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Symptom Presence and Resolution in Psychiatrically Hospitalized Adolescents

Margaret J. Rohde

Loyola University Chicago

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SYMPTOM PRESENCE AND RESOLUTION IN
PSYCHIATRICALLY HOSPITALIZED ADOLESCENTS

By
Margaret J. Rohde

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
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VITA

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INTRODUCTION

The effects of various family lifestyles for raising a child is a modern controversial issue which has had, and probably will continue for some time to have, far reaching implications in education, economics, and politics (Changing Times, 1976; Muchovej, 1976; Rolling Stone, 1977). As early as 1934, the White House Conference on Child Health and Protection focused on the detrimental effects of the broken home on the child, and today newspapers and magazines still abound with the debate as to whether or not family life is dying and whether or not that death would be welcome. Conservatives hold that it is essential for a child to be raised by his non-working mother, while liberals claim that the time has come for society to revamp its long-standing institutions, such as the family. Traditionalists recommend that couples remain married for the sake of the children, while contemporary writers suggest that the effects of a bad marriage may be more detrimental to the children than the effects which are claimed by conservatives to result from a divorce. Various statements are made by both factions, with really very little good evidence cited as background material (Etzioni, 1977; Rolling Stone, 1977). The effects of various family lifestyles on children
are so diverse and interactive that at this point only suggestions
can be made regarding specific consequences of different kinds of
evironments.

In addition, the home life of the child interacts with his social,
educational and religious culture, so that the relative influence of family
relationships is difficult to specify in conjunction with the other factors.
The effects of family factors are stressed in the research presented here,
in an attempt to sort out some of the variables which differentiate among
adolescents hospitalized for psychiatric reasons.

One of the purposes of the present research is to make more
explicit the role of specific family factors in the development of psychi­
atriic symptoms and the progression of treatment of adolescents in an
inpatient psychiatric hospital setting. For example, it is hypothesized
that the differences in the presence and resolution of psychiatric symp­
toms, in psychiatrically hospitalized adolescents, are due to such vari­
ables as the adolescent's sex, age, verbal IQ, birth order, his length
of stay in the hospital, intactness of his home, and the marital status
of the adolescent's parents. Differences in the presence and resolution
of psychiatric symptoms, in psychiatrically hospitalized adolescents who
come from broken homes, are hypothesized to be due to such variables as
the patient's sex and his age when the parent-child separation took place.
More detail regarding the literature and clinical bases for these hypo­
theses is provided in the sections below.
Parental Rejection of the Child

Early studies did not differentiate between emotional and physical rejection of a child, rendering interpretation of these studies difficult. The implication in most of these early studies was that, unless physical parent-child separation was specifically stated, the rejection was more an emotional reaction on the part of the parent to the child, rather than a physical separation of parent and child. With respect to the present research, a broken home is seen as more of a rejecting environment because the parent has physically separated himself/herself from the child, while an intact family is viewed as providing a more protective environment.

Wolberg (1944) early made the point that the family has a variety of influences on the child when he described the consequences of parental rejection as depending upon the age of the child at the time of the rejection, the manner in which rejection was imposed by the parents, the type and degree of compensatory gratification via acceptance by others, and the success or failure of impromptu attempts on the part of the child to establish accepting relationships. The developmental period of the child at the time of the rejection, whether the rejection was emotional...
or physical, the availability of parental substitutes, and the rigidity of the rejection, all were seen as important factors. Thus, maturational as well as environmental and intrapsychic factors are involved in determining the final result. While these factors determine the specific consequences which occur, Wolberg (1944) pointed out that, in general, rejected children develop character patterns which severely trouble their other interpersonal relationships as well as their general adjustment in other areas.

Newell (1934) subdivided children's reactions to maternal rejection into two types - aggression and submission. The aggressive child responds to parental rejection by becoming more rebellious, disobedient and argumentative, while the submissive child is typified by shyness, exclusiveness, inability to concentrate, sensitiveness, fearfulness, daydreaming, and cravings for affection. Newell (1934) seemed to be assuming that the child's personality type causes him to respond in a specific manner. While this would be a valid contention, it also would seem reasonable to state that different types of maternal treatment produce different responses on the part of the child. Newell (1936) made this point more evident when he stated that children tend to respond aggressively when parental treatment is consistently hostile, and to respond submissively when parental handling is consistently protective.

Newell (1936) also concluded that the major reason for maternal rejection of the child is not his personality or his behavior, even though
the child usually believes such is the case and feels he is regarded as worthless. However, Newell (1936) claimed that the mother's unhappiness in the marriage and the immaturity and instability of both marital partners are more to blame for the maternal rejection of the child. Thus, the problem of parental rejection of children is compounded by the interactions within the family - between husband and wife, between the child and his parents, etc., which provide the child with an unstable environment and inconsistent handling. While the current study does not assess psychopathology in the parents or the stability of the marriage, Newell (1936) suggested that these are relevant factors in the child's adjustment.

The reflections of the family interactions in the children's behavior have been documented as being varied but profound. Childers (1935) studied children rejected by their parents and noted that these children were hypersensitive; he attributed this characteristic to their feelings of insecurity and the impermanence of their environment. They seemed to be disturbed by small disruptions in their everyday routine and to feel devastated at the slightest suggestion of criticism or disapproval. He named four probable environmental factors in the development of behavior disorders in rejected children: 1) poor development of internal controls due to lack of external controls; 2) frequent environmental changes; 3) clear and long-standing overstimulation and indulgence; and 4) lack of sense of belonging or acceptance in family, school or community.

Symonds (1938) compared rejected children with children who
were more accepted by their parents and reported that the rejected children were more uncommunicative, rebellious and bewildered about life, and less friendly than the more accepted children. The families of rejected children were characterized by quarrelling, irritability and temper displays, and by a lack of mutual courtesy and thoughtfulness. Symonds also referred to parents' unmet needs, such as being rejected themselves, which cause them to reject their children.

Prendergast and Schaefer (1974) noted some patterns in the family typology which seem related to excessive drinking by the adolescent. While the basic pattern is one in which the father drinks, and the child perceives a great deal of tension in his relationship with the father, feels loosely controlled, specifically by the mother, and feels rejected by either parent, the latter two factors are the most influential. These results suggested that perceived parental rejection plays an enormous part in the child's development and symptomatology.

While the explanation of these findings would seem, intuitively, to be that parental rejection causes children to develop these particular character structures, the inverse rival hypothesis also would be viable - that children with these personalities are rejected by their parents. Further in-depth research into family dynamics would be necessary to settle this question, and this point should be kept in mind regarding most of the studies in this field.
Regardless of which factor "caused" the other, the long-range "effects" of parental rejection are striking. Pemberton and Benady (1973) collected retrospective data on 12 children who were consciously rejected by their parents - the parents had actually taken steps to have them placed elsewhere. The authors discovered that these children's interpersonal relationships were severely disrupted both before and after separation from their parents and that these children also displayed strong acting out tendencies. While they were capable of showing warmth, under stress they regressed and invited rejection.

It would be interesting to compare a group such as Pemberton and Benady's (1973) with a group which received family therapy throughout the placement proceedings to determine whether it is possible for children to adjust their reactions to stress over time. That children's interpersonal difficulties seem to be an interaction with family relationships, rather than a one-way, causal process, also has been discussed by Sabbath (1969), who related adolescent suicide to a last, desperate attempt on the part of the teenager to fulfill what he sees as his parents' wish to be rid of him, and thus to finally gain their approval. The family pattern is one in which a parent believes that his own sanity, marital stability and very existence are threatened by the child, and the child believes, on the one hand, that his parents are oppressive and persecutory but, on the other hand, that he can win them back by sacrificing himself.
Parental Separation from the Child

While earlier authors seem to have focused on parental rejection - which may or may not include separation - more recent research has distinguished between perceived rejection of the child by a present or an absent parent. A parent might reject a child by withdrawing emotionally and/or physically, and the latter aspect is emphasized in this experiment.

Bowlby, Ainsworth, Boston and Rosenbluth (1956) suggested that separation of a child from his parents might produce an "affectionless character", a person who is incapable of developing relationships with others but who nevertheless has an excessive need for love. Their thesis was that if separation of a child from his parents occurs during a critical time period when the child should be forming a relationship with a significant other - usually his mother - he will never learn this skill and will be handicapped interpersonally throughout his life. The separated children in the Bowlby, et al. (1956) study developed two syndromes: 1) lack of initiative, withdrawal, and inability to concentrate; and 2) aggressiveness and temper tantrums. These two tendencies are remarkably similar to Newell's (1936) finding that children who are treated in a protective manner develop symptoms such as those in the first syndrome, while children who are treated in a hostile fashion develop characteristics which resemble the latter syndrome.

Masterson (1971) related that the presenting psychopathology of borderline adolescents is the manifestation of a developmental arrest
reflecting a separation-individuation problem. The mother-child relationship pattern in borderline adolescents can often be described as a symbiotic bond which is cut off by separation and burdened by abandonment depression.

More specifically, Masterson (1971) discussed the stages in the development of children who become borderline adolescents. Between the ages of one and one-half to three years, these children struggle over the conflict between their desires for individuation and autonomy on the one hand and their needs for support from their mothers on the other hand. If their mothers withdraw support when the children move toward individuation, the children are caught between two stages — symbiosis and autonomy. They are separated from their mothers but really are not individuated and remain orally fixated. Through repression, as well as other defense mechanisms, such as acting out, reaction formation, obsessive-compulsive mechanisms, projection, denial, isolation, and withdrawal of affect, the children keep their feelings of abandonment out of awareness and are able to function adequately until puberty, when a second separation-individuation crisis occurs and they are required to intensify their defenses. At times, this crisis is aggravated by another environmental separation experience, which can be either overt or covert. Typically, the parents themselves are borderline individuals, and the methods of communication within the family are action-oriented rather than word-oriented.
Masterson (1971) went on to state that the goals of treatment of the borderline adolescent should be to resolve the abandonment depression and to allow the patient to work through the separation-individuation stage to autonomy from his parents. Masterson's data also suggested that the age of the adolescent at the time of separation is an important factor, with early separation being more detrimental.

