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EGO DEVELOPMENT, PSYCHIATRIC SYMPTOMATOLOGY, AND GENDER IN AN ADOLESCENT, INPATIENT SAMPLE

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EGO DEVELOPMENT, PSYCHIATRIC SYMPTOMATOLOGY, AND GENDER IN AN ADOLESCENT, PSYCHIATRIC INPATIENT SAMPLE

By

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ABSTRACT

EGO DEVELOPMENT, PSYCHIATRIC SYMPTOMATOLOGY, AND GENDER IN AN ADOLESCENT, PSYCHIATRIC INPATIENT SAMPLE

By

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This study attempts to explore the relationship among Loevinger's conception of ego development, psychiatric symptomatology, and gender in an adolescent, psychiatric inpatient sample (n=305). It was hypothesized that the impulsive stage of ego development would be associated with greater amounts of aggressive behavior, particularly among males, the conformist stage would be associated with greater levels of depressive symptomatology, especially among females, and the self-protective stage would be associated with greater amounts of delinquent behavior in both males and females. However, the data did not support these hypotheses, thus suggesting continuity among the levels of ego development. The present study also explores important limitations of the existing body of ego development literature and Loevinger's Sentence Completion Test.

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INTRODUCTION

Loevinger's (1976) conception of ego development is a unique description of moral, interpersonal, and cognitive development throughout the lifespan. Unfortunately, research on ego development in recent years has been limited, particularly with regard to the relationship between ego development and psychopathology. The research on psychopathology that does exist suggests that there is greater impulsivity and aggression among adults and adolescents who fall in the earlier (preconformist) levels of ego development. However, this body of research has two significant limitations. First, it neglects to examine distinctions in psychopathology that might exist between the two stages that make up the preconformist level. This deficiency is particularly problematic because Loevinger describes meaningful theoretical differences between the two stages. A second issue inadequately addressed by the existing literature is the role that gender may play in the relationship of psychopathology and ego development. A solid body of literature has suggested strong associations between gender and type of psychopathology. Thus, it is important to consider the possibility that gender may moderate the relationship between stage of ego development and psychopathology. The present study will explore these issues utilizing an adolescent, psychiatric inpatient sample.

Ego Development

The term "ego" has been used by many theorists and, as such, has acquired many meanings. When Loevinger refers to the ego, she is describing what also might be understood as the "self." In her conception, the ego is the frame of reference through which all behavior is organized. This organization is not simply what the ego *does*, but

is what the ego *is*. The ego structure creates a sense of stability and coherence in an individual's experience of his or her world (Loevinger, 1976).

Loevinger's conception of ego development describes ten major *stages* (presocial, symbiotic, impulsive, self-protective, conformist, self-aware, conscientious, individualistic, autonomous, integrated) that vary along four *dimensions* (impulse control/character development, interpersonal relations, conscious preoccupations, and cognitive complexity). All but the first two stages are considered to be measurable. Stages are represented by both symbols[1] (e.g., E2, E3, E4) and names (e.g., impulsive, self-protective, conformist). Although the names suggest the most salient characteristics present at each stage, the names are not meant to imply that the stage is only distinguished by one characteristic, or that the characteristic is only present at one stage. Stages cannot be defined without considering the entire constellation of characteristics present. Further, Loevinger has stated that the four dimensions are not meant to be examined individually, but rather they are best understood as a single dimension. They are four facets of a single, coherent process. This integration, described as a "complexly interwoven fabric," is the essence of the ego (Hy & Loevinger, 1996; Loevinger, 1976).

The stages of ego development are subsumed within three higher order levels: the preconformist, conformist, and postconformist levels. The preconformist level consists of the presocial, symbiotic, impulsive (E2) and self-protective (E3) stages. The presocial and symbiotic stages are considered to be theoretical and are not able to be measured. Therefore, they will not be considered further here. Individuals at the E2 and E3 stages

[1] Loevinger's (1976) original symbols for the stages of ego development (I-2, Delta, I-3, I-3/4, I-4, I-4/5, I-5, I-6) were revised in the second edition of her scoring manual (Hy & Loevinger, 1996) to become E-levels (E2, E3, E4, E5, E6, E7, E8, respectively.) For clarity, the present study will use the E-level terminology throughout this document.

of the preconformist level are impulsive and fearful, have stereotyped cognitive styles, and are interpersonally dependent or exploitive. Individuals in the conformist level (conformist [E4] or self-aware[2] [E5]) are especially concerned with maintaining interpersonal relationships. Internal states are often expressed in terms of clichés and stereotypes. The postconformist level consists of the conscientious (E6), individualistic (E7), autonomous (E8), and integrated (E9) stages. At this level, individuals cope with inner conflict through a high degree of self-awareness and show more cognitive complexity. Their interpersonal relationships are characterized by mutuality and respect for individual differences (Loevinger, 1976).

Loevinger suggests that ego development is applicable to individuals across the lifespan and is a major dimension of individual differences at all age levels. The process of ego development is not a smooth, linear course, nor does it have a finite beginning and end. It is best thought of as an on-going process. In fact, although Loevinger describes a "final" stage of ego development (E9), she emphasizes that this rather uncommon stage is not actually an endpoint, but rather "an opening to new possibilities." Consistent with this lifespan orientation, Loevinger has hesitated to tie specific ages to specific stages. The descriptions of each level are written without reference to normative developmental activities (e.g., attending school). However, she has recognized that it is theoretically impossible for children to be at the highest level, and it is maladaptive for adults to be at the lowest level (Loevinger, 1976). In a general sense, though, the different levels can be thought of as different personality types, with well-functioning individuals at each level.

[2] The self-aware stage was formerly known as the conscientious-conformist stage. The new terminology is intended to reflect a shift in the conceptualization of this stage from merely a transitional stage to an important stage in its own right (Hy & Loevinger, 1996)

Ego Development and Adolescence

The current study will focus on ego development in adolescence. Defining the exact boundaries of adolescence is a difficult task due to the numerous, diverse transitions which occur during the second decade of life. In many respects, determining when adolescence begins and ends is a matter of opinion rather than fact, with the definition varying according to the context (Steinberg, 2002). In the present study, adolescence will be defined as ages 12-17. The lower bound of this range reflects an age at which individuals generally have begun the physical transformations of puberty (Peterson, 1988). Additionally, in the United States, this age approximately coincides with the transition from elementary school to junior high or middle school. The upper bound of this range reflects sample availability. This age range also reflects fairly typical sample characteristics used in the existing literature on adolescent ego development (e.g., Borst & Noam, 1993; Noam et al., 1994; Noam & Houlihan, 1993).

Adolescence is a time of particular interest with regard to ego development because it involves both personality development and reorganization—the essence of ego development. Perhaps one of the best-known descriptions of this time in life is Erik Erikson's concept of identity versus identity diffusion. This stage is described as the consolidation of social roles and the integration of a variety of identities (Erikson, 1959). The work of Susan Harter and colleagues (1997) on adolescence suggests similar issues in the development of the self. She has suggested that young adolescents can only construct single abstractions of the self; that is, they can only understand their identity in one way. In mid-adolescence, individuals can compare, but not resolve, contradictory attributes of the self. Finally, in late adolescence, the individual can integrate and resolve

seemingly contradictory attributes into a single self-concept (Harter, Bresnik, Bouchey, & Whitesell, 1997). Although Loevinger does not directly tie specific ego development transitions to the adolescent time period, the transformations that she describes seem consistent with the emphasis that these theories place on reorganization and integration of the self.

According to Loevinger, individuals typically move from the preconformist level of functioning (E2 and E3 stages) to the conformist stage (E4) during the early elementary school years. If the individual transitions beyond the conformist stage, he or she is likely to do so around age 20 (Loevinger & Wessler, 1970). Thus, we would expect adolescents to typically fall in the E4 stage, with some transitioning beyond this stage to the E5 and E6 stages. Individuals in the conformist stage are characterized by conformity to external rules and experience much shame and guilt for breaking these rules. Interpersonally, they are concerned with belonging and helping, and they may engage in superficial niceness. E4 individuals are also concerned with appearance, social acceptability, and behavior. Finally, cognitively, they are characterized by conceptual simplicity, stereotypes, and clichés (Loevinger, 1976). Although the conformist stage is developmentally typical for adolescents (Loevinger & Wessler, 1976; Noam, Paget, Valiant, Borst, & Bartok, 1994), there are liabilities in this mode of functioning, and this, as well as earlier stages, may be conducive to developing certain types of psychiatric symptomatology.

Ego Development and Psychopathology

Although Loevinger (1976) describes ego development independent of chronological age, age has been the major predictor of ego development in a number of

cross-sectional and longitudinal studies of healthy adolescents (Noam et al., 1994). While Loevinger emphasizes that psychopathology occurs at all levels of ego development, empirical research has suggested that individuals with greater psychopathology are found at lower levels of ego development, particularly the E2 and E3 stages that make up the preconformist level (e.g., Frank & Quinlan, 1976; Noam, Hauser, Santostefano, Garrison, Jacobson, Powers, & Mead, 1984; Noam & Houlihan, 1990). In one study, healthy high school students were compared to adolescent, psychiatric inpatients. While 65% of the high school students were at or above the conformist level, only 10% of the psychiatric control group had advanced to the same level (Hauser, Jacobson, Noam, & Powers, 1983). In another study, only 21.1% of a psychiatric sample fell within the conformist level or above (Noam et al., 1984). Finally, in a third study, over 80% of psychiatric inpatients were delayed in ego development compared to only 10% of a non-clinical control group (Noam, 1984; as cited in Noam et al., 1984).

Research has also suggested that individuals at preconformist levels of ego development experience greater numbers of psychiatric symptoms (Noam et al., 1984). For example, when DSM-III diagnoses were rank-ordered according to severity among an adolescent, psychiatric inpatient sample, the results generally suggested that as the severity of the diagnosis increased, there were more subjects at the preconformist level and fewer subjects at the conformist level (Noam & Houlihan, 1990). In another study, with a similar sample, a modest, but significant inverse relationship was found between stage of ego development and likelihood of initiating assaults, having accidents, and

making suicide attempts. Additionally, individuals at lower levels of ego development tended to be hospitalized longer (Browning, 1986).

Unfortunately, previous research has been somewhat general and has rarely explored possible differences in psychopathology that might exist between the E2 and E3 stages, instead combining them and analyzing them together as the preconformist level (e.g., Noam et al., 1994). Therefore, an important goal of this study is to examine these stages individually. Loevinger's (1976) theory describes the E2 stage as characterized by impulsivity, fear of retaliation, and a dependent and/or exploitive interpersonal style. Individuals in this stage are particularly concerned with bodily feelings. Cognitively, they exhibit stereotypy and conceptual confusion. The E3 stage is described as characterized by a fear of being caught. These individuals are apt to externalize blame and act opportunistically. Interpersonally, they may be wary, manipulative, and/or exploitive. They are concerned with self-protection, advantage, and control (Loevinger, 1976).

