12-1986

An Analysis of Conduct Disordered Boys’ and Their Parents’ Perceptions of Their Family Social Environments

John Rolph
Western Michigan University

Follow this and additional works at: https://scholarworks.wmich.edu/dissertations

Part of the Educational Psychology Commons

Recommended Citation
https://scholarworks.wmich.edu/dissertations/2264

This Dissertation-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Dissertations by an authorized administrator of ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.
AN ANALYSIS OF CONDUCT DISORDERED BOYS' AND
THEIR PARENTS' PERCEPTIONS OF THEIR
FAMILY SOCIAL ENVIRONMENTS

by

John Rolph

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
December 1986
AN ANALYSIS OF CONDUCT DISORDERED BOYS' AND THEIR PARENTS' PERCEPTIONS OF THEIR FAMILY SOCIAL ENVIRONMENTS

John Rolph, Ed.D.
Western Michigan University, 1986

Conduct disordered behavior of male adolescents constitutes a major social problem. There are many disagreements among clinicians and researchers about the factors which cause and maintain antisocial child behavior.

The purpose of this study was to learn more about the differences between two types of conduct disordered boys, i.e., Stealers and Aggressors, and their families. The Family Environment Scale Form R and Form I were used to obtain parental and child measures of perceptions of family social climates. The Health and Daily Living Form was used to obtain measures of parental mental and physical health, social resources, and family life change events.

The research sample consisted of 50 adolescent males receiving inpatient psychiatric treatment and their parents. The subjects were placed into three groups: Stealers (N =16), Aggressors (N = 17), and a comparison group termed Internalizers (N =17), which consisted of neurotically adjusted adolescent males and their parents.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Results obtained indicated that none of the criterion instrument measures revealed significant mean differences among the three research groups. However, some significant mean differences were revealed when family social climate perceptions of the three research groups were compared to a nonclinical normative sample.

Based on these results it was concluded that there were no significant mean differences between the Stealer and Aggressor groups in terms of the criterion instrument scores. As expected, Aggressors' families reported greater efforts than Stealers' families to control family members' behavior. These results were large though nonsignificant. Compared to Aggressor adolescents, Stealer adolescents reported greater achievement frustrations and strivings.

Members of Aggressors' and Stealers' families possessed some inaccurate perceptions about their families' social environments. These misperceptions may be associated with an inability to accurately assess their family problems. Therefore, these misperceptions may also be associated with an inability to make satisfactory progress through psychotherapy.

It was recommended that further research be designed which would use additional assessment devices, larger samples, and the inclusion of Stealer adolescents selected from detention center populations.
INFORMATION TO USERS

While the most advanced technology has been used to photograph and reproduce this manuscript, the quality of the reproduction is heavily dependent upon the quality of the material submitted. For example:

- Manuscript pages may have indistinct print. In such cases, the best available copy has been filmed.

- Manuscripts may not always be complete. In such cases, a note will indicate that it is not possible to obtain missing pages.

- Copyrighted material may have been removed from the manuscript. In such cases, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, and charts) are photographed by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each oversize page is also filmed as one exposure and is available, for an additional charge, as a standard 35mm slide or as a 17"x 23" black and white photographic print.

Most photographs reproduce acceptably on positive microfilm or microfiche but lack the clarity on xerographic copies made from the microfilm. For an additional charge, 35mm slides of 6"x 9" black and white photographic prints are available for any photographs or illustrations that cannot be reproduced satisfactorily by xerography.
ACKNOWLEDGMENTS

I wish to acknowledge the kindness and support of several people who contributed to the completion of this project. First, Dr. Kenneth Bullmer, my advisor, who provided his time, interest, and expertise. His sense of humor helped to place into a manageable perspective the frustrations related to a project of this nature. I am grateful to committee member Dr. Edward Trembley who provided timely and insightful editing. I am also grateful to Dr. Mal Robertson who served as a committee member. Dr. Jack Stewart's help was invaluable in formulating the research topic and in facilitating the attainment of permission to include clinical subjects. Consultation regarding statistical analysis and data analysis was mercifully provided by Elgin Perry. Robin, my wife, with inordinate tolerance and love provided constant encouragement and support. Finally, I wish to thank my parents who provided me with a loving and stable family environment.

John Rolph
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................... ii  
LIST OF TABLES ............................................... vi  

## CHAPTER

I. INTRODUCTION ........................................... 1  
Background ............................................... 3  
Statement of the Problem ................................. 9  
Significance of the Study ............................... 9  
Limitations ................................................. 10  
Summary .................................................... 11  

II. REVIEW OF RELATED LITERATURE ..................... 13  
Historical Overview ....................................... 13  
The Influence of Family Characteristics on Individual Behavior ......... 32  
Current Research .......................................... 47  
Individual Child Assessment ............................. 57  

III. METHOD .................................................... 62  
Population and Sample .................................... 62  
Population ................................................. 62  
Sample ..................................................... 63  
Diagnostic Conditions .................................... 63  
Criteria Instruments ..................................... 64  
Child Behavior Checklist .................................. 64  
Family Environment Scale ................................ 68  
Health and Daily Living Form ............................ 74
Table of Contents—Continued

CHAPTER

Procedures ........................................ 74
Statistical Hypotheses .......................... 75
  Hypothesis One ................................ 76
  Hypothesis Two ................................ 76
  Hypothesis Three .............................. 76
  Hypothesis Four ................................ 76
  Hypothesis Five ............................... 77
  Hypothesis Six ................................ 77
Statistical Analyses ............................. 77

IV. RESULTS ....................................... 79
  Data and Their Analyses ....................... 79
    Hypothesis One .............................. 79
    Hypothesis Two .............................. 89
    Hypothesis Three ........................... 90
    Hypothesis Four ............................ 97
    Hypothesis Five ............................. 102
    Hypothesis Six .............................. 106
  Summary ...................................... 109

V. DISCUSSION, RECOMMENDATIONS, AND SUMMARY ... 111
  Discussion .................................... 111
  Recommendations ............................. 128
  Summary ...................................... 130

REFERENCES ..................................... 134
### Table of Contents—Continued

**APPENDICES** ......................................................... 143  
A. Child Behavior Checklist ............................. 144  
B. Family Environment Scale Form R ..............  149  
C. Family Environment Scale Form I .............. 155  
D. Health and Daily Living Form ................. 161  
E. Informed Consent and Assent Forms .......... 175

**BIBLIOGRAPHY** ..................................................... 178

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
# LIST OF TABLES

1. Multivariate Analysis of Variance of Total Parent Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers .......................... 80

2. Means, Standard Deviations, and t-Ratios for Family Environment Scale Form R Scores Comparing Total Parent Scores of Stealer, Aggressor, and Internalizer Parents to a Nonclinical Normative Sample ............. 81

3. Multivariate Analysis of Variance of Identified Patient Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers .................................. 83

4. Means, Standard Deviations, and t-Ratios for Family Environment Scale Form R Data Comparing Stealer, Aggressor, and Internalizer Identified Patients to a Nonclinical Sample .................... 84

5. Multivariate Analysis of Variance of Total Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers ............................................ 86

6. Tukey's Studentized Range Test For Variable Control-Total Family .................................. 87

7. Means, Standard Deviations, and t-Ratios for Family Environment Scale Form R Scores Comparing Stealer, Aggressor, and Internalizer Total Family Scores to a Nonclinical Sample ............................ 88

8. Analysis of Variance of Total Family Incongruence Scores ........................................ 89

9. Means, Standard Deviations, and t-Ratios for Family Environment Scale Form R Incongruence Scores Comparing Stealer, Aggressor, and Internalizer Families to a Nonclinical Sample .......................... 90
List of Tables—Continued

10. Multivariate Analysis of Variance of Total Parent Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors, and Internalizers .................................................. 91

11. Multivariate Analysis of Variance of Identified Patient Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors, and Internalizers ........................................ 92

12. Tukey's Studentized Range Test for Variable Achievement Orientation—Identified Patient Difference Score .................................................. 94

13. Multivariate Analysis of Variance of Total Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors, and Internalizers .................................................. 95

14. Tukey's Studentized Range Test for Variable Total Family—Achievement Orientation Difference Score .................................................. 96

15. Multivariate Analysis of Variance of Maternal Health and Daily Living Form Health Data Among Groups of Stealers, Aggressors, and Internalizers .................................................. 97

16. Means, Standard Deviations, and t-Ratios Comparing Health and Daily Living Form Mental and Physical Health Data from Mothers of Stealer, Aggressor, Internalizer, and Nonclinical Families .................................................. 99

17. Multivariate Analysis of Variance of Paternal Health and Daily Living Form Health Data Among Groups of Stealers, Aggressors, and Internalizers .................................................. 100

18. Tukey's Studentized Range Test for Paternal Alcohol Frequency—Quantity .................................................. 102

19. Multivariate Analysis of Variance of Maternal Health and Daily Living Form Social Data Among Groups of Stealers, Aggressors, and Internalizers .................................................. 103
<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td>Means, Standard Deviations, and t-Ratios Comparing Health and Daily Living Form Social Data from Mothers of Stealer, Aggressor, Internalizer, and Nonclinical Families</td>
<td>104</td>
</tr>
<tr>
<td>21.</td>
<td>Multivariate Analysis of Variance of Paternal Health and Daily Living Form Social Data Among Groups of Stealers, Aggressors, and Internalizers</td>
<td>105</td>
</tr>
<tr>
<td>22.</td>
<td>Multivariate Analysis of Variance of Weighted Maternal Positive and Negative Life Change Events Scores</td>
<td>106</td>
</tr>
<tr>
<td>23.</td>
<td>Means, Standard Deviations and t-Ratios Comparing the Number of Positive Life Change Events Reported by Mothers of Stealers, Aggressors, and Internalizers to a Nonclinical Normative Sample</td>
<td>107</td>
</tr>
<tr>
<td>24.</td>
<td>Means, Standard Deviations and t-Ratios Comparing the Number of Negative Life Change Events Reported by Mothers of Stealers, Aggressors, and Internalizers to a Nonclinical Normative Sample</td>
<td>108</td>
</tr>
<tr>
<td>25.</td>
<td>Multivariate Analysis of Variance of Paternal Positive and Negative Life Change Events Scores</td>
<td>109</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

In order to function acceptably and effectively within a particular society, children must learn to govern their behavior according to a complex array of explicit and implicit rules. Unfortunately, many children either do not learn or refuse to obey some of the formal and informal rules for social conduct. In contemporary America, if behavioral problems severely impair their capacity to function effectively in society, children are typically diagnosed as conduct disordered. The Diagnostic and Statistical Manual of Mental Disorders (1980) offers the following definition of conduct disorders:

The essential feature is a repetitive and persistent pattern of conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated. The conduct is more serious than the ordinary mischief and pranks of children and adolescents. Four specific subtypes are included: Undersocialized, Aggressive; Undersocialized, Nonaggressive; Socialized, Aggressive; and Socialized, Nonaggressive. These subtypes are based on the presence or absence of adequate social bonds and the presence or absence of a pattern of aggressive antisocial behavior. (p. 45)

Typically, these children are referred to as deviant, acting-out, behaviorally disordered, and/or aggressive. They exhibit such behaviors as physical violence against persons, threatening others, theft outside their home, 1
vandalism, truancy, substance abuse, running away from home overnight, temper outbursts, provocative recklessness, academic underachievement, irritability, low frustration tolerance, pathological lying, impulsiveness, and noncompliance. This behavioral pattern usually begins in childhood and becomes a gradually worsening condition which typically remains chronic until the individual reaches middle age.

These children fail to establish a normal degree of affection, empathy, or bond with others. They are likely to manipulate others for favors without any effort to reciprocate, blame others for their difficulties, and to feel unfairly treated by others. They are likely to develop an extremely negative attitude toward their family members, peers, authority figures, and people in general.

As adults, conduct disordered youngsters contribute significantly to some of our major social problems such as alcoholism, unemployment, incarceration, disability, psychosis, and welfare. Their misbehavior often causes emotional or physical suffering for their victims, legal difficulties for themselves and their families, and financial hardships for their families, victims, and society at large. They frequently require substantial intervention from the legal, educational, and mental health systems.

Adolescents with conduct disorder diagnoses pose
perplexing difficulties for social scientists who are attempting to understand their behavior and for clinicians who endeavor to provide treatment for them. These children represent anywhere from 1/3 to 1/2 of all children referred for mental health services (Patterson, Reid, Jones, & Conger, 1975; Roach, Gursslin, & Hunt, 1958; Rutter & Graham, 1970). Not only is their behavior abrasive, coercive, and generally unpleasant, it is also extremely resistant to change (Meltzoff & Kornreich, 1970; Patterson, 1974; Robins, 1966), and frequently leads to major psychological and behavioral maladjustment during adulthood (O'Neil & Robins, 1958; Prichard & Graham, 1966).

During the 1920's Robins (1966) began a landmark longitudinal study. She selected 500 children who were referred to a St. Louis child guidance center for antisocial behavioral problems. She assessed all of the subjects again when they reached age 40, and found that 1/4 of them had developed antisocial personalities as adults; 1/12 were alcoholic or drug addicted; and 1/9 were psychotic. Only 16% recovered by age 18 and had no further psychiatric problems by age 40.

Background

Historically, many views and theories have been articulated in an effort to explain the etiology and
nature of childhood antisocial behavior. Prichard (1837) used the term "moral insanity" to describe people who habitually engaged in antisocial behavior.

In 1909 The Juvenile Psychopathic Institute in Chicago was developed in response to the problems caused by juvenile delinquent behavior. Dr. W. Healy (1915), the institute's first director, stressed the importance of socioeconomic factors in the development and maintenance of delinquent behavior.

The psychoanalytic movement attempted to explain childhood antisocial behavior with such constructs as incomplete or pathological superego development, oedipal rivalry, and impairment of the parental identification process (Aichhorn, 1935; Freud, 1949). Bender (1947) reported that antisocial children were free from anxiety because they received so little emotional satisfaction during infancy. Therefore, they do not experience sufficient cognitive and emotional distress to keep them from behaving antisocially.

John Bowlby (1951) emphasized the importance of early and extended parental separations on the development of childhood antisocial behavior. Bowlby believed that such separations impaired the individual's ability to establish affectional bonds with others.

The first purely behavioral descriptions of antisocial behavior were made by Henderson (1939).
Karpman (1941) classified cases of psychopathology into two groups: symptomatic and idiopathic. Symptomatic conditions represented cases with clear psychogenic etiological antecedents. In these cases psychopathological behaviors were viewed as attempts to deny or distort the emotional pain of traumatic life events. No psychogenic factors were found in idiopathic cases which were thought to result from personality traits such as selfishness, egotism, hedonism, and self-centeredness.

Glueck and Glueck (1950) proposed that delinquency was caused by a combination of biological and psychosocial factors. They emphasized the high degree of relationship between the incidence of male delinquency and mesomorphic body style.

Some researchers have proposed that genetic factors are responsible for causing predispositions to behave antisocially (Quay, 1979; Thomas, Chess, & Birch, 1968), while others believed that cognitive deficiencies are responsible (Camp, 1977; Graham, 1979).

Several researchers have provided evidence of a link between parental rejection and the development of conduct disorders in children (Bender, 1947; Hewitt & Jenkins, 1946; Lewis, 1954; McCord & McCord, 1964; Schactel & Levi, 1945; Wolberg, 1943). Social learning theories emphasize the importance of parental disciplinary
practices and observational learning in the development of antisocial behavior (Dumas & Wahler, 1985; Patterson, 1976; Rutter, 1975).

A social-environmental perspective suggests that child physical and mental health is related to both the social environment of the child, particularly within the family, and the parents' mental health and level of adaptive functioning (Billings & Moos, 1982; Moos & Moos, 1981). Additional factors such as family stressors and family social resources are also thought to be related to child mental health. Examples of family stressors are divorce, marital separation, family death, legal or financial problems, prolonged illness, work-related stress and/or marital conflict. Examples of family resources are the quality and quantity of intra-familial and extra-familial supportive interactions and relationships.

Reid and Hendricks (1973) and Patterson (1982) hypothesized that at least two major types of male conduct disorders exist: Stealers and Aggressors. Both types of boys engage in similar noncompliant and coercive behavior. However, the major factor which differentiates the two groups is that Stealers steal outside of their homes and Aggressors do not. These authors hypothesized that these two types of children are raised in families which possess different types of family problems, which probably require
different types of treatment.

Few clinicians any longer rely exclusively on providing individual treatment for symptomatic children. Increasingly, it has become more apparent that effective assessment and treatment of certain childhood disorders requires observation and intervention within the natural family environment (Billings & Moos, 1983; Griest & Wells, 1983; Johnson & Szurek, 1952; O'Leary & O'Leary, 1976; Patterson, 1971).

Initial efforts to treat child behavioral disorders with behavioral techniques at the family level, focused exclusively on attempting to remediate parenting skills deficits. Recently however, several researchers have reported that the families of conduct disordered children manifest several problems, in addition to having an antisocial child, which require careful assessment and treatment (Billings & Moos, 1983; Dumas & Wahler, 1985; Griest, Forehand, Wells, & McMahon, 1980; Lewis, Beavers, Gossett, & Phillips, 1976). Examples of such family problems include dysfunctional family relationship and structural styles, lack of family social resources, family life change events, parental mental and physical health, and maternal social insularity.

Assessment of families is a relatively new and imprecise endeavor. A variety of disparate theories of family functioning have been developed; sometimes by
charismatic leaders who have developed loyal followings among mental health practitioners. For the most part, these theories are comprised of constructs and dynamic relationship formulations which have little or no empirical bases.

Currently, in many treatment settings, formal family assessments are not done at all. In some settings where family assessments are routinely done, clinicians base their formulations solely on their own subjective insights. These formulations are often created without the aid of any empirical assessment (Forman & Hagan, 1983). Further, most of the currently available assessment devices consider only individual or dyadic dimensions, rather than the overall family milieu (Billings & Moos, 1982). Cromwell, Olson, and Fournier (1976) report:

While counselors may assume it important to diagnose and evaluate marital and family counseling, such procedures infrequently receive serious discussion or debate and are even less likely to be undertaken in a systematic manner, either by the practitioner or the researcher. To date, it appears that counseling continues to be practiced and evaluated as if it were an art rather than a science. It is our view that counseling is science demanding more systematic and rigorous evaluation.

For purposes of discussion, diagnosis refers to the ability to describe and classify individual (intra-personal) and relationship (inter-personal) dynamics that can be effectively integrated into treatment. Diagnosis is primarily helpful if it enables the therapist(s) to develop and evaluate a treatment plan for a couple or family. (p. 517)
Perhaps one problem related to the relative lack of ability to effectively treat conduct disordered children, is that we lack widely accepted and empirically based constructs and theories about the functioning of their families. Also, we lack assessment strategies which are economical, reliable, valid, and helpful in designing more effective interventions for families.

