PARENT-LOSS IN CHILDHOOD: EGO FUNCTIONS, DEATH AND MOURNING

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DEATH AND MOURNING

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TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

II. REVIEW OF THE LITERATURE 3

A. Concepts of Death at Different Age Levels 3
B. Mourning Reactions in Children to the Death of a Parent 8
C. Object Relations 17
D. Hypotheses 21

III. METHOD 23

A. Subjects 23
B. Instruments 24
C. Procedure 25
D. Statistical Analyses 26

IV. RESULTS 28

A. Fantasy Material--Emotional Tone and Outcome of TAT Stories 28
B. Ego Functions 31
C. Conceptualization of Death and Mourning Behaviors . 36

V. DISCUSSION 39

A. Fantasy Material (TAT Themes) 40
B. Ego Functions 45
C. Conceptualization of Death and Mourning Behaviors . 51

A SELECTED BIBLIOGRAPHY 55

APPENDIX A - OBJECT RELATIONS 60

APPENDIX B - SUBJECT CHARACTERISTICS 71

APPENDIX C - ANALYSIS OF VARIANCE SUMMARY TABLES 73

APPENDIX D - SUBJECT CONSENT FORM 78

APPENDIX E - DESCRIPTION OF INSTRUMENTS 80

LIST OF TABLES

Table	Page

I. Pearson-Product Moment Correlation Coefficients for $Rater_1$ and $Rater_2$ Scores on Emotional Tone (ET) and Outcome (OUT) of TAT Stories, Sense of Reality (SR), Object Relations (OR), Regulation and Control (RC), Defensive Functioning (DF) for the Four Groups 29

II. Means and Standard Deviations on TAT Emotional Tone . . . 29

III. Means and Standard Deviations on TAT Outcome 30

IV. Means and Standard Deviations on Sense of Reality 32

V. Means and Standard Deviations on Object Relations 33

VI. Means and Standard Deviations on Regulation and Control of Drives, Affects, and Impulses 34

VII. Means and Standard Deviations on Defensive Functioning . . 35

VIII. Means and Standard Deviations on Nondefinitive Death Scale 36

IX. Means and Standard Deviations on Biological Death Scale . 37

X. Analysis of Variance Summary Table for Emotional Tone of TAT Stories by Groups (Loss Vs. Non-Loss) 74

XI. Analysis of Variance Summary Table for Outcome of TAT Stories by Groups (Loss Vs. Non-Loss) 74

XII. Analysis of Variance Summary Table for Sense of Reality Scale by Groups (Loss Vs. Non-Loss) 75

XIII. Analysis of Variance Summary Table for Object Relations Scale by Groups (Loss Vs. Non-Loss) 75

XIV. Analysis of Variance Summary Table for Regulation and Control Scale by Groups (Loss Vs. Non-Loss) 76

XV. Analysis of Variance Summary Table for Defensive Functioning Scale by Groups (Loss Vs. Non-Loss) 76

Table Page

XVI. Analysis of Variance Summary Table for Nondefinitive Death Scale by Groups (Loss Vs. Non-Loss) 77

XVII. Analysis of Variance Summary Table for Biological Death Scale by Groups (Loss Vs. Non-Loss) 77

CHAPTER I

INTRODUCTION

The significance of a primary caretaking person for normal development has been stressed by many individuals. While some have focused on the effect of object deprivation as an interference with the developmental process, research has been conducted on the mother-child relationship in early infancy, on longitudinal studies of child development, and on institutional or foster-home placement as it affects the growth of children. Relatively few reports have been made of observations on adults who have suffered the loss of a parent during their formative stages of development.

The psychoanalytic literature of adult patients who lost a parent by death in childhood reveals a picture of arrested development in their self-concept and object relationships. The level of development of ego-object relations in the adult patient appears to correspond to the level achieved at the time the loss of the parent occurred.

> A striking immaturity in self-image and in the development of ego-ideal and super-ego structures is apparent. Reality-testing, impulse control, object-need, and self-object awareness are not adequate for adult functioning in the patients studied (Fleming and Altschul, 1963, p. 420).

The manner in which the deficiencies are manifested seems to belong to levels of functioning which are more appropriate to earlier stages of development.

Researchers who have studied the reactions of children to the death of a parent also point to the significance of such a loss. There are

multiple dangers that may be encountered by such children during their psychological development. These include an arrested development, faulty reality-testing, lack of impulse control, and sociopathy (Barnes, 1964; Cain, 1964, 1966; McDonald, 1964).

The analyses of adults who suffered bereavement in childhood as well as the analyses of bereaved children contain many complex variables. However, systematic research in the area of childhood bereavement is lacking. Such investigations could contribute to psychotherapeutic intervention in further understanding the emotional concomitants involved in mourning parental loss. Further, they could aid in the prediction of the bereaved child's needs, as well as his family's. Therapy programs specifically aimed at furthering the development and maturation of the child's ego structure could then be established.

The present study investigated differences in conceptualizations of death, mourning behaviors, and ego functions of children who varied in their experience with parent loss through death. The following literature review will be organized as to: first, the general understanding of death as it is conceptualized at different ages; second, studies concerning mourning in children; and third, a brief review of the developmental phases of object relations will be presented.

CHAPTER II

REVIEW OF THE LITERATURE

A. Concepts of Death at Different Age Levels

Children's questions concerning death are often neglected, or at best, they are not fully answered. There is a general tendency in our society to avoid discussion of death or suppress associated concerns. However, studies have shown that while individuals may overtly express indifference toward death, many negatively-toned feelings and emotions are observed when projective techniques are employed to assess convert behavior (Alexander, Colley, and Alderstein, 1958; Jeffers, Nichols, and Eisdorfer, 1961; Roberts, Kimsey, Logan and Shaw, 1952).

> New sophisticated parents, who talk easily with their children about sex and birth, find it hard to speak with them about death and its meaning. But when anything as prevalent as death is excluded from easy communication, it creates an emotional vacuum into which fear and anxiety, mystery and uncertainty come (Jackson, 1965, p. 45).

In contrast, research has indicated that children whose parents had been more open in discussing death with them had better control and more appropriate feelings when dealing with the concept of death and were better able to imagine conditions in which they would die comfortably (Golburgh, Rotman, Snibbe and Ondrach, 1954; Portz, 1965).

A child's conception of death differentially develops with age. Through the use of varied projective techniques investigators have

observed the attitudes of children regarding death. Such techniques have included written compositions, drawings, story completion tests, and recorded discussions of death (Anthony, 1940; Cousinet, 1939; Gessel, 1940; Nagy, 1948). Researchers have found from three to five different stages of development in children's thoughts about death (Anthony, 1940; Cousinet, 1939; Nagy, 1948; Peck, 1966). Childers and Wimmer (1971) noted that children not only understand the universality of death, but observed that their understanding increases as their age level increases.

Peck (1966) found that the development of children's thinking about death was influenced by the mental age or I.Q. of the child. When chronological age was held constant, the level of understanding was positively correlated with mental age. Specifically, Peck (1966) found that the levels of understanding in children with average I.Q.'s were significantly different from the levels of understanding in children with high I.Q.'s. The concept levels, however, were not significantly different in the low and average I.Q.'s. The social class position of the child's family did not appear to modify the development of the concept of death in the child.

There is not a clear understanding of the meaning that death has to a child before the age of four or five. However, different observations in the young child's view of death have been noted. These have included the child regarding death as equivalent to a departure, sleep, or going on a journey (Freud, 1952; Nagy, 1948). Mitchell (1966, p. 55) acknowledged that before the age of four or five children "recognize death as a change of state. Immobility is almost synonymous with death." According to Cousinet (1939), young children may not accept

the idea of death altogether while Illig and Bates-Ames (1955) stated that under the age of five it is extremely difficult to discover what meaning a child attaches to death.

Between the ages of five and nine children attach meaning to death, but rarely in biological terms (Anthony, 1940; Cousinet, 1939; Gessel, 1940; Jackson, 1965; Nagy, 1948). Nagy (1948) noted that during this age period, death is often personified and that it is made contingent upon the actions of others. For example, death may be seen as "a boogie man who can get children at night" or as "a Death-Angel who carries people off to heaven or hell" (Nagy, 1948, p. 20). Cousinet (1939) acknowledged that children in this age period sometimes substitute a severe but curable illness for death. According to Gessel (1940), a seven year old child may express a morbid concern in death's rituals; he may also begin to suspect his own mortality. As the child matures, however, he is able to accept the idea that he himself will one day die.

A certain degree of cognitive maturation apparently must be reached before there is any realization that death is a final, biological process. A young child before the age of five conceptualizes death as a temporary process. A child between the ages of five and nine has not yet reached the maturity needed to view death as a biological process. It is not until the ages of eight or nine that the concept of death is referenced as a biological process.

Piaget (1959) dealing more specifically with the child's concept of life, agrees that between the ages of eight and twelve the child defines life by movement. This is followed by a stage in which life is regarded as the property of animals and plants. During this age

period, the child clearly distinguishes between animate and inanimate objects.

While the conceptualization of death as a biological process occurs somewhere between the ages of eight and twelve, the disappearance of death as a troublesome concept also occurs during this period. Alexander and Alderstein (1958) conducted a study which measured whether children in three age groups responded to death words with greater latencies and increased galvanic skin responses than they did to basal words. While children in the five through eight and thirteen through sixteen age groups showed significant decreases in skin resistance to death words when compared to basal words, the nine through twelve age group showed no reliable differences in skin resistance to death words as compared to basal words. They discussed their results in terms of cultural expectations and ego stability found in the nine through twelve age group. They stated:

> ...the interval from the ninth through the twelfth year has been labelled the pre-adolescent period, a time of latency. Measured in terms of psychological stress, it is generally regarded as being a rather benign age. Roles are well defined. Aggressive outlets are sanctioned by the culture in games and activities. In short, no great new demands are introduced. It is, as life goes, a 'Golden Age.' During this period questions about death disappear from the conscious repertoire as though this matter is no longer of interest. Children at this age seem to be too much involved in the routine of life and its attendant pleasures to be concerned with the concept of death (Alexander and Alderstein, 1958, p. 175).

In summary, literature on the child's conception of death demonstrates that the child's thoughts of death develop as he advances cognitively and emotionally. As children mature, their conceptualizations of death progress from the very limited meanings such as "going to sleep" to those including biological essentials such as "when you

can't breathe and when you have no temperature or pulse." A child begins to conceptualize death as a final, biological process between the eighth and twelfth year. A child in this age period appears to have reached the cognitive maturity needed to view death as a final, irreversible, biological process. Of significance is the observation that thoughts concerning death and dying are less frequent in this age range. Characteristic of this latency period is the lack of psychological stress which is generally encountered in other age groups. Therefore, a child in this age group may not respond with increased emotional intensity to the concept of death.

In part, the current investigation addresses the question as to whether experience with parental death per se affects conceptualization of death. A study by Arthur and Kemme (1964) revealed that disturbed children who had experienced the death of a parent manifested both intellectual and emotional problems. Intellectually, the children frequently manifested difficulties in abstract thinking relative to the concepts of finality and causality. An alternative interpretation is that experience with the death of a parent does not necessarily produce a serious disruption in the child's conceptualization of death. If the child has adjusted well and does not manifest abnormal forms of behavior, his ability to conceptualize death in age appropriate concepts may not be adversely affected. These children might define death in terms more appropriate to advanced stages of development, in contrast to children who have not experienced a parental death. Children who have experienced the death of a parent and are currently manifesting multiple forms of regression and abnormal behavior, however, may well manifest confusion around concepts of death and dying. In general,

they would demonstrate an arrest in their conceptualization of death; i.e., they would conceptualize death in terms that are more appropriate to earlier stages of development.

B. Mourning Reactions in Children to the Death of A Parent

Individuals who experience the loss, by death, of an emotionally important person normally exhibit a distinct pyschological process (Freud, 1917). "Mourning," Freud wrote,

> is regularly the reaction to the loss of a loved person... although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful (pp. 243-244).

Freud, among others, has observed in the bereaved individual significant emotional pain, loss of interest in the outside world, as well as loss of the capacity to form new love relationships while the individual is experiencing the mourning process. The process of mourning requires a very significant but precise function from the bereaved individual. The bereaved needs to experience a gradual and painful emotional detachment from the mental image of the deceased. The bereaved needs to separate himself from the deceased, since the deceased no longer exists. This occurs under the influence of reality-testing and frequently in opposition to strong internal wishes that the deceased be alive (Freud, 1926). Freud (1917, p. 245) described the process of mourning as follows:

> Each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected, and detachment of the libido is accomplished in

> respect of it...when the work of mourning is completed, the ego becomes free and uninhibited again.

Mourning requires, therefore, a tremendous amount of emotional energy; it involves retreating from a significant person all those situations in which there previously existed a high degree of emotional investment.

Many writers have contributed to descriptions of the adult mourning process. The process is usually described in successive stages, including initial shock followed by grief, during which the work of mourning takes place. The process concludes with the separation reaction from the deceased. The inner representation of the person is restructured from a representation of a reality to one of a memory (Bowlby, 1961a, 1961b; Engel, 1961; Miller, 1966; Polluck, 1961; Robertson and Bowlby, 1952).

While the mourning process is usually regarded as a normal and adaptive response to the death of a significant person, many pathological reactions and deviations from the process have been noted. For example, bereaved individuals manifest considerable resistance to accepting the discomfort involved in mourning, develop methods of defense such as overt denial of the loss, or fail to mourn altogether and subsequently do not establish new object relationships (Klein, 1940; Lindemann, 1944; Loewald, 1962; Moriarity, 1967).

Some writers have suggested a relationship between the inability to engage successfully in mourning and various forms of psychological and physiological pathology. The typical mourning responses in depressive patients have been differentiated from those of normals in adaptive mourning (Abraham, 1924). Others have noted either prolonged grief or a total absence of overt grief in clinical patients

(Barnacle, 1949; Bergler, 1948; Lehrman, 1956). Schmale (1958) presented the view that unsuccessfully resolved grief was often a precipitating factor in physical illness. He based his position on a group of clinically studied medical patients who were discovered to have expressed feelings of hopelessness and helplessness in connection with real or fantasied experiences of loss prior to becoming ill.

In brief, the observations of deviations from normal mourning in adults indicates that mourning as a response to loss, by death, is by no means universal. A particular issue to which many writers have attempted to address themselves is the chronological age or developmental stage at which human beings are capable of mourning. Some have attempted to conceptualize the mourning process within a systematic developmental framework. As has been mentioned, the process of mourning involves the expression and tolerance of powerful and painful affects. In addition, it requires the repeated demands for reality testing frequently in opposition to strong internal wishes that the dead person be alive. As such, important questions that confront many writers include the following. Can children mourn? Are children capable of tolerating or expressing such painful affects? Are children's responses to the death of a significant person, such as a parent, similar to the responses observed in adults?

A recently developed theoretical position is that the mourning process requires the operation of ego functions which the child has not yet well established. For example, the ego function of reality-testing, where a child needs to distinguish between his inner wish to maintain the parent alive and the outer or external reality of the death, may be a difficult operation for a child. The child's strong need to keep the

parent alive may indeed lead to a distorted perception and interpretation of the parental death. Mourning as observed in adults, according to this position, does not occur in children of preadolescent age (H. Deutsch, 1937; Fleming and Altshchul, 1963; Rochlin, 1965; Wolfenstein, 1966). These contributors feel that mourning is not possible until a child has successfully negotiated the major adaptive task of adolescence; i.e., children need to give up their parents as the principle love objects before mourning can take place. For younger children, the process is further complicated and interfered with by the basic developmental needs of the child.

If children of preadolescent age do not typically respond to the death of an important person with overt grief and/or a gradual detachment from the memories and hopes of the deceased, how indeed do they respond? The response of children to the death of a parent is striking. While the responses of children to the death of a parent assume a regular and specific pattern, the pattern is not at all similar to the normal adult adaptive mourning process. On the contrary, the process is remarkably similar to the pathological forms of mourning described in some adults. According to Freud (1913), the primary function of the mourning process is to detach memories and hopes from the dead. The reactions to parental loss in children, however, appear to have a defined but adverse purpose. Children manifest a proclivity to avoid the acceptance of the reality of the death. They tend to deny in various forms the emotional meaning of the death. Rather than gradually giving up memories and hopes, children attempt to maintain the parent alive. It is as if the dead parent remains alive inside the child. The child keeps his parent alive through fantasy and pretense.

As early as 1937, H. Deutsch outlined the reactions of children to significant object loss, by death, in presenting four cases of individuals who had experienced childhood and adolescent parental death. There was a lack of appropriate emotion at the time of the loss, at times exemplified by a total absence of grief. Their behavior showed features of denial, idealization, identification, and depression. Deutsch proposed the position that the child's ego is not fully developed to bear the strain that the mourning process requires; a child will thus use whatever mechanisms he has available to protect himself.

Clinical experience with children, as well as retrospective study of adults who have experienced the childhood loss of a parent through death, reveals a process of mourning where there was little weeping at the time of the loss; sad feelings were frequently curtailed. It is as if these children did not take time out from their everyday activities to occupy themselves with thoughts of the dead parent. Children's reactions to the death of a parent typically include unconscious and at times overt denial of the death, as well as the blocking out of all affective responses connected with the death. There is, however, a marked increase in identification and idealization of the dead parent, as well as persistent fantasies of an ongoing relationship with the dead parent. This pattern of responding has been viewed as the child's manner of avoiding the reality of the death and ultimately precluding the child from making the reorganization in personal attachments that such an acceptance would require.

Wolfenstein (1966) is an important contributor to the field of children's reactions to the death of a parent. She reported clinical

research data on 42 children, ranging in age from early latency to adolescence. Wolfenstein concluded that these children were denying, overtly or unconsciously, the finality of the loss. The gradual withdrawal of emotional involvement in the dead parent was avoided. These children did not seem to be overtly preoccupied with thoughts about the lost parent. Wolfenstein arrived at the interpretation that these children were more or less consciously expecting the parent's return.

Jacobsen (1965) also observed the child's wish to be reunited with the lost parent along with restitution fantasies, in the presentations of three patients who had experienced a parent loss in childhood. Unlike the mourning work of adults, children do not seem to experience the gradual decrease in the memories of the lost parent. In essence, the mental image of the dead parent is not decreased. It is as if these children never say "good-bye" to the deceased parent. They do not experience the gradual separation from the deceased but, rather, the dead parent becomes invested with an intensified importance. Wolfenstein (1966) pointed out that the denial of the parent's death coexisted with a correct conscious acknowledgment of what had occurred. All patients were able to state that their parent was, in fact, dead and could remember circumstances related to the death. "Yet," Wolfenstein (1966, p. 106) noted, "this superficial deference to facts remained isolated from the persistence on another level of expectation of the parent's return." There appeared to be a defensive splitting of the ego which allowed the child to deny the death and to continue to maintain the attachment to the dead parent (Miller, 1966).

The concept of a defensive splitting of the ego in the service

of the denial of emotionally painful realities was first introduced by Freud (1924, 1927, 1938). He described how frequently when two contrary and independent attitudes arise, it results in a splitting of the ego. Freud added that the ego often finds itself fending off some demand from the external world which is distressing.

Other writers, following Freud, have emphasized the strong tendency of children to employ denial when dealing with painful realities often leading to a distortion or alternation in relationships (A. Freud, 1936; Jacobson, 1957a; Modell, 1961). Elevations of mood have frequently been noted as well as the intense glorification and idealization of the dead parent (Jacobsen, 1965; Lewin, 1937). Altschul (1968) has further noted that children usually deny the emotional meaningfulness of their loss rather than its reality. While they may overtly accept death, i.e., state that "Mommy is dead," they may continue in their fantasies to keep the illusion that "Mommy is alive;" "Mommy is in heaven, but looking down" or "Mommy can hear and see me."

Perhaps one of the major observations noted in children who have lost a parent through death is, indeed, a glorification and idealization of the lost parent. Following the death, the child appears to perpetuate in fantasy an image of an ideal parent. The child remembers his deceased parent, not as he knew them prior to death, but as a glorified parent of early childhood (Jacobson, 1965; Miller, 1966; Wolfenstein, 1966). This idealization of the deceased parent frequently leads to the development of hostile feelings toward the surviving parent. This is an attempt by the child to deal with pre-loss ambivalent feelings, hostile feelings or guilt derived from the fantasy that it was their own hostile wishes which caused the death (Freud, 1897; Rochlin, 1965;

Wahl, 1958). One of the more frequent affects observed in these children is indeed intense rage rather than grief (Wolfenstein, 1969).