The only study to date that examined the E2 and E3 stages separately found important differences, consistent with theory (Frank & Quinlan, 1976). Delinquent girls were more likely to fall into the E2 stage than were non-delinquent girls. Further, qualitative information gleaned from interviewing the participants revealed that objectively similar behaviors often had dissimilar meanings for E2 and E3 individuals. For example, individuals in the E2 stage often reported fighting at random and were easily provoked. In contrast, individuals in the E3 stage tended to fight with a specific goal in mind and "when they had to" (Frank & Quinlan, 1976). Although this study is clearly an important contribution to the literature, it is limited by a unique sample (i.e. all

female, minority, inner city residents), which may not be generalizable to other non-clinical groups and psychiatric populations. Additionally, there is a need to attempt to replicate the findings.

One explanation for the relationship between delayed ego development and psychiatric impairment is the age-stage dysynchrony that occurs when an adolescent attempts to meet the demands of a more mature world with a primitive frame of reference (Noam et al., 1984). In adolescence, the individual must renegotiate relationships with parents and peers. Coping strategies that were adequate in childhood may no longer allow the individual to function appropriately in these complex relationships (Noam et al., 1984). For example, in adolescence, individuals typically begin to spend more time with peers rather than family members. They begin to look to these peers for emotional support, and in doing so begin to establish independence and greater autonomy from their family of origin (Larson & Richards, 1994). The adolescent must adapt to the significant reorganization of his or her world. The preconformist adolescent is equipped with unsophisticated models of interpersonal relationships, weak impulse control, and limited cognitive complexity, making this reorganization a significant obstacle.

The connection between ego development and psychological functioning is even more apparent when one considers the traits of several psychiatric diagnoses that are prevalent among adolescents. Disruptive behavior disorders are estimated to affect 10.3% of individuals ages 9 to 17 (Shaffer et al., 1996). Several of the behaviors associated with a diagnosis of Conduct Disorder (CD) can be construed as developmental deficits. The lack of guilt and concern for others' feelings and property corresponds to the self-interest characteristic of the preconformist levels of ego development (Noam et

al., 1984). For instance, Loevinger states that individuals in the E2 stage view and value others largely in terms of what the person will give them or do for them. Loevinger describes individuals in the E3 stage as prone to externalizing blame for problems. They are hedonistic and opportunistic and frequently unable to see their role in creating any negative outcome (Loevinger, 1976).

However, focusing only on DSM-IV diagnoses to better understand ego development and psychopathology is problematic, due to the imprecision of the DSM, which combines both overt or aggressive (e.g., physical fighting, bullying) and covert or delinquent (e.g., lying, theft, cheating) antisocial behaviors under the diagnosis of CD (American Psychiatric Association, 1994). This characteristic of the CD diagnosis has been widely criticized due to important differences in onset, correlates, and trajectories for individuals with predominantly overt versus covert behaviors (Achenbach, 1993). When relating antisocial behaviors to ego development, it is essential to distinguish among these behaviors. Although both overt and covert deviance relate to the preconformist level in a general sense, it is likely that they relate differentially to the levels that make up the preconformist level. Specifically, individuals in the E2 stage should engage in more impulsive behaviors, including aggression. On the other hand, individuals in the E3 stage should have a higher level of cognitive complexity and self-control leading them to engage in more planful, covert behaviors. It is also notable that the age of onset for overt and covert behaviors fits neatly with the ego development literature. As the impulsive stage of ego development precedes the self-protective stage, the development of overt behaviors, precedes the development of covert behaviors (Moffit, 1993). Thus, when relating conduct disorders to psychopathology,

differentiation of the E2 and E3 stages is valuable; however, with the exception of the Frank and Quinlan (1976) study, previous research has always combined the stages (e.g., Gold, 1980; Noam & Houlihan, 1991).

Examining ego development among adolescents may also aid in understanding another common adolescent psychiatric problem: depression. Major Depressive Disorder is estimated to affect 10% of adolescents, 75% of whom are female (McFarlane, Bellissimo, Norman, & Lange, 1994). A significant body of literature has suggested that there are two distinct groups of individuals who experience depression: those who experience mainly interpersonal preoccupations and those who experience mainly self-critical preoccupations (i.e., concerns about competence and personal goals) (Blatt, 1974; Blatt & Zuroff, 1992). Individuals classified in the interpersonal preoccupation group are prone to view themselves as helpless, fear abandonment by others, and have an extreme desire for closeness and nurturing by others (Blatt, 1974; Blatt & Zuroff, 1992). They may rely strongly on social approval to maintain self-esteem (Gold, 1980). Thus, it is hypothesized that depression occurs among interpersonally preoccupied individuals in response to disruptions in satisfying interpersonal relationships (Blatt, 1974; Blatt & Zuroff, 1992). The etiology of depression in the interpersonally preoccupied group is consistent with Loevinger's description of individuals in the E4 (conformist) level. Previous empirical research has also supported the connection between depression and the E4 level, suggesting that there are higher levels of depressive symptomatology among individuals in the conformist level compared to those in the preconformist level (Gold, 1980; Noam & Houlihan, 1991). Previous literature has combined the E2 and E3 stages into the preconformist stage when examining depressive symptomatology. This

consolidation has thus far prevented researchers from assessing whether symptoms occur with equal frequency among individuals in the E2 and E3 stages. Additionally, due to the level of cognitive complexity of E3 individuals, it seems likely that, while they will have lower levels of depressive symptomatology than the E4 individuals, they will have higher levels than the E2 individuals.

Ego Development and Gender

Relating psychiatric symptoms to specific stages of ego development has the potential to increase our understanding of both. However, because gender has a unique association with both ego development and specific forms of psychopathology, an examination of its influence is necessary to fully understand the symptomatology during adolescence. Block (1984) suggested that each stage of ego development can be associated with specific stages in the development of sex role identity. Although a detailed discussion of her theory is beyond the scope of this study, it is useful to note that she associates the preconformist stages with the initial understanding of gender identity and the desire to maximize personal advantage. Unfortunately, little of the empirical literature on ego development has addressed gender-related issues. Many studies include only females (Loevinger's original theory was developed using women only), and even those studies that use mixed samples frequently fail to examine gender differences (e.g. Jacobson, Hauser, Powers, & Noam, 1984; Noam & Houlihan, 1991). One study that did consider gender controlled for gender differences in psychopathology, rather than analyzing it as a primary point of interest (Noam et al., 1994).

Gender and Conduct Disorders. On the other hand, a voluminous body of research has addressed gender differences in behavioral problems. The two types of antisocial

behavioral problems described earlier (overt and covert), differentially affect males and females. While overt conduct problems are more prevalent among males, covert behavioral problems are equally prevalent in both genders (Zoccolillo, 1993). The higher rate of both physical and verbal aggression among males is a consistent finding, even found in cross-cultural research (Parke & Slaby, 1983).

It has been suggested that conduct problems follow two distinct pathways (Moffit, 1993). The life-course-persistent pathway is characterized by both overt and covert behaviors, onset in early to middle childhood, and behavioral problems lasting throughout the lifespan. The adolescence-limited pathway is characterized by a relative absence of overt, aggressive behaviors, adolescent onset, and substantial rates of recovery. It has been hypothesized that such conduct problems are highly influenced by socialization and may stem from attempts to attain status and prestige by copying peers who have been deviant since childhood (Moffit, 1993). These two pathways are pertinent to this discussion because the life-course-persistent pathway contains a higher proportion of males, while the adolescence-limited pathway contains roughly equal numbers of males and females (Moffit, 1993).

Although gender differences in expression of conduct problems may be influenced by biological and genetic factors, these differences may also be strongly influenced by socialization patterns beginning early in life. Through socialization there is an emphasis on agency for males and communion for females (Block, 1984). Parents may respond with greater disapproval when young girls act aggressively (Condry & Ross, 1985). In fact, by middle childhood, boys expect less parental disapproval and report feeling less guilty over aggression than do girls (Perry, Perry, & Weiss, 1989). Thus, there are

important differences in the types of antisocial behaviors in which males and females engage, regardless of the etiology of the behavior. Therefore, it seems probable that the relationship between psychiatric symptomatology and level of ego development will be particularly strong when the symptoms are consonant with common gender-related patterns of behavior. In other words, if individuals in the impulsive stage exhibit impulsive, under-controlled aggression, male adolescents will be more likely to exhibit these problems because such aggressive behavior is more common. On the other hand, the delinquent, social role violations that are expected to be associated with the self-protective stage are likely to occur with equal frequency among both males and females.

Gender and depression. Just as there are important gender differences in antisocial behaviors, there are notable gender differences in rates of depression in adolescence. Studies consistently find, beginning at adolescence, that girls begin to experience more depression than boys (Cyranowski, Frank, Young, & Shear, 2000). Although research has suggested that hormonal fluctuations, gender roles, and societal disadvantage are likely to play a role in this gender disparity (Cyranowski et al., 2000), research has also suggested that female adolescents' affiliative needs may make them particularly susceptible to depressive symptomatology (Nolen-Hoeksema & Girgus, 1994).

As previously discussed, interpersonally preoccupied individuals may experience depression in response to disruptions in satisfying interpersonal relationships (Leadbeater, Blatt, & Quinlan, 1995). Females are more likely to place a greater value on interpersonal relationships (Cyranowski et al., 2000). Although these differences in affiliative needs are present at a young age, they increase during adolescence (Larson & Richards, 1989). The increased desire for social connection can be a liability in

adolescence when social roles and structures are being redefined (Steinberg, 2002). The work of Carol Gilligan (1982) has also explored the great value women and girls place on social connections. She has described how in adolescence, girls are faced with a conflict where they must sacrifice their own desires and "take themselves out of the relationship" in order to maintain connections with others (Gilligan, 1982). Such a situation leaves the woman's identity and self-worth inextricably tied to interpersonal relationships and may leave her quite vulnerable when problems occur in relationships.

As previously mentioned, literature has suggested that individuals in the conformist stage of ego development are more likely to experience symptoms of depression (Gold, 1980, Noam & Houlihan, 1991). Further, Block (1984) has suggested that at the conformist stage, when individuals are particularly sensitive to societal influences, there is greater conformity to social roles, thus creating strong identity differences between males and females (Block, 1984). While boys are encouraged to control affect, girls are encouraged to control aggression (Block, 1984). This societal influence encourages females to exhibit depressive, rather than aggressive, symptoms. Therefore, it is expected that the depressive symptomatology associated with the conformist stage will be more prevalent among females. Unfortunately, previous research has not examined this potentially meaningful relationship between gender and ego development.

Rationale

Loevinger's conception of ego development provides a meaningful framework for understanding human behavior and development. The concept synthesizes diverse aspects of development, including moral development, the development of interpersonal relations and the development of cognitive complexity. Further, ego development encompasses many clinically relevant dimensions, including impulse control, responsibility taking, and social judgment (Hauser, 1993). Thus a better understanding of the concept could potentially facilitate meaningful clinical applications of ego development. While previous research has suggested that ego development is meaningfully related to psychopathology (e.g., Frank & Quinlan, 1976; Noam, et al., 1984; Noam & Houlihan, 1990), there are several important limitations to this literature.

Research addressing these issues has primarily been conducted by a small group of authors (e.g. Borst & Noam, 1993; Noam, 1984; Noam & Houlihan, 1990; Noam et al., 1984; Noam, et al., 1994). There is a need for additional researchers to replicate these findings in a different setting.

