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A

**THE USE OF DEFENSE MECHANISMS AMONG
ADOLESCENT BOYS DIAGNOSED AS
CONDUCT DISORDERED, DEPRESSED AND NORMAL**

by

William Hernandez

**A dissertation submitted to the Graduate Faculty in Psychology
in a partial fulfillment of the requirements for the degree of
Doctor of Philosophy, The City University of New York**

1999

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

THE USE OF DEFENSE MECHANISMS AMONG ADOLESCENT BOYS DIAGNOSED AS CONDUCT DISORDERED, DEPRESSED AND NORMAL

by

William Hernandez

Adviser: Professor Vera S. Paster

This study sought to examine how often adolescent boys diagnosed as Conduct Disordered, Depressed, and "Normal" used the defense mechanisms of denial, projection and identification. A total of 54, 12 to 16 year old Hispanic and African-American males were grouped according to psychological evaluations as Conduct Disordered (n=19), Depressed (n=17) and Normal (n=18). To assess the use of these defenses the Thematic Apperception Test (Morgan and Murray, 1935) stories of each subject were scored using Cramer's Defense Mechanism Manual (1991). Results indicated that boys classified as Normal used identification significantly more often than the clinical groups (P-value= .000). Conduct Disordered boys tended to use denial more on average than the other two groups (P-value= .063). Depressed boys did not rely on any one particular defense. Instead, they used several of the components of the three defenses, but not more so, or less so than did the other boys. As a result, the use of any of these defenses did not predict membership in the Depressed group. The findings also indicated

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that as all subjects emphasized the use of denial they deemphasized the use of identification and vice-versa.

Future studies should include larger samples of clinical and normal populations to allow more reliable statistical comparisons among these groups. In addition, the examination of additional defense mechanisms would provide a more complete profile of defense structures.

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DEDICATION

This dissertation is dedicated to my mother Delia Hernandez and the loving memory of my father Jose Hernandez. To my mother for all her love, care and devotion to our family and to my father whose pride, dreams and aspirations and spirit will forever stay with me.

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CHAPTER I

INTRODUCTION

There exists high rates of family break up, family violence, street violence, sexual abuse of children, run-away youngsters, homeless individuals and families, substance abuse, etc., in America in general and in poor communities in particular. For example, in certain deteriorating inner-city communities, such as the South Bronx, the father is absent in 57% of the families, while as many as 42% of the adolescents fail to graduate from high school (Goldstein, 1990).

There is a tragic reality that the effects of family, community and societal breakdowns are contributing to increases in emotional and behavioral problems in children. For example, Achenbach (1993), found that since the mid-1970's there has been a significant increase in problems which range from destroying other people's property and hanging out with other children who get in trouble, to doing poorly with school work, being sullen or underactive and whining. Among the largest changes were a drop off in the amount of time children spend with friends, increases in apathy and lack of motivation, in sadness and feelings of depression, and in children disliking school. Children in poverty were more likely to have these problems, both in 1976 and in 1989.

As a clinician, I have had the opportunity to provide psychotherapy to many underprivileged minority inner city children and families. A significant portion of my caseload consists of what Schaer (1988) labeled the "multiply traumatized inner-city child of poverty". Here he is referring to " young lives who often suffer the effects of deprivation and degradation; children who have been reared in an often frightening environment where the possibility of injury, exploitation and abandonment are ever present." (p.13). Schaer points out that in an effort to cope with such traumatic experiences these children regularly make adaptations. He reports that the child is socialized at an early age to understand that the world itself is an aggressive and dangerous place, "Where the only effective responses are to fight it out and intimidate one's antagonists, or to withdraw into helpless passivity because there is nothing anyone can do but accept one's fate."(p.19). In addressing the ego development of these traumatized children, Solnit (1966) stated that in such cases defenses are "...prematurely crystallized to shore up the porous ego. There is an increased dependence on avoidance and denial and as a result there is an inflexibility in the child's ability to adaptively respond." (p22).

Despite the fact that behavior disorders and depression represent two of the most common psychiatric conditions treated in children's out-patient clinics, review of the literature reveals a paucity of empirical studies of the defense mechanisms used by children diagnosed as

Conduct Disordered or Depressed. No studies could be found that focused exclusively on the two groups. Therefore, a major contribution of the present study is that it provides a direct comparison of the use of defense mechanisms in these two clinical groups. It seeks to answer the basic question, is there a specific configuration or pattern of defense which characterize youths diagnosed as Conduct Disordered in comparison to those diagnosed as Depressed?