Statement of the Problem

According to Patterson's research, which relied on both laboratory and in-home observations, it appears that differences between the families of Stealers and Aggressors do exist (Patterson, 1982). Further, it is believed that Stealers' and Aggressors' families require different, and as yet undefined, types of treatment. By using family and individual assessment strategies which are different than Patterson's, questionnaires completed by family members versus family behavioral observations, the present research will attempt to learn more about the differences between the families of Aggressor and Stealer conduct disordered adolescent males.

Significance of the Study

Learning more about the families of Stealers and Aggressors will contribute to our theoretical as well as practical knowledge. If family social environmental
and parental functioning differences between these two types of families can be identified, more information will be made available about possible causes of different types of conduct disorders. This knowledge could aid in the refinement of theory. It may also stimulate additional research regarding the etiology and treatment of conduct disorders and the improvement of family assessment strategies. Clinically, information from this study may help to improve approaches to treatment of these disorders. If factors can be isolated which differentiate the two experimental groups, it would be logical to develop experimental treatment strategies which consider these factors.

Limitations

In this ex post facto study subjects were selected by the researcher, making it impossible to insure equality among the groups. Because participation in the study was voluntary, another potential source of bias was created by the fact that data were available only from "participative" subjects, and not available from the "nonparticipative" subjects. Further, the amount of treatment having been received by the subjects varied considerably, and it is not possible to determine the impact treatment had on the subjects' questionnaire responses.
Research findings may not be generalizable to other groups, and may only pertain to the research subjects. In this study it was impossible to experimentally manipulate variables, making causal inferences uncertain. Under these conditions it was possible that an extraneous third variable could have accounted for the obtained differences.

Summary

It is important to recognize that the major theoretical viewpoints developed to explain childhood conduct disorders possess varying degrees of merit. However, this research emphasized a family level of social environmental analysis, and focused particularly on family and parental variables which are believed to be influential on the development and maintenance of childhood conduct disorders. Empirical strategies for assessing families are not yet highly refined. However, as a result of some pioneering family assessment research, we now believe that certain styles and degrees of family dysfunction are associated with the development and maintenance of certain types of childhood symptoms.

Typically, families of conduct disordered boys manifest several problems in addition to having an antisocial child. Several social-environmental factors such as certain types of family organization and family
behavior, parental physical and mental health, family social resources, and stressful life events are considered influential in the development and maintenance of childhood conduct disorders. However, little is understood about the relative influence of these variables. Further, among boys, at least two major types of conduct disorders exist: Stealers and Aggressors. Preliminary research suggests that the families of Stealers and Aggressors differ in systematic ways, which may require differential assessment and treatment considerations.
CHAPTER II

REVIEW OF RELATED LITERATURE

The purpose of this chapter is to review literature and research regarding the etiology of childhood conduct disorders. A selected review of literature includes a historical overview of the major etiological hypotheses regarding childhood conduct disorders, and a discussion about the characteristics of both healthy and dysfunctional families. Presented next is a summary of current research regarding parental and family-level clinical assessment variables which are considered important to the analysis and understanding of the families of conduct disordered children. Finally, a brief discussion regarding the clinical assessment of children is presented. The information presented in this chapter has been selected on the basis of its relevance to the research topic.

Historical Overview

Early psychoanalytic formulations attempting to explain childhood antisocial behavior focused primarily on oedipal issues (Aichhorn, 1935). It was believed that due to repressed feelings of antagonism and rivalry toward his father, a boy achieved unconscious revenge against his
father through delinquent acts.

Other early psychoanalytic explanations emphasized that if during infancy an individual was treated too strictly or suffered emotional deprivation from parents, he would be unable to develop adaptive social and emotional skills. Aichhorn believed that if a child was unable to establish strong emotional ties with his parents, he would possess little incentive to adopt prosocial attitudes and behaviors. Strong and positive identification with parents was considered the most crucial variable in the development of a superego, which is capable of controlling instincts and guiding prosocial behavior. Children who did not develop positive parental identifications were thought to be at risk for development of a regressive response style, wherein the pleasure principle became a dominant motivation and aggression became a predominant behavior.

Anna Freud (1949) believed that infants are at risk for exhibiting antisocial behavior if during their first year of life they experience severe maternal neglect, ambivalence, or absence. In such cases a lack of necessary emotional gratification was thought to interfere with the transformation of a narcissistic libido into an object libido. In other words if a baby's physiological needs are consistently satisfied, the libidinal interests of the child are gradually and naturally transferred from...
focus on bodily needs attainment to focus on achieving satisfactions through interpersonal relations. Freud believed that children are predisposed to a life-long tendency to avoid emotional attachments with people if their early bodily and emotional needs are not consistently met.

Further, Anna Freud believed that emotional impairment due to early deprivation leads to a weakening of ego and superego functions. When these functions are weakened, the ability to control impulsive strivings becomes impaired, increasing the likelihood of antisocial behavior. During normal child development, aggressive impulses are initially and primarily managed within the context of the maternal relationship. Approximately at ages 3 through 5, the child's aggressive impulses begin to be managed by both parents, within the context of the resolution of the oedipal conflict. In pathological situations wherein necessary adult emotional provisions are absent, aggressive impulses become isolated and therefore receive inadequate social feedback and control. Consequently, these aggressive impulses are expressed in outbreaks of aggression and other forms of antisocial behavior.

Parental rejection of children is thought by many researchers to be associated with the development of child antisocial behavior. Wolberg (1943) stated:
Parental rejection has a determining effect on the character structure of the developing child. By interfering with fundamental needs and strivings it generates tension, rage, and anxiety that flood the immature ego and jeopardize normal security feelings. (p. 87)

Wolberg believed that rejected children develop feelings of helplessness and convictions that their social environment is essentially hostile, because their needs for love and stimulation are deprived. Rejection undermines self-esteem and causes constant frustration. Wolberg thought that children who are secure in parental love desire to control their impulse strivings in order to please their parents. Without an adequate parental love bond, rejected children were considered handicapped by their relative incapacity to learn how to control their impulses.

Bender (1947) reported that rejecting parents have no love to offer their children. If emotional deprivation due to parental rejection occurs during infancy, children would not likely identify with their parents. Failure to develop parental identifications was thought to impair the individual's ability to develop and to maintain mutually satisfying human relationships. Because these children derive only minimal satisfaction from human relationships, they don't experience anxiety and guilt when they misbehave. Consequently, with a lack of internal pressure to conform,
they are likely to manage frustrations and conflicts by behaving antisocially. In other words, without adequate parental love and consequent parental identification, children were thought incapable of developing a conscience which is capable of guiding prosocial behavior.

Schactel and Levi (1945) believed that parental rejection negatively influenced children's attitudes toward all human relationships. Because these children believe they aren't loved nor capable of being loved they don't value love, when and if it is offered to them. Therefore, they view human relationships exploitively, attempting to maximize manipulation and gain without having to reciprocate or having to fear loss of love.

In attempting to find relationships between parental attitudes and dimensions of delinquency, Hewitt and Jenkins (1946) and Lewis (1954) derived similar findings. They found that parental rejection was most closely associated with the development of unsocialized or psychopathic children. Parental overcontrol was most strongly associated with neurotically disturbed children, and parental neglect was associated with the development of delinquency.

Mothers of inhibited children were rarely openly hostile toward their children (Jenkins, 1966). None of the inhibited children reported feeling rejected by their mother. Whereas, children in the aggressive groups
frequently reported feeling maternally rejected. Compared to children in the inhibited groups, the aggressive children were more likely to have experienced neglect or hostility, absence of natural father from the family, and more time without parental supervision.

McCord and McCord (1964) claimed that as children the vast majority of psychopaths were rejected, severely beaten, and emotionally deprived by their parents. They believed that aggression toward others is the dominant reaction to the frustration and resentment created by such harsh treatment. However, they believed that the most crucial variable responsible for increased aggression was a lack of inhibition rather than an increase in aggressive drive.

Rutter (1971) believed that separation of a child from his family has some bearing on the subsequent development of childhood antisocial behavior. He believed that the familial discord which precedes and accompanies separation is more potent than the emotional trauma due to loss in predisposing a child toward manifesting antisocial behavior. Rutter based this hypothesis on his finding that delinquency rates were nearly twice as high for boys whose parents were separated or divorced, compared to boys who lost a parent via death.

Bowlby (1951) found that a significant number of delinquent children whom he classified as affectionless
character types, experienced prolonged separations from their primary caretakers during their first six years of life. He speculated that this type of early separation was associated with the development of delinquent behavior. He believed that factors associated with separation such as deprivation of maternal care, separation anxiety, multiple parenting and multiple placements engendered a generalized lack of trust in others which led to an inability to form affectional bonds. Bowlby believed that parental separation simultaneously caused desires for affection from parents as well as for revenge against parents. The conflict resulting from this ambivalence was thought to cause unhappiness and antisocial attitudes and behavior.

Some researchers have proposed that biological factors are primarily influential in the development of childhood conduct disorders. Thomas, Chess, and Birch (1968) proposed that newborns possess innate tendencies, termed temperaments, which predispose a child to behave in certain generalized ways. Temperaments are thought to be determined by genetic and prenatal conditions. Children whose temperaments can be characterized by a high activity level, high response intensity, and irritability may be classified as an aggressive child. Because aggressive stimuli often elicit aggressive responses, some parents are likely to respond aggressively.
toward a child with a difficult temperament, thus establishing an aggressive parent-child interactional pattern. Preventive implications from this research suggest that early detection of difficult children could be combined with parent education programs which teach positive and nonaggressive child rearing strategies.

Quay (1965b) formulated a stimulation-seeking model to explain childhood behavior disorders. Quay thought that some children are born with a neural predisposition toward either low stimulus reactivity or quick adaptation to sensory stimulation. Consequently, these children are likely to experience sensory deprivation in conditions most children would find arousing. In order to achieve emotional satisfaction they require more variable and intense stimulation. Because sensory deprivation is an aversive state, these children actively seek strong environmental stimuli. This condition was thought to predispose them toward antisocial behavior. Rapid sensory adaptation was thought to make children less responsive to social and physical reinforcers. Therefore, many parents implement progressively stronger punishments in an effort to shape child behavior, and thus intensify the level of intra-familial aggression.

Lowered autonomic system activity is implicated in the research of Whitehill, DeMyer-Gapin, & Scott (1976). By comparing the viewing times of aggressive, neurotic,
and normal boys as they watched a boring set of slides, they found that the aggressive boys became bored and decreased their viewing time far more rapidly than the other groups.

In a related study, DeMyer-Gapin and Scott (1977) found that aggressive boys exhibited restless behaviors while they watched a boring set of slides. However, none of the boys in the other two groups exhibited restlessness.

Boys with aggressive behavioral disorders do not differ from normals in general, verbal, nor nonverbal intelligence (Quay, 1979). However, some evidence suggests that cognitive differences between these two groups do exist. Graham (1979) discovered that conduct disordered children demonstrated higher levels of reading retardation when compared to the general population. Some researchers argue that frustration experienced through school failure leads to aggression, while others believe that a third underlying factor may influence both.

Camp (1977) believed this third factor could be a covert verbal mediation deficit. Aggressive boys were able to control their behavior as well as normals when they were instructed to give themselves behavioral instructions out loud. However, they were not able to control their behavior as well as normals when they were instructed to give themselves subvocal behavioral
instructions.

Bell (1971) reported that during infancy youngsters are relatively helpless and are therefore extremely dependent on caretakers to provide for their survival needs. Infants are endowed with innate responses such as crying, which communicate states of deprivation to their caretakers. These responses can be considered to be essentially coercive and aversive in nature because they demand an adult care-giving response and are unpleasant to experience. Bell thought that infants shape maternal care-giving behavior by expressing such coercive behaviors as crying, screaming, and temper tantrums. By the age of two, most children have made tremendous strides in substituting an impressive range of verbal and motor skills for the more primitive coercive responses which they formerly employed in meeting their needs. With increasing age certain child coercive behaviors are no longer acceptable to parents, and therefore become targets for consistent monitoring.

Adults who assume responsibility for the socialization of children typically attempt to teach compliance to rules, control of impulses, and delay of immediate gratification. These adults employ such teaching techniques as verbal explanation, example, and the use of rewards and punishents.

Cairns (1979) found that approximately half of the
interchanges between one and two year olds could be considered aggressive. However, even at this young age only 5% of child behavior in relation to adults was classified as aggressive. This demonstrates that extremely young children have already begun to learn to control their aggressive impulses. By the time the children were 2 1/2 years old, only 20% of their interactions with peers were considered aggressive.

This developmental diminishment of aggressive behavior does not occur for some children. For these children continuing high rates of aggression set them apart from the norm, and they are labeled as deviant. These findings support the hypothesis that antisocial children represent a form of arrested socialization.

Social learning theory, emphasizing the roles of reinforcement and modeling, is particularly helpful in explaining the development of childhood antisocial behavior (Patterson, 1982). Through observational learning, fear of behaving antisocially is reduced for some children because they observe others engaging in instrumental and nonpunished antisocial behavior. Further, some parents actually shape antisocial behavior in their children through inappropriate application of positive and negative reinforcements.

Social learning theory postulates that learning antisocial behavior occurs primarily within a social
context. For example, antisocial children tend to be reared in families that exhibit high rates of antisocial behavior such as parental physical assault, verbal abuse, and thwarting of goal-directed behavior. This aversive parental behavior was thought to stimulate aggressive behavior in children. In other words, excessive aversive treatment of children can be counterproductive; it acts to increase rather than decrease child aggression.

Shaw (1971) and Sallows (1972) found that parents of aggressive boys allow their boys to disobey. Compared to parents of asymptomatic children, parents of antisocial children engage in more behaviors which are considered conducive to the development of child misbehavior. For example, they are less likely to attempt to condition prosocial skills through the use of verbal instruction or modeling. They are more likely to provide rich schedules of positive reinforcement or inconsistent or weak punishers in response to child coercive behavior. They are more likely to allow sibling conflicts to escalate to the point at which the target child begins to use coercive behaviors.

Patterson (1973) developed the Coercion Hypothesis to explain interaction patterns in aggressive families. In aggressive families, people use aversive behaviors in attempting to control one another. They administer psychological, emotional, or physical pain-inducing
behaviors in an effort to get what they want from others (e.g., to win disputes).

Patterson also reported that children learn from their parents through modeling and reinforcement contingencies that their aggressive behaviors can be instrumental. Many parents unknowingly shape antisocial behavior in their children by employing both positive and negative reinforcement contingencies in response to child misbehavior. For example, they are more likely to positively reinforce child aversiveness by complying with child demands. Also, they are more likely to negatively reinforce aversiveness by terminating a command if the child refuses to comply with it. Either parents or children can initiate coercive interchanges, which tend to escalate in intensity and to increase the level of family disruption. When family members either increase their use of coerciveness toward one another, or when families experience increased stress, several family management mechanisms are likely to become disrupted. Patterson defined family management skills as clearly-stated rules, monitoring behavior, providing contingent consequences for misbehavior, and attempting to solve problems in constructive ways. When family management skills are not effectively practiced, the level of aggression for all family members tends to increase.

In coercive families, Patterson believed that
attempts to negotiate become sidetracked because participants respond to aversive stimuli rather than to the problems at hand. Attempts to be supportive are accompanied by qualifications or criticisms.

Patterson (1982) contended that no matter when child antisocial behavior begins, it is produced by a disruption in parental monitoring and punishment for antisocial acts. These disruptions are caused by such traumatic events as unemployment, serious psychological or physical illness, or marital conflict. Once a severe antisocial child behavioral pattern evolves, it will likely persist into adulthood, unless the parents subsequently regain control of the child's behavior. Disruption of family management practices is associated with reductions in intrafamilial interaction and shared leisure time, and with an increase in negative perceptions of family members toward each other.

Many studies have attempted to determine if a relationship exists between parental discipline styles and child behavioral disorders. Inconsistency in administering punishments and rewards is associated with aggressive and delinquent behavior in boys (Rutter, 1975; West, 1969). A parent who is inconsistent will respond unsystematically to child misbehavior. For example, in response to stealing small sums of money from family members, a child might be placed in isolation one time,
scolded the next, or completely ignored the next time. Inconsistency can also be manifested between parents, when, in response to misbehaviors, one parent punishes while the other either ignores or responds with warmth.

The Indiscriminant Caretaking Hypothesis (Dumas & Wahler, 1985) posits that a child's antisocial behavior can be an indirect function of parental inconsistency. Offering approval and disapproval on an indiscriminant basis places the child in a noncontingent environment which is therefore aversive. Any response instrumental in reducing unpredictability is negatively reinforced. Behaving antisocially is instrumental under these conditions, since it tends to result in more predictable, albeit negative parental responses.

Two studies which support the Indiscriminant Caretaking Hypothesis are Patterson (1976) and Snyder (1977). Patterson conducted in-home observations of clinic-referred antisocial children and matched normal children. The clinic families displayed higher rates of aversive exchanges, and the clinic children received higher rates of aversive maternal attention, even when they behaved appropriately. Snyder (1977) found that indiscriminant use of attention to child behavior by mothers was much more evident in clinic-referred families than in control families. The probability of receiving a positive, neutral, or negative maternal response was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
almost independent of the child's behavior.

West (1969) believed that boys' conduct is more closely associated with maternal attitudes and behaviors than with paternal characteristics. West claimed that the following parental behaviors are associated with boys' misconduct at all socioeconomic levels: Erratic maternal discipline, inconsistent disciplinary practices between parents, and parental carelessness and undervigilence.

Similar findings in two comprehensive longitudinal studies revealed that two parental discipline styles, Love-Oriented and Punitive, militated against convictions and incarcerations for children reared under these conditions (McCord & McCord, 1959; Robins, 1966). Three discipline styles, Excessive Leniency, Inconsistent Discipline, and Disinterested were associated with convictions. Both of these studies also derived similar findings regarding paternal influences on conduct disordered behavior. Children whose fathers were diagnosed Antisocial Personality were diagnosed Sociopathic as adults 14% of the time when their fathers were strict disciplinarians, and 35% of the time when their fathers were too lenient. "If discipline was erratic, the role model strongly affected criminality. If discipline was consistent, however, the paternal role model did not seem to influence criminal behavior" (McCord & McCord, 1959, p. 112)
Block, Block, and Morrison (1981) reported that parental inconsistency was both an aspect of marital discord and a precursor of behavioral problems for children. Higher levels of parental disagreement regarding child rearing were associated with an increased likelihood of separation and divorce. They were also associated with future undercontrol problems in boys.

Block et al. (1981) believed that the frequency of discipline was more influential than the methods and severity of discipline in the development of child antisocial behavior. Boys who are punished frequently are likely to respond to punishment with aggression and antisocial behavior. Further, rates of punishment were found to be associated with child perceptions of parental hostility and rejection.

Too much parental permissiveness has been implicated as an etiological factor in the development of coercive child behavior. Baumrind (1966) compared three groups of middle class, nonclinic nursery school children. Baumrind found that assertive and self-reliant children had parents who were firm, controlling and loving. Parents of withdrawn children were controlling but detached, while parents of children lacking self-control were permissive.

