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Relationship patterns in families of adolescent suicide attempters

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San Jose State University

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Antons, Peter Michael, M.S.

San Jose State University, 1989

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RELATIONSHIP PATTERNS IN FAMILIES OF
ADOLESCENT SUICIDE ATTEMPTERS

A Thesis
Presented to
the Faculty of the Department of Psychology
San Jose State University

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

by
Peter M. Antons
December, 1989

APPROVED FOR THE DEPARTMENT OF PSYCHOLOGY

Norman L. Egger

(Thesis Chairperson)

Shula Brenenfeld

(Thesis Committee member)

Thomas A. Tutko

(Thesis Committee member)

APPROVED FOR THE UNIVERSITY

Serena R. Stanford

ABSTRACT

RELATIONSHIP PATTERNS IN FAMILIES OF ADOLESCENT SUICIDE ATTEMPTERS

by Peter M. Antons

This thesis addressed family patterns of cohesion, adaptability and communication that may be related to adolescent suicidality. Sixty families of adolescents (ages 12-18) completed the Family Adaptability and Cohesion Evaluation Scales (FACES III) and were scored on the FACES Clinical Rating Scale (CRS). Whereas FACES family mean scores failed to show differences between families of suicidal and non-suicidal adolescents, CRS and adolescent FACES scores indicated that the suicidal group more often showed chaotic and disengaged relationships. Further score analysis suggested that suicidal adolescents and their parents more often disagreed as to whether the family rules were rigid or chaotic.

ACKNOWLEDGMENTS

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TABLE OF CONTENTS

SECTION	PAGE
INTRODUCTION	3
Problem Statement	5
REVIEW OF LITERATURE	9
METHOD	15
Subjects	15
Measures	18
Scoring	22
RESULTS	24
DISCUSSION	29
REFERENCES	33
APPENDIXES	39
Appendix A. Approval for Research with Clients ...	39
Appendix B. Client Consent Form	40
Appendix C. FACES III Test Form	41
Appendix D. Format for Clinical Rating Scale	42
Appendix E. Scatterplot Diagrams of Adolescent FACES III, Family Mean FACES III, and CRS for the Circumplex Model	45

LIST OF TABLES

TABLE	PAGE
1. Client and Sample Group Distributions of Adolescents by Parent Marital Status, Age, Gender, and Ethnicity (Percentages)	17
2. Family Profile Scoring for the Clinical Rating Scale	20
3. Summary of Results: Values of t , Chi-square, and p for All Study Variables	26

LIST OF FIGURES

FIGURE	PAGE
1. Circumplex Model: Sixteen Types of Marital and Family Systems	8
2. Quadrants of Adaptability and Cohesion on a 4-cell Circumplex Model	23

Relationship Patterns in Families of
Adolescent Suicide Attempters

Peter M. Antons

San Jose State University

Running head: FAMILY RELATIONSHIPS AND SUICIDE ATTEMPTS

Footnotes

Requests for reprints should be sent to Peter Antons,
Department of Psychology, San Jose State University, San
Jose, California, 95192

Relationship Patterns in Families of
Adolescent Suicide Attempters

In the last few years, there has been a growing awareness of suicidal behavior among youth. The impetus has come from a dramatic increase in the suicide rate of adolescents over the past 20 years. Suicide is now the third leading cause of death among 15 to 24 year-olds, following accidents and homicides (National Center for Health Statistics (NCHS), 1986). Despite recent trends toward a lower suicide rate, predictions have been made that suicide among 15 to 24 year-olds will continue to increase over the next ten years (Pfeffer, 1986, p.31). Additionally, the ratio of suicide attempts to fatalities among adolescents remains exceedingly high. Estimates ranging from 50 to 200 attempts for every suicide have been reported (Jacobzinner, 1965; McIntire, Angle, Wikoff, & Schlicht, 1977; Schrut, 1964). A further complication in studying adolescent suicides is that many accidents and accidental deaths involve covert suicidality (Molin, 1986).

The role of the family is central in prevention of adolescent suicide. Although thoughts of suicide are most often revealed to family members, families of suicidal adolescents often fail to respond to clues and actual

suicide attempts (Hill, 1970; Richman, 1978). This is alarming when one considers that 15% to 35% of adolescent attempters will repeat attempts within two years (Morgan, Barton, & Pottle, 1976; Shaffer, 1974; Pfeffer, 1986, p.49) and that as many as 62% of adolescents who commit suicide have made prior attempts (Shaffer, 1974; Dorpat & Ripley, 1967). Considering the family support network, it is noteworthy that repeat attempts decrease markedly when the hospitalized attempter is returned to relatives other than parents or to foster care (McIntire, et al., 1977).

