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Conduct disorder of adolescence: an object relations approach.

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CONDUCT DISORDER OF ADOLESCENCE:
AN OBJECT RELATIONS APPROACH

A Dissertation Presented

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PREFACE

My interest in research in Conduct Disorder is a direct result of clinical experience and as such has an immediacy and importance to me that extends beyond the theoretical. While working on an adolescent inpatient unit in a medical center, I became increasingly intrigued by the phenomenon of the many adolescents who entered the unit with the diagnosis of Conduct Disorder. The diagnosis is of recent genesis, having originated in DSM-III (American Psychiatric Association, 1980), and is currently the most frequently used psychiatric diagnosis for children and adolescents. What was most striking was the diversity of the adolescents so labeled and the pejorative, pessimistic connotations that the diagnosis had for the staff. For many of the unit personnel, a diagnosis of Conduct Disorder seemed to imply that the adolescents were not amenable to treatment beyond a strict behavioral regimen aimed at controlling impulsivity and antisocial behavior. Ironically, the descriptive nature of the diagnosis had originally been seen as a strong point--a less negative label that would not stigmatize those so diagnosed. In practice, Conduct Disorder seemed to function as a pseudonym for that psychiatric bete noir--sociopathy.

For myself, the pragmatic and theoretical were joined most compellingly in the person of one of my patients, a young woman with a Conduct Disorder diagnosis who had been hospitalized following

repeated episodes of running away, truancy and aggression. I felt at the time, that while the diagnosis was, strictly speaking, accurate enough, it did not address what was to me more salient--my patient's borderline personality traits, along the lines described by Kernberg (1975) --that is, a defensive structure based on primitive defenses such as splitting, denial and projection, impulsivity, self-destructive behavior and intense difficulties with attachment and separation. Unfortunately for the young woman in question, she was caught in a system which most often provided rotations of short-term therapists resulting in her having three therapists in a span of six months. This type of "treatment" might be considered of small consequence if one is working with an "incorrigible" sociopath, but had considerable impact for someone as exquisitely sensitive to abandonment issues as this patient. While she was able to make gradual progress, I felt it was in spite of a treatment situation which generally ignored her personality dynamics. The Conduct Disorder diagnosis had to me what appeared a fateful imprecision which could lead, if not supplemented by further diagnostic understanding of intrapsychic dynamics, to nontreatment or, worse, iatrogenic escalation of existing personality conflicts.

Stimulated by my clinical experience, I began to explore the literature on Conduct Disorder, which was notable on a number of counts: its meagerness due to the newness of the diagnosis, the vastness of the related previous literature on delinquency and antisocial behavior, the wealth of descriptive material, and the

evident pessimism and perplexity about treatment. As a clinician, I felt that the behavioral precision of the DSM-III diagnosis was undermined by the lack of any etiological understanding or coherent treatment strategy.

In sum, I concluded that while the DSM-III diagnostic criteria had actuarial utility, there was need of further clinical exploration of the syndrome, if, indeed, it could accurately be considered a syndrome. The vague treatment implications seemed particularly disturbing considering the prevalence and prognosis of the disorder. What follows is my attempt to bring greater clinical clarity to those adolescents with the label of Conduct Disorder by integrating case material, previous research and recent relevant developments in Object Relations theory with regard to borderline and narcissistic personality disorders.

ABSTRACT

Conduct Disorder of Adolescence:
An Object Relations Approach

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Conduct Disorder of adolescence is investigated from the perspective of Object Relations theory. The inadequacies of the DSM-III diagnosis in providing etiological understanding and clear treatment implications for Conduct Disorder are discussed along with the reliability and validity of the diagnosis. Historical antecedents to the Conduct Disorder diagnosis are reviewed with reference to the concepts of sociopathy, psychopathy, delinquency, and acting out. Clinical correlates of Conduct Disorder and adolescent antisocial behavior, such as hyperactivity and depression, are also reviewed, and an overview of traditional treatment for antisocial syndromes is given.

Recent developments in Object Relations theory with respect to the diagnosis and treatment of borderline and narcissistic personality are reviewed with an emphasis on the work of Kernberg, Masterson and Kohut. The key features of each theoretician's approach are delineated and then applied to the case material of four adolescent

males who were given the diagnosis of Conduct Disorder. Intrapsychic development, defense mechanisms, transference and countertransference, themes of socialization and aggression, diagnosis and treatment implications are discussed for each case. Conclusions are drawn with respect to etiological, diagnostic and treatment issues, and suggestions are made for improvements to be made in DSM-IV.

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CHAPTER I

INTRODUCTION

An Object Relations approach to Conduct Disorder seems most opportune at this time. Conduct Disorder is a recently created diagnosis which is widely applied to children and adolescents who evidence persistent behavioral problems. The deceptive simplicity of the diagnosis belies the psychological complexity of the phenomena it addresses and, from a clinical standpoint, a more refined understanding of the etiology, development and treatment of Conduct Disorder is desirable. Object Relations theory, which over the past decade has provided considerable clinical insight into the general area of personality disorders, seems an appropriate perspective from which to view Conduct Disorder. In many respects Conduct Disorder appears to be an antecedent to adult personality disorder and it seems only logical to apply the theoretical and clinical advances related to personality disorders to Conduct Disorder. The present inquiry utilizes an interplay of clinical material and theory with hope of enriching both.

Chapter I provides a definition of Conduct Disorder and addresses its reliability and validity as a diagnosis, as well as other diagnostic issues such as its relation to adult diagnoses and its utility for treatment. Chapter II explores the history with special reference to the concepts of sociopathy, psychopathy, delinquency and acting out

as well as the clinical correlates which have emerged in the literature. Chapter III provides an overview of treatment perspectives which have been utilized with antisocial behavior, and then explores in considerable depth the Object Relations approaches which have proven so fruitful with borderline and narcissistic personality disorders. The perspectives of Kernberg, Masterson and Kohut are emphasized. Chapter IV contains extensive case material on four adolescent males with the diagnosis of Conduct Disorder who have been treated by this writer. A detailed Object Relations case analysis is provided for each patient. Chapter V reviews the findings of this inquiry and draws conclusions with respect to etiological, diagnostic and treatment issues. The limitations of this work and suggestions for the prospective DSM-IV are also briefly discussed.

Conduct Disorder Diagnosis

Definition of Conduct Disorder

The diagnostic criteria of Conduct Disorder, as defined in DSM-III, The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Third Edition (American Psychiatric Association, 1980), focus on specific behaviors which indicate a "...repetitive and persistent pattern of conduct in which either the rights of others or major age-appropriate societal norms or rules are violated." This definition subsumes much of the "acting out" behavior associated with adolescence, and indeed in

the DSM-III field trials over one-third of the sample was so diagnosed. Incorporated into the new schema were the previous diagnostic categories which appeared in DSM-II (American Psychiatric Association, 1968): Runaway Reactions of Childhood or Adolescence, Unsocialized Aggressive Reaction and Group Delinquent Reaction.

Conduct Disorder is divided into the categories of Aggressive/Nonaggressive and Socialized/Undersocialized, resulting in four primary subtypes which are generally based upon "the presence or absence of adequate social bonds and the presence or absence of aggressive antisocial behavior." (American Psychiatric Association, 1980, p. 45). Aggressive antisocial behavior is defined to be physical violence toward persons or property (e.g., assault, rape, vandalism and breaking and entering) or theft outside the home involving confrontation with the victim (e.g., armed robbery, purse snatching). Non-aggressive antisocial behavior is indicated by chronic truancy, substance abuse, serious lying and non-confrontive theft. The children or adolescents considered Socialized demonstrate some social attachment, especially in their immediate peer group, but still may be "callous or manipulative toward persons to whom they are not attached." Undersocialized individuals are defined by the lack of substantive, enduring (over six months) peer group relationships, the inability to feel appropriate empathic concern, guilt, or remorse, and by egocentric self-serving conduct.

Other associated features of Conduct Disorder, as outlined in DSM-III, are precocious sexual activity, avoiding responsibility

for one's actions, low self-esteem, substance use, poor frustration tolerance and impulse control, academic underachievement, and attentional difficulties. The age of onset varies widely but is generally considered to be later for the Socialized type than for the Undersocialized type. The course is considered variable with Undersocialized, Aggressive individuals having the worst prognosis and often continuing antisocial behavior into adulthood. Socialized, Nonaggressive individuals, not surprisingly, are considered the most likely to achieve "reasonable social and occupational adjustment as adults" (p. 46). The disorder is characterized as much more prevalent among males. Listed as predisposing factors for the Undersocialized types are Attention Deficit Disorder, parental rejection, inconsistent and harsh discipline, institutional living, frequent shifting of parental figures and being an illegitimate only child. Large family size, association with a delinquent subgroup, an absent father or alcoholic father are predisposing factors for the Socialized types. It should be noted that the diagnosis of Conduct Disorder is not made when the antisocial behavior is not part of a repetitive, persistent pattern or if the individual is oppositional to authority figures without violating the basic rights of others or societal norms.

Reliability

The development of DSM-III was in many respects guided by a desire to define diagnostic criteria more precisely in order to aid both

research and clinical work. To this end behavioral specificity was considered a priority. The Conduct Disorder diagnosis exemplifies the descriptive approach in its listing of certain clearly definable behaviors (e.g., theft, truancy, fire setting), yet at the same time it includes other more subtle and subjective criteria such as those taken to denote socialization (e.g., presence of guilt, remorse, concern for friends). Despite the attempt at behavioral precision, the reliability in the DSM-III field trials was not particularly impressive (.61 in both samples, American Psychiatric Association, 1980, p. 471).

Spitzer (1980) notes that the primary sources of unreliability in psychiatric diagnosis are information variance, observation and interpretation variance, and criterion variance. Information variance results when the obtained information on which clinicians base their diagnosis for a particular case is different. Observation and interpretation variance arises when clinicians exposed to the same information and behavior experiences remember or interpret the data differently. Criterion variance occurs when clinicians use different criteria to make a certain diagnosis. In the case of Conduct Disorder, interpretation and criterion variance are the most probable sources of unreliability, with the following factors likely contributors: (1) insufficient specificity in regard to socialization criteria (e.g., How does one consistently assess the presence of "friendship," "guilt" or "remorse"?); (2) vagueness about what constitutes a "persistent and repetitive pattern" (e.g., Are three thefts

in six years equivalent to three in six months?); (3) symptom presentations which mix emotional and behavioral problems (e.g., differential diagnosis between Affective Disorder and Conduct Disorder); (4) confusion about applicable "norms" for a given population (e.g, How broad is an individual's "society"). It should be evident that uniform application of the Conduct Disorder diagnosis is problematic at best.

Validity

Descriptive validity. Of even greater concern than the reliability of the Conduct Disorder diagnosis have been issues surrounding its validity, particularly with reference to the subtypes. While the dimensions of socialization and aggressivity have face validity, i.e., they make sense based on the clinical experiences of those in the field, their descriptive validity has remained controversial.

Descriptive validity is considered to be present when a diagnostic category "represents a distinct behavioral syndrome rather than a random collection of clinical features" (Cantwell, 1980, p. 345). In one sense the descriptive validity of Conduct Disorder may be undermined by the particularistic nature of DSM-III. In their discussion of DSM-III diagnostic categories for children, Rutter and Schaffer (1980), question the specificity of criteria of syndromes that have not been adequately validated. For example, in the case of Conduct Disorder the requirement that friendships must

last "over six months" seems arbitrarily precise. Validity may suffer then in the quest for increased reliability.

The heterogeneity of childhood behaviors also increases the difficulty in making precise diagnoses (Achenbach, 1980; Stewart, deBlois, Meardon, & Cummings, 1980; Wolff, 1971). The variety of behaviors, as well as the variability within each child, is further complicated by developmental factors. Not only are the distinctions between "normality" and "abnormality" blurred, but children's self-expression is so action-oriented that the same behaviors may be produced in response to a variety of internal states resulting in an alloplasticity that defies classification. In Achenbach's words, "Few children display such clearly pathognomonic behaviors as those that mark the classic adult syndromes" (1980, p. 398). Based on factor analysis of the behavior of 100 children, Wolff concluded that the diversity of children's behavior problems may be "an insuperable obstacle to devising a useful, valid, and generally applicable classification of childhood behavior disorders into mutually exclusive subcategories" (1971, p. 427). Achenbach (1980) is less pessimistic and has used factor analytic methods in an attempt to empirically derive syndromes in child psychopathology. He used a child behavior checklist filled out by parents upon their child's intake into in-patient mental health centers as a basis for his analysis. Defining syndromes as sets of behaviors which co-occur, two syndromes were found which approximated the DSM-III Conduct Disorder subtypes: an aggressive syndrome corresponding to Undersocialized, Aggressive

and a delinquent syndrome which for boys corresponded to Socialized, Aggressive, and for girls corresponded to Socialized, Non-aggressive. No empirically derived syndrome corresponded to Undersocialized, Non-aggressive, leading Achenbach to suggest that if the unfound syndromes do exist separately from those which were identified, they may be rare or restricted to unusual clinical populations.

An attempt to develop a more precise definition of aggressive conduct disorder was made in another research study (Stewart, deBlois, Meardon and Cummings, 1980). The researchers were particularly interested in whether aggressive conduct disorder (operationally defined by the presence of assaultiveness, fighting, cruelty, defiance of authority and destructiveness) could be separated from other behavior disorders (e.g., hyperactivity, anxiety reaction, depression and socialized conduct disorder). Although some descriptive differences were found between those two categories, there was not adequate confirmation of aggressive conduct disorder as a genuine syndrome. In particular, difficulties were acknowledged in discriminating between aggressive and antisocial adolescents, due to the fact that such adolescents overlap both in terms of behaviors and etiological factors such as parental alcoholism, psychopathology, and physical abuse. While Stewart and his fellow researchers support categorizing within the generic Conduct Disorder group they are unable to provide a clear picture of where the lines of demarcation should be drawn.

Even those who believe there is evidence for discrete behavioral

syndromes in childhood have critiqued the "yes or no" approach of DSM-III. Achenbach (1980) suggests that such a binary stance, which has clear utility from a research standpoint, is often inappropriate in the clinical study of children and adolescents. He states, "In childhood psychopathology, where specific organic categories are rarely known and where the child's entire behavior pattern is relevant to diagnosis, treatment, and prognosis, forced choices among unvalidated categories may be inappropriate or, at best, premature" (p. 406).

As a solution, Achenbach proposes greater reliance on trait scales which can reflect with more precision the degree and variety of the individual characteristics. He also argues for differentiations based on sex and age which are currently overlooked in the DSM-III categorization. A similar argument was made by Marohn (1981) from a psychoanalytic perspective. Marohn advocates a separation between childhood and adolescence in the classification of many disorders, based upon the differing developmental stages and the solidification of characterological patterns which may be identifiable in late adolescence but whose application in childhood would be premature. This has special relevance for Conduct Disorder as evidenced in adolescence and which may reflect an "engrained personality pattern" requiring intervention of a different sort than if similar behaviors occur in childhood. Rutter and Schaffer (1980) also comment that the frequent clinical picture of a mixture of emotional disturbance and aggression or antisocial behavior has no

diagnostic home in DSM-III. The Conduct Disorder diagnosis could be applied in such cases but would lack descriptive validity without additional information being provided through supplemental diagnoses or descriptors. Thus, the descriptive validity of Conduct Disorder has been questioned in regard to the specificity of diagnostic criteria, the heterogeneity of childhood behavior, the alloplastic expression of internal states, the lack of convincing empirical validation for the subtypes, and the postulated need for differentiations with respect to sex and age.

Predictive validity. From a clinician's perspective, predictive validity is even more important than descriptive validity. Cantwell (1980) defines predictive validity in relation to diagnosis as knowledge of correlatives such as natural history, biological factors, and prognosis including response to various types of psychiatric intervention. In the case of Conduct Disorder the predictive validity is a focal issue given the prevalence and frequently serious sequelae of childhood and adolescent antisocial behavior (Robins, 1966, 1981). Robins, who has done the most comprehensive, long term follow-up of childhood antisocial behavior, emphatically delineates the stakes involved.

> Epidemiological research has shown us how common childhood antisocial behavior is. It accounts for more referrals to child guidance clinics than any other disorder, and many additional cases are handled outside of the health system by the courts, school counselors and family welfare agencies. Further, through natural history research we have learned that the risk of persistence of childhood antisocial behavior is high and the consequences of continuation are very serious, not only for the child himself

> but also for his offspring. ...We now recognize that antisocial behavior in childhood is the single most costly childhood disorder to society. (1981, p. 573)

It is clear from Robins' (1966) landmark follow-up of delinquents that adult antisocial behavior is almost always preceded by antisocial behavior in childhood. However antisocial behavior in children does not necessarily lead to antisocial behavior in adulthood, although it does make it significantly more likely (69% of identified "sociopathic" children demonstrated antisocial behavior as adults). Of all children referred for antisocial behavior, 28% were later diagnosed sociopathic personality as adults. Other diagnostic outcomes in descending order of frequency were: (1) undiagnosed but sick, 23%; (2) no disease, 16%; (3) neuroses, 14%; (4) psychoses, 11%; (5) alcoholism, 8%. In assessing which children were more likely to be diagnosed sociopathic as adults, the most significant factors were the number and variety of antisocial behaviors. One can conclude that while childhood antisocial behavior problems are predictive of adult psychiatric problems, these difficulties are quite varied and by no means limited to sociopathic behavior.

Given the recent genesis of the Conduct Disorder diagnosis there have not been any longitudinal outcome studies following individuals diagnosed Conduct Disorder. While considerable overlap with those previously diagnosed Group Delinquent Reaction or Unsocialized Aggressive Reaction in DSM-II (American Psychiatric Association, 1968) can be assumed it will take time to validate predictive hypotheses about Conduct Disorder. A retrospective study by

Henn, Bardwell, and Jenkins (1980) examined the records of 286 boys sent to a state correctional facility in Iowa and applied DSM-III diagnostic criteria to that group. They classified 51 boys as Undersocialized, Aggressive, 49 as Undersocialized, Nonaggressive, and 107 as Socialized Delinquents (presumably subsuming Socialized, Aggressive and Socialized, Nonaggressive). Unable to be classified were 79 cases. The adult criminal records of the sample population were examined for evidence of unlawful behavior. It was found that 34% of the socialized delinquents were incarcerated versus 50% of the undersocialized individuals. In general, the socialized delinquents had a significantly more favorable outcome than either of the Undersocialized groups. The differences between the two Undersocialized Conduct Disorder groups were more qualitative and as expected: the Undersocialized Aggressive group had higher rates of arrest for violent crimes, as distinct from the Undersocialized Nonaggressive group which was more involved in offenses such as contributing to the delinquency of a minor and malicious damage to a building. Although the previous consensus has been that treatment of antisocial personality disorders is disappointing, the researchers concluded that further study of treatment outcome may find the Socialized subtype more amenable to treatment. In their view the key element is the history and presence of "caring and sharing" interpersonal relationships.

The literature on the predictive validity of Conduct Disorder is then very sparse and certainly not conclusive. There are those such as Stewart, deBlois, Meardon and Cummings (1980) who feel that

aggression is a key determinant, while others such as Henn, et al. (1980) look to socialization as a discriminating variable between groups and predictor of future outcome. Still others such as Achenbach (1980) have pointed to age and sex as important variables. Absent from the literature are clear guidelines for treatment, and the overall tone is very pessimistic.

Further Diagnostic Issues

Adult diagnostic classification. The relationship between disorders of childhood and adolescence and those of adulthood requires clarification. As noted by Achenbach (1980) most adult disorders have no clear counterparts in childhood, and even when the same diagnostic labels are employed, such as in the cases of schizophrenia and depression, similarities in etiology, epidemiology, course, and response to treatment have not been demonstrated. Another factor to be considered is the fact that most children are not self-referred and their diagnoses are based on the observations of adults rather than self-report. A third consideration raised by Achenbach is the developmental status of children and adolescents, with developmental failures and arrests often being more clinically significant than symptoms per se.

The diagnostic dilemma is further complicated by pubescence which is characterized by "adolescent turmoil" (Blos, 1962) and character formation which Blos (1968) later described as an integrative process aimed at eliminating conflict and anxiety. With ado-

lescents there remains the nagging question of whether their symptoms are an intensified transient response to the emotional upheaval of that stage of development or, more ominously, reflective of enduring psychopathology.

Masterson (1968, 1972) agrees that diagnosis in adolescence is problematic but argues that the role of "adolescent turmoil" in clinical populations has been overplayed, resulting in inadequate or belated treatment for many individuals. The use of overinclusive terminology can then serve to delay appropriate diagnosis. Once the adolescent enters adulthood the diagnostic confusion is usually resolved, but the opportunity for effective treatment may have been missed.

The relationship of Conduct Disorder to adult classification as given in DSM-III leaves much to be desired. In the section on personality disorders, Conduct Disorder is linked with Antisocial Personality Disorder. The obviousness of this connection--in behavioral terms--is belied by the abovementioned evidence (Robins, 1966) that the majority of those who exhibited antisocial behavior as children were not diagnosed as "sociopathic" in adulthood. Behavior problems considered sufficiently serious to warrant a Conduct Disorder diagnosis (as opposed to Adjustment Reaction) are likely to have implications broader than what is explicated in DSM-III. Further, the association with Antisocial Personality Disorder suggests an imperviousness to treatment that may discourage such efforts.

DSM-III admonishes against the utilization of Personality Disorder diagnoses until age 18, because by definition such diagnoses suggest a more permanent style of adaptation; developmental considerations, such as those raised by Achenbach, could be overlooked. However, with Conduct Disorder DSM-III does not specify the important developmental factors except to imply that they are related to socialization and aggression. Also ignored is the probability, as suggested by Masterson and Marohn, that adolescents with behavior problems evidence a premature closure of characterological development which may be more usefully understood with reference to personality disorder diagnoses.

Utility for treatment. The utility of the Conduct Disorder diagnosis for guiding treatment must at this point be seriously questioned. While the reliability of the diagnosis is only adequate and the evidence for descriptive validity is uneven, the most disturbing aspect remains the poor predictive validity and the meager understanding of underlying dynamics. Lewis and Balla (1976) clearly state the central issue: "Only when a so-called label, a categorization, leads to advantageous treatment for the deviant individual, to better, specific treatment and a better outcome than otherwise would have been the case, can such categorization be sanctioned ethically" (p. 12-13). As of yet these criteria have not been met for Conduct Disorder, and the obstacles to their being met are substantial.

Ironically one of the major constraints on the utility of the

diagnosis has been its behavioral emphasis--which was thought to be a virtue. Cantwell (1980) states that DSM-III was designed to be descriptive and purposely has not taken a particular etiological or theoretical perspective. However, it would seem that limiting diagnostic criteria to overt behavior in and of itself actually endorses a behavioral vantage point. Such a stance may be justified as an attempt to develop empirically validated categories, but it simply does not appear to be adequate for understanding the complex phenomena of antisocial behavior in children and adolescents. Malmquist (1978) comments and proposes an alternative:

> It is necessary to see all types of antisocial behavior as compatible with different diagnoses or even situational occurrences. Such behavior can be responsive to psychological realignments wherein the ego permits impulsive or regressive activities to occur. It is not inconsistent for adults or adolescents with neurotic or psychotic disturbances to engage in blatant antisocial conduct, nor is it inconsistent for a young child with similar problems to lie, cheat, steal or be physically assaultive. Rather than using conduct as diagnostic the criteria should involve appraisal of defects in socialization processes and ego functioning ... To focus on acts of an antisocial type as diagnostic criteria hardly suffices to establish anything more than the presence of unsocialized behavior. (p. 575)

The concept of supplementing the current DSM-III nosology with a sixth axis for psychodynamic evaluation has been suggested by Karasu and Skodol (1980). They point to widespread dissatisfaction with DSM-III among those actively engaged in psychotherapy (Bursten, 1978; McLemore & Benjamin, 1979) and note that the "characterological" dimension is often the most useful in designing treatment strategies

and predicting outcomes.

It is precisely the characterological dimension which needs to be addressed in those adolescents with Conduct Disorder diagnoses. The concepts of socialization and aggression within the diagnosis should be relevant to any psychodynamic evaluation. Certainly an individual's capacity to engage in interpersonal relations and to effectively channel aggressive impulses have been major themes in the analytic tradition beginning with Freud; however, the discrete behavioral matrix used for socialization and aggression may prove less useful for treatment than a developmental continuum addressing those variables in particular and personality structure in general.

The choice between categories and a continuum suggests a last point regarding the utility of the Conduct Disorder diagnosis, and it is one whose scope goes considerably beyond the purpose of this consideration. When evaluating the usefulness of any system one must always be aware of that system's functional context. A clinician whose primary interest is treatment will have very different criteria from those with other agenda. As Halleck (1967) points out, the criminal justice system tends to require a discontinuous model of diagnosis. The same is true for insurance companies, governmental agencies and researchers relying on statistical analyses. Thus, it is probably unrealistic to expect that clinical utility will necessarily be the determining factor in the development and creation of an official diagnostic system.

The purpose here is not to categorize but to bring greater clinical understanding to those adolescents diagnosed as Conduct Disorder, and based on that understanding make suggestions for treatment. With this in mind it is pertinent to review the history of diagnoses for antisocial behavior and the correlates of antisocial behavior which have been addressed in the literature.

CHAPTER II

HISTORY AND CORRELATES OF ADOLESCENT ANTISOCIAL BEHAVIOR

Historical Perspective on the Diagnosis of Antisocial Behavior

The history of the various diagnostic concepts relating to antisocial behavior is long, complex, and often confusing. At one time or another psychopathy, sociopathy, and antisocial personality have each gained prominence and been the preferred term. To complicate matters, they are often used interchangeably despite the fact that from a historical perspective they are not equivalents. Delinquency and "acting out" are also terms that are used frequently in reference to individuals, especially adolescents, who perform antisocial acts. A review of the history surrounding these concepts will provide the reader with a context for this consideration of investigation of Conduct Disorder.

Psychopathy, sociopathy, and antisocial personality

One of the most striking aspects that emerges from a review of the literature on psychopathy and its functional synonyms is a marked contrast between the clarity of what the terms connote and the confusion about what they actually mean. It is widely assumed that a "psychopath" is dangerous and incorrigible--certainly someone to be avoided; however, arriving at a consistently applied, consensual definition is another matter. Robins (1966) comments, "The psychi-

atric literature dealing with the syndrome sociopathic personality under its various diagnostic titles agrees only that it begins early and that the treatment is relatively unsuccessful" (p. 2). This assessment is frequently reiterated in the literature (Leaff, 1978, 1981; Malmquist, 1978; Millon, 1981; Reid, 1978, 1981). The enduring interest in antisocial behavior is indicative of its importance and the diagnostic confusion is indicative of its complexity.

Attempts to understand those who deviated from social norms began to be formalized from a medical perspective at the close of the 18th century. Pinel (1745-1826), considered the father of modern psychiatry, used the term manie sans delire (insanity without delirium) to describe those who engaged in impulsive, aggressive and self-damaging acts but whose intellect and capacity to reason logically remained intact (Malmquist, 1978; Millon, 1981). Prior to this time all mental disorder had been considered to result from a disintegration of reason. With Pinel it became possible to be considered insane without having mental confusion. Included in his descriptions were references to mood disturbances--defects in "passion and affect"--which, as Malmquist suggests, made the categorization quite broad.

The introduction of direct moral considerations became prominent with Rush (1812) and Prichard (1835). Rush, an American physician, characterized patients who combined antisocial behavior with unimpaired mental abilities as having an "innate preternatural depravity." The tone of moral condemnation was continued in Prichard's formulation

of the concept of "moral insanity;" this term referred to those with a disorder in feelings, temper, and habits in which, "The moral or active principles of the mind are strangely perverted or depraved; the power of self-government is lost or greatly impaired and the individual is found to be incapable, not of talking or reasoning upon any subject posed to him, but of conducting himself with decency and propriety in the business of life" (1835, p. 85). Prichard's conceptualization was extremely inclusive, subsuming a wide variety of current diagnostic entities. He did, however, as noted by Millon (1981), make a useful distinction in differentiating the prognosis of those with enduring clinical traits from those whose behavior was in response to transient stresses.

Controversy about the presence of cerebral deficits continued through the 19th century. Lombroso (1911) coined the term "born criminal" and, along with Gouster (1878), added anthropological "stigmata" such as the shape of the head, physique, and sexual development. Gouster pointed to childhood antecedents reflecting "perversion in infancy" which included being headstrong, malicious, disobedient, irascible, lying, neglectful, and often violent. Delighting in intrigue and mischief and a tendency toward seeking excesses in excitement in passion were other indicators of potential psychopathy.

The central question in the late 19th century, according to Malmquist (1978) and Millon (1981), was whether the antisocial behavior observed was part of an organic disease process or whether

such individuals should be held accountable for their actions. Not all criminals were considered to have organic defects, but those who were "morally insane" despite adequate education were suspected of having an inborn predisposition. It was at this point that Koch (1891) proposed that "moral insanity" be replaced with "psychopathic inferiority" to suggest more strongly the existence of a physical basis. Koch's terminology was promptly absorbed by Kraepelin who began to use "psychopathic personality" to describe "morbid forms of personality development" roughly corresponding to our current categories of personality disorders (Millon, 1981). Kraepelin (1915) went on to develop a typology of psychopaths, listing seven kinds: antisocial, eccentric, excitable, impulsive, liars and swindlers, quarrelsome and unstable. Hereditary and constitutional factors remained prominent in this schema.

At around the same time that Kraepelin published his typology, Birnbaum (1914) suggested that social conditioning played a much greater role in antisocial behavior than had been acknowledged, and he proposed the term "sociopath" as a more appropriate label. Birnbaum's emphasis on social contributions was slow in gaining acceptance, and it was not until the work of Healy and Bronner (1926) and Partridge (1930) that "sociopathy" became a serious alternative to "psychopathy." Thereafter, the terms were often used as synonyms although their connotations are quite different.