While the focus of this study is on both depressed and conduct disordered youths, the impetus for designing this study came from the wish to gain insight into the psychological dynamics of conduct disordered children in particular. There are several reasons for this. First, despite the many years of studies of delinquent youths and depressed children, as most clinicians would probably agree, the conduct disordered children represent the most difficult clinical group to treat in out-patient settings. Second, and not surprisingly, studies indicate that conduct disordered children account for one-third to three-quarters of the children referred to out-patient clinics for professional intervention (Forehand and Wells, 1981). Third, It is usually argued that long-term social and psychological adjustment is poorer for aggressive children who externalize their issues by behavior problems, the conduct disordered, than for withdrawn children who internalize their pain, becoming depressed (Robins, 1966). Fourth, in recent years there has been a growing interest in studying depression, borderline and

narcissistic disorders from a variety of psychoanalytic oriented view points, but there has been relatively little information available specifically directed to the examination of the personality dynamics of conduct disordered children. And finally, and probably most importantly, there is a great deal of confusion and lack of clarity surrounding the relationship between depression and disruptive behaviors. Many questions remain unanswered regarding the coexistence or role of depression in externalizing behavior problems such as oppositional defiant and conduct disorders.

Noam et al. (1994) reported that the relationship between conduct and affective disorders is poorly understood. While some authors report that in many and possibly in all children with disorders of conduct there exists a depressive core, others believe that in many cases antisocial and delinquent behaviors represent a "masking" or "equivalent" of depression, anxiety, and unconscious fears and fantasies. Garber (1984) points out that when adolescents experience depression, it is often accompanied by conduct disorders and behavioral problems such as delinquency, substance abuse, and truancy. Noam et al. (1994) states that this co-morbidity is a frequent diagnosis in inpatient facilities and that research needs to be extended so that developmental relationships between conduct disorders and affective disorders can be explored in greater detail.

The decision to examine the use of defense mechanisms in conduct disordered and depressed children was one which evolved over years of struggling with several interrelated questions. These included: First, why is it that children from similar backgrounds and life experiences react so differently to stress? Why do some fight, disrupt, oppose and harm others, and why do others present with despair, shame and a wish to hurt themselves? Second, where do these two groups fall developmentally in relation to ego strengths and weaknesses? Can the use of defense mechanisms provide any clues to these questions?

In working with conduct disordered and depressed boys I found that both groups demonstrated a strong tendency to use denial and projection to defend against feelings of anxiety and threats to the self. I wished to clarify which of the two clinical populations depended on these two defenses the most. While it appeared that the conduct disordered youngsters exceeded in their use of denial, it was not clear to what extent in comparison to the depressed children. I was fascinated by this apparent manifestation given that these "primitive" defenses played such an important role in the survival of these youths.

In a discussion of these types of defenses in children's response to stressful events, Anthony (1986) notes that studies of response styles to threatening illness suggests that repression may lead to better recovery. He reports that denial constitutes an unconscious defense against overwhelming external stimuli and a refusal to recognize the

reality of a traumatic perception (Goldberger, 1983). In these cases, and apparently in the children I see at the community mental health clinic, the turning away from reality may be either adaptive or maladaptive from the viewpoint of safety.

I hoped that through an examination of the use and frequency with which various defenses are used by these clinical populations, I would learn some aspects of the intrapsychic life of these children. Insights that can help me begin to piece these puzzling questions together, with an ultimate goal of contributing to the understanding and treatment of these under served clinical populations.

Over the years various researchers have attempted to get to the root of some of these questions. Their studies have sought to examine and clarify a wide range of important issues and concepts related to the usefulness of understanding defenses and their role in adaptation and coping, human development, psychopathology and treatment.

Among the numerous writers and researchers who have contributed to the growing understanding of defense mechanisms in clinical populations, the past and more recent works of Vaillant (1971, 1994) and Noam et al. (1994) have been particularly helpful in organizing my thoughts in this area.

Vaillant (1971) noted that the conceptualization of the ego mechanisms of defense remains one of the most valuable contributions that psychoanalysis has made. He stated that as soon as one postulates

that defense mechanisms exist, questions arise: What is the relation between their use and psychopathology? Why do some individuals use one constellation of defenses, while other individuals use another? Are defenses only intrapsychic or can we identify them in external behavior? Do defenses last only seconds or can they be manifested in individual life styles? If psychological health is indefinable, perhaps adaptive and maladaptive life styles can be identified by the underlying mechanisms.