Despite the importance of the family in preventing adolescent suicidality, there has been a relative lack of research into assessment and treatment of the "suicidogenic family" (Richman, 1979). Some of these few studies focus on treatment techniques rather than clinical research (Argles, 1983; Pfeffer, 1981; Richman, 1979). Also, many clinical assumptions regarding family systems of attempters are based on single-case studies (Pfeffer, 1981; Sabbath, 1971; Shapiro & Freedman, 1987) or general clinical experience with youth (Lansky, 1982; Pfeffer, 1982; Richman, 1978). There is an apparent need for more empirical validation for the assumptions of therapists working with families of suicidal youth.

Problem Statement

Recent family studies involving adolescent suicidality have indicated relationship patterns common among families of suicidal adolescents. Most studies have agreed on the hypotheses that the suicidogenic family can be characterized by rigidity of roles and rules (Masson & Collard, 1987; Pfeffer, 1981, 1982; Straus, 1984) as well as secretive or closed patterns of communication (Berman & Carroll, 1984; Keitner, et al., 1987; Pfeffer, 1981, 1982; Richman, 1979; Wodarski & Harris, 1987). There has been some discrepancy, however, in whether this type of family can be described as enmeshed (symbiotic) (Pfeffer, 1981, 1982; Richman, 1978, 1979; Shapiro & Freedman, 1987) or disengaged (emotionally distant) (Keitner, et al., 1987; Rubenstein, Heeren, Houseman, & Rubin, 1989; Straus, 1984; Wodarski & Harris, 1987).

One explanation for conflicting reports of enmeshed and disengaged families is that the suicidal adolescent, when compared to the parents, has viewed the family as less cohesive, higher in conflict and less supportive (Asarnow & Carlson, 1988; Asarnow, Carlson, & Guthrie, 1987; Keitner, et al., 1987; Straus, 1984). It has been proposed that the suicidal adolescent comes from an enmeshed family in which

there has been a recent threat of or actual abandonment (Argles, 1983; Masson & Collard, 1987). The focus of the present study was to assess family relationship patterns that may be consistent among families of suicidal adolescents. It was proposed that certain family attributes would differentiate this type of family situation from families of teens who were emotionally disturbed but not suicidal. The sample groups were limited to families seeking outpatient family therapy for an adolescent "identified patient." Family histories of suicide were studied as a predisposing factor in adolescent suicidality. Assessment of family relationship patterns employed the Circumplex Model of Family Systems (Olson, Russell, & Sprenkle, 1979). This model describes family dynamics in terms of three dimensions:

- 1) Cohesion: emotional bonding between family members.
- 2) Adaptability: the ability of a family to change its power structure rules in response to situational stress.
- 3) Communication: the mechanism by which families share their changing needs and feelings.

The three dimensions encompass relationship patterns that have been described in nearly all recent family studies of adolescent suicide. The Circumplex Model was developed from concepts central to many theories of family behavior. In

other family theories, concepts similar to cohesion and adaptability have been termed centripetal/centrifugal and systemic growth (Beavers & Voeller, 1983); affect and power (Kantor & Lehr, 1975); and affective involvement and roles (Epstein, Bishop, & Levin, 1978). It was assumed that all families can be classified according to a 2-dimensional model of adaptability and cohesion, called Circumplex (see Figure 1). A third dimension, communication, is dynamic: it facilitates movement (change) along the other axes. Thus, the model describes dynamic family patterns rather than family types. In relation to the Circumplex Model, the following hypotheses were proposed:

- 1) When compared to families of otherwise disturbed adolescents, families of suicidal adolescents more frequently have a history of suicide.
- 2) When compared to the nonsuicidal group, families of suicidal adolescents more often reveal relationships that are rigid and disengaged.
- 3) When compared to the control group, families of adolescent attempters reveal less ability to facilitate open communication.
- 4) When compared to the control group, suicidal adolescents more often see their families as less cohesive and less flexible than do their parents.

Note: Distance from Center of Circumplex (DFC) is a non-directional linear score.

Figure 1. The Circumplex Model: Sixteen types of marital and family systems

Note: from Family Adaptability and Cohesion Evaluation Scales (p. 17) by D. Olson, J. Portner and R. Bell, 1982, St. Paul, MN: Family Social Science, University of Minnesota.

