

AN ABSTRACT OF THE THESIS OF

Debra J. Matchinsky for the Master of Science

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Title: Fear of Success and Coping Styles as Predictors of
Need for Emergency Services by the Severely and Persistently
Mentally Ill

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Kurt D. Baker

One hundred severe and persistent mentally ill clients receiving services from either of one of two mental health centers in east central Kansas completed questionnaire packets containing a Fear of Success Survey, Coping Inventory for Stressful Situations, and demographics form. The results of a stepwise multiple regression analysis revealed that a model including fear of success and social diversion coping was most predictive of emergency service use during a two year period, $F(2,97) = 42.676$, $p < .001$, $R^2 = .684$. Those participants with high fear of success were found to be more likely to be recidivists ($R^2 = .657$). Those who reported low use of social diversion as a coping style were also more likely to be recidivists (change in $R^2 = .027$).

FEAR OF SUCCESS AND COPING STYLES AS PREDICTORS
OF NEED FOR EMERGENCY SERVICES BY
THE SEVERELY AND PERSISTENTLY MENTALLY ILL

A Thesis

Presented to
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by

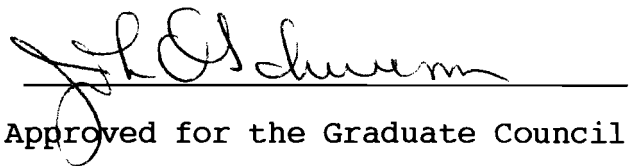
Debra J. Matchinsky

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A handwritten signature in cursive script, reading "Kenneth A. Deane", written over a horizontal line.

Approved for the Division of
Psychology and Special Education

A handwritten signature in cursive script, reading "J. O. Schum", written over a horizontal line.

Approved for the Graduate Council

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I dedicate this master thesis to my first professional role model, Dr. John Robertson, a hero without whom I may not have realized this dream.

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CHAPTER I

INTRODUCTION

According to many state laws, a person with severe and persistent mental illness is one who has undergone two or more episodes of inpatient care for mental illness within a two-year period, experienced a continuous psychiatric hospitalization or residential treatment exceeding six months, or have a diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder. This is a common description of chronic mental illness, which by definition includes recidivism. One unfortunate outcome of the move to deinstitutionalize people is that a large number of discharged patients have trouble making the transition from institutional life to independent living and are subsequently rehospitalized (Hall, Butt, & Wong, 1991).

Before the 1960s, the mental health field's answer to the treatment of the mentally ill was to "warehouse" them in large, long-term care facilities. Early definitions of mental illness were based primarily on prior or current care in state institutions, because the most seriously ill patients were often residents of state mental hospitals (Schinnar, Rothbard, Kanter, & Jung, 1990). Today, various legal, political, economic, humanitarian, and clinical concerns have resulted in a movement towards deinstitutionalization and reintegration (Hall et al., 1991).

Institutions are viewed as too great a burden on society economically. Community-based treatment facilities are considered more cost effective in terms of tangible and intangible benefits and costs (Rubinstein, 1984). Additionally, dehumanization and long term negative effects have been associated with institutionalization. Community care is also believed to lessen the stigma that may cause difficulty with rehabilitation (Hall et al., 1991).

Although the shift to community based treatment has led to the deinstitutionalization of many people, a large number of people with chronic mental illness have difficulty adjusting or coping and frequently return to mental hospitals. For example, Anthony, Buell, Sharratt, and Althoff (1972) found rehospitalization rates for 6 months, 1 year, and 3 to 5 years to be about 30 to 40%, 40 to 50%, and 65 to 75%, respectively. More recent studies indicate similar rates (Hasselback, Perez, Mack, & Wex, 1990; Smith 1978). Citrome, Green, and Fost (1994) examined recidivism rates between 1983 and 1991 and found 35% of all patients admitted during the eight years had two or more admissions.

Recidivism has traditionally been defined as "the relapse of a disease, symptom, or behavioral pattern which results in the readmission of a patient to a treatment program" (Polk-Walker, Chan, Meltzer, Goldapp, & Williams, 1993, p. 164). It has long been used as an indicator of system and/or patient failure. Despite the development of

community mental health clinics, more extensive aftercare, and a variety of day treatment centers, this "revolving door" phenomenon continues for persons living with a severe and persistent mental illness (Geller, 1992; Strochak, 1987).

The current trend is toward decreasing in the number of beds available to psychiatric patients with the closing of more state hospitals and downsizing of other psychiatric units. Traditional recidivism, an actual measure of the number of rehospitalizations, can no longer adequately describe the number of clients who are chronic reusers of the mental health system. Community mental health centers are attempting to compensate through careful screening and alternative emergency services such as attendant care, a crisis house, and/or intensive case management.

The Problem of Recidivism

Rehospitalizations create many problems in the mental health field. The difficulties increase as time passes and the need to keep costs down overshadows the need for improved services. Recidivism causes increased costs to insurance companies and the state government, frustration to mental health professionals, and difficulties for the client.

