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Adolescent Suicide and Family Interaction Patterns

Wendy Adelstein

LOYOLA UNIVERSITY CHICAGO

ADOLESCENT SUICIDE AND FAMILY INTERACTION PATTERNS

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WENDY ADELSTEIN

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CHAPTER ONE

INTRODUCTION TO ADOLESCENT SUICIDE

Adolescent suicide is becoming an ever increasing problem. Over the years, researchers have concentrated on diagnostic groupings, demographic factors, biological correlates, and psychological mind sets as primary causes of suicide (Keitner, Miller, Fruzzetti, Epstein, Bishop, & Norman, 1987). From all the research completed, only marginal progress has been made in predicting and preventing suicide. Statistics indicate that adolescent suicide is rising at an alarming rate. For instance, between 1960 and 1988, the adolescent suicide rate for the 15 to 19 year age group tripled, rising from 3.6 to 11.3 deaths per 100,000 people. Furthermore, in 1988, 2,059 adolescents or five teenagers a day successfully committed suicide. Currently, suicide is the third leading cause of death for adolescents, trailing accidental deaths and homicides (Garland & Zigler, 1993).

The purpose of this thesis is to address the increasing problem of adolescent suicide. Instead of focusing on the traditionally researched areas mentioned above, this thesis focuses on the role that family interaction patterns play in the development of suicidal adolescents. This thesis presents a review and summation of the current literature and proposes a new mediating model to account for adolescent suicide. Since family functioning is a relatively new area of study, it is the goal of this thesis to demonstrate its great potential for understanding, assessing and preventing adolescent

suicide.

In order to appreciate the potential of utilizing a family systems approach in understand adolescent suicide, other relevant theories are reviewed and critiqued. Beyond the value of distinguishing current theories, this review revealed two important findings. First, the review showed a common link between all the theories. When attempting to understand suicide etiology, all the theories are attempting to account for the various forces influencing adolescents to commit suicide. Basically, theses forces can be summarized into three levels of influence, the individual level, the family level and the societal level. At each influencing level there are a number of theories explaining the influencing forces. For example, at the individual level, possible influential forces can be accounted for through biological predispositions, psychological problems, and developmental difficulties. Additionally, possible influencing forces at the family level are accounted for by systems theory. Finally, the influencing forces at the societal level can be accounted for by sociological and ecological theories. In the following chapter, each of these theories will be broken down into their respective levels of influence and discussed in terms of adolescent suicide.

Secondly, the literature review reveals a gap in the number of studies performed at each influence level. For instance, there are numerous studies examining influences at the individual level, yet only a limited number of studies have been done on the other two levels. Taken with the fact that the studies preformed on the individual level have yielded only marginal results, a need for research in the other two areas has developed. Keeping that exact problem in mind, this thesis is designed to partially fill that gap by

examining the impact of family functioning on adolescent suicide. Unfortunately, it is beyond the scope to this thesis to address the societal influence level, although suggestions for this task are made in the final chapter.

How will family systems theory help to fill the gap? Traditionally, when family therapists assess a family's functioning, they assess for the four interaction patterns of communication, adaptability, cohesion, and emotional environment and their relationships to dysfunctional behavior. Similarly, this thesis utilizes these same four interaction patterns to understand adolescent suicide behavior. Unlike other studies of this nature, the thesis proposes that the key to understanding the relationship among these variables is communication. This thesis postulates that communication acts as a mediating variable between adolescent suicide and the three other interaction patterns. In Chapter three, each interaction pattern is discussed in terms of their subcomponents, level of influence on adolescent suicide risk, and the mediating relationship between communication and suicide.

After the interaction patterns have been discussed, the mediating model is presented. Based on the work of Olson, Russell and Sprenkel (1979), this model illustrates the mediating relationship of communication between suicide and the remaining three types of interaction patterns. Following the presentation of the model, the clinical implications are discussed.

The final chapter is divided into three sections. The first section discusses research possibilities that would aid in increased suicide assessment. The second section addressed the three main limitations of the thesis. The final section details future

theoretical implications of the model.

In the end, this thesis attempts to provide a better understanding of adolescent suicide etiology. By incorporating the four family interaction patterns into a comprehensive model, it is anticipated that gaps in the understanding and assessment of adolescent suicide will be closed.

CHAPTER TWO

THEORETICAL MODELS OF SUICIDE

A number of theoretical models attempt to explain suicidal behavior. This chapter reviews the biological, psychological, developmental, sociological, and systems models of adolescent suicide. As discussed in the introduction, each model is examined either at the individual, family or societal influence levels. Each model is summarized in terms of suicide etiology and adolescent suicide. Even though all three levels are important in conceptualizing adolescent suicide, the reasons for utilizing a systemic approach are outlined and discussed at the end of the chapter.

Individual Level of Influence

Biological Theory

Biological theory explains behavior in terms of how the brain and nervous system interact. When discussing the etiology of suicide, biological theorists focus on biochemical changes and genetically transmitted precursors (Cosand, Bourque, & Kraus, 1982; Hawton, 1986; Shaffer, 1974). They believe that biochemical changes make individuals more vulnerable to affective disorder. Researchers have found connections between specific psychiatric disorders, such as schizophrenia or manic depression, and

suicide (Holinger & Offer, 1981).

When assessing adolescents for risk of suicide, biological researchers consider three aspects. First, they take into consideration that adolescents are undergoing the extreme biochemical changes of puberty and therefore, are more susceptible to affective and thought disorders. Second, since disorders such as depression and schizophrenia have been linked to suicide, adolescent's should be assessed for specific affective mood and/or thought disorders. Third, they examine an adolescents' family background for suicide attempts and for incidents of affective or thought disorders. Past suicide attempts or psychological disorders in other family members could be the sign of a genetic predisposition.

Since this theory is based on biological process, treatment is usually drug related. The major criticism of this theory is that it places too much emphasis on biochemical correlates of suicidal behaviors, while ignoring the emotional component of affective disorders (Neiger & Hopkins, 1988).

Psychological Theories

Psychoanalytic theory. Psychoanalytic theory proposes that behavior is controlled by irrational forces, biological and instinctual drives, and unconscious motivations. Freud (1949) proposes two major hypothesis to account for suicide. First, he postulates that the death instinct, Thanatos, can turned inward and cause suicidal behavior. Second, he hypothesizes that suicide is an internalized attempt to deal with the rejection and deprivation that result from the loss of love and support. Either through death or divorce, this loss begins a process called ego-splitting (Litman, 1967). During this process,

energy is transferred from the lost loved object into the grieving individual's ego. Psychoanalysts state that this process can promote suicidal tendencies when the individual is harboring hostile wishes toward the lost object. Feelings of anger, resentment and guilt are turned inward, leading to self-destructive behaviors (Neiger & Hopkins, 1988).

When analysts assess adolescents for the risk of suicide they consider two factors. First, they consider unconscious motivation, such as the death instinct. Without actually psychoanalyzing an adolescent, the next best way of measuring this instinct is to examine the amount of impulsive, self-destructive behavior in an adolescent. Second, analysts' assess suicide risk by noting recent losses through death, divorce, separation or abandonment.

The goal of psychoanalytic treatment is to help clients become aware of the unconscious desires behind their behavior. Analysts focus on early family relationships and use a number of techniques to uncover the precipitating causes of suicide. Critics of this theory suggest that precipitating events are neither necessary nor sufficient to account for suicide. They also point out that probing the mind for the unconscious motivations is a slow process and not very effective in a crisis situation (Lester, 1994).

