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THE PREDICTION OF ADOLESCENT HOMICIDE:
Episodic Dyscontrol and Dehumanization

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The ability to predict both homicidal and nonmurderous violent behavior would theoretically be helpful in some types of crime.[1] Considerable efforts have been made in this direction. Statistical studies, although they are not helpful in individual prediction, show that violent behavior is more likely to occur in the mentally ill who have been chronic patients in psychiatric hospitals than in the population at large.[2] Adult crime is said to be more likely in those who as children showed a triad of enuresis, firesetting, and cruelty to animals, but this syndrome is not present with greater frequency in violent than nonviolent individuals.[3]

It has been generally agreed that dangerous acts cannot be predicted in a person who has not acted in a dangerous way.[4] However, recognizable homicidal characters have been shown on the stage ("Lorenzacchio," A. de Musset). Most psychiatric literature attempts from retrospective studies to deduce what ought to be sought to make the prediction of homicide possible, but recently some psychological tests on prisoners have been shown to have a predictive value indicating the possibility of violent behavior.[5] A study of ten adolescents, nine boys and one girl, in whom a prediction of murderousness was made, describes definable syndromes in which the attempted murder of another human being is more or less inevitable.

Theoretical Background

A study of murder without apparent motive in four individuals who made homicidal attacks described a syndrome which it was thought might be indentifiable prior to an actual episode.[6] All the patients studied had a history which included: (1) parental violence, (2) severe early emotional deprivation, and (3) erratic control over aggressive impulses. Psychological examination indicated that the patients had: (1) ego images of themselves as physically inferior, weak, and inadequate; (2) a violent and primitive fantasy life; (3) blunted and shallow emotional reactions; and (4) severe sexual inhibitions.

The homicides occurred at the end of a period of increasing tension and disorganization, and the victims were felt unconsciously by the murderers to represent figures from their internal conflicts. During the act of violence the murderers felt separated and isolated from themselves. This isolation was so extreme that it was possible for one of those studied to pass a lie detector test just before he impulsively confessed to the crime.

Another study of eight individuals accused of homicide[7] and suffering from a clinical syndrome based on the concept of "episodic dyscontrol"[8] used only psychological test information. In all cases, evidence was found of a history that showed disintegrated family relationships, and that, as a child, each individual had been called upon to deal

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with overwhelming affects when ego structure was too immature to cope with them.

Psychologically all these patients show evidence of early oral deprivation. This leads to such a distortion of character formation that the individual never develops boundaries to a sense of self and cannot separate "me from not me." The separation-individuation phase of human development in which the child begins to perceive his ego as being entirely separate from mother does not occur.[9] Thus the patients show the characteristics of a "weak ego."[10] The infantile omnipotence which thus remains present is almost certainly maternally reinforced. The murder victim is thought to be a symbol of the inevitably frustrating parents. The homicides are preceded by a history of nagging, carping, and derogatory criticism of the murderer, and the actual attack is related to the individual's fear of being overwhelmed.

A recent study of a seventeen-year-old murderer who slaughtered an elderly relative reviews the syndrome associated with episodic dyscontrol in the etiology of homicide.[11] In this patient it was clear that the early oral deprivation and perception of the parents as being excessively violent was idiosyncratic. It was perceived by the patient rather than a direct result of objectively assaultive or depriving parental behavior. Thus this patient's immature ego had to deal with excessive affects not because of environmental stimuli but because of infantile responsiveness.

Another study of twenty adolescents charged with homicide was particularly concerned with the prodromal events which led to the killings.[12] Psychological regression was often induced by the use of drugs, particularly barbiturates and alcohol. Increasing psychic tension had preceded the attack, and the history showed: (1) recent object loss, either of a mother or lover; (2) recent somatization as shown by hypochondriacal complaints; and (3) threats to manhood which were either overtly or covertly homosexual.

All this might reinforce the concept that murderousness is predictable, but studies of violence as distinct from homicidal aggression show a clinical syndrome that appears to differ hardly at all from that described. Violent subjects have been shown to suffer from emotional deprivation;[13] compared to a control group they are more likely to have been beaten as children; and their parents, in a statistically significant way, show a greater incidence of alcoholism than the parents of nonviolent individuals. Just like potential murderers, young people unable to control assaultiveness can be deduced to have experienced overwhelming affects which swamp immature ego functions. When a violent group is compared to one that is nonviolent, a greater incidence of temper tantrums is apparent, but similarly, a murderous group has a life history of erratic control of aggressive impulses.