REVIEW OF RELATED LITERATURE

The role of the family in adolescent suicide has been studied since the beginnings of psychotherapy. Family dysfunction, at the time, was viewed historically as a predisposing factor to later depression and suicidality. Only in the past ten years has family interaction been seen as crucial in treating the suicidal adolescent.

Freud, in his 1915 paper "Mourning and Melancholia," first related depression and suicide to early parental loss (Freud, 1915/1957). Following this premise, Zilboorg (1937) hypothesized that persons at highest risk for suicide are those who unconsciously identify with a dead person. Zilboorg believed that it was not the actual loss of the dead person that created the suicidal impulse; it was the fantasy of reunification with the deceased. Further development of this attachment theory came from a study by Bender and Schilder (1937). They formulated the idea that suicidal behavior was a result of the child's wish to escape from an unbearable situation that involved a deprivation of love. This fostered aggressive reactions directed against those who denied love. Resulting guilt feelings caused the

aggressive impulses to be turned back upon the self. This formulation is still considered to be one of the classic dynamics for adolescent as well as adult suicide.

Little family research specifically on youth suicide was reported until the 1960's, when suicide prevention centers began to develop. Farberow and Shneidman (1965) described attempted suicide as a regressive attempt to communicate pain. Bowlby (1961) defined three stages of a child's responses to separation from mother as protest, despair, and detachment. In cases of parental death, protest and denial would give way to feelings of hopelessness, apathy, and abandonment. In this phase of despair, many suicidal children would express wishes to reunite with a lost person. In treating suicidal children, detachment from this reunion fantasy was seen as crucial in relieving impulses to self-destruct.

The idea that family relationship history might be related to suicidal behavior was further developed in early family studies. Many studies, however, focused on a single dimension of family life in relation to suicide. Most retrospective studies reported a higher incidence of parent loss in suicidal than control subjects (Adam, Bouckoms, &

Streiner, 1982). The sample groups varied widely, however, and several studies produced negative findings (Haider, 1968; McConaghy, Linane, & Bickle, 1966; Birtchnell, 1981). There appeared to be even less agreement regarding which kinds of losses were important. Although some studies focused solely on the death of a parent (Hill, 1969; Birtchnell, 1970), most included separation from parents as well, and others included illegitimacy (Dorpat, Jackson, & Ripley, 1965) and parental instability (Adam, et al., 1982). Crook and Raskin (1975) found no differences in the histories of family death between suicidal and nonsuicidal psychiatric patients, but found that parental divorce was related to adolescent suicide.

Jacobs and Teicher (1966) postulated a "broken home syndrome" in relation to adolescent suicide, stating that early parent separation coupled with a period of more frequent rejections typified the adolescent attempt. Several studies also related adolescent suicidality to a history of suicide in the family, usually in a parent (Murphy & Wetzel, 1982; Murphy, Wetzel, Swallow, & McClure, 1969; Robins, Schmidt, & O'Neal, 1957; Woodruff, Clayton, & Guze, 1972). This correlation has remained fairly strong over time. From the above studies, three factors

influencing adolescent suicidality can be discerned: identification with a suicidal parent, perceived rejection, and family loss or disengagement.

As family theories of adolescent suicidality developed, family interactions that may reinforce suicide attempts, as opposed to predisposing causes, were hypothesized. Wenz (1979) postulated a "family anomie syndrome," in which the suicidal adolescent developed feelings of powerlessness in response to a breakdown in family norms, or values. A similar development of this idea came from Breault and Barkey (1982), who hypothesized that adolescent suicide was related to parental conflict and disintegration of family values. Both studies expanded on the premise of Durkheim (1897/1951) that suicide was related to social normlessness, or anomie.

Several recent studies found that families of suicidal adolescents can be characterized by rigidity of roles and structure, disintegration of parent-child bonds and closed communication. Suicidal adolescents often described their families as low in cohesiveness and unable to communicate clearly (Asarnow, et al., 1987; Berman & Carroll, 1984; Rubenstein, et al., 1989). Empirical validation of these

hypotheses, for adolescent females at least, came from Straus (1984). Using the Family Adaptability and Cohesion Evaluation Scales (FACES), families of suicidal adolescents were found to have more rigid (unchanging) and disengaged relationships than families of delinquent adolescents. Additionally, families of attempters revealed less congruent and more conflictive patterns of communication.