Another feature of children's reactions to the death of a parent is that of identification with the dead parent. The literature is replete with clinical studies and observations where the child identified in some unadaptive way with the deceased parent. Some observations have noted in the child physical symptoms the dead parent had manifested; other have related instances of attempted suicide with the motive to reunite with the dead parent. Krupp (1965) presented a comprehensive survey of published cases of extreme identification in relation to object loss; such reactions were viewed as a major variant of pathological mourning.

In summary, a widely held view of children's reactions to the death of a parent is that object loss is typically followed by attempts at restitution. This is usually exemplified by observations of identification, idealization, and desires to reunite with the dead parent. A child's response to the death of a parent is different from that of the healthy adult's reactions in that a child's grief is remarkably shortened. The immature ego of the child does not sustain itself for too long a period without noticeable defenses such as a denial of the loss and repression of affect. Therefore, the child's reactions are often marked by a failure to mourn. This may result in an arrest of certain ego functions, particularly in the area of object relations.

In brief, there exists a general consensus that children, unlike adults, do not generally experience the gradual and painful emotional detachment from the inner representation of the parent who has died, if not helped with the mourning process. The responses of children are

similar to the pathological forms of mourning found in some adults. The reactions include an unconscious denial of the reality of the loss, a denial of the meaningfulness of the loss, a marked increase in identification with the deceased parent as well as an idealization of the deceased. Feelings of guilt concurrent with a decrease of self-esteem have been observed. These responses have been interpreted as being directed toward avoiding the finality of the parent's death. Therefore, in investing all his energy to keep his mental image alive, the child fails to make the necessary mental reorganization in personal attachments necessary for future development. It is, therefore, reasonable to conclude that the death of a parent, produces for the child, a serious disruption in the child's developmental processes, per se. This is not to discount the significance of the event for the child, according to age and quality of the relationship, as well as other circumstances surrounding the death.

A child is in the middle of a multiplicity of processes of development. He is growing in all sorts of areas and directions; he is involved in processes that require for their normal unfolding and development the presence of an adult. It would be difficult for the child, if not impossible, to stop all development, so that the mourning process, leading to adaptation to the loss can take place, and resume normal life afterward, as with the adult (Furman, 1972). The pressures of internal developmental forces interfere with the possibility of a "time-out" for mourning. Therefore, whatever mourning is possible under this multiplicity of developmental pressures must take place simultaneously with, and in subordination to, such developmental needs as are appropriate to the age of the child. The whole

developmental process is thus complicated by the immediate distortions and repercussions of the loss suffered (Nagera, 1964).

It is important to emphasize that the absence of a parent, especially during certain stages of development, at times, forces a child to recreate the parent anew; i.e., to make the parent alive in fantasies or to ascribe such roles as the development stage requires to anyone available in the environment (Freud and Buringham, 1943; Nagera, 1961). In part, this developmental need interferes with the child's ability to mourn the loss of the parent. The child never gives up the dead parent. The child thus remains in close emotional contact with the deceased parent in his imagination.

An important consideration of this investigation is directed toward observing children who suffer parental loss in early childhood, but do not succumb to major mental illness. We know more about how children fail to adapt when they have experienced losses and deprivations than we know about those who make successful adaptation. We do not know, for example, why some children are so damaged while others get along fairly well. Perhaps the answer is hidden in a multiplicity of variables, including the child's endowed capacity to deal with trauma. One can speculate that the nature of the relationship with the surviving parent is crucial. Very likely, an almost infinite number of variables play a role. For the purposes of this investigation, one variable, i.e., the mourning reactions of children who have experienced the death of a parent, will be scrutinized.

C. Object Relations

Many authors have dealt with the significance of early object

relations in building a child's ego structure. The development of object relations is central to psychoanalytic formulations of ego development. As Kris said:

> There seems little doubt that the intactness of ego functions is to a higher degree than ever before anticipated, determined by the nature of the child's earliest object relations (1951, p. 166).

From the formidable amount of literature on object relations, only the significant stages in the development of object relations as proposed by theorists are reviewed (see Appendix A). Below is an elaboration of the importance of a child's successful separation from his mother leading to a brief explanation of the importance of the attainment of object constancy for the process of mourning.

Through the mechanism of introjection, in the course of this separation from the mother, the child assumes into his own ego those ego functions that the mother had previously performed for him. The child's own ego structure, therefore, becomes endowed with new functions, for example, ego boundaries against both inner and outer stimuli, strengthening of repression that makes more affect available for sublimation, improved reality perception, frustration tolerance and impulse control (Masterson, 1972). The child also begins to substitute the reality principle for the pleasure principle. The child's feelings about his own separate self-representation as being worthwhile or positive stem in part from the child's introjection. This new sense of self and these new functions can be viewed as by-products of achieving separation; that is, if the symbiotic phase and the subphases of separation-individuation are experienced adequately, the child reaches the point of differentiation between self and object representations, and the capacity to retain the representation of the object independent of the

state of need. Structuralization proceeds to normalcy or at worst, neurosis; borderline pathology is averted (Kernberg, 1975). The mastering of this phase is, therefore, an essential foundation upon which the rest of the ego structure is built. An important point of a successful separation-individuation experience which is also a pre-requisite for later interpersonal relations is the capacity to relate to others as individual whole objects, that is, to see them as a whole, both good and bad, gratifying and frustrating, and to have this relationship persist despite frustration at the hands of the object. This characteristic is essential for later satisfying interpersonal relationships and is termed object constancy.

Another fundamental consequence of successful separation-individuation is the attainment of object constancy. Fraiberg (1968) presented a complete discussion of this concept. The term as it is commonly used refers to the capacity to maintain object relatedness irrespective of frustration or satisfaction. That is, the emotional investment of the mother remains stable regardless of a child's need states or frustration. This quality is associated with, and some believe dependent on, the capacity to evoke a stable consistent memory image or mental representation of the mother whether she is there or not. The achievement of this capacity has been variously placed depending on the observer. For example, Spitz (1965) places it at eight months; Mahler (1975), however, places it at 25 months, specifically linking the attainment of object constancy with the emergence of a stable mental representation that enables the child to tolerate separations from the mother. The period of development of the libidinal object or of "true object relations" takes place therefore

somewhere between 6 and 15 months of age and can be divided into two steps (Decarie, 1965). The wish for approval from the mother has become stronger than the wish for material gratification from her. Hartmann (1952) termed this situation object constancy, the infant being interested in the other person independently of the pressure of his needs. It also allows the presence of an object representation of the mother, which allows the child to tolerate the mother's absence. Object constancy, according to this position, is dated but unstable at about the end of the first year; it gradually becomes more stable during the second year.

The importance of the attainment of object constancy for the process of mourning lies in the fact that a child needs to evoke mental images of the lost object in order to mourn, and thus begin to work through his loss. That is, in order for mourning work to be completed an individual needs to "decathect" the internalized image of the lost parent. This allows the child to slowly reinvest his energy to new objects. For the purposes of this investigation only children who were at least three years of age at the time of the parental death were included.

In summary, the relationship of a child to a parent is significant in a number of ways. Among the variety of developmental processes which a parent may foster include defensive structure, gender identity, and the capacity for impulse control. Of particular importance is the development of object relations which may be reflected in the child's manner of relating to others throughout his life. The child's object relations are reflected not only in how he relates to others but also in his intrinsic motivations, gratifications, and internalized

representation of self and others. All of these may be reflected in the child's interpersonal life. Therefore, the loss of a parent through death can be a powerful developmental interference.

D. Hypotheses

This research examined differences in children who varied in their experience with parental loss through death. Specifically, fantasy material, selected ego functions, conceptualization of death, and mourning behaviors were investigated. The following hypotheses were tested:

1. Parent-Loss children will differ in their fantasy material from those who have not lost a parent. In general, children who have lost a parent will manifest a greater concern and preoccupation with death and loss themes. They will differ in the Emotional Tone and Outcome of TAT stories. They will manifest a greater number of death and loss themes as well as a greater number of frustrated and/or submission to fate Outcome themes than Non-Loss children. Specifically, they will obtain lower scores on Emotional Tone and Outcome of TAT stories than their counterparts.

2. Experience with parental death affects emotional adjustment as reflected by the specific ego functions measured. In general, Parent-Loss children (Well-Adjusted and Psychiatric Referrals) will obtain lower scores on Object Relations and on Sense of Reality of the World and of the Self than Non-Loss children (Well-Controls and Psychiatric Referrals). Specifically, it is hypothesized that PLPsy will obtain lower scores than PsyNL. Also, PLWA will obtain lower scores than NWC.

3. It is predicted that Parent-Loss children will differ in the extent to which defense mechanisms have maladaptively affected ideation and behavior. They will also differ in the extent to which defenses have succeeded or failed. In general, Parent-Loss children (Well-Adjusted and Psychiatric Referrals) will demonstrate lower scores than Non-Loss children on the following scales: Regulation and Control of Drives, Affects, and Impulses and also in Defensive Functioning. Specifically, it is hypothesized that PLPsy will obtain lower scores than PsyNL. Also, PLWA will obtain lower scores than NWC.

4. Experience with parental loss affects conceptualizations of death. Specifically, the following order is predicted on the No-Definitive Death Scale: PLPsy will obtain the highest score, next in order will be PsyNL, NWC, and the lowest scores will be

obtained by the PLWA group. The reverse order is predicted on the Biological Death Scale.

5. The completeness of the process of mourning parental loss through death determines subsequent emotional adjustment. In general, children who have not completely worked through their loss will show evidence of poor emotional adjustment manifested by their presenting psychiatric symptoms. Specifically, Parent-Loss Well-Adjusted children will have a higher score on the Mourning Behavior Checklist than Parent-Loss Pyschiatric Referrals.

CHAPTER III

METHOD

A. Subjects

Thirty-two children divided into four groups took part in this study. The characteristics of the groups are presented below (see Appendix B for an expanded summary of subject characteristics). The critical matching variables across the four groups were as follows: age at time of parent loss, current chronological age, sex of child, race, sex of parent lost, and intellectual functioning (I.Q.).

The first group, Parent-Loss Psychiatric, (PLPsy) consisted of eight child patients who had experienced the loss of a parent through death and who had been referred for psychiatric evaluation subsequent to, but not necessarily specifically related to, the loss. Only children who were currently chronologically of latency age, i.e., between the ages of 6½ and 11 were included. This group of child patients was compared to the following three groups.

The second group, Parent-Loss Well Adjusted, (PLWA) consisted of eight children who had experienced the loss of a parent through death, who had never been referred for psychiatric evaluation, and who were considered "well-adjusted" as reported by their surviving parent or guardian and their teacher.

The third group, Psychiatric-Non-Loss, (PsyNL) consisted of eight child psychiatric patients who had experienced no parental loss through

death or divorce but who had been referred for psychiatric evaluation at the parents' request or through school referrals.

The fourth group, Normal Well-Controls, (NWC) consisted of eight child controls who were currently residing with both parents, who had experienced no significant losses through death or divorce, who had never been under psychiatric treatment, and who were considered "well-adjusted" as reported by their parents and teachers.

The parent or guardian of these thirty-two children served as evaluators of their child being "well-adjusted" versus "mal-adjusted" based upon behavior ratings. For those children who had experienced a parental loss, the parent or guardian also served as a subject (S) in reporting on the child's preloss adjustment as well as in relating the circumstances and specific issues involved in the parental death.

The teachers of these thirty-two children also served as evaluators of the child's current school adjustment as to it being "well-adjusted" versus "mal-adjusted."

B. Instruments

A total of seven instruments were utilized in the data collection. Of these seven instruments only four were included in the final statistical analysis. The instruments with their variables utilized as dependent measures are presented below. Refer to Appendix E for a discussion of each instrument and an elaboration of the specific variables measured.

Thematic Apperception Test (TAT--11 selected cards)

1. Emotional Tone of stories
2. Outcome of stories

Rorschach

1. Sense of Reality of the World and of the Self
2. Object Relations
3. Regulation and Control of Drives, Affects, and Impulses
4. Defensive Functioning

Children's Test of Death Concepts

1. Non-Definitive Death Scale
2. Biological Death Scale

Mourning Behavior Checklist

The remaining three instruments served as sources for descriptive data. They included the following:

Wechsler's Intelligence Scale for Children-Revised (WISC-R);

Child's Mourning Questionnaire;

Parent-Loss Questionnaire.

Two instruments were utilized only as indicators of adjustment as evaluated by the parents and teachers. They included the Louisville Behavior Checklist and the School Behavior Checklist.

C. Procedure

The data collection was conducted at the Child Psychiatry Clinic of the University of Colorado Medical Center. The instruments were administered to the child in the following order: WISC-R, Child's Mourning Questionnaire, Rorschach, Thematic Apperception Test, and Children's Test of Death Concepts. The total testing time with the child lasted approximately 3½ hours (three testing sessions). An interview with the surviving parent or guardian approximated one hour.

For those children who had been referred for psychiatric evaluation at the Child Psychiatry Clinic of the Medical Center, participation in this study was considered part of the child's overall

evaluation prior to treatment. The results of these various tests were incorporated in the overall evaluation of the child in the clinic. This information was shared with the child's primary therapist and in turn contributed to a more comprehensive view of the child. For those children who had not been referred for psychiatric evaluation or who were participating in the study as child controls, written parental permission was obtained and the data collection was gathered at the child's respective school (see Appendix D). When requested, the information obtained was shared with the child's parent and/or teacher.

In order to minimize any discomfort which may have been experienced by the surviving parent or guardian when responding to issues of death and loss, the surviving parent or guardian related the circumstances surrounding the child's parent death through a personal interview. The Parent-Loss Questionnaire thus served only as the interviewer's guideline. It was not filled out independently by the surviving parent or guardian.

Finally, the child's teacher evaluated the child's current school adjustment, independent of an interviewer, through the School Behavior Checklist. The parents or surviving parent provided similar behavioral adjustment data through completing the Louisville Behavior Checklist.

D. Statistical Analyses

The first phase of the study investigated the influence of mourning parental loss on subsequent emotional adjustment. A t-test was utilized to test differences between the two parent-loss groups on the Mourning Behavior Checklist.

In order to investigate further the influence of parental loss on

preoccupation with death themes, 2 x 2 factorial analyses of variance with Emotional Tone and Outcome of TAT stories as the dependent variables were computed. Also, 2 x 2 factorial analyses of variance were utilized in analyzing the effects of parental loss on a child's ego functions as measured by the designated scales.

Another phase of the study was concerned with a child's conceptualization of death; 2 x 2 factorial analyses of variance examined the influence of parental loss on the child's score on the Non-Definitive Scale and on the Biological Death Scale.

Finally, the degree of agreement among raters was reflected in reliability coefficients for psychological-test ratings by groups on the four ego functions scales and on the TAT death theme ratings.

CHAPTER IV

RESULTS

Each of the dependent variables measured was analyzed by means of a 2 x 2 factorial analysis of variance. The specific variables measured included the following: Emotional Tone and Outcome of TAT stories; Sense of Reality of the World and of the Self; Object Relations; Regulation and Control of Drives, Affects, and Impulses; Defensive Functioning; Non-Definitive Death Scale; and the Biological Death Scale. The Mourning Behavior Checklist data were analyzed by means of a t-test. The Pearson-Product Moment Correlation Coefficients for $Rater_1$ and $Rater_2$ on the dependent variables are presented below (see Table I).

A. Fantasy Material--Emotional Tone and Outcome of TAT Stories

The 2 x 2 factorial analysis of variance with Emotional Tone of TAT stories as the dependent variable showed significant main effects ($F = 20.908$, df - 2, $p < .001$). (See Appendix C, Table X for ANOVA Summary.) Table II below designates the means and standard deviations for the four groups. Parent-Loss Children (Well-Adjusted and Psychiatric) obtained significantly lower scores on Emotional Tone of TAT stories than Non-Loss Children ($F = 35.076$, df = 1, $p < .001$). Further, Psychiatric Child Referrals (Loss and Non-Loss) obtained significantly

TABLE I

PEARSON-PRODUCT MOMENT CORRELATION COEFFICIENTS FOR $RATER_1$ AND $RATER_2$ SCORES ON EMOTIONAL TONE (ET) AND OUTCOME (OUT) OF TAT STORIES, SENSE OF REALITY (SR), OBJECT RELATIONS (OR), REGULATION AND CONTROL (RC), DEFENSIVE FUNCTIONING (DF) FOR THE FOUR GROUPS

	Scale					
Groups	ET	OUT	SR	OR	RC	DF
P-L Psy.	$.93^1$	$.94^1$	$.79^2$	$.91^1$	$.78^2$	$.64^3$
P-L W.-A.	$.63^3$	$.91^1$	$.71^3$	$.60^3$	.23	.16
Psy. Non-Loss	$.90^1$	$.98^1$	$.96^1$	$.75^2$	$.81^2$	$.93^1$
Normal Non-Loss	$.73^3$	$.86^2$	$.61^3$	$.77^2$	$.76^2$	$.87^2$

$^1p < .001$.

$^2p < .01$.

$^3p < .05$.

TABLE II

MEANS AND STANDARD DEVIATIONS ON TAT EMOTIONAL TONE

Groups	X	S.D.
P-L Psychiatric	19.000	5.345
P-L Well-Adjusted	21.875	3.044
Psychiatric Non-Loss	27.000	5.782
Normal Non-Loss	32.125	2.167

lower scores than Normal/Well-Adjusted counterparts ($F = 6.740$, df = 1, $p < .014$). No significant interaction effects were observed.

In brief, the two parent-loss groups of children were unique in the Emotional Tone of their fantasies when compared to the normal children and psychiatric referrals who had never experienced a parental death. Both groups tended to obtain lower scores on Emotional Tone than Non-Loss children.

The 2 x 2 factorial analysis of variance with Outcome of TAT stories as the dependent variable showed significant main effects ($F = 29.360$, df = 2, $p < .001$) and significant treatment interaction effects ($F = 4.105$, df = 1, $p < .05$). (See Appendix C, Table XI for ANOVA Summary.) Table III below notes the group means and standard deviations for the four groups.

TABLE III

MEANS AND STANDARD DEVIATIONS ON TAT OUTCOME

Group	X	S.D.
P-L Psychiatric	14.875	5.540
P-L Well-Adusted	41.375	5.317
Psychiatric Non-Loss	28.125	13.653
Normal Non-Loss	43.000	4.243

Because of the significant treatment interaction effects observed, the significant main effect results cannot be simply interpreted. To assess the nature of the interaction effects, comparisons between the specific group treatment means were analyzed by means of a t-test. The results of the t-test analyses yielded the following: Parent-Loss Well-Adjusted children obtained significantly higher scores in Outcome of TAT stories than Psychiatric referrals who had never experienced a parental death (PsyNL) ($t = 3.266$, $df = 28$, $p < .01$). Psychiatric Non-Loss referrals (PsyNL) obtained significantly higher scores than Parent-Loss Psychiatric counterparts (PL-Psy) ($t = 3.265$, $df = 28$, $p < .01$). There was no significant difference in Outcome of TAT stories noted when both Normal/Well-Adjusted groups were compared (Parent-Loss and Non-Loss) ($t = 0.403$, $df = 28$). In summary, in response to Outcome of TAT stories the following were observed: Normal Well-Control and Parent-Loss Well-Adjusted children obtained the highest scores. Next in order of magnitude were the Psychiatric Non-Loss referrals. The lowest scores were obtained by Parent-Loss Psychiatric referrals.

B. Ego Functions

The 2 x 2 factorial analysis of variance with Sense of Reality (SR) as the dependent variable showed significant main effects ($F = 30.728$, $df = 2$, $p < .001$) and significant treatment interaction effects ($F = 5.790$, $df = 1$, $p < .023$). (See Appendix C, Table XII for ANOVA summary.) Table IV below notes the means and standard deviations for the four groups. Because of the significant treatment interaction effects observed, the significant main effects results cannot be simply interpreted. To assess the nature of the interaction effects, comparisons

between specific group means were analyzed by means of a t-test. The results of the t-test analyses yielded the following: Parent-Loss Psychiatric children (PL-Psy) obtained significantly lower scores on SR than Psychiatric Non-Loss counterparts ($t = 3.0345$, $df = 28$, $p < .005$). Parent-Loss Well-Adjusted (PL-WA) children did not differ significantly from Non-Loss Normal children ($t = 1.10$, $df = 28$). In essence, significant interaction effects note the following differences: the effect of experience with parental death is greater for psychiatric children than for normal children. That is, experience with parental death lowers the Sense of Reality score for the psychiatric group, while experience with parental death does not significantly affect the Sense of Reality score for the Normal group.

