THE IMPACT OF UNRESOLVED LOSS ON ADOLESCENT ANGER AND DEFIANT BEHAVIOR

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This study examines the impact of issues of loss on adolescents. It was hypothesized that adolescents who experienced incidents of loss which were not adequately supported or processed to the point of resolution are much more likely to exhibit more angry and defiant behaviors than those who did not have such life experiences.

Three instruments were used to identify loss and related impact. The first is the Interview Process, designed to identify issues of loss and screen for problematic behavior. This tool is used to qualify the participant for the study, and to designate which study group the participant will be assigned. The Family Constellation Exercise is an experiential assessment tool that exemplifies how emotionally close or distant the participant feels in relation to his or her nuclear family members. The Minnesota Multiphasic Personality Assessment – Adolescent version (MMPI-A) is used to identify behaviors and thought patterns associated with anger and defiance.

The study was able to conclude that there is a strong potential for unresolved loss to negatively impact an adolescent. The study also discovered that many teenagers who do not exhibit angry or defiant behaviors have also experienced loss, yet do not act out anger. Suggestions are made as to why this is so, and implications for future research are made.

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Chapter I

INTRODUCTION TO THE STUDY

The bond between parent and child is a dynamic and powerful, yet fragile covenant (Haley, 1980; Bowlby, 1969). The personality of a child is like a tapestry woven from a complex foundation of heredity and environmental influences (Cytryn, McKnew, Zahn-Waxler, & Gershon, 1986), and can be sensitive to any source that may be impactful.

It is through interactions with those most influential to us that we become who we are, and this process begins at birth (Bowlby, 1969; Garmezy, 1986). The primary mother-child bond first teaches us that we are lovable, and teaches us how to love and trust (Viorst, 1986). From this most primary relationship, we are also provided a sense of belonging which aids in developing social skills and influences how we relate to others (Corsini & Manaster, 1982).

Psychoanalytic theorists provided some of the earliest literature on mother-child attachment behaviors, and usually valued the mother as a food source and provider of normal sexual stimulation. Even Sigmund Freud realized that there can be a healthy, warm and nurturing relationship between mother and child (Bowlby, 1969).

Intensive research determined that beginning with infancy, humans are subject to grief when separated from objects of attachments, such as parents

(Bowlby 1969,1973,1980; Viorst, 1986). In furthering her father's research, Anna Freud studied the attachment behaviors of toddlers. She and her research partner, Burlingham, observed that the need for attachment was so strong and instinctual that when deprived a primary object (the parental figure) the child will attach to almost anyone (Bowlby, 1969). The implications for later life are predictable; problematic dependency needs and relationship dysfunction (Ackerman & Graham, 1990).

Bowlby (1964) learned much about personality development through observation of very young children and how they behave towards their mothers. His research focused patterns of interaction between mother and child, the child's activities and behaviors in the presence of mother, and the response of the child when mother was removed from the child's presence. The pattern of established relationship between mother and child is known as attachment behavior, which is necessary for the child's survival. Bowlby concluded that the kind of care an infant receives from mother plays a major role in determining the way in which attachment behavior develops in the child.

A child initially becomes attached to the mother through early attainment of basic physiological needs (food, shelter, cleansing), and then learns to seek other physical and psychological gratification, known as secondary drive (Bowlby, 1969). These needs, such as nurturing and socialization, may not be as imperative for survival, but are developmentally important to the child. Such purposive behavior may, at times, be burdensome for the mother, but is

imperative for the development of an emotionally healthy child who will learn to effectively attain and integrate wants and needs.

This study investigates how unresolved disruption of the relationship between parent and child is identified as loss (Bowlby,1969,1973,1980), and how symptomatic anger and defiant behavior results, even though it may not be evidenced until the teen years. Since so many of society's problems are being blamed on the dysfunctions of the young, it is time to look at causation. Through an examination of loss and effect on the lives of the adolescent population, this study will provide information that contributes to understanding teen anger and defiant behavior. Since there is little research in this area, this study will contribute significant information and direction for adolescent and family therapy, and for future research.

Literature Review

Attachment and Loss

Attachment behavior is behavior through which a discriminating, differential, affectionate relationship is established with a person or object. The behavior tends to evoke a response from the object, initiating a chain of interaction which serves to consolidate an affectionate relationship (Ainsworth, 1970). Attachment to mother is instinctual and necessary for survival, and a unique anxiety is experienced when attachment is threatened (Bowlby, 1969, 1980; Viorst, 1986). Bowlby (1969, 1980) premised disruption of the initial bond with mother may negatively influence subsequent personality development and

promote problems such as anxiety, ambivalent relationships, and future compulsive care-taking behaviors. The need for human connectedness is extremely strong, and absence of this bond can produce powerful consequences. Bowlby (1973), through his extensive and exhaustive study of attachment, separation, and loss, identified three phases of a child's response to separation from mother. The first, protest, is in direct response to separation anxiety, which is the initial reaction to separation. In this phase the child will cry, have tantrums, refuse comforting, and will be irritable and do whatever is possible, as he/she demands to "recover" mother. The second phase is despair, which describes grief and mourning associated with loss. The child is sad, preoccupied with thoughts of mother, and remains vigilant for her return. The third stage is detachment, which is a defensive reaction in an effort to protect oneself against further pain. The child may appear to lose interest and may emotionally detach from mother in response to her absence, but will recover and reform attachment if the absence was not so long as to cause traumatic disruption to the mother-child relationship.

"Loss" is a state-of-being caused by experiencing emotional rejection, uninvolvement by the object of loss; or physical absence, including death, separation, and divorce. Children often respond to these absences by withdrawing, becoming hopeless, feeling depressed, and/or getting angry. Garmezy (1986) reviewed research on early childhood loss and separation and

found children in the 5-10 year-old range to be most vulnerable to loss, often experiencing significant adaptive difficulties in adulthood.

An adolescent who has experienced loss may perceive, sometimes out of conscious awareness, that a parent has found something more worthy of his or her time and energy, and is not available as a resource for guidance and nurturance. The adolescent may then develop a lifestyle based on this perception, and may become angry, defiant and increasingly vulnerable to the influence of others outside the home to fill the void (Cramerus, 1990). There seems to exist a private logic shared by many who have experienced similar perceived abandonment; ‘You weren't here for me when I needed you; I don't want you now’. It becomes easier to push parents away rather than risk further pain. The adolescent begins a lifestyle evidenced by emotional detachment (Viorst, 1986). Cramerus (1990) presented narrative indicative of this private logic:

> My pain and inadequacy are not my fault. They are your fault. If you give me the nurturance that you are unjustly and maliciously withholding, which is rightfully mine, my losses and lacks will be repaired. You owe this to me, you should give it to me, and, above all, you should want me to have it (p.519).

The energy from these longings of emotional fulfillment may fuel other problems. One way to cope with loss is the "masking" of grief where the sufferer does not recognize or understand that behaviors are related to loss (Worden,

1982). Symptoms and behaviors that would not usually be related to adjustment of normal grief may include diminished or absent grief responses, acting out behaviors, and binge consumption of food, alcohol, drugs, sex, and/or smoking.

Viorst (1986) identified three major forms of defenses to loss and grief the adolescent may develop. They include emotional detachment, a compulsive need to take care of other people, and premature autonomy. Emotional detachment is emotional distancing by the young person to others in order to protect from further pain. Unfortunately, increased feelings of loss, isolation, anger, and loneliness can occur. The compulsive need to take care of other people may occur when an adolescent feels the need to be in control, fearing another loss. This compulsion is likely to promote feelings of anger, frustration, exhaustion, and depression when it becomes apparent that efforts to control others are futile. Premature autonomy comes from the sense that there is no one to trust for support and a personal sense of well being, so the young person takes it upon his or herself to provide self-care. This may cause a general lack of trust in relationships, and an inability to be reciprocally involved with others. It becomes imperative to the adolescent to not depend on the help or love of anyone. This is done, Viorst explained, "to dress the helpless child in the brittle armor of the self-reliant adult" (p.23).

Like mothers, the power of the connection of the child to it's father is soon evident. When there are disruptions to the father-child relationship, there are also significant problems. Erickson (1998) identified the impact of "father loss" as

> a condition wherein...father was literally absent from their life or was physically present but was emotionally unavailable to them. It is also experienced from not knowing their father, from having an inadequate father or from having lost day-to-day contact with him. The trauma caused to children by father loss is usually more severe than having no father at all, and the impact of his absence is more damaging than if he was present but unloving (p.xiii).

Fatherlessness and familial abandonment has been linked to rising male violence and declining child well-being, which is the underlying source of our most important social problems, especially those rooted in violence (Blankenhorn, 1995; Garbarino, 1999).

Little girls need fathers to help them develop into young women who feel positive, strong, assertive, confident of themselves, and able to negotiate relationships (Maine, 1991). When fathers were uninvolved, absent, or inconsistent, daughters often experienced an unrelenting "father hunger", which Maine described as “a deep, persistent desire for emotional connection with the father that is experienced by all children” (p.3). If this desire is adequately responded to, children can grow up feeling “confident, secure, strong, and good enough” (p.3).

Father hunger for men means a constant striving to become manly, even without a model at home. The consequence of this desire can be an incomplete sense of self, struggles with intimacy, and problematic overcompensation of

stereotypical traits of manliness - need for control over women, inability to express emotions, and constant competitiveness to prove oneself better than other men (McGee, 1993; Erickson, 1998; Blankenhorn, 1995). Erickson (1998) reports men who grew up without fathers become “amateur males...because without the experience of learning to be a man and a father by hanging around with one of them, boys who want to become men have to guess at what men are like” (p. 113).

The relationship between child and father, therefore, is crucial to the emotional development of the child. Fathers often hold a position of power which makes the child vulnerable and dependent on him to provide the right kinds of influence (McGee, 1993). Carlsmith (1970) reported “development of an appropriate masculine identity or self-concept is predicated to the success of this early identification with the father” (p.163), and for this to happen, the father must be physically and emotionally present at developmentally crucial times.

The effects of father loss are not singularly seen in children. Adults who experienced early loss of a constructive relationship with father often exhibit a fear of commitment, professional or academic failure, various addictions, and general malaise and melancholy. The consequences can be a perpetual loss of sense-of-self which can spawn codependency, anorexia, and other emotional and physical self-destructive tendencies, or feeling flawed, unlovable, or not good enough (Erickson, 1998).

Why do attachment and loss cause such dramatic changes in emotions and behavior? Schaffer (1986) sees the response to be a blend of inherited characteristics and environmental influences; the interaction of genetics and life experiences. Obviously, disruptions of primary relationships can have everlasting impact. Such powerful dynamics demands further investigation.

Abandonment/Perceived Abandonment

Abandonment is the act or perception of permanent leave-taking. When an adolescent is affected by abandonment, feelings of being unwanted, unloved, or thrown away may occur. The results are painful, often undesirable and conflictual behaviors that can be evidenced by administration of the Rorschach projective test (Sakheim & Osborn, 1986).

Perceived abandonment is covert absence. It is the perception that someone significant, although physically present, has become substantially unavailable, such as with emotional unavailability, alcoholism, depression, or workaholism. For this study, perceived abandonment will be considered present in the adolescent's life if the adolescent identifies it as such in the Interview Process.

Learned Helplessness

Learned helplessness is a psychological state that frequently develops when events are uncontrollable, and the subject of the situation believes there is nothing that can be done to change the situation. The results can be depression, self-defeating lifestyle, and even death (Seligman, 1974, 1975). Learned

helplessness occurs when an individual is exposed to repeated trauma and despite attempted interventions, experiences an inability to stop the trauma. Humans tend to exhibit hyperemotionality and reduced level of functioning when repeatedly exposed to stress (Seligman, 1975), such as those experienced through physical conflict, persistent emotional upset and repeated withdrawal of parental interest.

From his research on early childhood, Bowlby (1980) identified "motivational deficit", as a form of learned helplessness. Associated with motivational deficit is "cognitive deficit" which is a failing to successfully learn responses that may terminate traumatic situations. "Emotional deficit" is a lack of emotional response to trauma and suggests a numbing from losing hope that the situation would change, which is symptomatic of hopelessness and helplessness. Depression ensues and the individual may despair and may not continue to take action to escape. Bowlby (1980) observed problematic responses to loss as lack of stable, secure relationships with parents, self-reported messages of being unlovable, inadequate, and/or incompetent, and an increased risk of further parental loss. Self-esteem may diminish as loss-related helplessness or hopelessness increases (Seligman & Peterson, 1986).

Although many of the above symptoms may occur in childhood, it is most likely to develop when the child reaches puberty and seeks to identify him or herself as a young adult seeking independence from the family, that turmoil

begins. It is therefore necessary to understand the adolescent and the adolescent in relationship to the family.

Adolescence/Adolescent

Adolescence is the period of life from late childhood until physical growth is relatively complete, and also marks the beginning of early adulthood. Age 13 through 16 is considered early adolescence, and 17 through 21 is late adolescence (Wolman, 1989). The 'adolescent' is therefore the individual who is vulnerable in this stage to periods of intense physical (rapid growth and development of sex characteristics), emotional (hormonal and natural mood swings), and social change (change in school structure, change in peers, societal expectations). For this study, the terms 'adolescent' and 'teenager' may be interchanged since this is the targeted age group.

Anger

Anger is one of the basic human emotions. It is neither "good" nor "bad," but is an emotion innate to humans (Daldrup & Gust, 1990). Bowlby (1973) defines anger as a response to separation or threat of separation, and Kubler-Ross (1969) identifies anger as the second stage of grief response, with denial of loss as the first. Anger is an intense emotional reaction elicited by covert or overt threats such as interference, attack, aggression, and frustration, and characterized by an acute reaction of the autonomic nervous system (Wolman,1989).

Anger is a powerful and necessary tool for survival (Izard, 1977; Vallejo, 1988). The innate purpose of anger is to enable the mobilization of energy so that the person becomes capable of self-defense with vigor and strength in an assertively appropriate manner. Anger potentiates a sense of personal control which enables the person to take action (Biaggio, 1987).

The role of anger during separation of a child from its mother is to empower the child to overcome obstacles until they are reunited, and to discourage the loved person from going away again (Bowlby, 1973). The message is that we are being hurt, that our rights are being violated, that our needs or wants are not being adequately met, or simply that something is not right (Lerner, 1986). Anger responses provides the energy to be more extroverted than with any other emotion, and is often witnessed as rage, disdain, or intense dislike. Through its activating force, there is a suppression of more subduing emotions such as sadness and fear, and an increase in energy, tension and impulsivity joined with an elevated sense of self-assurance (Izard, 1978; Rutter, Izard, & Read, 1986). Together, these elements can actually facilitate constructive action that serves to ameliorate depression (Rutter, Izard, & Read, 1986).

Many are uncertain how to perceive anger. Although it may be accepted as normal and as potentially constructive, it is often considered to be more of a liability than an asset. There is fear that if anger is exhibited, insurmountable loss will occur; that the anger will kill or cause abandonment, and therefore the

individual will die (Englander-Golden & Satir, 1990). In actuality, it is not anger, but the action taken as a result of anger that can be destructive (Satir,1988; Daldrup & Gust,1990). Unfortunately, anger has a reputation of being an uncomfortable and unacceptable condition.

The MMPI-A (Archer, 1992) identified indicators of anger in adolescents as being irritable, grouchy, impatience, and aggressive. There may also be poor parental relationships, truancy, defiance, disobedience, drug abuse, high heterosexual interest, and potential to be assaultive. The leading antecedents of anger are the perceptions of being misled, betrayed, used, disappointed, and hurt by others. The disruption of a relationship between an adolescent and parental figure can be a powerful elicitor of anger (Wickless & Kirsch, 1988). In a study of adolescent suicidal behavior, anger was found to be the most prominent mood experienced just prior to the suicide attempt (Withers & Kaplan, 1987). Anger, no doubt, can be properly motivating, but when used for revenge, or for keeping others away, or to challenge those in authority, it is seen as defiance. Teenagers are notorious for defiant behavior.

Anger in adolescents is often expressed through what is considered unhealthy outlets. Cramerus (1990) defines adolescent hostility, resentment, blame, and reproach as “negative affect”. When the adolescent is frustrated or deprived, he or she may tend to behave aggressively against the environment (Adler, 1956; Manaster & Corsini, 1982) and may engage in behaviors such as fighting or inappropriate risk-taking, negativism, displaced anger, academic

failure or general indifference to school-related activities, running away from home, sexual promiscuity, alcohol and/or drug abuse, or identity diffusion (Hundley & Bratton, 1994). Unfortunately, open expressions of anger may be threatening to parents who then tend to respond with increased attempts to control the adolescent, which often escalates the conflict (Inoff-Germain,1988) and the child may respond negatively.

Internalized anger is less recognized as a true anger response. It tends to be manifested as a persistent presence of depression "masked by manipulative expression" (Hafen & Faux, 1972), which implies that sadness held within and not expressed with traditional grief responses may stagnate in the anger stage, or may be acted out in a defiant or maladaptive manner (Faux & Rowley, 1972).

Rage is a heightened state of anger during which energy is so great that it can create a sensation so intense that an enraged person will feel like “exploding” if he or she can not “bite, hit, or kick something, or act out the anger in some way” (Izard, 1978, p.331). Another aggressive behavior is also one of the most disturbing and destructive: the violent act of firesetting. Factors identified as occurring more frequently among juvenile fire-setters are strong feelings of maternal rejection, anger at father for abandonment or abuse, sexual excitement, and other behaviors that attempt to gain mastery or control over adults. These fire-setting adolescents are frequently diagnosed as conduct disordered (Sakheim & Osborn, 1986).

