Depression in Homicidal Adolescents

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The problem of adolescents who commit homicides is of increasing concern in its own right, as well as from the possibility of their facing execution. In this study, a psychiatric and psychological assessment was aimed at screening out a group of juveniles who were being considered for certification to adult court in terms of depressive symptomatology. Within a group of 213, 30 males and 14 females were assessed as depressed by clinical history, the Minnesota Multiphasic Personality Inventories (MMPI) and the Beck Depressive Inventory (BDI). Empirical and psychosocial data attempted to differentiate significant developmental components related to the homicides, as well as differences between the 30 males and 14 females. Although the problem of predicting such behavior from descriptive characteristics remains elusive, certain patterns were present among diverse homicidal behaviors. In conclusion, some psychodynamic hypotheses are offered.

The subject of juveniles who kill is always a dramatic topic. This is so whether the discussion takes place in the context of clinical or legal issues. In the past, the focus has often been from the perspective of one discipline, such as case reports by clinicians, demographic factors by sociologists, or dispositional problems in criminal justice systems. The literature dealing with causes of juvenile homicide has been reviewed by Cornell.[1] My initial interest in adolescents who are depressed and commit homicide was kindled by an awareness of this factor in a legal context.[2]

The relationship between depression, violence, and homicide is a complex one. When an additional component of a developmental variable, adolescence, is added, the complexity is multiplied. Perhaps we are still at the hypothesis-building stage of needing to take into account types of interactions between personality functioning and affective disturbances in terms of predisposing, modifying, complicating, and attenuating expressions of depressive components.[3] With depressed adolescents who commit violent acts, predisposing features of dependency, unresolved anger, histrionics, attentional deficits, and ambivalence can all contribute. Further, all of these can modify the clinical picture of depression in the adolescent.

There is the continuing unresolved problem of distinguishing affective from personality disorders. Personality disturbances viewed as an attenuation of affective disturbances have had a long history.[4] Since attempts to make a categorical distinction between affective and personality disorders are problematic, some have proposed the concept of a "depressive personality."[5] This is con-

gruent with findings that various diagnoses occur longitudinally, hence, a study that found 66 percent of cyclothymics previously diagnosed as hysterics or sociopaths.[6] A mixture of symptoms is present, such as aggressive outbursts, unstable work histories, unexplained promiscuous behavior, irritability, buying sprees, joining movements, and disillusionment. Another formulation has been depressive spectrum disease in which first-degree relatives of depressives show a loading of alcoholism or antisocial personalities.[7] Such a possibility is explored with the adolescents in this study. The situation is suggestive of the confusion in conceptualizing borderline personality disorders in adult populations who show a high comorbidity of affective disorders, organic disturbances, histrionics, and antisocial personalities.[8] Such diagnostic overlaps also distort base rates of psychopathology in particular populations.[9]

Few studies focus on depression and homicidal violence in adolescence. Even the clinical articles usually focus on broader aspects such as whether a psychosis was present or not, or relationships to victims. Offer *et al.*[10] looked at the problem with hospitalized delinquents. Another study of 13 to 15 year-old delinquents in a correctional setting found a diagnosis of major affective disorder in 23 percent.[11] Kashani *et al.*[12] looked at incarcerated delinquents and found 18 percent were depressed. Self-reported depressed moods were found significantly related to minor acts of delinquency but not major acts of violence.[13] A study of 19 males, age 17 to 29 at the time of evaluation, who had been condemned to death for acts committed while juveniles, found four had had histories consistent with severe mood disorders.[14] As in many of these investigations, a multitude of problems was present, such as neurological findings, undiagnosed seizure disorder, sodomization by adult relatives, and backgrounds of physical abuse and family violence. An evaluation of 72 adolescents at a forensic center over a nine-year span who were charged with homicide did not give a diagnostic breakdown, although the authors noted five of the subjects were psychotic.[15] Ten adolescent murderers studied in a psychiatric hospital setting found six diagnosed as schizophrenic.[16] Solway *et al.*[17] did not discover any significant depression in 18 adolescent murders.

