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A systemic analysis of the critical elements of self-image and the propensity to suicidal risk for the learning disabled adolescent.

Nancy Baron
University of Massachusetts Amherst

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A SYSTEMIC ANALYSIS OF THE CRITICAL ELEMENTS OF SELF-IMAGE AND THE PROPENSITY TO SUICIDAL RISK FOR THE LEARNING DISABLED ADOLESCENT

A Dissertation Presented
by
NANCY GAIL BARON

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of
DOCTOR OF EDUCATION
May 1989
School of Education
A SYSTEMIC ANALYSIS OF THE CRITICAL ELEMENTS OF SELF-IMAGE AND THE PROPENSITY TO SUICIDAL RISK FOR THE LEARNING DISABLED ADOLESCENT

A Dissertation Presented

by

NANCY GAIL BARON

Approved as to style and content by:

William Matthews, Chairman

Jack Hruska, Member

Harry Schumer, Member

Marilyn Haring-Hidore, Dean
School of Education
DEDICATION

Dedicated to the memory
of Michael.
ACKNOWLEDGMENTS

I greatly appreciate the support of the private schools and the parents of my subjects who believed in the value of this project and allowed me to enter their lives. I am most grateful, however, to the young people who volunteered to share their life experiences with me. I am pleased that their wish to have this project be of use to helping others will be fulfilled.

Deep appreciation is extended to all those who provided me with love and encouragement during the long process of my education and helped me to maintain my energy and motivation to achieve my goal. A loving thank you is extended to my friends Helene, Martha, and Ken and to my parents, Evelyn and Sidney Baron, and to my brothers, Glenn, Ronnie and Bruce.

I also want to thank my committee, Dr. William Matthews, Dr. Jack Hruska, and Dr. Harry Schumer, for their professional guidance, support, and reassurance.
This study compared the potential for suicide risk and the commonality of particular self-image factors between learning disabled and nonlearning disabled adolescents.

Research subjects were 30, learning disabled and 30, nonlearning disabled adolescents, equal numbers of males and females, attending private high schools.

A combination of quantitative and qualitative research methods were employed. The research measures were individually administered and included: the Suicide Probability Scale; the Offer Self-Image Questionnaire; and an individual interview.
Three hypotheses and one research question were developed and statistically tested to determine the relationship between the groups. The results of the investigation can be summarized as follows: Learning disabled adolescents were found to have an increased risk for suicide. The female learning disabled students were at greatest risk.

In addition, the learning disabled youths had a more negative self-evaluation. Most of the learning disabled youths reported frustrating and humiliating educational experiences that influenced their self-esteem.

The learning disabled adolescents were often dissatisfied with the limited constellation of their peer group. The females had poorer social relationships than the males.

Learning disabled youths at greatest suicide risk seemed to suffer from an object loss that resulted from their being learning disabled.

The major implication of these results is in the necessity for the development of suicide prevention programs specifically designed to meet the acute needs of this population. The responsibility for the implementation of these programs needs to be shared by schools, parents, and mental health professionals.
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Chapter 1

Introduction

Statement of the Problem

Adolescent suicide is a tragic problem. Each year large numbers of desperate youths choose to resort to suicidal acts.

Demographic statistics suggest that there has been a dramatic increase in the rate of adolescent suicide. From 1955-1978, suicides of youths ten to fourteen years of age increased by 166%; youths fifteen to nineteen years of age increased 208% (Pfeffer, 1986, p.26). See Tables 1.1 & 1.2 for additional evidence of the increase in suicide. It is believed by many that these statistics are understated.

Table 1.1

Male Suicide Rates in the U.S./100,000*
Age Groups (Years)

<table>
<thead>
<tr>
<th>Year</th>
<th>10-14</th>
<th>15-19</th>
<th>20-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>0.9</td>
<td>5.6</td>
<td>13.7</td>
</tr>
<tr>
<td>1965</td>
<td>0.9</td>
<td>6.1</td>
<td>16.3</td>
</tr>
<tr>
<td>1970</td>
<td>0.9</td>
<td>8.8</td>
<td>19.3</td>
</tr>
<tr>
<td>1975</td>
<td>1.2</td>
<td>12.0</td>
<td>25.9</td>
</tr>
<tr>
<td>1980</td>
<td>1.2</td>
<td>13.8</td>
<td>26.8</td>
</tr>
<tr>
<td>1981</td>
<td>1.2</td>
<td>13.6</td>
<td>25.6</td>
</tr>
</tbody>
</table>

**TABLE 1.2**  
FEMALE SUICIDE RATES IN THE US/100,000*  
AGE GROUPS (YEARS)

<table>
<thead>
<tr>
<th>Year</th>
<th>10-14</th>
<th>15-19</th>
<th>20-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>0.2</td>
<td>1.6</td>
<td>2.9</td>
</tr>
<tr>
<td>1965</td>
<td>0.1</td>
<td>1.9</td>
<td>4.2</td>
</tr>
<tr>
<td>1970</td>
<td>0.3</td>
<td>2.9</td>
<td>5.7</td>
</tr>
<tr>
<td>1975</td>
<td>0.4</td>
<td>2.9</td>
<td>6.7</td>
</tr>
<tr>
<td>1980</td>
<td>0.3</td>
<td>3.0</td>
<td>5.5</td>
</tr>
<tr>
<td>1981</td>
<td>0.5</td>
<td>3.6</td>
<td>5.6</td>
</tr>
</tbody>
</table>


It is important to note that suicide is the third leading cause of death in youths 15 to 24 years of age, in comparison to being the tenth leading cause of death for people of all ages (See Table 1.3).

**TABLE 1.3**  
TEN LEADING CAUSES OF DEATH FOR ALL PERSONS IN THE U.S., 1979*

<table>
<thead>
<tr>
<th>Ages 15-24</th>
<th>All Ages</th>
</tr>
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<tbody>
<tr>
<td>1. Accidents</td>
<td>1. Heart disease</td>
</tr>
<tr>
<td>2. Homicide</td>
<td>2. Malignant neoplasma (cancer)</td>
</tr>
<tr>
<td>3. Suicide</td>
<td>3. Cerebrovascular diseases</td>
</tr>
<tr>
<td>4. Malignant neoplasma (cancer)</td>
<td>4. Accidents</td>
</tr>
<tr>
<td>5. Heart disease</td>
<td>5. Chronic obstructive pulmonary</td>
</tr>
<tr>
<td>6. Congenital anomalies</td>
<td>6. Influenza and pneumonia</td>
</tr>
<tr>
<td>7. Cerebrovascular diseases</td>
<td>7. Diabetes and mellitus</td>
</tr>
<tr>
<td>8. Influenza and pneumonia</td>
<td>8. Cirrhosis/ chronic liver disease</td>
</tr>
<tr>
<td>10. Anemia</td>
<td>10. Suicide</td>
</tr>
</tbody>
</table>

*From *Youth Suicide*, Peck, Farberow, & Litman, 1985, p.6.
The first leading cause of death in youths 15 to 24 years of age is accidents, and it is speculated (but impossible to prove) that many accidents may really be suicides.

Determining the extent of attempted suicide within a society is even more complicated than determining committed suicide. "The number of living Americans with suicidal histories may be as great as ten million. Conservatively speaking, there are probably 500,000 to one million suicidal attempts annually." (Victoroff, 1983, p.14). Tishler, McKenry, & Morgan (1981) quote McIntire, Angle and Schlicht (1977) as estimating that there are 50 to 100 attempts for every completed act of suicide for adolescents. Rosenn (1982) suggests that suicide attempts are as high as "150 attempts for every completed act" (p.197) in adolescents. "At the very least teenagers are accounting for more than 12% of the nation's suicide attempts. The Institute for Destructive Behavior now estimates that approximately one million or more American children develop suicidal crises and preoccupations each year" (Rosenn, 1982, p.197). Due to the varied methods used and varying rationale given as reasons for the attempt (e.g. from a desire to die to a desire to let others know you're emotionally hurting), it is impossible to truly know the extent of attempted suicide. Yet, it is crucial to examine attempts since at least 10% of the people who have survived an attempt will eventually die of suicide (Victoroff, 1983).

Regardless of the exact percentage of attempted or committed suicide, in 1982, 200 youths aged five to fourteen and 5,025 youths aged fifteen to twenty-four are known to have committed suicide (in Peck et al., 1985, U.S. Monthly Vital Statistics, 1984). As noted earlier,
these figures are low estimates since we know that reported suicide is a small percentage of the actual figure. If one adds to that the fact that there are anywhere from 50 to 150 attempted suicides for each completed suicide, the suicidal behavior of American adolescents is of tragic proportions.

Numerous studies have been tried to identify the causal factors that lead a youth to attempt or commit suicide. No study has yet done so. Suicide is best understood by appreciating the systemic nature of the act. Each youth's life situation is unique and each suicidal act seems to be a result of an interlocking of a wide variety of factors. Suicidologists strongly support Shneidman's view (1987), "To understand any individual act of suicide completely we would need to examine the person and the situation from many perspectives: genetic, biochemical, sociocultural and psychological, to name just a few" (p.58). However, specific types of youth behavior and personality traits repeatedly coexist with suicidal activity.

Relationship Between Learning Disabilities and Adolescent Suicide

Learning disabled youth will be referred to as LD and nonlearning disabled youth as NLD throughout this paper.

In a review of the literature on suicide, a body of research was found that proposes that an unusually high number of youths who attempt or commit suicide had previously been identified as “learning
disabled" (Peck, 1985) and/or "minimally brain dysfunctioned" (Rohn, Sarles, Kenny, Reynolds, & Heald, 1977). The label given to them varies. They are interchangeably called "learning disabled", "dyslexic", "minimally brain damaged", "perceptually handicapped", "minimally brain dysfunctioned", "psychoneurologically disabled," or as having a "hyperkinetic syndrome." The reason for this brain or learning difficulty is widely debated but the differences can be identified through neurological, psychological and educational testing. The full extent of the meaning of these findings is unclear since only minimal research has been done.

There have been three specific studies that attempt to substantiate the claim that LD youth are overrepresented in the population of youth who attempt or commit suicide with only speculation from these findings as to why this occurs. The following is a review of the critical findings in these three pertinent studies.

While doing a study of all suicides under 15 years of age that occurred in Los Angeles County from 1975-1978, (a total of 14 cases) the Los Angeles Suicide Prevention Center discovered that seven of these youth were previously diagnosed as learning disabled. Actual diagnoses were "hyperactivity, perceptual disorder and dyslexia" (p.116). This number is clearly disproportionate to the general population, since actual learning disabilities occur in about 10% of the student population, while the percentage of actual youths so labeled in most school districts is below 5% (Lerner, 1976 from Peck, 1981). According to Michael Peck, Ph.D. (personal communication, May 15, 1987), this information was found during psychological
autopsies performed on these youths in an attempt to better understand the life experience of youths who committed suicide. Peck concluded, "It is clear that 'learning disabled' youngsters experience both pressure from parents to be 'normal' and pressure from peers deriding their disability, their feelings of frustration and hurt may be so great as to place a very young child in an at-risk category for suicide" (Peck, 1985, p.116). Since these suicides were all of the reported suicides in L.A. over three years, one can assume that they included a range of socioeconomic and racial backgrounds. Yet, many suicides are not reported as suicide, so this may still be a skewed sample.

The Rohn et al. (1977) study also had some important findings bearing on the relationship between school performance and suicide. They studied 65 youths, 75% female, median age of 16 but age range from seven to 19 years old, over a two-year period, who came to a hospital because of a suicide attempt. The subjects all came from an inner city, low socioeconomic, predominantly black neighborhood. They found that 75% of the youths who had attempted suicide had exceptionally poor school records. In this group, 19% had failed one or more grades and 35% were drop-outs or chronic truants. Another 35% were recorded as having behavior or discipline problems such as class disruption and fighting. Because of this high percentage of youth with school problems, they did further psychological tests on 25 youths and found that 60% had "minimal brain dysfunction". An overt manifestation of minimal brain dysfunction is a learning disorder. Rohn et al. believe that when learning problems are not identified and
remediated, youths often develop the type of academic and behavioral difficulties that are typified by the youths in this study. This suggests that the stress some students feel in school may stem from their inherent inability to be successful in the customary academic environment and that this potential feeling of inadequacy/ failure/ difference/ and confusion may contribute to some students' eventual choice of a suicidal act. The full meaning of these findings is unclear since the population studied is skewed and not representative of the overall population.

A study by Kenny et al. (1979) helps to support Rohn's findings. They studied 18 youths (mean age of 14.7 years) who had attempted suicide and compared them to a control group. Relevant here is that they found that a significant number of these youth had visual-motor problems of the type associated with learning disabilities and neurologic dysfunction. They found that 13 of the 18 attempters had failed at least one school grade. In the control group, eight out of 21 who had failed a grade. Twelve of the 18 attempters had problems at school, including: truancy, suspension, behavior problems. Only three out of the 21 control subjects had these school problems. Though the test and control groups were adequately matched for age, sex, race, and socioeconomic background, it is necessary to note that the racial breakdown of subjects is different from the overall population. Of the 18 youth tested who attempted suicide, 16 were black and two white. Therefore, these findings may not be relevant to youth with other racial and economic backgrounds.
In order to determine the extent of neurological dysfunction and learning disabilities, the youths in the Kenny et al. study were given the Bender Gestalt test and the Canter Background Interference Procedure. Both are well-studied procedures. Though the determination about degree of impairment may be quite accurate, using the standardized norms from these tests with black youth from economically deprived areas often has questionable validity. Also, it is unclear from the literature how long after the suicide attempt the youth were tested. If they were tested too soon after the attempt, it might influence their level of cooperation and motivation. Even with these potential limitations, this finding, added to the other two studies, provides evidence that an unusually high percentage of the youths who attempt or commit suicide are previously diagnosed as LD.

The feature articles in the *Journal of Learning Disabilities* (March, 1989) reviewed the relationship between suicidal risk and a specific learning disability termed the "nonverbal learning disability" (p.169). Rourke, Young, and Leenaars (1989) contend that nonverbal learning disabled adolescents and adults are at particular "risk for socioemotional disturbance of the internalized variety and, in turn, for suicide" (p.173). These authors hypothesize that this specific grouping of learning disabled youth are at an increased risk of suicide compared to youth with other forms of learning disabilities.

The neuropsychological characteristics of an nonverbal learning disabled person include:

1. "bilateral tactile-perceptual deficits"
2. "bilateral, psychomotor coordination deficiencies"
3. "deficiencies in visual-spatial-organizational abilities'

4. "deficits in nonverbal problem solving, concept formation, hypothesis testing, and the capacity to benefit from positive and negative informational feedback" and "significant deficiencies in dealing with cause-effect relationships and marked deficiencies in the appreciation of incongruities (e.g. age-appropriate sensitivity to humor)"

5. "well developed rote verbal capacities" and rote memory skills

6. "Extreme difficulty in adapting to novel and complex situations"

7. math skills deficient in comparison to proficiency in reading and spelling

8. "Much verbosity of a repetitive, straightforward, rote nature"

Misspellings that are phonetically accurate. "Reliance upon language as a principal means of social relating, information gathering, and relief from anxiety"

9. "Significant deficits in social perception, social judgment, and social interaction skills." Tendency to be socially withdrawn and isolated (p.169).

From these characteristics, the authors propose that the noverbal learning disabled person develops specific difficulties in social adaptiveness. In current slang, they could be considered "the nerd" (p.170). They are socially and physically clumsy. They have difficulty in social interactions due to simple things like difficulty determining how close to stand to someone or inability to understand subtle or even more blatant "body language" and often just missing the point of a social innuendo or comment. They tend to miss a situation's inherent dangers and misjudge the consequences of their actions. Their problem-
solving skills are limited since they rigidly attempt to use previously used strategies rather than adapt their coping to the uniqueness of the situation. Often this person's social difficulty leads people to avoid social contact with her/him. The person socially withdraws, becomes isolated and depressed. The authors suggest that these social factors lead this group to be at greater risk for suicide and "that these manifestations are predictable adaptive outcomes of the particular pattern of neuropsychological abilities and deficits that constitutes the nonverbal learning disabled syndrome" (p.173).

Critics of this article agree that the conclusions of this research group are based on logical patterns that seem to be supported by a few clinical case studies, but contend that the theories are not supported by empirical evidence. Kowalchuk and King (1989) state that "empirical research has not yet demonstrated any direct link between the low self-esteem of NLD persons in particular and increased suicidal risk" (p.178). Bigler (1989) concurs and states,

The whole issue of whether children with learning disabilities are at greater risk for suicide than non disabled children needs to be addressed. This will require further study in the area of emotional dysfunction and learning disability as well. These issues need to be solved before one can claim that nonverbal learning disabilities truly predisposes individuals to greater suicide risk (p.184).

This research study addresses the issues challenged by Bigler (1989) and Kowalchuk and King (1989).

Previous research implies that LD youth are at a greater risk of suicidal activity than NLD youth. Speculations are then made as to the
factors that might contribute to these youth being at greater risk. The strength, however, of this previous research is limited. This study was designed to first determine if LD adolescents are at greater risk for suicide than NLD youth. From the previous literature there is no clarity about the components of each LD youth's self-image that contributed to the suicidal ideation or attempt or led to her/his premature death. The lack of successful remediation of their LD or being LD and recognizing that they are different than the norm may cause tremendous pressure and frustration for some LD youth. This, in turn, may influence their self-esteem, encourage feelings of helplessness and hopelessness and lead some to acting out or depression and others to suicide. However, not all LD youth turn to suicide, so it is clear that simply being LD is not sufficient cause alone. This study further correlates the relationship between suicidal risk and specific adolescent self-image factors and compares these factors between LD and NLD youth.

**Purpose of the Study**

The purpose of this study is to determine:
1) if the degree of suicidal risk to normal learning disabled adolescents is significantly different than the risk to normal non-learning disabled adolescents;
2) if the factors that constitute the self-image of a learning disabled adolescent differ significantly from a non-learning disabled adolescent;
3) if some of the self-image factors are different, then to ascertain those that are significantly different for learning disabled and non-learning disabled youth who have a higher degree of suicidal risk; and
4) if there is a difference in self-image factors between learning disabled and non-learning disabled youth who are at increased suicidal risk.

Limitations of the Study

A major limitation in this research is that no clear cause and effect can be determined from these findings. Suicide is best understood by appreciating the systemic nature of the act and respecting the fact that each suicidal act involves a unique interlocking of circumstances specific to the individual. Studying a limited number of adolescents does not necessarily allow for generalization to the overall population. The results are specifically applicable only to the population tested. From the findings, however, one can determine possible trends that relate to similar populations.

Another limitation relates to the varied definitions of learning disability by educational and psychological experts. LD is defined for this research according to some very specific standards that clarify the population studied. Generalizations of this information beyond this study can only be done for youth who meet the same specific definition of LD.
It has been suggested that the use of volunteer subjects may influence a study’s results. Volunteers have been thought to have a greater need for social approval and to be more sociable, more altruistic, more self-disclosing, more maladjusted, more anxious, more extroverted, and have a greater need for achievement than nonvolunteers (Borg & Gall, 1983, p.252-3). Since volunteers were used for both subject groups, the possible volunteer bias is constant between the groups. Again, these results can not necessarily be generalized to the overall population.

There is also some question by the experts in suicide research as to whether or not the information generated from a study of people with suicidal ideation and/or attempts can be generalized to the population of people who commit suicide.

Hawton (1986) specifies that, though there is some overlap, a study of one area does not necessarily define the other area because of the differences in risk by age and sex, the usual predisposing factors, and the methods used. Holden (1986) states that the data on unsuccessful suicide attempts is so uncertain that it is not clear to what extent the psychological problems of the attempters resemble those of the completers. Others, like Safii (1985), downplay the variance between the attempters and the completers. He says "A very direct relationship exists between the talkers and the doers" (p.839). He believes that the profile for each is similar, particularly because 40% of all those who commit suicide have made a prior attempt. Yet, Peck (1986) clearly outlines the variance in personality between the adolescent attempters and those who have died. He emphasizes the life-
long isolation and withdrawal from society of the completer in contrast to the more recent withdrawal from society of the attempter.

It will be assumed that a study of one area does not necessarily translate equally to the other area. There is some overlap between the people in both categories with 10% of all the people who attempt eventually committing suicide (Victoroff, 1986) and 40% of all those who complete suicide having made a prior attempt (Safii, 1985). Therefore, information secured by researching attempters or those with suicidal ideation certainly can still be useful in designing suicide prevention programs.

Any study that attempts to get self-reported information from adolescents has potential limitations. There is the possibility that the adolescent may not honestly report her or his feelings or behavior. To best alleviate this limitation, the tests in this study were given in a quiet, private location either at the youth's school or in her/his home and an attempt was made to help the youth to feel comfortable. The adolescent was assured that her/his material was confidential unless the testing revealed that there was a serious risk of an imminent suicidal act. In situations of extreme risk, the youth was told that he or she and her/his parent (and in some cases the school) would be informed of the risk but that the content of the testing would not be shared. In an effort to assess the credibility of the youth's response, there was some overlap between the questions asked on the written forms and the verbal interview. The results of each subject's testing were reviewed for internal consistency between test measures.
With the population of LD youth there is an additional possible limitation due to their being LD and having a range of difficulties with reading and/or comprehending written or spoken language and/or with memory that can make testing difficult or inaccurate. To reduce this limitation, a significant teacher for each youth reviewed the strengths and limitations of her/his learning style with the tester. Efforts were made to minimize the differences in test administration but, when necessary, the test administration was modified to best meet the youth's skills. In three situations, the youth listened to an oral administration of the test materials on a tape recorder and responded on a written form.

Though there are a number of limitations, they do not undermine the value of the information that can be learned from this study.

**Definition of Terms**

**Suicide**

There are a number of definitions of suicide that bear mentioning. Durkheim (1897) defined suicide as follows: "The term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself (sic) which he (sic) knows will produce this result" (Shneidman, 1986, p.2).

Frederick (1978) says that the capability for committing voluntary or intentional self-destruction is the reason something should be considered suicide.

Victoroff (1983) has a number of classifications of suicide that are useful. They include:

**Intentional suicide**: An act or pattern of self-destructive behavior of high lethality, deliberately planned by the subject to result in his death.

**Subintentional suicide**: An act or pattern of self-destructive behavior of low or uncertain lethality, not clearly perceived by the subject as likely to result in his death.

**Unintentional suicide**: An act or pattern of self-destructive behavior of variable levels of lethality, not consciously expected by the subject to result in his death.

**Parasuicide**: An act designed by the subject to simulate suicide but characterized by low expectation of lethal outcome.

**Chronic suicide**: Instances of self-destructive behavior carried out over an extended period, resulting in deterioration of health and/or decompensation of mental stability, and eventually ending in death.

**Suicide attempters**: Persons who at any time have made an intentional or subintentional suicide attempt.

**Suicide contemplators**: Those persons who manifest suicide ideation.

**Suicide ideation**: Thoughts, contemplations, reveries, fantasies, and obsessions in which a person invents themes and stories with his suicidal death as an essential element.

**Psychosomatic suicide**: Severe ulcerative colitis, bronchial asthma, massive urticaria, hypertension and anorexia nervosa are some of the diseases that under certain circumstances may be unconscious means of suicide (p.7).

For present purposes, completed suicide will mean an act of self-destructive behavior of high lethality, deliberately planned by the subject and resulting in death.
There is some disagreement about the proper terminology to use for people who have made a self-destructive act and have not died. Shneidman (1986) feels that that term 'attempted suicide' should "be saved to use in those rare cases of lethal intention in which the individual, against all ordinary odds, fortuitously survives" (p. 2). Durkheim, 1897, says that "An attempt is an act thus defined by falling short of actual death" (in Shneidman, p.2).

Others, like Victoroff (1983), however, consider a person who attempts suicide to be anyone who has made an unsuccessful "intentional" attempt or "subintentional" attempt; Victoroff includes "subintentional" acts, "those acts or patterns of self-destructive behavior of low or uncertain lethality, not clearly perceived by the subject as likely to result in his death" (p.7).

For the purpose of this research, attempted suicide will be defined as an intentional self-destructive act that has not resulted in a person's death.

Learning Disability

A LD youth will be of at least average intelligence whose academic performance becomes the arena through which we can identify that her/his learning style or perceptual abilities are different than the norm. Her/his learning disability does not stem from a known physical handicap, emotional problem, mental retardation or cultural disadvantage. Yet, through educational, psychological, or neurological testing, a particular cognitive or perceptual dysfunction can be identified that accounts for the youth's learning difficulty. Specific learning disabilites are listed in Table 1.4.
The LD youth in this study were attending private schools whose admissions policies were synonymous with this definition of learning disability. Each school verified that each subject had been tested and diagnosed as learning disabled by an educational or psychological specialist. Youth were not accepted into these schools if they were dually diagnosed as emotionally disturbed.

Table 1.4: Specific Learning Disabilities*

<table>
<thead>
<tr>
<th>Input</th>
<th>Integration</th>
<th>Memory</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual perception</td>
<td>Visual sequencing</td>
<td>Visual short-term memory</td>
<td>Spontaneous language</td>
</tr>
<tr>
<td>Auditory perception</td>
<td>Auditory sequencing</td>
<td>Auditory short-term memory</td>
<td>Demand language</td>
</tr>
<tr>
<td></td>
<td>Visual abstraction</td>
<td>Visual long-term memory</td>
<td>Gross motor</td>
</tr>
<tr>
<td></td>
<td>Auditory abstraction</td>
<td>Auditory long-term memory</td>
<td>Fine motor</td>
</tr>
</tbody>
</table>

*From The Misunderstood Child, Silver, 1984, p.28

Normal

The youth in this study are being referred to as normal adolescents. Each private school that participated in the study is
designed to educate youth who are of average to above average intelligence and who are not known to have any diagnosable emotional problems.

Organization of the Dissertation

Chapter I includes an overview of the problem addressed in this dissertation. An explanation of the purpose of the research design and the limitations of the design are reviewed. The chapter ends with clarification of specific technical terms used in the writing.

There has been a multitude of research done in the field of adolescent suicide. In Chapter II, the research is narrowed down and contains a review of the literature on adolescent suicide and learning disabilities that is relevant to this particular study. The specific hypotheses to be tested are discussed.

In Chapter III, the specific design of the study, including methodological information about the subject selection, study instruments, research procedures and data analysis are reviewed.

The research results are presented in Chapter IV.

Chapter V draws conclusions from the research findings and includes recommendations for future research.
CHAPTER II

REVIEW OF THE LITERATURE

Within the extensive body of adolescent suicide literature, suicidologists describe innumerable research studies and posit many theories in an attempt to determine the exact variables that join together in a youth's life to lead him/her to suicidal thoughts, attempts, or death. Decades of findings clarify that there is no clear causal relationship in suicide and that each act is as unique as the individual. Each individual's act is a result of a unique series of lifelong interconnecting components that lead her/him to the choice of suicide.

Mental health professionals are challenged to find trends within the suicidal population in the hopes that with this knowledge active means for suicide prevention can be targeted to populations at greatest risk. Research was found proposing that the learning disabled population of adolescents might be at an increased risk of suicide. There are specific studies done with this population and certain general theories about adolescent suicide that seem to support the possibility that this might be a group at increased risk.

In this chapter, the theories and research studies that are specifically relevant to understanding why the learning disabled youth might be at an increased risk for suicide are reviewed. Specific psychosocial factors and self-image variables that may be particularly
important for this population are discussed. A synthesis of these variables was used to develop the research hypotheses.

Any thorough systemic analysis of a youth’s suicidal act must account for all the factors that are critical to her/his life system. These factors can be divided into four major categories: sociological, individual psychological, family, and biological. The following is a review of the findings in each area that are pertinent to the development of the self-image of the learning disabled adolescent.

**Sociological Perspectives**

At the outset it should be noted that the sociological dimension is critical but not sufficient by itself.

Sometimes we act as if we believe that modern social conditions (e.g., divorce rates, both parents working, stress, high unemployment rates and scarce jobs, sex role confusion, competition in schools, 'the bomb', etc.) alone were producing the rise in adolescent suicide rates. To be sure, changes in the meanings of work, love, marriage, family, stress, parent-child relations, religion, models of peer suicides, and lack of clear, consensual life-goals set the broad context for adolescent suicide. But we must always remember that social factors alone cannot account for young suicides. (Maris, 1985, p.104)

The majority of young people manage to cope with the strains of modern life without attempting suicide. This suggests that there must be other factors (e.g., individually focused psychological, situational, and biological dynamics) which interact with particular social factors to make certain youths vulnerable to suicide.
Even though Emile Durkheim’s ideas were put forth in the late nineteenth century, they are still the best developed and most widely accepted of the sociological explanations for suicide. Durkheim believed that the individual’s behavior was directed by a "collective reality" that was determined by society. He believed that the "collective conscience" of a group was a major source of individual control. Each social group has certain beliefs, values, and rules that its members need to follow in order to retain membership in that group (in Taylor, 1982). This is particularly relevant to adolescents whose membership in a social group is crucial to their development. Adolescents seem to be pulled between four distinctive social groups: their peer group, the larger society, school, and their family. "Young people who depend for a sense of worth on being valued by others are particularly vulnerable to psychological stress" (Miller, 1981, p.12).

The Importance of the Peer Group

The peer group becomes the major source of youth social connection and belonging as s/he becomes an adolescent. It is crucial to the individual adolescent’s sense of belonging and acceptance to closely follow the beliefs, values, and rules of the peer group. This sense of belonging also seems crucial to their sense of personal worth and self esteem (Maris, 1975, p.95).
Durkheim's notion was that the suicide rate is dependent upon forces external to and constraining the individual.

To the degree that the societal groups are harmonious, integrated and the individual is an active, central member of those societal groups, then the individual's suicide potential will be low and a population of such individuals will have a low suicide rate (in Maris, 1975, p. 95).

In contemporary adolescent culture there are certain rules that must be adhered to, or the adolescent risks being ostracized and excluded from being a member of a peer group. Few things are more painful than being ostracized by peers. The adolescent who does not or cannot follow the accepted rules often has a difficult time. This youth is often teased by the group, excluded from activities and friendships and scapegoated. "In high school, when peer acceptance is crucial for identity and belonging, the thoughtless cruelty of the teenage for others who lack social and athletic skills or who try to establish some independence in choice of behavior may drive susceptibles to suicide" (Victoroff, 1983, p. 38).

The youth who is unable to follow the rules of the adolescent social group due to some personal limitation, or structural flaw that doesn't allow them to melt into the whole, is in for more long-lasting difficulty and it would seem that the risk of depression, personal dissatisfaction and their vulnerability to suicide could be higher. Victoroff (1983) states, "Bright children who are ostracized by their classmates; retarded or physically handicapped youngsters who have been separated from their peers; shy, withdrawn, friendless youngsters playing by themselves are stigmatized at a young age by social
isolation" (p.37). As Victoroff so aptly states from the earliest history, exile has been known as the worst punishment a person can be made to suffer. "With no one to talk to and no one to touch, he (sic) suffers unbearable loneliness. Death seems preferable" (Victoroff, 1983, p.38).

There are many reasons why a LD youth might be outside of the normative peer group and thus at increased risk. These reasons include:

1) some "learning disabled" youths will either be outside of the mainstream because they act or think unusually;
2) some will be isolated because they do poorly in school or because they are placed in special, separate classes;
3) others will perceive themselves as different and place themselves outside of the group;
4) others will be pushed out through taunting by their peers for their differences; and
5) others may rightly or wrongly perceive other youth as not wanting them to be a part of the group so they bow out.

The plight of many of these youths within their social group seems to be riddled with frustration and pain. Peck (1981) concluded that "pressure from peers deriding their disability" might be part of the reason that he found that learning disabled youth were overrepresented in the population of youth who committed suicide. Without the usual adolescent peer group connection, their success or demise seems very dependent on the strength of their individual self esteem and level of support they receive outside of their peer group.
The "Loner"/ Egoistic Suicidal Type

Durkheim proposed that there are four types of people (egoistic, anomic, altruistic, and fatalistic) who commit suicide. The "egoistic" and "anomic" types are seen most frequently and are most relevant to the LD population.

Many of today's teenage suicides seem to fit into the egoistic group. The egoist is the "loner" who does not fit into society and lacks meaningful social interaction. This person commits suicide because she/he is not sufficiently integrated into society.