Second, previous research has not differentiated between the E2 (impulsive) and E3 (self-protective) stages, instead combining them as the preconformist stage and contrasting them with the E4 (conformist) stage in data analyses. In fact, only one study thus far has examined the distinction between the E2 and E3 stages (Frank & Quinlan, 1976). The paucity of literature on this topic is particularly problematic because Loevinger's theory describes important distinctions in impulsivity and cognitive

complexity between these stages. These distinctions may result in differences in psychiatric symptomatology.

A third limitation of the previous literature is that the measures assessing psychiatric status and impairment have notable weaknesses. For example, several studies have used DSM diagnoses. This is problematic because a variety of symptoms are included under each diagnosis and two individuals qualifying for the same diagnosis may have very different symptom pictures. This issue is especially salient with regard to the diagnosis of Conduct Disorder that combines both overt and covert forms of antisocial behavior (Achenbach, 1993). Another instrument commonly used in the literature is the Child Behavior Checklist (CBCL; Achenbach, 1991). On this measure, parents are asked to rate descriptions such as "disobedient at school" and "nervous, highstrung, or tense" using a rating scale in which 0 = not true, 1=somewhat/sometimes true, and 2=very true or often true. However, the child's score is dependent on parent's idiosyncratic definitions of which behaviors constitute the descriptor. For example, one parent might define disobedience as a relatively mild misbehavior such as talking during class; whereas another parent might define it as a very severe misbehavior, such as physical aggression toward the teacher. Further, while one parent may rate a behavior that occurs weekly as a somewhat true descriptor (1) another parent may rate the same situation as very true (2).

Because fine behavioral distinctions are integral to this study, assessment of relevant psychiatric symptomatology will be assessed by an instrument that provides detailed information pertaining to a wide range of specific behaviors over the past three months (the Functional Impairment Scale for Children and Adolescents—FISCA; Frank & Paul,

1995). This instrument includes scales that differentiate between overt and covert behaviors. Additionally, the measure utilizes specific items that offer greater accuracy and consistency than measures such as the CBCL. For example, parents are asked whether their child has or has not "disobey[ed] school rules, but in ways that did not harm others" and "on purpose destroy[ed] or seriously damage[ed] school property" within the past three months. Additionally, several items such as, "go joy riding in a car without permission," are rated using a specific number of incidents (never, one time, two times or more).

Finally, previous research has neglected to examine the influence that gender has on both ego development and psychopathology. While some work has described gender identity (e.g., Block, 1984) and some work has described psychopathology (e.g., Frank & Quinlan, 1976; Noam, et al., 1984; Noam & Houlihan, 1990) and their individual relationships to ego development, very little previous work has examined the possibility that gender may moderate the relationship between ego development and psychopathology. Specifically, previous research has suggested that adolescent males are more likely to engage in aggressive acts (Zoccolillo, 1993), while adolescent females are more likely to experience depressive symptoms (Cyranowski et al., 2000). This study provides the opportunity to compare a large sample of both male and female adolescents' level of ego development and psychiatric impairment—a unique contribution to the current body of literature.

The present study will utilize a sample of 135 male and 170 female adolescent inpatients. The inpatient nature of the sample is expected to provide a large number of individuals in the preconformist level of ego development (Noam & Houlihan, 1991).

Adolescents in the sample have completed the Washington University Sentence Completion Test (SCT; Hy & Loevinger, 1996), which is considered to be the most appropriate way to assess level of ego development. Their parent/guardians have completed the FISCA (Frank & Paul, 1995) in order to describe psychiatric impairment. This study will provide the opportunity to replicate the findings of Noam and colleagues, and will expand upon this literature, by examining differences between the E2 and E3 stages, precisely assessing adolescent behaviors, and considering the influence of gender on the relationship between ego development and psychopathology.

The specific hypotheses of the study are:

1. Because of the psychiatric nature of the sample, it is expected that subjects will fall in the E2, E3, and E4 stages, rather than largely in the E4 stage as predicted by Loevinger's theory.
2. Individuals in the E2 stage will have higher levels of under-controlled aggression (FISCA aggression scale) than those in the E3 or E4 stages. Additionally it is expected that there will be an interaction effect, such that males in the E2 stage will have higher levels of under-controlled aggression than females in this stage.
3. Individuals in the E3 stage will have higher levels of covert antisocial behaviors, or social role violations (FISCA delinquency scale), than those in the E2 or E4 stages.
4. Individuals in the E4 stage will have higher levels of depressive symptomatology (derived from FISCA feelings and moods scale) than individuals in the E2 and E3 stages. Individuals in the E3 stage will have higher levels of depressive symptomatology than individuals in the E2 stage. Additionally it is expected that

there will be an interaction effect, such that females in the E4 stage will have higher levels of depressive symptomatology than males.

METHOD

Subjects

Data for this study were collected as part of a larger study of psychopathology in adolescent psychiatric inpatients. The sample includes 305 adolescents between the ages of 12 and 17 (Mean = 14.8 years; SD = 1.50). The participants are predominantly Caucasian (79.9%). The sample consists of 135 male (44.3%) and 170 (55.7%) female patients. See Table 1.

Measures

All of the following measures were completed as part of the hospital's routine intake procedures.

Demographic Information. Demographic information was obtained from a Social History Questionnaire completed by the adolescent's parent or guardian at the time of intake. Parents provided information on the adolescent's age, family income, parent education, living situation (e.g., two-parent home, single-parent home, foster home, etc.), grade, race/ethnicity, and insurance. (See Appendix A for a copy of the measure.)

Ego Development. Ego development was assessed using the Washington University Sentence Completion Test for Measuring Ego Development (SCT; Hy & Loevinger, 1996). The SCT consists of 36 sentence stems from which the participant generates full sentences. Sample items include: "Education...," "Men are lucky because...," and "Raising a family..." (See Appendix B for a copy of the measure.)

There is strong evidence for good reliability and validity for this measure (e.g., Hauser, 1976; Loevinger, 1979). Sentences are scored according to procedures outlined in the scoring manual (Hy & Loevinger, 1996). Specific scoring rules can be found in Table 2. Initially, each sentence is coded independently of other sentences in the same

protocol. When all sentences in a protocol are scored, the frequency of responses at each stage of ego development is recorded. Then cumulative frequencies are calculated for each stage. After cumulative frequencies are calculated, an overall ego development stage is derived by utilizing the ogive rules presented in Table 3.

Table 1.
Demographic Characteristics of Sample

	Frequency	*Percent*	*Sample Size (N)*
Sex			305
Male	135	44.26%	
Female	170	55.74%	
Ethnicity			268
Native American	12	4.48%	
Asian	1	0.37%	
Latino/a	16	5.97%	
African American	13	4.85%	
Caucasian	214	79.85%	
Other	7	2.61%	
Multiracial	5	1.87%	
Family total income			255
Less than $8,000	28	11.0%	
$8,000-$11,999	40	15.7%	
$12,000-$19,999	41	16.1%	
$20,000-$29,999	31	12.2%	
$30,000-$44,999	46	18.0%	
$45,000-$69,999	50	19.6%	
$70,000-$100,000	12	4.7%	
More than $100,000	7	2.7%	
Mean age	14.8 (SD = 1.50)		304
Mean length of psychiatric hospitalization	13.11 days (SD = 6.06)		247

Table 2.
Rules for Scoring Individual Sentences.[1]

Rule 1	Match the content of the completion with one of the listed category titles.
Rule 2	Where the combination of two or more elements in a compound response generates a more complex level of conception, rate the response one-half step higher than the highest element.
Rule 3	Where the combination of ideas in a compound response does not generate a higher level of conceptual complexity, rate the response in the less frequent category, or rate the higher category.
Rule 4	In the case of a meaningful response, where there is no appropriate category and rules 2 and 3 do not apply, use the general theory to arrive at a rating.
Rule 5	Where the response is omitted or too fragmentary to be meaningful, it is rated E4.

[1] Adapted from Hy and Loevinger (1996)

Table 3.
Automatic Rules for Assessing Total Protocol Ratings to the Ogive of Item Ratings.[1,2]

Overall ego development stage is:	If there are:
E9[3]	No more than 34 ratings at E8
E8	No more than 31 ratings at E7
E7	No more than 30 ratings at E6
E6	No more than 24 ratings at E5
E5	No more than 20 ratings at E4
E2	At least 5 ratings at E2
E3	At least 6 ratings at E3
E4	Other Cases

[1] Adapted from Hy & Loevinger (1996)
[2] Apply these rules in the order given, from E9 to E4
[3] To receive an E9 rating , the E8 criterion must also be met.

Psychiatric Symptomatolgy. The Functional Impairment Scale for Children and Adolescents (Frank & Paul, 1995) is a 183-item, multidimensional parent-report questionnaire with eight scales: aggression, thinking, home, delinquency, alcohol and drugs, school, self-harm, and feelings and moods. Most items use "yes/no" or "never/occasionally/often" response formats. Several additional items employ a multiple-choice format. Sample items include "How many times in the past three months has the child skipped school?" and "How often in the past three months did your child have very sudden changes in mood?" (See Appendix C for a copy of the measure.) Each FISCA domain is scored on a three point scale ranging from 1-3 indicating mild, moderate, or severe impairment, respectively. The present study will focus on the aggression and delinquency scales and the depression-related questions from the feelings and moods scale.

The FISCA scoring criteria were influenced conceptually by the Child and Adolescent Functional Assessment Scale (Hodges, 1994; Hodges, Bickman, Kurtz, & Reiter, 1992; Hodges & Gust, 1995). Adequate internal reliability has been demonstrated for all scales, except for the Home scale ($\alpha = .28$). Alpha coefficients for all other scales range from .54 to .87, with a mean of .73 (Frank, Paul, Marks, & VanEgeren, 2000).

Assessment of relative and absolute agreement between parent report on the FISCA and adolescent report on a self-report version of the FISCA (FISCA-SR; Frank & Paul, 1995) indicates satisfactory agreement (Frank, VanEgeren, Fortier & Chase, 2000). Inter-informant correlation was strongest for the Aggression scale and weakest for the Thinking and Feelings and Moods scales. This was consistent with predictions that

agreement would be stronger on variables related to overt behaviors and weaker on variables related to the adolescents' private thoughts and feelings.

Procedures

Data for the study were collected as part of the hospital's routine intake assessment. Consent to utilize assessment data for research purposes as well as treatment planning was obtained at adolescent's hospital admission from a parent/guardian. This information was also presented to the adolescent when the measures were administered and verbal assent was obtained. A parent or guardian completed the Social History Questionnaire and FISCA at the time of the intake. During the first 24 to 36 hours of the adolescent's hospitalization, undergraduate externs individually administered the SCT. Externs were trained in a small group by a university faculty member and they were supervised at weekly group meetings. Information obtained from the questionnaires was used by the hospital for diagnosis, treatment planning, and development of family intervention strategies.

The SCT was scored by two raters trained according to published training exercises (Hy & Loevinger, 1970) and supervised by an experienced coder. Once acceptable reliability was obtained with the experienced coder ($\underline{r}$ = .71 and $\underline{r}$ = .74), the raters coded the protocols individually. Raters met regularly to address scoring-related issues and double-coded an additional subset of protocols (n=15) to prevent scoring drift. Overall inter-rater reliability was comparable to previously published studies utilizing the SCT ($\underline{r}$ = .82).