Psychoanalytic inquiry into criminal and antisocial behavior began to develop with more intensity in the 1930s with Alexander

(1930) and Aichorn (1935) being major figures. Alexander, building on Freud's (1915) identification of "criminals from a sense of guilt," described the "neurotic character" who attempted to resolve internal conflict through alloplastic activity, externalizing rather than developing classic neurotic symptoms. Alexander also postulated a hypothetical condition of "pure criminality" in which the expression of conflict through action and lack of guilt could exist simultaneously. He expressed confidence however that most criminals were, upon closer inspection, actually neurotic characters. Aichorn focused primarily upon delinquents and suggested a state of "latent delinquency," by which he meant a predisposition to criminality based on early trauma. Characteristics of latent delinquents were impulsivity, poor relationships with other people, and a lack of guilt. Alexander and Aichorn, as well as many subsequent analytic writers (Eissler, 1950; Friedlander, 1947; Glover, 1960; Johnson, 1949) ascribed antisocial behavior to defective ego and superego development. A more detailed exposition of the psychodynamic position will be developed later in this work.

Perhaps the most thoroughgoing examination into psychopathy has been conducted by Cleckley whose many editions of The Mask of Sanity (1941, 1950, 1955, 1964, 1976) were noted for their clear descriptions of diagnostic criteria and extensive case studies. The primary traits noted by Cleckley were guiltlessness, incapacity for object love, impulsivity, emotional shallowness, superficial social charm, and an inability to profit from experience. If caught

in a lie or deception the psychopath experiences little upset and often maintains the lie despite evidence to the contrary. Refusing to take responsibility for their actions, projecting blame onto others, or indifference typify their reactions to confrontation. A monumental lack of insight, difficulty in handling alcohol and the absence of suicidal motivation (despite gestures) is also seen as characteristic. Interestingly, Cleckley pointed out that psychopaths could be found not only among criminal populations but also within more elite professional groups, where their charm and self-serving behavior were instrumental in their success.

Another prominent study done by the McCords (1956) was largely consistent with that of Cleckley. They distinguished the psychopath from the neurotic character and considered it to be a specific syndrome among the personality disorders. They also emphasized that psychopaths were not necessarily criminals although that was often the case. Again, it was considered a matter of predisposition rather than behavioral definition.

The formal diagnostic status of psychopathy, in terms of the American Psychiatric Association's diagnostic manuals, has been in a state of flux. In DSM-I (American Psychiatric Association, 1952), Sociopathic Personality was a broad category under Personality Disorders, one subdivision of which was Antisocial Reaction. Other components were Sexual Deviation, Alcoholism, Drug Addiction, and Dyssocial Reaction. In DSM-II (American Psychiatric Association, 1968), the category of Sociopathic Personality was dismantled, and

Antisocial Personality became a separate diagnosis among Personality Disorders, while the other subdivisions generally became major categories of their own. Antisocial Personalities were described as being incapable of loyalty, selfish, callous, irresponsible, impulsive, unable to feel guilt or learn from experience, with a low level of frustration tolerance, and a tendency to blame others. DSM-II was notable for its inclusion of separate categories for Behavior Disorders of Childhood and Adolescence, among which were the precursors of Conduct Disorder: Runaway Reaction, Unsocialized Aggressive Reaction and Group Delinquent Reaction.

With the publication of DSM-III (American Psychiatric Association, 1980) the criteria for Antisocial Personality became even more specific. They included an onset before age 15 of what are essentially Conduct Disorder symptoms (e.g., truancy, delinquency, theft, vandalism, etc.), continuation of antisocial behavior into adulthood and, "failure to sustain good job performance over a period of several years." Some of the criteria, as in the case of Conduct Disorder, appear to be overly detailed; for example, inability to maintain an enduring attachment to a sexual partner is indicated by "two or more divorces and/or separations (whether legally married or not), desertion of spouse, promiscuity (ten or more sexual partners within one year)" (p. 321). The debatable presumption is that the quality of interpersonal relations can be derived from these overt behaviors. Millon (1981) has critiqued this type of narrow conceptualization expressing concerns about "picayunish specifics," the lack of a

more general appraisal of personality characteristics and dynamics, and a return to moralism with too great an emphasis on the delinquent criminal.

> The author considers it a major regressive step that DSM has returned to an accusatory judgment rather than a dispassionate clinical formulation: what we have before us is but a minor variation of earlier, ill considered, and deplorable notions such as "moral insanity" and "constitutional psychopathic inferiority."

The suggestion by such a knowledgeable researcher in psychopathology that we may have come full circle with regard to psychopathy is clear evidence that the phenomenon encompassed by "psychopathy," "sociopathy" and "antisocial personality" requires further investigation and clarification.

Delinquency

Delinquency has already been referred to in the course of the previous discussion of psychopathy and its symptoms. It is a much easier concept to grasp primarily because it is legalistic in nature, making its referents clearer and less open to misinterpretation, and being a social as opposed to medical or psychological term. As defined by Lewis and Balla (1976), "delinquents" and "delinquency" refer to children and children's behavior which come to the attention of the juvenile court. This definition is straightforward enough, but as we shall see it may be somewhat misleading, especially when attempts are made to understand who these delinquents really are.

Halleck (1967) points out a number of difficulties with regard

to concepts of criminality. For someone to be identified by the justice system he or she not only must break the law, but must also be apprehended. Thus many law violators never enter the justice system at all, and a large percentage who do are not convicted, usually eliminating them as objects of study. Further, what is defined as criminal behavior may vary from locale to locale and enforcement procedures may be arbitrary and dependent on who is wielding social power. Certainly some types of behavior defined as criminal at one time or another (e.g., substance use and homosexuality) have not been considered criminal by large segments of the population.

It should be evident that antisocial behavior and "antisocial personality" or "psychopathy" are not equivalents to criminality or delinquency. As already indicated many so-called "psychopaths" may in fact be quite successful individuals who never come into contact with the court system. Criteria such as "failure to plan ahead" or "inability to maintain enduring attachment to a sexual partner" are hardly criminal. With children and adolescents the water is also muddied by situations in which persistent truancy or running away may result in court appearances and labeling as delinquents. According to Halleck (1967) there are instances in which the recommendation of a welfare worker may be sufficient for an adjudication of delinquency. The presence of racial and socioeconomic bias in the justice system are additional confounds, as is the historical bias of considering "promiscuous" sexual activity on the

part of teenage girls to be evidence of delinquency. In summary, delinquency is not a unitary phenomenon and those included under its rubric may be even more diverse than the aforementioned psychopaths.

The literature on delinquency overlaps considerably with that already reviewed but there are some additional contributions worth noting. Healy (1915) and later Healy and Bronner (1926, 1936) were early investigators who provided detailed descriptions of delinquents. In Healy's first book, The Individual Delinquent, he cited broken homes, poor parental control, bad companions, and mental abnormalities and peculiarities as predisposing factors to delinquency. His work established a basis from which both psychological and sociological inquiries could begin.

The psychodynamic perspective as demonstrated by Aichorn (1935) was extremely influential in its elucidation of the unconscious mechanisms involved in delinquency. This tradition emphasized, as previously indicated, defects in ego and superego structure. Johnson and Szurek (Johnson, 1949; Johnson and Szurek, 1952) gained recognition with their conceptualization of "superego lacunae." This theory was developed to explain why certain otherwise normal children would evidence circumscribed areas of antisocial behavior. These children were considered to be unconsciously responding to their parent's antisocial wishes and as a result had a lack of guilt with respect to these particular behaviors. A more recent and influential figure has been Blos (1966, 1967, 1971) who has proposed psychodynamic explanations of adolescent antisocial behavior based on separation

struggles, precocious ego development, and the need to communicate symbolically through action.

Sociological theories of deviance tended to focus on socio-economic factors, deficient role models, and delinquent subcultures. Merton (1938, 1957) suggested that poverty amidst affluence led to illegal attempts to obtain material goods and their attendant status. Shaw and McKay (1942) pointed to variations in behavior as resulting from different social values and norms, while Cloward and Ohlin (1960) emphasized the lack of access to legitimate gratifying roles along with the increased access to illegitimate roles. A variant of this viewpoint was advanced by Cohen (1955) who described how delinquent subcultures arose in reaction to middle class values and certain deviant behaviors were attempts to gain status within the subculture by flouting societal norms. Another theme advanced by Wheeler and Cottrell (1966) was that societal intervention in the form of labeling youths "delinquent" and institutionalizing them, often only exacerbated matters. Sociologists, such as Reckless and Dinitz (1967), also recognized that delinquent behaviors could not be reduced to social factors, and that individual differences and development were important variables.

Lastly, it is important to touch on the typological investigations of delinquency which were influential precursors to the current Conduct Disorder typology. One of the most extensive investigations has been that of the Gluecks (1950, 1970) which attempted to isolate characteristics relevant to the prediction and

prevention of delinquency. They described delinquents as adventurous, extroverted and emotionally unstable with a pronounced tendency to "mesomorphic" body type. Important psychological phenomena included destructiveness and rebelliousness, while environmental influences included poor supervision and lax discipline on the part of the mother, and poor cohesiveness of the parents.

Jenkins (1947) was one of the first to differentiate specific types of delinquents. He described three: the Unsocialized Aggressive Delinquent, the Socialized Delinquent and the Overinhibited Delinquent. The Unsocialized Aggressive individuals were hostile, cruel, violent and destructive with a lack of guilt over their behavior. Socialized Delinquents were characterized by membership in a delinquent group or gang, and the Overinhibited delinquents were seclusive, shy, apathetic, sensitive, submissive, and tended to worry. The Socialized Delinquents were considered products of social learning, while the Unsocialized Aggressive and Inhibited types were reflective of individual psychopathology.

Another, simpler typology was that of Glover (1950) who distinguished between two types of delinquency, structural and functional. Structural delinquency was evidenced by psychopathology both before and after adolescence, while functional delinquency was considered the result of temporary imbalances of the adolescent maturational process.

The California I-level typology developed by Warren (1969) was a more complex systematization, utilizing a variety of developmental

stages with characteristic perceptual styles regarding self and others. Nine delinquent subtypes were identified: (1) the Asocial Aggressive, (2) the Asocial Passive, (3) the Immature Conformist, (4) the Cultural Conformist, (5) the Manipulator, (6) the Neurotic Acting-Out, (7) the Neurotic Anxious, (8) the Situational Emotional Reactive and (9) the Cultural Identifier. This typology was utilized to differentially classify and treat delinquents in two intervention projects (Jesness, 1971; Palmer, 1971; Warren, 1969), but without conclusive results.

Quay (1975) reports on another typology which was derived from multivariate statistical analyses of data obtained from behavior ratings, questionnaire responses and ratings of life history variables. The resulting four clusters were: (1) the Unsocialized-Psychopathic delinquent--characterized by aggression, hostility, defiance, interpersonal alienation, lack of regard for others, impulsivity, and sensation seeking; (2) the Neurotic-Disturbed delinquent--characterized by anxiety, social withdrawal, subjective distress, guilt, escape behaviors, and worrying; (3) the Socialized Subcultural delinquent--characterized by being peer oriented, engaging in group delinquent activities, being defiant of adult authority, capable of interpersonal closeness, and having delinquent value orientation; and (4) the Inadequate-Immature delinquent, characterized by passivity, dependency, and a tendency to daydream.

A more recent attempt at typology is that of Marohn, Offer, Ostrov and Trujillo (1979), who utilized a psychodynamic perspective

in deriving their types. Based on factor analysis of data and clinical experience they described four types of hospitalized juvenile delinquents: (1) the Impulsive--characterized by frequent antisocial behavior, a propensity for action and immediate discharge and considered quite disturbed and socially insensitive by staff; (2) the Narcissistic--who saw himself as well-adjusted and not delinquent, but whom staff and parents characterized as resistant, cunning, manipulative, superficial, and whose delinquency was exploitive and related to regulation of self esteem; (3) the Depressed--who demonstrated academic and therapeutic initiative, strong value systems, and the presence of structuralized or neurotic conflicts from which delinquency served as a relief; (4) the Borderline--described as a passive, emotionally empty and depleted person, who is not well liked, often needy and clinging, with a poor prognosis, and whose antisocial behavior is seen as preventing psychotic disintegration or fusion and as a relief from internal desolation. It was acknowledged that most of the delinquents did not fit exclusively into one pattern or another, but often combined characteristics of the different subgroups with one style being predominant at a particular time. Marohn (1981) in a subsequent analysis suggests that those delinquents who showed a mixture of motivations were healthier than those who demonstrated a more exclusive pattern. According to Marohn the more fixated adolescents may be evidencing the stunted personality growth reflected in adult personality disorders, and which require intensive therapeutic treat-

ment. However what such treatment would look like, beyond being structured for the Borderline type and limit setting for the Impulsive type, is not specified.

The literature on delinquency is the basis for the typology of Conduct Disorder which is found in DSM-III. In particular the work of Jenkins (1947) and Quay (1975) appears to have been influential. Yet as indicated earlier (Achenbach, 1980) the validity of the categories are questionable. Further, the degree of overlap between the Conduct Disorder and delinquent populations is unknown. No doubt there are many children and adolescents who are diagnosed Conduct Disorder without ever being adjudicated delinquent, and while delinquency seems prima facie evidence for Conduct Disorder, there are many circumstances in which a more appropriate diagnosis might be Adjustment Disorder, Schizophrenia, or Childhood or Adolescent Antisocial Behavior (for isolated acts and coded on Axis V of DSM-III--Conditions not attributable to a mental disorder that are a focus of attention or treatment). What is lost in most of these systems of classification are intrapsychic issues and subtleties. Marohn's typology comes closest to adequately addressing the psychodynamic variables, but with admitted and perhaps unavoidable imprecision. As Halleck (1967) concludes: the problem with any classification of delinquency is that it has to be "oversimplified beyond the point of validity" (p. 135). What the typologies have accomplished is to point toward specific parameters of antisocial behavior which can guide further exploration and eventual treatment.

Acting out

Whenever one enters into a discussion of behavior problems, especially with reference to adolescents, the term acting out is likely to arise. It is a phrase which arose in the context of intensive psychotherapy with a specific meaning and which has subsequently, through imprecision and overusage, come to be synonomous with virtually any form of inappropriate behavior.

Originally the term acting out was utilized by Freud (1905, 1914) to refer to the re-enactment and reliving of certain repressed emotional experiences which arose in the course of treatment. Rather than deal with these painful memories and affects the patient transfers them onto a therapist as well as onto other aspects of the current life situation. As Malmquist (1978) observes, the meaning gradually shifted to refer to repetitions of unresolved past conflicts outside the therapeutic setting to avoid dealing with them in therapy. Initially, acting out was of interest in individuals with relatively strong egos who rarely expressed unconscious past experience in action except under conditions of intense involvement such as therapy. The later developments related to those who were impulse ridden and engaged in alloplastic action to change or manipulate their external world. In some cases acting out has referred to antisocial acts which are part of a broader behavioral pattern.

Additional perspectives on acting out have been offered by Greenacre (1950), Blos (1963, 1971), Amini and Burke (1979) and Cary (1979). Greenacre suggests that preverbal trauma predispose to

acting out because of the inability to organize those early experiences into words and thoughts. Blos (1963) characterizes acting out as a phase specific phenomenon of adolescence spurred by two factors: the need to defend against passivity and the need to turn to the outside world to counteract the ego impoverishment resulting from the decathecting of infantile love objects. It is, from Blos' point of view, an organized mechanism which functions as a tension regulator protecting against conflictual anxiety or in the service of the ego to protect against structural defectiveness or disintegration. In a subsequent contribution, Blos (1971) described a subspecies of acting out--adolescent concretization--a symbolic action analogous to dream imagery which represents unconscious internal affects and contradictions attached to unassimilated experiences. Blos emphasizes the role of acting out in the separation-individuation process, a theme continued by Cary (1979) and Amini and Burke (1979). Cary considers acting out to be an attempt to assert individuality while maintaining involvement with parents, and he connects it to an inability to feel confident in one's own ability to act effectively. Amini and Burke emphasize the relationship of acting out to the need to maintain self-object relations unchanged. To give up the acting out, a grieving for the former pathological ways of relating and the availability of adaptive object relations are necessary.

All of these perspectives on acting out indicate the importance of understanding the meaning of the behavior in question. If one

goes no further than to classify the adolescent as "antisocial" in any of its variants, then an important opportunity to gain insight and formulate treatment is lost. Efforts aimed only at eliminating the unacceptable behavior are unlikely to be successful without addressing the longstanding conflicts or structural defects which the acting out represents. For the purposes of this work acting out will be used to refer to the behavioral repetition of significant themes and object-relationships from the past.

Correlates of Adolescent Antisocial Behavior

Adolescent antisocial behavior has been studied from a wide variety of perspectives, and because of the diversity of the phenomenon itself there are numerous correlates implicated as possible etiological factors. Following is a brief overview of the literature on some of these correlates.

Sociological correlates

In the previous discussion of delinquency many of the sociological factors were addressed; among these were poverty, delinquent subcultures, the lack of appropriate role models, class biases, the presence of broken homes and the effects of labeling. Another consideration, explored by Shaw and McKay (1942), was that of socioeconomic/geographical areas. They found delinquency to be highest in unstable urban areas which were undergoing social and ethnic changes along with socioeconomic deterioration. Also to be

considered is the role of schools, as agents of socialization and providers of skills, such as reading, which facilitate adaptation and reduce frustration (Malmquist, 1978). The media has also been construed as influential in exposing adolescents to violent and antisocial models (Bandura and Walters, 1963; Liebert, Neale and Davidson, 1973), although debate continues on this issue. In general the sociological approach is helpful in suggesting vulnerable populations and giving direction to preventive social action, but its explanatory power is limited when one moves to the level of the individual.

Familial factors

Familial factors include both the interpersonal and the genetic. The relationship of the children to their families is understandably considered very significant and as such has been the subject of a vast amount of research. One of the early influential positions was that of Bowlby (1946) who emphasized the effects of early maternal deprivation particularly as such deprivation related to the creation of the "affectionless character." Subsequent research has not confirmed Bowlby's premise but has focused more on the quality of relationship and types of separations. Rutter (1971) found that separations due to family discord or psychiatric illness resulted in a much higher rate of antisocial behavior in offspring than separations due to physical illness or vacation. Herzog and Sudia (1968) also emphasized that the overall home climate and

quality of supervision was more important than the simple absence of the father. As Malmquist (1978) points out, the effect of the absence of a parent is complicated by resultant socioeconomic factors such as lessened income, change of residence, etc. Hewitt and Jenkins (1946) have highlighted rejection by parents as a precursor to unsocialized aggression in children, and related absent or neglectful fathers with socialized aggression.

Parental psychopathology has also been a focus of many investigators and cannot be neatly separated from genetic issues. Kaufman and Reiner (1959), in a study of the parents of juvenile delinquents, found most to be impulse-ridden character disorders, marginal human beings living "on the edge of life." The chronic anxiety and unresolved depression of the parents made them inconsistent and unreliable as nurturant figures. In describing the mothers of antisocial children, Malone (1963) noted the mothers' narcissistic needs, devalued self-image, early conflicts, impulsivity, and ambivalence. Unresolved oral conflicts in mothers of antisocial children were felt by Rexford (1963) to result in failure to meet the child's need for love and affection, thus limiting later capacity for object relatedness. The tendency in some parents to be overstimulating and inconsistent in their parental attitudes was noted by Stubblefield (1975), who suggested that the child's antisocial behavior was vicariously gratifying to these parents, and in its self destructiveness reflective of covert hostility toward the child on the part of the parents. This position resembles in some respects the "superego

lacunae" notion of Johnson and Szurek (1952). Focal in all of this literature is the transmission of character pathology from one generation to the next.

Genetic influences are, of course, another mode of transmission. Twin studies have implicated heredity in criminal activity with an average concordance of 67% monozygotic twins versus a 33% concordance rate for dizygotic twins (Halleck, 1967). A more recent retrospective study (Christiansen, 1974) done in Denmark had somewhat lower rates of concordance. The twins studies have been criticized for underemphasis of environmental factors and failure to recognize the significant social element in defining crime (Halleck, 1967). Adoption studies, however, have given support to heredity arguments. In a large Danish adoption study Schulsinger (1972) found psychopathy to be overrepresented in the biological relatives of psychopathic probands--especially in the case of fathers. Another adoption study (Crowe, 1974) found higher rates of antisocial behavior in the offspring of antisocial mothers, but this was not a uniform phenomenon, indicating a mixture of environment and heredity. The twin and adoption studies taken as a group argue for recognition of a genetic component which predisposes but does not determine antisocial behavior.

Research on genotypes, especially the XYY configuration, have been inconsistent (Reid, 1981). Although the risks of psychiatric hospitalization or jail are 18 times the average for an XYY individual, Hook (1973) suggests that the associations with criminality and aggression have been overstated. Again, the search for the

"born criminal" comes up somewhat short.

Organic and neurological factors. The presence of organic and neurological deficits have long been implicated in the genesis of antisocial behaviors. The evidence for central nervous system involvement in delinquency has been presented by Lewis and Balla (1976). They indicate that while there are occasionally "hard" signs of actual brain damage, more often there exists a symptom complex frequently referred to as minimal brain dysfunction which is described as including "such behaviors as hyperactivity, impulsivity, distractibility, difficulty concentrating for any length of time, cognitive and learning problems, and, frequently, emotional problems including depression and/or low self-esteem" (p. 65).

Cantwell (1975) has referred to the same spectrum of problems as the hyperactive child syndrome and argues that the available evidence points to a characteristic clinical picture based on natural history, family background, and patterns of performance on psychological tests. At the same time Cantwell acknowledges that there is considerable heterogeneity among the children and that the origins of the disorder are unknown. Other studies involving Lewis and her collaborators (Lewis, Shanok and Pincus, 1979; Lewis, Shanok, Pincus and Glaser, 1979) have found neurological deficits to be associated with violent juvenile delinquents and to overlap with psychotic symptomatology.

The complex nature of the relationship among neurological deficits, hyperactivity and antisocial behavior is indicated by other

research, especially that done in Britain which defines the hyperactive syndrome in much narrower terms (Graham and Rutter, 1968; Sandberg, Rutter and Taylor, 1978; Shaffer, McNamara and Pincus, 1974). Generally the case is made that the symptoms of overactivity and distractibility are commonly associated with a wide variety of children's psychiatric disorders and are not necessarily evidence of a specific syndrome. Support for a narrower, more specific hyperactive syndrome came in a study by Stewart, Cummings, Singer and deBlois (1981) who found that psychopathology was associated more with Conduct Disorder than with hyperactivity, although hyperactivity was present in a majority of those diagnosed Unsocialized, Aggressive. Thus, while Conduct Disorder and Hyperactivity coexist in a number of children they do not appear to be aspects of a single syndrome.

Spreen (1981) has also raised questions about the connection between brain damage and delinquency. In a follow-up study utilizing 203 adolescents previously referred to a neuropsychology clinic because of learning problems and 52 control subjects, encounters with police, offenses and penalties were explored through a structured interview with the former clients and with their parents. Subgrouping of the learning disabled subjects on the basis of evidence of brain damage indicated that no association between brain damage and delinquency could be established. In discussing the discrepancy between his findings and previous work, Spreen noted that hyperactivity and delinquency were often hard to separate because bad behavior was an implicit criterion for hyperactivity. Spreen also

pointed to problems inherent in the frequently used retrospective research design--in particular an erroneous imputation of causality which overlooks, such things as the number of children who have learning disabilities and hyperactive type symptoms but do not evidence overtly serious behavior problems.

Neurological evidence has frequently centered on EEG studies. Kiloh and Osselton (1966) indicated a connection between low-frequency wave abnormalities and delinquency which was ascribed to a maturational lag in brain development. Schulsinger (1972) reported positive correlations between violence or impulsivity and one's chance of EEG abnormality. However, the predictive utility of this research is low and causality elusive (Reid, 1981).

Congenital antecedents have been suggested by Pasamanick (1961) who cited prematurity and perinatal central nervous system trauma. Cravioto and Delcardie (1970) implicate infant malnutrition and Stott and Latchford (1976) point to prenatal physical and psychological factors involving the mother as factors affecting the health, development, and behavior of children.

In summary, neurological and organic factors do appear to be correlated with antisocial behaviors. Unfortunately, the nature of the relationship, including causality remains unclear. As Stewart Cummings, Singer and deBlois (1981) suggest, it may make the most sense to consider neurological deficits and other evident organicity to be predisposing to antisocial behavior but not causative. Anti-social activity is too complex to be considered biologically determined

in any direct way; however, one can easily imagine the frustration derived from learning difficulties, an inability to concentrate and read, and continually being in trouble due to one's activity level, leading to a poor self-image--a sense of oneself as deviant and damaged--which could make antisocial behavior most compelling. Additional factors such as environmental and familial would naturally enter into any such equation describing the vulnerability of a particular individual. As Lewis (1978) sums up:

> The psychobiologically vulnerable child will often be less able than his peers to withstand the stresses of an unsupportive environment. He is more likely to find himself in conflict with his society. (p. 195)

Sex Differences

All studies of antisocial behavior have indicated a clear preponderance of males over females in prevalence. According to DSM-III the ratios for Conduct Disorder range from 4:1 to 12:1, excepting the Undersocialized, Nonaggressive type which is considered to be equally common in males and females. However, as reported by Achenbach (1980), there was not much empirical evidence for the existence of the Undersocialized, Nonaggressive subtype. There was support in Achenbach's study for a Socialized, Nonaggressive subtype among girls and one would suspect that for the most part the antisocial behavior of adolescent females would be subsumed by that category.

The preponderance of males over females in antisocial syndromes

has often been attributed to socialization and biological assumptions about stronger aggressive tendencies in males. Recent research (Cadoret & Cain, 1980; Rutter, 1970) has also suggested that boys are more vulnerable than girls to environmental stress. In particular, having a psychiatrically ill family member, divorced parents, or separation experiences early in infancy were seen as having a significantly greater impact on males. Delinquent girls were found to be more psychiatrically disturbed than their male counterparts in a review by Cowie, Cowie and Slater (1968). A more recent study (Lewis, Shanok & Pincus, 1982) challenged that finding, and indicated that for incarcerated delinquents the level of psychopathology is very much the same for both populations. Lewis and her associates (1982) suggest that the appearance of greater psychopathology in females is a result of overlooking psychiatric problems in male delinquents. They point out that violent males are more likely to be incarcerated while violent females are more often hospitalized, a bias probably based on perceptions of dangerousness. In the same study a racial bias was also found: the odds of being incarcerated were significantly increased, regardless of sex, when the offender was black. The results of the study by Lewis and her colleagues suggests the existence of a biased genetic determinism, which functionally assumes antisocial behavior to have a greater "inborn," unchangeable component for males and people of color.

The association of hysteria and antisocial personality is another interesting aspect pertaining to sex differences. Robins (1966)

found that one fourth of the adolescent girls referred to child guidance centers eventually received diagnoses of hysteria. Guze, Woodruff and Clayton (1971) also found high rates of hysteria among antisocial females and their relatives. Reid (1981) concludes that hysteria--or Histrionic Personality--as it is called in DSM-III--may be a phenomenologic or genetic equivalent of Antisocial Personality in males, recognizing that antisocial behavior per se is a relatively rare occurrence for females. It is also possible that many females diagnosed as Borderline Personality are quite similar in psychological structure and tendencies to males diagnosed as Antisocial Personality, but are classified differently due to the overt expression of their internal state and its interpretation by others.

The role of gender in antisocial behavior requires considerably more research. Socialization clearly has a powerful effect in terms of both modeling and role expectations and makes the establishment of behavioral equivalencies across gender problematic. Other factors such as vulnerability to stress are likely to be a combination of genetic and child-rearing practices. Biological differences which may affect how males and females respond to stress are difficult to separate from the consequences of having child-care and nurturance dominated by females. The ability to self-soothe may well be a product of early gender linked identifications. Again, remaining on the overt behavioral level can be deceptive.

Depression and the Concept of Masked Depression

Adolescents have long been seen as tolerating depression poorly and prefering action to handle feelings of loss and abandonment (Malmquist, 1971, 1978; Masterson, 1970, 1972, 1980). Depression in children and adolescents has been thought to only rarely display itself in classic adult symptoms but, more typically, in so-called "depressive equivalents" such as hyperactivity, delinquency, aggression, somatic complaints and school problems (Carlson and Cantwell, 1980). Running throughout the literature on childhood depression is the question of how broadly to define depressive symptoms. The spectrum of opinion ranges from those clinicians who infer depression from a variety of "depressive equivalent" behaviors, as well as from projective testing, to those who rely strictly on adult depressive symptoms such as dysphoric mood, low self-esteem, social withdrawal and diminished psychomotor behavior.

Toolan (1967), Glaser (1967) and Malmquist (1971) were among the first to suggest that children and adolescents who exhibit aggressive and antisocial behavior may actually be depressed despite an apparent lack of depressive symptoms. Antisocial behavior was seen as a defense against experiencing depression, often demonstrated by a tendency to attack others rather than oneself or act in such a way that the environment will be the agent of punishment. The "acting out" allows for the externalization of conflict and modulation of self-esteem. Masterson (1970, 1972) specifically discusses the need of borderline adolescents to act out as a defense against

"abandonment depression" which has been reactivated by separation experiences. As has been demonstrated, however, antisocial behaviors may be a response to a wide variety of problems and an inference of depression requires further substantiation.

Studies of antisocial behavior and depression have given empirical support to their association with each other. Shaffer (1974) found in a study of adolescents who committed suicide that 75% of the sample had histories of antisocial behavior. Ingalls (1978) found 10% of a delinquent population to be clinically depressed, while Chiles, Miller, and Cox (1980) in a study of 120 adolescents admitted to correctional facility reported that 23% met the criteria for a major depressive disorder and that a depressed or alcoholic parent was highly predictive of depression in the youth. More recently, Puig-Antich (1982) in assessing prepubertal boys referred to a depression clinic found that one third of the boys fitting the criteria for major depressive disorder also fit the DSM-III criteria for Conduct Disorder. Successful treatment of the mood disorder with antidepressant medication led to significant improvement of the conduct disturbance in a majority of the cases involved in the pilot study. Based on a review of the literature and his own work Puig-Antich suggests "sub-grouping some conduct disorders according to the presence of other psychiatric diagnoses and treating those as specifically as possible" (p. 126).