Several researchers have focused on the type of psychopathology developed in children who are separated from a parent. Caplan and Douglas (1969) studied 256 neurotic children ranging in age from five to sixteen, 71 of whom were depressed. About one-half of the depressed children and about one-fourth of the non-depressed neurotic children had experienced deprivation of some form or another by their parents which lasted at least six months and occurred before they reached eight years of age. The figures for disturbed children were compared by Caplan and Douglas (1969) to Witmer's (1965) data on parental loss in the general population of the United States for 1961. Witmer (1965) noted that 4.3% of children up to age 18 had lost one parent by death and about 15% were living apart from one or both their natural parents.

Bowlby (1970) maintained that depression is preceded by disrupted affectional bonds during childhood. The children are severely anxious and have an excessive need for love but at the same time resist the parents who left them. Spitz and Wolf (1970) observed depression in 19 (15%) of 123 babies in a nursery, all of whom had been separated
from their mothers when about six to eight months old. Goldfarb (1945, 1947) and Mednick and Schulsinger (1968) gathered evidence implicating early separation experiences in the development of schizophrenia. Hilgard and Newman (1961) and Pollack, Malzberg and Fuller (1939) found a relation between schizophrenia and broken homes. Herrmann (1974) related the risk of schizophrenia and early separation experience to maladjustment. Maladjustment was correlated with schizophrenic mothers and separation experiences. In addition, the number of milieu shifts seemed to be contributory to maladjustment.

Malmquist (1971a) classified childhood depression into five basic categories: 1) those associated with organic disease, 2) deprivation syndromes, 3) syndromes associated with difficulties in individuation, 4) latency depressions, and 5) adolescent depressions. If the child experiences an object loss, usually the mother, when he is between 6 months to 4 years of age, three pathological responses can be elicited: 1) hostility and self-reproach, 2) projective identification with vicarious mourning, and 3) conscious denial of the permanency of the object loss. The child's development of object constancy is arrested. He internalizes guilt about the loss, overly identifies with remaining significant others' feelings and expressions of bereavement, and/or deludes himself that the lost object will return.

In adolescents, Malmquist (1971b) noted seven features of depression: 1) mood swings, 2) unresolved dependency conflicts, 3) diverse
superego activity, 4) acting out, 5) insatiable seeking for affection and approval, 6) confusion in identification with others and in one's own identity, and 7) heightened self-condemnation. All these features appear to be related to the adolescent's feelings of loss, whether of an external object or of his own childhood, and they allow the adolescent to regress to earlier periods of development in which he felt less empty.

Mood swings permit the adolescent to perceive selected memories and cognitions, so that he can develop his own, distorted, perception of the world. He is ambivalent about wanting to be dependent on or independent from his parents, and he is overly sensitive to criticism, especially from his parents. The adolescent externalizes his conflicts by acting out against the world and himself, and he seeks to prevent himself from feeling lonely and isolated. He is fearful of overidentifying with others and thus having his own identity fused with someone else's. At the same time, he repeatedly finds fault with himself.

Cytryn, McKnew and Levy (1972) categorized depression in children into three types: 1) masked depression, which most often appears in children whose families and personalities are severely disturbed; 2) acute depression, which is a reaction to a traumatic event; and 3) chronic depression, which is found in children with a history of marginal premorbid social adjustment, depression, and repeated separations from important adults. In all of the acute cases studied, the precipitating cause was a severe trauma associated with object loss, sometimes in
the form of the death of a loved one, but more often by the loved one withdrawing interest.

Glueck and Glueck (1950) and Monahan (1960) both found the broken home to be a factor in juvenile delinquency. Power, Ash, Shoenberg and Sirey (1974) compared a large number of delinquent and nondeliquent males 11 to 14 years old from broken and unbroken homes. While quite a few of the delinquent adolescents came from unbroken homes, they were more likely to come from broken homes than were nondelinquent males. Neighborhood or school factors and possible family stress were ruled out as significant variables in delinquency. While the families may not have been in stress, the children certainly seemed to have been troubled, suggesting that broken home families are unresponsive to the child's situation.

Parent-child separation was seen as affecting not only emotional adjustment but also intellectual adjustment. McNeal (1973) compared school success of 243 junior high school students from broken homes to that of the same number of students from intact homes. While the sex of the parent with whom children from broken homes lived was not significant for any of the variables, children from broken homes had lower grade point averages and lower teacher evaluations of work habits, and were tardy and absent more often than children from unbroken homes. However, there were no significant differences in standardized achievement test results, extracurricular activities participation, and peer
evaluations of leadership. Females from broken homes had higher grade point averages and teacher evaluations of work habits and were less tardy and absent than males from similar home backgrounds.

The effects of the reasons for separation from one's parents on the child's behavior and personality have been investigated and are discussed in the sections below.

Parental Imprisonment

For example, Sack, Seidler and Thomas (1976) interviewed the spouses of 31 prison inmates regarding their children's behavior and found that the spouse reported an increase in children's aggressive reactions among one another and toward the parent at home while the other parent was imprisoned. Some of the children seemed to be taking on some of the antisocial characteristics of the incarcerated parent, as if in an attempt to hold on to him or to replace him. While the current research does not focus on the effects of parental imprisonment, the Sack, et al. (1976) results suggest that, even when separation is of a more temporary nature, it affects the child's behavior.

Moerk (1973) administered the Parent-Child Relations Questionnaire, the Tennessee Self Concept Scale, and a measure of internal-external control, to adolescent males from families in which the father was absent due to either imprisonment or divorce and from families in which the father was present. Males whose fathers were in prison were more similar to juvenile delinquents, and less similar to the controls,
than were boys from divorced families. The author suggested that father absence in itself may not be the effective element, but rather that discordant family relationships even before the father's absence may be involved. Again, the marital relationship was seen to be a factor in the child's personality development. In addition, it would seem that the reason for the separation, as well as its perceived permanence, are important variables.

**Parental Occupation**

Father absence for occupational reasons was researched by Tiller (1958), who compared Norwegian sailor families, in which the father was absent for long periods of time, to control families. He found that the mothers whose husbands were absent were less involved in the community, more overprotective of their children, and more concerned with the obedience and politeness of their children, rather than their happiness and self-realization, than the control mothers. The children whose fathers were absent were more dependent, more pseudo-mature, and more idealizing of their fathers.

Lynn and Sawrey (1959) examined 80 Norwegian mother-child pairs, in 40 of which the father was at sea and thus absent from the home at least nine months of the year. In contrast to boys whose fathers were present year round, boys whose fathers were at sea were more immature, showed stronger strivings toward father identification, and reacted to their insecure masculine identity with more compensatory masculinity.
Father absent boys also exhibited poorer peer adjustment in comparison to father present boys. Father absent girls were more dependent on their mothers than father present girls. Thus, the sex of the child determines in part the effect of the separation, and there also seemed to be some suggestion from these results that the effect of mother versus father absence is worth investigating. This is documented further in a later section of this paper.

**Parental Divorce**

McDermott (1967) found that after parental divorce, children between the ages of three and six seem to lose their capacity to master anxiety and depression through play, as if the departing parent had died. It also seemed from these data that the child feels as if he has lost part of himself when he loses a parent through divorce, perhaps because one parent typically no longer is physically present and the other parent, while physically available, is usually emotionally absent or distant.

Wallerstein and Kelly (1976) studied latency-age children's responses to their parents' divorce. During these years, the children's normal tasks are the formation and maintenance of peer relationships, but these tasks are disrupted and the children are required to attend more than usual to family relationships, if a divorce occurs. Normal defenses at this age are repression, denial, and reaction formation, and the authors stated that these age appropriate coping mechanisms are used, in the forms of seeking coherence in the situation, keeping busy,
consciously avoiding the subject, denying its existence, maintaining a courageous outlook, and seeking support from others. In contrast to younger children, shame was observed in these latency-age children, although few seemed to feel they caused the divorce. Conscious, intense anger characterized these children, and they seemed to fear being forgotten or abandoned. Some seemed to attempt to master the situation through angry outbursts, as if trying to prevent the separation. Often, the children appeared to align and empathize with the perceived betrayed parent. While the school performances of about half the subjects declined immediately following the divorce, within the one-year follow-up period they were back to their original levels. At follow-up, most affective responses surrounding the divorce were muted, although anger and bitterness were prevalent, as well as depression and low self-esteem.

Parental Death

Seligman, Gleser, Rauh and Harris (1974) reported that 31 (36.4%) of 85 adolescent patients referred for a psychiatric evaluation from a medical services clinic had suffered an earlier parental loss, while only 11.6% from a school sample and 16.6% from a general medical sample had experienced a similar loss. In the psychiatrically evaluated sample, parental loss was concentrated in adolescents who were three to six years old and twelve to fifteen years old at the time of the loss, and the reasons they were referred for psychiatric evaluation included neurotic conflict, self-destructive injury, and drug overdose. The
authors suggested three possible explanations for the effect of earlier parental loss on adolescents. First, adolescence, being the loss of childhood and its love objects, ending of dependent relationships on parents, and changing body image and cognitive ability, reawakened other losses. Second, biological changes stirred up grief which had been suppressed via the normal defenses of latency—repression, denial, and reaction formation. Finally, the increase in psychosocial crises in adolescence led to the onset of problems.