Numerous studies on adolescent suicide show that the suicidal youth is often lonely and without an adequate support system. The earliest discussion of the "loner" was by Jan-Tausch (1964). He found that the difference between youth who attempted suicide and those who committed suicide centered on the former having had a close relationship with someone who was instrumental in their rescue (Peck, 1981). Teicher (1973) and Jacobs (1971) found that a chain of events resulting in a history of unreliable interpersonal support escalates just prior to the suicide attempt.

Peck (1981) describes the "loner" in great detail. He suggests that the pattern of isolated behavior begins to emerge in the early teens and seems to include a clear-cut symptom cluster. The "loner" is more likely to be male than female, and white rather than nonwhite. This adolescent often has a long history of spending his spare time alone. These young boys usually have very poor interpersonal relationships with both peers and adults. Much of the time they feel isolated and lonely and with no one to confide in when they feel upset. When they
do make friends, the relationship is often superficial. These boys appear to feel sexually inadequate and have serious doubts about their ability to ever relate to women. If they are seen in a psychiatric setting, they are commonly diagnosed as "borderline state," "schizoid personality," and "depressive character." They are less likely than other suicides to communicate their impending attempt. As these youths move into their later teens and are faced with increased stresses such as dating, getting a job, leaving home, they often become overwhelmed with a feeling of helplessness that they will not be able to compete. Unable to share these feelings with anyone they often enter a suicidal crisis, feeling helpless, hopeless and totally alienated. There are important family dynamics that exist for these youth that will be examined in the family section.

Some LD youth fit the "egoist" pattern. According to Durkheim (1897), the "egoist" is deficient in collective activity and is not able to find a basis for existence in life. The LD youth is often outside of the collectivity and many are deficient in the traits necessary to completely fit in. Many of these youth are excluded from the larger adolescent social group and forced into the "loner" category. Others place themselves out of the large group and become the "loner" because of their sense of humiliation at being different. Not wanting to continually feel this pain, some opt to be alone.
Conclusion: Importance of the Peer Group.

Though no study has shown a relationship between the "loner" and the LD adolescent, it is reasonable to assume that Victoroff's account of the pain of the youth who is different and becomes a "loner" is an accurate portrayal of some LD youth. It would appear that the risk of social isolation and peer group rejection is high for this group because they have distinct differences that are particularly obvious in the educational setting. This would become most apparent in junior high and high school when youth are their least tolerant toward individual differences and when the youth most longs to be part of a peer group. Of course, not all LD youth are exiled from their peers and the realization of their differences does not lead all of them to suicide.

The Relationship Between the Adolescent and the Larger Society

Social conditions have an important influence on the impressionable adolescent. Specifically, changes in values and mores and the attendant pressures of the society are of great influence to the adolescent's evolving sense of self. Garner (1975), an educator, writes,

Children are confronted today with a variety of life styles, values, attitudes, and behaviors that is greater than in any previous time in history. The mass media provides visual and auditory
representation of intense human experiences including love relationships, human suffering, violence, sexual alternatives, alcohol, and drugs. It is no surprise that today's youth are confused about their future identity. The amount of choice each must make is astronomical and their ability to do so limited by their youthfulness. They are fearful to make the wrong choices and confused by the ever changing nature of the society. What's not morally okay today, is often changed tomorrow or if your parents have certain beliefs they are often different from other friends' and relatives' values (p.241).

Durkheim suggested that this lack of societal consistency can lead to what he termed anomie.

"Anomic" Suicidal Type

Durkheim(1897) defines anomie as "the disintegrated state of a society or group that possesses no body of common norms or morals that effectively govern conduct" (in Wenz, 1979, p.388).

Anomie, as conceived by Durkheim, means:

1) declining regulations in social structure
2) lack of integration in social interaction
3) a 'psychological' sense of relative deprivation (Wenz, 1979. p.388).

Durkheim did not believe that acute change was responsible for the rise in suicide. Recent evidence tends to bear this out. Stein (1970) found only one-third of suicide cases at the L.A. Prevention Center were crisis cases. A crisis or acute case is usually a severe stress followed by severe emotional arousal and an urge to resolve the homeostatic imbalance. Most crises only last six weeks. Peck (1985) found that most adolescent suicides are not acute cases. This acute category would represent the youth who has had a normal development and while in a
vulnerable period of life faces a dramatic loss, or other stress. "It is our guess that a relatively small number of adolescent suicides fit the classical crisis picture" (Peck, 1985, p.117).

According to Durkheim and more recent researchers, it is chronic anomie that is responsible for the gradual rise in suicide rates. Taylor, in a review of Durkheim's work, says that in our modern society individuals are more often placed into situations of competition with one another and that "social existence is no longer ruled by custom and tradition" (Taylor, 1982, p.15). As people "demand more from life, not specifically more of something but simply more than they have at any given time, so they are more inclined to suffer from a disproportion between their aspirations and their satisfactions, and the resultant dissatisfaction is conducive to the growth of the suicidogenic impulse" (p.15).

Conclusion: Relationship Between the Adolescent and the Larger Society

It would certainly appear that the rapidly changing nature of our society affects the adolescent's sense of personal and emotional safety. Youths are insecure about how to fit into a world whose values are not clear, and are thus fearful about their ability to succeed as an adult. Since every youth is not committing suicide based on this societal confusion, one must examine those adolescents who are suicidal to
determine the additional factors that interface with the societal complications that put them at greater risk.

Some LD youths may have a more intense fear of the complications of society due to their realization that they are different and their belief that their limited or unique ability may prevent them from adequately competing and managing the society. This may more readily lead them to feel helpless in their ability keep up with the necessary changes, and hopeless about their future.

The Influence of Intelligence and School Problems

This section is a review of the research on the relationship between adolescent suicide and innate intelligence and particular school problems. School is considered by some to be the second most important social system; the family being first (Miller, 1981). Through the decades, numerous studies have shown that suicidal youth often have problems in school. Tishler et al. (1981) examined the most common precipitating events for attempted suicide and found from his subjects' self report that 52% had parent problems, 30% had school problems, 16% sibling problems, 15% peer problems, and 5% were psychotic. There are varying opinions about the reason for the suicidal youth's problems in school and questions as to whether these issues truly precipitate a suicidal act.
Schools, however, may only be the receptacle of a child's difficulties. The youth's problems may well exist prior to entering school and have their roots in the family, individual, or social structures. These problems may only come to the fore because this is the primary arena where the youth must deal with rules, structure, responsibility, competition, achievement, motivation, and attention. The cause and effect of the influence of school is unclear and though many of the research findings seem to suggest that school may be a prime causal factor in an adolescent's suicide, this has been proven. The ramifications of a difficult involvement between the youth and the school might, however, be one powerful contributing factor since the school's influence is a major force in the youth's development of a sense of self.

Studies have examined more closely the specific types of school problems including: rate of intelligence, academic difficulties and misbehavior.

**Intelligence**

Glaser (1971) believes that a great deal of stress exists for youth with "limited intelligence" (p.29), especially when these youth have parents and siblings with normal intelligence. He draws his conclusions about this from his experience as a private practitioner working with middle class socioeconomic and educational level clients. He believes that parents often do not recognize, do not accept, or do not understand their children's limitations and place impossible pressures and expectations on them. The youth then become frustrated because s/he can not please the parent or the teachers or because the youth does not
understand or can not explain the difficulty. The end result is often a feeling of guilt, helplessness and hopelessness that could lead to suicide. A youth with a learning disability may not be properly diagnosed and thought to have limited intelligence. The family dynamics that Glaser mentions may be relevant to middle class families with LD youth but we must be cautious as his research was based on his subjective experience with a limited population.

**Academic Performance/School Misbehavior/ Learning Disabilities**

It is important to make a clear distinction among the types of youth who have academic performance problems. Some reasons for academic problems include: lack of academic motivation, disinterest in school, problems outside of school that make concentration difficult, limited intelligence, fear of school (including school phobia), classroom misbehavior, incompetent teachers, to name only a few. The LD youth may also have any one of these problems but the root of the difficulties is different. These youths can be highly motivated and have a high IQ but still do poorly academically in the conventional educational system. Their difficulties stem from neurological or perceptual dysfunctions or problems with their sensory systems. Most studies do not specifically discuss the possible relationship between suicidal acts and youths with learning disabilities. It is also not clear what percentage of youths with school problems are LD and what percentage of LD youths have school problems. The following review is of the limited available literature on adolescent suicide and academic performance, school misbehavior, and includes the limited research on suicide and youth with "learning disabilities". 
A number of studies suggest that suicidal youths have academic difficulties. Rosenberg and Latimer (1966) found that the 14 males and 37 females they studied who attempted suicide were one to four years behind grade level. No mention was made about LD.

In the Peck (1981) study, reviewed in Chapter 1, of all suicides under 15 years old that occurred in Los Angeles County from 1975-1978, a total of 14 cases, the L.A. Suicide Prevention Center found that seven of these youth were previously diagnosed as "learning disabled" (p.116). Peck's conclusion was that, "It is clear that 'learning disabled' youngsters experience both pressure from parents to be 'normal' and pressure from peers deriding their disability, their feelings of frustration and hurt may be so great as to place a very young child in an at-risk category for suicide" (1985, p.116).

The Rohn et al. (1977) study, also reviewed in Chapter 1, had some important findings bearing on the relationship between school performance and suicide. They studied 65 youths who came to a hospital because of a suicide attempt. From tests on 25 of these youths they found that 60% had "minimal brain dysfunction." One of the overt manifestations of minimal brain dysfunction can be a learning disorder. Rohn et al. believe that when learning problems are not identified and remediated, then youth often develop the types of academic and behavioral difficulties that are typified by the youths in this study. This suggests that the stress some youths feel in school may stem from their inherent inability to be successful in the customary academic environment and that this potential feeling of inadequacy.
failure, difference, and confusion may contribute to some adolescents' eventual choice of implementing a suicidal act.

Even though there are numerous differences between the populations of youths in these studies, there is a consistent finding that suggests that an unusually high percentage of suicidal youth have been diagnosed as LD.

Conclusion: The Influence of Intelligence and School Problems

Since school is a primary influence in a youth's life, the relationship between the youth and school is important to the youth's evolving sense of self. Certain school difficulties seem to be present for many youths who commit or attempt suicide. Tishler (1981) found that 30% of his subjects reported that school issues were a precipitating factor to their making a suicide attempt. These factors alone do not "cause" a suicide but may be significant contributing factors.

The research in this area is very limited and without conclusive findings. The research suggests that many of the youths who attempt or commit suicide have problems in school. The types of problems vary from truancy to poor academic performance to misbehavior. These types of "acting-out" behaviors have varied causes.

An unusually high percentage of the youths who attempt or commit suicide are diagnosed both before and after the suicidal act as learning disabled and/or minimally brain dysfunctioned (Rohn et al.,
The lack of successful remediation of this problem or just having this problem and recognizing that they are different from the norm may cause tremendous pressure and frustration for these youths. This may influence their self-esteem, encourage feelings of helplessness and hopelessness, and lead some to acting out at school, and others to suicide. However, not all LD or M.B.D. youth turn to suicide, so it is clear that simply having these problems is not sufficient cause alone.

**Conclusion: Sociological Perspectives**

Certain sociological aspects of living seem to be critical contributory factors in the incidence of adolescent suicide when they interface in a particular way with other individual, family, situational, and biological factors. Reviewed here are three of the adolescent’s social systems: peers, society at large, and the school. The following conclusions seem warranted based upon the available theory and research.

1) **Acceptance by the Peer Group.** It is very important to the adolescent to belong to a peer group and to fit into peer norms (Maris, 1979). Youth who are suicidal are often the "egoist" and do not fit into a peer group and are socially isolated (Victoroff, 1983). The youth who commit suicide often have life-long histories of isolation.
Both are often "the loner." The attempters, however, often have had a close relationship with someone who becomes instrumental in their rescue (Peck, 1981).

2) **The Relationship Between the Youth and the Society.** The "anomie" associated with the rapidly changing nature of our society affects the adolescent's sense of personal and emotional safety. Adolescents are insecure about how to fit into a world whose values are not clear and are fearful about their ability to succeed as an adult. Though every youth is not committing suicide based on society's complications, there do appear to be a percentage of youths for whom these issues, interlocked with other factors, are critical.

3) **The Influence of the School.** The relationship that the adolescent has with school is a crucial piece of her/his developing sense of self. Numerous studies have been done to assess the relationship between certain school problems and suicidal acts (Tishler, 1981; Rosenberg & Latimer, 1966; Peck, 1981; Rohn et al., 1977; Kenny et al., 1979). The literature does not show a clear causal relationship between poor school attendance, academic achievement and school misbehavior and suicide. Yet, many suicidal youth have school problems. It has been found that a significant percentage of youth who commit or attempt suicide have learning disabilities. (Kenny et al., 1979; Peck, 1981; Rohn et al., 1977). The lack of successful remediation of this problem or just having this problem coupled with the realization that they are different, may lower
the youth’s self-esteem, encourage feelings of helplessness and hopelessness, and lead some to acts of suicide.

Based on this literature it appears that LD youth may well be affected by the sociological factors related to suicide. Certain questions can be formulated from the research.

These questions include:

1) Have LD youths who attempted suicide had a particularly difficult time feeling accepted by the peer group of their choice and do they suffer from the pain of feeling different and excluded/or rejected by these peers?

2) The rapidly changing nature of our societal values and mores coupled with the many political threats, dishonesties and inconsistencies makes the world a complicated place that may be viewed by the adolescent as threatening and unsafe. Furthermore, strong societal pressure to be successful and achieve places great demand on the adolescent who is beginning to think about adult life. Is this particularly threatening for a youth who feels personally insecure and questions her/his ability to compete and be competent?

3) Do learning disabled youths who attempt suicide feel helpless, believing that their differences make them less able to compete with other youth?

4) Do they also feel hopeless about their future, since they fear that they will not be able to competently manage adult life?
Family Dimensions of Adolescent Suicide

Research indicates that particular family dynamics are related to adolescent suicide.

What follows is a review of the classic and contemporary theories of the relationship between the family and adolescent suicide that are relevant to the learning disabled adolescent. The particular family dynamics reviewed are: parent-child symbiosis without empathy, family alienation, "closed family system," "the expendable child syndrome," and family communication disturbances.

A Symbiosis Without Empathy

Richman (1971) believes that each suicidal family is characterized by a symbiotic relationship. "In a symbiotic relationship one person cannot be seen, and cannot see himself (sic) as an individual, but only as part of a larger whole, such as the family, or as an attachment to some other person, such as a parent. If he (sic) does attempt to become an individual, dire consequences can follow" (p.36). In this type of relationship, the symbiotic people depend on each other for exploitation and satisfaction of neurotic needs, rather than for love and cooperation.
In the suicidal family there is little recognition of the suicidal person's needs. His/her motives will always be interpreted in terms of its effect on others. Richman feels that this failure in empathy comes from an inability to be separate and the symbiotic other is only seen in terms of oneself. The family is often able to empathize with other people but not with the symbiotic other. Often times the suicidal person is involved in a symbiotic relationship with one parent and the rest of the siblings and other parent collude in the continuation of the symbiosis. The threat of the suicidal person leaving the symbiosis causes anxiety and fear in the family.

This set of notions is supported by Gill (1982). "Some parents are so caught up in their own needs that they are unable to perceive accurately the child's individuated signals and respond instead with inaccurate feedback based on their own needs, thereby invalidating the child's developing sense of self" (p. 11). These parents feel deprived and require enmeshed relationships in order to feel whole. They may punish a child's attempt to separate or try to vicariously live through their children and only allow those behaviors that fulfill their aspirations. The child is not loved for her/himself but is an unindividuated extension of the parent. The youth, therefore, may have a distorted sense of self and may live in constant dread of abandonment. S/he experiences separation and autonomy as dangerous, rather than as healthy, normal growth.

In a symbiotic connection between parent and child, there is usually minimal capacity by the parent to understand the youth's needs or to feel empathy for her/his separate life experience. This may cause
the youth to believe her/his feelings are invalid and unimportant. This may be particularly difficult in the case of the learning disabled youth. Being different than the norm can leave the youth vulnerable to feelings of confusion, shame, alienation, failure, humiliation, and hurt. They often need strong support and reassurance from their parents. A parent who is unable to understand and respond to the youth's separate needs may contribute to adolescent feelings of despair and may precipitate a suicidal act. Lack of empathy between parent and child can also be due to alienation.

Alienation from Parents

Peck (1981) spent years at the Los Angeles Suicide Prevention Center using psychological autopsies (direct interviews with many people involved in the youth's life) to study hundreds of histories of youth who committed suicide. He found a pattern among the parents where, in striving for success for themselves, they put great pressure on their children to be successful. Though this is not an unusual characteristic, the difference he found in his interviews with parents was that for this group the parents were trying to compensate for their feelings of insecurity, inadequacy, and failure. He felt that they saw their children as an extension of their fantasized success and

...are likely to screen out all other kinds of communications especially those that might suggest their failure as parents. These adolescents learn early that only by effective projection of their
parents' fantasies will they win parental approval. These parents have great personal expectation for their adolescents and place a heavy responsibility on them to perform (p.223).

The failure to live up to parental expectations is humiliating to the adolescent whose superego is making its own demands. The end result can be a total lack of acceptance of the child as an individual.

Theorists portray a difference between the family of the adolescent who attempts and commits suicide (Yusin, 1972; Peck, 1981). They suggest that the attempter's family is more prone to have passive, uninvolved parents who only minimally react to the youth's misbehavior and fail to adequately communicate concern. The family of the adolescent who commits suicide is more likely to be an enmeshed system where the parent has a symbiotic relationship with the youth and expects the youth to live up to the parent's expectations for success. A failure to be able to live up to the parent's high expectations may be one of the humiliations and disappointments that the suicidal LD youth suffers.

Families of suicidal youths are often "closed family systems." Yusin et al. (1972) found that parents of suicidal youths were less likely to contact a mental health facility for help with a suicidal crisis.

A Closed Family System

A "closed family system" according to Richman (1971) refers to a family that cannot tolerate any outside contacts that would threaten to
change its established structure. While closed off from any outside
contacts, these families often have diffuse internal boundaries and lack
separation from the extended family and family of origin of both
parents. Little input from the outside is allowed so little knowledge
about alternate ways to relate is available. If the adolescent tries to
make the normal age-appropriate connections to the outside world, this
family tries to hold him/her back. For some youths a suicidal act is used
as an effort to break out of the family.

Being part of a closed system is particularly difficult for a
learning disabled youth who needs specialized education. To get the
educational support necessary it is often necessary for the parents to be
active and vocal advocates for the child's rights and needs. In a closed
system, the family will be reluctant to seek outside help.

Some families have certain other dynamics that may contribute
to an adolescent's suicidal act. One important theory is that of the
"Expendable Child" (Sabbath, 1969).

The Expendable Child

One of the classics in the area of family dynamics is Sabbath's
(1969) ideas about "the expendable child." "It presumes a parental
wish, conscious or unconscious, spoken or unspoken, that the child
interprets as their desire to be rid of him, for him to die" (p.272). "The
expendable child refers to one who no longer can be tolerated or
needed by his family" (p.282). S/he ceases to be useful for affection or to vicariously fulfill the needs of the parents. This is seen in

..the delinquent, the daughter who is illegitimately pregnant, the child who is the object of incest, the schizophrenic, the juvenile homicide. All these children serve a specific need for the particular psychopathology of each parent, and help to maintain the precarious equilibrium within the family structure (p.282).

The child becomes expendable at a point when they are no longer of use or become a threat. When the child feels this death wish, s/he is faced with an actual loss which is tantamount to being abandoned. The child has become expendable and knows it. It is a degree of rejection taken to a potentially tragic extreme.

The LD youth may well become an "expendable child." When the family initially recognizes the youth's limitations, the first response may be to care for the young child as if it were "handicapped." As the child matures s/he is not quite as cute and desirable and the family may tire of caretaking, or the child may begin to act out. The family's needs are no longer fulfilled by care of this child and they no longer want to be bothered with the different member. The adolescent may have already compromised some of her/his growth by not developing more mature coping styles and may have suffered severe injuries to her/his sense of self. The youth may succumb to the parental wish to be rid of her/him by attempting suicide.

There are also certain family-centered communication disturbances that affect the family relations of potentially suicidal adolescents.
Communication Disturbances

Often the suicidal person expresses her/his despair and is ignored, cut off, criticized, or rejected. Suicide is seen as a form of communication. A suicidal act "is a cry for help, an appeal to others, a method of retaliation or revenge, an expression of atonement and a confession" (Richman et al., 1971, p.49). The literature indicates that up to "75% or more of people who kill themselves communicated their intent in advance" (Richman et al., 1971, p.49).

Family conflict, characterized by anger, ambivalence, rejection, and/or communication difficulties, is frequently present in families in which adolescent suicidal behavior occurs. Family conflict is not unique to suicidal situations, but suicidal families have a distinctly different kind of conflict.

Sabbath (1969) found that adolescents who attempt suicide tend to view their family conflict as extreme and long standing. Parents are seen as a major source of anger and the children believe that they can not depend on them for support (Cantor, 1972). There is frequent quarreling, distrust, and resentment (Jacobs, 1971).

Family conflict is not only a part of the background for adolescent suicide, but is also one of the most common precipitating events. Hawton (1986) found that 28% of the youth who attempted suicide reported problems with parents, opposite sex, or schoolwork in the 48 hours prior to the attempts. Tishler et al. (1981) found that
parental problems accounted for 52% of the precipitating events for attempters. Shaffer (1974) found that one-third had interpersonal problems with peers, parents, or close friends as the precipitating event to their completed suicide.

Suicidal families also often have "double bind" communication difficulties.

The double bind we are here referring to is a particular ambivalent relationship in which neither distance or closeness can be tolerated, but where the person or persons involved receive messages to be both distant and close simultaneously, and then are punished no matter what they do (Richman et al., 1971, p.46).

The double bind relationship makes it impossible to meet the needs of each member. This inability to please others and to be subject to constant criticism can lead to conflict, extreme frustration, hopelessness, helplessness and suicide.

Families with suicidal members have disturbed forms of communication that often cause conflict between members. A lack of ability to communicate makes problem-solving and resolution difficult. Also the family may be a fixed system that does not allow for change and a closed system so it will allow no one in to help.

Conclusion: Family Dimensions of Adolescent Suicide

Clearly the suicidal adolescent does not exist in a vacuum and the characteristics and dynamics of the family are critical to the
development of the suicidal act. Certain deficits in development, family characteristics, styles of intimacy, communication, and empathy combine to form the suicidal family system.

Certain of the factors outlined in this chapter are particularly critical to the development of the suicidal LD adolescent. The critical question is whether or not there is a difference between the family relations of LD youth who are suicidal and those who are not suicidal. Also, is there a difference between the family relations of suicidal LD and suicidal NLD youth?

Some of the particular dynamics that might exist in suicidal LD families include:

1) A symbiotic relationship between at least one parent and the youth.
2) The youth and parent place an inordinate amount of importance on the LD and either deny or ignore it, or are obsessed by it.
3) The youth and parent have an unreal image of the youth and either work together to infantilize him/her or are unrealistic about the youth’s capabilities and feel s/he can overcome the LD if s/he tries harder. All are invested in having the youth be someone that s/he is not.
4) The family system is closed to outside professional intervention which is often crucial to LD children.
5) The communication within the family is limited and does not allow for discussion about these dilemmas.
6) The family is riddled with confusing or "double bind" communications so that messages are unclear and no one is ever able to satisfactorily please her/himself or to understand each other.
7) The youth is an inherent part of the family in her/his role as "problem child" and all are invested in maintaining this role. If the parent becomes involved elsewhere and no longer needs the child in this role, then the risk is that the child may become an "expendable child." Otherwise the family will work together to sabotage any efforts at changing roles.

**Individual Psychological Variables**

The theories of adolescent suicide that emphasize the importance of individually focused psychological dynamics are reviewed in this section. Even though each suicidal situation is unique, suicidal adolescents do share some common issues and concerns that make them a specific sub-group at risk.

Freud and the early psychoanalytic school developed some of the first ideas about the suicidal personality. Litman (1967) theorizes that the basic tenets of Freud's (1917) theory included:

1) Suicide results from an important object loss in early development.
2) No neurotic person harbors thoughts of suicide which s/he has not turned back onto him/herself from murderous impulses against others. (Freud, 1917).
3) Similarly, murder is aggression turned against another and suicide is aggression turned upon the self.
4) The suicide victim is not just influenced by hostility but also by rage, guilt, dependency, anxiety, feelings of helplessness, hopelessness, and abandonment.

Shneidman (1987), a long time expert in this field, adds a cognitive component. He states, "Suicide, I have learned, is not a bizarre and incomprehensible act of self-destruction. Rather, suicidal people use a particular logic, a style of thinking that brings them to the conclusion that death is the only solution to their problems" (p.4).

The literature review in this section describes the relationship between certain individual psychologically focused theories about adolescent suicide and the learning disabled adolescent.

The organization of this section is as follows:

Section 1: Becoming Suicidal includes a review of a number of theories that suggest that a youth is led into suicidal actions because of a certain chain of historical life situations and individually focused variables. The theories that address these ideas include: "the suicidal career"; developmental theory; object loss; and the importance of precipitating events.

In section 2: Adolescent Suicidal Personality the literature on the particular personality traits of some suicidal adolescents is reviewed, including: the acting-out/ depressed adolescent; confused feelings about sexuality; problem-solving abilities; feelings of helplessness, hopelessness, guilt; and relationship to "mental illness."

Finally, in section 3: Conclusion: Psychological Variables Pertinent to the L.D. Suicidal Adolescent questions about the
particular individually focused dynamics pertinent to the LD population of suicide attempters are raised.

The literature suggests that suicide is not just a spontaneous response to a painful, frustrating, or difficult situation. Rather, people are led into suicidal actions based on a chain of particular life events, situations, or feelings.

Becoming Suicidal

The Suicide Career

Maris (1981) wrote about the "suicidal career." He found that suicidal acts did not occur out of confusion, disorganization or despair but rather were "an accumulated life history of trauma/ insult/ and just plain bad luck leading to chronic melancholy or genuine helplessness..." (p.68). He said, "Suicide is one product of a gradual loss of hope and the will and resources to live, a kind of running down and out of life energies, a bankruptcy of psychic defenses against death and decay" (p.69). He believes that many self-destructive people have made an accurate empirical assessment of their life chances and have then decided to commit suicide. Supporting this, he found that 75% of the adults who commit suicide are successful the first time.

Developmental Theory

Leonard (1967) was the first to put forth a developmental theory of suicide. He believed that the "seeds for potential suicide are sown"
at two to three years of age during the process of
differentiation from the mother (he made no mention of fathers).
According to Leonard, an inadequate resolution of differentiation has
three primary effects:
1) "lack of a separate identity because of failure to differentiate the self
from the environment adequately and a resulting fusion of identity
with early parental figures at the expense of individual identity"
(p.313). Leonard believes that the choice of suicide is possible because
there is a fusion of identity with others and this makes the turning
inward of aggression equivalent to striking at the frustrating external
source.

This might relate to LD youths since some are frustrated and
angry about their being learning disabled. If they see themselves as a
part of the parent, they could feel that the parent is responsible for
making them different and be so angry that they want to hurt or kill
the fused parent/child being.
2) "inadequate impulse control because of a blocking of the child’s
growth as an individual, and a resulting heavy dependence on external
controls" (p.316).

If the youth has not developed internal impulse control then, in
fact, s/he might well expect that some all knowing, parental agent of
control will come and again protect her/him and stop the suicidal act.

An LD youth’s physical make-up might further complicate this
type of situation since some youth may have an additional biological
vulnerability that may reduce their impulse control (Horowitz, 1981;
3) "rigid adherence to one pattern of adaptation and lack of normal flexibility in responding to the pressures of life" (p.318).

If the LD youth has developed a limited spectrum of coping mechanisms then s/he may not be prepared to handle unusual life pressures. Coping with the additional stress of LD may go beyond her/his coping ability. This gets further complicated in adolescence when the youth developmentally wishes for increased autonomy and lessened dependency yet cannot figure out how, or does not have the skills, to independently cope.

Leonard states that these three "factors combine to leave a person vulnerable to suicide in later life under certain precipitating stresses" (p.318). Certainly these factors could potentially contribute to a LD youth's suicidal act.

Object Loss

Most present-day suicidologists agree that object loss, which usually occurs in childhood, is a crucial element that may eventually lead an adolescent to suicide (Toolan, 1981; Margolin & Teicher, 1968; Frederick, 1985). Object loss usually relates to the loss of the parent as an important object where the parent has died, disappeared or withheld care and affection. The suicidal youth experiences losses "such as the birth of a sibling, parental hospitalization, separation, divorce, or death represented by real and perceived losses-of people, of 'only child status', of a sense of security and so forth" (Cohen-Sandler, Berman, & King, 1982, p.184) as critical. Object loss can also include the loss of a state of well being. As Sandler and Joffe (1965) state, loss of a "love
object includes not only a person, but also the loss of psychological or biological well-being, as well as the loss of an idealized state.

Is object loss a critical factor for many LD youths in adolescence? As they begin to formulate a sense of self and begin to experiment with a budding adulthood, LD adolescents may be rudely awakened to the reality of their differences and limitations. This realization is likely to be felt by some as a tremendous loss: the loss of an idealized self that s/he realize cannot be. The loss is further intensified by the loss of an equal position with her/his peers and either a real or perceived sense of rejection and alienation by these peers. For some, an additional loss occurs when the parents, unable to accept or understand the youth’s limitations and feelings about it, flounder in their ability to support the youth. The youth then feels a real or perceived loss of affection from the parent in her/his belief that s/he can never be the type of child the parents want. The budding adolescent feels s/he cannot achieve her/his desired identity and becomes riddled with pain and frustration. A combination of supportive factors gets some youths through this crisis. For others, the result is acting-out behavior, depression, and emotional problems; and possibly, for some, suicide.

**Importance of Precipitating Events**

If Leonard and Maris and the object relations theorists are accurate and suicidal action is indeed the result of a chain of life events beginning in early childhood, then one must question if particular events that immediately precede the act have any effect on the suicidal decision.
Adolescents frequently report problem incidents with parents, school, or with a friend or love relationship that occur immediately before their suicidal act. Yet all adolescents have the kinds of problems, at one time or another, that suicidal youth state were the events prior to their attempt. Numerous studies have been done in an effort to understand if these common events influence some youth to make suicidal acts.

Hawton (1986) studied 50 youths, aged 13-19, who were referred to a general hospital over a six month period following suicide attempts. Three-quarters of the youths reported a precipitating event which included problems with members of the opposite sex or with parents. He found one-third also had a chronic physical disorder such as asthma or arthritis.

Tishler et al. (1981) studied 108 adolescents who attempted suicide over a two-year period and were seen in an emergency room. They found that the most commonly reported precipitating events were: parent problems (52%), school problems (30%), sibling problems (16%), peer problems (15%), experienced a recent death of a friend or relative (20%).

Shaffer (1974) studied 31 cases of completed suicide, aged 12-15. The most commonly reported precipitating events were: disciplinary problems with parents or school (36%), fights with peers (13%), fights with opposite sex (19%), no precipitating event (32%).

Suicidal acts seem to follow a lifetime of pain. Based on that fact it would be expected that the suicidal act would have been thought about and planned before being executed. Yet, studies suggest that
youthful suicidal acts occur without much thought or planning and frequently appear to be impulsive. Hawton (1986) found that many suicidal youths had histories of impulsiveness. Less than ten percent of his sample said they had considered their attempt for more than 24 and half had thought about the act for less than 15 minutes. This suggests a rapid impulsive decision.

Rosenkrantz (1978) explains this seemingly impulsive act by stating that even though, in many adolescent cases, the suicidal act seems to be a "sudden impulsive reaction to a precipitating stressful situation" (p.210), the impulsive act was "usually the result of multiple psychodynamic factors that have influenced the adolescent's behavior over a longer period of time" (p.210).

Some LD youths have problems with impulsiveness (Struve, Klein & Saraf, 1972). This may be due to their having a neurological impairment that limits their impulse control. Like any adolescent, a certain percentage of LD youths also have unusually high amounts of life stress and less than adequate means of coping. It is possible that this specific group of LD youths may respond to stressful situations more impulsively and possibly increase their risk of suicidal behavior.