In these more recent research studies the trend has been one of moving away from the concept of "depressive equivalents" toward

the understanding that if depression is part of the clinical picture it should be revealed through a comprehensive interview. Kovacs and Beck (1977) noted that the "masks" of masked depression were merely the presenting complaints. Research by Carlson and Cantwell (1980) indicated that depressive disorders were often obscured by more dramatic symptomatology--such as attention deficit disorder, conduct disorder and anorexia nervosa--but revealed themselves in systematic interviews. Carlson and Cantwell concluded that the behavioral "masks" for depression were typically rather thin and in cases without depressive behavior or self-reports the hypothesis of "masked depression" was difficult to prove. In a comprehensive overview of the childhood depression literature, Kashani, Husain, Shekim, Hodges, Cytryn and McKnew (1981) suggest that the concept of "masked depression" has provided more confusion than clarity and should be discarded in favor of clear DSM-III type criteria which specifically address depression in childhood.

What emerges from the literature is the need for further clarification of the relationship between depression and antisocial behavior. Clearly, both symptom clusters are found in a significant number of children and adolescents, and while the behavioral difficulties are often perceived as secondary to the depression, the possibility of depression resulting from a failure of social adaptation with the attendant rejection cannot be ignored (Stewart, deBlois, Meardon and Cummings, 1980). Careful evaluation of depressive symptoms seems warranted in cases of antisocial behavior,

with subsequent treatment, if appropriate, of both the affective and behavioral disorder. Complicating such evaluations are continuing questions about the form depression takes in children with particular reference to the impact of developmental processes. Lastly, there are significant depressive elements in borderline and narcissistic personality disorders and as these configurations begin to take their adult form in adolescence one would expect an admixture of behavioral and affective difficulties to be present. From an Object Relations perspective it would be a developmental advance for these individuals to experience true depression, a point which will be addressed later in greater detail.

Neurosis, Psychosis and Personality Disorders

The relationship between neurosis, psychosis and personality disorders is complex. Each disorder can potentially involve antisocial behavior. Despite their diversity, personality disorders in DSM-III are isolated in a separate category while neurosis and psychosis are considered to be symptomatic and etiological factors that are present in distinct diagnostic groupings (e.g., Schizophrenic Disorders, Affective Disorders, Anxiety Disorders, Dissociative Disorders, Psychosexual Disorders). When antisocial behaviors are the presenting problem, as in the case of Conduct Disorder, etiological distinctions will play a major role in determining the treatment of choice, particularly for those clinicians operating from a psychodynamic perspective. A brief exposition of the role

of neurosis, psychosis, and personality disorders in antisocial activity seems warranted.

Neurosis in the psychoanalytic tradition has been used to refer to a process in which unconscious conflicts involving the expression of desires or impulses result in anxiety and are defended against in a maladaptive, symptomatic fashion. The conflict for the most part remains internalized and tends to persist, often finding expression in symbolic symptoms, which are distressing to the individual and recognized as unacceptable or "ego dystonic" (American Psychiatric Association, 1980; Malmquist, 1978). The nature of the neurotic conflicts is considered psychosexual and not of a degree to seriously threaten personality integration or reality testing, although effective functioning may be significantly impaired. Cases where the symptomatic expression of the conflicts are subsumed by the individual's personality traits and are not a source of internal distress or anxiety (ego-syntonic) are examples of character neurosis. The neurotic character tends to externalize conflicts and seek alloplastic solutions, giving rise to the possibility of antisocial behavior. Under stress or when avenues for externalization are blocked the classic neurotic symptoms are likely to manifest themselves (Frosch, 1970). As indicated in DSM-III, what were formerly referred to as the character neuroses now constitute much of the current Personality Disorders section. Both Malmquist (1978) and Blos (1971), have addressed the neurotic aspects of delinquent behavior in particular focusing on the symbolic meaning of anti-

social acts.

Psychosis has been increasingly implicated in adolescent antisocial acts, particularly in the extensive research of Lewis and her associates (1973, 1976, 1978, 1979). In the psychoses the ego is extremely vulnerable, with tenuous boundaries and there exist serious difficulties in preserving the self as an integrated and differentiated psychic entity (Frosch, 1970). As explicated by Frosch, the threat of personality disintegration is due to the overwhelming nature of early aggressive and libidinal impulses and is defended against by primitive defense mechanisms such as fusion, introjective-projective techniques, splitting, massive denial and somatization. Reality testing is severely impaired with symptoms such as hallucinations, delusions and fragmented thinking often present. When psychotic manifestations are brief and reversible with the capacity for reality testing intact, then the diagnosis of Borderline Personality Disorder is frequently given and corresponds generally to what Frosch (1970) has described as the psychotic character. Under stress these individuals may regress to undifferentiated states, have distortions in their perceptions of reality, and resort to primitive defenses, but these states are reversible and relatively transient. In order to preserve the self or defend against loss and abandonment impulsive actions often occur which may be of an antisocial nature. A more detailed exposition of the borderline personality will be given later in discussing recent theoretical developments.

The prevalence of psychotic manifestations among antisocial and delinquent youth is not precisely known. Morris, Escoll and Wexler (1956) reported that 20% of their sample of behaviorally disordered children were diagnosed schizophrenic as adults. Only 20% of the sample was considered to have made normal adjustments, a figure which as Lewis and Shanok (1978) point out is almost exactly that found in Robins' (1966) landmark study. Robins also found that of the antisocial children not labeled delinquent 30% were later diagnosed psychotic. Lewis, Balla, Sacks and Jekel (1973) reported that 25% of a sample of juvenile delinquents had experienced psychotic symptoms, and in a later study Lewis & Shanok (1978) found that in a sample population of frequent and serious juvenile offenders, 17% had experienced psychotic symptomatology. A relationship between schizophrenic and antisocial behavior is also implied by the finding that 17% of schizophrenics had a child known to the juvenile court as compared to 6% of a comparison sample. Lewis and Balla also found significantly more schizophrenia among parents of delinquents than normals.

Psychotic symptoms in delinquent populations are frequently overlooked. Bender (1959) remarked over 20 years ago that the psychotic or borderline child often appeared "merely sociopathic." Lewis and Shanok agree and feel that the role of what they describe as the schizophrenic spectrum of disorders has been underestimated in the delinquency literature due in part to an overemphasis on the psychopathic personality. They suggest that obvious social depri-

vation and histories of drug abuse tend to obscure any evidence of thought disorder. Confusion with other syndromes is also possible.

> It is not yet well appreciated that some of the early behaviors child psychiatrists tend to associate with minimal brain dysfunction and the hyperactive child syndrome (e.g., inattention, inappropriate classroom behaviors, moodiness) are equally characteristic of the prepsychotic youngster who later tends to behave antisocially. (Lewis and Shanok, 1978, p.273)

Lewis and Shanok conclude by suggesting that delinquent children require closer examination to determine psychotic involvement, with an eye towards more appropriate treatment which might include anti-psychotic medication. In addition they point out that the vulnerability of children with schizophrenic parentage to the development of antisocial syndromes strongly indicates the need for early preventive treatment.

Antisocial behavior in adolescence may result from psychiatric conditions existing at any point along the neurotic-psychotic spectrum. While a certain number of antisocial adolescents may be overtly psychotic--perhaps as many as 20%--the majority present symptom complexes which, if they persisted into adulthood, would fall under the diagnostic umbrella of personality disorder. As noted earlier, there has been historical reluctance to diagnose personality disorders in adolescence because of the fluidity of adolescent personality and the confounding presence of "adolescent turmoil." However, growing evidence exists that adolescent psychopathology is more stable than previously thought (Fard, Hudgens, & Welner, 1978; Strober, Green & Carlson, 1981; Welner, Welner & Fishman, 1979) and

that many of the so-called "behavior disorders" may reflect engrained characterological problems. Diagnosing a neurotic or psychotic character in childhood would be premature, but by midway through adolescence the "repetitive pattern" referred to in the Conduct Disorder symptomatology may be described in Personality Disorder terms.

> Conduct disorders conveys a sense of fleeting symptomatic behavior; yet we know that in some adolescents there is a well-entrenched personality pattern, not at all unlike the psychopathology of the antisocial personality, the narcissistic personality or the borderline personality disorders.
> (Marohn, 1981, p. 305)

Substituting one set of diagnostic terms for another is not much of a gain unless there is a distinct advantage in the translation. In this case the advantage lies in developmental conceptualizations and treatment implications. Recent advances in the diagnosis and treatment of personality disorders, particularly those derived from psychoanalytic Object Relations theory (Kernberg, 1975, 1976, 1978, 1979, 1980; Kohut, 1971, 1977; Kohut and Wolf, 1978; Masterson, 1972, 1981), may have significant applications to Conduct Disorder. The emphasis on narcissistic and borderline personalities has special relevance for the study of Conduct Disorder because of the similarity of the behavioral manifestations and inferred psychodynamics. For example, the tendency to use "primitive" defensive operations such as denial, splitting and projection, the poor impulse control, lack of anxiety tolerance and the impoverished quality of interpersonal relationships are common elements of Conduct Disorder and narcissistic

and borderline personalities. In addition, there are similarities between the depressive qualities of many borderline personalities and "acting-out" adolescents (Marohn, 1979; Masterson, 1980; Stone, 1980). Even the "core psychopath" or antisocial personality has begun to be viewed as a severe form of narcissistic personality structure (Leaff, 1978).

Some confusion is inherent in the conflicting or overlapping usages of Narcissistic and Borderline Personality Disorder and psychodynamic formulations of personality development and structure. A delineation of necessary distinctions will be addressed in the next chapter, when the Object Relations perspective will be discussed.

The presence of Conduct Disorder, particularly in adolescence, is strongly correlated to developing personality disorders and not limited to the antisocial personality per se. Personality disorders had been considered resistant to psychotherapy but current developments in the assessment and treatment of borderline and narcissistic personality have implications for adolescent Conduct Disorder which have not been fully explored.

CHAPTER III

PERSPECTIVES ON TREATMENT

Overview

Treatment of the antisocial syndromes is considered problematic and taxing under the best of circumstances. As previously noted there is an air of gloom and pessimism that pervades the relevant literature. Cleckley (1964), through his classic work on the psychopathic personality, has been a particularly influential voice expounding the futility of treatment with such individuals. Nevertheless, recent reviews invariably begin with statements to the effect that the untreatability has been exaggerated (Carney, 1978; Cavanaugh, et al., 1981; Kellner, 1982; Leaff, 1978; Morrison, 1981; Reid, 1981). Personality disorders have historically been considered resistant to treatment almost by definition since they refer to relatively fixed patterns of adaptation, and antisocial behavior, more often than not, has been linked to the personality disorders.

It should be evident, however, from the previous section on the correlates of antisocial behavior that there is great complexity within the syndromes. As Morrison (1981) points out, there is no single diagnosis applicable to this population and thus no single treatment. Behaviors labeled sociopathic may be signs or symptoms of neurosis, affective disorder, functional psychosis or organic central nervous system deficit, conditions for which there are proven and often successful treatment modalities (Reid, 1981). It is usually

suggested that diagnostic caution be exercised in order not to confuse these syndromes with those representing the "true" personality disorders.

Perspectives on the specific treatment of Conduct Disorder have been limited by its relative newness as a diagnostic entity. Stewart, deBlois, Meardon and Cummings (1980) have suggested a cognitive-behavioral approach for Aggressive Conduct Disorder, focusing on teaching social skills, training parents in effective parenting skills and utilizing role playing to reduce egocentricity. Treatment with antidepressants has also been proposed by those who associate Conduct Disorder and depression (Puig-Antich, 1982). Aside from these contributions, treatment approaches and assumptions are largely derived from those applied to delinquency, sociopathy, psychopathy and antisocial personality.

The resistance to treatment characteristic of most antisocial types and many personality disorders is the usual basis for inferences of untreatability. Carney (1978) suggests that it is only the more neurotic-like personality disorders which are amenable to outpatient treatment and that, for most, effective treatment is only possible in a residential setting where treatment is in essence involuntary. Those who act in a criminal and violent fashion are likely to be relegated to prison, while the more irrational, acting out individuals may be hospitalized. The degree to which those diagnosed as a personality disorder are motivated for treatment is often reflective of outside pressure or state anxiety--discomfort with their circum-

stances--for which they seek relief through alloplastic action. Kellner (1982), summarizing a review of treatment approaches, concludes that non-directive methods have not been as effective as more directive tactics requiring active engagement and guidance. I would now like to briefly review some of the treatment modalities which have been utilized with antisocial behavior.

Biological Treatment

The most frequently used biological treatment has been the use of medication. Reviews of psychopharmacological treatments (Cavanaugh et al., 1981; Kellner, 1981, 1982; Tupin, 1981) have associated symptoms and diagnosis with the use of certain classes of drugs. Antianxiety agents (the minor tranquilizers) have been used primarily with neurotics in helping to reduce impulsivity and aggression. Antipsychotic agents (the major tranquilizers) have been utilized to greatest effect with the functional and organic psychoses, usually in response to violent behavior. Lithium has received considerable attention of late as a treatment for antisocial and aggressive behavior which is associated with dramatic mood swings or manic activity. Stimulants have been utilized with children who exhibit hyperactivity and other signs of "minimal brain dysfunction" and have been suggested as a treatment for antisocial adults who have such histories (Kellner, 1981). Anticonvulsants have also been used on occasion where there is evidence of EEG abnormalities and/or temporal lobe epilepsy. With the possible exception of Lithium, which warrants further study (Kellner, 1981; Tupin, 1981), none of

the psychopharmacological treatments have been shown to be effective in cases of Personality Disorder. The tendency towards noncompliance or abuse also tends to contraindicate the use of medication with characterological difficulties.

Other biological methods have been psychosurgery and plastic surgery, and electroconvulsive treatment (ECT). Psychosurgery remains controversial despite becoming more refined, and its use is largely limited to only the most severe cases of unpredictable, violent and aggressive behavior. The results of plastic surgery in changing the behavior of physically deformed delinquents are equivocal (Morrison, 1981). ECT is also controversial and generally considered to have short-lived effects.

Overall, biological treatment in the form of medication is considered most effective with neurotically and psychotically derived forms of antisocial and aggressive behavior. Personality disorders are seen as generally unresponsive to drugs. Lion (1981) also extends the caveat that the immediate and dramatic effects of medication or ECT may obscure the need for other types of treatment, particularly psychotherapy.

Behavioral Treatment

Behavioral techniques have been popular forms of treatment, particularly in institutional settings where operant conditioning models, such as token economies, are frequently utilized. In the more sophisticated versions, such as that explicated by Rossman and Knesper (1976), the final goal is to move to interpersonal rather

than concrete or material reinforcement. Time out and response cost systems have also been used, and, as Morrison (1981) notes, the consistency and timing of their implementation is more important than the intensity.

Difficulties with behavioral systems have arisen in regard to lack of generalization and variable implementation. Staff presence is often the crucial variable and behaviors brought under control in a particular setting often reappear under differing circumstances. Disagreements exist over whether group or individual contingency is most effective (Morrison, 1981). Halleck (1967) has also critiqued behavioral treatments due to the tendency to become punitive rather than therapeutic, with punishments being much easier to implement than rewards. The danger exists, then, of replicating the early sadistic parental relationships often experienced by these individuals if great caution is not used in behavioral treatment.

Community and Group Treatment

Community and group treatments are frequently used to remediate delinquent and antisocial behavior. The outer directedness, lack of insight and responsiveness to external control and peer influence are cited as reasons for using these approaches. In the therapeutic community literature, as reviewed by Liebman and Hedlund (1974), the key concepts are acceptance--accepting the patient or criminal and his or her their chosen role; control--gradually shifting from external to internal control; support--supplying encouragement, empathy and opportunities for success; and learning--teaching adaptive

behaviors through modeling and behavior modification.

Group therapy is often viewed as a method which circumvents the resistance of antisocial types to authority by engaging them with their peer group, who are more sensitive to manipulative tendencies and in better position to confront them. The opportunity to observe and help others, learn alternative interpersonal roles and engage in mutual feedback are considered beneficial. The group process is more action-oriented than individual therapy and allows for diffusion of both anger and intimacy, thereby being less threatening. The primary question facing the group orientation from a psychodynamic point of view is the permanence and depth of personality change possible without a more intense and enduring transferential relationship.

Individual Treatment

Individual psychotherapy of antisocial individuals is made difficult by both the resistance of the prospective patient and the intensity of countertransference reactions which are likely to develop. Carney (1978) has delineated four factors associated with personality disorders which should be considered in developing treatment: (1) the inability to trust, (2) the inability to feel, (3) the inability to fantasize, and (4) the inability to learn. As one can easily imagine, these factors greatly inhibit the forming of a therapeutic alliance or relationship and limit the benefits derivable from the relationship once it has been formed. Carney suggests that for these individuals to be real and to feel in a relationship

leads to hurt, and makes them extremely wary of the therapist, with participation often coming only under coercion. Their difficulties with fantasy leaves them frequently acting on impulse without any thought-out plan, and the inability to generalize undermines the transfer of accrued personal knowledge from one situation to the next. The minimal response to therapy, along with the tendency to project unacceptable, usually angry, feelings onto the therapist, may result in rejection or counterhostility on the part of the therapist which, of course, only confirms the antisocial individual's world view. Managing the countertransference under these circumstances becomes a key factor in the continuance of therapy.

The therapeutic alliance. The establishment of some form of therapeutic alliance with antisocial individuals has been considered both the most difficult and most critical factor in the success of treatment. Aichorn (1935, 1964) stressed the importance of making the delinquent "emotionally dependent" upon the therapist through establishing a strong identification with the therapist as a gratifying and powerful figure. Eissler (1958) expressed similar views noting that once the dependency was created then gradual modification of the relationship could take place with a resultant corrective experience. The need to avoid the traditional neutrality with antisocial individuals has been emphasized by Lion (1978, 1981) who encourages the therapist to take a stand as a real person, confronting manipulations while at the same time acknowledging the patient's frailty. A similar approach is advocated by Chwast (1977)

who proposes a sequence of control, support and uncovering. The establishment of effective external controls is seen by both Lion and Chwast as a prerequisite for the therapeutic alliance, and once that relationship has taken hold then the gradual development of internal controls becomes possible through the use of assimilable interpretation (Chwast, 1977) and fantasy (Lion, 1981) which prevents the intolerable build-up of anxiety requiring discharge and helps connect affect to action. Friedlander (1960) suggests that the "delinquent character disorder" may be converted into neurosis by blocking the discharge of internal tension, thereby making the anti-social individual amenable to treatment and facilitating dependence upon the therapist. As Kellner (1982) summarizes in his review, the treatment of these patients requires great involvement on the part of the therapist, acceptance of the patient and the establishment of a trustful relationship.

Countertransference. The frequency and intensity of counter-transference reactions with personality disorders in general and antisocial individuals in particular has been noted by numerous authors (Giovacchini, 1975; Halperin, Lauro, Miscione, Rebhan, Schnabolk, & Schachter, 1981; Kernberg, 1976; King, 1976; Leaff, 1981; Lion, 1981; Marshall, 1979; Millon, 1981; Proctor, 1959). Countertransference is used herein in the "totalistic" sense explicated by Kernberg (1976), meaning the entire emotional reaction of the therapist to the patient. Included in this conception are the conscious and unconscious reactions of the therapist to the patients'

reality and transference. According to this view countertransference is not necessarily a negative development, but may be utilized productively when the therapist becomes aware of the countertransference and uses it to gain insight into both the inner world of the patient and the ongoing therapeutic interaction.

Psychotherapy with children and adolescents often produces more intense countertransference reactions than that with adults due to the dependency of the patient and the primitive nature of his or her fantasies which are apt to arouse the therapist's unconscious anxieties (Marshall, 1979). Proctor (1959) notes that these intense reactions are even more likely to arise in cases of character pathology and the therapist may regressively identify with the patient's aggressive or libidinal impulses, his punitive superego or a psychotic fragment within him. In reviewing his experience with violent youth, King (1976) commented on the spectrum of responses elicited from staff. At one end rage, anxiety and a sense of helplessness lead to rejection of the youth, while at the other extreme necessary confrontations are avoided in order to attain even minimal cooperativeness, or unconscious identification with patients' antisocial impulses actually encourages inappropriate behavior.

Lion (1981), who has written extensively on countertransference and the antisocial syndromes, suggests that the fragility and easily aroused anger of these patients make them hard to confront, and notes that inexperienced therapists have a tendency to "freeze" in the presence of labile character disorders. The long periods of

hostility and nonalliance place tremendous strain on the therapist, and it is not uncommon for depression to develop out of a sense of inadequacy and helplessness in the face of the patient's seemingly constant need to behave abnormally, manipulate and avoid intimacy and trust. If the therapy is sustained and reality conflicts diminish, the therapist must then tolerate the patient's often overwhelming feeling of emptiness and, according to Lion, encourage the patient to develop meaningful skills and emotional outlets to replace the previous maladaptive behavior patterns. A bilateral sharing of existential concerns around the genuine limitations and frustrations of life is seen as appropriate in the latter stages of successful treatment.

Additional countertransference issues have been raised by Halperin et al. (1981). In particular they comment on the resentment that a therapist may feel about being placed in a coercive role vis-a-vis his patient, especially when treatment has been mandated by the judicial system. When working in an inpatient setting the therapist may also feel pressure from other staff to quickly bring the patient's behavior under control, thereby increasing the likelihood of countertransferential anger and frustration and reducing empathic concern. Rescue fantasies, almost invariably unfulfilled due to the resistance of these patients, often result in bewilderment and anger which may be displaced onto residential staff or parents.

Giovacchini (1975) aptly points out that the desire to rescue the patient is often the other side of the therapist's murderous

feelings toward his client, with both aspects the result of projections onto the therapist. Unless the therapist recognizes the source of these feelings in the traumatic infantile environment, "psychotherapy may become an unrewarding, disruptive struggle or a doomed attempt to achieve magical salvation" (p. 338). While the destructive projections and provocations of the patient may produce counter hostility and/or exasperation in the therapist, a further and potentially more fateful reaction may be induced by the projection of the patient's blank, amorphous self onto the therapist. The therapist may then experience an existential crisis, feeling empty and nonexistent, and defend against the resultant anxiety by rationalizing the untreatability of the patient. According to Giovacchini, therapists are especially prone to this type of inner disturbance during the treatment of adolescents due to their undeveloped self images. Thus, the pessimistic prognosis associated with personality disorders and antisocial syndromes may be determined as much by the countertransference reactions these individuals elicit as by their more direct and overt resistance.

Towards an Object Relations approach

The considerable difficulties entailed in establishing a therapeutic alliance and the potential for negative countertransference reactions have historically militated against the regular use of psychoanalytic psychotherapy in the treatment of severe characterological disturbances, especially those with antisocial aspects.

Giovacchini (1975) implies that much of the difficulty experienced with these patients is a result of an incomplete understanding of their psychodynamic structure and characteristic defense mechanisms. As indicated at the close of Chapter II, recent developments in Object Relations theory regarding the treatment of Narcissistic and Borderline Personality Disorders may provide additional insight into those adolescents diagnosed as Conduct Disorder. The various Object Relations theorists have proposed specific treatment recommendations for the personality disorders based on developmental psychoanalytic conceptualizations and, as suggested by Marohn (1981), these approaches have applicability to Conduct Disorder.

An Object Relations approach to Conduct Disorder is appealing for a variety of reasons. A clear developmental understanding of Conduct Disorder which would address both the etiological factors in early childhood and later transformations or sequelae in adolescence and adulthood is currently lacking. Object Relations theory, in all its variants, is essentially a developmental model which can potentially remedy this situation and eliminate the discontinuity between adult and child diagnoses. The need for greater diagnostic discrimination among the relatively heterogenous population who engage in antisocial behavior was emphasized earlier. Treatment approaches developed to address the broad category of personality disorders are too general for effective application to Conduct Disorder and remedial interventions aimed at the Antisocial Personality appear too limited in scope and goals. DSM-III's subdivision of

Conduct Disorder along the dimensions of socialization and aggression is an earnest attempt to bring order to the phenomenon but the criteria for the subtypes have been criticized as superficial (Marohn, 1981) and the treatment implications remain unclear. Object Relations theorists, in this regard, have expended considerable energy refining both the diagnosis and treatment of personality disorders and focus much of their attention on interpersonal relations and aggressive impulses especially as they are constituted in the internal world of the individual. They have also made significant contributions regarding the establishment of workable parameters for conducting individual psychotherapy with these patients and have commented extensively and sensitively on the management of countertransference. Lastly, the previously noted similarities in behavior and psychological functioning between adolescents diagnosed Conduct Disorder and the Borderline and Narcissistic Personality Disorders strongly suggest utilization of the compelling Object Relations analyses of those disorders.

Object Relations Approaches to Personality Disorders

The purpose of this section will be to review some of the current conceptualizations of personality development and psychopathology within what is broadly referred to as Object Relations theory. Object Relations theory is an approach within the psychoanalytic movement which emphasizes the development of psychological structure and function as derived from internalized representations and affects

associated with significant interpersonal relations in the first few years of life. The word "object" refers to persons or representations of persons which are invested with emotional energy and attachment. The progressive development of intrapsychic structure (ego, id and superego) is, generally speaking, seen as a result of the internalization, differentiation and integration of an individual's experiences in interacting with objects, most often the mother, during infancy. These formative relationships become the basis of personality development and the expression of libidinal and aggressive impulses. Thus Object Relations theory, as will be elaborated upon shortly, is grounded in the definitive dimensions of Conduct Disorder, socialization and aggression, and may provide a framework through which that disorder can be better understood and treated.

In the discussion that follows no attempt will be made to present a comprehensive overview of Object Relations theory. Such an undertaking, as valuable and needed as it is, would be well beyond the scope of this work. Let it suffice to note that there exits a vast literature which falls under the general rubric of Object Relations theory, and the reader is referred to Kernberg's overview (1980), as well as the work of Fairbairn (1954), Guntrip (1973), Jacobson (1964), Klein (1975a, 1975b), Kohut (1971, 1977), Mahler (1968), Masterson (1981) and Winnicott (1958) among others. While the British Object Relations school of thought, with Fairbairn, Klein and Winnicott as its foremost proponents, has been of great theoretical and historical interest, the focus here will be on recent American developments,

especially as evidenced in the work of Kernberg, Masterson, and Kohut.

Kernberg is a significant and influential analyst who has written extensively on the borderline personality organization, a term which he uses in a broad way to describe a personality structure existing on a continuum between psychoses and neuroses. Notable in Kernberg's work is the emphasis on ego development combined with belief derived from more traditional psychoanalytic theory, in the importance of instincts. Masterson's views are similar to Kernberg's in many respects, but his emphasis is on the abandonment depression of the separation-individuation phase of development and not so much on instinct theory. Masterson's writings are particularly relevant to the discussion of Conduct Disorder because they focus largely on the "borderline adolescent." Kohut is an influential analyst who has developed what he refers to as a "psychology of the self" (1971, 1977) which places considerable emphasis on narcissism, both normal and pathological. While Kohut (1977) came to view his self psychology as discontinuous with mainstream psychoanalysis, many of his concepts are derivative of Object Relations theory and his descriptions of the "grandiose self" and the narcissistic transferences have been widely accepted by Object Relations theorists (Masterson, 1981). Kohut himself did not address adolescent psychopathology in any detail, but Marohn (1977, 1979, 1981) and Wolf (1980) have begun to apply his views on narcissism to that population. Leaff (1978, 1981) and Reid (1978, 1981) have also commented on the utility of both Kohut and Kernberg in understanding antisocial behavior.

The commonality among Kernberg, Masterson and Kohut lies in their focus on the narcissistic-borderline spectrum of disorders. Their differences, which are substantial in terminology, theory and practice, preclude any easy integration of their ideas, but each has a perspective capable of advancing diagnostic precision and treatment efficacy with adolescent Conduct Disorders. Each theoretician's contributions will now be presented in greater detail.

Kernberg

The borderline personality organization. The borderline personality organization has been a major focus of Kernberg's writings over the past fifteen years and he has made detailed presentations of its diagnosis, structural development and treatment. It is important to reiterate that Kernberg uses the term "borderline" to refer to personality structure, not overt behavioral chracteristics. Borderline Personality Disorder, as listed in DSM-III, is characterized by instability of interpersonal relations, behavior, mood and self-image, symptoms which are frequently but not necessarily found in those Kernberg would consider "borderline." In general, Kernberg's use of the term is broader than that utilized in DSM-III and implies a personality organization characterized by identity diffusion, primitive defensive operations centered around splitting and the maintenance of reality testing (Kernberg, 1978). The presence of identity diffusion and primitive defenses differentiate borderline from neurotic organization, and the maintenance of reality testing distinguishes borderline from psychotic structure.

Identity diffusion is seen by Kernberg as indicative of "ego weakness" and is defined as a lack of integration of the concepts of the self and significant others. In Kernberg's words, "It is manifested typically by a chronic subjective feeling of emptiness, contradictory self-perceptions, contradictory behavior that the patient cannot integrate in an emotionally meaningful way, and shallow, flat, impoverished perceptions of others" (1980, p. 8). The quality of interpersonal relations suffers due to emotional instablility, distorted perceptions and lack of empathy. The inability to integrate the "good" and "bad" parts of oneself and others makes continued, substantial relationships virtually impossible.

The defensive operations described by Kernberg function to protect the weakened ego from overwhelming anxiety due to intrapsychic conflict. Through the use of dissociative defenses, such as splitting, denial, projection, omnipotence and devaluation, contradictory experiences of the self and others are kept apart, thus preventing or controlling anxiety related to these experiences. These defenses, at the same time, maintain the lack of ego integration and as a result reduce the individual's "adaptive effectiveness and flexibility."

Reality testing is defined by Kernberg as, "The capacity to differentiate self from nonself, intrapsychic from external origins of perceptions and stimuli, and the capacity to evaluate realistically ones own affect, behavior, and thought content in terms of ordinary social norms" (1980, p. 15). Specifically, reality testing is indicated by the absence of hallucinations, delusions and grossly

inappropriate or bizarre affect, thought content or behaviors. In addition, reality testing is recognized by the ability of the patient to empathize with and clarify the clinician's observations of inappropriate or puzzling aspects of the patient's affect, behavior or thought content. In borderline conditions, according to Kernberg, weakened reality testing is restored through interpretation of the primitive defense operations involved. In cases of psychoses the reverse is true; interpretation of the defense is seen as leading to further loss of reality testing.