Cognitive-Behavioral Theory. Cognitive-Behavioral theory is based on the notion that irrational thinking causes negative emotions and disruptive behaviors. According to Ellis (1962), emotional problems can be explained in terms of his ABC theory of personality. An actual event (A) activates a particular belief system (B) to which there are specific consequences (C). In a healthy sequence, rational beliefs correct irrational

ones. In the case of a suicidal adolescent, an activating event leads to irrational beliefs which, in turn, lead to negative emotional consequences.

When assessing adolescent suicide risk, cognitive behavioral therapists assess irrational thought processes. Their therapy sessions involve teaching clients how to identify and correct their irrational beliefs. Criticisms of cognitive behavioral therapy has focused on low personal warmth, the lack of attention paid to a client's history, and the confrontational nature of the techniques employed (Corey, 1990).

Behavioral theory. Behavioral therapy views human behavior as a product of learning. In order to treat maladaptive behaviors, behavioral therapists systematically apply the principles of classical and operant conditioning to their clients. Behavioral therapists believe that suicide develops from inadequate reinforcement and/or modeling of suicidal behavior. When family members or friends commit suicide, an adolescent may conclude that suicide is an acceptable means of addressing life's problems or for gaining attentions (Hawton, 1986). When parents respond to the suicidal gestures of youth with increased attention, they are reinforcing this coping style. Thus, adolescents learn pathological rather then adaptive coping strategies (Frederick & Resnick, 1971). When assessing adolescents for suicide risk, behavior therapists look for inadequate reinforcement, history of suicide in any other family members, and ineffective coping styles.

The therapeutic goal of behavior therapy is correcting the presenting problems. Research has shown behavioral techniques, such as modeling, to be effective in treating

suicidal clients presenting with problems of inadequate reinforcement, poor social skill, and learned-helplessness syndrome (Bostock & Williams, 1974; O'Farrell, Goodenough, & Cutter, 1981; Lester, 1994).

A major criticism of behavioral theory is that it de-emphasizes the role of insight and feelings. Corey (1990) stated that by de-emphasizing the importance of these factors, behavior therapists are not helping their clients understand and therefore, prevent future suicide attempts.

Developmental Approaches

The developmental approach addresses when and how physical, mental and social functions unfold and change and interact over a life span (Liebert, Wicks-Nelson & Kail, 1986). Developmental theories incorporate aspects from many theories such as maturation, psychoanalytic, social learning, and cognitive. Freud 's (1949) sexual stages, Erikson's (1963) psychosocial stages, and Piaget's (1952) cognitive stages are just a few examples of developmental theories. When explaining maladaptive behaviors, developmental theorists can pull from a variety of factors such as early life development, learning histories, current life crisis, and/ or biological predispositions.

Developmental theorists recognize that adolescence is a period of stress, involving emotional growth, physical changes and social challenges. Some developmental theorists suggest that if adolescents are not able to adapt to their new developmental roles, suicide becomes an option (Gilead & Mulaik, 1983). Other developmental theorists suggest that the catalyst for suicide is a precipitating event that is the culmination of a long standing sense of entrapment and rage. This event can be associated with moving, change of

schools, romantic break up, death of a loved one, or divorce of parents (Neiger & Hopkins, 1988).

When assessing adolescents for suicide risk, again, developmental theorists can pull from many theories. One example would be utilizing Erikson's psychosocial stages and assessing for health identity development. There are no specific criticisms of developmental theories, although all the criticisms applied to the other theories can be, indirectly apply to development theories.

Family Level of Influence

System Approaches

Family systems. Family system theory states that suicide is not the result of individual problems, but is a symptom of family dysfunction (Heillig, 1983; Landau-Stanton & Stanton, 1985). System theorists believe that an adolescent attempts suicide in order to focus family attention away from other family problems.

System theory suggests that there are specific patterns in which families interact. Specifically, four types of interaction patterns that have been associated with adolescent suicide. The first type of interaction pattern is communication and it can range from open to closed. The second type of interaction pattern is cohesion and it can range from enmeshment to disengagement. The third type of interaction pattern is adaptability and it can range from chaotic to flexible. The fourth type of interaction pattern is emotional environment and it can range from hostile to nurturing (Miller, King, Shain, & Naylor, 1992).

When assessing adolescents for suicide risk, system theorists need to be able to identify how a family is functioning in terms of the four interaction patterns. An effective form of intervention is family therapy, where members can be taught appropriate boundaries, communication and problem solving skills (Heillig, 1983; McLean & Taylor, 1994; Walker & Mehr, 1983; Wonzica & Shapiro; 1987). One criticism of this approach is that it only accounts for family influence on adolescents, not taking into account other variables, such as peers, school, or society at large.

Societal Level of Influence

Sociological Theory

In Durkheim's (1951) sociological theory of suicide, he asserts that suicide is the result of society's control over the individual. Specifically, he hypothesizes that suicide is the result of too much or too little social integration. He defined social integration in terms of family, church, and political institutions.

Durkheim proposed four types of suicide that are determined either by the degree of social integration or by the degree of regulation with in the society. The first two types of suicide, Egoistic and Altruistic, are determined by the degree of social integration. Egoistic suicide occurs when there is a lack of social integration and members do not have common beliefs, values, traditions and supportive ties. An adolescent in this environment feels detached from the social group, and responsible for managing his/her burdens alone. Without social support, suicide is a viable option. In opposition to Egoistic suicide, Altruistic suicide occurs when adolescents are overly integrated and

absorbed into social institutions. The individual wants and desires of adolescents are stifled at the benefit of the larger society. Feeling trapped by their environment, adolescents commit suicide.

The second two types of suicide are determined by the degree of societal regulations. Anomie suicide occurs in a society that has a low degree of social regulation, changing often. There is a breakdown of moral and religious values in which members no longer feel social restraint. Suicide results when a once-secure society is perceived as disintegrating and no longer dependable (Neiger & Hopkins, 1988). In contrast, Fatalistic suicide occurs when a society has overly rigid social restraints that are inflexible and stifle members' goals. Suicide results when adolescents feel trapped by societal restraints.

When assessing for suicide risk, sociological theorists examine the amount of integration and regulations adolescent's have with family, church, and political systems. One criticism of this model is that it discusses how to identify the risk factors associated with suicide, but does not propose any intervention strategies.

Human Ecological Approach

This is a multi-disciplinary approach which incorporates individual and environmental factors in an attempt to understand behavior. Structured in terms of a five level ecosystem, theorists propose that adolescent suicidal behavior may result from the interaction of biological, psychological, social and cultural forces acting within the ecosystem. Using Bronfenbrenner's (1979) model, Garbarino (1985) has applied the five levels of the ecosystem to adolescent suicide. In doing so, he has created an integrative

and comprehensive approach to understanding adolescent suicide (Henry, Stephenson, Hanson, & Hargett, 1993).

As mentioned above, the ecosystem is comprised of five levels. The first level of the ecosystem is the individual organism (adolescent) and is defined by demographic features and psychological qualities of an individual. The second level is the microsystems and is defined as the immediate setting surrounding the adolescent, such as family, peer group, school and work. The third level is the mesosystem and can be described as the relationship between subsystems in the microsystems. For example, how the family subsystem and friends subsystem interact. The fourth level is the exosystem and is the broader environmental level of the organism, including parents' employers, school boards, and the media. The last level, the macrosystem, is the largest level of the ecosystem, including institutions or ideological patterns for a culture or subculture. Examples of the macrosystem would be economic, social educational, medical, legal and political systems.

Each level of the ecosystem presents a new and different opportunity to influence adolescent behavior. The influencing factors are not randomly chosen, but are derived from the theories reviewed in this chapter. For example, influencing factors at the microsystem level are loss of family members (psychoanalytic), depression or suicide attempts in other family members (biological or behavioral theory), residential mobility (developmental theory), and ineffective interaction patterns (family systems). Using the ecosystem model, specific risk factors found in other theories can be integrated to create a comprehensive environmental model (Henry et al, 1993).