Contrary to the above studies, Argles (1983) found that the suicidal adolescent often comes from an enmeshed family in which there has recently been a threat of abandonment. Similarly, Richman (1978, 1979) reported that suicide is often attempted when symbiotic ties with a parent are threatened, in an attempt to restore the symbiosis. Richman (1979) addressed treatment of the "suicidogenic family," in which open communication of needs is blocked and an enmeshed parent is openly or covertly rejecting of the child. One explanation of these contradictory findings is tied to the hypothesis of closed communication in suicidogenic families. Keitner, et al. (1987) and Asarnow and Carlson (1988) found that suicidal adolescents perceived their families as more disengaged, conflicted and unsupportive than did their parents. Depending on which member is reporting, then, the family could be seen as either enmeshed or disengaged.

Pfeffer (1981,1982) described four factors common to families of suicidal adolescents: lack of parent-child boundaries (enmeshment), severe parental conflict, projection of feelings onto and lack of empathy for the child, and inflexible family rules. The hypotheses of Lansky (1982) and Shapiro and Freedman (1987) also support this paradoxical notion of a symbiotic attachment (enmeshed parent and child) with lack of empathy for the child.

The history of family research into suicide has identified early parental loss and detachment as a predisposing factor in adolescent suicidality. Attempted suicide in the adolescent has been clearly related to a family history of suicide. Subsequent family studies have found that loss of cohesion and effective communication within the family may isolate the adolescent and further contribute to suicidal ideation. It seems, however, that recent family studies have disagreed on whether the family of the suicidal adolescent is generally enmeshed or disengaged. The notion of a "threatened symbiosis" may partially explain these discrepancies. Loss of an overly close parental bond during the adolescent stage of individuation from parents and failure of the family to adapt to this change may contribute to feelings of abandonment and suicidality in the adolescent.

METHOD

Subjects

The sample group consisted of families of emotionally disturbed adolescents (ages 12-18) seeking treatment with the Eastfield Ming Quong Adolescent In Home Program. Data for the study were collected as part of an initial interview for outpatient family therapy. From a total population of 89 clients, 60 volunteer families were selected, 30 from each of two study groups: families of nonsuicidal, but emotionally disturbed adolescents (ND) and families seeking treatment for an emotionally disturbed adolescent who recently attempted suicide (SD).

Attempted suicide was operationally defined as any act of willful, self-inflicted, life-threatening behavior not leading to death. This standard was proposed by Dorpat and Boswell (1963). Such a definition excluded adolescents showing threats, superficial cutting gestures, and accidental overdose, as well as covert or unreported suicide attempts. Control group subjects (ND) consisted of families in which the identified patient was an adolescent with no reported history of attempted suicide, but was referred to the clinic due to delinquent or emotionally disturbed behavior.

For purposes of consistency, only the family triad (father, mother, adolescent) was studied. Controlling for family size has been proposed as crucial in eliminating confounds in this type of study (Haley, 1962). Although single parent families were over-represented among nonsuicidal controls, only two parent families were included in the sample groups. This included natural, adoptive, and custodial parents. In situations involving multiple parent figures, the parental unit entering treatment with the adolescent was considered.

Of the 89 client families, 21 were excluded for the following reasons: single parent status (15), control adolescents (ND) having a prior history of attempted suicide (4), and incomplete interviews (2). The remaining 68 subject families were screened so as to match sample groups on the basis of age, gender, and ethnicity of the adolescent. In the sample population, nonsuicidal adolescents tended to be younger males as compared to the suicidal group, but ethnicity was distributed equally between the two study groups. A comparison between client population and matched sample groups for marital status, age, gender, and ethnicity is presented in Table 1.

Table 1.

Client and Sample Group Distributions of Adolescents by
Parent Marital Status, Gender, Age, and Ethnicity
(Percentages).

	Nonsuicidal	..Suicidal..	Matched distribution
	%	%	%
<u>Dual-parent</u>			
Unmarried	6	36	30
Married	28	23	23
<u>Step-parent</u>	19	30	30
<u>Single-parent</u>			
Separated	41	6	6
Unmarried	6	0	0
<u>Gender</u>			
Male	69	19	27
Female	31	81	73
<u>Age</u>			
12-13	50	12	10
14-15	12	50	50
16-17	10	38	40
<u>Ethnicity</u>			
Asian	0	6	0
Black	12	6	12
Caucasian	76	76	76
Hispanic	12	12	12

Measures

All measures used in the study were taken from a standard clinical family assessment in use at the the Eastfield Ming Quong In Home Program. The assessment consisted of a one-hour interview with all family members and a 30-minute self-report questionnaire given to each family member. The social work staff of the Eastfield Clinic performed a standard clinical family interview with each family. Information from this interview determined demographic variables and the family history of suicide, which was operationally defined as a history of attempted or completed suicide in a parent or grandparent of the adolescent.