Patterson (1982) reported that permissive parents typically provide for their children's basic needs for food, clothing, and shelter. However, these parents allow
their children to assume primary responsibility for making decisions about achievement, conduct, and how to spend leisure time. Patterson believed that the likelihood of engaging in antisocial behavior increased as children were given more responsibility for controlling their own social environment.

Goldstein (1984) reported that in families where high levels of child supervision were provided, there were no significant differences in the number of police contacts for children of father-present versus father-absent situations. Goldstein also thought it was possible that children with severe conduct disorders do not allow parents to supervise their behavior. He thought many parents were simply unable rather than unwilling to provide effective supervision.

Olweus (1980) obtained peer nominations for aggressiveness from 6th and 9th grade students. He evaluated the child rearing practices used by the parents of the subjects, by using a structured interview. By correlating the child rearing practices with child behavior, Oleweus found that three factors contributed to the criteria measures for child aggressiveness: Maternal permissiveness toward child aggressive behavior, maternal negativism, and the child's temperament. Therefore, he concluded that childhood aggressivity is typically associated with an overly-permissive and irritable mother,
who has a child with a difficult temperament.

Rutter (1975) proposed that family behavioral rules are more influential in determining children's behavior when parent-child relationships are based on mutual love and respect. Further, he believed that children respond more cooperatively when they view family rules as reasonable and necessary. Such understanding requires frequent problem solving discussions between parents and children. Optimally, in order for children to develop their own internal behavioral controls, they should have free access to parents for discussions about confusing issues and for participation in family decision making.

Rutter also believed that rewards and punishments are much more effective in shaping prosocial child behavior when given immediately, and that a few family rules which are firmly and consistently applied are more effective than many rules which are enforced haphazardly.

Several researchers have reported that marital dissatisfaction is positively related to the development of childhood conduct disorders. Framo (1975) may have made the boldest claim regarding this hypothesis by stating, "Whenever you have a disturbed child, you have a disturbed marriage" (p. 22). Oltmanns, Broderick, and O'Leary (1977) found that the parents of clinic-referred children reported significantly lower marital satisfaction than did the parents of nonclinic children.
Christensen, Phillips, Glasgow, and Johnson (1983), comparing nonclinic families with families with behaviorally disordered children, assessed marital discord, parental psychopathology, parental knowledge of behavioral principles, tolerance for child deviance, and expectations regarding their children's behavior. They found through correlation analyses that marital discord was the only variable which was highly associated with child behavioral problems.

Emery (1982) postulated that there are several mechanisms through which marital discord affects childhood behavioral problems. Marital discord can cause disruptions of attachment bonds, model coercive behavior, modify disciplinary practices, increase stress, and/or induce the child to misbehave in order to distract parents from their marital discord.

The Influence of Family Characteristics on Individual Behavior

Parsons and Bales (1955) defined the primary task of families to be the socialization of children and the stabilization of adult personalities. Many family researchers believe that certain patterns of family structure and interaction are more conducive than others in facilitating positive mental health for its members.

During the past three decades, a growing body of
family systems research has linked the development and maintenance of individual psychopathological symptoms to dysfunctional patterns of relationship between family members (Bowen, 1978; Haley, 1976; Lewis; Beavers, Gossett, & Phillips, 1976; Minuchin, 1974). Families tend to maintain and reinforce individual psychopathological symptoms through using habitual and dysfunctional interactional and organizational patterns. An individual's symptoms may serve functional purposes in maintaining family stability, by distorting or deflecting underlying forms of family conflict and tension.

Systems theorists posit that in order to alleviate individual symptoms, concomitant therapeutic changes must also occur within the symptomatic individual's family. It is believed that if left untreated, family dysfunction will likely either lead to a recurrence of the identified patient's symptoms, or to the development of symptoms in other family members. Gurman and Kniskern (1978) state, "We would agree that a higher level of positive change has occurred when improvement is evidenced in systemic (total family) or relationship (dyadic) interactions than when it is evidenced in individuals alone" (p. 885).

With a systems perspective, it becomes clear that clinicians need to be more pluralistic in their diagnostic formulations, and in planning intervention strategies. Clinicians should have the capacity to move from
individual, to marital, to family levels of conceptualization and therapeutic intervention (Lewis et al., 1976).

Most conceptual models designed to assess family functioning, have arisen from a family systems orientation. Family systems theories postulate that normal families operate as an interactional system, according to rules and principles that apply to all systems (Bertalanffy, 1968).

Walsh (1982) outlined the major propositions of family systems theory:

(1) **Circular Causality.** A family system can be defined as a group of individuals interrelated so that a change in any one member affects other individuals and the group as a whole; this, in turn, affects the first individual in a circular chain of influence. Every action in this sequence is also a reaction. Causality is thus seen as circular rather than linear.

(2) **Nonsummativity.** The family as a whole is greater than the sum of its parts, and it cannot be described simply by summing up characteristics of individual members. The family organization and interactional patterns involve an interlocking of the behavior of its members.

(3) **Equifinality.** According to this principle, the same origin may lead to different outcomes, and the same outcome may result from different origins. Watzlawick, Beavin, and Jackson (1967) refer to the error, or genetic fallacy, in confusing origin with significance in determining outcome. Rather, they assert, the influence of initial conditions or events will be outweighed by the impact of the family organization—its ongoing interactional patterns and responses to stress. Thus, one family may be disabled while another family rallies in response to the same crisis; or two well-functioning families may have evolved from quite different
circumstances.

(4) Communication. All behavior is regarded as communication, transmitting interpersonal messages. Every communication has two functions: a "content" (report) aspect, conveying factual information, opinions, or feelings; and a "relationship" (command) aspect, which, in conveying how the information is to be taken, defines the nature of the relationship (Ruesch & Bateson, 1951).

(5) Family Rules. Relationship rules, both explicit and implicit, organize family interaction and function to maintain a stable system by prescribing and limiting members' behavior. They provide expectations about roles, actions, and consequences that guide family life. Through the operation of a "redundancy principle", a family tends to interact in repetitious sequences, and predictable rules.

(6) Homeostasis. In order to maintain a steady stable state in the ongoing interaction system, norms are delimited and enforced by homeostatic mechanisms. All family members contribute to the homeostatic balance through a mutually reinforcing feedback loop, such as in complementary or reciprocal behavior. Too great a deviation from the family norm may be counteracted in the negative feedback process in order to regulate tension and to restore the family equilibrium or homeostasis. (pp. 9-10)

In assessing dysfunctional families, it is helpful for the sake of comparison to know something about how healthy families function. Lewis et al., (1976) assessed families through the use of observations, interviews, and clinical ratings of videotaped therapy sessions. Their research data indicated that various levels of family competence reflected differences in degrees on several dimensions of family functioning. Members of competent families tended to possess affiliative rather than
oppositional expectations toward one another. Expectations influence the ways in which people behave toward one another. When people expect to receive warmth, support, and respect from human encounters, they tend to strive for interpersonal closeness and toward friendly relationships. Oppositional attitudes foster a generally negative approach to human encounters, marked by distance, anger, and fear. Members of competent families respected their own and other's opinions and perceptions. They were able to listen and support one another, even under conditions of disagreement. They refrained from speaking for one another, and from verbally attacking one another. Members of competent families manifested open and honest expression of thought and feeling in negotiating. Even though members were free to speak their minds, their conversations did not become chaotic. A strong parental coalition was evident in matters related to child discipline and setting family rules. The degree of marital support and satisfaction was related to measures of family competence. Competent families did not rely on rigid and direct control techniques in solving disagreements nor in shaping child behavior. Rather, they were flexible; able to redefine problems and to attempt new strategies, if initial problem-resolution attempts had failed. Family members were able to relate with one another in spontaneous and
new ways. They weren't limited to a narrow band of predictable response styles. Finally, members of competent families actively sought to broaden their interests and involvements with ideas, people, and organizations which were external to the family. In pathological families, the outside world was viewed as dangerous or unfriendly, and was thus avoided.

Mishler and Waxler (1968) compared three groups of families: Families with a schizophrenic child who had a good premorbid adjustment, families with a schizophrenic child with a poor premorbid adjustment, and control families with no schizophrenic children. They found that the control families possessed several characteristics which distinguished them from the two groups with schizophrenic children. Control families were more positive and expressive of affect; they possessed flexible roles; power was clear, but not rigid and authoritarian; communication was less disruptive; and they did not single out one member toward whom they expressed feelings.

Westley and Epstein (1969), through psychological tests and extensive psychiatric interviews of family members, investigated the relationship between college students' emotional health and the organization of their families. Their findings indicated that the family characteristics are more powerful than intrapsychic factors in determining the behavior of individual family
members. They proposed that a reciprocal relationship exists between family functioning and the behavior of individual family members. They concluded that the way in which a family organizes itself is both a consequence and a cause of mental health or illness of family members.

Westley and Epstein proposed that families which produced emotionally healthy offspring manifested several characteristics in common. They welcomed new experiences as means for enriching life. Family relationships were based upon warm emotional bonds and mutual respect. Individual and shared responsibilities were clearly established. Individual development of autonomy was encouraged. Family problems were readily recognized, and problem solutions were actively sought. Husbands and wives willingly accepted their parental and conjugal roles. Finally, the family power hierarchy was clearly established.

Through review of typescripts and audiotapes of family interactions, Riskin & Faunce (1970) analyzed the form rather than the content of family communication. In families which they rated as normal, family members tended to continue focusing on a particular topic until related issues were resolved, prior to discussing new topics. Further, normal families scored high on measures of spontaneity, and low on intrusiveness. They readily requested and exchanged information. They were able to
disagree without causing strife, and to express a wide range of feelings with an emphasis on supportive affects. Differences were tolerated and humor was common.

Johnson & Szurek (1952) produced the first paper which postulated that certain familial dynamic patterns are responsible for causing defects in superego development, which in turn cause antisocial behavior. This family interaction perspective was the forerunner of contemporary family systems theory. The authors proposed that behaviorally symptomatic children act out the socially unacceptable and unconscious impulses of one or both parents. Parents obtain vicarious gratification for their own poorly integrated impulses through their child's misbehavior. Parents displace self-punishment unto their misbehaving child through the expression of hostility. The end result is that the child may obtain some impulse gratification, while the family system is maintained through scapegoating of the sick child.

Johnson and Szurek believed that parents who are ambivalent about certain impulse expressions and corresponding societal restrictions transmit their ambivalence to their children by consciously or unconsciously reinforcing child misbehavior through inconsistent punishment and/or overpermissiveness. For example, parental accusations, detailed questioning, provocative suggestions, dire warnings and ignoring child
misbehavior can communicate subtle permission for the child to misbehave.

Relatively little research has investigated the relationship between specific types of family systems, and the development of conduct disordered children. Lewis et al. (1976) rated families on 14 different family characteristics. Their data revealed significantly worsening score trends for family groups with asymptomatic, neurotic, conduct disordered, or psychotic children respectively. That is, the severity of scores on their 14 family assessment variables generally showed significant increases between family groups in the following way: Asymptomatic < neurotic < conduct disorder < psychotic.

The data which was generated by the Lewis et al. (1976) family studies supported the idea of the importance of a systems perspective for assessing families. The authors believed that the way a family organizes itself is both a cause and a consequence of mental health or illness of family members. A significant relationship was established between the global measure of family competence and the level of severity of adolescent patient psychopathology. As global measures of family competence increased, the level of adolescent psychopathology decreased. This correlation (r=.52) was surprisingly high, considering that constitutional,
temperamental, and developmental factors were not directly involved in the measure of family competence.

Lewis et al. reported that healthy families tended to produce healthy offspring; midrange families tended to adopt centripetal or centrifugal family styles which were associated respectively with the development of neurotic and conduct disordered child symptoms; and the severely disturbed families were associated with the development of psychotic symptoms in children. Centripetal family configurations were associated with the development of neurotic personality styles within children. These families possessed a stable hierarchy of power, which was helpful in controlling child behavior. Negotiation and compromise were rarely evident in these families. Relations and responsibilities within and outside of the family were managed efficiently and effectively. For instance, their homes were clean and orderly, financial resources were adequate, and employment was steady. Strong feelings were viewed as threatening within centripetal families, and tended to be repressed. Family members possessed constricted, and guilt-laden self images. Control of one's impulses was viewed as virtuous. These families were likely to create scapegoats, internal or external to the family, for expressing bad behavior.

Lewis et al. believed that centrifugal families were associated with the development of conduct disordered
youngsters. In those families, parental dominance was in a constant state of flux, as neither parent was able to gain consistent control from the other. In efforts to maximize their power, parents invited transient coalitions with children against the other parent. These tactics vicariously taught children how to exploit and manipulate others. Intrafamilial interaction was marked by competitiveness and unfriendliness. Severe overt and covert conflict existed because these families lacked negotiation skills. In attempting to negotiate, several people were likely to talk simultaneously, reducing the chance to understand one another's viewpoints and to resolve disputes. Minimal emphasis was placed on mutual support, and development of autonomy. Various family members, rather than just one, were targeted for blame and attack. Explosive behavior was commonplace.

In comparing families with conduct disordered children with normal families, Rogers, Forehand, and Griest (1981) found that parents of conduct disordered children issued more commands, and emitted more negative behavior but approximately the same amount of positive behavior toward their children. Parents of conduct disordered children perceived their children and themselves as less well adjusted, and reported lower marital satisfaction. The authors concluded that the families of conduct disordered children manifested several
problems, in addition to having an antisocial child, which warranted careful assessment and intervention.

Patterson (1982) reported that a large body of empirical literature is consistent with the interactional viewpoint. Family observational studies have shown higher rates of parental negative behavior, higher rates of parental commands, higher rates of child negative behavior, and lower rates of child compliance in families with behavior problem children when compared to matched normal families.

Two research projects have hypothesized that discernable differences in family functioning exist between the families of the two major forms of child conduct disorder: Aggressive and Delinquent. Reid and Hendricks (1973) compared three different types of children which they labeled Aggressors, Stealers, and Normals. Although Aggressors and Stealers were both referred for conduct problems, they were differentiated by the fact that the Stealers engaged in theft while the Aggressors typically did not.

Reid and Hendricks found that the families of Stealers were distant from one another, exhibiting loose intra-familial social ties. Discovery of this trait led to a hypothesis that the low rates of both positive and negative exchange within Stealers' families motivated the child to escape his boring family.
environment to seek experiences in unsupervised extra-
familial settings. Also, the Stealers' families were less
willing to participate in treatment, and experienced the
least desirable treatment outcome measures. The
researchers speculated that parental unwillingness to
participate in treatment may have been due to the fact
that Stealers misbehave more outside the family context
than within it. Therefore, since Stealers direct most of
their coercive behavior toward people outside of the
family, parents don't experience sufficient emotional pain
to induce them to attempt change.

Patterson (1982) extended and refined the analysis of
Stealers' and Aggressors' families. He believed that the
kind and magnitude of child disobedience allowed by
parents during preschool years leads to the development of
one or the other of these two patterns of behavior. For
example, parents of Stealers are likely to reinforce
and/or fail to punish childrens' stealing behavior.
Parents of Aggressors are more likely to reinforce and/or
fail to punish childrens' aggressive and coercive
behaviors.

Patterson (1982) stated, "The family processes that
produced Stealers differed from those that produced
Aggressors. Both processes seemed to differ from what was
observed in normal families" (p. 239). Parents of
Stealers tended to be emotionally distant from their
children, and relatively uninvolved in the child caretaker
role. For example, they were not highly motivated to monitor school work nor to support achievement. These parents were motivated only enough to teach their children the bare minimum of survival skills. They demonstrated relatively little concern when their children engaged in minor thefts, administering few if any consequences. They tended to readily accept their child's excuses and explanations for stealing without administering any consequences. Finally, these parents allowed their children more unsupervised street time compared to Aggressors or Normals.

Patterson thought higher levels of coerciveness were exhibited by all family members in families of Aggressors. The parents were extremely irritable, and scolded or threatened at the slightest provocation. These parental responses tended not only to incite aggressive responses from children, but they were also an ineffective means of shaping behavior through punishment. Further, nonpatient siblings were found to be 2 to 5 times more coercive than children in Normal families.

Patterson also thought parents in Aggressors' families tended to be overly-inclusive in differentiating normal from deviant behavior. They tended to classify as deviant many behaviors that parents of normals would classify as borderline or acceptable. These parents also allowed their children to be more coercive toward one
another than did parents of Stealers or Normals.

In expressing their belief about the current state of knowledge regarding childhood conduct disorders, Griest and Wells (1983) state:

The data we reviewed, as well as our current speculations about the data, suggest that we know very little about the interplay of various family variables and the etiology and treatment of conduct disorders in children. In terms of etiology, we are unable to verify that a causal relationship exists between family variables and conduct disorders and, if it does, the direction of causation. In addition, we are uncertain about the relationships among the various family variables themselves. Our knowledge of family variables and treatment of conduct disorders is equally sparse. (p. 49)

Multimodal family therapy may be more effective in treating conduct disorders than circumscribed treatment focusing only on child behavior or parenting deficits. Griest and Wells state, "If multimodal family therapy is used, the most efficacious sequence of treating target areas must be delineated" (p. 49). Further, they state:

Hopefully, future research will dissect the relationships of family variables and the development of childhood psychological disorders. Such research will promote appropriate targets for preventive measures and identify which treatment(s) is/are most effective for various combinations of family problems and childhood disorders. (p. 49-50)

Griest and Wells identified four areas of family functioning which they believed should be assessed prior to initiating treatment: Parental perceptions of child behavior, parental mental health, marital adjustment, and parental social adjustment.
Current Research

Because the empirical assessment of families is a relatively new area of research, there is a dearth of related literature. However, preliminary work in this area illustrates the relevance and importance of family-level assessment information in developing more understanding about dysfunctional child behavior.

Billings and Moos (1983) reported that the Stressor-Illness model presumes that stressful life events and social supports are related to vulnerability and to psychological and physical illness. Examples of family stressors are divorce, marital separation, family death, legal or financial problems, prolonged illness, work-related stress, and/or marital conflict. Examples of family resources are the quality and quantity of intra-familial and extra-familial supportive interactions and relationships. A positive correlation exists between stressful life events and illness, while a negative correlation exists between social support and illness. Evidence is increasing that a combination of both life stressors and lack of social supports is a better predictor of illness than either of these variables alone. Families that don't have a viable social support system may be more vulnerable to life stressors, and therefore more susceptible to illness.

Recent studies suggest that parental depression and
anxiety may be related to discrepancies between parental perceptions of child misbehavior and actual child behavior (Griest et al., 1980; Rickard, Forehand, Wells, Griest & McMahon, 1981). Griest and Wells (1983) state, "The inconsistencies between observed child behavior and the parents' view of the behavior is certainly of concern, considering that parents are the primary source of clinic child referrals. In addition, the way that parents perceive their children undoubtedly affects how the parent interacts with the child and, consequently, how the child behaves" (p. 40).