The adolescent who feels unloved, unwanted, or emotionally deprived, or who has suffered paternal abuse, abandonment and/or death is likely to develop intense anger and resentment of parental and authority figures. Often, elaborate sadistic, spiteful, and retaliatory fantasies are envisioned and sometimes acted upon (Sakheim & Osborn, 1986). These displays of anger may be directed at oneself or at others. Worden (1982) suggested that:

> If the anger is not turned toward the deceased or displaced onto someone else, it may be retroflected – turned inward and experienced as depression, guilt, or lowered self-esteem. In extreme cases, retroflected anger may result in suicidal behavior, either in thought or in action (p.40).

The Impact of Families

Emotional and behavioral problems in adolescence are often rooted in childhood. The relationship between parents and children provides a unique opportunity for emotional development to occur, and disruption of the relationship can be devastating. Children who were neglected may exhibit aggressive behavior at school much as abused children do. They may have failed to learn skills necessary to cope nonaggressively with the provocation and frustration inherent in more structured environments, such as school (Reidy, 1980). Although most teens who exhibit antisocial behavior showed some form of deviance at an early age, the social consequences of that behavior (e.g., suspension and expulsion from school, arrest) tend to become more severe with increasing age (Schaffer, 1986). Females may be prone to increased incidents of

physical assaultiveness, truancy, poor parental relationships, defiance and disobedience, and anger. Boys tend to show high heterosexual interest, drug abuse, hyperactivity, and threatened assaultiveness for boys (Archer, 1992).

Built on mutual trust and reasonable expectation, when the relationship between parent and child falters, sadness and grief from losing the much desired and badly needed relationship causes the child to react (Brown, Harris, Bifulco, 1986; Garmezy, 1986; Maine, 1991). Serious problems such as chronic stress, fear, anxiety, sadness, and confusion occur. The result is often fragmented play, social retardation, less imagination, negative social behaviors, behavioral instability, and problems at home such as noncompliance, dependency, aggression, and negative demands (Garmezy, 1986). Multiple factors that contribute to the disturbance, such as perceived physical or emotional abandonment of the child by parents, are commonly caused by divorce or separation, alcoholism or drug abuse, emotional abuse, or physical abuse (Garbarino & Gilliam, 1980; Trickett & Susman, 1986). Sexual abuse (Murphy, et al, 1988), neglect, (Martin, et al., 1987), physical or emotional illness, frequent absences, workaholism, or disinterest are also sources of disruptions.

Severe maternal rejection may result in a child feeling emotionally deprived (Sakheim, 1986), and with paternal abuse, abandonment or death, it is likely the child will develop intense anger and resentment of parental figures, and may displace these feelings toward adults in general. Parent-child alienation which results from such disruption has been identified as a common feature of

psychiatric problems among adolescents (Mufson, 1993), and creates a propensity for problems in other relationships.

Problematic relationships can evolve from virtually any situation which interferes with healthy physical or emotional proximity of parent to child, or which prevents the adolescent's narcissistic needs from being met (Cramerus, 1990). Such emotional needs of maturing adolescents are very specific. They have a need to be believed in and listened to uncritically, to be comforted and allowed to cry without teasing or taunting, and to have supportive boundaries set.

Imperatively, there is a need for honesty between adolescents and parents which provides trust and an understanding of love (Parrish, 1990). When the family is in turmoil, these qualities are hard to acquire (Wegscheider, 1982). Disturbed relations with parents was the most important extrinsic factor identified in adolescents who attempt suicide (Withers & Kaplan,1987).

Adolescents from abusive homes are often subjected to parents who have strong beliefs about isolating themselves and their children from the external world. As children approach adolescence and their need for peer group affiliation becomes greater, there may be increased frustration and conflict due to the parent’s preference to remain an isolated unit. Insistence that the adolescent forgo close peer relationships and friendships can damage self-esteem, which increases the likelihood that the adolescent’s frustration will lead to aggression. Adolescents who are victims of abusive parents are also more likely to exhibit a

reduced amount of affection toward those parents. They are also less likely than nonabused adolescents to express pleasure in life in general (Martin et al, 1987).

Sexual abuse is another form of loss - the loss of the relationship, a betrayal of trust, and loss of childhood innocence. When a child experiences the disintegration of family structure through intrafamilial sexual assault, he or she is more likely to experience elevated anxiety, heightened interpersonal sensitivity, increased anger problems, more paranoid ideation, and increased obsessive compulsive symptoms (Murphy, 1988).

Divorce is the leading cause of turmoil and loss in childhood. It was approximated 6.1 million children are growing up in divorced families, with one-third of children having lost all contact with the exiled parent (Hundley & Bratton, 1994). Teachers, pediatricians, and mental health workers rank divorce second to death in the family as needing the greatest amount of adjustment for the student. Children of divorce constitute 50% to 75% of the outpatient caseload of child psychiatrists, and some adolescent specialists consider divorce to have replaced death as the most traumatic event in the life of children in this country (Coffman & Roark, 1988). Divorce constitutes major disequilibrium in the lives of nearly all children, and promotes consistently negative short-term effects such as poor academic performance, poor social adjustment, and inadequate emotional well-being (Coffman & Roark, 1992). Evidence suggests that parental divorce can exert a lasting negative impact on children and adolescents in the way of emotional pain and developmental disruption (Kalter, 1987). Hundley & Bratton

(1994), report divorce is what children see as the single major trauma of their childhood, ahead of death of family members or friends, and relocation of the family, which are also extremely impactful. Forty–five percent of all children born in any given year will live with only one of their parents before reaching their 18th birthday. Consequential differences seem to be based on the age of the child at the time of marital dissolution. If divorce occurred prepubertally, the adolescent may appear to be emotionally developmentally delayed and especially prone to prolonged sadness (Coffman & Roark, 1988). Children in the 5 to10 year-old range are reported by Garmezy (1986) to be most vulnerable to loss, often experiencing significant adaptive difficulties in adulthood (Garmezy, 1986). For the pre-teen to young adult population, anger will often follow. Direct effects of divorce also include aggressive and antisocial behavior due to the externalizing of problems, dysthymia, depression, self-esteem (internalizing) problems, and difficulty in establishing and maintaining heterosexual relationships. Heightened conflict, pervasive unhappiness, and unrestrained sexual and aggressive behavior often mark the year following parental divorce (Garmezy,1986).

Denial and sadness appear to be the typical initial reaction, and anger may intensify and remain largely unresolved if the custodial parent spends less time with family members than before the divorce or separation. The family, as the child knew it and experienced it, has died (Diamond, 1985). Teachers, pediatricians and mental health workers observed the adjustment to divorce for adolescents to be almost as great as that of death of a family member. Divorce

often causes economic distress, a lowered standard of living and downward social mobility (Blankenhorn, 1995). Frequently, increased stress contributes to mental health problems in children of divorce (Garmezy, 1986). Other concerns of the divorced family are interparental hostility and conflict, loss of an emotional relationship with one or both parents, and economic distress. There are often multiple home relocations, emotional loss of the non-resident parent, and parent dating and remarriage (Kalter, 1987).

Bowlby (1980) reported longitudinal studies with 11,329 fifteen year olds who were administered the Minnesota Multiphasic Personality Inventory (MMPI). At age thirty-three 800 were selected from the original group and given the MMPI again and a life history was taken. The result suggested those who had experienced “broken homes” (parental separation, death, or divorce) had an increased number of major illnesses and emotional disturbances than those coming from intact families.

The adolescent growing and developing in a two-parent home faces challenges that can sometimes seem insurmountable, but for the adolescent that is not growing up in a home with both biological parents, life can be even tougher. A child raised in the home of divorced parents often feels abandoned or rejected by the parent who left home, and may suffer injury to self-worth. The child is then likely to react with aggressive behaviors (Kalter, 1987), and like the neglected or abandoned child, may fail to learn the skills necessary to cope

nonaggressively with the provocations and frustrations inherent in more structured environments, such as school (Reidy, 1980).

The adolescent who experiences divorce is also more likely to live in an alternative living situation at some time. Coffman & Roark (1992) examined the profile of the adolescent in diverse family configurations that include stepfamilies, parents cohabiting with others, and single parenting. They found the effects of divorce and transformation into other family arrangements can generate intense anger that can be fierce, pervasive, and trigger acting-out behaviors. The strength which the child emerges from such a situation depends on the appropriateness and flexibility of his or her coping strategies, such as the inability or ability to rationalize and tolerate change, and the availability of and willingness to utilize family support (Wallerstein, 1983). Although there may be the presence of a step-parent, it appears that the longer the adolescent lived in a reconstituted family, the more likely it is that anger will be expressed outwardly, sometimes through antisocial behaviors. The antisocial child is less likely to participate in extracurricular school activities, which helps the child with a well-rounded and constructive lifestyle (Coffman & Roark, 1992).

Clearly, adolescence is a time of rapid change and pressures from within and from others. Optimally, there will be opportunities to explore life from a solid foundation, a home base that is supportive and encouraging. Unfortunately, one of the leading causes of family stress is alcohol or drug abuse by at least one, if

not both, of the parents. Such substance abuse places the young person at very high risk for serious problems (Wegscheider, 1984; Ackerman, 1983).

The Alcoholic and Drug Abusing Family

The substance abusing family is included in this study for several reasons. If the desired optimal result of a pregnancy is a healthy full-term baby, what chance does a child have when it is exposed to drugs and/or alcohol en utero? In 1997, over 500,000 newborns were exposed to drugs and alcohol during pregnancy (GDCADA, 1998), which can lead to birth defects, retardation, and learning disabilities.

When a parent is frequently intoxicated, he or she is often emotionally unavailable to family members. Drinking behaviors such as lengthy periods in bars, heightened emotionality, diminished self-control, and poor judgment preclude healthy interactive quality time (Wegsheider, 1984). "The alcoholic parent behaves like several different individuals with conflicting reactions and unpredictable attitudes" (Ackerman,1983, p. 41). An example of such is when a parent is in a drunken rage and verbally blasts the child just prior to the child's birthday celebration, declaring that love is the underlying motive for his or her actions, and then wonders why the child does not enjoy the party. Such an environment of uncertainty and confusion provides a child with little emotional security.

Children of alcoholics often feel rejected by both parents, possibly due to the actions of not only the drinker, but also the co-dependent spouse whose life

is dictated by the dynamics of the alcoholic system (Wegscheider, 1982; Priest, 1985). Children from homes with an addicted parent often feel abandoned by both parents because neither is psychologically safe (Erickson, 1998). The non-using parent, if there is one, is often unable to provide an environment secured from the problems often associated with substance abuse.

In homes with chemical dependency, physical, sexual, and emotional abuse due to the loosening of inhibitions that accompany substance abuse are not uncommon. Children raised in such environments are at risk of becoming substance abusers and continuing family dysfunction as they produce their own families, as it is all they know of family life. “Chaos is natural, and normal is boring” (Erickson, 1998, p.79).

Priest (1985) reported that in 1974, 56 percent of teen runaways were from homes in which one or both parents were alcoholics, and 66 percent of suicidal adolescents were from similar homes. In 1978, over 50 percent of the juvenile delinquents in court had an alcoholic parent. An estimated 80 percent of children of alcoholics suffer disabling emotional problems (Priest, 1985). Current statistics indicate that adolescents are much more likely to be exposed to domestic violence due to the 15 times higher occurrence of violence in homes where husbands drink (GDCADA, 1998). Alcohol and drug use is a factor in 60% of parents referred to Child Protective and Regulatory Services in Texas (GDCACA, 1998). If the adolescent is exposed to alcohol abuse in the home they are much more likely to drink themselves, and if drinking occurs before age

15 they are 4 times more likely to become an alcoholic than if they started after age 21 (GDCADA, 1998). There is a reported 14% decreased risk for each year drinking is delayed until age 21 (GDCADA, 1998).

Emotional development is a prime factor in personality development, influencing how the child sees and navigates life's issues. Children of alcoholics experience normal emotions during development, but typically experience fear and anxiety more than children whose parent/parents are not alcoholic. For these children normal emotional development may not be sufficient to overcome the effects of living with fear and anxiety (Ackerman, 1983).

> "Not every family in stress is alcoholic, but every alcoholic family is in stress - severe stress. They evidence all the characteristics of the unhealthy family that we have observed...but usually to a more extreme degree than families with other problems" (Wegscheider, 1982, p.54).

The impact of family loss, distress, and chaos can cause symptoms of physical damage, low self-esteem, anxiety, lack of empathy, poor social relationships, drug or alcohol abuse (Oetting & Beauvais, 1988). Also, fire-setting (Sakheim & Osborn, 1986), suicide, delinquency, and homicide (Garbarino & Gilliam, 1980), acting-out behavior, depression, generalized anxiety, and extreme adolescent adjustment problems, as well as emotional and thought disturbances have been reported. Helplessness and dependency, poor school performance, lack of empathy, external locus of control, and a decreased ability to express pleasure in life in general are also symptoms (Martin, et al, 1987;

Herrenkohl, 1977, Lane & Dickey, 1988), as well as fighting, negativism, running away from home, sexual promiscuity, substance abuse, and identity diffusion (Hundley & Bratton, 1994). Alcohol use, drug use, aggressive and antisocial behavior, and rebellion toward authority have been the behaviors most exhibited by adolescents just prior to attempting suicide (Withers & Kaplan, 1987; Shaffer, 1986). Children can be very vulnerable to influences of the environment; particularly those presented by parental figures.

Claudia Black (Wholey, 1988), a well-known addictions expert, reported loss as the common denominator of dysfunctional family system. Children from families such as these often...

> ...experience loss on a chronic basis, and they experienced that loss at the time in their lives when they were developing their worth and their identity. The loss varies, but the loss is blatant. The loss is in embarrassing incidents. The loss is in parents not showing up for events. The loss is in parental anger that attacks... The loss is often related to the normal childhood and adolescent development that the youngster didn't have. Therefore, the child could not grow spontaneously, couldn't grow up with flexibility, couldn't laugh, and couldn't express his or her feelings with freedom (p.117).

Priest's (1988) study of the consequences of growing up in the alcoholic family revealed impoverished relationships between parents and children. Such relationships prevent good role modeling for both sons and daughters and can

contribute to poor gender identification. Daughters of alcoholics frequently act out sexually and are often promiscuous, and sons tend to be negatively aggressive and often instigate fights.

Families of alcoholics are characterized by an abnormal degree of sibling tension and competition that deprives teens of an important source of support. There is often an absence of a positive bond between family members, and this can produce a great desire to escape from the home situation where there is little or no family fun. Frequently, there is a negative, hostile mode of communication, and a high level of distrust of authority and of people in general which translates into defiant behaviors at school and in society.

Not surprisingly, there is a high incidence of stress-related illness among adolescents from alcoholic homes, largely due to the constant tension under which they live and the lack of outlets for that tension. Teens from homes such as these tend to believe no one cares, and may experience great anger at having been cheated out of a "normal" life. The child raised in the alcoholic home is likely to experience self-defeating thoughts, poor choice-making, and a tendency to self-medicate through alcohol or other drugs (Priest, 1985).
The consequential level of depression and feelings of hopelessness and helplessness over the situation will be discussed in the next section. As indicated in this literature review, there are many problematic situations that severely disturb a parent-child relationship, causing potential life-long consequences for the affected child. It is imperative that those who work with, live with, or care for

adolescents be trained to identify symptoms of emotional stress and related behaviors. Interventions need to be available for families, schools, and agencies, and support systems need to be accessible so as to diminish the impact of the trauma of family disintegration, possibly reducing long-term consequences.

Adolescent Depression

There has been debate and concern about whether a difference exists between adolescent depression and adult depression, specifically regarding causation and symptomotology (American Psychiatric Association, 1987; Cyntron, et al., 1986). Adolescents were thought to resemble adults in their depth of despair, sense of hopelessness, propensity for suicide and accompanying anxiety and agitation. Depression in adults is usually evident by sad affect and lethargy, and although there are some similarities, adolescent depression is more often exhibited through symptoms of conduct disorder, anxiety disorder, and learning problems, anger and rebellion (Mufson,et al, 1993; McCoy, 1986).

The teen who is prone to restrict open expression of feelings is more likely to become passively depressed, with symptoms of sadness and lethargy. For adults or adolescents who do not react to loss through sadness or depressed mood, there may be a tendency to utilize alternate means of expression, such as aberrant or maladaptive behavior due to insufficient ego development (Worden, 1982).

There are two types of depression for both adolescents and adults. Reactive depression is the result of a particular experience, particularly one of loss or trauma. Reactive depression may abate when time and adjustment to the situation occurs. Most adolescent depression is reactive. Endogenous depression appears to be unrelated to any event or cause, but is considered a biochemical disturbance that may be related to genetics, exposure to toxins, hormonally based, secondary to head injury, or any other insult to the brain which can disturb the delicate balance of neurochemistry (McCoy, 1986; Rutter, 1986).

For this study, depression will be measured through use of the National Computer Systems' Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) version (Archer, 1992). Particular interest will be paid to MMPI's subscales that reflect indicators of both depression and anger.

Defiance

Alfred Adler (1956) considered defiance a symptom of inferior feelings: the adolescent sees the parents' view of him or her as unworthy of their time, energy, and/or affection. Then, discouragement and engagement in destructive thoughts of revenge and death are often expressed against the self and the environment (Adler, 1956; Dewey, 1978). Haley (1980) reported "disobedience" as protective; no matter how strange, violent, or extreme the behavior, as it serves to "stabilize" the organization - the family - by defining family roles and

expectations. Delinquent behavior is also considered "adaptive" when it serves as a masked grief reaction (Schoor & Speed,1963).

Teenagers are notorious for their unique clothing, friends, music, and behavior, which are often used to express feelings of anger and defiance. They tend to act more unemotional, unreachable, and nonchalant in order to reduce attempts of control by authority. The more defiant adolescent no longer trusts guidance offered by parents and well-meaning others, and often struggles with authority figures and limit setting (Schoor & Speed,1963). These young people are less likely to participate in extracurricular or other constructive activities with their peers at school (Coffman & Roark, 1992). They engage in behaviors that imply parental failure and ineptitude (Cramerus, 1990), frequently playing a victim role. These adolescents show anger with openly expressed non-constructive criticism or rejection of parents (Inoff-Germain, et al,1988). As a result of the chaos accompanying the behavior, the adolescent is often blamed and scapegoated for the family problems which further separates the teen from parents, and causes the cycle of behavior-blame-behavior to repeat itself. As the extreme behavior serves to mask underlying sadness, it would only be natural to grieve and feel sad when the family unit falls apart.