Interviewers also completed, for each family, a Clinical Rating Scale of the Circumplex Model of Marital and Family Systems (CRS) (Olson & Killorin, 1985). This scale used information from the clinical family interview to rate each family on dimensions of adaptability and cohesion, as well as a facilitating dimension of communication, from an outsider's perspective, that of the clinician. A second measure of adaptability and cohesion used the Family Adaptability and Cohesion Evaluation Scales, third edition (FACES III) (Olson, Portner, & Bell, 1982). These scales provided a family self-report of adaptability and

cohesion to compare with the Clinical Rating Scale, as well as a measure of Family Discrepancy in reporting adaptability and cohesion.

Clinical Rating Scale

This scale was developed by Olson and Killorin (1985) in order to clinically assess cohesion, change (adaptability), and communication. Typically, the rater uses information from a semistructured family interview or observes family members as they interact while completing some interactive task, such as describing a daily routine or planning a family weekend.

Each dimension is broken down into concepts and standard descriptors of each concept, which allow the interviewer to assign a point value to rate the family on each concept. These values are averaged to provide a global rating for each dimension. Adaptability is rated on a scale from one (rigid) to eight (chaotic). Cohesion is rated on a scale from one (disengaged) to eight (enmeshed). Communication is rated on a scale from one (low) to six (high ability to facilitate communication). A family profile is used to summarize the ratings on these three dimensions (see Table 2).

Family Profile Scoring for the Clinical Rating Scale

Disengaged Separated Connected Enmeshed								
Cohesion	1	2	3	4	5	6	7	8
Emotional Bonding	.	.	.	.	.	.	.	.
Family Involvement	.	.	.	.	.	.	.	.
Marital Relationship	.	.	.	.	.	.	.	.
Parent-child Coalitions	.	.	.	.	.	.	.	.
Internal Boundaries	.	.	.	.	.	.	.	.
External Boundaries	.	.	.	.	.	.	.	.
Global Rating..	.	.	.	.	.	.	.	.

Rigid Structured Flexible Chaotic								
Adaptability	1	2	3	4	5	6	7	8
Leadership	.	.	.	.	.	.	.	.
Discipline	.	.	.	.	.	.	.	.
Negotiation	.	.	.	.	.	.	.	.
Roles	.	.	.	.	.	.	.	.
Rules	.	.	.	.	.	.	.	.
Global Rating..	.	.	.	.	.	.	.	.

Low Facilitation High						
Communication	1	2	3	4	5	6
Continuity Tracking	.	.	.	.	.	.
Respect & Regard	.	.	.	.	.	.
Clarity	.	.	.	.	.	.
Freedom of Expression	.	.	.	.	.	.
<u>Listeners' Skills</u>						
Empathy	.	.	.	.	.	.
Attentive Listening	.	.	.	.	.	.
<u>Speakers' Skills</u>						
Speaking for Self	.	.	.	.	.	.
Speaking for Others	.	.	.	.	.	.
Intrusions/Interruptions	.	.	.	.	.	.
Premature Closure	.	.	.	.	.	.
Global Rating..	.	.	.	.	.	.

The Clinical Rating Scale provides a measure of family functioning that is not dependent upon self-report. Olson (1977) found that self-report and clinical ratings often provide conflicting data. Used together, such measures help capture the complexity of marital and family systems. Additionally, inter-rater reliability with the Clinical Rating Scale has been assessed at rather high levels ($r=.70-.80$) (Olson, Logasz, & Stewart, 1985).

Family Adaptability and Cohesion Evaluation Scales, 3rd Ed.

This is the third version in a series of FACES scales developed to assess the two major dimensions on the circumplex model (i.e., family cohesion and family adaptability) as developed by David Olson (Olson, Russell, & Sprenkle, 1979). This is a 40-item, Likert-type family opinion survey, consisting of 20 items each, covering perceived and ideal family functioning. Scores (individual or family mean) are plotted on a 2-dimensional grid, measuring adaptability and cohesion (see Figure 1, above). A separate score, Family Discrepancy, identifies families who would otherwise score in the normal (balanced) range due to conflicting self-reports. For example, the mother may see the family as disengaged while the adolescent reports enmeshed relationships.