Intrapsychic development. Developmentally, the major factor raised by Kernberg is the presence of what he calls, using classical Freudian psychosexual stage terminology, "pregenital aggression" occurring in the first few years of life. Utilizing a model of infant psychological development derived largely from Mahler (Mahler, 1971, 1972; Mahler, Pine, & Bergman, 1975), Kernberg describes a process whereby an initial undifferentiated "autistic" stage yields to a symbiotic stage during which time good self-object representations are consolidated simultaneously with the consolidation of bad self-object representations. The good self-object image is created from pleasurable, gratifying mother-infant interactions, while the bad self-object image results from frustrating, painful dyadic experience. The "good" self-object representations form the intrapsychic structure initially invested with libido and the "bad" self-object representations are invested with aggression. By the close of the symbiotic stage differentiation of self and object repre-

sentations has begun within the "good" and "bad" self-object cores. The psychopathology associated with these first two stages are autism and the psychoses. The separation-individuation stage follows, during which differentiation of the self and object representations is completed, followed by integration of the "good" and "bad" self representations into an integrated self concept and the integration of "good" and "bad" object representations into "total" object representations, thereby achieving object constancy.

In the borderline personality organization, according to Kernberg (1976, 1980), the separation-individuation stage is only partially completed. Differentiation of self and object representations occurs, permitting the establishment of stable ego boundaries and the capacity for reality testing. The second process, involving the integration of "good" and "bad" self components and "good" and "bad" object components is blocked by the intensity of internalized aggression. The "good" representations are protected through their defensive idealization and splitting, the active separation of contradictory "good" and "bad" internalizations. Thus unbearable conflict and anxiety are avoided, but only with the loss of ego integration. Identity diffusion results, along with inadequate superego integration and a failure to attain object constancy. The lack of integration is further evidenced by what Kernberg calls "nonspecific" signs of ego weakness: low anxiety tolerance, poor impulse control and poor subliminatory capacity.

Narcissistic personality structure. The borderline personality

does not reach the next stage in Kernberg's schema which involves the further integration of self representations and object representations, along with the consolidation of higher level intrapsychic structures, i.e., ego, id and superego. Psychopathology originating at this level of development is seen as resulting in neurotic or "higher level" character disorders. An "abnormal condensation" of the intrapsychic structures appearing at this stage combined with regression to the personality organization of the previous developmental level is indicative of the narcissistic personality. More specifically, Kernberg outlines the following characteristics of narcissistic structure.

> The structure of narcissistic personalities is characterized by (1) a pathological condensation of real self, ideal self, and ideal object structures; (2) repression and/or dissociation of "bad" self-representations; (3) generalized devaluation of object representations; and (4) blurring of normal ego-superego boundaries. The end result is the development of a grandiose self (Kohut, 1971) embedded in a defensive organization similar to that of borderline personality organization (Kernberg, 1974).
>
> (1976, p. 68)

The grandiose self, in effect, masks the underlying borderline personality organization by projecting devalued part self and object representations onto the external world. The search for admiration and/or idealized objects with whom to identify becomes the major preoccupation of the narcissistic personality. These part object relations are inevitably unsatisfactory, being either exploitative--in an effort to gain narcissistic supplies, deprecatory--as devaluation of those who are depleted or mediocre, or fearful--

through paranoid projections of attacking, rageful and exploitative internalizations. What is received is "spoiled" to protect against envy, leaving the individual ever needful and empty. The same type of dissociative defense mechanisms utilized by the borderline personality organization are evident in the narcissistic personality, with the difference being that the latter has developed more stable ego boundaries although they demarcate a pathological, grandiose self which includes superego forerunners. For Kernberg, narcissistic personality is a variant of borderline personality organization with both having their roots in non-integrable pregenital aggression.

Classification of character pathology. Kernberg's classification of character pathology (1970) is also relevant to his discussion of borderline and narcissistic personality. Three levels of character pathology are proposed based upon the level of instinctual development and fixation (genital or pregenital), the extent of superego integration, the nature of defense mechanisms (e.g., repression versus splitting) and the quality of internalized object relations. The highest level of organization of character pathology is evidenced by genital primacy, a well integrated but severe, punitive superego, repressive defense mechanisms, adequate overall social adaptation and relatively deep and stable object relations with the capacity to experience a wide variety of emotions. At the intermediate level pregenital, especially oral, conflicts predominate, although they usually represent a regression from oedipal conflicts and are characterized by less aggression than is present at the lower level.

The superego is more punitive and less well integrated than at the higher level and this is reflected in a reduced capacity for guilt and the development of paranoid trends. Neurotic defenses continue to be utilized along with some dissociation, and object relations retain stability despite marked ambivalence and conflict. The lowest level is characterized by pathological condensation of genital and pregenital drives with a predominance of pregenital aggression. Superego integration is minimal with a marked tendency to project primitive sadistic components, thus reducing the capacity for guilt and concern while increasing paranoid trends. Primitive, dissociative defenses organized around splitting predominate and instinctual discharge through contradictory, repetitive behavior patterns is characteristic. Object relations tend to be need gratifying or threatening based upon part-object representations and without the attainment of object constancy. Hallmarks of this level are identity diffusion and generalized ego weakness as evidenced by the lack of anxiety tolerance, impulse control and developed subliminatory channels.

Kernberg essentially equates the lowest level of organization of character pathology with borderline personality organization. He includes in this grouping prepsychotic personalities, chaotic, impulse-ridden character disorders, patients with multiple deviations of a sexual or drug related nature, most infantile personalities, many narcissistic personalities and all antisocial personalities. Kernberg places higher functioning narcissistic personalities in the

intermediate level. In general Kernberg considers prognosis to be worse at the lower level and to be particularly poor for antisocial personality, although he recognizes that antisocial behavior often reflects character pathology other than antisocial personality proper and for which treatment is more likely to be successful. The presence of anxiety and ego-dystonic reactions to pathological character traits also augur well for treatment.

Treatment of the borderline personality. In regard to treatment itself, Kernberg (1975, 1978, 1979) has specific recommendations for patients with borderline personality organization. His overall view is that these patients should be treated with psychoanalytic psychotherapy and not with supportive techniques. He further distinguishes psychoanalytic psychotherapy from psychoanalysis proper in three ways: (1) transference interpretations cannot be systematic due to the severity of acting out and disturbances in external reality which impact upon the therapy and which must be addressed as they arise, (2) technical neutrality is limited by the necessity on occasion to become involved in structuring the patient's external life, especially when part of a therapeutic team, and deviations should be reduced by interpretation, (3) transference interpretations are often conducted in a hypothetical fashion based upon the present interaction with connections made to intrapsychic structure but not directly to past developmental history. Nonetheless, the basic analytic approach to exploring and resolving primitive transferences through interpretation is maintained. According to Kernberg primitive

transferences may be transformed into more advanced ones by: (1) clarifying the primitive emotional relationship evident in the transference, (2) defining the self-object polarity of that interaction and the patient's alternating attributions, and (3) integrating the part-object relations with their split-off counterparts.

Treatment of the narcissistic personality. Kernberg's suggested treatment for narcissistic personalities is informed by his developmental understanding of the borderline personality organization, but does differ in some important ways (Kernberg, 1975). Psychoanalysis, rather than the expressive, psychoanalytically oriented treatment proposed for borderline personalities, is considered the treatment of choice for the narcissistic personality. An exception is the narcissistic personality functioning at the overt borderline level who may severely regress in psychoanalysis and for whom a supportive approach is indicated until sufficient containment allows for a resumption of psychoanalysis. Kernberg feels that the most significant aspect of treating the narcissistic personality is the constant devaluation and attempts to defeat the therapist's efforts. This situation demands that the therapist carefully observe the resultant countertransference reaction which can provide clues to the patient's dissociated emotional experiences. Kernberg considers interpretation of the negative as well as positive transference to be extremely important in these cases in order to reassure the patient that his aggression will not destroy the analyst. Prognosis is guarded with all narcissistic patients but does improve with increased

tolerance for depression and mourning, subliminatory potential, impulse control, anxiety tolerance and superego integration.

Psychotherapy with adolescents. Psychoanalytic psychotherapy with adolescents while not supportive in design does, as Kernberg (1978) points out, have supportive effects based upon the adolescent's identification with the interpretive stance and integrative function of the therapist. At the same time, this process may stir up hatred and envy toward the therapist due to the patient's increased, often disturbing, self-knowledge and need to destroy the therapist as a giving maternal image. Kernberg encourages an empathic response to these patients but one that is broadly defined to include awareness of those split-off aspects of internalized representations which the patients cannot themselves tolerate.

The acting out of the borderline adolescent must be carefully evaluated for transference implications with consistent interpretation of the part-object relations involved. The meaning of the behavior and reasons for using action to express unacceptable cognition and affect should also be addressed. Lastly, countertransference reactions are common in response to the intense projections. Dangers include re-enacting a parental response or actively avoiding same in an attempt to establish an alliance. The therapist must come to realize that his/her own subjective experience in the therapy is a vehicle for understanding projected aspects of the patient, and containment and interpretation of that experience provides both insight and a model for the adolescent.

Diagnostic complications in adolescence. The application of Kernberg's analysis of the borderline personality organization to adolescents is complicated by a number of diagnostic factors which Kernberg (1978) is careful to delineate. Among these are: (1) the severity of the symptomatic neuroses in some adolescents which can mimic borderline organization, (2) rapid shifts in identification which would ordinarily indicate poor ego integration, (3) the presence of severe pathology of object relations, which may be underestimated as compatible with neurotic structure, (4) antisocial behavior that is a "normal" adaptation to an antisocial subcultural group, or conversely the masking of pathology by inclusion in such a group, (5) narcissistic reactions common to adolescence which make pathological narcissism more difficult to discern, and (6) the polymorphously perverse sexual tendencies of adolescence which can obscure more severe sexual pathology. With respect to adolescent antisocial behavior, Kernberg (1975, 1978) agrees with Masterson (1978) that "adolescent turmoil" and "adjustment reaction to adolescence" have been overused as explanatory concepts and have contributed to an underestimation of the character pathology involved. He also emphasizes that antisocial behavior is most commonly reflective of severe character pathology other than antisocial personality proper, and that differential diagnosis requires "prolonged observation of the patient, in the course of which the quality of his object relationships and the type and degree of superego pathology can be more accurately evaluated" (1975, p. 117). In essence it is an

assessment of socialization and aggression from an object relations perspective which determines the differential diagnosis and echoes the form if not the substance of the DSM III criteria for Conduct Disorder.

Summary. The detailed developmental considerations and treatment guidelines provided by Kernberg for borderline personality organization and narcissistic personality lend a framework within which Conduct Disorder may be better understood. Kernberg has emphasized the diagnostic importance of assessing the presence of identity diffusion, the use of primitive defenses and the ability to reality test. He has pointed to pregenital aggression as being a primary factor in the development of pathological personality structure and has suggested a continuum of character pathology based upon the quality of object relations, instinctual fixation and superego integration. Psychoanalytically oriented psychotherapy, a modification of psychoanalysis facilitating improved management of intense transference acting out, is recommended for patients with borderline personality organization with the exception of narcissistic personalities who are viewed as needing psychoanalysis in higher functioning cases or supportive therapy in overtly lower functioning cases. Kernberg also makes specific suggestions for the diagnosis and treatment of borderline personality organization in adolescence and places great emphasis on constructive use of countertransference phenomena in these cases.

Masterson

Masterson's approach to the borderline personality organization is similar to Kernberg's, most obviously in their shared debt to the developmental theory of Mahler (1968, 1975). Both focus on the separation-individuation phase as the key period in development and ascribe similar object relations and defenses to the borderline personality. Masterson (1980, 1981), however, has placed much greater emphasis on the pathological symbiosis of the mother-child interactions, which lead to an "abandonment depression" and developmental arrest in the separation-individuation phase. Kernberg, as previously noted, weighs the presence of pregenital aggression most heavily.

Masterson's developmental perspective. The primary dynamic in the development of the borderline personality, according to Masterson (1980), is the mother's need to maintain a symbiotic union with the child, thereby continuing dependency and aborting the normal separation-individuation process. The child's growing independence threatens the previously gratifying symbiosis and the mother withdraws in response but is available if the child behaves in a regressive, clinging fashion. As an object for parental gratification the child must sacrifice his/her own needs and growth in order to prevent the mother's withdrawal.

The experiential or threatened loss of the mother results in the abandonment depression, an intense and complex state comprised of six constituent feelings: depression, rage, fear, guilt,

passivity and helplessness, emptiness and void. These feelings are so painful that they must be defended against and kept from consciousness, thus the use of splitting mechanisms: denial, clinging and avoidance. The cost of these defenses is developmental arrest and fixation in the separation-individuation phase. Ego functions which are normally internalized through identification are either weakened or absent, resulting in the ego weaknesses noted by Kernberg such as poor frustration tolerance and impulse control. Object constancy, the ability to maintain object relatedness regardless of frustration or satisfaction (Masterson, 1980), is also not attained resulting in part rather than whole object relationships, relational instability, the need for the physical presence of others to confirm their continued existence and the inability to mourn. It is characteristic of these patients to react in extreme fashion to any loss of or separation from a significant person, a factor that becomes quite evident in treatment at the time of therapist absence or vacation.

The pathology of the mother-child dyad is frequently supported by a father who has characterological difficulties and/or other severe psychiatric problems. Most often the father is either psychologically or physically unavailable to the child and thus reinforces rather than opposes the intensity and dependency of the mother-child relationship. Other contributing factors may derive from genetic or environmental bases, increasing the vulnerability of both child and parent to borderline psychopathology (Masterson, 1981).

Intrapsychic Structure and defenses. Masterson's conceptualization of the intrapsychic structure that results from these interpersonal relations is reminiscent of Kernberg' in substance if not terminology. Masterson (1980) postulates that images of two mothers, one rewarding and the other withdrawing, are introjected to form a split object relations unit consisting of two separate part-units each with a part-self and part-object representation: a withdrawing part-unit invested with aggressive impulses and a rewarding part-unit embodied with libidinal energy. The withdrawing part-unit is, in essence, the repository of "bad," hostile, depressive feelings associated with a maternal part-object that is attacking, critical, angry and withdrawing in response to efforts aimed at separation and a part-self representation of being inadequate, helpless, empty, guilty and bad. The rewarding part-unit contains the pleasurable feelings of being loved, good and reunited with the mother. These "good" feelings are linked with a maternal part-object which rewards and gratifies regressive, clinging behavior and a part-self representation of being the good, passive, compliant child. As a result of these object relations a split ego structure develops: a pathological or pleasure seeking ego, functioning to avoid separation and the abandonment depression, and a reality ego operating on the reality principle.

The pathological ego utilizes the dissociative, splitting defenses to keep the rewarding and withdrawing part-units separate and forms alliances with one or the other as its defense against

the abandonment depression. When allied with the rewarding part-unit the gratifying part-object is projected onto someone in the environment, while the part-self representation is enacted through good, compliant behavior. An ego alliance with the withdrawing part-unit results in projection of the associated critical, hostile feelings and distancing behavior to protect the self from that hostility. Alternatively, the patient may project the part-self representation and become hostile and attacking toward the person onto whom the projection is made. The pathological ego alliances just described may alternate in the patient, with one type usually predominant. The goals, however, remain the same: the promotion and maintenance of good feelings and avoidance of the abandonment depression. The overall pattern is termed by Masterson the borderline triad: separation leading to the abandonment depression which in turn leads to the mobilization of defenses.

Diagnosis of borderline conditions. The defenses employed by the patient are focal in Masterson's approach to the diagnosis of borderline conditions in adolescence. He states that the most common clinical picture is that of the adolescent whose defense is aggressive acting out and acknowledges the diagnostic confusion often present with these individuals. Masterson emphasizes the need to make the diagnosis on two levels--the presenting symptomatic episode and the underlying character structure--and suggests five factors as diagnostic aids: (1) the present illness with special attention to defenses against the abandonment depression, (2) the precipitating

stress usually associated with a separation experience, (3) the past history of underlying character structure with evidence of narcissistic oral fixation, (4) the type of parents, especially indications of borderline or other character pathology and related deficiencies in the capacity to parent, (5) the type of family communication with action preferred to words.

Masterson describes the borderline adolescent as acting out in a variety of ways ranging from school difficulties to antisocial behavior, drug use and other self destructive behavior. Often part of the clinical picture is the use of dependent sexual relationships with older males or females to substitute for reunion with the mother. The separation experience which precipitates symptom formation may be obvious, as in the case of death or divorce, or subtle, as in a brief illness. The history of the narcissistic-oral fixation is established through evidence of prolonged dependency and passivity and defects in ego structure (poor impluse control, poor frustration tolerance, etc.). Also significant is a history of trauma during the separation-individuation stage (18-36 months of age), clinging to the mother, separation anxiety when beginning school and childhood phobias. Overall there is usually a disparity between developmental level and chronological age. The parents' character structure is often reflective of their own inadequate parenting and typically results in fathers who are passive, distant men and mothers who are demanding and controlling and attempt to meet their own emotional needs through their child. Due to the impulse ridden qualities of

both parents and child and their characteristic unresponsiveness to mere verbalization, actions are the prefered mode of family communication. The adolescent's behavior must then be viewed as communication and, as such, often an expression of angry desperation.

A last addition to Masterson's description of borderline psychopathology is the notion of the "false self" (Masterson, 1981). The false self refers to the self-image distortion that results from the child's attempt to conform to the mother's projections so as to prevent her withdrawal. The child's ability to identify and then assert his or her own thoughts and feelings is severely compromised. The difficulties with self-esteem, self-expression and self-regulation are considered by Masterson to be the narcissistic psychopathology of the borderline disorder.

Treatment of the borderline personality. Treatment from Masterson's perspective is organized around making the patient aware of the borderline triad: the pattern of faulty separation-individuation, leading to depression, leading to self-destructive defensive behavior. The goals are the resolution of the abandonment depression and the repair of ego defects which will then allow personality growth to continue.

The initial stage of treatment is the testing phase during which time the therapist attempts to control the acting out and gradually establish a therapeutic alliance. To accomplish these tasks the therapist must change the patient's perception of the functioning of the pathological ego from ego syntonic to ego alien

by confrontive clarification of the destructive pattern and by connecting affect to behavior. The therapist's confrontation is experienced as abandonment and the withdrawing part-unit is activated, re-enacting separation-individuation within the therapy and leading to the second stage of working through. According to Masterson, "There results a circular process, sequentially including resistance, reality clarification, working through feelings of abandonment (withdrawing part-unit), further resistance (rewarding part-unit), and further reality clarification, which leads in turn to further working through" (1980, p. 27). With the establishment of the therapeutic alliance words replace actions in the therapy and interpretation of defenses becomes effective in working through the abandonment depression and the original conflict with the parents as it evidences itself in the transference. The last phase of treatment is separation, in which the patient's anxiety over separation from the therapist and over becoming an autonomous, independent individual is worked through. The patient's identification with internalization of the therapist as a figure who approves of separation-individuation facilitates this process.

The narcissistic personality. The etiology and psychodynamics of the narcissistic personality are acknowledged by Masterson (1981) to be less clear than that of the borderline personality. As Masterson points out, Object Relations Theory has usually conceptualized self and object representations developing in parallel to ego functions. In the narcissistic personality, primitive (fused) self-

object relations exist concurrently with more advanced ego functioning. Thus the narcissistic personality has firm ego boundaries and generally good reality testing (except in areas of narcissistic investment) but impoverished interpersonal relations.

Descriptively, what is most notable for Masterson is the grandiosity, extreme self-involvement and the lack of interest in and lack of empathy for others, with the primary motivation being the search for perfection and for others who will mirror and admire his or her grandiosity. Underneath the superficially good functioning is emptiness, rage and intense envy. Masterson further delineates three levels of functioning: (1) effective surface functioning due to talent or skill, (2) patients' with severe difficulty in object relations and evidencing neurotic or sexual problems, (3) borderline level functioning with marked ego weakness. What all levels share is the characteristic primitive defenses, most notably idealization, avoidance, denial, devaluation and projection.

Developmental arrest of narcissism. Masterson considers the narcissistic personality to be the result of a developmental arrest prior to the rapprochement subphase within the broader separation-individuation process. The normal child who has been exploring the environment with a grandiose confidence and imperviousness to frustration derived from a fused self-object relation gradually, with increasing differentiation of the self and object representation, loses the sense of omnipotence and of grandiosity and returns to the mother (the rapprochement). Unable to recreate the earlier fused state,

infantile fantasies are aligned with reality and the abandonment depression begins to be worked through. In the development of the narcissistic personality, reality is denied and the grandiose self representation is maintained in unity with the omnipotent object.

Two explanations are offered by Masterson for this form of developmental arrest. In one, an emotionally cold and exploitative mother utilizes the child to satisfy her own perfectionistic, emotional needs while sacrificing the child's age-appropriate needs for separation and individuation. By identifying with the mother's idealization the grandiose self-representation is preserved to defend against awareness of the mother's failures and the child's associated depression. The alternative scenario involves the child's identification with a narcissistic father. Prior to resolution of the rapprochement subphase, the child may transfer the symbiotic relationship with the mother to the father in an effort to avoid the abandonment depression. The narcissistic father encourages this identification thereby preserving the grandiose self. When the transfer to the father occurs after the rapprochement period in which the child's grandiosity and omnipotence have been tempered and split object relations established, then a narcissistic identification may be imposed on an underlying borderline structure. Masterson suggests that since the identification with the father occurs more readily with boys than girls the prevalence of male narcissistic disorders is also explained by this model.

Treatment of narcissistic personality. The treatment of the

narcissistic disorder in Masterson's view is structurally similar to that of the borderline personality but with some important differences in technique. The stages of treatment are the same: a testing stage of resistance and defense, a working-through stage of anger and depression and a separation stage of regressive avoidance of autonomy. As with the borderline, the greatest obstacle is establishing a therapeutic alliance. The narcissistic personality also acts out split object relations in the transference: either the grandiose self, omnipotent object fused unit or the empty, aggressive fused unit.

The differences in technique center around the need to consider the narcissistic personality's vulnerability and sensitivity to empathy failures. Whereas confrontation of self-destructiveness is perceived by the borderline personality as constructive, the narcissistic personality experiences such confrontation as an attack and reactivates his or her defenses of denial, avoidance and devaluation. Masterson suggests that a more productive approach involves pointing out to the patient the aspects of reality that are being denied, devalued or avoided and interpreting the patient's vulnerability to narcissistic disappointment and need for perfect "mirroring." The initial focus of treatment is interpreting the behavior occurring within the session in contrast to the theory of the borderline where the initial focus is the acting-out outside of the hour.

Of relevance to the treatment of Conduct Disorder is the differentiation that Masterson makes between upper and middle level

narcissistic personalities and the psychopathic personality which he essentially equates with a lower level narcissistic personality. Masterson holds that the treatment of the psychopath is fruitless and much frustration may be avoided through early and accurate diagnosis. He suggests that the diagnosis of psychopathy be based on a number of factors: a long history of antisocial behavior, often present in both the child and the parents; a lack of anxiety or depression except when caught in an inescapable predicament; a virtually complete lack of object relatedness reflective of severe early emotional deprivation, and an inability to learn from experience. The defensive withdrawal of investment in any object renders the psychopath unable to utilize therapy.

Summary. Masterson's potential contribution to the understanding of Conduct Disorder lies in his perspective on the diagnosis and treatment of borderline and narcissistic disorders. His conceptualizations emphasize the vicissitudes of separation-individuation, the prevalence of aggressive acting out and the working through of the abandonment depression. He stresses the "borderline triad" of separation, depression and defense and the necessity of a confrontive approach. With respect to the narcissistic personality, the fused self-object representations are emphasized along with the need for an empathic, interpretive technique sensitive to narcissistic vulnerability. From this perspective socialization is conceptualized on a continuum from part to whole object relations, and aggression results from activation of the "abandonment depression" (borderline

personality or non-empathic responses to the grandiose self (narcissistic personality). As with Kernberg, Masterson provides a developmental understanding of characterologically based acting-out behavior which is applicable to the Conduct Disorder population.

Kohut

Kohut's contributions regarding a "psychology of the self" provide a significantly different perspective from that of Kernberg and Masterson on the borderline-narcissistic spectrum of disorders. Similarity of terminology and imprecisely overlapping clinical populations of study, combined with Kohut's assertion of a discontinuous theoretical model create inevitable confusion about the relationship of Kohut's work to the body of Object Relations Theory. Fortunately, the attempt here is not to integrate Kohut and the aforementioned therapists, as that would be a difficult and, perhaps, impossible task. The goal is rather to note Kohut's insights and suggest how they too may illuminate the clinical phenomena subsumed under Conduct Disorder. In particular, Kohut's views on narcissistic transferences and narcissistic rage may prove useful in furthering the understanding and treatment of antisocial and aggressive adolescents.

Narcissism and the "psychology of the self." Central to Kohut's formulations is the postulate that there are two distinct developmental processes, one of object love and the other of narcissism (Kohut, 1977). Narcissism, instead of being a way station in the development of object relations, is considered to have mature trans-

formations of its own which are characterized by enthusiasm, empathy and healthy self-esteem and ambition. These later transformations of narcissism--secondary narcissism--are therefore seen as consistent with advanced object relations and indicative of a cohesive, resilient self. The development of the self and transformations of narcissism are integral and essentially equivalent processes.

Self-structure and development. Kohut posits two primitive structures as basic constituents of the developing self: the grandiose or mirrorizing self and the idealized parent imago (Kohut and Wolf, 1978). These structures are called "self-objects" by Kohut--objects which are experienced as part of the self and therefore over which control is expected. As Masterson (1981) points out, this use of self-object is confusing given the previous usage of the term and the blurring of the boundary between self and object. In any event, the grandiose self is derived from experiences with persons (usually parents) "who respond to and confirm the child's innate sense of vigor, greatness and perfection," and the idealized parent imago is derived from experiences with "those to whom the child can look up and with whom he can merge as an image of calmness, infallibility and omnipotence" (Kohut and Wolf, 1978, p. 414). The self is conceptualized as resulting from the interactions between the child and his or her self-objects and three components: poles of ambitions and ideals and an intermediate area of basic talents and skills activated by the tension between the poles.

In normal development the archaic structures of the grandiose

self and idealized parent imago are modified over time by empathic responses to the child's need for mirroring or idealization of the parent, combined with phase-appropriate frustration of that need. This process is called transmuting internalization and leads to a "gradual replacement of the self-objects and their functions by a self and its functions" (Kohut and Wolf, 1978, p. 416). Severe frustration or disillusionment consitutes a trauma to the developing self which may leave it damaged or incohesive and lead to the persistence of the unmodified, archaic structures in repressed or split-off condition. The grandiose self and idealized parent imago may emerge later as elements of personality configuration and/or transference phenomenon (Marohn, 1977).

Self-pathology. Various levels of self pathology are suggested by Kohut and Wolf (1978) based upon the timing and severity of the frustration and deprivation. Secondary disturbances of the self are "reactions of a structurally undamaged self to the vicissitudes of life," and as such are usually transitional states. Primary disturbances of the self range from the psychoses and borderline states to the narcissistic behavior and personality disorders. The psychoses are reflective of permanent, protracted damage and minimal cohesion of the self. Borderline states are seen as having a similar enfeeblement or lack of cohesion, but benefit by the presence of defenses. The narcissistic behavior and personality disorders represent more resilient and cohesive selves with the underlying disorder being temporary and responsive to analysis. The

psychotic and borderline disorders are not considered appropriate for analytic treatment.

Diagnosis of narcissistic disorders. The narcissistic personality disturbance is defined by Kohut (1978) as an insecure cohesion of the self with only fleeting fragmentation of those configurations. In addition, these individuals have great instability in their self-esteem, being extremely sensitive to failures, disappointments and slights. Their most outstanding characteristic, however, according to Kohut is the type of transference that they evidence in treatment. Kohut has described two types, the mirror and idealizing transferences, both of which derive from the previously mentioned archaic self-objects. The mirror transference indicates a child who did not receive adequate acceptance and confirmation earlier in life and attempts to elicit some from the therapist. The idealizing transference signifies the need to idealize and merge with the omnipotent and soothing early parent as represented by the therapist.

Within this category of narcissistic disorders Kohut and Wolf (1978) have also described syndromes which represent pathological states of the self and which may be experienced at different times even by the same person within relatively short periods of time. These are: the understimulated self--evidenced by lack of vitality and self-experience as boring and apathetic resulting from prolonged lack of responsiveness by self-objects in childhood; the fragmenting self--evidenced by a lack of bodily and psychological integration deriving from a lack of early integrating childhood responses; the

overstimulated self--unempathic overstimulation of the grandiose-exhibitionistic pole of the self leading to withdrawal from creative, gratifying activities; the overburdened self--characterized by the absence of self-soothing capacity and the experience of the world as hostile due to the lack of an empathic and omnipotent self-object with whom to merge in childhood.

Another interesting phenomenon addressed by Kohut (1972) with reference to the transference is that of the pseudoneurotic or pseudonarcissistic individual. In the former, overtly neurotic oedipal issues give way to the previously described narcissistic tranferences, whereas in the latter the overt grandiosity and devaluation becomes replaced over time with triangular oedipal issues.

Treatment of the narcissistic personality disturbance. Treatment of the narcissistic personality disturbance is organized around repairing the damage to the self. The primary vehicle for this repair according to Kohut (Kohut and Wolf, 1978) is the use of empathic understanding followed much later with interpretation of dynamic and genetic factors. Kohut argues that basing the therapeutic intervention primarily on reality considerations will only drive these unmet needs deeper and that the real goal must be to foster self-acceptance and empathy. With time the observing ego can facilitate further integration of the archaic structures, transforming them into self esteem and realistic ambition. Narcissism is thereby transformed but not destroyed. In this therapeutic process the therapist becomes the self object being used for cohesion and

defending against fragmentation, thus reinstating the original conditions and reworking them in a self-strengthening fashion. Countertransferentially, the maintenance of an empathic stance is often difficult. This is especially true, according to Kohut, because of the acting out of the patient and the therapist's inclination to restore order and establish control over the patient.