Griest and Wells (1983) suggested that parental depression may contribute to the initiation and maintenance of child conduct disorder in at least two different ways. First, depressive symptoms such as loss of sleep, psychomotor agitation, and concentration difficulties, may lead to a lowered tolerance for child misbehavior. In turn, this lowered tolerance may induce parents to increase their level of child punishment, even if the child doesn't deserve punishment. This phenomenon could contribute to the negative cycle of parent-child interactions described by Patterson's Coercion Hypothesis (Patterson, 1976). Patterson (1982) states:

The mother's disposition to react irritably is viewed as an alternative to problem solving. She reacts in such a way as to make her pain stop immediately. Rather than train the child, she scolds. Rather than confront the child and change his deviant behavior, she natters and threatens.
Second, depressive symptoms such as decreased energy, hyposomnia, and feelings of hopelessness, would reduce the amounts of time and attention the parent could invest in the child. Given this condition, antisocial child behavior could arise from either lack of parental supervision and/or as an attempt by the child to gain maternal attention.

Patterson believed that prolongation of a system of coercive exchange among family members makes mothers more susceptible to depression. They are faced with constant conflict which leads to a sense of hopelessness. Further, they receive few positive reinforcements from family members. Depression may affect a mother by increasing her irritability and her negative perceptions of the target child and herself, as well as of other family members. She may come to see other family members as non-caring or intending to make her feel badly. This pattern could establish a self-perpetuating cycle which increases family coercion.

Billings and Moos (1983) assessed the relationship between various risk factors such as parental depression, family social resources, and family stressful events, and the development of behavioral, emotional, and/or somatic symptoms in children. They found significantly more child symptoms in children of depressed parents, when compared
to children of nondepressed parents. For example, only 2.7% of the families showing no risk factors, had symptomatic children. The prevalence of child disturbance rose to 26.2% in families with a depressed parent; to 32.9% if the parent was acutely depressed; to 38.1% if such families also were experiencing high levels of stress, and to 41.2% when the previous risk factors were combined with a lack of external sources of family social support. In other words, variations in the levels of family stressors and social resources seemed to mediate the effect of parental depression upon the development of child dysfunction. Greater levels of dysfunction were found in children of depressed parents, when their families experienced higher levels of stress and lower levels of social support.

Billings and Moos reported that children of acutely depressed parents exhibited significantly more impairment than did children of chronically depressed parents. This suggests that parental depression may be more disruptive to family members during its onset. Also, families with a depressed parent, when compared to nondepressed parent families, perceived less Cohesion, Expressiveness, and Organization, and more Conflict as measured by the Family Environment Scale (FES) (Moos & Moos, 1981). Further, families of depressed parents also showed less emphasis on such personal growth dimensions as Independence,
Intellectual, Moral-Religious, and shared recreational activities.

Billings and Moos believed that complex reciprocal relationships exist between family environments and the adaptation of individual family members. For example, parental depression may be fostered by an unsatisfactory marital relationship. If depressive symptoms persist, they may encourage the withdrawal of familial social support, which in turn may reduce the chances for recovery.

In comparing mother-antisocial child dyads, Wahler, Hughey, and Gordon (1981) classified mothers according to a factor they termed insularity. Insularity ratings were obtained from the mothers' responses to a questionnaire which assessed the quantity and quality of their extra-familial social contacts and relationships.

As a result of these ratings it was found that, compared to noninsular mothers, insular mothers had fewer and more coercive social relationships outside of the family. The insular mothers were more likely to report feeling depressed. Further, the duration of coercive exchanges between insular mothers and their children were longer when compared to noninsular mother-child exchanges. During the course of coercive mother-child exchanges, insular mothers tended to become increasingly more aversive toward the child. This
maternal inability or unwillingness to stop coercive mother-child exchanges was thought to be related to chronic child opposition. Presumably this aversive maternal behavior provided children with a sense of desired predictability, thus reinforcing child oppositional behavior.

Wahler and Afton (1980) found that people who experienced prolonged coercive exchanges were likely to report their experiences in vague terms. The authors argued that prolonged coercive exchange could reduce the participants' attending capabilities. The tendency of parents to engage in coercive exchanges was thought to be related to deficits of attentional tracking of their children's behavior. Therefore, termination of mother-child coercive encounters was made difficult, because the relevant issues of conflict were not clearly understood. Further, insular mothers reported high rates of coercive exchange with both kinfolk and helping agency representatives.

Forehand, Wells, and Griest (1980) reported significant and positive child behavioral changes as a result of treatment. However, they noticed that many parents continued to view their child's behavior as deviant.

Wahler and Afton (1980) found that families which maintained posttreatment therapeutic gains, were the
families in which parents showed both behavioral changes as well as changes in the way they viewed their child. Also, mothers who reported fewer and more aversive extrafamilial interactions were less likely to maintain positive treatment effects than mothers who reported more frequent and less aversive extrafamilial contacts.

Dumas and Wahler (1985) found that insular mothers of an antisocial child were more indiscriminant and aversive than noninsular mothers of an antisocial child in their use of aversive consequences for child misbehavior. When compared to noninsular mothers, insular mothers were more likely to respond aversively to aversive child behavior, to respond aversively to any child behavior, and to engage in aversive interchanges which were twice as long. Further, insular children were more aversive than noninsular children. The authors concluded that when working with conduct disordered children and their families, it is necessary for researchers and practitioners to include extra-familial relations in their studies and analyses.

Wahler (1980) reported that the quality rather than the quantity of maternal extrafamilial social relationships may be a more important factor in the development of harmonious mother-child relations. On days when mothers reported high friendship contacts, maternal aversive behavior and oppositional child behavior were
consistently lower than the same measures taken on low friendship days.

A social-environmental perspective suggests that a child's physical and mental health is related to both the social environment of the child, particularly within the family, and the parent's mental health and level of adaptive functioning (Billings & Moos, 1983). The following studies focused on social-environmental issues.

In studying families of runaway children, Steinbock (1977) analyzed family communication styles and family member's perceptions of their family in three groups of families: Families with a runaway child, families in crisis without a child runaway problem, and non-problem families. Data derived from the Family Environment Scale were analyzed from three separate vantage points: Parents, adolescents, and total family perceptions. No significant differences within or between any of the groups were found between mother and father perceptions. Runaway adolescents consistently reported the highest perceived degrees of family Control and Conflict, and the lowest degrees of family Cohesion and Expressiveness. They were more frequently seen by themselves and their parents as isolated and separated from their families. Parents of runaways were more likely to deny the existence of family problems as the degree of perceptual incongruence about family environment between
runaways and their parents became more pronounced.

These results suggested that increases in parental denial of family conflicts were associated with the likelihood that adolescents would overtly express their dissatisfactions. However, the runaway act seemed to exacerbate family problems rather than solve them. Families in non-runaway crises were remarkably similar to the runaway families on all measures. In non-problem families, parents' and children's perceptions about their family were congruent. Further, non-problem families fostered perceptions of greater family cohesion and conformity.

Scoresby and Christensen (1976) administered the Family Environment Scale to a group of clinic and to a group of nonclinic families. In considering interpersonal variables they found that nonclinic families reported significantly more Cohesion and Expressiveness and less Conflict than the clinic families. In terms of organizational variables, nonclinic families reported significantly more stability and orderliness in their families than did the clinic families. The authors concluded that many clinic families are likely to be interested in learning how to develop more closeness, open communication and orderliness, and less conflict.

Fowler (1980) examined the relationship between family environments as measured by the FES, and behavior
problems in pre-kindergarten children. Developmental delay, aggressivity, and speech and language deficits were associated with less familial Cohesion. Shyness and anxiety were associated with lower familial organization and structure.

Malin (1978) examined the FES scores of 45 families who had placed an adolescent child in a residential treatment facility. Compared to the FES normative families, these families scored lower on Cohesion, Independence, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Moral-Religious emphasis, and obtained higher scores on Conflict.

Fox, Rotatori, Macklin, Green, and Fox (1983) administered the FES to 17 socially maladjusted adolescents who were enrolled in an alternative high school program. Compared to the FES normative sample these adolescents reported that their families possessed significantly less Cohesion, Independence, Achievement-Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, Moral-Religious Orientation, and Family Organization. The authors concluded that their data supported the necessity for providing treatment which addressed these family environmental issues.

Forman and Forman (1981) investigated the relationship between family environments and adolescent
personality by administering the FES and the High School Personality Questionnaire. Families which scored highest on Cohesion and Expressiveness tended to have children who were relatively free from anxiety. Assertiveness and self-sufficiency characterized children in families which scored highest on Independence and Achievement, while high scores on Moral-Religious were associated with child insecurity and guilt. Families emphasizing Organization and Control had children who were relaxed. The authors concluded that children raised in cohesive and well-organized families tend to be more self-confident and relaxed, and to experience fewer emotional and behavioral problems.

**Individual Child Assessment**

Achenbach (1978) argued for improved methods of classifying child behavioral disorders by stating, "Even more than adult psychopathology, child psychopathology lacks a coherent conceptual framework for describing and discriminating among disorders, much less for supporting inferences about the etiology, course, or appropriate treatments for specific disorders" (p. 763). Achenbach believed that in the area childhood psychopathology we need to develop improved conceptual categories which can be reliably used by researchers of different theoretical persuasions. He believed that narrative descriptions and
inferences regarding childhood psychopathology, which were formulated by committees of psychiatrists, lacked in interjudge reliability and were thus inferior to empirically-based classification systems. Efforts to classify childhood psychopathology through empirical methods have consistently found that childhood antisocial behavior is not a homogeneous entity, and that it can be classified into two or more groups.

Jenkins and Hewitt (1946) abstracted referral problems from 500 case files from a Michigan child guidance clinic. They identified two clusters of problem behaviors through correlation analyses which are germane to this study: Unsocialized Aggressive, and Socialized Delinquent. Unsocialized aggressive behaviors were abrasive and directed toward a victim. Examples of unsocialized aggressive behaviors are fighting, quarreling, destruction of property, and incorrigibility. Delinquent behaviors were not necessarily observable as immediate reactions to another person. Delinquent behaviors included stealing, property destruction, fire setting, truancy, and running away from home.

Quay (1965a) through factor analysis of child behavior ratings, classified childhood antisocial behavior into three groups. The unsocialized–psychopathic dimension was associated with a lack of socialization and concern for others, and was manifested as impulsiveness,
assaultiveness, and a rebellious antiauthoritarian and amoral attitude. The Neurotic Disturbed dimension was associated with anxiety, guilt, and social withdrawal. The Socialized-Subcultural group was associated with acceptance of delinquent sub-group norms, rather than with a failure to be socialized or with a neurotic acting out of conflicts. Quay recommended that these three dimensions not be considered discrete types, because considerable overlap existed between them.

Through cluster analytic techniques, Jenkins (1966) classified disordered child behavior into two general groups: Inhibited and Aggressive. Three sub-groups, Hyperactive, Undomesticated, and Socialized Delinquent, were found within the Aggressive group, while Shy-Seclusive, and Overanxious-Neurotic sub-groups were found within the Inhibited group. Mothers of Inhibited children were rarely openly hostile toward their children. None of the Inhibited children reported feeling rejected by their mother. Whereas children in the Aggressive groups frequently reported feeling maternally rejected. Compared to children in the Inhibited groups, the aggressive children were more likely to have experienced maternal neglect or hostility, absence of natural father from the family, and more time without parental supervision.

Achenbach's (1979) classification schema for disordered child behavior was similar to the schema
developed by Jenkins (1966). Achenbach delineated through factor analytic procedures two broad-band categories of disordered behavior which he labeled Internalizing and Externalizing. Internalizers generally exhibited impulse repression and problems with the self, while Externalizers generally exhibited impulse expression and problems with society. Internalizing and Externalizing categories were each subdivided into several narrow-band categories according to sex and age ranges.

The two narrow-band Externalizing subscales germane to this study are Delinquent and Aggressive. High scores on such behaviors as stealing, lying, and cheating, vandalism, truancy, and setting fires are associated with a Delinquent classification. Aggressive children are rated highly on such behaviors as threatening people, temper tantrums, disobedience at home, screaming, arguing and stubbornness.

Two common factors, Social Aggressive and Delinquent, have emerged from all major attempts to classify childhood antisocial behavior. Patterson (1982) termed these two groups Aggressors and Stealers.

In summary, empirical strategies for assessing families are not yet highly refined. However, as a result of some pioneering family assessment research, we now know that certain styles and degrees of family dysfunction are associated with the development and maintenance of certain
types of childhood symptoms.

Typically, families of conduct disordered boys manifest several problems in addition to having an antisocial child. Several social-environmental factors such as certain types of family organization and family behavior, parental physical and mental health, family social resources, and stressful life events are considered influential in the development and maintenance of childhood conduct disorders. However, little is understood about the relative influence of these variables. Further, at least two major types of male conduct disorder exist; Stealers and Aggressors. Preliminary research suggests that the families of Stealers and Aggressors differ in systematic ways, which may require differential assessment and treatment considerations. It was hoped that this present study would help to further clarify what types of differences exist between the families of Stealers and Aggressors.
CHAPTER III

METHOD

Population and Sample

Population

The population for this study consisted of all of the male patients between the ages of 12 and 17 who were participating in the treatment program at the Regional Institute for Children and Adolescents (RICA) as either Day or Residential Students. Day Students attend educational and therapeutic programming on weekdays and return to their homes at the end of each school day. Residential Students are housed on the RICA campus, and are typically allowed to spend weekends at home. RICA is a multidisciplinary psychiatric treatment center and school for emotionally disturbed youngsters and their families. RICA is located in Rockville, Maryland. RICA's primary catchment area includes Montgomery County, Maryland, a suburban area located adjacent to Washington D.C. Students represent a wide range of socioeconomic backgrounds and are approximately 85% caucasian, and 15% black. Students are referred to RICA by a county-level public school admission and review committee, and by the juvenile justice system.
Sample

Every male student at RICA between the ages of 12 and 17 was a potential subject for this study. The researcher contacted the students and their parents, explained the nature and purpose of the study, and asked them to participate by completing the criteria instruments. Subjects were informed that their participation was voluntary, and that their questionnaire responses would remain confidential.

Subjects were selected between May and August of 1986. Fifty four male students and their parents were selected as subjects for this study from the population identified. Four subjects refused to participate in the study, leaving a final sample of 50 families consisting of 50 adolescent boys, 44 mothers and 25 fathers. Each boy and his parents were placed in one of the three research groups on the basis of the boy's profile typology classification which was derived from the Child Behavior Checklist (CBCL) (Edelbrock & Achenbach, 1980). Seventeen boys and their parents were selected for an Aggressor group, 17 boys and their parents were selected for an Internalizer group, and 16 boys and their parents were selected for a Stealer group.

Diagnostic Conditions

For the purpose of this study the term Aggressor
refers to a subject who received a CBCL profile rating of Immature Aggressive, and an Aggressive narrow-band score of at least 90% on the Child Behavior Checklist. Behaviors characteristically manifested by Aggressors include threatening people, temper tantrums, cruelty to others, disobedience at home, argumentation, and stubbornness.

The term Stealer refers to a subject who received a CBCL profile typology classification of either Delinquent, or Uncommunicative Delinquent, and a Delinquent narrow-band score of at least 90%. Behaviors characteristically manifested by Stealers include stealing, keeping bad friends, vandalism, lying and cheating, and truancy.

The term Internalizer refers to a subject who received any CBCL Internalizing profile typology classification, along with a corresponding Internalizing narrow-band score of at least 90%. Behaviors characteristically manifested by Internalizers include somatic complaints, guilty feelings, shyness, crying, and obsessions.

Criteria Instruments

Child Behavior Checklist

The CBCL is a child behavior checklist comprised of 113 behavior problem items, plus 20 social competence items. (See Appendix A) It was designed as an attempt to provide a standardized, reliable, and valid system for
assessing children's behavior disorders. Parents are normally asked to complete the CBCL, because they are generally thought to be able to make more accurate and comprehensive assessments of their children than either teachers or clinicians.

Parents score items on a 3-step response scale, with 0 indicating that the item is not true of the child; 1 indicating that the item is sometimes true of the child; and 2 indicating that the item is true or often true of the child. Parents are asked to base their ratings on child behavior which has occurred within the past 12 months.

Individual subscale raw scores can be plotted on a profile sheet, making it convenient to compare broad and narrow-band scores to T scores and percentiles, which were derived from a nonclinical normative sample. Computer-scored profile sheets provide abbreviations of each item the parent marked, along with its numerical rating.

Eight narrow-band behavior problem scales for boys, aged 12-16, were derived through factor analysis and were labeled as follows: Somatic Complaints, Schizoid, Uncommunicative, Obsessive-Compulsive, Hostile Withdrawal, Delinquent, Aggressive; and Hyperactive. Eight narrow-band behavior problem scales for girls were labeled as follows: Somatic Complaints, Schizoid,
Depressed-Withdrawal, Anxious-Obsessive, Immature-Hyperactive, Cruel, Aggressive, and Delinquent. Second-order factor analyses revealed two broad-band behavior groupings labeled Internalizing and Externalizing. These groupings were respectively comprised of problems which are manifested as conflicts within an individual versus problems of conflict with the outside world.

The social competence and behavior problem scales were derived through factor analysis of checklists completed by 450 parents of children who were referred for mental health services. Separate editions of the profile based on separate norms, have been developed for each sex in the age ranges 4-5, 6-11, and 12-16. These age ranges are thought to reflect major changes in cognitive and emotional functioning, physical development, and educational and social status.

In an effort to provide empirically based discriminations among disturbed children, a system was developed whereby children can be classified according to CBCL profile types. These profile types allow for relatively homogeneous groupings of children for diagnostic and research purposes (Edelbrock & Achenbach, 1980).

Separate hierarchical cluster analyses can be performed on narrow-band problem scales to identify profile types for each age and sex group. The cluster
analyses were based upon samples of clinically referred rather than normal children. A centroid clustering method developed by Sokal & Michener (1958) was used. Measures of profile pattern and elevation similarity are obtained by calculating the proportion of variance shared by two profiles. First, the two most highly correlated profiles are found and combined into a cluster. By averaging the scores of these two profiles, their centroid is determined. That centroid is then treated as a single subject profile, and intraclass correlations between possible pairs are then recomputed.

Test-retest mean Pearson r reliability ratings for Social Competence, narrow-band, wide-band, and total behavior problems scores was: .89 for 6-11 year old boys; .82 for 12-16 year old boys; .88 for 6-11 year old girls; and .90 for girls aged 12-16. Mothers and fathers of clinically referred children received the following interparent agreement ratings: .79 for boys; .63 for 6-11 year old girls; and .54 for 12-16 year old girls. Comparisons of clinical and nonclinical samples on all social competence and behavior problem scores revealed significant differences (p < .001) (Achenbach & Edelbrock, 1979).

