FOUR TROUBLED ADOLESCENTS

by

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Special thanks goes to the adolescent patients and their families who served as subjects for this study. May it contribute to a greater understanding of mental illness, especially for him whose life is most difficult, the adolescent.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I

INTRODUCTION

The researcher spent four months as a participant observer at a state mental hospital during the spring of 1968. At this time she developed an interest in the needs of the adolescent patients. The hospital's professional staff and the researcher believed a study of these patients would contribute to a better knowledge and understanding of emotionally troubled adolescents. The author chose to study four adolescent patients and their families for her Master's thesis research.

The author's interest in mental problems of adolescence developed through personal contact with youth in a hospital setting. Determining how the adolescent views himself and his family and how the family feels about having an emotionally troubled adolescent were reasons for establishing personal and informal relationships. She learned to understand and accept these people as individuals and realized the need for others to gain a similar understanding and acceptance.

Mental illness is no respecter of persons and can and does strike anytime and anywhere. Emotional disturbance is especially difficult to detect during adolescence when the changes in one's personality are greater than they have ever been or ever will be again.

According to Ginott (1969):

> The search for a personal identity is the life task of a teenager. When he looks in the mirror, he often asks himself, "Who am I?" He is not sure what he wants to be, but he knows what he does not want to be. He is afraid of being a nobody, an imitation of an image, a chip off the old block. He becomes disobedient and rebellious, not so much to defy his parents but in order to experience his identity and autonomy.
>
> A teenager's task is tremendous, and the time is short. Too much is happening at once, (p. 27).

And because so much is happening at once, the more help and support a child receives, the better he can relate to and integrate his life with reality--with "real" people, with "real" talk, conversation, jokes, laughter, and silence. For the emotionally troubled adolescent this help and support are vital in the struggle toward normality or recovery from abnormality.

The purpose of this study was to develop a greater understanding of the human interactions involving emotionally troubled adolescents and their families. The human interactions that were observed were: (1) staff-patient and peer-patient relationships on the hospital wards, (2) researcher-patient interactions, and (3) patient-family and researcher-family involvements.

Three methods used for collecting information about the patients were: (1) observing and interviewing patients and staff on the hospital wards, (2) using hospital medical records, and (3) interviewing families in their homes. Hospital medical records and family interviews yielded data for the following descriptive characteristics: (1) race, (2) sex, (3) age, (4) educational level of the adolescent, (5) number of

times admitted to the hospital, (6) admission diagnosis, (7) size of the family, (8) age of siblings, (9) position in regard to sibling sex, (10) parents' occupations, and (11) locality of family.

The adolescent unit section chief assisted the researcher in selecting subjects, and in planning interactions with patients and their families. Data were collected and recorded completely confidentially. The names of the patients in the case studies have been changed to assure confidentiality.

CHAPTER II

REVIEW OF LITERATURE

The amount of literature concerning the emotionally troubled adolescent is immense. The review of literature has been divided into the following three areas: (1) the adolescent and his family relationships, (2) the adolescent and his peers and friends, and (3) the adolescent as a patient in a psychiatric hospital. Each of these specific areas is discussed after a brief section on the meaning of the term adolescence.

Adolescence

An adolescent is neither a child nor an adult, but a young person somewhere between the ages of twelve and twenty. Adolescence is a time of inner turmoil, and a time when interactions between the adult world and adolescent world form a vicious circle (Stone and Church, 1968).

Cole (1967) indicates that adolescence lasts for about eight years and not only involves pubertal changes but also developments in intellectual capacities, interests, attitudes, personal adjustments, emotional adaptations, vocational and academic interests, aptitudes, and religious and moral standards. Ackerman (1958) describes the same adolescent changes and developments in different words: insecurity; instability

of mood and action; egocentricity; the sexual drives; shifting images of self and emotional disorientation; preoccupation with physique and health; self-consciousness and fear of exposure; conflict with authority; rebelliousness; craving for independence; hero worship; suggestibility to outside influence; fear of inadequacy and failure; finally, aspirations to be big in some field of human achievement.

The adolescent does not mature in a consistent forward movement. Anxiety induces an irregular movement. The adolescent loses the protection of childhood but does not yet have the strength and privileges of the adult. The realities of adult living represent an unknown and undefined threat. Fear of being a child pushes the adolescent forward. Fear of being an adult pushes him backward.

The closeness of the adolescent to his group is a significant molding force during this transitional adaptation. The distinction between what is inside and outside the adolescent mind cannot always be clear. Within the family circle, the adolescent rebels. Outside the family, the urge to conform to group standards is often extreme. The adolescent seeks to "find himself". But there is just as great a danger of losing himself in his unreasoned rebellions and conformities. The adolescent may merge his personality with the activities of his group or isolate himself. He may entrench a positive group identification or show a negative effort toward self-preservation through isolation. Thus, in the end, the adolescent may become an individual or a defensive conformist.

The term adolescence encompasses many facets of a young person's life and personality, but perhaps this group can best be approached with the attitude of understanding that Anna Freud (1958) suggests: that it is normal for an adolescent to behave in an inconsistent and unpredictable manner; to fight his impulses and to accept them; to love his parents and to hate them; to thrive on imitation of and identification with others while searching unceasingly for his own identity; to be more idealistic, artistic, generous, and unselfish, but also the opposite. But a single sentence can never describe all that the term adolescence could mean. The three areas of discussion that follow attempt to convey the influence each has upon adolescent development.

The Adolescent and His Family Relationships

Parents

Christensen (1964) reports that most studies focus on mother-child relationships rather than parent-child relationships. Brim (1965) also supports this fact. While Christensen admits there is little doubt that interpersonal familial relationships affect the personality of the child, there is little specific evidence that a particular type of parent-child interaction will result in a particular personality.

Parental behavior patterns or personality sets mentioned by Christensen which lead to particular qualities or traits in the child's personality were permissiveness, warmth, rejection, indulgence, overprotection. The following conclusions were drawn by Christensen (1964).

> Permissive (not extreme) and democratic parent-child interaction appears to be associated with children who demonstrate self-confidence, initiative, independence, creativity, and cooperation.
>
> Restrictive or overprotective parent-child interaction is associated with children who are withdrawn, submissive, and dependent.
>
> Rejection by parent(s) is associated with children who are aggressive.
>
> Punishment by parent(s) is associated with children who are aggressive, (p. 766).

The quality of warmth seems to be significant for contributing to the establishment of identification in the child.

Specific effects from parent-child interactions are hard to determine because none is of direct linear significance from time to time. Many personality traits are also "role-specific", which Christensen explains as a person acting one way in one role situation and another way in a different role situation.

Christensen (1964) also found that extreme permissiveness or extreme structure can lead to deleterious effects on a child's personality. Extreme permissiveness can be construed as rejection or indifference on the part of the parent, resulting in a lack of organization for the child. Self development is difficult under these conditions. The child's status is in doubt and because he is part of a relatively unstructured situation, he may have difficulty in categorizing himself in relation to other family members. Extreme structure in the form of overprotectiveness impedes self development because the self merely becomes an extension of an adult, leaving the child with little status and no independence. Extreme structure in the

form of punishment leads to a negative self concept. The child feels he cannot do anything right and often exhibits excessive aggressive behavior in an attempt to achieve some semblance of status.

Both Baldwin (1948) and Psathas (1957) found that for middle-class homes a greater verbal contact existed between parent and child, as well as a more democratic atmosphere, than existed in lower-class families. A higher regard for sons' opinions was also found. The high verbal contact provided the youth a more repetitive and predictable set of relations with parents, and therefore a greater knowledge of norms and expectations plus status with positive connotations. Lower-class children are less likely to receive this kind of treatment which may explain their higher rate of personality disorganization and greater tendency to deviate (Christensen, 1964).

Kohn and Clausen (1955) found that schizophrenic and manic-depressive patients recalled their mothers, compared to fathers, as being more dominating, more easily angered, more restrictive, and less satisfied with children's behavior. Fathers were recalled as being less strict, less certain of themselves, and more likely to give in during arguments. Schofield and Balian (1959) found overprotection and dominance most prominent in schizophrenics. Myers and Roberts (1959) indicated that schizophrenic patients from lower-class families were subject to parental control that was physical, harsh and inconsistent; fathers were feared but uninvolved in family

affairs; mothers had almost sole responsibility for family affairs, had little time for the patients and had difficulty maintaining order in the household, and patients had few rewarding relationships with their siblings.

Acting-out disorders were found to be associated with parent-child interaction (Christensen, 1964). The Gluecks (1950) found an oversupply of delinquents in homes wherein there was overstrict or erratic discipline by the father, unsuitable supervision by the mother, indifference on the part of both parents, and a comparatively disorganized or non-cohesive family organization.

Ackerman (1958) indicated that social conduct of adolescents can impose the severest test on a family and community. Parents often fail to understand such behavior. Sometimes they fear the worst--the beginning of a hardened criminal career or a psychosis--when actually the child is experiencing a temporary adolescent storm from which he will emerge intact, unscarred, and with reasonably good emotional health. Or sometimes parents come to the psychiatrist with a mentally sick adolescent but are grudging and suspicious of the professional consultation. They insist that the disturbed boy is "normal", that he is just "adolescing" and will "grow out of it".

To misjudge the fleeting shifts of adolescent behavior may have serious consequences. A parent who vacillates, who alternatingly imagines the worst and dismisses the problem as trivial, may do permanent harm to the unfolding of adolescent personality.

Siblings

Christensen (1964) stated that although parents have the greatest influence on childrens' personalities, siblings intrude into the family situation a different structure and set of interpersonal relationships. Change occurs in the family group as well as in the personalities of those involved with the addition of each child.

The first child is usually subject to an inordinate amount of attention because he is often the product of two young and inexperienced people, who view his arrival as a crisis (LeMasters, 1957). His world can be extremely upset upon the arrival of the second child. He usually feels rejection as well as hostility. He also learns to compete and hopefully to learn to cooperate and accommodate his behavior to others. The degree, intensity, and timing of this learning are important.