More recently, Vaillant (1994) stated that the validity of defenses makes them a valuable diagnostic axis for understanding psychopathology. He believes that by including a patient's defensive style as part of the diagnostic formulation, the clinician is better able to comprehend what seems initially most unreasonable about the patient and to appreciate what is adaptive as well as maladaptive about the patient's defensive distortions of inner and outer reality. He reports that clinical appreciation of the immature defenses (e.g., acting out and projection) is particularly useful in classifying and caring for individuals with personality disorders.

In my experience, many of the children referred for disruptive disorders, particularly the more disturbed ones which could receive a diagnosis of Conduct Disorder, were among the most difficult to treat. This was partly due to their negativistic attitudes, limited capacity to talk about their feelings, provocative and aggressive behaviors, and difficulties accepting responsibility for their actions. These patients easily

felt criticized and misunderstood despite many efforts to establish rapport with them. One way of understanding their ways of relating and interacting with others comes from concepts drawn from ego psychology and object relations theory.

In following this line of reasoning, in a perspective known as the clinical-developmental approach, Noam et al. (1994) investigated the developmental aspects of conduct and affective disorders in hospitalized adolescents. They hypothesized and found that conduct problems are associated with delays in ego development whereas affective disorders are in part associated with the developmentally more mature, "internalizing" states of ego development. This hypothesis stems from the recognition that in conduct disorders, the lack of guilt and concern for others' feelings and property corresponds to typical descriptions of early levels of social and ego development (e.g., Loevinger, 1976). On the other hand, certain dimensions of affective disorder, especially the more typical internalized guilt feelings and concern with the loss of others, corresponds with more mature ego developmental descriptions. These ideas suggest that the course of psychiatric disorders needs to be understood in developmental terms. Consequently, in order to develop a greater understanding of these children's subjective inner life, particular attention focused on concepts drawn from developmental-psychoanalytic perspectives.

In conclusion, with increasing numbers of troubled children, especially those locked in poor isolated areas with surrounding pathology, and decreasing resources devoted to mental health services, it becomes increasingly imperative to improve our understanding of the children with whom we are confronted. This will enable us to be more effective in using those resources that remain. This study is also designed to elucidate the similarities and differences between the conduct disordered and the depressed groups, as well as to contribute to the development of empirical basis for theoretical formulations concerning such children.

CHAPTER II

REVIEW OF THE LITERATURE

Defense Mechanisms

In this section, the use of defense mechanisms with clinical populations will be reviewed.

Apter et al. (1989) points out that despite the wide acceptance of the concept of defense mechanisms and despite their use in clinical context, there has not been much empirical research in general, and there have been even fewer attempts to use clinical methods in the study of defense mechanisms of violent and suicidal patients.

Cooper, Perry and Arnow (1988) note that the concepts of defense mechanisms and defensive organization have been central to the understanding of ego development (Freud, 1936) and psychopathology (Fenichel, 1945; Kernberg, 1975; Vaillant, 1971). For example, in recent years there has been a particular interest in the defense mechanisms of patients with Borderline Personality Disorder (Kernberg, 1975; Lichtenberg & Slap, 1973; Ogden, 1979; Robbins, 1979) and narcissistic disorders.

A few studies have differentiated diagnostic groups on the basis of characteristic defense mechanisms. Lerner and Lerner (1980) examined the use of defenses from Rorschach data and found that projective identification and splitting characterized the responses of persons

diagnosed as borderline, but not characteristic of those diagnosed as neurotic. Bellak, Hurvich, and Gediman (1973) found that schizophrenics used more low-level, primitive defenses; normal subjects used more high-level, adaptive defenses; and neurotic patients fell in between.

Cytrn and Mcknew (1974) noted that the depressive process in children manifests itself in four different ways: fantasy, verbal expression and mood and behavior. This observation led them to formulate a pattern of defenses for the different levels. According to Cytrn and Mcknew, at each level most of the children make attempts to avoid the experience or awareness of depressive affect. On the first level (depressive fantasy) the defenses chiefly employed include denial, projection/introjection, acting out, avoidance, and splitting. At the second level (depressed talk) the predominant defenses are dissociation of affect and reaction formation. At the third level (mood and behavior) the above defenses against depression failed.