The CBCL was used to classify subjects by disorder profile types and to place them accordingly into one of three groups: Stealer, Aggressor, or Internalizer.
The CBCL was selected for use in this study because Patterson (1982) reported his belief that Achenbach's CBCL is a useful tool for discriminating between types of antisocial children. Patterson stated:

The systematic work by Achenbach and his colleagues, lends itself nicely to the identification of "types" of antisocial children. The distribution of scores for each factor has been normalized and converted to T scores. Thus, one can construct typologies based on profiles that are defined by the available factor scores. Of particular interest are the children high on Achenbach's Delinquent and Aggressive factors. They seem to describe two very different kinds of cases referred for treatments. (p. 31)

Family Environment Scale

The Family Environment Scale (FES) (Moos & Moos, 1981) is a 90-item true-false questionnaire, which is comprised of ten subscales with 9 items each, that measure social-environmental characteristics of families. Subscales are grouped into the following three major dimensions: Relationship, which includes the Cohesion, Expressiveness, and Conflict subscales; Personal Growth, which includes the Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Moral-Religious Orientation subscales; and System Maintenance, which includes the Organization, and Control subscales.

The Cohesion subscale measures the perceived level of commitment, help, and support family
members provide for one another. Expressiveness measures how much family members are encouraged to act openly and to express their feelings directly. The Conflict subscale measures the amount of openly expressed anger, aggression, and conflict among family members. The Independence subscale assesses the extent to which family members are assertive, self-sufficient, and make their own decisions. The Achievement Orientation subscale looks at the extent to which activities (e.g., school and work) are cast into an achievement-oriented or competitive framework. The Intellectual-Cultural Orientation subscale assesses the degree of interest in political, social, intellectual, and cultural activities. The Active-Recreational subscale measures the extent of participation in social and recreational activities. The Moral-Religious subscale measures the emphasis on ethical and religious issues and values. The Organization subscale assesses the importance of clear organization and structure in planning family activities and responsibilities. The Control subscale measures the extent to which set rules and procedures are used to run the family.

The FES has three forms: The Real Form (Form R) measures people's perceptions of their current nuclear family environments; (See Appendix B) the Ideal Form (Form I) measures perceptions about how family members would
ideally like their family to be; (See Appendix C) and Expectations Form (Form E) measures expectations about what families will be like after having experienced significant events.

The FES Form R is printed in a reusable booklet form which is designed to be used with a separate answer sheet. Subjects are instructed to respond to each test item as true or mostly true regarding their family or false or mostly false regarding their family.

In scoring, a transparent template is used to count the number of responses to each subscale. Individual and family scores can be obtained. Family scores can be computed by averaging each family member's subscale scores. Averaged family subscale scores can then be converted into standard scores by using a conversion table. Profiles displaying individual and family raw and standard scores may be produced. The standard score normative sample was comprised of 1,125 nonclinical respondents.

Incongruence scores can also be obtained. Family incongruence scores assess the extent of disagreement among family members, regarding their perceptions about their family's social climate. Incongruence scores are derived by obtaining difference scores on each of the ten FES variables for every possible family pair.
The FES Form R and Form I were used to assess families. In addition to providing family-level assessment data, these instruments were chosen for their ease of administration, scoring, and interpretation, and because the areas of familial functioning they purport to assess are considered germane to the present study. These features make it more likely that clinicians would use the FES as a part of formal assessment procedures, should it prove clinically worthwhile in assessing families of conduct disordered male adolescents. Further, comparisons of the FES Form R and Form I data have been used effectively to enlist client participation in establishing treatment goals, and to provide an on-going treatment outcome measure (Fuhr, Moos, & Dishotsky, 1981).

In developing the FES, an initial item pool consisting of 206 items (Form A) was developed through information obtained in structured interviews of different types of families, and through adapting items from other Social Climate Scales (Moos, 1974). The 90-item form R was developed by administering Form A to over 1000 people in 285 families which represented minority, clinical, and nonclinical samples.

The following psychometric criteria were met: Items correlated more highly with their subscale than with any other subscale. Each subscale contained approximately equal numbers of items scored true and false. Subscales
had low to moderate correlations. Each item and subscale was able to discriminate among different families. The overall item split was close to 50-50 to avoid items which characterized only unusual types of families.

Normative data for Form R were collected for 1,125 normal and 500 distressed families. The normal family subsample represented all major geographic areas of the United States, single-parent families, multi-generational families, ethnic minorities, and families representing different age groups.

Intercorrelations between subscale scores were computed on a sample of 1,468 husbands and wives and 621 children from 266 distressed families and 534 normal families. Intercorrelations for parents and children were similar. The FES scales do measure distinct aspects of social environments. For example, negative correlations were obtained between Cohesion and Conflict (-.44), and between Independence and Control (-.24). However, overlap between some subscales did exist. Positive correlations were obtained for Cohesion and Organization (+.41), and between Intellectual-Cultural Orientation and Active-Recreational orientation (+.45).

The ten subscales have adequate internal consistencies (Cronback's Alpha) ranging from .61 to .78. Item-subscale correlations ranged from .27 to .44.

Two-month test-retest reliabilities for individual's
scores ranged from .68 to .86; four-month reliabilities ranged from .54 to .91; and twelve-month reliabilities ranged .52 to .89.

Family profiles of FES scores remain relatively stable over time. Profile stability correlations for 35 families tested 4 months apart, and 85 families tested 12 months apart revealed test-retest reliability correlations of .78 and .71 respectively.

The FES has demonstrated an ability to show a relationship between certain perceived family environmental qualities and success of treatment for alcoholism. High scores on Cohesion and Active-Recreational Orientation, and low Conflict scores indicated a more positive prognosis for treatment of alcoholism (Finney, Moos, & Mewborne, 1980; Moos, Bromet, Tsu, & Moos, 1979).

The FES has been consistently able to find perceived family environmental differences between distressed and normal families. Families with at least one dysfunctional member tend to show less Cohesion and Expressiveness, low Organization, and greater Conflict (Scoresby & Christensen, 1976; White, 1978). Janes and Hesselbrock (1976) found that children of a schizophrenic parent perceived less family Intellectual-Cultural Orientation and Active-Recreational Orientation than did children with nonschizophrenic parents.
Differences in perceptions of family environments according to gender were slight as were perceptual differences between parents and children.

Health and Daily Living Form

The Health and Daily Living form (HDL) (Moos, Cronkite, Billings, & Finney, 1985) is a questionnaire which can be used with clinic and nonclinic populations. (See Appendix D) The HDL includes various indices which tap health-related and social functioning, life stressors, coping responses, and social resources. The HDL indices were developed from data obtained from 424 depressed adult patients and 159 of their spouses, and 424 sociodemographically matched and randomly selected nonsymptomatic adults and 184 of their spouses. HDL Global Depression items were developed to tap the presence and severity of symptoms involved in obtaining a Research Diagnostic Criteria diagnosis of major or minor depression as described by Spitzer, Endicott, and Robins (1978).

Procedures

The researcher contacted the students and their parents, explained the nature and purpose of the study, and asked them to participate by completing the criteria instruments. Subjects were informed that their
participation was voluntary, and that their questionnaire responses would remain confidential.

During the week following the selection of subjects, the researcher administered the criteria instruments to both parents and identified patients. Parents were asked to complete another CBCL if the CBCL data was more than one year old. The CBCL was scored and subjects were classified into profile types through the use of a program for computer scoring. The researcher administered the criterion instruments to both parents and identified patients. The researcher scored the FES forms with the use of scoring templates, and scored the HDL by hand.

Prior to participating in this research project, all adult subjects were asked to sign an informed consent form and all boys were asked to sign an informed assent form. (See Appendix E) Every effort was made to insure confidentiality for each subject.

Statistical Hypotheses

The present study is designed as an attempt to determine if family assessment differences exist between the families of Stealer and Aggressor conduct disordered adolescent males. Based on these research questions the following hypotheses were formulated and stated in the null form.
Hypothesis One

There will be no significant differences among the ten family assessment variables for Total Parent, Identified Patient, and Total Family, as measured by the Family Environment Scale Form R, across the groups of Stealer, Aggressor, and Internalizer families.

Hypothesis Two

There will be no significant differences among the Total Family Incongruence scores as measured by the Family Environment Scale Form R, across the groups of Stealer, Aggressor, and Internalizer families.

Hypothesis Three

There will be no significant differences among the ten Real minus Ideal difference scores for Total Parent, Identified Patient, and Total Family, as measured by the Family Environment Scale Form R and Form I, across the three groups of Stealer, Aggressor, and Internalizer families.

Hypothesis Four

There will be no significant differences among scores for maternal and paternal Self-Confidence, Global Depression, Depressed Mood, Number of Medical Conditions, Number of Medications Used, Number of Physical
Symptoms, and the Frequency-Quantity measure for parental alcohol consumption as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

**Hypothesis Five**

There will be no significant differences among the number of maternal and paternal Social Activities with Friends, Social Activities with Relatives, Number of Close Relationships, Number of Social Network Contacts, and Quality of a Significant Relationship as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

**Hypothesis Six**

There will be no significant differences among either the Weighted Positive Life Change scores or the Weighted Negative Life Change scores as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

**Statistical Analyses**

First, for hypotheses 1, 3, 4, 5, and 6, which include multiple measures, a test for general group differences was made using multivariate analysis of variance (MANOVA). The MANOVA procedure, which
calculates a single probability level for all of the measures taken jointly, had to be used because of the likelihood that the various measures were correlated in some arbitrary manner. Further, correlations among all the measures were computed through the MANOVA procedure.

Second, if significant differences were found among the groups by using MANOVA a univariate analysis of variance (ANOVA) was computed on each measure to determine which measures contributed the most to group differences. If significant differences were found through the use of ANOVA, the Tukey multiple comparison method was implemented to determine which pairs of groups differed. An ANOVA was used for Hypothesis 2, because it involved only one variable.

Criterion instrument scores obtained by the research groups were compared to the scores obtained by a nonclinical normative sample. These comparisons were made by t-tests.
CHAPTER IV

RESULTS

This chapter will present the results of the statistical analyses which were conducted to test the six null hypotheses described in Chapter III. Further, additional analyses that are indirectly related to the hypotheses will be described. These research findings will be discussed in terms of their implications in relation to the research questions.

Data and Their Analyses

Six statistical hypotheses were developed to test the research questions of this study. These hypotheses are presented in the null form.

Hypothesis One

There will be no significant differences among the ten family assessment variables for Total Parent, Identified Patient, and Total Family, as measured by the Family Environment Scale Form R, across the groups of Stealer, Aggressor, and Internalizer families.

The first null hypothesis involved three levels of multivariate analyses of variance (MANOVA) of FES Form R data: Total Parent, Identified Patient and Total Family.
Table 1 shows the results of the MANOVA of Total Parent data.

### Table 1

Multivariate Analysis of Variance of Total Parent Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.94</td>
<td>0.3978</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>0.01</td>
<td>0.9934</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.34</td>
<td>0.7165</td>
</tr>
<tr>
<td>Independence</td>
<td>1.72</td>
<td>0.1902</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>0.50</td>
<td>0.6098</td>
</tr>
<tr>
<td>Intellectual Cultural</td>
<td>0.38</td>
<td>0.6871</td>
</tr>
<tr>
<td>Active Recreational</td>
<td>1.18</td>
<td>0.3154</td>
</tr>
<tr>
<td>Moral Religious</td>
<td>0.29</td>
<td>0.7466</td>
</tr>
<tr>
<td>Organization</td>
<td>1.18</td>
<td>0.3177</td>
</tr>
<tr>
<td>Control</td>
<td>1.34</td>
<td>0.2707</td>
</tr>
</tbody>
</table>

Note. N = 50

**MANOVA Test on Total Parent FES Form R Scores**

- Hotelling-Lawley Trace = 0.59028600
- F-Approximation = 1.09
- F Probability = 0.3760

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
These results showed no significant differences among groups on all scales. Based on these results the first level of analysis of the first null hypothesis cannot be rejected. Additional $t$-test computations were made to compare each of the research groups' mean scores on the ten FES Form R scales to the scores obtained by the nonclinical normative sample. Table 2 presents the results of these $t$-tests.

Table 2

Means, Standard Deviations, and $t$-Ratios for Family Environment Scale Form R Scores Comparing Total Parent Scores of Stealer, Aggressor, and Internalizer Parents to a Nonclinical Normative Sample

<table>
<thead>
<tr>
<th>FES Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
<th>$t$-Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion-S</td>
<td>5.25</td>
<td>2.80</td>
<td>6.61</td>
<td>1.36</td>
<td>2.89**</td>
</tr>
<tr>
<td>Cohesion-A</td>
<td>5.09</td>
<td>1.88</td>
<td>6.61</td>
<td>1.36</td>
<td>3.37**</td>
</tr>
<tr>
<td>Cohesion-I</td>
<td>6.1</td>
<td>2.32</td>
<td>6.61</td>
<td>1.36</td>
<td>1.02</td>
</tr>
<tr>
<td>Express-S</td>
<td>5.06</td>
<td>1.65</td>
<td>5.45</td>
<td>1.55</td>
<td>0.87</td>
</tr>
<tr>
<td>Express-A</td>
<td>5.00</td>
<td>1.65</td>
<td>5.45</td>
<td>1.55</td>
<td>1.00</td>
</tr>
<tr>
<td>Express-I</td>
<td>5.06</td>
<td>1.97</td>
<td>5.45</td>
<td>1.55</td>
<td>0.87</td>
</tr>
<tr>
<td>Conflict-S</td>
<td>4.47</td>
<td>2.77</td>
<td>3.31</td>
<td>1.85</td>
<td>2.46*</td>
</tr>
<tr>
<td>Conflict-A</td>
<td>4.65</td>
<td>2.01</td>
<td>3.31</td>
<td>1.85</td>
<td>2.97**</td>
</tr>
<tr>
<td>Conflict-I</td>
<td>4.00</td>
<td>2.32</td>
<td>3.31</td>
<td>1.85</td>
<td>1.50</td>
</tr>
<tr>
<td>Indepen-S</td>
<td>6.31</td>
<td>1.62</td>
<td>6.61</td>
<td>1.19</td>
<td>0.88</td>
</tr>
<tr>
<td>Indepen-A</td>
<td>5.38</td>
<td>1.11</td>
<td>6.61</td>
<td>1.19</td>
<td>3.62**</td>
</tr>
<tr>
<td>Indepen-I</td>
<td>6.00</td>
<td>1.63</td>
<td>6.61</td>
<td>1.19</td>
<td>1.79*</td>
</tr>
<tr>
<td>Achieve-S</td>
<td>4.97</td>
<td>1.63</td>
<td>5.47</td>
<td>1.61</td>
<td>0.79</td>
</tr>
<tr>
<td>Achieve-A</td>
<td>5.41</td>
<td>1.43</td>
<td>5.47</td>
<td>1.61</td>
<td>0.09</td>
</tr>
<tr>
<td>Achieve-I</td>
<td>4.97</td>
<td>1.39</td>
<td>5.47</td>
<td>1.61</td>
<td>0.79</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Table 2—Continued

<table>
<thead>
<tr>
<th>FES Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intell-S</td>
<td>5.06</td>
<td>2.55</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-A</td>
<td>4.44</td>
<td>2.24</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-I</td>
<td>5.03</td>
<td>2.20</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Active-S</td>
<td>4.09</td>
<td>2.64</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-A</td>
<td>4.76</td>
<td>1.28</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-I</td>
<td>3.71</td>
<td>1.98</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Moral-S</td>
<td>4.38</td>
<td>2.26</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Moral-A</td>
<td>4.85</td>
<td>2.18</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Moral-I</td>
<td>4.97</td>
<td>2.59</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Organiz-S</td>
<td>5.16</td>
<td>1.93</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Organiz-A</td>
<td>5.59</td>
<td>2.62</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Organiz-I</td>
<td>4.41</td>
<td>2.16</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Control-S</td>
<td>4.66</td>
<td>1.79</td>
<td>4.34</td>
<td>1.81</td>
</tr>
<tr>
<td>Control-A</td>
<td>5.41</td>
<td>0.87</td>
<td>4.34</td>
<td>1.81</td>
</tr>
<tr>
<td>Control-I</td>
<td>4.94</td>
<td>1.24</td>
<td>4.34</td>
<td>1.81</td>
</tr>
</tbody>
</table>

*P < .05;
**P < .005

Through a Total Parent level of t-test analysis, the following results were obtained: Significantly less (P < .005) Cohesion and significantly more (P < .005) Conflict were perceived by Stealer and Aggressor parents; significantly less (P < .005) Independence and Intellectual-Cultural were perceived by Aggressor parents; significantly less (P < .005) Active-Recreational was perceived by Internalizer parents.

The second level of analysis for Hypothesis One involved Identified Patient data. Table 3 shows the
results of the MANOVA of Identified Patient data.

Table 3
Multivariate Analysis of Variance of Identified Patient Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.09</td>
<td>0.9164</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>2.30</td>
<td>0.1119</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.01</td>
<td>0.9903</td>
</tr>
<tr>
<td>Independence</td>
<td>0.49</td>
<td>0.6134</td>
</tr>
<tr>
<td>Achievement</td>
<td>1.59</td>
<td>0.2150</td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual</td>
<td>2.08</td>
<td>0.1364</td>
</tr>
<tr>
<td>Cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>0.68</td>
<td>0.5138</td>
</tr>
<tr>
<td>Recreational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moral</td>
<td>1.72</td>
<td>0.1896</td>
</tr>
<tr>
<td>Religious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>0.03</td>
<td>0.9737</td>
</tr>
<tr>
<td>Control</td>
<td>1.12</td>
<td>0.3364</td>
</tr>
</tbody>
</table>

Note. N = 50
df = 02, 49

MANOVA Test on Identified Patient FES Form R Scores

Hotelling-Lawley Trace = 0.96681302
F-Approximation = 1.74
F Probability = 0.0461
The results showed no significant differences between groups. Therefore, the second level of analysis of the first null hypothesis cannot be rejected.

Table 4 shows the results of the Identified Patient \( t \)-tests.

### Table 4

Means, Standard Deviations, and \( t \)-Ratios for Family Environment Scale Form R Data Comparing Stealer, Aggressor, and Internalizer Identified Patients to a Nonclinical Sample

<table>
<thead>
<tr>
<th>FES Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion-S</td>
<td>5.19</td>
<td>2.31</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Cohesion-A</td>
<td>5.47</td>
<td>2.58</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Cohesion-I</td>
<td>5.24</td>
<td>2.11</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Express-S</td>
<td>3.63</td>
<td>2.09</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Express-A</td>
<td>4.41</td>
<td>1.70</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Express-I</td>
<td>4.71</td>
<td>1.72</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Conflict-S</td>
<td>4.13</td>
<td>2.33</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Conflict-A</td>
<td>4.12</td>
<td>3.00</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Conflict-I</td>
<td>4.24</td>
<td>2.46</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Indepen-S</td>
<td>6.00</td>
<td>1.83</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Indepen-A</td>
<td>6.24</td>
<td>1.03</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Indepen-I</td>
<td>6.41</td>
<td>1.12</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Achieve-S</td>
<td>5.50</td>
<td>1.67</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Achieve-A</td>
<td>6.24</td>
<td>0.90</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Achieve-I</td>
<td>6.29</td>
<td>1.61</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Intell-S</td>
<td>5.19</td>
<td>1.68</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-A</td>
<td>4.06</td>
<td>1.40</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-I</td>
<td>4.71</td>
<td>1.40</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Active-S</td>
<td>5.25</td>
<td>1.91</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-A</td>
<td>5.41</td>
<td>1.54</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-I</td>
<td>4.76</td>
<td>1.44</td>
<td>5.35</td>
<td>1.87</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
The Identified Patient level of analysis revealed the following results: Significantly less (P < .005) Cohesion by all three research groups; significantly more (P < .005) Intellectual-Cultural by Aggressors and Internalizers; and more (P < .005) Control by Aggressors.