Recidivists take beds from those who are currently coming into the system for the first time and need the long-term hospitalization necessary for assessment and adjustment to medications. According to Geller (1992), the recidivism of patients with serious mental illness drains

public resources in a pattern of care that is often senseless. For those clients who need rehospitalization and remain in the private system, there is an increased cost to insurance companies because of the greater expense to hospitalize clients than to have them remain in the community.

Continual rehospitalization interrupts the continuity in treatment and the process of reintegration into the community--the typical goal of both the professional and client. Recurrent hospitalizations can lead to frustration for the professional, who may believe the client is beyond help. What is even more important is the disruption of the client's life that may lead to further loss of self-esteem and sense of control over life events. Smith, Stefan, Kovalski and Johnson (1991) found recidivists become dependent on state hospitals to satisfy their needs and come to view themselves as victims and failures.

The need for screening for emergency services can put strain on mental health centers, particularly those with a high population of chronic clients. Furthermore, what should be done with clients who need hospitalization when no beds are available? Information that could increase the ability to predict the need for emergency services could be used to target clients at greater risk and pinpoint treatment goals.

Causes of Recidivism

Research into the possible causes of hospital recidivism has at times examined problems in the mental health system. Hall et al. (1991) noted the necessary aftercare is not always available, and the follow-up services often fail to meet the important needs of a normalized and structured environment. They also point out problems with the widely used residential linear continuum model where many small transitions (i.e., halfway house, board and care, supervised living, and independent community living) create repeated forced dislocations and a lack of individualized planning. Some clients "slip between the cracks" and fail to be followed after discharge or are not monitored to make certain they take their prescribed medications or have a place to live. Due to lack of funding, there is little that can be done to solve these system-related problems. Additionally, recidivism continues to be a problem despite model community-based programs and movement of funding to the community (Geller, 1992).

Most often, research examines characteristics of the individuals being rehospitalized to determine the cause of recidivism. Higher recidivism rates have been found in patients who are socially unskilled, withdrawn, depressed, anxious, manifest psychotic, likely to drink excessively, and prone to antisocial behavior (Smith et al., 1991). Geller (1992) found the worst recidivists were those with

schizophrenia, bipolar disorder, and personality disorders (especially borderline personality disorder). In addition, aggressive patients were shown to be three times more likely to end up rehospitalized than those referred for suicidal behavior (Citrome et al., 1994). However, Rosenblatt and Mayer (1974) concluded measures of social processes were more likely to give an accurate prediction of recidivism than diagnostic and psychopathological measures.

The poor social functioning of the mentally ill has been mentioned in a few studies. For example, a study examining the important needs of the chronically mentally ill found 13% needed social rehabilitation and 14% needed family therapy (Lynch & Kruzich, 1986). Willer and Miller (1977) developed a brief scale to predict rehospitalization. Using multiple regression to determine predictors of recidivism, they developed a 13-item scale that provided highly accurate prediction of rehospitalization in the six months after discharge. Twelve of the 13 items related to social functioning.

Researchers have been interested in the number of previous admissions or an increase in symptomatology due to stopping of medications against medical advice as the key predictors of rehospitalization. Casper and Regan (1993) found non-compliance with medication regimens is a prominent and distinguishing characteristic of recidivists and the

major reason for rehospitalization. However, there was an equal chance the readmission was caused by a combination of multiple precipitants such as program non-compliance, chemical abuse, violent acts, or suicide attempts. In another study, the only variable consistently related to recidivism was number of previous admissions (Rosenblatt & Mayer, 1974). Neither one of these studies investigated the possible underlying reasons for the number of previous admissions or medication noncompliance.

Suggesting a variety of factors affect recidivism, Solomon and Doll (1979) examined the predictability of pathway and gatekeeper variables. Pathway variables are those that move a potential patient toward hospitalization (e.g., age, sex, social class, and number of dependents). Gatekeeper variables are those found within the hospital environment (e.g., type of diagnosis, hospital admission policy, and patient's admission history). A follow-up study by Polk-Walker et al. (1993) indicated that being a woman, having a history of previous admissions, having children living with someone else, and denials of financial, sexual and impulse problems are the most predictive of readmission. In contrast to this finding, Willer and Miller (1977) suggest rehospitalization is often caused by factors completely outside the influence of the hospital and, at the same time, may even be unrelated to the mental health of the former patient.

Reduction of Recidivism

Many studies have proposed to reduce recidivism through education. Dincin and Witheridge (1982) concluded problem solving groups, discussion groups to avoid stresses, and comprehensive treatment plans including reality based treatment to enhance clients' vocational, social, and independent living skills are more successful at keeping patients out of the hospital. Living situations that promote independence through allowing residents to make decisions and resolve problems themselves are also beneficial (Hall et al., 1991; McCarthy, & Nelson, 1991). An intensive residential treatment program operating as a feasible alternative to state hospitalization has already demonstrated similar theories at work (Bedell & Ward, 1989). Utilizing psychoeducational activities with a primary focus on improving social skills such as communication and problem solving, this program was able to achieve comparable results to state hospitalization in a shorter time, with greater cost efficiency, and with less rehospitalization of patients after discharge.