Blatt and colleagues (Blatt, 1974; & Blatt & Shichman, 1983) suggested two parallel developmental lines, anaclytic and introjective as the basis for two distinctive types of psychopathology. Defenses in anaclytic psychopathology are primarily avoidance strategies including repression, denial and displacement. Their aim is to maintain interpersonal relationships. The price is the neglect of the development of self. Defenses in introjective psychopathology are characterized as counteractive and include projection, externalization, intellectualization,

introjection, and identification with the aggressor. Their aim is to defend and preserve the self at the cost of neglecting the development of satisfying interpersonal relationships.

Cramer et al. (1988) investigated the use of defense mechanisms of hospitalized psychiatric patients with either an anaclitic or an introjective personality configuration. The results showed that within the anaclitic group, pathology was positively related to the use of denial and projection and was negatively related to the use of identification.

Surprisingly, the anaclitic and introjective patients did not differ in their use of projection, denial and identification. She hypothesized that the failure to find significant differences in defense between the anaclitic and introjective patients is that these long-term hospitalized patients may have been arrested psychologically at an early developmental stage.

Cooper et al. (1991) also used the Rorschach to investigate the ability of defenses assessed to predict future levels of depression, anxiety, and psychosocial role functioning in a sample of adults with personality and affective disorder. Findings indicated that in general, defenses were less powerful predictors than a descriptively oriented assessment done at the beginning of the study. However, certain defenses did have predictive value. For example, devaluation and, to a lesser degree, projection were associated with poor outcome in areas of affective disturbance and social relations. In contrast, intellectualization, isolation, reaction formation, and Pollyannaish denial were associated

with better outcome on these measures.

Schultz (1973) used the Defense Mechanism Inventory to assess the defenses of 35 suicide attempters. His results supported psychoanalytic theory in that the suicidal subjects showed more turning against the self than did the control subjects. Pfeffer et al. (1987) evaluated the ego defense mechanisms in suicidal children and reported that introjection was significantly more common in suicidal children than in non suicidal children. This study also examined defenses of children who committed assaultive behaviors and found that projection and displacement were the most highly correlated with such behavior. In Apter's (1989) study, the results showed that the use of regression as a defense differentiated suicidal from non suicidal patients, and use of displacement differentiated violent from nonviolent patients. Repression tended to turn aggression inward, and projection and denial turned aggression outward. Pfeffer et al. (1984) reported that ego defenses such as projection and displacement, are positively associated with a child's assaultive behavior. On the other hand, children with such ego defenses as sublimation, reaction formation and intellectualization are less likely to be assaultive.

The Hierarchy of Defense Mechanisms

Defenses may be conceptualized as forming a developmental hierarchy (Blatt and Scichman, 1983; Cramer, 1983,1988; Vaillant, 1971). According to this theory, within each personality configuration the patient may manifest a higher or lower level of personality organization, from the more primitive to the more mature, and may consequently vary in the developmental level of predominant defense mechanisms.

Freud (1915) first commented about the chronological classification of defenses in *Instincts and Their Vicissitudes*. He referred to certain vicissitudes of the instincts, such as turning around against the self and reversal into it's opposite, as early modes of defense against the instincts themselves. Anna Freud (1936) elaborated upon Freud's ideas and proposed that it was possible to develop a chronological classification of defense mechanisms. She stated that repression and sublimation cannot be employed until relatively late in development, while such processes as regression, reversal, or turning around against the self are probably among the earliest defense mechanisms used by the ego. Klein's (1946) analytic work with children and adults led her to describe the defenses of splitting of the object and the impulses, splitting of the ego, idealization, denial of inner and outer reality, stifling of emotions, projection, introjection, omnipotence and projective identification. She believed that these defenses came into operation at the age of three months during the paranoid-schizoid position.

Cramer (1988) stated that denial is a primitive defense, projection is related to a somewhat higher level of functioning, and identification requires a more mature level of personality organization.

In a study by Gacono et al. (1992) Rorschach data was used to "map" the internal psychological operations of narcissistic, borderline and antisocial personality disordered adult patients. Findings suggested that as Kernberg (1975, 1984) noted, borderline personality organization is regulated by primitive defenses. It was also indicated that a lack of idealization ability was found in antisocial personality disordered patients. These patients had defenses that were more rigid and less adaptive. This included less tolerance for dysphoric affects which interfered with establishing relations to external objects, and increased the need for discharge of affect into action.