**Mother Absence**

Mednick (1971) investigated 207 Danish children who were determined to be at high risk for schizophrenia and found that those who developed schizophrenia, compared to those who did not, were more likely to have lost their mothers earlier and to have experienced more severe pregnancy and birth complications.

**Father Absence**

Most studies of the effects of parental separation on children focused on homes in which the father was the absent parent; very likely this was the most available pattern. For example, the moral development of seventh grade father absent and father present boys was compared by Hoffman (1971). The father absent boys scored lower than father present boys on indices of internal moral judgment, guilt, acceptance of blame, moral values and rule conformity. Hoffman (1971) commented that father
absence results in a similar, but more intense, effect as non-identification with a present father, and that the effects of father absence can be mitigated to some extent by the mother's interactions with her children.

However, Mumbauer and Gray (1970) found no difference between father absent and father present young Negro boys on a resistance to temptation task. Again, there seems to be a distinction between actual behavior and expressed attitude, suggesting that there may be a difference between father absent and father present boys in their respective abilities to transform attitudes into action.

Zold (1975) followed up on 80 white father absent individuals who had been seen for psychiatric reasons in adolescence. Father absence was categorized as early (before age 5) or late (after age 5) and was defined as permanent separation from biological father (but not from biological mother) for at least two years prior to being seen for psychiatric reasons during adolescence. Adjustment ratings were based on measures of heterosexual adjustment, antisocial behavior, achievement related activities and psychiatric status. The results indicated that early father absent males and late father absent females adapted less satisfactorily than late father absent males and early father absent females. Subjects whose fathers had died were better adjusted than subjects whose fathers were absent for other reasons. The presence of father surrogate figures seemed to have no effect on these patients, and the mother's adjustment was not a useful predictor of level of adjustment in
their children. It seems that the developmental period during which the separation begins is crucial in understanding the effects, especially the sex differences. Death of a parent seems to be a less traumatic experience for the child than separation from a parent due to divorce. This probably is related to the child's ability to understand that his parent's death is beyond human control, while other reasons for his parent's absence involve more of a choice and a perceived active rejection of the child on the part of the separating parent.

Newman and Denman (1970-71) found that felons did not differ from nonfelons in the frequency of having lost their mothers, but were more likely to have lost their fathers before age 18 for reasons of death, desertion, or divorce. The effects of race on these results were not discussed.

Daniels (1972) noted that hospitalized adolescent boys with backgrounds of emotional deprivation and uncontrollable acting out, and warm, friendly, charismatic personalities, were characterized by an absent father, an indifferent mother, a disrupted home and eventual institutionalization. He described these boys as "exploded teenagers" in that they had difficulties with defining the boundaries between themselves and the world around them.

Nelsen and Vangen (1971) compared a total of 95 father absent and father present eighth grade girls on heterosexual behaviors and concepts. Among girls who dated, father absent girls dated earlier and more
frequently than father present girls. The authors interpreted the results to mean that father absent girls are exposed to sexually provocative experiences at an earlier age and that the sexual expressiveness of father present girls is more controlled and restricted by their fathers. Perhaps another explanation would be that father absent girls crave male companionship more than father present girls.

Father absence has been hypothesized as affecting the child's sex role identification. Suber (1976) studied sex role preference and gender identification in 96 pre-school age girls between the ages of 4.6 to 5.6 years old. The subjects also differed in socioeconomic class and father presence versus father absence. The father absence variable could not be differentiated on the basis of the girl's preference for a male or female stereotyped toy, although father absent girls did have higher scores on female gender identification than father present girls. The author also documented an interaction between socioeconomic class and father presence or absence in that middle class father present girls scored higher in own sex role preference and lower in own gender identification than middle class father absent girls.

Silverman and Dinitz (1974) addressed the causes of delinquency in father absent boys, and they suggested that these adolescent males repudiate the feminine identification with the mother by compulsive masculinity. Compared to father present boys, they were more hypermasculine, had the most exaggerated perceptions of their own manliness, placed
greater emphasis on tough behavior, emphasized sexual athleticism, were more impulsive, and were overly influenced by peer pressure, as measured by the Lykken Scale, the Zuckman Sensation Seeking Scale, and a compulsive masculinity index.

D'Andrade (1973) measured patterns of sexual identification and sexual identity of 121 black children with the Franck Test, verbal self-descriptions and a role preference task. Subjects who did not have a father present during the first three years of life exhibited a feminine response pattern. Paternal absence affected the means by which sex roles were learned, making them more indirect. Longabaugh (1973) tested the semantic style and rate of mother-child interactions of 51 black mother-child dyads, the children ranging in age from 5 to 12 years. Semantic style (feminine versus masculine) was unrelated to father presence or absence. Mothers of father absent sons interacted with their sons more than mothers of father present sons did, but this still did not increase the femininity of the son's semantic style.

LeCorgne and Laosa (1976) examined conceptualization of sex role characteristics and the social adjustment of 248 fourth grade students in Mexican American families at or below the poverty level via the Draw A Person, Raven Coloured Progressive Matrices, Bender Gestalt, and teacher ratings of personal adjustment. Father present children had higher Goodenough-Harris scores on the Draw A Person on both male and female figures, drew more feminine attributes on the female figures, and
tended to have fewer emotional indicators on the Bender Gestalt, than father absent children. In addition, father absent boys were rated by the teachers as more socially and emotionally maladjusted than father present boys and father absent or present girls.

Father absence versus presence influences the correlation of mother and child field dependence, state Goldstein and Peck (1973). Father present blacks and father present white males were significantly positively correlated with their mothers' levels of differentiation, as assessed by the Rod & Frame Test, but father absent children were not correlated with their mothers' levels of differentiation.

Racial differences in the effects of father absence or presence were discovered by Hunt and Hunt (1975) in their study of 445 male junior and senior high school students. White father absent boys were more withdrawn from conventional paths of success and adult respectability than were white father present boys. Although blacks scored lower than whites, blacks did not differ among themselves on these variables, nor on the self-control variable, in terms of father absence and father presence. White father absent boys did have lower self-esteem than white father present boys. Class differences were ruled out as a plausible rival hypothesis. The greater acceptability of father absence in black families may explain these results.

Steinberg (1974) found that differences in occupational values in a group of 410 subjects varying in terms of sex, age, race, geographical
location, and father presence or absence, could best be explained, within the white group, by the sex and father absence or presence variables. In general, though, the subjects seemed to be coping with the supposed burden of father absence, and Steinberg (1974) suggested that further research examine more fully the strengths which enable children to survive disasters in their families.

**Surrogate Parent**

One such strength could be the presence of a surrogate parent. The effects of the stepfather on psychosocial development in males were identified by Oshman and Manosevitz (1976). A group of 125 male college students, 39 with father present, 39 with father absent but stepfather present, and 47 with no father or stepfather, answered the Rasmussen Ego Identity Scale, which is based on Erikson's stages of development. The father and stepfather groups did not differ on any subscale nor on the total score, while those with father present were better adjusted than those without father or stepfather on the Trust vs. Mistrust, Autonomy vs. Shame, and Industry vs. Inferiority Scales, as well as the total score, and the stepfather group was better adjusted on the Industry vs. Inferiority Scale and the total score. The authors pointed out that stepfathers prevented paternal deprivation. Other factors to take into consideration would be the stepfather-stepson relationship and the possibility that the mothers who remarried may have been better adjusted.
Mednick (1973) studied 40 children, 20 of whom had suffered a breakdown and 20 of whom had not, but all of whose mothers were schizophrenic. Those children who had decompensated tended to have mothers who experienced more emotional stress during their pregnancy, generally had mentally ill fathers as well, and often lost their mothers at an earlier age. The children who broke down tended significantly not to acquire a surrogate mother. The lack of appropriate maternal care seems to be an important factor here.

Berman and Jensen (1973) noted in a study of four girls and their adopted fathers that girls tend to develop roles in adolescence which will be appropriate for adulthood, while boys tend to need to unlearn their adolescent roles as they enter manhood.

Family Constellation

Dielman, Barton and Cattell (1974) researched the role of the number and sex of siblings on personality traits of junior high school students and found that subjects with more sisters received higher scores on guilt proneness, while subjects with more brothers received higher scores on self-sentiment.

Birtchnell (1971) analyzed numerous sibling constellations of psychiatric patients and controls from sibships of two and three. In sibships of two, firstborn patients were more likely to have opposite sex siblings, and secondborn patients were more likely to have same sex
siblings, compared to controls. Women neurotics in sibships of two
tended to be the secondborn in the sibship. In patient sibships of three,
the patient tended to be firstborn or secondborn rather than lastborn.

George and Devadas (1971) administered the Taylor Manifest
Anxiety Scale to 40 firstborn and 40 laterborn high school students and
found that the firstborn subjects had higher anxiety scores than laterborn
subjects.

Intellectual Capacity

Timms, Carney & Stevenson (1973) found five factors related to
drug abuse: 1) personality disordered (with disordered father), 2) neu­
rotic family environment, 3) psychiatric admission, 4) low intellectual
capacity, and 5) chronic presentation at institutions.

Satisfactory Follow-Up

Roff (1974) found that adolescent schizophrenics with poor out­
comes were more likely to have chronic schizophrenic relatives, a
disturbed parent, below average IQ, hebephrenic subtype diagnosis,
and distinctive developmental changes. Prior to adolescence, these cases
typically were emotionally disturbed but not schizophrenic, never got
along with other children, actively antagonized others, and were subse­
quently rejected. The more favorable outcome cases always tended to have
been shy, quiet and nervous, and were ignored rather than rejected by
peers.
Pichel (1974) conducted a follow-up investigation of 60 adult psychiatric outpatients formerly seen as adolescents. Those who had been diagnosed as adjustment reactions adjusted most satisfactorily, while those with more severe diagnoses, such as schizophrenia, made the poorest adjustments.