Research investigations of psychological rehabilitation programs attempting to restore the capacity of people to function in the community have successfully demonstrated that the mentally ill can in fact learn new skills. These skills, when properly integrated into a comprehensive rehabilitation program that provides reinforcement and support for the use

of these skills, can have a positive effect on functioning in the community (Anthony & Margules, 1974). For example, in a study of patients with chronic mental illness, the group trained in skills such as personal hygiene, cooking, money management, and socialization combined with community support had significantly reduced recidivism compared to the group that received traditional hospital treatment and aftercare (Weinman, Sanders, Kleiner, & Wilson, 1970).

There continues to be an emphasis on a psychoeducational model as a means to reduce recidivism in the severe and persistent mentally ill. Hogarty, Anderson, and Reiss (1987) found a psychoeducational model that teaches patients with schizophrenia how to recognize signs of relapse and use effective coping mechanisms is beneficial in reducing recidivism rates in the first year postdischarge. Maxmen (1984) proposed a nonpsychoanalytic alternative called an educative group model that stresses group therapy as a way of learning to cope with mental illness and daily problems.

Maxmen (1994) highlights the important point that various theories view the mentally ill differently. The educative group model views the patient as "an otherwise normal person who must negotiate life with the added burden of mental illness (p. 365)." Psychiatric patients are considered no different from medical patients who try to cope with the illness and reduce stress that may exacerbate the problem. Adler, Drake, and Stren (1984) suggested it is

beneficial to view the chronic patient in an adaption-oriented rather than illness-oriented manner. Quality of life, present adjustment, patients' attitudes, and coping capacities are emphasized in this paradigm.

Fear of Success

Horner (1972) pioneered research into and postulated a motive termed "fear of success" (FOS). He believed this fear was present in some women and responsible for observed gender differences in achievement behavior. According to Hyland (1989), other explanations for gender differences in achievement behavior, and the differences in fear of success score between men and women have decreased over time to become small or nonexistent. The fear of success construct has more recently been used across gender to examine such things as differences in achievement motivation, task performance, and problem solving.

Horner's measure is a projective test that infers fear of success from stories written in response to a verbal cue. Zuckerman and Wheeler (1975) reviewed problems related to Horner's measure and suggested inter-rater reliability as well as the operationalization of the fear of success construct are the reasons for disappointing results. Because of the problems associated with Horner's measure, several new instruments including Allison and Zuckerman's (1976) Fear of Success Scale have been introduced. This scale was shown to measure a more general fear of success instead of the usual

fear of academic or career success (Griffore, 1977).

Fear of success has only been examined minimally in the mentally ill population. In one study, anorexic young women scored higher on fear of success than both bulimic and control group members (Gilbert, 1993). Ohri and Malhotra (1993) found no significant difference existed between neurotic women who were categorized as high in fear of success versus those low in fear of success on their performance time on a problem solving task.

Individuals with a mental illness who have high FOS are more likely to sabotage their chance for success in the community than persons with low FOS. How success is anticipated to impact an individual may determine the degree of fear involved. Success for the psychiatrically disabled may mean moving into independent living, finding a job, and taking back the control over their lives. However, achievement for the client often means being totally cut off from services they have learned to become dependent on, such as the stability of a monthly check from social security, and the social support provided by structured groups and therapist appointments. This construct may even explain some of the reoccurrence of symptoms often expressed when a patient is about to take on more responsibility. Therefore, that fear of success has not been applied more often to the severe and persistent mentally ill is surprising since it

involves fears of achievement and may involve behaving in ways that destroy chances for success.

Coping

Plutchik and Conte (1989) measured eight basic coping styles based on a theoretical model for emotions proposed by Plutchik in 1990. These coping styles and their related emotions include: minimization (acceptance), suppression (fear), help-seeking (surprise), blame (disgust), substitution (anger), reversal (joy), replacement (sadness), and mapping (expectation). Attempts have been made to predict suicide risk (Botis, Soldatos, Liossi, Kokkevi, & Stefanis, 1994; Josepho & Plutchik, 1994; Kotler et al., 1993) and violence risk (Botis et al., 1994; Kotler et al., 1993) in psychiatric patients using these eight coping styles. Rim (1993) determined which coping styles are related to extroversion (1987), optimism (1989), self-confrontation (1989), and the pathological functions of schizophrenia and anhedonia.

Folkman and Lazarus (1980) differentiated between an "emotion-focused" coping strategy defined as an attempt to reduce or manage emotional stress and "problem focused" coping strategy defined as a direct attempt to alter or manage the situation. A self-report questionnaire was developed to identify a broad range of strategies that people use to cope with stressors and situations (Lazarus & Folkman, 1984). These strategies include distancing, self-controlling,

seeking social support, accepting responsibility, escape-avoidance, active problem solving, and positive reappraisal. They can be combined to form three general coping strategies: task or problem-focused, emotion-focused, and avoidance.