Lasko (1954) found that mothers are less consistent and more coercive and restrictive with a first than they are with a second child. This change occurs after the birth of the second child, so it is perceived as change by the first child, with subsequent reactions of significance in personality. Sewall (1930) found jealousy among older children and related this to inconsistent homes. Other variables which affect the impact that birth order has on personality are: size of family, socioeconomic status, spacing, sex, changing family atmosphere with each new child, learning about children by parents, weaning time, and others.

The first child often meets with disappointment, and as his ever increasing efforts are met with frustration, he tends to become increasingly anxious. Anxiety ultimately results in withdrawal or aggression and whether or not he exhibits these symptoms is partly determined by such factors as sex, spacing, and parental disciplinary measures. Sears, Maccoby, and Levin (1957) found first children to be slightly more aggressive. Others found first children more likely to be withdrawn and dependent (Kawin, 1934) and less aggressive (Sears, 1951). Schacter (1959) found first children to be the most anxious and frightened when faced with standard anxiety-provoking situations. The firstborn child then, due to the accident of being born first, is subject to structural variables that are more likely to create personality problems. Available evidence indicated proportionately more firstborn were referred to clinics than children of other ordinal positions (Levy, 1931; Rosenow and Whyte, 1931).

Less is known about children of other ordinal positions. If the second child remains the youngest, he receives treatment similar to the oldest child (Sears, et al, 1957), the main difference being that he is the younger of the two and not as subject to parental anxiety or to the feelings of rejection. However, if he is followed by a third child, putting him in an intermediate position, then his world changes similarly to the first child's, although not to the same degree and with a somewhat different structure with which to contend (Christensen, 1964).

The addition of more siblings makes an even larger family system, with an increasingly smaller number of intimate contacts between children and parents and a probable increase in the assumption of the parent-surrogate role by older children (Bossard, 1953). In the small family system, children are more likely to be open to overprotection, too much concern, and overindulgence. At the same time, they may be more prone to develop feelings of jealousy (Levy, 1931). However, children from small families are likely to have more economic advantages and reap the benefits of greater intimate contacts with parents, possibly without the adverse effects of overprotection and indulgence.

Another factor affecting the influence of ordinal position on personality is sex of the child. Whether one has siblings of one sex or the other appears to make a difference in one's own sex-role learning. Koch (1956) found that girls with older brothers tended to be more tomboyish than girls with older sisters. Brim (1958) reported that cross-sex siblings tended to assimilate traits of the opposite sex and that the assimilation is more pronounced in the younger siblings. Thus boys with older sisters tended to be more feminine, and girls with older brothers tended to be more masculine.

The Adolescent and His Peers

The adolescent shuttles back and forth between the two cultures of adults and of peers (Stone and Church, 1968). The adult world is represented by his family, teachers, school

counselors, community leaders, and others. These people hopefully offer useful and practical models for adolescent behavior (Beckett, 1965), but the adolescent migrates to the group where he is most accepted and feels comfortable (Stone and Church, 1968). This is usually with peers. He is not accepted into adult society so he creates his own. He carries fads to extremes because he wants to stand out and yet reassure himself of the solidity of his new culture.

He is in an active attempt to create a personality and so he plays many roles and has many masks. He is very dependent on others to tell him what he is and where he stands. He cannot feel the parts he plays unless he gets some sort of reaction from his surrounding (Stone and Church, 1968).

Setting up an adolescent society offers the youth an outlet for his feelings of rebellion and hostility against adult standards that, particularly in a disturbed home, seem to surround and oppress him (Beckett, 1965). It is a chance for expressing independence and obtaining answers to the questions of sexual and social functions which have not been answered by adults.

The social distance existing between adults is probably based on personal distrust of adults derived from relations within the family and in part from the feeling of some adolescents that they are not sharing in the benefits and privileges of adult society (Beckett, 1965).

Coleman (Muuss, 1964) describes the influence of the peer group in shaping adolescent values, ideals, attitudes, and

interests. Adolescents find psychological support and reward and depend upon each other. The subculture creates its own language and value system. Coleman describes high school as a "cruel jungle of dating and rating", with tightly knit, ingrown cliques, maintaining only a few threads of connection with the outside adult society. He has collected a great deal of empirical evidence which explains the value system of adolescent society. Among boys, the adolescent society values the athlete, the car owner, and the right family background. These are important assets in being rated popular or in becoming a member of the leading crowd. Among girls, social success, physical beauty, enticing manners, and nice clothes are highly rated assets. All these are more important in the adolescent society than they are in the adult society. For neither sex is academic success as important as adults would like to think (Muuss, 1964).

The Adolescent as a Psychiatric Patient

In adolescents who are seen by a psychiatrist the most frequent family situation is one where a close, or dependent, or even seductive, attitude exists between the parent of the opposite sex and the adolescent patient and a rejecting, distant, cold attitude between the adolescent and the same sexed parent (Beckett, 1965).

Future studies may point up more specific relationships between particular family patterns and particular symptoms, but present studies indicate that adolescent boys seen by a

psychiatrist are characteristically closer to mothers than fathers and that mothers play a dominant role. The details vary widely from case to case. Sometimes the coldness of the father, the lack of identification with him, or his overt lack of interest in or rejection of the boy seem most important. At other times the principal problem is the inability of the boy to free himself from a strong-minded over-protective mother, or of a girl to disentangle herself from close confidences with a father who has long ceased to have a meaningful sexual life with his wife and may have some incestuous feelings for his daughter. A mother may be preventing her daughter's emancipation in various subtle or not-so-subtle ways, such as derogatory remarks about friends, refusal to allow her to wear other than plain clothes, or insistence on very early curfew.

These examples of family interaction presume a home that the neighbors might think looks stable because both parents are present and outwardly responsible. However, even the outward appearance of stability is missing in many cases where patients are referred to a psychiatrist. Absence of a parent or presence of a step-parent offer problems enough to the adolescent in communication and identification. But when absence of a parent is coupled with continual criticism or beatings, with outright rejection by a step-parent, by a continual procession of drunken "uncles", or with some other gross disturbance, then it is inconceivable that the adolescent can get anything from home other than utter confusion in his emotional and characterological development. He may even be better off as a

homeless child fending for himself on the streets rather than constantly trying to balance rare glimpses of affection with daily brutality. The amazing thing is that some of the patients are as emotionally stable as they are!

Parents may be present in the flesh but be offering very little support or stability to the adolescent. The father may be so interested in and busy with his work that he pays no attention to his son; or the father may have hurt his back at work ten years ago and ever since have been "disabled" at home, drinking beer, watching TV, complaining and cursing, drawing his pension while his wife works, and offering nothing to his son except a poor example. The possibilities are endless since the varieties of family life are endless (Beckett, 1965).

The need for services for adolescents in emotional turmoil is overwhelming. The techniques of management and therapy are different for the adolescent from those used for either children or adults. Admission of an adolescent to a psychiatric hospital presents problems for the family, the patient, and the staff. The family is likely to become unbalanced by such a shift in its internal emotional equilibrium. The significant adults will need a detailed explanation of the situation and a good deal of support from the psychiatrist; they often may need a series of interviews, possibly leading to psychotherapy (Beckett, 1965).

Problems for the Family

A suggestion for nonemergency cases is that the entire family visit the ward briefly beforehand so that some of the

anxiety may be eased, at least that part of it having to do with fear of the unknown. However, other aspects of the anxieties are more complex. It has become clear in the last twenty or thirty years that many types of disturbed behavior patterns in a family are directly related to the emotional needs, conscious or unconscious, of individuals in that family. For the adults some of these needs may be made tolerable by their condoning or even encouraging disturbed behavior by the adolescent family members. When this habitually disturbed behavior, which may have gone on for years, is interrupted by hospitalization, the emotional equilibrium of the family is suddenly upset. This is true even where organic disease in the adolescent is responsible for much of the disturbed behavior.

The anxiety and dissatisfaction of the parents may be expressed in many ways. There may be attempts to undermine the authority of the patient's physician by telephone calls to the hospital director or avoidance or breaking of hospital rules. The parents may develop clear-cut symptoms themselves, such as anxiety or depression. It is essential that the physician responsible for the adolescent's inpatient care devote an early interview to the anxieties of the parents or other important family members. In this interview he can evaluate their problems and the ways in which these problems interact with those of his adolescent patient. If the physician does this personally, rather than having the parents interviewed by a social worker, he is able to open a direct channel of communication with the parents and minimize conscious and unconscious

distortion of information; he observes family interaction with and without the adolescent being present; he can personally intervene and protect the adolescent from any outspoken or violent hostility expressed by the parents, and vice versa. The valuable contributions of social service can be left to a later stage in the treatment program.

Problems for the Adolescent

The adolescent also has to adjust to major changes in the external emotional forces that immediately surround him. Usually his initial relations with the ward staff will be less disturbing to him than the difficulties he was having within his family. But he may find himself immediately carried away by the strong flow of powerful peer-group emotional pressures which exist within the patient population. If the patient-group leadership is currently influencing the ward climate in a therapeutically useful direction, the new patient is likely also to move in this direction. But if the group leaders are antagonistic to a therapeutic climate, they are likely to push the new addition to the group in this same antitherapeutic direction.

Like his parents, the adolescent has developed habitual modes of behavior to deal with family conflicts. Hospitalization interrupts these. In contrast to his parents, though, the adolescent patient has the many supports offered him in the hospital by staff and patients immediately at hand, so that for the first week or so he often shows a reduction in

disturbed behavior. This early conformity may be partly a withdrawal and is usually encouraged by the attitude of the staff and by the attitude of the other patients if the emotional climate on the ward is a therapeutically useful one. The principal task of the hospital service is to use psychotherapy and manipulation of the milieu to promote the adolescent's own control over his behavior (Beckett, 1965).