Theoretical Framework

This chapter has categorized and reviewed the biological, psychological, developmental, sociological and system theories in terms of their influence levels. As the review revealed, the majority of theory and researcher has focused primarily at the individual influence level. As mentioned in the introduction, diagnostic groupings, demographic factors, biological correlates, and psychological mind sets have all been researched, yet the adolescent suicide rate still continues to climb (Cosand et al., 1982; Hawton, 1986; Shaffer, 1974). Therefore, it logically follows that a more thorough investigation of the family and societal influence levels is required.

It is the purpose of this thesis to increase the understanding, assessment, and prevention of adolescent suicide through increased insight into an adolescents' world at the family influence level. Due to the limited scope of this thesis, addressing the societal influence level is not feasible. Suggestion are made in the final chapter as to future theoretical possibilities.

In examining the family influence level of adolescent suicide, family systems theory is appropriate for the following reasons. First, family systems theory generates numerous assessment possibilities. Since the component parts of systems theory (interaction patterns) can be broken down, they can be assessed using already normed and validated measuring instruments.

Second, systemic concepts supply clinicians with ways to move directly from assessment to intervention strategies. For example, if a family is assessed as having low cohesion, then a therapist can focus specifically on increasing cohesion levels.

Third, family therapists have been successful in treating the families of adolescent suicide attempters (Heillig, 1983; Mclean & Taylor, 1994; Walker & Mehr, 1983; Wonzica & Shapiro; 1990). Believing that adolescent suicide is a symptom of a larger family problem, therapy focuses less on victim blaming and more on assessing and correcting inadequate interaction patterns.

Conclusion

Now that the theoretical framework has been developed, the remainder of this thesis is dedicated to utilizing systemic principles in further conceptualizing and assessing adolescent suicide. To this end, the following chapter will define, discuss, and support the assessment value of the four interaction patterns of communication, adaptability, cohesion, and emotional environment.

CHAPTER THREE

FOUR FAMILY INTERACTION PATTERNS

The previous chapters have explained how the current theories have accounted for the roles that individuals, families, and societies play in influencing adolescent suicide. Even though all the theories described at the three level are important in conceptualizing the forces that influence adolescent suicide, the remained of this thesis focuses specifically on the family level of influence and utilizes a systemic approach.

As mentioned in the discussion of systems theory, family interactions have traditionally been broken down into four types of interaction patterns (Miller et al., 1992). The amount and quality of these four types of interactions define the relationship among family member. The interaction patterns of communication, adaptability, cohesion, and emotional environment reveal familial influences on adolescent members. To further understand these influences, each of the four interaction patterns can be divided into two subcomponents. For example, communication can be open or closed, adaptability can be rigid or chaotic, cohesion can be disengaged or enmeshed, and emotional environment can be neglecting or hostile.

Of these four types of interaction patterns, the key to understanding the relationship between suicide and family interaction patterns is communication. This

researcher proposes that communication is the mediating variable between adolescent suicide and the other three types interaction patterns. Specifically, poor or unhealthy communication patterns influences the development of other dysfunctional interaction patterns, where as healthy communication patterns coevolve with healthy interaction patterns. Further more, this researcher proposes that particular subcomponents of the interaction patterns are more likely to increase suicide risk. In particular, impermeable (closed) communication, rigid adaptability, disengaged cohesion, and a neglecting emotional environment are hypothesized to increase suicide risk. This chapter defines the four interaction pattern, explains how communication effects their development, and outlines the subcomponents that are hypothesized to increase suicide risk.

Communication

Over the years, a number of researchers have proposed that poor communication is a primary problem effecting adolescent suicide (Spirito, Brown, Overholser, & Friz, 1989; Wodarski & Harris, 1987). Going a step beyond these researchers, this researcher proposes that communication is the central component in understanding the families influence on adolescent suicide. As defined by Gavin and Brommel (1991), communication is the symbolic transactional process by which meaning is created and shared. Traditionally, it has been conceptualized in terms of a open to closed continuum, where healthy communication is considered open. Unfortunately this conceptualization is too limited for this thesis. This researcher has opted to define communication in terms of a diffuse to impermeable continuum, where both ends of the continuum are considered

extreme and dysfunctional. Figure 1 illustrates the communication continuum.

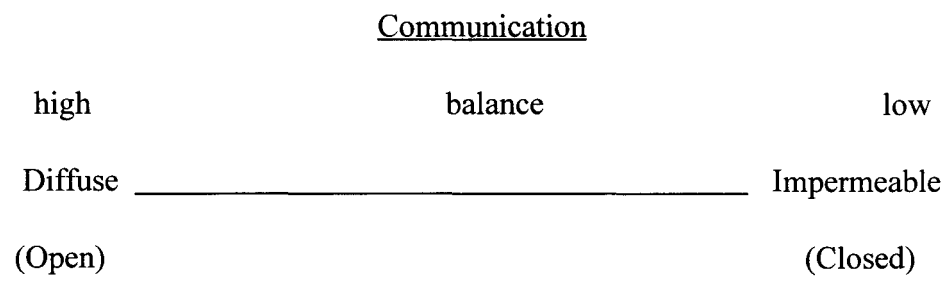

Figure 1. Continuum of Communication.

Communication that is diffuse or impermeable is consider poor or unhealthy. Impermeable communication is consider unhealthy because of the obvious lack of interaction among family members. Even if a line of communication exit, families with this type of interaction pattern send negative and rejecting messages. Further more, diffuse communication is considered unhealthy when family interactions become inappropriate, invasive, hostile, rejecting, and ineffective in conveying meaning.

In the middle of the continuum, communication is consider balanced or healthy. The content and quality of balanced communication is honest, respectful, and effective in conveying meaning. Balanced information exchanges are direct, open, and congruent in regard to verbal and nonverbal messages..

Overall, information exchanges are considered poor or unhealthy if they are inappropriate, invasive, openly hostile, closed (non-existent), indirect, or lack congruency between verbal and nonverbal communication.

Through these definitions of communication, it will be shown how chaotic and rigid adaptability are communicated, how enmeshed and disengaged cohesion are communicated and how hostile or neglecting emotional environment are communicated.

Adaptability

Adaptability is the second variable in suicidal adolescents' families. According to Olson & McCubbin (1983) adaptability is the ability of a system to change its power structure, role relationship and relationship rules in response to situational and developmental stress. The best way to conceptualize adaptivity is in the form of a continuum. Adaptability is considered dysfunctional when family patterns are extremely low(rigid) or extremely high (chaotic).

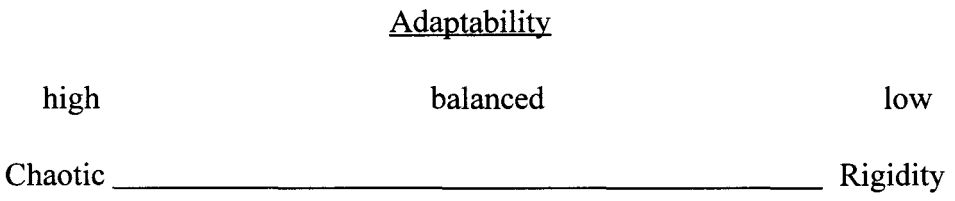

Figure 2. Continuum of Adaptability.