Although not included as a general coping strategy by Folkman and Lazarus (1980), avoidance coping was one of the dimensions measured in their Ways of Coping Scale (Lazarus & Folkman, 1984). Several other measures of coping have been developed including these three general coping strategies (Carver, Scheier, & Weintraub, 1989; Endler, & Parker, 1994). Roger, Jarvis, and Najarian (1993), using factor analysis, separated coping into four strategies: problem solving, emotional, avoidance, and distancing or detachment.

Many studies have examined the predictive ability of coping strategies in various subpopulations of the mentally ill. Tremblay and King (1994) discovered a positive correlation between depression and emotion-oriented coping and a negative correlation between depression and task-oriented coping in a sample of 43 adult psychiatric inpatients. Similar results were obtained using depressed outpatients two years previously (Turner, King, & Tremblay, 1992). In a study of elderly depressed patients, Colenda and Dougherty (1990) found patients with major depression used problem-focused and emotion-focused coping equally often. Veiel, Kuhner, Brill, and Inle (1992) determined all

coping variables they measured (problem avoidance, support seeking, negative appraisal, and distraction) differentiated patients considered "non-recovered" from those considered "recovered" after inpatient treatment for clinical depression.

In addition, several studies have examined the differences in coping styles utilized by persons often classified as severely and persistently mentally ill. Chronic schizophrenic patients who use more adaptive coping styles such as active problem solving (task-oriented coping) were found to have less hospitalizations and less severe symptoms (Takai, Umatsu, Kaiya, Inoue, & Ueki, 1990). A study of substance abusers with borderline personality disorder found greater use of escape/avoidance coping, and less use of problem solving and positive appraisal in that subpopulation (Kruegelbach, McCormick, Schultz, & Grueneich, 1993). Additionally, women actively suffering from bulimia nervosa were less likely than a control group to utilize adaptive methods of coping such as problem solving, planning, and seeking emotional support (Yager, Rorty, & Rossotto, 1995).

Studies related to the issues being faced by the mentally ill have also been conducted. Romme, Honig, Noorthoorn, and Escher (1992) indicated people who came to accept hearing voices were more likely to utilize a combination of active and avoidant coping strategies including distraction, ignoring the voices, selective

listening, and setting limits to their influence. During times of high mental stress where subjects have no control over the situation, Bohnen, Nicolson, Sulon, and Jolles (1991) found the most effective coping style to be an emotion-focused use of comforting cognitions. Lu (1991) indicated people who have experienced many hassles in their life tend to use less direct action to cope, and this causes an adverse effect on mental health in the long run.

Conclusion

There appear to be many possible precipitants that contribute in some way to the rehospitalization or increased need for services of the mentally ill. An underlying cause such as a client's coping style or fear of success appears to result in an increase in those precipitants. A person who has a greater fear of success would be expected to have an increase in symptoms during periods when there is a chance to achieve. The use of an avoidance coping style would likely undermine a person's chance to stay in the community. Research indicates that skills training is a feasible and successful option for this population. Therefore, if level of fear of success and style of coping are shown to predict recidivism, then clients can be taught more productive coping strategies, and therapy can focus on reducing fears of success.

Merely providing the chronically mentally ill with treatment designed to alleviate symptoms does not necessarily

guarantee the ex-patient will be able to do well in the community (Anthony et al., 1972). The question addressed by the current research is what more can be done to reduce the chance of rehospitalization and need for other emergency services in persons with severe and persistent mental illness? To address this question, the factors precipitating re-entry into the mental health care system must be ascertained. The purpose of this study is to determine if coping styles and/or fear of success are predictive of re-utilization of mental health center services.

CHAPTER II

METHODS

Participants

The sample consisted of 100 severe and persistent mentally ill Kansas residents who were receiving services at either of one of two mental health centers in east central Kansas. All adults assigned to case management through a community support program were given an opportunity to participate. This included patients with a primary diagnosis, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4th ed., 1994), of one of the following: schizophrenia, schizo-affective disorder, schizotypal personality disorder, atypical psychosis, bipolar disorder, depression, or borderline personality disorder.

This sample included participants involved in a variety of treatment situations: case management, day treatment, individual therapy, group therapy, and group home. The participants were identified by their involvement in the Mental Health Center's Community Support Program. In this program case managers make personal visits to clients in the community to assess functioning and assist in problem solving. All clients currently receiving case management services were asked to read the informed consent form and decide whether to participate. There could not be random assignment to groups because all variables measured occur

naturally, and any differences existed before the collection of data.

Of major concern in the collection of self-report data from this population is reliability of the report. There is even more concern when collecting data from a population where there may be less reliable reporters. To determine the reasonable accuracy of the information reported by the participants, the responses to the demographic question for date of birth were checked against the mental health center file. Failure to indicate a proper birth date was used as an indication of inability to competently answer questions. However, no participant was dropped from the analysis based on this criterion.