Purpose of Study

The purpose was to select, from a larger population of those being considered for certification to adult court for criminal trial, a subgroup of those showing the clinical manifestations of depression. The group selected would be those who had engaged in homicidal violence or been an accomplice to the act in the sense of the legal charge. Antecedents or accompaniments of their depressions would be obtained such as personality traits and family dispositions. The approach would be an empirical-level descriptive study of homicidal adolescents. It would allow some psychodynamic hypotheses to be raised, but this was not the primary purpose. Also, given the rarity of the event, an approach of com-

paring this study group with some other control group of juvenile offenders would not be seen as having significant validity.

Methodology

An original population of 6,500 alleged juvenile delinquents presented in a juvenile court setting over a three-year time span. By intake, dispositional judgments, and prosecutorial discretion, the initial group was narrowed down by legal processing. Among the more serious group of 1,241 juveniles referred for clinical evaluation, 213 were in the category of a violent offense, such as homicide, aggravated assault, or rape, being charged where certification to adult court was under consideration. Issues pertaining to certification have been discussed elsewhere.[18]

Part of the clinical screening process involved administering a Minnesota Multiphasic Personality Inventory (MMPI) in which a cut-off score of "60" or greater on the "D" scale (Depression) would alert to the possibility of depressive items being checked. This screening allowed an initial group of 54 who had participated in a homicidal act directly, or as an accessory, to be selected with other offenses being excluded. Further screening then involved a Beck Depressive Inventory (BDI) and a clinical assessment to determine whether criteria from DSM-III for a Major Depressive Episode were met.[19] Because the study was begun prior to 1987, a shift to DSM-III-R was not made.

Unless a score of 18 or higher on the BDI was achieved, the individual was excluded despite the MMPI score. A score of 18 or over on the BDI would encompass mild, moderate, and severe degrees of depression. Beck's data have mean scores of mild, moderate, and severe depression of 18.7, 25.4, and 30.0, respectively. The correlation between the BDI and the MMPI "D" scale is noted as .75.[20] If both of these psychometric devices for depression met the criteria indicated, the investigation to meet DSM-III symptoms was pursued. The final group of 44 subjects meant that the adolescent had then not only met the initial legal criteria, but three clinical criteria as well. Table 1 presents the differences in mean scores between the males and females on the MMPI and BDI.

Results

Once the diagnostic criteria for the group of adolescents with a major depression were met, significant differences emerged between the symptom pictures in the males and females (Table 2). All of the adolescents reported some symptoms connected with a dysphoric mood. Irritability was present in half the males, but in 80 percent of the females. Vegetative signs revealed contrasts with an absence of poor appetite and weight loss, but some with a history of weight gain. Since DSM-III did not specify when a weight gain or loss was to be considered significant, the study used 10 pounds as significant, and added a requirement that the gain or loss should have taken place in the three months prior to the offense. Although four of the 30 boys gained over 10 pounds, half the girls (7 of 14) had such a weight gain. Such a finding raised questions about

Table 1
Ratings on Depressed Delinquent Adolescents

Item	Male Probands (N = 30)	Female Probands (N = 14)
MMPI (Mean scores for D scale)	65.6	72.4
BDI	22.3	25.5

Table 2
DSM-III Symptoms of Depression in Violent Delinquents

Symptoms	No. Possessing the Symptom (N = 30) Gender of Patients			
	Male (N = 30) N	%	Female (N = 14) N	%
Dysphoric Mood				
Depressed	27	90	14	100
Feeling sad, blue, or in the dumps	27	90	14	100
Hopeless about future	18	60	7	50
Irritable	15	50	11	80
General Symptoms				
Poor appetite	0	0	0	0
Weight loss (10 lbs.)	0	0	0	0
Weight gain (10 lbs.)	4	13	7	50
Insomnia	0	0	0	0
Hypersomnia	8	25	6	45
Psychomotor agitation	15	50	5	35
Psychomotor retardation	1	3	3	21
Loss of interest or pleasure in usual activities	15	30	11	80
Decrease in sexual drive	8	25	11	80
Loss of energy; fatigue	1	3	3	21
Feelings of worthlessness; self-reproach, or excessive or inappropriate guilt	18	60	6	40
Problems in thinking (slowed thinking, indecisiveness, or difficulty in concentrating)	8	25	3	21
Suicidal ideation	8	25	6	40
Attempted overdose	4	13	1	7
Wrist-slashing	0	0	1	7
Presence of Psychotic Features				
Gross impairment in reality testing	3	10	1	7
Hallucinations	0	0	0	0
Delusions	3	10	1	7
Depressive stupor	0	0	0	0