RESULTS

The present study included a sample of three hundred and five adolescent, psychiatric in-patients who completed Loevinger's Sentence Completion Test, a measure of ego development (Hy & Loevinger, 1996; Loevinger & Wessler, 1970). The number of subjects that fell at each ego level is presented in Table 4. As noted, 86 subjects were rated at the E5 or E6 level and therefore were excluded from the analyses of hypotheses two through four, which did not make predictions about these higher levels[3].

Table 4.

Number of Participants Rated at Each Level of Ego Development (n=305)

	E2	E3	E4	E5	E6
Number of Participants	30	144	45	80	6
Percent of Sample	9.8%	47.2%	14.8%	26.2%	2.0%

The major variables in this study were: ego development level, aggression, delinquency, and depression. Correlations among these variables, as well as income, age, and length of stay, are presented in Table 5.

[3] The E5 group will be discussed further in the post hoc analyses section.

Table 5.
Correlations Among Major Variables

	Ego Level	Income	Age	Length of stay	Aggrssn	Delnqncy	Deprssn
Ego Level	1.00 (n=305)						
Income	.081 (n=255)	1.00 (n=255)					
Age	.250** (n=293)	.160* (n=255)	1.00 (n=293)				
Length of stay	-.144* (n=247)	-.212** (n=229)	-.227** (n=247)	1.00 (n=247)			
Aggrssn	.001 (n=305)	-.061 (n=255)	-.126* (n=293)	.134* (n=247)	1.00 (n=305)		
Delnqncy	-.054 (n=305)	-.073 (n=255)	-.093 (n=293)	.113 (n=247)	.302** (n=305)	1.00 (n=305)	
Deprssn	-.019 (n=302)	0.71 (n=253)	.113 (n=290)	.061 (n=244)	.084 (n=302)	.004 (n=302)	1.00 (n=302)

* significant at the $p<.05$ level

**significant at the $p<.01$ level

As noted in the table, level of ego development was significantly and positively correlated with age ($r=.250$, $p<.01$), consistent with previous literature. There was also a significant, positive correlation between aggression and delinquency ($r=.302$, $p<.01$).

Due to missing data for individual subjects, analyses including the aggression and depression scales contained 209 and 207 subjects, respectively. Descriptive statistics for the aggression, delinquency, and depression scales are presented in Table 6.

Table 6.
Scores on FISCA Aggression, Depression, and Delinquency Scales as a Function of Level of Ego Development and Sex

		E2		E3		E4	
		Female (n=10)	Male (n=20)	Female (n=73)	Male (n=63)	Female (n=23)	Male (n=20)
Aggression (n=209)	Mean	2.30	2.50	2.55	2.65	2.43	2.45
	SD	1.06	0.83	0.76	0.77	0.90	0.80
		Female (n=9)	Male (n=20)	Female (n=72)	Male (n=63)	Female (n=23)	Male (n=20)
Depression (n=207)	Mean	3.00	2.75	2.96	2.92	2.78	2.80
	SD	0.00	0.64	0.26	0.33	0.52	0.52
		(n=30)		(n=144)		(n=45)	
Delinquency (n=219)	Mean	1.83		1.89		1.71	
	SD	1.15		1.21		1.29	

The first hypothesis was that, due to the psychiatric nature of the sample, subjects would fall in the E2, E3, and E4 stages rather than largely in the E4 stage. In order to test this hypothesis, a chi-square statistic was computed. Expected number of subjects at or above the E4 level was set at 65% of the sample, as suggested by results of the work of Hauser et al. (1983). Since previous work did not adequately distinguish between subjects at the E2 and E3 levels, it was impossible to make a precise prediction with

regard to the expected number of subjects at each of these levels. Therefore, the E2 and E3 levels were combined when calculating the chi-square statistic and it was expected that 35% of the subjects would fall at this combined level. The chi-square was significant [$\chi^2(1, 305) = 181.59$, $p<.01$]. These results support the hypothesis that this psychiatric sample has a greater number of individuals in the E2 and E3 levels than would be expected in a non-psychiatric sample.

It was hypothesized that individuals in the E2 stage would have higher levels of under-controlled aggression than those in the E3 or E4 stages. Further, it was predicted that gender would interact with ego stage, such that E2 males would have higher levels of under-controlled aggression than E2 females. In order to test this hypothesis, a 3 x 2 between subjects analysis of variance was conducted. The ANOVA did not result in a significant main effect for ego development level [$F(2, 208) = 1.098$, MSE = .704, ns]. The interaction between level of ego development and sex also was not significant [$F(2, 208) = 0.112$, MSE = .0717, ns] See Table 7.

Table 7.
Analysis of Variance for Aggression (n=209)

Source	Df	F	MSE	p
Ego Level	2	1.098	.704	0.336
Gender	1	0.578	.371	0.448
Ego Level x Gender	2	0.112	0.071	0.894
Error	203		0.641	

The third hypothesis was that individuals in the E3 stage would have higher levels of delinquent behaviors than those in the E2 or E4 stages. This hypothesis was tested with a one-factor between subjects analysis of variance to determine whether level of ego development (E2, E3, or E4) affected delinquency levels reported on the FISCA. The ANOVA did not result in a significant main effect for ego development level [$F(2, 218) = .368$, MSE = .544, ns]. See Table 8.

Table 8.
Analysis of Variance for Delinquency (n=219)

Source	Df	F	MSE	p
Ego Level	2	0.368	0.544	0.693
Error	216		1.480	

The fourth hypothesis was that individuals in the E4 stage would have higher levels of depression than individuals in the E2 and E3 stages and individuals in the E3 stage would have higher levels of depression than individuals in the E2 stage. Additionally, an interaction was predicted such that females in the E4 stage would have higher levels of symptomatology than males. Depression scores were derived from a subset of questions from the FISCA feelings and moods scale. In order to test this hypothesis, a 3 x 2 between subjects analysis of variance was conducted. The ANOVA did not result in a main effect for ego level [$F(2, 207) = 2.420$, MSE = .365, ns]. Additionally, there was not a significant interaction effect between ego level and gender [$F(2, 206) = .999$, MSE = .151, ns]. See Table 9.

Table 9.
Analysis of Variance for Depression (n=207)

Source	Df	F	MSE	p
Ego Level	2	2.420	0.365	0.092
Gender	1	1.702	0.257	0.193
Ego Level x Gender	2	0.999	0.151	0.370
Error	201		0.151	

POST HOC ANALYSES

One surprising finding of the present study was the relatively large number of adolescents who were at the E5 level of ego development (26.2%). Exploratory analyses were undertaken to better understand both the E5 group and the sample utilized in this study. Three major possibilities existed for interpreting the E5 data. First, the E5 individuals may simply be a distinct category, with their own unique patterns of psychopathology. Second, the E5 individuals may be somewhat similar to the E4 individuals, as the E5 stage follows the E4 stage. Finally, due to the design of the SCT scoring system, it is possible that a single response could move a protocol from an E3 rating to an E5 rating. Therefore, the E5 category may appear similar to the E3 category.

Statistical analyses of hypotheses 2-4 were re-calculated including all E-levels in order to determine if the inclusion of the E5 individuals would suggest trends not visible in prior analyses. However, this alteration in analyses did not result in changes in significance of results. The results of these additional analyses are presented in Tables 10-13.

Table 10.
Scores on FISCA Aggression, Depression, and Delinquency Scales as a Function of Level of Ego Development and Sex, Including All Ego Development Levels

		E2		E3		E4		E5		E6	
		F (n=10)	M (n=20)	F (n=73)	M (n=63)	F (n=23)	M (n=20)	F (n=55)	M (n=23)	F (n=4)	M (n=2)
Aggrsn (n=293)	Mean	2.30	2.50	2.55	2.65	2.43	2.45	2.56	2.39	2.50	3.00H
	SD	1.06	0.83	0.76	0.77	0.90	0.80	0.66	0.72	0.58	0.00
		F (n=10)	M (n=20)	F (n=73)	M (n=63)	F (n=23)	M (n=20)	F (n=55)	M (n=23)	F (n=4)	M (n=2)
Delnqncy (n=293)	Mean	1.50	2.00	1.59	2.19	1.30	2.35	1.55	1.87	2.00	2.50
	SD	1.35	1.03	1.29	1.05	1.29	0.99	1.32	1.25	1.41	0.71
		F (n=9)	M (n=20)	F (n=72)	M (n=63)	F (n=23)	M (n=20)	F (n=55)	M (n=23)	F (n=4)	M (n=2)
Deprssn (n=293)	Mean	3.00	2.75	2.96	2.92	2.78	2.80	2.91	2.78	3.00	3.00
	SD	0.00	0.64	0.26	0.33	0.52	0.52	0.35	0.60	0.00	0.00

Table 11.
Analysis of Variance for Aggression, Including E5 and E6 Levels (n=293)

Source	df	F	MSE	p
Ego Level	4	0.795	0.467	0.529
Gender	1	0.655	0.384	0.419
Ego Level x Gender	4	0.564	0.331	0.689
Error	283		0.587	

Table 12.
Analysis of Variance for Delinquency, Including E5 and E6 Levels (n=293)

Source	Df	F	MSE	p
Ego Level	4	0.629	0.961	0.642
Error	300		1.528	

Table 13.
Analysis of Variance for Depression, Including E5 and E6 Levels (n=293)

Source	df	F	MSE	p
Ego Level	4	1.479	0.237	0.209
Gender	1	0.890	0.142	0.346
Ego Level x Gender	4	0.582	0.093	0.676
Error	280		0.160	

DISCUSSION

The results of this study support the hypothesis that this psychiatric sample had greater number of individuals in the preconformist stages than would be expected in a healthy adolescent sample. However, results did not support the other three hypotheses of this study. There were not significant differences in aggression, delinquency, or depression scores for the different levels of ego development. There also were not significant differences between males and females on aggression or depression scores.

These findings suggest continuity between stages of ego development. Loevinger has stated that no single presence of or lack of a behavior defines a stage and that ideas present at one level of development are often present in a more complex form in later stages (Loevinger, 1976). Although Loevinger presents a description of ego development with clearly defined boundaries between stages, she also acknowledges meaningful continuity among them. The results of the present study emphasize the similarities among the E2, E3, and E4 stages.

The findings of this study also suggested similarity in psychiatric symptomatology between male and female subjects. One possible explanation for this finding is that the psychiatric nature of the sample created a restriction of range. All of the adolescents were considerably impaired in one regard or another, such that they required psychiatric hospitalization. It is possible that the influence of the subjects' severe psychopathology was greater than the influence of the subjects' gender roles. Perhaps the hypothesized differences between groups would appear more readily in a non-hospitalized or community sample.

A second possibility is that gender roles have not been thoroughly socialized in this sample. First, the sample contained a large number of individuals who were at early levels of ego development. Although Block (1984) has stated that the preconformist stages are associated with an initial understanding of gender identity, it is plausible that this limited understanding was insufficient to exert a measurable influence over symptomatology. Secondly, research has suggested that the intensification of gender roles that occurs in adolescence is directly related to the chronological age of the adolescent (Galambos, Almeida, & Petersen, 1990). Perhaps the subjects in the present study (mean age =14.8) were too young for the effects of gender to be pronounced.