TABLE IV

MEANS AND STANDARD DEVIATIONS ON SENSE OF REALITY

Group	X	S.D.
P-L Psychiatric	5.438	1.954
P-L Well-Adjusted	9.250	0.845
Psychiatric Non-Loss	7.500	1.439
Normal Non-Loss	10.000	0.886

The 2 x 2 factorial analysis of variance with Object Relations (OR) as the dependent variable showed significant main effects ($F = 47.077$,

df = 2, $p < .001$). (See Appendix C, Table XIII for the ANOVA Summary.) Table V below designates the means and standard deviations for the four groups.

TABLE V

MEANS AND STANDARD DEVIATIONS ON OBJECT RELATIONS

Group	X	S.D.
P-L Psychiatric	4.813	1.580
P-L Well-Adjusted	8.938	0.860
Psychiatric Non-Loss	5.313	1.280
Normal Non-Loss	9.938	1.348

There was a trend for Parent-Loss Children (Normal/Well-Adjusted and Psychiatric) to obtain lower scores on Object Relations than Non-Loss Children (F = 2.688, df = 2, $p < .10$). Psychiatric referrals (Loss and Non-Loss) obtained significantly lower scores on Object Relations than Normal/Well-Adjusted children (Loss and Non-Loss) (F = 91.467, df = 1, $p < .001$). No significant treatment interaction effects were observed. In summary, as a group Parent-Loss children obtained lower scores than Non-Loss children and as a group Psychiatric referrals obtained lower scores than Normal/Well-Adjusted children.

The 2 x 2 factorial analysis of variance with Regulation and Control of Drives, Affects, and Impulses as the dependent variable showed

significant main effects (F = 38.441, df = 2, p < .001). (See Appendix C, Table XIV for the ANOVA Summary.) Table VI below designates the means and standard deviations for the four groups.

TABLE VI

MEANS AND STANDARD DEVIATIONS ON REGULATION AND CONTROL OF DRIVES, AFFECTS, AND IMPULSES

Group	X	S.D.
P-L Psychiatric	5.063	1.237
P-L Well-Adusted	9.188	1.067
Psychiatric Non-Loss	6.125	1.482
Normal Non-Loss	9.813	1.335

There was a trend for Parent-Loss children (Normal/Well-Adjusted and Psychiatric) to obtain lower scores on Regulation and Control of Drives, Affects, and Impulses than Non-Loss children (F = 3.427, df = 1, p < .07). Psychiatric referrals (Loss and Non-Loss) obtained significantly lower scores than Normal/Well-Adjusted children (F = 73.455, df = 1, p < .001). No significant treatment interaction effects were found.

In essence, as a group, on the ego function of Regulation and Control of Drives, Affects, and Impulses Parent-Loss children tended to obtain lower scores than Non-Loss children. Psychiatric children obtained lower scores than Normal/Well-Adjusted children.

The 2 x 2 factorial analysis of variance with Defensive Functioning (DF) as the dependent variable showed significant main effects (F = 51.246, df = 2, p < .001). (See Appendix C, Table XV for the ANOVA Summary.) Table VII below notes the group means and standard deviations.

TABLE VII

MEANS AND STANDARD DEVIATIONS ON DEFENSIVE FUNCTIONING

Groups	X	S.D.
P-L Psychiatric	3.875	1.408
P-L Well-Adjusted	8.750	0.756
Psychiatric Non-Loss	5.875	1.529
Normal Non-Loss	9.750	1.336

Parent-Loss children (Normal/Well-Adjusted and Psychiatric) obtained significantly lower scores on Defensive Functioning than Non-Loss children (F = 10.781, df = 1, p < .003). Psychiatric referrals (Loss and Non-Loss) obtained significantly lower scores on DF than Normal children (Loss and Non-Loss) (F = 91.711, df = 1, p < .001). There were no significant interaction effects observed.

C. Conceptualization of Death and Mourning Behaviors

The 2 x 2 factorial analysis of variance with Non-Definitive Death Scale as the dependent variable showed significant main effects ($F = 42.068$, df = 2, $p < .001$) and significant treatment interaction effects ($F = 46.173$, df = 1, $p < .001$). (See Appendix C, Table XVI for the ANOVA Summary.) Table VIII below designates the group means and standard deviations.

TABLE VIII

MEANS AND STANDARD DEVIATIONS ON NON-DEFINITIVE DEATH SCALE

Groups	X	S.D.
P-L Psychiatric	13.125	2.900
P-L Well-Adjusted	1.125	0.641
Psychiatric Non-Loss	3.375	2.134
Normal Non-Loss	2.625	2.925

Because of the significant treatment interaction effects noted, the significant main effects results cannot be simply interpreted. In order to assess the nature of the interaction effects, comparisons between the group treatment means were analyzed by means of a t-test. The results of these analyses yielded the following: Parent-Loss Psychiatric

referrals obtained significantly lower scores on the Non-Definitive Death Scale than Non-Loss Psychiatric counterparts (t = 8.32, df = 28, $\underline{p}$ < .001). Parent-Loss Well-Adjusted children, however, did not differ significantly from Normal Well-Controls (t = 1.28, df = 28). In essence, significant treatment interaction effects notes the following: Experience with parental death is greater for the psychiatric group than for the Normal/Well-Adjusted group. That is, experience with parental death significantly increases the PL-Psychiatric child's Non-Definitive Death score while it does not significantly affect the score for the Parent-Loss Well-Adjusted group.

The 2 x 2 factorial analysis of variance with the Biological Death Scale as the dependent variable showed significant main effects (F = 42.068, df = 2, $\underline{p}$ < .001) and significant interaction effects (F = 46.173, df = 1, $\underline{p}$ < .001). (See Appendix C, Table XVII for the ANOVA Summary.) Table XI below designates the group means and standard deviations.

TABLE IX

MEANS AND STANDARD DEVIATIONS ON BIOLOGICAL DEATH SCALE

Groups	$\bar{X}$	S.D.
P-L Psychiatric	2.875	2.900
P-L Well-Adjusted	14.875	0.641
Psychiatric Non-Loss	12.625	2.134
Normal Non-Loss	13.375	2.925

Because of the significant treatment interaction effects observed, the results of the main effects cannot be simply interpreted. To assess the nature of the interaction effects, comparisons between the specific group treatment means were analyzed by means of a t-test. The results of the t-test analyses yielded the following: Parent-Loss Psychiatric referrals obtained significantly lower scores than Non-Loss Psychiatric counterparts ($t = 8.32$, $df = 28$, $p < .001$). Parent-Loss Well-Adjusted children, however, did not differ significantly from Normal Well-Controls on the Biological Death Scale ($t = 1.28$, $df = 28$). In essence, the effect of experience with parental death decreases the Biological Death score for the Psychiatric group, while it does not significantly affect the score for the Normal/Well-Adjusted group.

On the Mourning Behavior Checklist the following difference was observed: Parent-Loss Well-Adjusted children obtained significantly higher scores than Parent-Loss Psychiatric referrals ($t = 5.6$, $df = 14$, $p < .001$). That is, Parent-Loss Well-Adjusted children showed evidence of engaging in mourning behaviors. This was in contrast to the Parent-Loss Psychiatric group who manifested few mourning behaviors.

CHAPTER V

DISCUSSION

It is with full awareness of the limited sample size that significance found in this study is discussed. However, clinical interpretations of the data will be presented as this is an emerging area of investigation and these hypotheses will hopefully lend themselves to generalizations for future study.

One of Freud's early discoveries involved the observation that hidden fantasies play a significant role in the development of normal as well as psychopathological mental functioning. The significance of this knowledge concerning the fantasy life of children lies in the realization that the reaction to a death cannot be assessed by considering only its behavioral aspects. A distinction between the Parent-Loss child's internal representational world and his world of outer reality is crucial. Therefore, the fantasies which may be dominant in the child's mind at the time of the loss, as well as years thereafter, need to be considered. Other significant considerations include identifying the developmental phase of the child and the tasks inherent in that stage; assessing the success the Parent-Loss child has had in accomplishing these tasks; and noting the impact the loss has had on the child's developmental work. An evaluation of the child's ego functions is crucial in accomplishing these assessments. The present study included, therefore, an assessment of the child's fantasies and selected ego functions as measured by the following scales: Emotional Tone and Outcome of

Thematic Apperception Test (TAT) stories; Sense of the World and of the Self; Object Relations; Regulation and Control of Drives, Affects, and Impulses; and Defensive Functioning.

The children who participated in this study were chronologically of latency age. A characteristic of the latency period is the minimal amount of psychological stress which appears more prominent in other age groups. Measured in terms of psychological concerns it is generally regarded as being a rather benign age.

> During this period questions about death disappear from the conscious repertoire as though this matter is no longer of interest. Children at this age seem to be too involved in the routines of life and its attendant pleasures to be concerned with the concept of death (Alexander and Alderstein, 1958, p. 175).

The results of this study indicated, however, that experience with parental loss through death affects both the projective material of children as well as their conceptualization of death. Specifically, experience with parental death influenced both the Emotional Tone and Outcome of children's fantasy TAT stories, as well as apparently contributing to their concerns around concepts regarding death and dying. Also differences in those ego functions measured by the scales noted above were observed.

A. Fantasy Material (TAT Themes)

In reference to the children's fantasy material as presented on the Thematic Apperception Test, the following differences occurred. The two Parent-Loss groups of children that were observed in this study (Psychiatric Referrals and Well-Adjusted) were unique when compared to the Normal children and Psychiatric Referrals who had never experienced a parental death. Both Parent-Loss groups of children revealed a

proclivity to describe themes which portrayed conflict, questions and speculations regarding death and dying, as well as fantasies of fear and loneliness regarding life and living. For example, the following two stories reveal some of the children's themes:

TAT CARD 11:

Looks like something is blowing up. Someone - some careless hunters - they went outside without...they left their stove on inside their tent and then there was a rain-storm and the stove fell over and caught the weed on fire and then they tried to put the fire out and they couldn't and then all the animals couldn't get away, and the animals died, and then.... the hunters died...it burned the whole place on fire, and then the fireman got there and everything was black and oily. That's the end.
(Parent-loss Psychiatric Child, Male, Age: 8yrs.6mo.)

TAT CARD 11:

This is a cave and there are spooky things it it - that people don't know what is going to happen. People live in it and at times they feel uncertain about things - like when people are going to die. But most of the time its a fun cave where kids play. It's a story like about live - people live and die. The people that stay alive feel sad for awhile and miss the ones that die. But then things go on and they feel better after awhile.
(Parent-Loss Well-Adjusted Child: Male, Age: 8-6)

One distinction between the two Parent-Loss groups emerges in the Outcome of their fantasy productions. Children who had experienced the death of a parent but who were considered well-adjusted as reported by their parents and teachers, revealed themes which led to recovery from temporary disability or depression, as well as manifesting themes involving a tolerable resolution of conflicts. For example:

TAT CARD 7Gf:

This is a little girl talking with her mother. The little girl liked to suck her thumb and her mother thought she was too old for that. So they're having a talk. The little girl was asking her mother all sorts of questions, like what marriage was about. The little girl didn't know about it. So her mother is trying to explain to her but its hard for the mother because her husband had died when the little girl was younger. So the little girl and mother talk about it

and the mother says she can ask her questions when she feels like it.
Q. What did the little girl wonder about?
A. She wondered about marriage, just things like kissing and stuff. In the end she feels glad she can ask her mother.
(Parent-Loss Well Adjusted, Female, Age: 9-6)

In essence, Parent-Loss Well-Adjusted children related Outcome themes which were more similar to the Outcome themes of Normal children who had never experienced a parental death. On the other hand, Parent-Loss Psychiatric Referrals, i.e., children who had experienced the death of a parent and who were overtly manifesting difficulties in school, home, and/or in relationships with peers and/or with surviving parents, revealed a tendency to relate Outcome themes which yielded to failure, submission to fate, death, murder, suicide, extreme punishment or remorse. It is as if these children saw no hope or pleasure in life's activities. To them, life means loss and dying.

One of the purposes of this study included integrating and expanding current research in the area of the effects of parental death on personality development. It has frequently been mentioned by researchers, that experience with parental death complicates future development. Moriarity (1967), for example, presented the thesis that children exposed to death bear "emotional scars" which have an effect on their future development. The scars are said to be related to guilt, real absence, desires to bring back the dead, the desires to reunite with the dead parent. In essence, these children invest a tremendous amount of emotional energy in fantasies concerning their deceased parent. Some children in the present study indeed revealed, that experience with parental death has left them with "emotional scars." Other children appear to have adjusted well, however, as observed in their overt

behavior as well as reflected in the parents' and teachers' perceptions of the child's behavior. The child's projective material, on the other hand, reveals that experience with death has indeed left its "tell-tale marks." For example, in general, children who had lost a parent manifested a greater concern and preoccupation with death and loss themes. Specifically, they differed in the Emotional Tone of TAT stories, i.e., they revealed a greater number of death and loss themes than children who had never experienced a parental loss.

The specific differences between the two Parent-Loss groups regarding their Outcome of stories, as well as the similarities of their emotional fantasy material, raises the question whether the parent-loss well-adjusted children have indeed been spared from future conflict, whether they have worked through their loss, or whether they have merely adopted the necessary defenses appropriate for latency and manifested in their relatively healthy overt behavior. That is, has the adoption of specific defenses helped the process of psychological development and growth, including the reorganization of personal attachments that latency requires?

As such, important considerations include the following: has the experience with the parental death merely been suppressed, only to be brought out and resolved at a later time when the child's ego structure is more developed? Will the memories be reactivated after the child has reached adolescence or adulthood? While these questions remain open for further research, the retrospective psychoanalytic studies on adult patients who have experienced early childhood primary object loss may be considered in speculating as to possible answers. There is an abundance of clinical evidence in the literature to document in a general way the

pathological effects on personality development of such children, including a developmental arrest, an interference with the establishment of mature interpersonal relationships, a predisposition to depressive reactions and/or depressive neurosis. Moreover, since the process of adaptation continues throughout life, the reaction of the child to parental death may not be fully experienced until a later time in life when the child is forced to give up an earlier state of psychological well being, such as leaving latency and entering into adolescence, graduating from college, making vocational choices, finishing an advanced degree, entering into a love relationship, marriage, parenthood, or experiencing a move to a different city or a new job. All of these ocassions have reportedly been experienced as potential triggering points for depressive and/or anxiety reactions in adult patients who have experienced a parent loss. It is as if the pressure of events that might result in a separation is experienced with tremendous conflict and pain; Fleming (1963) attributes these reactions as manifestations of the early trauma experienced, which in turn produced massive separation anxiety. These patients thus manifest a difficulty or inability to manage the developmental tasks of separation-individuation, i.e., of moving toward adulthood. The Parent-Loss children in this study indeed may not have been spared similar future reactions. The observations of their fantasy material reveals that these children may be increasingly vulnerable to future losses and future separations. For example, children who had lost a parent revealed themes which often portrayed loneliness and conflict with attempt at departure, and frequently manifested complete hopelessness and resignation toward death. This was in contrast to their Non-Loss counterparts who often revealed themes which

portrayed a desire for aspiration.

Another important consideration includes investigation into the following: how has the Parent-Loss Well-Adjusted child's defensive structure adopted to allow him to cope effectively with the loss in latency? On the other hand, what has precluded the psychiatric parent-loss referrals from making the reorganization in personal attachments that experience with death requires? For example, one might pose the following speculations. Have these child-patients coped with their trauma by attempting to deny the reality of the loss and/or attempted to keep their parent alive in fantasy? Are these children investing all their energy in protecting themselves against the pain of grief? Have their resources for coping kept them in an arrested state of development manifested by their current psychiatric symptoms? The course that a child's development may take subsequent to experiencing a parental death may indeed be influenced by a multiplicity of factors, including the child's previous life experiences, the degree of success that the child had in mastering previous developmental phases, the relationship with the surviving parent, subsequent mourning reactions, as well as the child's endowed capacity to deal with trauma. For the purposes of this investigation, the mourning reactions of these children were studied. These observations will be presented later in this discussion.

B. Ego Functions

As has been mentioned, a crucial consideration in noting the reactions and adaptation of a child to a parental death involves an assessment of the child's ego functions. For the purposes of this research four ego functions were measured. These included: Sense of

the World and of the Self; Object Relations; Defensive Functioning; and Regulation and Control of Drives, Affects, and Impulses. It would be an error to discount the importance of other ego functions in relating the internal forces that may be operating in Parent-Loss children. The significance of an assessment of object relations in treating Parent-Loss children, however, has been frequently mentioned by several authors, specifically in relation to our understanding of the possibility of arrested development. In addition, the assessment of the ego function of reality testing is significant in that a Parent-Loss child is faced with the task of integrating the reality of the loss. The manifestations of the child's defensive structure are also part of his adaptation to the external as well as internal world and they were thus included in the present study.

In response to the four ego functions measured, the following differences were noted. As a group, there was a trend for Parent-Loss children (Well-Adjusted and Psychiatric) to obtain lower scores on Sense of Reality of the World and of the Self, than children who had never experienced a parental death. The effect of parental death was greater for the Psychiatric group than for the Normal group. That is, Parent-Loss Psychiatric children obtained significantly lower scores on Sense of Reality Scale than Psychiatric Referrals who had never experienced a parental death. A comparison with past clinical findings may help elaborate the possible meaning of these results. For example, a number of investigators have consistently indicated that a child's first reaction to the death of a parent is denial, i.e., the denial of the reality and/or meaningfulness of the loss. The mourning process requires the operation of ego functions which are not yet well

established in the child. For example, the ego function of reality testing, where a child needs to distinguish between his inner wish to maintain the parent alive and the outer or external reality of the death, may be a difficult operation for the child. The child's compelling wish to keep his parent alive may indeed lead to a distorted perception and interpretation of the parental death, especially if the child is not helped with the mourning process.

In order for mourning work to be completed, a child needs to decathect the internalized image of the lost parent. That is, he needs to reinvest his emotional energy to new objects "and make it possible to move on, away from the past into the future" (Fleming, 1973, p. 26). This process, however, may be too difficult and painful for a child. That is, it may be beyond his current developmental capacities to cope with by himself. A child who has experienced a loss needs to adopt to the stresses involved in the change with external reality. A child's ego is called upon to integrate the terminal separation from his parent, a person essential for the child's ongoing development. Maturation is a difficult task, even in optimal situations. Yet, on top of this, when a child experiences the death of a parent, he is forced to deal with an overwhelming reality. His whole world of self-object reference points is disturbed and his orientation to reality may be thrown severely off balance (Mahler, 1968). This observation was indeed supported by the present study. Specifically, children who had lost a parent and who were referred for psychiatric evaluation obtained the lowest scores on the ego function of Sense of Reality of the World and of the Self.

In addition to assessing the degree to which a child's

self-representations are distinguished from object representations (that is, the extent to which a child correctly ascribes which qualities are self-representative and which belong to others) the ego function of Sense of Reality of the World and of the Self includes an assessment of the degree to which a child has developed individuality, a sense of self, a stable body-image, and self-esteem. Jacobson (1965), among the more orthodox contributors to the theory of depression, has given perhaps the most detailed exposition of the conditions allegedly necessary for the development of depressive feelings. She has described how an optimal level of self-esteem develops "only in an atmosphere of parental love and care with sufficient libidinal gratification." In such an atmosphere, manageable quantities of frustration and dissappointment are growth producing. For example, a certain degree of frustration is necessary to promote the process of self-discovery and reality-testing, to throw the child back on his own resources and to facilitate the establishment of solid endo-psychic boundaries between self- and object images. In essence, it facilitates the child's learning to tolerate his own ambivalence and is conducive to the establishment of a realistic ego ideal.

Jacobson has, moreover, stressed the importance of severe early disappointments in the development of depressed patients. She emphasizes that the child who has been disappointed too massively in life cannot profit from such an experience. Instead, he sustains a deep narcissistic injury. This narcissistic blow may correspond to the feeling of being unvalued, unwanted, and unloved. The results of the present study indicate that experience with parental death occurring at a time when a child is learning to tolerate his own ambivalence seems to interfere

with the optimal cathexis of self- and object-representations, i.e., with the development of normal self-esteem and satisfactory interpersonal relationships. Specifically, as a group, Parent-Loss children tended to obtain lower scores on Sense of Reality of the World and of the Self than children who had never experienced a parental death. The effect was greater for the Psychiatric group than for the Normal/Well-Adjusted group. That is, children who had experienced the death of a parent and who were manifesting psychiatric symptoms obtained the lowest scores on this ego function, which includes the degree to which a child has developed a sense of self, a stable body image, and self-esteem.