Adaptability is relevant when discussing adolescent suicide since crisis resolution is dependent on the adaptability of the individuals and his/ her support system. An adolescent becomes suicidal when he/ she is unable to adapt to make new role changes appropriate to developmental level (Gilead & Mulaik, 1983). Examples of ineffective

coping skills that suicidal adolescents develop are avoidant coping method, such as social isolation, substance abuse (Curran, 1987) and an inability to identify positive consequences for their problem solutions. Since they perceived negative consequences, adolescents are discouraged to implement the few solutions they do generate (Spirito et al., 1989).

When discussing adaptability two important issues need to be addressed. First is the fact that communication mediates between rigid and chaotic family interaction patterns and suicide. Second is the hypothesized relationship between rigidly-adaptive families and increased suicide risk. In order to address these two issues a systemic approach is used, describing low and high adaptability in term of boundaries, communication patterns, and the emotional overtones.

To begin with rigidly-adaptive families have overly structured boundaries, which are limited or closed. Rigid systems set strict rules and regulations governing family interactions. Communication is curtailed by the formality of the system. When communication does occur it has negative overtones which are delivered overtly or covertly. The overall emotional environment leaves adolescents feeling trapped and constrained. Restricted by their rigid family interaction patterns, adolescents are unable to generate alternative solutions to suicide.

Researchers have found that problems do occur in families having low or rigid adaptability (Mitchell & Rosenthal, 1992). Additionally, researchers have found that families with low adaptivity produce adolescents that have inflexible relationships that

cannot adapt to changing individual needs (Neuringer,1964; Miller, et al., 1992).

In contrast to rigid-adaptive families, chaotic-adaptive families have boundaries that lack clarity. Chaotic families are characterized by changing role relationships and overall instability. Communication in this type of family has no consistency or predictability, conveys negative messages and can be delivered overtly or covertly. An adolescent in this environment has no ground rules to play by and therefore lacks stability. Developing in this environment, adolescents may feel out of control and overwhelmed, two feelings commonly associated with depression and suicide. Coupled with the fact that chaotic families are not able to teach problem solving skills to their adolescents', adolescents in this environment see suicide as a viable solution.

Researchers have found that family environments that are high in adaptability (chaotic) do not allow for the appropriate development of coping skills. Evidence put forward by Miller, King, Shain, & Naylor (1992) described family environments filled with chaos and emotional instability that interfere's with the adolescent psychosocial development, resulting in the inability to develop coping skills.

To summarize, research supports the idea that families that are rigid or chaotic, maintain an unhealthy family environment. If the family is rigid, there is no room and no options for change constructively. If the family is chaotic, they do not develop the ability to learn how to change effectively. Either way a developing child will not be able to develop the appropriate coping mechanism/ problem solving skills necessary to negotiate through trouble times. However, this researcher posits that rigid adaptability is more detrimental than chaotic, based on the emotional overtones it produces.

Cohesion

Cohesion is the third variable used in the assessment of family functioning. Cohesion is defined as the emotional bonding members have with one another and the degree of individual autonomy a person experiences in the family system (Gavin & Brommel, 1991). Basically, cohesion refers to the level of emotional connection among family members. Similar to the concept of adaptability, cohesion can be unhealthy when family systems move to extremes, as in being disengaged or enmeshed.

Cohesion

high balanced low

Enmeshed _____ Disengaged

Figure 3. Continuum of Cohesion.

Similar to adaptability, the relationship between disengaged and enmeshed cohesion level can be understood in terms of boundaries, communication patterns and emotional affect. For instance, disengaged-cohesive families have limited or closed boundaries that support little or no communication. Members of disengaged families can be described as highly autonomous, and lacking closeness. Only high levels of stress can reverberate strong enough to activate the family's support system. The negative messages of this system are communicated mostly covertly, as free communication happens rarely. Adolescents in this types of family situation are apt to feel emotionally

withdrawn, isolated, and lacking support.

Research supporting the role disengagement plays in adolescent suicide have found families of suicidal adolescents to be significantly more disengaged (emotional distant) than psychiatric or health comparison (Miller et al., 1992; Northcutt, 1989). Similarly, Asarnow, Carlson and Guthrie (1978) found that children who attempted suicide saw their families as less cohesive, higher in conflict and less controlled than nonsuicidal children.

Conversely, enmeshment is the decreased distance between family member's (Munichin,1974). When boundaries are enmeshed, one family member's problem immediately affects other family members. Closely bonded and overly involved, this type of interaction allows individuals little autonomy or individual fulfillment. Communication of individual needs are secondary to the needs of the family. The communication style is overly invasive, not encouraging individual identity development. This message can be conveyed overtly or covertly, resulting in feelings of little personal identity and of being smothered.

Research supports the role of enmeshment in suicidal acts. Since adolescent is a time of identity development, it is imperative for adolescents to separate from their parents (Hendin, 1987; Pfeffer, 1981; Richmand, 1979). Failure to separate results in poor identity development. Since enmeshed families do not allow their adolescents to establish their own autonomy, suicide becomes one way out of an intolerable situation.

An additional option not yet explored is family systems that have shifting or incongruent levels of cohesion. Since systems are ever changing, Richman (1979) and

Pfeffer (1987) have suggest that families that vacillate between extreme enmeshment and extreme disengagement can produce a suicidal adolescent. Other researchers, such as Kalman & Maldaver (1993) have focused on the affect of incongruent family types. For example, when one parent is enmeshed, while the other is disengaged. Their study found that this kind of mixed parental style is also detrimental to adolescent development. When comparing disengaged, enmeshed, and mixed parental type, the study revealed that suicide attempts occurred more frequently in disengaged types, followed by mixed and then enmeshed types.

Overall, the research demonstrates that adolescents whose families are disengaged have more problems. This supports the hypothesis that disengaged cohesion is more detrimental than enmeshed, even though they are both dysfunctional.

Emotional Environment

The best way to conceptualize emotional environment is in terms of a neglecting vs. hostile continuum. At both ends of the continuum, parental messages become negative and rejecting.

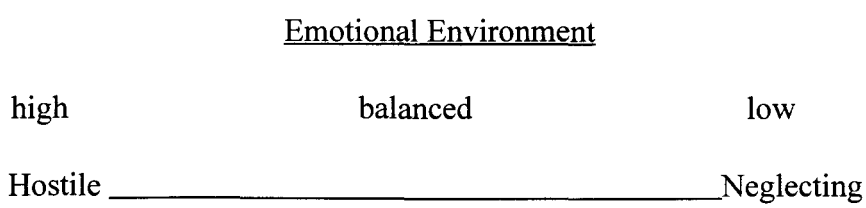

Figure 4. Continuum of Emotional Environment.

Again, the systemic concepts of boundaries, communication patterns and emotional affect are used to illustrate the mediating role of communication and the hypothesized increase suicide risk of a neglecting-emotional environment. Adolescents develop in a neglecting-emotional environment when families display a blatant lack of interest for them. This type of environment usually develops overtly or covertly in families that has closed or rigid boundaries. The emotional overtones of the messages being received by adolescents' are of ambivalence and indifference.

On the other hand, families with a hostile type of interaction pattern either have open or limited boundaries. Whatever the boundary system, tensions are built through the overt exchange of highly charged emotional messages. These messages are predominately negative and leave adolescents feeling unloved and expendable. In either type of environment, hostile or neglecting, the emotional need of family members are left unsatisfied.