different character structures or defenses when a depressive episode occurs in adolescent boys and girls prone to violence.

For psychomotor agitation, 15 of the 30 boys reported feeling a greater restlessness and agitation in the month prior to the violent act; only one boy felt grossly slowed down, but three girls did. Perhaps this picture of agitation correlates with an "agitated subtype" of affec-

tive disorder found in an incarcerated sample of depressed adolescents compared with a hospitalized group.[21]

Descriptive correlates were matched with "problems in thinking." Sixteen boys had psychomotor symptoms (15 agitated and one retarded), and three girls had "problems in thinking." One interpretation is that depression in adolescence reflects more agitation, turmoil, and restlessness in contrast to the withdrawn and inhibited varieties. Although three girls did seem to present an inhibited model, five others were agitated, but only one boy was inhibited. The impact on their capacity to think, concentrate, and make decisions would consequently be impaired. These deficiencies could also be interpreted as attentional deficits with difficulties in focusing and organizing thoughts existing alongside impulsivity. Such findings illustrate the problem of a mixed symptom picture and, depending on which group of symptoms is emphasized, overlapping diagnostic possibilities.

The behavior of these juveniles could be classified as a variety of conduct disorder (group or solitary aggressive), with depressive affect simply being part of the picture. However, there is the problem that manifestations that seem like an attention deficit disorder may simply be part of a conduct disorder. Such questions will not be pursued but are part of the continuing problem of overlapping symptom pictures in disturbed adolescents. Similarly, conduct disorders overlap with affective disorders in this age group and are difficult to differentiate.[22] Criteria do not exist in terms of biological or etiological precursors for a valid syndrome to differentiate hyperactivity connected with attention deficits from the aggression connected with conduct problems.[23] For the 44 adolescents studied, the symptom picture of a major affective disorder was present that often included some of the attentional, motoric, impulsive, and conduct disturbances seen with these other two diagnoses.

All of the adolescents had previous contact with school counseling, agencies, or independent mental health services. Almost the entire group (all of the males and 10 of the females) had previous involvement with some court system for delinquent behavior. Does an emphasis on their antisocial conduct, such as delinquent behavior in a legal setting, contribute to focusing on this and ignoring other significant variables, such as their difficulties with attention and focusing or episodes of dysphoria? A possibility is that once classified as delinquent, they are assumed to fit a personality or conduct disorder without need for further inquiry. It is the problem in reverse from initially presenting with depressive symptoms and then missing the characterological manifestations. Work with adult patients emphasizing the frequency of personality disturbances (48%) in recurrent depressions is suggestive.[24]

The subjects did not present as generally inhibited. Though clinically depressed on clinical and psychometric assessment, they were not perceived as depressed by those who had ongoing contact with them. Although having a dysphoric mood, and feeling "down" a

good deal of the time, they had not resorted to verbalizations about how sad they were in the manner of some depressed adults. Many did not know what being depressed was, although they used phrases such as "being down" or "not feelin' like doin' much."