Averbach (1973) noted that academic failure or success could be predicted in a group of male adolescents who had undergone psychotherapy during adolescence.

Kivowitz, Forgotson, Goldstein and Gottlieb (1974) discovered that adolescent psychotic patients did poorly over time, with significant improvement rare. However, patients with neurotic disorders, adjustment problems and personality disorders progressed well.

Development of Specific Problems

Fitzgibbons, Berry and Shearn (1973) studied the MMPI configurations of hospitalized drug abusers and found a suggestion that those who use drugs only minimally may be more identified with a rebellious subculture and less socially inhibited, while those with increasing drug use are associated with passivity. It also seemed that traits often associated with the drug user are characteristic of all young people with psychological difficulties, regardless of drug history.

Davidson (1973) characterized adolescent drug abusers into three general categories, with much overlapping of traits and behavior patterns:
1) the acting out, neurotic, intensely rebellious youth; 2) the emotionally distressed, passive, dependent adolescent; and 3) the deeply disturbed borderline or schizoid person who uses drugs for their hallucinogenic effects.

Problem-Oriented Medical Record

The symptom list employed in this study is part of the Initial Psychiatric Evaluation and Treatment Plan (Appendix A), which is to be filled out by the attending psychiatrist within 24 hours of a patient's admission. The symptom list made up one of the four components of the problem-oriented medical record utilized in this particular psychiatric hospital; the other three elements include the initial data base, progress notes, and the problem-oriented discharge summary. Since the progress notes are narrative reports, they were not used in this research, but the social history and psychological testing material, from the initial data base, and the discharge summary, were important sources of information.

For the purposes of the problem-oriented approach used here, the definition of "problem" given by Fowler and Longabaugh (1975) was invoked. They defined a problem as follows:

[A] dysfunction affecting the patient, perceived by the clinical staff (and usually the patient or others meaningful to him) as existing or being imminent, in one or more of the following areas: 1) physiological, including abnormal physical or laboratory findings as well as specific diseases; 2) psychological, as manifested by impaired cognition or feeling states, or both, including abnormal test or laboratory findings; and 3) social relationships or social functioning.
This definition takes into consideration the patient's as well as the clinician's perceptions of the patient's adjustment in various areas.

The advantages and disadvantages of the problem-oriented medical record are currently being debated in the psychiatric community, and preference for this or a more traditional approach seems to be based on the theoretical background of the critic. For example, Liston (1976) noted that the problem-oriented medical record is more appropriate for use in behavioral and psychobiological frameworks than in institutions weighted on the side of psychodynamic and analytic orientations. Fowler and Longabaugh (1975) maintained that the problem-oriented record can be criticized by those who favor working with the "whole patient" rather than with individual problems.

Klonoff and Cox (1975) recognized that the problem-oriented system has the potential of delineating specific issues, but they faulted their seven-category list (inappropriate thought content, interpersonal problems, affective problems, somatic complaints, socio-economic problems, alcohol and/or drug abuse, and self-control) on five counts. They claimed that 1) diagnosis and problem formulation sometimes seem disjointed; 2) patients and staff sometimes disagree on statements of problems and goals; 3) some treatment approaches are less specific than others (e.g., milieu versus reinforcement); 4) total resolution of problems is rare; and 5) follow-up is not included in the approach.
Proponents of the problem-oriented record, such as Draper (1975) and Katz and Woolley (1975), cited several advantages of the system. Problems are identified in semantically clear, behavioral terms, allowing for briefer notes, more concise documentation, communication and integration among staff members, and integration of problems with the treatment plan. Up-to-date information, from which hypotheses about the patient can be developed and tested, is provided. In addition, the problem-oriented medical record is seen as an accurate document which can be used for program evaluation, research, and legal purposes.

Sehdev (1974) viewed the problem-oriented medical record as reflecting a holistic attitude toward patient care, as emphasizing the team approach, and providing clear treatment guidelines for the staff.

Predictions

In light of the above literature findings and the clinical observations of the author, the following hypotheses regarding psychiatrically hospitalized adolescents are offered in the current investigation:

1. There are proportionately more male adolescents from broken homes than female adolescents from broken homes.

2. Adolescents from broken homes appear to be more aggressive, both toward others and toward themselves. Thus, adolescents from broken homes exhibit more Suicidal ideation, threats, or acts, Homicidal ideation, threats, or acts, Uncontrollable destructive acts; and Anxiety
or depression that interferes significantly with daily activities, than adolescents from intact homes. On the other hand, adolescents from intact homes appear to be more withdrawn and submissive, resulting in the hypothesis that adolescents from intact homes exhibit more inability to make day-to-day decisions on an independent basis, and withdrawal from environment, than adolescents from broken homes.

3. Separation experiences seem to be related to the development of depressed affect. As a result, adolescents from broken homes are more likely to be diagnosed as Major Affective Disorder, Other, than adolescents from intact homes.

4. McNeal (1973) found that, while school performances suffered in children from broken homes, standardized achievement test scores did not differ in terms of the type of home from which the child came. This led to the null hypothesis that adolescents from broken homes do not have significantly different verbal IQ scores than adolescents from intact homes.

5. Male adolescents from broken homes exhibit more uncontrolable destructive acts, compared to female adolescents from broken homes.

6. Overall progress ratings in adolescents from broken homes are better than overall progress ratings in adolescents from intact homes.

7. The age at which a child is separated from a parent has been noted as a critical variable. Adolescents separated from a parent
at age six or earlier exhibit more Inability to make day-to-day decisions on an independent basis, Delusions, Suicidal ideation, threats, or acts, and Anxiety or depression that interferes significantly with daily activities, than adolescents separated from a parent at age seven or later.

8. Adolescents separated from a parent at age six or before exhibit more Anxiety or depression that interferes significantly with daily activities, than all other adolescents.

9. Among adolescents who were separated from a parent, this separation is more likely to have occurred when the adolescent was 4 to 6 years old or 13 to 15 years old than when he was 1 to 3, 7 to 9, or 10 to 12 years old.

10. Male adolescents who were separated from their fathers exhibit more Uncontrollable destructive acts than all other adolescents.

11. Overall progress ratings in male adolescents separated from a parent at age seven or later and in female adolescents separated from a parent at age six or earlier are better, compared to the overall progress ratings for male adolescents separated from a parent at age six or earlier and for female adolescents separated from a parent at age seven or later.

12. Birth order and sex of siblings have been found to be related to the development of psychopathology, and this concept resulted in four hypotheses regarding psychiatrically hospitalized adolescents.
In sibships of three, firstborn or secondborn subjects outnumber last-born subjects.

13. In sibships of two, female subjects are more likely to be secondborn than firstborn.

14. In sibships of two, firstborn subjects are more likely to have opposite sex siblings than same sex siblings.

15. In sibships of two, secondborn subjects are more likely to have same sex siblings than opposite sex siblings.

16. The problems with the best progress ratings for all adolescents are Suicidal ideation, threats, or acts, Homicidal ideation, threats, or acts, and Uncontrollable destructive acts.

17. Suicidal ideation, threats, or acts, Uncontrollable destructive acts, Anxiety or depression that interferes significantly with daily activities, and Mood swings that interfere significantly with daily activities, are more common in adolescents diagnosed as Major Affective Disorder, Other, than in adolescents with other diagnoses. Repeated grandiose decisions and behavior, Inability to make day-to-day decisions on an independent basis; and disordered or irrational thinking, are less common in adolescents diagnosed as Major Affective Disorder, Other, than in adolescents with other diagnoses.

18. Adolescents diagnosed as Major Affective Disorder, Other, do not have significantly different verbal IQ scores from adolescents with other diagnoses.
19. Finally, overall progress ratings in adolescents diagnosed as Major Affective Disorder, Other, are better than overall progress ratings in adolescents with other diagnoses.
Subjects

The subjects were 59 adolescents (26 males, 33 females) between the ages of 13 years, 4 months, and 18 years, 8 months, at time of admission to an adolescent psychiatric inpatient unit at Riveredge Hospital in Forest Park, Illinois. The subjects were admitted between August 10, 1977, and January 24, 1978, and were discharged between September 2, 1977, and March 12, 1978. The criteria for inclusion in this study were admission to an adolescent unit at the hospital under the care of Associates in Adolescent Psychiatry on or following August 10, 1977, and discharge from the hospital on or before March 12, 1978. The length of stay in the hospital ranged from 3 days to 127 days.

The subjects were referred for psychiatric hospitalization by a number of sources and for a variety of reasons. The referral sources included other professionals in the mental health field, social agencies, the court system, schools, and parents. The reasons for admission for each subject varied, but typically involved home and school maladjustment, negative peer group, dangerous behavior, suicidal ideation and/or attempts, withdrawal from the environment, drug abuse, etc.
Materials

File data were obtained for all subjects from the following documents: Admission Sheet, Initial Psychiatric Evaluation and Treatment Plan (Appendix A), Social History, Psychological Evaluation, and Discharge Progress Note (Appendix B).

The following data were obtained from the Admission Sheet: sex, age, and religion. The data on this form were compiled by the admitting clerk on the basis of information given by the patient and/or the person who accompanied him to the hospital.