Narcissistic rage. The phenomenon of narcissistic rage is an especially interesting and relevant one when studying the Conduct Disorder population. Kohut (1972, 1977) is clear in his view that aggression, when linked to disorders of the self, is usually a response to a narcissistic injury or empathy failure in the environment. Withdrawal is the other response of the narcissistically vulnerable individual to a narcissistic blow. The driving force behind narcissistic rage is to revenge a hurt and this "unrelenting compulsion" is, according to Kohut, its distinguishing characteristc. Normal goal-directed aggression subsides after its aims have been achieved, but narcissistic rage being an "archaic mode of experience" is not rational or empathic and is directed at removing a "flaw in a narcissistically perceived reality" (Kohut, 1972). Often the rage will be in response to a seemingly insignificant occurrence, and will appear disproportionate unless one is empathic to the level of narcissistic injury. In the context of psychoanalysis the lack of empathic responsiveness is viewed by Kohut as a major source of narcissistic rage, along with the recognition that analysis is a narcissistic injury for all patients in that its method demonstrates

a lack of conscious control over portions of the self. Such a realization is particularly difficult for the narcissistic individual who clings to the archaic omnipotent ideal. The therapeutic goal in coping with narcissistic rage is the transformation of the narcissistic structures from which it originates. As stated by Kohut:

> Our principal goal is the gradual transformation of the narcissistic matrix from which the rage arises. If this objective is reached, the aggressions in the narcissistic sector of the personality will be employed in the service of the realistic ambitions and purposes of a securely established self and in the service of the cherished ideals and goals of a superego that has taken over the function of the archaic omnipotent object and has become independent from it. (1972, p. 652)

Kohut goes on to acknowledge that, in practice, the hoped for result is only partially achieved and that patients subject to narcissistic rage are likely to retain some vulnerabliity, but with briefer and less frequent outbursts. In general, as their self-esteem increases and the self becomes more cohesive, assertiveness replaces aggression.

Summary. Kohut's theory of the self, particularly in the manner in which it addresses the narcissistic transferences and narcissistic rage has promising application to Conduct Disorder. The omnipotence, idealization and vulnerability that one often finds in these young people, combined with, at times, a seemingly implacable rage warrants continued attempts to apply at least portions of Kohut's perspective to the antisocial and aggressive adolescent.

CHAPTER IV

CONDUCT DISORDER: CASE HISTORIES

Overview

In this chapter case material on four adolescent males will be presented and then analyzed from the perspective of Object Relations theory as embodied in the work of Kernberg, Masterson and Kohut. The overall goal is to determine how well their conceptualizations of borderline and narcissistic psychopathology fit the clinical phenomenon of Conduct Disorder. To accomplish this goal each case will be reviewed with reference to intrapsychic development and structure, defense mechanisms, transference and countertransference, themes of socialization and aggression, diagnosis and treatment implications. Since the object is to deepen the clinical understanding of Conduct Disorder and not to prove or disprove any particular theory, each theorist's constructs will only be applied in cases where they appear especially relevant and illuminating.

All the cases to be presented are those of young men whom the writer has treated in twice a week individual psychotherapy for not less than ten months. The first three cases, William, Julian and Michael, are ongoing; the fourth, that of Philip, was terminated upon his return to live at home after 10 months. Each boy is a student at a residential treatment center for emotionally disturbed and learning disabled adolescent males. The age range at the insti-

tution is approximately 13 to 21 years of age. Referrals typically come from school systems and social service agencies, and there are often histories of court and/or hospital involvement. The judicial system has entered into each of the cases presented here in response to antisocial or aggressive behavior. Whether or nor they were so diagnosed, all of the boys to be discussed fit the DSM-III criteria of Conduct Disorder at the time of their admission.

The inclusion of these individuals in the study did not alter in any formal way the course of their treatment. They were not subject to any psychological testing beyond what is normal for the placement and there was no taping or observation of the therapy sessions. To assure confidentiality, names and all other potentially identifying data have been altered, but an effort has been made to retain the overall historical flavor of their backgrounds.

The case material presented was derived from a combination of sources: referral material (including psychiatric, social, family and academic histories), parental interview, behavioral reports from the school and residential setting, the process of therapy sessions and projective testing (Rorschach, TAT and Draw-A-Person). The psychological testing was performed by an outside consultant unaware of and unconnected with this study and its objectives. The full reports may be found in the Appendix.

Case 1: William

Clinical Material

Descriptive data. William is a fifteen year old male of average size and stature who has been at this placement for two years. He is an engaging but awkward boy, unkempt in appearance and very active and distractible. He gives the impression of a street urchin of the type found in the novels of Dickens: mischievous, bedraggled yet surviving a difficult existence. Adopted away from his natural parents at an early age, he is currently a ward of the state. His adoptive parents live in a medium sized New England city, where the father manages a small store and the mother is a nurse. He has two stepbrothers and a stepsister, all natural offspring of the adoptive parents. William has no contact with his natural family.

Presenting problem. William was referred for placement following a period of aggressive and destructive behavior both at home and at school which resulted in his being adjudicated delinquent and custody being given to the state. In the home William's attention-getting, impulsive and, at times, threatening behavior placed him in frequent conflict with other family members. He had also on one occasion threatened a neighbor with a knife when asked to leave her house. At school where he had constant academic and social difficulties, William responded to teasing and abuse from other students with increasingly aggressive and destructive behavior towards teachers and staff which culminated in his expulsion.

Psychiatric history. Prior to the events which led to William's placement he had not received any psychiatric or psychological treatment. He had, however, been observed to have scholastic difficulties upon entry to elementary school and in grade 3 was diagnosed as having perceptual problems, reading difficulties and other learning disabilities which led to a special education placement. Psychological and psychiatric evaluations mandated by the court concluded that William had an attention deficit disorder with hyperactivity and learning disability, and low-average to average intellectual ability. His egocentricity, impaired judgment, social incompetence, tendency to perseverate and to place himself in self-victimizing situations were also seen as suggestive of a developing personality disorder. Without intervention he was considered at risk for further antisocial behavior and psychological deterioration.

Psychosocial history. William was adopted from his family of origin at age 2. Little is known of the first two years of his life beyond the fact that he was reportedly abused by the father, a violent and neglectful man, who worked menial jobs despite a college education and may have had a history of mental illness. The mother was characterized as a marginal individual with limited intellect. The failings of his natural parents, especially the father's violent character, have been impressed upon William by his adoptive parents. At the time of adoption William was observed to be developmentally delayed--physically, psychologically and socially. His speech and self-care skills were minimal and he was described as being unco-

ordinated, hyperactive, noisy, distractible and in need of constant attention. William's immature and disruptive behavior proved very difficult for his strict and somewhat rigid adoptive parents who were repeatedly frustrated in their efforts to contain and socialize him. With peers William attempted to gain acceptance through "clownish" behavior and acts of defiance towards adults. Failing in his attempts to gain approval, he would revert to provocative behavior which would usually result in his victimization and ostracization.

Medical health and history. William's health prior to adoption is unknown. Since that time his only reported significant illness was a prolonged upper respiratory infection which resulted in intermittent deafness when William was about 3 years old. A neurological examination completed just before his placement revealed that William had "soft" neurological abnormalities consistent with learning disabilities and Attention Deficit Disorder. No serious or progressive organic involvement was found but repeated follow-up was recommended.

Course of treatment. William has been in the current treatment program for two years, during which time his progrsss has been erratic with brief periods of improved functioning followed by regressive, impulsive behavior. An initial placement at a foster care component of the treatment center was terminated due to rivalry with another boy and related rageful, destructive outbursts. Increasing regressive behavior was also noted before and after visits to his adoptive parents who have maintained a distant, critical stance towards

William. During this period William also had a second court involvement due to inappropriate sexual overtures to an adult woman. Subsequent to these events William was moved to a dormitory setting where it was felt his behavior could better be contained.

Throughout his placement William's interpersonal relationships have been fraught with difficulty. In desperation for approval and acceptance, he has often allowed himself to be victimized and exploited. When provoked by older and stronger students he typically has had tantrums of varying intensity directed at both inanimate objects and staff, and sometimes requiring physical restraint. William becomes the aggressor with the rare student who has less stature than himself. Although he has a greater affinity for some boys than others, he is for the most part socially isolated and cannot be said to have any friend. With adults William can be quite personable and endearing, which facilitates having some of his needs met but also reinforces his dependent stance. He looks to parental figures to gratify and contain him while at the same time being quite fearful of rejection. One solution he utilizes is to befriend marginal adults in the community who are in many respects as needy as William. The relationships that he sustains in this manner appear to be based upon a mutual recognition of the other as damaged.

In individual psychotherapy William tends to be very invested in the relationship but has great difficulty tolerating the intimacy or focusing on his problems. He is dependent and is anxious to maintain attachment; he attends every session, asks to make up any

that are missed and regularly attempts to make contact outside of the scheduled hours. William initially attempted to control and extend the relationship by asking for loans, special favors or to meet outside of the therapy place and time. When boundaries were kept firm William was provocative and tested limits within the sessions through regressive behavior: stealing objects, hiding in closets or disrupting the office. Generally, but not always, he has been able to bring this behavior under control when confronted with termination of the session. Simply being with another person creates considerable anxiety for William which he attempts to allay and structure through clownish, provocative behavior or transparent bravado regarding sexuality and drugs. There have often been sudden and unpredictable shifts in his behavior within the session. At other times his acting out has followed discussion of his problematic interpersonal relationships. Occasionally, he has been able to speak of his anger toward his natural and adoptive parents, but resists exploration in depth preferring to simply discharge the feelings. He describes a great sense of relief following incidents in which he has completely lost control out of rage, but has little capacity to understand or reflect upon his actions, giving the impression of one who functions on a moment to moment basis with limited ability to plan for the future. When asked to explain his behavior, William responds that "It was just for fun," "Because the kids were bothering me," or, most frequently, "I don't know." Therapy, itself, has focused primarily on identifying and then connecting William's

affective states with his behavior, providing him with a sense of causality. Maintaining appropriate boundaries and being a reliable, nonrejecting and nonexploitive parental model with whom he can identify is another part of the therapeutic approach aimed at providing him with the internal structure so evidently absent.

Psychological assessment findings. William has been tested twice since his admission to the center. The first assessment done just over a year ago suggested that William was most seriously stressed when confronted with nurturant and protective maternal figures who stimulate both his dependency longings and fears of depriving or sadistic treatment. The experience of physical abuse was seen as organizing and giving meaning to an early and traumatic separation from the mother. William's defenses against the helplessness of this experience were identified as the adoption of a stance of pseudomaturity and independence or, alternatively, the utilization of sadistic imagery and impulsive, violent action in an attempt to master the early trauma. His self image was described as being that of a "grotesque, deformed creature." While not seen as psychotic, the risk of future serious disorganization was suggested and the recommendation was for a slow paced treatment sensitive to his "oral-affiliative" needs.

More recent testing (see Appendix), done 1½ years later, diagnosed William as a mixed personality disorder who required constant structure in the environment to maintain a sense of organization and stability. Without structure and clear expectations

his anxiety and aggressive impulses were seen as overwhelming him, leading to fragmentation and faulty reality testing. Under stress William was noted to revert to an impressionistic, undifferentiated experience which he is unable to articulate due to a lack of self awareness. Relative to social interactions William was assessed as confused and handicapped by his poor judgment, planning ability and sense of causality. Failing to experience himself as in control and responsible for his behavior, his expressions of guilt and remorse are attempts to comply with social convention and not a result of empathic concern for others.

DSM-III diagnosis. William presents an interesting diagnostic picture in that while he fits the criteria for Conduct Disorder he appears qualitatively different from most boys with this diagnosis due to his primitive functioning. In particular, his case highlights some of the ambiguities of the stated criteria for socialization and aggression. The best fit diagnosis is Conduct Disorder, Under-socialized, Aggressive. He has repetitively and persistently engaged in physical violence against persons and property; he has physically attacked adults and peers over a period of longer than two years (the criteria being only six months) and, even more frequently, has destroyed property as part of his angry tantrums. William also has a penchant for stealing objects--usually a provocation to elicit interaction or as a way to have something from that person in his possession. Usually those objects are returned once they have served their purpose. This "aggressive" behavior appears quite spontaneous,

without premeditation or any criminal intent. Nonetheless, the rights of others are violated and they are usually left annoyed and exasperated. William must also be considered "undersocialized" in that he certainly has not established "a normal degree of affection, empathy or bond with others" (American Psychiatric Association, 1980, p. 48). This determination, however, depends on a qualitative view of the criteria because superficially he does express remorse and show concern for others. Somewhat paradoxically, he does attach to others and is object seeking in an intense way but at such a primitive level that to diagnose him as Socialized would be very misleading. Characterologically, William does not fit the "sociopathic" model implied by the socialization criteria. His egocentrism is not manipulative and callous; it is infantile. He desperately wants to connect with others, but he is simply too ill-equipped to be successful. Nonetheless, he does fit the behavioral criteria for the Conduct Disorder, Undersocialized, Aggressive diagnosis. Attention Deficit Disorder with Hyperactivity continues to be an appropriate secondary DSM-III diagnosis for William. William, although too young for an official diagnosis of Personality Disorder, does exhibit Borderline Personality traits, a subject to be discussed further in the case analysis.

Object Relations Case Analysis

Intrapsychic development and structure. It should be evident that William does not have an integrated self when viewed from any

of the developmental perspectives discussed. The level of trauma he allegedly endured with the resultant lack of self cohesion places William in the borderline category of all the theorists and thereby limits the utility of Kohut's approach in this particular case. The presence of unintegrated pregenital aggression is easily inferred from the history. Also evident is the condensation of pregenital and genital drives manifest most obviously in the two "attacks" William made upon women. In both cases dependency needs, sexual impulses and aggression were linked, supporting Kernberg's description of object relations at the lower or borderline level of character pathology. The split-self and object relations are indicated by the marked shifts in William's relationships to others. Notable is the phenomenon of his attempting to engage those staff in punitive action with whom he is most dependent and affiliative. When a positive mode of relating is operative, he denies or avoids negative aspects of that particular relationship. In therapy itself, William shifts from dependent compliance to attack in moments. His lack of superego integration is demonstrated by the absence of genuine guilt or remorse, his inability to tolerate depressive affect, and the frequent projection of sadistic components onto others.

While few details are known about William's early life, psychological testing inferred an early and traumatic maternal separation. The physical separation in the third year of life may have been preceded by an experienced psychological abandonment due to the inadequacy of the mother. An abusive father would also have under-

mined any healthy separation or identification process. Thus, Masterson's postulated abandonment depression has applicability. William's regressive attention-getting behavior which alternated with superficially compliant and clinging behavior may well have been his only strategy for garnering parental involvement of any sort. The subsequent demands of William's rigid adoptive family for him to behave and be "normal" can be seen as attempting to impose a "self" onto a non-integrated entity who can conform but not without constant external structure to compensate for that lacking within.

Defense mechanisms. The primitive defenses identified by Masterson and Kernberg as part of the borderline syndome are present. Particularly prominent are splitting, denial, and projection. William's difficulty in integrating shifting and disparate affects toward the same people has already been noted. His wish to deny unpleasant, upsetting, or depressive content in regard to certain relationships is also marked. For example, he initially denied any anger or feelings of rejection toward his adoptive parents who had essentially ignored him for long stretches of time, and he would blame his social worker for keeping him apart from his family. It was only much later in the therapy that he became able to acknowledge resentment toward his adoptive parents. William's use of projection or, more precisely, projective identification, is constantly evident in his relationship with others. In therapy he frequently creates situations in which the unconscious goal appears to be the dis-

sociative location of angry, sadistic impulses in the therapist. These incidents often occur during exploration of material involving his own aggression. In one instance with a black staff member, he repeatedly and provocatively called him a "nigger" until the staff member removed himself to control his own building anger. Not coincidentally one of the school incidents which led to William's placement was a fight which began with another boy calling him "nigger." Projecting his "bad" self-representation enables him to both attack the other and, alternatively, be the victim rather than the repository of critical, hostile feelings. This defensive stance seems essentially equivalent to that described by Masterson (1981, p. 134) as associated with the "withdrawing part-unit." Defensive, compliant clinging behavior and idealization would be expected when the "rewarding part-unit" is activated (Masterson, 1981, p. 134).

Transference and countertransference. The issues involved with transference and countertransference have been introduced in the preceding material with the enacting of the rewarding and withdrawing part-units. The rewarding part-unit in William's case elicits caretaking and nurturant responses from staff and therapist. In the early stages of therapy, William would repeatedly attempted to get the therapist to "take care" of him by asking to go out for ice cream cones, take walks or give him money, and when these requests were refused he would complain, but only mildly to avoid outright rejection. Alternatively, when expressing the withdrawing part-unit in the transference he has been provocative: verbally through anger

or the fabrication of sex and drug related experiences, or behaviorally through disrupting the office, stealing objects, or hiding in the closet. Such activity seems to be an attempt to structure an otherwise dangerous and unpredictable intimacy. Countertransferentially, the impulses are to nurture and soothe a wounded, helpless, and needy child or to sadistically control and punish an obnoxious brat. The transference and countertransference phenomenon described are consistent with what both Kernberg and Masterson would suggest on the basis of the split object relations of the borderline personality organization.

Socialization and aggression. The level of William's socialization is very primitive. He has gone beyond the stage of symbiosis, having made the differentiation between self and other, although under severe stress those boundaries may become blurred. The intensity of the early aggression has prevented William from developing whole object relations, leaving him with contradictory and non-integrated internal representations of both himself and others. Kernberg (1980) points out that this lack of integration interferes with the development of empathy and concern for others, and that the contradiction between the idealized all good object representation and the sadistic, all bad superego forerunners undermines the capacity for guilt, depression and mourning. Thus, as suggested in the psychological testing, William's apologies for his misbehavior stem more from a desire to adhere to social convention and expectations than from a sense of guilt. Masterson's view on the alternating

part-units is useful here as well: following enactment of the withdrawing part-unit characterized by angry, attacking or provocative behavior the rewarding part-unit is engaged during which time William protects himself from rejection by compliant, charming and apologetic behavior toward the valued, idealized other. In this way, his response is more to an external threat than the result of an internal superego process. William, unlike the seemingly impervious "sociopath," is engaged with others and his extreme responses are reflective of the shifting expression of his unintegrated object relations.

From an Object Relations perspective the same split object relations are implicated in the expression of William's aggression. Experiences of being bad, worthless, abandoned, and the victim of tremendous parental rage need to be defended against to protect the good self and idealized good object representations. Since William's good internalizations are not sufficient to soothe him when feeling "bad" or angry, he defends himself through projection of the bad self which he can attack, or through projection of the bad object which attacks him. His aggressive responses are consistently primitive and immediate in nature without mediation by ego processes. Thus more "advanced" types of aggression such as planned breaking and entering are not at all part of his modus operandi. The condensation of aggression and sexuality was probably a major factor in the two aggressive incidents with women and is evident in his frequent description of women as bitches and in his rape fantasies involving desirable women. At the same time he expresses longing

for an older caring girlfriend with "big breasts"--more confirmation of the infantile, orally based sexuality. William's adoptive parents have, no doubt out of immense frustration and a sense of parental failure, frequently warned William that he was on his way to being just like his natural father. This warning has surely served to reinforce William's negative identity with his violent father, unwittingly creating a self-fulfilling prophecy in terms of William's behavior and deepening his need to dissociate these self and object representations through splitting mechanisms.

Diagnosis. From an Object Relations perspective William fits the descriptions of borderline personality rendered by Kernberg and Masterson. Identity diffusion is clearly evident in William's contradictory and rapidly shifting behavior: at one moment he is extremely dependent, seeking attachment, and at the next moment he may be angry, attacking, and destructive with virtually no ability to integrate the two states. His interpersonal relationships are characterized by instability and lack of emotional depth. The second characteristic of primitive defense mechanisms, centered on splitting, has also been established in regard to William. William's reality testing is essentially intact, with weaknesses noted under stress. William has never experienced an actual "break" with reality as exemplified by hallucinations and delusions. However, when considered on the borderline continuum between psychosis and neurosis he is much closer to the former, and episodic psychotic behavior cannot be ruled out as a future possibility. Of the nonspecific

signs of ego weakness delineated by Kernberg--poor impulse control, low anxiety tolerance and poor sublimatory capacity--the first two have already been addressed and the last is evidenced by William's chronic academic difficulties in staying in class, not to mention his inordinate struggle to complete any assignment unless absolutely structured.

Masterson's criteria are somewhat more inferential but also seem to apply to William's case. The defenses against the abandonment depression have been outlined, and while the precipitants for William's chaotic behavior are often difficult to determine, events such as visits to his adoptive parents and removal from class have often precipitated severe reactions. The historical separation from the parents during the separation-individuation stage also supports the borderline picture. William's clinging dependent stance with constant requests for favors is reflective of the oral-narcissistic fixation of which Masterson writes, and parental characterological difficulties are not difficult to infer from the known history. The behavior of his adoptive parents suggests characterological problems of a different, more rigid and obsessive type which in some ways compounds the difficulties of an impulse ridden individual such as William who has found further rejection in his second family.

Overall, the assessment of William as a lower level borderline personality appears to be appropriate. As an adult he may continue to engage in certain types of antisocial behavior, but a diagnosis of Antisocial Personality would not reveal, however, much about his

personality structure or how one might approach treatment. It should also be noted that none of the complications of diagnosing borderline conditions in adolescence as described by Kernberg seem to be operative in this case. Given the severity of William's problems it would be difficult to confuse him with higher functioning neurotic types, and, at this point at least, he is clearly not psychotic.

Treatment implications. The first step in treating an adolescent like William, according to both Masterson and Kernberg, is to control the acting out of the patient through confrontation and interpretation. Both emphasize the need to maintain therapeutic neutrality and objectivity in the face of the intense transference. In William's case the therapeutic challenges in the initial stages of treatment lie in two opposing situations: responding to his constant dependency needs or to his hostile, disruptive acting out. In the first instance the temptation is to gratify his needs rather than interpret his desire to be taken care of. In the second instance a punitive countertransferential reaction must be avoided and replaced again with confrontation of the self-destructive behavior along with interpretation of the projected sadistic, self-punitive impulses and the underlying fears of rejection and abandonment. In this process behavior and affect are connected, and the contradictory self-object representations are pointed out and their concomitant existence acknowledged, gradually leading to integration of both. William's need for an idealized parent who will gratify him must slowly be integrated with his desire to exact revenge upon

parent figures who reject or "abuse" him and with his willingness to accept punishment for his murderous rages. In William's current treatment milieu the therapist inevitably becomes involved in some of the needed limit setting both in and out of sessions. Kernberg suggests that such deviations from therapeutic neutrality must always be interpreted to the individual in order to reduce their impact in the transference and make continued analytically oriented work possible. Thus, when transference acting out necessitates the premature termination of a session, as has happened with William, the therapist must interpret the desire to test the therapist as a good object and the need to defend against perceived rejection or badness of the self. In doing so therapeutic neutrality is restored and eventually transference interpretations may be able to focus on less primitive defenses, continued self-object integration and a very painful depressive stage. In William's case this latter phase of treatment will need to be monitored closely for suicidal impulses due to the extremely sadistic introjects. As therapy progresses the increased ego integration should promote a stronger therapeutic alliance and reduce the need for deviations from neutrality in order to control acting out. Assuming success in these stages, the eventual separation from the therapist and reworking of the abandonment depression in that context would conclude treatment.

At present William's prognosis is, at best, fair. As he gets older his increasing physical size and strength combined with more intense sexual impulses makes the containment of his aggression both

more necessary and problematic. The longer he is able to be maintained in the current placement and continue with the same therapist the better his prognosis becomes. If he does not develop more internal structure and life skills over the next few years then he is likely to become a marginal and, perhaps, dangerous adult. For these reasons and due to the lack of any substantial family support, a transitional supervised living situation will probably be necessary upon termination from his current placement.

Case 2: Julian

Clinical Material

Descriptive data. Julian is a tall, handsome sixteen year old male who has been at the treatment center for slightly over a year. With soft features and longish hair Julian's self-presentation is one of sexual ambiguity which he mockingly plays upon at times with exaggerated feminine behavior. Alternately between being charming and abrasive, he has a charismatic persona which both attracts and repels other students and staff. His parents are divorced and his mother, who has custody, works as a secretary. Julian has no contact with his father.

Presenting problem. Julian was referred from a large psychiatric hospital where he had been placed because of antisocial behavior including theft and drug use, truancy, depression, and suicidal ideation. He was seen as needing a structured, residential program to contain his acting out behavior and address his depressive

symptoms.

Psychiatric history. Julian's psychiatric history dates from the age of five when he was referred to a mental health center by his family physician for hyperactive and aggressive behavior. Family treatment and individual therapy for the mother were recommended but not followed through in any consistent fashion. Three years later Julian was referred again due to hyperactivity, anxiety, sleeping problems, headbanging, and poor school performance, and the following year at age 9 he began play therapy. He was described in that therapy as being angry, aggressive and fearful of being hurt and abandoned. Unfortunately that therapy, which was progressing well, ended due to a change of schools, and Julian had great difficulty reinvesting himself in another therapist. The abrupt separation upset him greatly, interfering with his ability to develop trust or discuss painful experiences with the succeeding therapist. His therapist described him as "hostile-dependent," "whining," "manipulative" and "relentlessly after supplies," such as candy and toys. Overall the therapy was seen as "disheartening." At age 12, during a brief trial of living with his father, Julian and his father attempted family therapy but terminated after one session. Returning again to live with his mother, he continued to evidence the behavioral and emotional problems which led to his hospitalization at age 14. These problems included antisocial behavior, depression, suicidal ideation, and deteriorating school performance. Initially Julian responded well to the structure and support of the hospital

setting, but any relaxation of that structure caused behavioral regression, including antisocial behavior. He was transferred at age 15 to his current placement.

Psychosocial history. Julian is the only shared offspring of his natural parents, who separated when he was one year old and divorced the following year. The father had two sons by a previous marriage and both parents were hoping to have a girl. The parental relationship was unstable and often violent, with the father allegedly physically abusive to Julian's mother and halfbrothers, replicating a pattern in the mother's family of origin. Her father was described as abusive and the mother as alcoholic. During the initial years following the separation Julian's mother described herself as an erratic parental figure burdened by emotional problems and the requirements of work and schooling. According to Julian's mother his father was unreliably available, often failing to show for scheduled visits. Julian spent much of his time during these early years with his maternal great grandmother and babysitters.

Julian was delivered one month early by Caesarian section and had breathing and heart-rate difficulties at birth. At three weeks of age he was returned to the hospital due to a severe rash and excessive crying due to a food allergy. Developmental milestones were achieved within normal limits, with toilet training accomplished at age 2 under the strict discipline of one of the mother's boyfriends. Bedwetting occurred periodically until age 7. Occasional sleep disturbance in the form of nightmares and sleepwalking was

also reported.

Upon entering school Julian made a relatively good initial adjustment but a series of school changes caused a regression in his behavior, most specifically truancy, disruptive attention seeking behavior, and difficulties in concentration. These problems were exacerbated by the death of his great grandmother when he was eight and of his oldest half brother two years later. During this time period the mother also entered college, limiting her availability to him even further. Julian's antisocial behavior increased, his trial living arrangement with his father was unsuccessful, and after another year back with his mother he was hospitalized.

Julian's mother has been in therapy since he was eight years old and has reportedly made considerable progress in breaking her own pattern of self destructive behaivor. Her own mother had been an alcoholic and her father a strict, punitive and, at times, violent man. Over time she was able to recognize and change her pattern of choosing relationships that were inconstant, harsh, and depriving. While guilty about Julian's earlier years, she also began acknowledging her limitations with him, differentiating his needs from hers and developing greater limit-setting ability with him. The father, following the abortive attempt to have Julian live with him, has had negligible involvement with him.

Medical and health history. Aside from the complications of birth and the subsequent feeding and allergic difficulties, Julian has had no medical or health problems. He was tried for a short

period on antidepressant medication while hospitalized with equivocal results.

Course of treatment. The focus of Julian's treatment has been the effort to control his antisocial acting out sufficiently so that his conflicts could be addressed on an internal rather than external basis. Success has been limited to an overall decrease in the magnitude and frequency of his antisocial actions but his resistance to treatment and change has been substantial, and as a result his appropriateness for the placement has been an ongoing question. Julian has alienated both staff and students with his thievery, lying, and refusal to accept responsibility for his actions. Julian became particularly disruptive and attacking during and immediately following a period of administrative disorganization which included the departure of his first therapist. Constantly suspected but seldom caught, he has engaged in drug use, destruction of property and breaking and entering both within and outside of the placement. Some de-escalation took place with increased structure, and following an incident in which he was caught by the police attempting to break into the school administration building. Confronted with his actions, Julian denies complicity unless confronted with incontrovertible, physical evidence at which time he may acknowledge that what he has done was "stupid"; he does not display guilt or concern about those victimized, and he tends to blame others for his actions.

In the classroom Julian evidences a high level of anxiety, usually being unable to remain in class, especially in subject areas

where he had a history of failure. He frequently attempts to stay out of school by feigning illness, or he travels from class to class if in school. Behavioral contingency plans are of little use with Julian and are often provocative especially in the case of punishment or fines, which he experiences as attacks. On the positive side, Julian is an exceptional artist who is able to accept supervision and work diligently and creatively in that one area. Interestingly, if Julian is given praise while in the process of creating a work he will spoil or not finish it, and the art teacher has learned to reserve comment until completion. His art work remains relatively uncontaminated by the turmoil that characterized the rest of his life, and his talent in that area is shared to some degree by both his parents. His mother currently does painting and for a period of time she and Julian communicated through the drawing of a serial cartoon.