Summary

Adolescence is the period in life an individual becomes aware of all the things that affect him in the present and for the future. As the youth's body begins to change physically, intellectual, social, and emotional changes quickly follow. He struggles to maintain an emotional equilibrium and an anxiety-relieving perspective on the situations that surround him. Whether or not he adequately achieves this depends upon the quality of interactions with both his family and peers. Developing appropriate behavior and thought patterns, according to the standards set by society, are essential in attaining and maintaining mental health. The task is not easy, and for those who cannot achieve it alone, psychiatric care and treatment foster hope that they can become "normal" in the future.

The previous discussions concerning families, peers, and mental illness of adolescence attempted to relate reasons why some youth suffer more than others from life's consequences and contract mental illness.

After reading the literature, three questions were formulated which provided a basis for the research: (1) What characteristics do emotionally troubled adolescents have in common? (2) Do emotionally troubled adolescents have realistic self-concepts? (3) How are families with troubled adolescents affected by mental illness?

CHAPTER III

PROCEDURE

Subject Selection

The research was done in a midwestern United States, state mental hospital. The name of the hospital and the names of the patients and their families will be kept completely confidential to protect and maintain their privacy. All names used in this thesis, therefore, have been changed. The case material itself, however, is true to the best of the researcher's knowledge and ability.

The adolescent unit where all four of the patients spent their week days is an individual and unique section of the hospital. It had a treatment philosophy and milieu therapy program all its own. The section chief commented, "We are preparing our patients to be productive, responsible individuals for community and society. Part of why they are here is because they cannot get along in society." (Scheetz, 1969)(p. 1).

The eight-hour, five-day-a-week program created structure for adolescents, most of whom exhibited behavior disorders. The average hospital stay for a patient on the adolescent unit was nine to twelve months. The patient-staff ratio was approximately three to one. The staff personnel included the following positions: (1) section chief and head clinical psychologist

of the adolescent unit, (2) psychiatric aides, (3) school teachers, and (4) social workers. The unit population fluctuated between thirty and forty patients.

Future plans included making the unit a twenty-four hour, seven-day-a-week treatment program. The existing staff would remain, but a medical doctor, a ward nurse, another clinical psychologist, and more school teachers would be added.

The unit followed the "team approach" in treating the adolescent patients. The "team" coordinated their efforts and strived together to achieve the best therapeutic atmosphere for each patient. Because the unit "team" met together each morning for one hour the staff communications were among the best in the hospital. The unit section chief who presided at the staff meetings respected the opinions of every staff member, regardless of title or job (Scheetz, 1969).

The average age on this state hospital adolescent unit in the spring of 1969 was sixteen years and eight months. Twenty of the patients were from broken homes and fourteen were from intact homes. Twenty-six had had academic problems and twenty-eight had exhibited behavior problems prior to being hospitalized. Ten of them had sexual problems. Several had experimented with drugs. Deviant behavior also included running away, suicidal attempts, and stealing (Scheetz, 1969).

The section chief assisted the researcher in patient selection based on the following criteria:

1) that all be from the same locality for convenience in visiting homes and families

2) that there be a minimum of organic disorders among the patients
3) that patients have as complete a family or set of guardians as possible
4) that ethnic and socioeconomic background be immaterial.

The characteristics of hospital patients and the families are indicated in Table 1.

Data Collection

The descriptive information was obtained from the hospital medical records, from interviews with the adolescents themselves, through observations of the adolescents on the wards, and through interviews with their families in their own homes.

After the section chief and the researcher decided on the criteria for patient selection, the researcher read through medical records of those patients who might qualify for the study. Another consultation with the section chief resulted in the final selection of subjects. Each patient was observed and/or talked with on the adolescent unit before the parents themselves were contacted.

After getting to know the patients, the researcher began contacting the parents by telephone from the hospital. The first contact served to introduce the researcher and the study. The researcher also requested permission to visit them in their homes and all consented. A second telephone call was made later to arrange interview times.

TABLE 1

CHARACTERISTICS OF SUBJECTS

Variable	Jon	Betty	Steve	Ann
Personal characteristics				
Race	W	W	W	W
Sex	M	F	M	F
Age	15	16	14	15
School (grade)	9	9	9	9
Hospital record				
Times admitted	1	1	1	1
*Admission Diagnosis	1	2	3	4
Family characteristics				
Size (No. members)	4	5	6	6
Parents (No.)	2	2	2	2
Guardians (No.)	-	-	-	-
Siblings (No.)	1	2	3	3
Sisters (ages)	11	17	9, 16	11, 13, 17
Brothers (ages)	-	9	18	-
Parent's occupations				
Mother	Housewife	Unskilled	Groc.store clerk	Housewife
Father	Postal official	Truck driver	Dry-wall finisher	Retired army

*Admission diagnosis.

[1]"Schizophrenia reaction, paranoid type."

[2]"Adjustment reaction to adolescence."

[3]"Borderline psychotic disturbance--schizophrenia, latent type with possible organic brain damage of unspecified type."

[4]"Adjustment reaction of adolescence with probably transient stress dissociation."

Talking with hospital personnel and reading hospital records provided background information before the home visits were made. After scheduling home interviews with the families over a two-day period, the researcher went alone to visit them.

The families were home at the scheduled times and the researcher found them friendly, cooperative, and willing to talk openly. At the end of the visits a form letter was left with each family. It was written and personalized to assure that they understood why they had been contacted and were being visited. No notes were taken by the researcher during the interviews, but the conversations were summarized on a portable tape recorder immediately following the interviews.

An additional trip to the same locality was made two months later. Those families not scheduled the first time were visited and one family was visited a second time.

After the home visits, additional reading and recording of information from medical records, more observations and interviewing adolescents on the hospital wards completed data of collection. Another letter was written and mailed to the parents, informing them that the researcher had completed her study and would not be contacting them again.

Limitations of the Study

The purpose of the study was to develop a greater understanding of human interactions involving emotionally troubled adolescents and their families. However, it was difficult for the researcher always to view the interactions objectively after

knowing the families personally. First impressions, even though they are not always lasting ones, were carefully considered because the number of home visits was limited due to lack of time and resources. In only one family was the researcher able to meet and talk with all the members.

The question of validity of the hospital case studies also could be raised on the basis of conflicting case entries. It was evident, from reading case accounts from various institutions, that patients and hospital staff have personality conflicts as well as "normal" people.

Mental health and mental illness are on a continuum, and determining on which end of the scale a person functions, and for what reasons, can be extremely difficult. Because of the uncertainties that exist in each human situation, any conclusions or inferences drawn about these patients and their families were purely as the researcher saw them and not as another person might perceive them.

CHAPTER IV

CASE STUDIES AND DISCUSSION

Jon

"Profound"

> "Being alone is very lonely. I would like to be like everyone else, but it violates all principals I have set up. I need Debbie because she is the only (thing) I have with the world outside my shell. I pray for Debby."

Those are the words of a fifteen-year-old adolescent mental patient whose admission diagnosis was recorded as "Schizophrenic reaction, paranoid type."

Getting to know Jon was not easy. The researcher first met him in the ceramics class in which most of the adolescent boys on the ward were participating. All of them were introduced by the aide-in-charge who was also the ceramics teacher, but since there are often visitors on the ward, few of them paid much attention to another strange face. The researcher took special notice of Jon's reaction, though, and believed he had a rather suspecting and distrustful look in his eye, typical of individuals with paranoid tendencies. Gradually, with time, Jon and the researcher became friends.

In looking back over Jon's childhood one finds that even though he seemingly had no unusual trouble at childbirth, he showed symptoms of emotional disturbance during early

childhood. One seemed his difficulty in getting along with other children and in making and keeping friends. Another was Jon's running away from home. His father's occupation required him to be gone one or two weeks at a time. Jon ran away only during the periods his father was home. When Jon ran away, both his father and mother became upset and searched for him. Finally they told Jon that even though they did not want him to run away, they were not going to look for him again. "If you insist on leaving, just go." Jon no longer ran away.

During this time Jon became increasingly depressed and so belligerent and verbally aggressive that his parents became quite alarmed. On at least three occasions he threatened to kill all of the family members. He also took an overdose of pills on one occasion in a suicidal attempt. As a result of his running away from home and becoming demanding and destructive his parents realized they must seek professional help and arranged for his admission to a hospital mental ward in their home town. He remained there except for short visits home, until he was admitted to the present hospital.

To understand further why Jon may have become a mental patient, the following describe some of the things that were discovered by the researcher.

During his early childhood Jon developed more of an interest in animals than he did in people. He was reported to have dissected dead animals.

Jon has also been obsessed with Catholicism from time to time. The doctor in his home town felt the obsession was

stimulated by feelings of guilt and fear he had concerning his sexual impulses. He has talked about becoming a monk and has, on occasion, put himself on fasts. At other times, he has made requests to be placed under restraint. He has threatened to cut himself and has shown marked compulsions such as ones requiring him to scrub floors and other similar activities.

Earlier reports also stated that Jon was afraid of the dark and of fires. There was even a time when he would become hysterical when he discovered a house had a fireplace.

Even though Jon's parents are considered very concerned and caring and cooperative by the hospital staff, some of Jon's records reveal that his father sometimes would be impatient and angry with his behavior. Jon may have sensed this strong disapproval of some of his actions. Once reportedly he said, after being reprimanded by his father for an incident, "the only reason you love me is because you have to." Many of the fears he seems to have had are concerned with the anxiety of being rejected, of experiencing pain, and of meeting personal failure. For example, Jon once told a doctor, "I don't want to play baseball. I might get hit with the bat," and "I don't want to go into the army, I might get shot."

Jon's admission meeting note (5/69) revealed that Jon was neatly groomed and was cooperative and friendly. He would not talk of his problems at home, but did state that he had learned that he should do as he was told by his parents and not disobey. He then began talking about the fact that he wanted to become Catholic because he liked the ritual of the Catholic

Church. Jon expressed that being in the hospital was a waste of time because there was absolutely nothing wrong with him.

Jon denied having any hallucinations or delusions, but the hospital section chief stated that Jon had told him he had heard voices since he was nine years old.