In a paper by Anthony (1986) focusing on resiliency and children's reaction to severe stress, he reported that individuals differ in vulnerability to the degree that they suppress awareness of threatening stimuli or, contrariwise, are hyperalert to them. For example, Cohen and Lazarus (1973) studied the response styles to threatening illnesses and suggest that repression may lead to a better recovery. According to Goldberger (1983) the mechanism involved in this is denial, and it constitutes an unconscious defense against overwhelming external stimuli as well as refusal to recognize the reality of a traumatic perception. Anthony suggests that this is probably an element in all outer

directed defenses, such as projection and displacement and is viewed psychodynamically as a primitive process at work in the pre-stage of defense. He states that the "turning away from reality" may be adaptive or maladaptive from the viewpoint of safety.

Theoretical Conceptualizations of Three Defenses

This section will be devoted to a review of psychodynamic theoretical conceptualizations of three defense mechanisms- Denial, Projection and Identification.

A. Denial

Goldberger's (1983) review of the literature shows that denial is a complex and unclear concept that has acquired many meanings and connotations, depending on the context in which it is used. The dictionary definition reads, "denial is the act of saying no". However, the term in its psychoanalytic application means an unconscious defense mechanism acting to prevent from awareness unpleasurable ideas, affects, and perceptions.

Breznitz (1983) indicates there are different degrees and kinds of denial, ranging from having massive reality distortions to forms having minor and selective reality distortions. Dorpat (1985) points out that at the present time, the term defense is usually used in both psychoanalysis and psychiatry in the broad sense, to designate unconscious protective responses to any kind of psychic pain or unpleasure. It includes reactions to anxiety, guilt, sorrow, danger, temptation (instinctual drives)

and trauma.

Anna Freud (1936) noted that from a developmental viewpoint denial was a primitive mechanism, a prestage of defense, which itself develops in denial in word fantasy. Denial may be pathological or adaptive, or both, depending on multiple functions, as in the denial of illness or death.

Erich (1985) examined the developmental crisis of adolescence through the operation of denial or disavowal. In his paper he reports that as early as 1957, Jacobson pointed to a linkage between denial and action, or a tendency toward acting out: to the extent that acting out is designed to avoid remembering, it is a form of denial. According to Erich when we speak of denial or disavowal [which he uses interchangeably] we are referring to a process by which something that is 'really real,' so to speak, is rendered psychologically nonexistent, (i.e., is nullified by the ego). Erich explains that this is very different from the case of other defenses whose impact is primarily or exclusively on internal reality, and which strive to make all sorts of shifts and alterations only in our inner, psychic reality. Whereas the latter affect what happens at the interface of ego and id, the work of denial proceeds primarily at the level of ego and reality.

B. Projection

Similarly to denial, projection has its beginnings in early childhood but does not become predominant until late childhood and

adolescence. Projection can be understood as a defense that protects the child from disruptive anxiety by attributing unacceptable feelings, wishes, and impulses to someone else. The disturbing thoughts are placed outside of the self (Cramer 1991). Schafer (1954) defined projection as a process by which an objectionable internal tendency, either an id impulse or superego attitude is unrealistically attributed to another person or to other objects in the environment instead of being recognized as part of one's self.

Another component of projection is the alteration of reality. According to Knight (1980) projection alters the perceived, what is intended, and the interpretation of what occurs. When projection is used as a defense, this alteration or misperception makes the experience of events more negative, or more ominous, than they are in objective reality.

Cramer (1991) states that projection involves the capacity to differentiate between inside and outside, between self and other. It requires the ability to make judgments- pleasure-pain, good-bad, acceptable-unacceptable. Projection is carried out by breaking the connection between the conscious ego and certain thoughts or impulses, and then attributing the origin of these thoughts elsewhere.

C. Identification

According to the developmental model of defense mechanisms, identification is considerably more complex than denial and projection.

According to Cramer (1991) the literature on identification shows considerable inconsistency and confusion in its definitions. For example, in a review by Sanford (1955) eight different definitions were discussed. Similarly, ten definitions were reported in White's (1961) review.

Additional confusion is created because it is characteristic of the literature in this area that the terms identification, introjection, and incorporation are often used interchangeably.