Socially Julian is both feared and respected by other students: feared because of his size and threatening behavior and respected for his artistic talent and accomplished stealth. His potential for destructive behavior either towards himself or others, his lack of trustworthiness, and his ambiguous sexuality has also made students uneasy. Julian considers himself among the elite of his dormitory and generally is treated as such by other students. His friendships, while enduring, have been centered around rebellious and antisocial activity and are not characterized by much empathy or concern. With adults Julian is oriented toward those who provided

him with attention or whom he perceives as having sufficient power to grant him favors. He devalues others who permit his exploitation of them and respects only those whom he perceives to be more powerful than himself.

In individual psychotherapy Julian exhibits two basic styles of relating. Most often he is angry and demanding, complaining of unfair victimization and unmet needs which leave him rageful, and justify any self-gratifying action he takes. Failing to receive the gratification he desires, he typically has stormed out of the office saying "I knew talking about it wouldn't get me anywhere. You just won't give me what I need." His other stance is characterized by a charming, playful, seductiveness and an evident desire for approval and attention. At these times he elaborates on fantasies of being wealthy and successful, having his own art studio and a girlfriend. He has also animatedly shared the adventures of his character in a fantasy game: A character who was extremely powerful and clever with a "lawful, evil" nature--that is, predictable but without morals and motivated only by self-interest. Even sessions largely constituted by this type of sharing often end with an angry departure and accusation of being misunderstood.

Julian is exquisitely sensitive to the therapist's attitude toward him, and he experiences rejection quite readily. This has been especially true at times of therapist vacation or absence and following these interruptions, Julian usually reacts by refusing to attend therapy, while simultaneously making his presence known to

the therapist. Similarly, he frequently misses a session and then drops by later that day or the next demanding to be seen or visiting briefly. He often gives the impression of hovering about the therapist but fearful of landing and making sustained contact.

Interpretations of his behavior are often cause for anger and devaluation, particularly those that he perceives as locating the difficulties he has been experiencing within himself. Empathic comments about the level of his neediness or hurt are more readily received. On occasion he has been able to discuss his hopelessness and helplessness and the fear of depression which would make him feel "bloated and heavy, unable to move." He has tremendous difficulty tolerating depressive affect and usually moves to an angry interaction immediately. This shift is most easily accomplished through outrageous demands such as that to provide him with $20 a week to buy marijuana thus keeping him from "needing" to steal. Questioning the reasonableness of this type of request or even interpreting it provokes an angry outburst and immediately changes the tenor of the sessions. The slightest hint of amusement in response to Julian's behavior also results in rage, unless it follows his more calculated clownishness.

Throughout the treatment there has existed the sense that Julian wants to make contact and establish a therapeutic alliance but is inhibited by an extreme vulnerability and a vengeful reactivity to the slightest hurt. The requisite process of building trust is the most crucial goal for his treatment.

Psychological assessment findings. Psychological testing prior to Julian's arrival at the center indicated a boy of average to above average intelligence with impaired concentration and paranoid trends, suggested by an obsessive attention to detail and great sensitivity to interpersonal cues. Projective testing highlighted his emptiness, fearfulness, lowered self-esteem, suspiciousness, fear of abandonment, rage, and identity confusion. Although not seen as psychotic, he did demonstrate impaired reality testing under stress.

A more recent assessment (see Appendix) diagnosed Julian as Antisocial Personality Disorder with Paranoid Features. Interpersonally, Julian was described as shallow and insensitive, preoccupied with gratifying his own needs, and having minimal capacity for attachment. Expecting to fail and to be hurt, Julian is seen as taking from others in an exploitative fashion which leaves him feeling "disadvantaged and unsubstantial." Julian's adoption of stereotypical masculine roles is viewed as an attempt to bolster his low self-esteem and reduce his sexual identity confusion. The intense anger that Julian experiences, especially toward maternal figures, combined with his poor impulse control often results in self-destructive behavior which serves as revenge upon the other person. His victimization of others reflects his own sense of being abused and exploited along with his alienation from others and inability to feel affection or concern.

DSM-III Diagnosis. Julian arrived at the treatment center with

a diagnosis of Conduct Disorder, Socialized, Unaggressive and Major Depression, Recurrent. Again, problems with the concepts of socialization and aggression are immediately evident. Julian, despite a smooth and charming style appears to have very little concern or empathy for others. As noted in the psychological testing, his relationships tend to be shallow and exploitative and in many respects are less socialized than those of William in the previously discussed case: Julian does not extend himself for others, shows no evidence of guilt or remorse, will inform on companions, and evidences little concern for their welfare. Likewise, while Julian is an unlikely candidate for a physical fight he has frequently hit weaker students and on numerous occasions has broken into automobiles, buildings, and other rooms. His fantasies are also quite violent and vengeful, and his unbridled aggression must certainly be considered part of the clinical picture. Thus a diagnosis of Conduct Disorder, Undersocialized, Aggressive seems more appropriate in Julian's case. The inclusion of Major Depression is more questionable and would now have to be considered in remission given that the overt depressive symptoms, such as vegetative signs, have significantly diminished outside the hospital setting. In addition, a diagnosis related to Julian's substance abuse and dependence could also be justified but is not essential. The relevance of a personality disorder diagnosis will be discussed in the upcoming section.

Object Relations Case Analysis

Intrapsychic development and structure. Julian's history and self-presentation are suggestive of a narcissistic personality at the overt borderline level of functioning (Kernberg), a lower level narcissistic personality (Masterson) or a narcissistic behavior disorder (Kohut). The developmental prerequisites suggested by each author for his version of the narcissistic disorder are arguably present in this case and while the differences among the authors as to the developmental processes involved in narcissistic psychopathology are too complex to be resolved here, some of the key components from the various perspectives can be highlighted. The aggressive aspects focused on by Kernberg are certainly evident with the violent, abusive father; the separation and abandonment experience suggested by Masterson took place very early on and was exacerbated by two significant deaths; the lack of empathic mirroring central to Kohut's view of pathological narcissism is also inferable from the unreliablility of the mother and departure of the father at age one.

The key developmental feature from all the perspectives is the creation of a grandiose self, whether it arises as a regressive refusion of self and object images (Kernberg, 1975) or as a developmental fixation or arrest (Masterson, 1981 and Kohut, 1977). In Julian's case the grandiose self is manifested by his self-centeredness, his consistent demand to be seen and treated as "special," with separate rules to meet his particular needs, and his devaluation

of others who do not mirror his grandiosity or who are not idealized objects with whom he can merge. The "bad" unacceptable aspects of himself are projected by Julian onto other students who are seen as defective and weak or onto adults who are described as cruel, insensitive, withholding, and, in the case of some males, homosexual. For Julian the consistent splitting and tendency to maintain a stronger alliance with the inflated ideal and grandiose aspects of his early experience allows him to maintain a protected and circumscribed area of competent functioning--his artwork--which in turn enables him to obtain the admiration and success he sees as rightfully his. Kernberg (1975) refers to this capacity for directed and active work in narrow areas by narcissistic personalities as "pseudosublimatory" and notes that their later development is often superficial and disappointing.

Retrospectively the origins of Julian's grandiose self appear to lie in the events occurring in the first year and one-half of his life. Given the trauma experienced at that early age it seems questionable to assume that he developed firm ego boundaries and then underwent a regression. The explanation offered by Masterson (1981) of a developmental fixation prior to the rapprochement subphase seems most applicable in Julian's case, making sense chronologically and in terms of Julian's impoverished object relations. One can also speculate that a traumatic and sudden failure of empathy, as suggested in Kohut's formulations (Kohut, 1977; Kohut and Wolf, 1978) was instrumental in the development of Julian's

narcissistic pathology. Looked to by the mother as the potential savior of the marriage, his inevitable failure at age one when the family split up may have brought about a dramatic change in the mother's attitude characterized by anger and neglect. At the very least, the history supports a view that Julian was receiving very little in empathic mirroring beyond the first year or so of life, making fixation at an oral-narcissistic level of development a probable outcome. Such a fixation would account for his incessant demands to be gratified, the lack of empathic concern for others and his unrealistic view of himself. Julian's poor impulse control, low anxiety tolerance, and primitive dissociative defenses are also indicative of "ego weakness" and a "lower level" narcissistic disorder regardless of which frame of reference is utilized.

Defense mechanisms. The defense mechanisms utilized by Julian are dissociative in nature, with denial, projection and avoidance the most commonly used. Regardless of how many times he has stolen or broken into buildings or rooms, he continues to see himself as the intruded upon victim. Despite his own periodic flamboyant exhibitionism around his sexual ambivalence he has angrily denounced staff members as "faggots" and spoken of his disgust for them, while denying any concern whatsoever about his own sexuality. This pattern of projecting bad parts of himself and then attacking them in the other person is his most consistent defense, and evidence of his paranoid tendencies. His constant use of marijuana serves a defensive end as well, by helping him avoid his self-described sense

of deadness and boredom--what has been called "empty depression" (Kohut and Wolf, 1978). Masterson (1981)suggests that the narcissistic personality, like the borderline, is attempting to guard against the abandonment depression, a hypothesis supported by Julian's severe reactions around therapist absences and the losses in his early history. Julian's experience of the world as dangerous, attacking and rejecting requires that he be vigilantly defensive and ready to avenge his hurts.

Transference and countertransference. The transference phenomena with Julian can best be seen as an example of the "narcissistic" transferences described by Kohut (Kohut, 1977; Kohut and Wolf, 1978). In the "mirror" transference, the ummet needs for acceptance and confirmation are revived in the therapeutic relationship. Julian frequently "displays" himself to the therapist, looking for approval and endorsement of his artistic talent, physical attractiveness and clever mimicry and humor. The need to be seen as a uniquely creative individual is almost always in evidence. The idealizing transference has also been present and characterized by the need to merge with and be soothed by an idealized, omnipotent parental figure. Whenever in trouble or need, Julian has approached the therapist with requests for help, suggesting that the therapist is powerful enough to successfully intercede on his behalf. In either transference situation, when the response is not sufficiently empathic Julian becomes rageful declaring his disappointment in the therapist and sometimes acting out outside of the session.

Countertransferentially, the most difficult aspect of Julian's behavior is his intense devaluation and anger which leaves the therapist with the feelings of emptiness, helplessness, and impotence, defended against so well by the patient. Julian's often ferocious and insatiable demands to be soothed and gratified has at times led the therapist to mistakenly extend sessions in an attempt to calm him or find solutions where none are allowed. Alternatively, the countertransference impulse is a self-protective one to withdraw and avoid the devouring aggression. Julian's sensitivity to narcissistic slights has also made the work of interpretation and the establishment of a therapeutic alliance extremely difficult. His need to be in control of interactions is threatened by interpretations of needs and desires of which he is not fully aware.

A final permutation of the countertransference is the potential for conflict between the therapist and other staff members due to Julian's splitting of transference components. It is not unusual for Julian to enact the idealizing transference in therapy while the grandiose self is operative in the milieu, thereby creating a situation in which the therapist is responding to Julian's need to be soothed, while the dormitory or teaching staff is confronted with his hostile, devaluing behavior. When recognized, it is important for the splitting to be acknowledged with both Julian and other staff members in order to bring those internal conflicts back into the therapy. As should be apparent, the countertransference demands in a case like Julian's are significant and Kernberg's (1975) caveat

that the therapists should not carry very many cases involving narcissistic pathology at any given time is well taken.

Socialization and aggression. The severe limitations present in Julian's interpersonal relationships have already been addressed. Most striking with Julian is his tendency to experience others only as extensions of himself, and there to meet his narcissistic needs. He never appears to be concerned or even interested in other people. Whereas most adolescents in treatment have a keen curiosity about their therapist, for Julian the therapist does not seem to exist outside of the narcissistic sphere. Because Julian can only ally himself with the grandiose or idealized aspects of other people, his capacity for genuine attachment or empathic understanding of others as "total" objects is negligible. Traumatically disappointed early in life, he self-protectively withdrew into a world populated by deities and devils and with precious little space for those who were neither.

Julian's intense vengeful anger that is so quick to arise and so implacable can best be conceptualized as "narcissistic rage," a term most closely associated with Kohut's work (1977, 1978) but also utilized by Kernberg (1975) and Masterson (1981). Aggressive behavior on Julian's part, can almost always be associated with narcissistic injuries and those who are the source of those injuries. He has physically attacked or harassed those boys at the treatment center whose behavior is the greatest affont to him. For example, he has regularly struck at a boy who makes compulsive, ritualistic

gestures and he has stated that what bothers him most is the boy's lack of control--a lack of control which of course, mirrors his own. The victims of his thieving also tend to be those well known to him who have not responded to his perceived needs. On a number of occasions he has been able to acknowledge that his primary motivation, aside from money, has been to have others feel the way he feels--abused, deprived, and intruded upon. In one therapy session he responded to an unempathic intervention with an especially virulent harangue and then said, "Now doesn't it feel shitty when no one listens to you."

Given the presence of actual violence in Julian's early life which he witnessed and may have himself experienced, his uncontrolled aggressive impulses cannot be entirely attributed to narcissistic injury. The self-destructive aspect of his aggression is another significant factor. His aggressive behavior or projection of aggression onto others frequently places him in situations where he is a potential victim. When his outlets for acting out or projecting his aggressions are blocked then suicidal ideation is more likely to emerge.

Diagnosis. The most critical and difficult assessment that needs to be made in Julian's case is whether or not he represents a developing antisocial personality. Kernberg (1975) considers the "true" antisocial personality to be a variant of narcissistic personality, functioning at the overt borderline level and having severe superego pathology, as evidenced by the absence of a capacity for

guilt and depression and overall lack of moral values. Masterson (1981) acknowledges that the "psychopathic" personality is essentially indistinguishable from the lower or borderline level narcissistic personality and is characterized by a complete lack of emotional investment in other people, an inability to integrate confrontation about the destructiveness of his behaviorm and an inability to learn from experience. Kohut does not address the differential diagnosis of antisocial and narcissistic personality, but does generally consider delinquent behavior to fall within his classification of narcissistic behavior disorders.

Julian's grandiosity, vulnerable self-esteem, devaluation of others, lack of empathy, and the tendency to develop narcissistic transferences are all indicative of narcissistic personality disorder. Further, signs of ego weakness such as poor impulse control and low anxiety tolerance point to a borderline level of functioning, as does the presence of persistent antisocial behavior. From Kernberg's perspective Julian would appear to fit the portrait drawn of antisocial personality due to his apparent absence of guilt or genuine depression. Julian only became upset about his behavior when caught, has steadfastly denied involvement unless confronted with indisputable, tangible evidence, and has never apologized or expressed remorse for his behavior. Masterson's criteria (1981) are only slightly less definitive. Julian has typically responded to confrontation or even interpretation of his antisocial behavior with anger and recriminations, and has not appeared to learn from his experience

of being arrested on at least three occasions. It is only Julian's investment in others that gives any prognostic hope. While he seems entirely self-absorbed in his relations, there are indications in his narcissistic transferences and reactions to separations that he may not have completely withdrawn all investment in others. The key question remains whether his efforts to reach out to others indicate the possibility of object relatedness or are simply efforts to manipulate his environment and reduce his immediate pain. Unless Julian is able to overcome his monumental distrust of others and actually invest himself in a therapeutic alliance, then Antisocial Personality is likely to be the adult diagnosis.

Treatment implications. The treatment implications for Julian basically follow one of two lines. If considered to be a "true" antisocial or psychopathic variant of narcissistic personality then the prognosis is extremely poor; psychoanalytic treatment of any kind is contraindicated, and structured, supportive psychotherapy in a contained milieu is the treatment of choice. However, if Julian's character pathology is seen as other than antisocial, then a psychoanalytically oriented treatment may be possible once the acting out is contained. As indicated earlier, Kernberg's approach for a lower level narcissistic personality is essentially the same as for the borderline personality, including interpretation of both negative and positive tranferences, but with the increased use of countertransference as a guide for understanding and devising interventions in the treatment. Masterson (1981) emphasizes pointing

out denied aspects of reality and being especially sensitive to needs for mirroring of the grandiose self. Kohut (1977) advocates an even more extreme empathic stance, allowing for the emergence and gradual modification of the "archaic" narcissistic structures. In Julian's case such an approach would require consistent acknowledgement of his early deprivation and the legitimacy of his need for a transference figure who will accept and confirm his infantile grandiosity and soothe and comfort him in his state of oral-narcissistic need. Once that is accomplished, then the gradual molding of these structures to conform with reality would allow for the development of self-esteem and realistic ambition, which for Julian could be productive use of his artistic talent. Whether Kohut's approach, which eschews confrontation, could work with an adolescent whose acting out is as severe as Julian's is, of course, controversial.

Case 3: Michael

Clinical Material

Descriptive data. Michael is a good looking 14 year old boy, of above average size who has been in treatment at the residential center for approximately a year. He comes from an intact, upper middle class suburban family. The father has a professional position in a business and the mother is a housewife. Michael is the second oldest of four children and the oldest male.

Presenting problem. Michael was referred due to his continuing difficulty in managing his impulsive, disruptive, and often des-

tructive behavior in school and at home. He was also considered to have an attentional deficit disorder with hyperactivity which interfered with his ability to benefit from and function in a normal classroom situation. His placement was precipitated by his expulsion from junior high school following two fire-setting episodes, which were part of a persistent pattern of behavioral difficulties. The first episode resulted in probation at juvenile court. The second episode occurred on the very date that the first case was to be dismissed. Earlier in the same year he had been expelled from a private school for a series of behavioral difficulties which culminated in theft.

Psychiatric history. Michael's initial psychiatric evaluation was at age 8 following completion of the second grade. The immediate precipitant was a shoplifting incident, but the parents reported a history of overactive, impulsive, and disruptive behavior for most of his life. Beginning in kindergarten he was provocative with peers, impulsive, and distractible. Consultation at that time suggested minimal brain dysfunction. At home Micahel's behavior was unresponsive to discipline and included at least one incident of fire setting at age 5. The parents attempted to utilize a behavior management program with Michael when he was eight years old, followed by individual psychotherapy and then two years of group psychotherapy. He was also prescribed Ritalin from ages 9 to 13, with some improvement in attention span being attributed to its use. Individual therapy with occasional parental involvement occurred

intermittently up until the time of his placement.

The parents also explored the possibility of an organic etiology for Michael's behavior. Based on their observation of hyperactivity following the ingestion of large quantities of sugar, he was given a glucose tolerance test which proved negative. He was also given a dexamethasone suppression test for primary depression which also proved negative. Later psychiatric consultation resulted in a trial of Lithium, which he was taking at the time of his admission to the treatment center.

Psychosocial history. Michael's early development was within normal limits. The mother reported an unremarkable pregnancy and delivery and a healthy infancy, although Michael was an irritable, cranky baby. Developmental milestones were passed at or before the expected times, but Michael did remain periodically eneuretic until age 11. An active child who needed to be watched constantly, Michael was often in trouble at home for breaking things or disrupting the home. The parents reported difficulty disciplining Michael because of his unresponsiveness to spankings, restrictions, and other forms of punishment. Irritable, moody, and self-centered, he has been seen by his parents as insensitive to the needs of others in the family which has often led to arguments between himself and his father. He is described as having gotten along poorly with his siblings and peers, with most of his friendships being of short duration. Easily led, much of his antisocial behavior has occurred with other boys of similar disposition. Outside of the family he

has generally related well to adults. His abiding interests have been hockey, automobiles and stereo equipment.

Michael's parents have had marital difficulties over the past few years into which he has been drawn at times. The father appears insecure and depressed and gives the impression of colluding with Michael's acting out on some occasions and at other times being overly punitive. There is also a history of manic-depressive illness on the father's side of the family. The mother appears to be more inhibited and passive, with a tendency toward over-protection. Michael is quite reactive to difficulties in the parental dyad and frequently blames himself as the source of their problems.

Medical and health history. Michael's medical and health history has been unremarkable for the most part, except for the tests he has been given for hypoglycemia and depression. Medication for hyperactivity has shown some efficacy, but the results of Lithium therapy have been equivocal.

Course of treatment. The main themes in Michael's treatment have been the expression of his angry, aggressive impulses and the acknowledgement of his narcissistic and dependent needs. The prankish and destructive acting out which characterized his pre-placement behavior have continued in sporadic fashion: he has plugged up toilets, discharged fire extinguisheers, broken windows, damaged walls and kicked in doors. His reckless impulsivity combined with his tendency to avoid responsibility and externalize blame has alienated him from many staff members and other students. Michael's

relationship with staff and students have been extremely labile, feeling close and attached to someone one day and then enemies the next. He has been especially provocative with the more authoritarian male teachers but over time the consistency of the faculty and structure of the school has reduced that behavior to a minimum. In the dormitory, with structure and a higher student-staff ratio, Michael has much greater difficulty with his impulse control. When confronted with his behavior he typically has one of two reactions: he either angrily and vehemently denies involvement or becomes extremely penitent, sad, and remorseful, often crying and being openly upset with himself. In the latter situations his expressed wish for expiation and resolve to change his ways tend to be short-lived and further incidents follow. It should be noted that Michael's Lithium treatment was stopped after four months at the center with no appreciable change in behavior.

In psychotherapy he was initially distant and removed, seldom making eye contact, and seemingly preoccupied with his private thoughts. What he did verbalize tended to be complaints about his unfair treatment and victimization and threats of revenge upon those who had wronged him. In fact, he prided himself on his ability to find the vulnerability of others and "get to them". The intensity of his fear and rage has been at times overwhelming to him and he has described himself as turning into "the Incredible Hulk" who could go berserk.

As the therapy relationship has deepened he has been able to

talk more about his own vulnerabilities and to use therapy to soothe and contain himself. Implicated in many of his destructive actions is a prior experience of neglect on the part of the staff. When the hurt underneath his rage is empathically responded to, he opens up dramatically about his need for feedback, attention, and consistent limit setting. Exploration of these issues vis a vis staff and in the transference has led to the historical family conflicts around Michael's relationship with his parents. He has become extremely upset and sad in discussing how he has disappointed his father, and how he has been the cause of considerable family strife. While he generally maintains a very protective attitude toward his parents, he is on occasion able to recognize his own needs that have gone unmet and express disappointment. He prefers, however, to deny the importance of the past, stating that he simply wants to "forget it" as being reminded of earlier events and circumstances is quite painful. As he put it, he wants to focus on "the positive," but his continued acting out has led to reiteration of the past's influence on his current behavior and interpersonal relationships.

Other phenomena which have consistently arisen in the therapy include his envy of other students whom he perceives as being "spoiled" by staff and recipients of much more attention his upset around the time of therapist vacations, and his continuing concern about the mood of his parents, especially the father, whom he sees as overburdened and depressed. The therapy, has focused for the most part, on his need to maintain impulse control, his sensitivity to

narcissistic slights (especially those coming from important adults), and the differentiation of his own emotional needs and states from those of his parents. Also emphasized has been the desirability of his reconciling the "good kid," who is usually present in therapy, and "the Incredible Hulk," who makes his presence known outside of the therapy hour. Michael is usually able to make use of interpretations and clarifications, and while he sometimes rejected them outright in angry fashion, most often they serve to calm him and make his feelings more manageable. The greatest concern with Michael remains his poor tolerance of depressive affect and subsequent self-destructive acting out.

Psychological assessment findings. Psycholgoical testing prior to admission suggested an "underlying depression, characterized by loneliness, fear, and concern about the future." He evidenced difficulty in understanding the interrelationship between events, a limited ability to express his feelings, and a tendency to displace his anger in ways that made his behavior often appear pointless. There was evidence of a concern for others, especially his father, despite the superficiality of his peer relationships. Intellectually, he tested in the superior range, with markedly better performance (versus verbal) scores, indicative of a style of handling anxiety and depression through action.

Recent psychological testing (see Appendix) suggested a diagnosis of Narcissistic Personality Disorder with paranoid and depressive features. Michael was assessed as feeling ineffectual

in his efforts to structure and impact upon his environment in such a way as to meet his needs and, as a result, having to rely largely on external cues and controls. Specifically emphasized was his constant struggle to cope with his aggressive impulses, which he accomplishes through avoidance, denial, reaction formation, over-compensation and superficial compliance. Also noted were Michael's paranoid style, hypervigilance, and need to distort reality under stress in order to minimize conflict and restore order. His idealized view of the world is frequently undermined by his fears and perceptions of a sadistic, dangerous, and depriving environment in which his needs for love will not be met. Interpersonally, Michael was assessed as viewing women as frightening and attacking, and devalued for their inhibition, lack of ambition, and limited lives. Men are idealized models of ambitious striving. Lastly, Michael's affinity for intense, violent, and depressive affects was addressed with concern expressed about his suicide potential.

DSM-III Diagnosis. The primary areas of diagnostic concern are Michael's acting out behavior, depression, and hyperactivity. The level and persistence of Michael's behavioral difficulties certainly quality him for a Conduct Disorder diagnosis and his position on the dimensions of socialization and aggression is relatively clear. Despite his frequent insensitivity to others and egocentricity, Michael has extended himself to some boys and defended others or empathized with their predicaments. He has expressed frequent concern about his parents and other family members, and

has evidenced guilt and remorse over his inappropriate actions. Admittedly, Michael has had difficulty maintaining friendships for long periods of time due to his impulsivity and envy and does tend to blame other boys or inform on them to reduce or diffuse what he experiences as attacks upon himself. He does, however, demonstrate sufficient evidence of attachment to others and investment in interpersonal relationships to justify a categorization of socialized. The evidence for a label of Aggressive is even more straightforward based upon his repetitive angry, destructive outbursts. While usually displaced onto property, Michael's aggression is also expressed directly toward the offending person, especially if it is a smaller, weaker boy. Towards adults and more powerful boys Michael tends to attack or gain revenge through less direct prankish, annoying behavior. This pattern of aggressive conduct has lasted for a few years, well beyond the six month criterion. Thus Conduct Disorder, Socialized, Aggressive is be an appropriate diagnosis. Michael's depressive symptoms have not been of sufficient intensity to justify major depression, but their persistence probably warrants a diagnosis of Dysthymic Disorder, and the potential for more severe depression certainly exists. The diagnosis of Attention Deficit Disorder with hyperactivity continues to be applicable although Michael has improved in this area and may be "outgrowing" that symptom formation.

Object Relations Case Analysis

Intrapsychic development and structure. Due to the complexity

of Michael's symptom presentation and the lack of overt trauma in his early history, inferences about his intrapsychic development and structure are somewhat more speculative than in the previous cases. Michael's combination of narcissistic, borderline, and depressive features defies any simple assessment. Overall, one can safely place him along the narcissistic-borderline continuum, but exactly where is more difficult to determine. The qualities of identity diffusion, primitive defenses and maintenance of reality testing associated by Kernberg (1976; 1980) with the broad concept of borderline personality organization are applicable to Michael and indicative of a poorly integrated internal structure. The prominence of Michael's aggression and its fitful expression, along with his alternating sadistic projections and harsh, self-punitive reactions suggest overwhelming pregenital aggression with resultant superego pathology. The source of this aggression cannot be derived from the type of obvious familial trauma that characterized the earlier cases. Given the narcissistic aspects of Michael's behavior and his crankiness and hyperactivity as a young child, the likelihood of frequent empathy failures on the part of the mother is considerable. Parental frustration with Michael appeared to begin early, and the reported volatile reactions of the father to his disappointment with Michael no doubt contributed to the creation of sadistic internalized object representations and "bad" self representations. Thus both narcissistic rage and experienced nonintegrable aggression can be implicated in Michael's intrapsychic development.

The father's intense identification with Michael and often inappropriate sharing of personal frustrations have made Michael something of a narcissistic receptacle and left him overburdened with concern about his father's welfare. It is not unusual for Michael to go on at length about how he needs to change his behavior for his father's benefit--to make his father less depressed and restore happiness to the marriage. This sense of grandiose and omnipotent control over his parents is the other side of his sense of being controlled almost entirely by others and his refusal to take responsibility for his actions. The evidence exists then for Michael's defensive maintenance of a grandiose self, mirrored in his father, who himself has compensated for feelings of inadequacy with narcissistic involvement in fast sport cars and blustery, sporadic and usually ineffectual attempts at self-assertion. At one point there had been a significant delay in making a repair to Michael's room and Michael described with a manifest sense of empowerment how his father had become so angry about this delay (necessitated by Michael's destruction) that he was going to come to the center and "chew out the director of this place." In actuality his father never said a word about the problem. Embedded in this incident is also the desire to have that idealized protective parent who will meet one's needs. From Masterson's (1981) viewpoint the lack of empathic maternal response, perhaps due to a genetically determined hyperactivity, may have led to an abandonment depression which was defended against by identification with an angry, depressed,

narcissistic father who responded punitively to Michael's failure to satisfy his own frustrated grandiosity.

The somewhat unexpected aspects of Michael's functioning are his relatively ready access to depressive affect, capacity for guilt, ability to accept confrontative feedback, and occasional evidence of empathic concern. These qualities are not normally associated with narcissistic disorders and suggest that his narcissistic structure is not as rigid and air-tight as is often the case and may be superimposed upon a more enduring borderline personality. Also to be considered is the role of oedipal issues into which Michael has been drawn--yet again these seem to be an overlap on the primitive structure.

Defense mechanisms. The defense mechanisms utilized by Michael have been the dissociative-splitting type: avoidance, denial, and projection most frequently. Michael attempts to keep certain unpleasant aspects of his behavior at a distance by acting as if they didn't exist, compartmentalizing them as limited to one sphere of his life ("I only do that here") and blaming others for either having done the action, or provoked and encouraged him. Michael's paranoia creates for him a state of mind in which he seems to be regularly on the defensive, anticipating rejection or attack, and frequently misinterpreting other people's behavior as such. Bad feelings arising from the empathic failures of the environment in the present or remembered past are almost always externalized through aggressive, destructive action in order to ward off deep depression. Also

employed by Michael are grandiose fantasies about himself regarding how easily he could change his behavior, earn desired privileges, or control others. His idealization of significant others also is a self-protective approach to avoiding dissappointment.