When Jon was asked if he had many friends he replied, "That's a word I use quite carefully as I pick my friends carefully."

Jon is known to be quite talented musically and has taken piano lessons. The report stated that he would often play alone and would also compose music. The researcher and Jon discussed music in general and organ music and organ parts in particular. His report stated that he has talked to some people about a pipe organ collection as if it were alive. Even though he did not talk with the researcher about them in this manner, his vast knowledge of pipe organ parts and their workings was impressive. The same is true of other rather complicated pieces of equipment, such as cars and airplanes. Jon talked of loving to fly with his father's friend and fellow employee who owns his own plane. Jon has expressed many times that he would someday like to be a commercial pilot, and explained what kind of plane he would like to fly and why. Times like this alerted one to his intelligence.

When Jon is feeling well, he exhibits a delightful dry-witted sense of humor. While he can be very personable to talk with on a one-to-one basis, he "freezes" when confronted with any kind of group interaction, especially at school. Jon seems

to be a loner much of the time. He relates to objects and shares secrets with them, rather than with people.

So far no one has been able to discover why Jon is so afraid of school. Until his sophomore year he did well academically. However, he has never liked math, algebra in particular, or gym class.

Earlier records revealed that when Jon was in the sixth grade, he often exhibited a "mental block" towards his school work. He seemed unable to complete assignments, was sometimes rebellious, and independent and argumentative. He would "freeze up" under pressure, run himself down, and give the impression of being afraid of being thought of as stupid.

Up until his hospitalization Jon had never dated, but he was known once to "walk a girl home from school." His parents, at the time of his hospitalization, felt that his interest in girls was normal and that there were no sexual problems involved. However, in the adolescent unit admission meeting in June, 1969, Jon expressed that he was afraid that the other adolescents on the unit would think that he was a homosexual. At the time of this writing, it is reported that more and more things have occurred concerning Jon and the possibilities that he has homosexual tendencies. The staff members hypothesized that either (1) Jon is possibly getting worse, or (2) that he is now allowing some suppressed feelings and actions to come forward which may be beneficial later in treatment. Some of these tendencies were so strong that the hospital staff believed it best that Jon not be allowed to go

home for Christmas vacation, as had been planned. He had been put in seclusion the week before for not only bothering some of the boys on the ward, who he claimed he loved as brothers, but for again showing suicidal tendencies.

The researcher visited Jon on his home ward on Christmas Eve. He tends to be overweight sometimes but it was evident that he had lost some weight and his physical appearance was good. He was well-groomed, alert, and seemed eager to talk. When Jon was told of the researcher's arrival and came into the conference room off of the ward, he was friendly and immediately the two were old friends again and talked for about an hour. Jon claimed that he could not remember the incident that had happened on the previous Thursday for which he had been "warded" as well as for being placed in seclusion and for not going home for Christmas. The issue was not forced and he was allowed to offer information as he felt like it. He was only asked a few basic questions in the beginning to bring the communication between the two persons up to date.

One of the things he brought up was about his recent involvements with girls in the hospital. Boyfriend-girlfriend relationships are a very important part of the adolescent culture at the hospital, and even for a person like Jon who supposedly had never dated "on the outside" it was evident that he felt the pressure to at least take an interest in the opposite sex, too! Therefore, one of the first things Jon asked was whether or not the researcher had heard about him and a certain girl at the hospital. When the answer was "no," he explained

that they had gone together for awhile, but that "it didn't work out," giving the impression that he still liked her very much. However, he went on to talk more about a Theresa, in whom he seemed most interested at the moment, although he maintained, "I love all people equally and I hate no one." When asked whether or not he found that a rather hard thing to do, he insisted that it was not and mentioned several times how much he liked the people on the ward and how well they got along. This was somewhat hard to believe since Jon had never been able to get along extremely well with very many people at the same time.

There is no doubt that Jon does want desperately to "love everyone," just as he claims he does. He is a boy of high ideals. He knows the difference between moral right and wrong and seems to be determined to live up to the standards he has set, much of which goes against what it seemingly takes to get along in society and to be considered "normal".

Jon seems to have a fairly keen sense of what is abnormal. Once when he was asked about a particular patient at the hospital, he said, "He's weird! but then I guess I was pretty weird when I came here, too."

From many indications, Jon has seemingly been asking for structure and controls for years. When admitted to the adolescent unit the following treatment was recommended by the staff: structure, encouragement of peer group interaction, occupational therapy, recreation, swimming, not being permitted to change church membership, and woodworking shop.

Jon did progress very well under this program during the summer and returned home on temporary visit a short time before his own school started to see if he might be able to enroll at home, rather than taking classes at the hospital. The temporary visit seemed to go well, and Jon was released for a Trial Visit period of one year. Jon's parents seemed extremely relieved and encouraged as did Jon, that he could enroll in school at home.

The psychologist made the following suggestions for Jon's welfare: (1) postpone math and algebra, (2) contact tutor for school work if necessary, (3) encourage choir try-outs, (4) encourage socialization with more peers, and (5) contact a guidance or mental health center for additional help and support for all of the family.

Things went well for Jon for awhile. However, when the home was visited for the first time, school had been in session for about one week. Jon had gone by himself to enroll and had attended classes regularly. However, that very day Jon began his old pattern of becoming ill at school, returning home and then sleeping until late afternoon.

While the interviewer was making the home visit, Jon's sister, the only other child in the family, came home from school. She is four years younger than Jon, red-headed, alert and vivacious. The mother says they get along very well together, that the sister is very matter-of-fact about Jon's illness and idolizes him.

Jon's sister sat on the sofa beside her mother during

the interview. The mother's sister was also there. Later in the conversation, Jon's sister was asked what she and Jon do together. She immediately reacted with "fight!" as if it were the most natural and common thing in the world!

Jon's mother talked about many things concerning Jon. Much of the talk seemed to be a release and of listening to herself express her thoughts of concern for Jon and what to do about his situation. She seemed to feel that the general atmosphere of the school was the cause of Jon's problems, rather than it being anyone or any particular thing. "But then he would never tell me anyway until some weeks later if it were anything else!", she commented.

One of the things the mother has constantly been concerned with is "Is it ok to treat Jon, in most cases, as if he were normal?" The parents have shown a real concern in not making too many allowances for Jon by not making him do anything around the house. Instead they wanted to make him feel that helping them with the normal chores would be useful and important. However, they also seemed careful to try to detect the things that Jon really could not do. She definitely was struggling with trying to find out on which side of the fine line she could put particular situations and have them be of value, rather than harm, to Jon.

One of the final things Jon's mother emphasized, "I'll fight having to take Jon back to the hospital. I wouldn't want him to get so low again, but I feel our problems are here at home, and that we should work them out here and not at the

hospital. We will contact the Guidance Center soon. We know we need outside help."

Jon did have to return to the hospital, much to the disappointment of both his family and the hospital staff.

One of the things that he was doing just before he did return was "clinging" close to his parents. They were pleased he was fond of them again, but he was near them so much that he was actually getting in the way of the normal daily activities.

Jon had also learned how to make himself so sick at school that the nurse would send him home, often with severe chills and blurred vision, even though he was taking his medicine regularly. He was also eating and sleeping to such an extent that both his parents and the hospital staff felt he should return to the institution for further observation and treatment.

Discussion of Jon's Case

What feelings could be more typical of an adolescent and at the same time be more paramount to him than the two simple statements: "Being alone is very lonely." and "I would like to be like everyone else."

The literature constantly stresses the many things an adolescent feels. A review of Jon's case, keeping the literature in mind, reveals that he has felt self-consciousness and experiences inner turmoil (Stone and Church, 1968). He has also experienced the developments in intellectual capacities, interests, attitudes, personal adjustments, emotional adaptations, vocational and academic interests, religious and moral

standards that Cole (1967) mentions. Likewise, Jon's personality has already undergone deep transformation, with a shift in equilibrium characterized by emotional disorganization and reorganization as Ackerman (1958) suggests. Much of his behavior reveals his feeling of insecurity. For example, it was important to him to know that his parents would look for him when he ran away from home. It was also evident when he insisted he liked the set structure and ritual of Catholicism because it was less vague and anxiety-producing than might be other religious philosophies. "Instability of mood and action" (Ackerman, 1958) was illustrated by Jon's early threats to kill his family and later exhibiting "clinging" behavior toward his parents in an attempt to show and feel love. While this smothering kind of love is a questionable substitute for a more healthy and genuine love, it nevertheless reveals that Jon is struggling to obtain a relationship with his parents that he knows should exist or that he wants to exist.

It has been very interesting to consider as another possibility for some of Jon's problems, his ordinal position in the family. Jon is the only case among the four who is firstborn. Irwin (1969) states that the firstborn is likely to be restless in his sleep, timid, over-sensitive, and demanding of attention. He seems closest to his parents and tends to be an introvert and learns to hide his aggressiveness. Trying to hide aggressiveness seemed likely in Jon's personality until he became so ill that his frustrated composure turned to aggression in the form of threats toward his family. Irwin

further states that fathers are prone to be more authoritative with their eldest child. To support this fact, it was brought out in Jon's medical records that his father had been demanding of and strict with him at times. Levy (1931) states that because the firstborn are subject to structural variables that are more likely to create personality problems, proportionately more of them are referred to clinics than children of other ordinal positions.

Preoccupation with religious ideas and idealism is common among adolescents and they are among Jon's list of compulsions. Hadfield (1962) claims that most religious conversions take place at sixteen years of age, that the adolescent is constantly searching for a perfect world and perfect people. He judges both himself and others by his ideals.

Two evident and specific examples of Jon doing this were: (1) when Jon was asked in an interview if he had any friends and he replied with, "That's a word I use quite carefully as I pick my friends carefully;" (2) when he was relating to the researcher on the ward about his recent relationships with girls but at the same time insisting, "I love all people equally and I hate no one."