Investigators of early child development have consistently indicated the importance of significant external objects in childhood. In regard to the Parent-Loss child and the mourning process, the availability of significant external objects should therefore be stressed. The mourning process in childhood requires that an external object be available to help the child work through his loss. With the death of a parent, certain functions for which the child relied upon his parent to provide must be provided by someone else. These may include the surviving parent, relatives, friends, or at times the child's therapist; the absence of these functions, i.e., when these functions are not being provided by someone, may indeed represent the precursor of a developmental arrest (Portnoy and Fleming, 1976). It is important to make a distinction, however, between the available external object who may attempt to replace the deceased parent and the available external object who relates to the child as a substitute parent (Portnoy, 1976). The replacement parent may attempt to completely take over the deceased parent's place or relate to the child as if he were the child's deceased

parent. In essence, he interferes with the child's mourning work in not facilitating or evoking memories of the deceased from the child. The child, therefore, never gives up the fantasy that his parent is alive. This is in contrast to the substitute parent who may provide certain functions for which the child relied upon his parent to provide but clearly distinguishes himself from the deceased parent. Such statements as "I am helping you with your homework as your father/mother would have if he/she were alive" are helpful in both facilitiating the differentiation between the deceased parent and the available parent, as well as in evoking memories of the deceased. This begins the work of mourning.

An assessment of the Parent-Loss child should examine, therefore, the development of object relations. Close examination of a child's relationships with others and his image of himself may reveal at what developmental level of relating he may be functioning. It may be an indicator that the child is attempting to restore and maintain the illusion of a preloss period, or that the child has the ability to use available providers in accomplishing developmental tasks (Portnoy and Fleming, 1976). Therefore, peer and family relations and assessment of the child's internal view of himself, and how he relates to the world is crucial. The Parent-Loss children in this study (Well-Adjusted and Psychiatric) tended to obtain lower scores than Non-Loss children on the ego function scale of Object Relations. This observation supports the view that childhood loss may be a predisposing factor in developmental failures. Such failures may significantly impact on the subsequent development of object relations.

On the ego function scales of Regulation and Control of Drives and Defensive Functioning, there was a trend for Parent-Loss children to

obtain lower scores than Non-Loss children. Of importance, however, is the observation that there were no significant differences on these two scales when Parent-Loss Well-Adjusted children were compared to Normal Well controls. That is, Parent-Loss Well-Adjusted children tended to respond with defenses similar to those of Normal children. This particular tendency, however, is questionable, for in comparison to all other scales, these two scales apparently posed difficulty for the raters. The inter-rater reliability was especially low for the Parent-Loss Well-Adjusted group. It is clear that this is a function of the group rather than of the raters or of the scales, because the reliability coefficients between the raters on all other scales and on all other groups within this scale was significant. One might speculate that the adaptations of this group suggest unique personality reorganizations which are further reflected in a less clear clinical picture, despite the ostensibly adequate adjustment to the external world. This is clearly an area for futher investigation.

C. Conceptualization of Death and Mourning Behaviors

The differences between the two Parent-Loss groups were revealed not only in their projective material but also in their conceptualization of death. Parent-Loss children who were manifesting multiple forms of regression and abnormal overt behaviro conceptualized death as merely a brief separation or a sleep; they denied definitions conceptualizing death as a final, biological process. In essence, their conceptualization of death was more appropriate for an earlier stage of development. It is as if these children have never fully worked through the initial

stage of mourning. That is, they have continued to deny the reality of the parental death. They are not only denying the significance of the death, but are operating as if death is only brief or temporary. They seem to be conceptualizing death in terms which may be egosyntonic with their magical wishes. If death is only temporary, then their parent will surely return sometime in the future. Parent-Loss children who were considered well-adjusted, however, conceptualized death in terms appropriate to their phase of development. Unlike the Parent-Loss Psychiatric group, their conceptualization of death was not adversely affected.

To speak of bereavement only as a determining factor in development is to greatly oversimplify the issues. Of enormous relevance is noting how the child was helped to endure his bereavement. Another aspect of this study included noting the mourning reactions of the two Parent-Loss groups as they were reported by an interview with the surviving parent and/or guardian. Of significance is the observation that Parent-Loss Well-Adjusted children experienced a period of adjustment which was markedly different from the Parent-Loss Psychiatric group of children. In general, the surviving parent and/or guardian of Parent-Loss Well-Adjusted children reported observing behaviors in their children which had not been noted in the child prior to the parental death. These behaviors included clinging, frequent crying, and talk concerning the deceased parent, bed-wetting, sleep disturbances, frequent temper-tantrums, hostility directed toward the surviving parent, whining and complaining. It is as if these children reacted with overt manifestations to the death of their parent. Their surviving parent and/or guardian also reported a period of adjustment where they themselves

experienced frequent weeping in the presence of the children and discussion about the deceased. This period of adjustment ranged from 8 months to 1½ years subsequent to the parental death. Other significant observations included the stability of the family after the death. Children and surviving parents of the Well-Adjusted group remained in the same household subsequent to the death. No new family members were added for at least one year following the death. In addition, they tended to remember the deceased in more realistic terms. Visits to the graveside were frequent and talk concerning the deceased parent was encouraged. Anniversary dates and holidays such as Christmas, Mother's Day and Father's Day prompted discussion of the deceased. The availability and supportiveness of family and especially friends was noteworthy. As one surviving parent indicated, "it was easier to relate to friends than to my own parents during this difficult time."

Parent-Loss Psychiatric Referrals, however, revealed a period where there was an absence or little expression of emotions as reported by their parent. These children tended to respond in ways similar to children's reactions which have been reported in the literature; there was little weeping at the time of the loss, and sad feelings were curtailed. There was infrequent discussion by the family concerning the deceased parent. In addition, the surviving parent and/or guardian generally minimized the significance of the parental death on the child's subsequent emotional adjustment.

In brief, as a group, Parent-Loss children are unique in that they are faced with a significant but precise task, a task that requires a tremendous amount of emotional energy, i.e., the resolution of the loss of one of the most important individuals in their life, their parent.

As one child remarked, "I don't like saying good-bye to Mommy every time I visit her at the grave." Indeed, these children perhaps have not said "good-bye" but only "so-long" in that the memories and conflicts may be reactivated when the child has reached a more advanced stage of emotional development.

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APPENDIX A

OBJECT RELATIONS

As early as 1895, Freud formulated the contribution of object relations to the evolving of the pleasure and reality principles; he pointed out, for example, that the cooperation of a more mature person was necessary for the gratification of the infant's instinctual impulses. Freud's major focus on the "object" was initially on the sexual object as one aspect of instinctual drives, while the others were source, aim, and impetus. Much of what Freud had to say about object relations during the years prior to 1923 had to do with object cathexis, object choice, and kinds of considerations for the object. He showed in many ways how the kind of object relationship was different at each stage of libidinal development. For example, an anaclitic relationship (dependent attachment) predominates during the oral phase, and consideration for the external object appears during the anal phase. In the phallic phase, the oedipal concerns imply further development of an object relationship capacity. Sexual curiosity of children during this period, for example, may have an impact on their object relations with other children.

In his last works, Freud showed a growing recognition of the importance of the early mother-child bond for the development of ego structures and for optimal later object relations, but he did not explore this aspect of the family ties as clearly as he studied the later-developed oedipal relationships. In 1931 he pointed out that where a woman's attachment to her father was found in analysis, for example, an earlier intense relationship to the mother was subsequently uncovered. In 1938 he described the child's attachment to its mother as: ". . . unique, without parallel, established unalterably for a whole lifetime as the first and strongest love-object and as the prototype of all later love-relations for both sexes" (p. 188).

More currently, the development of object relations has been divided into phases in terms of various criteria, including the formation of object representations, the mode of libidinal and aggressive cathexis, or the development of psychic structure (Decarie, 1965). It was in the context of libidinal development that object relations were formulated and understood by Freud. Oral, anal, and phallic features were shown to dominate the object relations of individuals fixated at, or regressed to, these stages.

More recently, in line with the emphasis on ego aspects of development and functioning, a number of theorists have conceptualized the development of object relations into several stages. Hartmann (1952), for one, called these stages primary narcissism, need gratification, and object constancy. Hartmann proposed a progression in the development of object relations. According to him, the developmental phases of object relations proceed from the objectless stage of primary narcissism, through the stage in which the object is experienced as existing only to fulfill the infant's needs, to the level of object constancy. Object constancy has far-reaching implications for development; it provides a therapeutic goal of extreme importance in the treatment of borderline patients. For example, a large part of the therapeutic task becomes one of raising the level of object relations to approach representation (Blanck and Blanck, 1964, p. 35).

> That the image of the object is retained regardless of the state of need means not only that the individual has cathected the object with neutralized libido, but also that he has reached a stage of development which makes him less dependent upon his environment. Self and object representations, and the drives, are no longer vulnerable to splitting. Identity is maintained by continuous cathexis not only of object but of self representations. On this solid foundation Spitz, Mahler, and Jacobson build their elaboration of psychoanalytic developmental psychology.

The developmental stages of object relations can be examined from a number of vantage points, including the degree of development of psychic structures, and the distribution and mode of libidinal and aggressive cathexis. The specific phases will be presented below.

Narcissistic: Autism and Symbiosis

During the narcissistic period (first three months of life, roughly) the infant is assumed to be dominated by needs; objects are perceived only in relation to the satisfaction of those needs (Hartmann, 1952). The breast is the first object (or part-object) and the relationship an anaclitic one; as Anna Freud put it: "What is cathected with libidinal interest at that stage is the moment of blissful satisfaction, not the object which enables satisfaction to be attained" (1954, p. 58). The mother, therefore, "merely plays the role of a signal announcing the drive gratification through kinesthetic and cutaneous cues" (Decarie, 1965, p. 93).

M. Balint (1937) held that the first stage after birth is not objectless but rather involves a primary love relation between infant and mother. According to Bellack (1972) the earliest phase of the extra-uterine mental life is not narcissistic; it is directed toward objects, but this early object-relation is a passive one. Its aim is briefly this: "I shall be loved and satisfied, without being under any obligation to give anything in return" (p. 82).

Perhaps more than any of the other theorists, Mahler's contributions lend themselves to transposition into technical therapeutic procedures (Blanck and Blanck, 1974). Mahler's conclusions are based upon observation of children and their mothers in interaction in a

specifically designed nursery school setting. As with Spitz' (1965) work, some of her observational material had always been available, but through her creativity she linked observation with psychoanalytic theory and innovated elaborations of that theory (Mahler, 1968). Out of her early work she proposed that there are three phases of development, leading at approximately the fourth year of life, to the establishment of identity. These include the autistic, the symbiotic, and separation-individuation phases (Mahler, 1968). Her later observational studies rounded out and refined her scheme; she divided the separation-individuation phase into four subphases: differentiation, practicing, rapprochement, and separation-individuation proper (Mahler, 1975). These phases will be outlined below.

Mahler (1975) includes normal autism and then symbiosis in the period which Freud and others designated as primary narcissism. During normal autism (about the first month of life), the infant's attempts to achieve homeostasis are its main waking preoccupation. The infant's first weeks of life are spent in a "state of primitive hallucinatory disorientation, in which need satisfaction belongs to his (the neonate's) own omnipotent, autistic orbit" (Mahler, 1968, pp. 7-8). In that state, the goal is homeostasis. At first, the infant is objectless. Shortly thereafter, the infant is able to distinguish his own tension-reducing operations from his mother's. Slowly he begins to separate those experiences that feel pleasurable from those that feel painful. Following this phase, at approximately the second month of life, the infant becomes dimly aware of a need-satisfying object; the symbiotic phase is about to begin. Beginning around the second month, the phase of symbiosis is reached, during which the infant presumably

gains an awareness of the need-satisfying mother and behaves and functions as though he and his mother were an "omnipotent system--a dual unity with one common boundary."

> The essential feature of symbiosis is hallucinatory or delusional, somato-psychic-omnipotent function with the representation of the mother and, in particular, the delusion of a common boundary of the two actually and physically separate individuals (Mahler, 1968, p. 9).

This period in the development of object relations includes the emergence of the smiling response (Spitz, 1965), the ability to wait (Anna Freud, 1954), and the voluntary use of one part of the body to decrease tension in another part, as in thumb-sucking (Hoffer, 1955). What had been an experience of need satisfaction becomes more personalized as the mother is seen more and more as the source of the satisfaction. The other person is still a preobject, however, and only a precursor of the "true libidinal object" (Mahler, 1975).

In brief, symbiosis can be defined at an extreme as an interdependent relationship in which the combined energies of both individuals involved are necessary for the existence of each; separate from each other, each individual appears to "perish" (Masterson, 1972). The importance of the symbiotic phase for normal development of ego functions and ego structure cannot be overemphasized. Beginning at around three or four months of life the child's image of himself and of his mother are said to be of one symbiotic unit. Spitz (1965) suggests that it is the mother who mediates every perception, and every action. The mother interacts with the infant in a stimulating mutual experience that propels the infant into new experiences and responses. The quality of the mothering, therefore, is crucial for the infant's ego development. For example, the mother's ability to pick up clues and signals from her

child pave the way for future growth. According to Mahler the mother's role is of extreme importance in that she serves as the child's buffer against both inner and outer stimuli since the infant cannot do this for himself. The mother gradually orients the infant to the inner versus the outer world, to boundary formation and sensory perception. Therefore, in the symbiotic stage the mother performs many of the ego functions the child will later learn to perform himself.

Separation-Individuation

The concept of separation-individuation as a normal phase of the mother-child relationship is relatively recent and has emerged as an outgrowth of ego psychology and increased interest in mothering patterns. Although many theorists have contributed to its evolvement, some important contributors include Benedek (1959), Jacobson (1964), Spitz (1965), and Mahler (1975) who studied by direct observation the separation-individuation process of normal children. The subphases of separation-individuation are differentiation, practicing, rapprochement, and separation-individuation proper in the sense of formation of discrete identity, separateness, and individuality (Mahler, 1975). It is important to note that Mahler's use of the word "separation" refers to the child's psychological awareness of his separateness; it is, therefore, an intrapsychic phenomenon.

Differentiation Subphase

According to Mahler, the symbiotic phase reaches its height at around four or five months, with the infant directing more attention to the outside world, checking back, however, to the mother's face; a kind

of "hatching process" begins. Central to Mahler's conclusions from her observations of infants is that optimal symbiotic gratification is essential to development. There can be, for example, extreme "communicative mismatching" between mother and infant so that psychosis ensues. The more optimal the symbiosis has been, however, the more ready the youngster will be for differentiation, that is, differentiating himself (his self-representations) out from the symbiotic unity. If the mother, because of absence or other reasons, no longer satisfies the child's needs or if too many frustration are associated with her, libidinal cathexis is withdrawn from her and the child finds another love object, which may be himself, his ego, or part of his body. These situations can be traumatic to the child.

According to Mahler, this differentiation subphase occurs at the height of the "hatching process" when an increase in active locomotion spurs the child into greater and more frequent physical separations from the mother. This occurs at the beginning of about the ninth month.

Practicing Period

About the end of the first year (10 months to 16 months, roughly) the average toddler seems to become so preoccupied with practicing his newly-developed skills that he does not seem to mind his mother's short departures from the familiar playroom. This period, called by Mahler (1975) the "practicing period," is reflected by the toddler distancing himself from the mother. He does not demand his mother's attention and bodily closeness during this practicing period. Once in a while the child does toddle up to his mother for what Mahler calls "libidinal

refueling." For the most part, however, his behavior indicates that he takes his mother's emotional presence for granted.

Mahler further states that as soon as the child masters free locomotion, the toddler only returns to the mother to seek proximal communication with her. This behavior is indicative of the fact that the child and his mother are now well on their way to differentiation. As the toddler masters the ability to move from and to the mother, the balance dramatically shifts within the mother-toddler interaction from activity on the part of the mother to activity on the part of the child. Mahler concludes that the mother serves as the catalyst of the individuation process. She emphasizes the resiliency with which the child's autonomy unfolds from within his own ego if he has experienced the mother's emotional acceptance, including what Mahler calls "communicative matching" on the mother's part.

Rapprochement Subphase

The second 18 months of life is a period of great vulnerability according to Mahler. With increasing awareness of physical separateness, pleasure in autonomous functioning, capacity for semantic communication, representational thought which leads to object constancy, "the relative obliviousness to his mother's presence, which prevailed during the practicing period, wanes" (Mahler, 1975, p. 24). It is replaced by active approach behavior, the rapprochement subphase. The pitfalls of this subphase are great because so many otherwise adequate mothers fail to respond to it; for example, a mother might regard the child's behavior during this subphase as regressive and as an imposition

just when she is beginning to enjoy the child's independence from her (Blanck and Blanck, 1974).

Separation-Individuation Proper Subphase

This phase begins around 24 months and parallels the development of the child's capacity to walk; the child, therefore, can physically separate himself from his mother (Mahler, 1975). Mahler also suggests that the two-year-old child soon experiences his separateness from his mother in different ways; for example, he enjoys his independence in exercising mastery with great tenacity. Accompanying these events the infant's sense of individual entity and identity develops; that is, his image of the self as an object is also mediated by bodily sensation and perception. It is, therefore, during this phase that the child may experience an intrapsychic separation and begins to perceive his own ego as being separate from the mother's.

Some of the important accomplishments of the separation-individuation phase as outlined by Rinsey (1955) are as follows: the child develops the capacity to relate to objects as wholes with a decrease in object splitting. Aggression becomes separated from positive or affectionate feelings, and energy is made available to the child's ego for further growth and development. The child's self and object representations progressively become more differentiated as his perceptual apparatus matures. These perceptions of the self and the object then become associated with positive and/or negative feelings. For example, the child's sense of feeling worthwhile develops in part from his introjections during this phase of the mother's positive attitude toward him. In brief, the infant's unfolding individuality, the

mother's encouragement and support; that is, continuation of supplies, and the mastery of new ego functions press the child on his developmental pathway through the stages of separation-individuation toward autonomy.

APPENDIX B

SUBJECT CHARACTERISTICS

The 32 children (four groups) that participated in the study were within the age range of 6.5 years and 10.5 years at the time of the evaluation. There were no recent losses; all children were evaluated from 1 year 5 months to 4 years subsequent to their parent's death. Each group consisted of five males and three females. In each of the two Parent-Loss groups, five children (four boys and one girl) had experienced the death of their mother and three children (one boy and two girls) had experienced the death of their father. All children were at least 3 years of age at the time of the loss.

Each group consisted of seven Caucasions and one Black child ranging from Average to High Average Intellectual functioning.

In the Parent-Loss Psychiatric group, six out of the eight children could recall only positive memories regarding their deceased parent; one child had one "thing he did not like" about his deceased parent and one child had no recollections (positive or negative). This is in contrast to the Parent-Loss Well-Adjusted group where all children could give both positive and negative characteristics of their deceased parent. Some children, however, could only give one or two characteristics even when specifically asked for "three things they didn't like about their parent and three things they liked about their parent." Interestingly, all the children from the Non-Loss group (Psychiatric and Normals) apparently had no difficulty in giving the examiner an excess number of positive and negative characteristics of their parent.