The third level of analysis for Hypothesis One involved Total Family FES Form R data. Table 5 shows the results of the MANOVA of Total Family data.
Table 5

Multivariate Analysis of Variance of Total Family Environment Scale Form R Scores Among the Three Groups of Stealers, Aggressors, and Internalizers.

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.38</td>
<td>0.6853</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>1.13</td>
<td>0.3330</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.05</td>
<td>0.9533</td>
</tr>
<tr>
<td>Independence</td>
<td>0.50</td>
<td>0.6127</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>1.76</td>
<td>0.1841</td>
</tr>
<tr>
<td>Intellectual Cultural</td>
<td>1.17</td>
<td>0.3196</td>
</tr>
<tr>
<td>Active Recreational</td>
<td>1.71</td>
<td>0.1922</td>
</tr>
<tr>
<td>Moral Religious</td>
<td>0.94</td>
<td>0.3995</td>
</tr>
<tr>
<td>Organization</td>
<td>0.79</td>
<td>0.4595</td>
</tr>
<tr>
<td>Control</td>
<td>3.16</td>
<td>0.0519</td>
</tr>
</tbody>
</table>

Note. N = 50
df = 02, 49

MANOVA Test on Total Family Environment Scale Form R Scores

Hotelling-Lawley Trace = 0.74106247
F-Approximation = 11.33
F Probability = 0.1868
No significant group mean differences were found through the MANOVA procedure. Based on these results the third level of analysis of the first null hypothesis cannot be rejected.

Table 6 shows the results of the Tukey's Studentized Range test for the Total Family analysis of the Control scale.

Table 6
Tukey's Studentized Range Test For Variable Control—Total Family

<table>
<thead>
<tr>
<th>Family Comparison</th>
<th>Simultaneous Lower Confidence Limit</th>
<th>Difference Between Means</th>
<th>Simultaneous Upper Confidence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressor Versus Internalizer</td>
<td>-0.3754</td>
<td>0.6882</td>
<td>1.7518</td>
</tr>
<tr>
<td>Aggressor Versus Stealer</td>
<td>0.0250</td>
<td>1.1235</td>
<td>2.2220 *</td>
</tr>
<tr>
<td>Internalizer Versus Aggressor</td>
<td>-1.7518</td>
<td>-0.6882</td>
<td>0.3754</td>
</tr>
<tr>
<td>Internalizer Versus Stealer</td>
<td>-0.6632</td>
<td>0.4353</td>
<td>1.5338</td>
</tr>
</tbody>
</table>

Note. *P < .05

Table 7 shows the results of the Total Family t-tests.
Table 7
Means, Standard Deviations, and t-Ratios for Family Environment Scale Form R Scores Comparing Stealer, Aggressor, and Internalizer Total Family Scores to a Nonclinical Sample

<table>
<thead>
<tr>
<th>FES Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion-S</td>
<td>5.36</td>
<td>2.35</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Cohesion-A</td>
<td>5.31</td>
<td>1.80</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Cohesion-I</td>
<td>5.85</td>
<td>1.57</td>
<td>6.61</td>
<td>1.36</td>
</tr>
<tr>
<td>Express-S</td>
<td>4.41</td>
<td>1.31</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Express-A</td>
<td>4.76</td>
<td>1.35</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Express-I</td>
<td>5.04</td>
<td>1.42</td>
<td>5.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Conflict-S</td>
<td>4.26</td>
<td>2.41</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Conflict-A</td>
<td>4.22</td>
<td>2.18</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Conflict-I</td>
<td>4.07</td>
<td>1.76</td>
<td>3.31</td>
<td>1.85</td>
</tr>
<tr>
<td>Indepen-S</td>
<td>6.23</td>
<td>1.21</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Indepen-A</td>
<td>5.88</td>
<td>0.92</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Indepen-I</td>
<td>6.22</td>
<td>1.15</td>
<td>6.61</td>
<td>1.19</td>
</tr>
<tr>
<td>Achieve-S</td>
<td>5.18</td>
<td>1.15</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Achieve-A</td>
<td>5.72</td>
<td>0.91</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Achieve-I</td>
<td>5.75</td>
<td>1.06</td>
<td>5.47</td>
<td>1.61</td>
</tr>
<tr>
<td>Intell-S</td>
<td>5.27</td>
<td>1.95</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-A</td>
<td>4.34</td>
<td>1.57</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Intell-I</td>
<td>4.93</td>
<td>1.54</td>
<td>5.63</td>
<td>1.72</td>
</tr>
<tr>
<td>Active-S</td>
<td>4.74</td>
<td>1.98</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-A</td>
<td>5.11</td>
<td>1.02</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Active-I</td>
<td>4.16</td>
<td>1.36</td>
<td>5.35</td>
<td>1.87</td>
</tr>
<tr>
<td>Moral-S</td>
<td>4.05</td>
<td>1.88</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Moral-A</td>
<td>4.66</td>
<td>1.98</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Moral-I</td>
<td>5.01</td>
<td>2.33</td>
<td>4.72</td>
<td>1.98</td>
</tr>
<tr>
<td>Organiz-S</td>
<td>4.96</td>
<td>1.78</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Organiz-A</td>
<td>5.41</td>
<td>2.43</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Organiz-I</td>
<td>4.55</td>
<td>1.55</td>
<td>5.41</td>
<td>1.83</td>
</tr>
<tr>
<td>Control-S</td>
<td>4.90</td>
<td>1.47</td>
<td>4.34</td>
<td>1.81</td>
</tr>
<tr>
<td>Control-A</td>
<td>6.02</td>
<td>1.25</td>
<td>4.34</td>
<td>1.81</td>
</tr>
<tr>
<td>Control-I</td>
<td>5.34</td>
<td>1.12</td>
<td>4.34</td>
<td>1.81</td>
</tr>
</tbody>
</table>

*P < .05; **P < .005
Hypothesis Two

There will be no significant mean differences among the Total Family Incongruence scores as measured by the Family Environment Scale Form R across the groups of Stealer, Aggressor, and Internalizer families.

Incongruence scores were obtained for each pair of family members by computing differences between each of their ten FES Form R scale Scores. Differences for each pair were summed and then divided by the total number of family pairs. Incongruence scores provide a measure of the degree of disagreement among family members about their perceptions of their family's social environment.

To test for a difference of Incongruence scores among groups, a one-way analysis of variance (ANOVA) was completed. Table 8 presents the results of this ANOVA.

Table 8
Analysis of Variance of Total Family Incongruence Scores

<table>
<thead>
<tr>
<th>FES Form R Incongruence Scores</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Family</td>
<td>0.76</td>
<td>0.4722</td>
</tr>
</tbody>
</table>

Note. N = 50
  df = 02, 49

The results showed no significant mean differences among groups. Therefore, the second null hypothesis
cannot be rejected.

Table 9 shows the results of the $t$-tests for the Incongruence data.

### Table 9

Means, Standard Deviations, and $t$-Ratios for Family Environment Scale Form R Incongruence Scores Comparing Stealer, Aggressor, and Internalizer Families to a Nonclinical Sample

<table>
<thead>
<tr>
<th>Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative $t$ Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealer</td>
<td>16.42</td>
<td>6.98</td>
<td>15.34</td>
<td>5.20</td>
</tr>
<tr>
<td>Aggressor</td>
<td>18.76</td>
<td>6.24</td>
<td>15.34</td>
<td>5.20</td>
</tr>
<tr>
<td>Internalizer</td>
<td>18.47</td>
<td>4.52</td>
<td>15.34</td>
<td>5.20</td>
</tr>
</tbody>
</table>

The $t$-tests revealed no significant differences between any of the research groups and the nonclinical sample in terms of Incongruence scores.

**Hypothesis Three**

There will be no significant mean differences among the ten Real minus Ideal difference scores for Total Parent, Identified Patient, and Total Family as measured by the Family Environment Scale Form R and Form I, across the three groups of Stealer, Aggressor, and Internalizer families.

Difference scores were obtained for each of the ten
Family Environment Scales, by subtracting the Form R score from the corresponding Form I score.

The third hypothesis involved three levels of analysis of difference scores. The first level of analysis involved Total Parent data. Table 10 presents the results of this MANOVA test.

Table 10

Multivariate Analysis of Variance of Total Parent Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.45</td>
<td>0.6415</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>1.41</td>
<td>0.2554</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.64</td>
<td>0.5306</td>
</tr>
<tr>
<td>Independence</td>
<td>0.28</td>
<td>0.7559</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>1.44</td>
<td>0.2476</td>
</tr>
<tr>
<td>Intellectual Cultural</td>
<td>0.86</td>
<td>0.4290</td>
</tr>
<tr>
<td>Active Recreational</td>
<td>1.77</td>
<td>0.1822</td>
</tr>
<tr>
<td>Moral Religious</td>
<td>1.17</td>
<td>0.3202</td>
</tr>
<tr>
<td>Organization</td>
<td>0.25</td>
<td>0.7832</td>
</tr>
<tr>
<td>Control</td>
<td>1.60</td>
<td>0.2123</td>
</tr>
</tbody>
</table>

Note. N = 50

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
The results showed no significant mean differences among groups, indicating that the first level of the third hypothesis cannot be rejected.

The second level of analysis for Hypothesis Three involved Identified Patient data. Table 11 presents the results of this MANOVA test.

Table 11
Multivariate Analysis of Variance of Identified Patient Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors, and Internalizers.

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.24</td>
<td>0.7914</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>1.44</td>
<td>0.2465</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.07</td>
<td>0.9370</td>
</tr>
<tr>
<td>Independence</td>
<td>0.21</td>
<td>0.8131</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>3.42</td>
<td>0.0413*</td>
</tr>
</tbody>
</table>
Table 11—Continued

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual Cultural</td>
<td>0.18</td>
<td>0.8334</td>
</tr>
<tr>
<td>Active Recreational</td>
<td>1.11</td>
<td>0.3382</td>
</tr>
<tr>
<td>Moral Religious</td>
<td>0.36</td>
<td>0.7014</td>
</tr>
<tr>
<td>Organization</td>
<td>0.62</td>
<td>0.5434</td>
</tr>
<tr>
<td>Control</td>
<td>0.29</td>
<td>0.7525</td>
</tr>
</tbody>
</table>

Note. N = 50
\[ df = 02, 49 \]

MANOVA Test on Identified Patient Family Environment Scale Form R Minus Form I Difference Scores

Hotelling-Lawley Trace = 0.79682038
\[ F \text{-Approximation} = 1.43 \]
\[ F \text{ Probability} = 0.1350 \]

No significant group mean differences were found through the MANOVA test. However, the ANOVA test revealed a significant difference (P < .05) on the Identified Patient Achievement Orientation difference score.

Table 12 shows the results of the Tukey's Studentized Range test for the Identified Patient Achievement
Orientation difference scores.

Table 12
Tukey's Studentized Range Test For Variable Achievement Orientation-Identified Patient Difference Score

<table>
<thead>
<tr>
<th>Family Comparison</th>
<th>Simultaneous Lower Confidence Limit</th>
<th>Difference Between Means</th>
<th>Simultaneous Upper Confidence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressor Versus Internalizer</td>
<td>-0.87524</td>
<td>0.17647</td>
<td>1.22818</td>
</tr>
<tr>
<td>Aggressor Versus Stealer</td>
<td>-2.01169</td>
<td>-0.92549</td>
<td>0.16071</td>
</tr>
<tr>
<td>Internalizer Versus Aggressor</td>
<td>-1.22818</td>
<td>-0.17647</td>
<td>0.87524</td>
</tr>
<tr>
<td>Internalizer Versus Stealer</td>
<td>-2.18816</td>
<td>-1.10196</td>
<td>-0.01576 *</td>
</tr>
</tbody>
</table>

*P < .05

The Tukey analysis showed that Stealer Identified Patients perceived more (P < .05) Achievement difference than Internalizer Identified Patients.

The third level of analysis for Hypothesis Three involved Total Family data. Table 13 presents the results of the MANOVA test.
**Table 13**

Multivariate Analysis of Variance of Total Family Environment Scale Form R Minus Form I Difference Scores Among Stealers, Aggressors and Internalizers.

<table>
<thead>
<tr>
<th>FES Form R Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>0.07</td>
<td>0.9325</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>2.71</td>
<td>0.0769</td>
</tr>
<tr>
<td>Conflict</td>
<td>0.17</td>
<td>0.8436</td>
</tr>
<tr>
<td>Independence</td>
<td>0.06</td>
<td>0.9456</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>5.68</td>
<td>0.0062 *</td>
</tr>
<tr>
<td>Intellectual Cultural</td>
<td>0.21</td>
<td>0.8078</td>
</tr>
<tr>
<td>Active Recreational</td>
<td>2.70</td>
<td>0.0780</td>
</tr>
<tr>
<td>Moral Religious</td>
<td>0.76</td>
<td>0.4743</td>
</tr>
<tr>
<td>Organization</td>
<td>0.21</td>
<td>0.8112</td>
</tr>
<tr>
<td>Control</td>
<td>0.76</td>
<td>0.4741</td>
</tr>
</tbody>
</table>

Note.  
N = 50  
df = 02, 49  
*P < .05

MANOVA Test on Total Family FES Form R Minus Form I Difference Scores

Hotelling-Lawley Trace = 0.92629951  
F-Approximation = 1.67  
F Probability = 0.0601

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
No significant group nor scale mean differences were found through the MANOVA test. However, the ANOVA test revealed significant differences ($P < .05$) on the Achievement Orientation scale between the Stealer-Aggressor and Stealer-Internalizer groups.

Table 14 shows the results of the Tukey's Studentized Range test for the Total Family Achievement Orientation difference scores.

<table>
<thead>
<tr>
<th>Family Comparison</th>
<th>Simultaneous Lower Confidence Limit</th>
<th>Difference Between Means</th>
<th>Simultaneous Upper Confidence Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressor Versus Internalizer</td>
<td>-0.6211</td>
<td>0.2294</td>
<td>1.0799</td>
</tr>
<tr>
<td>Aggressor Versus Stealer</td>
<td>-1.8133</td>
<td>-0.9349</td>
<td>-0.0565 *</td>
</tr>
<tr>
<td>Stealer Versus Aggressor</td>
<td>0.0565</td>
<td>0.9349</td>
<td>1.8133 *</td>
</tr>
<tr>
<td>Stealer Versus Internalizer</td>
<td>0.2859</td>
<td>1.1643</td>
<td>2.0427 *</td>
</tr>
</tbody>
</table>

*P < .05
**Hypothesis Four**

There will be no significant differences among the scores for maternal and paternal Self-Confidence, Global Depression, Depressed Mood, Number of Medical Conditions, Numbers of Medications Used, Number of Physical Symptoms, and the Frequency-Quantity measure for parental alcohol consumption as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

The fourth hypothesis included two levels of analysis of the Health and Daily Living Form health data: Maternal and paternal. The first level of analysis involved maternal health data. Table 15 shows the results of the MANOVA among the aforementioned Health and Daily Living Form scores.

**Table 15**

<table>
<thead>
<tr>
<th>HDL Health Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Confidence</td>
<td>0.15</td>
<td>0.8629</td>
</tr>
<tr>
<td>Global Depression</td>
<td>0.28</td>
<td>0.7600</td>
</tr>
<tr>
<td>Depressed Mood</td>
<td>0.35</td>
<td>0.7040</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>0.21</td>
<td>0.2772</td>
</tr>
<tr>
<td>Number of Medications</td>
<td>1.29</td>
<td>0.2850</td>
</tr>
</tbody>
</table>
Table 15—Continued

<table>
<thead>
<tr>
<th>HDL Health Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Symptoms</td>
<td>0.90</td>
<td>0.4152</td>
</tr>
<tr>
<td>Alcohol Frequency-Quantity</td>
<td>1.72</td>
<td>0.1919</td>
</tr>
<tr>
<td>Number of Cigarettes Daily</td>
<td>0.27</td>
<td>0.7677</td>
</tr>
<tr>
<td>Number of Smoking-Related Problems</td>
<td>0.15</td>
<td>0.8588</td>
</tr>
</tbody>
</table>

Note. N = 44  
df = 02, 43

MANOVA Test for Maternal HDL Health Data

Hotelling-Lawley Trace = 0.32351805  
F-Ratio = 0.58  
F Probability = 0.9046

The results showed that there are no mean significant differences in maternal health functioning among the three groups.

Table 16 shows the results of the t-tests which compared maternal health scores to the nonclinical normative sample.
Table 16
Means, Standard Deviations, and t-Ratios Comparing Health and Daily Living Form Mental and Physical Health Data From Mothers of Stealer, Aggressor, Internalizer, and Nonclinical families.