The personality dynamics of those who have committed murders have been discussed in psychoanalytic literature. But this does not adequately differentiate between those who are likely to kill and those who are not. The murderous personality is said to be suffering from a basic depression with intense persecutory anxiety. The depression is projected onto the persecutor who is thus destroyed in an attempt at relief: "Murder is only the tip of a pathological iceberg."[14] Many murderers are said to be relatively normal in one area of life but have an aggressive murderousness in another. When it erupts, this explosive element within the personality inflicts irreparable damage. The other individual may be a scapegoat representing the internal figure of a mother or a sister. There is "an untamed

savagery in the personality. Thus, cutting and stabbing, phallic and oral aggression, are common."[15] A disturbance in intrapsychic equilibrium, which easily occurs because of "the terrible rage which exists beneath the surface of the murderous mind at a moment of tension,"[16] is said to explode. A savage attack on a maternal image,[17] homosexual anxiety,[18] and oedipal anxiety[19] have all been described.

In all these reports, the intensity of the epithets is all that might be said to differentiate those who might be given to murderousness from those who are assaultive but not homicidal. A study of young men who participated in the slaughter of defenseless people in the Vietnam War[20] gives clues to what might make a definable syndrome in which individual homicide could be predicted. Slaughter, which presupposes the destruction of the defenseless, is possible under the following circumstances: (1) The enemy is everywhere. Trust can only be given to one's own group; others are pervasively dangerous. (2) The responsibility for the slaughter is shared. (3) The pressure to act out aggressively is expected. Often this pressure is enhanced by the visual sight of genital mutilation inflicted on peers by bombs and other weapons. (4) The psychopath—cold, brutal, and violent—at last finds himself in a world suited to his character structure. He becomes the leader of the murderous group. (5) The enemy is not human, the person becomes a thing. For example, Orientals are referred to as "gooks."

It is the hypothesis of this study, deduced from the adolescents in whom a prediction of murderousness was made, that the capacity to dehumanize others, easily produced under stress and either associated with episodic dyscontrol or pervasive in the personality, is the issue which differentiates the murderous from the violent.

Identification of Patients with a Murder Syndrome

A significant number of individuals who are responsible for homicide in both adolescence and adulthood have been in previous contact with helping agents: probation officers, court social-workers, psychiatrists, psychologists, and the therapeutic personnel of schools. Sometimes these contacts may be unrelated to the imminent onset of a breakdown in aggressive controls. Sometimes individuals seek help but may be quite indirect in their presentation, so the prodromal events of homicide are often looked upon as a muted call for help. Some patients, if they seek assistance, may unconsciously attempt to manipulate possible helpers so that they are not likely to recognize the gravity of the situation. Like potentially suicidal behavior, the murderous act can then be justified because someone failed to help.[21] Recognition of the seriousness of a threat to kill may, however, abort some murderous attacks:

> An eighteen-year-old youth, an exprisoner on probation, felt that his social worker was humiliating him and became acutely agitated. He did not indicate to his social worker the cause of the agitation, but he was referred for an emergency psychiatric consultation.
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> In the course of the interview he indicated that he felt he was going to kill his probation officer. It was very clear that the young man was under great stress, and the interviewing psychiatrist thought that there was indeed a likelihood that he would lose control and become murderous. The patient refused to consider going into a psychiatric hospital. Nevertheless, when this suggestion was made, his obvious agitation subsided. He became somewhat aggressive toward the psychiatrist and told him that if anyone tried to force him to be admitted to such a hospital he would deny his intent to kill. He went on to say that

> he felt sure that under those circumstances, even if he was forced in, "they would certainly let me out." This was felt indeed to be accurate. It was also apparent that if the young man chose to control his wishes and their overt expression, he was certainly not likely to be committed as legally incompetent.
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> Interpretations were made to him about his need to make others helpless, to "murder" the value of any help that might be offered. It was suggested to him that if he could succeed in making the psychiatrist useless he might then feel that he had implicit permission to behave in a homicidal fashion. None of this seemed to be of any value. The patient persisted in his refusal to be hospitalized and left; apparently nothing could be done.
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> After leaving the psychiatrist's office, the youth walked to a nearby shopping center and hurled a brick through the window of a large jewelry store. He made no real effort to get away, but waited to be arrested and was then put in prison. When he was jailed he was very relieved and said, "Now I am safe."