Transference and countertransference. The narcissistic transferences are much in evidence with Michael. The "idealizing" transference is most frequently operative and characterized by Michael's complaints about life outside the session, and requests for soothing, following narcissistic injuries. He has looked to the therapist to be in Kohut's words, the "idealized parent imago," (Kohut and Wolf, 1978, p. 414) powerful, protective and nurturant. He has rarely attacked the therapist directly, although he has become momentarily angry when he has felt misunderstood. In this sense he is also seeking "perfect mirroring" (Masterson, 1980) in which his grandiose self would get the approbation it desired.

The narcissism evident in Michael's transference, including his acute sensitivity to slghts of any kind, appears to exist simultaneously with more labile borderline characteristics. Michael has not hidden his dependent attitude toward the the therapist and is quite vocal when other staff, usually male authority figures, are not available for him. In fact, interpreting this need for paternal guidance and reassurance has led to exploration of that issue with reference to his own father and released considerable depressive affect not usually seen so readily in narcissistic syndromes. The abandonment depression which Masterson postulates

as underlying both narcissistic and borderline conditions is accessible to Michael despite his evident discomfort with that affective state. Michael has also demonstrated the tendency to make quick and intense attachments to peers and staff and an equally significant tendency to spoil or disrupt those relationships.

The most problematic feature of the countertransference in this case has been due to Michael's splitting. He strives to maintain an idealized realationship with the therapist and in doing so has tended to deny or downplay his acting out outside of the session, often with displays of righteous indignation. Thus, the therapist's experience of Michael, being on the receiving end of his idealization, is often markedly different from that of other staff who are confronted with his angry devaluation and impulsivity. The therapist, needing to be empathic to Michael's sense of victimization and hurt, has at times lost sight of the split-off aggression being released upon staff and, conversely, the dormitory and teaching staff have tended to respond primarily to the aggression in a defensive fashion. As therapist and staff came to recognize this process the splitting became a therapeutic issue to address with Michael. Not surprisingly, Michael's relationship with his parents has reflected a similar type of splitting, with either parent forming an alliance with Michael. After Michael's admission he also struggled mightily to construct an idealized relationship with his parents based on denial of his acting out at the center. When the parents were informed of the true nature of his activities they were naturally upset and Michael

predictably went into a rage at the center for having spoiled his image of perfection.

The other notable countertransference aspect involving Michael's therapy is the toll on the therapist in being a container for his rage. The ferocity of his feelings have often appeared beyond soothing. In one instance Michael deposited a dead mouse in an envelope on his therapist's desk. He had ragefully killed the mouse which belonged to another student and brought it over as if to say, This is the intensity of my aggressive feelings; I can't contain them, they scare me, and in some ways I am as damaged as this mouse. He required an extra session that day to diffuse his feelings of being out of control and stimulated both the therapist's concomitant desires to be the hoped for omnipotent healer and the wish to withdraw helplessly in face of a terrifying and implacable rage.

Socialization and aggression. The drive to be a socialized, accepted individual is very strong with Michael. Despite his egocentricity and frequent insensitivity, it was clear that Michael is desperate for a sense of relatedness and attachment, and severely frustrated by his repeated failure to be successful in the sphere of social relations. His inability to gain peer acceptance had been an historic reality for him and he has continually explored ways to make friends, often by adopting a stereotypical masculine image of toughness and bravado which covers his insecure and frightened self. When attempting to make friends with girls he presents what he terms a "snow job,"--an essentially distorted and idealized version of

himself which he hopes will prove more appealing. He has rationalized this approach, stating he will eventually present the truth but wants to avert outright, initial rejection. As opposed to Julian who often appears impervious to the opinions and standards of others, Michael is, if anything, overly sensitive and overwhelmed by the prospect of having his true self evaluated.

Michael's aggressive impulses appears to be a product of both unmanageable, internalized aggression and narcissistic rage. A severely punitive superego is evidenced by his intense guilt reactions and fears of depression and alternatively by his paranoid projections onto others which then justify aggression. The aggression also serves in this way as a defense against the abandonment depression through the engagement of the withdrawing-aggressive part-unit. Related to the abandonment depression is the narcissistic rage which is so easily stimulated in Michael by experiences of rejection. If he is being ignored he attacks. Given that the perceived lack of attention is usually associated with an idealized figure such as his father or the therapist the anger tends to be displaced with the secondary gain of engaging the idealized figure. It is interesting to note in this regard that Michael's most intense period of acting out prior to placement occurred during and following a time when his father was almost totally absorbed in professional matters, leaving little time for Michael or other family members.

Diagnosis. Michael presents a complex diagnostic picture in that he seems to have elements of both the narcissistic and border-

line personality. In one sense this is no great matter since Kernberg (1975) considers the narcissistic personality a variant of borderline personality organization and Kohut (1977) at the other extreme, has broadened the concept of narcissistic disorders to include most of those who Kernberg refers to as borderline. Masterson (1981) assumes an intermediary position, agreeing with parts of each conceptualization. The importance of a differential diagnosis lies primarily in the realm of treatment since the approaches do vary. Due to the lability of Michael's reactions, his ability to tolerate some depression and confrontation, and the intense vicissitudes of his interpersonal relationships, a diagnosis of borderline personality organization with narcissistic features appears most appropriate. The narcissistic identifications and transferences are much in evidence but the expected seamless grandiosity and ego-superego fusion do not appear to be present. Nonetheless, from Kohut's more inclusive perspective of narcissistic disorders an argument can be made for a diagnosis of narcissistic behavior disorder based upon the obvious incohesion of the self, vulnerability to narcissistic rage, instability of self-esteem, and presence of narcissistic tranferences. Further the most applicable syndromes of self-pathology outlined by Kohut and Wolf (1978) appear to be the fragmenting self and the overburdened self indicative of Michael's shifting states of incohesion and his inability to soothe himself in a hostile world.

The family history of manic-depressive illness also raises the

possibility of a genetic component to Michael's difficulties, yet there has been no evidence of responsiveness to antidepressants or lithium carbonate. The degree to which the father has shared his depressive affect and stimulated some inappropriate identification with his son confounds any attempt to unequivocally sort out the nature-nurture dilemma. Certainly a serious depression is possible for Michael in the future should he continue to fail to realize the demanding goals he has internalized.

Oedipal issues make an appearance with Michael, yet he has clearly not reached the level of true neurotic conflict. The involvement of Michael in his parents' issues seems largely a result of his use by them as a narcissistic object--especially in the father's case. Thus the oedipal conflicts create what Kohut (1972) has called a pseudoneurotic individual who is functioning at the narcsisistic level. The primitive aspects of Michael's defenses and his personality incohesion also indicate narcissistic or borderline structure rather than a neurotic level.

Treatment implications. Michael is clearly a treatable adolescent. Despite his narcissistic features and history of antisocial behavior he is not an incipient Antisocial Personality Disorder. He is receptive and eager for treatment even if frustrated by his limited improvement. The consistency of his acting out is a constant threat to therapeutic neutrality because of the need to coordinate efforts with other staff members. As a result consistent confrontation and interpretation of the splitting is required, with reference

made to the lack of internal integration. While an extremely empathic therapist stance is necessary to establish an alliance with Michael, he does appear to respond well to confrontation--not of an accusatory sort but of the type recommended by Masterson (1981) recognizing the vulnerability that led to acting out. Bringing the split-off aspects of Michael's experience and the transference directly into the therapy also seem necessary in order to gradually facilitate the integration of disparate representations of the ideal and the actual within Michael. Over time if he is able to become more empathic with his own previously unmet needs then the severely self-punitive reactions to failure may be alleviated, facilitating further integration. It is the aggressive, rageful impulses which seem so important to understand and accept in Michael. The therapist is confronted by the same fears that occupy Michael: that the aggression is so devastating that unless it is kept at bay through denial, projection and avoidance it will turn Michael into "The Incredible Hulk" of untold destructive power or that, alternatively, the anger and rage will be turned against Michael and, lacking the self-soothing mechanisms he so desperately seeks in the therapist, he will become hopelessly overwhelmed and suicidal. Thus the depressive content must be approached slowly, with sensitivity to Michael's fragile defenses, being careful not to overwhelm him or collude with his denial and avoidance. Fortunately for Michael, his genuine desire for interpersonal relatedness and willingness to accept the dependency of the therapeutic relationship suggest that

he may be able to derive sufficient soothing from the relationship to tolerate and work through the underlying depression.

Case 4: Philip

Clinical Material

Philip is a tall, very handsome seventeen year old male who was a resident at the treatment center for one and one half years before returning home to live with his parents in a well-to-do suburban town. Philip presented an image that was envied by virtually every boy at the treatment center: strong, athletic, intelligent, relatively wealthy, and attractive to girls. His family was intact, with both parents being successful professionals. His older sister had also recently married a wealthy young man.

Presenting problem

Philip was referred due to his chronic truancy, antisocial behavior (fighting, theft and alcohol and drug abuse), and the inability of his parents to control him at home. The parents described Philip at that time as unrealistic, lacking in self-assurance, having poor judgment and being unaware of the consequences of his behavior. At the time of admission, Philip was on probation for attempted larceny and had lost over a year school credit due to truancy.

Psychiatric history. Philip had been noted to have learning difficulties from his entrance into elementary school, but the first psychiatric involvement was not until he reached the ninth grade.

By that time he was failing in school and had a number of court involvements for reckless, endangering behavior, malicious destruction of property, and alcohol use as a minor. He was also defiant and manipulative at home, demanding money and special favors for positive behavior such as going to school and doing chores around the house. The therapist evaluated Philip as being an angry, impulsive young man with low self-esteem, poor motivation, and signs of depression. Philip was also described as glib and matter of fact about his problems, tending to externalize them and blame others. Egocentric and manipulative, he was focused on his own interest and would "say whatever it takes" to get out of trouble, but evidenced no guilt about his behavior, only anger and frustration at being caught. The psychotherapy was minimally documented and, according to Philip, very loosely structured. Included were some efforts to help the parents cope more effectively with Philip's behavior, but they also met with little success. Philip's overall opinion of psychotherapy was that it was a "waste of time."

Psychosocial history. Philip's early development was unremarkable except for being a "colicky" baby and having crossed eyes, which were surgically corrected at age five. He walked at 10 months and talked at 18 months, but was not toilet trained until 3½ years of age. Philip was considered an "extremely" active child and attentional difficulties were noted in the first grade. Evaluation in the second grade indicated that he had deficits in visual learning skills, in grade five a further evaluation described him as intellec-

tually able, with a serious reading disorder, feeling frustration, lowered self-esteem but "no evidence of emotional disturbance." Tutoring, a structured classroom approach, and a medication consult were recommended at that time. A subsequent evaluation when Philip was 15 noted his specific learning problems and added that he was unmotivated, distractible, disorganized and disruptive in class. His antisocial behavior and school avoidance were also increasing, a progression the parents felt helpless to stop.

The transition to high school seemed a particularly difficult one for Philip and his relationship with his parents became very strained. The mother began devoting almost all of her time to Philip's "problems," while the father, who had maintained a cool distant relationship with Philip, became involved only at times of acute crisis. In general, Philip and his mother were overinvolved in this process while the father remained a peripheral figure.

Despite some improvement in the 10th grade when Philip received considerable individual help, the next year was a failure which began inauspiciously with the firing of the young female tutor of whom he was very fond. Philip again went downhill scholastically and behaviorally, withdrawing to become increasingly involved with a reckless, drug and alcohol oriented peer group, whose antisocial behavior was usually rationalized as "having a good time." After Philip's arrest on a larceny charge, his parents, who felt powerless to control him, sought residential placement for him.

Medical history and health. With the exception of eye surgery

at 5 years of age for strabismus and nose surgery at 12 years, Philip's health history is unremarkable. He did receive phenobarbital for colic as an infant, and in elementary school had a brief, unsuccessful trial on Ritalin. In recent years he has not received any psychiatric medication.

Course of treatment. Philip made an adaptive adjustment to the treatment center after a difficult initial period. Shocked and upset at being sent away from home, Philip was at the outset hostile toward both the center and his parents. His attitude changed once he began to receive academic and social recognition, and he rapidly became one of the leaders among the students. Despite the gain in self-esteem, Philip's manipulative behavior continued at a high level. He often tried to wrangle favored treatment from staff, often with considerable success due to his charm and willingness to lie when it suited his purposes. He continued to challenge his parents' authority at home, especially around returning to school and frequently extorted bribes from his mother as a condition of his return.

Socially, Philip rose to pre-eminence among the students within a few months and exerted considerable power and influence over other students, most of whom courted his favor. Beneath the overt deference there was considerable envy and resentment on the part of other students but this was rarely expressed openly. His leadership did often have a positive aspect, in encouraging students to cooperate and adhere to rules, but this often appeared to be a self-serving

way of ingratiating himself with staff or of obtaining narcissistic gratification of his own as an influential role model. He generally saw himself as superior to the other students, with his true peer group being his friends at home. Unlike the other boys Philip made no attempt to socialize in the town outside the center, prefering to maintain the hometown social ties almost as if he hadn't left. With adults he often attempted to blur boundaries, treating them as peers. While this attitude had some age appropriate aspects, it also appeared to reflect a continuing need to identify and merge with powerful adults in order to bolster his self-esteem. With female staff he was often exhibitionistic and seductive, but he did not idealize them as he did males.

Scholastically, Philip tended to avoid situations in which he might do poorly and often had difficulty following through and completing extended projects. When he would fail he would rationalize the tasks as meaningless or impossible, avoiding any responsibility as a result of his own behavior.

In individual psychotherapy Philip was notable for his grandiose self presentation, denial, avoidance of problems, and his overall self-protectiveness. His unrealistic view of himself evidenced itself early on with his proclamation that he would "definitely be a millionnaire by age 35," by being either a professional athlete, physician, lawyer, or engineer. The naivete of his ambitions were well represented by one interchange when he voiced his plan to become rich by becoming a physician. Told the amount of education required,

Philip was unruffled and blithely replied, "Well, then I'll be a lawyer; they make lots of money." The maintenance of an aggressive, masculine self-image was important to him as well. He spoke of his desire to join the Army special forces so that he could engage in legalized violence, and he did not follow-up on an opportunity to become a male model because he didn't want anyone to think he was gay. Philip also showed little tolerance for depressive ideation, and when a girlfriend of his was tragically killed he seemed remarkably unaffected, except in an incident when he "had to defend her name" and he physically assaulted another boy who made a derogatory remark about her.

Philip's attitude toward therapy was generally one of devaluation: he did not need therapy because he did not have any problems and even if he did he could solve them himself. Philip appeared to want confirmation of his self-perceived perfection and responded to any lack thereof with anger or simply ignoring the offending comment. He initially attempted to engage the therapist only in regard to his immediate needs and it was only after reported limit setting and maintenance of therapeutic neutrality that his demands abated. Philip's desire to be perceived as "best" and his sensitivity to failure were explored repeatedly, especially with reference to the high ideals set for him by his father and his internalization of these ideals. He viewed his father as a "brain" whom he could never match in raw intelligence, but whom he could out maneuver through cleverness, especially with the mother's help. Philip described

his relationship with his mother as one of mutual manipulation, based on extreme sensitivity to one another such that they could "virtually read each other's mind." His closeness to the mother was evidenced by his keeping of "secrets" with her which excluded and, not infrequently, undermined the father. While Philip was usually gratified by the mother, he experienced all refusals on her part to be intentionally "withholding," aimed to "hurt" him. He also was frequently angered by her attempts to "control" him or infantilize him by such things as procuring jobs for him. He tended to respond in a disruptive and destructive fashion after which she would placate him with gifts of one sort or another. The father was stricter in overt policy than the mother but in practice was also subject to dyadic pacts and secrets from the mother.

Oedipal issues were often in the forefront of the therapy either in peer relationships in the form of battles with other young men or over girls--at times resulting in physical confrontations--or in the form of Philip's intermediary position between his parents. That relationship with the parents, initially idealized, became a sore point for him later in treatment especially as he began to appreciate the ways in which his parents' involvement was not always helpful. The mother's arguments with Philip often took on the feel of a marital dispute as evidenced by her frequently calling him a "bastard" or "son of a bitch." Over time Philip began to differentiate more consciously his needs from that of his father and mother, and was able to acknowledge the burden of his father's idealized

view of him and the mother's need to avoid separation. As plans were being made for his return home Philip developed greater realism about his academic deficits, and more openly accepted the need for continued special services and support. However he resisted any continuation of psychotherapy past discharge--an attitude paralleled by the parents' resistance to any family therapy. As with Philip they tended to hope that superficial change was sufficient and operated largely on avoidance or denial of a conflict. For both Philip and his parents the motivation for change lay largely in the resolution of crises and, with Philip out of the home the possibility of a crisis was minimized. His return reinstated the circumstances where stress could lead to change, but as Philip once said, "If you think my parents are going to change, you're crazy." Philips' own ability to function superficially well suggested that stress or failure as an adult, perhaps in an important relationship, would have to provide the stimulus for his more active engagement in treatment.

Psychological assessment findings. Psychological testing prior to Philip's placement indicated a boy with low self-esteem who was restless, angry and frustrated. He was seen as tending to view things in a black or white manner, and as using physical anger as a way of resolving conflict. His strategies for dealing with anxiety included denial, manipulation and bravado. Notably lacking was a lack of realism about his own skills, as he seemingly defended against his sense of inadequacy and powerlessness. Part of this

picture was his expressed belief that he could resolve all his problems on his own, which effectively cut him off from sources of support. His skills, talents, and interpersonal charm were noted to function in both adaptive and maladaptive ways. In the latter case they served to mask his underlying difficulties and help him avoid dealing with his problems in more than a superficial fashion.

The recent psychological assessment done on Philip (see Appendix) suggested a diagnosis of Narcissistic Personality Disorder and pointed to his lack of a stable, integrated identity. In lieu of such an identity, Philip is seen as relying on stereotypes in order to guide his interactions with others. Women are consciously viewed as dependent upon men's caretaking and protection, while unconsciously they are "oppressive, angry, withholding and rejecting." Philip's idealized masculine image of the confident, controlling, capable and intelligent male is one which he attempts to project while covering up a real self that feels ineffective, insecure, and insubstantial. Philip works hard to maintain his enviable image and any attacks on it are seen as likely to provoke aggressive impulses leading to withdrawal, mild depression, and subtle power struggles in which oppositional behavior may be hidden behind superficial compliance. While Philip makes reasonably adaptive responses to mild stress, severe stress may produce disorganization and lapses in reality testing in an effort to make reality conform to his idealized view and to avoid destructive expression of his aggressive impulses. His vulnerability to narcissistic wounds leads

to a defensive facade which constricts and isolates him and limits the real satisfactions available to him.

DSM-III Diagnosis. Philip's behavior was most consonant with the diagnosis of Conduct Disorder, Socialized Aggressive. Philip maintained relationships for long periods of time and was very invested in his friends as sources of gratification. While he did not appear to have a highly developed conscience in regard to his behavior, loyalty to friends was important and he did at times express concern for his companions. The quality and depth of his interactions were suspect due to his reliance on stereotyped sex roles, but he met the stipulated behavioral criteria for the "Socialized" label. His aggressive pattern of conduct included violence towards both persons and property--most often to defend his masculine image or to firm up his relationship with peers. He also responded with aggression to withholding and rejection on the part of his parents. While he had much better control over his impulses than many others, his aggression when released was often of surprising intensity and primitiveness. Philip was yet another boy for whom the mere categorization of his behavior under socialization and aggression did not adequately portray the nature of psychological problems. Until he reaches 18 years of age, a Personality Disorder diagnosis is not possible under DSM-III, and Conduct Disorder would technically be the only appropriate diagnosis.

Object Relations Case Analysis

Intrapsychic development and structure. Of all the cases presented, Philip's is the one which most closely fits the generally accepted view of the narcissistic personality. He evidenced the best surface functioning, the strongest ego boundaries and the least overt anxiety. The obvious borderline characteristics evident to varying degrees in the other boys were not present with Philip. His grandiose self was much more firmly entrenched and better defended. Extremely exhibitionistic and self-absorbed, Philip nonetheless developed a charming interpersonal style which successfully distracted attention from his flaws and weaknesses. The consistency and seamlessness of his grandiose self-presentation contrasted markedly with Julian and Michael who were not capable of Philip's degree of self-containment. As indicated by Masterson (1981), to the casual observer the pathological or aggressive fused unit of the narcissistic personality will be hidden from view. Certainly this was the case with Philip who regularly drew the response of "Why is he here?" from those unfamiliar with his history and underlying fragility. It was only through observing Philip's handling of stress and his difficulty in integrating unacceptable flawed parts of himself that one could begin to appreciate the pathological and arrested aspects of his personality.

The development of Philip's narcissism must remain somewhat speculative in that there were no obvious and dramatic events or traumas in his early history. What is apparent is the historical

closeness with the mother and difficulties around separation which are linked by Masterson (1981) to the narcissistic as well as borderline personality. Philip's mother, even up until the point of discharge, rewarded regressive behavior while also being erratically withholding. In one instance after Philip was refused money for a movie (usually he received whatever he wanted from the mother) he broke a window and said he would not return to the center. His father at this point made a show of force by asserting that Philip was no longer welcome at the house, but this was quickly undermined when Philip came back while the father was at work, repaired the window and then "made up" with the mother who took him out and bought him an extremely expensive pair of sneakers--the "best" according to Philip. In similar fashion, both Philip and his sister had been bribed by the mother to attend schools when they balked going on their own--raising the question as to whose needs were being met in this process. The mother also continued to arrange jobs for Philip through her friends, even when he asserted a desire to find his own. Despite the maternal indulgences received, Philip was left with a feeling which he expressed a number of times that he was an object of his mother's gratification, her handsome charming son, and not recognized as an individual with his own separate needs. She appeared to use Philip as a narcissistic object, and the liveliness of her relationship with him contrasted sharply with that between herself and her husband, a cooly distant man who had a very successful professional career. While information about the family's early

years is sketchy the pattern of mother-son overinvolvement, combined with disengagement of the father, appears to have been a long-standing one. Philip identified more with his mother seeing both himself and her as clever, manipulative, and socially successful, but insubstantial and incompetent beneath that exterior. He saw the father as remote, brilliant, and critical, having goals for him which he feared were beyond his capacity, yet he defended himself with the omnipotent fantasy that he could do anything.

The source of Philip's narcissistic structure would seem to lie in the identification and infantile grandiosity stimulated in the narcissistic relationship with the mother and in the existence of a remote, idealized father with whom there was little opportunity to establish a realistic counterpoint to the encompassing maternal relationship. Philip's anxiety over separation and possible abandonment from an erratic mother combined with a lack of realistic confirmation from others, can be seen as having inhibited his self development. When he gratified the mother's narcissism he was wonderful and accepted; when he did not he became the rejected "bastard," with the implicit threat of abandonment and the cutting off of supplies. Thus the grandiose self and the omnipotent, idealized relationship could only be maintained by avoiding separation and dissociating bad parts of the self and others. As explicated by Kernberg (1975) this process results in the ideal self, ideal object, and actual self being joined, and the unacceptable self and object representations being projected onto others who can then be devalued. Super-

ego integration is not accomplished because the aggressive, punitive aspects are kept from being moderated by the ideal object images. In Philip's case, experiences of failure or loss raised the spectre of intolerable self-directed aggression and therefore needed to be avoided, denied, or projected. The lack of superego integration is then the determining factor in Philip's poor tolerance for guilt or depression.

Defense mechanisms. The primary defenses utilized by Philip were denial, avoidance, devaluation, omnipotence, and idealization. These mechanisms were called into play whenever his idealized self image was threatened, but were used so glibly and matter-of-factly that they could easily go unnoticed if one was not attuned to this characterological style. Philip's denial was evidenced in his outright lying at times and by his reluctance to take seriously his own destructive or inappropriate behavior. He also tended to avoid conflicts or situations in which his weaknesses might be exposed. A case in point was his refusal to take parts of a standardized test which tapped his weak academic areas. He knew he would do poorly and did not want to experience what was for him humiliation. Devaluation frequently came into play regarding situations in which his neediness might be identified and responded to. This was particularly true in therapy, which he viewed as a meaningless activity. As Kohut (1972) points out psychotherapy is a de facto narcissistic injury, and especially so for those who cling to an omnipotent self-image. Philip's omnipotence was expressed regularly through his

reiteration that he was capable of anything if he set his mind to it. This stance, as has already been noted in the psychological testing, protected him against his underlying feelings of helplessness and powerlessness. Philip also had a marked tendency toward idealization and when he experienced something as good it became the "best" and imperfections were defended against by this mechanism. He also tended to identify himself with idealized people and material possessions, as if taking on their idealized qualities through contact. When these defenses were not sufficient he became either rageful or withdrawing; but these states were transitory and soon after Philip would present himself as if nothing painful had occurred.

Tranference and countertransference. The outstanding characteristic of the transference was Philips' need for perfect "mirroring" as described by Kohut (1977, 1978). Philip, especially at the beginning of the treatment, presented himself in a grandiose manner in terms of his past, present and future and appeared to expect unqualified acceptance on the part of the therapist. Comments which addressed problems he was having either in school or with his family usually were responded to as irrelevancies to be ignored or were experienced as attacks inciting his anger. Only when his disappointments or sense of being used and controlled were empathized with was there a sense of therapeutic alliance.

Philips' grandiosity and omnipotence necessitated devaluation of the therapist as someone who could help him, because accepting help would be an admission of weakness and imperfection. The

therapist was only valued as a source of supplies or gratification and when these were not forthcoming the therapist was treated as useless. Philip consistently gave the impression that he was doing the therapist a favor by coming to the sessions and as if to emphasize their valueness and his boredom he frequently referred to his multi-functioned digital watch to determine how much time was left. The issue of boredom was one which extended beyond the sessions for Philip. He constantly complained of having nothing to do while at the center and it was only during weekends at home that he felt "alive." Those weekends were usually spent in a blur of manic activity and one sensed that whenever Philip ran out of distractions he immediately became the bored, empty individual evident in the therapy.

Interestingly, while Philip devalued the therapist and staff as not having been of any help to him and saw all his progress as being self-generated, he praised the center inordinately to outsiders. This split stance derived from his identification with the treatment center vis a vis those outside. To the extent that he was identified with the program, it was the best, but he was able to separate that cognition from any therapist that he needed or valued and the treatment he received. This "idealizing transference" (Kohut and Wolf, 1978) was naturally easier to tolerate but no less pathological than the previously described "mirror transference."

Kernberg (1975) suggests that it is the devaluation of the narcissistic patient which is most difficult to manage and that the

therapist must not only endure it but also interpret the negative aspects and underlying aggression. He points out that the therapist may at times mirror the patient's grandiosity in order to defend against devaluation and a sense of emptiness and boredom projected by the patient. In working with Philip the therapist needed to constantly monitor his countertransferential reactions and evaluate whether his "mirroring" was empathic or defensive. While this was often a difficult task, the therapist did find that when he was able to recognize through the countertransference negative affective states, such as anger or disappointment, commenting upon them as transference phenomena was perceived as empathic. Over the course of the therapy, the use of the countertransference to identify Philip's dissociated negative feelings did facilitate some integration of these aspects and helped to develop a more realistic self-image, at least in regard to his academic deficits.

Socialization and aggression. The paradox of socialization in the Narcissistic Personality was exemplified by Philip. On the surface he appeared actively engaged in many relationships both with peers and adults. Upon closer inspection however, these relationships revealed their narcissistic and often exploitative quality. He spoke of his relationship with girl friends as if they were interchangeable and related a number of incidents in which he had clearly humiliated a girl without having sensitivity or concern about her feelings. He viewed women in an objectified fashion as ornamental or sources of erotic gratification and was able to relate a rape fantasy about

a woman staff member without any evident guilt. In general he conformed well to social expectations, i.e., he knew how to play the game, but lacked empathic concern for others. Fitting with his overall character he gravitated toward and identified with idealized figures, such as certain staff members, and associated with others--such as lower status peers--only to the extent that they gratified his needs.

Philip's aggressive impulses were for the most part held in check during the time he spent at the center. When Philip was aggressive it was usually to reassert his hierarchical position among the students. On occasion he would threaten violence when his needs weren't met but never followed through. He was able to sublimate his aggression through sports and used aggressive terms such as "annihilated" and "destroyed" to describe his exploits in that area. His aggression was much more prominent while at home where he would fly into rages when he felt deprived, as in the previously mentioned incident with his mother. He also engaged in fights with other boys in his home town, usually in some test of supremacy. In one instance he "beat up" a rival for a girl and one sensed that the girl was secondary to his own need to be "macho." The narcissistic quality of this anger is evident, and the aforementioned rape fantasy also suggests the interplay of pregenital aggression and oedipal strivings.

Diagnosis. The diagnostic label of Narcissistic Personality Disorder seems most appropriate for Philip given the grandiose and

ego-syntonic way in which he has resolved his conflicts. His ability to contain or minimize his anxiety through the use of dissociative defenses without rapidly shifting ego states was indicative of narcissistic as opposed to borderline functioning. Philip's integrated self-presentation and better surface adaptation were also more in keeping with narcissistic psychopathology (Kernberg, 1975). The transference phenomena associated with narcissistic disorders by Kohut (Kohut, 1977; Kohut and Wolf, 1978) were also present, especially the mirror transference previously described and characterized by grandiosity and devaluation. Philip's responses to confrontations--anger, denial, withdrawal--were, as Masterson (1981) has noted, typical of the narcissistic personality, as was his lack of empathy, guilt, or remorse.

Considering Philip's overall ego functioning he seemed to fit best in Kernberg's (1970) intermediate level of character pathology as indicated by his predominantly oral conflicts (demands to be gratified), poorly integrated superego, and, despite their shallowness, the relative stability in his object relations. In Masterson's (1981) narcissistic schema he falls more in the middle range, superficially appearing to have oedipal conflicts, and certainly not functioning at the overt borderline level. However despite the presence of some oedipal themes, Philip's tendency to be more of an opponent than an ally in the treatment is, according to Masterson (1981), a clear clue that his condition was more narcissistic than neurotic. From Kohut's perspective, Philip's narcissistic pathology

can be seen as an example of what he has called the "overstimulated self" (Kohut and Wolf, 1978),--unempathic overstimulation of the grandiose-exhibitionistic pole of the self evidenced by Philip's exhibitionism, his lack of creativity, and his inability to follow through and complete projects. A good argument can therefore be made that Philip represents a Narcissistic Personality Disorder from all three perspectives.