Similarly, inferences can be drawn from the category of "Feelings of worthlessness" (see Table 2) as part of DSM-III criteria for a depressive episode. Although 60 percent of the males and 40 percent of the females had low self-esteem, this can easily be missed. First, adolescents do not present themselves with overt complaints of guilt. Nor, if asked directly whether they feel guilty, do many respond affirmatively. A similar void exists for those who associate with them on a peer level, or from adults such as teachers. When inquiry was directed to their self-concept, such as how they felt about themselves and their believed failures and lack of accomplishments, phrases were used such as, "I don't seem to come through," or "I don't know why I haven't been able to get my act together." What happens is a subtle distortion in assessment, once their delinquent conduct is known. Deficits in self-esteem are assumed when their antisociality is known. A confluence of the legal category with a subsequent clinical impression that seemingly goes with their antisocial behavior occurs so that an affective disorder is not considered primary.

Suicidal Ideation Although suicidal ideation suggests depression, its absence does not rule it out. A significant minority of these adolescents had recurrent thoughts of suicide in the 60 days preceding the offense. Four of the males had drug overdoses in the past two years which they qualified by stating they had not intended to kill themselves. Recurrent phrases had the theme of wanting to "get away from the scene," or "wanting my parents to get off my back." Only one of the four came close to succeeding. The conscious intent was to kill himself by an overdose of tranquilizer medication. When he did not appear for dinner, his parents checked his room, discovered him in a stupor, and rushed him to an emergency room. He was admitted to a psychiatric unit but left in three days, with a diagnosis of passive aggressive personality when his mother acceded to his wishes to leave against medical advice. One girl took an overdose of six diazepam tablets after an angry confrontation with her boyfriend. A second girl slashed her wrists when feeling lonely and neglected. The pattern of suicidal thoughts or attempts that are ignored subsequent to the eruption of a violent act is frequent and deserves further work.

Drug Usage Drug abuse-chemical dependency problems complicate the depressive picture through masking. Usage of some drugs is so common in a general delinquent population that the problems may be ignored as endemic. The type of drug, amount of use, circumstances, and duration are all significant. Inquiry elicited not simply whether any of the drugs listed in Table 3 had ever been used, but whether there was a consistent pattern over time. A girl who said she had drunk alcohol to

Table 3
Drug Usage in Depressed Adolescent Delinquents

Drug Usage	Gender of Patients			
	Males (N = 30)		Females (N = 14)	
	N	%	N	%
Marijuana	18	60	7	50
Stimulant types of drugs (amphetamine type)	8	26	3	21
LSD (lysergic acid diethylamide)	3	10	0	0
PCP (phencyclidine, angel dust)	1	3	0	0
Opiates	0	0	0	0
Sedative hypnotics (barbiturates and benzodiazepines)	8	26	6	43
Alcohol	27	90	8	57

excess on three occasions over the past two years was not included as a "user." A boy who said he smoked marijuana only once a week, such as on weekends, but did so in a pattern of two to three times per month, was included.

The pattern of drug use in these homicidal, depressed adolescents may be little different than the pattern among a nondepressed group of delinquent adolescents. Of the 20 males who used drugs out of the sample of 30, 50 percent were classified as alcohol users and 60 percent as marijuana users. For girls, the comparable figures were 57 and 50 percent, respectively. Cultural and demographic variables would have to be considered that were not controlled in this investigation.

Impressive besides the past history connected with drug usage was the finding that only one of the 44 subjects was ever diagnosed as depressed before the acts that led to their being included in this study. The difficulty is partly explained by where they made contact, such as in a court probation system, a chemical dependency referral, a clinic, or a hospital unit. The few times depression was considered, it was viewed as secondary to the primary problem of chemical dependency. A related finding was that 10 of the males and three of the females had previously been through chemical dependency treatment programs.

Child Abuse History Child abuse was present in the history and records of seven of the 14 girls, and eight of the 30 boys. Caution is needed in interpreting such histories. First, sexual abuse needs delineation from physical abuse. For the latter, gradations of physical discipline confuse the issue. The validity of a history of child abuse, given its current popularity as an explanation for diverse types of social and psychological problems, can often be questioned. What is included as child abuse raises difficult legal questions when the juvenile has not admitted such a history prior to the current legal charges. If reports of abuse were antecedent to the current episode of violence, the abuse was counted as positive. A girl who reported that her stepfather had made unsuccessful sexual

advances to her that were rebuffed was not included. Covert conflicts involving power struggles and accusations in a family, without confirmation, were not included. Only a full picture of repeated, physically assaultative acts by a parental figure, or overt sexually coerced behavior, were included. A history of being slapped or the use of physical discipline *per se* by the parents was not accepted as child abuse.