Many theorists have postulated that being socialized in a hostile or neglecting environment makes adolescents feel alienated from their family and contributes to the development of a suicidal personality (Hendin, 1987; McIntire & Angle, 1973; Sabbath, 1969; Teichner & Jacobs, 1966). The idea that negative parental messages influenced suicidal adolescents was first introduced by Gould (1965) and described as a parental desire to increase their happiness by wishing their child did not exist. Schrut (1968) described the same concept as a unconscious parental message that their child is a burden. The term "expendable child" was added to the literature by Sabbath (1969). He

described the concept as a conscious or unconscious parental wish, that the child interprets as their parents' desire to be rid of them. The rejection hypothesis was put forth by Dorpat (1975) explained suicide as an adolescent's internalized environmental rejection. These adolescents become such a disturbance in the family that the parent wish them gone (Sabbath, 1969).

In more recent studies attempting to validate the rejection theory, Pfeiffer (1981, 1987), added that children are not valued for themselves, but only for the role they play in satisfying parental conflicts and needs. Also, a study conducted by Wonznic and Shapiro (1990) assessed the concept of expendability. These researchers found that suicidal adolescents reported significantly higher rating on an expendability measure than non-suicidal adolescents. Finally, in a study by Miller et al. (1992), they reviewed Sabbath's model of the expendable child adding that it is the chronicity of hostile and rejecting interaction that lead adolescent to act out their parent's perceived wish of expendability.

Closely related to the rejection theory, Stocker (1987) suggested that a rejecting can take two other forms. First, rejection can come from certain types of disciplinary actions, such as failing to react properly and discourage negative behavior and withdrawal from the child. Second, Stocker suggested that the loss of a loved object, through death, separation, or divorce is also a form of rejection. Researcher have found that when separation or divorce occurs, it increases family conflict causing ambivalence, anger and rejection; disruption of the marriage affects the emotional environment. A childhood characterized by parental discord and frequent separations has been associated with later suicide attempts (Spirito et al, 1989; Wodarski & Harris, 1987).

Conclusion

This chapter has defined and discussed the four types of interaction patterns in terms of their subcomponents and their relationship to adolescent suicide. Additionally, the literature has supported the assessment value of the interaction patterns. So, when screening for potentially suicidal adolescents, clinicians should note whether the adolescents' families have poor communication, high or low levels of adaptability, cohesion and emotional environment. To assess for increase suicide risk, this researcher suggest to assess adolescents for closed communication, rigid adaptability, disengaged cohesion and a neglecting emotional environment. The following chapter will specifically focus on the mediating role of communication, through the presentation of a mediating model.

CHAPTER FOUR

COMMUNICATION AS A MEDIATOR

In the last chapter, communication was hypothesized as a mediating variable between adaptability, cohesion, emotional environment and suicide. Building on that foundation, this chapter presents a model that further address the mediating role of communication. This mediating model integrates the four variables into an encompassing diagram. After the model has been presented, an assessment strategy is outlined and discussed.

Theoretical Overview

Before presenting the mediating model, it is first important to understand how other theorists have attempted to account for family interaction patterns and their affect on family functioning. Three models are presented, with the first two focusing on the interaction patterns of adaptability and cohesion, and the third focusing solely on cohesion.

The first model developed by Olson, Sprenkle and Russel (1979) proposes that a curvilinear relationships exist between adaptability and cohesion. Illustrated by the Circumplex model, Olson et al. (1979) suggest that heathy interaction pattern develop when levels of adaptability and cohesion are balanced, being neither too high or too low.

Conversely, poor interaction patterns develop when families are functioning at extreme levels of adaptability (chaotic/rigid) and cohesion (enmeshed/disengaged). Furthermore, Olson et al. (1979) explains that the movement from one end of the continuum to the other is facilitated through communication. This means that communications patterns that are more open, allow for the development of balanced families. The literature has revealed that evidence for the Circumplex theory is especially convincing for the curvilinearity of cohesion, yet it is only marginally supportive of the curvilinearity of adaptability (Anderson, 1986).

The second model, developed by Beavers and Voeller (1983), attempts to account for the alleged short coming of the Circumplex model. Agreeing with Olson et al.'s (1979) view of cohesion, their model differs in respects to adaptability. They proposed that a linear relationship, rather than a curvilinear relationship, exists between adaptability and healthy family functioning. Instead of viewing adaptivity in terms of rigidity and chaos, Beaver and Voeller (1983) view adaptability in term of a continuum ranging from dysfunctional to optimal functioning. At one end of the continuum, there is leaderless, invasive and chaotic families, with diffused interpersonal boundaries. At the mid-point of the continuum, families exhibit rigid interpersonal controls, little closeness, and projection. At the optimal or competent end of the continuum, families are well structured, with autonomous members who share both intimacy and separateness (Green, 1989). Beaver's model suggests that optimal family functioning occurs when families are highly adaptable and moderately cohesive (Bakken & Romig, 1989).

Finally, the third model suggests that cohesion has a linear, rather than

curvilinear relationship with optimal family functioning (Cohen & Willis, 1985; Persoa & Persoa, 1990). Supporters of this model believe that families high in cohesion have better communication, better marital consensus and better behavior outcomes for adolescent children (Farrell & Barnes, 1993).

Mediating Model

Of the three prevailing models, the mediating model is based on the same underlying principles of Olson's Circumplex model. In agreement with the curvilinear theory and operational definitions of adaptability and cohesion, the mediating model also incorporates two important changes. First, the mediating model accounts for three interaction patterns (with the addition of emotional environment), while the Circumplex model accounts for only two interaction patterns (adaptability and cohesion). Second, the mediating model identifies communication as a mediator, as opposed to a facilitator. This represents an essential theoretical difference between the two models Olson (1979) works off the premise that communication is linear (Barens & Olson, 1985). This means that the more open communication is, the more it influences the development of balanced interaction patterns. In opposition, the mediating model is based on the premise that like all the other interaction patterns, communication is also curvilinear. This means that communication patterns that develop at both the diffuse (open) and the impermeable (closed) end of the communication continuum are considered unhealthy. In order to distinguish the theoretical difference between the two models and to re-emphasize the importance of communication as influencing the development of unhealthy interaction

patterns, this research has chosen to identify communication as a mediator, rather than a facilitator.

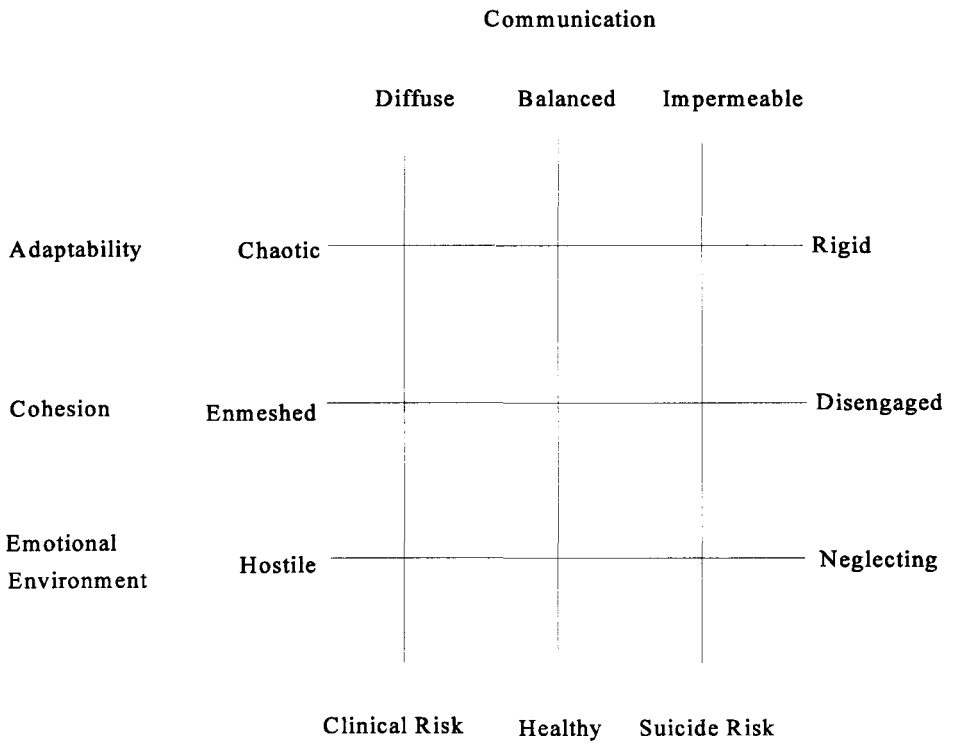

Figure 5. Mediating Model.