<table>
<thead>
<tr>
<th>HDL Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC-S</td>
<td>11.87</td>
<td>7.35</td>
<td>14.63</td>
<td>4.31</td>
</tr>
<tr>
<td>SC-A</td>
<td>14.53</td>
<td>4.42</td>
<td>14.63</td>
<td>4.31</td>
</tr>
<tr>
<td>SC-I</td>
<td>11.35</td>
<td>6.53</td>
<td>14.63</td>
<td>4.31</td>
</tr>
<tr>
<td>GD-S</td>
<td>17.81</td>
<td>15.15</td>
<td>19.21</td>
<td>11.79</td>
</tr>
<tr>
<td>GD-A</td>
<td>24.88</td>
<td>13.47</td>
<td>19.21</td>
<td>11.79</td>
</tr>
<tr>
<td>GD-I</td>
<td>21.0</td>
<td>15.77</td>
<td>19.21</td>
<td>11.79</td>
</tr>
<tr>
<td>DM-S</td>
<td>2.12</td>
<td>2.36</td>
<td>2.01</td>
<td>1.74</td>
</tr>
<tr>
<td>DM-A</td>
<td>3.18</td>
<td>1.68</td>
<td>2.01</td>
<td>1.74</td>
</tr>
<tr>
<td>DM-I</td>
<td>2.65</td>
<td>2.39</td>
<td>2.01</td>
<td>1.74</td>
</tr>
<tr>
<td>MC-S</td>
<td>0.18</td>
<td>0.54</td>
<td>0.47</td>
<td>0.84</td>
</tr>
<tr>
<td>MC-A</td>
<td>0.88</td>
<td>1.45</td>
<td>0.47</td>
<td>0.84</td>
</tr>
<tr>
<td>MC-I</td>
<td>0.82</td>
<td>1.50</td>
<td>0.47</td>
<td>0.84</td>
</tr>
<tr>
<td>MED-S</td>
<td>1.56</td>
<td>1.59</td>
<td>2.01</td>
<td>1.52</td>
</tr>
<tr>
<td>MED-A</td>
<td>3.11</td>
<td>2.20</td>
<td>2.01</td>
<td>1.52</td>
</tr>
<tr>
<td>MED-I</td>
<td>2.47</td>
<td>5.58</td>
<td>2.01</td>
<td>1.52</td>
</tr>
<tr>
<td>PS-S</td>
<td>0.87</td>
<td>2.09</td>
<td>2.25</td>
<td>2.54</td>
</tr>
<tr>
<td>PS-A</td>
<td>0.76</td>
<td>1.30</td>
<td>2.25</td>
<td>2.54</td>
</tr>
<tr>
<td>PS-I</td>
<td>0.53</td>
<td>1.37</td>
<td>2.25</td>
<td>2.54</td>
</tr>
<tr>
<td>ALCOH-S</td>
<td>0.05</td>
<td>0.07</td>
<td>0.76</td>
<td>1.72</td>
</tr>
<tr>
<td>ALCOH-A</td>
<td>0.10</td>
<td>0.13</td>
<td>0.76</td>
<td>1.72</td>
</tr>
<tr>
<td>ALCOH-I</td>
<td>0.54</td>
<td>1.54</td>
<td>0.76</td>
<td>1.72</td>
</tr>
<tr>
<td>SP-S</td>
<td>0.37</td>
<td>0.67</td>
<td>0.31</td>
<td>0.76</td>
</tr>
<tr>
<td>SP-A</td>
<td>0.52</td>
<td>1.06</td>
<td>0.31</td>
<td>0.76</td>
</tr>
<tr>
<td>SP-I</td>
<td>1.29</td>
<td>0.68</td>
<td>0.31</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Note.  N = 44

df = 1174

*P < .05

**P < .005

SC = Self-Confidence; GD = Global Depression; DM = Depressed Mood; MC = Number of Medical Conditions; MED = Number of Medications; PS = Number of Physical Symptoms; ALCOH = Frequency-Quantity Measure of Alcohol Consumption; SP = Number of Smoking-Related Health Problems
The t-tests showed that Aggressor mothers reported a significantly greater number of medical Conditions (P < .005), and also reported taking a significantly greater variety of medications than a nonclinical normative sample. Stealer mothers reported significantly fewer Medical Conditions than a nonclinical sample.

The second level of analysis for Hypothesis Four involved a MANOVA of paternal health data. Table 17 shows the results of the MANOVA test.

Table 17
Multivariate Analysis of Variance of Paternal Health and Daily Living Form Health Data Among Groups of Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>HDL Health Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Confidence</td>
<td>0.18</td>
<td>0.8366</td>
</tr>
<tr>
<td>Global Depression</td>
<td>0.25</td>
<td>0.7797</td>
</tr>
<tr>
<td>Depressed Mood</td>
<td>0.03</td>
<td>0.9665</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>1.48</td>
<td>0.2504</td>
</tr>
<tr>
<td>Number of Medications</td>
<td>0.30</td>
<td>0.7433</td>
</tr>
<tr>
<td>Number of Symptoms</td>
<td>0.13</td>
<td>0.8747</td>
</tr>
<tr>
<td>Alcohol Frequency-Quantity</td>
<td>3.50</td>
<td>0.0480 *</td>
</tr>
<tr>
<td>Number of Cigarettes Daily</td>
<td>1.18</td>
<td>0.3251</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Table 17—Continued

<table>
<thead>
<tr>
<th>HDL Health Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Smoking-Related Problems</td>
<td>0.16</td>
<td>0.8494</td>
</tr>
</tbody>
</table>

Note. N = 25
df = 02,43
*P < .05

MANOVA Test for HDL Paternal Health Data

Hotelling-Lawley Trace = 0.97822420
F-Ratio = 0.71
F Probability = 0.7750

The results showed that there are no mean significant differences in paternal health functioning among the three research groups. However, the ANOVA test revealed Internalizer fathers obtained higher scores (P < .05) than the Stealer fathers on the Alcohol Frequency-Quantity measure.

Table 18 shows the Tukey comparison between Internalizer and Stealer fathers on the Alcohol Frequency-Quantity measure of the HDL.
Table 18
Tukey's Studentized Range Test for Paternal Alcohol Frequency-Quantity

<table>
<thead>
<tr>
<th>Family Comparison</th>
<th>Simultaneous Difference</th>
<th>Simultaneous Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Confidence Limit</td>
<td>Between Means</td>
</tr>
<tr>
<td>Stealer Versus Internalizer</td>
<td>0.02325</td>
<td>0.46778</td>
</tr>
</tbody>
</table>

*P < .05

Hypothesis Five

There will be no significant differences among the number of maternal and paternal Social Activities with Friends, Social Activities with Relatives, Number of Close Relationships, Number of Social Network Contacts, and Number of Social Clubs as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

The fifth hypothesis included two levels of analysis of HDL social data: Maternal and Paternal. The first level of analysis for Hypothesis Five involved maternal data. Table 19 shows the results of the MANOVA test.
Table 19
Multivariate Analysis of Variance of Maternal Health and Daily Living Form Social Data Among Groups of Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>HDL Social Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Social Activities With Friends</td>
<td>0.52</td>
<td>0.5966</td>
</tr>
<tr>
<td>Number of Social Activities With Relatives</td>
<td>1.73</td>
<td>0.1896</td>
</tr>
<tr>
<td>Number of Close Relationships</td>
<td>0.36</td>
<td>0.7004</td>
</tr>
<tr>
<td>Number of Social Network Contacts</td>
<td>0.28</td>
<td>0.7598</td>
</tr>
<tr>
<td>Number of Club Affiliations</td>
<td>0.31</td>
<td>0.7342</td>
</tr>
</tbody>
</table>

Note. N = 44
\[ df = 1166 \]

MANOVA Test for HDL Maternal Social Data

Hotelling-Lawley Trace = 0.36411824
F-Ratio = 0.65
F Probability = 0.8476

The results showed no significant differences between groups on all measures. Based on these results the first level of analysis of the fifth null hypothesis cannot be rejected.

Table 20 shows the results of the t-tests which
compare maternal social data to a nonclinical sample.

Table 20

Means, Standard Deviations, and t-Ratios Comparing Health and Daily Living Form Social Data from Mothers of Stealer, Aggressor, Internalizer, and Nonclinical Families

<table>
<thead>
<tr>
<th>HDL Scale Per Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFR-S</td>
<td>3.56</td>
<td>3.10</td>
<td>5.38</td>
<td>2.79</td>
</tr>
<tr>
<td>SAFR-A</td>
<td>4.00</td>
<td>2.52</td>
<td>5.38</td>
<td>2.79</td>
</tr>
<tr>
<td>SAFR-I</td>
<td>2.82</td>
<td>2.19</td>
<td>5.38</td>
<td>2.79</td>
</tr>
<tr>
<td>CREL-S</td>
<td>9.56</td>
<td>13.37</td>
<td>6.77</td>
<td>5.85</td>
</tr>
<tr>
<td>CREL-A</td>
<td>10.29</td>
<td>7.33</td>
<td>6.77</td>
<td>5.85</td>
</tr>
<tr>
<td>CRES-I</td>
<td>7.11</td>
<td>6.87</td>
<td>6.77</td>
<td>5.85</td>
</tr>
<tr>
<td>NC-S</td>
<td>7.56</td>
<td>7.78</td>
<td>17.95</td>
<td>14.71</td>
</tr>
<tr>
<td>NC-A</td>
<td>11.35</td>
<td>7.74</td>
<td>17.95</td>
<td>14.71</td>
</tr>
<tr>
<td>NC-I</td>
<td>9.00</td>
<td>8.19</td>
<td>17.95</td>
<td>14.21</td>
</tr>
</tbody>
</table>

**P < .005**

SAFR = Number of Social Activities with Friends Per Month
CRES = Number of Close Relationships
NC = Number of Social Network Contacts Per Month

The results of the t-tests showed that Internalizer mothers reported significantly fewer (P < .005) social contacts with friends than nonclinical sample.

To test for differences of paternal social resources among groups, a MANOVA was completed. The results of this analysis are presented in Table 21.
Table 21
Multivariate Analysis of Variance of Paternal Health and Daily Form Social Data Among Groups of Stealers, Aggressors, and Internalizers

<table>
<thead>
<tr>
<th>HDL Social Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Social Activities With Friends</td>
<td>0.19</td>
<td>0.8258</td>
</tr>
<tr>
<td>Number of Social Activities With Relatives</td>
<td>2.22</td>
<td>0.1321</td>
</tr>
<tr>
<td>Number of Close Relationships</td>
<td>0.12</td>
<td>0.8870</td>
</tr>
<tr>
<td>Number of Clubs</td>
<td>0.25</td>
<td>0.7786</td>
</tr>
</tbody>
</table>

Note. N = 25
   df = 1141

MANOVA Test for HDL Paternal Social Data

Hotelling-Lawley Trace = 1.89399695
F-Ratio = 1.66
F Probability = 0.1175

The results showed no significant mean differences between groups. Therefore, the second level of analysis of the fifth hypothesis cannot be rejected.
Hypothesis Six

There will be no significant differences among the Weighted Positive Life Change scores and Weighted Negative Life Change scores as measured by the Health and Daily Living Form across the three groups of Stealer, Aggressor, and Internalizer families.

The sixth hypothesis included two levels of analysis of Health and Daily Living Form Life Change Events data: Maternal and paternal. The first level of analysis involved maternal data.

To test for differences among Weighted Life Change Events scores, a MANOVA was implemented. Table 22 presents the results of this MANOVA.

Table 22
Multivariate Analysis of Variance of Weighted Maternal Positive and Negative Life Change Events Scores

<table>
<thead>
<tr>
<th>HDL Life Change Events Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Positive Life Change Events</td>
<td>0.05</td>
<td>0.9530</td>
</tr>
<tr>
<td>Weighted Negative Life Change Events</td>
<td>0.91</td>
<td>0.4114</td>
</tr>
</tbody>
</table>

Note. N = 44
\[ df = 1166 \]
\[ *P = .05 \]

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Table 22—Continued

MANOVA Test for Maternal Perceptions of Family Life Change Events

Hotelling-Lawley Trace = 0.04501119
F-Ratio = 0.44
F Probability = 0.7801

The results showed no significant differences between groups. Therefore, the first level of analysis of the sixth null hypothesis cannot be rejected.

Table 23 shows the results of the t-tests which compare maternal perceptions of Positive Life Change Events to a nonclinical normative sample.

Table 23
Means, Standard Deviations and t-Ratios Comparing the Number of Positive Life Change Events Reported by Mothers of Stealers, Aggressors, and Internalizers to a Nonclinical Normative Sample

<table>
<thead>
<tr>
<th>Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealer</td>
<td>0.59</td>
<td>0.87</td>
<td>0.80</td>
<td>1.00</td>
<td>1.40</td>
</tr>
<tr>
<td>Aggressor</td>
<td>0.62</td>
<td>1.04</td>
<td>0.80</td>
<td>1.00</td>
<td>1.13</td>
</tr>
<tr>
<td>Internal</td>
<td>0.57</td>
<td>1.03</td>
<td>0.80</td>
<td>1.00</td>
<td>1.44</td>
</tr>
</tbody>
</table>

The results of the t-tests showed no significant mean
differences in Positive Life Change Scores between the mothers of the three research groups and the Normative group.

Table 24 shows the results of the t-tests which compare the three research group's maternal perceptions of Negative Life Change Events to the nonclinical normative sample.

**Table 24**

Means, Standard Deviations and t-Ratios Comparing the Number of Negative Life Change Events Reported by Mothers of Stealers, Aggressors, and Internalizers to a Nonclinical Normative Sample

<table>
<thead>
<tr>
<th>Group</th>
<th>Clinical Mean</th>
<th>Clinical Standard Deviation</th>
<th>Normative Mean</th>
<th>Normative Standard Deviation</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealer</td>
<td>2.00</td>
<td>2.06</td>
<td>0.80</td>
<td>1.00</td>
<td>0.51</td>
</tr>
<tr>
<td>Aggressor</td>
<td>1.53</td>
<td>1.04</td>
<td>0.80</td>
<td>1.00</td>
<td>1.87*</td>
</tr>
<tr>
<td>Internal</td>
<td>2.50</td>
<td>1.79</td>
<td>0.80</td>
<td>1.00</td>
<td>3.11**</td>
</tr>
</tbody>
</table>

*P < .05  **P < .005

The results of the t-tests showed no significant mean differences between any of the maternal research groups and the nonclinical normative sample. Aggressor mothers reported greater (P < .05) and Internalizer mothers reported significantly greater (P < .005) numbers of Negative Life Change Events than the nonclinical normative sample.
The second level of analysis of the sixth hypothesis involved paternal Weighted Life Change scores. Table 25 shows the results of the MANOVA of paternal data.

Table 25

Multivariate Analysis of Variance of Paternal Positive and Negative Life Change Events Scores

<table>
<thead>
<tr>
<th>HDL Life Change Events Scale</th>
<th>F-Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Positive Life Change Events</td>
<td>0.17</td>
<td>0.8410</td>
</tr>
<tr>
<td>Weighted Negative Life Change Events</td>
<td>0.21</td>
<td>0.8097</td>
</tr>
</tbody>
</table>

Note. N = 19
\[ \text{df} = 02.41 \]

MANOVA Test for HDL Paternal Social Data

Hotelling-Lawley Trace = 0.046479000
F-Ratio = 0.23
F Probability = 0.9185

The results showed no significant differences between groups. Therefore, the second level of analysis of the sixth null hypothesis cannot be rejected.

Summary

The results of this study indicated that subjects comprising the Stealer, Aggressor, and Internalizer groups
the criterion instrument measures. Aggressors' families perceived more effort in their families to control family members' behavior (P < .052) than did the Stealers' families. Stealer Total Family scores for the Family Environment Scale Form R minus Form I difference scores on Achievement were larger (P < .05) for Stealers' families than for either the Aggressors' or Internalizers' families.
CHAPTER V

DISCUSSION, RECOMMENDATIONS, AND SUMMARY

Discussion

The statistical results which have been reported will be discussed in terms of their implications to the research questions. In question is whether or not various measures of perceptions of family social climates and measures of parental mental, physical, and social characteristics are differentially related to two different types of families of conduct disordered boys: The families of Stealers and Aggressors. Statistical analyses, in addition to those originally planned, will also be discussed.

Some researchers believe that specific organizational and behavioral patterns in families are influential in initiating and maintaining specific forms of child maladjustment. Research has suggested that families of neurotically adjusted children are likely to exhibit different behavioral patterns than families of conduct disordered children (Lewis et al. 1976). For example, families of neurotically adjusted children were thought to possess high achievement strivings, a lack of behavioral spontaneity, and high levels of organization and
behavioral control. Families of conduct disordered children were expected to show low levels of child behavioral control, low levels of emotional support and autonomy, and high levels of conflict. Patterson (1982) reported his belief that conduct disorders in children generally were developed in families in which parents did not practice effective family management skills. The family management skills that Patterson considered most important were the development of clearly stated rules for child behavior, careful monitoring of child behavior, providing fair and consistent consequences for child misbehavior, and the ability to solve problems constructively. Patterson believed that if these management strategies were not consistently implemented, child misbehavior would increase, family members would spend less leisure time together and family members would develop increasingly more negative views of one another.

Patterson (1982) suggested that families of conduct disordered children can be classified more precisely into two major types: Stealers' families and Aggressors' families. He believed that even though these two types of families possess many similar behavioral characteristics, some behavioral differences do exist between them. Parents in Stealers' families were thought likely to exhibit low levels of such traits as parental guidance and support for child achievement, supervision of out-of-home
child behavior and emotional closeness among family members. Families of Aggressors were characterized by high levels of intra-familial conflict and aggressiveness.

If behavioral differences between Stealers' and Aggressors' families do exist as described by Patterson, it appears that family members' perceptions of these behavioral trait differences do not coincide with actual behavior. If perceptions of family social climates and parental traits were consistent with the behavioral traits described by Patterson, then larger mean differences between Stealer and Aggressor groups should have occurred on the scores of the criterion instruments used in this present study.

In Hypothesis One data generated by the Family Environment Scale (FES) Form R were analysed from three different perspectives: Total Parent responses, Identified Patient responses, and Total Family responses. Based on results of the MANOVA test, the first null hypothesis could not be rejected. These results suggest that members of Stealers', Aggressors', and Internalizers' families do not perceive their family social environments to be significantly different from one other. The FES Form R does not appear to possess measures which are capable of delineating diagnostically significant differences in family social climates between the Stealer and Aggressor groups, or else there are in fact no group
Patterson (1982) believed that Stealers' parents made less effort than Aggressors' parents to control child out-of-home behavior. The present research data support this belief. No significant mean differences regarding perceived Control existed among parents of the three research groups. However, an ANOVA test revealed that Aggressors' families perceived more (P < .052) Control than the Stealers' families. Perhaps Stealers' parents either don't care that their families possess low Control or they may perceive that their families possess sufficient Control when in fact they may not.

In either case, parents of Stealers' families might possess little motivation to modify their child management strategies. This condition could result in parental overpermissiveness toward child misbehavior. Many researchers and theorists believe that parental overpermissiveness is associated with the development and maintenance of child conduct disorders (Patterson, 1976; Robins, 1966).

The Aggressors' parents appeared to perceive that they were trying hard to maintain behavioral control of their children. Their lack of success in this endeavor is probably frustrating, and may contribute to increased parental irritability, coerciveness, or avoidance of their children. These parental traits have been associated with
the development of conduct disorders.

Through a Total Parent level of analysis, t-tests comparing the three research groups to a nonclinical normative sample revealed the following results: Significantly less (P < .005) Cohesion was perceived by Stealers' and Aggressors' parents; significantly more Conflict was perceived by Aggressors' parents; significantly less Independence and Intellectual-Cultural were perceived by Aggressors' parents; and significantly less Active-Recreational was perceived by Internalizers' parents.

Based upon perceptions of their family social climates, Aggressors' parents appear to rate their families more unfavorably than the Stealers' or Internalizers' parents. They perceived the most Conflict and least Control, Cohesion, Intellectual-Cultural, and Independence.

These data appear to support Patterson's (1982) belief that compared to Stealers' families, Aggressors' families experience more intra-familial coerciveness, argumentation and enmity. Even though these criterion instrument score differences were in the expected direction, it should again be noted that these differences were not statistically significant.

Patterson also believed that Stealers' parents placed less emphasis on family member achievement than did
Aggressors' parents. However, the results of the MANOVA test indicated no significant mean differences among the three research groups in terms of perceptions of familial Achievement. The t-test analyses revealed that Stealers' parents perceived only slightly less Achievement Orientation than did the parents of Aggressors or Nonclinical children.

It is likely that Stealers' parents overestimated the actual amount of Achievement Orientation in their families. This possible overestimation could be functional in maintaining familial homeostasis. For example, it might be important to the maintenance of a parent's positive self-concept to maintain an illusion that achievement strivings are higher among family members than they actually are.