School problems and difficulties for Jon seemed to be more than he was capable of handling alone. Before hospitalization, he would often run away from home, probably in an attempt to escape those conflicts at home or at school with which he could not seem to deal. It is likely that he wanted to escape because he has not ever been able to mix well with youth his

age at school and has never had many close friends. He seemingly has always been afraid of failing and of being rejected, so much that he would "freeze up" around a group of people. This would bring about more fears and feelings of rejection, whereas becoming more aggressive in his interactions with others might have increased his confidence and prevented failure and rejection.

It is likely that Jon's homosexual tendencies might have resulted from his wanting to be alone much of the time. When he has had girlfriends, which was not until he became a hospital patient, most of the relationships had not been successful. This could be why he felt he could get along better with boys. Ginott (1969) says homosexuality is a matter of degree. He claims that research shows that about thirty-seven per cent of all males (and about half as many females) have had some homosexual experience between their adolescence and old age. Only four per cent of them become lifetime homosexuals. Therefore, because some teenagers occasionally engage in homosexual relationships, this temporary behavior does not predict a life of deviancy. For example, if a family moved from one location to another when their child was just beginning to experience intimate same-sex friendships, which is a necessary step before development of normal boy-girl relations, this step might take place later in adolescence. What looks like homosexual behavior may only be a process toward heterosexuality. This seems a possibility in Jon's case because his parents moved to a new city when Jon was at the age for this to have occurred.

Betty

According to her mother, Betty was a well-adjusted girl until she began having seizures at eleven years old and was diagnosed as having epilepsy. She was immediately placed under medical care and given phenobarbital and dilatin which she has continued to take. Betty's mother said seizures were well controlled, but even so Betty averaged two of them a week. Betty frequently had seizures at school, which was greatly embarrassing and humiliating to her. She became increasingly withdrawn, and felt that no one liked her. She felt that her parents, particularly her mother, preferred her brother and sister to her and that she was "left out" of everything. As her personality changed, Betty became morose and hostile. "At times she was very good--too good, but at other times just the opposite," reports her mother.

Betty blamed her mother for her epilepsy, although several doctors talked with her assuring her that it was not something her mother did to cause it.

Betty has frequently had violent spells during which she struck her mother and sister who is one year older. Betty had done this in her father's presence who told her to sit down in a chair.

Betty's school adjustment used to be very good and she never had much trouble with grades, but her grades became poorer and poorer. She continued to go to school, but she was confused and forgetful at home and also at school. The principal at the high school where Betty attended the ninth grade,

frequently called Betty's mother to report that Betty was not getting along with the other girls. It was felt that she feigned some seizures in order to go home. She complained so constantly of not feeling good that her doctor finally told the school officials to keep her at school. This made Betty very angry at the principal. At home, the mother related that Betty has always been hard to control and that her attitude has been to "fight" them.

The family has moved frequently within the past few years and Betty has had various doctors. Betty's violent temper continued to get worse after their last move, and she began threatening both her mother and her sister. Betty is reported to have said, "I'm going to kill you," and has run after them with scissors, guns, or knives. She would also kick and bite them. She seems to have stretched the truth many times, such as telling that her father runs around with other women, and that she is mistreated at home. She seems to believe that everyone is against her. She takes things and then claims that she does not remember doing it. She was finally admitted to a hospital psychiatric ward in her present home town after becoming angry at school and at home, and after taking an overdoes of medication in a suicidal attempt. In the hospital she broke out a window claiming it was because her mother did not come visit her, but it seems that she had told her mother not to visit her.

Betty is the second of three children. The father is thirty-seven and has a fourth grade education, and the mother

is thirty-four. Betty's sister is seventeen and her brother is nine. Both are reported to be in good physical and mental health according to the mother. The sister is an outgoing, very attractive blonde, who is quite popular at school. She has never made the good grades that Betty did earlier, however. The mother reported that Betty's sister tries very hard to get along with her, but Betty seems extremely jealous of her. This jealousy seemed to come to a peak when Betty's sister became pregnant just within the last year and has since had the child. The sister did not marry but the implications of jealousy seem to be that the sister now had something she could call her own, something close to her that she could love. The jealousy between Betty and her sister does not seem to be as bad now as it was.

The father is currently a truck driver but has worked at various jobs. In an interview the mother said the family had an average economic status, and that her husband had always worked "steady." She described him as "easy-going" and a very good husband and father. The father had never been in the armed forces because of one leg that has given him trouble since he was a small child.

The parents were married after they had dated approximately one year, when she was sixteen and he was nineteen. The mother said the marriage is good with no problem with sexual adjustment. The mother had never worked until recently. She now works nights. The parents are reported to not go out much socially.

Betty's parents have twice applied for welfare in the past, but their applications were rejected each time. The first time Betty's father had suffered a heart attack and was not able to work full-time for at least four months. The second time Betty's mother applied for medical assistance for Betty herself to help meet the girl's hospital costs and other medical bills connected with her psychiatric treatment.

Betty's mother said there is no known mental illness, retardation, or epilepsy in the family background, but most of Betty's trouble seems to stem from the discovery of her epilepsy. She changed a great deal, became depressed, preferred quiet things and preferred to be left alone. It is reported that she had friends at school, but when she would come home from school, she would go to her room, do her homework, play records, and spend her time reading, writing poetry, and keeping a President's Book. Betty was described as a "perfect child" before her epilepsy, never displaying anger and always loving and well-behaved.

In the hospital "admission meeting note" on Betty, it is reported that the general impressions of Betty were that she is quiet and retiring, appearing younger than she is. She displayed much ambivalence toward her parents, appearing also angry, destructive and unable to think abstractly. She gave the impression of experiencing extreme turmoil, with a possible underlying schizophrenic process. The activities that were suggested for Betty were: a singing class, a home economics class, academic classes, art, social graces, group therapy, and dance class.

When Betty was transferred to the adolescent unit from her home ward, she gave the impression of being a very sick girl, confused in her thinking, and probably schizoid in nature. She was admitted to the adolescent unit on a trial basis. Until that time, she had been a difficult problem on her home ward. She had broken windows, scratched herself, and swallowed a ring. She did not get along well with the other patients and was known as the "best liar." She seemed to have few friends and those that she did have were also quite emotionally disturbed.

Betty's adjustment during the first week on the adolescent unit was "very, very poor." She got into disagreements, fights, and had several seizures. At the end of the first week, though, things were made clear to her what was expected of her and how she could earn ward privileges like everyone else.

The second week she seemed to be a changed girl. She cooperated in every way and displayed no significant outbursts. However, when Betty went home on a trial visit during the next month, her mother called the hospital, quite upset, and said Betty was "worse than ever, acting out, talking about murdering a cousin and completely out of control." Arrangements were made to bring her back to the hospital that night. During this visit Betty had threatened all of them so severely that both of the parents took off work so that one or the other of them could be home at all times.

Five months later Betty was scheduled to go home again, but after having another temper outburst the hospital postponed

the visit one month. The parents were extremely upset about this and threatened to remove her from the hospital, because "the hospital is not doing a good enough job and she might as well be at home." Later Betty's father was extremely concerned for Betty and helpful and cooperative and did not press for dismissal. The hospital staff felt that he was generally a good resource for his daughter's treatment.

When the researcher visited the home, Betty had experienced an unsuccessful visit the month before. Therefore, Betty's mother was still very concerned and upset about it because it had left such unpleasant thoughts with all of the family. Betty's sister was pregnant at the time and was present in the home, but she did not sit in on the discussion. Neither the son nor the father were home. Only one visit was made to the home, a rather plain, cared for, comfortable looking, dwelling but in a very poor section of town.

Because Betty's mother works nights, and had slept late, she was still in her robe. She sat quietly on their living room sofa and talked for almost an hour concerning Betty's problems. Many times she was close to tears. She explained how they wished Betty could get better, but because she seemed worse each time, they felt the situation hopeless. Both Betty's brother and sister, who used to "worship" her, are now afraid of her when she comes home. They never know exactly what she is going to do next. Betty was even very mean talking and acting to a favorite aunt when she was home last time. The mother felt badly about this because this aunt had always done many nice things for Betty.

Betty has expressed to her parents her great dislike for the hospital staff and activities. Her mother was concerned for her current involvement in activities. She was also concerned about Betty's weight, and asked about her epilepsy. The mother said that Betty has always seemed jealous of her and so will not talk to her. She feels that Betty has a closer relationship with her father. Another thing that was on the mother's mind was Betty's smoking cigarettes. Smoking is a popular habit for many of the hospital patients. Her parents were quite concerned about this and expressed the wish that she would quit and encouraged the hospital to help her.

The general impression of the home interview and the situation was that Betty's parents were concerned and tried very hard to understand her problems. However, Betty's illness was at such a stage that she was very difficult to understand. Because the parents seemed unable to do anything for her, they felt very inadequate and had an attitude that Betty would not get better.

The length of her illness dimmed hope for a satisfactory recovery.

Discussion of Betty's Case

It was unfortunate that Betty developed epilepsy when she was eleven years old and became so obsessed with the fact that she also developed emotional illness. However, it is a prime example of how such an occurrence, even though a controllable one, can seem so crucial to an adolescent. As was emphasized in Jon's case, an adolescent seeks a perfect world

and perfect people and his being "out of step" in that world and with those people is often too humiliating for him to bear alone. If he does receive the help and support he needs so desperately, there is still no guarantee that it will be the right kind or that it will be enough for him to get him past the crisis.

"Something must be done for this girl and her family, but what?" was the intense feeling with which the researcher left Betty's home after visiting with her mother.

Betty blames the epilepsy on her mother even though doctors have told her repeatedly that the mother is not at fault. However, the mother is a good target for venting bitter, angry, and aggressive feelings, which makes it even more difficult for Betty's family to give her the understanding and support she needs. While Betty needs her family and talks at times about how much they have done for her and how much she loves them, the struggle of wanting to become independent of them presents continual conflicts.

In an attempt to understand some of Betty's behavior, the fact that she is a middle child is considered. Irwin (1969) says middle children are not as restricted and are usually tougher than firstborn children, and often they are always trying to "catch up" with someone. Because they dislike being bossed, they often fight authority in later life; above all, they resent being criticized.