Meissner (1974) examined the three main identification processes: incorporation, introjection, and identification. He stated that with incorporation, the motive is to possess, to have, to become merged with the object. This is a primitive, primary process in which boundaries are fluid and ambiguous. With introjection, there is a clearer distinction between self and the object, although the boundaries are still somewhat fluid. Messinger (1974) describes the motive of introjection as the desire to be the same as the model. In contrast with incorporation or introjection, identification requires that the other person be recognized as separate. The motive of identification is to be like the model.

Cramer (1991) proposes the point of view that incorporation and introjection are precursors to identification, but they do not lie on a straight-line continuum with it. Rather, they are conceptualized as discontinuous processes, and each is prominent at different phases of development.

According to Cramer (1991), from the multitude of definitions offered it is possible to summarize the main features of identification. She states that these include a change that occurs in the ego (i.e., the personality, behavior or motives of the person); the change is in the direction of becoming like some other individual, group or cause; the change serves the purpose of maintaining an affective relationship with a significant other; and the change is related to the development and maintenance of self-esteem.

The following section will review the concept of acting out. The term "acting out" as a defense is frequently used when describing the defensive behaviors of both clinical groups under study.

The Concept of Acting Out

Masterson, J.F. (1973) pointed out that "Acting out" is a term which has several usages: it is used most commonly to denote any form of disruptive behavior. It can be defined also as a defense mechanism in which the patient reproduces forgotten memories, attitudes, and conflicts by actions rather than words without conscious awareness or recognition of the fact. Masterson states that the intrapsychic mechanism of the acting out can be called externalization which involves the use of two defense mechanisms: denial and projection.

Freud (1905) was the first to use the term acting out in the case report on the first adolescent to be analyzed, namely, Dora. He referred to her dropping out of analysis as having "acted out an essential part of

her recollections and phantasies instead of reproducing them in treatment." Again, in 1914, Freud used the term acting out in a paper where he reported " We have learnt that the patient repeats instead of remembering, and repeats under the conditions of resistance (in treatment)."

In Blos' (1963) paper on acting out in relation to the adolescent process he states that the incidence of acting out rises sharply when the child enters puberty. The adolescent has a need to deny his helplessness through action, to affirm by exaggeration his independence. Action and motion is not goal-directed behavior, instead it is a means of resisting the regressive pull to the active mother and of averting the surrender to primal passivity.

McCarthy (1984) stated that acting out typifies the adolescent's defensive efforts to overcome separation anxiety. While a need for rebellion is characteristic of adolescents in this society, some adolescents unfortunately seek self-definition through dangerous forms of rebellion as drug use, vandalism, fighting and conduct problems. In McCarthy's discussion of identity loss and acting out in adolescents, he points out that healthy children use locomotion fantasies, play and dreams to express conflicts with internal objects. The poorly integrated adolescent recreates the object relations problems interpersonally.

Fenichel (1945) described acting-out adults as impulsive people who depend upon the external world to correct narcissistic instabilities.

According to Fenichel (1945) a weakness in symbolic functioning predisposes these adults to act out the unconscious residue of childhood trauma. Action remains their principal means for reducing tension. Greenacre (1958) reported two related characteristics of the acting out individual: persisting belief in the magical power of actions, and distortion of the connections between action, speech and thought.

According to Sperry et al. (1957) preadolescent boys who were part of a group with learning difficulties and hyperactivity expressed their conflicts through physical activity. More specifically, physical activity served both defensive and expressive purposes in denial and avoidance of thought and affect. These boys were considered frightened youths. They fear castration if they should assume certain executive functions that is natural for boys to assume in the course of growing... these boys exhibit a marked sense of deprivation, although it is mainly autonomy rather than oral supplies of which they feel deprived." (Sperry et al. 1957).

McCarthy (1984) stated that reliance on acting out as a defense, and deficiencies in object relations, contribute to an impulse-ridden adolescent character style. A tendency to treat other people exploitively, stealing, drug use and assault all are efforts to force the environment to satisfy unconscious needs that arise in the internal object world or in the family constellation. They rely on aggressive and antisocial acts to counter depression or anxiety.

Conduct Disorder

The reported prevalence of rates for antisocial behavior in this country have varied between 3 and 25 percent. One study estimates the incidence of conduct disorders at 74 percent among a clinic population of primary school children (Wolff, 1971). Robins (1981) called antisocial behavior the society's single most costly childhood disorder.

It is a serious problem that spares no locality or group (Kaplan, 1988). Statistics indicate that conduct disorders occur about five times more frequently in males as in females. However, females have been closing the gap (Rutter, 1981).