Generally, it seems that suicidal youths have a lifelong history of stressful and painful events that set the stage for the suicidal act. The precipitating event merely becomes "the last straw" and leads them to the suicidal act which is their "cry for help" (Farberow & Shneidman, 1961, p.12).
Conclusion: Becoming Suicidal

A synthesis of this literature would seem to suggest that adolescent suicide is not an impulsive act but the result of an accumulated life history of trauma, emotional pain, and turmoil. Though there are particular common precipitating events, these events cause havoc for the suicidal adolescent because of certain early inadequacies in development. Youth who become suicidal have had a lifetime of real or perceived stressful events, as well as developmental stages and difficult life experiences that are not adequately resolved.

For many, the seeds for suicide are sown at ages two-three when the necessary process of differentiation is not completed adequately. This leaves the youth unusually dependent on others and vulnerable to life stresses since s/he is without the necessary adequate age-appropriate methods of coping. The resulting suicidal behavior is often felt by the youth to be the only logical method of coping.

It is also commonly agreed that many suicidal youths have suffered early object losses that have been critical to that individual. Not everyone who suffers this type of loss becomes suicidal so that the nature of her/his life and relationships prior to the loss is a crucial factor. For the suicidal youth, the loss of a parent through death, divorce or neglect or the loss of a state of well-being has been felt as critical. It is believed that many youth become suicidal when another object loss is imminent in adolescence and the youth has an insufficient ability to handle loss due to her/his early experiences. It is possible
that some LD youths suffer from object loss in adolescence that relates to their feeling a loss of their desired idealized self. These youths may feel inadequate and, due to their limited life experience, have no understanding of how to compensate for this loss and define a new satisfactory sense of self.

The Adolescent Suicidal Personality

Though adolescence is often a difficult time of development, suicidal behavior is not a common means of coping for the adolescent. Suicidal behavior and suicidal ideation is not normative during adolescence (Petzel & Riddle, 1981).

Numerous studies have been done in an attempt to differentiate the characteristics of the "normal," "emotionally disturbed," and "suicidal" adolescent (Marks & Haller, 1977; Shaffer, 1974; Tishler, 1981; Inamadar, 1982). Since each individual is so unique it is impossible to develop a clear profile of the personality traits of the suicidal adolescent. Yet, there are some characteristics that research has shown to be common to many. The following literature review examines these traits.

Problem Solving Skills

The decision to use suicide as a means to solve one's problems suggests that one has an inadequate repertory of coping mechanisms. Kimmel and Weiner (1985) describe the suicidal adolescent's problem-
solving abilities: Youths who become suicidal "have progressed without
success through a series of increasingly desperate efforts to resolve
their escalating problems" (p. 509). Often they began with what seemed
to be reasonable methods of problem-solving that prove unsuccessful
so they move to more dramatic attempts to convey their distress or
bring about the desired change. Death can be seen as a way to end their
pain/frustration or humiliation and is used when they see no other
recourse. Some youths who attempt suicide typically feel that their
parents and friends are unaware of or indifferent to their problems. It
seems that they "have decided that harming themselves is their last
hope for making some impact on their family and friends" (p.509). If
the attempt gets the desired action, then this can forestall any further
attempts or become a learned means to continue to get the desired
response. If there is little response or the parent becomes angry or
ridicules the youth, then more serious attempts may follow.

LD youths have an added complication. For some, a part of their
learning problems and differences has to do with possible minimal
brain dysfunction. This dysfunction may make it difficult to process or
code information, logically order information, grasp meaning with more
complex abstract functioning, communicate effectively, remember
things sequentially, or comprehend variations. Any combination of
these factors can certainly make it difficult for a youth to think logically
and to problem-solve effectively. When saddled with a number of life
issues, problems, or intense feelings at one time, the end result might
well be a sense of overload and an inability to logically separate and
figure out a resolution. Suicidal activity could then become a quick means to relieve the confusion or a mechanism to get someone else to take charge.

Relationship to "Mental Illness"

Due to the conflicting definitions of mental illness, the incidence of mental illness in suicidal adults and adolescents remains unclear. The prevalence of adults who are mentally ill and suicidal has been reported anywhere between 53 to 100 percent (Rushing, 1968 in Maris, 1981). Some believe that anyone who thinks about, attempts, or commits suicide should be automatically diagnosed as mentally ill, while others believe that a suicidal person is not necessarily mentally ill. Both people who are mentally ill and those who are not might consider suicide as a means to deal with their emotional turmoil. There are a number of studies that attempt to show a relationship between suicidal adolescents and mental illness.

Shaffer (1974) studied 31 cases of completed suicide of children aged 12 to 15. He reported that one-third suffered from "emotional instability" and 17% had had previous psychiatric treatment. He found that one-half had hostile affect. The specific personality traits noted included: paranoid, suspicious, critical, explosive, quiet, uncommunicative and perfectionist. The fact that one-third of these youths were emotionally unstable and had the characteristics he states does not necessarily prove that a suicidal adolescent is mentally ill. Any combination of these traits could describe most any adolescent.

Tishler et al. (1981) did a study of 108 suicide attempters followed over a two-year period from an emergency room. They found
that according to the DSM III diagnostic category, only 5% of the youths who exhibited suicidal behavior were psychotic. That seems to strongly suggest that most suicidal youths are not seriously mentally ill.

Inamadar et al. (1982) studied 30 females, 21 males, aged 12 to 17 years, who were hospitalized for psychosis for the first time. Of these psychotic youths, they found that 90% had a history of violent and/or suicidal behavior; 40% had a history of violent acts; 16% had a history of suicidal acts; and 25% had a history of both. This suggests that most psychotic youths also exhibit suicidal behavior.

Miller (1981) talks of a type of suicide that is associated with a cognitive conscious decision to kill the self- a type of predatory aggression. The youth has appeared to be well-adjusted and has no history of psychiatric illness. Because the youth outwardly conformed to society it is not until after the attempt that it becomes clear that this youth had been withdrawn and without intimate peer relations. These youth are often found to be schizoid individuals

whose suicidal attempt is either a despairing rejection of their profound feelings of emptiness or they may by overtly schizophrenic. Others have been depressed for years either on the basis of emotional deprivation or neuroendocrine vulnerability as manifested in endogenous unipolar or bipolar affective disorder (p.333).

Based on all of these studies, there are no clear trends in the relationship between mental illness and adolescent suicide. This lack of significance may be as much due to there being no relationship between the two as to the inconsistent method of study. Each study has a limited number of subjects and the ages of the subjects are not
consistent between the studies. The type of suicidal activity ranges from completion to all severities of attempts. All diagnoses of mental illness are also subjective and, even though all may use DSM III, the determination of a diagnosis is still based on the individual subjective bias of the clinician.

**The Acting-out/Depressive Type**

Peck (1985) suggested that there is an increase in the acting-out/depressive category which he believes may account for the rise in the overall adolescent suicide rate.

These people are characterized by illegal, dangerous, disruptive, aggressive, and overtly rebellious behavior. These youths are often involved with drugs, alcohol, running away, promiscuity, and/or assault. They develop these behaviors because in their early teens they have surges of depression with which they are unable to cope. They interpret this depression as boredom and decide to use some acting out behavior as an action to end the boredom. For as long as the action works the youths are not overtly depressed but when the action no longer works the depression breaks through. The youths are then in grave difficulty because they are now an older teen and have never developed coping mechanisms to deal with depression. The youths then become suicidal because they know of no way to cope with their intense depression. The true extent of this type of suicidal act is hidden since many result from dangerous acts or drug, alcohol, and car-related accidents.
Feelings of Hopelessness and Helplessness

Many people suffer from feelings of hopelessness about their life situation. Tabachnick (1981) describes periods of hopelessness as times when an individual attaches no special meaning to her/his life or when the meaning seems to be uncertain. Often a lack of hope is connected to an inner feeling of emptiness. Some suicidal individuals feel hopeless because they have a very good idea of what they would like to be and do with their life, however, they feel that there is no chance that they can do it.

The link between depression and suicide is not straightforward. Perlin (1975) found that a feeling of hopelessness is a better indicator of suicidal risk than what is usually termed "depression".

Hopelessness is an important dynamic for LD youths. Like most youths they have hopes and dreams for their future. A feeling of hopelessness develops when they feel that these aspirations may not be able to become a reality.

Helplessness is an experience closely related to hopelessness but is more specifically connected with one's abilities and feelings of impotence. This is frequently related to sexuality, work ability, attraction to friends, and any life goal (Tabachnick, 1981).

This may be particularly relevant to LD youth who may feel impotent in their ability to be more desirable and successful.

Feelings of Guilt

Though no studies could be found to substantiate this, Victoroff (1983) believes that people with high ideals and high standards of self-conduct may set up a self-imposed punishment for
their transgressions based on their feelings of shame and humiliation derived from real or imagined incidents. They decide that they have done wrong and deserve punishment and prefer to punish themselves. Perlin (1975) states:

In a depressed individual, the guilt of transgression, real or fantasied, may be mollified by a suicidal attempt which symbolically serves as a form of atonement or by suicide itself. Similarly, in the depressed person, real or imagined failure may have preceded or have been a response to feelings of shame, inadequacy, worthlessness, and so forth; overwhelmed by helplessness and hopelessness, he may obsessively ruminate on suicide as the only solution. (p. 148)

Guilt may be an important factor for LD youths. These youths may feel guilty about their inability to achieve. They may believe that it is their fault that they cannot achieve and that if they would only try harder they would be a greater success. They may feel that their lack of success is an embarrassment to their family. They may blame themselves and decide that they deserve to be punished for their inadequacies. A self-destructive act can be a sign of self-punishment and a suicide attempt a further gesture of self contempt.

Conclusion: The Adolescent Suicidal Personality

Though numerous studies have tried to distinguish between the "normal," "emotionally disturbed," and "suicidal" adolescent, no one has ever been able to clearly define the character traits of each. Because of the uniqueness of the individual, there is no one distinct personality
profile of the suicidal adolescent, but there are a series of characteristics that are common to many. Some of these traits include:

1) The youth has limited problem-solving abilities and is unable to effectively cope with life stresses.

2) Since the definition of "mental illness" is so vague, it is unclear as to how many adolescents who attempt or commit suicide are also mentally ill. Studies do suggest that suicidal youths are not seriously mentally ill since only five percent of those who attempt suicide were diagnosed as psychotic (Tishler, 1981).

3) Many youths who commit suicide lead a very isolated, solitary life.

4) There is a category of suicidal youths who express depression through acting-out behavior.

5) Suicidal adolescents often feel hopeless and helpless about their life situation. They feel empty and believe they cannot be, or do, what they desire.

6) Some suicidal youths feel guilty and filled with shame and humiliation and believe that they deserve punishment or death for real or perceived reasons.

**Conclusion: Individual Psychological Variables**

Certain individual psychological dynamics seem particularly critical to the development of suicidal actions for LD youths. The LD youth's "suicidal career" is likely to contain features common to any
suicidal youth but certain factors are likely to have more important impact. Some possible critical factors include:

1) It is possible that some LD youth will have an increased sense of anger, frustration and feelings of helplessness, hopelessness and guilt due to their disability. They may feel helpless and hopeless because they cannot be, or do, what they want, due to their disability. They may feel guilty and believe that their disability is due to their lack of hard work.

2) Some LD youth have limited means of coping with the stresses of life. Numerous possible reasons could include: inadequate differentiation from parents, limited intellectual and perceptual ability to problem-solve, and immature means of coping.

3) Due to biological factors or learned behavior some LD youth may have inadequate impulse control.

4) Some LD youth have suffered from severe object loss that relates to their loss of their idealized self and feelings of real or perceived rejection or alienation by peers and family.

**Biological Factors**

It appears to many suicidologists that there may be a critical biological component for a certain population of suicidal people. It seems that biomedical indicators may, in time, have the ability to
identify certain members of the population who are at high risk for suicide if social, cultural, personal and life events are also conducive to suicide.

A biological variable may be important to the LD population. There is a great controversy in the field of learning disabilities about the potential relationship between biology and LD. Terms for identifying youth with learning difficulties often have biological connotations. These youth have been interchangeably termed as dyslexic, minimally brain damaged, minimally brain dysfunctioned, perceptually handicapped, psychoneurologically disabled, and having a hyperkinetic syndrome.

For a certain population of LD youth, their particular biology may contribute to their resulting emotional difficulties including depression, poor sense of self-esteem, impulsivity or high aggression. There has been specific research on suicidal youth who are diagnosed as "minimally brain dysfunctioned." Many of these also have learning disabilities.

The specific research on the biology of adolescent suicide is limited, and most studies have examined a range of suicidal people at all ages and not differentiated the adolescent. This seems unfortunate since one can only assume that as the human body goes through the massive biological changes of adolescence, specific adolescent biological malfunctions might be possible that affect the act of suicide. Obviously age-related biological changes alone are not the sole reason for adolescent suicide since human biology makes these changes in all
youths and not all become suicidal. Only limited attempts to tease-out the biology of the adolescent and its potential relationship to suicide have been documented.

The limited research that connects biological factors, learning disabilities and suicide is reviewed in this section.

CSF 5-Hydroxyindoleacetic Acid (5-HIAA) or Serotonin

A number of theories assert that there is a relationship between depression and a reduced amount of the serotonin transmitter at certain neuronal receptors in the central nervous system.

Asberg et al. (1975) reported that a low level of 5-HIAA in the CSF was a predictor of suicidal acts. Their study showed 8 suicidal acts (2 lethal) in 20 subjects with a low level of CSF 5-HIAA and 7 suicidal acts (0 lethal) in 48 subjects with a high level of CSF 5-HIAA. Montgomery and Montgomery (1982) correlated low CSF 5-HIAA with a lifetime history of suicide attempts. Asberg et al. (1975) showed a relationship between low CSF 5-HIAA and nondepressed suicide attempts. Asberg et al. (1975) also found that patients with low CSF 5-HIAA attempt suicide more frequently and when they do, use more violent means. Asberg's group also found low CSF 5-HIAA in nondepressed and nonpsychotic suicide attemptors and in persons with personality and anxiety disorders. Though inconclusive, other studies have replicated these findings and also found low
CSF 5-HIAA in persons with minor depressive illness, anxiety states, borderline personality, and substance abuse.

It is tentatively concluded that low CSF 5-HIAA may relate to a disturbed aggression regulation (Asberg et al, 1975) and may cause a vulnerability to self-destructive and impulsive action. Victoroff (1983) suggests the possibility that low CSF 5-HIAA may be linked to "genetic determinants that cause increased vulnerability to many psychiatric illnesses as well as suicidal impulsive behavior" (p.28).

Low levels of serotonin have also been shown to be important predictors in adolescent suicide. "The best lead so far in predicting which young people are at high risk for ending their lives is a low level of the neurotransmitter serotonin" (Alper, 1986, p.49). According to Alper, boys with low serotonin commit suicide, while many girls with low serotonin do not commit suicide but rather develop bulimia. It is unclear why there is this difference in the sexes.

This research on serotonin has received a great deal of media coverage. It appears from all the findings that serotonin may well be an important factor in assessing suicidal risk but as of yet the research remains inconclusive. It appears that a low CSF 5-HIAA may suggest a vulnerability to suicide or self-destructive behavior but most researchers continue to believe that in order to make vulnerability express itself in behavior, other life factors must also be problematic. Research has suggested that some LD youths have a decreased ability of impulse control (Horowitz, 1981; Crabtree, 1981) and possibly a low serotonin level exacerbates this problem.
Types of Brain Damage

Epilepsy

Victoroff (1983) states, but cites no statistical evidence, that a "high percentage" of adults and adolescents with seizure disorders attempt suicide.

According to Maris (1986), Gunn (1973) studied affective and suicidal symptoms in epileptic prisoners, ages 15-24. Those with the temporal lobe form were significantly more suicidal.

It is unclear if the reason for this increase in suicidal behavior in epileptics is biological or related to the social and psychological pressure of having a seizure disorder.

Episodic Dyscontrol Syndrome

According to Maris (1986), Bach-y-Rita, Loin, Climent, and Ervin (1971) and Maletsky (1973) developed the concept of an "episodic dyscontrol syndrome" which is characterized by repeated, often unprovoked, episodes of violence that occur in individuals who demonstrate subtle rather than obvious brain dysfunction. Bach-y-Rita et al. report in a study of 130 violent patients (aged 16 to 60), mostly male, that 41% made a suicide gesture. EEGs and other tests have shown that these patients have minimal brain damage. They also had histories of episodes of unconsciousness and seizure-like histories as
well as histories of personal difficulties and family problems, especially violence and alcoholism (in Maris, 1986).

Maletsky (1973) studied 22 male patients (aged 18 to 31). Each had the episodic dyscontrol syndrome in which the repeated episodes of violence happened in a seizure-like state. As children, these patients had history of hyperactivity, febrile seizures, and truancy. Eighteen had suicidal ideation and eight attempted suicide. Fourteen of the patients had abnormal EEGs (Maris, 1986).

Suicidal behavior occurs with disproportionate frequency among youths with abnormal EEGs. Struve, Klein and Saraf (1972) studied electroencephalographic correlates of suicidal behavior in psychiatric patients aged 15 to 25. They found that for males and females there was a positive, significant association between paroxysmal EEG dysrhythmias and suicide ideation alone, suicide ideation plus attempts, and assaultive-destructive behavior without a suicidal component. They are not suggesting cause and effect but rather that dysrhythmias may be associated with impairment of control under stress. Struve et al. (1972) suggest that, since there is a positive relationship between abnormal EEGs and suicidal behavior, this might provide a rationale for including suicide among the other acting-out behaviors of the episodic dyscontrol syndrome. Miller (1981) suggests a psychological reason for the increased rate of suicide, "Adolescents who suffer from episodic dyscontrol syndromes are vulnerable to suicide because of the helplessness the syndrome engenders" (p.338).

Irregular EEGs, epilepsy and episodic dyscontrol syndrome all seem to occur because of some type of brain irregularity. It is suspected
that some of the youths who have learning disabilities also have a form of brain irregularity (Rohn et al., 1977). Clearly this is not true for all, since some of the people with irregular brain patterns do not have learning disabilities. One can only wonder if, for some, there may be an overlap in brain dysfunction that may link brain irregularity with limited ability to cope with stress, with violent acting out against self and others and with learning disabilities.

**Minimal Brain Dysfunction/ Learning Disabilities**

There is a body of psychological research suggesting that some adolescents suffer from some type of "minimal brain dysfunction" (M.B.D.). Originally M.B.D. was considered to be a childhood disorder that one outgrew by adolescence. However, more researchers are beginning to find that M.B.D. persists into adolescence and young adulthood, and that there may be a relationship between M.B.D. and adult psychopathology (Horowitz, 1981). Crabtree (1981) gives a definition of M.B.D. first coined by Horowitz (1981). To be M.B.D. one "must have a basic deficiency of greater than two years in language and/or math, and a history of developmental lag, and current evidence on psychological testing of perceptual motor dysfunction or equivalent evidence of underlying organic interference" (p.307).

Crabtree (1981) evaluated psychiatrically hospitalized youth and found that 38% of these youth were M.B.D. Of this group, one-half were hyperactive. The other half were "hypoactive", a "diffuse developmental disorder which is the bizarre, awkward, social isolate—the school misfit who presents as borderline retarded or who academically overachieves at the expense of other developmental tasks" (p.307). One-quarter of the
total sample had a special "cognitive disorder which is a discrete attention and/or cognitive difficulty" (p.308).

Crabtree (1981) found that youth who are M.B.D. share the common "wounded narcissism and helplessness" (p.412) traits of other psychiatric patients and in addition have:

the experience of a brain which will not consistently work for him, a brain which continues to occasion him (sic) with overwhelming frustration and humiliation in his relations to others and the unbearable pain of feeling incompetent. For those with the hyperactive picture, yearnings for peer acceptance combined with deficit-based impulsivity, explosivity, and poor judgment to propel them toward negative notoriety and delinquency. For those with the hypoactive picture, the sense of being a misfit commonly leads to withdrawal, school and work phobia, or overcompensatory enslavement to achievement and social isolation (p.308-9).

Many M.B.D. youth have behavior problems and become involved with drugs or alcohol and are delinquent (Cantwell, 1978). Crabtree suggests that these youth have an implicit motto of "I'd rather be bad than stupid" (p.310).

Though Crabtree discusses the serious emotional pain of these adolescents and gives case examples where the youths made suicide attempts, he gives no data about the percentage of youths in his study who were M.B.D. and made suicide attempts. He also is not clear as to what types of learning problems these youths have. It is therefore difficult to determine what percentage of these youths are also learning disabled, though by definition it seems there would be a large overlap.

Rohn et al. (1977) believe that adolescence is a critical period in psychosocial maturation and can be a very disruptive time for youths.
They further state that, "Any additional stresses on the already susceptible teen-ager will impinge even more harshly; for this reason the difficulties caused by minimal brain dysfunction appear to be a major unrecognized substate leading to juvenile suicidal behavior. The susceptible youth often is less able to withstand such adversity and may be more apt to attempt suicide as alternative coping mechanisms fail" (p.638).

The major question that arises is: how does a youth's brain dysfunction, behavior problems, and learning disabilities relate to his/her increased rate of attempted and completed suicide? It has been found that M.B.D. youths are often easily frustrated, hypersensitive, hyper-reactive, and impulsive (Horowitz, 1981). These youth are often genuinely confused by interpersonal events and expectations and by the complexities of relationships and life events. They seem unable to follow the course of events in a consistent and timely manner, but rather get lost or confused by minute detail. The end result is often anger, frustration, low self esteem and social isolation (Horowitz, 1981). Is this a result of their biological difference? It would appear that, for some, their inherent biological differences might contribute to a process of psychological feelings and behavioral events that interfaces with their social network and leads to a suicidal act.
Until recent years there was some question by psychologists and psychiatrists as to whether adolescents could suffer from depression. It has now been shown that, "Adolescents, even children, suffer from major depression as much as adults do" (Alper, 1986, p.49).

There is much research that shows that certain types of depression have a biological base. It is believed that genes contribute to a vulnerability for depression or manic depression but certain psychological, social and biological factors need to occur to make the vulnerability a reality.

Youth who are depressed often display this very differently than adults. The adult often displays the vegetative signs of depression which include sleep and eating disturbances, anxiety, agitation, psychosomatic symptoms, distressed affect, memory problems, disorientation, crying, and lethargy. The adolescent display of depression is less obvious and is often masked with acting-out behavior. These behaviors may include hyperactivity, somatic complaints or by acting bored and listless (Toolan, 1981). Adolescents may also show their depression through conduct disorders, school problems, running away, promiscuousness, eating disorders, or drug and alcohol abuse. Since youth do not display their depression in the same manner as adults, it is often very difficult to distinguish between the youth who acts out because s/he is rebellious and the youth who is depressed.
It is often helpful to look at the family history to see if there is a history of affective disorders. Studies show that if a youth has a parent with bi-polar affective disorder (manic depression) then the youth has a 25% chance of developing an affective disorder as an adult; if both parents have an affective disorder then the youth has a 50 to 75% chance of developing an affective disorder (Alper, 1986). Alper (1986) reports that Blumenthal of N.I.M.H. estimates that one-third of adolescents who commit suicide have an untreated or undiagnosed affective disorder.

**Conclusion: Biological Factors**

Though the research remains inconclusive, it does appear from the present findings that there is a critical biological component that is inherent to a certain population of suicidal people. The research suggests that biological factors alone will not lead to suicide but, rather, that a combination of biological, social, and individual factors contribute to an individual's propensity to suicide.

Studies have examined numerous physical functions in order to find the pertinent biomedical indicators for suicide. They have included studies about serotonin levels, genetics, types of brain dysfunction, and depression.

Most pertinent to the examination of adolescents with LD who attempt suicide are those studies reviewed under Types of Brain
Dysfunction. Though only a limited number of studies have been done, it can be concluded from the findings that an unusually high number of youths who attempt or commit suicide are LD (Rohn et al., 1977; Peck, 1985) Some suspect that certain LD youths have some subtle form of brain dysfunction that affects their level of self-control or impulsivity (Horowitz, 1981; Crabtree, 1981).

The biological correlates of suicide and LD are not within the domain of this study. Though fully appreciating the importance of the potential biological component to suicide, this study concentrates on the psychosocial parameters of adolescent suicide.

**Conclusion: Review of the Literature**

The literature contains numerous research studies and theories that attempt to understand the reasons that adolescents become suicidal. The greatest error made in trying to understand this tragic phenomenon is to simplify causation and to attempt to show direct simple cause/effect relationships. The rationale for any suicidal act needs to be appreciated systemically as containing a complex interconnecting of numerous variables.

In an effort to understand all possible variables, the review of literature is divided into four major areas: sociological perspectives, family dimensions, individually focused psychological variables and
biological factors. In the review of each area, the major research studies and theories that are specifically relevant to the population of learning disabled youths are described.

In the section on sociological perspectives is a review of the relationship between the adolescent and three distinctive social groups: the peer group, the larger society, and the school. Problems between the youths and these social groups which might lead some to suicides are discussed.

Family Dimensions contains a review of specific family dynamics including: parent-child symbiosis, family alienation, "closed family system," "the expendable child," and disturbed family communications. It goes on to explain the potential ways each can lead to adolescent suicide.

The particular individually focused psychological dynamics that are critical to the development of suicidal actions in learning disabled youth are reviewed. Included in this section are theories suggesting a youth is led into suicidal acts by a chain of life events, and the importance of object loss. Specific personality characteristics are discussed including: acting out/depressive type, difficulty with problem-solving, feelings of helplessness and hopelessness and guilt.

The importance of a biological component is reviewed and includes discussion about serotonin levels, types of brain damage and depression.

A unique combination of variables from each of these areas is believed to lead some learning disabled youths to suicidal thoughts or acts. In an effort to decipher which variables are most critical to some
LD adolescents becoming suicidal, three specific hypotheses and one research question are developed to be tested by this research design. In the following section, these hypotheses and the rationale from the literature used to develop these hypotheses and research question are reviewed.

Hypothesis I

Learning disabled adolescents are at a significantly greater risk of suicidal activity than nonlearning disabled adolescents. They have higher levels of feelings of hopelessness, hostility, suicidal ideation, and negative self-evaluation.

Rationale for Hypothesis I

Research suggests that an unusually large number of LD youths can be found in the population of youths who attempt or commit suicide. The Peck (1981) and Rohn et al. (1977) studies found that between 50 to 60% of the youths who attempt or commit suicide are learning disabled.

It is probable that some learning disabled adolescents might have strong feelings of hopelessness and hostility due to their having an inherent, lifelong invisible disability. Perlin (1975) states hopelessness has been found to be a better indicator of suicidal risk than depression. Rohn et al. (1977) suggest that learning disabled youths might choose a suicidal act because of: their feeling different
than the norm, frustrated because they feel academically inadequate, and hopeless to do anything to improve their situation.

It is suspected that LD youth will have a more negative sense of self than NLD youth. In two case studies of learning disabled youth who committed suicide, studied by this author, evidence suggested that each youth's sense of self was strongly and negatively influenced by her/his being learning disabled. Each felt humiliated by her/his learning difficulty. Each seemed to feel helpless in her/his inability to be able to be the person s/he desired or to create the type of life s/he wanted.

Hypothesis II

As a group, learning disabled adolescents have a significantly greater difficulty with specific self-image factors. The factors affected include: peer relationships, mastery of the external world, vocational and educational goals, life adjustment, impulse control, and family relations.

Hypothesis III

The learning disabled youth with a significantly greater suicidal risk will have a significantly greater difficulty with the mentioned self-image factors than learning disabled youth at a lesser suicidal risk.
Rationale for Hypotheses II and III

The following is a review of the theories that support hypotheses II and III:

On peer relations: According to Maris (1975), Durkheim’s notion was that the suicide rate is dependent upon forces external to and constraining the individual. “To the degree that the societal groups are harmonious, integrated and the individual is an active, central member of those societal groups, then the individual’s suicide potential will be low ...” (Maris, 1975, p.95). This is specifically true of adolescents where belonging to the peer group of choice is particularly important to the adolescent. A youth who feels excluded from that group is more susceptible to feelings of isolation, depression and, potentially, suicide. Rohn et al. (1977) found that 50% of the suicidal youths they tested were described by themselves or others as loners or socially isolated. Often times, youths who are different are excluded from the peer group and ostracized for their differences. LD youths might feel excluded from the normative peer group because they are academically and/or socially different than the norm and/or because they are placed in separate classes or school. Their real or perceived sense of separation, isolation or rejection can increase the likelihood of suicidal activity. Peck (1981) speculated that LD adolescents might be at an increased risk for suicide because they feel humiliated by other youths “deriding their disability” (p.116).

On mastery of external world, vocational and educational goals and life adjustment: The youths, from the two case studies reviewed by this author, questioned their academic and intellectual competence and
felt the likelihood of their being able to master the external world and achieving their educational and vocational goals was negligible.

On family attitudes: The literature suggests that there are certain family dynamics that are dysfunctional in suicidal families. In the case studies previously mentioned, both youths seem to be part of a loving family yet somehow the support and reassurance that was needed by each was never realized. Richman (1971) and Gill (1982) suggest that the suicidal youth is often involved in a symbiotic relationship with one or both of the parents. In this type of relationship "Some parents are so caught up in their own needs that they are unable to perceive accurately the child's individuated signals and respond instead with inaccurate feedback based on their own needs, thereby invalidating the child's developing sense of self" (p.11).

Another family dynamic that may likely be critical to families with learning disabled adolescents involves the family's expectations of the youth. Peck (1981) suggested that learning disabled adolescents might be at greater risk for suicide because of the feelings of hurt and frustration they experience because of their parent's pressure to be "normal." Both youths from the previously mentioned case studies seemed to feel that they had failed their parents and were unable to achieve to the degree necessary to satisfy them.

On impulse control: Though suicide may appear to be a "sudden impulsive reaction to a precipitating stressful situation (Rosenkrantz,1978, p.210), the impulsive act usually was "the result of multiple psychodynamic factors that have influenced the adolescent's behavior over a longer period of time (Rosenkrantz,1978,p.210). Even
so, youthful suicide acts occur without much thought or planning and Hawton (1981) found that many suicidal youths had histories of impulsiveness. Less than 10% of his sample had considered their attempt for more than 24 hours and half had thought about the act for less than 15 minutes. Horowitz (1981) states that LD youths often have difficulty with impulse control. It is possible that a segment of the LD population may have high amounts of life stress and less than adequate means of coping and thereby might react more impulsively to suicide than NLD youth.

Research Question

Will learning disabled youths at greater suicidal risk experience their learning disability as a major complication and/or major loss in their life?

Rationale for Research Question

Many suicidologists agree that object loss which occurs in childhood is a crucial element that may eventually lead an adolescent to suicide (Toolan, 1968; Margolin & Teicher, 1968; Frederick, 1985). Though object loss usually refers to the loss of a loved person, it can also include the loss of a state of well being (Sandler & Joffe, 1965). In the case of the learning disabled adolescent, the youths' realization that they are different than other youths may be felt as a tremendous loss, i.e.: the loss of an idealized self that can never be realized. This loss is
further intensified by the feeling of loss of an equal position with their peers and either a real or perceived sense of rejection and alienation by their peers.

The methodology used to test these hypotheses and research question are reviewed in Chapter III.
CHAPTER III

METHODOLOGY

Methods

The purpose of this study was to compare the self-image factors and potential for suicidal risk between learning disabled and nonlearning disabled adolescents. In order to best evaluate the relationship between these factors, quantitative and qualitative research methods were employed. This combination of methods is believed to be the most comprehensive means of research analysis (Shontz, F.D., 1986).

The quantitative technique is able to analyze the complex relationships among the variables. In this study quantitative measures are used to determine the relationships between LD and suicide risk, gender and suicide risk, LD and eight specific self-image factors, self-image and suicide risk, gender and LD interactions.

"Qualitative research designs require that the evaluator get close to the people and situations being studied in order to understand the minutiae...." (Patton, 1980, p. 43). In this study, the qualitative method is
used to more accurately describe the unique educational and life experience of each subject. The life experiences of LD and NLD youths are then compared.

The use of this combination of research methods allows for empirical results that specify the significance of the relationship between the variables and between the groups and provides an individual description of each youth’s life story.

In the following sections, the specific details of the research design are outlined. First, is a description of the study’s subjects. In the second section is an outline of all the steps taken to complete this project. Third, is a review of the instruments used and the method of administration. The final section includes a description of the methods used to analyze the data.