Potential limitations of the SCT

On the other hand, it is possible that limitations of the SCT prevented the present study from revealing differences among the levels of ego development. One explanation is that the SCT does not sufficiently differentiate between the preconformist E2 and E3 levels. Due to the theoretically small number of individuals at these levels in the general population, standardization samples have included relatively few of these subjects. Table 14 presents the distribution of the sample for both the original and revised manuals along with the distribution for the present study. As noted in the table, the total number of subjects in both standardization samples for the E2 and E3 stages was only 82 and 129, respectively. This is strikingly smaller than the sample sizes for other stages, such as E4 and E5, which included 769 and 831 subjects, respectively (Westenberg, Jonckheer, Treffers, & Drewes, 1998).

Not only were there few preconformist subjects in the samples used to create the manuals, but the manuals were developed using a sample older than the sample in the

present study (Westenberg et al., 1998). In the original sample, 85% of the subjects were over the age of 16. In the revised edition, the subjects were mostly college students (Hy & Loevinger, 1996). Although Loevinger states that her theory and manual are designed to be applicable to individuals at all age levels (Loevinger, 1976, Hy & Loevinger, 1996), experience applying the manual to an adolescent sample, in the present study, suggests that the manual may have meaningful limitations when applied to the unique culture of adolescence. By definition, the conformist stage is characterized by behaviors and attitudes that are conventional in order to promote social acceptability (Hy & Loevinger, 1996). However, socially normative thoughts and actions in adolescence are quite different from those in adulthood. This difference may result in some conventional adolescent responses being rated at a lower level because they would have different implications if they had been given by adult respondents. One specific example from this sample was that the stem "Education..." was often followed by responses such as "is stupid" or "is boring" which would be rated level E3 under reason b (is worthless). However, during adolescence an attitude of rejecting school may be presented to promote an image of nonchalance and independence—socially desirable attributes. Thus, the lack of attention to the culture of adolescence may artificially depress ego level.

Table 14.
Distribution of Ego Development Levels in Three Samples of Participants

	E2	E3	E4	E5	E6	E7	E8-9	Total
1970 manual[1]	62	82	589	403	374	88	42	1640
1996 manual[2]	20	47	180	428	367	101	17	1160
Present study	30	144	45	80	6	0	0	305

[1] Loevinger and Wessler (1970)
[2] Hy and Loevinger (1996)

There are also ways in which the lack of attention to adolescence may inflate ego levels. Many question stems do not have any prosocial responses scored at the E2 and (sometimes) E3 levels. When Westenberg et al. (1998) adapted the manual for a Dutch sample, they noticed that there were a number of E2 and E3 individuals who gave simplistic, but prosocial responses. They proposed that such responses could be incorporated into the manual without compromising the meaning of the E2 and E3 stages. This has not yet occurred.

One surprising finding of the present study was the large number of adolescents who were at the E5 level of ego development (26.2%), while a fairly small number were E4 (14.8%). Although the precise implications of this are unknown, it seems likely that this unexpected distribution is related to the re-conceptualization of the E5 level

(formerly I-3/4). Although originally the E5 level was considered to be a transitional stage, Loevinger's recent work emphasizes that E5 should be considered a stage in its own right (Hy & Loevinger, 1996). The body of literature on which the present study is based largely predates this revision and thus has not incorporated the revised conception of the E5 level (e.g., Frank & Quinlan, 1976; Noam et al., 1984; Noam & Houlihan, 1990; Browning, 1986). Further complicating this issue are the ways in which this level is treated in the literature. Some studies combine the E5 and E4 levels, referring to this combined stage as "conformist" (e.g., Jacobson et al., 1984), while others consider the E5 level to be "post-conformist" (e.g., Gold, 1980). Still other studies do not clearly address where this level has been placed in their analyses (e.g., Noam et al., 1994). The question of whether the E5 level of ego development is, in fact, a separate level will be an important issue to address in future studies.

Finally, although the SCT is designed to be a fairly objective measure, it does require a certain level of skill and inference from coders. Total protocol scores are determined by utilizing the ogive rules (see table 3). Often one response will determine the difference between being placed in one E-level or another[4]. Particularly notable is that due to the structure of the ogive rules, one answer can move a protocol from an E5 to a E3 score, an especially problematic issue for the present study due to its emphasis on the preconformist levels. The current scoring manual advises, "Where there is a discrepancy between the ogive and the impressionistic [total protocol rating] it is necessary to take a more analytic attitude..." (Hy & Loevinger, 1996). The manual further goes on to describe trends that may aid in deciding the E-level for a protocol;

[4] Previous manuals described a set of more complex "borderline rules," but these were abandoned as research suggested that they lead to more errors than improvements in ratings (Hy & Loevinger, 1996)

however, clinical judgment plays a significant role in the final assignment to a level. In fact, in the most recent revision of the scoring manual Hy and Loevinger recommend that coders have at least one year of graduate training and that all protocols be coded by at least two coders (1996). Resources did not permit such arrangements for the present study. It is also notable that the vast majority of previous literature also did meet this standard. In fact, a number of studies used a single coder for the entire group of protocols (e.g., Evans, Brody, & Noam, 2001; Hauser, 1978). It is likely that the variability in training standards has resulted in variability in scoring outcomes among studies. Once again, the body of literature upon which this study was developed has some serious weaknesses that must be addressed for future work in this area to be meaningful.

Design limitations of the present study

There are several limitations of the present study that should be considered when evaluating results. First, the FISCA was completed by the subjects' parents rather than the subjects themselves. Although previous work has suggested that there is satisfactory agreement between parent-report and child-report on the FISCA (Frank, VanEgeren, Fortier & Chase, 2000), child completion of the measure would have added valuable information to the study. Child-report would be of interest especially for the mood subscale, which has shown weaker agreement than other subscales (Frank et al., 2000) and limited variability in the present study (e.g. SD=0 for E2 females).

The FISCA was also the only measure of psychiatric symptomatology. Multiple measures and methods would have helped ensure that particular attributes of the FISCA did not obscure findings. Additionally, both the FISCA and the SCT were completed

shortly after psychiatric hospital admission, a uniquely stressful situation. These circumstances may have influenced parents' FISCA ratings of their children's behavior. This situation also may have influenced the child's level of distress, compliance, and effort while completing the SCT. Although previous work has not addressed the specific factors associated with the psychiatric environment, some work has suggested that SCT protocol ratings may be influenced by situational motivation (Redmore & Waldman, 1975).

Finally, previous research utilizing data from the same hospital setting suggested that biases in hospital admission standards for males and females may have resulted in unique sample characteristics (Frank, Poorman, VanEgeren, & Field, 1997). Generally, males who engaged in externalizing problems only were not admitted to the psychiatric hospital, but rather sent to juvenile court. Males were only admitted to the hospital if they exhibited depressive symptomatology, either alone or in combination with externalizing behaviors. Thus, the sample utilized in the present study may contain a particularly high number of depressed, male adolescents. In contrast, female adolescents were more likely to be admitted to the hospital if they exhibited externalizing problems. Therefore the characteristics of this particular sample may have limited the ability to detect gender-related interactions that may be present in other populations.

Future directions

Clearly there is much room for future work in the area of ego development, particularly with regard to implementing stringent and consistent scoring standards. The revised conception of the E5 level also needs to be addressed in future studies. However,

the most compelling implication of the present study is that the SCT manual should be adapted to an adolescent population.

One final issue to address is the limited amount of research involving the SCT in recent years. Perhaps this limited popularity is related to insignificant research results, as found in the present study. Additionally, SCT training and the subsequent scoring of a large number of protocols can be a labor-intensive process, an unattractive prospect to many researchers. While it is possible that additional revision of the manual will address these issues, we should not lose sight of the clinical applications of the SCT. In clinical settings, the SCT may be used as part of a larger battery to better understand patients' impulse control/character development, interpersonal relationships, conscious preoccupations, and cognitive complexity. In research settings the need for clinical judgment to interpret protocols is an obstacle and may lead to variability in findings. On the other hand, the need for such judgment would not be problematic in a clinical environment with emphasis on the assessment and treatment of an individual.

APPENDICES A-C

PATIENT/FAMILY QUESTIONNAIRE
Child & Adolescent Services

Please complete the following questions. This information will help us know and understand as much as possible about you and your situation in order to develop and provide treatment to meet your specific needs.

Person Completing Questionnaire:			Relationship to Patient:
Patient Name			Today's Date:
Street address:			Phone:
City:		State:	Zip:
County:	[] Male [] Female	Business Phone:	
School:			Grade:
Place of birth:		Age:	Date of Birth:
Hand preference: [] Left [] Right		Eye Color:	Hair Color:
Height:	Weight:	Social Security #:	
Primary Language:		Ethnic Group: []Native Amer []Asian []Hispanic []Black []White Other:	
Biological/Adoptive Parent's Marital Status: []Married []Widowed []Separated []Divorced []Never Married []Permanent Partner			

Physical Health: [] Poor [] Fair []Good [] Excellent	
Name of Biological Father:	Name of Biological Mother:
Name of Legal Guardian:	
Is there currently a custody dispute involving the child? [] Yes [] No	Is the child currently in foster care? [] Yes [] No
Father who lives in home with child (guardian):	**Mother who lives in home with child (guardian):**
Highest grade completed: [] 8th or less [] Some High School [] H.S. Grad/GED [] Some college/specialized training [] College Graduate [] Graduate or Professional school [] Unknown	Highest grade completed: [] 8th or less [] Some High School [] H.S. Grad/GED [] Some college/specialized training [] College Graduate [] Graduate or Professional school [] Unknown
Occupation: What kind of work activities or duties does he perform?	Occupation: What kind of work activities or duties does she perform?
Does he work for: [] private company [] government []self (own business) [] family business (without pay)	Does she work for: [] private company [] government []self (own business) [] family business (without pay)
Employment status: [] part-time [] full-time [] laid-off []armed forces [] retired [] volunteer [] other	Employment status: [] part-time [] full-time [] laid-off []armed forces [] retired [] volunteer [] other
Household income: (annual before taxes)	
Biological Father, if not living in home with child:	**Biological Mother, if not living in home with child:**
Highest grade completed: [] 8th or less [] Some High School [] H.S. Graduate or GED [] Some college/specialized training [] College Graduate [] Graduate or Professional school [] Unknown	Highest grade completed: [] 8th or less [] Some High School [] H.S. Graduate or GED [] Some college/specialized training [] College Graduate [] Graduate or Professional school [] Unknown

SCT

Complete the following sentences.

1. When a child will not join in group activities_____

_____

2. Raising a family_____

_____

3. When I am criticized_____

_____

4. A man's job_____

_____

5. Being with other people _____

_____

6. The thing I like about myself is_____

_____

7. My mother and I_____

_____

8. What gets me into trouble is_____

_____

9. Education_____

_____

10. When people are helpless_____

_____

11. Women are lucky because_____

_____

12. A good father_____

_____

13. A girl has a right to_____

_____

14. When they talked about sex, I_____

_____

15. A wife should_____

_____

16. I feel sorry_____

_____

17. A man feels good when_____

_____

18. Rules are_____

_____

19. Crime and delinquency could be halted if_____

_____

20. Men are lucky because_____

_____

21. I just can't stand people who_____

_____

22. At times she worried about_____

_____

23. I am_____

_____

24. A woman feels good when_____

_____

25. My main problem is_____

_____

26. A husband has a right to_____

_____

27. The worst thing about being a woman_____

_____

28. A good mother_____

_____

29. When I am with a man _____

_____

30. Sometimes she wished that_____

_____

31. My father_____

_____

32. If I can't get what I want_____

_____

33. Usually she felt that sex_____

_____

34. For a woman a career is_____

_____

35. My conscience bothers me if_____

_____

36. A woman should always_____

_____

Child's Name: Today's Date:

FUNCTIONAL IMPAIRMENT SCALE FOR CHILDREN AND ADOLESCENTS (FISCA)

General Instructions: Your answers to this questionnaire will help us learn more about the kinds of problems your child has been having during the **past three months**. The questionnaire is for both younger and older children, so some of the questions may not seem appropriate for your child. Please be as honest as you can. Your answers will be kept confidential.