As figure 5 illustrates, communication is the central factor in understanding the relationship of suicide to the three other variables. The mediating model incorporates the continuums of the four interaction patterns, discussed in last chapter, in a way that illustrates the mediating effects of communication. Similar to the Circumplex model, the mediating model suggests that healthy interaction patterns develop at mid-ranges between

the continuum lines. Conversely, poor interaction patterns develop at the extreme ends of the continuum lines. It is hypothesized that interaction patterns that develop at the extremes of the continuum are the ones more likely to contribute to dysfunctional behavior. Specifically, extreme interaction patterns that develop on the impermeable side of the model are hypothesized to contribute to increased suicide risk. Additionally, extreme interaction patterns that develop on the diffuse side of the model are hypothesized to contribute not to suicide risk, but to other clinical concerns. Possible clinical concerns could be disorders of undercontrolled behavior (conduct disorders), disorders of overcontrolled behavior (childhood fears and affective disorders), and eating disorders (anorexia and bulimia).

The development of extreme interaction patterns are influenced by familial communication patterns. Communication that is either diffuse (open) or impermeable (closed) influences or results from the development of the extreme interaction of chaotic or rigid adaptability, disengaged or enmeshed cohesion, and hostile or neglecting emotional environments. On the other hand, balanced communication patterns falling at the mid-ranges, influences or results from the development of healthier interaction patterns.

To summarize, the mediating model proposes that communication patterns influence and are influenced by the development of extreme continuum levels, which are more likely to increased suicide risk or clinical risk. Due to the specific goal of addressing adolescent suicide, the remained of this thesis focuses just on extreme interaction patterns that influence the develop of suicide risk, leaving the clinical risk

factors to be discussed at a later date.

Clinical Applications

The mediating model supplies clinicians and researchers with two important pieces of assessment information. First and foremost, when assessing for adolescent suicide risk, clinicians must address the mediating role of communication by evaluating for poor communication patterns. Adolescent's identified as having poor communication patterns can then be placed in a risk group for developing suicidal tendencies. In addition to evaluating for problematic communication, clinician should simultaneously assess for extreme levels of adaptability, cohesion and emotional environments. Although poor communication is hypothesized to be a mediating factor in adolescent suicide, by assessing levels of the other interactions patterns clinicians can account for variation not overtly manifested through poor communication.

Depending on the goal, the assessment strategies generated from the model can be implemented in or outside of a therapeutic setting. For instance, if the goal is to assess for suicide risk before a family enters therapy, then the school system, extra-curricular activities, or peer groups would be a good place to intervene. Or, if a family has already entered therapy, the model could be used to assess and implement therapeutic strategies.

Planning an assessment strategy for both situations required different resources. Since school setting are not very conducive to standardized assessment instruments (excluding school counselors), a behavioral checklist would be more useful to teachers, coaches and peers. The list would include behaviors that indicate communication

problems, as well as, extreme ranges of adaptability, cohesion, and emotional environment.

One such behavioral check list was developed by Olson's et al. (1979) as part of their Family Adaptability and Cohesion Evaluation Scales II: Family Version (FACE II). Designed with a Likert scale, clinicians rank family responses to 30 question on a almost never/ almost always continuum (Bagarozzi, D. A.,1985).

Unfortunately, this check list is not fully applicable to the mediating model since it only assess for communication, adaptability and cohesion, excluding emotional environment. In order to create a more complete checklist, this researcher developed a new checklist, incorporating four questions from the FACES II check list with six new questions developed by this researcher. The format is generally the same, utilizing the same Likert scale and continuum (almost never/ almost always) and consisting of one form for all family members.

This new checklist is designed to assess all four interaction patterns and is comprised of ten questions. The first two questions establish whether family interaction patterns are stable over time or are the result of some recent event. If a family's problem is event related, the family may not have inherent interaction problem. It is possible that the family does have the internal resource to deal with their everyday problems, but is having difficulties responding to a particular crisis situation. On the other hand, families with stable, poor interaction patterns do not have the internal resources to deal with their problems. Consequently, therapy would involve the development of new interaction patterns rather than just the enhancement of already function patterns.

The remaining eight questions tap into each of the subcomponents of the four interaction patterns (closed/open communication, rigid/chaotic adaptability, disengaged/ enmeshed cohesion, and neglecting/hostile emotional environment). The questions addressing the mediating variable of communication do so in terms of expressiveness (open vs. closed). The two questions are, "Family members are afraid to say what is one their minds" and "In our family, it is easy for everyone to express his/her feelings." The questions addressing adaptability do so in terms of rigid or chaotic family regulations (Bagarozzi, p.77). The two questions are, "It is difficult to get a rule changed in our family" and "It is hard to know what the rules are in our family"(Bagarozzi, p.78). The questions addressing cohesion do so in terms of disengagement and enmeshment and relate to boundary issues. The two questions are, "I have little interaction with my family members" and "I have little privacy and time alone in my family." Finally, the last two questions address emotional environment in terms of neglect and hostility. The two question are, "Family members openly express feelings of anger and resentment" and "I feel ignored and unwanted by family members." This check list can be found in appendix one. Scoring and interpretation of the scale can be found in appendix two.

Unlike school setting, once a family presents for therapy standardized test and inventories, in addition to behavioral checklists, can be used to asses for interaction problems. Appropriate instrument to use would, again, assess for the interaction pattern of communication, adaptability, cohesion, and emotional environment. However, upon reviewing the literature, it became apparent that there are only a few instruments that adequately test systemic concepts. A good portion of the instruments, including the ones

chosen to be reviewed, have some reliability and validity problems. It is not the focus of this thesis to discuss these problems in detail, but a brief criticism of each measure will be mentioned.

A total of three assessment instruments are presented. The first two instruments are based upon the curvilinear theory as proposed by Olson (1979) and assess for communication and adaptability and cohesion. The last instrument presented is designed to assess for emotional environment.

The first instrument, the Parental-Adolescent Communication Scale (PACS) assess for the quality of communication between parents and their adolescents. Developed by Barnes & Olson (1985), it is comprised of 20 items that reflect adolescents' and parents' perspectives on the quality of their interpersonal communication. There are three forms of the scale, a mother and a father form for the adolescent and one form for both parents. The instrument is designed with two subscales, the Open Family Communication and the Problems in Family Communication. The first scale represents balanced communication which is free, flexible and satisfying to all family members. Examples of three test items are, "It is easy for me to express all my true feelings to my mother/father/child," "My mother/father/ child tries to understand my point of view" and "My mother/father/child is always a good listener" (Barnes & Olson, 1985, p. 59).

The second scale, Problems in Family Communication, represents extreme communication patterns consisting of hesitancy, caution and selectivity in reveal information and feelings. Three example items are, "My mother /father /child has a tendency to say thing to me which would be better left unsaid," "I don't think I can tell

my mother/father/child how I really feel about something," and "When we are having a problem, I often give my mother/father/child the silent treatment" (Barnes & Olson, 1985, p. 59).