As in the case of the above individual, if enough ego and superego functions are intact, those who are overwhelmed with the fear of a breakthrough of murderous impulses may seek protection. Murder may occur if this is not offered. Many of those who do not seek assistance appear to be the apparently impulsive killers of society.

Murder Syndromes

Over a period of eight years in Britain and the United States, predictions of the presence of potential murderousness have been made on the basis of clinical interviews, psychological test studies, and physical and neurological examinations. From these studies an hypothesis is deduced that because of the inevitable stresses of day-to-day living there are definable syndromes in which attempted murder will occur.

Most homicides are thought to happen by chance and there is at present no evidence that all murderers suffer from predictable syndromes. But these may occur in individuals who have not been socially defined as criminals and who are not legally incompetent by current definition. One of the authors of this paper, who at the time did not belong to any correctional system, predicted murder in advance of a homicidal attempt in all but two of the cases studied. In one of these two cases, a prediction of murderousness had been made by a psychiatrist when the murderer was a child. In the other, no such prediction had been made. He had assaultively attacked another boy at the age of eight, but at that time he was not seen by a potentially helping agent.

Three types of murder syndromes appear to be definable and can be understood in terms of the risk factor. (1) High Risk: Permanent (total) Dehumanization. The murderer can totally dehumanize others. Since violence is egosyntonic, destruction is looked upon as inconsequential; it will take place when the murderer's wishes are actually or potentially thwarted. (2) High Risk: Transient (partial) Dehumanization associated with episodic dyscontrol. The murderer "slaughters" helpless people because they represent an unacceptable part of his own personality. The slaughter takes place during episodes of "episodic dyscontrol" which are related to specific external provocation which stimulates the internal conflicts of the patient. Splitting and projection then occur. (3) Low Risk: Transient Dehumanization associated with episodic dyscontrol requiring consensual validation. The murderer slaughters other people who represent an unacceptable part of his personality. This can only be done when permission is explicitly or implicitly obtained

from a peer group who is perceived as validating the activity. The group gives permission to abandon both ego and superego controls.

Dehumanization

All the syndromes imply permanent (total) or transient (partial) dehumanization. In total dehumanization the other individual is seen as a nonperson, merely a thwarting object. In partial dehumanization the unacceptable part of an individual's personality is split off and projected onto the other. The "internal gook" thus becomes projected on someone else who temporarily ceases to be human and becomes only an unacceptable bad object to be destroyed.

Dehumanization[22] is seen developmentally in all children. It first appears in association with the concurrent capacity to humanize animals. Dehumanization may be highly transient; this is typically seen in small children who become extremely angry with one another and see the other child only as a thwarting object. The physical weakness of children is the quality that makes this not dangerous.

All psychological projections to some extent imply a limited capacity to depersonalize others, but reality testing of human qualities is not lost. Projection becomes pathologically dangerous when the projection of the bad inner self is so intense that dehumanization, either total or partial, overwhelms individual perception. Recovery of these ego functions, which allow for the recognition of common humanity, is temporarily or permanently impossible. This is demonstrable both in clinical interviews and psychological tests.

If the Rorschach content of psychological tests of these who dehumanize is examined from the viewpoint of object relations,[23] it is clear in the patterns that emerge that humans are not seen as people. There is a paucity of images that would suggest a stance that other people are full, warm, and alive. Similarly, TAT stories indicate that other people are not seen as human, and often there is obvious confusion about whether a figure is alive or dead. In addition, in those who have the capacity to easily dehumanize, projective tests indicate that the distinction between life and death seems to be quite unclear. There appears to be no sense of human death; people who are perceived as alive are godlike and immortal.

When, as children, vulnerable individuals are treated in a violent or exploitative manner by others, they are likely to become pathological dehumanizers. This is because the immature ego is not only overwhelmed, but the child is also transiently dehumanized. Irrespective of the conscious intent of the brutalizer, the victim does not perceive himself as being recognized as a person with feelings; ultimately others are treated in the same way. The historical data that separates typical borderline personalities who cannot separate-individuate from those who become capable of murderous and dehumanizing behavior, appears to be that of an inexplicably violent parent with the other parent being either absent or passively collusive. The extent to which the child perceives himself as dehumanized is thought to be a measure of the likelihood of this capacity being a part of his own personality structure.