Grief

Grief is a powerful emotion experienced by everyone. Grief is a response as old as humankind, and is reported in the Old Testament of the Bible where reference is made to the "broken-hearted" (Worden, 1982). It is the intense

feeling of sadness that is related to loss (Wolman, 1989), and is considered the act of mourning (Viorst, 1986; Tatelbaum, 1980).

Bowlby (1980) considered grief to be both a powerful response and an adaptive function of survival. The child who is attached to a caretaker, primarily the mother, will react to the absence of the caretaker with crying, screaming, anger, and striking out, so as to motivate the caretaker to return and care for the infant. When this does not occur, the child withdraws and becomes resistant to being comforted.

Normal grief reactions include feelings of sadness and anger, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, and numbness, and recovery from the impact may take up to two years. Hundley and Bratton (1994) considered, "There are three universal truths connected with loss which must be recognized and addressed: loss is a universal experience, grief is a universal process, and healthy grief work is a universal responsibility" (p.10).

Death is one of the most traumatic blows a child can endure. Kandt (1994) reports ninety percent of junior and senior high students have experienced a loss associated with death. Bowlby (1980) states,

> “There is a tendency to underestimate how intensely distressing and disabling loss usually is and for how long the distress, and often the disablement, commonly lasts. Conversely, there is a tendency to suppose

that a normal healthy person can and should get over bereavement not only fairly rapidly but also completely" (p.8).

Death of a parent has been considered one of the most powerful experiences one can endure. Maternal death during childhood has been correlated with depressive disorders of female daughters in adulthood. Large-scale population studies linked parental death in childhood to later psychiatric disorders (Black, 1978). Hundley and Bratton (1994) reported that the deaths of family members or friends, the divorce of parents, and the relocation of the family are losses that are most impactful on adolescents. In young children, an experience of separation from, or loss of, the mother-figure is especially apt to evoke psychopathology (Bowlby, 1980). The loss of the loved person gives rise to anger at the mother-figure's departure, and provides an intense desire for their reunion. It also may cause some degree of detachment from her while she is gone and after her return. This behavior not only serves as a cry for help, but is also a rejection of those who respond to the cry (Bowlby. 1980).

Tennant, et al. (1982) studied childhood loss and deprivation related to parent deaths, separation, and other disruptions in parental care. They report that loss and deprivation for the child between the ages of five and ten was likely to cause an immediate impact. In older age groups, when specific child-parent relationships were established and have some meaning to the child, disruption may have some longer-term effects. Severe separations in early life leave emotional scars because they assault the essential human connection (Viorst,

1988). With loss of the mother figure the adolescent is likely to be affected remarkably. Rutter (1984) reports that the loss of mother in childhood predisposes the individual to depressive conditions in adult life. And infant who lost his mother is deprived of love and of control over the most important outcomes in life (Seligman, 1974). Shaffer (1984) lists recent bereavement as a precipitant of suicide in children, and is considered the most severe of childhood stressors (Garmezy, 1986). Hundley & Bratton (1994) report that both parents were present in the home of less than one fifth of those in their study. These and the following citations support concern that issues of loss, due to whatever causation, can negatively impact the developing child.

Grief is a challenge for adults. For the child or adolescent who may not have adequate coping skills, grief may become problematic, symptomatic of underlying problems. Abnormal grief reactions may include chronic sadness, prolonged grief resolution; and/or an excessive grief process is without satisfactory conclusion. Unresolved grief as an expression of pathological mourning has been related to psychiatric illnesses, and is often evidenced by anxiety, depressive illness, hysteria and several kinds of character disorders (Bowlby,1980).

At any age, if grief is held within and never addressed or resolved, it can become pathological. Children may be particularly susceptible to pathological grief due to their dependence on adults for comfort, and their inability to accurately comprehend the loss. Alone, they may not be able to mourn in a way

that lets them work through the enormity of their loss (Viorst, 1986), and the result can be life-long emotional consequences and stunted emotional development (Kandt, 1994; Hundley & Bratton,1994). Break-up of the home, changes of family roles, financial and material disadvantage, and arrival of a stepparent, are identified long-term consequences of grief (Rutter, 1994).

Delayed grief reactions may be exhibited through inhibited, suppressed, or postponed response. Evident by symptoms and behaviors which, although often less obvious, can cause problems that are not often recognized as related to loss (Worden, 1982; Viorst, 1986). When assessing the presence or type of grief, consideration should be given to what coping skills the grieving person may utilize, and what the relationship was like before loss.

Periodically, emotions of grief may resurface unexpectedly, often triggered by certain events or memories, and can keep turmoil in the family. Counseling intervention of grief responses has been shown to be extremely beneficial. The National Grief Institute indicated that young persons who do not receive help with grieving often have difficulties as adults with relationships, emotional disorders, and chemical dependency. A staggering 90% of young people in chemical dependency programs lost a parent by divorce or death (Hundley & Bratton, 1994).

It is imperative that grief is understood, and healthy coping encouraged, in order to reduce long-term negative consequences. Grief for the adolescent can

be particularly perplexing, and helping the adolescent to identify and resolve the grief can minimize engagement in problematic behaviors.

Resilience

Rubin (1996) presented suggestions of how adults emerge from experiences of childhood adversity without dysfunction. It is possible for an individual to disidentify with a troubled family, increasing the ability to recognize and grasp healthy alternatives when they are presented. Personal creativity allows painful emotions and hurtful thoughts to be better tolerated, and development of outside interests or activities (books, music, art, sports) helps to carry the individual out of the family and into a healthier world (Rubin, 1996; Wolin & Wolin, 1982). Life becomes easier to manage, and a different and more hope-filled future is envisioned. Through relationships with role-models and mentors, different views of the world give impetus to overcoming troubled beginnings (Rubin, 1996) while providing support and a sense of value that may not have been obtained from the biological family (Wolin & Wolin, 1992; Pipher, 1996).

It is remarkable when a resilient child emerges from a family in which turmoil and serious problems are constant, and the child's siblings have fallen victim to the dysfunction. What are the differences among siblings? Wolin & Wolin (1992) identified seven qualities that lead children to be resilient survivors of life trauma as insight, independence, constructive relationships, initiative,

creativity, humor, and morality. Just as people respond differently to adversity, they also utilize different levels of creativity, spontaneity, and flexibility.

Painful experiences can offer powerful life lessons. It is not the impact of stress, but what people do with stress that matters. “Some give up, some work harder”, and the most resilient adolescents grow from adversity with “depth, energy and problem-solving abilities” (Pipher, 1996, p.121). Sometimes adolescents find a creative and desperate, although often destructive, way to get out of the chaotic family; through drug use, running away, or pregnancy. These teenagers are considered ‘symptom bearers’ for the family (Dinkmeyer, et al.,1987).

Why, then, do some children face adversity and succeed, while some become angry and destructive to themselves and others? Although adversity can build strength, too much stress and constant defeat can lead to bitterness, despair and apathy, and may impede successful overcoming (Pipher,1996).

This study supports the thesis that unresolved loss and perceived abandonment are related to adolescent anger and defiant behavior. A target population (students referred to the study due to a history of angry and defiant behavior), was compared to a comparison group (those operating within normal limits and no history of pathological behavior). A higher incidence of unresolved loss in the target population was expected, and it was found that these adolescents tend to exhibit angry and defiant behaviors in response. Treatment considerations for resolution of loss and healing disrupted families are presented

so that therapists and counselors will be better able to help the adolescent achieve resolution of issues of loss and to become resilient, able to re-establish a healthier relationship with the parents, whenever possible. Concerns for future research are identified and proposed.

CHAPTER II

This chapter presents the purpose, hypotheses, and definitions of the study. Also described were the instruments, participants, and procedures for the collection of data.

Purpose of the Study

The purpose of the study was to consider whether those who exhibit defiant behaviors have suffered unresolved loss more often and more intensely than those who do not. Related literature suggests that adolescents who experience loss stemming from divorce, death, separation, illness, or emotional or physical abandonment are more likely to exhibit defiance and angry behaviors. Due to the significance of the literature addressing the need of adolescents, this study will attempt to provide evidence that there is a relationship between unresolved loss and angry and defiant behavior. Through examination of adolescents who demonstrate anger by engaging in oppositional behavior, and adolescents who do not exhibit such behavior, an understanding of causation was identified. Treatment considerations were presented so that therapists and counselors are better prepared to assist adolescents in healing loss, reducing defiant behaviors, and possibly improving parent/child relationships. This chapter addresses the hypotheses, methods, procedures,

participants, instruments and statistical analyses that define this study. Concerns for future research and suggestions for treatment are identified and presented.

Hypotheses

The literature is sufficiently developed to form several hypotheses which serve as the basis of this study. These hypotheses were tested for the purpose of examining the relationship between incidents of loss and angry and defiant behavior in adolescents.

1. Those who exhibit defiant behaviors (target group) report more incidents of loss than those who do not (comparison group). Loss was measured by self-report of loss incidents and related life experience as evaluated through the Interview Process.

2. Participants in the defiant group experience more symptoms of depression than those in the non-defiant non-defiant group. Depression was measured by significantly elevated scores of the A-dep scale of the MMPI-A.

3. Participants in the defiant group exhibit more symptoms of anger as indicated by significantly elevated scores of the A-ang scale of the MMPI-A than those in the non-defiant group.

4. Participants in the defiant group show more signs of immaturity than those in the non-defiant group. Immaturity was measured by significantly elevated scores of the IMM scale of the MMPI-A.

5. Participants in the defiant group experience more substance abuse than participants in the non-defiant group. Significantly elevated scores of the MAC, ACK, and PRO scales of the MMPI-A measure substance abuse.

6. Participants in the defiant group use cynicism more than the participants in the non-defiant group as indicated by significantly elevated scores of the A-cyn scale of the MMPI-A.

7. Conduct problems was reported more by participants in the defiant group than those in the non-defiant group. Conduct problems was measured by significantly elevated scores of the A-con scale of the MMPI-A.

8. Participants in the defiant group exhibit more indicators of low self-esteem than participants in the non-defiant group. Low self-esteem was measured by significantly elevated scores of the A-lse scale of the MMPI-A.

9. Participants in the defiant group exhibit more symptoms of family problems than participants in the non-defiant group. Family problems were indicated by significantly elevated scores of the A-fam scale of the MMPI-A.

10. Participants in the defiant group experience more school academic and behavioral problems than participants in the non-defiant group. These problems were measured by significantly elevated scores of the A-sch scale of the MMPI-A.

11. Participants in the defiant group demonstrate greater emotional distance between self and family members than the non-defiant group.

Emotional distance was measured by significantly elevated Mean scores of the Family Constellation Exercise.

Definition of Terms

Defiance: Defiance is the display of behaviors that reflect resistance to compliance. There may be passive defiance in which the resistance is present but unobvious, such as when the adolescent "forgets" to do chores; or active defiance, such as when the adolescent walks out of a classroom when told to sit down. In this study, "defiance" was used to describe behavior that meets criteria for "oppositional defiant disorder" in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV (American Psychiatric Association, 1994). In the DSM IV, oppositional defiant disorder was identified by the existence of "a pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months." Adlerian theory considers defiant behavior to be continuous and chronic behavior that violates the rights of others (Dinkmeyer, Dinkmeyer, & Sperry, 1986).

Depression: Depression is a mood state, characterized by sadness and varying degrees of decreased functioning. Wolman (1990) defines depression as a feeling of helplessness and blaming oneself for being helpless. Endogenous depression comes from within, with organic origins; exogenous depression is a reaction to misfortune.

The DSM IV (1994) reports depression in children or adolescents as often dysthymic, and was manifested by more days than not of depressed or irritable

mood for at least one year. They may also exhibit patterns of poor eating or overeating, insomnia or hypersomnia, fatigue, low self-esteem, poor concentration or difficulty making decisions, or feelings of hopelessness.

Depression in the adolescent can also take the form of a more extreme disorder, such as major depressive states. The DSM IV (1994) identifies characteristics of major depression as depressed mood, with a loss of interest in most or all activities, a change in the level of functioning for most of each day, tearfulness, feelings of worthlessness, psychomotor retardation, difficulty thinking, hopelessness about change in the situation, and persistent thoughts of death or suicide.

In the adolescent, negative or antisocial behavior and use of alcohol and drugs may be indicative of a depressive or angry state. Feelings of wanting to leave home, not being understood and approved of, restlessness, grouchiness and sulkiness, and aggression may also persist. Socially, there may be withdrawal from activities, perceptions of rejection in love relationships, and academic and behavioral problems in school. The list continues with isolative behaviors, resistance to family activities, decrease in personal grooming and hygiene, and hyperemotionality, all as reported in the DSM IV (1994).

Emotional Distance

Emotional distance is the description of how a psychological relationship is perceived to be close or distant. For this study, interfamilial relationships were considered. The loss of mother can create emotional developmental delay and

interfere with healthy relationship development with others (Edelman, 1994). The father is considered to be important in the child's identification with others, the development of proper social behavior, and maintenance of family structure. From the relationships with both parents, social skills, interpersonal skills, and psychopathological patterns were developed. Parents' over or underinvolvement with their children was greatly significant in the development of emotional closeness, which can impact the individual's well being (Brown, Hyer, & Harrison, 1989). Obviously, the child's relationship with the parents provides an enormous impact on the developing child. It is paramount, therefore, that the developing years of a child's life be ones of love and support to provide emotional wellness and the ability to co-exist successfully with others.

Subjects and Methods

Subjects

For the purpose of this study, adolescents referred to participate were males and females between the ages of 14 and 18. The participants were placed in one of two groups: the defiant (target) group or the non-defiant (comparison) group. Participants were assigned to study groups based on previous identification by referral sources as meeting the study guidelines for being included in one of the two groups. The defiant group consists of the acting-out adolescents, and the non-defiant group included the adolescents functioning within normal limits.

The defiant group consisted of 15 male and female adolescents. Participants were assigned to the defiant group based on having been identified as having been identified as an angry or defiant teen by the referral sources; therapists and from information gathered during the assessment interview. Typical identifiers for this group were academic failure, excessive absenteeism and tardiness, defiant behavior, misconduct, and illegal activity. Those considered too pathological for this group were those who face felony charges. Felony charges may indicate conduct disorder or sociopathic personality rather than oppositional defiant disorder. Also, those with organic or chronic mental disorders with poor prognosis for change, i.e., those with mental retardation, schizophrenia, severe drug dependencies, or those with borderline or narcissistic personality disorder, were excluded. People in this group may have trouble understanding the research tasks, or may have a poor sense of self-reference which could distort the outcome results. Those considered but excluded were the adolescents who occasionally have problems with anger and behavior, but have not been considered chronic with their behavior. This group may be exhibiting normal adolescent emotions and behaviors, and were not considered to have oppositional defiant disorder, a definitive qualification.

The comparison group consisted of adolescents from the same community as the defiant group and from the same age range. The adolescents must have not been identified or referred to any counseling program for any pathological reason. Adolescents for this group were recruited from the same

referral sources. None of the population reported substance use, or declared a close family member as having a serious psychiatric disorder.

Omitted from the non-defiant group were those that were considered to be at the extreme of the continuum; those who were known as outstanding or "model" students as defined by school counselors and peers. Model students were identified by the combination of extremely high grade point averages (top 10% of their class), excellent attendance (less than 5 absences per semester), extraordinary extracurricular activities (active in more than three extracurricular organizations), and were in multiple high visibility positions at school (club or class officer, etc.). These adolescents were omitted as they were considered to fall at the extreme end of what was normal for most adolescents. Their exemplary status may be indicative of strong resilience, or may play the role of the “hero” child that is frequently found in highly stressed families (Wegscheider, 1982). They may have an extremely high IQ which would possibly separate them from the normal adolescent experience, or may come from a rigid family that insists on such achievement without an individual’s choice to do less for fear of severe consequences. It was important to minimize the impact of such a variable on the study outcome.

Also omitted from either group was any person who was not able to read on at least the sixth grade level, since this is the minimum reading requirement for the MMPI-A. Those who had been diagnosed, yet treated unsuccessfully for severe attention deficit hyperactivity disorder (ADHD) were excluded. Severe

ADHD could potentially disrupt the ability to concentrate which is needed to effectively complete the MMPI-A.

The participants resided with at least one biological parent. In order to maintain homogeneity, those living outside the home or not with a biological parent were excluded from the study.

Instruments

Interview Process. This procedure provided the opportunity for the participants to identify incidents of loss, and evaluated how significant they considered the losses to be. Each question presented was devised to address what relevant literature considers loss situations to be, and served to determine to which participant group the adolescent was assigned. Questions 12 through 15 were for information purposes only and may be used for future research.

The verbal interview process consisted of the following questions:

1. Before I was a teenager I experienced a major loss or sadness.
2. I was frequently put down or made fun of by my parents, teachers and/or others.
3. I was never told things that made me feel worthless, embarrassed, or ashamed.
4. I was never threatened with harm or abandonment.
5. Someone or some tragic act physically injured me.
6. I have experienced being touched, fondled, raped, or asked to touch or look at someone else in a sexual way.

7. I was exposed to other sexual behavior before I was a teenager.

    a. How did you feel about it at the time it happened?

    b. Did you receive any help for what happened?

    c. How do you feel about the experience now?

8. My parents were not still together.

9. I have not had a parent die.

10. I have had someone else close to me die.

11. I believe that one or both of my parents, parent figures, or other family members had or have a drug or alcohol problem.

12. I have cut myself or burned myself to cope with my feelings.

13. When I get really angry, I…

_____

_____

14. My anger has caused me problems or has gotten me in trouble.

15. I believe that my anger has helped me.

All questions above except #13 were answered on a scale of "Agree, Slightly agree, Slightly disagree, Disagree".