Although this instrument is properly normed for the adolescent population (over age of 12), caution should be used in assessing ethnically diverse populations. Additionally, critics have also suggest that is an insufficient amount of data to establish reliability and validity evidence (Goldenthal, 1990).

Also based on Olson's theory is the second instrument, the Family Adaptability and Cohesion Evaluation Scales III (FACES III). Developed by Olson, Portner & Lavee (1985), it is a 20 item self-report measure that assesses adaptability and cohesion. Ten item assess cohesion which is divided into five categories: 1) emotional bonding, 2) supportiveness, 3) family boundaries, 4) time and friends, and 5) interest in recreation. The other ten item assess adaptability and are divided into five categories: 1) leadership, 2) control, 3) discipline, 4) roles, and 5) rules. The test items are stated in sentence form and respondents are asked to rank the frequency of behavior from 1 (almost never) to 5 (almost always). When completed, the clinicians classify respondents into one of sixteen family types based on the Circumplex Model. After the appropriate classification, a profile of family functions is developed, identifying families as balanced, midrange, or extreme. Extreme family type are the ones identified at risk for suicide attempts.

This measure is adequately normed on 2,453 adults across the life cycle and on 412 adolescents. Olson (1986) claims that this measure is internally consistent and has adequate face, construct, and discriminate validity. Despite his claim, critics have

questioned reliability and validity of the adaptability subscales (Green, 1989).

Third, the Family Environment Scale (FES) is a 90 item true/false instrument designed to measure social-emotional attributes of various types of families. Developed by Moos & Moos (1981), this scale consists of three parallel forms comprised of ten subscales. The subscale cover three domains, the Relationship Dimension, the Personal Growth Dimension, and the Systems Maintenance Dimension.

For our purpose, the area of concern lies in the Relationship and System Maintenance Dimensions. The Relationship scales measure the elements of cohesion, communication, and emotional environment under the three subscale of cohesion, expressiveness and conflict. For example, cohesion is measured in terms of commitment and assistance and an example questions is, "We really get along well with each other." Communication is measured in terms of expressiveness of feelings and an example question would be "We tell each other about our personal growth." Emotional environment is measured in terms aggression, conflict and anger and an example question would be, "Family members often criticize each other" (Fredman & Sherman, 1987, p. 88).

The System Maintenance scale is comprised of two subscales, Organization and Control. The Control scale assess for rigidity by measure the extent to which established procedures and regulations are abided by when running family life. An example question from this scale would be, "You can't get away with much in your family" (Fredman & Sherman, 1987, p. 88).

This measure is well normed and has robust face validity. Critiques have noted a

lack of predictive validity, a problem associated with projective techniques (Caldwell, 1984).

Even though the assessment strategies of the inside vs. outside a therapeutic setting are different, the ultimate goal is the same. Use of behavioral checklist could enhance assessment possibilities outside of a hospital or agency , where as the standardized test and inventories could enhance assessment in therapeutic settings. As an overall assessment strategy, all four of these instrument should be used to assess for the four interaction patterns. Scores that reflect extreme interaction patterns automatically place adolescents in an at risk group for suicide. Again, it is hypothesized that a higher risk group can further be distinguished by noting scores that indicate the extreme interaction patterns of closed communication, rigid adaptability, disengaged cohesion and a neglecting emotional environment. It is this researchers hope that the three assessment devices, in addition to the behavioral checklist, will prove to be an effective assessment strategy.

Conclusion

It is only through a better understanding of the relationship between the interaction patterns and suicide can clinician determine which patterns have the most impact on adolescents and then asses for them accordingly. This chapter has attempted to increase the understanding by presenting the mediating model, illustrating the impact of poor communication on suicide risk, and generating social and clinical assessment strategies.

CHAPTER FIVE

RESEARCH, LIMITATIONS AND IMPLICATIONS

The goal of this thesis was to address the increasing problem of adolescent suicide using a family systems perspective. After reviewing systemic concepts and incorporating them into a working model, this thesis has illustrated the mediating role of communication between adaptability, cohesion and emotional environment and suicide. The remained of this thesis discusses potential research, theory and model limitations, and future theoretical implications.

Research Possibilities

The mediating model has the potential to generate numerous research possibilities, especially for suicide assessment strategies. For example, similar to the idea that certain subcomponets of interaction patterns are more detrimental than other in creating a suicidal environment, the same could be hypothesized about certain sequences of interaction patterns. In particular, the combination of closed communication, rigid adaptability, disengaged cohesion, and neglecting emotional environment could contribute to increase suicide risk. Figure 6 highlights this particular sequence of

interaction patterns.

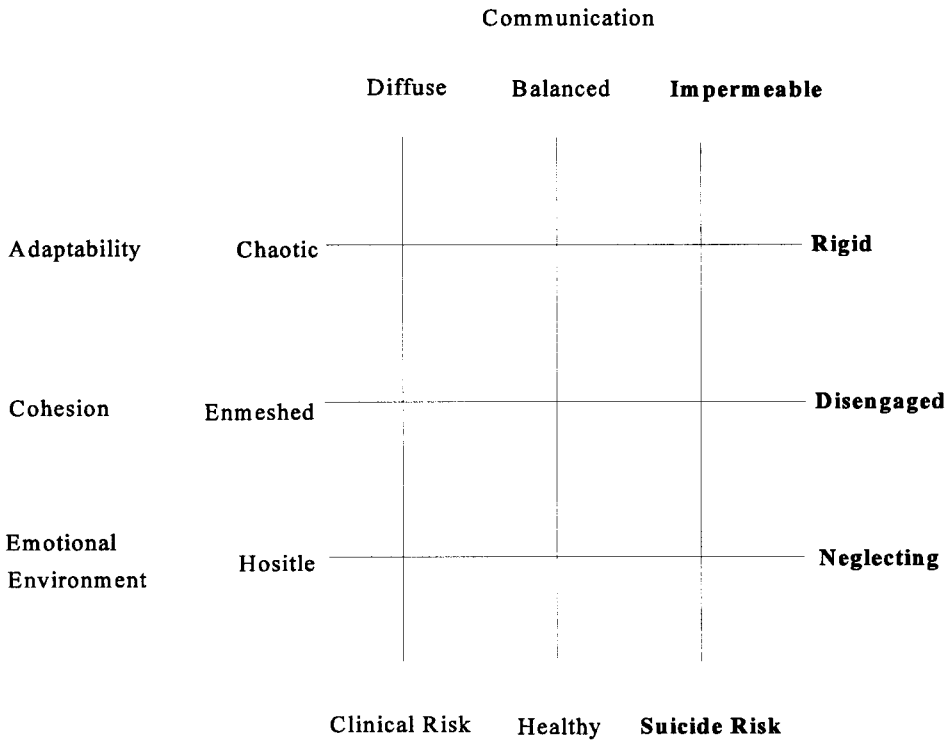

Figure 6. Increased Suicide Risk Factors.

On what basis is this sequence of interaction patterns hypothesized to be more likely to increase suicide risk? First of all, by understanding and utilizing the mediating role of communication, it can be assumed that families with suicidal adolescents have poor communication patterns. This researcher believes that the absence of interaction or impermeable (closed) communication is more detrimental than diffuse (open)

communication (Asarnow, Carlson and Guthrie, 1978; Miller et al., 1992; Northcutt, 1989).

Second, rigid adaptability is consider more detrimental than chaotic adaptability since it produces an environment that makes adolescents' feel trapped. Adolescents in both type of environment develop problem solving deficiencies. Adolescent's in rigid families are trapped by their lack of options, leaving them with feelings of hopelessness and despair. Adolescent's in chaotic families are confused by the lack of clear rules and roles, which leads them to feel overwhelmed. Rigid adaptability is believed to be more detrimental since adolescents' feel trapped, without the resources to figure a way out (Neuringer, 1964; Miller, et al., 1992 Mitchell & Rosenthal, 1992).