The Initial Psychiatric Evaluation and Treatment Plan listed diagnosis and symptoms. This form was filled out by the attending psychiatrist within 24 hours of admission. Hospital policy required that the attending psychiatrist check off at least three symptoms on which mental health counselors could chart for each patient. The attending psychiatrists chose symptom areas they felt were most relevant to each patient, to facilitate charting, as mental health counselors were required to chart on at least one symptom per day and each symptom at least once a week.

The Social History, written by members of the hospital social work staff, usually was based on information obtained from the parents of an adolescent patient within approximately two weeks of admission. The Social History and Initial Psychiatric Evaluation and Treatment Plan were used in conjunction with one another to determine number, sex and age of immediate siblings and stepsiblings, parental marital situation and, for
subjects from broken homes, the parent with whom the subject lived, the age at which the parent and subject were separated, which if either parent remarried, and the age of the subject at the time of the remarriage.

The Psychological Evaluation was conducted by a registered clinical psychologist, typically within one month of admission. Because some subjects were discharged before this psychological evaluation took place, verbal IQ data was not available for five subjects.

Finally, the Discharge Progress Note, which was written by the attending psychiatrist within 24 hours after discharge, yielded information regarding length of stay in the hospital, a rating of overall progress, and degree of progress on each symptom checked on the Initial Psychiatric Evaluation and Treatment Plan.

Procedure

The author of this study conducted all the data gathering activities and assigned an identification number to each subject. Throughout the data analysis, all subjects were referred to by their identification numbers in order to insure confidentiality. Since the data were archival, there was no stress or threat to the subjects.

Data Analysis

Hypotheses involving continuous variables, such as verbal IQ scores, were investigated with the $t$ test. The $t$ test was also used to compare subjects on the basis of types of symptoms. When two groups of symptoms were being contrasted, each subject received a score based on
the proportion of his symptoms to the total symptoms being considered. Those hypotheses which compared the subject sample to the general population on two categories of a variable, such as birth order, were tested with the binominal test. The \( \chi^2 \) test was used to test hypotheses involving two levels of two categorical variables, such as the hypothesis concerning subject's sex and type of home. Finally, the Mann-Whitney \( U \) was employed to test the hypotheses involving two groups of subjects and serial order categorical variables.
RESULTS

The data analysis provided descriptive and inferential statistics regarding the demographic, familial, diagnostic and progress characteristics of the sample. Data were collected for 59 subjects, 33 (56%) of whom were female, and 26 (44%) of whom were male.

Table 1 summarizes the information concerning the relationships among verbal IQ score, sex, and age of the subjects.

The ages of the female subjects ranged from 13 years, 6 months, to 17 years, 10 months; for the males from 13 years, 4 months, to 18 years, 8 months; and for the total sample from 13 years, 4 months, to 18 years, 8 months. The mean age for the females was 16 years, 2 months; for the males 15 years, 11 months; and for the total sample 16 years, 1 month (median = 16 years, 2 months; \( \text{SD} = 14.778 \)).

Verbal IQ data were available for 54 of the 59 subjects. The five subjects for whom this information was unavailable were discharged before psychological testing could be conducted. The verbal IQ scores ranged from 79 to 136 for the females; from 69 to 124 for the males; and from 69 to 136 for the total sample. Mean verbal IQ for the female subjects was 96.38, for the males 99.84, and for the total sample 97.98 (median = 98, \( \text{SD} = 13.451 \)).
### Table 1

Relationships Among Verbal IQ Scores, Sex, and Age

<table>
<thead>
<tr>
<th>IQ</th>
<th>Border-line 66-79</th>
<th>Dull Normal 80-90</th>
<th>Average 91-110</th>
<th>Bright Normal 111-119</th>
<th>Superior 120-127</th>
<th>Very Superior 128+</th>
<th>Female X Age Totals</th>
<th>Male X Age Totals</th>
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One female subject's verbal IQ score was in the Borderline range of intelligence, 11 females in the Dull Normal range, 12 in the Average range, 2 Bright Normal, 1 Superior, and 1 female in the Very Superior range of intelligence. For males, there was 1 subject with Borderline, 6 Dull Normal, 11 Average, 5 Bright Normal, and 1 with Superior intelligence. For the total sample, 2 subjects had Borderline verbal IQ scores, 17 Dull Normal, 23 Average, 7 Bright Normal, 2 Superior, and 1 Very Superior levels of intelligence.

Religious data were also collected on these subjects. The breakdown by stated religion was as follows: 29 Catholic, 7 Protestant, 5 Jewish, 5 Lutheran, 4 no religion, 3 Baptist, 1 Christian, 1 Episcopalian, 1 Greek Orthodox, 1 Methodist, 1 Seventh Day Adventist, and 1 Unitarian.

Figure 1 is a compilation of the data on sex and number of immediate siblings. The term "immediate siblings" was operationally defined as the children with the same natural or adopted mother and father. The number of immediate siblings of the subjects ranged from 0 to 11 for female subjects, from 0 to 6 for male subjects, and from 0 to 11 for total subjects. Mean number of immediate siblings for females was 2.18, for males was 2.38, and for total subjects was 2.27 (median = 2.125, $\text{SD} = 1.799$).

Figure 2 shows the number of total siblings (immediate plus step-siblings) for female and male subjects. The number of total siblings of the subjects ranged from 0 to 11 for female subjects, from 0 to 7 for male
Figure 1. Number of subjects per number of immediate siblings.
Figure 2. Number of subjects per number of total siblings.
subjects, and from 0 to 11 for total subjects. The mean number of total siblings for females was 2.636, for males was 2.769, and for total subjects was 2.695 (median = 2.393, SD = 1.959).

Figure 3 depicts the relationship between sex and birth order within the immediate sibship. There were 7 subjects who were only children, 17 subjects were firstborn, 20 were middle children, and 15 were lastborn children. Of the only children, 4 were females and 3 males. There were 9 female and 8 male firstborn subjects, 10 female and 10 male middleborn subjects, and 10 female and 5 male lastborn subjects.

Figure 4 illustrates birth order within the total sibship for females and males. Within the total sibship, 4 subjects were only children, 17 subjects were firstborn, 22 were middle children, and 16 were lastborn children. Of the only children, 3 were females and 1 was male. There were 10 female and 7 male firstborn subjects, 10 female and 12 male middleborn subjects, and 10 female and 6 male lastborn subjects.

Subjects can also be differentiated on the basis of their diagnosis, as shown in Table 2, which combines number of symptoms, sex, and diagnosis.

There were 30 (18 female, 12 male) subjects diagnosed as Major Affective Disorder, Other; 20 (12 female, 8 male) diagnosed as Schizophrenia, Latent Type; 5 (2 female, 3 male) Schizophrenia, Paranoid Type; 2 (1 female, 1 male) Schizophrenia, Acute Type; and 2 (male) Psychosis with Drug or Poison Intoxication.
Figure 3. Number of subjects per birth position in immediate sibship.
Figure 4. Number of subjects per birth position in total sibship.
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</tr>
<tr>
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<td>13</td>
<td>14</td>
<td>10</td>
<td>1</td>
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<tr>
<td>Number of Symptoms Totals</td>
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<td>24</td>
<td>3</td>
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<td>Total Subjects</td>
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</table>
The number of symptoms assigned to each subject ranged from 3 to 6, with the mean being 3.559 (median = 3.452, SD = .676). Female subjects averaged 3.727 symptoms, while males averaged 3.654 symptoms.

By sex and diagnosis, female subjects diagnosed as Major Affective Disorder, Other, averaged 3.44 symptoms; male subjects diagnosed Major Affective Disorder, Other, averaged 3.417 symptoms; female Schizophrenia, Latent Type, 3.583; male Schizophrenia, Latent Type, 3.5; female Schizophrenia, Acute Type, 3.0; male Schizophrenia, Acute Type, 4.0; female Schizophrenia, Paranoid Type, 3.5; male Schizophrenia, Paranoid Type, 4.667; and male Psychosis with Drug or Poison Intoxication, 4.0 symptoms.

Table 3 summarizes number of symptoms, sex, and age. Female 13 year old subjects averaged 3.0 symptoms; 13 year old males averaged 3.333 symptoms; 14 year old females averaged 3.4; 14 year old males 3.0; 15 year old females 3.4; 15 year old males 3.667; 16 year old females 3.467; 16 year old males 3.75; 17 year old females 3.714; 17 year old males 4.0; and 18 year old males averaged 3.667 symptoms.

Regarding the parental marital situation of the subjects, 35 subjects came from families in which the natural or adopted parents were married to one another, 2 from families in which the father was widowed, 19 in which the parents were divorced, and 3 in which the mother never married the father of the subject. Each of these categories can be broken down further.
Table 3
Relationships Among Number of Symptoms, Sex, and Age

<table>
<thead>
<tr>
<th>Number of Symptoms</th>
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<th>Male X Age Totals</th>
<th>Age Totals</th>
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<td>F M</td>
<td>F M</td>
<td>F M</td>
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<td></td>
</tr>
<tr>
<td>Age</td>
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<td>1</td>
<td>0</td>
<td>15</td>
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<td>17 years</td>
<td>2</td>
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<td>5</td>
<td>1</td>
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<td>1</td>
<td>7</td>
</tr>
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<table>
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</thead>
<tbody>
<tr>
<td>Number of Symptoms Totals</td>
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<td>24</td>
<td>3</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Subjects: 59
Of the subjects from married families, 29 were families in which the natural parents were married to one another, and 6 were families in which the adopted parents were married to one another. Both subjects from widowed families had deceased mothers but only one father had remarried. In the divorced families, 7 subjects came from families in which neither parent had remarried and the subject lived with the mother; 5 from families in which only the mother had remarried and the subject lived with the mother; 1 from a family in which only the father had remarried but the subject lived with the mother; 2 from families in which only the father had remarried and the subject lived with the father; 2 from families in which both parents had remarried and the subject lived with the mother; 1 from a family in which both parents had remarried and the subject lived with the father; and 1 from a family in which the adopted parents were divorced and the subject lived with the adopted father. One of the 3 subjects from a home in which the mother never married the father had a mother who subsequently married another man, while the 2 other mothers remained single.