A. **BACKGROUND INFORMATION**: Please **write in** or put a **check** (✓) in the box with the correct information.

A1. Child's sex?	☐ Male ☐ Female
A2. Your relation to the child?	☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Other (explain):
A3a. Date of your child's birth?	(month/day/year):
A3b. Child's present age in years?	____ years old
A4. Child's grade in school? If it is summer or the child is not in school, check the highest grade the child completed to date.	☐ preschool ☐ kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th
A5a. Has the child been diagnosed by a **doctor or mental health professional** with any of the following conditions that might affect how well the child does in school? (Check **ALL** that apply)	☐ Mental retardation ☐ Learning disability ☐ Brain injury ☐ Speech or language disorder ☐ Attention deficit/hyperactivity disorder (ADHD) ☐ Other (Explain)_____
A5b. During the **past three months** has the child been in a special education classroom?	☐ No ☐ Yes, my child was in special education part of the school day ☐ Yes, my child was in special education all of the school day
A6a. Did the child's mother (or mother-figure in the child's home).....	graduate from high school? ☐ Yes ☐ No graduate from a 4 year college? ☐ Yes ☐ No Put a check in this box if there is no mother in the home ☐
A6b. Did the child's father (or father-figure in the child's home)...	graduate from high school? ☐ Yes ☐ No graduate from a 4 year college? ☐ Yes ☐ No Put a check in this box if there is no father in the home ☐
A6c. What is the yearly household income in the child's home (before taxes)?	☐ Less than $8,000 ☐ $8, to 11,999 ☐ $12, to 19,999 ☐ $20, to 29,999 ☐ $30, to 44,999 ☐ $45, to 69,999 ☐ $70, to 100,000 ☐ Greater than $100,000
A7. Child's ethnicity? (Check **ALL** that apply)	☐ Native American ☐ Asian ☐ White, Hispanic ☐ Hispanic, Non-White ☐ Black ☐ White, Non-Hispanic ☐ Other (explain?)

How many times in the child's lifetime has the child...	Never	1 time	2 times	3 times or more
A8. been arrested by the police?	☐	☐	☐	☐
A9. been found guilty of a crime in a court of law?	☐	☐	☐	☐
A10. been in a detention center or jail?	☐	☐	☐	☐
A11. attempted suicide or made a suicide gesture?	☐	☐	☐	☐

Section B. SCHOOL **The following questions ask about how your child has been doing in school during the past 3 months. IF SCHOOL IS OUT for the summer or your child just began a new school year, think about the last 3 months of the past school year.**

B1. **Was your child in school at least some days during the past 3 months (or the last 3 months of the school year)?**	☐ If No, Go TO B2 ☐ If Yes, Go TO B3
B2. **IF NO, why wasn't your child in school at least some of the time?** Check **ALL** that apply. Then GO TO Section C which begins on the top of page 4.	☐a. My child refused to go to school. ☐b. My child was too afraid, worried or nervous to go to school ☐c. My child was expelled. ☐d. My child dropped out after reaching legal age AND is working ☐e. My child dropped out after reaching legal age BUT does not have a job ☐f. My child was physically ill ☐g. My child graduated from high school ☐h. Other (Explain):_____ (please continue on the top of page 4)
B3. **How many times during the past 3 months has your child skipped school?** Include times your child refused to go to school, skipped school to "play hooky", or was too worried or anxious to go to school.	☐a. Never. **Go to B5** ☐b. Between 1 and 4 times ☐c. 5 to 10 times ☐d. 11 to 20 times ☐e. More than 20 times

B4. **Have any of the following resulted BECAUSE your child did not go to school?** (Check **ALL** that apply)	☐a. My child had to serve detention 3 or more times ☐b. My child lost course credit or was getting poor grades ☐c. School officials called, wrote, or sent home a note to complain about the absences ☐d. School officials suspended my child or warned that my child might be suspended or expelled ☐e None of these

B5. **During the past three months were your child's grades lower than they should have been because your child did not really try** (for example, he or she did sloppy work or did not complete some assignments)?	☐ No ☐ Yes
B6. **On your child's last report card, in how many academic subjects did your child have an "Unsatisfactory" (U) or failing grade (D, E, or F)?**	☐a. None ☐b. 1 academic subject ☐c. 2 academic subjects ☐d. 3 or more but not all academic subjects ☐e. All my child's academic grades were below average ☐f. My child stopped taking academic classes and now only takes vocational courses.
B7. **Was your child's overall or total grade point average in academic subjects LESS than "C" (below average or unsatisfactory?)**	☐ No ☐ Yes
B8. **Will your child probably have to repeat the grade he or she is in now?**	☐ No ☐ Yes

During the past 3 months ...	**No**	**Yes**
B9. **did your child find it hard to sit still or stay seated in class or did teachers often get upset with your child for not paying attention in class?**	☐	☐
B10. **did the teachers have to supervise your child more than others in the class to get your child to behave or did they have to keep reminding your child to follow instructions or requests?**	☐	☐
B11. **did your child get in trouble a lot for not doing what the teacher asked or for behaving in an inappropriate or weird way** (for example, clowning, swearing, or making silly noises)?	☐	☐
B12. **did your child get in trouble a lot for bullying, bothering, or disturbing other children at school?**	☐	☐

During the past 3 months, did your child....	No	Yes
B13. disobey school rules, but in ways that did not harm others?	☐	☐
B14 on purpose, destroy or seriously damage school property?	☐	☐
B15. physically attack or really try to harm a teacher or student?	☐	☐
B16. bring a gun or other weapon to school?	☐	☐

During the past 3 months, did your child's behavior in school result in any of the following?	No	Yes
B17. Teachers said your child was almost impossible to manage or control in the classroom.	☐	☐
B18. Your child had to serve detention 3 or more times or had to see the principal 3 or more times.	☐	☐
B19. School officials sent a note or letter or called home to complain about your child's behavior.	☐	☐
B20. School officials suspended your child or warned that your child might be suspended or expelled from school.	☐	☐
B21. Your child was expelled or permanently removed from the school.	☐	☐

Section C. HOME **The following questions are about whether it has been hard for you to get your child to do things at home that children your child's age are expected to do in your family. Younger children and children with developmental disabilities may need help with these things. What we want to know is whether it has been hard for you to get your child to do what you expect** WITHOUT A LOT OF DEFIANCE, FIGHTING, OR EMOTIONAL UPSET.

During the past 3 months how often have you had a very hard time getting your child..	Never	Occasionally	Often
C1. to use the toilet?	☐	☐	☐
C2. to get dressed?	☐	☐	☐
C3. to eat with utensils (a knife, fork or spoon)?	☐	☐	☐
C4. to take care of his or her hygiene? (for example, to brush his or her teeth, or take a bath or shower)	☐	☐	☐

	Never	Occasionally	Often
C5. **to get up in the morning?**	☐	☐	☐
C6. **to catch the bus or get to school on time?**	☐	☐	☐
C7. **to do his or her chores?** (for example, to pick up toys or clothes, do the dishes, or take out the garbage)?	☐	☐	☐
C8. **to come home on time?**	☐	☐	☐
C9. **to use appropriate language or not swear?**	☐	☐	☐
C10. **to not take, damage or destroy others' belongings?**	☐	☐	☐
C11. **to not hit or hurt others in the home when he or she could not have or do something right away?**	☐	☐	☐
C12.**to mind rules about safety?** (for example, turning off the stove)	☐	☐	☐

C13.**During the past 3 months, how many times did your child run away overnight?**	Never ☐	1 time ☐	2 times or more ☐
C14. **IF AT LEAST ONE TIME, did you know where your child was every time he or she ran away?**		No ☐	Yes ☐

C15. **During the past 3 months, was your child's behavior so out of control that your child was removed or there was talk of removing your child from your home?**	No ☐	Yes ☐
C16. **During this time, did you have a counselor, social service worker, or other professional come into your home to help you manage or control your child's behavior?**	No ☐	Yes ☐
C17. **If YES, if that person had not been there to help, would your child have been able to stay in your home?**	No ☐	Yes ☐

Section D. **DELINQUENCY. If you know for sure that during the past 3 months your child did any of the things listed below, put a check (✓) in the box that shows how often the behavior occurred. You should check "Never" if you only suspect that your child did something, but you are not sure.**

During the past 3 months, how often did your child...	Never	1 time	2 times or more
D1. shoplift or steal something worth more than $20 when he or she thought no one was looking?	☐	☐	☐
D2. vandalize, deface, or paint graffiti on public or private property?	☐	☐	☐
D3. get a speeding ticket or citation for a moving violation?	☐	☐	☐
D4. act so out of control that someone filed a complaint?	☐	☐	☐
D5. get into trouble by hanging out with a gang?	☐	☐	☐
D6. knowingly keep or try to sell stolen property worth $200 or more?	☐	☐	☐
D7. go joy riding in a car without permission?	☐	☐	☐
D8. play with fire so that damage to property or people was likely?	☐	☐	☐
D9. on purpose, severely damage a car, school building, or other valuable property outside the home?	☐	☐	☐
D10. set fires on purpose to destroy property or hurt people?	☐	☐	☐
D11. snatch a purse or wallet?	☐	☐	☐
D12. try to get money from someone by threatening them, or try to rob someone by beating them up?	☐	☐	☐
D13. break into or steal something from a house, car, or building?	☐	☐	☐
D14. steal or try to steal a car?	☐	☐	☐
D15. carry or sell drugs?	☐	☐	☐
D16. threaten someone with a weapon?	☐	☐	☐
D17. fire a gun or use a knife on someone, or severely beat or club someone?	☐	☐	☐

D18. sexually abuse or molest someone, or sexually assault someone of the same or opposite sex (including date rape)?	☐	☐	☐
D19. forge something, or pass phony checks?	☐	☐	☐
D20. kill someone on purpose?	☐	☐	☐

During the past 3 months, was your child...	No	Yes
D21. arrested by the police?	☐	☐
D22. in court, or told to appear in court for something he or she was suspected of doing?	☐	☐
D23. found guilty of breaking the law?	☐	☐
D24. on probation or under court supervision?	☐	☐
D25. in a detention home or jail for breaking the law?	☐	☐

Section E. THINKING.