Total or partial dehumanization may be hidden and may only be evident when the patient is asked about his attitude to other people, particularly those who are perceived as frustrating. Those who totally dehumanize have a pervasive inability to make genuine

human attachments. Although the patient may show apparent warmth, this has no depth and it is a superficial learned response.

The patients in this study alternated between showing a capacity for apparent human friendliness and a cold self-reference. The latter appeared either when the patient was asked about his perception of frustrated wants or when frustration was felt in the interview, often the cause of an accurate interpretation:

> A seventeen-year-old boy was describing how, if he went to jail for murder, he would become "like a wild animal." The comment was made that he must currently feel exactly like that. With great coldness, which was his immediate affective response, the patient described how he thought of killing the staff of the hospital where he was a patient. He went on to say, "But I won't do it because I'd get caught."

Thus the projection of the bad part of oneself onto the victim may be so intense that feelings about a part object may lead to the total dehumanization of the individual. While being interviewed one boy said:

> "I will be fucking her and then I will think how disgusting her cunt is. Then I will get a knife and tear it to pieces. I can imagine how bloody it will be; I will cut it and cut it and cut it."

This boy's anxiety about devouring, attacking female genitalia led him, in fantasy, away from seeing the girl, who was the object of his sexuality, as an entity and a person in herself.

High-Risk Murderousness

Those who totally dehumanize are primitive, narcissistic, and omnipotent personalities who show both a disinclination to value human life and an egosyntonic acceptance of violence. The presence of this syndrome arouses a specific response of hostile anxiety on the part of the examiner. This response appears to be pathognomonic of its presence.

> Jane, a thirteen-year-old black girl, was seen at a university hospital because she had made an impulsive attack on a teacher who tried to control her. The patient came from a lower socioeconomic background, had no wish to be interviewed by a psychiatrist, but came under pressure from the school and her mother. She was a small, rather ugly girl who, in her first interview, spent much time looking out the window. Ultimately, she was able to relate to the psychiatrist with a superficial, if intermittent, warmth and interest.
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> The girl was fatherless and said that her mother, who drank excessively, controlled her by "whipping" her. The teachers reported that the girl had been repeatedly extorting money from other children. She herself said that she did not see why she should not take money from "honkies" and "teachers are not people anyway." She said that she neither enjoyed nor disliked hurting others. She did not think that either concept was relevant—if she wanted something, she was going to get it. The worst that would happen to her she said, was that she would go to a juvenile court.

The patient was perceived by the examiner as being intolerant of frustration, infinitely greedy, and, when her wishes were thwarted, prepared to go to any length to get them gratified. People were seen as objects who were not significant and who were to be removed from her path. This attitude is similar to that described in the study of Vietnam veterans involved in slaughter.[24]

The psychiatrist, in writing to the referring agency, said that he thought the girl was

murderous. Since people were meaningless to her, and since she saw herself as entitled to get satisfaction for her wants, the prediction was made that she would ultimately become homicidal. This prediction assumed that it would be impossible for her to get her wishes met.

The referring agency was in a difficult situation; adequate facilities for the treatment of such children are difficult to obtain. A typical human response to such helplessness is denial; the prediction of murderousness is not really possible. The girl was therefore referred to another social agency, presumably with the hope that they would negate the prediction. This agency offered counseling help to the girl and her mother.

Two years later she was seen in consultation at a juvenile court by the psychiatrist who had originally diagnosed her as homicidal. A recommendation about an adequate disposition was requested. The patient was an inmate of the juvenile detention home because she had apparently killed an old lady who had refused to part with her purse. The patient was quite pleased to be recognized by the interviewer, and she well recalled her first consultation with him. She did not think, however, that it had been of any value, but she was quite prepared to be cooperative. She described the homicide with complete unaffectedness: "The old bitch was stupid and tried to stop me." She did not think that anything very significant was going to happen to her, and she had no expectation that she might not do the same thing again.

A similar syndrome was present in another sixteen-year-old girl. An as yet unfulfilled prediction has been made that she will inevitably behave in a murderous fashion.