APPENDIX C

ANALYSIS OF VARIANCE SUMMARY TABLES

TABLE X

ANALYSIS OF VARIANCE SUMMARY TABLE FOR EMOTIONAL TONE OF TAT STORIES BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	666.125	35.076	.001
Non-Loss	1	128.000	6.740	.014
Two-Way Interactions				
Loss x Non-Loss	1	10.125	.533	.999
Residual	28	18.991		
Total	31	43.097		

TABLE XI

ANALYSIS OF VARIANCE SUMMARY TABLE FOR OUTCOME OF TAT STORIES BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	442.531	6.721	.014
Non-Loss	1	3423.781	51.999	.001
Two-Way Interactions				
Loss x Non-Loss	1	270.281	4.105	.050
Residual	28	65.844		
Total	31	192.910		

TABLE XII

ANALYSIS OF VARIANCE SUMMARY TABLE FOR SENSE OF REALITY SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	6.570	3.557	.067
Non-Loss	1	106.945	57.899	.001
Two-Way Interactions				
Loss x Non-Loss	1	10.695	5.790	.022
Residual	28	1.847		
Total	31	5.675		

TABLE XIII

ANALYSIS OF VARIANCE SUMMARY TABLE FOR OBJECT RELATIONS SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	4.500	2.688	.100
Non-Loss	1	153.125	91.467	.001
Two-Way Interactions				
Loss x Non-Loss	1	.500	.299	.999
Residual	28	1.674		
Total	31	6.613		

TABLE XIV

ANALYSIS OF VARIANCE SUMMARY TABLE FOR REGULATION AND CONTROL SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	5.695	3.427	.071
Non-Loss	1	122.070	73.455	.001
Two-Way Interaction				
Loss x Non-Loss	1	.383	.230	.999
Residual	28	1.662		
Total	31	5.635		

TABLE XV

ANALYSIS OF VARIANCE SUMMARY TABLE FOR DEFENSIVE FUNCTIONING SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	18.000	10.781	.003
Non-Loss	1	153.125	91.711	.001
Two-Way Interaction				
Loss x Non-Loss	1	2.000	1.198	.283
Residual	28	1.670		
Total	31	7.093		

TABLE XVI

ANALYSIS OF VARIANCE SUMMARY TABLE FOR NONDEFINITIVE DEATH SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	136.125	24.831	.001
Non-Loss	1	325.125	59.306	.001
Two-Way Interactions				
Loss x Non-Loss	1	253.125	46.173	.001
Residual	28	5.482		
Total	31	27.996		

TABLE XVII

ANALYSIS OF VARIANCE SUMMARY TABLE FOR BIOLOGICAL DEATH SCALE BY GROUPS (LOSS VS. NON-LOSS)

Source	df	MS	F	Significance of F
Main Effects				
Loss	1	136.125	24.831	.001
Non-Loss	1	325.125	59.306	.001
Two-Way Interactions				
Loss x Non-Loss	1	253.125	46.173	.001
Residual	28	5.482		
Total	31	27.996		

APPENDIX D

SUBJECT CONSENT FORM

Subject Consent Form for Participation in Clinical Investigation Project

Project Description

When a child's parent dies, the surviving family faces a complex, difficult, and painful experience. At times, it may seem that no form of assistance seems adequate to the task. We are interested in observing children who have experienced a parental loss. In the long run we hope to utilize this knowledge to better assist parents and children who are faced with such a significant loss.

If you and your child agree to participate in this study, you will be asked to give us some background developmental history on your child. You will also be interviewed by a mental health professional on the issues surrounding the child's parent death. In addition, you will be asked to fill out another questionnaire that gives us your impression of your child's current behavior. Your total involvement in this study will probably require one hour of your time.

If your child participates in the study, his/her current emotional and intellectual functioning will be assessed using a variety of psychological tests. Total testing time for your child will require approximately three hours in three testing sessions.

It is important that you realize that if you decide to participate in this study, you will be helping us better understand the issues involved in death and mourning, and in the process you will be helping future children and their families who experience a parent's death. In addition, we will have a better understanding of your own child's current functioning.

If your child has been referred for psychiatric evaluation at either the Child Psychiatry Clinic or the Adolescent Clinic at the Medical Center, participation in this study will be considered part of the child's overall evaluation prior to treatment. We would like to share the information from your child's test results with the child's primary therapist, so that in turn he can have a more comprehensive view of your child. This will help him decide how best to help your child. We will in turn discuss the results of this evaluation with you. If your child is participating in this study only as a child control, the results of this evaluation will be discussed with you upon request.

The information we obtain will be kept in strict confidence. The data collected will be released only to qualified professionals for scientific or training purposes.

AUTHORIZATION: I have read the above and understand the discomforts, inconveniences, and risks of this study. I agree to the participation of <u>The Influence of Parent Loss in Childhood</u>. I understand that if I refuse to participate or withdraw at any time, my child's treatment will not be affected in any way.

Signed: ______________________

Relationship to Child: ______________________

Witness: ______________________

APPENDIX E

DESCRIPTION OF INSTRUMENTS

Children's View of Death Concepts Scale*

The Children's View of Death Concepts Scale is a 20-item scale constructed by the current investigator to help assess a child's attitudes regarding death. This investigation is based on the research by M. Nagy (1948, Journal of Genetic Psychology, 73:3-27) who observed the child's attitudes regarding death from a developmental model. Specifically, Nagy investigated the ideas of children, aged 3 to 10 years, concerning their meaning of death. Based on the children's responses to written compositions, drawings, and discussions around death, she delineated three major developmental stages. The first stage, which includes children between the ages of 3 and 5 years, characterizes the denial of death as a regular and final process. That is, for a child in this age period, there exists no definitive death. For example, death is envisioned as a departure, a sleep; death may be seen as going on a journey. Death for this age group is temporary. The second stage, which characterizes children between the ages of 5 and 9, indicates that death is personified, i.e., it may be considered as "a death ghost who carries children off." Finally, in the third stage of development, death is viewed by the child as a biological process. Death is recognized as a process which occurs to all mankind. It includes the cessation of bodily activities.

The current investigator constructed the Children's View of Death Concepts Scale based on some of the actual responses given by children in Nagy's research. The responses are single sentence abbreviations of the specific concepts delineated according to Nagy's developmental outline. They include the concepts of "No Definitive Death" and the "Biological Conceptualization of Death"; only four responses utilized in this scale are considered concepts related to the personification of death.

The current investigator is interested in studying the concepts of children who vary in their experience with parental death. Specifically, the following question is proposed: does experience with parental death affect conceptualization of death? A child's view regarding two major concepts will be investigated. The "No Definitive Death Concept," characteristic of a younger stage of development, and the "Biological Death Concept Scale," characteristic of more advanced stages of development, where death is viewed as a final, biological process, will be utilized. These two sub-scales are composed of 16 items each, where the child answers "yes" or "no," according to his or her view of death and dying. Since only four items (items 9, 10, 11, and 12) are considered concepts dealing specifically with the personification of death, they will be excluded from the final analysis. Also, one would expect that the children participating in the current study (ages 6½ to 10) would typically personify death, since this is characteristic of this age group.

---

*Scale constructed by Lupe-Rebeka Samaniego, Ph.D. candidate, based on research by M. Nagy, 1948.

Answer Sheet

No Definitive Death Scale	Personification Scale	Biological Death Scale
T - 1	T - 9	F - 1
T - 2	T - 10	F - 2
T - 3	T - 11	F - 3
T - 4	T - 12	F - 4
T - 5		F - 5
T - 6		F - 6
T - 7		F - 7
T - 8		F - 8
F - 13		T - 13
F - 14		T - 14
F - 15		T - 15
F - 16		T - 16
T - 17		F - 17
T - 18		F - 18
T - 19		F - 19
T - 20		F - 20

Lupe-Rebeka Samaniego
Research Project Investigator

Children's View of Death Concepts Scale

Instructions to Child

I am going to read some sentences to you. The sentences are about your ideas about death and dying. I want you to listen to me carefully and tell me whether you agree with what I say or not. If you think the sentence is true, you say "Yes." If you don't agree or don't believe what I read to you, you say "No." For example, if I say, "All cars are blue," what would you say?

Stage One: No Definitive Death

____ 1. Sometimes dead animals close their eyes because sand can get into them.

____ 2. Sometimes dead people can move themselves in the coffin.

____ 3. When a person dies, it is (means) the same as if they were asleep.

____ 4. Dead people know it when somebody goes out to visit them at the grave.

____ 5. At funerals you're not allowed to sing because otherwise the dead person could not sleep peacefully.

____ 6. Dead people can feel it when you put flowers on their grave.

____ 7. When people die, they still know what is happening on earth.

____ 8. When people die, they can feel it if someone thinks of them.

Stage Two: Personification of Death

____ 9. Death is like a skeleton-type man who can carry people off.

____ 10. Death is a man who lives in heaven.

____ 11. When someone dies, the death angels carry him away.

____ 12. Death is an invisible man, a ghost.

Stage Three: Biological Death

____ 13. Death is the end of life on earth.

____ 14. If someone dies and they bury him, he turns to dust in the earth.

____ 15. Everyone has to die once.

____ 16. When people die, they cannot hear or feel anything.

____ 17. Some people never die; they can live forever.

____ 18. When people die, they can come alive again if they want to.

____ 19. When people die, they sometimes get hungry.

____ 20. Sometimes people are killed with a knife, but if you take the knife out they can live again.

Child's Mourning Questionnaire*

The Child's Mourning Questionnaire was devised by the current investigator to help assess a child's conceptualization of death as well as to include a child's memories regarding his parent. Since the questions asked are open-ended and descriptive in nature, they were included in the descriptive analysis of the study. A child's conceptualization of death, behaviors related to mourning, and memories of his deceased parent were included.

In order to minimize discomforts and not overload a child with questions regarding death and loss at any one interview, the questions were combined and interspersed with the neutral, objective questions of the WISC-R. For example, the question "What does the word death mean?" was asked subsequent to the last item missed on the WISC-R Vocabulary Subtest. Question 2, "What is the thing to do when something (for example, a pet) you love dearly dies?" was asked subsequent to the last item missed on the WISC-R Comprehension Subtest. Question 3, "What happens when someone dies?" was asked subsequent to the last item missed in the General Information WISC-R Subtest. The questions regarding the child's description of his parents and his three wishes were asked at the end of the WISC-R administration.

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*Questionnaire constructed by Lupe-Rebeka Samaniego.

Lupe-Rebeka Samaniego
Research Investigator

Child's Mourning Questionnaire

Name: ______________________ Age: __________
Group: ______________________ Date: __________

Part I. Child's Conceptualization of Death

1. Define "death"--what does the word death mean? (WISC-R Vocabulary subtest).

____
____
____
____
____

2. What is the thing to do when something (for example, a pet) you love dearly dies? (WISC-R Comprehension subtest).

____
____
____
____
____
____

(After child responds to question, inquire about previous experience with death, including child's age at time of loss. Include child's reactions to loss, affect(s) experienced, availability of other adults or discussion of death with peers, teachers, or significant others. Also inquire about child's fears (if any). Record verbatim child's responses. Information will later be sorted as to the above issues.)

____
____
____
____
____
____

3. What happens when someone dies? (WISC-R General Information subtest.)

Part II. Child's Memories of Parent

1. Tell me three things you like about your father (mother). (Begin with child's description of surviving parent.)
   a.
   b.
   c.

2. Tell me three things you dislike about your father (mother). (Begin with child's description of surviving parent.)
   a.
   b.
   c.

3. Tell me three things you like about your step-parent.
   a.
   b.
   c.

4. Tell me three things you dislike about your step-parent.
   a.
   b.
   c.

5. Tell me three things you liked about your deceased parent.
   a.
   b.
   c.

6. Tell me three things you disliked about your deceased parent.

   a.
   b.
   c.

(FOR ALL OF THE ABOVE QUESTIONS, RECORD VERBATIM CHILD'S RESPONSES--INCLUDING SUCH RESPONSES AS "I can't," "I don't know," and "I can't remember.")

Part III. Child's Wishes

1. If you could have three wishes, any three wishes at all, what would you wish for?

   a.

   b.

   c.

After child has responded, inquire about each wish; what each wish means to child. Try to ascertain if wishes are realistic (can child distinguish between fantasy and reality). For example, ask, "Do you think that is possible, that you will be able to get x?" Record responses verbatim.

____

____

____

____

____

Parent-Loss Questionnaire (PLQ) and Mourning Behavior Checklist (MBC)*

The Parent-Loss Questionnaire is an unpublished 42-item instrument devised by the current investigator to provide information specifically related to the circumstances surrounding the child's parent's death, and the issues involved in mourning. The format of the questionnaire includes open-ended responses, multiple choice questions, and descriptive responses. The information obtained from the questionnaire served as descriptive data in the summary characterization of the two Parent-Loss groups.

While the child's parent or guardian could respond to the questionnaire independent of an interviewer, it is strongly recommended that the information be obtained through a personal interview with the surviving parent or guardian. This will help minimize discomforts which may be experienced by the surviving parent or guardian when responding to issues of death and loss.

The Mourning Behavior Checklist (MBC) was also devised by the current investigator to help delineate those specific behaviors in which the Parent-Loss child might have engaged subsequent to the parent's death. The MBC was administered to the parent following the interview. It was designed to aid in further differentiation of the two Parent-Loss groups.

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*Constructed by Lupe-Rebeka Samaniego, Ph.D. candidate, Clinical Psychology.

Parent-Loss Questionnaire

Name of Child: ____________ Today's Date: ________
Birthdate: ____________
Sex of Child: ____________
School: ____________
Address: ____________
Grade: ____________
Teacher's Name: ____________

1. Name of person responding to this questionnaire: ____________

2. Relationship to child: ____________

3. Is surviving parent also a parent loss:
   a. Not a parent loss
   b. Father parent loss only
   c. Mother parent loss only
   d. Mother and father parent loss

4. Age of surviving parent when:
   a. Father died ____
   b. Mother died ____
   c. Not appropriate ____

5. Mark appropriate letter:
   a. Child's mother deceased--child currently living with father; father has not remarried
   b. Child's father deceased--child currently living with mother; mother has not remarried
   c. Child's mother deceased--child's father has remarried or currently living with someone; child living with father
   d. Child's father deceased--child's mother has remarried or currently living with someone; child living with mother
   e. Child's mother deceased--child currently living with other relative (specify relationship to child) ____________
   f. Child's father deceased--child currently living with other relative (specify relationship to child) ____________

6. Significant adults currently living at child's household:

Name	Relationship to Child

7. Birth order of child: Number _____ of _____ children.

8. Religious Preference:
   a. Jewish
   b. Catholic
   c. Protestant
   d. None
   e. Other (specify) ____________

9. Date of child's parent death ______________________

10. Child's age at time of death _____

11. Briefly explain below circumstances surrounding child's parent death:

____

____

____

____

____

12. Parent's death was:
    a. An accident
    b. A suicide
    c. A homicide
    d. A sudden illness
    e. A prolonged illness
    f. Other

13. If an illness, was child informed about the possibility that his parent might die?
    a. Yes
    b. No
    c. Not appropriate

14. Who informed child of his parent's death:
    a. Surviving parent
    b. Relative (specify) ________________
    c. Sibling
    d. Friend
    e. Other (specify) ___________________

15. What was child told? Please be specific.

16. When informed of his parent's death, what were some of the child's main questions? Please check box if child asked no questions. ☐

    Examples: Question asked:

    Response given:

    Question asked:

    Response given:

17. Was a funeral held?
    a. Yes, and child attended
    b. Yes, but child did not attend. Reason for non-attendance:
    ____
    ____
    c. No, a funeral was not held. Reason: ____________________
    ____
    ____

18. As briefly and as specifically as possible, describe below how surviving parent (or guardian) and child mourned parent's death, including subsequent visits to graveside, activities that child might have been restricted from, etc.

19. When grieving parent's death,
    a. Surviving parent (or guardian) cried in front of child occasionally but did not verbalize how he/she was feeling.
    b. Surviving parent (or guardian) cried in front of child occasionally and verbally expressed how he/she was feeling.
    c. Surviving parent (or guardian) seldom cried in front of child. Reason: ____
    ____
    ____

20. Subsequent to parent's death, did child ever talk about or mention his deceased parent?
    a. Very frequently
    b. Only occasionally
    c. Seldom
    d. Never

21. Please check one of the following:
    a. Child's deceased parent is currently mentioned by child but not by surviving parent (or guardian).
    b. Child's deceased parent is currently occasionally mentioned by surviving parent (or guardian) but not by child.
    c. Child's deceased parent is currently frequently mentioned by both child and surviving parent (or guardian).
    d. Both surviving parent (or guardian) and child rarely talk about deceased parent.

22. Describe below how <u>child related to deceased parent</u> prior to death.
    a. Developmentally appropriate
    b. Distant
    c. Oppositional
    d. Overly dependent
    e. Rebellious
    f. Overly independent
    g. Hostile
    h. Ambivalent
    i. Rivalrous
    j. Compliant
    k. Other ______________
    l. Unknown

23. Describe how <u>deceased parent related to child</u> prior to death.
    a. Developmentally appropriate
    b. Supportive/empathic
    c. Rejecting
    d. Distant
    e. Appropriately close
    f. Inappropriately close
    g. Physically abusive
    h. Scape oating
    i. Inconsistent/ambivalent
    j. Angry/aggressive
    k. Other ______________
    l. Unknown

24. Has surviving parent remarried or currently living with someone?
    a. Yes--length of time that elapsed between child's parent death and remarriage __________
    b. Has not remarried or is not living with someone.

25. What was child's reaction to new spouse?
    a. Full acceptance of new spouse
    b. Initial acceptance, later non-acceptance
    c. Initial non-acceptance, later acceptance
    d. Non-acceptance of spouse
    e. Question is not appropriate--parent has not remarried

26. Describe how <u>child relates to step-parent</u>:
    a. Developmentally appropriate
    b. Distant
    c. Oppositional
    d. Overly dependent
    e. Rebellious
    f. Overly independent
    g. Hostile
    h. Ambivalent
    i. Rivalrous
    j. Compliant
    k. Other ______________
    l. Unknown

27. Describe how <u>step-parent relates to child</u>:
    a. Developmentally appropriate
    b. Supportive/empathic
    c. Rejecting
    d. Distant
    e. Appropriately close
    f. Inappropriately close
    g. Physically abusive
    h. Scapegoating
    i. Inconsistent/ambivalent
    j. Angry/aggressive
    k. Other ______________
    l. Unknown

28. Describe how child relates to surviving parent (or guardian):
    a. Developmentally appropriate
    b. Distant
    c. Oppositional
    d. Overly dependent
    e. Rebellious
    f. Overly independent
    g. Hostile
    h. Ambivalent
    i. Rivalrous
    j. Compliant
    k. Other ______________
    l. Unknown

29. Describe how <u>surviving parent (or guardian) relates to child</u>:
    a. Developmentally appropriate
    b. Supportive/empathic
    c. Rejecting
    d. Distant
    e. Appropriately close
    f. Inappropriately close
    g. Physically abusive
    h. Scapegoating
    i. Inconsistent/ambivalent
    j. Angry/aggressive
    k. Other ______________
    l. Unknown

30. Describe <u>child's current relationships with siblings</u>:
    a. Rivalrous
    b. Hostile/physically abusive
    c. Dependent
    d. Distant
    e. Scapegoating
    f. Minimal interaction
    g. Supportive
    h. Rejecting
    i. Developmentally appropriate
    j. Other ______________
    k. Unknown

31. Describe child's current relationships with his peers:
    a. Predominantly older friends
    b. Predominantly younger friends
    c. Developmentally appropriate
    d. Predominantly same sex friends
    e. Predominantly opposite sex friends
    f. Many friends
    g. Isolated
    h. Feels relationships are a problem
    i. Overly aggressive
    j. Overly passive
    k. Other ________________
    l. Unknown

32. Prior to child's parent death, had child experienced the death of any other significant member of the family?
    a. Yes Relationship to child ________________
    b. No previous experience with death

33. Prior to parent's death, had child experienced the loss of a significant object, for example, death of a pet?
    a. Yes; what was the object: ________________
    b. No
    c. Unknown

34. Subsequent to parent's death, has child experienced the loss of any other significant member of the family?
    a. Yes. Relationship to child ________________
       Child's reactions to death: ________________________________
       ____
    b. No

35. Subsequent to parent's death, has child experienced the loss of a significant object?
    a. Yes; what was the object: ________________
       Child's reactions: ____
       ____
    b. No
    c. Unknown

36. Following parent's death, did child remain at the same household?
    a. Yes
    b. No. If not, what length of time elapsed before move? _______

37. Subsequent to parent's death, did child manifest any symptoms or behaviors or fears that he had not expressed before?
    a. Yes
    b. No

    If yes, list fears or behaviors. Be specific.

38. Subsequent to parent's death, did family receive any ongoing counselling or psychiatric treatment?
    a. Yes
    b. No

39. Counselling received was through a:
    a. Clergyman
    b. Mental health professional
    c. Other ______________
    d. Received no counselling

40. Has surviving parent and/or guardian previously been under psychiatric treatment?
    a. Yes. Date _________ Presenting problems(s): ______________

    ____

    ____

    b. Has received no previous treatment

41. Describe below surviving parent's and/or guardian's greatest worry regarding child subsequent to parent's death:

42. In retrospect, would surviving parent and/or guardian have handled anything differently regarding child subsequent to parent's death. Explain below:

Mourning Behavior Checklist

Directions

I am going to read a list of behaviors that you may have observed in your child subsequent to his parent's death. As I read the item, please indicate to me if you noticed the behavior in your child.