Subjects

The subjects were 60 youths, 30 learning disabled and 30 nonlearning disabled, equal numbers of male and female, ranging in age from 13 to 18 years of age. The definition of LD youth is provided in Chapter I. According to the subjects, they have these types of LD: dyslexia (9), reading difficulties (10), memory problems (5), distractability (3), math difficulty (2), disorganization (2), attention deficit disorder (4), language difficulty (4) and sequencing difficulty (1). A NLD youth is defined as any student who has not been diagnosed as having a learning disability.
All of the youths were volunteer subjects and had signed parental permission to participate in the study (see Appendix A).

All were from middle to upper economic class families.

Fifty-six of the youths were white, two were Black, one Chinese-American and one Cambodian-American.

All of the youths attended private high schools located in Massachusetts or Connecticut. Though some of the LD students' school districts are paying for a segment of their tuition, each family is paying at least part of the school's tuition. Participating were three schools designed specifically for NLD students, three schools specially structured for LD students and one school that services both groups of students.

All of the schools have a number of important common admissions criteria. They include:

1) all of the youths are believed to possess average to above average intelligence;
2) they are selected for admission because of their desire to succeed academically; and
3) all are considered by their school to be "normal" (according to the definition in Chapter 1) and are not known to presently have a diagnosable emotional disturbance or mental illness.

There are a wide variety of reasons that these youths are attending private rather than public schools. They include:

1) academic problems in previous school;
2) social problems in previous school;
3) desire to participate in a small educational environment with small classes; 
4) belief that private schools have more concern for the individual needs of their students and decision that this type of environment is to be preferred; 
5) fear of the problems, including drugs and violence, existing in the urban public high schools; 
6) parental decision that youth attend private school against youth's will; 
7) desire to participate in school's extracurricular activities i.e.: sports or art programs; and 
8) decision that the chosen private school could provide the best learning environment for that student.

None of the youths were academically failing and none were displaying serious disciplinary problems at school at the time of the study. When asked by the tester, all of the youths stated that they liked their school and felt that they were receiving appropriate academic instruction.

As reviewed under the Procedures section, the subject selection process was somewhat different for the two groups. Securing LD subjects was much more difficult than securing NLD subjects. There was a great deal of hesitation on the part of school administrators, teachers, and parents about allowing their students to be participants. The schools and parents were wary of a study that was investigating suicidal risk and the possibility that the LD group might be at an increased risk. They were also reluctant to participate because most of
the LD youths had been subject to many batteries of tests to determine if they were LD. Many parents were concerned about the viability of subjecting their child to yet another battery of tests. Though all spoke of the great value and need for this research, only a small number of schools and parents were comfortable with the design and chose to have their youth participate. The LD youths were given the option to participate only after their parents approved the project.

The participating NLD schools had no concern about the subject material and felt that the testing would be a learning experience for their students. The youths decided if they wanted to participate and they informed their parents of their decision and asked for the parents' permission.

Even though there are these differences, the groups are well matched. They are matched for age, sex, academic interest, positive feelings about their educational experience and economic status. The youths' interest and final decision to participate are very similar. Some of the reasons that they chose to participate included:

1) curiosity and interest in a psychology research project;
2) interest in becoming a psychologist or social worker;
3) need to make $5.00;
4) belief in the importance of the research; and
5) concern about their emotional well being that they wanted to share, and possibly get some advice.
Procedures

A pilot study of three youths was done to evaluate the effectiveness of the research design and to assess the level of stress caused by the test measures on the subjects. The basic design was found to subject the youth to a minimal level of stress so it remained unchanged. As a result of the pilot study some of the interview questions were reworded or clarified. It was also decided to pay each subject $5.00 for participation in the study.

The following is a listing of the procedures used in completing this project:

1) Listings of all the private schools for LD youth in Massachusetts, Connecticut, Rhode Island, New Hampshire, and New York were secured by contacting the state boards of education.

2) The Foundation for Children with Learning Disabilities Resource Guide was used to clarify the specific population serviced by each of these schools. Schools were only considered that were specifically designed to educate youths with LD and not those dually diagnosed as emotionally disturbed. The selected schools also only accepted youths with average to above average intelligence.

3) A personal letter (Appendix B) and the dissertation proposal were mailed to the Headmaster or Headmistress of twelve schools. A sufficient number of subjects was not secured after one mailing, therefore, two months later an additional mailing was sent to 10 more schools.
4) Within a week of receipt of the letter each school was contacted by telephone to discuss its' willingness to participate. Usually the head person chose to share the proposal with other school personnel before making a decision.

5) If the school chose to participate, then the practical details of its' involvement were discussed. All of the 22 schools contacted felt that the project was well designed and a critical piece of research. Yet only six schools decided to participate. There were many reasons for a refusal, including:

a) school policy forbidding participation in research;
b) fear that mention of suicide to a student would cause the youth stress and precipitate a decision to be suicidal;
c) belief that such research exploited LD youths;
d) school feeling that the student population was fragile and not wanting to take the chance of adding an unknown factor like a research study; and
e) fear that the students' parents and other private schools competing for student enrollment would experience participation as admitting that problems existed with students that it was unable to handle.

6) A letter from the school's head and the tester explaining the research (see Appendix C) and a permission slip were mailed to each student's parents. In some schools the letter was sent to the parents of each student enrolled in the school. In other schools, the letter was sent to just those students who met the subject selection criteria.
On one occasion, a parents' group disagreed with the Headmaster's decision to participate and insisted that the testing not be allowed on the school grounds.

In another school, a parent group was concerned about participation and invited the tester to present the project design at a parents' meeting. After the presentation, many parents agreed to allow their children to participate.

7) The subjects were chosen based on their willingness to participate. The only information the tester had previous to meeting the subject was name, age, home address and knowledge that s/he had been diagnosed as LD.

8) After the tester received a signed permission slip, the student was contacted to arrange a meeting for the testing to occur at either their home or at school.

9) Once all of the LD subjects were arranged, a search began for the control group. A listing of all of the private schools in the Boston area was secured from the state board of education.

10) Each school was contacted to be certain that it's admissions criteria and the type of student it serviced were similar to the LD schools.

11) The psychology teachers at eight schools were contacted by letter (Appendix D).

12) The letters were followed up with a telephone call. Four schools readily agreed to participate in exchange for the tester speaking to the psychology class about her research.
13) The students in the psychology class learned about the project from their teacher and volunteers were asked to participate. A permission slip and letter explaining the project was then sent to each student’s parents (Appendices A & E).

14) Upon receipt of the permission slip, an appointment was made to interview and test each student.

Instrumentation

There were three segments to each subject’s interview. First, the Offer Self-Image Questionnaire (OSIQ), which contains 130 items that are specifically designed to analyze adolescent functioning, was administered to the subject. It was administered in 30 to 60 minutes. Items call for a numerical response ranging from one to six where one corresponds to "describes me very well" and six corresponds to "does not describe me at all". Some items are worded positively and some negatively. The test provides results on eleven separate scales, each representing a dimension or aspect of the adolescent self. They include:

The Psychological Self

Scale 1: Impulse Control
Scale 2: Emotional Tone
Scale 3: Body and Self-Image

The Social Self

Scale 4: Social Relationships
Scale 5: Morals
Scale 9: Vocational and Educational Goals
The Sexual Self

Scale 6: Sexual Attitudes

The Coping Self

Scale 8: Mastery of the External World
Scale 10: Psychopathology
Scale 11: Superior Adjustment

The OSIQ is a well-respected measure that assesses multiple areas of functioning to gauge self-image and adjustment in the normal population. It has been used with 15,000 youths and there are norms developed for younger and older males and females and within eight teenage populations, including normal Americans (1960, 1970, 1980); Australians; Irish; Israeli; American Delinquents; American Disturbed; and American Physically Ill. (A copy of this test booklet is found in Appendix F.)

Next, the Suicide Probability Scale (SPS) designed by Cull and Gill (1982) composed of 36 items, was administered to each youth. This test is understandable to someone with a fourth grade reading level. It describes specific feelings and behaviors and was administered in 10 to 20 minutes.

The SPS reflects the individual's suicidal feelings at the time of administration but does not predict future suicidal activity. The respondent indicates how often the item applies to her/him by responding on a four-point scale ranging from "none or little of the time" to "most or all of the time." The scale provides an overall indication of suicide risk and clinical information on four subscales: hopelessness, suicide ideation, negative self-evaluation and hostility.
The SPS was standardized using a sample of 579 even-numbered cases, and then replicated on a sample of 579 odd-numbered cases. Both odd- and even-numbered groups included 281, normal, non-clinical sample; 130 psychiatric inpatients and 168 suicide attempters. The authors report odd-even internal consistency for the total scale at .93 and ten day test-retest reliability for the entire group at .94. The results suggest that the SPS is not subject to situational variability.

Validity testing confirmed that the SPS scores are relatively unaffected by moderator variables such as age, sex, ethnic background and educational level. Criterion validity is supported by the test's accuracy in classifying suicide attempters (p<.001), particularly among the high (98.2%) and intermediate (83.0%) presumptive risk groups and less effective with the low risk (29.2%). Construct validity is supported by factor analysis that generated these four subscales: suicide ideation, hopelessness, negative self-evaluation, and hostility, and had a .70 correlation with the Farberow and Devries Suicide Threat Scale. (A copy of this test and the format for scoring is found in Appendices G & H.)

After the administration of the two tests described above, each subject was interviewed using the format found in Appendix I.

Some of the questions asked duplicate those in the standardized tests and were used to check for consistency of response. Mostly, however, this interview was designed to yield descriptive information from the youth's life experience. From the review of the literature in Chapter II, it was conjectured that certain theories on adolescent suicide might shed light on potential reasons that the population of LD youth might be at an increased risk of suicide. The particular questions
asked attempt to ascertain if there is a relationship between some of these theories and the lives of the subjects.

A semistructured interview style is used as a guide to produce the desired information. A specific list of questions was asked in sequence. Many of the questions were initially structured and then probed more deeply by asking open-ended questions. This type of procedure is "reasonably objective while still permitting a more thorough understanding of the respondent's opinions and the reasons behind them...." (Borg & Gall, 1983, p.442).

Certain steps were taken to minimize the "response effect" (p.441) or the difference between the response given and the truth. Each interview was of a reasonable length and was conducted individually in a private room. The testing process and purpose were carefully explained. Clarification was made about confidentiality. The tester was a well-trained adolescent specialist and easily able to help each youth to feel comfortable and free to speak. The tester was sensitive to the youth's mood and if s/he seemed uncomfortable because of the sensitivity of the material or confusion about the question the tester was reassuring and clarified the difficulty.

The initial interview questions (numbers 1,2,3) were designed to help the youths feel comfortable with the interview process by discussing things they enjoyed doing.

In Chapter II, certain theories about the great importance of peer relations and group belonging were reviewed and the plight of the adolescent "loner" was discussed. In the next grouping of questions,
the youth's feelings about peer involvement and friendship are investigated (numbers 4, 5, 6, 7, 8, 9, and 28).

It was suggested in the literature that suicidal youths possibly have greater fears about their ability to handle the risks and complexities of the world. Question 10 asks about their world concerns.

It is indicated in the literature that suicidal youths often experience increased life stress and have had a life-long history of problems. The next question number 11, inquires about the type and severity of emotional, school, relational and family problems.

It has also been stated that the difference between youths who attempt and those who commit suicide is the involvement of someone who cares about them and intervenes. Question, number 12 asks about how the subject handles problems and if s/he have ever been in psychotherapy.

It is suggested in the literature that suicidal youths often have families with certain dysfunctional dynamics. Question number 13 asks about parent and sibling relations.

The literature questions the relationship between academic achievement, intelligence, misbehavior, and suicide risk. The following group of questions, numbers 14, 15, 16, 17, and 18 inquires about the youth's experience with each of these.

A group of questions attempts to determine if there is a difference between the experience of LD and NLD youths on these factors:

a) feelings about level of intelligence or academic achievement (question 19) ;
b) feelings about how ability to learn affects other aspects of life (question 20);

c) feelings about whether ability to learn affects peer relations (question 21);

d) degree of parental and internal pressure about academics (question 22);

e) the youth's and the family's feelings and desire for achievement (question 22); and

f) whether or not this youth was ever teased at school, and whether the teasing related to ability to learn and if the teasing was significant or traumatic (question 28).

A series of open-ended questions (numbers 24, 25, 26, and 27) are asked of the LD youths to get a clearer sense of how each feels about her/his disability. Attempts are made to understand the youth's experience by unraveling a life history about her/his experience of being LD. It was previously conjectured that there might be a difference in the level of importance the learning disability might have in a youth's life and speculated that the LD youth who is at greater risk of suicide might experience the LD as a major loss or complication in her/his life.

To get a sense of the youth's hopes and the realism of her/his plans for the future, questions 29 and 30 are asked.
Administration

Efforts were made to maintain as similar as possible an administration for each subject.

Each individual interview took one - two hours depending on the youth’s level of conversation and ability to complete the written materials.

Each interview took place in a quiet, private room in either the youth’s home or school. This choice was based on scheduling and the youth’s preference.

Each youth was given a varying amount of information prior to meeting with this tester. Regardless of what information the youth had previously been given, each interview began with an explanation of this project. The content of this explanation included:

1) Clarification that this project was part of the tester’s doctoral dissertation and a brief explanation of the doctoral process.

2) Statement about confidentiality:

Whether or not to grant anonymity to the youth was a major consideration. It was explained to each youth that the exact content of the testing would be confidential. Clearly all people experience periods of depression and unhappiness as well as pleasure and it was expected that this would appear on the testing. However, ethical considerations did not allow for full anonymity. It was explained that a clinician is ethically and legally bound to report any imminent suicidal risk. Since part of the purpose of this testing is to determine suicidal risk, it was important that each youth understand that if severe risk was found
parents and, depending on the agreement with the school, also the school personnel would be notified.

3) Description of the purpose of the testing:

It was explained that the testing was designed to better understand the self-image factors of each adolescent. Questions would be about the positive and negative ways the individual feels about her/himself including feelings about relationships with friends, family, school, and future plans, as well as feelings about depression and suicide. The subjects understood that two groups of students, LD and NLD, would be compared on these factors.

4) Clarification was made that the individual's name and the name of her/his school would not appear on any written documentation.

5) Before beginning, each youth was asked if she/he understood the project and if s/he was still willing to participate. Each signed a permission slip (see Appendix J).

6) Demographic information was collected (see Appendix K).

7) The directions for the Offer test were read aloud by the tester. Each youth was told that she/he was free to ask as many questions as necessary to clarify the questions and could take as much time as necessary.

Since some of the LD youths have difficulty reading and/or comprehending written and spoken language and/or with memory, it was necessary to modify the standard administration of the tests on three occasions. This modification was minimal and consisted of the youth listening to the test question being read on audio tape rather than having to read it her/himself. Every youth responded on a written
answer sheet. The tester spoke to a teacher or school administrator prior to meeting each youth to be aware of those youths who might need to use the audio system. Each youth examined the written materials and was given the choice as to whether s/he felt comfortable reading the material or preferred to use the audio.

To be certain that each youths understood the test materials the results of all three measures were compared for consistency of response.

8) The youth was asked if s/he were prepared to continue or needed a break.

A break was necessary for some youths who had particularly short attention spans. The directions for the Suicide Probability Scale were read aloud by the tester and the same procedures as described for the Offer test were followed.

9) The youth was again asked if s/he was prepared to continue or needed a break. The interview was then administered (see Appendix I)

10) After completion of all three segments, the youth was given a token payment of $5.00 to compensate for her/his time.

11) It was understood by each youth that her/his tests would be reviewed individually and if there was a serious risk of suicide the tester would notify her/him.

Prior to the testing, the school and parents were aware that if any youth scored in the severe level of suicidal risk, determined by the SPS, the youth and the parents and, depending on the agreement with the school, the school would be notified. For the youths who were found to be depressed and at a moderate level of risk of suicide
determined by their score on the SPS, based on the written agreement with the subject and the parents, it was not always appropriate to contact the family or the school. This determination was based on the individual needs of each youth.

Analysis of the Data

Analysis of the data begins with a presentation of the demographic information. Descriptive statistics describe personal data and the family's structure.

In order to determine the relationship between the variables a two factor design was employed with four groups of people, two groups with two levels each.

The following is a breakdown of the statistical measures used to determine if there is a significant relationship between the variables questioned in the null hypotheses.

**Hypothesis 1.** Learning disabled adolescents are not at a significantly greater risk of suicidal activity than nonlearning disabled adolescents. They do not have higher levels of feelings of hopelessness and hostility, suicidal ideation, and negative self-evaluation.

The Suicide Probability Scale by Cull and Gill that was administered to each of the LD and NLD subjects elicits five scores: a total score which is an overall indicator of the individual's present risk of suicide and four specific subscales that assess the individual's feelings of hopelessness, suicidal ideation, negative self-evaluation, and hostility.
In order to determine if there is significant relationship between the groups, male and female, and LD and NLD (the independent variables) and these scores (the dependent variables), a multivariate analysis of variance (MANOVA) was used. The MANOVAS tested the strength of the association between these independent and dependent variables and also determined whether there was an interaction between the independent variables. In this study, this determined whether or not the effect of being learning disabled was different for a male or female on the five scales.

**Hypothesis II.** As a group, learning disabled adolescents do not have a significantly greater difficulty with specific self-image factors. These factors include social relationships, mastery of the external world, vocational and educational goals, life adjustment, impulse control and family relationships. The youth's self-image does not affect her/his emotional tone and level of psychopathology.

The Offer Self-Image Questionnaire provides information on the individual's feelings of self-image on eleven scales. A standard score was determined for each scale based on a normative sample. A multivariate analysis of variance was used to test for a significant relationship between the groups, male and female and LD and NLD, on any one or more of eight of Offer's scales. The scales that were tested were: social relationships, mastery of the external world, vocational and educational goals, superior adjustment, impulse control, family relationship, emotional tone and psychopathology. The MANOVA also determined if there was a significant interaction between being male or female, and LD and NLD on any of the eight scales.
Hypothesis III. Youths with a significantly greater suicidal risk do not have a significantly greater difficulty with the mentioned self-image factors than youths at lesser suicidal risk.

A Pearson Product Moment correlation coefficient is used to describe the relationship between two variables. In this analysis, the Pearson correlation was used to determine which self-image variables determined by the Offer test correlate significantly for the youth who are at greater suicidal risk, as determined by the SPS test.

Research Question. Will learning disabled youth with greater suicidal risk experience their learning disability as a major complication and/or major loss in their life?

A qualitative research measure was used to assess this question. The interview was specifically designed to encourage the LD youths to describe their life experience and the factors that were critical to the development of their self-image. Specific questions were asked to determine the importance that each youth placed on her/his disability to understand if it was experienced by her/him as a major complication and/or loss in her/his life.

As Patton (1980) indicated "there is no right way to go about organizing, analyzing and interpreting qualitative data...." (p.299). Each researcher is left to determine the best means to make sense of the data. Each of the interview questions is coded to simplify the organization of the data. From this, common patterns and trends and meanings are traced and then compared between the groups. Emotional material quoted from the youths about their specific life experience is also used to help to expose the magnitude of their true feelings.
Conclusion: Methods

The purpose of this study is to examine the relationship between certain self-image factors, and the potential of suicidal risk for LD and NLD youth. In order to test the significance of the relationships between the variables, the research employed 60 subjects, 30 LD and 30 NLD, equal numbers of male and female, aged 13 to 18.

The research design consisted of quantitative and qualitative research measures. The quantitative measures were elicited through the administration of the Offer Self-Image Questionnaire (OSIQ) and the Suicide Probability Scale (SPS) to each subject. A multivariate analysis of variance was used to compare all the independent and dependent variables. A Pearson correlation was used to determine the correlation between the self-image factors for those youths at greater risk of suicide.

The qualitative measure was a semistructured interview designed to elicit detailed descriptive information about each youth's life and educational experiences.

The results of this methodology are reviewed in Chapter IV.
CHAPTER IV

RESULTS

This chapter is a presentation of the results of the statistical analyses. A description of the subjects is given, followed by the results of the quantitative analyses of hypotheses I, II and III and a qualitative analysis of the research question.

Abbreviations used are: LD- learning disabled, NLD- non learning disabled, F- female and M- male.

Demographic Information

There were 60 subjects, 30 LD and 30 NLD, equal numbers of male and female. All attended private high schools. All were from middle to upper economic class families. Fifty-six were White, two Black (one MNLD, one FLD), one Chinese-American (FNLD.), one Cambodian-American (MLD).
Age

The subjects ranged in age from 13 to 18 years of age with an overall mean age of 16.3.

The ages of the subjects are categorized in two year clusters in TABLE 4.1.

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE</th>
<th>FEMALE</th>
<th>FLD</th>
<th>MLD</th>
<th>MNLD</th>
<th>FNLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-14</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15-16</td>
<td>14</td>
<td>12</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>17-18</td>
<td>12</td>
<td>16</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Family Description

The following describes the make-up of the subjects' families. See TABLES 4.2, 4.3, and 4.4.

<table>
<thead>
<tr>
<th>NUMBER OF SIBLINGS IN SUBJECTS' FAMILIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>only child 3</td>
</tr>
<tr>
<td>one 14</td>
</tr>
<tr>
<td>two 12</td>
</tr>
<tr>
<td>three 2</td>
</tr>
</tbody>
</table>
### TABLE 4.3
SUBJECTS’ FAMILY LIVING ARRANGEMENTS

<table>
<thead>
<tr>
<th></th>
<th>LD</th>
<th>NLD</th>
<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
<th>MNLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>with mother and father</td>
<td>14</td>
<td>19</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>with mother</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>with father</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>with parent and step-parent</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>parents divorced</td>
<td>12</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>parents separated</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>parents never married</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>parents dead</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>foster family</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>adopted</td>
<td>3</td>
<td>unknown</td>
<td>2</td>
<td>1</td>
<td>unknown</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 4.4
SUBJECTS’ PARENTS’ AGES

<table>
<thead>
<tr>
<th>AGE</th>
<th>MOTHER</th>
<th>FATHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LD</td>
<td>NLD</td>
</tr>
<tr>
<td>30-35</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>35-40</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>41-45</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>46-50</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>51-55</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>55-60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>61-65</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>66 plus</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Suicide Risk

The Suicide Probability Scale (SPS) was administered to each of the subjects. This test elicits five scores: a total score which is an overall indicator of the individual's present risk of suicide and scores for four specific subscales that assess the individual's feelings of hopelessness, suicidal ideation, negative self evaluation, and hostility.

Each test is scored individually according to a specific format. Each subject receives a raw score for each test item. These raw scores range from 0-5. The item scores are then categorized based on the four subscales. A score for each subscale is then determined. The subscales range from 7-49. The total weighted score (total suicide risk score) is the sum of the four subscale scores; this score ranges from 32-115. The total suicide risk score and the subscale scores are then converted to T scores that range from 25-85. The T score for total suicide risk is further converted to a probability score. See the SPS scoring profile form, Appendix H, for clarification.

Suicide Risk Categories

The SPS categorizes its total suicide risk score based on probability. This probability score refers to the present "statistical likelihood that an individual belongs in the population of lethal suicide
atemptors" (Cull & Gill, 1982, p.13). Cull and Gill caution that the category cutoffs are "arbitrary" (p.13) and warns that, based on situational determinants or measurement errors, an individual could be in either a higher or lower category. Even so, these four categories are a useful means to look at the variance between the LD and NLD groups.

The four categories:

**Severe (75-100):** Individuals who need "extreme suicide precautions".

**Moderate (50-74):** Individuals at serious though not extreme risk but in need of observation.

**Mild (25-49):** Individuals with, "Some suicide potential, although may just be generalized depression without specific suicide ideation" (p.14). Further clinical evaluation is needed to determine the need for intervention.

**Subclinical (0-24):** All those without measured risk. Also in this category may be those individuals "faking good" (p.14).

TABLE 4.5 shows the variation between the groups.

**TABLE 4.5**
**RANGE OF SUICIDE SCORES**

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>LD</th>
<th>NLD</th>
<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
<th>MNLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total at some risk</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Subclinical</td>
<td>20</td>
<td>28</td>
<td>9</td>
<td>11</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>
According to the SPS, 20%, or 12 of the 60 youths interviewed were at an increased risk of suicide. These are the youths at mild, moderate, or severe risk. Of the youths at increased risk, ten are LD, two are NLD.

At first glance it certainly appears that there is a difference between the two groups since 33.3% of the LD population in contrast to 6.6% of the NLD, is at an increased risk of suicide. The literature reports that in the general population of adolescents from ten (Klagsbrun, 1976 from Peck, 1981, p. 149) to thirteen percent (Peck, 1981) have made at least one suicide attempt.

The SPS further designates a procedure to determine the suicidal risk for each individual. It suggests that the clinician:

1) Assess the validity of the test responses to determine if the responses seem to be valid indicators of the respondent's feelings.

   It is suggested that a score under 40 could either be due to an individual who functions very well or might be caused by a person who was "faking good" and should be examined again. At least one of the MLD youth in this study who scored less than 40 may have been "faking good," since the rest of the content of the interview implied that the youth was having more emotional difficulties than he admitted on the SPS.

2) Evaluate the overall suicide risk using the total score.

3) Look for special problem areas based on the variability of the subscale scores.

4) Examine the individual items for qualitative information about the nature and seriousness of the risk.
5) Integrate the test results with other clinical information about the person.

6) Determine an intervention strategy.

This procedure was used for each individual subject. According to the SPS scoring, only one youth was found to be at "severe" risk of suicide. This was a 16 year old FLD. Her overall SPS probability score suggested that there was a 93% chance that she belonged in the population of individuals called "lethal suicide attemptors". (Cull & Gill, 1982, p.13). Based on the test results and the material learned in the interview, which included the fact that she had previously made a suicide attempt, it was determined that she was at severe risk. The tester spoke to the youth in the presence of a teacher within a few hours of the testing. The parent was called by the teacher and notified by mail by this tester within 24 hours of the testing (Appendix N).

In addition, two FLD and one MNLD were found to be at moderate risk. In one situation, based on the specific content of the test results and the content of the interview, the tester chose to speak to the youth in the presence of a teacher within a few hours of the testing. The parent was called by the teacher and notified by mail by this tester. In the other two situations, this tester requested to meet with each youth a second time to share her concern and to assess the risk. In order to arrange these meetings it was necessary to inform a teacher of the moderate level of concern. One of the youths requested that the tester contact his parents by mail and recommend professional clinical treatment. The other was feeling less depressed during the second meeting and agreed to consider reinvolve in psychotherapy.
Three FLD, four MLD, and one FNLD were at mild risk of suicide. The specific item responses on the testing and the interview were reviewed to assess the suicide risk. In one situation, the tester attempted to contact the subject but she was unavailable, so the parents were notified by telephone. In one other situation, the tester's concern was shared with the subject and supportive counseling at school was arranged. Though the six additional youths were clearly depressed, based on the specific content of the SPS and the interview and the youths' level of parental and professional support, no further contact was necessary.

The other 48 subjects were at a subclinical level on the testing and at no imminent risk.

In order to determine if there is a significant relationship between the groups, male and female, and LD and NLD, and the SPS scores, a multivariate analysis of variance was used. The following is a review of the statistics and their relationship to null hypothesis I.

Hypothesis I

IA) Learning disabled adolescents are not at a significantly greater risk of suicidal activity than non learning disabled adolescents.

IB) They do not have higher levels of feelings of hopelessness, hostility, suicidal ideation, and negative self-evaluation.
Statistical Analysis of Total Suicide Risk

A series of statistical analyses were completed to determine the relationship between LD and gender on overall suicide risk. Overall suicide risk is determined by the SPS total suicide score.

Chi Square: Gender by LD on Suicide Risk. Since there was an extreme range of scores, a Chi Square was used because this measure is less sensitive to extreme scores.

The SPS scores were divided into four probability categories: severe (75-100), moderate (50-74), mild (25-49) and subclinical (0-24) risk.

There was no significant effect for gender on suicide risk, F(1,3) = .7016, p > .05.

There was also no significant effect for LD on suicide risk, F(1,3) = .0668, p > .05. Though this is not significant at the .05 level, it is quite close. It is possible that no significant relationship was found because of the small sample size. The contingency table for suicide risk by LD is found in TABLE 4.6.

MANOVA: Gender by LD on Suicide Risk. A MANOVA was completed to determine if there is a significant effect for gender by LD, as determined by the SPS, on the total suicide risk score. The mean scores are in TABLE 4.7 and the analysis of variance in TABLE 4.8.
### TABLE 4.6
CROSS TABULATION OF SUICIDE RISK BY LD

<table>
<thead>
<tr>
<th>Level of Suicide Risk</th>
<th>LD</th>
<th>NLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>100.1</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>3.3</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>1.7</td>
<td>0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>6.7</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>3.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Mild</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>87.5</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>23.3</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>11.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Subclinical</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>41.7</td>
<td>58.3</td>
</tr>
<tr>
<td></td>
<td>66.7</td>
<td>93.3</td>
</tr>
<tr>
<td></td>
<td>33.3</td>
<td>46.7</td>
</tr>
</tbody>
</table>

### TABLE 4.7
MEAN SCORES: SUICIDE RISK BY GENDER AND LD

<table>
<thead>
<tr>
<th></th>
<th>Male SD</th>
<th>Female SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>51.733</td>
<td>62.200</td>
</tr>
<tr>
<td>NLD</td>
<td>48.000</td>
<td>48.333</td>
</tr>
</tbody>
</table>
Table 4.8

**ANALYSIS OF VARIANCE: GENDER BY LD ON TOTAL SUICIDE RISK**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>Sig of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Cells</td>
<td>12720.667</td>
<td>56</td>
<td>227.155</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>437.400</td>
<td>1</td>
<td>437.400</td>
<td>1.926</td>
<td>.17074</td>
</tr>
<tr>
<td>L.D.</td>
<td>1161.600</td>
<td>1</td>
<td>1161.600</td>
<td>5.114</td>
<td>.02764</td>
</tr>
<tr>
<td>Gender by L.D.</td>
<td>385.067</td>
<td>1</td>
<td>387.067</td>
<td>1.695</td>
<td>.19825</td>
</tr>
<tr>
<td>(MODEL)</td>
<td>1984.067</td>
<td>3</td>
<td>661.356</td>
<td>2.911</td>
<td>.04229</td>
</tr>
<tr>
<td>(TOTAL)</td>
<td>14704.733</td>
<td>59</td>
<td>249.233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R-squared = .135
Adjusted R-Squared = .089

The relationship between the two main effects, LD and gender, are assessed using a MANOVA. No significant relationship is found for gender on total suicide risk. A significant relationship is found for LD on total suicide risk, $F(1,56)=.02764, p<.05$. This implies that being LD has a significant effect on increased suicide risk.

Since this was an investigation about the effects of suicide risk, it was very important that every possible relevant analysis be pursued. The mean scores were plotted and the slopes intersect suggesting that there might be a statistically significant interaction that was not found by the previous statistics. See FIGURE 4.1.
Since an interaction effect is found in this second group of MANOVAS that was not previously found, it implies that there was a previous difference in error variance. This significant interaction effect is the more valid determination of interaction.

**MANOVA: Total Suicide Risk by FLD and MLD.** There was no significant difference between FLD and MLD on the total suicide risk score, $F(1,56) = .11619, p>.05$.

**MANOVA: Total Suicide Risk by FNLD and MNLD.** There was no significant difference between FNLD and MNLD on the total suicide risk $F(1,56) = .93942, p>.05$. 

FIGURE 4.1
MEAN SCORES: TOTAL SUICIDE RISK BY GENDER AND LD

SPS Mean Scores
65-
60-
55-
50-
45-

LD NLD
Subject Groups
**MANOVA: Total Suicide Risk by FLD and FNLD.** A significant relationship was found for females on total suicide risk, F(1,56) = .02861, p < .05. Based on the mean scores this shows that there is a significant effect for FLD on total suicide risk.

**MANOVA: Total Suicide Risk by MLD and MNLD.** No significant difference was found between MLD and MNLD on total suicide risk, F(1,56) = .45673, p > .05.

**Conclusion: Statistical Analysis of Total Suicide Risk**

These statistics provide important data on the relationship of overall suicide risk as a function of LD and gender.

A MANOVA found no significant effect for gender on total suicide risk; however, a significant effect was found for LD on total suicide risk. This implies that being LD has a significant effect on increased suicide risk.

A significant interaction is also found between being FLD and FNLD on overall suicide risk. This suggests that there is an increased risk of suicide for the FLD over the FNLD.