Third, disengaged cohesion level are hypothesized to be more detrimental than enmeshed levels, based on the assumption that no communication is more harmful than hostile communication. In disengaged families, there is limited or even no interaction between family members. Additionally, the interaction that do occur are negative. In enmeshed families, there is communication, but it is usually inappropriate or hostile in nature. Again, no interaction is hypothesized to be more harmful than hostile interactions (Asarnow, Carlson and Guthrie, 1978; Miller et al., 1992; Northcutt, 1989).

Finally, a neglecting emotional environment seems more detrimental than a hostile environment for the same reason stated above. In a neglecting environment, there is little interaction between family members, leaving adolescents' feeling expendable. At least in a hostile environment, there is some overt interaction taking place (Dorpat, 1975; Hendin, 1987; McIntire & Angle, 1973; Sabbath, 1969; Teichner & Jacobs, 1966;

Wonznic and Shapiro,1990).

Taken together, a family with this sequence of patterns would be characterized by having little or no communication, little or no social or emotional support from family members, and an inability to solve problems. When taking into account the feelings of isolation, hopelessness and expendability generated from this sequence of interaction patterns, it becomes easier to conceptualize why adolescents commit suicide.

Current research supports that families that are rigid, disengaged, and have poor communication patterns may provide less opportunity for healthy adolescent identify development and increase the risk of suicide behavior (Asarnow, Carlson & Guthrie, 1987; Miller, et al., 1992; Northcutt, 1989; Pillay & Wassenaar, 1991). However, these studies do not take into consideration emotional environment, therefore, leaving a gap for future studies to fill. Additionally, further research is needed validating the assessment value of all hypothesized sequence of interaction patterns. If their assessment value can be validated, it will help clinicians better identify adolescents who are at higher risk of committing suicide.

Additionally, the mediating model has generated two other research possibilities. First is the validation of the hypothesis that diffuse sequences of interaction patterns influence the development of clinical concerns (not necessarily suicide). Second, is the validation of the behavior checklist. Although it has good face validity, only a further research study could prove its worthiness.

Limitations

Three main limitations of this thesis need to be addressed. First, due to the limited scope of the thesis, it was not able to comprehensively address all the influences on adolescent suicide. Focusing just on family influences leaves the individual and the societal influence levels unexplored. Suggestions to remedy this problem are given in the future implication section. Secondly, the overall theoretical bases of the thesis is still in question. Since it is based primarily on Olson's model, the same empirical problems (reliability and validity) associated with his Circumplex model, indirectly apply to the mediating model. Only further research will determine the answer to that question. Third, and inherent to systems theory, it is impossible to determine causal relations, since all components in a systems are interrelated. So, whether poor communication causes the development of dysfunctional interaction patterns or dysfunctional interaction patterns are exacerbated by poor communication is not determinable by this thesis.

Future Theoretical Implications

As mentioned in the introduction of this thesis, the majority of adolescent suicide research and prevention has focused on individual influence levels. As the first limitation suggested, this thesis has addressed only the family influence level, leaving the societal level unattended. To address this issue, one place to start is Durkheim's sociological theory. Interestingly, the four type of suicide he outlines, reflects the four subcomponets of systems theory. For example, egoistic suicide, which is tied a lack of social integration is similar to the systemic term of disengaged cohesion. Altruistic suicide

which is tied to overly integrated adolescents is similar to enmeshed cohesion. Anomie suicide occur in a low degree of often changing social regulations, which is similar to chaotic flexibility. Fatalistic suicide involves overly rigid restraints which is similar to rigid adaptability.

Since disengaged cohesion and rigid adaptability have been hypothesized to increase suicide risk, it follows that societies having these components have increased egoistic and fatalist suicide risk. If societal levels of integration and regulation can be gauged, Durkheim's theory could be used to assess for and prevent suicide.

Other external influencing forces not accounted for Durkheim's theory are accounted for in human ecological theory. As reviewed in chapter two, the ecosystem is comprised of five levels. The first level account for the individual adolescent. The second level accounts for the adolescent's family, in addition to his/her peer group, school and work. These are three additional influence factors that future research still need to be consider when examining adolescent suicide risk. The third level described as the relationship between subsystems (how the family subsystem and friends subsystem interact). The fourth level touches on broader environmental influences such as including parents' employers, school boards, and the media. The last level includes the broadest influences level (as discussed in Durkheim's theory) such as the economic, social educational, medical, legal and political systems. A future research project could presumably use constructs set forth in the human ecological theory to present an all encompassing analysis of influences on adolescent suicide behavior.

Conclusion

The goal of this thesis was to develop a deeper understanding of adolescent suicide etiology, utilizing a family systems approach. Only recently has a family systems perspective been used in examining and assessing for adolescent suicide. This thesis has suggested that by integrating the four family interaction patterns of communication, adaptability, cohesion and emotional environment into a comprehensive assessment strategy, a new way of understanding and assessing for adolescent suicide can be developed. By utilizing communication as a mediator, the mediating model can generate an abundance of assessment strategies and future research possibilities with the hopes of furthering the prevention of adolescent suicide.

APPENDIX 1

BEHAVIORAL CHECK LIST

Circle the appropriate response:

Is the client/student/family exhibiting constant, sporadic, or one time distress?

Has there been a recent traumatic event? YES or NO. Specify_____

1	2	3	4	5
Almost Never	Once in a while	Sometimes	Frequently	Almost Always

---

Communication (closed vs. open)

( )_____1) Family members are afraid to say what is on their minds.

_____2) In our family, it is easy for everyone to express his/her feelings.

Adaptability (rigid vs. chaotic)

( )_____3) It is difficult to get a rule changed in our family.

_____4) It is hard to know what the rules are in our family.

Cohesion (disengaged vs. enmeshed)

( )_____5) I have little interaction with my family members.

_____6) I have little privacy and time alone in my family.

Emotional Environment (neglecting vs. hostile)

( )_____7) I feel ignored and unwanted by family members.

_____8) Family members openly express feelings of anger and resentment.

APPENDIX 2

SCORING SYSTEM AND INTERPRETATION

1. Code scores for the odd numbered items only and place the number in parentheses.

Code as follows:
5 = 1
4 = 2
3 = 3
2 = 4
1 = 5

2. Total the changed odd number questions _____

Total the even numbered questions _____

Suicide risk scale:

4 - 6	increased suicide risk
7 - 9	concern suicide risk
10 - 14	average risk level
15 - 17	concern clinical risk
18 - 20	increased clinical risk

3. Add scores with in each category (changed odd score + even score). Then divide by 2.

For example, {(1)____ + (2) ____ }/ 2 = _____

If the score = 1 or 2, then closed, rigid, disengaged, or neglected

If the score = 4 or 5, then open, chaotic, enmeshed, or hostile.

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VITA

The author, Wendy Adelstein, was born in Highland Park, Illinois. In May of 1993, Wendy Adelstein received a Bachelor of Arts in psychology at the University of Missouri at Columbia. While attending the University of Missouri, she was a member of Psy Chi and Golden Key National Honor Society. In August of 1993, she entered Loyola University and began working on her Master of Arts in Community Counseling.

THESIS APPROVAL SHEET

The thesis submitted by Wendy Adelstein has been read and approved by the following committee:

Edward Quinnan, S. J., Ph. D.
Assistant Instructor, Counseling Psychology
Loyola University Chicago

Carol Harding, Ph. D
Professor, Counseling Psychology
Loyola University

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.

28 March 1996
Date

Director's Signature