During the past 3 months, how often did your child....	Never	Occasionally	Often
E1. find it impossible to stop thinking certain thoughts, or have a hard time getting certain images or pictures out of his or her mind?	☐	☐	☐
E2. repeat certain words or sentences over and over again?	☐	☐	☐
E3. find it very difficult to remember things or not remember where he or she was or what just happened?	☐	☐	☐
E4. believe that just by thinking something he or she could make it happen?	☐	☐	☐
E5. draw, write, or talk about things that other people would find really strange, weird, or gross?	☐	☐	☐
E6. think a lot about evil spirits or believe he or she is possessed by the devil?	☐	☐	☐
E7. think that he or she has special or magical powers or others have these powers?	☐	☐	☐

During the past 3 months, how often did your child....	Never	Occasionally	Often
E8. act very suspicious of others or seem unable to trust anyone?	☐	☐	☐
E9. see or hear things that are not really there?	☐	☐	☐
E10. not know for sure whether something he or she saw or heard was really there or just in his or her mind?	☐	☐	☐
E11. believe that an outside force was putting thoughts into his or her mind or was making him or her do, say, or feel certain things?	☐	☐	☐
E12. become extremely confused, to the point of not knowing what he or she was doing?	☐	☐	☐
E13. talk in a way that other people found really weird or strange or could not understand?	☐	☐	☐
E14. repeat or echo other people's words in an almost robot-like way that you or others found very weird or strange?	☐	☐	☐
E15. do things or act in ways that other people would say are very crazy or weird?	☐	☐	☐

E16. All in all, was your child's talk, behavior, or thinking during the past 3 months a good deal more strange, odd, or confused than other children your child's age?	☐ IF No, Go to F1 ☐ IF Yes, Go to E17

Was your child's thinking or behavior so confused or odd the past 3 months that...	No	Yes
E17. your child was in a special classroom or a specialized school program?	☐	☐
E18. your child needed special supervision or had to be watched very closely (more so than other children the same age)?	☐	☐

During the past 3 months, how often did each of the following happen BECAUSE your child's thinking, talk, or behavior was weird or strange?	Never	Occasionally	Often
E19. your child was unable to make friends or have normal friendships?	☐	☐	☐
E20. your child did not know how to act in restaurants, stores, or other public places or people in these places complained about your child or asked your child to leave?	☐	☐	☐

Section F. CONTROL OF AGGRESSION.

During the past 3 months, how often did your child....	Never	Occasionally	Often
F1. argue or fight with other children?	☐	☐	☐
F2. bully, threaten, or shove other children?	☐	☐	☐
F3. tease, ridicule, or pick on other children?	☐	☐	☐
F4. lie, con, or take advantage of other children?	☐	☐	☐
F5. blow up or get annoyed at other children over little things?	☐	☐	☐
F6. act too young or immature around children the same age, or prefer to play with younger children?	☐	☐	☐
F7. have trouble getting along or find it hard to make or keep friends with other children your child's own age?	☐	☐	☐

F8. During the past 3 months, has your child had at least one really close friend around the same age as your child?	No	Yes
	☐	☐

During the past 3 months, how often did your child...	Never	Occasionally	Often
F9. have trouble getting along with adults?	☐	☐	☐
F10. annoy others on purpose, or damage their belongings on purpose?	☐	☐	☐
F11. say very mean or cruel things to others?	☐	☐	☐
F12. act very cruel to animals?	☐	☐	☐
F13.do things without thinking that were dangerous and could injure others?	☐	☐	☐
F14.have temper tantrums or outbursts of anger?	☐	☐	☐
F15. destroy or damage property in the home when angry?	☐	☐	☐
F16. get very upset if he or she could not do or have something right away?	☐	☐	☐
F17. come on to someone in an inappropriate, sexual way or do unusual or inappropriate things of a sexual nature in public?	☐	☐	☐

During the past 3 months, how often did your child...	Never	Occasionally	Often
F18. **act sexually promiscuous or loose, engage in high risk sexual behaviors, or have unprotected sex?**	☐	☐	☐
F19. **participate in gang activities that included harassing or bullying others?**	☐	☐	☐
F20. **bite or throw things at others?**	☐	☐	☐
F21. **physically attack or really try to hurt another child or adult living in the child's home?**	☐	☐	☐
F22. **physically attack or really try to hurt another child or adult NOT living in the child's home?**	☐	☐	☐

F23. **During the past 3 months, did any of the following happen BECAUSE your child's behavior was very disruptive or dangerous to others?** (Check **ALL** that apply)	☐a. Someone suggested that your child should be removed from school. ☐b. Your child was removed from school. ☐c. Someone suggested that your child should be removed from the home. ☐d. Your child was removed from the home. ☐e. None of these.

Section G. **FEELINGS & MOODS**.

During the past 3 months, how often did your child...	Never	Occasionally	Often
G1. **have very sudden changes in mood (more so than other children the same age)** for example, act very happy one moment and very sad or angry the next moment?	☐	☐	☐
G2. **have a very hard time expressing strong feelings, such as hate, fear or love or not show any feelings at all?**	☐	☐	☐
G3. **feel very sad, blue, or depressed?**	☐	☐	☐
G4. **find it hard to have fun, or not want to do things he or she used to enjoy?**	☐	☐	☐

During the past 3 months, how often did your child...	Never	Occasionally	Often
G5. **criticize or put him or herself down or feel worthless and good for nothing?**	☐	☐	☐
G6. **get easily upset over making a mistake because of wanting to be perfect?**	☐	☐	☐
G7. **become sad, withdrawn, or anxious when criticized?**	☐	☐	☐
G8. **want to die or think seriously about committing suicide?**	☐	☐	☐
G9. **feel very anxious or afraid or worry far too much about things?**	☐	☐	☐
G10. **express feelings in a way that was so unusual, unreasonable or extreme for someone your child's age that others saw your child as odd or strange?**	☐	☐	☐
G11. **get very upset about having to leave home or having to separate from a parent or someone like a parent?**	☐	☐	☐
G12. **insist on special arrangements (unusual for someone your child's age) to make sure a parent or someone like a parent was always near by?** (for example, sleeping with or near a parent or calling home a lot to keep from being anxious or afraid)	☐	☐	☐
G13. **worry far too much about gaining weight or being too fat even though others do not think your child is too heavy or overweight?**	☐	☐	☐
G14. **IF YOUR CHILD WORRIED ABOUT GAINING WEIGHT, did he or she...** (Check **ALL** that apply)	☐ a. lose a lot of weight or become too thin? ☐ b. throw up on purpose, use diet pills or laxatives or exercise too much to lose weight? ☐ c. overeat and then vomit or purge with laxatives? ☐ d. if child is a girl, stop having or delay her periods?		

G. Feelings & Moods, continued.

During the past 3 months, how often did your child...	Never	Occasionally	Often
G15. complain of muscle tension?	☐	☐	☐
G16. feel keyed-up or on edge?	☐	☐	☐
G17. have nightmares?	☐	☐	☐
G18. have trouble sleeping?	☐	☐	☐
G19. have headaches, stomachaches or other pains with no medical cause?	☐	☐	☐
G20. lose her appetite, not want to eat, or eat too much?	☐	☐	☐
G21. have difficulty concentrating?	☐	☐	☐
G22. feel tired a lot, have no energy, or sleep too much?	☐	☐	☐
G23. complain of heaviness in his or her arms or legs?	☐	☐	☐

During the past 3 months, did your child...	No	Yes
G24. worry a great deal or feel very anxious or afraid at least half of the days in a usual week?	☐	☐
G25.feel very sad or depressed at least half of the days in a usual week?	☐	☐

During the past 3 months, did any of the following result BECAUSE your child was afraid, anxious, worried, sad or depressed? Was your child so distressed that he or she...	No	Yes
G26. could not be in a regular classroom?	☐	☐
G27. missed school or work at least one day a week (or more)?	☐	☐
G28. got poorer grades than usual or was failing subjects at school?	☐	☐
G29. avoided being with other children or spent a lot less time with friends?	☐	☐
G30. refused to leave home to do things with other people?	☐	☐

Section H. **SELF-HARM BEHAVIORS**.

	No	Yes
H1. **During the past 3 months, did your child make sores or wounds on his or her body on purpose?** (for example, by scratching, picking, repeatedly punching, or burning his or her skin with a cigarette)? **If yes, what did your child do?**	☐	☐
H2. **During the past 3 months, did your child threaten to commit suicide?**	☐	☐
H3. **IF YES, did your child have a PLAN as to how he or she would commit suicide? If yes, what was the plan?**	☐	☐

H4. **IF YOUR CHILD HAD A SUICIDE PLAN, how did you find out about it?**	☐ a. My child told someone about the plan. ☐ b. Someone discovered the plan even though my child did not tell. anyone.

H5. **During the past 3 months, did your child actually make a suicide attempt (either to get attention, as a call for help, or because he or she really wanted to die)?** You should check (✓) "Yes" if your child actually tried or if your child would have tried had someone not stopped him or her in time.	☐ **IF NO, GO TO** section I ☐ **IF YES,** complete questions H6 to H14 on this page before going to page 12

How did your child try to commit suicide? Did your child (or was your child about to)...	No	Yes
H6. **hurt him or herself with something sharp in a way that usually results in death, for example, by leading to major and quick blood loss?**	☐	☐
H7. **shoot him or herself in a way that usually results in death, for example, in the chest or head?**	☐	☐
H8. **inhale, drink or eat something that is very poisonous or deadly, or take enough of something to usually result in death?**	☐	☐
H9. **do something else that usually results in death, for example, jumping from a high building or hanging him or herself with a thick rope? If YES, what did your child do?**	☐	☐
H10. **use a handgun, but in a way that would probably not result in death, for example, shooting him or herself in the leg or foot?**	☐	☐

How did your child try to commit suicide? Did your child (or was your child about to)...	No	Yes
H11. hurt him or herself with something sharp, but in a way that would probably not result in death, for example, making cuts on his or her arms that were not very deep?	☐	☐
H12. inhale, drink or eat something that would probably not result in death or take a very small amount of something that could only lead to death in much larger amounts?	☐	☐
H13.do something else that would probably not result in death, for example, try to choke him or herself with a piece of string? If YES, what did your child do?	☐	☐

H14. When your child tried to commit suicide, did your child...	☐ a. in some way warn someone before actually trying? ☐ b. tell someone right after the attempt in time to get help? ☐ c. keep it a secret and someone accidentally discovered the child before the attempt? ☐ d. keep it a secret and someone accidentally discovered the child during or after the attempt.

Section I. ALCOHOL & DRUG USE

11. During the past 3 months, how often did your child drink alcohol?	☐ Never ☐ Less than once a month ☐ Less than once a week ☐ Once a week ☐ 2 times a week ☐ 3 or more times a week ☐ I know or suspect my child used alcohol, but I do not know how often.
12. During the past 3 months how often did your child have enough alcohol to get intoxicated or drunk?	☐ Never ☐ Less than once a month ☐ less than once a week ☐ Once a week ☐ 2 times a week ☐ 3 or more times a week ☐ I know or suspect my child used enough alcohol to get drunk, but I do not know how often.

13. During the past 3 months, how often did your child use drugs or inhalants?	☐ Never ☐ Less than once a month ☐ less than once a week ☐ Once a week ☐ 2 times a week ☐ 3 or more times a week ☐ I know or suspect my child used drugs or inhalants, but I do not know how often.
14. During the past 3 months, how often did your child use enough drugs or inhalants to get high?	☐ Never ☐ Less than once a month ☐ less than once a week ☐ Once a week ☐ 2 times a week ☐ 3 or more times a week ☐ I know or suspect my child used enough drugs or inhalants to get high, but I do not know how often.