**Analysis of the Suicide Subscales**

The SPS was also used to measure the four suicide subscales: hopelessness, suicidal ideation, negative self-evaluation, and hostility. To determine the relationship for gender by LD on the four SPS subscales, a MANOVA was done. See TABLES 4.9, 4.10, 4.11, and 4.12 for the means for each variable.
Suicide Subscales Mean Scores

According to Cull and Gill (1982) the hopelessness scale "assesses an individual's overall dissatisfaction with life and generalized negative expectations about the future" (p.14) (See TABLE 4.9).

**TABLE 4.9**
MEAN SCORES: HOPELESSNESS SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>16.800</td>
<td>8.029</td>
<td>18.867</td>
<td>8.323</td>
</tr>
<tr>
<td>NLD</td>
<td>14.133</td>
<td>4.897</td>
<td>14.600</td>
<td>4.469</td>
</tr>
</tbody>
</table>

The suicidal ideation scale according to Cull and Gill (1982), "reflects the extent to which an individual reports thoughts or behaviors associated with suicide" (p.14) (See TABLE 4.10).

**TABLE 4.10**
MEAN SCORES: SUICIDAL IDEATION SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>9.733</td>
<td>2.738</td>
<td>15.000</td>
<td>8.435</td>
</tr>
<tr>
<td>NLD</td>
<td>12.067</td>
<td>5.650</td>
<td>10.400</td>
<td>4.290</td>
</tr>
</tbody>
</table>

Cull and Gill (1982) state that the negative self-evaluation scale is a "reflection of an individual's subjective appraisal that things are not going well, that others are distant and uncaring and that it is difficult to do anything worthwhile" (p.14) (See TABLE 4.11).
TABLE 4.11
MEAN SCORES: NEGATIVE SELF-EVALUATION SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>14.333</td>
<td>3.016</td>
<td>17.067</td>
<td>4.667</td>
</tr>
<tr>
<td>NLD</td>
<td>12.133</td>
<td>2.748</td>
<td>13.467</td>
<td>3.091</td>
</tr>
</tbody>
</table>

The hostility scale infers that there is the tendency for the subject to break or throw things when angry or upset and has items that examine feelings of hostility, isolation, and impulsiveness (See TABLE 4.12).

TABLE 4.12
MEAN SCORES: HOSTILITY SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>10.867</td>
<td>3.204</td>
<td>12.200</td>
<td>2.426</td>
</tr>
<tr>
<td>NLD</td>
<td>12.400</td>
<td>6.445</td>
<td>9.867</td>
<td>1.922</td>
</tr>
</tbody>
</table>

Statistical Analysis of Suicide Subscales

A number of statistical analyses were run to determine the relationship between the suicide subscales and gender and LD.

Interaction Effect on Suicide Subscales for Gender and LD. A multivariate test of significance was done to determine if there was an interaction between gender and LD on the four SPS subscale variables. No significant interaction was found:

1) hopelessness $F(1,56) = .64381$, $p > .05$;
2) hostility $F(1,56) = .06109$, $p > .0125$;
3) suicidal ideation $F(1,56) = .02154$, $p > .0125$;
4) negative self-evaluation $F(1,56) = .43705$, $p > .0125$. 

**MANOVA: Suicide Subscales by LD.** A significant effect for LD on negative self-evaluation was found, $F(1,56)=.00200$, $p<.0125$. Upon examination of the means, LD youths are found to score significantly higher than NLD, which implies that they have greater difficulty with negative self-evaluation.

No significant effect is found for the other variables:

1) hopelessness $F(1,56)=.04877$, $p>.0125$;
2) hostility $F(1,56)=.69402$, $p>.0125$;
3) suicidal ideation $F(1,56)=.44275$, $p>.0125$.

**MANOVA: Suicide Subscales by Gender.** No significant effect was found for gender on the four suicide variables:

1) hopelessness $F(1,56)=.46476$, $p<.0125$;
2) hostility $F(1,56)=.55546$, $p>.0125$;
3) suicidal ideation $F(1,56)=.22467$, $p>.0125$;
4) negative self-evaluation $F(1,56)=.02683$, $p>.0125$.

However, upon examination of the means, a possible trend is noted where LD females scored higher on three of the variables, hopelessness, suicidal ideation, and negative self-evaluation, than any of the other groups.

**Variation Between the Suicide Subscales’ Means.** The previously mentioned analyses found no statistically significant interaction for gender on the four suicide variables. Since this is an investigation about suicide risk, every possible analysis is critical. The mathematical variation between the means suggested that there was a difference in the slopes so that a plot was done of the means for each of the variables. The slopes were different on two of the variables.
and did intersect, suggesting that a significant interaction could possibly be found (See FIGURES 4.2 and 4.3).

There are a couple of possible reasons that the statistics did not pick up this interaction due to error variance:
1) due to the small sample size;
2) the interactions were due to chance;
3) the mean score for all of the youths of one gender or all of the LD or NLD groups cancelled the variation between the groups i.e.: on the suicidal ideation scale, FLD mean=18.867, and FNLD mean=14.600, were compared to MLD mean=16.800, and MNLD mean=14.133. Though the FLD scores appears to be quite different from the other three, when it is grouped for analysis with the FNLD score this difference may be cancelled out.

In order to determine if there might be a statistically significant interaction between the groups, a number of additional MANOVAS were run. Since there was a significant interaction, it suggests that the previous interaction statistics had a different error variance, therefore, these are the more valid results.

**MANOVA: Suicide Subscales for FLD and MLD Interaction.** No significant effect was found for FLD and MLD interaction on the four subscales:
1) hopelessness $F(1,28)=.49453$, $p>.0125$;
2) hostility $F(1,28)=.20936$, $p>.0125$;
3) suicidal ideation $F(1,28)=.02910$, $p>.0125$;
4) negative self-evaluation $F(1,28)=.06708$, $p>.0125$. 
FIGURE 4.2
MEAN SCORES: SUICIDAL IDEATION SCALE

FIGURE 4.3
MEAN SCORES: HOSTILITY SCALE
MANOVA: Suicide Subscales for FNLD and MNLD Interaction. In the examination of the relationship between FNLD and MNLD on the four suicide variables no significant relationship was found:

1) hopelessness $F(1,28) = .78714, p > .0125$;
2) hostility $F(1,28) = .15576, p > .0125$;
3) suicidal ideation $F(1,28) = .37063, p > .0125$;
4) negative self-evaluation $F(1,28) = .22215, p > .0125$.

MANOVA: Suicide Subscales for FLD and FNLD Interaction. The relationship between FLD and FNLD on one of the four suicide variables was found to be significant. A significant relationship was found between FLD and FNLD on hostility, $F(1,28) = .00685, p < .0125$. This suggests that FLD have more hostile feelings than NFLD. The relationship between FLD and FNLD on negative self-evaluation was close, $F(1,28) = .01895, p > .0125$, but not statistically significant. The other two were not significant: hopelessness, $F(1,28) = .09120, p > .0125$; suicidal ideation, $F(1,28) = .07017, p > .0125$.

MANOVA: Suicide Subscales for MLD and MNLD Interaction. No significant relationship between MLD and MNLD on the four suicide variables was found:

1) hopelessness $F(1,28) = .28146, p > .0125$;
2) hostility $F(1,28) = .41632, p > .0125$;
3) suicidal ideation $F(1,28) = .16114, p > .0125$;
4) negative self-evaluation $F(1,28) = .04599, p > .0125$.

Conclusion: Analysis of Suicide Subscales

There is not a significant effect due to the main effect of LD on feelings of hopelessness, suicidal ideation, and hostility. However, there
is a significant effect due to being LD on negative self-evaluation. This suggests that LD youth have a significantly more negative self-evaluation.

There were no significant effects for the main effect of gender on the four suicide subscales.

A significant relationship was found, however, in the effect due to being FLD on hostility. This suggests that FLD have more hostile feelings than FNLD. Yet, no significant difference occurs between these groups on the other variables.

Self-Image Variables

Hypothesis II

As a group, learning disabled adolescents do not have a significantly greater difficulty with specific self-image factors. These factors include: social relationships, mastery of the external world, vocational and educational goals, life adjustment, impulse control, and family relationships. The youths’ self-image does not affect their emotional tone and level of psychopathology.

Statistical Analysis of Self-Image Variables

The Offer Self-Image Questionnaire (OSIQ) was administered to all of the subjects. It provides standard scores on an individual’s feelings
on eleven subscales. An analysis of eight of these scores was used to determine the significance of hypothesis II.

Each individual's test results were professionally computer scored by a testing service administered by Daniel Offer at Michael Reese Hospital and Medical Center, Chicago, Illinois. Each individual received a score for each of the subscales. Standard scores are used and are developed using age by sex-appropriate 1970s normal reference groups' means and standard deviations. A score of 50 signifies a score equal to the appropriate normal reference group mean. A score lower than 50 signifies poorer adjustment than that of "normals" (Offer, 1977, p.5) and a score higher than 50 signifies better adjustment than normal.

A MANOVA was used to determine if there was a significant relationship between the groups, male and female and LD and NLD, on any one or more of eight of the OSIQ scales.

Mean Scores for Self-Image Variables

In this section, the eight self-image variables are reviewed including tables of the means and standard deviations (SD) for each of the variables (See TABLES 4.13, 4.14, 4.15, 4.16, 4.17, 4.18, 4.19 and 4.20).

The first of these scales is for impulse control. The impulse control scale, according to Offer (1977), "measures the extent to which the ego apparatus of the adolescent is strong enough to ward off the various pressures that exist in his internal and his external environments" (p.3). A low standard score implies a poorly organized defensive structure, including low frustration tolerance and frequent
impulsive acts. A high standard score implies a well-developed ego and an ability to delay gratification (See TABLE 4.13).

**TABLE 4.13**
MEAN SCORES: IMPULSE CONTROL SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>51.667</td>
<td>18.650</td>
<td>40.733</td>
<td>17.734</td>
</tr>
<tr>
<td>NLD</td>
<td>49.429</td>
<td>15.810</td>
<td>54.867</td>
<td>12.357</td>
</tr>
</tbody>
</table>

The Emotional Tone Scale "measures the degree of affective harmony within the psychic structure, the extent to which there is fluctuation in the emotions as opposed to feelings that remain relatively stable." A low standard score implies poor affective control and a great deal of emotional fluctuations while a high score shows an ability to satisfactorily experience many affects (See TABLE 4.14).

**TABLE 4.14**
MEAN SCORES: EMOTIONAL TONE SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>51.600</td>
<td>16.379</td>
<td>36.467</td>
<td>21.360</td>
</tr>
<tr>
<td>NLD</td>
<td>53.071</td>
<td>17.826</td>
<td>49.267</td>
<td>14.753</td>
</tr>
</tbody>
</table>

The social relationship scale assesses "object relationships and friendship patterns" (p.13). A low standard score describes a youth who has not developed good object relations and feels lonely and isolated while a high score shows a well-developed ability to empathize with others (See TABLE 4.15).
TABLE 4.15
MEAN SCORES: SOCIAL RELATIONSHIPS SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>55.933</td>
<td>19.437</td>
<td>37.400</td>
<td>13.912</td>
</tr>
<tr>
<td>NLD</td>
<td>51.000</td>
<td>16.067</td>
<td>50.267</td>
<td>13.063</td>
</tr>
</tbody>
</table>

The vocational and educational goals scale shows how well the teenager is accomplishing the task of learning and planning for a vocational future. A low score represents a poor ability to work within the school structure to make a reasonable future plan while a high score indicates a youth who is doing this work effectively (See TABLE 4.16).

TABLE 4.16
MEAN SCORES: VOCATIONAL AND EDUCATIONAL GOALS SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>51.933</td>
<td>21.536</td>
<td>38.533</td>
<td>13.087</td>
</tr>
<tr>
<td>NLD</td>
<td>56.286</td>
<td>15.137</td>
<td>45.133</td>
<td>12.966</td>
</tr>
</tbody>
</table>

Offer (1977) believes that a teenager's feeling and attitudes toward her/his family is critical to her/his overall psychological health and that the family contributes more to the positive development of the youth than any other psychosocial variable. The family relationships scale measures "the emotional atmosphere in the home" (p.4) and how the youth feels about his/her parents and the type of relationship they have. A low scale implies that there are major communication gaps and
that the youth does not get along well with his/her parents while a high score indicates that the youth communicates well with his/her parents (See TABLE 4.17).

**TABLE 4.17**

**MEAN SCORES: FAMILY RELATIONS SCALE**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>44.267</td>
<td>18.148</td>
<td>39.800</td>
<td>20.613</td>
</tr>
<tr>
<td>NLD</td>
<td>49.429</td>
<td>14.669</td>
<td>44.467</td>
<td>17.020</td>
</tr>
</tbody>
</table>

The mastery of the external world scale "demonstrates how well the adolescent adapts to the immediate environment" (p.4). A low score shows a youth who is unable to visualize him/herself finishing a task while a high score shows a well-functioning youth able to deal with frustration (See TABLE 4.18).

**TABLE 4.18**

**MEAN SCORES: MASTERY OF THE EXTERNAL WORLD SCALE**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>46.667</td>
<td>21.589</td>
<td>38.200</td>
<td>17.644</td>
</tr>
<tr>
<td>NLD</td>
<td>54.571</td>
<td>13.501</td>
<td>47.133</td>
<td>13.320</td>
</tr>
</tbody>
</table>

The psychopathology scale identifies severe or overt psychopathology. A low score indicates severe pathology while a high score shows a well functioning adolescent (See TABLE 4.19).
TABLE 4.19  
MEAN SCORES: PSYCHOPATHOLOGY SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>48.600</td>
<td>22.290</td>
<td>39.667</td>
<td>18.867</td>
</tr>
<tr>
<td>NLD</td>
<td>49.857</td>
<td>18.123</td>
<td>50.400</td>
<td>13.217</td>
</tr>
</tbody>
</table>

The superior adjustment scale measures ego strength, the youth's ability to cope with self, significant others, and the world. A low score indicates a youth not adequately dealing with the environment while a high score indicated a well-functioning coping system (See TABLE 4.20).

TABLE 4.20  
MEAN SCORES: SUPERIOR ADJUSTMENT SCALE

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>SD</th>
<th>Female</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>47.933</td>
<td>21.835</td>
<td>39.067</td>
<td>12.458</td>
</tr>
<tr>
<td>NLD</td>
<td>49.643</td>
<td>17.509</td>
<td>47.000</td>
<td>14.172</td>
</tr>
</tbody>
</table>

Interaction Effect: Gender by LD on Self-Image Factors.
No significant interaction was found between gender by LD on the eight self-image factors: F(1,55) = (PS1 = .05944) (PS2 = .22569) (SS1 = .03504) (SS3 = .78949) (FS1 = .95759) (CS1 = .90751) (CS2 = .32765) (CS3 = .48175), p > .006.


MANOVA: Self-Image Variables by Gender. The analysis of variance found a significant effect for gender on vocational and
educational goals, $F(1,55) = .00516, p < .006$. A review of the means shows that the females score significantly lower than the males. This suggests that females are working less well in their educational system and have made less reasonable plans for their future. The LD females scored lower than the FNLD suggesting that the LD females may be even less successful than the FNLD.

No significant effect is found for gender on the other self-image variables: $F(1,55) = (PS1 = .51498) (PS2 = .04581) (SS1 = .02181) (FS1 = .32255) (CS1 = .08154) (CS2 = .38796) (CS3 = .19782), p > .006$.

Though not shown to be statistically significant, it is interesting to note a possible trend in self-image. The LD females have the lowest mean score on every one of the eight self-image variables.

Again, since this is an investigation of suicide risk, every analysis is critical. MANOVAS to determine if there is an interaction between MLD and MNLD, FLD and FNLD, MLD and FLD, and MNLD and FNLD, on the self-image variables were completed.

**MANOVA: Self-Image by MLD and MNLD.** These relationships were not significant.

**MANOVA: Self-Image by FLD and FNLD.** These relationships were not significant.

**MANOVA: Self-Image by FNLD and MNLD.** These relationships were not significant.

**MANOVA: Self-Image by FLD and MLD.** A significant relationship was found for FLD and MLD on social relations, $F(1,27) = .00558, p < .006$. Upon review of the means, it is found that the FLD have poorer social relations than the MLD.
Conclusion: Statistical Analysis of Self-Image Variables

These statistical analyses support the acceptance of most null hypothesis II. There is no statistically significant difference between the groups in six of the self-image variables: impulse control, family relations, emotional tone, psychopathology, mastery of the external world, and superior adjustment.

There are two self-image factors that do have significant relationships with LD or gender. There is a significant effect due to being female on vocational and educational goals. This implies that females have a significantly more difficult time in the educational system and in making reasonable plans for their future.

There is also a significant effect due to being FLD on social relations. This suggests that FLD have a significantly poorer capacity to develop good object relations and feel more isolated and lonely.

Correlation between Suicide Risk and Self-Image Factors

Hypothesis III

The youth with a significantly greater suicidal risk do not have a significantly greater difficulty with the mentioned self-image factors than youth at a lesser suicidal risk.
Statistical Analyses: Interaction between Suicide Risk and Self-Image

The following analyses determine if there is a significant interaction between the suicide risk factors and the self-image variables.

Correlation Between Total Suicide Risk and Self-Image Scales. The Pearson Product Moment Correlation Coefficient was used to determine if there was a relationship between any of the eight self-image scales and an increased risk of suicide. See TABLE 4.21 for the results of the correlation.

TABLE 4.21
PEARSON PRODUCT MOMENT CORRELATION: SELF-IMAGE SCALES BY TOTAL SUICIDE RISK

<table>
<thead>
<tr>
<th></th>
<th>Impulse Control</th>
<th>Emotional Tone</th>
<th>Social Relationships</th>
<th>Vocational and Educational Goals</th>
<th>Family Relations</th>
<th>Mastery of the External World</th>
<th>Psychopathology</th>
<th>Superior Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.6062</td>
<td>-.7740</td>
<td>-.4813</td>
<td>-.4135</td>
<td>-.6741</td>
<td>-.5922</td>
<td>-.6739</td>
<td>-.3796</td>
</tr>
<tr>
<td></td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.001</td>
<td>p=.002</td>
</tr>
</tbody>
</table>

There is a significant negative correlation between suicide risk and self-image. As the suicide risk increases the degree of positive self-image decreases.

In order to reduce the type one error, the correlation must be less than .006 to be significant at the .05 level. All of these variables are significant, implying that there is a correlation between each of
these and suicide risk. As a youth's risk for suicide increases the youth's competence or strength in the eight particular self-image scales decreases.

The strongest correlations are for Emotional Tone, Family Relationships, Psychopathology and Impulse Control, implying that these are weakest for the youth at greatest risk.

**Correlation Between Suicide Subscales and Self-Image Scales.**

A further analysis was completed to determine the correlation between each of the four SPS subscales and the eight self-image scales. The results are in TABLE 4.22.

From this analysis it is determined that certain self-image and suicide factors are correlated. There are significant correlations between:

1) impulse control and the four suicide subscale;
2) mastery of the external world and the four suicide subscales;
3) psychopathology and the four suicide subscales;
4) emotional tone and the four suicide subscales;
5) family relations and hopelessness, suicidal ideation, and negative self-evaluation;
6) social relationships and hopelessness, suicidal ideation, and negative self-evaluation; and
7) vocational and educational goals and negative self-evaluation.
TABLE 4.22
CORRELATION: SELF-IMAGE SCALES BY SUICIDE SUBSCALES

<table>
<thead>
<tr>
<th></th>
<th>Hopeless</th>
<th>Suicidal</th>
<th>Neg.Self-Eval.</th>
<th>Hostility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impulse Control</td>
<td>-.4795</td>
<td>-.6410</td>
<td>-.4474</td>
<td>-.5205</td>
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<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td>Emotional Tone</td>
<td>-.6571</td>
<td>-.7356</td>
<td>-.6588</td>
<td>-.5051</td>
</tr>
<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td>Social Relations</td>
<td>-.4464</td>
<td>-.4373</td>
<td>-.3872</td>
<td>-.3051</td>
</tr>
<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td>Voc.-Educ. Goals</td>
<td>-.3723</td>
<td>-.3105</td>
<td>-.4034</td>
<td>-.2506</td>
</tr>
<tr>
<td></td>
<td>p= .002</td>
<td>.008</td>
<td>.001</td>
<td>.028</td>
</tr>
<tr>
<td>Family Relations</td>
<td>-.5293</td>
<td>-.6317</td>
<td>-.6558</td>
<td>-.3724</td>
</tr>
<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.002</td>
</tr>
<tr>
<td>Mastery of World</td>
<td>-.5425</td>
<td>-.4445</td>
<td>-.5790</td>
<td>-.4573</td>
</tr>
<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td>Psychopathology</td>
<td>-.6081</td>
<td>-.6520</td>
<td>-.4638</td>
<td>-.5277</td>
</tr>
<tr>
<td></td>
<td>p= .001</td>
<td>.001</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td>Superior Adjustment</td>
<td>-.3603</td>
<td>-.3045</td>
<td>-.3323</td>
<td>.2715</td>
</tr>
<tr>
<td></td>
<td>p= .003</td>
<td>.010</td>
<td>.005</td>
<td>.019</td>
</tr>
</tbody>
</table>

From this analysis comes a rejection of null hypothesis III. There is a significant negative correlation between total suicide risk and the eight self-image variables. As suicide risk increases, the level of strength or competence in the eight self-image variables decreases.

Guided Interview

The results of the Guided Interview can be found in Appendix M.
CHAPTER V

DISCUSSION

This chapter contains a summary of the study, followed by a discussion of the conclusions reached from the quantitative and qualitative research. Also included is a review of the study's limitations and recommendations and implications for future research.

Summary of the Study

This study was designed to examine the relationship between certain self-image factors and the propensity for suicidal risk to learning disabled adolescents.

The personal motivation to undertake this research was elicited from a clinical experience. This author treated an adolescent in therapy for a couple of years. A number of years after culminating what seemed to be a successful therapeutic experience, this young man, then 22 years old, committed suicide. He was a learning disabled person. Developing a sense of self is a major developmental task of adolescence, and for this young man it appeared that his learning problem was the cornerstone around which he developed his sense of self. He felt a tremendous sense of personal dissatisfaction and disappointment, for
which, he blamed his learning disabilities. Though he had a peer group, he put a great deal of stock in what the "popular" youths felt about him and these youths often taunted and teased him about his differences and called him a "retard." He had a tremendous love for his many pets that seemed to satisfy his need for intimacy much more than with people. Though he graduated from high school and went to work and seemed to have an active, productive daily routine, he seemed to suffer from an overwhelming sense of personal worthlessness. He appeared to have a loving, giving family; yet, part of their concern for him included an overinvolvement in his education, and a constant criticism of what they felt were the ineptitudes of the local school system. Speculations of what led him to his death haunted this author. The questions as to why were endless. His death provided the impetus for further investigation on adolescent suicide.

Three relevant studies were found that suggested that there was a significant relationship between LD and adolescent suicide. Peck (1985) studied all of the suicides of youth under 15 years of age that occurred in Los Angeles County from 1975-1978. He found that seven of the 14 youths had been previously diagnosed as LD.

Rohn et al. (1977) studied 25 youths who had made suicide attempts and found that 60% of them had "minimal brain dysfunction." One of the overt manifestations of minimal brain dysfunction can be a learning disability.

Kenny et al. (1979) studied 18 youths who had attempted suicide and found that a "significant" number of them had visual motor problems which can also be considered to be learning disabilities.
These research studies contend that LD youths can be found in high proportions in the population of adolescents who have either attempted or committed suicide. No research had been previously done to determine if "normal" LD youths were at greater risk within the larger population of "normal" adolescents. Each of these previous authors speculated about the factors that might have led these LD adolescents to suicidal acts, but no research had ever investigated the particular life experience or specific self-image factors of LD youths at suicidal risk.

Rourke, Young, and Leenaars (1989) contend that a specific grouping of LD adolescents are at an increased risk for suicide. They define this group as having a "nonverbal learning disability." This group has difficulties in social interaction and limited abilities for problem-solving. The authors posit and support with clinical studies the theory that poor social adaptiveness leads people who have nonverbal learning disabilities to become depressed, isolated, and withdrawn. They suggest that these social inadequacies lead members of this group to an increased risk of suicide. Though an interesting theory, it is not backed by empirical evidence. A critic of this theory, Bigler (1989) stated,

The whole issue of whether children with learning disabilities are at greater risk for suicide than non disabled children needs to be addressed. This will require further study in the area of emotional dysfunction and learning disability as well. These issues need to be solved before one can claim that nonverbal learning disability truly predisposes individuals to greater suicide risk (p.184).
The research questions for this dissertation were designed in response to the unanswered questions from previous research. From these questions three hypotheses and one research question were generated. The research question and the null hypotheses for study by this dissertation are:

1) Is the degree of suicidal risk to "normal" learning disabled adolescents significantly different than the risk to "normal" nonlearning disabled adolescents?

Hypothesis I:

IA.) Learning disabled adolescents are not at a significantly greater risk of suicidal activity that nonlearning disabled adolescents.

B.) They do not have higher levels of feelings of hopelessness, hostility, suicidal ideation and negative self-evaluation.

2) If the self-image factors are different, then, which of these factors is significantly different for learning disabled and nonlearning disabled adolescents?

Hypothesis II: As a group, learning disabled adolescents do not have a significantly greater difficulty with specific self-image factors. These factors include social relationships, mastery of the external world, vocational and educational goals, life adjustment, impulse control and family relationships. The youths' self-image do not affect their emotional tone and level of psychopathology.

3.) Which, if any, self-image factors are significantly different for learning disabled and nonlearning disabled youths who have a higher degree of suicidal risk?
Hypothesis III: The youths with a significantly greater suicidal risk do not have a significantly greater difficulty with the mentioned self-image factors than youths at a lesser suicidal risk.

4) Research Question: Will learning disabled youths at greater suicidal risk experience their learning disability as a major complication and/or major loss in their life?

This is discussed in a section in this chapter on object loss.

To answer these questions, a study using a blend of quantitative and qualitative research methods was employed. The study consisted of 60 subjects, 30 LD and 30 NLD, equal numbers of males and females.

A select group of LD youths was chosen for this study. All of these youths attended private high schools and were from middle to upper economic class families. Each youth liked her/his school and felt s/he was receiving an appropriate education. All were receiving passing grades and were not presenting disciplinary problems at school. This population was intentionally chosen since the literature suggests that part of the reason LD youth may choose a suicidal act is due to feelings of frustration and discouragement caused by inadequate academic remediation (Rohn et al., 1977). It was felt that if increased suicidal risk occurred within this select academically satisfied group of LD youths, then the risk to adolescents in less satisfying academic environments and with school problems would in all likelihood also be increased.

In addition, since not all LD youths who struggle in school are suicidal this can not be the only reason for suicidal activity. By studying this population, an attempt was made to go beyond only academic
difficulties and to try to identify additional areas of concern, specific to LD youth, that might contribute to suicide risk.

In order to assess the suicide risk and self-image factors for the subjects, three research measures were individually administered:
1) Suicide Probability Scale (SPS) by Cull and Gill (1982);
2) Offer Self-Image Questionnaire (OSIQ) by Offer (1977);
3) Guided interview designed by this author.

The specific results of each of these measures is reviewed in Chapter IV.

In this chapter, the quantitative and qualitative results are synthesized and discussed, again dividing the information into three of the categories used to review the literature in Chapter II: Sociological Perspectives, Individual Psychological Variables, and Family Dimensions. The fourth category previously used, Biological Factors, is not within the realm of this study.

When reference is made to findings from the guided interview, the question number referred to will appear in parenthesis, along with the number of LD youths responding favorably to that question, and the number of NLD who responded favorably (ie: question15,17 LD/28 NLD).
Conclusions Drawn from the Research

Sociological Perspectives

The literature discussed in Chapter II examined the adolescent's relationship to three primary social groups: peers, society and the school. The following is a discussion of the ramifications of these relationships for this study's research subjects.

Comparison of LD and NLD Peer Relations

Importance of the Peer Group. The peer group is the major source of social connection and belonging for the adolescent. This sense of belonging seems to be crucial to the youth's sense of personal worth and self esteem (Maris, 1985).

All of the subjects in this study were asked about their peer relationships. The research measures showed somewhat different findings.

The OSIQ social relationships scale assessed the individual's object relations and friendship patterns. A low standard score described a youth who had not developed good object relations and felt lonely and isolated while a high score showed a well-developed ability to empathize with others. The mean scores for the MLD, MNLD and the FNLD were within the normal range. The FLD mean score was below the
normal range. A MANOVA was completed to determine if there was a significant effect due to being LD on social relationships. No statistically significant effect was found. According to these statistics, the LD youth do not have poorer social relations than the NLD youth. An additional MANOVA found a significant interaction between FLD and MLD on social relations. The FLD were found to have significantly poorer social relations than the MLD.

The findings of the qualitative interview are somewhat different from the statistical results. This can be attributed to the fact that the OSIQ and the interviewer asked some similar and some very different questions. Some of the OSIQ statements on social relationships included: "I think other people do not like me."; "I prefer being alone (than with other kids my age.)"; and "Being together with other people gives me a good feeling." When the tester asked similar questions, the responses were consistent between the two measures. In the interview, however, the youth was asked direct questions about the availability of friends and the youth's satisfaction with these contacts. These questions were not asked on the OSIQ.

It is important to note that the interview was not examined for statistical significance. It's primary purpose was to offer useful descriptive experiences and feelings by the subjects.

Some distinctly different responses were found between the groups on the interview questions. As a group, the LD youths more frequently described long-term histories of peer difficulties (question 11, 15 LD/9 NLD). The level of discontent with their peer group
was greater for the LD youths and they often felt less satisfied with the constellation of their peer group (question 5, 17 LD/28 NLD).

The LD group was not without friends, however, and similar numbers of both groups had a best friend (question 5, 24 LD/20 NLD). The LD youths were more likely to socialize one to one since they less frequently had a close group of friends (question 5, 13 LD/23 NLD).

Another difference was that all of the NLD youths in contrast to only 21 of the LD youths had friends they could definitely do things with after school and on weekends. Many of the adolescents in both groups complained about the social difficulties of private school. The students came from numerous towns to attend their school thereby making socializing outside of school more difficult. This reason for social estrangement was as valid a reason for both groups to have limited contact with friends and does not explain the specific estrangement of the LD group.

Both groups preferred to be with a peer group rather than with family or alone. Only half of the LD youths reported that they liked to spend time alone (question 8, 15 LD/21 NLD).

In interview question 5, "What changes would you like to make in your friendships?", the LD youths were clear about their dissatisfaction with their peer group. Twenty-two of the youths, in contrast to four NLD, stated that they would like to have more social contacts with peers. Comments included:"I would like to have more kids to do things with."; "It would be great if more kids liked what I like so we can do things together."; "I'm always alone. I would like to have a best friend or some guys to do things with."
The NLD adolescents were more frequently interested in fine tuning their friendships by making improvement in style of interaction. Comments included: "I would like more in-depth conversations with my friends.; "I wish my friends weren't so fickle.; "I wish my friends weren't two-faced and didn't talk behind each others backs."

**Reasons for Inadequate Peer Relations.** The reasons some youths felt they had inadequate peer relations were explored. Each youth was asked if s/he felt that her/his learning ability had ever affected her/his peer relations. Seventeen of the LD youths responded yes, in contrast to two NLD. The LD adolescents perceived that much of their peer difficulty stemmed from having a learning disability which separated and made them different than the general population of youths.

A couple of the LD youths described this well. One FLD stated,

I realized I had trouble learning in the sixth grade, so my parents pushed for the school to test me. I was then placed in separate classes, so I became very isolated and a loner. Not because I wanted to, but because I was kept separate. The classes had LD and emotionally disturbed kids in them. They shouldn't do that. The disturbed kids get all the attention and they're usually the trouble makers. They were the kids I was in class with, but they weren't the kids I wanted to hang around with. The kids in regular classes didn't know me and didn't want anything to do with me.

Another FLD described her experience.