Treatment implications. The establishment of a therapeutic alliance is really the most crucial aspect of the treatment with someone like Philip. As should be evident from the clinical material this was never fully accomplished. Philip's reluctance to acknowledge his needs except in limited circumscribed ways was a barrier to engagement. He was receiving so much narcissistic gratification as the best and most powerful male resident that his grandiose self was seldom depleted and his defenses were not overtaxed. Had the family and perhaps the staff been better able to confront Philip then he might have experienced sufficient stress to increase his motivation for therapy. Philip's parents frequently appeared to collude with his defenses by avoiding scheduled family therapy appointments and failing to follow through on treatment plans. Philip's refusal to consider individual treatment following discharge was mirrored by his parents' refusal to engage in family therapy. Their attitude was that Philip would either "shape up" or he'd have to leave the home, but in their minds there was no need to work on the family interactions. In retrospect it is possible that greater

focus on the negative transference, as recommended by Kernberg (1975), may have created more therapeutic tension and made Philip's conflicts less elusive. However, the fact that Philip and his family were thinking of his return home almost from the beginning of the therapist's involvement undermined the motivation for change.

Prognostically, Philip's success depends to a great degree on external circumstance. If he is able to find situations which foster or at least, collude with his grandiose self then he may continue to function in a superficially good fashion for a considerable time. More likely, his very real deficits in academic skills, his impaired capacity for prolonged sublimatory activity, his potential for narcissistic rage and his rather shallow interpersonal relationships will cause him sufficient stress to require some type of therapeutic intervention. The eventual separation from the mother will predictably be a source of trauma for both mother and son and may in itself precipitate a significant crisis which could lead to treatment. A last possibility is that Philip will engage in some form of antisocial activity--probably in a less impulsive and more controlled way than Julian--which may necessitate intervention of a punitive or legalistic nature. Philip's adaptive response while at the center and his re-establishment of a narcissistic equilibrium are viewed as having only delayed the need for structural personality change.

CHAPTER V

CONCLUSION: AN OBJECT RELATIONS PERSPECTIVE ON CONDUCT DISORDER

Conduct Disorder Reconsidered

This investigation began with the premise that the diagnosis of Conduct Disorder, with its overtly behavioral emphasis, belied the psychological complexity and diversity of those adolescents so diagnosed and as a result was not an adequate guide to their treatment. In particular, concern was expressed about the association of Conduct Disorder with Antisocial Personality Disorder and its connotation of untreatability. A less pessimistic and more clinically illuminating approach was perceived in the realm of Object Relations theory, as exemplified by recent explorations into the borderline and narcissistic personalities. The Object Relations theorists, most notably Kernberg (1975, 1976, 1980), Kohut (1971, 1977) and Masterson (1972, 1978, 1980, 1981), have expanded the clinical understanding of these patients, especially with regard to intrapsychic development and psychotherapy. The insights derived from the Object Relations approach have been applied herein to a Conduct Disorder population in order to assess their utility in diagnosis and treatment.

Overall there appears to be a good fit between the clinical phenomena described by Kernberg, Kohut and Masterson and the boys described in the case histories, all of whom met the DSM-III criteria

for Conduct Disorder. To varying degrees, but without exception, the boys evidenced the dissociative defense mechanisms (splitting, denial, projection, avoidance, etc.), the problems with self-image and self-esteem, the difficulties in modulating and integrating aggression, and the impoverished or disturbed interpersonal relationships associated with the borderline-narcissism spectrum of personality disorders. William, with his extremely unstable personality and the weakest ego functioning of the group, best represents the borderline personality as described by Kernberg (1975) and Masterson (1981). Philip, with his consistently grandiose self-presentation, exquisite sensitivity to injuries to his self-esteem, and his relatively good ego functioning and anxiety tolerance, is most representative of the narcissistic personality described by Kohut (Kohut, 1971, 1977; Kohut and Wolf, 1978), Kernberg (1975) and Masterson (1981). Michael and Julian appear to have qualities mixing aspects of both the borderline and narcissistic personalities. Michael's affective responsiveness placing him closer to the borderline personality, while Julian's tendency towards grandiosity and devaluation suggest a narcissistic structure at the overt borderline level of functioning if one adopts Kernberg's (1975) schema.

Admittedly, Kernberg, Kohut, and Masterson are more in agreement with regard to the clinical picture than they are with respect to etiology and treatment. Oversimplifying greatly, Kernberg has a greater focus on pregenital aggression and its manifestations in the treatment; Kohut prefers to emphasize the pathology of the self,

especially in the narcissistic transferences; and Masterson is most sensitized to issues of separation-individuation with the associated "abandonment depression." Given the newness of the Conduct Disorder diagnosis and the ongoing developments and refinements within Object Relations theory it seems reasonable at this time to adopt an eclectic approach to applying Object Relations theory and then point to areas requiring further investigation. How then does Object Relations theory, as applied to the case material presented, enrich our understanding of Conduct Disorder and, more broadly speaking, adolescent antisocial behavior? This question will now be addressed in terms of the etiological, diagnostic, and treatment issues raised in the body of this investigation.

Etiological considerations

Genetic, biological, and familial factors. The idea of a genetic, biological predisposition to antisocial behavior has not been confirmed by research in any direct fashion (Reid, 1981). Lombroso's (1911) notion of the "born criminal" certainly has not been supported. However, the research on hyperactivity (Stewart, Cummings, Singer and de Blois, 1981), neurological deficits (Lewis and various co-authors, 1976, 1978, 1979, 1982) and genetic factors in the borderline personality organization (Stone, 1980) suggests that vulnerabilities in the child and/or the parent may predispose to aggressive behavior and personality disturbance. It is interesting to note that each of the boys presented had a history of hyperactivity and

were usually seen as being very active or "colicky" right from birth. One can speculate that the activity level of these boys got them in trouble with parental figures from an early age and subjected them to the unmanageable pregenital aggression that Kernberg (1975) has emphasized in the development of the borderline personality organization. A child who is upsetting to the parents also becomes much less likely to receive the mirroring or affirmation from the parents which Kohut (1977) views as necessary for self-development. The child is apt to find his/her self-control to be lacking, leading to many experiences of failure and frustration and further diminishing self-esteem and a sense of autonomy. An over-reliance on the mother and lack of separation may result from this, or, alternatively, an identification with the father as ideal, powerful and confident may develop to restore self-esteem. Philip and Julian appear to be examples of this compensatory alliance with the mother, while Michael is a possible example of the latter process involving the father. In either situation, the development of narcissistic identifications may result and also make the threat of abandonment both more real and more devastating due to an already impaired self.

The parental role in the development of later antisocial behavior, whether genetic or interactional, is also suggested by the case histories. In two cases, those of William and Julian, the father was described as violent and abusive and in both situations was separated from the son at a very early age. William also underwent a separation from the mother at the same time, a mother who

was considered by some criteria an unfit parent. Julian's mother was, of her own admission, an inadequate parenting figure, unreliable, unstable and often unavailable, with a similar pattern present in her own family of origin. Thus for both William and Julian the presence of parental psychopathology, probably in the form of personality disorder, seems confirmed.

In the cases of Michael and Philip the evidence is less dramatic. Michael's father has received treatment for depression, and a history of manic depressive illness is documented in the father's lineage. Depression is, according to Stone (1980), the most prevalent psychiatric condition found in the relatives of those with borderline personality organization. Michael's father is also considered to be explosive and volatile, again a probable source of "pregenital aggression." Michael's mother, although passive and inhibited, does not evidence any psychopathology. Philip's family is superficially the most psychologically intact, but as noted earlier the mother's extremely narcissistic identification with her son and her emotional reactivity suggest characterological difficulties. The father is distant and aloof, preoccupied with work, a stance which certainly encourages overinvolvement by the mother. With Michael and Philip, the unavailability of parents to meet their needs, presents itself more subtly and without the trauma evident with William and Julian.

This difference in quality and kind of separation experience is, as Rutter (1971) suggests, probably a key factor in the type of psychopathology. In these cases those with the most severe separation

experiences, William and Julian, were the least socialized and from an Object Relations perspective showing the greatest ego weakness and identity diffusion. The role of this type of separation experience in the development of the borderline personality has also begun to receive empirical (Bradley, 1979) as well as theoretical support.

The Object Relations perspective provides a means by which to integrate the history of genetic, biological, and family trauma which are all known correlates of antisocial behavior and of Conduct Disorder, and to demonstrate how these factors create ongoing personality disturbance. Although the specific mechanisms vary from case to case, the disruption of the internalization of whole object relations and the use of dissociative defense mechanisms to cope with these early traumas are pervasive. The need to control the environment which has been threatening and unrewarding becomes paramount, especially when one lacks the soothing internalized representations and is all the more vulnerable to injury from the outside. The borderline and lower level narcissistic personality are particularly threatened, while a better functioning narcissistic personality like Philip is able to exert more influence and control through his adaptive, albeit superficial, social skills.

Depression. Depression has been increasingly implicated in Conduct Disorder and adolescent antisocial behavior (Carlson and Cantwell, 1980; Kashani et al., 1981; Puig-Antich, 1982) and in the borderline syndromes (Masterson, 1980, 1981; Stone, 1980). Masterson's conceptualization of the abandonment depression is quite

compelling in this regard because it provides a link from the borderline personality to Conduct Disorder and also makes sense of the concept of "masked depression." According to Masterson it is the abandonment depression which is central to both borderline and narcissistic pathology and which is avoided through the externalization or activation of "aggressive part-units." The poor tolerance for depressive affect is most notable with the narcissistic personality, but the continually shifting affects of the borderline also prevent its working through. For Masterson it is the eventual resolution of this depression deriving from the separation-individuation stage of object relations development which is the key to successful treatment. From the Object Relations perspective the "masking" of the depression reflects the defenses against its painful emergence. The working through of the depression theoretically resolves the rapprochement crisis and allows the object constancy necessary for stable and whole object relations. In this process the severely punitive but previously unintegrated superego becomes tempered and more realistic. In the case of Michael, for example, one would expect such resolution to be signaled by the end of the rageful aggression and penance cycle which has been characteristic of his functioning. Masterson also suggests that when reviewing the presenting problem one should be sensitive to separations which may have precipitated aggressive acting out. Again, the Object Relations perspective provides a means of integrating various aspects of the literature on Conduct Disorder.

Personality disorders, psychosis and neurosis. DSM-III makes the connection of Conduct Disorder to adult personality disorder, specifically Antisocial Personality Disorder. As has been demonstrated, that connection is a rather narrow and limiting one. Kernberg (1975, 1976) has effectively argued that only a small percentage of those engaging in antisocial behavior fit the diagnosis of Antisocial Personality Disorder. Of the four cases presented, all of whom have court involvements, only Julian can be considered an example of antisocial personality as defined from an Object Relations viewpoint. Even at that, the antisocial personality is considered, at least by Kernberg (1975, 1976), to be a variant of the narcissistic personality, operating at the overt borderline level of functioning.

While the entire personality disorder section of DSM-III has been the subject of controversy (Frances, 1980; Millon, 1981), Antisocial Personality Disorder has become perhaps the most maligned due to its overinclusiveness, which subsumes virtually anyone who has a history of criminal activity (Wulach, 1983). The prejudicial connotations of that diagnosis, which have also accrued to Conduct Disorder, and the pessimistic treatment implications, which are most likely to be applied to lower socioeconomic populations, have led Wulach to recommend that the diagnosis be abolished completely. If used in the more restrictive sense of Kernberg (1975, 1976) such a step would be unnecessary.

The relationship among the various personality disorders is

an intriguing one which also raises the issue of sex bias in diagnosis. As indicated earlier there is empirical evidence for a Socialized, Aggressive Syndrome for boys and a Socialized, Nonaggressive Syndrome for girls. It would be interesting to follow-up males and females so diagnosed under Conduct Disorder and find the adult diagnoses. A reasonable speculation is that males would be diagnosed Antisocial Personality Disorder and females would be diagnosed Borderline Personality Disorder or possibly Narcissistic or Histrionic Personality Disorder. Reid (1981) has suggested that Antisocial Personality Disorder in males and Histrionic Personality Disorder in females may be "genetic equivalents," although this writer suspects that a stronger case, based on an Object Relations analysis, can be made for Borderline Personality Disorder as the female counterpart.

The concomitant presence of psychosis or neurosis with a diagnosis of Conduct Disorder is probably rarer than was the comparable association when delinquency was a diagnostic entity. Conduct Disorder requires at least a six month history, whereas an adjudication of delinquency can result from one event or even, as Halleck (1967) points out, the recommendation of a social worker. In most instances, psychosis will probably be recognized and a diagnosis in that spectrum utilized. Nonetheless, it is often surprising how little attention is paid to psychotic symptomatology when there is dramatic antisocial behavior (Lewis and Balla, 1976). Neurotic conflicts are also likely to be uncovered before a Conduct Disorder label is applied, but this is an area that warrants further investigation, perhaps with an out-

patient population of Conduct Disorder adolescents. Those who have been placed at hospitals or residential treatment centers have a greater likelihood of falling into the personality disorder--psychotic range of disturbance.

Diagnostic Considerations

The utilization of an Object Relations perspective both expands on and brings into question aspects of the Conduct Disorder Diagnosis. The focus in Object Relations theory is internal structure, in sharp contrast to the behavioral dimension of the official diagnositc criteria. The advantages of making a diagnosis based on an assessment of internalized object relations are that it provides a developmental context for the symptomatology, suggests the nature of defenses likely to be encountered, and implies both a treatment strategy and a prognosis. The disadvantages are that such a diagnosis is more time consuming and is subject to variations in interpretation which can make it less reliable. As should be evident, even within the category of Object Relations theory there are considerable variations in emphasis and a consensual diagnostic approach is not yet in the offing. In the interim the efforts of Masterson (1981) and Kernberg (Kernberg, Goldstein, Carr, Hunt, Bauer, & Blumenthal, 1981) could possibly be adapted for use with an adolescent Conduct Disorder population.

A diagnostic proposal. One approach to such a diagnostic evaluation might be the following: (1) Presenting problem, including

immediate precipitants with special attention to separation experiences, rejections, injuries to self-esteem, or experienced aggression; (2) Developmental history, including evidence of hyperactivity, neurological deficits, and parental loss or separation; (3) Parental pathology, focusing on evidence of overt psychiatric disorders, and on more subtle conditions such as well functioning narcissistic personalities; (4) Ego functioning, including an evaluation of impulse control, anxiety tolerance, capacity for guilt, mourning and depression, and evidence of reality testing; (5) Object relationships, with an assessment of their stability, degree of dependence, evidence of empathic concern, and the presence of interwoven sexuality and aggression; (6) Defense mechanisms, with attention paid to dissociative versus repressive defenses. Such an evaluation could be done in part through an inventory, items (1) - (3), and the rest, (4) - (6), as a structured interview along the lines suggested by Kernberg et al. (1981).

The suggested approach could more accurately place individuals along the Socialization-Aggression spectrum but that does not seem an adequate return on the effort. The experience and theoretical bias of this investigation plus the empirical research of Achenbach (1980) suggests that Conduct Disorder, for males at least, always involves a form of aggression and making it a subcriterion is redundant. More to the point is the type of personality structure in which the aggression is located, whether borderline or narcissistic. The degree of socialization, as demonstrated in the cases, does appear

to be a useful dimension which has a clearer developmental etiology and prognostic implications if evaluated on an object relations basis. One possible diagnostic scheme would be divisions into Socialized Borderline and Narcissistic, and Unsocialized Borderline and Narcissistic. Another reasonable alternative might be that of Marohn et al (1979) using Impulsive, Borderline, Narcissistic, and Depressed, although discriminating among those categories might prove extremely difficult. Kernberg's suggestions on character pathology (1970) while useful do not have much discriminatory power within the Conduct Disorder realm, as most individuals would probably fall in the lower level with a few, such as Philip, in the middle level of character pathology.

Lastly, with reference to diagnosis, it seems important to discriminate between adolescents--somewhat arbitrarily defined as 13 years and older--and children. The view that adolescents should not be subject to personality disorder diagnoses is belied by the enduring nature of their psychiatric difficulties. This conclusion appears particularly warranted in regard to Conduct Disorder which almost by definition refers to a persistent maladaptive pattern. Thus, having variants of Conduct Disorder which reflect in some way personality patterns which, based on the literature and this inquiry, probably had their origins in the first few years seems only reasonable. The question of Conduct Disorder prior to adolescence is outside the purview of this investigation, and it may well be that the current diagnostic category is adequate for that age group.

Treatment considerations. The major treatment contribution to Conduct Disorder from the Object Relations perspective is the recognition that the condition is treatable and not merely from the perspective of a controlling behavioral remediation. Any implication that antisocial adolescents are untreatable functions on the level of a self-fulfilling prophecy. This is particularly true when viewed from the standpoint of Object Relations theory which recognizes the severe nature of the early trauma to intrapsychic development and which suggests that long term intensive treatment is vital in these cases. It should also be pointed out, as Wulach (1983) has done, that non-treatment based on presumptive and unproven incorrigibility is, in essence, unethical.

Specific recommendations for treatment as derived from the work of Kernberg, Kohut, and Masterson focus on the need to adapt the traditional psychoanalytic model to these patients. A key component of the approach of both Kernberg (1979) and Masterson (1980, 1981) is limit setting in order to bring the adolescent's behavior under control. Kernberg recommends that all necessary deviations from therapeutic neutrality be reduced through interpretation. Both Kernberg (1975, 1976, 1979) and Kohut (1971, 1977) place special emphasis on the analyses of transference and countertransference as a means to gain insight into the internal processes of patients who have little insight of their own due to their characteristic use of dissociative and projective processes. In the case of narcissistic disorders, Kohut recommends a thorough going empathic approach aimed

at healing the narcissistic wounds and stimulating the arrested narcissism. Kernberg (1975) recognizes the narcissistic vulnerability of these patients but feels that the aggression of the negative transference must also be interpreted. Masterson (1981) in essence agrees with Kernberg on this point, and the experience of this writer, limited though it is, also supports their view. Nonetheless, the types of transference phenomena described by Kohut (1971, 1977) were very much in evidence in these case studies and the need to monitor the empathy of one's responses with these patients is clear. Lastly, the constant reworking of the "borderline triad" described by Masterson (1981) consisting of separation, depression, and defense seems a valuable way to conceptualize the treatment of borderline patients and, by extension, many of the adolescents diagnosed as Conduct Disorder.

Limitations of this Investigation

The limitations of this inquiry into Conduct Disorder are in many respects self-evident. The sample used was very small and limited in geographical, socioeconomic and ethnic background. Only males were utilized, although this is less of a limitation than it might appear since the great majority of adolescents diagnosed Conduct Disorder are in fact male. There is also the possibility that a residential treatment center such as the one where these cases were treated extracts by an inherent selection procedure only a narrow band of the population under consideration. Certainly a broader

spectrum which included both incarcerated juveniles as well as outpatients would add to the generalizability. As the work of one clinical investigator with a limited population generalizability is constrained, but it is hoped that such in-depth case studies may prompt further exploration of Conduct Disorder from an Object Relations perspective.

Toward DSM-IV

Diagnostic manuals are always a mixed blessing in that they help organize and classify, yet are invariably outdated by the time they are printed. As such they must be considered working hypotheses, ever in need of revision but of value because they do stimulate and reward systematic investigation. DSM-III represented a continuation of a trend to become more discrete and behavioral in orientation in a search for greater reliability of diagnosis. As suggested earlier, that reliability may have been purchased at the cost of validity, at least in the case of Conduct Disorder. In DSM-IV it can be hoped that there will be room for a return to some dynamic formulations which may imply more in the way of etiology and treatment even if at the cost of descriptive imprecision. It is the unfortunate truth that many disorders masquerade under the same symptoms, and nowhere is that more evident than in the case of adolescent antisocial behavior. One possible variant on the Conduct Disorder diagnosis was proposed herein. No doubt others will be suggested and from other orientations.

In the interim until DSM-IV does arrive and create a new, temporary standard, it is probably best to take full advantage of the multiaxial properties of DSM-III. By using all axes, and most especially Axis II to specify personality traits, a reasonably accurate diagnosis which does point to treatment can be created. From a clinician's perspective the goal must be to represent the individual as fairly and with as much understanding as possible, always aware of our limitations. Otherwise, we are left applying caricatures of treatment to caricatures of people.

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APPENDIX

PSYCHOLOGICAL ASSESSMENTS

Case 1: William

Date Tested: April 20, 1983

Tests Administered: Rorschach
TAT
Figure Drawing

The test diagnosis is mixed personality disorder. William can be expected to function reasonably well in situations that are highly structured, where the demands of the environment are unambiguous, and when the expectations of those interacting with him are clearly defined. In such situations, he is able to comply with relatively simple demands and exercise acceptable judgment. William attains this level of performance, however, by being highly sensitized to cues in his environment that provide the structure he is lacking within. Preoccupied with a continual, methodical, and oftentimes desperate search to seek out these cues and model his behavior accordingly, he can appear outwardly intact. However, any sense of stability is artificial and is achieved at the expense of his hiding his aggressive impulses, accompanying anxiety, and fear of losing control over them behind a rigid, constricted, mask-like exterior.

William's fragile equilibrium is easily derailed by even minimal demands of reality. He rapidly becomes overwhelmed when expectations of him are unclear, the environment is less structured, or if more is demanded from him than a simple imitative or accommodative response. Initially, he may respond in a counterphobic manner, attempting to be bold and assertive in order to hide his feelings of tentativeness, fear of failure, and inability to commit himself.

Pressure to perform basic cognitive tasks overwhelms William. Reality testing is compromised as his thinking becomes fragmented, and he attempts to compartmentalize his thoughts into smaller, increasingly arbitrary units. As more pressure to justify his thought processes is brought to bear, his already faulty reality testing worsens. Frustrated, William easily gives up and becomes oppositional and impulsive, molding reality to conform to his own needs. He feels little need to justify his perception.

At these times, William's experience of himself and his environment either blend into a vague, impressionistic, undifferentiated whole or reality is perceived as hazy, impenetrable, and floating somewhere--at a distance--"out there." He cannot articulate this experience because, although he tries, he cannot penetrate his inner experiences and make some connection between his emotional life and external reality. The self-awareness needed to do this is not available to him, nor is he able to assume a critical perspective with respect to himself or others.

William is left with profound confusion over the requirements for everyday living and conventional social interaction. He exhibits poor judgment, poor planning ability, and little awareness of the consequences of his behavior. Thus, self-destructive behavior is not experienced as an act over which he has control or responsibility, but rather as something that inexplicably "happened" to him. Consequently, attempts at expressing remorse or guilt are more the result of his sensing and fulfilling a social expectation rather than arising from his sensitivity to the perspective of others.

Case 2: Julian

Date Tested: April 8, 1983

Tests Administered: TAT
Rorschach
Figure Drawing

The test diagnosis is antisocial personality disorder with paranoid features. Julian's style is characterized by a shallowness and insensitivity to those around him. His judgment and planning ability are poor and his attention span and concentration are narrowed due to his almost exclusive preoccupation with furthering his own needs. He is in a power struggle with those around him, believing that if he is to get his needs met he must strike first against a hostile world which is hurtful, oppressive, and ungiving.

Julian is anxious about performing adequately and having his work observed and judged. Anticipating failure, he feels unable to meet his needs in more traditional ways. His efforts to beat the system and to take from someone else what he needs leave him feeling disadvantaged and insubstantial. In an effort to bolster his low sense of self-esteem and insecurity over his sexual identity and sense of masculinity, he embraces romantic notions in which men are seen as powerful and fulfilling stereotyped roles. Men are the breadwinners and women exist as a source of pleasure for them; they are there for sex and fun.

His fantasies and ideals are easily compromised by his self-destructive behavior. Julian's intense anger, poor impulse control and planning ability lead him to repeatedly place himself in situations which will end in some form of self-destructive behavior. Moreover, his anger is of such intensity, especially toward maternal figures, that the price he pays for being self-destructive is worthwhile because of the hurtful effects his acting out will have upon the other person. In this manner, he uses his own suffering as a weapon to seek revenge. He is not aware of his role in carrying out this process, but instead sees himself as a victim of external circumstances which in turn are responsible for causing his behavior.

Much of his anger and resulting depression stem from his long-standing sense of feeling abused, teased, and used to fulfill someone else's needs at his own expense. Attempts to mask his feelings of unworthiness and loathsomeness result in his treating others as he,

himself, feels treated. He has developed a seductive, disarming style in which he attempts to devalue and take advantage of others. Charming, playful and mocking, he distracts others from his manipulative abilities. Julian is extremely cut off from others as well as from his own capacity to feel affection or concern.

Specific Questions

1. Presence of depression/suicidal themes and potential: The presence of underlying depression is described in the report. Suicide is not a concern at this time. His self-destructive behavior will most likely be in the form of defying social conventions.

2. Capacity for interpersonal attachment: It is minimal at this time as described in the report.

3. Recommendations for treatment: The two main difficulties faced by a therapist are the extreme problem of engaging Julian on a less than superficial level and Julian's willingness (as described in the report) to engage in self-destructive behavior as a means of expressing his anger toward the therapist.

4. Sexual identity issues: His sense of his own masculinity is fragile at this time and he relies upon stereotypes as a substitute for the clarity which he lacks.

Case 3: Michael

Date Tested: March 9, 1983

Tests Administered: Figure Drawings
TAT
Rorschach

The test diagnosis is a narcissistic personality disorder with paranoid and depressive features. Michael has considerable difficulty structuring his world so that he can have a reasonable impact upon it and insure that his own needs will be met. He is fearful that his efforts to get straightforwardly on the environment will fail and he will be revealed as puny, insecure, and incompetent. Because he is unable to take charge, Michael tries to use external controls, cues, and structures as substitutes for the boundaries he cannot set internally.

His intense aggressive impulses, with which he is constantly struggling, interfere with his ability to integrate his internal need states with external demands. Avoiding these impulses is a major determinant in the structure of Michael's defenses. Evasive and superficially compliant, he stereotypes relationship to provide him with clues as to how to act. His paranoid style, capacity to compartmentalize, and unusual attention to detail enable Michael to act accommodating and conventional. Denial, reaction-formation, and his ability to overcompensate further reinforce his appearance of conformity.

Michael's scrupulous attention to detail and need to explain all threatening aspects of the environment lead him to be hypervigilant and overinclusive in his attempts to make reality conform to his needs. This results in compromised reality testing when he is under stress.

At these times, he overlooks the more obvious aspects of his environment and, in a grandiose way, compulsively and systematically attempts to account for and minimize whatever conflict he perceives. On the surface, Michael needs to see the world as benevolent, logical, reasonable, orderly, and caring. Underneath, however, exists an image of the world as malevolent, sadistic, and depriving, leaving him feeling that there is a limited supply of caring and that ultimately he will be unable to get the love he needs. He feels used by others as if he were an object of gratification and adornment for them.

Michael has difficulty with interpersonal relationships; he feels apart from others whom he sees as ungiving and distant. He is condescending and denigrating toward them, especially women, whom he additionally views as frightening and attacking. Superficially, men are idealized and are seen as helping you get ahead by encouraging you to follow your dreams. Women, on the other hand, are viewed as inhibited, sacrificing ambition for a simple, restricted but happy life. He is most comfortable with and sensitive to violent and depressive affects, at times to the exclusion of others. There is intense underlying depression and some concern at this time that he may resolve his feelings of deprivation and loss through suicide. While this is not an immediate concern, it is nonetheless something to be mindful of in the future.

Case 4: Philip

Date Tested: March 18, 1983

Tests Administered: Rorschach
TAT
Figure Drawings

The test diagnosis is narcissistic personality disorder. Actively struggling with significant identity issues, Philip lacks a stable, coherent, internalized sense of himself and, in its absence, relies upon stereotypes to serve as guides to how he and others function. Philip has little awareness of or capacity to feel the subtleties and complexities of interactions between people. Thus, his reliance upon stereotypes serves also to mask his lack of relatedness. Consistent with this, bolstered by his use of denial and reaction-formation, he views women, on the surface, as depending on men to fulfill their traditional masculine roles as providers, protectors, and caretakers. Unconsciously, however, he sees women as exceptionally nonmaternal: they are oppressive, angry, withholding and rejecting. Men, on the other hand, are more giving and can engage in gratifying interactions, especially in the absence of women.

Philip struggles hard to project a view of himself that is consistent with his idealized masculine image; that is, as active, in control, the object of envy, self-confident, intelligent, and capable. In an effort to maintain this image, any challenges to it are denied by his exhibitionistic style, use of overcompensation and reaction formation. Beneath his enviable exterior, Philip views his real self far from his male ideal. He feels ineffective, insecure over his intellectual abilities, inhibited and lacking in substance.

Philip expends much energy keeping his idealized and actual self-image separate. Any threat to this separation, such as an attack on his idealized self-image, triggers aggressive impulses, which leave him feeling extremely uncomfortable. His initial response to such impulses is withdrawal accompanied by mild depression. When his idealized image of himself or others is further attacked or threatned, his anger and subsequent disappointment over this lead him to have additional difficulties controlling his aggressive feelings. His next line of defense is to engage in subtle power struggles where, although superficially compliant, he becomes oppositional and expresses his defiance through withholding by being literal or concrete rather than by fighting more openly.

When stress is mild to moderate, he can reasonably, even creatively at times, integrate his aggressive impulses with the demands of his environment. Under more severe stress, however, there are lapses in reality testing. Philips fear that he will not be able to contain his aggression leads him to take serious liberties with reality, forcing his own structure upon it as a means of artificially creating a sense of safety. At these times, his thinking is characterized by denial, arbitrariness, fluidity, and confusing the symbolic with the literal. Disorganization can occur as he attempts to flee the threat of his aggressive impulses. Sometimes this takes the form of Pollyannish denial in his effort to portray a foreboding situation as one of frivolity. Underneath, however, he feels that this is an act and that he is hiding behind a barrier in order to conceal an inner sense of vulnerability. This leaves him feeling constricted, weighted down and at the mercy of his environment. He feels more awareness of his discomfort at these times, which leaves him feeling more isolated and narcissistically wounded.