Figure 5 shows that, of the 21 (36% of the total sample) subjects who were separated from a parent, 13 (62%) were female and 8 (38%) were male. The ages at separation from a parent ranged from one year to 14 years for female subjects, 1 year to 15 years for male subjects, and 1 year to 15 years for total subjects separated from a parent. The mean age at separation was 8.615 for female subjects, 7.875 for male
Figure 5. Number of subjects per age at separation from parent.
subjects, and 8.333 (median = 9.875, SD = 4.564) for all subjects separated from a parent.

As shown in Figure 6, subjects who experienced the remarriage of a parent numbered 15 (10 female, 5 male), or 25% of the total sample. The mean age of the female subjects at the time of the remarriage was 9.0 years, 10.2 years for the male subjects, and 9.4 years for the total subjects (median = 11.667, SD = 4.501).

The length of stay of the female subjects ranged from 3 to 127 days, from 3 to 119 days for the male subjects, and from 3 to 127 days for the total number of subjects. The mean length of stay was 72.879 for the female subjects, 55.577 for the male subjects, and 65.254 days (median = 63, SD = 35.944) for all the subjects. Table 4 shows length of stay in relationship to number of symptoms and sex, and Table 5 shows the relationships among length of stay, overall progress rating, and diagnosis.

With regard to the symptom checklist, Disordered or irrational thinking was the most commonly indicated symptom for all subjects. For female subjects, the most common symptom was Disordered or irrational thinking, and for male subjects the two most common symptoms were Disordered or irrational thinking and Anxiety or depression that interferes significantly with daily activities.

By age, the most common symptoms were as follows: Inability to make day-to-day decisions on an independent basis and Anxiety or depression that interferes significantly with daily activities were
Figure 6. Number of subjects per age at first remarriage of parent.
### Table 4
Relationships Among Number of Symptoms, Sex, and Length of Stay

<table>
<thead>
<tr>
<th>Number of Symptoms</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>Female X Length of Stay Totals</th>
<th>Male X Length of Stay Totals</th>
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</tr>
</thead>
<tbody>
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<td>Sex</td>
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<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
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<td>Length of Stay (days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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Sex Totals

33 26
Table 4 (Cont.)

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Total Subjects: 59
Table 5
Relationships Among Overall Progress Rating, Diagnosis, and Length of Stay

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<th>Moderately Improved</th>
<th>Somewhat Improved</th>
<th>Unimproved</th>
<th>Length of Stay (days)</th>
<th>Diagnosis A* X Length of Stay Totals</th>
<th>Diagnosis B* X Length of Stay Totals</th>
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<td>B*</td>
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Table 5 (Cont.)

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<td>6</td>
<td>11</td>
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</tr>
<tr>
<td>B*</td>
<td>Somewhat Improved</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>B*</td>
<td>Unimproved</td>
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</tr>
</tbody>
</table>

Total Subjects: 59

*Diagnosis A = Major Affective Disorder, Other
Diagnosis B = Any diagnosis except Major Affective Disorder, Other
most common among 13 year olds, Anxiety or depression that interferes significantly with daily activities among 14 year olds, Disordered or irrational thinking among 15 and 16 year olds, and Disordered or irrational thinking and Anxiety or depression that interferes significantly with daily activities among 17 and 18 year old subjects.

The results of the tests of significance of the various hypotheses are listed below. Unless otherwise indicated for the non-significant findings, the data fall in the hypothesized directions but the null hypotheses could not be rejected statistically. For the purposes of the statistical tests which compared subjects from broken homes to those from intact homes, broken homes were operationally defined as those families in which the natural or adopted parents were widowed, divorced or never married, and intact homes were operationally defined as those families in which the natural or adopted parents were married to one another.

1. There was no significant difference ($\chi^2 = .705, df = 3, p > .05$) between the proportion of male and female subjects from broken versus intact homes.

2. There were no adolescents with the symptom of Homicidal ideation, threats or acts; therefore, that symptom was left out of this analysis. Adolescents from broken homes exhibited significantly more ($t = 3.246, df = 57, p < .002$) Suicidal ideation, threats or acts; Uncontrollable destructive acts, and Anxiety or depression that interferes
significantly with daily activities than adolescents from intact homes, while adolescents from intact homes exhibited significantly more Inability to make day-to-day decisions on an independent basis and Withdrawal from environment than adolescents from broken homes.

3. There was no significant difference ($\chi^2 = 4.968$, $df = 3$, $p > .05$) in the proportion of diagnosis of Major Affective Disorder, Other, in adolescents from broken and intact homes. In fact, the findings were about as evenly split as possible.

4. Subjects from broken homes did not have significantly different ($t = 1.947$, $df = 52$, $p > .05$) verbal IQ scores in comparison to subjects from intact homes.

5. Male adolescents from broken homes do not exhibit significantly more ($t = .939$, $df = 22$, $p > .05$) Uncontrollable destructive acts than females from broken homes. In fact, the data were in the opposite direction, with females from broken homes exhibiting more Uncontrollable destructive acts, but the difference was not significant.

6. Overall progress ratings of adolescents from broken and intact homes were not significantly different ($z = .995$, $p > .05$).

7. Subjects who were separated from a parent either before or after age six did not differ significantly ($t = .864$, $df = 18$, $p > .05$) in the extent to which they were characterized by Inability to make day-to-day decisions on an independent basis, Suicidal ideation, threats or
acts, and Anxiety or depression that interferes significantly with daily activities.

8. Subjects who were separated from a parent at age six or earlier did not differ significantly ($t = .983, \text{df} = 57, p > .05$) from all the other subjects in the number of times Anxiety or depression that interferes significantly with daily activities was listed as a symptom.

9. The distribution of ages at which separation from a parent occurred in the sample was not significantly different from chance.

10. Males separated from their fathers did not differ significantly ($t = .456, \text{df} = 57, p > .05$) from other subjects in the number of times Uncontrollable destructive acts was listed as a symptom.

11. Overall progress ratings did not differ significantly ($z = .0115, p > .05$) for females separated at age six or earlier and males separated at age seven or later, compared to females separated at age seven or later and males separated at age six or earlier.

12. The distribution of firstborn, middleborn, and lastborn subjects in sibships of three was not significantly different from that expected by chance.

13. The distribution of female firstborn and secondborn subjects in sibships of two also was not significantly different from chance expectations.

14. The distribution of same and opposite sex siblings of first-born subjects in sibships of two was not significantly different from
chance. In fact, the results were in the opposite direction from that hypothesized.

15. The distribution of same and opposite sex siblings of second-born subjects in sibships of two was not significantly different from chance. The results were in the opposite direction from that hypothesized.

16. There were no adolescents with the symptom of Homicidal ideation, threats or acts. Therefore, that symptom was left out of this analysis. Suicidal ideation, threats or acts, and Uncontrollable destructive acts received significantly poorer ($z = 2.287, p < .05$) progress ratings than all other symptoms. While this is a significant result, it is in the opposite direction from that predicted.

17. Subjects diagnosed as Major Affective Disorder, Other, did not differ significantly ($t = .844, df = 57, p > .05$) from subjects with other diagnoses in the extent to which they were characterized by Suicidal ideation, threats or acts, Uncontrollable destructive acts, Anxiety or depression that interferes significantly with daily activities, and Mood swings that interfere significantly with daily activities, on the one hand, or by Repeated grandiose decisions and behavior, Inability to make day-to-day decisions on an independent basis, and Disordered or irrational thinking, on the other hand.

18. As hypothesized, adolescents diagnosed Major Affective Disorder, Other, did not have significantly different ($t = .403, df = 57, p > .05$) verbal IQ scores, compared to adolescents with other diagnoses.
19. Finally, overall progress ratings in Major Affective Disorder, Other, adolescents were not significantly better ($z = .963, p > .05$) than overall progress ratings of adolescents with other diagnoses.

The post hoc analyses which were conducted revealed the following findings. Subjects from broken versus intact homes did not differ significantly in their lengths of stay ($t = .404, df = 57, p > .05$). Sets of symptoms - Suicidal ideation, threats, or acts, Uncontrollable destructive acts, and Anxiety or depression that interferes significantly with daily activities, versus Inability to make day-to-day decisions on an independent basis, and Withdrawal from environment - could not be significantly differentiated ($t = .379, df = 57, p > .05$) on the basis of short ($\leq 59$ days) versus long ($> 59$ days) lengths of stay in the hospital. Subjects with Suicidal ideation, threats or acts, and/or Uncontrollable destructive acts, did not differ significantly ($t = 1.191, df = 57, p > .05$) from subjects without those two symptoms in their lengths of stay. Subjects with the diagnosis of Major Affective Disorder, Other, did not differ significantly ($t = 1.584, df = 57, p > .05$) in their lengths of stay from subjects with other diagnoses. However, subjects with good - Recovered, Markedly Improved, or Moderately Improved - overall progress ratings tended significantly ($t = 3.129, df = 57, p < .01$) to have longer lengths of stay than subjects with poor - Slightly Improved or Unimproved - overall progress ratings. Females and males differed in their overall progress
ratings ($z = 1.809, p < .10$), with the trend being for females to improve more than males. In addition, female subjects exhibited a trend ($t = 1.886, df = 57, p < .10$) of longer lengths of stay in the hospital.
DISCUSSION

The purpose of this thesis was to determine some of the variables influencing the presence and resolution of various symptoms in psychiatrically hospitalized adolescents. In particular, the role of demographic variables, such as age, sex and verbal IQ score, in differentiating the symptoms, diagnoses and progress of psychiatrically hospitalized adolescents was examined. Also, it was hypothesized that the type of home environment in which a psychiatrically hospitalized adolescent was raised affects the symptoms he has developed as well as his diagnosis and ability to progress, given appropriate treatment. This study actually served to clarify which factors are the relevant ones and which specific effects they have on this kind of adolescent.