Because of the violence that Betty has shown at school, in her family, at the hospital, and among her peers, she shows

she is a very frustrated and angry individual. She thinks she is "different" because of her epilepsy and therefore has a low self-concept. She cannot seem to divorce this fact and feeling from anything she does and allows it to affect her behavior in everything that she does. Her attitude is defensive and this unpleasantness turns people against her quickly.

Other reasons for the occurrence of Betty's illness could include the lack of stability in her home life due to the family moving several times and the father holding various jobs, and the many different doctors she has had because of the family's mobility. Still another could have been financial pressures in the home when the father was ill with a heart attack and their applications for welfare assistance were rejected.

It is likely that when there were such pressures at home, Betty often felt neglected. Whether or not she was neglected any more than the other siblings is questionable, but evidently she suffered more from the situation in which they were all involved. Because of the resulting need for more love and attention, she began acting out at home and at school and began lying to almost everyone and threatening them as well. This behavior resulted in her becoming a mental patient and the longest-termed patient of the four cases.

Betty had improved a great deal during the past year and everyone was encouraged. However, temper outbursts, threats, and violence toward her family caused her trial visit to be cut short. A reason to account for this behavior, when seemingly

Betty had been doing much better, was that she was afraid of leaving the hospital. This may seem unlikely, but institutionalization becomes a problem for many patients, and after a time they cannot function anywhere else, but depend upon the continual support and protection of an institution.

Steve

Steve is a slightly built, blond-headed adolescent boy of fourteen years of age. His hospital admission diagnosis reads, "Borderline Psychotic Disturbance Schizophrenia, Latent Type with Possible Organic Brain Damage of Unspecified Type".

Steve is a sick boy, just as his diagnosis suggests. However, he quickly revealed his personality when seen interacting with other adolescents on the hospital ward and in discussion groups. For example, in a "group session", a once-a-week activity on the adolescent unit, Steve was the one who talked the most. He revealed that he has definite opinions about things. However, he was often inconsistent in what he said, showing confusion in his thinking.

He has also been caught talking to himself on the ward much of the time. He knows he should not do this but he must constantly be reminded by the hospital staff.

One of Steve's main problems has been control of his temper. He has become angry on the ward and exhibited such behavior as slamming doors, hitting fellow patients going to and coming from the cafeteria, and using foul language profusely. The result of some of this behavior has been confinement to the

seclusion room. Steve also has revealed some sexual problems, specifically masturbation and exhibitionism. These problems have occurred both at home and at the hospital. It was reported that Steve first exhibited this when he was out in the garage with his sixteen-year-old sister where he pulled down his pants and had an erection. He has used obscene language toward his sisters and has undressed in front of them. However, the hospital staff reportedly believed that since Steve was admitted he had shown more understanding of his problems and seemed to be working very hard to overcome them. His special education classes at the hospital included: world history, English, and math. Steve seemed to enjoy school.

Steve is believed to be quite intelligent, but at one time he was considered mentally retarded. When Steve was very young, his family lived in Colorado. One day he dashed out of the house and ran to a step ladder which was against the barn and immediately climbed up it. When he was about to the top he slipped through the rungs and fell to the concrete slab below. His parents said they felt they should keep him up and walking since he appeared dazed and bewildered after the fall. When they felt he was not recovering, they called the doctor who immediately put him to bed. Steve slept for two and one-half hours and woke up vomiting clear liquid. He was put into the hospital and remained in a coma for two days. However, the x-rays and other examinations proved to be negative and he soon recovered. Both parents felt that Steve had been more difficult to control since that time. There is reported to have been no other

illnesses or accidents or operations. Because Steve seemed to be having problems in school, his parents took him to the Boettcher Clinic in Denver. The mother said that ten or twelve doctors shared Steve's case at the time and decided he was mentally retarded and that there was no hope for his recovery. She said, "we were told to learn to accept this, but learned later that his problems were more emotional than physical".

When Steve was about eleven, his case was evaluated by a diagnostic and resource center to determine his proper school placement. He was seen by a child psychiatrist and it was recommended that he be in a special class for emotionally disturbed children in his home town. The same child psychiatrist continued to be his doctor and diagnosed Steve "Borderline Psychotic Disturbance".

The records reported that Steve got along well in this school and made no grades below a C, mostly A's and B's. One of his teachers had this to say about Steve's experiences and progress in the school where he attended classes for the emotionally disturbed:

> When Steve came to this school, he was confused and emotionally disturbed with introvert tendencies. His first progress began after a change of two teachers and the elimination of two students in his class. The change was so successful with the new teacher that soon he was phased out into regular classes. He made much progress, but has much more to go.

In music classes Steve was reported to have done excessive talking and giggling. He seemed to have an aversion to electrical outlets. However, the guitar has been a favorite thing to Steve and has been regarded as an "important rehabilitation vehicle for the boy".

The art consultant of the school reported that Steve was not as verbal later as when he first came to the school. It seemed to him that he talked and laughed more to himself. Steve's creativity is regarded as being above normal, but his art concepts are considered primitive. "He starts pell-mell on a project, with no organization of thought in his approach to his art work."

Steve has been a constant source of irritation for various teachers and children. He would become angry and cry when he would make an out in softball or fail to get a position he wanted. Children seemed to tease him more than necessary and he responded with cursing and temper tantrums.

Steve seldom followed classroom procedures or directions. He never wanted to do things at the proper time. He would also talk to others in the class discussions and distract in other ways such as walking around the room. His written work and desk were untidy. He would frequently tear his books and papers. Steve likes to read and reads a lot and sometimes it was the only way he could be kept quiet in class and not disturb others. A day-to-day occurrence with Steve seemed to be his involvement in several conflicts or problems arising out of association with other boys and girls in the classroom. Steve also experienced hallucinations sitting in class. He would call his dog and then pretend the dog was sitting. Steve would scratch him to remove the flies crawling on his back. This occurred before Steve attended the special education classes. After the new teacher helped him in music, role-playing, art, and playing the

guitar, Steve maintained a much better grip on reality. He needed much structure and attention to complete his homework, because his attention span was short. Steve's strongest academic areas were music, English, and math.

Both of Steve's parents had been married before and have had marital problems in this marriage. Efforts were made to involve the family members in therapy. The parents went to a family consultation service for awhile, but it did not seem to help. The mother stated that her husband felt he had done his duty when he had provided food and lodging for his family and did not feel he should have to help with care and training of the children. Several years ago the mother sued for divorce, but became ill and was hospitalized. While in the hospital her husband, who had been out of the home, moved back to care for the children. She was still advised by two doctors to get a divorce but it was never completed.

The father is a dry-wall finisher and the mother is a grocery store checker. There are two older half-siblings of the mother's, a boy eighteen and a girl sixteen; one younger full sister who is nine. Steve himself is fourteen.

The past relationships with both of the older half siblings may have added to some of Steve's emotional problems. He and his half brother have never gotten along well and this was believed to have caused some of Steve's school set backs. The half-sister was always somewhat bossy with both Steve and his younger sister when they were growing up. The mother mentioned that she was afraid it has caused some of Steve's problems.

Steve was born one month premature and weighed four pounds, eleven ounces. He was slow in developing; he did not sit up until seven months, walked at seventeen months, and was partly toilet trained at three years. He has always had trouble sleeping.

During the two home interviews that were made, all of the family members were met except the older son. The older sister, sixteen, seemed very concerned for her brother Steve and made frequent, appropriate comments to the conversation. She commented how she would like to go into social work or youth work someday herself so that she could help the adolescent age child.

At one point in the conversation, when the parents were asked if they had ever felt the stigma of mental health was held against them, they commented they had, but had learned to ignore it or how to handle it. They also mentioned how many other people, because of their problems with Steve, they had discovered were touched by mental ill health also. They had learned how common a thing it can be.

Steve's home visits have ranged from good to bad. Earlier he needed fairly close supervision, but needed it less and less and showed more independence at home. The mother said that it was hard for her at first because she was used to having his full attention. Steve's mother is the kind to demand everyone's full attention and dominated much of the discussion when the researcher talked with her and the other family members. Even though she seems very genuinely concerned for Steve and his

problems, it is the opinion of the hospital staff and the researcher that she still could be a part of them.

Both of the parents had much praise for the hospital where Steve is now a patient. They feel the staff is good and that he has been helped a great deal. They were still concerned, however, about his talking out loud to himself. The mother related when Steve was home how he would sometimes play in his room like he was a disc jockey on the radio, talking and singing to himself. She also told how she felt one of the hospital patients had been a bad influence on Steve. Her other worries concerned: the hospital not sending enough medication home with Steve on his visits, Steve's eyesight being checked, his messy eating habits, cussing, and playing with himself. Steve described himself once as being generally anxious and unsure of himself and stated that he would like to get over his problem of disrobing in the presence of children.

Both parents related several times how they felt that moving back to Arkansas, from which they originally came, would be better for Steve. They felt the rural setting would be much better as well as getting away from the people there at home who hold against them Steve's illness and having been in a mental hospital. They also felt that he was facing too many pressures now.

They were concerned for what Steve can possibly do in the future, maybe play a guitar in a band since it is something he loves so much.

Discussion of Steve's Case

The researcher enjoyed meeting with Steve's family. They were friendly, cooperative, and seemed eager to talk. This family was visited in their home twice, whereas the other families were visited in their homes only once. Steve's family was even more eager to talk the second time the researcher visited them and expressed their appreciation in having someone come to their home. The researcher felt they were relieved to talk about their problems, and it was easy to consider that more of this kind of supportative visitation would be beneficial to families dealing with problems such as this one. By visiting the family twice, more of the family members were met, providing for an even better perspective on the family relationships. The researcher also felt that the family confided in her more than they might have done for anyone. This can be a good feeling as well as a troubling one because the experience carries with it the feeling that something ought to be done for these people because they touched and trusted you with their pain.