The phenomenon of possible overestimation of perceptions of Achievement Orientation by Stealers' parents also supports the thinking of Johnson and Szurek (1952). Unconscious psychological processes could cause a parent to overestimate his or her family's Achievement Orientation. This distortion could function to lower parental expectations for child achievement. Lowered parental expectations for child achievement may result in lowered child achievement. An underachieving child is more likely than his normally achieving counterparts, to experience lowered self-esteem and to
engage in deviant behavior.

Johnson and Szurek believed that parents of maladjusted children actively reinforced child misbehavior in order to vicariously satisfy their own poorly integrated impulses through their children's misbehavior. In such cases, child misbehavior would be functional within the child's familial context because it would serve to gratify parental unconscious or conscious impulse strivings. Therefore, parents might implement family dynamic patterns which deny or distort pathogenic familial traits in order to insure continued reinforcement of child misbehavior.

Several theorists believed that parental emotional deprivation of children can cause child conduct disordered behavior (Bowlby, 1951; Freud, 1949; Wolberg, 1943). Patterson (1982) believed that Stealers' families possess less emotional cohesiveness than Aggressors' families. If perceptions of family social climates are in accord with actual behavior, Stealers' families would be expected to perceive less emotional cohesiveness in their family than would Aggressors' families.

Stealers' families showed significantly less Cohesiveness ($P < .005$) than the nonclinical normative sample on the Total Parent and Identified Patient levels of analysis. On the Total Family level of analysis the same comparison showed less Cohesiveness ($P < .01$) than the
normative sample. However, no significant differences on cohesion occurred among the three research groups.

Stealers' families did not perceive less cohesiveness than the families of Aggressors and Internalizers. This may indicate that Stealers' families tend to underestimate low and potentially pathogenic levels of cohesiveness in their families. If Stealers' families do not accurately perceive potentially pathogenic conditions of emotional distance in their families, it is unlikely they would possess sufficient motivation to increase intra-familial cohesiveness.

In some Stealers' families, potentially pathogenic levels of emotional distance are likely to represent a preferred level of closeness for parents. Any threat of change toward more emotional closeness may be threatening to them, and thus raise the overall family distress level. An increase in family distress could result in intensified symptoms for the identified patient or in an onset of symptomatology in another family member. This reasoning reflects the thinking of family systems theorists (Bertalanffy, 1968; Bowen, 1974).

Perhaps any form of child behavioral or emotional maladjustment is associated with decreases in family members' perceptions of familial cohesiveness. For example, dissimilar forms of child deviant behavior such as physical assaultiveness versus fearful withdrawal from
interpersonal contact may cause or be caused by similar forms of familial distress. This distress, though associated with different forms of child misbehavior, may result in the development of similar perceptions of emotional distance among family members.

In comparing Stealers' and Aggressors' families, Patterson (1982) believed that higher levels of aggressiveness and conflict would typically be found in Aggressor families. However, the results of the MANOVA test revealed that a significant mean difference in Conflict was not found between these two groups. This may mean that Aggressor family members may underestimate the level of Conflict in their families. Aggressors' families may as Patterson believes, tolerate higher levels of familial conflict. It is possible that a higher tolerance level for family conflict would cause a lowered perception of familial Conflict on the FES.

If a higher level of tolerance for family conflict is combined with inadequate behavioral controls, intra-familial aggressiveness would easily accelerate progressively to a point beyond the family's tolerance limit. Aggressive behavior of one family member toward another is likely to provoke an aggressive response from the person being aggressed against. This pattern often initiates a chain reaction of increasingly more aggressive responses.
As expected, t-test Total Family and Identified Patient analyses revealed that Stealers and Aggressors perceived significantly more family Conflict than the nonclinical group.

It is possible that family members' perceptions of their family social climates may not always accurately reflect actual family behavior. These misperceptions may sometimes be functional in maintaining dysfunctional family traits. For example, people who prefer to avoid familial emotional closeness may overestimate the level of Cohesion in their families. This overestimation would allow them to formulate an acceptable self-image, while maintaining potentially pathogenic levels of emotional distance among family members.

This type of problem accentuates the importance of developing accurate clinical assessments, and of bringing pathogenic individual and relationship traits into conscious awareness through the process of psychotherapy. This type of awareness must be facilitated by therapists, prior to the initiation of intervention strategies.

Moos (1981) defined the term incongruence as "the extent of disagreement among family members with regard to their perceptions of family climate" (p. 9). The results of the ANOVA test for Hypothesis Two revealed no significant mean differences among the three research groups with regard to Total Family Incongruence.
scores. The t-test analyses revealed that Stealer and Internalizer families obtained greater ($P < .05$) Incongruence scores than the nonclinical normative sample. The Aggressors' families obtained Incongruence scores which were similar to the scores obtained by the normative group.

Based on Patterson's research, Aggressors' families would be expected to obtain higher Incongruence scores than the other groups. This possible underestimation of Incongruence in Aggressors' families could be due to a higher tolerance for differences of opinion in Aggressors' families. Further, it is possible that less Incongruence was found in Aggressors' families because they engage in more verbal exchange with one another, albeit negative exchange. Greater rates of verbal exchange may help to develop greater degrees of homogeneity among family members' perceptions of their family's social climate.

Form R of the FES purports to measure family members' real, or actual, perceptions of their family's social climate. Form I of the FES purports to measure family member's ideal, or desired, family social climate. A difference score was obtained for each of the ten FES scales by subtracting the Form R scores from the corresponding Form I scores for each family member. The third null hypothesis tested for differences among difference scores among the three research groups.
The MANOVA which was used to test Hypothesis Three revealed that no mean significant differences in terms of difference scores were found among the three research groups. However, the ANOVA tests revealed some large though nonsignificant differences (p. < .05) among difference scores. The Total Family level of analysis revealed that Stealers' families obtained larger (p. < 05) difference scores in Achievement Orientation than both the Aggressor and Internalizer groups. This finding may suggest that Stealers' family members are more dissatisfied with their failure to meet their achievement expectations than are members of the two other groups.

The Identified Patient level of analysis for the third null hypothesis revealed that Stealer Identified Patients perceived greater dissatisfaction with their families' Achievement Orientation than did Aggressor or Internalizer Identified Patients. The Stealers' parents reported approximately the same amount of dissatisfaction with their family's Achievement Orientation as did their children.

It is surprising that Stealer identified patients reported the greatest level of dissatisfaction with their families' Achievement Orientations. Their antisocial behavior connotes an extreme disregard for conventional goals and values. Perhaps Stealer identified patients possess aspirations to succeed in socially acceptable
terms, but may lack the requisite skills to do so.

Stealers' parents appear to be generally unable to help channel their child's frustrated achievement strivings into socially acceptable behavior. Stealer children may derive some satisfaction from succeeding through antisocial behaviors. For example, they may derive satisfaction from behaving antisocially without getting caught. The child may wish to excel, but may not wish to or be able to excel in socially acceptable terms.

Maternal mental and physical health problems and social isolation have frequently been associated with the development of child conduct disorders (Billings & Moos, 1983; Patterson, 1982; Wahler, 1980). Further, Patterson (1982) and Billings and Moos (1983) reported that familial distress due to family life change events can disrupt the effectiveness of parental attempts to manage child behavior.

Three groups of data obtained from the Health and Daily Living Form; mental and physical health, social resources, and family life change events were analyzed from two different perspectives: Maternal and paternal. Hypothesis Four attempted to ascertain if there are differences in parental mental and physical health measures among the three research groups.

The MANOVA test revealed no significant mean differences among the three research groups on these
scores. Based on these results, the fourth null hypothesis cannot be rejected. These results suggest that neither mothers nor fathers of the three research group families possess significantly different states of mental and physical well-being. Since there were only 25 paternal subjects, it was determined that meaningful conclusions could not be derived from this limited data.

Griest and Wells (1983) proposed that depressive symptoms such as sleep loss and concentration difficulties, may create lowered tolerance for child misbehavior for some mothers. This lowered tolerance for child misbehavior was thought to be related to increases in maternal irritability and coerciveness toward children. High degrees of coerciveness, compared to other types of clinical families, was a trait associated with Aggressor families (Patterson, 1982).

There were no significant differences on HDL depression measures among the three research groups. Also, there were no significant mean differences between any of these three groups and the nonclinical normative sample. The data generated by the present research contradict the thought that many Aggressor mothers are excessively depressed. However, it is possible that some of the sample mothers could formerly have experienced depressive symptoms which may have been alleviated through treatment or through the passage of time.
Patterson also believed that a second constellation of depressive symptoms such as loss of energy, excessive sleeping and feelings of hopelessness were commonly found in overpermissive mothers. Overpermissiveness in matters related to child aggression was associated with mothers of Aggressors. Overpermissiveness related to theft committed by children was associated with mothers of Stealers. This study did not confirm nor disconfirm that a link may exist between maternal depression and child conduct disorders.

The t-test analyses revealed that Aggressor mothers reported experiencing significantly more Medical Conditions and taking more medications than the nonclinical group. It is possible that maternal medical problems may contribute to increased maternal irritability. Conversely, high levels of family conflict may contribute to higher levels of maternal physical illness.

It is not clear from these data if family distress causes maternal physical ailment, if maternal physical ailment contributes to familial distress, or if some unknown variable contributes to the cause of both poor maternal physical health and to the overall level of family distress.

Several researchers have proposed that mothers of conduct disordered children are more socially isolated than mothers of other types of children (Wahler, 1980;
Hypothesis Five was developed to determine if maternal and paternal HDL social resource measures differed among parents of the three research groups. The MANOVA test revealed no significant mean differences among the three research groups on these measures. Therefore, the fifth null hypothesis cannot be rejected.

Further, a t-test analysis revealed that Internalizer mothers possessed significantly fewer (P < .005) social contacts with friends than nonclinical normative parents. The two conduct disordered groups of mothers also possessed fewer social contacts with friends than the normative mothers. However, the differences between these two groups and the normative sample were not significant.

These findings suggest that mothers of a clinical child, regardless of the child's diagnosis, may be more socially isolated from friends than mothers of nonclinical children. This isolation may be due to personality tendencies to withdraw from social interaction. However, this isolation may be caused because the extra time and energy demands required to manage a clinical child, and may reduce the chances and/or inclinations to be more socially involved. Further, parents of clinical children may experience rejection by their community, because they have a troubled child.

Wahler (1980) reported that the quality of maternal
social resources was more important than quantity in affecting the quality of mother-child relations. On days when mothers experienced aversive extra-familial social encounters, their level of irritability increased. This increase in maternal irritability resulted in increased coercive exchanges with her children and increased child misbehavior.

No measures of quality of maternal social relations were included in this research. It is possible that such quality measures might detect differences between the Stealer and Aggressor mothers.

Some researchers have reported that stress due to family life changes can disrupt family dynamic patterns resulting in increased mental and physical dysfunction in family members (Billings & Moos, 1983; Patterson, 1982). The MANOVA test for the sixth null hypothesis revealed that no mean significant differences were found among the three research groups in terms of measures of either Positive or Negative Life Change scores. A t-test analysis showed that Internalizer mothers reported significantly more (P < .005) Weighted Negative Life Change events than the nonclinical normative sample.

The data did not support the belief that family life change events are associated with the development and maintenance of child conduct disorders. However, it is possible that family life change events, which occurred
more than one year before the time of this investigation, may have adversely affected family management practices and thus child behavior.

Recommendations

Effective treatment and accurate clinical assessment of conduct disordered adolescent males and their families remain imprecise endeavors. In view of the significant scope of problems created by these boys, it is imperative that continued research efforts be made to increase our understanding about the etiology, assessment, and treatment of conduct disorders.

Because families are complex and dynamic entities, it may be unreasonable to expect that any of our currently available assessment devices are capable of providing valid and reliable descriptions of family characteristics. In order to make more valid and reliable family assessments, we may be required to develop more precise constructs for describing family characteristics and more sophisticated techniques for assessing them.

However, research efforts made in the near-future that are related to this study might benefit from using family assessment techniques and instruments in addition to those used in the present study. For example, it might be productive to assess different aspects of family functioning such as family coping styles or family
communication patterns. It might be productive to use different family assessment devices such as the Family Adaptability and Cohesion Evaluation Scales (FACES), (Olson, Bell & Portner, 1978), or the Beavers-Timberlawn Family Evaluation Scale (Lewis et al., 1976).

The subjects who were classified as Stealers for the purposes of the present study were selected from a population of adolescent males receiving treatment from a mental health facility. Perhaps greater assessment differences between Stealer and Aggressor groups would have been obtained if some or all of the Stealer subjects had been selected from a juvenile justice system detention facility. It is possible that juvenile justice Stealers and their families are in some ways qualitatively different from mental health Stealers and their families.

The present research population consisted of families which had received varied amounts of mental health treatment. For example, some of the families had received anywhere from one month to three years of various combinations of individual, group, pharmacological, and family treatments.

In all cases parents continued to view their child's behavior as significantly deviant from normative child behavior. However, it is possible that the lack of significant differences among groups found in the present study may be due in part to differences which were due to
family-level changes that were facilitated through treatment. In order to eliminate this potential source of bias from future research efforts, it might be beneficial to select only those subjects who have just begun in treatment for the first time.

Finally, it is possible that the small number of subjects involved in the present research may have limited the ability of the criterion instruments to delineate differences between the research groups. A larger sample might have revealed larger group differences on criterion instrument scores.

Summary

The purpose of this study was to learn more about the differences between the families of two types of conduct disordered adolescent males: Stealers and Aggressors. The criterion instruments provided measures of family members' perceptions of their family social climates, and various measures of parental physical and mental health and social resources. A comparison group termed Internalizer was composed of neurotically adjusted adolescent males and their parents.

It was thought that if differences were found among groups on criterion instrument measures, that this information could be helpful in terms of improving understanding about the etiology, clinical assessment and
treatment of conduct disorders.

Conduct disordered boys constitute a major child diagnostic group. The impact of their behavior on others can cause anywhere from minor annoyance to major emotional, physical or financial suffering. These boys are frequently referred to the juvenile justice or mental health systems for treatment. Professional treatment is seldom successful, and conduct disordered boys often continue their pattern of antisocial behavior through their adolescent and early adult years. Oftentimes their antisocial behavioral patterns lead to their incarceration.

A variety of research and theoretical perspectives have been developed to help increase understanding about the factors which contribute to the etiology and maintenance of these deviant behavioral styles. However, our understanding of these behavioral disorders remains limited.

In order to address the research questions a sample of adolescent male patients and their parents were selected from the Regional Institute for Children and Adolescents (RICA) which is located in Rockville, Maryland. RICA is a multidisciplinary psychiatric treatment center and school for emotionally disturbed youngsters and their families.

The sample included a total of 50 adolescents and
their parents: Seventeen boys and their parents were selected for placement in the Aggressor and Internalizer groups, and 16 patients and their parents were selected for placement in the Stealer group.

Child Behavior Checklist profile typologies were used to classify boys and their families into one of the three research groups. The Family Environment Scale Form R and Form I and the Health and Daily Living Form were selected as criterion instruments to measure perceived family social climates, desired family social climates, and parental functioning respectively.

Six statistical null hypotheses were developed to test the research questions. Five of the six null hypotheses involved multiple measurement variables, and were therefore tested by multivariate analyses of variance. A univariate analysis of variance was used to test Hypothesis Two because it involved only one measurement variable. Additional statistical analyses using t-tests were computed to test for criterion instrument measure differences between nonclinical normative samples and each of the three research groups.

Based on the research data none of the null hypotheses could be rejected. There were no significant mean differences among the three research groups in terms of any of the criterion instrument measures. Therefore, no conclusive statements can be made about differences
between Stealers' and Aggressors' families. Several large though nonsignificant mean differences between groups did occur. For example, Aggressors' families reported making greater efforts than Stealers' families to control family members' behavior. Aggressors' parents perceived their family social climates more unfavorably than the Stealers' or Internalizers' parents; they perceived the most conflict and least Control, Cohesion, Intellectual-Cultural Orientation and Independence. Stealer boys reported greater Achievement frustrations and strivings than the Aggressors and Internalizers.

It appeared that members of families of conduct disordered boys possessed some inaccurate perceptions about their families' social environments. These misperceptions may be associated with an inability to accurately assess their family problems. For example, it appeared that Stealers' families may have overestimated their families' levels of emotional cohesiveness and achievement strivings. These misperceptions may be associated with an inability to make satisfactory progress through psychotherapy.

It was recommended that further research be designed which would use additional assessment devices, larger samples, and the inclusion of Stealer adolescents selected from detention center populations.
REFERENCES


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.


Appendix A

Child Behavior Checklist
PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

These consist of pages:

Appendix A, pages 145-148
Appendix B, pages 150-154
Appendix C, pages 156-160
Appendix D, pages 162-174

University Microfilms International
300 N. ZEEB RD., ANN ARBOR, MI 48106 (313) 761-4700

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Appendix B

Family Environment Scale Form R
Appendix C

Family Environment Scale Form I
Appendix D

Health and Daily Living Form
Appendix E

Informed Consent and Assent Forms
We are interested in attempting to learn more about how to improve services for children and their families. Therefore, we have developed the RICA Family Assessment Study which is designed to investigate how children and parents view themselves and their families.

Participants in this project will be asked to complete three simple questionnaires, requiring about one hour of time. All questionnaire data will be coded to protect the confidentiality and anonymity of the participants. Analysis of questionnaire data will yield group information so that no individual scores will be examined.

We would like to include you and your son in this project. Your consent and your child's assent are needed. You may withdraw your consent and discontinue participation at any time without penalty. If you consent, please sign in the space provided below.

Name of Family: ____________________________________________

Address: __________________________________________________

Telephone: _________________________________________________

We the undersigned consent to participate in the RICA-Rockville Family Assessment. We have had the opportunity to ask questions and they have been answered to our satisfaction. It is understood that we are participating of our own free will and that consent may be withdrawn and participation discontinued at any time without penalty.

PARENT/GUARDIAN SIGNATURE ________________________________

DATE ________________________________

PARENT/GUARDIAN SIGNATURE ________________________________
We are interested in attempting to learn more about how to improve services for Students and their families. Therefore, we have developed the RICA Family Assessment Study which is designed to investigate how Students and parents view themselves and their families.

Students who participate in this project will be asked to complete two simple questionnaires, requiring about 45 minutes of time. All questionnaire data will be coded to protect the confidentiality and anonymity of the participants. Analysis of questionnaire data will yield group information so that no individual scores will be examined.

We would like to include you in this project. Your assent is needed. You may withdraw your assent and discontinue participation at any time without penalty. If you agree to participate, please sign in the space provided below.

Name of Student: ____________________________________________
Address: ___________________________________________________
Telephone: ___________________________________________________

I, the undersigned assent to participate in the RICA-Rockville Family Assessment. I have had the opportunity to ask questions and they have been answered to my satisfaction. It is understood that I am participating of my own free will and that assent may be withdrawn and participation discontinued at any time without penalty.

STUDENT SIGNATURE ______________________ DATE __________

PARENT SIGNATURE ______________________ DATE __________
BIBLIOGRAPHY