If your child used <u>ANY</u> alcohol, drugs, or inhalants during the past 3 months, please complete the questions on the next page.

If your child <u>NEVER</u> used any alcohol, drugs, or inhalants during the past 3 months, please go to the end of this questionnaire.

I. Alcohol & Drug Use, continued. Check Yes ONLY if a problem listed below happened in the past 3 months BECAUSE your child used alcohol or drugs.

As a RESULT of using alcohol, drugs or inhalants during the past 3 months, did your child...	No	Yes
15. physically or mentally crave alcohol, drugs or chemicals?	☐	☐
16. get to the point of using alcohol, drugs, or inhalants in the morning?	☐	☐
17. have withdrawal symptoms (for example, nausea, shaking, irritability, or depression) or use drugs or chemicals to function or do things well?	☐	☐
18. black out or have tremors or seizures?	☐	☐
19. fail most or all of his or her classes, get suspended or expelled from school, or get fired from a job?	☐	☐
110. become involved in a car accident, get injured or have serious health problems, or do something to injure others?	☐	☐
111. commit a felony or sell sex to get money for drugs or alcohol?	☐	☐
112. not do chores or not take care of other responsibilities at home?	☐	☐
113. get into trouble at work, for example, by fighting or arguing a lot or by breaking important rules?	☐	☐
114. use drugs or chemicals or drink on school days or before work?	☐	☐
115. not show up, come late, or miss out on important activities at school or work, or work below his or her ability at school or on the job??	☐	☐
116. break important rules at school or get into trouble with teachers or school authorities?	☐	☐
117. miss curfew or stay out all night, get picked up by the police, have a traffic violation, or commit a minor crime (not a felony)?	☐	☐
118. have arguments or fights with family or friends, or withdraw from or avoid family or friends.	☐	☐
119. lose a good friend, or change his or her friends to mostly alcohol or drug users?	☐	☐
120. have minor health problems (for example, feeling tired a lot or not eating properly)?	☐	☐
121. do drugs or use chemicals while driving or drive under the influence of alcohol?	☐	☐

122. get taken advantage of sexually or get involved in sexual behavior that he or she later regretted?	0	0
123. (If child is a girl) risk the health of an unborn child by misusing alcohol or drugs while pregnant?	0	0

Thank you for completing this questionnaire.

REFERENCES

Achenbach. T.M. (1991). Manual for the child behavior checklist/4-18 and 1991 profile. Burlington: University of Vermont Department of Psychiatry.

Achenbach, T.M. (1993). Taxonomy and comorbidity of conduct problems: Evidence from empirically based approaches. Development and psychopathology, 5(1-2), 51-64.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Blatt, S.J. (1974). Levels of object representation in anaclytic and introjective depression. The Psychoanalytic Study of the Child, 24, 107-157.

Blatt, S.J. and Zuroff, D.C. (1992). Interpersonal relatedness and self-definition: Two prototypes of depression. Clinical Psychology Review, 12, 527-562.

Block, J.H. (1984). Sex role identity and ego development. San Francisco: Jossey-Bass.

Borst, S.R. & Noam, G.G. (1993). Developmental psychopathology in suicidal and nonsuicidal adolescent girls. Journal of the American Academy of Child and Adolescent Psychiatry, 32(3), 501-508.

Browning, D. (1986). Psychiatric ward behavior and length of stay in adolescent and young adult inpatients: A developmental approach to prediction. Journal of Consulting and Clinical Psychology, 54, 227-230.

Condry, J. and Ross, D. (1985). Sex and aggression: The influence of gender label on the perception of aggression in children. Child Development, 56, 225-233.

Cyranowski, J.M., Frank, E., Young, E., Shear, M.K. (2000). Adolescent onset of the gender difference in lifetime rates of major depression: A theoretical model. Archives of General Psychiatry, 57, 21-27.

Erikson, E. (1959). Identity and the life cycle. Psychological Issues, 1, 18-164.

Evans, D.W., Brody, L., and Noam, G. (2001). Ego development, self-perception, and self-complexity in adolescence: A study of female psychiatric inpatients. American Journal of Orthopsychiatry, 71, 79-86.

Frank, S.J., and Paul, J. S. (1995). The Functional Impairment Scale for Children and Adolescents. Department of Psychology, Michigan State University.

Frank, S. J., Paul, J. S., Marks, M. and VanEgeren, L. A. (2000). Initial validation of the functional impairment scale for children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 39,1300-1308.

Frank, S. J., Poorman, M.O., VanEgeren, L. A and Field, D.T. (1997). Percieved relationships with parents among adolescent inpatients with depressive preoccupations and depressed mood. Journal of Clinical Child Psychology, 26(2), 205-215.

Frank, S. J. and Quinlan, D. M. (1976). Ego development and female delinquency: A cognitive-developmental approach. Journal of Abnormal Psychology, 85, 505-510.

Frank, S. J., VanEgeren, L. A., Fortier, J. L., and Chase, P. (2000). Structural, relative, and absolute agreement between parents' and adolescent inpatients' reports of functional impairment. Journal of Abnormal Child Psychology, 28(4), 395-402.

Galambos, N. Almeida, D. and Petersen, A. (1990). Masculinity, femininity, and sex role attitudes in early adolescence: Exploring gender intensification. Child Development, 61, 1905-1914.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge: Harvard University Press.

Gold, S. (1980). Relations between level of ego development and adjustment patterns in adolescents. Journal of Personality Assessment, 44, 630-638.

Harter, S., Bresnick, S., Bouchey, H., Whitesell, N. (1997). The development of multiple role-related selves during adolescence. Development and Psychopathology, 9, 835-853.

Hauser, S.T. (1976). Loveninger's model and measure of ego development: A critical review. Psychological Bulletin, 83(5), 928-955.

Hauser, S.T., Jacobson, A., Noam, G., and Powers, S. (1983). Ego development and self-complexity in early adolescence. Archives of General Psychiatry, 40, 325-332.

Hill, J. and Lynch, M. (1983). The intensification of gender-related role expectations during early adolescence. In J. Brooks-Gunn and A. Petersen (Eds.), Female puberty. New York: Pelnum.

Hodges, K. (1994). The Child and Adolescent Functional Assessment Scale. Unpublished measure, Department of Psychology, Easter Michigan University, Ypsilanti, MI.

Hodges, K., Bickman, L., Kurtz, S., and Reiter, M. (1992). A multidimensional measure of level of functioning for children and adolescents. In A. Algarin and R. M. Friedman (Eds.) A system of care for children's mental health: Building a research base, Florida Mental Health Institute, University of South Florida.

Hodges, K. and Gust, J. (1995). Measures of impairment for children and adolescents. Journal of Mental Health Administration, 22, 403-413.

Hy, L. and Loevinger, J. (1996). Measuring Ego Development (2nd Ed.). Mahwah, NJ: Lawrence Erlbaum Associates.

Jacobson, A.M., Hauser, S.T., Powers, S., and Noam, G. (1984). The influences of chronic illness and ego development on self-esteem in diabetic and psychiatric adolescent patients. Journal of Youth and Adolescence, 13(6), 489-507.

Larson, R. and Richards, M.H. (1989). Introduction: the changing life space of early adolescence. Journal of Youth and Adolescence, 18, 510-509.

Larson, R. and Richards, M. (1994). Divergent realities: The emotional lives of mothers, fathers, and adolescents. New York: Basic Books.

Leadbeater, B. J., Blatt, S. J., Quinlan, D.M. (1995). Gender-linked vulnerabilities to depressive symptoms, stress, and problem behaviors in adolescents. Journal of Research on Adolescence, 5(1), 1-29.

Loevinger, J. (1976). Ego development: Conception and theories. San Francisco: Jossey-Bass.

Loevinger, J. (1979). Construct validity of the sentence completion task. Applied Psychological Measurement, 3, 281-311.

Loevinger, J. and Wessler, R. (1970). Measuring ego development 1: Construction and use of a sentence completion test. San Francisco: Jossey-Bass.

Loevinger, J., Wessler, R., and Redmore, C. (1970). Measuring ego development 2: Scoring manual for women and girls. San Francisco: Jossey-Bass.

McFarlane, A.H., Bellissimo, A., Norman, G. R. and Lange, P. (1994). Adolescent depression in a school-based community sample: Preliminary findings and contributing social factors. Journal of Youth and Adolescence, 23(6), 1994.

Moffit, T.E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. Psychological Review, 100(4), 674-701.

Noam, G. (1984). Ego Development and psychopathology: A study of hospitalized adolescents. Child Development, 55(1), 184-194.

Noam, G., Hauser, S. T., Santostefano, S., Garrison, W., Jacobson, A.M., Powers, S., and Mead, M. (1984). Ego development and psychopathology among adolescents. Child Development, 55, 184-194.

Noam, G.G. and Houlihan, J. (1990). Developmental dimensions of DSM-III diagnoses in adolescent psychiatric patients. American Journal of Orthopsychiatry, 60(3), 371-378.

Noam, G. Paget, K., Valiant, G. Borst, S. and Bartok, J. (1994). Conduct and affective disorders in developmental perspctive: A systematic study of adolescent psychopathology. Development and Psychopathology, 6, 519-532.

Nolen-Hoeksema, S. and Girgus, J.S. (1994). The emergence of gender differences in depression during adolescence, Psychological Bulletin, 115, 424-443.

Parke, R.D., and Slaby, R.G. (1983). The development of aggression. In P.H. Mussen (Series Ed.) and E.M. Hetherington (Vol. Ed.), Handbook of Child Psychology: Vol. 4. Socialization, personality, and social development. (pp. 547-641). New York: Wiley.

Perry, D.A., Perry, L.C., and Weiss, R.J. (1989). Sex differences in the consequences that children anticipate for aggression. Developmental Psychology, 25, 225-233.

Peterson, A. (1988). Adolescent development. Annual Review of Psychology, 39, 583-607.

Redmore, C. and Waldman, K. Reliability of a sentence completion measure of ego development. (1975). Journal of Personality Assessment, 39, 236-243.

Shaffer, D., Fisher, P., Dulcan, M., Davies, M., Piacentini, J., Schwab-Stone, M., Lahey, B., Bourdon, K., Jensen, P., Bird, H., Camino, G., and Reiger, D. (1996). The NIMH diagnostic interview schedule for children version 2.3 (DISC 2.3): Description, acceptability, prevalence rates, and performance in the MECA study. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 865-877.

Steinberg, L. (2002). Adolescence. (6th Ed.). New York: McGraw-Hill.

Westenberg, P.M., Jonckheer, J., Treffers, P.D.A., and Drewes, M.J. (1998). Ego development in children and adolescents: Another side of the impulsive, self-protective, and conformist ego levels. In P.M. Westenberg, A. Blasi, and L.D. Cohen (Eds.), Personality development: Theoretical, empirical, and clinical, investigations of

Loevinger's conception of ego development. (pp. 89-112). Mahwah, NJ: Lawrence Erlbaum Associates.

Zoccolillo, M. (1993). Gender and the development of conduct disorder. Development and Psychopathology, 5(1-2), 65-78.