Family Constellation Exercise. The literature on the effects of loss on adolescents is consistent in findings and presents strong content validity for the development of The Family Constellation Exercise. When loss occurs the adolescent is prone to feel distanced from the family member, and a set of associated behaviors is likely to occur. The Family Constellation Exercise is a

non-quantified instrument designed for this study to obtain approximate information relating to familial emotional closeness. The content validity of the instrument was confirmed by a panel of mental health professionals who specialize in the use of psychometrics. This exercise was used to understand how the participants see themselves in emotional relationship to other family members, and data emerged about the differences between family members of the defiant group and those in the non-defiant group.

Through configuration of identical paper figures, the Family Constellation Exercise provided information about how the participants related themselves to immediate family members. Ten identical six-inch figures resembling "gingerbread people" (Figure 1) were placed on a standard-sized, laminated poster board which was laid on a table before each participant. The figures had a simple dot located in the center neck area of each one, which provided measurement points. The participant was asked to position the figures on the poster board. The instructions were,

"Place a figure on the table that represents you. Place one figure that represents the person in your family that you were closest to, in a position that shows how emotionally close you feel to that person. If you feel very close to that person, you may want to place it right next to you. If you do not feel very close to that person, you may want to place the figure farther away. I would like you to do this with each family member so that I can understand how close you feel to each one. Please tell me who each person is you place him or her.

The participant was given verbal reinforcement (“Good”, “Thanks for working so hard on this”, “I appreciate your work.”) for any effort to cooperate. Measurements were obtained by carefully measuring the distance between the dot located in the center of the participant figure to the dot on the related figure. The identity of each figure and measured distance was recorded on the specialized recording form and used for statistical analysis.

Minnesota Multiphasic Personality Inventory - Adolescent. The Minnesota Multiphasic Personality Inventory - Adolescent (MMPI-A) version (Archer, Butcher, Tellegen, Williams, Graham, & Ben-Porath, 1992) is an empirically based test of adolescent psychopathology, including anger traits, which were focal for this study. The MMPI-A is a specially designed derivation of the original MMPI which was developed for adults and is used primarily for problem identification, diagnosis, and treatment planning in a variety of settings, including hospitals, clinics, school counseling programs, private practice, and correctional facilities. The MMPI-A was designed for adolescents aged 14 to 18, and consists of 478 true/false items of a sixth grade reading level (Archer, 1992).

The normative sample of the MMPI-A, the adolescent version, consisted of 805 adolescent males and 815 adolescent females from eight communities in the U.S. Care was taken to balance the sample of participants due to geographic region, rural/urban residence, and ethnic background (Archer, 1992). The MMPI-A scales were developed specifically for adolescents, and include validity measures for lying, inconsistency, and defensiveness. For the purpose of this

study, the significant components considered were anger (1 scale), depression (3 scales), family conflict (2 scales), and authority problems (2 scales). Complete profiles was examined for any extreme scores which may identify psychopathology (Archer, 1992).

Validation of the MMPI was obtained through standard validation tools, along with specially developed methods of evaluation. The MMPI utilized the 10 standard clinical scales, and four validity scales for which the purpose was to detect deviant test-taking attitudes or response sets. Technical validity of the MMPI was established through analysis of individual and configured interpretation of the standard validity scale findings, and for atypical response set features. Additional methods were developed for assessment of content validity; these include Test-Retest (TR), Carelessness (CLS), Variable Response Inconsistency (VRIN), and True Response Inconsistency (TRIN). VRIN is specific to the MMPI-A. The FLK is a measurement developed to detect deviant test-taking attitudes and responses (Archer, 1992).

The F scale of the MMPI and MMPI-A is referred to as the Frequency or Infrequency scale. It includes responses that were considered related to strange or unusual experiences, thoughts, sensations, paranoid ideation, antisocial attitudes and behaviors. Adolescents tend to produce more elevated F scale raw scores than adults. Therefore, use of this scale for adolescents tended to be contraindicated due to developmental influences that were not what the scale was designed to identify. For the MMPI-A the F scale items were revised into F1

and F2. For all F scales moderate to extreme elevations may indicate severe psychiatric illnesses, may indicate the test-taker is attempting to fake-bad, over-reporting symptoms, or may suggest a random-response pattern due to either a conscious attempt to do so or due to poor reading ability (Archer, 1992)

The primary purpose of the F1 and F2 scales of the MMPI-A was to detect aberrant experiences, thoughts, sensations, paranoid ideation, and antisocial attitudes and behaviors of test-takers. The F1 and F2 scales include criterion requiring that no more than 10% of the normal population were answered in a deviant direction. It also provides information regarding validity of the adolescent's responses to the basic scales. F2 concerns the adolescent's response to the latter part of MMPI-A, which may reflect a change in the adolescent's test-taking focus in final parts of the assessment which may invalidate scores (Archer, 1992).

The Lie (L) Scale is designed to detect individuals deliberately attempting to lie, or to avoid answering the item pool in an open and honest manner. Higher L scale scores have been related to longer treatment duration for hospitalized adolescents. Evidently, moderate elevations, in the range of T-score values of 60 to 65, were related to trends of conformity and the use of denial among adolescents tested (Archer, 1992).

Individuals who display significant degrees of psychopathology but still produced profiles within normal limits are identified through use of the K scale. Although it this scale is not normed for teens, no changes were made in the item

content from the MMPI-2 (the updated MMPI) and tends to focus on self-control, family and interpersonal relationships. The mean raw score values for adolescents tend to be lower than with adults. Very low elevations on the K scale suggests adolescents may be consciously or unconsciously exaggerating their degree of symptoms in an attempt to fake-bad, or as a "cry-for-help". Extremely elevated scales may indicate an attempt to underreport psychological problems suggests a poor prognosis for improvement due to the reluctance to accept help (Archer, 1992). This study did not produce scores that would suggest any attempt to lie, fake-bad, or otherwise manipulate the results, and all assessment results were considered valid.

Particular interest was paid to the MMPI-A supplementary scales. These scales represent characteristics that would be expected to coordinate with issues of loss and angry or defiant behavior. A discussion of the supplementary scales follows.

The MAC scale is the most empirically researched of the subscales. High MAC scores among adolescents appear to indicate the abuse of a variety of drugs in addition to alcohol. Archer et al., (1989) discovered adolescents with high MAC scores were more likely to be assertive, independent, self-indulgent, undercontrolled. They were more likely to have an arrest record and to receive conduct disorder diagnoses. Other research corroborated the findings that high MAC scores were related to acting-out behaviors and lower academic grade point averages. High MAC scorers appear to pursue a "bold, impulsive lifestyle,

with little concern for the consequences of behaviors" (Archer, 1992). The descriptors Archer related to adolescents with high MAC scores also apply to adolescents who did not get needs met from caretakers and authority figures early in life. Children who were not given sufficient time, instruction, and nurturing from parents during the early developmental years may learn to parent themselves. They may be considered assertive, independent, self-indulgent, and undercontrolled, and more likely to use drugs (Archer, 1992).

The supplementary scale of the MMPI-A which examines immaturity (IMM) reflects the developmental level of the adolescent, and potentially correlates with the maturity level of one who suffered a form of perceived parental loss (Kandt, 1994). Hundley & Bratton (1994) reported complicated or delayed grief reactions could have extremely adverse long-term effects on development. Elevated IMM scores were likely to reflect a preconformist stage of development when interpersonal relationships were likely to be described as opportunistic, demanding, and exploitative. High IMM scorers were more easily frustrated and angered, untrustworthy and undependable, have a history of academic and social difficulties, as well as being defiant and resistant (Archer, 1992).

The Alcohol/Drug Problem Acknowledgment (ACK) Scale was designed to assess the adolescent's willingness to acknowledge alcohol or drug use related symptoms, attitudes, and beliefs. The PRO Scale was developed to identify the adolescent who is prone to develop drug/alcohol problems. It is well documented

in the literature on adolescent behavior that the teen who frequently exhibits defiant behavior has an increased propensity for substance abuse or dependency, as previously reported in the discussion on MAC scores (Archer, 1992).

The Adolescent-Depression (A-dep) Scale items appear to be related to depression, sadness, apathy, low energy, poor morale, despondency, and hopelessness, and were related to a variety of behaviors and symptoms typically associated with depression and suicidal gestures. These indicators provide information about the presence and degree of depressed mood the adolescent experiences (Archer, 1992).

The degree to which an adolescent possesses anger was obtained from the Adolescent Anger Scale (A-ang) which assesses the presence of characteristics such as being irritable, grouchy, and impatient. Such moods can increase the occurrence of physical assaultiveness and aggression. Adolescents scoring significantly on the A-ang Scale typically exhibit behaviors such as truancy, poor parental relationships, defiance, and disobedience. Anger and assaultiveness were more likely to be exhibited by girls, and high heterosexual interest, drug abuse, hyperactivity, and threatened assaultiveness were more likely to be exhibited by boys (Archer, 1992).

Cynicism in the MMPI-A was identified in adolescents who may be described as distrustful, cynical, suspicious of the motives of others, and unfriendly and hostile in relationships. They may also have a tendency to believe

that all individuals manipulate and use each other selfishly for personal gain. These behaviors may be expected in individuals that have distanced themselves from objects of affections due to emotional pain, such as loss. There appears to exist a high correlation between female high A-cyn scorers and the presence of sexual abuse and poor parental relationships as primary presenting problems, with concurring resistive behaviors and negative attitudes. For males, the correlates increased occurrence of hallucinations and the excessive use of fantasy (Archer, 1992).

The A-con Scale examines adolescent conduct problems and was designed to identify adolescents who admitted problem behaviors, including impulsivity, risk-taking behaviors, and antisocial behaviors. These adolescents were likely to exhibit behaviors that may result in school suspensions and legal violations. Males who were high scorers on the A-Con Scale were likely to be associated with legal problems such as theft, truancy, drug and alcohol abuse, and assaultive behaviors. Female high A-con scorers had a tendency to present with more truancy, defiance and disobedience, anger, and running away from home (Archer, 1992).

The Adolescent Low Self-Esteem (A-lse) Scale identifies low self-esteem and little self-confidence. Adolescents with these traits exhibited poor school performance and a tendency to focus on faults and flaws. They tended to feel disrespected or rejected by others. Females who score high on the A-lse Scale were more likely to experience depression, obsessive thoughts, social

withdrawal, tiredness, and fatigue, and suicidal thoughts. Suicidal thoughts, passivity, and self-blame or condemnation were often found in the boys (Archer, 1992).

Family problems were considered in the A-fam scale. High scores reflect the presence of substantial family conflict and discord, and report little love or understanding within their families. They were likely to have frequent family quarrels, feel misunderstood and unjustly punished by family members, and tend to report physical or emotional abuse. Such dynamics can distance family members from one another, and the result can be angry behaviors such as a desire to run away or escape from the homes or family. High scores were positively related with delinquent and neurotic symptoms and behaviors. Females with high A-fam scores were more likely to have problems with anger, be loud and boisterous, and have a higher frequency of running away. Males were more likely to have drug and/or alcohol abuse, anger control problems, and a history of physical abuse (Archer, 1992).

The A-sch scale examines adolescent school problems. High scorers on the scale tend to not like school, were likely to encounter many behavioral and academic problems, may have developmental delays or learning disabilities, and may have behavioral problems so significant that academic achievement and acquisition of academic skills were unsuccessful. High scores on this scale in the female population reflect academic decline and failure, truancy, and defiance.

Males who score high on the A-sch Scale tend to have more legal difficulties, drug abuse, fighting, and intense interest in the opposite sex (Archer, 1992).

With the above standard clinical scales, the MMPI also includes 4 validity scales to detect deviant test-taking attitudes or response sets. The Cannot Say scale considers the total number of test items that were omitted or endorsed as both true and false. The Lie (L) Scale includes 15 rationally derived items that consider common human faults or mistakes, such as with the attempt to present oneself in an unrealistically favorable manner. The F Scale provides a means of determining invalidity of the clinical scale due to careless answering by the participants, inability to comprehend the items, or that extensive scoring errors have occurred. Using 50 psychiatric patients who provided what could be considered false negatives developed the K scale. Therefore, the K scale serves to improve the discriminative power of the clinical scales in detecting psychopathology. The above scales were used in this study to aid in identifying a profile persistent in the defiant population; those who have significant early loss experience. The non-defiant group was not expected to score as high on these scales (Archer, 1992)

The MMPI-A can be administered through paper and pencil format, audiocassette, or on-line administration. For the purpose of this study, administration was by pencil and paper, and then computer scored. Particular interest was given to scales that reflect family conflict, grief, and angry and defiant behavior as described above.

Procedure

Approval of the University of North Texas Human Subjects Committee was obtained for the use of human participants. The interviewer/researcher for this study was doctoral-level student who had completed internship in counseling and is licensed in the State of Texas as a Professional Counselor, Marriage and Family Therapist, and Chemical Dependency Counselor.

Following standardized procedures, an adolescent was identified as a candidate for the study by one of the referring sources, and the participant's parent was given a letter explaining the study, and instructed to call the researcher. Upon contact, the participant and parent/guardian were advised of the purpose and design of the study. An explanation was provided that the study examines adolescents and the impact of loss. Measures of confidentiality were explained, and that participation earns the adolescent two movie passes, if chosen for the study. They were also advised they could discontinue participation in the assessment at any time without concern for penalty, harassment, or prejudice, and if all agreed, an appointment was made for the assessment. The caller was informed of the length of time needed for completion of the study, and that it was necessary for a custodial parent to sign permission to participate. A follow-up phone call was made the evening before the testing session to remind of the date and location.

Upon arrival at the testing site, written consent to participate was obtained from the teenagers and parents/guardians. They were also offered the

opportunity to have interpretive results of the MMPI-A made available to the adolescent's therapist or counselor, if there was one at the time of testing, and if the teenager and parent/guardian signed releases. They were informed that it would not be possible to request MMPI-A results at a later time, since documentation of names or other identifying information was not kept. Procedure dictated that temporary file identification tags were disposed of following the mailing of the results to the appropriate recipient. The teen and guardian were provided business cards, should questions or problems arise following the study. A list of referrals to counselors and agencies to provide follow-up services were made available.

The assessment session followed a predetermined format. The Interview Process first, then the Family Constellation Survey, followed by administration of the MMPI-A. A ten-minute break offered between the Family Constellation Survey and the MMPI-A reduced the likelihood of any unnecessary distractions, disruptions, or fatigue during the testing process. The interviewer remained in the testing room, available for questions or concerns, and to encourage the participant to stay on task, yet took care not to be distracting.

Archer (1992) suggested the examiner establish adequate rapport with the adolescent prior to administration of the MMPI-A, which increases the likelihood that the more oppositional adolescent will cooperate with the lengthy testing procedure. Casual conversation during the signing of permission and explanation of the study served this purpose.

The participant was provided the test, answer sheet, and two sharpened pencils, and given instruction which followed suggestions provided by Archer (1992): "Read each statement and decide whether it is true as applied to you or false as applied to you. Remember to give your own opinion of yourself. There are no right or wrong answers. Your test will help us to understand you" (p.77).

Following successful completion of all three instruments, a brief exit interview was conducted during which the participants were asked why they chose to participate in the study, and what the research experience was like for him or her. No participants chose to make any comments. The participants were reminded to contact the researcher at the number provided, should any questions or concerns arise from the study. At completion, the participants were thanked for cooperating, given 2 movie passes, and dismissed.

It was hoped that inclusion in the study would motivate the adolescent to question his or her own issues of loss, and possibly seek, or continue, working towards resolution, if necessary. Referrals to individual counselors and agencies were provided, if requested.

Analysis

After collection of the data, processing and analysis was conducted. For this study, the independent variable was the presence of loss, and the dependent variable was the presence of angry/defiant behaviors.

Interview Process

The standard responses for each item were given a numerical value based on the strength of the response. If an item was strongly endorsed, it was given the value of '4'. Values decreased accordingly with responses of "Strongly Disagree, Disagree, Agree, Strongly Agree". Each endorsement identified some component of the study hypotheses or foci of the study. The responses for each item were summed, and a total sum for each of the items tabulated. The means were identified compared between the groups for significant differences through use of the t-test.

Family Constellation Exercise

Completion of the evaluative Family Constellation exercise produced a set of numbers that represents the perceived emotional distance of each participant to family members. The numbers were gathered through measuring the distance between the marked central points of the participant figure to each family member figure. The mean of the distances for each participant was calculated and compared through use of the t-test. It was expected that the defiant group would show an overall greater emotional distancing from family members than the non-defiant group.

Minnesota Multiphasic Personality Inventory - Adolescent

The MMPI-A provided valuable information regarding whether the defiant group differs substantially from the non-defiant group of adolescents. Scores from each scale of the MMPI-A were totaled and the mean computed. On the

advice of two statistical experts, the means for each individual scale of the MMPI-A, for both the defiant group (target group) and the non-defiant group (comparison group) was statistically analyzed through the t-test. Results were examined for relationships between the different variables.

Chapter III

This chapter presents the results of analysis of the data for each hypothesis tested in this study. Included also is a discussion of the results and implications.

Results

The results of this study are presented in the order the hypotheses were posed. T-tests were performed on all hypotheses and a level of probability that the difference between the two groups occurring by chance was set at less than .05. This is the criterion level for which all study hypotheses will either be accepted or rejected. The decision for acceptance of each of the hypotheses was determined through use of the two-tailed t-test for analysis of variance.