Examination of the demographic characteristics of the sample revealed that both sexes, all the teen years, a wide range of verbal IQ scores, and several religions were represented. Thus, the range of the psychiatrically hospitalized sample did not differ from what would be expected in a typical adolescent population. However, the distributions of these variables may differ from the general population and therefore the findings may be generalized to psychiatrically hospitalized adolescents rather than to all adolescents.
The issue of generality of results from the proposed study was indirectly addressed by Langner, Gersten, Greene, Eisenberg, Herson and McCarthy (1974), who pointed out that, of a sample of Manhattan families of children who needed psychiatric treatment, families which actually referred their children were colder, less punitive and of higher social status. The present study assesses the incidence of few variables in the general population, and therefore the results are generally reflective of psychiatrically hospitalized adolescents and their families rather than adolescents in general.

That the results may be generalized beyond the particular adolescent treatment program employed here is reflected in Lucero and Vail's (1970) discovery that, at two-year follow-up, although there were differences in the effectiveness of traditional (adults and adolescents on the same ward and receiving the same treatment), isolated (adults and adolescents on different wards and receiving different treatment), and integrated (adults and adolescents on the same wards but receiving different treatment) psychiatric hospitalization programs, all three types of programs were judged to be "doing a good job in treating adolescents."

The current study revealed that equal proportions of female and male psychiatrically hospitalized adolescents come from broken and intact homes (Hypothesis 1). Adolescents of either sex do not appear to be differentially affected by the intactness of their parents' marriages. Among psychiatrically hospitalized adolescents, females
are just as likely as males to come from intact homes, and, vice versa, males are just as likely as females to have been raised in broken homes. In addition, the type of family situation in which a psychiatrically hospitalized adolescent was involved prior to hospitalization cannot be predicted on the basis of the sex of the patient.

It should be noted that this non-significant finding does not indicate that adolescents in general are unaffected by the intactness of their home situations. Rather, psychiatrically hospitalized female and male adolescents are not differentially affected by a broken or intact home. Perhaps adolescence is a stage during which the developmental problems of the two sexes are similar and therefore any differences in the degree of response to the home situation may be masked. Both females and males at this age must deal with several other development issues, such as bodily changes, establishment of one's identity, involvement in intimate peer relationships, etc. Both females and males are developing physically, especially sexually, during adolescence. Both sexes are attempting to try out new roles in order to find a unique, suitable identity, and they often act this out in becoming involved in intense but fickle relationships with the opposite sex. The facts that these conflicts are intense ones and that they affect both females and males, may influence the lack of difference between females and males in their responsiveness to the stability or disruptiveness in the parents' marital situations. As will be
discussed later, while psychiatrically hospitalized female and male adolescents cannot be differentiated on the basis of the intactness of their homes; the types of symptoms they develop are influenced by their home situations (Hypothesis 2).

A closer analysis of the psychiatrically hospitalized adolescents from broken homes showed that a particular symptom, Uncontrollable destructive acts, also was not more common in one sex than the other (Hypothesis 5). Cultural sex role stereotypes would suggest that this particular symptom would be more common in males than in females. However, at least among psychiatrically hospitalized adolescents, this does not seem to be the case. The explanation for this phenomenon is not clear, and further research is needed in order to clarify the relevant factors. A 2 X 2 design, with female and male, psychiatrically hospitalized and non-psychiatrically hospitalized, adolescents would enable the main effects of sex and of psychiatric hospitalization, as well as any interaction between the two, to be discovered.

Psychiatrically hospitalized female adolescent patients showed a slight tendency to receive better overall progress ratings than male adolescent patients. This probably was due to the tendency for females to remain in the hospital for longer periods of time than did the males, thus enabling the females to benefit more from psychiatric treatment. Other possibilities exist to explain this phenomenon. If females in the general population are more likely to be labeled as
disturbed, then the females in this sample may not have been as severely
disturbed as the males. The females' conditions may have been acute
rather than chronic. Further investigation of these trends would be
enlightening.

The null hypotheses which were made concerning verbal IQ score
and type of home (Hypothesis 4), and verbal IQ score and diagnosis (Hypo-
thesis 18), were not rejected. Verbal IQ of psychiatrically hospitalized
adolescents does not differentiate the type of home - broken versus intact -
in which they were raised. Thus, the family backgrounds of psychi-
atrically hospitalized adolescents do not vary in terms of their verbal IQ
scores. This supports the literature (McNeal, 1973) previously cited
which found no difference in standardized achievement test scores of
adolescents from broken and intact homes. The results contradict the
literature statements that drug abuse (Timms, Carney and Stevenson,
1973) and schizophrenia (Roff, 1974) are associated with low intelligence.
The mean verbal IQ scores for all groups were well within the Average
range, and adolescents diagnosed as Major Affective Disorder, Other,
could not be differentiated from adolescents with other diagnoses on
the basis of their verbal IQ scores. It may be, as McNeal (1973) found,
that adolescents from broken homes exhibit lowered intellectual per-
formances in applied settings, but their potential intellectual capacity
does not seem to be impaired. It would be enlightening to determine
whether the same is true of adolescents with varying diagnoses;
while their potential does not seem to be lowered, their application of this potential may be decreased.

Four hypotheses (12, 13, 14, 15) suggested that psychiatrically hospitalized adolescents differ from the general population of adolescents in the distribution of the number and sex of their siblings. None of the null hypotheses could be rejected on the basis of the current findings. In sibships of three, there is no difference in the likelihood that psychiatrically hospitalized adolescents will occupy the first, middle or last birth position (Hypothesis 12). Similarly, in sibships of two, psychiatrically hospitalized adolescents are as likely to be firstborn as second-born (Hypothesis 13); and opposite sex and same sex siblings are equally likely for firstborn and secondborn psychiatrically hospitalized adolescents (Hypotheses 14 and 15). Therefore, family constellation is helpful in discriminating neither between psychiatrically hospitalized adolescents and the general population of adolescents, nor between various groups of psychiatrically hospitalized adolescents. These results do not refute the concept that particular problems accompany particular birth positions and family constellations. The oldest child may feel he is often given responsibilities for which he is not ready; the middle child may feel ignored and forgotten; the youngest child may be spoiled and pampered; the only child may be overindulged or left without peer emotional support. It seems that the problems of each birth position and the various constellations are equally severe. A much
larger group of subjects would be needed to determine whether and which specific symptoms and diagnoses are related to the family constellation variables.

The hypothesis (2) that psychiatically hospitalized adolescents from broken homes exhibit more aggressive symptoms, such as Homicidal ideation, threats or acts, Suicidal ideation, threats or acts, Uncontrollable destructive acts, and Anxiety or depression that interferes significantly with daily activities, while psychiatically hospitalized adolescents from intact homes exhibit more submissive symptoms, such as Inability to make day-to-day decisions on an independent basis, and Withdrawal from environment, was given support in this research. Psychiatically hospitalized adolescents from broken homes seem to be more able to externalize their difficulties, while those from intact homes appear to internalize their problems. Perhaps psychiatically hospitalized adolescents from broken homes feel less controlled because one of their parents is missing and therefore are less fearful of being punished for their inappropriate or dangerous behavior than are such adolescents from intact homes. Those from broken homes may have less opportunity to identify with a parent in a positive way to integrate their own controls over their behavior. Psychiatically hospitalized adolescents from broken homes may act out more because they are angry at the missing parent for leaving, believe that is the reason for their unhappiness, and therefore attempt to strike out at him, while those from intact homes may be angry at themselves,
see themselves as the root of their difficulties, and focus more on themselves.

While the types of symptoms exhibited by the adolescents from the two types of homes varied, their overall progress ratings did not (Hypothesis 6). This attests to the flexibility of the treatment plans implemented in this inpatient program and the ability of adolescents from various backgrounds to benefit from the treatment program. While all the adolescents participated in basically the same types of treatments - individual, group, family and milieu - the emphases and the content for each patient differed.

The subjects from broken and intact homes also did not differ in their diagnoses (Hypothesis 3). While parent-child separation has been found in the literature to relate to depression in adolescents (Caplan and Douglas, 1969; Bowlby, 1970), this was not found to be true in the current investigation. Several reasons probably contributed to this end. First, parent-child separation is not the only factor which causes depression in adolescence. The loss of childhood is also a grief-evoking event, as are other pressures of adolescence - peer relationships, academic stresses, etc. Second, it may be that these adolescents from broken homes experienced depression when the separation from the parent first occurred but have since resolved or at least masked it through other resources which have been available to them over the years - relatives, friends, school, etc. Third, disturbed adolescents may not necessarily


exhibit the adult symptomatology of depression, and therefore the diagnoses may not be valid.

Adolescence is well recognized as a separate life stage from childhood and adulthood, but there are few diagnostic categories which are well suited to psychiatrically hospitalized adolescents. Adjustment Reaction of Adolescence is one diagnostic category which is specific to this particular stage, but it does not reflect the severity of psychopathology in psychiatrically hospitalized adolescents. Many of these adolescents exhibit symptoms which overlap several diagnostic categories. They often seem to be borderline individuals who function at neurotic, character disorder, and psychotic levels, in various areas of their lives and at different points in time.