> In the course of a clinical interview, this pretty, blond, doll-like girl revealed that she regularly stole clothes from a fashionable department store. She was contemptuous of the store's security system: "They don't even count the number of dresses you take into the booth." She was asked what she would do if a salesgirl tried to stop her leaving the store. She said, "I always carry a knife. I would kill *anything* that gets in my way." This was said with a chilling coldness which made the examiner both anxious and angry.

The girl, who was intelligent, rationalized her stand by saying that "she was entitled to rip things off because the store was rich." No one was entitled to stop her, and if they did get in her way, then they were stupid. She indicated that people ought to know that one might be killed if one attempted to stop a robber; therefore homicide was justified. This was said in response to the examiner's apparent doubt about whether she really meant it when she talked of killing others. She became impatient when questioned about the desirability of eliminating a potential opponent and was somewhat irritated by the examiner's doubts about her abilities to be murderous. This patient was reported to the juvenile court judge as being, in the opinion of the examiner, potentially homicidal. An appropriate therapeutic disposition was impossible because of lack of facilities, and the girl was sent to a long-stay juvenile home.

Both these patients demonstrated a cold and brutal capacity to totally dehumanize those who frustrated their perception of their wants. They both had a history of early deprivation and had initially been treated violently by one or another parent. This history may appear in many adolescents who become violent, but the violent individual who is not homicidal does not dehumanize others:

> A sixteen-year-old boy with a history of early emotional deprivation and parental violence was interviewed at a juvenile court. In the course of the interview he revealed that he was a thief and a dealer in drugs, and highly successful at both. It was very clear that the possessions of others meant nothing to him. The question was raised with him about what would happen if, when he broke into a house, the owners were to wake up. He indicated that he would have to silence them but would prefer to run away if he could. Since he was a big boy he was asked about this and he said, with genuine feeling, that he had no wish to hurt people. "People matter, things do not." On the other hand, he said, that if he had to behave violently to get away he would do that.

The violent individual who is not homicidal is aware of assaultiveness, but is also aware of a conflict about humanizing:

> A fourteen-year-old girl gave a long history of theft which she did not stop despite the fact that she was on probation. She was also a chronic drug-user. She described how her whole family stole and how she would take money from a department store and from a university athletics building. She freely discussed her bad temper and told how on occasion she hit her younger brother with a steel pipe.
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> She demonstrated a certain capacity to empathize with people and was contradictory in her description of her attitude toward them. On the one hand she said she did not like hurting people, on the other that if people interfered with her stealing, she might feel obligated to hit them. In the event that she did this, she said she did not want to hurt them but did not mind particularly if she did.

This assaultive girl was conflicted and anxious about her potential for violence. She recognized the humanity of others; clinically she was depressed and unhappy.

When individuals dehumanize, assault is irrelevant and death is inconsequential. Since infantile wants are inevitably frustrated, and since this produces dehumanization of the frustrator, sooner or later homicide becomes inevitable.

Partial Dehumanization

When partial dehumanization occurs during periods of episodic dyscontrol, it is then hypothesized that the consequent violence leads to inevitable homicide. The destruction of the dehumanized object becomes necessary to resolve internal tensions associated with inextricably mixed conflicts about sexuality and aggression. The dehumanized individual becomes a depository of a split[24] representing for the murderer a bad, frustrating, depriving mother, who produces such intense rage that perception of the other person as human is lost.

Diagnosis may be made by the appearance, during a clinical interview, of a murderous fantasy. This is both egosyntonic and exhibitionistic; its appearance temporarily appears to resolve internal conflict and relieve overt tension. The affect associated with the fantasy is diagnostic of murderousness. The description of the fantasy produces masturbatory satisfaction and excitement in the patient. This indicates minimal controls which are the crucial etiological factors in the syndrome. The patient is apparently as compelled to convey the fantasy to an involved listener, when it is triggered off by an appropriate stimulus during an interview, as he is to act out the fantasy when he is stimulated by the presence of an appropriate victim. The excitement of the murderous act is mimicked in the description of the fantasy. The patient's appearance is not unlike that of an individual

having an orgasm. The details of the fantasy arouse horror and anxiety in listeners; it is a different psychic experience from the hostility and anxiety of the total dehumanization syndrome.