In order to find answers to the questions posed in Chapter II, data was collected from the two designated study groups; the Target Group, and the Comparison Group. Referrals for the Target Group came primarily from mental health clinicians and an outpatient counseling agency. Referrals for the Comparison Group came from a church youth ministry, a local high school choral program, and from mutual referrals of some of the participants (therefore, carefully screened by the tester). There were several which, upon screening, were not accepted into either study group as they fell outside criteria guidelines, or had a primary diagnosis of substance abuse or attention deficit disorder. Although not previously identified, dyslexia became a reason for exclusion due to

the reading accuracy required for completion of the MMPI-A. A recorded version of the MMPI-A that could have been utilized for those with reading differences was not available for this study. A total of fifteen participants were selected and assigned to each of the study groups. The study began with the parent/guardian and adolescent signing participation permission. All other standards were followed as designated above.

Hypotheses

Using the 2 tailed t-test; the following hypotheses were investigated and assessed for accuracy.

Table 1

Hypothesis 1. There will be a higher incidence of loss in the Target Group than in the Comparison Group as identified through elevated scores on the Interview Process Scale.

Group	n	Mean	SD
Target	15	35.68	10.4
Comparison	15	25.44	6.0
Results: Accept	t = .005	ρ = < .05	

Table 1 represents the findings of the instrument used exclusively to qualify participants for the study, and to determine to which group the participant is assigned, either the Target Group (the angry, defiant teens), or the

Comparison Group (those functioning within normal limits). To arrive at the numerical findings, participants were asked to respond to a series of one-sentence comments which were drawn from information reported in related literature. They were asked to respond to statements by selecting "Strongly Disagree, Disagree, Agree, Strongly Agree". Each response was assigned a numeric value of one to four, according to how the response correlates with primary or major loss factors reported in the literature. "1" indicates low correlation, and "4" indicates high correlation. The cumulative total for each item was compared. It was expected that those who were reporting major loss issues would generate higher totals. These totals were added and the means were calculated for both groups. The means were then compared through use of the t-test to identify if the difference between the two groups was significant. According to the findings reported in Table 1, there was a significant difference (t =.005). Therefore, Hypothesis 1 is accepted.

Table 2.

Hypothesis 2. Subjects in the Target Group experience more symptoms of depression than those in the Comparison Group as evidenced by elevated scores on the A-dep scale of the MMPI-A.

Group	n	Mean	SD
Target	15	13.33	8.26
Comparison	15	4.80	2.68

Results: Accept t = .001 $\rho < .05$

The A-dep scale of the MMPI-A evaluates the presence of depression in adolescents by identifying depressive symptoms while screening for the presence of associated high-risk behaviors. The diagnostic criteria and literature regarding depression considers depressive symptoms to be typically found in angry kids. For those adolescents who have experienced significant loss, such as those in the Target Group, it was imperative to evaluate the level of depression. It was expected that those who have experienced significant loss to be more sad and depressed, and prone to acting out sadness through angry behavior. Therefore, it was expected that those in the Target Group would present more elevated scores in the A-dep scale than those in the Comparison Group. Table 2 reflects such findings. By responding to those assessment items that relate to indicators of depression, the Control Group presents with a significantly higher level of depression ($\rho<.05$), and Hypothesis 2 is accepted.

Table 3

Hypothesis 3. Subjects in the Target Group will exhibit more symptoms of anger than the comparison group as indicated by higher scores on the A-ang scale of the MMPI-A.

Group	n	Mean	SD
Target	15	12.93	5.82
Comparison	15	7.8	3.05

Results : Accept	t =.005	$\rho < .05$

Table 3 presents the findings of one of the most important concerns of this research – adolescent anger. The MMPI-A identifies indicators of angry feelings and anger responses in the adolescent, which made the MMPI-A an extremely valuable instrument for this study. The scores on the A-ang scale were tabulated and compared for significance. The Target Group did report significantly more indicators of anger than the Comparison Group. Table 3 presents a comparison of data from each of the groups. The results indicate the Target Group's scores were significantly higher (t = .005) than the Comparison Group at the .05 level. Hypothesis 3 is accepted.

Table 4

Hypothesis 4. Subjects in the Target Group will exhibit more symptoms of immaturity than the Comparison Group as evidenced by higher scores of the IMM scale of the MMPI-A.

Group	n	Mean	SD
Target	15	11.86	4.82
Comparison	15	12	4.29
Results : Reject	t = .936	$\rho = < .05$	

Immaturity is a lack of emotional development, which can occur as a consequence of repeated or impactful loss. The MMPI-A IMM scale identifies

indicators of immaturity in both study groups. For this study, the Target Group's cumulative sums were slightly less than those of the Comparison's Group (Target Mean = 11.86; Comparison Group 12). By analyzing the significance of the difference between these means through use of the t-test, it can be concluded that there is not a significant difference between the two groups ($t = .936$, $\rho > .05$), and Hypothesis 4 is rejected.

Table 5

Hypothesis 5. Subjects in the Target Group will experience more substance abuse than the Comparison Group as evidenced by higher scores on the MAC, ACK, and PRO scales of the MMPI-A.

MacAndrew Alcohol-Revised (Mac-R)

Group	n	Mean	SD
Target	15	24	5.01
Comparison	15	18.46	3.24
Results : Accept	t = .001	$\rho < .05$	

Alcohol/Drug Problem Acknowledgment (ACK)

Group	n	Mean	SD
Target	15	3.6	1.89
Comparison	15	3.20	1.62
Results : Reject	t = .615	$\rho > .05$	

Alcohol/Drug Problem Proneness (PRO)

Group	n	Mean	SD
Target	15	19.73	6.27
Comparison	15	14.06	4.71
Results : Accept	t = .009	$\rho < .05$	

Hypothesis 5 incorporates three scales of the MMPI-A to find the best indicators of or tendency toward substance abuse in the study groups. It is well documented that the targeted population is much more prone to abuse chemicals. The MAC-R identifies traits of substance abuse problems, and personality characteristics that are typically found in adolescent substance abusers. For this scale, there was a significant difference between the two study groups as identified through analysis utilizing the t-test (t = .001) with $\rho<.05$. This component of Hypothesis 5 is accepted.

Considering there are many covert behaviors associated with angry adolescents, it became important to explore the willingness of the adolescent to admit to drug or alcohol problems. The MMPI-A ACK scale accomplishes this task. Angry adolescents are more likely to abuse drugs, and the ACK scale was expected to be more elevated for the Target Group than the Comparison Group. However, it appears that there was not a significant difference for those in either of the two groups to willingly admit substance abuse problems. The comparison through use of the t-test was not significantly different, and this segment of Hypothesis 5 is not accepted (t = .06; $\rho>.05$).

Adolescents who have experienced difficult life situations are historically more likely to develop drug or alcohol problems. The MMPI-A PRO scale was developed to assess the likelihood of alcohol or drug problems in adolescents. The scale identifies behaviors that are associated with drug-using lifestyles, such as the tendency to be influenced by negative peer influence, problematic behaviors, bad judgment, and difficulties with parents. In this study, the significance of the difference of the two groups was assessed through utilization of the t-test, where $\rho > .05$, t = .009. The Target Group did report engaging in more of the behaviors related to substance abuse, and this portion of Hypothesis 5 is accepted.

Table 6

Hypothesis 6. Subjects in the Target Group will exhibit symptoms of cynicism more often than those in the Comparison Group as indicated by higher scores on the A-cyn scale of the MMPI-A.

Group	n	Mean	SD
Target	15	15.53	4.29
Comparison	15	11.86	3.39
Results : Accept	t = .01	$\rho = < .05$	

Information regarding the adolescent's view of him or herself in relation to the world is obtained through use of the A-Cyn scale, which evaluates the level

of cynicism. Overly cynical adolescents view others as manipulative and self-serving, and often see the world as an unsafe world in which to live, if one does not keep on one's guard. They often feel misunderstood by others. Although these characteristics can be considered typical for almost any adolescent who is learning to navigate the world, those who live a cynical lifestyle often have other problematic areas of their life due to this perspective. By examining A-cyn scores for both study groups, and calculating and comparing the means of the total scores, it is possible to evaluate significance of the findings through use of the t-test. For this study, there was a significant difference ($t = .03$; $\rho < .05$). Hypothesis 6 is true, and teens in the Target Group to be more likely to engage in a cynical lifestyle.

Table 7

Hypothesis 7. Conduct problems will be reported more frequently by the subjects in the Target Group than the Comparison Group as indicated by higher scores on the A-con Scale of the MMPI-A

Group	n	Mean	SD
Target	15	13.6	4.17
Comparison	15	8.66	3.59
Results : Accept	t =.001	$\rho = < .05$	

Individuals scoring high on MMPI-A's conduct problems (A-con) scale experience trouble in many areas of their lives. Through identifying the tendency for engaging in problematic behaviors and adherence to related beliefs, the Target Group generated profiles which were compared with those of the Comparison Group. The means of the cumulative scores revealed that those in the Target Group significantly engage in more conduct problems than those in the Comparison Group, as proven by t-test. Hypothesis 7 is accepted ($t = .001$, $\rho < .05$).

Table 8

Hypothesis 8. Subjects in the Target Group will exhibit more indicators of low self-esteem than subjects in the Comparison Group as evidenced by higher scores on the A-lse scale of the MMPI-A.

Group	n	Mean	SD
Target	15	8.6	4.03
Comparison	15	4.6	2.58
Results : Accept	t = .005	ρ = < .05	

The literature on adolescents who engage in problematic, angry behaviors or substance abuse, reports they are much more likely to struggle with decreased self-esteem. Those who are more positively engaged in life, and have healthier expression of emotions and sufficient coping skills are much more likely to feel good about themselves. The comparison of the MMPI-lse scales for both

study groups support this hypothesis. Through analysis by t-test, the Target Group does suffer from low self esteem more than those in the Comparison Group ($t = .005$, $\rho < .05$), and Hypothesis 8 is accepted.

Table 9

Hypothesis 9. Subjects in the Target Group will exhibit more symptoms of family problems than subjects in the Comparison Group as evidenced by higher scores on the A-fam scale of the MMPI-A.

Group	n	Mean	SD
Target	15	19.6	5.89
Comparison	15	13.6	6.04
Results : Accept	t = .008	ρ = < .05	

Several measures of family conflict and family problems have been included in this study. However, the A-fam scale of the MMPI-A most adequately quantifies the difference between the Target and Comparison Groups and their families. The presence of angry and defiant behaviors toward other family members is the focus of this scale. An elevated score also suggests the presence of delinquent behaviors and neurotic symptoms. For this study, the means of the cumulative scores for both groups were compared through use of the t-test, and found a significant difference between the two groups ($t = .008$, $\rho <$

.05). Hypothesis 9, which suggests that there is more family problems for the Target Group population than those in the Comparison Group, is accepted.

Table 10

Hypothesis 10. Subjects in the Target Group will experience more school problems than subjects in the Comparison Group as evidenced by higher scores on the A-sch scale of the MMPI-A.

Group	n	Mean	SD
Target	15	11.13	4.61
Comparison	15	6.2	3.38
Results : Accept	t = .002	ρ = < .05	

Adolescents who are typically angry and have trouble with authority figures often act this out at school. Poor grades, conflicts with teachers and administrators, truancy, and inattentiveness are often characteristic of those who score high on the A-sch scale. By comparing the two cumulative score group means through the t-test, it is apparent that those in the Target Group score significantly higher on this scale than those in the Comparison Group. Hypothesis 10 is accepted at the $\rho < .05$ level (t = .002).

Table 11

Hypothesis 11. Subjects in the Target Group will demonstrate greater emotional distance between self and family members than those in the Comparison Group as evidenced by greater Mean scores on the Family Constellation Exercise.

Group	n	Mean	SD
Target	15	35.68	12.03
Comparison	15	25.46	6.68
Results : Accept	t = .007	ρ = < .05	

Table 11 represents the perceived emotional distancing from nuclear family members demonstrated through the Family Constellation Exercise. Each individual score provided measurements exemplifying relationships by displaying figures in relative proportion to how each felt toward other family members – either emotionally close, or emotionally distant. The distance was measured metrically. The totals of centimeters from the self-figure to all other nuclear family figures were calculated. The totals were added and the means calculated. The means were then compared through the t-test, and the difference between the means was examined for validity at the ρ=.05 level. It can be considered with t = .007, Hypothesis 11 is accepted.

Interview Process

The Interview Process was the first part of the study. A laminated sheet was placed in front of the participants that read, “Strongly Disagree, Disagree,

Agree, Strongly Agree". Participants were encouraged to respond to the Interview Process using only these four replies. Below is a summary of the number of participants choosing the particular response, which is located before the response, and the value assigned to each is noted in parentheses following the response. Question 13 is not scored as it is subjective and non-quantifiable. Questions 12 and 15 were not scored as these are included for informational purposes, and provide data for future research only. The following are results for each of the groups. 'T' represents the Target Group, and 'C' is for the Comparison Group.

1. Before I was a teenager I experienced a major loss or sadness.

T 0 Strongly Disagree (1) 1 Disagree (2) 9 Agree (3) 5 Strongly Agree (4)

C 2 Strongly Disagree (1) 9 Disagree (2) 3 Agree (3) 0 Strongly Agree (4)

T = 49 C = 29

2. I was frequently put down or made fun of by my parents, teachers and/or others.

T 0 Strongly Disagree (1) 2 Disagree (2) 10 Agree (3) 3 Strongly Agree (4)

C 9 Strongly Disagree (1) 2 Disagree (2) 2 Agree (3) 2 Strongly Agree (4)

T = 46 C=27

3. I was never told things that made me feel worthless, embarrassed, or ashamed.

T 9 Strongly Disagree (4) 5 Disagree (3) 1 Agree (2) 0 Strongly Agree (1)

C 2 Strongly Disagree (4) 13 Disagree (3) 0 Agree (2) 0 Strongly Agree (1)

T = 53 C = 47

4. I was never threatened with harm or abandonment.

T 8 Strongly Disagree (4) 7 Disagree (3) 0 Agree (2) 0 Strongly Agree (1)

C 0 Strongly Disagree (4) 5 Disagree (3) 8 Agree (2) 2 Strongly Agree (1)

T = 53 C = 33

5. Someone or some tragic act physically injured me.

T 5 Strongly Disagree (1) 8 Disagree (2) 1 Agree (3) 1 Strongly Agree (4)

C 2 Strongly Disagree (1) 12 Disagree (2) 1 Agree (3) 1 Strongly Agree (4)

T = 28 C = 33

6. I have experienced being touched, fondled, raped, or asked to touch or look at someone else in a sexual way.

T 3 Strongly Disagree (1) 7 Disagree (2) 3 Agree (3) 2 Strongly Agree (4)

C 8 Strongly Disagree (1) 6 Disagree (2) 1 Agree (3) 0 Strongly Agree (4)

T = 34 C = 23

7. I was exposed to other sexual behavior before I was a teenager.

T 5 Strongly Disagree (1) 4 Disagree (2) 5 Agree (3) 1 Strongly Agree (4)

C 4 Strongly Disagree (1) 9 Disagree (2) 2 Agree (3) 0 Strongly Agree (4)

a. How did it make you feel?

T “Don’t recall”, “Don’t remember”, “Scared”, “Curious”

C “Powerless”, “Used”, “Don’t know”

a. Did you receive any help for what happened?

T “No”

C “No”

b. How do you feel about the experience now?

T “Angry”, “Doesn’t bother me”, “A little scared about sex.”

C “Put it behind me...don’t think about it”, “Sometimes I have nightmares.”

T = 32 C = 28

8. My parents are not still together.

T 1 Strongly Disagree (1) 2 Disagree (2) 2 Agree (3) 10 Strongly Agree (4)

C 5 Strongly Disagree (1) 9 Disagree (2) 1 Agree (3) 0 Strongly Agree (4)

T = 51 C = 26

9. I have not had a parent die.

T 1 Strongly Disagree (4) 0 Disagree (3) 8 Agree (2) 6 Strongly Agree (1)

C 0 Strongly Disagree (4) 0 Disagree (3) 14 Agree (2) 1 Strongly Agree (1)

T = 26 C = 29

10. I have had someone else close to me die.

T 0 Strongly Disagree (1) 4 Disagree (2) 1 Agree (3) 10 Strongly Agree (4)

C 0 Strongly Disagree (1) 7 Disagree (2) 7 Agree (3) 1 Strongly Agree (4)

T = 52 C = 39

11. I believe that one or both of my parents, parent figures, or other family member had or have a drug or alcohol problem.

T 5 Strongly Disagree (1) 1 Disagree (2) 3 Agree (3) 6 Strongly Agree (4)

C 4 Strongly Disagree (1) 9 Disagree (2) 1 Agree (3) 1 Strongly Agree (4)

T = 40 C = 29

12. I have cut myself or burned myself to cope with my feelings.

T 2 Strongly Disagree 10 Disagree 2 Agree 1 Strongly Agree

C 6 Strongly Disagree 9 Disagree 0 Agree 0 Strongly Agree

13. When I get really angry I :

T Yell.

Cry.

Burn something (candles, paper).

Drive / go mudding.

Hit the wall.

Hit someone if I'm mad enough.

Break something.

Hit my punching bag.

Tell everyone to back off.

Cuss a lot.

Hurt someone.

Hurt myself (bang head, bite hand, burn self with cigarette).

Listen to music.

Write songs/play my guitar.

Smoke.

Work out (exercise).

Leave / Walk out.

Call someone.

Plan my “escape” (think about leaving home, quitting school, driving off).

C Play Golf.

Shut down/ Stuff it.

Sit in room alone.

Maybe talk about it/Call someone/talk to someone.

Pray and let it go.

Exercise.

Use harsh sarcasm.

Yell / Scream.

Verbally lash out.

Leave – go to a friend’s.

Talk to stuffed animals- they don’t tell.

Stay away from everyone else –time helps.

Take a walk.

Cry.

Listen to music.

Write in my journal / write poetry.

Go in my room and hit a pillow.

Talk to my friends on the computer (instant messaging).