Four girls reported sexual abuse involving three stepfathers, one stepbrother, and grandfather (one girl was involved with two of her relatives). Five girls reported a pattern of regular physical beatings by their mothers or fathers when younger (including two who also reported sexual abuse). The pattern in the eight boys was that of repeated strappings or beatings when younger by one or both of their parents. The history of child abuse related to delinquent or violent behavior has received increased attention.[25] How much significance should be attached to this variable in a group who later emerged as depressed and performed a homicidal act? Do we know enough to say what the incidence of child abuse is in different types of delinquent populations? Careful assessment would be required to determine whether the incidence of abuse is significantly different from other delinquent samples with varieties of antisocial behavior. What behaviors are encompassed under "abuse" needs careful definition, as does the frequency and the impact on specific areas of development.[26] If the abuse is carefully documented, it may be related to the hostility, anger, and irritability seen in the clinical picture.

Discussion

There are different conclusions and possibilities related to the findings on depression in this homicidal group of adolescents. One is the difficulty in discriminating diagnostic subtleties through the diverse types of community and legal contacts they had. There is also the possibility that they may not have been depressed before the homicide but only became so after the violence. Such a hypothesis would be either in the direction of diagnoses changing over time, or disparate diagnoses. Although the latter is a possibility, it is contradicted by the overlap in time of the symptom picture presented by these juveniles. The problems in prediction of rare events has long been known and is relevant to the difficulties of extreme violence occurring in adolescence.[27]

A hypothesis was whether this group of depressed adolescents might fulfill the criteria for depressive spectrum disease as earlier noted by Winokur.[7] His study dealt with adult patients who were depressed, but their first-degree family members had problems with alcoholism and/or antisocial personalities. The relatives meet the spectrum criteria whereas the patient is depressed. Is this group of depressed adolescents the offspring of parents who fullfill the criteria of first-degree relatives, either with antisocial personalities or alcoholic problems, in which the adolescents manifest violent behavior along with their depression?

Table 4
Comparison of Alcoholism and Antisocial Personality in First-Degree Relatives of Depressed Delinquents

Family Member	Gender of Subjects					
	Males (N = 30) Antisocial			Females (N = 14) Antisocial		
	Depression	Personality	Alcoholism	Depression	Personality	Alcoholism
Father	4	12*	6†	0	4*	7†
Mother	1	3*	2†	3‡	0*	4†
Brothers	1	1	2	1	0	2
Sisters	1	0	0	0	1	2

* $p < .05$ in comparing both parents of boys and girls.
† $p < .001$ in comparing both parents of boys and girls.
‡ $p < .05$ in comparing mothers with depression for boys and girls.

To examine this hypothesis further, inquiry was made about the relatives (Table 4). The criteria used were stringent due to the fact that the data on relatives was obtained from the juveniles and their court files which contained family data. In all cases the family history was supplemented by outside information from at least one parental person in accord with a family history approach to diagnosis.[28] When the cases of alcoholism or antisocial personality were only suggestive in family members, they were not included as positives. The result was a minimally positive detectable group. If the findings were positive in a restricted group, greater significance would prevail.

A higher degree of validity was attained in the histories of alcoholism than with antisocial personality in family members. To attain a degree of validity for a diagnosis of antisocial personality in family members, prominent symptoms and signs over a period of time were required; if not, they were excluded. A history of a family member receiving treatment for a drinking problem and/or a history of bouts of intoxication confirmed the diagnosis in a family member.