Part I. Initial Reactions

a. Frequently longed for deceased parent; would say things like "I miss daddy/mommy" or "I want daddy/mommy back."

b. Would talk about deceased as if deceased were not dead; for example, would make comments like "daddy/mommy and I will do _____ tomorrow."

c. Preoccupied with fears of death; for example, afraid significant others may die, he may die, or become frightened when others would talk about death and/or dying.

d. Remembered deceased parent and talked about deceased parent at death anniversary date or significant holidays (for example, Mother's Day, Father's Day, Christmas).

e. Infrequent expression of any emotion related to deceased (manifested little or no sadness, crying, or happiness when talking about deceased or when deceased was mentioned by someone else).

f. Frequent weeping and/or increasing tendency to sighing.

g. Frequent whining and/or complaining.

Part II. Hostility

a. Had a period when he had problems at school (example, getting along with teacher or peers).

b. Became increasingly more disobedient than usual.

c. Constantly fighting with siblings and/or playmates.

d. Had temper tantrums (would yell, scream, cry over the least thing).

e. Bossy with friends and/or siblings.

f. Would defy surviving parent and/or guardian or step-parent.

g. Physically abusive toward others (children and/or adults).

Part III. Appeals for Help

a. Began wetting bed at night.

b. Sleep disturbances (nightmares and restless sleep, awakening, etc.).

c. Developed nervous habits such as biting or picking fingernails, excessive blinking, rubbing eyes, pulling hair.

d. Restless (became very active, could not sit still).

e. Overtalkative, chattered constantly.

f. Afraid of being left alone.

g. Withdrawn, aloof, unresponsive.

h. Frequently complained of at least one of the following: stomach aches, rapid heart beat, dizziness, inability to swallow, headaches.

i. Seemed tired, tended to lie around showing little interest in doing things.

j. Had separation difficulties (for example, would cry or have a tantrum when surviving parent left).

Thematic Apperception Test (TAT)

The Thematic Apperception Test (Murray 1943), familiarly known as the TAT, is a method of revealing to the trained interpreter some of the dominant drives, emotions, sentiments, complexes and conflicts of a personality. Special value resides in its power to expose the underlying inhibited tendencies which the subject, or patient, is not willing to admit or may not be able to admit because he is unconscious of them.

The procedure is merely that of presenting a series of pictures to a subject and encouraging him or her to tell stories about them, invented on the spur of the moment. The fact that stories collected in this way often reveal significant components of personality is dependent on the prevalence of two psychological tendencies: the tendency of people to interpret an ambiguous human situation in conformity with their past experiences and present wants, and the tendency of those who write stories to do likewise, i.e., draw on the fund of their experiences and express their sentiments and needs, whether conscious or unconscious.

For this investigation, 11 selected TAT cards were administered to children between the ages of 6½ and 10. They were presented to the child in the following order: Card 1, 5, 15, 3BM, 14, 10, 11, 6GF, 7BM, 7GF, 12M.

A psychometric approach to the TAT responses was utilized. The use of empirically derived rating scales which cover a wide range of responses and which have demonstrated consistently high reliability uninflated by the use of the contingency coefficients will be utilized; in this way statistical treatment could be applied. Scales of Emotional Tone and Outcome of TAT stories were rated for each story. In this way it was possible to isolate those elements of a TAT protocol which were either deviant or peculiarly characteristic of a group of subjects. These items then furnished the basis for inferences made of the four groups of Ss studied; this in turn allowed the investigator to assess the personality organization and conflict areas typical for each group of Ss.

All of the stories of the 32 protocols were independently rated by two judges. Each story of every protocol was judged as to where it ranked for Emotional Tone and Outcome.

The Scale for Emotional Tone and the Scale for Outcome are presented below. A general scale for emotional tone is included, utilized when a given story could not be suitably matched to the scale for the specific card. The Emotional Tone Scales for each TAT card used are presented below together with the General Rating Scale for Emotional Tone of TAT stories and the Scale for the Outcome of the stories.

Scales for Emotional Tone and Outcome of TAT Stories*

Because of the great similarity among the outcome scales for the various cards, only one general scale of outcome will be utilized, whereas specific scales will be used for the emotional tone of each card. A general scale for emotional tone is included, to be utilized when a given story cannot be suitably matched to the scale for the specific card. The emotional tone scales for each individual TAT picture to be used in the study are presented below together with the general rating scale for emotional tone of TAT stories and the scale for the outcome of the stories.

General Rating Scale for Emotional Tone

0 Subject cannot make up a story

1 Complete failure, submission to fate, death, murder, suicide, illicit sex with violence, revenge, aggressive hostility, severe guilt, complete hopelessness

2 Conflict with attempt at adjustment, rebellion, fear, worry, departure, regret, illness, physical exhaustion, resignation toward death, loneliness

3 Description, lack of affect, balance of positive and negative feelings, routine activities, impersonal reflection

4 Aspiration, desire for success and doubt about outcome, compensation for limited endowment, description with cheerful feeling, reunion with friends, contentment with world, feeling of security

5 Justifiably high aspiration, complete satisfaction and happiness, reunion with loved ones

General Rating Scale for Outcome

0 Subject cannot give an outcome even when explicitly asked for, conditional (if) outcomes, alternative outcomes of different emotional value or no outcome, descriptive story

1 Complete failure, submission to fate, death, murder, suicide, extreme punishment, extreme remorse

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*Taken from An Experimental Approach to Projective Techniques, by Zubin, Eron, and Schumer, 1965.

2 Some frustration, incomplete success in attaining goal, goal attained at expense of happiness, disappointment to friends and family, acceptance of unsatisfactory situation or submission to authority

3 Continuation of ordinary situation, balance of happy and unhappy situations

4 Moderate success, reunion with friends, recovery from temporary disability or depression, happiness in success of others, tolerable resolution of conflict

5 Great success, discovery and/or happiness, extreme contentment, marital bliss, unusual good fortune, reunion with loved ones

Rating Scales for Emotional Tone of Stories in Response to Specific Cards

Card 1

I. 0 Complete frustration and hopelessness with no resistance

1 Dejected, inadequacy with attempt to adjust, parental pressure

2 Frustration with no depression, aspirations balanced by conflict, lack of feeling tone

3 High aspirations with cooperation but some hindrance

4 High aspirations with approbation and no conflict

Card 5

II. 0 Overdominant parent or mate, extreme parental or partner

1 Parental or partner pressure without aggression, loneliness, slight frustration

Card 15

III. 0 Death of close relative, loneliness for deceased, mourning, hopelessness, hero rejected by society, suicide

1 Impersonal speculation on death, return of dead to cemetery, visiting grave of friend

2 Description of painting or picture, no affect

Card 3BM

IV. 0 Uncontrolled emotionality, murder, mentally ill, complete frustration, death of loved one, suicide

1 Self-pity, aggressive parental pressure, transitory depression, adolescent confusion over reality principles, physical incapacity

Card 14

V. 0 Complete failure, submission to fate, death, murder, suicide, illicit sex with violence, revenge, aggressive hostility, severe guilt, complete hopelessness

1 Resignation to death of relative, reflection on worldly conflicts with or without appeal to religion, loneliness

2 Daydreaming without emotional involvement, any other theme with no emotional involvement, adolescent reverie

3 Contentment with environment, appreciation of world around

4 Happy well-adjusted hero, vacation, planning for future, happiness

Card 10

VI. 0 Death, extreme sorrow, tragedy

1 Departure, leaving loved ones, personal failure, being comforted for minor misfortune

2 Lack of affect, balance of conflict

3 Reunion, happiness, acceptance, feelings of pleasure

4 Marital bliss, extreme contentment, satisfaction, good adjustment

Card 11

VII. 0 Life is futile or horrible, complete absence of hope, no ambivalence of fate, death, destruction, war

1 Struggle against aggressive forces, animals fighting, story detached from reality

2 No emotional involvement, little interpersonal action, description

3 Vacation, pleasure trip, happy people

Card 6GF

VIII. 0 Complete failure, submission to fate, death, murder, suicide, illicit sex with violence, revenge, aggressive hostility, severe guilt, complete hopelessness

1 Crime (of murder-mystery type, without extreme grief), fear, guilt, marital discord, threatening male

2 Description, impersonal discussion

3 Happy marital situation, proposal, successful career, popularity with opposite sex

Card 7BM

IX. 0 Disappointment of parents in child, guilt, repeated failure

1 Disagreement, recalcitrance, rebellion against parental authority, feelings of inadequacy

2 Parental advice, impersonal discussion, counselling

3 Aspiration with encouragement and/or advice

Card 7GF

X. 0 Extreme feelings of rejection, hatred for parents

1 Painful or shameful revelation

2 Disinterested explanation of facts of life, listens while daydreaming to neutral story, child growing up

3 Filial affection, aspiration, parental encouragement

Card 12M

XI. 0 Death, suicide, malpractice (hypnotism) with aggression, rape, curse

1 Reconciliation to death, illness, parental pressure

2 Hypnosis with no harm involved (experimentation with or demonstration of hypnosis), being awakened from sleep

3 Reunion

TAT Emotional Tone and Outcome Rating Scales

Subject No. ____________
Age: ____________
Sex: ____________

Rater: ____________

I. Card 1 A. Emotional Tone ____________
B. Outcome ____________

II. Card 5 A. Emotional Tone ____________
B. Outcome ____________

III. Card 15 A. Emotional Tone ____________
B. Outcome ____________

IV. Card 3BM A. Emotional Tone ____________
B. Outcome ____________

V. Card 14 A. Emotional Tone ____________
B. Outcome ____________

VI. Card 10 A. Emotional Tone ____________
B. Outcome ____________

VII. Card 11 A. Emotional Tone ____________
B. Outcome ____________

VIII. Card 6GF A. Emotional Tone ____________
B. Outcome ____________

IX. Card 7BM A. Emotional Tone ____________
B. Outcome ____________

X. Card 7GF A. Emotional Tone ____________
B. Outcome ____________

XI. Card 12M A. Emotional Tone ____________
B. Outcome ____________

Manual for Rating Ego Functions

Below is a listing of the component factors as used in this study. The Manual is taken specifically from "The Manual for Rating Ego Functions from a Clinical Interview" as found in the book _Ego Functions in Schizophrenics, Neurotics, and Normals: A Systematic Study of Conceptual, Diagnostic, and Therapeutic Aspects_ (Bellak, Hurvich, and Gediman, 1973).

Ego Functions and Component Factors

1. Sense of reality of the world and of the self
    a. Extent of derealization and related altered state of consciousness. The extent to which external events are experienced as real and as embedded in a familiar context.
    b. Extent of depersonalization and related altered states of consciousness. The extent to which the body (or parts of it) and its functioning and one's behavior are experienced as familiar and unobtrusive and as belonging to (or emanating from) subject.
    c. The degree to which subject has developed individuality, uniqueness, a sense of self, a stable body image, and self-esteem.
    d. The degree to which subject's self-representations are distinguished from object representations; that is, the extent to which subject correctly ascribes which qualities are self-representative and which belong to others. Stated in another way, the extent to which ego boundaries between the self and the outside world are clearly demarcated.

2. Object Relations
    a. The degree and kind of relatedness to others (taking account of narcissism, symbiosis, separation-individuation, withdrawal trends, egocentricity, narcissistic object choice or extent of mutuality, reciprocity, empathy, ease of communication); degree of closeness or distance and the degree of flexibility and choice in maintaining object relations.
    b. Primitivity-maturity of object relations, including the extent to which present relationships are adaptively influenced by, or patterned upon, older ones.
    c. The extent to which the person perceives and responds to others as independent entities rather than as extensions of himself.

d. The extent to which he can maintain object constancy; that is, can sustain both the physical absence of the object and the presence of frustration or anxiety related to the object, degree and kind of internalization (the way subject perceives and responds to people who are not physically present).

3. Regulation and control of drives, affects, and impulses

   a. The directness of impulse expression, ranging from primitive and psychopathic acting out, through the activity of the impulse-ridden character, through neurotic acting out, to relatively indirect forms of behavioral expression. Maladaptiveness would be a function of the extent to which awareness of drive, affect, and impulse are experienced and expressed disruptively.

   b. The effectiveness of delay and control mechanisms (including both under- and overcontrol); the degree of frustration tolerance and the extent to which drive derivatives are channeled through ideation, affective expression, and manifest behavior.

4. Defensive Functioning

   a. Extent to which defense mechanisms, character defenses, and other defensive functioning have maladaptively affected ideation, behavior, and the adaptive level of other ego functions.

   b. Extent to which defenses have succeeded or failed; for example, degree of emergence of anxiety, depression, and/or other dysphoric affects.

Manual for Rating Ego Functions from a Child's Rorschach and TAT Protocols*

Contents

General Guide

- Ordinal Scales
- Global Ratings
- Rating Procedure

Ego-Function Scales

1. Sense of Reality
2. Object Relations
3. Regulation and Control of Drives
4. Defensive Functioning

General Guide for Use of the Manual

The Manual consists of scales for rating each of the four Ego Function Scales. "Instructions to Raters" precede each scale. They explain each particular ego function in terms of the component factors and suggest ways to interpret and apply each scale.

Ordinal Scales

Each of the four ego function scales is an ordinal scale. The variables are dimensionalized on a seven-point continuum and are numbered 1 to 7. Raters are encouraged to score a subject 1.5, 2.5, and so on when the relevant data seem to fall between any two defined scale points, here called modal stops. Modal stop 1 represents the most maladaptive manifestation of the function being rated, and modal stop 7 represents the most adaptive. Each ego function scale is also broken down into separate scales representing the "component factors" of the function being rated.

Although the scales are ordinal and not equal-interval, an attempt has been made to peg all stops across scales so that they reflect about the same degree of adaptation at any given stop. That is, stop 3 on any given scale is approximately equal in maladaptiveness to stop 3 on other scales, but this can only be approximate. While stops 1 and 7 serve primarily as anchor points to orient the rater with respect to the two extremes of the dimension(s) he is rating for each function, they may infrequently apply literally to a subject, such as an unusually well-functioning individual.

A final point about the rank ordering of modal stops involves the scale placement of "average" functioning. It was decided to consider stop 6 as average. Thus, the meaning of "average" as used here has less to do with the statistical norm of functioning of some known population group and more with a meaning denoting the sense of absence of any notable maladaptation or pathology, yet short of optimal.

Global Ratings

The rater's major task is to make a global rating on a 13-point scale (1 through 7 with "half" points) for each of the four ego functions. The global rating will be influenced by his separate ratings of each component factor for each ego function.

In the absence of statistical weighting of the contribution of each component factor to the overall ego function score, the latter must be obtained from a global clinical estimate of the overall adaptive level of that function.

An attempt has been made to describe the function each scale represents, both abstractly (as in accordance with the component-factor definitions) and concretely (with illustrative descriptive material for each stop).

Rating Procedure

1. The rater should familiarize himself with all scales, the component factors and the implied psychological dimensions upon which the modal stops of each have been ordered.

2. The rater should be familiar with the child's TAT and Rorschach protocols.

3. The rater picks the scale point that most closely reflects the subject's current levels for the given component factor, basing the rating on the specific data, and qualified by his overall impression from the entire interview. When the subject falls between two defined (modal) scale points, then the rating should be made at the nondefined stop falling between the two (i.e., 1.5, 2.5, 3.5, etc.). Finally, he makes one overall global ratings for the ego function as a whole. In the absence of statistical weighting of the contribution of each component factor to the overall ego function score, the latter must be arrived at from a global clinical estimate of the adaptive capacity of that function and not from an arithmetic mean of the component scores. (Note: The defined scale points plus the undefined stops add up to 13. If the user of this scale desires to work with whole numbers, any score on the above scale can be converted to a 13 full-point scale by multiplying by two and then subtracting one.)

I. Sense of Reality of the World and of the Self

Instructions to Raters: This scale assesses disturbances in the sense of oneself as it relates to the outside world. It refers, on the optimally adaptive end, to a subjective experience, usually preconscious, of one's unique, dynamic wholeness, mentally and physically, as defined by clearly delimited self boundaries from other people and the general physical and social environment.

II. Object Relations

Instructions to Raters: Optimal relationships are relatively free of maladaptive elements suggesting patterns of interaction that were more appropriate to old situations than to present ones. The most pathological extreme would be essentially an absence of relationships with any people; next would be present relations based on very early fixations, unresolved conflicts, and very hostile, sadomasochistic relationships. Optimal relations would be most mature, relatively free of distortions, and gratifying to libidinal, aggressive, and ego needs.

Intensity, diversity, and pervasiveness are not always essential components to span the entire scale, but to make global ratings, the rater is instructed to keep in mind the quality of the child's relationships to central and peripheral people. For more pathological adaptations the disturbances in object relations will be assumed to extend to a broader range of contacts than they would in the moderately maladaptive categories, where pathology might be limited to one or two significant relationships.

III. Regulation and Control of Drives, Affects, and Impulses

Instructions to Raters: This function refers to the extent to which delaying and controlling mechanisms allow drive derivatives to be expressed in a modulated and adaptive way, characterized, optimally, by neither under- nor overcontrol.

Evidence here is from behavior, associated or indirect behavioral manifestations, fantasies and other ideation, and inferences made from symptoms, defenses, and controls.

Regulation and control might very well be regarded as one aspect of defensive functioning, but since concerns here are limited to behavioral and ideational indices of impulse expression and since drives and impulses may be controlled and channeled by ego structures other than defenses, regulation and control would appear to merit a scale of its own. Defensive functioning also relates in its own way to dealing with anxiety and intra-psychic conflict, thus differing from regulation and control.

Among the drives under consideration are the libidinal and aggressive, in both their developmentally earlier and more advanced forms. Included also are impulse expressions deriving from superego pressures

such as guilt and self-destructive urges, ranging from suicidal tendencies to less extreme manifestations of depression, then moral and instinctual masochism. Where relevant, one would also include pressures from the ego-ideal, such as "driving ambition," which, when it regulates self-esteem, may reflect varying degrees of impulse control.

IV. Defensive Functioning

Instructions to Raters: Defenses protect preconscious and conscious organizations from the intrusions of id derivatives, unconscious ego, and superego tendencies. They aid adaptation by controlling the emergence of anxiety-arousing or other dysphoric psychic content, such as ego-alien instinctual wishes and affects (including depression), which conflict with reality demands. Any function may at specifiable times be erected defensively against any other ego function, and a drive derivative (e.g., aggression) may defend against another (e.g., passivity).

This scale differs from the regulation-and-control-of drives scale in that the latter measures the degree of impulse expression and motor discharge in behavior. Defensive functioning is not a scale of impulsivity but of measures employed to deal with disturbing elements of mental content, anxiety, and intrapsychic conflict.

Formation of a hierarchical ordering of the specific, classic 10 or 12 defenses with respect to pathology is an issue that has yet to be resolved in psychoanalytic theory, so the basis for ordering the scale will mainly be a dimensionalization of the efficacy of defensive functioning rather than an attempt to order specific mechanisms along an adaptive continuum. While certain stops explicitly list certain defenses and not others, the rater is to rate according to the overall rationale of the scale.

Excessive use of defenses is added at stop 3 in addition to relative failure of defenses. Stops 4 and 5 illustrate defenses as they are used in symptoms or compromises; stops 6 and 7 delineate circumstances where the defenses operate optimally to accomplish the most adaptive aims of the ego, and not as intrusions. In making his ratings, the rater should rely on the child's style of responding.