I was given very little help in public school even though they knew I had a LD. Eventually they placed me in the Romper Room (resource room) classes. This was awful because it separated me from all the other kids and they didn't want to be my friend. I tried not to let anyone know it bothered me but it was awful and I had no friends. I started skipping. It was pathetic. I had no friends and I didn't know anything.
It was speculated in Chapter II that LD youths might be excluded from their peer group and teased by the other youths about their disability. It was interesting to learn that almost equal number of LD and NLD youths felt that they received an unusual amount of teasing by their peers (question 29, 11 LD/9 NLD). The LD youths most frequently were teased because of their LD and taunted for being stupid, dumb or retarded. The NLD youths were also most frequently teased about their intelligence. They were teased for being too smart. Though the rejection by peers was traumatic to both groups, the LD youths seemed to maintain the more long-lasting wounds. One FLD described this everlasting pain. "Even now when I walk by a group of kids and they're laughing - laughing at anything - I still feel uncomfortable and feel like they're laughing at me again. It can put me in a bad mood for the rest of the day." This is in contrast to a NLD youth's experience with teasing by his peers, "The kids would call me a nerd or the brain. It was no big deal because I knew they were just jealous."

**Importance of Peer Relations to Group at Increased Suicide Risk**

Belonging to a peer group is of critical importance to most adolescents. According to Maris (1985), Durkheim believed, "To the degree that the societal groups are harmonious, integrated and the individual is an active, central member of those societal groups, then the individual's suicide potential will be low..." It is believed by many suicidologists that a youth who feels excluded from her/his peer group is most susceptible to feelings of isolation, depression and potentially suicide (Peck, 1985; Rohn et al., 1977).
In reviewing the research results for the twelve youths at greatest suicide risk, it is clear that peer relations was a major issue. During the interview, nine out of the ten LD youths complained about unsatisfactory peer relations. One FLD, who attended a regular school, described her feelings.

I have two best friends but I feel beneath the other kids because they're on the honor roll. I'm different. I feel in back and they're above me. I can't follow their conversations because they take classes that are more advanced. I don't get their jokes and they have to explain things to me all the time. Most of the time they don't know I'm struggling as much as I am. I can't understand why they want to be my friend. It makes them angry when I say that. But I find it a mystery why they like me because I wouldn't like me if I were them. What I think is important to be as a person I don't have. So I don't see why they do like me at all."

Five of the ten LD youths at greatest risk complained about feeling lonely. On the OSIQ scale on social relations, these subjects scores ranged from 4.86-57.93. The standard score is 50 and anything above it is better than average and below it less than average. Eight of the ten scored below 50 and two above. Of those below 50, five are female and two are male.

It was speculated by Peck (1985) that LD youths might be at increased risk of suicide because they often feel humiliated by other youths "deriding their disability"(p.116). Of the ten LD adolescents at greatest risk, four felt that they were unusually teased by their peers. There were three FLD who had previously made a suicide attempt, and none said that teasing by peers precipitated or contributed to this attempt
Only one of the two NLD youths at greatest risk of suicide felt that she was unusually teased by her peers. She was teased about being too smart. She said this experience was not traumatic since she learned how to make her intelligence less obvious and the teasing stopped.

The most extreme experiences of peer teasing came from two FNLD who had previously made suicide attempts. Neither was found to be at increased risk during this testing. Both young women described cruel teasing by their peers that they felt led them to attempt suicide.

One explained that the other students in her school teased her for being sexually promiscuous because a male student said he had sex with her. He neglected to say he had raped her. She says she attempted suicide in despair over their teasing. She hoped to get them to feel sorry for her and to teach them a lesson. Another young woman explained that other students teased her unmercifully because she was "weird" and academically smart. She also said she made a suicide attempt in order to get away from these youths and to make them feel sorry for what they had done to her. Both of these young women were hospitalized for a few months in a psychiatric hospital. Though there were other life experiences that may have contributed to each young woman's despair, each clearly believed that the most important precipitant was the teasing by her peers.

Peck's notions that peers deriding the LD youth's disability would frequently precipitate a suicide attempt or promote suicidal ideation was not supported by this research. Part of the reason this discrepancy occurred was probably because this group was different from most other LD groups. The majority of the students in this study were in
schools solely for LD youths and, therefore, teasing about LD would not exist. Only four of the ten LD youths at increased risk attend schools for both LD and NLD. None of these adolescents were presently complaining about peer teasing. Four of ten LD youths complained about previous peer teasing in other school settings. Of the three FLD who had attempted suicide, none said peer teasing was a precipitant. However, both FNLD youths who had attempted suicide reported that cruel treatment by their peers did contribute to their attempt.

Feelings of isolation are often believed to be critical components of the suicidal adolescent's life experience. Peer relations certainly is a major concern for the sample group at greatest risk. Nine out of the ten LD youths and one out of the two NLD youths complained about inadequate peer relations. Listening to these youths' painful stories about their exclusion from the peer group leads this author to believe that the resulting feelings of rejection and isolation contributed to this group being at increased suicide risk. The reasons for their peer exclusion seemed to be a result of rejection by the other youths and the LD youths' own feelings of inadequacy which caused them to withdraw from the group.

Conclusion: Peer Relations

The statistical analyses based on the OSIQ scale on social relations stated that there was no statistically significant difference due to being LD. The guided interview, however, examined different areas of peer relations and some interesting differences were noted between the LD and NLD groups.
The OSIQ results found that the FLD had a greater difficulty with social relations than the MLD. This suggested that the FLD had not developed good object relations and felt more lonely and isolated.

The interview results, however, suggested that both the males and females had less than adequate social relations. Equal numbers of MLD and FLD reported that they felt dissatisfied with their social contacts. It was reassuring to find that these LD youths did not feel completely isolated, since most reported having a best friend. However, the LD youths seemed to have difficulty in group relations. A substantial number of males and females were without a close group of friends (question 5, 10 FLD/7 MLD) and without a consistent group for social activity (question 5, 4 FLD/5 MLD). This suggested that, though the difficulties with group relations were similar between the genders, the males did not feel as distraught over this lack of social connection as the females. Extensive research by Carol Gilligan (1982) supports this finding. She theorizes that social connectedness is critical to the development of females and that "femininity is defined through attachment" (p.8). She states, "Male gender identity is threatened by intimacy while female gender identity is threatened by separation" (p.8). This does not necessarily mean that the males feel satisfied with their friendships. Quite the contrary. Many of the males in this study complained in the interview about the lack of intimacy and a number were wishful that they could have friends where they could share "deeper feelings." However, the lack of adequate social connection had a more serious effect on the females. Not having close friends and attachments was felt as a loss and was a critical element of self-esteem.
This author speculates that females attempt suicide more frequently than males (Frederick, 1985) as a means to get others to take notice of their unhappiness. It can be a way to put friends and family on alert. It forces them to pay more attention and to be more intimate with the despairing adolescent. This explains why more FLD as compared MLD are found to be at increased risk of suicide in this study.

Males, however, commit suicide more frequently (Frederick, 1978). Peck (1985) contends that the youths who commit suicide have a life-long history of isolation and withdrawal from society. It is conceivable that many males may not identify that they have a lack of social connection. These males may only recognize this lack when they reach early adulthood and are no longer in an educational setting that easily provides group contact. They may then feel more alone and isolated and without people to share their concerns. It has been suggested that a major difference between the attempters and the committers is due to the attempters having a close significant other who was instrumental in their rescue. (Jan-Tausch, 1964). It could be speculated that some males undermine their need for attachment until their feelings of despair become desperate. Their lack of social skills leaves then without the necessary resources to ask for help and the result may be suicide. Based on this, it is possible that males in this study, as in the general population of those who commit suicide, may not recognize their discontent until it reaches a desperate stage.

Coping With Society

Comparison of LD and NLD Youths' Ability to Cope with the Society. It was questioned in the literature review whether LD youths
might feel more concerned than the NLD about their ability to compete in the world and less optimistic about future success. In this study, both groups of youth had some awareness of world issues and had concerns about the state of the world. When asked about her/his adult plans, no one complained that the world issues might stand in the way of success.

The OSIQ scale of superior adjustment measured the youth's ability to cope with self, significant others, and the world. A low score indicated a youth not adequately dealing with the environment while a high score indicated a well-functioning coping system. There was no significant difference between the groups on this scale but the results did show that all of the groups were below the mean. The MLD, MNLD and FNLD groups were minimally below, while the FLD were below by 11 points. This suggested an overall trend of all the sample youths having some difficulty adequately coping with the environment.

From the interview, it appeared that most of the youths in both groups had realistic future plans that included college, adult social relations, and a reasonable career and living plan. A MANOVA, however, found that there was an effect due to gender on educational and vocational goals. This finding implied that females had greater difficulty with educational goals, a poorer ability to plan for their vocational future, and felt more concerned about their ability to compete. Though the females described reasonable future life plans in the interview, they frequently nullified these plans by stating, "But I don't think this can really happen." Many doubted their ability to attain their desired career or to find a relationship that would bring them happiness. On FLD described this fear. She said, "I'm sure that my future
will not be what I think, but I hope it will be like this: a good job, get married, have a huge family and lots of dogs and live in Rhode Island."

This finding is supported by Gilligan's (1982) theory that female adolescents struggle to integrate their early childhood female aspirations for intimate attachment to family and friends with the more masculine competencies they have acquired at school. The female fears that academic success and adult professional success will alienate her peers and leave her isolated. Due to these fears, the female often chooses not to compete with her peers and not to achieve to her capacity.

The FLD had even poorer scores on educational and vocational goals. Previous findings suggested that FLD youths more frequently felt lonely and discontented with their peer relations. In an attempt to enhance their peer attachments, these young women might choose to avoid the risks of alienation, thought to be synonymous with high achievement, by avoiding educational and professional competition with their peers.

When asked in the interview, "If you had three wishes what would they be?", there were some distinct differences between the groups. Seventeen of the NLD in contrast to three of the LD youths wished for "lots of money." The LD youths more frequently wished for success in school or career. This implied that the LD adolescents were more concerned about their ability to achieve success in the concrete areas of their lives while the NLD youths were more self confident in their ability to successfully achieve the basics and were able to use their wishes for luxury and riches.
Ability to Plan for the Future for Group at Increased Suicide Risk.

Within the group of youths at greatest risk of suicide the NLD and LD adolescents had different feelings about the future. The two NLD felt confident that they would succeed. The LD youths were less confident. Eight of the ten expressed serious doubts about their future adult abilities. One FLD imagined herself alone in a tiny apartment with her art work around her trying to find happiness. Another FLD said, “I want to go to college but I don’t think I can do it. I want to be an actress but doubt I can do that. I’d like to go to law school but it’s too much work. I’d like to get married but I doubt I’ll find someone.” A MLD was to the point and said, “I’m very scared about what’s going to happen to me when I graduate from high school.” The LD youths seemed to have serious doubts about their potential for future success.

Conclusion: Coping with the Society

The mean scores for all of the sample youths were somewhat below the expected norm on the OSIQ scale on superior adjustment. This suggested that many of the youths were just managing to cope with the environment. No statistically significant difference was found between the groups though the FLD had a lower mean score than the others.

A statistical difference was found between being female on the vocational and educational goals scale. This implied that females were having greater difficulty establishing realistic future plans. This certainly can be problematic, since it has become critically important to
females to have equal confidence in their abilities so they can compete in the professional world. The FLD had even more difficulty than the FNLD.

The Importance of School

The suicide literature contains numerous conflicting reports about the relationship between school problems i.e., misbehavior, poor grades, truancy, and learning disabilities and suicidal activity.

All of the subjects in this study liked their schools and were getting passing grades.

Most of the youths had confidence in their academic abilities and felt that they were average to above average in intelligence. Five of the LD youths felt they were below average.

All but one youth felt that s/he was receiving an academically appropriate education. The one not included was a FLD in a nonspecialized education program. She had positive feelings about her school, but felt she could use some remedial support.

A history of school problems was common for the LD youths. Double the number of LD, 24, in contrast to 12, NLD had some type of school difficulty. The youths explained some of these problems. One MLD stated,

Other people realized before I did that I had a learning problem. I realized in the fourth grade. I started fighting and was always angry. I was frustrated because I couldn’t do the work and felt like tearing my math book in two. The school didn’t respect my problems and didn’t provide what I needed.
Another MLD explained his school problems.

In the fourth grade I wasn't able to read yet but kept thinking I would learn. The other kids would tease me about being stupid. I caused all sorts of trouble in class and could never sit still. A teacher's aid told me I was too stupid to learn to read; in front of all the other kids. I thought about suicide or killing her. I started cheating so no one would realize I couldn't read and even made the honor roll. Yet, inside I knew I couldn't read and it felt awful cause I thought I would end up pumping gas all my life.

An FLD explained how her school problems were blamed on her mother. "I did terrible in public school but they blamed my problems on my parents' divorce and my mother working. I was doing five hours of homework a night but I couldn’t keep up. I started skipping and causing trouble."

All of the LD youths recognized that they had a learning problem. There were a wide variety of ways in which they integrated this into their life. There was a distinct difference in the school experience of those youth who were identified as LD when very young and given appropriate remediation. Most of the youths who now had positive or neutral feelings about their LD had been identified and received remediation in grades one or two. Comments included, "I'm glad I knew I had dyslexia when I was little, otherwise I might have thought I was stupid." "I was tested in the first grade and got some help. I learned to compensate for my dyslexia when I was little so it has never been a major problem. I just need to read slowly and take extra time." "I was lucky because all the schools I was sent to were there to help me and my parents were behind me." "Dyslexia is a gift that teaches you to work
harder for what you want to accomplish." "I can still do whatever I want to in life. I'm not dumb. I'm no different than anyone else I just learn different. Lots of great people are LD." However, only six of the LD youths fell into this category.

The other LD youths told painful stories about poor educational experiences. Their complaints included: "My school ignored my problems."; "My teachers told me I was stupid."; "The teachers yelled at me because they thought I wasn't trying."; "The teacher humiliated me in front of the other kids by saying I was lazy when I was trying as hard as I could."; "My teachers kept passing me even though I couldn't do the work. They saw I was trying and I was a good kid."

Just having a learning disability was not reason alone for adolescents to have school problems. When proper remediation was secured at a young age, most of the youths seemed to compensate both academically and emotionally for their disability by the time they reached adolescence.

School Concerns for Group at Increased Risk

The statistical analyses in this study showed a significant effect due to being LD on an increased risk of suicide. In addition, FLD were found to be at increased suicide risk when compared to FNLD.

Rohn et al. (1977) studied a group of youths who had made a suicide attempt. From his research he suggested LD youths were more prevalent in the suicide population when their LD was not identified and they did not receive proper remediation. He felt that these youths felt stress due to their inherent inability to be successful in the usual academic environment. He suspected that feelings of inadequacy,
failure, difference, and confusion that stemmed from feeling academically deficient might lead to a suicidal act. This study clarified some of the ideas that Rohn et al. postulates.

Of the ten LD youths at increased risk in this study, only two received early remediation. The problems that these two youth presented in this study did not seem to stem from feelings about learning. The other eight had extremely negative early school experiences and feelings of inadequacy and failure continued to prevail. All felt that they were presently receiving a good education and all but one felt that the remediation they were receiving was adequate. Yet, even though they were receiving adequate remediation, seven of the ten youths continued to complain about their present educational frustrations and limitations imposed by being LD. A sad quote about her frustration came from a 13-year-old FLD. She said, "I like my school and I'm learning more now than ever before but it's so frustrating. I hate being LD. Having a LD feels like, if someone dies. There's a pain in you and it won't go away." For these youths a deeper feeling of inadequacy or loss seems to permeate their feelings.

**Conclusion: The Importance of School**

Since we have become more sophisticated in our methods of identifying and remediating youths with learning disabilities it would seem that the tales that the youths in this study are telling about late identification and improper remediation should be less prevalent. Certainly early remediation has proven to be critical to the emotional and academic well-being of LD youths.
Individual Psychological Differences

In the first section, the relationship between psychological traits and LD are discussed. This is followed by a discussion of the relationship between specific psychological traits that are known to have a relationship to suicidal adolescents.

Comparison of Individual Psychological Variables for LD and NLD

Negative Self-Evaluation. A significant effect was found due to negative self-evaluation on being LD. This implied that the LD youths had a more negative self-evaluation than the NLD. The SPS negative self-evaluation scale reflected the present feeling by the youths that life was just not going well. It suggested that they felt others were distant and uncaring, which supported the premise previously made that LD youths were often dissatisfied with their social relations. It also implied that these youth felt that it is difficult to do anything worthwhile.

Hopelessness. The statistical analyses did not find a significant relationship between LD and hopelessness. The SPS hopelessness scale assessed both the individual’s overall dissatisfaction with life and her/his negative expectations for the future. These findings implied that though the LD youths have a significantly poorer self-evaluation they still have optimistic feelings about the future.
In the past, many of the LD youths had extremely negative school experiences that might well have contributed to their feeling of negative self-evaluation. Now all were involved in positive school programs that were providing them with hope for the future. Sadly, this implies that LD youths who remain in inadequate school programs will have a greater likelihood of poor self-evaluations and feelings of hopelessness, since they will have little opportunity within their academic world to introduce hope for the future.

**Emotional Tone and Psychopathology.** The OSIQ has two scales that examine the emotional make-up of the adolescent. The emotional tone scale assessed the individual’s ability to manage and control emotional fluctuations. The psychopathology scale identified overt psychopathology.

There was no significant difference found between any of the groups on either of these scales. The MLD, FNLD and MNLD mean scores fell within the normal range. The FLD mean score fell below the norm and was lower than the others, but was not statistically significant.

Since the definition of mental illness is subjective, the incidence of mental illness in the adolescent population is uncertain. Offer (1977) believes that 20% of adolescents will have the type of emotional difficulties that will warrant professional treatment.

In searching for appropriate subjects for this study, each school was asked if the youths in its' school had known emotional problems. All of the schools stated that the youths were “normal” adolescents and had no known mental illness. School personnel realized that some of the
the youths had previously had family or emotional difficulties but they considered the youths now fit the definition (see Chapter 1) of "normal."

There was, however, a distinct difference between the groups in number of reported emotional problems. Eighteen of the LD and five of the NLD reported previous emotional difficulties. Many of the LD youths' difficulties related to school problems.

A surprisingly large number of the youths in this study had been involved in psychotherapy. Twenty-three of the LD and 14 of the NLD adolescents have been in psychotherapy. At the time of the study, 11 LD and four of the NLD youths still had personal or family issues that warranted involvement in therapy. There are a number of possible reasons for this therapy involvement. The subjects were mostly white, middle class youths from educated families who were more likely to use therapy. Since these youths were attending private schools, it was likely that they come from proactive families who use community resources.

The LD youths were more frequently in therapy than the NLD. It is possible that, within the so called "normal" population, LD adolescents have a more serious range of emotional difficulties than NLD youths. It is just as likely that these families and youths are proactive in their response to resolving problems and are more accepting of professional support because of their involvement in specialized education programs.

Nearly equal numbers in both groups had been hospitalized for psychiatric problems (question 12, 4 LD/3 NLD). It was again surprising to find such a large number of youths within a seemingly "normal"
population who had been hospitalized for psychiatric reasons. Out of the four LD youths, two females were hospitalized because of a suicide attempt and two males for acting out and being "out of control." Two FNLD were hospitalized for suicide attempts and one male was hospitalized for being "out of control." It is likely that the private school population is a wide mix of students. It contains youths with varying academic abilities and healthy psyches as well as adolescents with emotional difficulties. It is important to note that the school personnel were most often unaware of the youths' emotional difficulties.

**Relationship between Individual Psychological Variables and the Group at Increased Suicide Risk**

There were some differences between the subgroup of ten LD and two NLD youths at increased suicidal risk and various psychological variables.

**Superior Adjustment or Problem Solving Behavior.** It is suggested in the literature that a suicidal act is sometimes used as a means to solve one's problems when one has an inadequate repertory of coping skills (Kimmel & Weiner, 1985). In this study, a correlation is found that showed that, as a youth's suicidal risk increased, her/his superior adjustment or ability to cope decreased.

The OSIQ superior adjustment scale examined the youths' ego strength and coping system. No significant relationship was found between the superior adjustment scale and any of the groups, suggesting that there was no difference in coping skills between these groups.
Impulse Control. This study's results did not show a significant difference between the groups and impulsiveness.

The literature has conflicting theories about the commonality of impulsiveness in adolescent suicidal activity. A correlation was found in this study that inferred that as a youth's impulse control became poorer there was an increased risk of suicide.

Hostility. It was suggested that suicidal people are often hostile and that suicide is anger turned inward which comes from murderous impulses against others (Litman, 1967).

The statistical analyses found no significant effect due to the main effects, of gender and LD, on hostility. However, a significant interaction was found between FLD and FNLD on hostile feelings. FLD had more hostile feelings than FNLD.

In order to assure emotional attachment and social connection, feelings of anger and hostility toward others are usually discouraged in females (Gilligan, 1982). In previous findings in this study, FLD were found to have poorer social relations than MLD. Possibly their resulting increase in hostile feelings came from their anger at not having the types of social connection they desired. Since the research also found that FLD were at increased suicidal risk compared to FNLD, this implies that the hostile feelings manifested themselves through increased self-contempt and desire to hurt, punish, or be rid of themselves. This implies either that they blamed their inadequacies on themselves or that hurting themselves had a hoped-for secondary gain in that they hoped this would have a major effect on others (i.e. friends and family) whom they really blamed for their unhappiness. Rather than express
this anger directly and possibly risk losing all social connection, they instead expressed it indirectly with the hope that their significant others would feel guilty and move closer to them, rather than angry and push them away.

**Suicidal Ideation.** Suicidal people often have suicidal thoughts or ideation. Even though a significant relationship was found between LD and the SPS total suicide score, no significant relationship was found between suicidal ideation and the main effects of gender or LD. The total score was a special weighted combination of the four suicide variables and does not only refer to suicidal ideation.

**Clinical Treatment.** Six of the ten LD youths were involved in therapy, while eight of the ten had been involved at some time in their lives. These youths' present emotional issues included: depression, poor self-esteem, and post traumatic stress syndrome. Based on the information gathered by this research, this author believes that all but one of these youth had emotional difficulties that warranted clinical treatment. Four of the nine who needed treatment, however, could have best been treated by family therapy.

Neither of the NLD have been involved in therapy. Both had emotional difficulties that were family based and could have benefited from family treatment.

Three of the LD youths found to be at increased risk had previously been hospitalized in a psychiatric facility. Neither of the NLD has been hospitalized.

**Object loss.** Many suicidologists believe that object loss is a crucial element that leads some youth to suicidal activity. Object loss
can be either the loss of a parent or loved one, or the loss of a psychological state of well-being (Sandler & Joffe, 1965).

Both of the NLD youths seemed to suffer from a type of object loss that related to the loss of affection within the family. This will be further discussed in the section on Family Dimensions.

Nine of the ten LD youths had in common a sense of internal disappointment and dissatisfaction with themselves. This was also shared by many of the LD youth not at increased risk, but rarely shared by the NLD youths.

Six of the ten, however, seemed to have suffered from the pain synonymous with a serious ongoing feeling of object loss. Only one of the LD youths not found to be at risk would seem to fit in this category. He was the youth referred to earlier who was suspected of "taking good" on the SPS.

On the SPS each of these six youths responded to, "I feel, if I could start over, I would make many changes in my life" with, I feel this "most or all of the time." This suggested a strong internal dissatisfaction with the course of their life.

As a group, they had a mean score on the SPS that placed them in a moderate risk category for hopelessness and negative self-evaluation. This was different than the total LD sample who scored significantly poorer than the NLD on self-evaluation but average on hopelessness. This suggested that the subgroup at risk had negative feelings of self-esteem and also felt pessimistic and hopeless about the future.

These six youths seemed to share a sense of loss that centered from a loss of an idealized self that they believed cannot exist. They
blamed the LD for this loss. Each has a fantasized self that s/he seemed to believe had died. Each was now struggling to find a new sense of self but felt lost because that which s/he wanted to be was felt to be impossible. Comments by these youth that supported this included: "I have tried so hard to fit in with the other kids and to be just like them that I lost all sense of who I am. I just can't be like them. What I think is important for a person to have, I don't have and never will." "I hate being LD. Being LD feels to me, like if someone dies, there's a pain in you and it won't go away." "I try in school. I'd love to do well but I just can't. I just can't do it." "I'm never really myself, not my real image. I don't even know what that is." "I wish I could go back in time and start over. I'd be different. I'd do everything different."

**Conclusion: Individual Psychological Variables**

There were a number of psychological variables that were significantly different for the LD adolescent. A statistically significant difference was found between being LD and negative self-evaluation. This reflects that the LD youths felt that their lives were not going well. Yet, the hopelessness scale was within normal bound, implying that they generally still had hope for the future.

A large number of both groups have had emotional and family problems and have been in psychotherapy. The LD youths had a greater amount of problems but many of these related to their learning or school difficulties.

The FLD youths were found to have stronger feelings of hostility than the NFLD youths.
There were some differences between the groups at greatest suicide risk. Six of the ten LD youths seemed to have suffered from a form of object loss that related to their LD.

Family Dimensions

Positive family relations are of major importance to the adolescent. Offer (1977) states that the adolescent's feelings and attitudes toward her/his family is critical to her/his overall psychological health. He believes that the family contributes more to the positive development of the youth than any of the other variables.

Comparison between LD and NLD on Family Dimensions

The majority of youths in this study had adequate or positive relations with their families.

The OSI IQ has a scale that examined family relations. A MANOVA found no significant relationship between the main effects of gender or LD on family relations.

The guided interview also asked about family relations. No differences were found between the groups in the interview. The majority of youths reported average or better relations with their mother, father, and siblings (question 13, positive relations with mother: 23 LD/26 NLD; with father: 19 LD/16 NLD; with siblings 21 LD/20 NLD).
Family Relations for Group at Increased Risk of Suicide

The literature indicates that particular family dynamics are related to adolescent suicide. The following is a review of the relationship between family dynamics thought to have an impact on suicidal activity and the specific results from this study.

There was a significant correlation between increased suicidal risk and family relations implying that as a youth's risk of suicide increased her/his family relations were poorer. This was supported by the information reported by the twelve youths at greatest suicidal risk. In contrast to the adolescents not at risk, eight of the ten LD youths at greatest risk complained about problems with their parents. The problems were mostly with communication and trust. Both of the NLD youths had similar family issues.

Speculations were made that certain theories of family dysfunction would be common in suicidal LD youths' families. Since the families were not interviewed for this study, many communication patterns and family dynamics were not discernible. Also, the family interaction was being reported by the adolescent who often had a limited understanding of the family dynamics because of her/his limited life experience and knowledge about the rationale for certain family members' behaviors.

The following is a review of the family dynamics related to suicide and their relationship to the subjects in this study.

Symbiosis. The literature suggested that there might be a symbiotic relationship in families with suicidal adolescents. It was suggested that this type of relationship would be characterized by a
parent who was unable to separate her/himself from the child and would be unable to empathize with the child’s needs, thereby invalidating the child’s sense of self.

It appeared that this type of relationship was experienced by both NLD youths at risk. The FNLD described a sad family scenario. Though the mother’s rationale was unknown, the daughter explained that, for no reason, her mother decided to look at her private papers and read her diary. From this reading, she learned that her daughter was having sexual relations with her boyfriend. When the father learned of this, he became irate, and physically abused the daughter. The daughter was forbidden to ever see this boyfriend again and relegated to a strict series of rules. The parents seem to lose sight of any of the daughter’s other traits which included being an honor roll student, and according to the daughter, an obedient child. Their moralistic attitude and fear of damnation for sexual misconduct seemed to override everything. The daughter could not tell this tale without trembling and crying even though it had taken place a year ago.

According to the daughter, the parents are unaware of her feelings and have no understanding or empathy for her present emotional state.

Based on limited information it was unclear how common this dynamic was for the LD youths. It appeared that it may be true for at least three of the ten. The most obvious situation was that of a FLD. Though the girl’s dyslexia was identified at a young age, the family decided to have her educated in regular private schools. The mother was invested in her daughter having proper social connections so she never allowed her to enter special schools. The girl’s father and brother were
also dyslexic. According to the girl, her father was so upset about having passed this trait to his children that he refused to discuss it. The mother was determined to find a "miracle cure" for her LD and brought her to numerous specialists and quacks who promised results. The girl cried as she told the tales of her painful history. It seems that the parents were so concerned with their feelings about her LD that they completely neglected trying to understand or empathize with their daughter.

**Parental Pressure or High Expectations.** A number of suicidologists believe that parents of suicidal youth often place an inordinate degree of pressure on their child to succeed. This pressure might come from them their trying to make-up for their own feelings of inadequacy. Peck (1985) speculated that one reason the LD youths might be at increased risk of suicide could stem from the hurt and frustration a youth could feel at a parent placing unreasonable pressure on them to be "normal" and succeed in school.

Peck's ideas were not supported by this study. A small number of LD and NLD youths felt pressure from their parents to do well in school (question 22, 7 LD/9 NLD). The LD youths complained of situations from the past before they were identified as LD, where parents pushed them to succeed in school, however, only two of the youths complained that parental pressure was traumatic or continued to have a negative effect. A large number of LD youths felt no pressure at all, by parents or themself, to do well in school (12 LD/5 NLD), while a large number of NLD felt internal pressure to do well (question 22, 8 LD/12 NLD).
Also related to this notion was the thought that parents with a LD youth at greatest risk might have an unreal image of their child's LD and either place an inordinate amount of energy into trying to have the child overcome the LD or completely ignore the importance of the LD. The life experience described by the FLD in the section on symbiosis certainly underscored this. The two previously mentioned case studies of LD youths who committed suicide contained this dynamic. In one, the parent refused special treatment and, in the other, the parents fought with the school almost daily to improve the child's schooling. There was not enough information to allow for an analysis of this dynamic for the youths in this study.

**Family Communication.** A common family dynamic for all adolescents is inadequate family communication. However, the majority of youth in this study felt they had adequate to positive communication with their parents. The adolescents at greatest suicidal risk differed and eight of the ten LD youths and both of the NLD youths complained of a lack of trust or inability to communicate their feelings to their parents. One of those who did not complain was only 13 years old and the other was in a foster home.

Double bind communications had been suspected in these families but there is no way from this study to judge this.

**Closed system.** Richman et al. (1971) suggested that suicidal families are often closed systems and it was suspected that this would be true of LD families. The contrary was true for this sample. The
families were quite open to professional intervention. All were involved regularly with their child’s school and many had been in individual or family psychotherapy.

Conclusion: Family Dynamics

There was no statistically significant difference between the main effects of LD and gender on family relations. The majority of youths in this study, regardless of whether they were LD or NLD, had adequate or positive relations with their families.

A significant negative correlation was found where, as the suicide rate increased, the level of positive family relations decreased. The group of youths at greatest suicide risk in this study, regardless of whether they are LD or NLD, consistently had poorer family relations than the youths not at risk.

The suicide literature suggests that certain family dynamics are prevalent in families with a suicidal adolescent. A number of dysfunctional family patterns were found in the population of youths in this study who are at greatest risk. There seemed to be no difference between the dysfunctional patterns of the LD and NLD youths. In both groups two major dysfunctions prevail: symbiotic relations and inadequate empathy between at least one parent and child, and poor communication.
Conclusion

The major reason for undertaking this research project was to attempt to determine if normal LD adolescents are at an increased risk of suicidal activity when compared to a controlled group of normal NLD adolescents.

Hypothesis I

IA) Learning disabled adolescents are not at a significantly greater risk of suicidal activity than nonlearning disabled adolescents.

IB) They do not have higher levels of feelings of hopelessness, hostility, suicidal ideation, and negative self-evaluation.

Part IA of this null hypothesis is rejected. The research determined that there was a statistically significant effect due to being LD on suicidal risk. The LD group of adolescents were at significantly greater risk of suicide than the NLD group. Furthermore, the FLD were at significantly greater risk than the FNLD.

A portion of part IB is rejected. There was no statistically significant difference between the main effects of gender and LD on the variables of hopelessness, suicidal ideation, and hostility.

A significant effect was found due to being LD on negative self-evaluation. The LD adolescents had a significantly more negative self-evaluation than NLD adolescents.

A significant interaction was also found between FLD and FNLD on hostility. This implied that FLD had more hostile feelings than FNLD.
Hypothesis II

As a group, learning disabled adolescents will not have a significantly greater difficulty with specific self-image factors. The factors not affected include: social relationships, mastery of the external world, vocational and educational goals, life adjustment, impulse control, and family relations.

Most of this hypothesis is accepted. No statistically significant difference was found between the main effects of LD and gender on mastery of the external world, life adjustment, impulse control and family relations.

A significant effect was found due to being female on vocational and educational goals. This implied that the females in this study had greater difficulty developing future plans than the males. FLD had greater difficulty than the FNLD.