Descriptive statistics indicated that of the 100 participants (50 men and 50 women) who completed the questionnaires, 92 were white, 7 black, and 1 Hispanic. The ages ranged from 18 to 76. Education levels included 12 high school dropouts, 20 with General Education Degrees, 43 high school graduates, 17 with some college, 3 with a two-year degree, 3 with a bachelor degree, 1 with some master's level work, and 1 with a master's degree. Seven were involved in volunteer jobs, 11 held jobs for pay and 82 were not employed. Only 36% of the participants responded that they were concerned about losing services if their mental health improved.

Materials

Recidivism

Due to the reduction in beds available to clients who have historically needed hospitalization in Kansas, the actual number of rehospitalizations was not considered an adequate indicator of the recidivism rate. Therefore, recidivism was defined in this study as the number of occurrences involving the need for Emergency Services to evaluate the client. The number of Emergency Service contacts was coded with one additional contact for each participant to eliminate a score of zero as a possibility (for data analysis purposes). Emergency Services is called in by either a professional at the mental health center or the local hospital emergency room to assess the need for psychiatric hospitalization based on suicidal risk, homicidal risk, or danger to self due to psychotic symptomatology. Such an evaluation may result in efforts to simply ease a potential crisis situation through contact with a professional, attendant care, voluntary or involuntary hospital placement, or increased use of outpatient services such as day treatment and individual therapy.

Fear of Success Scale

The Fear of Success Scale developed by Zuckerman and Allison (1976) is a 27-item questionnaire that measures fear of success (FOS) on a 7-point scale. This questionnaire requires subjects to agree or disagree with statements

describing the benefits of success, the costs of success, or the respondent's attitude toward success compared to other alternatives.

Of the 27 questions, 16 are worded so that agreement indicates high fear of success and 11 are worded to indicate low fear of success. High and low fear of success questions were randomly ordered so that no more than three consecutive questions were worded in the same direction. The range of possible scores is between 27 and 189 with a midpoint of 108. The average score for a sample of 133 college students obtained by Santucci (1989) was 97.7 (SD = 14.10). This scale has been found to by its developers to have a Cronbach alpha of .69 for males and .73 for females (Zuckerman & Allison, 1976). Significant Pearson correlations have been found between the Fear of Success Scale and Pappo's (1972) and Good and Good's (1973) fear of success measures (Chabassol & Ishiyama, 1983; Griffiore, 1977).

Coping Inventory for Stressful Situations

The Coping Inventory for Stressful Situations (CISS), developed by Endler and Parker (1990), is a multidimensional measure of coping based on their original scale called the Multidimensional Coping Inventory. It is a 48-item scale which consists of three 16-item scales that assess task, emotion, and avoidance-oriented coping on a 5-point Likert scale. The avoidance-oriented scale provides two additional subscales which assess distraction and social diversion

methods of coping. Participants are asked to indicate how much they engage in various activities when dealing with a stressful, difficult, or upsetting situation. Scores were converted to standard T-scores ($M = 50$, $SD = 10$) using the hand scored profile form provided by the publisher to allow for comparisons between the various coping styles.

The CISS has been reported to be a reliable and valid measure across a variety of settings and situations (Endler & Parker, 1994). The eight-week test-retest correlations for the CISS task, emotion, and avoidance subscales were .74, .66, and .68, respectively, indicating relative stability over time. Cronbach alphas for the three main subscales ranged from .76 for men on the emotion subscale to .91 for women on the task subscale. The factor analytic structure of this instrument has been found to be consistent across adolescents, college students, normal adults and psychiatric samples (Endler & Parker, 1990).

Procedures

Case managers, who are the primary caregivers of the clients in the Community Support Program, approached their clients with a prepared script (see Appendix A) requesting participation in a thesis project. The script was provided to reduce the chance of clients' feeling coerced into participation. Agreement of the participant resulted in the presentation of the questionnaire packet and consent form (see Appendix B) to the client. The packet contained a brief

demographic form that introduced the study and requested age, gender, level of education, work status, and level of concern over loss of services if mental health improves (see Appendix C), and both the Fear of Success Scale (see Appendix D) and the Coping Inventory for Stressful Situations (not included due to copyright concerns).

The case managers obtained informed consent, wrote the client's individual case number on the questionnaire packet, and allowed the client to finish the forms in privacy. An envelope was provided to seal the packet to ensure confidentiality. The signed consent form and envelope was to be returned to the researcher by the case manager.

The individual case number was used to access the client's records from the mental health center's database. The number of evaluations by Emergency Services during the past 24 month period and any missing demographics were the only information transferred to the questionnaire packet.

The predictor variables included fear of success score, task coping score, emotion coping score, avoidance coping score, distraction coping score, social diversion coping score, and demographic variables. The criterion variable was recidivism measured by the number of evaluations by Emergency Services during a 2-year period plus one to eliminate the possibility of zero contacts.

CHAPTER III

RESULTS

The purpose of this study was to determine the ability of fear of success and various coping strategies to predict recidivism. The statistical prediction tool multiple regression was used. One benefit of this method is that it shows both the combined effects of a set of predictor variables and the separate effects of each predictor variable controlling for the others. This statistic also requires larger samples to obtain an accurate analysis. The generally accepted minimum is 150 participants. However, due to limited subject availability data was analyzed using at least 100 participants.