I. Sense of Reality of the World and of the Self

Stop	a	b	c	d
	The extent to which external events are experienced as real and as being embedded in a familiar context.	The extent to which the body (or parts of) and its functioning and one's behavior are experienced as familiar and unobtrusive and as belonging to (or emanating from) S.	The degree to which S has developed individuality, uniqueness, a sense of self, a stable body image, and self-esteem.	The extent to which the ego boundaries are clearly demarcated to between the self and the outside world.
1	Extreme derealization. Feels the world as being a completely strange place. Otherwise familiar objects and events appear alien. Extreme deja vu experiences. Surrounding people and things feel unreal, changed in appearance, as though they were not there or could not have happened. All of the above are experienced as subjective sensations. May feel the world is in chaos or disintegrating (very prominent "world destruction" fantasies). Very slight environmental changes may	Extreme depersonalization. May be oceanic feeling of nothingness, feeling dead, inanimate, selfless. Parts of body may feel unreal, extremely strange, or disconnected from the rest of the body (e.g., head or tongue or other part feels very much bigger or smaller than usual; the shape of some parts feels changing). Feeling literally or physically empty inside. Feeling literally like two or more different people.	Identity grossly distorted and unstable: esteem is so low that S may feel extremely worthless. Or extreme grandiosity may be apparent. Unsuccessful and pathological means of regulating self-esteem are repeated ineffectually. Continuous feedback from external sources is ineffectual in helping the individual to establish a stable sense of self. There is virtually no continuity in self-feeling from past to present, moment to moment. Self-evaluations practically never correspond to	May experience states of fusion or merging with others, suggesting near-total loss of boundaries between the self and the outside world. Opinions about self may be affected in a chameleonlike fashion, depending on what S knows others feel about him. S may believe he possesses mystical powers of communication with others, such as exceptional talent for ESP. At this stop, body boundaries may be extremely fluid and permeable, or else S erects firm or hard, nonpenetrable, exaggerated barriers.

produce strange sensations.		realistic aspects of the self. Indications of excessive departures of body image from actual bodily configurations. Enormous discrepancy between sense of self and ego ideal.	
2 Somewhat less than extreme derealization, trances, fugues, and other dreamlike states. Outer reality often seems unfamiliar and produces feelings of confusion and estrangement. May feel as though a glass boundary separates him from his surroundings.	Strong feelings of depersonalization. Some major disassociations. Body and its functioning are often experienced as strange, peculiar, and unfamiliar. Things may seem to be happening to "someone else" rather than to own self. Many strange and peculiar feelings, like hole in stomach, electricity sensations.	Strong, unrealistic feelings of unworthiness. Or strong feelings of grandiosity. Marked use of pathological self-esteem regulators. Feedback from external sources is rarely effectual in establishing stable sense of self. Large discrepancy between self-image and ego-ideal.	Fusion phenomena are promiment, without total loss of distinction between self and outer reality. May also be overreaction to fusion needs by exaggerating separateness: as in segerely overprotesting one's integrity as a person.
3 Marked but partial derealization likely to be less pronounced than depersonalization.	Marked but partial depersonalization. Parts of body may be seen somewhat bigger or smaller than usual.	Self-esteem is quite poor. Identity is fragmented, unintegrated, and not very stable. Insatiable quests for money, status, assurance of sexual attractiveness. May often ruminate, "Who am I."	Self-image usually dependent on external feedback. Where feedback is negative or absent, sense of self as a separate entity falters. Often feels in "special communication" with others.
4 Very occasional signs of derealization, such as being in a fog or at sea.	Occasional signs of depersonalization, usually under stressful circum-	May be "as-if" personality, or other manifestations of role-playing at	Sometimes dependent on external feedback to maintain identity. Under relatively

Seeing people through a haze. May sometimes feel on the outside looking in.	stances. Some moderately unrealistic feelings about the body (e.g., becoming too bloated, fat, or thin when actual changes are in fact minimal).	identity rather than experiencing it from within. Often feels humiliated.	stable conditions he is not dependent on outside support and can maintain a feeling of separateness.
5 Altered views of external reality are the exception rather than the rule, occurring primarily with radical environmental changes.	Depersonalization phenomena are fairly rare and limited to unusual conditions: falling asleep, waking up, drugs producing altered ego states.	More or less stable identity, self-image and self-esteem noted here. Identity sense may falter when external circumstances and people are unfamiliar or novel. Often feels important through significant others' accomplishments.	There are signs here of an independent sense of self, with a moderately good sense of inner reality, continuity and internalized self-representations. Only sometimes does _S_ depend on external cues for his full sense of individuality.
6 Derealization occurs only under conditions of extreme environmental alteration. It disappears with restoration of average expectable conditions.	Depersonalization occurs only under conditions of extreme environmental alterations. It disappears with restorations of average expectable conditions.	Stable identity, a distinct sense of self, and self-esteem are well internalized.	Requires only occasional feedback to maintain a sense of oneself as solidly separate from others.
7 Under average expectable environmental conditions or under conditions of extreme change and stress, experience of the world remains stable.	No disturbances in the sense of reality of the self, the body, or the body image.	Stable identity, distinct sense of self, and self-esteem are so well established and solid that they remain intact even under conditions of unusual stress or of minimal external cues ordinarily	_S_ is exceptionally well able to differentiate between his own feelings, thoughts, and motives, and those of others. Minimal feedback from external sources is required for him to delineate his own self-

required for self-anchorage points.

boundaries. While S may enjoy temporary regressed states of fusion, merging, and unusual communications with others, he does not require them for the maintenance of his own sense of separate identity. Virtually no confusion between experiences emanating from within oneself and phenomena with points or origin outside the self.

II. Object Relations

Stop a	b	c	d
The degree and kind of relatedness to others (taking account of narcissism, symbiosis, separation-individuation, withdrawal trends, egocentricity, narcissistic object choice, or extent of mutuality, reciprocity, empathy, ease of communication). Degree of closeness, distance and degree of flexibility and choice in maintaining object relations.	The primitivity maturity of object relations. Includes the extent to which present relationships are adaptively or maladaptively influenced by, or patterned upon, older ones.	The extent to which the person perceives and responds to others as independent entities rather than as extensions of himself.	The extent to which he can maintain object constancy, i.e., can sustain both the physical absence of the object and the presence of frustration or anxiety related to the object. Degree and kind of internalization (the way S perceives and responds to people who are not physically present).
1 Essential lack of any object relatedness. Withdrawal, as into stupor or muteness; or living like a hermit or recluse. "Relationships: are presymbiotic, mostly autistic. When rudiments of relationships are present, they are fraught with turmoil, struggle, and other near total disruptive elements, deteriorating quite	Because of impoverishment and essential lack of relatedness, only the most primitive early elements characterize "relationships."	Minimal ability to perceive people in their own right. Extreme "Parasitism" or narcissism.	Not developed enough even for separation anxiety. Bland withdrawal in response to "object loss." People do not "exist" when not present.

rapidly. 'Distance regulators' are poor." S can tolerate little stimulation from other people.			
2 Considerable withdrawal-schizoid detachment rather than total withdrawal. Severely narcissistic, parasitic, or symbiotic relationships; folie a deux, vicarious objects, intensely sadomasochistic binds. Either overattachment or underattachment of an infantile nature.	Present relationships characterized by transference based on very early fixations and may reflect disturbances in early mother-child relationships. Recurrent difficulties are the rule rather than the exception.	People's feelings, motives and beliefs are rarely understood from the other's point of view, but mostly in terms of the direct impact they have upon S. Exceedingly difficult for S to ignore his own needs as he responds to others primarily from an egocentric frame of reference. Derives pleasure from exercising "power" over others.	Separation anxiety may be prominent and may be maladaptive reaction to object loss, loss of love, or narcissistic injury. Reactions to loss still tend to be fairly catastrophic.
3 Relationships may be characterized by detachment or else by some overdependence and clinging. Considerable difficulty striking a comfortable balance between distance and closeness. Prefers either very intense or very cool relationships. May be distant for fear of a close relationship breaking up.	Present relationships are quite childlike and bear marks of earlier, similar ones. Expects to be "fed" emotionally. May wait for things to get better.	Other people only very occasionally are perceived and responded to as existing in their own right. Many "self-references" in responding to others. Own identity overly dependent on perception of others. Inordinate attempts to "change" others with belief that this will crystallize self-identity. May use and exploit people to satisfy own ambi-	Inordinate strivings for either dependence on, or independence from, significant others, exaggerated attempts to prove one's self-sufficiency. Or S may feel quite easily hurt or rejected. Represention of significant people still not too well internalized--overreactions to loss and separations. Virtually unable to live alone; or else distinctly prefers isolation from people in living arrangement.

		tions, oblivious to how others feel about this.	
4 Relations with significant others are characterized by neurotic type interactions. Can be of withdrawn, narcissistic, or symbiotic types, but such manifestations are more complex than primitive. Examples would be Don Juanism, more "advanced" forms of sadomasochism, where usually just significant relationships are of this sort. Also includes the fringe, hanger-on person, most of whose relationships are superficial. "Game-playing."	Contains elements of conflicts characterizing early childhood, including relationships with both parents. In this sense they are a step more mature than relationships reflecting only the earliest ties to the mother, alone.	Other people can be responded to in their own right in situations that are not too emotionally charged or are neutral or nonstressful. Under more difficult circumstances, emphasis may be on trying to get other people to change in order to promote a stable self-feeling.	Sensitive to potential rejections and abandonments when not being clearly focused in others' attention. Loneliness, living alone are not tolerated very well.
5 Disturbed interactions with only a few people, and sporadically rather than chronically. Object choice and behavior with significant people shows some important degree of flexibility, but under stress becomes more compulsive or less free.	Transference and repetitions of early patterns of relating are the exception rather than the rule in everyday encounters, but may persist under very charged conditions. Some recurrent difficulties in important relationships.	Others are perceived as separate and well differentiated from the self, except under rather stressful or charged circumstances. E.g., S may recognize the other person's feelings, understand them, and respond appropriately, but when threatened, may have unreasonable expectations of what others urge and can do.	Internalization of objects is evident, but under severe or prolonged stress, absences and losses are overreacted to. May have some difficulty being alone, but finds ways to compensate for loneliness.

6 Flexibility of choice and mode in most relationships, with conscious and automatic maintenance of optimal distance.	Tending toward mature object relations with goals that are mutually satisfying to self and significant others.	S is usually responsive to other people as separate individuals in their own rights. A reasonably good degree of empathy, but not so much as to get "lost" in the other person's feelings or point of view.	Object constancy is well developed, as important people are internalized. Losses, separations, and other such potential traumas are weathered without undue strain. Thoughts about, reactions to, and respect for others continue whether or not the others are physically present.
7 Relationships are characterized by mutuality, reciprocity, depth, and extensivity. They maintain smoothness and stability despite stresses that might otherwise threaten them. They are flexibly maintained out of choice, as opposed to compulsion. "Distance regulators" are optimal. S functions adaptively even with maximal stimulation and excitement generated by other people.	No substantial evidence of fixations or distortions from early relationships. Maturity nearly completely replaces primitivity. Gratifications in relationships are in response to current needs. Flexibility and choice characterize object relationships.	Person responds to others as people in their own right, empathic to their needs as separate people. Understands people for what they are and not from an egocentric frame of reference. Person can temporarily ignore his own needs in an effort to respond primarily to the other person. High degree of "field independence."	Object constancy excellent as judged by easy adaptations to separations, adaptive resiliency following loss of important objects. Relationships to significant others are highly viable, even when those people are not physically present.

III. Regulation and Control of Drives, Affects and Impulses

Stop a	b
The directness of impulse expression (ranging from primitive and psychopathic acting out, through activity of the impulse-ridden character, through neurotic acting out, to relatively indirect forms of behavioral expression). Maladaptiveness would be a function of the extent to which awareness of drive, affect, and impulse is experienced and expressed disruptively.	The effectiveness of delay and control mechanisms (including both under- and overcontrol); the degree of frustration tolerance and the extent to which drive-derivatives are channeled through ideation, affective expression, and manifest behavior.
1 Aggression, and/or depression, and/or sexual manifestations at their most disruptive extreme. Persons may have committed or attempted murder, suicide, or rape. Indirect or associated drive behavior is not observed at this stop, as impulses achieve full discharge through direct expression. Polymorphous perverse behavior in the extreme and in many areas (e.g., feces-smearing).	Extreme lack of control. Minimal frustration-tolerance inferable from inability to restrain impulse-dominated behavior. When thinking is at all rational, there is no evidence to show that this rationality exercises any delay or control over impulse expression. Weak controls in relation to the experience of extreme drive pressure leave physical or externally imposed constraints as about the only effective way to curb most urges. At times, no matter how hard the person tries to control urges, he cannot.
2 Aggression, depression, and sexual manifestations are quite disruptive. May be impulse-ridden personality. Psychopathic behavior may be quite pronounced. Assaultive-type acts short of homicide. Sadistic superego pressure against the self could include serious self-inflicted injury short of suicide. Fantasy content would vary only a little from actual sexual or aggressive behavior,	S has great difficulty holding back sexual, aggressive or other urges because of weak controls in relation to the experience of drive pressure. Physical constraints are the most effective way of curbing most urges. Frustration-tolerance is almost always poor. Very little tolerance for anxiety or depression.

hardly ever as substitute formations at this level. May be rapid mood changes from one extreme to the other.

3 Strong urges are usually acted upon. Sometimes, although present, they are not experienced at all, and knowledge of them can only be deduced from behavior. There may be sporadic rages, tantrums or binges, as with alcohol, food, or sex. Affects and moods may be very labile, crying one moment, laughing the next. May be psychopathic personality. May be hyperkinetic, or need to be physically on the go all the time.

Urges are controlled either very poorly or excessively (overcontrol is first scored here). Excessive controls would be of the extremely rigid or brittle sort so that periods of overcontrol alternate with flurries of impulsive breakthroughs or psychosomatic spill-over. Where urges are extremely low (as in prolonged depressive states), few overt outlets are available. In cases of overcontrol of strong urges, sexual and aggressive preoccupations receive outlets in areas other than overt behavior. With strong urges and undercontrol outlets might be voyeurism, promiscuity, "addiction" to pornographic material.

4 Drive-dominated behavior shows a few signs of adaptive directedness here. Aggressive behavior is more often verbal than physical, sometimes quite disguised and indirect, as in occupational choice of correction officer, butcher, photographer's model. May be overeating or have excessive interest in collecting and neatness. Acting out of unconscious wishes and fantasies may be quite prominent. Maybe general rebelliousness. Moderately high general excitability.

Controls may appear reasonably good but are of the "grit-your-teeth" or "count-to-ten" variety rather than of the smooth, automatic sort. Attempts to keep a rein on drive expression may also lead to a somewhat rigid picture. May involve overreacting, overdramatizing.

5 Drives, etc., are experienced and expressed either somewhat more or somewhat less than average. Irritability, arousability, or impulsivity in behavior tend to be responses to specific or conflict-ridden areas or to situational stress and external provocations. Associated, indirect behavior and interest may include mild teasing, sparring repartee, mildly inappropriate flirting or secularization

Controls are somewhat less than automatic, but may be automatic in conflict-free areas. When not automatic, they can be mustered on the spot with moderate effort. Occasional work or social inhibitions.

of work. Some symptomatic acting out of unconscious conflicts. Moderate depressions (disappointments).

6 When general behavior and interests are aggressively and sexually oriented, it is with effective sublimination and neutralization (e.g., physical assaultiveness occurs only in the interest of survival of self and others when there is no other alternative). Intercourse is preferred outlet for sexual urges. Unusual sexual or aggressive behavior is seen only under extreme provocation or prolonged stress.

Reasonably smooth expression of urges, behaviorally, with the aid of fairly flexible controls. Degree of tightening or relaxing of controls is appropriate to the situation and is generally volitional and/or fairly automatic.

7 Overly aggressive behavior or its derivatives are seen only when there is no alterantive, as in the interest of survival and the regulation of self-esteem along effective, adaptive lines. Effective action, whether automatic or by conscious choice in mastering tasks and achieving life goals, makes unnecessary any sort of aggressive behavior short of th t mentioned above. Preferred sexual behavior is sexual intercourse. Depression and related states are limited to sadness, grief, and mourning in response to expectably provocative losses.

Control of urges to motility, etc., comes fairly quickly, calmly, and automatically. Flexibility of delay and control mechanisms allows S to respond according to his own choice rather than to pressures beyond his control. A minimum of subjective and automatic difficulties with automatic regulation and control of drive expression, such that the person functions extremely smoothly in work, sex, play, and object relations generally.

IV. Defensive Functioning

Stop a	b
Extent to which defense mechanisms, character defenses, and other defensive functioning have maladaptively affected ideation, behavior,and the adaptive level of other ego functions.	Extent to which defenses have succeeded or failed (e.g., degree of emergence of anxiety, depression, and/or other dysphoric affects).
1 Defense mechanisms and elements are among those in the general hierarchy of defense mechanisms that reflect least adaptation or are most pathological. Might be projection at its most extreme, manifest in broad delusional systems. Massive repression and denial might rule out any reflective thinking. Splitting mechanisms are prominent.	Massive failure and/or pathological misuse of defensive functioning, so that there is emergence of id derivatives and unconscious contents producing extreme anxiety, depression, or other dysphoric affect. Degree of anxiety and panic is extreme.
2 Rather extensive and inflexible use of primitive defenses (denial, splitting) are generalized in character and behavior. Affect storms usually defend against reflective thinking since thoughts may be potentially disturbing. Extreme uses of projection. Socially pathological forms of identification with the aggressor. Functioning has a highly defensive quality which interferes considerably with general adaptation.	Considerable failure of defenses. Anxiety likely to be free-floating and unbound, thus interferes with adaptive functioning to a significant degree. May be chronic depressive states. Feels as though he is falling apart.
3 Defenses analogous to "overcontrol" score here. May be extreme overideational defenses, such as isolation and intellectualization, where thought predominates over affect. May also be fairly pervasive projections, quasi delusions, perceptual vigilance, avoidance, evasions, severe inhibitions and ego	Frequent breakthroughs of anxiety, depression, drive-related material, ego-alien thoughts, parapraxes. Free-floating anxiety of the sort seen in agoraphobia or claustrophobia. A pervasive feeling of vulnerability.

restriction. Whatever the defenses, their effect is more maladaptive than adaptive.

4 _S_ may show evidence of rationalization, reaction-formation, transient projections, occasional parapraxes, and malapropisms. Also, symptomatic acting out (where action is a substitute for a repressed thought). Generally defensive behavior is fairly prominent.

Anxiety more likely to be bound in symptoms than free-floating. Tolerance for anxiety and other dysphoric states is not very good. When jumpy, upset, or anxious, means of protection and recovery do not come easily.

5 Some ability to adaptively relinquish or adaptively employ defensive operations, whatever they may be, except in situations that are characteristically conflictual for the individual.

Anxiety is present to a moderate degree; there is some tolerance for it, so that while it sometimes interferes with functioning, it need not do so markedly. May feel temporarily thrown but shows some adaptive resilience in recovery.

6 Defensive functioning, or the lack of it, is employed primarily in the service of adaptation with good resilience and recovery to nondefensive modes. An absence of excessive or insufficient use of defenses.

Anxiety is present only when appropriate to situational stress and is well tolerated.

7 Only the most adaptive defensive elements are present (e.g., denial when in the service of adaptation to reality). The warding off of painful or dysphoric material is accomplished by recognizing, considering, making judgments and taking appropriate action about it. Defensive functions observable at this stop are in the service of adaptation to external events as well as involved in the resolution of intrapsychic conflict. Under conditions of stress, there is minimal disruption of other ego functions by defensive functioning.

Access to unconscious contents and id derivatives does not produce disruption and/or anxiety.

Date: ____________

Protocols Rating Form

Age of Child: ______
Sex of Child: ______

Subject No.: ____________
Group Code: ____________
Rater: ____________

I. Sense of Reality

A. Extent of Derealization → [ ]

B. Extent of Depersonalization → [ ]

C. Self-Identity and Self-Esteem → [ ]

D. Clarity of Boundaries Between Self and World → [ ]

Overall Level of Functioning

II. Object Relations

A. Degree and Kind of Relatedness → [ ]

B. Primitivity-Maturity → [ ]

C. Others Perceived Independently → [ ]

D. Object Constancy → [ ]

Overall Level of Functioning

Subject No.: _____

Group Code: _____

III. Regulation and Control of Drives, Affects, and Impulses

A. Directness of Impulse Expression ——————→ [ ]

B. Effectiveness of Delay Mechanisms ——————→ [ ]

Overall Level of Functioning

IV. Defensive Functioning

A. Presence of Defensive Indicators ——————→ [ ]

B. Success and Failure of Defenses ——————→ [ ]

Overall Level of Functioning

Louisville Behavior Check List: Form E2

The Louisville Behavior Check List (LBCL) is an inventory of behaviors designed to help parents to conceptualize and to communicate concerns about their children. The inventory covers the entire range of social and emotional behaviors from extreme social deviance to social compliance. The check list helps parents to search their memories and to record behaviors characteristic of their children. This recording also provides the mental health worker with an overview of a child's deviant behavior.

The check list is composed of 164 items of deviant and prosocial behaviors presented in a four-page booklet. The 19 scales derived are as follows:

1. Aggression (AG): A broad band factor scale composed of items from three scales: IA, HA, and AS.
2. Infantile Aggression (IA): Describes egocentric, emotionally demanding and interpersonally belligerent behavior.
3. Hyperactivity (HA): Refers to impulsive and constant motion involving both large and small muscles.
4. Antisocial (AS): Describes illegal and destructive behavior where the main thrust is against property and person, self and others.
5. Inhibition (IN): A broad band factor scale composed of items from three scales: SW, SN, and FR.
6. Social Withdrawal (SW): An apparent reluctance to interact with others, and a preference for social isolation and uninvolvement.
7. Sensitivity (SN): Disability characterized by a subjective sense of "unlikableness," combined with a tendency to cope with stress by a combination of somatizing and impulsive, immature and rivalrous behaviors.
8. Fear (FR): Refers to general anxiety focalized around multiple objects with special concern over sleep, death, and assuring the availability of a soteria.
9. Learning Disability (LD): A broad band factor scale composed of items from three scales: AD, IM, and TDI.