Over half the adolescent patients in this study were diagnosed Major Affective Disorder, Other, but there is disagreement in the literature over whether depression even exists in adolescence. Rie (1967) claims that emotions such as despair and hopelessness are impossible in the young person because he is incapable of conceptualizing "self". Rochlin (1959) also stated that "clinical depression, a superego phenomenon, as we psychoanalytically understand the disorder, does not occur in childhood." Yet, Toolan (1962) disagrees, asserting that depression exists in adolescents, although it is manifested differently from adult depression.

Admittedly, adolescents are difficult patients to diagnose
because they have not exhibited symptoms for long periods of time and because adolescence itself is considered by many clinicians to be a psychopathological time of life. Clearly, though, revision of the diagnostic categories to accommodate this type of adolescent would be preferred.

Regarding separation from a parent, this experiment showed that male psychiatrically hospitalized adolescents separated from their fathers are not more violent, i.e., do not exhibit more Uncontrollable destructive acts than those females and males not separated from their fathers (Hypothesis 10). The father's controlling influence over his sons does not appear to be as strong as cultural sex role stereotypes would suggest. This discovery, as well as the lack of difference between psychiatrically hospitalized females and males in their exhibition of Uncontrollable destructive acts (Hypothesis 5), leads to the conclusion that violent behavior probably is determined by some other variable beyond sex or type of home situation. Perhaps violent behavior is caused by more intrapsychic events, such as low self-esteem against which the adolescent defends through reaction formation and projection. The number of rival hypotheses is great, and an exploratory investigation into this particular symptom is warranted, especially considering the severity of its consequences. Adolescents who exhibit this particular symptom in varying degrees, including
vandalism, etc., and in different settings, might be studied, in order to determine the relevant variables.

The age at which a child is separated from a parent was noted as a critical variable by several authors (Bowlby, Ainsworth, Boston and Rosenbluth, 1956; Masterson, 1971) who stated that severe results may occur if the child is separated from a parent during critical developmental periods. While this was not specifically addressed, the results did indicate that early versus late separation does not differentiate the types of symptoms exhibited by psychiatrically hospitalized adolescents (Hypotheses 7 and 8). Separation from a parent may have a deleterious effect on development, as those authors claim, but if the effect exists, it is a global one. In addition, even when the age at separation categories were broken down more finely, the distribution still was not different from that which would be expected by chance in the normal population, so that the numbers of psychiatrically hospitalized and normal adolescents separated from a parent at various ages are not different from one another (Hypothesis 9). Separation from a parent at a particular age does not appear to lead to psychiatric hospitalization. Overall progress ratings of female and male psychiatrically hospitalized adolescents separated at various ages also could not be differentiated (Hypothesis 11).

With respect to diagnosis, it was found that symptoms of psychiatrically hospitalized adolescents could not be differentiated on the
basis of diagnosis (Hypothesis 17). The explanation for this most likely relates to the previously discussed unsuitability of the current diagnostic categories for adolescents.

Adolescents with varying diagnoses do not progress in different degrees, as shown in this research (Hypothesis 19). The explanation for this is probably to be found in the treatment programs employed with the adolescents, which, as stated, were structured in terms of monitoring the adolescent's behavior but were flexible in terms of resolving the dynamics behind the adolescent's symptoms.

The symptoms of Suicidal ideation, threats, or acts, and Uncontrollable destructive acts, tend to receive the poorest progress ratings of all the symptoms (Hypothesis 16). Perhaps this is due to the severity of these symptoms, i.e., they are dangerous and life threatening rather than merely unhealthy or not growthful. Because these symptoms are so severe, they may be very deep seated and difficult to resolve in a short-term hospitalization.

With regard to length of stay in the hospital, there were no differences between psychiatrically hospitalized adolescents from broken and intact homes, with various sets of symptoms, and with differing diagnoses. Length of stay, appropriately, was related to overall progress ratings such that those patients with better progress ratings tended to have been hospitalized longer than those with poor improvement ratings. It seems that patients who remain in
treatment longer, progress more, which is an encouraging result for clinicians. In addition, those patients who remain hospitalized longer and progress more are, typically, the female patients. Further research as to the possibility of diminishing returns, though, might be conducted.

Several proposals for future investigations have already been mentioned in this section. Briefly, they include comparison of psychiatrically hospitalized and non-psychiatrically hospitalized females and males in their exhibition of violent behavior; exploration of the role of intrapsychic events in the exhibition of violent behavior; study of the effects of other diagnoses on IQ scores, both potential and applied; and the role of the family constellation in differentiating psychiatrically hospitalized adolescents from the general population and from one another. Replication of the current study in other settings with other treatment programs is definitely called for. Comparison of normal adolescents, non-psychiatrically hospitalized but disturbed adolescents, and psychiatrically hospitalized adolescents would be a fruitful endeavor, also. Adolescence is a relatively stressful period for the normal teen, and those pressures appear to push the disturbed adolescent to the need for hospitalization. Research into the strengths and resources available to non-psychiatrically hospitalized adolescents would be a significant aid. The effects on later adjustment of failing to receive
treatment in adolescence would be a fascinating research topic, even if somewhat difficult to conduct. The relationships among the factors in these kinds of research are quite complex and require a large number of subjects and probably the use of factor analytic techniques.

This study has begun the task of sorting the wheat from the chaff - the relevant from the inconsequential factors in differentiating adolescent psychiatric patients. While the type of home situation appears to influence the presence of particular symptoms, it is not useful in other tasks, such as diagnosis. Continued study will be required to further hone these findings.

The general picture of the typical psychiatrically hospitalized adolescent patient has been given more focus in this study. In general, the home environment and family constellation of the adolescent is of little predictive value, although there is a connection between aggressive symptoms and adolescents from broken homes, and between submissive symptoms and adolescents from intact homes. The sex of the patient affects the degree of progress, but not the kinds of symptoms. Separation from a parent also does not appear to affect these patients. Patients' symptoms which are more severe and life threatening improve the least. While these adolescents defy traditional diagnostic categories, they are characterized especially by loose, disorganized thought processes, feelings of anxiety and depression, and low self-esteem. The longer they remain in treatment, the better chance they
have of improving their conditions on discharge and, presumably, follow-up. The latter point is an important one in evaluating the effectiveness of treatment programs, which would be a worthwhile area to investigate in order to better meet the needs of adolescent patients.
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RIVEREDGE HOSPITAL
Initial Psychiatric Evaluation & Treatment Plan

PROVISIONAL DIAGNOSIS

PROBLEM LIST:

- Manic speech pattern  
- Excessive motor activity  
- Physical retardation  
- Purposeless wandering  
- Repeated grandiose behavior/decisions  
- Inability to make day-to-day decisions on an independent basis  
- Disorientation to time, place or person  
- Severe memory loss  
- Disordered or irrational thinking  
- Delusions  
- Paranoid ideation  
- Hallucinations  
- Suicidal ideation, threats, or acts  
- Homicidal ideation, threats, or acts  
- Uncontrollable destructive acts  
- Anxiety or depression that interferes significantly with daily activities  
- Mood swings that interfere significantly with daily activities  
- Withdrawal from environment  
- Psychophysiological, hypochondriacal, or hysterical symptoms which interfere significantly with daily activities  
- Significant weight loss  
- Sleep disturbance

TREATMENT PLAN:

<table>
<thead>
<tr>
<th>Modalities</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy (medical, other)</td>
<td></td>
</tr>
<tr>
<td>Individual Counseling</td>
<td></td>
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<tr>
<td>Behavior Modification</td>
<td></td>
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<tr>
<td>Group</td>
<td></td>
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<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Dance &amp; Movement/Relaxation</td>
<td></td>
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<tr>
<td>E.C.T.</td>
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<tr>
<td>Activity &amp; Occupation -</td>
<td></td>
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<tr>
<td>On Unit</td>
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<tr>
<td>Off Unit</td>
<td></td>
</tr>
<tr>
<td>Educational</td>
<td></td>
</tr>
<tr>
<td>Riveredge School</td>
<td></td>
</tr>
<tr>
<td>Tutorial</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B
STATUS OF PROBLEMS
(See: Initial Psychiatric Evaluation & Treatment Plan.)
On Discharge:
1.
2.
3.
4.

CONDITION AT DISCHARGE

<table>
<thead>
<tr>
<th>Recovered</th>
<th>Slightly improved</th>
<th>Regressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markedly improved</td>
<td>Unimproved</td>
<td>Deceased</td>
</tr>
<tr>
<td>Modestly improved</td>
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<td></td>
</tr>
</tbody>
</table>

POST DISCHARGE TREATMENT PLAN AND/OR FOLLOW-UP
A. GOALS

B. MODALITIES
1. Psychotherapy
   (Source)
   a. Attending physician
   b. Riveredge outpatient
   c. Mental health clinic
   d. Social agency
   e. Other

2. Medication
   (Note name, dosage, and frequency.)

3. Placement
   a. Halfway house
   b. Group home
   c. Foster home
   d. Residential trtmt. ctr.
   e. Boarding school
   f. Other
   g. Transfer
      Medical hospital
      Public mental hospital
      Private mental hospital
      Other

C. OTHER PLANS

D. NO TREATMENT PLAN (Document basis)

PROGNOSIS ON DISCHARGE
This thesis submitted by Margaret J. Rohde has been read and approved by the following committee:

Dr. Alan DeWolfe, Director
Professor, Psychology, Loyola

Dr. James Johnson
Associate Professor, Psychology, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

Date: 12/12/78

Director's Signature