Among the 14 females, seven fathers, four mothers, and two brothers and sisters had a history of alcoholism. Hence, 15 first-degree relatives had problems with alcoholism in a cohort of 14 depressed adolescent females who had participated in homicidal behavior. In addition, four of their fathers qualified for a diagnosis of antisocial personality. None of the subjects was yet beyond the age of 18. In time, further diagnoses of alcoholism or antisocial personalities would likely develop in relatives. The overlap of these diagnoses in first-degree relatives and the pattern of child abuse correlated for the biological fathers and stepfathers as well. These findings are impressive given the small sample size, although the 44 subjects (20%) came from a larger sample of 213 considered for special legal processing. The sample is suggestive for some variation of depressive spectrum disease.

Significance was found when the boys and girls were compared. If antisocial

personality in both parents was considered, it attained significance with half of the boys coming from such families ($p < .05$). For alcoholism in both parents, 26 percent of the boys, but 79 percent of the girls ($p < .001$) had such a finding—a striking finding in the opposite direction. There is also significance ($p < .05$) if the girl, in contrast to a boy, had a depressed mother.

Critical questions can be raised from the suggestiveness in this sample. Is the incidence of alcoholism in the first-degree relatives of the girls, despite using stringent criteria, no different from what might be found in a general population of delinquent adolescent girls? This study did not compare the girls involved in homicidal violence to such a control group on this variable. Comparability would also require both groups of females to be diagnosed as depressed. Although it is difficult to obtain valid data on the incidence of depressions in relatives, data is beginning to merge for specific subtypes with large samples of adults.[29]

Hypotheses can be raised with respect to alcoholism in families that have a depressed girl who had committed a homicidal act. We would be distinguishing a differential pattern of alcohol use in the families of two female delinquent groups—one depressed and the other not. The theory would postulate parental alcoholism as an antecedent variable when an act of extreme violence occurred. This theory is congruent with a social learning theory of modeling in observing and internalizing parental behavior conducive to a potential for violence as well as factors contributing to depression. A combination of alcoholism and depression in parents, in comparison to groups of offspring whose parents were either rated as "normal" or "nonalcoholic depressed," found a higher incidence of conduct disorder and deviant drinking behavior.[30] This does not resolve the problem of primacy between alcohol dependence and depression, but would be in the direction of a loading effect.

Difficulties in assessing such empirical variables are related to the large number of relevant factors. Even in a descriptive nosology there is low validity due to the overlap of diagnostic categories. There is also the difficulty with a seemingly endless list of developmental and environmental variables that can affect a child and take a toll in adolescence. The significance of the variable of parental alcoholism might lie in: prenatal exposure to excess maternal alcohol consumption, the age at which the effects of the parents' alcoholism became manifest to the child, how severe or persistent the pattern was, whether there was any treatment or hospitalization of the parents, family reactions to the problems that emerged, assessment of the efficacy of diverse treatment modalities tried, etc. Any of these could account for differences not just due to the alcoholism. A similar set of strictures could be given for assessing the significance of antisocial personality in a family member. Diverse outcomes are also possible for any given adolescent even though a similar set of environmental antecedents is documented.

Overlap of symptom patterns of hyperactivity and conduct disorder complicates assessment of the impact of parental alcoholism. Distinguishing the significance of symptoms of agitation/hyperactivity from that of aggressive behavior is difficult.[31] Attributing delinquent behavior in adolescents to an alcoholic parent is frequent. However, when a comparison was made using families with nondelinquent sons, parental alcoholism in itself did not increase the risk for delinquency beyond what could be attributed to divorce.[32]

Similar caution emerges from long-range (over 20 years) studies of children from lower-class families.[33,34] Parental alcoholism is then seen as only one stressor among many, such as living on welfare, divorce being twice as prevalent with children of alcoholics, and almost the same differential for variables of parental arrest, imprisonment, absence, or hospitalization. The complexity of interacting variables in such milieus is more the normative pattern, which means that causal attribution to alcoholism, psychopathy, or any one variable, is not satisfactory. Nor can we ignore the impact of possible genetic predispositions toward alcoholism or psychopathy, although it would appear that family environmental factors may be crucial in eliciting such behavior. Perhaps most significant is that something happens to disrupt the family interaction and equilibrium toward psychopathological development. The question is then pushed back to what could have functioned to have such a critical developmental impact toward homicidal violence—mental disorder, disrupted family values, inadequate guidance and nurturance, modeling of maladaptive coping styles, etc.? Or, was the homicidal act simply a situational phenomenon that chanced to occur in a high-risk group of adolescents?