> David, a tall, gangling, fourteen-year-old boy, was seen in a school for deprived adolescents because he was "depressed." He was a pale youngster who sat huddled in his chair. Initially he was reluctant to be seen, but this disinclination rapidly melted away as he felt empathy from the interviewer. He then showed some apparent warmth.
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> He was the offspring of an apparently stable nuclear family, but his father treated him with a great deal of aggressive violence, punching and kicking him with minimal provocation. The boy said, "I don't know why he would hit me. Somteimes I had not done anything." David had been sent away from home because he was thought to be in need of care and protection. In the course of the interview he gave a history of having been aggressive toward other children for a number of years. He clearly saw them as things he should torment and punish, inferentially the way his father had perceived him. His attitude toward others was reminiscent of the Shakespearean "Flies to wanton boys are we to gods. They kill us for their sport."
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> He was asked if he had any feelings about hurting people. With mounting excitement he described how he hated homosexuals. This intense excitement abruptly terminated when he rather suddenly seemed to return to the reality of the situation. In response to a question as to what homosexuals did, he described how they sodomized other people. He went on to talk about how if somebody tried to do this to him, he would have no alternative but to slaughter them. He lost himself in this fantasy which he clearly found exciting, and he appeared quite depersonalized. He was then asked about male friends. He said that he did not like them very much because "all they want to do is talk about sex." He went on to say that he was unhappy in the school because he thought the boy in the bed next to him was interested in him sexually. He was asked if he was trying to say how he felt about this boy; he said that if he propositioned him, he would have to kill the boy.

The patient was thought to be potentially homicidal. The recommendation was made to the school authorities that he be placed in a psychiatric hospital. The school principal found it difficult to accept the concept that the boy might be murderously assaultive and sent him to another psychiatrist for an opinion. He disagreed that there was evidence of the difficulties described.

Six months later the boy was seen in a juvenile detention home. He had been placed there because in the middle of the night he had gotten up and beat his roommate over the head with a stake. He then attempted to drive this stake through the boy's stomach. The noise he made aroused the school staff and rescue occurred just in time. Neurological investigation showed no evidence of brain damage, nor was there evidence of significant electroencephalographic abnormality. Psychological tests showed evidence of a minimal capacity to differentiate between the living and the dead.

Six patients have been seen who showed evidences of partial dehumanization in association with the projection of a bad part of themselves. In three an apparently homicidal attack occurred, and in one case the victim died. One boy who proposed to kill another who was the mirror image of himself was treated by psychoanalysis. In two others follow-up has not been possible. None of the individuals with this syndrome had significant attachments to others, either peers or adults.

Low Risk Murderousness

This syndrome, which is the most difficult to diagnose in advance, includes those who

partially dehumanize. In them the murderous fantasy requires the validation of peer approval to make action possible. A history of the perception of parental brutality and early emotional deprivation is present. Excitement in the telling of an aggressive and sexual fantasy is clinically apparent, but it is not as explicitly masturbatory and self-referent as in those patients who are not able to use, and do not need, peer contact. The group of adolescents who become homicidal with partial dehumanization need significant attachments to peers who share their conflicts to make the assault possible. This is true both in penal settings and in society at large. Such individuals often belong to groups who have a gang leader who uses the group to act out his own dehumanization of others, both the victim and the members of the gang. Gang slaying allows for the reinforcement of the part of the personality that dehumanizes others and which projects into them the unacceptable self.

At the age of eleven a boy was seen by a psychiatrist who was impressed with his ability to project his hatred onto others and who thought he might become an adult murderer. Five years later the boy was involved in an episode in which he and six others brutally tortured and killed a girl of seventeen. He described almost with tenderness how he led her to be slaughtered and how he cut her throat after she had been beaten by the other boys.

> James is a sixteen-year-old boy with significant psychological and social problems of a chronic nature. His infancy and early childhood were characterized by an absence of stable relationships with a dependable and constant mother. He grew up in an environment in which aggression and violence were a basic life-style. His father constantly beat him while his mother stood helplessly by.
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> James saw himself as a valueless and unloved person. As a result of this self-perception he appeared to carry within himself feelings of great rage and resentment. He developed no appropriate nondestructive behavior patterns. He appeared to have no firm, ingrained code of ethics or values to help restrain destructive expression of anger. He attempted to avoid expression of rage either by bottling it up inside himself or by expressing it in rich, destructive fantasies. Neither mechanism served him adequately. However, without external permission he did not behave in a particularly aggressive way insofar as direct aggression is concerned.
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> He appeared to have very complex sexual conflicts. He had an apparent ability to fuse sexual excitement and gratification with aggressive behavior. He talked with a degree of excitement of how he would enjoy sexually using women. His view of women was confused and unrealistic. He needed women to be perfect, pure, and protective, and when women invariably failed him in his expectations he devalued and dehumanized them. They then became worthless objects to be condemned and destroyed. He related to men in positions of authority in a passive and submissive way. With such men he seemed to derive a sense of gratification from being submissive.