Preliminary analysis demonstrated significant correlations between a number of the predictor variables at the .05 level indicating multicollinearity (see Table 1). Social diversion, distraction and avoidant coping were highly correlated. This was expected since social diversion and distraction are two types of avoidant coping. Using the more specific types of avoidance may provide a clearer description of the type of client likely to need emergency service screening repeatedly. Consequently, to address concerns regarding multicollinearity the less specific avoidant type coping style was eliminated from the model. The tested model included fear of success, task-oriented coping, emotion-oriented coping, distraction coping, and social

Table 1

Correlation Matrix of the Criterion Variable and Possible Predictors Before Transformations

Predictor	1	2	3	4	5	6	7	8
1 EMERG	---							
2 FOS	.61**	---						
3 TASK	-.19*	-.30**	---					
4 EMOT	.05	-.07	-.11	---				
5 AVOID	-.04	-.01	.17*	.29**	---			
6 DIST	.07	.07	.04	.34**	.87**	---		
7 SOC	-.13	-.01	.21*	.17*	.75**	.49**	---	
8 AGE	-.09	-.18*	.09	.01	-.19*	-.18*	-.19*	---
9 EDUC	.25**	.16	.04	-.07	-.19*	-.21*	.12	-.14

Note: * $p < .05$, ** $p < .01$, EMERG = emergency service contacts, FOS = fear of success score, TASK = task-oriented coping score, EMOT = emotion-oriented coping score, AVOID = avoidant coping score, DIST = distraction coping score, SOC = social diversion coping score, EDUC = education level achieved.

diversion coping. See Table 2 for means and standard deviations.

The normal probability plot of the standardized residuals illustrated a linear normal model. However, a scatterplot of the residuals versus predicted values demonstrated a trapezoid shape which suggests nonconstancy of error variance. To eliminate this problem, the model was transformed using weighted least squares (Neter, Wasserman, Kutner, 1990). The variances were further stabilized by using a square root transformation on the criterion variable. This is recommended when the criterion variable is a count, such as the number of emergency service screenings (Neter et al.). Residual plots of the remaining predictor variables indicated normally distributed linear variables supporting their appropriateness for the analysis.

Multiple regression was conducted to determine the ability of fear of success, task-oriented coping, emotion-oriented coping, social diversion coping, and distraction coping to predict emergency service use. The alpha for inclusion in the model was set at the .05 level. The result of stepwise introduction of these primary variables indicated that a model including fear of success and social distraction was most predictive of emergency service use, $F(2,97) = 42.676$, $p < .001$, $R^2 = .684$). A stepwise addition of the demographics variables (age, gender,

Table 2

Means and Standard Deviations of Predictor Variables

<u>Variable</u>	<u>M</u>	<u>SD</u>
Emergency Service Contact	3.41	3.26
Fear of Success	110.48	15.91
Task-oriented Coping	43.30	11.60
Emotion-oriented Coping	56.80	10.21
Avoidant Coping	60.22	12.12
Social Diversion Coping	54.62	10.73
Distraction Coping	61.07	12.34
Age	39.92	11.77

and education level) indicated no significant increment in variance explained (See Table 3).

Table 3

Multiple Regression Analysis: Significant Predictors of
Emergency Service Use

<u>Step</u>	<u>Predictor</u>	<u>Beta</u>	<u>t</u>	<u>p</u>	<u>R²</u>
1.	Fear of Success	.65	8.73	.00	.66
2.	Social Diversion Coping	-.19	-2.59	.01	.68

CHAPTER IV

DISCUSSION

Fear of success and social diversion coping were found to be useful predictors of emergency service use. Together they accounted for 68% of the variance. Clients who had lower FOS and frequently used social diversion coping were less likely to use emergency services. Fear of success alone accounted for 65% of the variance. Individuals with a mental illness who have high FOS appear more likely to sabotage their chances for success in the community than a person with low FOS. Therefore, being afraid of success appears to result in the increase of precipitants such as medication noncompliance which have been repeatedly found to lead to rehospitalization.

Although only to a limited degree, use of social diversion as a primary coping style was also a significant predictor of emergency service use. Patients who rarely used social diversion as a coping style were more likely to use emergency services repeatedly. These results support a study by Smith et al. (1991) which found that recidivists relied on few people to solve problems. Other studies have proposed the use of social skills training and psychosocial groups to improve coping and reduce recidivism (Polk-Walker et al., 1993; Willer & Miller, 1977). Helping a client to become more comfortable in social situations and build a larger support

system could increase the likelihood that the client would seek out social support as a coping style.

In addition, correlational results indicated those who frequently used social diversion were more likely to use all other styles of coping. Perhaps people who use social diversion also use a wide variety of coping styles and are therefore better able to address difficulties as they arise. They may be more likely to use their variety of coping skills to prevent crisis.

Task-oriented coping that involves using direct problem solving skills was not found to be predictive of recidivism. However, correlations indicated people who use more task-oriented coping are less likely to repeatedly use emergency services. This supports the findings of Takai et al. (1990) who found less frequent hospitalization in people who used task-oriented coping.