At this junction, some psychodynamic hypotheses are suggested to move beyond the empirical data. The course of development seems to have gone awry in these adolescents that was then handled with different coping styles and mechanisms. Whatever their different adaptive mechanisms, there seemed to be an adverse loading of family factors tending toward unresolved anger and dependency needs. In terms of defenses employed, externalization, displacement, projection, denial, and acting out were prominent. However, they did not work well as adolescence progressed. Depressive affect continued to hover and lead to more desperate efforts either at denial or a ceaseless round of activities and seeming engagements. Yet, even in retrospect, it would be difficult, if not impossible, to predict prior to the act that this group would perpetrate or participate in such a homicide.

One retrospective sign present in several was verbalizing, usually to a peer, about the unhappiness or hopeless predicament in their home life. They would then add a comment in a more lighthearted manner, as if it was simply a passing comment, that they were thinking of killing someone. Seeing no way out of their home situation, they became more desperate. One boy attempted suicide, grappling with what he perceived

as a continued parental disappointment in him. Six months later he reflected on his options such as beginning to indulge in drugs or liquor, giving up entirely on school performance, etc. After a week of such ambivalent ruminating, he carried out a killing in his family. It is not possible to know at what point to take suicidal cognitions to be homicidal as well, or when such a threshold has been crossed. The problem is overwhelming for a clinician, let alone someone in a community setting, in grappling with when such a threshold has been reached.

One prominent theme in some of the males was playing an exaggerated "macho" role that had begun to wear thin for many reasons such as time passing and a sense it was simply an act. Concealed beneath such a facade were feminine interests and frustrations in maintaining intimate or close relationships. A youth might be seen as popular by his peer group but would confide during psychiatric evaluation that he was really a loner with constantly shifting friends.

Dependency on parental figures had been denied or disavowed. In one case the pattern was a two-year history of running from home, being apprehended and brought back, admitted to treatment centers, and failed contacts with different therapists. At the point of utter frustration after an argument, the parents told the boy they were done with him and no longer wished him to remain at home. Within a matter of minutes he got a gun and shot them. The "bluff" against their being the oppressors and not letting him leave had been called by the parents who had stepped out of their previous roles. His inability to separate initiated a panic episode. For several days after the killings, he did not leave the home area but continued to "sneak" into the house via a basement window, just as he had done when the parents were alive, except now the dead bodies lay upstairs. A year after the events, he expressed a desire to continue to live in the same area: "I've never lived anywhere else and I don't know if I could handle living away."

Increasing degrees of denial loomed as an ominous sign. The need to avoid anxiety to the degree of banishing it, but instead handling things by agitated states, physical flight, drugs or alcohol, alternating with periods of lethargy and indifference, became the pattern to attempt such banishment. Denial also operated to deny their degree of anger or agitation and ultimately to deny they were depressed. There was no emotional response to events that would ordinarily elicit the response, indicating progressive withdrawal. In some cases, a valiant effort at forced gaiety or entertaining others was a hope to avoid despair.

Finally, there was the *goetterdaemmerung* finale for some of these depressed adolescents. It was associated with a conviction that everything was over and there was no hope. However, rather than suicide, they killed others and perhaps were killed by others or attempted suicide. Their despair was about themselves and the world, with a feeling that everyone would be better off if dead. The hopelessness was externalized in its origin and resulted in attack-

ing others as if this would destroy the hopelessness. This could lead to killing family members or a shoot-out in a crowded location. The suffering their behavior would cause many others was denied as was a sense of guilt. Their guilt was of a deeper kind in which relief was sought in a culminating act of destruction. A sense of relief or calmness subsequently took over as they were already beyond the desire to live.

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