14. My anger has caused me problems or has gotten me in trouble.

T 0 Strongly Disagree (1) 0 Disagree (2) 8 Agree (3) 7 Strongly Agree (4)

C 0 Strongly Disagree (1) 8 Disagree (2) 4 Agree (3) 3 Strongly Agree (4)

T = 52 C = 40

15. I believe that my anger has helped me.

T 9 Strongly Disagree 4 Disagree 2 Agree 0 Strongly Agree

C 0 Strongly Disagree 13 Disagree 2 Agree 0 Strongly Agree

The results of the Interview Process complemented the literature review presented in Chapter One, and confirmed the powerful impact of early childhood loss.

For Question One of the Interview Process, 14 of the Target group reported significant losses in the pre-adolescent years, compared to 4 in the Comparison Group. However, since both groups reported loss of someone close (T=11, C=8) in Question Ten, this discrepancy could be due to the structure of the question not limiting the loss to a particular time period as Question One did. Some of the participants, although having experienced the death of someone close, may not have considered the loss to be dynamically impactful. Most of the losses were reported to be grandparents, aunts, uncles, and pets, and although significant, may not have been as profound as other losses such as parents or close friends. Some participants of the Target Group volunteered they had experienced the loss of friends and siblings due to unexpected acts of violence, suicide, or serious illness.

Question Two revealed that most of the Target Group, in contrast to the Comparison Group, had experienced being teased more (T=13, C=4). This can be considered an emotional loss, especially if it is accompanied by feeling inferior to peers. Question Three is interesting in that all but one participant (T=14, C=15) reported experiencing being told something that made them feel worthless, embarrassed, or ashamed. This appears to be a common childhood experience in both groups.

Threat of harm or abandonment addressed in Question 4 was reported more in the Target Group (T=15) than the Comparison Group, which reported only five threats. Most of both groups (T=13, C=14) denied encountering actual physical injury (Question Five). Exposure to early sexual behaviors was not heavily reported in Question 7 (T=6, C=2). However, those that did experience exposure apparently did not get help although there was mention of persisting impact related to the instances.

Sexual abuse of the participants was minimally reported (T=5, C=1) in Question Six. This kind of abuse historically tends to be under-reported, although it can have serious and lasting impact.

One of the most remarkable differences between the two groups is the participants' parents' marital status. In Question Eight, of the Target Group, 12 of the 15 participants reported that their parents were not still together, while only one in this group reported it being due to a parent's death (Question 9). Of the

Comparison Group, only one did not live with both biological parents nor reported a parental death.

The literature on the impact of substance abuse suggests a potential for significant problems to exist in families where substance abuse is present. Substantiating this claim, nine of the Target Group, and two of the Comparison Group report believing that a parent, parent figure, or other family members have, or have had a drug or alcohol problem in Question 11.

Since this study is particularly interested in adolescent anger responses, it was interesting to note the ways by which adolescents cope with, and express, anger. Only three in the Target Group and none of the Comparison Group report cutting or burning themselves as a means of coping with anger. Instead, they share several of the same coping skills such as “cry, yell, listen to music, write (journal, poetry, music), talk to friends, and drive around”. There was a tendency for more aggressive responses from the Target Group, such as “burn something, hit the wall or hit someone, break something, cuss, hurt myself”, all of which were not unexpected

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aggressive responses from the Target Group, such as “burn something, hit the wall or hit someone, break something, cuss, hurt myself”, all of which are not unexpected from adolescents who exhibit anger as a primary emotional response. In Question 14 both groups acknowledge having had problems or have been in trouble for their anger responses, although the Comparison Group reported this less frequently (T=15, C=7). The majority of neither group considered anger as ever having been helpful (T=2,C=2) in Question 15. The difference between the means ($T \times = 34.4$, $C \times = 25.33$) of each study group was analyzed using the 2 tailed t-test which found a significant difference at the $\propto .05$ level (t =0.00561), and Hypothesis 1 should be accepted as true. Clearly, there is a difference between life experience of the participants in the Study Group and those in the Comparison Group (see Figure 1).

Participation in this portion of the study was met without resistance, and many volunteered additional information, particularly about losses from deaths, and about being made fun of by others. There was no refusal by anyone to respond to interview questions. All participants were willing to continue with the next phase of the study.

Family Constellation Exercise

The Family Constellation Exercise is a means by which participants demonstrate how emotionally close or distant to other nuclear family members they consider themselves to be. Procedurally, the participants were seated at a

large table with a medium-shade green laminated poster board placed before them. They were given a stack of gingerbread man-shaped figures (Figure 1) with a small dot in the exact center neck area of each one. The instructions were given as designated in Chapter Two of this paper. Each participant identified a central position for him or herself on the poster board, and placed family members around the self-figure, in proximity to how emotionally close or distant the participant felt to that family member. The only limitation was that the figures must be on or touch the green of the poster board. A metric tape measure was used to identify the distance between the participant's figure and each figure representing family members.

The cumulative total for each participant was recorded and used for analysis of differences. The means of the two groups were: Target Group $\times$ 35.68, Comparison Group $\times$ 25.46. Through analysis using t-test, it was discovered that there is a significant difference between the two groups ($t = .007$, $\rho < .05$). The total scores of the Target Group reflect a greater perceived emotional distance than those from the Comparison Group. These scores suggest that those in the Target group see themselves not as close to their family members as those in the Comparison Group. Therefore, Hypothesis 11 is accepted (Table 11).

Minnesota Multiphasic Personality Assessment – Adolescent

The Minnesota Multiphasic Personality Assessment – Adolescent version (MMPI-A) is an instrument designed to profile personality characteristics, identify

risk behaviors, and provide suggestions for treatment modalities to help the adolescent. MMPI-A's interpretive report includes suggestions and considerations for therapeutic concerns and interventions. The interpretive report was provided to mental health clinicians upon written request and release signed by the participant and the participant's parent. Only numerical reporting was used for the findings of this research.

Following paper and pencil administration of the MMPI-A, answers were manually entered into the computer and verified for accuracy. Tabulation for the Basic Scales and Supplementary Scales were processed using NCS software. There were some expected results, and some surprises. The Target Group scores are elevated in almost every category on the Basic and Content Scales (Figures 4 & 2). On the Supplementary Scales (Figure 3), the scores are closer. Extreme differences (> 10 points) on the Basic and Content Scales are found in areas of depression, psychopathic, schizophrenia, social introversion, anger, and family problems. On the Supplementary Scales, the extreme differences are in the area of alcohol/drug proneness only. The least areas of difference (< five points) of the Basic and Content Scales hypochondriasis, are in the categories of conversion hysteria, paranoia, depression, social introversion, and anxiety. In the Supplemental Scales, every scale was significantly elevated for each area except Immaturity and Drug and Alcohol Acknowledgment. A closer look at these categories will help increase understanding of these findings.

Hypochondriasis is a condition where inordinate focus is placed on multiple physical complaints, ailments, and bodily functioning. Since many of the participants in this group were in school athletics, cheerleading, theatre, or music where the focus is on physical performance, this finding is not surprising. Also, with the adolescent going through rapid physical changes, and are daily bombarded with messages that food, cigarettes, the environment, and sex can cause physical illness and death, many adolescents attend to their bodies with curiosity and worry.

The Social Discomfort scale relates to an adolescent's discomfort in social situations, and the propensity to be introverted and shy. Those who score high in this area might be introverted, shy, and may avoid social situations. Those who find social situations problematic tend to be prone to eating disorders, depression, increased tendency to behavior provocatively, anxiety, and nervousness. Such profound discomfort can lead to thoughts of suicide. For the adolescent who is trying hard to fit in and struggling with social acceptance, the pressure is intense. For those who quit trying to fit in socially (more likely in the Target Group), the pressure is off. They don't care anymore and don't consider themselves to be part of the same social circles as those above.

Most of the Basic and Supplementary Scales scores of the MMPI-A do not reflect a great variance between the Target and Comparison Groups. The Basic Scales that do reflect extreme elevations are dominated by the Target Group, and were in the areas of psychopathic traits, hypomania, anger, cynicism,

conduct problems, and school problems. In the Supplementary Scales, elevations were exhibited in the areas of Mac Andrew Alcoholism-Revised, the alcohol/drug problem proneness, and subjective depression.

Psychopathic deviate traits are considered to be characteristics of antisocial personality disorder, according to the DSM IV. Those who carry this diagnosis tend to engage in delinquent actions, such as committing forgery, lying, stealing, truancy, sexual promiscuity, and prone to abuse illegal substances. Significant elevations on this scale suggest the presence of antisocial beliefs, attitudes, and convictions, and rebellious, hostile, and resistant behavior, as well as running away. There is a high incidence of these adolescents coming from homes of divorce or separation. These traits are typical of many of the adolescents found in the Target Group.

Hypomania is manifested through egocentric and grandiose beliefs and behaviors. Those who exhibit hypomanic traits are often irritable, cognitively and behaviorally hyperactive, and experience expansive mood. Typically, hypomanic individuals are impulsive, narcissistic, socially extroverted, and action-oriented. They are prone to be argumentative, hostile, moody, and unrealistic dreamers. Substance abuse, particularly of stimulants, is not uncommon among this group. These elevated scales support the literature which suggests that these characteristics would be found in the Target Group.

As reported elsewhere in this paper, anger is a normal emotion provided to enable an individual to take protective action when necessary. For the

adolescent with marked elevations on the MMPI-A anger scale, anger can be more hindrance than help. The angry adolescent is often irritable, grouchy, and impatient with a potential for physical aggression and hostility. Elevations of the anger scale (A-ang) are associated with defiant and disobedient behavior, high heterosexual interest, substance abuse, poor relationships with parents, and truancy.

The cynicism (a-cyn) scale identifies possible characteristics of distrustfulness, increased cynicism, and suspiciousness of others. Cynical adolescents are often wary of the motive of others and believe people choose their actions based on personal gain, rather than altruism. They also see ethical and honest behavior as merely a response to fear of being caught and punished. They believe, and expect people to lie, cheat and steal. Female adolescents who are score high in cynicism often have experienced sexual abuse and poor parental relationships. They are resistant and negative by nature. Males who score high in cynicism often engage in fantasy and may experience hallucinations.

Teenagers are notorious for gregarious behavior. Most will test limits and engage in thrill seeking and acting out behaviors. Sometimes the impulsive, risky, and antisocial behaviors become a lifestyle and cause school suspensions and legal problems, qualifying them a diagnosis of conduct disordered. For this group, the attitudes and beliefs are often in conflict with those of society. Elevations of the conduct problems scale (a-con) indicate a propensity to engage

in stealing, truancy, substance abuse, defiance, disobedience, running away, and problems with authority figures.

Adolescents who score high on the school problem scale (a-sch) do not like school and are likely to be disruptive through behavioral and academic challenges. It is not unusual for teens in this group to have learning differences or developmental delays, and may fall behind academically. These individuals tend to be maladjusted and prone to fighting, defiance, drug abuse, truancy, and intense attraction to the opposite sex. These adolescents resist authority and often disobey teachers and principals, which is a criteria for defiance.

The Mac Andrew Alcoholism Scale (MAC-R) is the first of the Supplementary Scales, and was designed to identify substance abuse among adolescents. Those scoring high on the MAC-R scales are typically extroverted, domineering individuals who tend to be self-focused, self-indulgent, and egocentric. They are more likely to be extremists who live outside the norm, and are likely to have legal problems, possibly related to impulsive behaviors and drug use. These individuals are also more likely to also be diagnosed as conduct disordered. It is not surprising that the Target Group scored significantly higher than the Comparison Group on this scale.

The Alcohol/Drug Problem Proneness scale identifies the likelihood that an adolescent will develop a drug or alcohol problem. This scale showed essentially the same level of elevation by the Target Group as with the MAC-R scale. By assessing the same problem areas as the MAC-R, such as familial

discord, academic problems, problematic behaviors, and personal interests, it is not surprising that the Target Group again scored higher than the Comparison Group.

Several hypotheses were answered through use of the MMPI-A scores (Appendix D), many of which are described above. Although some of the concerns may regard developmental or personality characteristics, which are typically resistant to therapeutic intervention, many of the problematic areas can have favorable outcomes if identified as problems, and intervened on with therapy and restructure in the home.

Conclusion

The instruments used in this study were specifically chosen or developed based on trends in therapeutic work with adolescent and their families, the extensive literature on adolescent behavior and developmental issues, as well as the demands of societal concerns. Each of the findings was expected. Perhaps the most interesting results of the instruments were those suggesting that "normal" teenagers also have significant struggles, and scored higher than expected in many areas.

Chapter IV

Discussion

The impact of loss on adolescent anger and defiant behavior began as a study targeting the relationship between loss and the obvious attributes that are present in most ‘angry kids’. According to the statistical findings of this study, it is no accident that there is a strong correlation between incidents of unresolved loss, and anger and defiance.

Case Study

The decision to examine and substantiate the relationship between adolescent anger and defiant behavior and loss issues was easily made, for it has been an interest for a long time. The awareness that there may be a correlation came many years ago due to a therapeutic encounter with a young 15 year-old male who will be referred to as “Jason”. Jason was admitted into an inpatient psychiatric facility through emergency services after he had fallen into a ravine in the middle of the night and broke his arm. Jason awoke the next morning, and due to his intoxication the previous evening, was unable to recall what happened or why.

Jason was a quiet, observant, physically attractive young male, but seething with anger and initially resistant to therapeutic interventions. Jason’s hair was died black and he dressed in black. His music preference was limited to songs with sad or angry lyrics, and his affect was often sullen and sad,

fluctuating to openly angry and verbally aggressive. Although intelligent, he was not performing academically. He was the eldest of two teen sons with a divorced mother, and had little contact with his father.

It took a while for Jason to trust this writer, who served as his counselor, and become willing to share information about his life. While exploring the roots of his angry and self-destructive lifestyle, it became evident that he felt abandoned by his father who lived in the same metropolitan area as Jason, but was rarely involved in his life. He also was angry toward his mother, and his anger intimidated her to the point that she rarely set limits on his actions or activities. As Jason addressed his anger through music and art therapy, and individual therapy and family therapy with his mother and younger brother, he became more in touch with his core issues. He prepared to address the loss of the relationship with his father, who agreed to join Jason in conjoint sessions.

At first, Jason was resistant to the idea of therapy with his dad. He believed opening up to his father about how powerful the loss of the relationship had been would make him seem weak and more vulnerable to pain from his father. He also feared making contact with his father, then losing him again, would be even more painful. He prepared himself to be disappointed. The goal of the first session was designated to be an opportunity for Jason to express his disappointment with his father's lack of involvement. He had no expectations of his father's response. The first session between them was awkward. Neither knew how to communicate with the other. Jason began the session by asking his

father why he was so distant from him and his brother. His father expressed feeling unwelcome around them, and believed that it would be less hurtful to everyone if he stayed away. Jason was able to tell Dad of his disappointment, and of his need for contact with him. Jason was willing to try again if Dad was.

The trust was slow to build, and both had to learn to communicate openly and honestly. Both were willing to address their substance dependency problems, agreed to attend Twelve Step recovery groups and support each other's recovery.

Jason's angry affect eventually softened, he began to smile more, and he became less socially withdrawn. He also became supportive for his brother to seek help for his own similar problems. He reluctantly began to let go of his role of substitute father to his younger brother. Mother became more attentive and increased the structure in their home, and decreased her enabling behaviors. She worked on her own anger toward her ex-husband, Jason's father, and supported Jason's renewed relationship with his dad. Jason's anger toward her also decreased, and they began to develop a more mature relationship based on mutual respect. His progress was tedious, but continued to be productive and guided him into young adulthood. Jason's story also provides a respect of the powerful relationship between adolescent loss and anger. Since working with Jason and his family, this model of anger resolution through the healing of loss issues has been used repeatedly, with similar results. From this experience

evolved a desire to research and substantiate these powerful dynamics, hence this study.

The Study

There are many challenges inherent in working with this special population. Although angry and defiant kids are mentioned almost daily in the media, it was difficult to study this population. Agencies and therapists contacted about referring potential participants frequently expressed that they “just didn’t work with that population”. Does this mean that there are not that many angry and defiant kids in American society? Or is it that there is a resistance by those in the helping community to address the special challenges of this population? It implies that this population is being under-served.

As is typical of angry and defiant adolescents, this study was affected by unreliability and tendency for those identified for the Target Group to not come for scheduled assessments. This problem put this study at risk of not being completed. Consequently, several potential participants were dropped after attempts to reschedule were unfruitful.

Some parents of those meeting criteria for the Target Group also presented challenges. Despite being provided standardized instructions and explanations by phone, there were several that sent their adolescents with non-custodial adults. This meant there was no one available to authorize participation in the study. There were also potential participants who were brought and dropped off without a parent coming into the testing office, and they had to be

rescheduled so as to have a legal representative present who could authorize participation. One under-age adolescent drove himself, and was rescheduled for the same reason.

What does this mean, and why did these same problems not affect those identified for the Comparison Group? This study acknowledges there are significant dynamics involved in a family that is emotionally distanced, as presented in the literature and the Family Constellation Survey. How do parents that do not follow through with commitments impact their children? If we expect teenagers to be responsible and reliable, perhaps we should begin by holding the parents accountable for the same.

The issue of the under-served needs of the adolescent has been raised. There are also concerns that the problems of the adolescents are under-diagnosed. Several assessments, although completed, could not be used for this study due to struggles with completion of the MMPI-A. One teenager asked for explanation and clarification on almost every page. One teen was extremely verbose, and could not comply with requests to not talk during the MMPI-A. It took him three hours to complete the MMPI-A, which was then not used. Another teen was in the middle of the MMPI-A, revealed she had dyslexia and admitted to struggling with the lengthy MMPI-A. One young man of 14 had trouble focusing and exhibited tangential thinking, as well as some mood lability.

Considering the referral sources were given screening guidelines, it is concerning that the dyslexia, suspected Attention-Deficit Hyperactivity Disorder,

and the cognitive looseness of the last young man, were not reported by the referring sources. This presents some concern that these kids are being either underdiagnosed or misdiagnosed. How effective are their therapies if they are not being appropriately assessed and diagnosed?