Studies of FACES III (Rodick, Henggler, & Hanson, 1985) reveal high internal consistency ($\bar{r}=.68$), high retest reliability ($\bar{r}=.80$), low interscale correlation ($\bar{r}=.03$), and low correlation with social desirability ($\bar{r}=.35$ for cohesion, $\bar{r}=.00$ for adaptability), suggesting very good construct validity. Clinical studies (Olson & McCubbin, 1982; Russell, 1980) reveal very good face and content validity.

Scoring

The Clinical Rating Scale for each family was completed by a clinical social worker employed by Eastfield Ming Quong. Ratings of adaptability and cohesion were plotted on a 4-cell circumplex model (see Figure 2). A global rating for communication was averaged for each family, on a scale from one (low) to six (high ability to facilitate communication within the family).

Three groups of scoring procedures were performed using FACES III. First, adaptability and cohesion scores were plotted on a 4-cell circumplex model (see Figure 2). Two scores were plotted for each family: the adolescent's self-report score and a family mean score (adolescent, father and mother). Second, a linear score, Distance from Center of Circumplex (DFC), was calculated for each adolescent and

Figure 2. Quadrants of adaptability and cohesion on a 4-cell circumplex model.

family mean score on FACES III. This indicated the distance of an individual adaptability and cohesion score from the norm, or center of circumplex. A final score, Family Discrepancy, measured the consistency among family members in self-reports of adaptability and cohesion. Four discrepancy scores were calculated for each family: adolescent-father, adolescent-mother, father-mother, and total family discrepancy. This linear score, derived from the differences in self-report scores between family members, served as a measure of family congruence, or the degree to which family members agree or disagree on perceptions of adaptability and cohesion within the family.

RESULTS

Scores on the circumplex model are curvilinear: both ends of the continuum for adaptability, cohesion, and communication represent extreme scores; the majority of scores cluster in the middle range. Therefore, a chi-square was calculated for CRS and FACES III measures. As Distance from Center of Circumplex (DFC) is a linear score, a t-test for difference between means compared ND and SD groups on this measure. Family Discrepancy scores were grouped into three levels: low (0-10), medium (11-20), and high discrepancy (21-30). A 2 x 3 chi-square test was completed

for each discrepancy score: adolescent-father, adolescent mother, father-mother, and total family discrepancy.

Frequencies of family histories of suicide for the study groups (ND, SD) were compared in a 2 x 2 contingency table. Therefore, chi-square was utilized for this measure, using Yates' correction (Minium, 1978). The level of significance for all statistical comparisons was set at $\alpha=.05$. A summary of statistical findings is presented in Table 3.

Adaptability and Cohesion

Suicidal and nonsuicidal groups were compared on DFC. This score measures degree of deviance from the norm and is indicative of family dysfunction. No significant differences between group means were found for adolescent FACES III scores ($t(29)=0.27$, $p>.25$) and FACES III family mean scores ($t(29)=0.34$, $p>.25$). Both groups (ND, SD) showed mid-range to extreme scores on DFC, indicating a similar degree of family dysfunction.

A 2 x 4 chi-square test was calculated for each of 3 measures: FACES III family mean scores, FACES III adolescent self-report scores, and the Clinical Rating Scale (CRS). This compared the two study groups (ND, SD) according to

Table 3.

Summary of Results: Values of t, Chi-square, and p for All Study Variables.

Study Variable	t	Statistic χ^2	p
<u>DISTANCE FROM CENTER</u>			
Adolescent FACES III	0.27		>.25
Family mean FACES III	0.34		>.25
<u>ADAPTABILITY AND COHESION</u>			
Adolescent FACES III		8.45	<.05
Family mean FACES III		4.91	>.05
Clinical Rating Scale		9.91	<.025
<u>DISCREPANCY SCORES</u>			
Family mean		2.65	>.10
Mother-adolescent		5.02	>.05
Father-adolescent		11.73	<.005
Mother-father		1.66	>.10
<u>COMMUNICATION</u>		0.78	>.10
<u>FAMILY HISTORY OF SUICIDE</u>		2.24	>.10

four quadrants of the circumplex model: chaotic-disengaged, chaotic-enmeshed, rigid-disengaged, and rigid-enmeshed.