A significant interaction was found between FLD and MLD on social relations. The FLD had significantly poorer social relations than the MLD.

Hypothesis III

The learning disabled youth with a significantly greater suicidal risk will not have a significantly greater difficulty with the mentioned self-image factors than learning disabled youth at lesser suicidal risk.

This hypothesis is rejected. There was a significant negative correlation between suicide risk and self-image. As the suicide risk increased, the degree of positive self-image on all eight of the factors decreased.
Research Question

Will learning disabled youths at greater suicidal risk experience their learning disability as a major complication and/or major loss in their life?

According to this research, yes. Six of the ten LD youths at greatest suicide risk experienced their learning disability as a major loss in their life.

Limitations

Certain limitations of this research project were discussed in Chapter II. These limitations were obvious prior to the initiation of the research. Some additional limitations were manifested during the study that are mentioned in the discussion of the results. These limitations and their implications in the research are now discussed.

This research began with a clear process for subject selection. The cooperating schools were given specific subject criteria and assured the author that the volunteer subjects fell into the guidelines. Even so, the composition of the subject group became somewhat different than was originally planned. The groups took on a structure that seemed to replicate the overall structure of the private schools. Many youths who were overtly functioning well at school also had histories of emotional and family difficulties but this was not known to the school personnel. It was impossible to rule out the youths with these problems in order
to remain with the original definition of "normal," as established in Chapter I, since some history of emotional or family history of difficulty was so predominant in the population and unknown to the school personnel.

Most important for the purpose of this study is that the groups continued to be well matched. The student structure of the private schools were similar and youths with similar emotional and family difficulties were in both groups. The LD youths had a greater number of emotional problems yet most of these seemed to stem from their learning and school difficulties. A surprisingly large number of youths had been psychiatrically hospitalized but the numbers were nearly even (question 12, 4 LD/3 NLD) between the groups.

Though somewhat different than originally planned, the study populations remained well matched, and seemed to be representative of the overall private school population.

Implications

This research concentrated on studying a select group of normal adolescents from private schools presently receiving an adequate education. The purpose of using this select population was to determine if, even in a grouping of LD adolescents receiving adequate academic instruction and support, the risk of suicide was greater than to a matched group of NLD adolescents.
The youths in this study were fortunate enough to have entered private schools that were providing them with adequate remediation, encouragement, and hope for the future. Yet, even in these good educational settings, the statistical evidence found that the LD youths were at greater risk of suicide. Based on this, it is safe to assume that if LD adolescents receiving a good education are found to be at increased risk, then surely LD adolescents not receiving adequate education would also be at increased risk.

The results further showed that LD adolescents have a more negative self-evaluation than NLD youths. Most of the youths' reported that school achievement had played a major role in their development of feelings of self-worth. The majority of LD youths in this study had negative educational experiences in early childhood that weakened their self-esteem and caused them pain, frustration, and humiliation.

A consistent trend is noted in that the FLD group had higher mean scores on the suicide variables, suggesting increased suicide risk, and lower self-image scores, suggesting poorer self-image, than the other three groups. Statistical evidence reported that FLD were at increased suicide risk compared to FNLD; FLD had poorer social relations than MLD; and FLD had more hostile feelings than FNLD. This evidence implies that this group may in fact be the group at greatest suicide risk.

There are a number of reasons why females may be the group at greatest risk. According to LD author Larry Silver (personal communication, August 7, 1989) there are far fewer females than males identified as LD. This is either due to a decreased likelihood that LD
occurs in females or that a female's response to being LD does not cause her to be readily identified. The youths from this study support the notion that the female's response to academic frustration is usually to become withdrawn and passive, while the male's usual response is to act out. Therefore, for a female to be identified as LD, she may also need to have more serious or obvious emotional problems. This would infer that a group of females identified as LD would also be likely to have emotional problems. This would explain why the FLD group in this study continually had scores that were different than the other three groups. Based on this, the FLD group might consistently be the group at greatest suicide risk.

Clearly this research clarified that LD youths are a population that warrant suicide prevention programs specifically tailored to their needs. This group of youths has specific issues and needs that relate to their LD and prevention programs need to be designed specifically for them.

Ideally, suicide prevention should begin at a very young age with early enhancement of positive self-esteem. In this study, when a LD youth was identified and received proper academic remediation in the early years of grammar school, the risk of emotional and academic damage was lessened.

In the ideal circumstances, all youths should be academically tested at a young age so that proper remediation, when necessary, could begin. Resources within the schools, however, are not ideal and will probably never be able to provide that service. At the least, all youths should be given yearly reading and academic testing, one on one
with a teacher, to be sure that they are learning at grade level. Any youth who is having academic difficulty and all those who are acting out should automatically be tested for learning disabilities.

One of the newest educational trends is to avoid labelling students and to minimize student differences. Though this may be academically effective, it does not respond to the psychological needs of LD youth. Members of this group benefit from being a part of an LD group and knowing about their disability. The LD youths often have a confused sense of self. In many ways, they know that they are as smart and capable as the other students, yet they have deficits that obviously make them different from the norm. If we do not label or identify these differences as LD, then often the youths remain confused as to their capabilities and their identity. This identity becomes further complicated when the LD youths are placed in resource rooms with emotionally disturbed and retarded youths. The LD youths become socially isolated because they do not fit in with their disturbed and retarded classmates and feel unwelcome and unworthy of association with the normal peer group. As is sadly typical of adolescents, the normal peer group often excludes and ridicules those that are different.

The LD youths need to be mainstreamed, when they are able to handle the academic load, into environments where the other students and teachers are educated and accepting of their differences. If the LD student and the others around her/him accept differences as commonplace, then mainstreaming can be quite effective. Any individualized help is then understood in a positive context. If this can not be done,
then the LD youths will be better served in separate LD schools that have accepting students and faculty and academic instruction individualized to the student’s needs.

Suicide Prevention Services

Responsibility of the School. All too often the school is expected to be the sole provider of services to children. Suggestions are repeatedly given to schools on the ways they can enhance a student’s psychological health. At the same time, constant criticism is heaped on schools for providing less that adequate educational services. With limited resources, expecting them to provide high-quality psychological and educational services is unreasonable and impossible. In addition, most adolescents view the school as their work place and do not choose to share their personal life with teachers. Schools that have adequate resources should be encouraged to provide psychological services and suicide prevention programs, sponsored by outside personnel who are not members of the academic team. But most schools do not have the resources, and the responsibility for suicide prevention needs to be shared by parents and mental health services. The school can only be expected to provide those components of a prevention program that are educational and can be provided by available resources. Schools could reasonably be expected to provide the following:

1) The school should take an active role in educating the LD students about their learning disability. Youths who are educated about their disabilities seem to have greater positive self-esteem. This author visited a LD school soon after all of the students and teachers returned from a professional conference on learning disabilities. Each youth had
studied a specific area of learning disabilities at the conference. The experience of being a part of a professional gathering where people were discussing an issue of major concern to their lives was tremendously beneficial. These youths seemed to feel a sense of personal pride, rather than the usual disdain for being a member of the LD population. Youths who were interviewed for this study and had little knowledge about their LD, seemed to feel more powerless and less hopeful about their abilities and future. Schools could easily implement the teaching of this knowledge by holding workshops for the students led by special education teachers.

2) Since a substantial number of LD youths had peer difficulty, schools could sponsor workshops also taught by special education teachers or school psychologists for NLD about learning disabilities. Educating the NLD youths might reduce many of the misperceptions and encourage them to befriend the LD students.

3) Schools could also provide educational workshops for parents to educate them about the potential social difficulties for youths who have LD and ways to remediate this problem.

Additional services could be provided by professionals outside of the school.

Responsibility of Mental Health Professionals. LD youths are often tested by educational and psychological specialists who are not members of a school staff. These persons could become important early agents for LD suicide prevention. They need to be educated to the potential social ramifications of LD. They could then be prepared to discuss ways to enhance the youth’s self esteem with the parents and
youth right when the youth is identified as LD. Some of what might be discussed at that early session would include:

1) Education about the specific nature of the youth's learning disability so that family living is supportive rather than additionally frustrating.

2) Encouragement of strong advocacy. Parents need to take an active role in assuring that their adolescent is learning and receiving adequate remediation.

3) Development of parental empathy for child's difficulties learning.

4) Parental active involvement in helping their child with school work.

5) Parental awareness about potential social isolation. Encourage the parent to take an active role in helping the adolescent to have adequate peer relations.

Mental health professionals employed in clinics and private practice also need to share the responsibility for LD suicide prevention. A good portion of the LD youths in this study have been involved in psychotherapy. This means that therapists are already involved in many of these youths' lives. Unfortunately, therapists are often not trained about learning disabilities and are unaware of ways that they can make therapy more beneficial for this population. It is important to recognize that the manifestations of learning disabilities do not end in the classroom. Therapists need to know that, when a LD youth says "I don't know" in response to a question, s/he may either mean that or might also mean "I don't know because I don't understand what you asked me." Therapists need to understand the specific differences in their clients. They need to recognize when it is necessary to talk more slowly or concretely. They need to know when it is best to use
behavioral treatment or to use visual imagery rather than only trying to make change through talking. They need to be aware of the client's memory capacity and when things need to be written down rather than trusted to memory. All too often the therapist, even with the best of intentions, is contributing to the youth's frustration by using styles of treatment that exacerbate the disability. Therapists need to develop an awareness of all of this so that they can help the youth and family to understand how to comfortably live with the youth's differences.

Since a substantial number of LD youths were dissatisfied with their social relations, supportive mental health services that concentrated on this difficulty would also seem advisable. Certain forms of group treatment might be helpful including:

1) Support groups for LD adolescents and adults. These groups could provide necessary support and reassurance from other LD people for the dilemmas of being LD.

2) Therapy groups for LD adolescents. Groups composed of people with similar concerns can be reassuring and allow for problem solving and empathy specific to the dilemmas most felt by this group.

3) Recreational groups for LD adolescents. This type of group can be very beneficial for the LD adolescents since it provides social contact and creative ways to build self esteem.

In conclusion, this study has clearly shown that adolescents with learning disabilities are a subpopulation of people at increased risk of suicide. These youths have a significantly more negative self-evaluation that evolves from the confusion and frustration of being different in a world where being stereotypic is desired. FLD may well be the
subgroup at greatest suicide risk. Suicide prevention programs need to be specifically tailored to meet the needs of this population. Educators, parents, and mental health professionals need to share the responsibility of implementing these services.

Recommendations for Future Research

Based on the experience of this study, it was found that securing subjects for research on adolescent suicide is very difficult. Populations that are suspected to be at greatest risk are protected by parents, educators, and clinicians and thought to be emotionally fragile and, therefore, are often unavailable for study. This author found that interviewing potentially suicidal subjects was complicated. A substantial number of the youths in this study were found to be at risk and the author needed to use her crisis intervention and clinical skills to handle these difficult situations.

Since it is so difficult to secure subjects for suicide studies, additional studies that look to further determine the degree of risk to LD youths would seem less useful than research efforts that attempt to broaden the understanding of the most effective interventions, to help minimize the suicide risk to LD youth.

Clearly, early identification and remediation of a learning disability seems to be the most effective intervention. Early intervention is not always possible and alternate styles of intervention
for youth at older ages need to be compared for effectiveness. Some possible styles of intervention that might be investigated include:

1) the effectiveness of support, therapy and/or recreation groups specifically designed for LD youths;

2) the benefits of educating NLD peer groups about learning disabilities;

3) parent education workshops about methods of helping youths with the possible social ramifications of a learning disability; and

4) educational seminars for mental health professionals about effective individual and family psychotherapy techniques for this population.
Appendix A
Participant Consent Form - Parent Version

Nancy Baron, M.Ed., L.C.S.W.
University of Massachusetts
School of Education
Amherst, MA. 01003

By signing below, I understand that I am agreeing to allow my son/daughter (name) to be interviewed and participate in testing done by Nancy Baron, M.Ed., L.C.S.W. for purposes of dissertation research.

A written explanation of this project has been presented to me.

I am aware that my child's name will not appear on any written documentation.

Though not the intended purpose of the testing, if it uncovers that my child has a serious psychological problem that warrants concern, I understand that I and the necessary school personnel will be informed.

I am aware that I may withdraw my child from the study at any time.

__________________________

date

__________________________

signature

__________________________

relationship to child
Letter of Explanation to LD Schools

Nancy Baron, M.Ed., L.C.S.W.
26 Royal Street
Allston, MA 02134
(617) 787-3536

Dear Dr. //////////////

I am a Doctoral Candidate at the University of Massachusetts in the Dept. of School, Consulting and Counseling Psychology. I am sending you my research proposal in the hope that the ////////// School will be willing to participate in what I believe to be an important study about the critical factors that contribute to the development of a positive self-image in learning disabled adolescents. My research and practical experience suggest that learning disabled youth may have an increased risk of adolescent suicide so that determining the factors that are necessary for positive growth becomes essential information to schools that specialize in working with learning disabled youth.

I am in the process of arranging to do my research in a number of private schools and feel that your school's involvement in this study would be greatly beneficial.

My hope would be to meet with about 10-15 of your students, equal numbers of male and female, aged 14-19, at the school within the next few months. Each student would need to have written parental permission. All of the rest of the information that you might need is contained in the enclosed research proposal. I have also enclosed my resume.

Since I have extensive teaching experience, in return for your support, I would be willing to provide an in-service training to your staff about the identification; particular researched psycho-social factors that contribute to causation; and treatment of adolescent suicide, as well as about my research findings. I am also willing to do an educational seminar about my research findings for your students' parents.

Thank you for your time and consideration.

Sincerely,

Nancy Baron
Appendix C
Explanation of Research Project to LD Students’ Parents

Nancy Baron, M.Ed., L.C.S.W.
26 Royal Street
Allston, MA. 02134

Dear Parents:

My name is Nancy Baron and I am a Doctoral candidate at the University of Massachusetts in the Department of School, Consulting and Counseling Psychology. I know that we all share a concern for the necessity of providing the best education for all youths and in particular for youths with learning disabilities. As part of my doctoral dissertation I have designed a research project that studies the specific self image factors that are necessary to enhance the growth and development of learning disabled youths. Your child's school is supportive of my project and with your individual permission has agreed to allow me to interview a group of its students.

It is with a great deal of professional expertise and practical experience with adolescents that I have designed this study and come to you asking for your permission to have your child participate. Prior to becoming a doctoral student, I was employed for fifteen years as a therapist and program administrator specializing in work with adolescents and families. I also was a psychological consultant to resource rooms in a Massachusetts public school and a Professor in a Master’s degree program teaching courses in counseling techniques.

The purpose of this research project is to try to identify the pertinent factors that specifically relate to the development of the learning disabled adolescent’s self image. The factors that will be studied include the youths’ feelings about their ability to learn, peer and family relations, body image, self esteem, stress and potential for suicidal risk, and feelings about their future. The best way to find out this information is to ask the adolescent so that this study is designed to do just that. Each youth will be given two standardized tests and be interviewed by me. The entire process will take about two hours. The results of each individual youth's testing will be joined with all others
tested to formulate a generalized picture of those factors that are particularly important to helping learning disabled adolescents to be well adjusted and have a positive self image.

Here are some specific questions commonly asked by parents that I would like to address.

1) "Why should my child participate? What purpose can it serve for him or her?"

The most important end result of this study will be that my overall findings will be shared with professionals that provide clinical and educational support to learning disabled youth. These results should enhance their knowledge and help them to provide the best possible education and support. Therefore, the greatest benefit to your child is that her/his participation will help in the process of gaining greater knowledge which will help other learning disabled youth.

Though I am unable to pay each youth for the true worth of her/his time, each will be paid $5.00 as a token of appreciation.

At his or her request, I am also willing to review any youth's individual testing profile with him or her. This might provide the youth with some interesting highlights about her/his personality.

I have also offered to come to your school to share my overall final project results with the staff and parents.

2) "What are the specific test questions?"

I am using two widely used standardized tests that are designed to learn about how a youth feels about him/herself and their present and future life. These tests have been used with thousands of youth. Depending on the youth's reading ability the test will given in either written or oral form.

In the specific test format a statement is made and the youth is asked to respond to how well it describes him/her using a scale that ranges from:

1) describes me very well to 6) does not describe me at all.

Some examples of the types of statements include:

"I think that I will be a source of pride to my parents in the future."
"The recent changes in my body have given me some satisfaction."
"If I would be separated from all the people I know, I feel that I would not be able to make a go of it."
"I am going to devote myself to making the world a better place."
"Sometimes I feel so ashamed of myself that I just want to hide in a corner."
"I find it very difficult to establish new friendships."
"I prefer being alone than with kids my age."
"At times I feel like a leader and feel that other kids can learn something from me."
"I repeat things continuously to be sure that I am right."
"I feel the world is not worth continuing to live in."
"I feel hostile toward others."
"I feel tired and listless."
"I feel I can't be happy no matter where I am."

The youth will then be interviewed by me. I will ask questions about lifestyle:
What do you like to do best?
Do you feel satisfied with your friends?

learning:
How do you think your learning disability has affected your life?
If you could give advice to a young child who has a learning disability what would you say to them? to their parent? to their school?

future:
What do you imagine your life will be like in ten years?

3) "Will the results of the tests influence my child's scholastic standing?"

The youth's individual results are confidential and will in no way affect her/his scholastic standing. The individual names will not appear in any of my findings and the individual testing will be destroyed after completion of this project. I am sure that you would agree that the results should only be shared if it is found that a youth is at suicidal risk. In this case the school and parent will be immediately notified.

I know that many of your youths have busy schedules and have been through numerous batteries of tests yet I am hopeful that you will agree on the importance of this project and that participation is a way to be helpful to others.
Please discuss this project with your daughter/son and then sign the attached consent forms and immediately return them in the envelope provided. I will call your child in the next week to explain the project and to secure her/his agreement to be tested and then set up a time that is convenient for him/her to meet with me at either home or school.

If either you or your child have any further concerns, please call me at (617) 787-3536.

Thank you.

Sincerely,

Nancy Baron
Appendix D
Letter of Explanation to NLD Schools

Nancy Baron, M.Ed., L.C.S.W.
26 Royal Street
Allston, MA. 02134
(617) 787-3536

Dear Dr.xxxxxxxxxxx,

January 25, 1989

I am a Doctoral Candidate at the University of Massachusetts in the Department of School, Consulting and Counseling Psychology. I am presently working on a research study that examines the critical elements that contribute to the development of a positive self-image in adolescents. It is with a great deal of professional expertise and practical experience with adolescents that I have designed this study. Prior to becoming a doctoral student, I was employed for fifteen years as a therapist and program administrator specializing in work with adolescents and families. I also was a psychological consultant to resource rooms in a Massachusetts public school and a Professor in a Master’s degree program teaching courses in counseling techniques.

I chose this area of research because I became concerned about the increase in adolescent suicidal activity and decided to examine self-image factors as a mechanism to better understand and prevent suicidal risk. Previous research has suggested that youths who have learning disabilities may have specific difficulties with self-image and may be at an increased risk of suicide. I am, therefore, examining these factors particularly for adolescents who have learning disabilities and contrasting those findings to students without learning disabilities.

I am presently working with five schools for learning disabled youth in Connecticut and Massachusetts and am just beginning to search for schools in which to interview the non-learning disabled youth for my control group. I understand that you teach a course in psychology at the xxxxxx School and I was hopeful that you might be interested in having your students participate in my project. I have also
taught a psychology class at a private high school as well as have been a guest speaker about the field of psychology in a high school. I know that it is often beneficial to help the students to understand the usefulness of the field of psychology by showing them practical applications within our society. I was hopeful that you would be willing to ask your students to voluntarily participate in my study and in exchange I would be very willing to come to the school to discuss the field of clinical psychology and psychological research with your students.

In addition to having a practical experience in psychological research, the students would be providing a useful community service since the results of this research will be used to better educate therapists and educators in ways to enhance adolescent self-image.

In order for a youth to voluntarily participate in this study the parents would need to be informed and both the youth and parents would sign a permission slip. I would then hold a 1 1/2 hour individual interview with each youth. I am able to conduct the interviews during study halls or after school so that there is no interference with their school work. The interviews are not stressful and most of the youth find the interview process interesting. Each youth completes two written questionnaires and participates in a brief verbal interview. I would certainly share the specific instruments that I use with you before interviewing your students. The youth feel compensated for their time since each is paid $5.00.

I am hopeful that you will feel that this research is useful and that your students can benefit from participation in this study. I will contact you in the next week to answer any questions and discuss your participation in this project.

Thank you for your consideration.

Sincerely,

Nancy Baron
Appendix E
Explanation of Research Project to NLD Students’ Parents

Nancy Baron, M.Ed., L.C.S.W.
26 Royal Street
Allston, MA. 02134
(617) 787-3536

Dear Parents:

I am a Doctoral Candidate at the University of Massachusetts in the Department of School, Consulting and Counseling Psychology. I am presently working on a research study that examines the critical elements that contribute to the development of a positive self-image in adolescents. I am examining the importance of certain life factors to positive self-image including: the adolescent’s ability to learn and academic proficiency, peer and family relations, morals, stress and suicidal risk, future life planning, emotional tone and self esteem. It is with a great deal of professional expertise and practical experience with adolescents that I have designed this study. Prior to becoming a doctoral student, I was employed for fifteen years as a therapist, program administrator and college professor specializing in work with adolescents and families.

Your child’s psychology class was asked to participate in my research study. Your school supports the importance of this research and has, therefore, agreed, with parental permission, to allow its students to be interviewed. In addition to having a practical experience in psychological research, the students would be providing a useful community service since the results of this research will be used to better educate therapists and educators in ways to enhance adolescent self-image.

In order for a youth to voluntarily participate in this study, you and the student need to sign the attached permission slips and return them to Mr. ///////. I will conduct a 1 1/2 hour individual interview with each youth. I am able to conduct the interviews during study halls so that there is no interference with school work. The interview is not stressful and most of the youth find the interview process interesting. Each youth completes two written questionnaires and participates in a brief verbal interview. The youth feel compensated for their time since each youth is paid $5.00. The data gathered in the interview is
confidential unless it is found that the youth is at serious psychological risk and then you will be immediately informed.

I am hopeful that you will feel that this research is useful and that your child can benefit from participation in this study. If you have any questions, I can be called at (617) 787-3536.

Thank you.

Sincerely,

Nancy Baron
Appendix F
Offer Self-Image Questionnaire

INTRODUCTION
TO THE
OFFER SELF - IMAGE QUESTIONNAIRE

THIS QUESTIONNAIRE IS USED FOR SCIENTIFIC PURPOSES. THERE ARE NO RIGHT OR WRONG ANSWERS.

AFTER CAREFULLY READING EACH OF THE STATEMENTS ON THE FOLLOWING PAGES, PLEASE CIRCLE THE NUMBER ON THE ANSWER SHEET THAT INDICATES HOW WELL THE ITEM DESCRIBES YOU: THE NUMBERS CORRESPOND WITH CATEGORIES THAT RANGE FROM "DESCRIBES ME VERY WELL" (1) TO "DOES NOT DESCRIBE ME AT ALL" (6). PLEASE CIRCLE ONLY ONE CHOICE FOR EACH STATEMENT.

EXAMPLE

STATEMENT: I AM AN ADOLESCENT.

CHOICE OF ANSWERS:

1—DESCRIBES ME VERY WELL  2—DESCRIBES ME WELL  3—DESCRIBES ME FAIRLY WELL  4—DOES NOT QUITE DESCRIBE ME  5—DOES NOT REALLY DESCRIBE ME  6—DOES NOT DESCRIBE ME AT ALL

RESPONSE: 1 2 3 4 5 6

PLEASE RESPOND TO ALL ITEMS.

THANK YOU

COPYRIGHT: 1977 ©

DANIEL OFFER, M. D
1- DESCRIBES ME VERY WELL
2- DESCRIBES ME WELL
3- DESCRIBES ME FAIRLY WELL
4- DOES NOT QUITE DESCRIBE ME
5- DOES NOT REALLY DESCRIBE ME
6- DOES NOT DESCRIBE ME AT ALL

1. I CARRY MANY GRUDGES. 1
2. WHEN I AM WITH PEOPLE I AM AFRAID THAT SOMEONE WILL MAKE FUN OF ME. 2
3. MOST OF THE TIME I THINK THAT THE WORLD IS AN EXCITING PLACE TO LIVE IN. 3
4. I THINK THAT I WILL BE A SOURCE OF PRIDE TO MY PARENTS IN THE FUTURE. 4
5. I WOULD NOT HURT SOMEONE JUST FOR THE "HECK OF IT." 5
6. THE RECENT CHANGES IN MY BODY HAVE GIVEN ME SOME SATISFACTION. 6
7. I AM GOING TO DEVOTE MY LIFE TO HELPING OTHERS. 7
8. I "LOSE MY HEAD" EASILY. 8
9. MY PARENTS ARE ALMOST ALWAYS ON THE SIDE OF SOMEONE ELSE, e.g. MY BROTHER OR SISTER. 9
10. THE OPPOSITE SEX FINDS ME A BORE. 10
11. IF I WOULD BE SEPARATED FROM ALL THE PEOPLE I KNOW, I FEEL THAT I WOULD NOT BE ABLE TO MAKE A GO OF IT. 11
12. I FEEL TENSE MOST OF THE TIME. 12
13. I USUALLY FEEL OUT OF PLACE AT PICNICS AND PARTIES. 13
14. I FEEL THAT WORKING IS TOO MUCH RESPONSIBILITY FOR ME. 14
15. MY PARENTS WILL BE DISAPPOINTED IN ME IN THE FUTURE. 15
16. IT IS VERY HARD FOR A TEENAGER TO KNOW HOW TO HANDLE SEX IN A RIGHT WAY. 16
17. AT TIMES I HAVE FITS OF CRYING AND/OR LAUGHING THAT I SEEM UNABLE TO CONTROL. 17
18. I AM GOING TO DEVOTE MY LIFE TO MAKING AS MUCH MONEY AS I CAN. 18
19. IF I PUT MY MIND TO IT, I CAN LEARN ALMOST ANYTHING. 19
20. ONLY STUPID PEOPLE WORK. 20
21. VERY OFTEN I FEEL THAT MY FATHER IS NO GOOD. 21
22. I AM CONFUSED MOST OF THE TIME. 22
<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>23. I feel inferior to most people I know.</td>
<td>23</td>
</tr>
<tr>
<td>24. Understanding my parents is beyond me.</td>
<td>24</td>
</tr>
<tr>
<td>25. I do not like to put things in order and make sense of them.</td>
<td>25</td>
</tr>
<tr>
<td>26. I can count on my parents most of the time.</td>
<td>26</td>
</tr>
<tr>
<td>27. In the past year I have been very worried about my health.</td>
<td>27</td>
</tr>
<tr>
<td>28. Dirty jokes are fun at times.</td>
<td>28</td>
</tr>
<tr>
<td>29. I often blame myself even when I am not at fault.</td>
<td>29</td>
</tr>
<tr>
<td>30. I would not stop at anything if I felt I was done wrong.</td>
<td>30</td>
</tr>
<tr>
<td>31. My sex organs are normal.</td>
<td>31</td>
</tr>
<tr>
<td>32. Most of the time I am happy.</td>
<td>32</td>
</tr>
<tr>
<td>33. I am going to devote myself to making the world a better place to live in.</td>
<td>33</td>
</tr>
<tr>
<td>34. I can take criticism without resentment.</td>
<td>34</td>
</tr>
<tr>
<td>35. My work, in general, is at least as good as the work of the girl next to me.</td>
<td>35</td>
</tr>
<tr>
<td>36. Sometimes I feel so ashamed of myself that I just want to hide in a corner and cry.</td>
<td>36</td>
</tr>
<tr>
<td>37. I am sure that I will be proud about my future profession.</td>
<td>37</td>
</tr>
<tr>
<td>38. My feelings are easily hurt.</td>
<td>38</td>
</tr>
<tr>
<td>39. When a tragedy occurs to one of my friends, I feel sad too.</td>
<td>39</td>
</tr>
<tr>
<td>40. I blame others even when I know that I am at fault too.</td>
<td>40</td>
</tr>
<tr>
<td>41. When I want something, I just sit around wishing I could have it.</td>
<td>41</td>
</tr>
<tr>
<td>42. The picture I have of myself in the future satisfies me.</td>
<td>42</td>
</tr>
<tr>
<td>43. I am a superior student in school.</td>
<td>43</td>
</tr>
<tr>
<td>44. I feel relaxed under normal circumstances.</td>
<td>44</td>
</tr>
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</table>
1-DESCRIBES ME VERY WELL  
2-DESCRIBES ME WELL  
3-DESCRIBES ME FAIRLY WELL  
4-DOES NOT QUITE DESCRIBE ME  
5-DOES NOT REALLY DESCRIBE ME  
6-DOES NOT DESCRIBE ME AT ALL

45. I FEEL EMPTY EMOTIONALLY MOST OF THE TIME. 
46. I WOULD RATHER SIT AROUND AND LOAF THAN WORK. 
47. EVEN IF IT WERE DANGEROUS, I WOULD HELP SOMEONE WHO IS IN TROUBLE. 
48. TELLING THE TRUTH MEANS NOTHING TO ME. 
49. OUR SOCIETY IS A COMPETITIVE ONE AND I AM NOT AFRAID OF IT. 
50. I GET VIOLENT IF I DON’T GET MY WAY. 
51. MOST OF THE TIME MY PARENTS GET ALONG WELL WITH EACH OTHER. 
52. I THINK THAT OTHER PEOPLE JUST DO NOT LIKE ME. 
53. I FIND IT VERY DIFFICULT TO ESTABLISH NEW FRIENDSHIPS. 
54. I AM SO VERY ANXIOUS. 
55. WHEN MY PARENTS ARE STRICT, I FEEL THAT THEY ARE RIGHT, EVEN IF I GET ANGRY. 
56. WORKING CLOSELY WITH ANOTHER GIRL NEVER GIVES ME PLEASURE. 
57. I AM PROUD OF MY BODY. 
58. AT TIMES I THINK ABOUT WHAT KIND OF WORK I WILL DO IN THE FUTURE. 
59. EVEN UNDER PRESSURE I MANAGE TO REMAIN CALM. 
60. WHEN I GROW UP AND HAVE A FAMILY, IT WILL BE IN AT LEAST A FEW WAYS SIMILAR TO MY OWN. 
61. I OFTEN FEEL THAT I WOULD RATHER DIE, THAN GO ON LIVING. 
62. I FIND IT EXTREMELY HARD TO MAKE FRIENDS. 
63. I WOULD RATHER BE SUPPORTED FOR THE REST OF MY LIFE THAN WORK. 
64. I FEEL THAT I HAVE A PART IN MAKING FAMILY DECISIONS. 
65. I DO NOT MIND BEING CORRECTED, SINCE I CAN LEARN FROM IT.