One adolescent's exclusion to either group was necessitated due to an MMPI-A profile so disturbing that it could not be used. It is possible that this teenager could have a serious mental illness, an emerging personality disorder, or she could have had some recent disturbing experience that caused some temporary rational and emotional distortions. Regardless, her scores were not used for this study due to the predetermined parameter guidelines. Her results also posed a question of ethics. If the MMPI-A reflected a true and chronic state, the girl seriously needed psychiatric help. But the guidelines of the study guaranteed anonymity and confidentiality. These guidelines might have been re-visited had she indicated some risk of harm to self or others, but she did not.

Clearly, there are overt differences that delineate the Targeted population from the Comparison population. However, this study uncovered some similarities that warrant further investigation. Adolescents in both groups reported experiencing significant losses, yet those in the Comparison Group did not develop the angry affect or defiant lifestyle the others did. These teens also acknowledged being told things that made them feel "worthless, embarrassed, or ashamed" to such a degree that it was still considered impactful, even into their

teen years. Why was their life path so different if they shared similar experiences?

The Resiliency Model proposes a theory that may provide reasonable explanation. Resiliency describes the dynamics that move people through challenging life circumstances, yet enables them to become functional, encouraged adults that lead productive lives. There is an identified formula for resiliency, as reported earlier in this paper. According to this theory, the teens in the Comparison Group may have had a more supportive network at the time of loss than the Target Group. They may also have been encouraged to express grief responses at the time of incidence, rather than let the feelings remain submerged and powerful, and their longer-term impact was less profound. There may have been other significant relationships that filled the void left by the absence or inadequacies of family-of-origin members. Such relationships facilitate healthier emotional growth and development. To be able to interrupt the devastation of loss for the adolescent, the Resiliency Model offers the best hope.

The Instruments

Interview Process

The Interview Process was developed as a means to qualify a potential participant for the study, to verify participant appropriateness for the study, and to identify to which group the participant would be assigned. The Interview Process was successful in its task, but at the same time, illuminated many areas of intrigue regarding adolescents who developed defiant behaviors and those who

did not. Through this instrument, the similarities between the groups became evident. Both groups reported negative experiences related to being put-down or called names, and both groups reported losses. However, many differences emerged as well. Clearly, the adolescents in the Target Group act out their anger more than those in the Comparison Group. They also report more parental separation and other significant losses.

Family Constellation Exercise

The participants appeared to enjoy this particular part of the assessment, as evidenced by their verbalizations. Several participants considered their responses carefully, and made a couple of changes before accepting their final arrangements. Both groups had participants who considered themselves to be close to all members of their families, and both had participants who felt distanced. Overall, the Target Group maintained a greater cumulative emotional distance from self to family members. With the incidence of divorce and parental absence, and familial substance abuse in this group, this was not surprising. The literature well documents the impact of substance abuse and family problems, and this was observed to be true through the Family Constellation Exercise for the Target Group, with the reverse being true for the Comparison Group.

With the primary concern of this study being the impact of loss on adolescents, the results of this instrument produces a profound picture. The correlation between the reported distancing and emotional duress, acted out in

this group as anger responses, is pictorial validation of the thesis of this research.

Minnesota Multiphasic Personality Assessment – Adolescent Version (MMPI-A)

Although the scales of the MMPI-A were instrumental in finding answers to the hypotheses of the study, there were some problems with the administration of the instruments. A trend was noted with confusion on some of the wording. Some of the terms used were dated, such as the word “brood”. Also, some of the questions were awkward and challenging for the adolescents to interpret. There are concerns there may have been some misunderstanding of the items’ intent and subsequently generated erroneous responses.

Some examples are: “I have at times stood in the way of people who were trying to do something, not because it amounted to much but because of the principle of the thing”, and “I prefer work which requires close attention to work which allows me to be careless”.

Regardless, the MMPI-A remains an extremely valid tool for identifying the areas of concern in this study. Although there appeared to be some minimal differences between the two study groups on many scales, significant elevations of the targeted scales were sufficient in identifying the characteristics of the angry and defiant adolescent.

The typical angry adolescent, if there is one, is one who has developed a lifestyle of protection and defense. They have experienced early trauma and

losses, and the world is often a hostile and threatening environment. By using anger as nature intended it to be used (for protection), the angry adolescent attempts to keep others at bay, particularly those who hurt, or failed to prevent the hurt caused by others. The angry adolescent learns to navigate his or her way in life, often not trusting parents and other authority figures to give advice or show the way. They prefer to make it on their own, and often make plenty of mistakes.

The outsider looking in sees “different”, “hostile”, “unapproachable”, and “freaky”. They often blame, ridicule, chastise, and segregate the adolescent rather than try to understand and help. This further serves to isolate the adolescent, and reinforces the loss experience. The teens get angrier and withdraw more. Sometimes, they strike out. There is a growing phenomenon of adolescents who commit tragic acts of violence towards themselves and others. Every single one of the young people who were implicated in school shootings of the recent past shared similar profiles that include origins from disintegrated and/or chaotic homes, and rejection by family members and/or peers.

It is not unusual for adolescents without solid family structure to become gang members, which serves as substitute family. Many gang members do not have the presence of a father figure in the home. They resort to ‘parenting’ each other, often unsuccessfully, and are high risk for becoming young parents themselves. The loyalty and power of gangs perfectly exemplifies the innate need for the intimate familial relationships. Unfortunately, what makes the gang

system problematic is the angry violence and disregard and disrespect for those not in the immediate gang family, often to the point of destructive eradication of any outsiders.

How better it would be to work with the adolescent in the context of the nuclear family-of-origin, rather than point blaming fingers at the angry teen! The beginning of healing starts with a comprehension of what went wrong and why. This helps remove blame, but places accountability where it needs to be. Amends can then be offered, and families can identify what needs to happen next to decrease the perceived emotional distance that was demonstrated in the Family Constellation Scale. This requires growth from the family, not just the adolescent. Through such work, the adolescent can be encouraged to choose healthier coping skills and expression of emotions instead of acting out. If the family is not available, or not willing to work on these impactful issues, then intensive psychotherapy and healthy adult mentoring for the adolescent can facilitate healing and growth. The mentor offers support and unconditional regard for the adolescent's worth, and serves as a confidant who will provide guidance with respect.

Healthy "families of choice" can be a constructive alternative when the biological family is not safe or available. A constructive family of choice is one the adolescent can latch on to in order to get unfulfilled needs met. It is often the family of a friend, favorite teachers or other specific authority figures, neighbors, or employers. Such substitutions are imperative to enable the adolescent to

begin to make healthier choices for him or herself, and to learn what a healthy family is like. If it does not happen, the adolescents are at risk to recreate the same dysfunction in the families they begin.

The defiant adolescent knows the failure and disappointment that feeds low self-esteem and discouragement. To counteract such power and negative energy, constructive activities and relationships outside the family provides opportunities to be successful, to be noticed by others in a positive manner, and to build self-esteem. The adolescent is finally able to envision something better for him or herself. The anger subsides, and although the parent-child relationship, or whatever the source of the loss was, is rarely completely healed, it can improve. When the struggle is removed, the adolescent is much more likely to calm down, and have less need to keep the world distanced through the anger and acting out.

Limitations of the Study

Due to the study design, the selection of participants and their assignment to the study groups was not random. The lack of randomness may have had an influence on the study, but the recruitment of participants from many different sources helped to minimize such dynamics.

This study also used a small sample size. This may explain why some of the MMPI-A scores of the Comparison Group were not in keeping with the mean averages reported by Archer. It was difficult to get many referrals for the study,

but the samples that were used are believed to accurately represent the larger population.

There may have been under-diagnosed or misdiagnosed conditions that may have influenced responses, as indicated by the difficulties in the test-taking process. Such conditions may have produced inaccurate profiles for some of the participants. It is hoped that by providing findings of the MMPI-A to participant's counselors and therapists, appropriate diagnostics can be made. It leaves a concern, however, that many adolescents that could otherwise be helped must go through life with undiagnosed problems and no treatment.

There also was no control for manipulation by the defiant or oppositional adolescent who may choose to purposely respond in a dishonest or non-reflective manner, although the MMPI-A does provide several measures of validity and truthfulness. However, most of the adolescents appeared to be cooperative with testing, and seemed to be honest. By discussing the measures in place to protect the participant's anonymity and confidentiality, the adolescents did not have as strong a need to manipulate their responses.

Since this is a post-hoc study design where the incidents of loss occurred much earlier than the onset of this study, there was no means to identify what responses the adolescents exhibited at the time of loss, what support systems were in place at the time, or how helpful or hurtful any interventions may have been. In this study, there was no manipulation of the impact or frequency of losses, as is available in a traditional experimental design.

It is not enough to identify the problems. There needs to be answers. There was intent from the conception of this study that possible solutions be identified and presented. It is hoped that those who live with, work with, know, or care about adolescents will pay attention to these findings and take action.

Healing Therapies

Hardy and Laszloffy (1998) suggests that clinicians working with adolescents identify loss and patterns of loss when assessing the adolescent client, and provide information about how the loss is linked with anger. They suggest that the adolescent "join" the anger or rage, and embrace an understanding of how impactful the loss can be. Opportunities for mourning and healing can then be created through rituals, poetry, songs, and letters.

Hardy and Laszloffy also created a "VCR Model" which promotes emotional healing in the rageful adolescent who has experienced traumatic loss. In "VCR", 'V' stands for validation, 'C' is for challenge, and 'R' is reinforcing the messages of recovery. It is the task of the clinician to accept, or validate the loss as real and significant, then provide the challenge of, "How can this death/leaving be used for good?" The ongoing challenge of therapy remains to reinforce the message, and assist the adolescent in motivation.

Hardy and Laszloffy also use a Loss Diagram, which is basically a genogram of attachment and losses with color and shape identifying whether the loss is emotional or physical. Use of articles or items that had belong to person or thing that was lost, or something that represents that person, can be very helpful

in the therapy session. These things can be personified in the therapy session and subsequently serve as a physical anchor for healing.

The recent use of biofeedback to treat mental, addictive, and physical disorders shows promise for use with adolescents as well. Having been proven effective with alcoholics and for treatment of attention-deficit and hyperactivity disorders, there are strong indicators that adolescents can be taught to self-soothe and reduce anger reactions through biofeedback.

Another tool for self-awareness and healing is the Life Map, which is a "road map" of the adolescent's life, from birth to the present. Along this map are notations of the people, events, and activities that most impacted his or her life, both negatively and positively. It serves as a visual tool of resiliency and survival, as well as provides graphic evidence that the road continues, as does life. The adolescent can choose what direction they will take next, and what or who they need to help them get to where they want to go.

However, for the adolescent who is reminded often about loss through interactions with the family, family therapy can be the most powerful mechanism for healing. By helping the family acknowledge the loss, and providing a means by which they all heal, it removes or decreases anger and blame to a much lesser degree. Although the relationship may not be optimal, it can improve greatly, and the need for anger is not as paramount. The adolescent can calm down.

Implications for Future Research

In this study, the term “major losses” was an objective to be defined by the participant. Since this study focused primarily on losses related to the family, it would be interesting to explore the effect of friendship loss, and any interpersonal changes that accompany such a profound experience.

Despite an intensive search, there were no assessment instruments identified which assess the issues of adolescent loss. The development of such a tool would be valuable since the family unit is becoming more disposable, families are more transient, and adolescent traumatic deaths on the increase. When a teenager is acting out, or appearing chronically angry or depressed, such an assessment might eliminate the guesswork of diagnosis, and target interventions at the source of the problem.

Included in the Interview Process were questions that might pose interesting and important research directives in the field of adolescent study. The twelfth question, regarding self-mutilation, is grossly under-represented in academic and therapeutic literature. A few books and fewer articles have been written. Most people not want to talk about self-mutilation, including those that engage in such behavior. However, there are references of self-mutilation that go back centuries.

Curiously, adolescents that were isolated from American media and trends, and who denied knowledge of anyone else that self-mutilated, sometimes

start the behavior without influence or instruction. How, and why? And what can be done about the addictive nature of such behavior?

Can early education about emotions and healthy expressions of emotions make an impact on emotional responses as adolescents? Can an increased understanding of emotions provide options for the adolescent coping with unresolved loss and sadness? Teaching children and adolescents that anger is normal, and meant to be a survival tool, and that there are effective alternatives to angry destruction, may empower the adolescent to better cope with all emotionally charged situations, such as loss. The adolescent may come to see anger as something that is helpful, rather than destructive. Appropriately expressed anger may be used as motivation for healthy conflict resolution, rather than avoidance and destruction.

The above suggestions and awarenesses are invaluable, but if attention is paid to the many references of children in this paper, it becomes obvious that the key to prevention of the destructive teen is to start with intervention in childhood. Children and families who are taught healthy expression of feelings, effective coping and problem-solving skills, and who receive support from significant others, are much more likely to effectively navigate adolescence.

Conclusion

Adolescents are our future – our next generation to lead us. It is remarkable how misunderstood, and underrepresented they are in the world of research. Considering we are all impacted when any segment of the population

acts out negatively, it is imperative that we spend the time and effort to seek interventions. This study has been successful in identifying a major cause of anger and defiant responses of adolescents – unresolved loss. This study presents a challenge for the development of a model of healing, education for those who work with kids and families, and implementation of intervention strategies. For those who are already stuck in the sadness, isolation, and stress of defiance and anger, immediate steps need to be taken to facilitate change and healing. The adolescents can grow into calmer, more productive adults, capable of successfully navigating their world and fostering wellness in their own families while experiencing emotional health. By helping these kids make changes, we optimize the possibility that their families, ourselves, and those that come after us will live in a more peaceful world.

Appendix A

Information for Referral Sources

Janell Myers
7475 Skillman Ste 102B
Dallas, TX 75231
972-699-8002

Dear Colleague,

I need your help with an opportunity to participate in important research. I am a doctoral candidate at the University of North Texas in the departments of Counseling and Addiction Studies, and am working on my dissertation. The title of my study is "The Impact of Unresolved Loss on Adolescent Anger and Defiant Behavior". I am in need of your identification and referral of subjects, ages 14-18, who meet the following requirements.

- Reads on at least a 6th grade level
- Does not have a diagnosis of attention deficit disorder, psychotic disorder, mental retardation, severe drug dependencies, borderline or narcissistic personality disorders, or have a primary diagnosis of chemical dependence
- Is not considered "perfect' i.e. involved in many activities while maintaining a very high grade point average, and hold several positions as organization officers

Subjects are needed for the target group and the comparison group. The target group includes those that have been identified as often engaging in defiant and angry behaviors at home, school, or in society. The comparison group will include those who are functioning within normal limits and do not routinely express themselves through anger or rebellion.

Subjects for both groups should reside with at least one biological parent. Those who may be in a treatment facility must be in the admission or first phase of treatment in order to be considered for the study.

The research will include an interview, a family constellation exercise, and administration of the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A) version. After completion of the study, and with parental or adult participant permission, therapists and/or treatment centers will receive extended reports of their participants' MMPI-A. For their cooperation, participant will receive tow movie passes. No names of participants will be recorded.

To refer potential participants for either group, please call me at 972-699-8002. If I am not available, I will be automatically paged and will return your call. I wish to let you know how appreciative I am of your assistance. My hope is to provide insight into the motivating factors of certain adolescent behaviors. Such research may change the way we look at adolescent defiance. I hope you will want to make such research successful by referring potential participants.

Sincerely,

Janell Myers, MS, LPC, LMFT, LCDC, MAC

Appendix B

Information for Parents

Dear Parent,

Your teenager has been identified as being appropriate to participate in an important research study on the impact of loss on adolescents. This study is part of a Doctoral Dissertation at the University of North Texas, and will be conducted by a doctoral candidate who is licensed to practice independently in the State of Texas. This study is expected to provide valuable information to assist family therapists in their work with adolescents and their families.

The research session consists of:

- an interview regarding losses your child may have experienced during his or her life
- a family constellation exercise
- a personality assessment (MMPI-A)

Participation in this study is confidential and voluntary, and no identifying information is recorded except if you give permission for your child's therapist, if there is one, to receive results of the MMPI-A.

The risk to your child is minimal since there is no experimental treatment involved. Your child will receive two movie passes at the completion of the study in appreciation for his or her cooperation. The study will be conducted in a clinical office or other similar environment in your community, and you are requested to escort your child to the study to sign permission forms and any relevant releases. The time spent should be about 1 to 1 and ½ hours total.

Please consider this request. An immediate response is necessary. Any questions regarding this study should be directed to **Janell Myers** at **214-221-2121**. Thank you in advance for your participation.

Respectfully,

Janell Myers, MS, LPC, LMFT, LCDC

Participant's initials _____

Parent Consent for Minor Participation
in Research

You have agreed to consider allowing your minor to take part in an academic research study on adolescents and the impact of loss on behavior. Below are a few details you should know before giving consent. Please read and initial beside each one.

____ The researcher is Janell Myers, M.S., who is a doctoral candidate at the University of North Texas. She has completed doctoral internship and is licensed in the State of Texas as a Professional Counselor, a Marriage and Family Therapist, and as a Licensed Chemical Dependency Counselor.

____ The possible benefit to participants is a better understanding of themselves, through the opportunity to be express thoughts and feelings about incidents they have experienced. With permission, the results of the participant's assessment may be shared with a counselor or therapist who might assist the therapeutic process. If necessary or requested, resources for counseling will be provided.

____ The threat of risk to participants is very low. The most prominent risk is some level of emotional disturbance from discussing issues that may stir up feelings. If this should occur continued participation in the study will be assessed, and appropriate action will be taken as deemed necessary.

____ The research will be done in three parts. The first will be an interview where the focus will be on the adolescent's life experiences. Based on the information gained from this interview, the participant will be assigned to one of two study groups. The second assessment will be an activity where the participant will use paper figures to exhibit how emotionally close or distant family members are perceived to be from other family members. The last part will be a pen and paper personality assessment, the Minnesota Multiphasic Personality Inventory - Adolescent (MMPI-A) version.

