S.D.=3.82)</td>
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<tr>
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<td>13.85 (S.D.=2.03)</td>
<td>13.71 (S.D.=2.75)</td>
<td>14.0 (S.D.=2.65)</td>
<td>11.83 (S.D.=2.64)</td>
<td>14.47 (S.D.=2.42)</td>
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<tr>
<td>Adaptability</td>
<td>54.86 (S.D.=16.41)</td>
<td>52.08 (S.D.=9.72)</td>
<td>59.0 (S.D.=13.1)</td>
<td>55.27 (S.D.=9.6)</td>
<td>52.67 (S.D.=7.55)</td>
<td>55.27 (S.D.=9.6)</td>
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<td>External Support</td>
<td>43.14 (S.D.=3.24)</td>
<td>37.69 (S.D.=9.62)</td>
<td>37.71 (S.D.=4.23)</td>
<td>41.85 (S.D.=4.52)</td>
<td>36.0 (S.D.=3.75)</td>
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<td>31.08 (S.D.=6.0)</td>
<td>28.29 (S.D.=5.77)</td>
<td>28.38 (S.D.=6.4)</td>
<td>22.0 (S.D.=1.41)</td>
<td>20.8 (S.D.=0.77)</td>
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</table>
REFERENCES


Richman, J. (1978). Symbiosis, empathy, suicidal behavior, and the family. Suicide and Life-Threatening Behavior, 8, 139-149.