Analysis of FACES III family mean scores indicated no significant differences between the study groups ($\chi^2(3, N=60)=4.91, p>.05$). Distribution of adolescent self-report scores, however, revealed mildly significant differences ($\chi^2(3, N=60)=8.45, p<.05$). Suicidal adolescents more often reported their families as rigid and disengaged, while the nonsuicidal group was over-represented in the chaotic-disengaged quadrant of circumplex. These findings would indicate that a discrepancy existed between self-reports of suicidal adolescents and their parents. Visual observation of FACES III score patterns indicated that mothers and fathers of suicidal adolescents more often saw the family as disengaged, but flexible in terms of rules and change, than did the adolescent (see Appendix E).

Taken as a separate measure, CRS ratings of adaptability and cohesion confirmed adolescent self-reports, that families of suicidal adolescents more often showed rigid and disengaged relationship patterns than did families of nonsuicidal adolescents ($\chi^2(3, N=60)=9.91, p<.025$). Further, visual observation of the CRS score distribution suggested that two

distinct family patterns characterized the suicidal group: rigid-disengaged and chaotic-enmeshed.

Analysis of Family Discrepancy scores revealed mixed findings. Suicidal and nonsuicidal groups were similar in terms of mother-father ($\chi^2(2, N=60)=1.66, p>.10$), mother-adolescent ($\chi^2(2, N=60)=5.02, p>.05$), and total family discrepancy ($\chi^2(2, N=60)=2.65, p>.10$). Suicidal adolescents and their fathers, however, showed greater discrepancy in reports of family adaptability and cohesion than nonsuicidal pairs ($\chi^2(2, N=60)=11.73, p<.005$).

Communication

A 2 x 3 chi-square test revealed no significant differences between the study groups on Clinical Rating Scale family communication scores ($\chi^2(2, N=60)=0.78, p>.10$). Both groups were rated overall as low in effective patterns of communication.

Family History of Suicide

A history of attempted or completed suicide was only reported six times between the two study groups. Due to low obtained frequencies, no significant difference was found in family history of suicide ($\chi^2(1, N=60)=2.24, p>.10$).

DISCUSSION

The two study groups were matched in order to show similar frequencies for the following demographic variables: age, gender, and ethnicity of the adolescent and marital status of the parents. It should be noted that, in the client population, the suicidal adolescents were more often female and older than the nonsuicidal adolescents. Similarly, parents of suicidal adolescents were more often divorced and remarried, while nonsuicidal, but disturbed teens more often had single mothers who were either divorced or had never married. In future studies, age, gender, and parent marital status could be studied as indicators of adolescent suicide.

Regarding family histories of suicide, suicidal adolescents more often reported a suicidal family member, but the difference was not statistically significant. Therefore, the first hypothesis was not confirmed. It should be noted that both study groups reported a low incidence of attempted or completed suicide in the family histories. Given a larger sample size, the hypothesis that suicidal adolescents more often had a history of suicide in the family may have been confirmed. It may also be that a more detailed family history would reveal greater differences in family history of suicide between the two study groups.

The three measures of adaptability and cohesion (adolescent FACES III scores, family mean FACES III scores, and Clinical Rating scores) revealed a rather wide discrepancy for families of suicidal adolescents. First, both study groups appeared to be similar in degree of family dysfunction: DFC scores placed the suicidal and nonsuicidal groups in the extreme range of circumplex. In all three measures, families of nonsuicidal teens tended to show chaotic-separated and chaotic-disengaged relationships. The FACES III family mean scores failed to differentiate suicidal from nonsuicidal family patterns. Adolescent FACES III scores, however, revealed differences between the two study groups. This difference supported the second hypothesis, that families of suicidal adolescents more often revealed relationships that are rigid and disengaged. The Clinical Ratings of adaptability and cohesion confirmed these differences between the suicidal and nonsuicidal groups. Moreover, these ratings suggested that the suicidal group may show two distinct relationship patterns: The CRS scores for this group were tightly clustered in both the rigid-disengaged and chaotic-enmeshed quadrants of circumplex. This would suggest a need to further explore the family dynamics of the suicidal adolescent.

As a global measure of effective communication, the CRS scores failed to confirm the third hypothesis, that families of adolescent attempters showed less ability to facilitate open communication. Suicidal and nonsuicidal groups were similarly low in ratings of family communication. It may be that the CRS communication score is indicative of family dysfunction generally, but cannot pinpoint family patterns associated with adolescent suicide. If the communication subscales could be compared, distinct communication patterns may be found in the family of the suicidal adolescent.