____The study should take approximately one to one-and-a-half hours. For participating, each adolescent will receive two movie passes.

____ Participation in the study is voluntary and the adolescent may withdraw at anytime without penalty, prejudice, or loss of benefit or compensation (movie tickets).

____ The study is designed to be confidential. No names are recorded, and no information is released to anyone without written consent from the parent/guardian and the adolescent. An audio tape recording is used at the end of the study when the participant will be given the opportunity to ask question or express any needs or concerns. To protect the integrity of the study, parents will not be given results of individual results. Upon written request, a final report of the research findings will be provided to the parents or participants. With written authorization, results of the individual assessments will be released to mental health professional with whom the adolescent has a clinical relationship.

____ Please call 214-221-2121 should you, or your adolescent, have questions or concerns about the study, or need to change your assessment time.

____ In order to insure compliance with established standards, this project has been reviewed and approved by the UNT Committee for the Protection of Human Subjects. The Committee may be reached at 940-565-3940.

By signing below, you are agreeing you understand the structure and risks of the study, and agree for your adolescent to take part, should he or she want to.

_____ _____
Parent/Guardian Date

_____ _____
Participant Date

CONSENT TO RELEASE RESEARCH FINDINGS

TO: _____

_____

_____

INITIALS OF PARTICIPANT: _____

I, the undersigned, hereby consent to, direct, and authorize Janell Myers, MS, to release or disclose to the above, confidential findings of the MMPI-A obtained from participation in research.

_____ _____

Parent/Guardian Date

Appendix C

Information for Participants

Participant Consent Form

I agree to participate in a study on teenagers, family relationships, and loss. I understand that I will be asked a series of questions about my life experiences. I will also be asked about my family relationships and how close or distant I feel to others in my family. There will also be a pen and paper test that will provide information about my thoughts, beliefs, and personality.

I understand that this study is designed so that I will not be harmed in any way. If any part of the study causes me to get upset or depressed, I will be provided with names and phone numbers of places that may provide counseling for me and my family. I also understand that I can decide not to participate at any time without anyone getting angry or harassing me, and that I will still receive two movie passes as compensation.

I understand neither my parents nor I will be given my results. The information gathered might be shared with a counselor or therapist, if I am seeing one, and if my parents and I give our permission. My identity will be kept secret and my name will not be recorded anywhere. The close of the assessment may be tape recorded, and at that time, I will have the opportunity to ask questions and talk about what being in the study was like for me.

I am willing to spend about one to one-and-a-half hours for this study. After completing the testing, I will be given two movie passes.

_____ _____

Initials of the participant and birth date Date

_____ _____

Signature of Parent/Guardian Date

Appendix D

Assessment Tools

Participant # _____

Interview Process

1. Before I was a teenager I experienced a major loss or sadness.
2. I was frequently put down or made fun of by my parents, teachers and/or others.
3. I was never told things that made me feel worthless, embarrassed, or ashamed.
4. I was never threatened with harm or abandonment.
5. Someone or some tragic act physically injured me.
6. I have experienced being touched, fondled, raped, or asked to touch or look at someone else in a sexual way.
7. I was exposed to other sexual behavior before I was a teenager.
    a. How did you feel about it at the time it happened?
    b. Did you receive any help for what happened?
    c. How do you feel about the experience now?
8. My parents were not still together.
9. I have not had a parent die.
10. I have had someone else close to me die.
11. I believe that one or both of my parents, parent figures, or other family members had or have a drug or alcohol problem.
12. I have cut myself or burned myself to cope with my feelings.
13. When I get really angry, I…

_____

_____

14. My anger has caused me problems or has gotten me in trouble.

15. I believe that my anger has helped me.

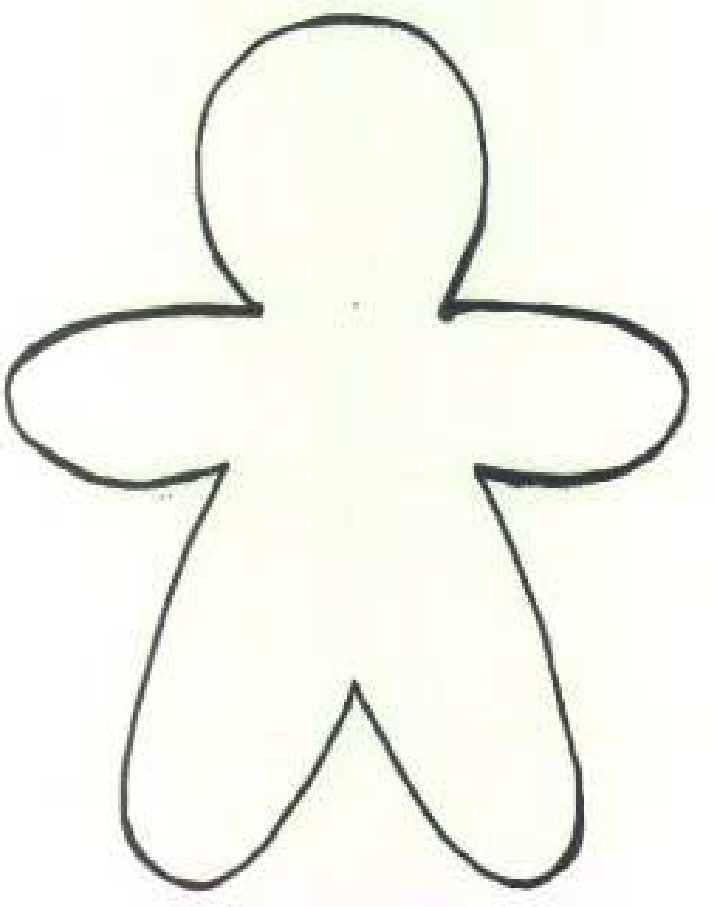


Figure 1

Family Constellation Figure

Instructions for Family Constellation Survey

“Place a figure on the table that represents you. Place one figure that represents the person in your family that you are closest to, in a position that shows how emotionally close you feel to that person. If you feel very close to that person, you may want to place it right next to you. If you do not feel very close to this person, you may want to place the figure farther away. I would like you to do this with each family member so that I can understand how close you feel to each one. Please tell me who each person is as you place him or her.

Appendix E

Graphs

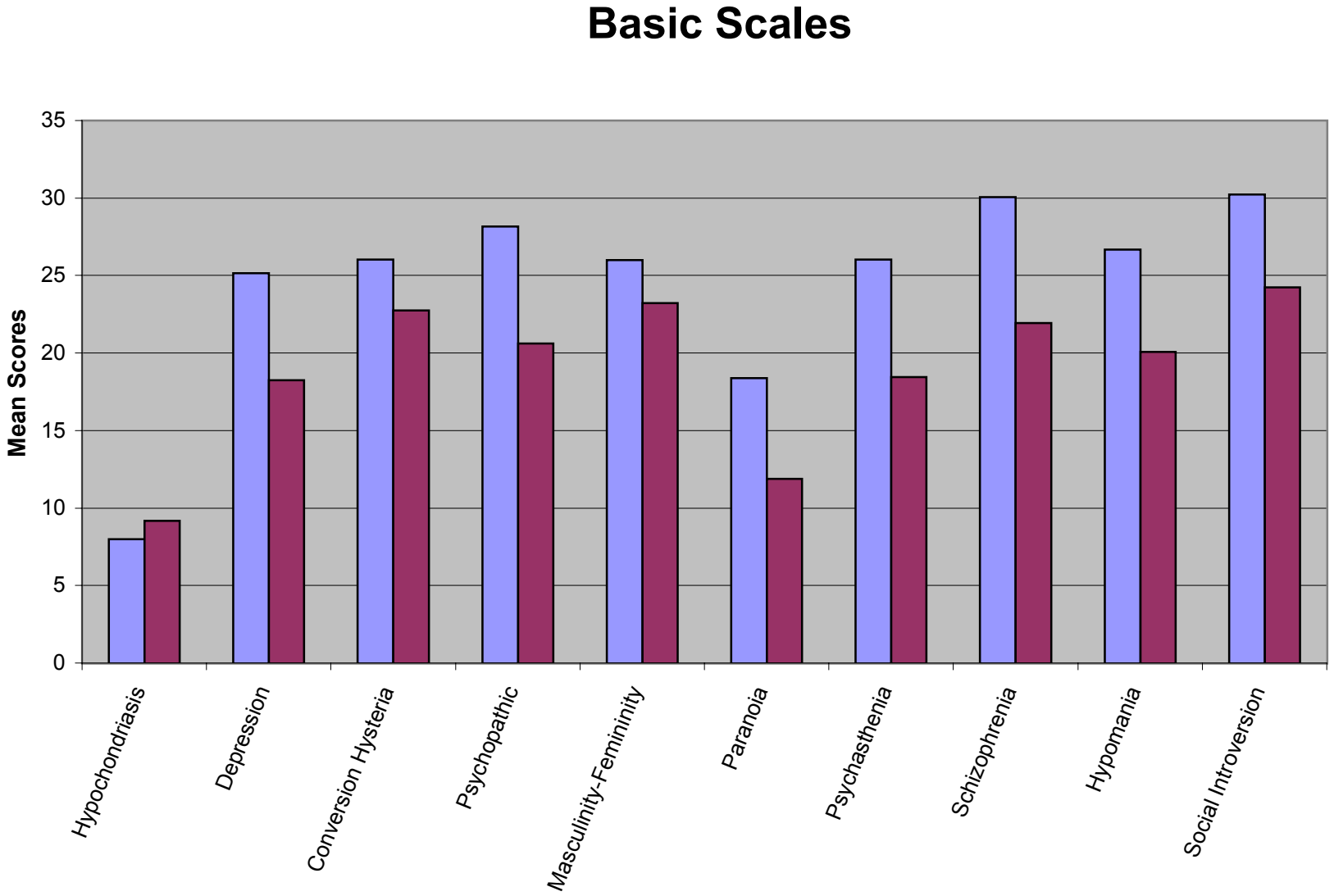
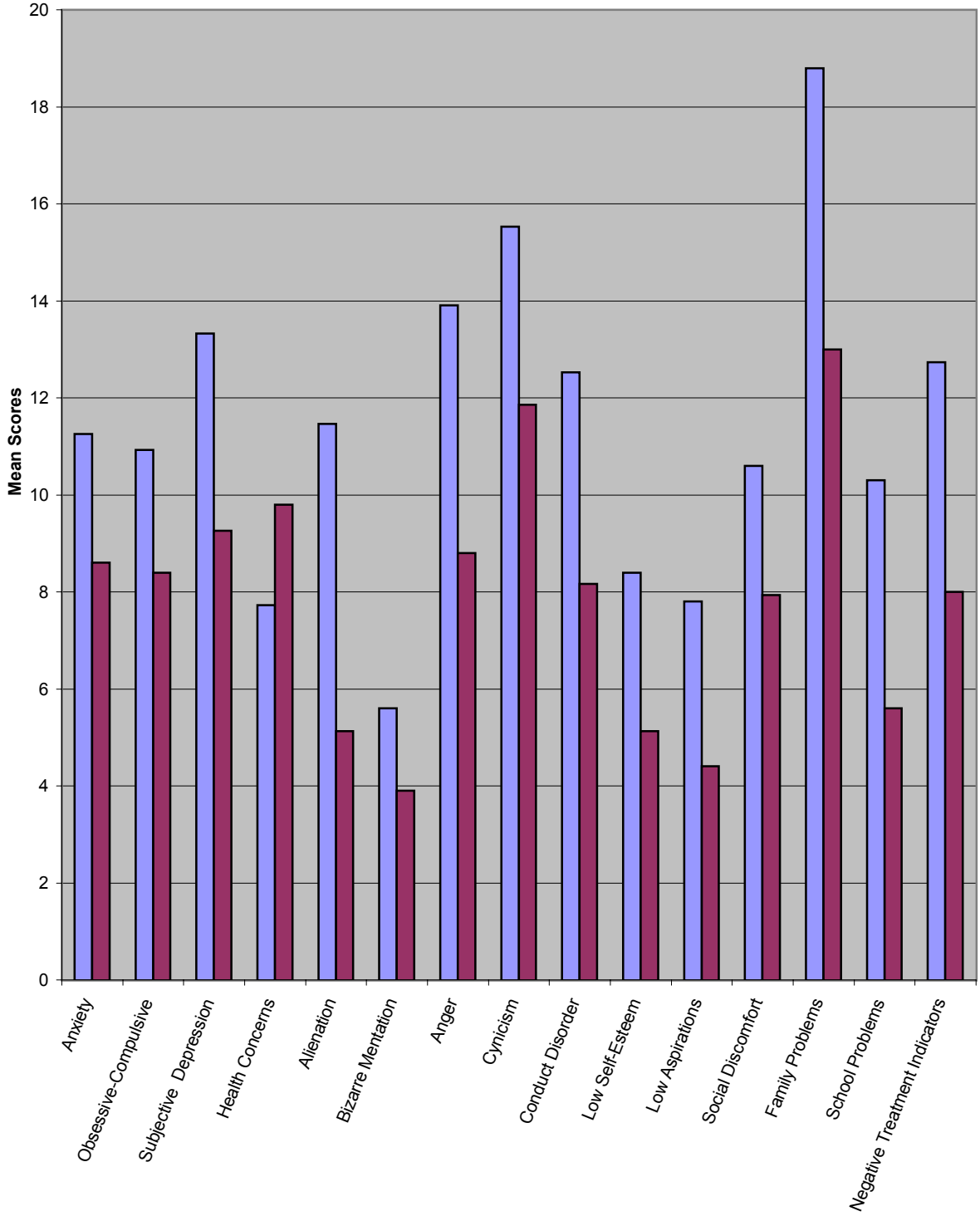

Basic Scales
Mean Scores
35
30
25
20
15
10
5
0
Hypochondriasis
Depression
Conversion Hysteria
Psychopathic
Masculinity-Femininity
Paranoia
Psychasthenia
Schizophrenia
Hypomania
Social Introversion
Blue - Target Group
Green - Comparison Group

Figure 4

Content Scales



Blue - Target Group Green - Comparison Group

Figure 2

Supplementary Scales

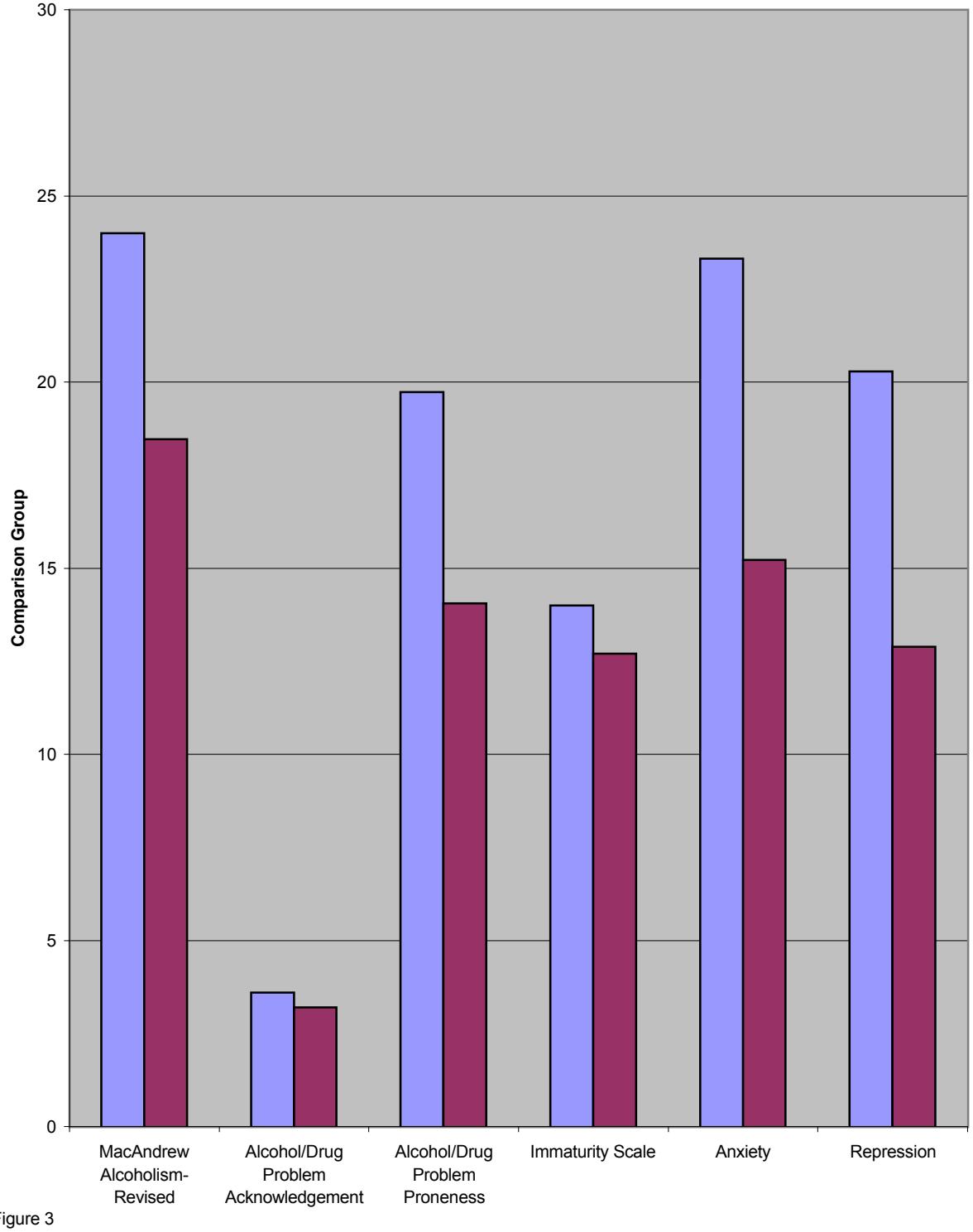


Figure 3

Blue - Target Group Green - Comparison Group

Appendix F

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