People who used higher levels of task-oriented coping also tended to have lower fear of success. Perhaps people who fear success are less likely to take active steps to solve problems for fear that these steps will lead to success. Not acting to solve problems could then result in the accumulation or worsening of difficulties to the point of crisis and inevitable need for emergency service intervention.

People who have achieved a higher level of education were found to use emergency services more often, although

this relationship disappeared when fear of success was considered. A positive relationship between education and recidivism contradicts findings by Polk-Walker et al. (1993) that people with no rehospitalizations had higher education levels. People who are more educated may be more aware of their problems and are therefore more likely to ask for assistance when needed. More educated participants rarely used avoidance and distraction as coping styles. If institutions of higher learning provide more experience with problem solving, people with lower education levels may not have been exposed to other types of coping and consequently rely more heavily on activities and cognitions that reduce stress through avoidance. The clients with less education may also be from a lower socioeconomic level and are therefore in a group whose psychiatric needs are less likely to be adequately met (Kendall & Hammen, 1995).

Older clients tended to be lower in fear of success and less likely to use avoidant styles of coping. Older people may worry less about success because they believe it is too late to be successful in life, or they may have more experience with success and therefore have a more realistic perspective. Younger clients, like those with less education, may simply need to learn other coping styles as a way to reduce the level of dependence on avoidance techniques.

Limitations

Since all participants in this study were receiving case management, and many were attending a day treatment center, there is limited generalizability to clients receiving no community support services. In addition, the diagnosis of the participants were not recorded and may have impacted the results. Characteristics of the participants who agreed to complete the questionnaire packet may differ substantially from those who chose to decline participation. The operational definition of recidivism as the number of emergency service contacts during a two year period could be further refined to include only those clients who contact emergency services for crisis intervention which results in hospitalization or increased service use.

Implications

This study supports the theory that recidivism depends on a number of factors working together (Polk-Walker et al., 1993). It also supports the theory that fear of success can lead to lack of achievement behavior (Hyland, 1989). Fear of success was found to be a powerful predictor of recidivism when defined as the number of emergency service contacts. This construct had not been examined in previous research on recidivism. Ohri and Malhotra (1993) found fear of success to be of no significant importance in distinguishing neurotic women from controls. However, this study demonstrates the

importance of fear of success as a predictor of recidivism and should be considered in future studies.

The theory proposing coping styles can have important implications on the ability of people to recover from stressful situations was also supported (Endler & Parker, 1990). A particularly interesting finding was people who used social diversion less often were more likely to use emergency services. This supports the theory stating the degree of social interaction can impact the ability of clients to function better in the community (Bedell & Ward, 1989).

Future research in this area could directly address interventions to reduce fear of success and increase social diversion coping. Outcome studies using a variety of techniques such as behavior modification, education and increased social contact would be beneficial to determine the best course of action to lower fear of success and increase use of social diversion coping to reduce recidivism.

Larger scale studies, which include more variables and more participants, may allow researchers to discover more complete and robust predictive models. Compliance with medications, number of previous hospitalizations, length of time institutionalized, amount of family support, locus of control, and impulse control are just some of the possible variables to be examined.

The practical implications of this study are that a simple 10 to 15 minute session to fill out the FOS

scale and CISS questionnaire will allow a case manager or other treatment team member to determine if a client is more likely to use emergency services repeatedly. Those with high fear of success and low social diversion coping scores can then be specifically targeted to prevent recidivism. Mental health centers facing a reduction in hospital beds available to their clients may target the reduction of FOS as a way to reduce emergency service screenings and inevitably rehospitalizations.

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APPENDIX A
REQUEST FOR PARTICIPATION SCRIPT

#####

REQUEST FOR PARTICIPATION SCRIPT

#####

***If the client agrees to participate, skip the fourth paragraph and proceed.

A graduate student from ESU, Deb Matchinsky, who is also an intern who works at the Rainbow Club a couple days a week is seeking volunteers to fill out a questionnaire packet for her thesis. It is totally voluntary and only takes about 20 minutes to complete.

The Mental Health Center has given Deb permission to ask for volunteers because this research may be beneficial to both the client and the center. The questionnaires will give you a chance to think about how you cope with various situations in your life. At the same time, you will be providing information that may help everyone being discharged from the hospital to adjust more easily to living in the community.

If you are willing to participate, I will leave the packet with you. You can fill in the forms and seal them in the provided envelope. Your answers will be confidential. Even I won't see your responses. Simply drop the sealed envelope in the mail, give it to a Mental Health Center staff or drop it by the center.

If you decide not to participate, that is OK and I will understand. There is no pressure to volunteer. Just say "No thanks." If you change your mind and decide within the next two weeks to help Deb with her thesis, I'll have a packet delivered to you.

If you have any questions about the packet or participating in the study you can call Deb Matchinsky at the Mental Health Center 342-0548.

APPENDIX B
CONSENT FORM

Participation Consent Letter

Read this consent form carefully. You are invited to participate in a study investigating the ability to predict the use of emergency services with fear of success and coping styles questionnaires. You will be asked to complete a packet which includes these questionnaires.