But, because it is finally rationalized that maybe the important thing was that someone listened to them, the feelings of desperately wanting to help become less and less intense and the problems that face the patient and his family are considered coldly objectively once again.

Excessive masturbation and exhibitionism have been serious problems of Steve's. These are common practices among adolescents, but few seem to carry them to the extreme that Steve has shown. Davis (1968) estimates that ninety to ninety-

six per cent of all boys engage in masturbation. However, it has become a problem for Steve because he has never learned how to handle it appropriately. Davis says that masturbation becomes excessive when a boy spends time on it when he ought to be out doing other important things he enjoys or should be doing, such as studying, dating, or engaging in sports. Most masturbation occurs when a boy is idle or alone.

Steve's habit of talking to himself is no doubt another indication of his basic loneliness and lack of congruence with the real world. He is known to go into his room alone as if to escape to his own world and occupy himself by the hours, also a trait of schizophrenia.

The extreme fits of temper and violence and foul language Steve has also exhibited is another typical consequence of adolescent frustration and aggression. Steve's mother has had emotional problems herself and it seems natural that her anxiousness has had an effect on Steve's personality, contributing to his instability and anxiety. It is likely, even though his parents expressed concern for his inappropriate behavior and speech, that he learned some of his actions by examples set in the home.

The relationships among these family members are quite interesting. The older son and daughter are by the mother's first marriage. The older son was the only one of the family that the researcher did not meet. During the course of the conversation during one home visit, the mother made the comment to the researcher when speaking of her oldest son, "Now, there's

a case for you, too! That kid's really messed up, he doesn't know what he wants to do." Her husband nodded in agreement. It seems he has had some difficulty with school and also faces problems with the military.

Even though the older daughter is believed to have bossed Steve and his younger sister around during childhood, she seemed to be a mature and sensible girl for her age when she was present during one of the home visits.

The younger daughter is a very pretty child and it seemed evident that she is probably a favorite among the family members. That Steve may have been jealous of this sister is a possibility to consider, but there were no indications that this was true.

Both conversations with the family were dominated by the mother. This woman seems to have remarkable insight into mental problems and the first impression is favorable because she is forthright, alert, and seems very concerned. However, with time, she also appears to have had many problems of her own and she expressed this the more that the conversations continued. She has not only undergone treatment in the past but gives the definite impression that she relies on tranquilizers as a common daily medication.

There is no doubt much pathology in this family situation, but it is a difficult one to speculate upon. The family seems to be concerned and shows insight and understanding, patience and hope in their attitudes. However, one comes to

learn that some of this "insight" and "understanding" might be lip service rather than applied knowledge.

Ann

Ann's history is one of many dimensions. She lives with her paternal aunt and uncle and has done so since she was five weeks old. She calls them "mother" and "father".

Her natural father is approximately thirty-seven years old. He was born in Arkansas and probably completed the sixth grade. He is noted to be a heavy drinker, but otherwise is known to be in good physical health. At one time Ann wanted to go live with her father, but her uncle reported that it was a very bad experience and she was badly neglected so her permanent "home" is with her aunt and uncle.

The natural mother is approximately thirty-nine years old. Her whereabouts are unknown.

When Ann's natural parents were married it was the first marriage for him and the second marriage for her. The mother is alleged to have had two children by her first marriage, whom she adopted out to a relative. It is unknown if the couple have legally divorced, but they have not lived together as man and wife since Ann was five years old. Besides Ann there were three other daughters born to this union, one who is two years older than Ann and two who are two and four years younger, respectively. They live with relatives--all aunts.

Ann was allegedly given to her aunt and uncle by her natural mother, while the natural father was out of town seeking

employment. At one time Ann was taken back by her parents and lived with them for nine months. Supposedly it was a vindictive gesture on the part of the natural parents because the aunt and uncle would not extend to them money for their liquor.

Ann and her aunt and uncle have lived in the same town for approximately seven years. During that time the natural father has contacted her only once. Neither he nor his wife has financially contributed to Ann's care during the time she has lived with her aunt and uncle.

The paternal aunt was also born in Arkansas and completed the ninth grade and business college. She is presently a housewife and is in very poor health and under the regular care of a doctor. The uncle was born in Kansas and completed the twelfth grade and two years of GED college in the army. He is now retired after having been in the service for twenty-one years. He stated in an interview that there is a sixty per cent disability with his spine, but that he is still employed. Ann's aunt and uncle were married the year she was born. It is her aunt's second marriage and the third for her uncle. They have one son together, who is six years old. The family is reported to be Protestant but does not employ regular church attendance.

In an interview, Ann estimated that there has been trouble in the home for about four years, but admitted that much of it stemmed from the fact that she wanted to do as she pleased. She feels that her aunt and uncle are rather overprotective, but it is reported that they allowed Ann to date at age fourteen with a curfew of 12:30 or 1:00 a.m.

According to Ann both her aunt and uncle drink to some extent, stating "they only get drunk when they are drinking heavily, and remain drunk for only a short time--maybe one, two or three days".

In interviews Ann's uncle did most of the talking and his wife agreed with him and added to what he said. They felt that Ann's main problem was refusing to mind them and staying out late at night, sometimes all night. The uncle stated that perhaps he was a little too strict sometimes in having his orders carried out, but definitely felt that they should be carried out.

Both the aunt and uncle expressed much interest in Ann's problems and expect her to return home when she is released from the hospital. They seemed to feel that her problems are all her own fault and that any changing done to correct them would have to be done by Ann herself. They seemed defensive during part of the interview. At the beginning of it the uncle brought up on his own that his home is not littered with beer cans as Ann's probation officer may have reported. He stated that there had been eight beer cans from four people one morning when the probation officer visited the home. This was not brought up or pursued by the interviewer but is in the report of the probation officer. The uncle stated that he had no use for the probation officer.

Ann was assigned a probation officer when she ran away from home when she was thirteen, and a petition was filed alleging her to be a wayward child. She had been a runaway for two

days, having left school with a car. She met friends at a bowling alley and then spent the night with her boyfriend at his brother's house. On the first night she claimed they stayed in the same bedroom, but slept in different beds. The second night she admitted that they slept in the same bed, but denied any sexual involvement. She also admitted she and her friends had drunk beer but said that she returned home voluntarily after two days.

Ann said the reason for her running away was that two days before her uncle had beaten her with his fists and a broom handle, but she admits calling him obscene names. She said she called her natural father in Memphis concerning the situation and although he promised to write her a special delivery, air mail letter, she did not hear from him so left home. The aunt asserted that Ann provoked the uncle into physical punishment on her behalf because of her profanity and derogatory remarks to elders. Ann has insisted to her aunt and uncle that she is a virgin, but related to the probation officer that she had indulged in sexual relations with approximately three different boys and at one time thought she was pregnant but was not.

Ann is reported to hate school because of the harassment received by a few of the girls. Her uncle is reported to have told her to fight back. When she was involved in a fight at school she was suspended for five days. The uncle feels that the principal is unfair in his treatment of Ann. The principal contends that Ann's attitude ranges from fair to bad and has

been involved in several fights. Her grades are poor, mostly C's, D's, and F's.

In interviews, the uncle would often become quite emotional after relating how hard Ann was to control. He claimed that he loved her very much and expressed that he would abstain from drinking if Ann would only correct her behavior.

When Ann was first a patient on the adolescent unit she was hostile, rebellious, and showed little trust for anyone. She had temper tantrums, cussed, and cried often. She became more controlled with time, but still seemed to remain resentful of authority figures. Gradually she was able to converse with the hospital staff about her problems and fears. On the wards she seemed to get along fairly well with her peers, but seemed to lean to male companionship.

When she was admitted to the hospital she was fourteen years old and had an eighth grade education, and her type of admission was "order for care and treatment". Ann has no organic abnormalities.

Ann had several home visits since being hospitalized. They have ranged from very good to very bad. If they were good it seemed it was because she stayed home and obeyed her aunt and uncle and did not do much with her friends. It was good also if the aunt and uncle were not on a drinking spree. Therefore, if it was bad it was because of the things she had done with her friends and/or because her parents had been drinking.

At one time Ann expressed to the researcher that she had thought about boarding school so she would not have to stay

at the hospital and go to school, but yet would be away from her home town friends who always seemed to get her into trouble. She talked of having several friends, but yet always seemed critical of them, too. She mentioned one good girl friend who seemed very interested in her hospitalization and was always asking her questions about what she does at the hospital. Ann indicated that she appreciated her friend taking such an interest and feeling that it was kind of "cool" that she was a hospital patient. When asked if she thought boarding school would be strict, she said, "not as strict as home".

When the aunt and uncle were visited in their home they were ill with the flu. Ann was supposed to have been home for the week-end, but they had been unable to go get her because they were not feeling well. The uncle, who always did the talking, discussed at length his dislike for both Ann's probation officer and her principal. It seemed Ann's older sister went through as many behavior problems as Ann seemed to be having herself. The sister is married now and has settled down somewhat.

Their young son was home, a cute, blond-headed boy who seemed to be strictly disciplined by his parents. However, the parents showed that they were *extremely* proud of their son.

The general impression was that even though the "parents" were very much interested in Ann, they did not know how they should be with her. The uncle said a couple of times that he realized that maybe he had been too strict with her, but did not know how else to make her mind him. They also talked of

Ann's friends and how little they trusted most of them. The uncle even told of incidents of following Ann and her dates after they had picked her up to see where they were going and if they were observing the speed limit. He talked of having run several of her boyfriends off and explained how they were such undesirable and bad influences on Ann.

As the researcher left their home the aunt and uncle seemed interested in news about the hospital and staff and concerned for what kind of an institution it is.

Discussion of Ann's Case

There are many things to consider in a case such as Ann's. Her homelife has been consistently undesirable and one of many experiences. She has probably suffered from never really feeling that she was wanted as a daughter or that she had a family who cared.

Her life has lacked structure when she has needed structure most. When structure was there it was forced upon her with the attitude that "you better carry out my orders or else!"