FOR COMPUTER USE ONLY

66-69  70  71-72  73  74  75  76-80
<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Describes me very well</td>
</tr>
<tr>
<td>2</td>
<td>Describes me well</td>
</tr>
<tr>
<td>3</td>
<td>Describes me fairly well</td>
</tr>
<tr>
<td>4</td>
<td>Does not quite describe me</td>
</tr>
<tr>
<td>5</td>
<td>Does not really describe me</td>
</tr>
<tr>
<td>6</td>
<td>Does not describe me at all</td>
</tr>
</tbody>
</table>

66. I feel so very lonely. 66  
67. I do not care how my actions affect others as long as I gain something. 67  
68. I enjoy life. 68  
69. I keep an even temper most of the time. 69  
70. A job well done gives me pleasure. 70  
71. My parents are usually patient with me. 71  
72. I seem to be forced to imitate the people I like. 72  
73. Very often parents do not understand a person because they had an unhappy childhood. 73  
74. For me good sportsmanship in school is as important as winning a game. 74  
75. I prefer being alone than with kids my age. 75  
76. When I decide to do something, I do it. 76  
77. I think that boys find me attractive. 77  
78. Other people are not after me to take advantage of me. 78  
79. I feel that there is plenty I can learn from others. 79  
80. I do not attend sexy shows. 80  
81. I fear something constantly. 81  
82. Very often I think that I am not at all the person I would like to be. 82  
83. I like to help a friend whenever I can. 83  
84. If I know that I will have to face a new situation, I will try in advance to find out as much as is possible about it. 84  
85. Usually I feel that I am a bother at home. 85  
86. If others disapprove of me I get terribly upset. 86  
87. I like one of my parents much better than the other. 87  

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Rating</th>
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<tbody>
<tr>
<td>88</td>
<td>BEING TOGETHER WITH OTHER PEOPLE GIVES ME A GOOD FEELING.</td>
<td>88</td>
</tr>
<tr>
<td>89</td>
<td>WHENEVER I FAIL IN SOMETHING, I TRY TO FIND OUT WHAT I CAN DO IN ORDER TO AVOID ANOTHER FAILURE.</td>
<td>89</td>
</tr>
<tr>
<td>90</td>
<td>I FREQUENTLY FEEL UGLY AND UNATTRACTIVE.</td>
<td>90</td>
</tr>
<tr>
<td>91</td>
<td>SEXUALLY I AM WAY BEHIND.</td>
<td>91</td>
</tr>
<tr>
<td>92</td>
<td>IF YOU CONFIDE IN OTHERS YOU ASK FOR TROUBLE.</td>
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<tr>
<td>93</td>
<td>EVEN THOUGH I AM CONTINUOUSLY ON THE GO, I SEEM UNABLE TO GET THINGS DONE.</td>
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</tr>
<tr>
<td>94</td>
<td>WHEN OTHERS LOOK AT ME THEY MUST THINK THAT I AM POORLY DEVELOPED. L.</td>
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</tr>
<tr>
<td>95</td>
<td>MY PARENTS ARE ASHAMED OF ME.</td>
<td>95</td>
</tr>
<tr>
<td>96</td>
<td>I BELIEVE I CAN TELL THE REAL FROM THE FANTASTIC.</td>
<td>96</td>
</tr>
<tr>
<td>97</td>
<td>THINKING OR TALKING ABOUT SEX FRIGHTENS ME.</td>
<td>97</td>
</tr>
<tr>
<td>98</td>
<td>I AM AGAINST GIVING SO MUCH MONEY TO THE POOR.</td>
<td>98</td>
</tr>
<tr>
<td>99</td>
<td>I FEEL STRONG AND HEALTHY.</td>
<td>99</td>
</tr>
<tr>
<td>100</td>
<td>EVEN WHEN I AM SAD I CAN ENJOY A GOOD JOKE.</td>
<td>100</td>
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<tr>
<td>101</td>
<td>THERE IS NOTHING WRONG WITH PUTTING ONESelf BEFORE OTHERS.</td>
<td>101</td>
</tr>
<tr>
<td>102</td>
<td>I TRY TO STAY AWAY FROM HOME MOST OF THE TIME.</td>
<td>102</td>
</tr>
<tr>
<td>103</td>
<td>I FIND LIFE AN ENDLESS SERIES OF PROBLEMS—WITHOUT SOLUTION IN SIGHT.</td>
<td>103</td>
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<tr>
<td>104</td>
<td>AT TIMES I FEEL LIKE A LEADER AND FEEL THAT OTHER KIDS CAN LEARN SOMETHING FROM ME.</td>
<td>104</td>
</tr>
<tr>
<td>105</td>
<td>I FEEL THAT I AM ABLE TO MAKE DECISIONS.</td>
<td>105</td>
</tr>
<tr>
<td>106</td>
<td>I HAVE BEEN CARRYING A GRUDGE AGAINST MY PARENTS FOR YEARS.</td>
<td>106</td>
</tr>
<tr>
<td>107</td>
<td>I AM CERTAIN THAT I WILL NOT BE ABLE TO ASSUME RESPONSIBILITIES FOR MYSELF IN THE FUTURE.</td>
<td>107</td>
</tr>
<tr>
<td>108</td>
<td>WHEN I ENTER A NEW ROOM I HAVE A STRANGE AND FUNNY FEELING.</td>
<td>108</td>
</tr>
<tr>
<td>109</td>
<td>I FEEL THAT I HAVE NO TALENT WHATSOEVER.</td>
<td>109</td>
</tr>
</tbody>
</table>
110. I DO NOT REHEARSE HOW I MIGHT DEAL WITH A REAL COMING EVENT.  
111. WHEN I AM WITH PEOPLE I AM BOTHERED BY HEARING STRANGE NOISES.  
112. MOST OF THE TIME MY PARENTS ARE SATISFIED WITH ME.  
113. I DO NOT HAVE A PARTICULARLY DIFFICULT TIME IN MAKING FRIENDS.  
114. I DO NOT ENJOY SOLVING DIFFICULT PROBLEMS.  
115. SCHOOL AND STUDYING MEAN VERY LITTLE TO ME.  
116. EYE FOR AN EYE AND TOOTH FOR A TOOTH DOES NOT APPLY FOR OUR SOCIETY.  
117. SEXUAL EXPERIENCES GIVE ME PLEASURE.  
118. VERY OFTEN I FEEL THAT MY MOTHER IS NO GOOD.  
119. HAVING A BOYFRIEND IS IMPORTANT TO ME.  
120. I WOULD NOT LIKE TO BE ASSOCIATED WITH THOSE KIDS WHO "HIT BELOW THE BELT."  
121. WORRYING A LITTLE ABOUT ONE'S FUTURE HELPS TO MAKE IT WORK OUT BETTER.  
122. I OFTEN THINK ABOUT SEX.  
123. USUALLY I CONTROL MYSELF.  
124. I ENJOY MOST PARTIES I GOTO.  
125. DEALING WITH NEW INTELLECTUAL SUBJECTS IS A CHALLENGE FOR ME.  
126. I DO NOT HAVE MANY FEARS WHICH I CANNOT UNDERSTAND.  
127. NO ONE CAN HARM ME JUST BY NOT LIKING ME.  
128. I AM FEARFUL OF GROWING UP.  
129. I REPEAT THINGS CONTINUOUSLY TO BE SURE THAT I AM RIGHT.  
130. I FREQUENTLY FEEL SAD.
**Appendix G**

**Suicide Probability Scale**

**SPS Rating Form**

John G. Cull, Ph.D., and Wayne S. Gill, Ph.D.

---

**Name:**

**Sex:** M F

**Age:**

**Marital Status:**

**Education:**

**Race:**

**Usual Occupation:**

**Today's Date:**

---

**Directions:**

Listed below are a series of statements that some people might use to describe their feelings and behaviors. Please read each statement and determine how often the statement is true for you. Then circle the letter T in the appropriate box to indicate how often you feel the statement applies to you.

Be sure to rate every item. When you are through, return the completed rating form to the person who gave it to you.

---

**Example:**

<table>
<thead>
<tr>
<th>Name of a little of the time</th>
<th>Some of the time</th>
<th>Good part of the time</th>
<th>Most of all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel anxious.</td>
<td>T</td>
<td>T</td>
<td>T</td>
</tr>
</tbody>
</table>

---

1. When I get mad I throw things.  
2. I feel many people care for me deeply.  
3. I feel tend to be impulsive.  
4. I think of things too bad to share with others.  
5. I think I have too much responsibility.  
6. I feel there is much I can do which is worthwhile.  
7. In order to punish others I think of suicide.  
8. I feel hostile toward others.  
9. I feel isolated from people.  
10. I feel people appreciate the real me.  
11. I feel many people will be sorry if I die.  
12. I feel so lonely I cannot stand it.  
13. Others feel hostile toward me.  
14. I feel, if I could start over, I would make many changes in my life.  
15. I feel I am not able to do many things well.  
16. I have trouble finding and keeping a job I like.  
17. I think that no one will miss me when I am gone.  
18. Things seem to go well for me.  
19. I feel people expect too much of me.  
20. I feel I need to punish myself for things I have done and thought.  
21. I feel the world is not worth continuing to live in.  
22. I plan for the future very carefully.  
23. I feel I don't have many friends I can count on.  
24. I feel people would be better off if I were dead.  
25. I feel it would be less painful to die than to keep living the way things are.  
26. I feel/feel close to my mother.  
27. I feel/feel close to my mate.  
28. I feel hopeless that things will get better.  
29. I feel people do not approve of me or what I do.  
30. I have thought of how to do myself in.  
31. I worry about money.  
32. I think of suicide.  
33. I feel tired and listless.  
34. When I get mad I break things.  
35. I feel/feel close to my father.  
36. I feel I can't be happy no matter where I am.  

---

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Appendix H

Suicide Probability Scale (SPS)
Profile Form

John G. Cull, Ph.D. and Wayne S. Gill, Ph.D.

Published by

WESTERN PSYCHOLOGICAL SERVICES

Name: ________________________________
Race: ________________________________
Sex: M F Age: __________________________
Marital Status: _______________________

Education: ____________________________
Usual Occupation: ______________________

Date: ________________________________

<table>
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<th>Suicide Idation</th>
<th>Negative Self-Evaluation</th>
<th>Hostility</th>
<th>Total</th>
</tr>
</thead>
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<td>T</td>
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</tr>
</tbody>
</table>

* For the total weighted score, numbers and hash marks are presented for possible raw scores up to 55. Above a raw score of 55, only numerical values for every five raw scores are listed.

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Appendix I
Guided Interview

1) What do you like to do best?
What kind of activities? hobbies? interests?
2) What do you do during the majority of your free time?
3) If you could get up one day and do whatever you wanted, what would you do?
4) Are your interests similar to or different from other youth your age?
5) Do you feel satisfied with your group of friends? Tell me about them.
Do you have a best friend or a group of close friends?
Do you have a friend or group that you can call do things with?
What do you usually do with your friends?
If there are things about your friendships that you would like to change, what are they?
6) Do you use drugs or alcohol? If not, why not?
If yes, tell me about your use. Is it a problem for you?
7) Do other youth usually like you? boys? girls?
What do they like? dislike?
8) Do you like to spend time alone? How much? What do you do?
9) Would you rather spend your time alone or with youths your age/younger/older or adults?
10) What is the most important world or country issue that concerns you?
11) Have you had any problems in the last couple of years?
What were they and what has happened?
12) What do you do when you have a problem? Does it help?
Have you ever seen a therapist? What were the circumstances?
Was it helpful, why or why not?
13) Tell me about your relationship with your mother? father? siblings?
14) How well do you do academically at school?
Has this always been your experience?
What factors influence how you do at school?
15) Do you like your school?
What do you like? dislike? in comparison to other schools?
16) Have you ever had any problems at school? What happened?
17) Do you have difficulty learning?
Would you call your learning difficulty a learning disability?

18) How smart are you? Average/Above Average/Below Average?
19) If you could change anything about your level of intelligence or how well you do in school, what would you change?
20) Does your ability to learn affect the rest of your life?
21) Does your ability to learn affect your relationships with your friends? In the past? In the present?
22) In what ways is either being smart or doing well in school important to you? Is it more important to you or your parents?
23) Who puts the most pressure on you about school, you or your parents?

Questions for the LD subjects.
24) When did you become aware of your particular style of learning?
   Tell me a little about that time in your life.
25) If you have had learning or school problems, when did the school and your parents realize that your learning style was causing you difficulty and what did they do? Describe that time in your life and how you felt.
26) If you could change that time in any way, what would you change?
27) How would you describe to someone what it feels like now to have a learning disability? Tell me about your present learning experience.
28) If you could give advice to a young child who has a learning disability what would you say to them? to her/his parent? the school?
End of LD questions.

29) Has anyone ever teased you about how well you do in school? or about anything else? Describe this experience and its importance to you?
30) What do you imagine your life will be like in ten years?
   Where will you live? How will you feel? Will you marry or have children? What will you be doing?
31) If you had three wishes, what would they be?
Appendix J
Participant Consent Form - Student Version

Nancy Baron, M.Ed., L.C.S.W.
University of Massachusetts
School of Education
Amherst, MA. 01003

By signing below, I understand that I am agreeing to be tested and interviewed by Nancy Baron for the purpose of dissertation research.

An oral explanation of this project has been presented to me.

I am aware that my name will not appear on any written documentation.

I understand that I may withdraw from participation at any time.

______________________________
date

______________________________
signature
Appendix K
Interview: Demographic Information

Name:

Age: Sex:

Address:

School Data:
School Grade: School:

How long in this school?
What school previously?
Why a change in schools?
Do you like this school?
What do you like or dislike?

Family Data:
Who do you live with?

Mother’s name: Age: Occupation:

Father’s name: Age: Occupation:

Are parents married/ divorced/ separated/ remarried? How long?

If not living with one parent, where does that parent live and how often do you see him/her?

Income level? Upper/ Middle/ Lower

Siblings:
Names: Address: Age:

School/Work:
Appendix L
Letter about Student Concern Sent to Parent

Nancy Baron, M.Ed.
26 Royal Street
Allston, MA. 02134

Mr. and Mrs.////////
//////////////////
//////////////////  March 15, 1989

Dear Mr. and Mrs. //////////,

I interviewed your son, //////////, as a subject for my doctoral dissertation project on 2/24/89.

//////////// was very cooperative and very open and honest during the interview. He is clearly an intelligent young man with a great deal of potential.

Though I assure each of the students that the content of the testing is confidential, I did inform you in the permission slip that you signed, that I would notify you if the testing suggested that your son was having emotional difficulties.

As you know, one of the testing measures that I gave ////////// examined feelings of depression and suicidal risk. It was clear from these test results that ////////// is feeling depressed.

(This paragraph was different for each student.)

I met with ////////// to discuss my concern and was pleased that he was amenable to my recommendation for psychotherapy. I would suggest that it would be helpful to ////////// for your family to have a professional consultation as soon as possible.

If you have any questions, please call me at (617) 787-3536.

Sincerely,

Nancy Baron
Appendix M
Results of the Guided Interview

The responses to the guided interview are used as additional information to test hypotheses I, II and III and to respond to the research question.

The following describes the subjects’ responses to the interview questions:

1) What kind of activities, interests, hobbies do you like best?

The LD youths’ top three choices were numerous kinds of individual and group sports (33); different creative and artistic activities (23); and going out with friends (13).

The NLD youths’ top three choices were “hanging around” with friends (26), different types of sports (24), and numerous creative and artistic activities (12).

2) What do you do during most of your free time?

Added to the above list for the LD youth was homework (14) and for the NLD youth listening to music (9).

3) If you could get up one morning and do anything you wanted, what would you do?

The most popular response for both groups was to travel to a faraway place.

4) Are your interests similar to or different from other youth your age?
Similar  |  LD  |  NLD  |  FLD  |  MLD  |  FNLD  |  MNLD  
---|---|---|---|---|---|---
Different  |  16  |  14  |  10  |  6  |  8  |  6  
So So  |  4  |  8  |  1  |  3  |  2  |  6  
|  10  |  8  |  4  |  6  |  5  |  3  

5) Do you feel satisfied with your group of friends? Tell me about them.

The LD youths are quite a bit less satisfied with their friends than the NLD youths.

|  LD  |  NLD  |  FLD  |  MLD  |  FNLD  |  MNLD  
---|---|---|---|---|---
Yes  |  17  |  28  |  8  |  9  |  14  |  14  
No  |  4  |  2  |  2  |  2  |  1  |  1  
So So  |  9  |  0  |  5  |  4  |  0  |  0  

Do you have a best friend or a group of close friends? Tell me about them.

Nearly equal numbers of LD and NLD youth have a best friend.

|  Best friend  |  LD  |  NLD  |  FLD  |  MLD  |  FNLD  |  MNLD  
---|---|---|---|---|---|---
Yes  |  24  |  20  |  13  |  11  |  11  |  9  
No  |  6  |  10  |  2  |  4  |  4  |  6  

The NLD youth more frequently have a close group of friends.

|  Close group  |  LD  |  NLD  |  FLD  |  MLD  |  FNLD  |  MNLD  
---|---|---|---|---|---|---
Yes  |  13  |  23  |  5  |  8  |  11  |  12  
No  |  17  |  7  |  10  |  7  |  4  |  3  

Do you have a friend or group that you can call to do things with?

Nearly one-third of the LD youth do not have a consistent group of friends for activity.
<table>
<thead>
<tr>
<th></th>
<th>LD</th>
<th>NLD</th>
</tr>
</thead>
<tbody>
<tr>
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<td>30</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>So So</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>FLD</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>MLD</td>
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<td>4</td>
</tr>
<tr>
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</tr>
<tr>
<td>MNLD</td>
<td>15</td>
<td>0</td>
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</tbody>
</table>

What do you usually do with your friends?
Responses mostly same as activities in questions 1 and 2.

If there are things about your friendships that you would like to change, what are they?

The LD youth more frequently commented that they wanted more social contact while the NLD reported a desire to improve the quality of present friendships.

The LD youths' comments:
- like to have more friends (6)
- have kids like me more (5)
- wish it were easier to maintain public school friends (4)
- wish it were easier to see private school friends (3)
- wish other kids liked what I like more (2)
- like to have a best friend (2)
- like to have friends to do things with (2)
- like friends to smoke and drink less (1)
- see best friend more (1)
- "...wish I felt I deserved my friends" and were equal to them (1)
- wish friends wouldn't lie so much (1)
- wish friends weren't so silly (1)
- wish "I could trust kids in school to not tell secrets." (1)

The NLD youths' comments:
- wish it were easier to see private school friends outside of school (4)
- wish friends wouldn't talk behind each others backs so much (4)
- wish "...more kids liked what I like" (3)
- would like more in depth conversations with my friends (3)
- wish friends weren't so fickle (1)
- wish friends were more easy going (1)
- wish friends would stop "kissing up" to people (1)
- wish more people liked me (1)
6) Do you use drugs or alcohol?

No present major drug or alcohol use was self reported.

<table>
<thead>
<tr>
<th>Drugs</th>
<th>LD</th>
<th>NLD</th>
<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
<th>MNLD</th>
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</thead>
<tbody>
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<td>5</td>
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<td>2</td>
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<td>25</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>13</td>
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</tbody>
</table>

If yes, tell me about your use. Is it a problem for you now?

Two of the LD youths stated that drugs had been a problem for them in the past and one stated that alcohol had previously been a problem.

Two of the NLD youths also stated that drugs, particularly pot, had been a problem for them in the past and one stated alcohol was previously a problem.

None of the youth stated that they presently had a drug or alcohol problem.

7) Do other youths usually like you? boys? girls?

Both groups report feeling liked by their peers.

<table>
<thead>
<tr>
<th>Both groups report feeling liked by their peers.</th>
<th>LD</th>
<th>NLD</th>
<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
<th>MNLD</th>
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<td>4</td>
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<tr>
<td>So So</td>
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<td>3</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

What do they like? dislike?
The NLD girls thought these were the traits that other girls liked about them:

- humor (4)
- easy to get along with (2)
- not competitive (1)
- interesting (1)
- "I'm boy crazy." (1)
- trustworthy (3)
- quiet (1)
- listen (1)
- different (1)
- understanding (1)
- personality (1)
- fun (3)
- nice (1)
- calm (1)
The NLD girls thought these were the traits other girls disliked about them:
"The way I think, they don't care about world issues like I do." (1)
critical (3)
temper (2)
involved in school work (1)
good student (1)
quiet (2)
serious (1)
flirtatious with boys (2)
"I don't trust them." (1)
"...frightened because I am a witch" (1)

The NLD girls thought that these were the traits that boys liked about them:
good-looking (3)
easy to talk to (2)
personality (1)
don't get mad (1)
"I'm safe" because I'm not looking for a boyfriend (2)

The NLD girls thought these were the traits that boys disliked about them:
didn't know (4)
smart (2)
quiet (1)
flirtatious (1)
"...frightened because I'm a witch" (1)

The LD girls thought these were the traits other girls liked about them:
listen well (4)
help with their problems (2)
good company (1)
I'm myself." (1)
don't cheat with their boyfriend (1)
can't understand why they would like me (1)

The LD girls thought these were the traits other girls disliked about them:
not trustworthy (1)
can't hold onto friends (1)
never make a fuss (1)
get frustrated easily (1)
"I'm intimidating." (1)
The LD girls thought these were the traits the boys liked about them:
- don't know (3)
- personality (3)
- funny (2)
- way I dress (1)
- willing to help (1)
- sensitive (1)
- easy going (1)
- nice (1)
- not shy (1)
- not afraid to play sports (1)
- independent (1)
- "A mystery, I wouldn't like someone like me." (1)
- wild and crazy (1)

The LD girls thought these were the traits the boys disliked about them:
- don't know (5)
- can't be trusted (1)
- immature (1)
- chubby (2)
- not cute enough (2)
- quiet (1)
- "I'm intimidating." (1)
- not aggressive (1)
- smoke (1)
- won't have sex (1)
- personality (1)

The NLD boys thought these were the traits other boys liked about them:
- nice (2)
- similar interests (3)
- intellectual (1)
- don't talk behind backs (1)
- humor (3)
- fun (1)
- "I'm with the crowd." (1)
- trustworthy (1)
- good competition (1)

The NLD boys thought these were the traits other boys disliked about them:
- won't follow the crowd (1)
- don't know (2)
- temper (1)
- don't drink or stay out late (2)
- too obnoxious (1)
- not a sports fanatic (1)
- too mature for kids my age (1)
- like to do things alone (1)
- not exciting (1)

The NLD boys thought these were the traits girls liked about them:
- personality (4)
- humor (3)
- nice (1)
- respectful (1)
- friendly (1)
- looks (1)
- interesting (1)
- creative (1)
- outgoing (1)
- sensitive (2)
- funny (1)
- tall (1)
- listen to them (1)
- don't know (1)

The NLD boys thought these were the traits girls disliked about them:
- looks (4)
- intellectual not sexy (1)
- nervous (1)
- shy (1)
- don't know (1)
- quiet (1)
- violent (1)
- not popular (1)
- fickle (1)
play pranks (1)  
too emotional (1)  
negative attitude (2)  
obnoxious (2)  
radical conservative ideas (1)

The LD boys thought these were the traits other boys liked about them:
don't know (4)  
"I'm different." (1)  
adventurous (1)  
things in common (1)  
comfort them when they have a problem (1)  
play sports together (1)

The LD boys thought these were the traits other boys disliked about them:
don't know (5)  
short temper (1)  
picky (1)  
into Satanic music (1)  
drug use (1)  
different interests (1)  
violent (1)  
not into sports (2)  
too talkative

The LD boys thought these were the traits girls liked about them:
looks (4)  
funny (2)  
"I'm different." (1)  
buy them stuff (1)  
things in common (2)  
physically and emotionally strong (1)

The LD boys thought these were the traits girls disliked about them:
don't know (8)  
not into same things (1)  
quiet (1)  
most people like me (1)  
"I lie." (1)  
smoke too much pot in the past (1)

8) Do you like to spend time alone?

<table>
<thead>
<tr>
<th></th>
<th>LD</th>
<th>NLD</th>
<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
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<tr>
<td>So So</td>
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<td>6</td>
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</table>

9) Would you rather spend your time alone or with youths your age/younger/older or adults?
Both groups prefer spending time with peers their age.

<table>
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</tbody>
</table>

10) What is the most important world or country issue that concerns you?

The LD youth stated:
- Don't Know (6)
- Nuclear Arms (4)
- Russian Jews (1)
- Peace (2)
- Ethiopia (1)
- Dan Quayle (1)
- Death Penalty (1)
- Drugs (2)
- Homeless (1)
- Apartheid (1)

The NLD youth stated:
- Don't Know (5)
- Aids (5)
- Nuclear Arms (5)
- Abortion (1)
- Pollution (1)
- Apartheid (2)
- War (2)
- Human Rights (1)
- Drunks on the road (1)
- Drugs (2)

11) Have you had any problems in the last couple of years? What happened?

These problems are reviewed in Chapter V.

Past Problems:

<table>
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<tr>
<th></th>
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<tr>
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<tr>
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Present Problems:

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<td>1</td>
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<td>School</td>
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<td>2</td>
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<tr>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>No present problems</td>
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<td>12</td>
<td>11</td>
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</table>

12) Who do you talk to when you have a problem?

Neither group talks to a teacher about their problems.

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>talk to a friend</td>
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<td>16</td>
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<tr>
<td>talk to a teacher</td>
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<tr>
<td>talk to a parent</td>
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<tr>
<td>keep it to self</td>
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<table>
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</thead>
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<td>0</td>
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<tr>
<td>talk to a parent</td>
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<td>5</td>
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<tr>
<td>keep it to self</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>4</td>
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</table>

Have you ever seen a therapist? What were the circumstances?

A large number of both groups have seen a therapist. Over two-thirds of the LD youths have seen a therapist.

<table>
<thead>
<tr>
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<tr>
<td>Yes</td>
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<table>
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<tr>
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<td>12</td>
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<tr>
<td>No</td>
<td>4</td>
<td>3</td>
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</table>

Was it helpful, why or why not?

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</table>

<table>
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<th>MNLD</th>
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</thead>
<tbody>
<tr>
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<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
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</tbody>
</table>

Do you presently see a therapist?

Almost half of the LD group still see a therapist. Three of the LD youths (two males and one female) are in therapy because it is required by their school not because they are having any serious problems.
Have you ever been hospitalized for psychiatric reasons?

Nearly equal numbers of each group have been hospitalized.

<table>
<thead>
<tr>
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<th>FLD</th>
<th>MLD</th>
<th>FNLD</th>
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<td>2</td>
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<td>26</td>
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<td>8</td>
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</table>

13) Tell me about your relationship with your mother, father, siblings.

The quality of family relations is much the same between the groups.

**Relationship with mother**

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<td>10</td>
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<td>5</td>
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<td>5</td>
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<tr>
<td>average</td>
<td>8</td>
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<td>5</td>
<td>3</td>
<td>5</td>
<td>5</td>
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<tr>
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<td>3</td>
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<td>1</td>
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**Relationship with father**

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<tbody>
<tr>
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<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
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<tr>
<td>good</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>4</td>
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<tr>
<td>average</td>
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<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>fair</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>4</td>
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<td>poor</td>
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<td>7</td>
<td>4</td>
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**Relationship with siblings**

<table>
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<tbody>
<tr>
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<td>3</td>
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<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>good</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>average</td>
<td>15</td>
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<td>7</td>
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<tr>
<td>fair</td>
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<td>2</td>
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<td>poor</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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</table>
14) How well do you do academically at school?

All of the students in both groups are passing.

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<td>6</td>
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<td>B</td>
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<tr>
<td>B/C</td>
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<td>0</td>
<td>0</td>
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</table>

Has this always been your experience?

The LD youth have much more frequently had a history of school problems.

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<td>11</td>
<td>13</td>
<td>6</td>
<td>6</td>
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</table>

What factors influence how you do at school? (one to three youth made this response when no number is listed)

The LD youth stated:

hard work
improper learning when little
mother’s pressure
not understanding work
doing the homework
my attitude
having enough time to complete my work

sense of personal pride
future hopes and plans
understanding teachers
small classes
less distraction
a supportive educational
environment
The NLD youth stated:
parents give me a hard time
better school
small classes
work hard
praise by teachers

future hopes and plans
keeping my priorities straight
motivation
my sense of pride
expectations by others

15) Do you like your school?

All of the youths like the school they attend.

<table>
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<tr>
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<th>NLD</th>
</tr>
</thead>
<tbody>
<tr>
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<td>30</td>
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<tr>
<td>No</td>
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</tr>
</tbody>
</table>

What do you like? dislike? in comparison to other schools?

The LD youth stated they like:
small classes (20) activities feel successful
individual attention (21) better education “feel at home”
everyone nice to you teachers are supportive structure

The NLD youth stated they like:
small classes (8) other students feel successful
educational environment sports close atmosphere
teachers interested in me classes challenging no drugs/violence

The LD youth disliked:
miss public school friends lousy resources
not enough kids to socialize with no trouble to get into
restricts who can be their friends smallness (3)
not enough choice of boy/girlfriend

The NLD youth disliked:
too easy kids not so cool
too small not enough kids to socialize
not enough class choices gossip
not enough boy/girlfriend choices “snobby” students
taking subjects they have no interest in
too many L.D. kids in their school (makes it less academically competitive)
16) Have you ever had any problems at school? What happened?

Twice the number of LD youth have had school problems.

<table>
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<tr>
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<tbody>
<tr>
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<td>11</td>
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<td>18</td>
<td>4</td>
<td>2</td>
<td>9</td>
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</table>

17) Do you have difficulty learning?

All of the LD youths recognize they have learning difficulty.

<table>
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<th>FLD</th>
<th>MLD</th>
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<td>25</td>
<td>0</td>
<td>0</td>
<td>12</td>
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</table>

Would you call your learning difficulty a learning disability?

Though only twenty-seven of the LD youth declared their learning disability previous testing had diagnosed all of them as LD.

<table>
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<tr>
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<td>1</td>
<td>15</td>
<td>15</td>
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</tbody>
</table>

18) How smart are you?

All but five of the LD youth feel they are below average in intelligence. Educators indicated that each of the subjects were of at least average intelligence.

<table>
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<tr>
<td>Average</td>
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<td>Below Average</td>
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</table>
19) If you could change anything about your level of intelligence or how well you do in school, what would you change?

The LD youth most frequently stated they would like to not be LD.

The LD youth stated:

- not have a LD (25)
- not to have seizures
- spell better
- write easier

just be a "normal kid"
"I want to be smart."
pay better attention
read more quickly

be in public school
improve grades
do math easier

The NLD youth stated:

math skills improve
improve spelling
not be so lazy
manage time better
not need to study so hard

get better grades
improve study habits
speak out more in class
try not to act too smart with friends

read better
do more homework
be more mechanical
try harder

20) Does your ability to learn affect the rest of your life?

The NLD youths more commonly felt their ability to learn affected their life.

<table>
<thead>
<tr>
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<th>FLD</th>
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<td>9</td>
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</table>

21) Does your ability to learn affect your relationships with your friends?

Half of the LD youths felt that their LD had historically affected their peer relations.

In the past:

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<td>28</td>
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</table>
Few of either group felt their learning ability affected peer relations in the present.

In the present:

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<td>10</td>
<td>12</td>
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</table>

22) In what ways is either being smart or doing well in school important to you?

Doing well in school is more frequently important for the NLD parents.

Is it more important to you or your parents?

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</table>

Neither group experiences a lot of parental pressure about school.

Who puts the most pressure on you about school, you or your parents?

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</table>

Questions for the LD subjects:

The pertinent responses to these questions are reviewed in Chapter V.

24) When did you become aware of your particular style of learning?
Tell me a little about that time in your life.

25) If you have had learning or school problems, when did the school and your parents realize that your learning style was causing you difficulty and what did they do? Describe that time in your life and how you felt.
26) If you could change that time in any way, what would you change?

27) How would you describe to someone what it feels like now to have a learning disability? Tell me about your present learning experience.

28) If you could give advice to a young child who has a learning disability what would you say to them? to their parent? to their school?

End of LD questions.

29) Has anyone ever teased you about how well you do in school?

Equal numbers in each group have experienced peer teasing.

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</tbody>
</table>

Describe this experience and its importance for you.

30) What do you imagine your life will be like in 10 years? Where will you live? How will you feel? Will you marry or have children? What will you be doing?

Most of the youths had realistic future plans that included college, a love relationship and future employment.

LD

All but three of the LD youths had realistic future plans.
plan to attend college (24)
plan to enter the military (1)
plan to marry (18)
plan to have children (7)
plan to eventually work (all)

Their future career choices include:
sales          forestry          architect
marine biologist hairdresser       actress
photojournalist psychologist (2)   housewife
art            civil engineer      Navy pilot
policeman
landscaping business
child care centers (2)
father's business

social worker (3)
language translator
preschool teacher

lawyer (2)
electronics

NLD

All but two of the NLD youth had realistic future plans.
plan to go to college (all)
plan to join the military (3)
plan to marry (16)
plan to have children (11)
plan to eventually work (all)

Career choices include:
real estate
medical school (5)
business
work on TV
don't know (3)
commercial artist

computers (3)
housewife
diplomat
celebrity
psychologist (2)

military (3)
electrical
actress
lawyer

31) If you had three wishes what would they be?
Some of the more interesting responses the LD youth made were:

wish about something to do with education (11)
not to have a LD (5)
to be older and finished with schooling (7)
school success (8)
wished for lots of money (3)
wished for happiness (3)
wished for future success (12)
wished for something for the world (i.e.: peace, no pollution...) (5)
wished for something for their family (9)
wished for health (1)

Some of the more interesting responses of the NLD youth were:
wished for something to do with education (4)
wished for something for the world (i.e.: peace, no hunger...) (9)
wished for something for their family (4)
wished for health (6)

A discussion of these qualitative findings can be found in Chapter V.
BIBLIOGRAPHY