The patient's problems were played out in full during his involvement in a group slaying of an adolescent girl. He was himself a rather small, unattractive young man, and his loneliness and intense need for acceptance led to his joining the gang. He willingly submitted himself to the orders of the powerful gang leader. The victim had a reputation for being promiscuous, and with her he played out his conflicts about femininity. He blandly described the gurgle as he cut her throat. The group's perception of the victim as a whore allowed him to fully play out his fused sexual and aggressive instincts. He described the feeling after the slaying as a warmth similar to that he had previously felt after sexual

intercourse.

This boy received an overt permission to kill, but the permission to kill might also be quite subtle. The social environment can sometimes give the individual permission to live out his impulses.

> An eighteen-year-old art student made an impulsive attempt to strangle a fellow student, an elegant, long-haired, blond girl. He had just started at art school which he felt was a loose, promiscuous place where "everyone smokes pot and you can do what you like." During clinical interviews the patient described how he was fascinated by such girls. He said with much affect that it would make sex wonderful to have intercourse with such a girl and at the same time strangle her with her hair. He had thought of going to Scandinavia because he felt it was sexually free and he could easily get away afterward.

The boy's mother had been particularly violent toward him, and his father had been passive and distant. He had been brought up in poverty, but because of his undoubted talent he had been able to get scholarships. Permission to act out the impulses appeared when he started art school. From being a quiet, rather studious person, he began to use drugs. He was impressed by what he saw as the sexual availability of the girls around him. This gave him permission to act out the conflicts he had previously contained.

Conclusion

Three basic types of murder syndromes are described with varying accuracy of risk and difficulty of prediction. The likelihood of murder is thought to be extremely high in the presence of either total dehumanization or partial dehumanization when part objects are aggressively eroticized. The likelihood of homicide is present at lower risk when partial dehumanization requiring validation from the external world is needed to make murderousness possible. It is possible that the latter is the syndrome that can lead to the slaughter of innocent victims during war.

The prediction of murderousness clearly produces great difficulties for society. If homicidal adolescents—both the ones who experience dehumanization and episodic dyscontrol and those who experience dehumanization alone—are treatable, the society's present solution of long-term incarceration in mental hospitals or prisons would seem inappropriate.

Treatability of assaultive and murderous adolescents can be initially assessed by their capacity to make emotional attachments. If these are possible in a one-to-one relationship or in multiple temporary attachments with a network of people, treatment is possible. The case in which episodic dyscontrol is likely to appear is also significant in the assessment of treatability. Treatability does not depend on immediate access to psychotherapy. Initially the patient's ego functions have to be reinforced so that internalization of conflict becomes possible, dyscontrol becomes ego dystonic, and individuals become capable of beginning to differentiate themselves from others.

Particular therapeutic problems are created if dangerously disturbed adolescents are placed in a psychiatric hospital in which murderous youngsters are not generally placed. Intense anxiety may be created among staff and patients so that environmental responses are distorted. If such adolescents are placed in a specially secure setting, this typically produces institutionally pathological reactions among both patients and the staff. The aberrant behavior and attitudes of the staff, the distorted interpersonal relationships and

peer group anxieties are all unsatisfactory identification models for the patients. Possible internalized images, helpful in ego building, are not then created. In most open settings if in the course of therapy a murderous adolescent absconds, the risk of destructive behavior in the community places an undue burden on patients, staff, and the population at large.

Seriously disturbed, aggressively murderous adolescents require long-term placement in a therapeutic setting which can be both open and closed, and which can provide the same human contacts through this variation of institutional placement. Such settings should not be emotionally, cognitively, vocationally, or imaginatively depriving. The adolescents within them should be able to identify with meaningful adults who have significance in terms of the community at large and the hospital community. In such a setting these adolescents ultimately become accessible to psychotherapeutic intervention and growth becomes possible.[25]

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