The packet will be returned to the experimenter in a sealed envelope to ensure confidentiality. The only identifying information will be your case number (as used by your case manager) which will be used to access emergency services files at your local Mental Health Center. Only the experimenter will have access to this information.

Your participation in this study is completely voluntary. Should you wish to end your participation, you are welcome to do so at any point in the study. Deciding not to continue the study will have no consequences. There is no risk or discomfort involved in completing the study.

If you have any questions or comments about this study, feel free to ask the experimenter. If you have any questions once the study is over, please contact Debra J. Matchinsky, Division of Psychology and Special Education, 301 Visser Hall, Emporia State University, 341-5803.

Thank you for your participation.

I, _____, have read the above and have decided to participate. I understand that my participation is

voluntary. I further understand that I may withdraw at any time without prejudice after signing this form should I choose to discontinue.

(signature of participant)

(date)

(signature of experimenter)

*THIS PROJECT HAS BEEN REVIEWED BY THE EMPORIA STATE UNIVERSITY COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS AND THE EXECUTIVE BOARD OF THE MENTAL HEALTH CENTER OF EAST CENTRAL KANSAS.

APPENDIX C
DEMOGRAPHICS FORM

DEMOGRAPHIC QUESTIONNAIRE

Case Number: _____

Date:

Date of birth:

Age: _____

Race: _____

Sex:

Educational status: (circle one)

Dropped Out

G.E.D.

High School Diploma

Some college

Two year degree

Four year degree

Some graduate training

Master Degree

PhD

Do you currently hold a job for pay or volunteer job?

Yes _____ No _____

If yes, describe the job:

Are you concerned that if your mental health improves you will lose services? Yes _____ No _____

If yes, what services are you worried about losing?

////////////////////////////////////

Thank you for taking the time to fill out these questionnaires for my thesis project!

////////////////////////////////////

APPENDIX D
FEAR OF SUCCESS SURVEY

ATTITUDES INVENTORY

Instructions: In this questionnaire you will find a number of statements. For each statement a scale from 1 to 7 is provided, with 1 representing one extreme and 7 the other extreme. In each case, circle a number from 1 to 7 to indicate whether or not you agree with the statement. This is a measure of personal attitudes. There are no right or wrong answers. Please answer all items.

1. I expect other people to fully appreciate my potential.

1 2 3 4 5 6 7

2. Often the cost of success is greater than the reward.

1 2 3 4 5 6 7

3. For every winner there are several rejected and unhappy losers.

1 2 3 4 5 6 7

4. The only way I can prove my worth is by winning a game or doing well on task.

1 2 3 4 5 6 7

5. I enjoy telling my friends that I have done something especially well.

1 2 3 4 5 6 7

6. It is more important to play the game than to win it.

1 2 3 4 5 6 7

7. In my attempt to do better than others, I realize I may lose many of my friends.

1 2 3 4 5 6 7

8. In competition I try to win no matter what.

1 2 3 4 5 6 7

9. A person who is at the top faces nothing but a constant struggle to stay there.

1 2 3 4 5 6 7

10. I am happy only when I am doing better than others.

1 2 3 4 5 6 7

11. I think "success" has been emphasized too much in our culture.

1 2 3 4 5 6 7

12. In order to achieve one must give up the fun things in life.

1 2 3 4 5 6 7

13. The cost of success is overwhelming responsibility.

1 2 3 4 5 6 7

14. Achievement commands respect.

1 2 3 4 5 6 7

15. I become embarrassed when others compliment me on my work.

1 2 3 4 5 6 7

16. A successful person is often considered by others to be both aloof and snobbish.

1 2 3 4 5 6 7

17. When you're on top, everyone looks up to you.

1 2 3 4 5 6 7

18. People's behavior change for the worst after they become successful.

1 2 3 4 5 6 7

19. When competing against another person, I sometime feel better if I lose than if I win.

1 2 3 4 5 6 7

20. Once you're on top, everyone is your buddy and no one is your friend.

1 2 3 4 5 6 7

21. When you're the best, all doors are open.

1 2 3 4 5 6 7

22. Even when I do well on a task, I sometimes feel like a phony or a fraud.

1 2 3 4 5 6 7

23. I believe that successful people are often sad and lonely.

1 2 3 4 5 6 7

24. The rewards of a successful competition are greater than those received from cooperation.

1 2 3 4 5 6 7

25. When I am on top the responsibility makes me feel uneasy.

1 2 3 4 5 6 7

26. It is extremely important for me to do well in all things that I undertake.

1 2 3 4 5 6 7

27. I believe I will be more successful than most of the people I know.

1 2 3 4 5 6 7

I, Debra J. Matchinsky, hereby submit this thesis/report to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available to use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Debra J. Matchinsky

Signature of Author

7-23-96

Date

Fear of Success and Coping Styles as Predictors of Need for Emergency...

Title of Thesis/Research Project

Wendy Cooper

Signature of Graduate Office Staff

August 1, 1996

Date Received