It is possible, too, that there was often competition among the sisters to obtain any affection available from among the relatives with whom they lived.

Ann's life has been one of being shifted from place to place and hardly ever landing anywhere for very long. Because of this insecurity within her family structure and lack of the proper role models, it is likely that these "messed up" family relationships could have contributed also to her undesirable peer relationships.

Ann has a poor concept of herself and has often depreciated herself to hospital ward personnel. It was the opinion of a hospital consultant visiting the adolescent unit that because Ann's mother is thought to be a prostitute and Ann knows it, that Ann has been trying to identify with her mother, as a "no good" and a "slut", because she is not worth being any better.

The tone of Ann's comments about her aunt's and uncle's drinking habits indicated that she has probably never been exposed to anything other than several degrees of drinking and perhaps would find it hard to believe that sometimes people do not drink.

The possibility of there being sex links between Ann and her uncle has been mentioned. Again, it is a hard thing to determine because it becomes a matter of taking one person's word over another's when it is questionable whether or not either would tell the full truth. It is possible that Ann's aunt and uncle have never really wanted her, even though they will say that they love her very much. One reason they could have taken her in was out of guilt and feelings that they should, to make amends for their "sinful" lives and drinking habits.

There are many inconsistencies in the lives of this family. While the aunt and uncle, not to mention the natural parents, drink and lead what could be considered undesirable lives, they nevertheless criticize Ann for drinking, promiscuity,

going out, and running away. They also tell her to fight back and stand up for her rights, but then are critical of her for being such a "wild one".

Ann wants to have friends and probably likes the ones she has, but feels she should not because they represent the evil her aunt and uncle talk against.

CHAPTER V

SUMMARY

And so...an adolescent learns, perhaps for the first time in his life, that things are not easy, that life is a struggle much of the time. There is probably not a single adolescent mental patient who has not turned over and over in his mind, "why did this have to happen to me?", "why am I different?", "will I get well?", "can I be 'normal'".

Ackerman (1958) relates so well some of the typical manifestations of adolescence. They came to mind time and time again when each of the four cases was being studied and considered. Ackerman mentioned insecurity and immediately each case is reviewed in one's mind in an attempt to use the concept to justify each example of inconsistent behavior, all of it being a result of desperately trying to gain and then maintain some type of emotional equilibrium.

"Instability of mood and action" describes Jon's running away from home and school, his inability to make and keep friends, his various behavior toward his family; Steve's violent fits of temper, his problems with peer relationships; Betty's threats to her family and unpredictable behavior from day to day; and Ann's constant chain of "new ideas" and solutions to her problems in a desperate effort to establish some constancy in her life.

The sex drive is a powerful force in all young lives and is no exception in these cases. Learning how to use this powerful force to a constructive advantage is a difficult and painful process, during which there occurs such things as homosexuality (Jon), promiscuity (Ann), exhibitionism and masturbation (Steve),and misunderstandings about different kinds of love (Betty).

Conflicts with authority figures, too, are evident in all the cases as well as the usual teenage rebellion, cravings for independence and the immature need for dependence, suggestability to outside influences, fears of inadequacy and failures, and, finally, the hope to some day really be somebody!

All of these things are a result of the usual bodily changes at this age, and the fact that one does not mature at a consistent rate. This alone breeds anxiety and a host of other chain reactions which can result in abnormal behavior and personality.

The adolescent, as has been illustrated again and again, is pushed and shoved by many forces: family, peers, influential adults in school, church, and community, in addition to his own inner needs, thoughts, and desires.

Parent and sibling relationships must be considered carefully. Certainly being a parent must be one of the most difficult things a person ever experiences, even when things go smoothly. However, the family with the special problem of dealing with mental illness can be a very distraught group. Why mental illness came to <u>them</u> seems not only unfair, but also a

mystery to most of them. But few people concern themselves with something that does not seem to be concerning them at the time. Perhaps this can be one of the safest and yet best reasons for assuming why the particular family did not do more to prevent their child from becoming a mental patient. Unfortunately, though, even awareness and an understanding of mental health is still no guarantee that the illness will not strike.

So...what can be done for adolescents who are on the way to becoming the adults of tomorrow to bring their deranged thoughts, feelings and desires back to the world of reality? As with most research, this study only raises more questions than answers.

To focus in, though, on the three major questions cited earlier, the following conclusions were drawn. The four adolescents have similar characteristics because they are all adolescents with unusual and unfortunate experiences which happened to be serious enough for them to become mental patients. Most importantly, though, they are, without question, individuals in their own right. Each has the potential to endure the "storm and stress" of adolescence with some help and hopefully he will. Actually nothing is certain in the course of life and especially adolescence, but life goes on.

Secondly, all the adolescent patients were observed to have had a low self-concept at one time or another and certainly each had been both hostile and indifferent to their respective families and others. Even though these are inevitable adolescent characteristics, they still must be dealt with and exhibited through appropriate behavior.

Finally, the researcher was very warmly accepted and received by the families and they cooperated to the fullest. All were likable in their own ways, and it made the evident pain that each was bearing difficult for the researcher to reflect objectively upon her visits with them. Few are aware of the dangers that may eventually befall them and once something of this nature does occur, the questions can only be asked, "what did I do wrong?", "what could we have done differently?" The burden can linger long and hard and any help that comes hopefully is a beginning to discovering that there is light somewhere in a long, dark, lonely, hellish tunnel of confusion, hurt, guilt, and despair.

The ultimate goal is understanding, for whomever it may help and whenever it can be given. Without it, not too much else seems important, because there is no guarantee that one person ever really helps another, except by helping him to help himself.

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APPENDICES

ILLEGIBLE DOCUMENT

THE FOLLOWING DOCUMENT(S) IS OF POOR LEGIBILITY IN THE ORIGINAL

THIS IS THE BEST COPY AVAILABLE

Appendix A

Profound.
Being alone is very lonely.
I would like to believe
everyone else, But it violates
all principals I have set up
I need Debbie because
she is the only [redacted]* I have
with the world outside of myshell.
I pray for. Debby

Appendix B

August 28, 1969

Dear Mr. & Mrs. ,

Even though I have talked with both of you about meeting with you in your home in the interest of I feel you should know just a little more about me and the study I am doing.

I am a graduate student at Kansas State University majoring in Family and Child Development. Approximately one year ago I worked here at the hospital in a program entitled , under the auspices of both K-State and the . While I was here I enjoyed working with the patients on the adolescent and so for my Master's Thesis I am studying "the emotionally disturbed adolescent and his family". This kind of study should not only help university people understand more about mental illness, but also help mental institutions know more about how to help adolescent patients and their families help each other as well.

All of the information I will gather about your family will be strictly confidential. Everything will be checked by the hospital personnel before anything is released.

I am working quite closely with my major professor, Dr. Steve Bollman in Manhattan, as well as with and the psychologists and social workers on the adolescent unit in assuring that the study will be in the best interest of and you, his family.

Because we are all interested in helping you with your own particular situation, your willingness to cooperate with me is greatly appreciated.

Thank you for listening!, and I will be looking forward to meeting with you and your family this fall.

Sincerely,

Ginny Ward
Kansas State University

Dr. Steve R. Bollman
Associate Prof.
Family & Child
Development

January 1, 1970

Dear Mr. & Mrs. ,

I would like to thank you for being so willing to cooperate with me while I was doing my research for my Master's Degree Thesis at the last summer and last fall. It was good getting to know both you and your adolescent.

I wish I could have met with some of you a second time, but since I am a full-time graduate student at Kansas State University, time simply did not allow it for all of you.

However, enough information has been gathered to complete my study and I do not think I will need to contact you again and so I have terminated my visits.

All of the information has been and will continue to be kept completely confidential. Anything I felt would help the hospital help your adolescent has been brought to their attention.

I know after getting to know you how concerned we all are for helping this age child over some of the rough spots in growing up. I sincerely hope that my work in this area will be a part of the continuing effort to help adolescent mental patients and their families.

Thank you again for your help.

The very best to you and your family in this new year.

Sincerely,

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FOUR TROUBLED ADOLESCENTS

by

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B. S., Kansas State University, 1969

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

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Manhattan, Kansas

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Adolescent years are difficult ones for both youth and their parents, and when mental illness further complicates the family situation, support is needed as never before to help them deal with the crisis with which they find themselves involved. This study attempted to learn about the human interactions in the families where an emotionally troubled adolescent was a member.

The human interactions that were observed for the study were: (1) staff-patient and peer-patient relationships on the hospital wards, (2) researcher-patient interactions, and (3) patient-family and researcher-family involvements.

The three sources contributing information about the patients were: (1) the observation data from interacting with patients and staff on the hospital wards, (2) the hospital medical records, and (3) the interview data from meeting with the families in their homes.

The data includes the descriptive characteristics of: (1) race, (2) sex, (3) age, (4) educational level of the adolescent, (5) number of times admitted to the hospital, (6) admission diagnosis, (7) size of the family, (8) age of siblings, (9) position in regard to sibling sex, (10) parents occupations, and (11) locality of family.

Determining how the adolescent views himself and his family and how the family feels about having an emotionally troubled adolescent were reasons for establishing personal and informal relationships with both the patients and their families. All of the information collected and recorded was kept

completely confidential.

Four adolescent patients, two girls and two boys in their mid-teens, were mutually agreed upon and selected for the study by the hospital's adolescent unit section chief and the researcher. The research focused upon the following major questions: (1) What characteristics do emotionally troubled adolescents have in common? (2) Do emotionally troubled adolescents have realistic self-concepts? (3) How are families with troubled adolescents affected by mental illness?

Mental illness can strike anytime and anywhere and even an awareness of it is no guarantee that it will not occur. But, by knowing some basic characteristics of troubled adolescents, by understanding why they may have become hostile or indifferent, and by realizing why society's attitude toward mental illness may foster a low self-concept, perhaps a deeper understanding and further enlightenment of mental illness will result and can contribute to making the disease a less painful one for those many whom it involves.