The strongest findings of this study involve the Family Discrepancy scores. For both study groups, the parents similarly revealed moderately high discrepancy in how they perceived the family's adaptability and cohesion. Suicidal adolescents and their fathers, however, showed much greater discrepancy in self-reports than did nonsuicidal adolescent-father pairs. It is possible that this finding isolated a major source of family tension: the suicidal adolescent reported the family as severely disengaged and rigid, while the father reported much higher flexibility and cohesion in the family.

The above findings may suggest a profile common to the suicidal teen of this study, at least. The child was typically female, had a divorced mother and stepfather, and was somewhat more likely to have a history of suicide in the family. The child viewed the family as far more rigid in terms of rules and felt a greater lack of family cohesion than did the parents, especially the father.

SUGGESTIONS FOR FURTHER STUDY

Limited sample size in this study prevented an in-depth analysis of the family history of suicide and subsequent adolescent attempts. As suicide is a rare occurrence, the effects of suicide on the family are difficult to measure empirically without large sample studies. It would be helpful then, to more closely investigate histories of attempts, threats, and covert suicidality in the family. This may increase the likelihood of relating adolescent suicidality to a similar family history.

Regarding adaptability and cohesion, it appears that the suicidal adolescent views the family quite differently from the parents, especially the father. Future family studies would benefit from identifying the family alliances and triangles that may isolate or scapegoat the suicidal child.

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Appendix A.

Approval for Research with Eastfield Ming Quong Clients

EASTFIELD MING QUONG

Human Subjects
Institutional Review Board
1 Washington Square
San Jose State University
San Jose, Ca. 95192

July 28, 1989

Institutional Review Board:

This letter will confirm that I met with Mr. Peter Antons on July 28, 1989, and reviewed his request to use data from Eastfield Ming Quong's Adolescent In-Home Program's case files, as part of his Master's thesis. I have granted him access to our case records under the following conditions:

- 1) At no time will case records be taken from Eastfield Ming Quong offices, and
- 2) No names, or other identifying case information will be used in the study (i.e. the absolute confidentiality of our clients will be maintained).

As the program supervisor of this most creative and innovative program I welcome research efforts, such as Peter's, that will serve to increase our knowledge regarding the families we serve.

Sincerely,

Barry J. Goldman-Hall, LCSW
Clinical Program Manager
Adolescent In-Home Program
(408) 379-3798

Appendix B.

Client Consent to Participate in Research

AGREEMENT TO PARTICIPATE IN RESEARCH AT SAN JOSE STATE UNIVERSITY
RESPONSIBLE INVESTIGATOR: Peter M. Antons

TITLE OF PROTOCOL: Relationship Patterns in Families of Adolescent
Suicide Attempters

You and your child are invited to participate in a research study that is investigating family relationship patterns that may be related to attempted suicide in adolescents. The results of this study should further our understanding of adolescent attempts with the goal of working with the family to prevent and treat such attempts.

I understand that:

1) My child and I will be asked to complete the following procedures as a routine part of the Eastfield Ming Quong Adolescent In Home counseling program:

a) A one-hour family interview with a Social Worker employed by the Adolescent In Home program.

b) A forty question family opinion survey, known as the Family Adaptability and Cohesion Evaluation Scales.

2) With permission from my child and myself, certain information from this procedure will be used to study family patterns that may accompany suicide attempts in adolescents.

3) The results from this study may be published, but any information from this study that can be identified with me or my child will remain confidential and will be disclosed only with my permission or as required by law.

4) The study will not interfere with the normal course of treatment for my child. No other risks will be imposed upon me or my child.

5) Any questions about my child's participation in this study will be answered by Peter Antons (Ph. 379-3790). Complaints about the procedures may be directed to Dr. Norman Egger, Thesis Chairman, SJSU (924-5349). For questions or complaints about research subjects' rights, or in the event of a research related injury, contact Dr. Serena Stanford, Associate Academic Vice President for Graduate Studies and Research, at 924-2480.

6) My consent is given voluntarily without being coerced; my child may refuse to participate in this study or in any part of this study, and I may withdraw my consent at any time, without prejudice to my relations with SJSU or Eastfield Ming Quong.

7) I have received a copy of this consent form for my file.

I HAVE MADE A DECISION WHETHER OR NOT MY CHILD MAY PARTICIPATE. MY SIGNATURE INDICATES THAT MY CHILD AND I MAY PARTICIPATE AND ARE WILLING TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.

(Parent's signature)

(Date)

(Child's signature)

(Date)

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