10. Academic Disability (AD): Items reporting specific deficits in academic skill and abilities commonly associated with learning failures.

11. Immaturity (IM): Refers to both social and physical processes, e.g., babyishness, dependency, whining, slow physical growth and clumsy, poor coordination.

12. Total Disability I (TDI): All pathogenic items (N = 93) found to load on any one of the factor scales (Nos. 2, 3, 4, 6, 7, 8, 10, 11). Items which overlap are counted only once; hence, Total Disability means will tend to be lower than the composite means.

13. Normal Irritability (NI): Noxious behaviors reported to occur in at least 25% of the general population.

14. Rare Deviancy (RD): Noxious behaviors reported to occur in less than 1% of the general population.

15. Prosocial (PS): Highly valued behaviors such as "relaxed and able to concentrate," "able to study and meet school requirements," and "has a good sense of right and wrong."

16. Neurotic (NEU): Items traditionally assumed to indicate a psychoneurotic process. Items such as phobias, obsessions, compulsion, depression, and the use of tranquilizers are included on this scale. Highly correlated with the fear scale.

17. Psychotic (P): Items traditionally assumed to indicate a psychotic process. Items reflecting uncontrolled behavior such as smearing of feces; speech problems such as echolalia and no speech, excessive seclusiveness and unresponsiveness, as well as hallucinations and delusions are included on this scale. It clearly distinguishes an autistic group from a learning disability group.

18. Sexual Deviance (SD): Composed of items which are on no other scale.

19. Somatic (S): Composed of items which are on no other scale.

Instructions for checking items on the form are given below the demographic section. The check list can usually be completed in one half hour.

School Behavior Check List: Form A2

The School Behavior Check List (SBCL) is an inventory of behaviors which are observable in a school setting. It was developed to obtain teacher ratings of children's deviant behavior and has been used as an objective assessment of emotional disturbances in children.

A four-page booklet was prepared for teacher ratings which is divided into four sections:

1. Demographic: includes age, sex, race, religion, grade, type of school, I.Q., father's highest educational level and estimated income, and the rater's years of teaching experience.
2. Disability information: includes six yes-no questions designed to isolate extreme categories of adjustment such as "the best adjusted," "the most disturbed," or "in need of referral" for emotional disability or special education.
3. Teacher rating scales: includes five 9-point rating scales measuring intellectual ability, academic skill, overall academic performance, social-emotional adjustment, and personal appeal, constructed to provide global measures of adjustment.
4. School Behavior Check List items: includes 80 items from the Pittsburg Adjustment Survey Scale (Ross, Lacy and Parton, 1965), 14 Learning Disability items and 2 additional Anxiety items. Six of the earning Disability items refer to academic failure; eight remaining items refer to intelligence and habits or attitudes.

The six factor scales with their assigned names are described below:

1. Low Need Achievement (LNA): This scale is similar to the Ross Prosocial factor with the addition of new items from the Learning Disability scale. These new additions show a bipolar Task Avoidance-Need Achievement factor. Low motivation, failure to master difficult tasks, and a defeatist attitude characterize the pathological pole opposite the Prosocial items of Ross, e.g., fails to carry out tasks (homework assignments, seat work, etc.); lacks the ambition to do well in school.
2. Aggression (AGG): This scale is made up of Ross' Aggressive and Passive-Aggressive factors which collapsed into one scale, e.g., does things to get others angry; tries to get other children in trouble.

3. Anxiety (ANX): This scale is similar to Ross' Withdrawal factor with the addition of seven new anxiety items and the elimination of six Pittsburg items, e.g., becomes frightened easily; easily upset by changes in things around him.
4. Academic Disability (AD): This scale is composed entirely of items indicating poor academic skills and low intelligence, e.g., behind at least one school grade due to academic difficulty; spelling performance at least one grade level below age expectation.
5. Hostile Isolation (HI): The small number of items on this scale probably limits utility, but the scale is reported because the items closely approximate the well-known "schizoid character" with its implied pathogenic prognosis, e.g., has no friends; never fights back even when he has every right to be angry.
6. Extroversion (EXT): An egocentric, "pushy" extrovert factor made up primarily of items loading high on social desirability, e.g., friendly; tries to be the center of attention.
7. Total Disability (TD): Composed of each item except No. 30, loading significantly on one of the six Pittsburgh factors.

Clinic No. ____________

LOUISVILLE BEHAVIOR CHECK LIST© - FORM E2

Child's Name ______________________ (LAST / FIRST / MIDDLE INITIAL)

SEX
___ 1—Male
___ 2—Female
___ 0—No Inf.

Age ________ Date of Birth ______________________ (MONTH / DAY / YEAR)

Home Address ______________________ Phone No. ________

City ______________________ State ______________ Zip ________

Questionnaire Filled Out By ______________________ AT HOME ___ OFFICE ___ Date ________

CURRENT SCHOOL GRADE

___ 1—1st	___ 7—7th	___ 13—College
___ 2—2nd	___ 8—8th	___ 14—Post Grad.
___ 3—3rd	___ 9—9th	___ 15—Pre-Sch.
___ 4—4th	___ 10—10th	___ 99—None
___ 5—5th	___ 11—11th	___ 00—No Inf.
___ 6—6th	___ 12—12th	

NO. SIBLINGS

	Bro.	Sis.
None	___	___
One	___	___
Two	___	___
Three	___	___
Four	___	___
More	___	___
No Inf.	___	___

PARENT INFORMATION

NAME: FATHER ______________________ Age ___ MOTHER ______________________ Age ___

OCCUPATION: FATHER ______________________ MOTHER ______________________

MARITAL STATUS
Mo. Fa.
___ ___ 1—Married
___ ___ 2—Separated
___ ___ 3—Divorced
___ ___ 4—Widowed
___ ___ 5—Remarried
___ ___ 6—Unmarried
___ ___ 7—Other
___ ___ 0—No. Inf.

HIGHEST EDUCATION OBTAINED
Mo. Fa.
___ ___ 1—Sixth Grade
___ ___ 2—Ninth Grade
___ ___ 3—Twelfth Grade
___ ___ 4—2nd Yr. College
___ ___ 5—4th Yr. College
___ ___ 6—Post Graduate
___ ___ 7—Other
___ ___ 0—No Inf.

ESTIMATED FAMILY INCOME
___ 1—$2,999 or Below
___ 2—$3,000-$4,999
___ 3—$5,000-$7,999
___ 4—$8,000-$14,999
___ 5—$15,000-$24,999
___ 6—$25,000 or Above
___ 0—No Inf.

SES ________

READ DIRECTIONS BEFORE BEGINNING

DIRECTIONS: Below you will find statements often used by parents to describe children's behavior. Read each statement and decide if it describes your child. If it does, mark (T) TRUE; if not, mark (F) FALSE.

Note: It is important to mark EACH statement. If you are in doubt, check the answer which is most correct.

EXAMPLE
#1. (T) (F)
#2. (T) (F)

1. Cries easily .... (T) (F)
2. Whines and complains .... (T) (F)
3. Shy .... (T) (F)
4. Dependent; leans heavily on others .... (T) (F)
5. Generally considerate and able to share .... (T) (F)
6. Demands that parents do what wants done .... (T) (F)
7. Cruel with animals or people in a shocking way (sadistic) (T) (F)
8. Handwriting unusually poor .... (T) (F)
9. Finds it hard to talk with others .... (T) (F)
10. Wets the bed at night at least once a month .... (T) (F)
11. Feels inferior; says not as good as others .... (T) (F)
12. Constantly fighting or beating up others .... (T) (F)
13. Reads poorly .... (T) (F)
14. Afraid of school; has to be forced to attend .... (T) (F)

YOUR ANSWERS WILL BE CONFIDENTIAL. CAREFUL READING OF EACH QUESTION WILL HELP US HELP YOUR CHILD.

15. Has been unconscious for a period of five minutes or more during the past year .... (T) (F)

16. Tosses and turns in sleep, rolls, gets up often at night, etc., (poor or restless sleeper) .... (T) (F)

17. Frightened of using the toilet .... (T) (F)

18. Has temper tantrums; yells, screams, cries, kicks feet, over the least thing .... (T) (F)

19. Rushes off to do things before instructions are finished, "can't wait" (impulsive) .... (T) (F)

20. Has a severe physical handicap; partial or total loss of sight, hearing, speech, or limb; paralysis or weakness in muscle, chronic disease—heart, lung, kidney, etc. .... (T) (F)

21. For Girls Only: Acts more like a boy (masculine)
    For Boys Only: Acts more like a girl (effeminate) .... (T) (F)

22. Afraid of being in cars, or trains, or airplanes, or elevators .... (T) (F)

23. Wets clothes during the day .... (T) (F)

24. Nervous habits such as biting or picking fingernails, twisting hands, rubbing eyes, or pulling hair .... (T) (F)

25. Ambitious; desires to do well and get ahead .... (T) (F)

26. Poorly coordinated when doing things with the hands, such as writing or coloring .... (T) (F)

27. More involved with animals or things than people .... (T) (F)

28. Reacts too much to pain, even from slight aches or injuries .... (T) (F)

29. For Girls Only: Prefers to play with boys
    For Boys Only: Prefers to play with girls .... (T) (F)

30. Is absent from school repeatedly without permission (truant) .... (T) (F)

31. Withdrawn, aloof, unresponsive .... (T) (F)

32. Afraid of things such as the dark, thunderstorms, or being alone .... (T) (F)

33. Fails to carry out tasks (school assignments or chores) (T) (F)

34. Is clumsy when walking, running, or playing games .... (T) (F)

35. Generally relaxed and able to concentrate .... (T) (F)

36. Shows unusual sexual curiosity (peeping, exploration, etc.) .... (T) (F)

37. Insists on doing the same meaningless thing over and over again, such as touching or never touching certain objects, or always washing hands (ritual behavior) (T) (F)

38. Sets fires .... (T) (F)

39. Uses poor judgment; will do or say anything .... (T) (F)

40. Cannot stop certain movements such as a twitching mouth or eye, jerking of the head (has a tic) .... (T) (F)

41. Preoccupied with fears of war, physical injury or death (T) (F)

42. Acts immature; is babyish .... (T) (F)

43. Gets upset when not the center of attention .... (T) (F)

44. Finds it hard to study .... (T) (F)

45. Takes things in stride; not easily upset .... (T) (F)

46. Bullies or frightens others .... (T) (F)

47. Gets upset when routines are changed; insists on having everything the same .... (T) (F)

48. Hyperactive, some part of body is always moving; can't sit still .... (T) (F)

49. Sucks thumb or fingers .... (T) (F)

50. Has run away from home in the past year .... (T) (F)

51. Prefers to play with younger children although children own age are around .... (T) (F)

52. Demands to have someone to sleep with .... (T) (F)

53. Says "everyone picks on me" .... (T) (F)

54. Thinks or worries about sexual matters too much .... (T) (F)

55. Thoughts and ideas are sensible and understandable .... (T) (F)

56. Has an unusual number of accidents .... (T) (F)

57. Over-talkative, chatters constantly, interrupts others .... (T) (F)

58. Behind in school at least *one* grade .... (T) (F)

59. Refuses to play rough games .... (T) (F)

60. Behind in school at least two grades .... (T) (F)

61. Complains "nobody loves me" .... (T) (F)

62. Talks and acts silly .... (T) (F)

63. Seems dull; slow to catch on .... (T) (F)

64. Plays with bowel movements, smears, or willfully has B.M.'s where not supposed to have them .... (T) (F)

PLEASE MAKE SURE THAT YOU HAVE ANSWERED EVERY QUESTION.

65. Steals outside the home .... (T) (F)

66. Picks at food, fusses, or demands special foods .... (T) (F)

67. Has difficulty in arithmetic .... (T) (F)

68. Gags or vomits easily .... (T) (F)

69. Fear of death; always worrying about dying .... (T) (F)

70. Has epilepsy, blackout spells, convulsions, or staring spells .... (T) (F)

71. Constantly complains that brothers and sisters are favored .... (T) (F)

72. Talks frequently in sleep .... (T) (F)

73. Doesn't care about the feelings of others .... (T) (F)

74. Unusually slow at dressing, bathing, eating (dawdles) .... (T) (F)

75. Is able to study and meet ordinary requirements of school .... (T) (F)

76. Frequently rocks back and forth .... (T) (F)

77. Recently involved in homosexual relations .... (T) (F)

78. Cries when parents leave (separation problem) .... (T) (F)

79. Seems tired, tends to lie around, shows little interest in doing things .... (T) (F)

80. Often complains of at least one of the following: frequent stomach aches, rapid heart beat, inability to catch breath, feeling faint, dizziness, or inability to swallow .... (T) (F)

81. Distractible, can't concentrate .... (T) (F)

82. Behind in physical development, such as climbing, bike-riding, throwing a ball, etc. .... (T) (F)

83. Has physical sensations like numbness or things crawling on skin .... (T) (F)

84. Does not participate in group activities, stays in background (said to be retiring) .... (T) (F)

85. Enjoys being with children own age .... (T) (F)

86. Exhausts self; constantly on the go, seldom relaxed .... (T) (F)

87. Fearful, constantly afraid .... (T) (F)

88. Hears voices, sees things, smells or tastes things that others cannot .... (T) (F)

89. Has been sent to an institution for delinquents .... (T) (F)

90. Has been taken to a probation officer or accused by police of committing a crime .... (T) (F)

91. Moves constantly, "gets into everything," swarms all over (overactive) .... (T) (F)

92. Demands special attention or fusses at bedtime .... (T) (F)

93. Keeps on playing with one object for hours; cannot stop from doing the same thing over and over .... (T) (F)

94. Is a pest in school—irritates teachers or playmates .... (T) (F)

95. Is as mature as other children own age .... (T) (F)

96. Not dependable; irresponsible .... (T) (F)

97. Worries constantly or feels very guilty .... (T) (F)

98. Doesn't speak as clearly as you would expect for age .... (T) (F)

99. Gives in to others; does not take up for self .... (T) (F)

100. Afraid of dirt or germs; will not use things that have been used by others, even after they have been washed .... (T) (F)

101. Is disruptive; tendency to annoy and bother others .... (T) (F)

102. Doesn't say "I" when talking about self, says "you go," or "he goes," when meaning "I go" .... (T) (F)

103. Pushed and picked on, called names, laughed at by others .... (T) (F)

104. Worries that parents may get hurt or sick or die .... (T) (F)

105. Sexual interest and awareness normal for age .... (T) (F)

106. Gets very upset when criticized or makes mistakes .... (T) (F)

107. Swears or curses inappropriately .... (T) (F)

108. Does not put things away in room, does not comb hair, does not dress neatly (untidy) .... (T) (F)

109. Shows no shame or guilt after being caught .... (T) (F)

110. Steals at home .... (T) (F)

111. Argues about daily routines, such as putting on clothes, washing face and hands (argumentative) .... (T) (F)

112. Frequently complains of headaches .... (T) (F)

113. Lacks self-confidence .... (T) (F)

114. On medication for emotional or behavior problems: tranquilizers, ritalin, phenobarbital, etc. .... (T) (F)

PLEASE MAKE SURE THAT YOU HAVE ANSWERED EVERY QUESTION.

115. Has threatened or attempted suicide .... (T) (F)

116. Recent sex play with neighborhood children .... (T) (F)

117. Faints frequently .... (T) (F)

118. Likes to play with matches or fire in dangerous places (T) (F)

119. Frequently exposes self (shows genitals) .... (T) (F)

120. Says words that don't make sense: echoes you; talks or rhymes words without any sense to them .... (T) (F)

121. Spells poorly for age .... (T) (F)

122. Argues and fusses with friends .... (T) (F)

123. Refuses to get a shot or have a tooth filled .... (T) (F)

124. Recent sexual relations with a person of the opposite sex .... (T) (F)

125. Has a good sense of right and wrong .... (T) (F)

126. Appears to be totally alone or secluded: becomes irritable when seclusiveness is disturbed .... (T) (F)

127. Unusually afraid of social events or activities outside the home .... (T) (F)

128. Defies parents: is unmanageable .... (T) (F)

129. Prefers to be alone .... (T) (F)

130. Soils underpants or bed clothing .... (T) (F)

131. Complains of bad dreams or nightmares .... (T) (F)

132. For Girls Only: Concerned with body changes: menstruation, breast development, rapid or slow growth, etc.
For Boys Only: Concerned with body changes: voice, body hair, sexual discharges, rapid or slow growth, etc. (T) (F)

133. Is afraid of seeing or hearing something frightening at night .... (T) (F)

134. Masturbates—plays with self openly .... (T) (F)

135. Generally healthy .... (T) (F)

136. Bright, but doesn't apply self .... (T) (F)

137. Is overweight .... (T) (F)

138. Depressed: nothing seems worthwhile .... (T) (F)

139. Physically abusive, assaultive, hurts other children .... (T) (F)

140. Does not try new situations, "hangs back" (considered by others as fearful or shy) .... (T) (F)

141. Has trouble making and keeping friends .... (T) (F)

142. Very much afraid of loud noises .... (T) (F)

143. Is boisterous, rowdy .... (T) (F)

144. Destroys property willfully .... (T) (F)

145. Expresses delight over the happiness of others .... (T) (F)

146. Sticks pretty close to home .... (T) (F)

147. Excessively modest about body, in dressing and undressing, going to the toilet, etc. .... (T) (F)

148. Becomes "jittery," builds up tension, becomes "wound up" .... (T) (F)

149. Daydreams excessively; gets lost in own thoughts .... (T) (F)

150. Has recently been involved in unacceptable sexual behavior .... (T) (F)

151. Lies or cheats .... (T) (F)

152. Has asthma .... (T) (F)

153. Preoccupied with the body parts of others—like hands or breasts, etc. .... (T) (F)

154. Excessively afraid of taking tests, speaking or performing in public .... (T) (F)

155. Secure and confident—seldom worries .... (T) (F)

156. Can't talk—only grunts, points, or screams .... (T) (F)

157. Has frequent diarrhea for which the doctor has found no cause .... (T) (F)

158. Is a tattle-tale .... (T) (F)

159. Bossy with friends .... (T) (F)

160. Is disobedient; out of control of adults .... (T) (F)

161. Has migraine or "sick" headaches .... (T) (F)

162. Repeatedly in trouble with school authorities .... (T) (F)

163. Is always constipated; needs repeated laxatives or enemas .... (T) (F)

164. Has been hospitalized or placed in a special school for a mental or emotional disorder .... (T) (F)

165. Has used drugs or alcohol (T) (F)

PLEASE MAKE SURE THAT YOU HAVE ANSWERED EVERY QUESTION.

2

VITA

Lupe-Rebeka Samaniego

Candidate for the Degree of

Doctor of Philosophy

Thesis: PARENT-LOSS IN CHILDHOOD: EGO FUNCTIONS, DEATH AND MOURNING

Major Field: Psychology

Biographical:

Personal Data: Born in El Paso, Texas, December 17, 1949, the daughter of Jose Luis and Guadalupe Samaniego, and the granddaughter of the late Rafael Samaniego and Concepcion A. Samaniego.

Education: Graduated from Father Yermo High School, El Paso, Texas, in May, 1968; received the Bachelor of Arts degree in Psychology from the University of Texas at El Paso, El Paso, Texas, in August, 1971; received the Master of Science degree in Psychology from Oklahoma State University, Stillwater, Oklahoma, in July, 1974; completed the requirements for the Doctor of Philosophy degree in Psychology at Oklahoma State University in May, 1977.

Professional Experience: Counselor at Salem Rehabilitation Facilities in Salem, Oregon, summer, 1970; graduate research assistant, Department of Psychology, Oklahoma State University, 1971-1972; graduate teaching instructor, Department of Psychology, Oklahoma State University, 1972-1973; psychology graduate associate (pre-internship training) at the following settings: Payne County Mental Health Clinic, 1971-1972, Psychological Guidance Center, 1972-1973, Bi-State Clinic and Stillwater Municipal Hospital, 1973-1974; Psychology Trainee III at the Veteran's Administration Hospital in Oklahoma City, Oklahoma, 1973-1974; completed a pre-Doctoral APA approved internship in Clinical Psychology at the University of Colorado Medical School, Denver, Colorado, 1974-1975; Clinical Research Associate, Department of Psychiatry, at the University of Colorado Medical Center, 1975-1976; Clinical Psychology NIMH Fellowship in Child Clinical at the University of Colorado Medical School, Denver, Colorado, 1976-1977.