Urban areas have the highest prevalence rates. The urban poor from disadvantaged minority groups are at greatest risk for disorders of conduct (Robin, 1981). The peak age range appears to be between 15 and 18 years.

Rutter (1981) noted that there is no single cause and background factors will not affect all children the same way. Constitutional factors such as temperament and cognitive skills, acquired habit patterns such as coping strategies and defense mechanisms, and mediating factors such as the social support system all influence the outcome and thus preclude a single common pathway leading to anti-social behavior.

The most common symptoms of childhood antisocial behavior, according to Robins (1981), are truancy, school failure, incorrigibility, theft, running away, curfew violations, early sexual activity, fighting, and

illicit drug use.

According to Hinshaw (1992), there is a prevalence of school underachievement associated with externalizing behaviors, including conduct disorder, oppositional defiant disorder attention deficit disorder. Underachievement also includes a host of problems including possibly subaverage IQ, specific cognitive deficits, and/or social stresses.

According to Kernberg and Chazan (1991) the child with a conduct disorder is understood to manifest major developmental impairments. Throughout their development, children with conduct disorders tend to internalize negative parental images associated with negative feelings. These authors report that rage, hostility, anxiety, and concomitant negative self-images accrue to form a negative self-concept with low self-esteem and dysphoria.

Several investigators have utilized attachment theory (Ainsworth 1972 & Bowlby 1969) to inquire about the etiology of conduct disorders, and Bowlby (1979) found that the early childhoods of individuals with antisocial personality disorder were grossly disturbed by events resulting in disruption of attachment.

Kernberg and Chazan (1991) indicate that conduct disorder children have ego deficits in the following areas: cognitive functioning, attention, impulse control, judgment, modulation of affects, language, and tolerance for anxiety and frustration.

Halcomb et al. (1991) reported that significant differences were found between a group of conduct disordered and non conduct disordered adolescents on a personality inventory. Results indicated that conduct disordered youths reported being harshly critical, and disrespectful of others. They tend to seek out the unpredictable and to be moody and pessimistic. They expressed a lack of confidence in school performance and dissatisfaction with family life.

Childhood behaviors marked by defiance, impulsivity, disruptiveness, aggression, antisocial features, and overactivity are considered "under controlled", or "externalizing" (Achenbach & Edelbrock, 1978). There is another dimension or set of behavior patterns termed overcontrolled, or internalizing which is evidenced by withdrawal, dysphoria, and anxiety (Quay, 1986). However, Achenbach et al. (1983), & Rose et al. (1989) reported that externalizing and internalizing domains are not completely independent. Their data suggests that correlations between these two domains are often moderate to high, particularly when considerable psychopathology exists and especially in young children. Robins (1979) has noted that externalizing problems are more stable than internalizing behaviors, and carrying (except in instances of severe inhibition or depression) a worse prognosis as well as resistance to most forms of intervention.

Co-existent Disorders

Various studies have focused on the association between major depression and conduct disorder. Results have indicated that there is an association between major depression and conduct disorder in children referred to mental health clinics.

Puig-Antich (1982) reported unexpected clinical observations made during the course of a study of the effectiveness of imiprimine in prepubertal major depressive disorder. They found that the successful outcome of the subjects' mood disorder was followed by abatement of conduct disorder in the majority of their subjects.

Chiles et al. (1980) interviewed 120 consecutive admissions (adolescent boys and girls ages 13 to 15) to a correctional facility. They found that 23 percent met research diagnostic criteria for depression.

In the Puig-Antich study (1982), data revealed that over one-third of the prepubertal boys who met criteria for a major depressive disorder also met criteria for a conduct disorder.

Studies of children and adolescents diagnosed with conduct disorders are in agreement that they are at high-risk of developing such future psychiatric disorders as antisocial personality, alcoholism and adult criminality (Robbins, 1979; Gersten et al., 1976; Rutter, 1979; and Masterson, 1967).

Other problems that commonly occur in conjunction with conduct disorders include attention deficit disorder, associated with a prevalence

of 75 percent (Safer and Allen 1976); reading disabilities, associated with a prevalence of 33 percent (Rutter, Tizard et al. 1976); social skills deficits, associated with a prevalence of 72 percent (Lorber and Patterson, 1981).

Chadwick et al. (1981) established that head injury does increase the risk of psychopathology, including conduct disorder. Lewis and Balla (1976) found that 6.3 percent of court-referred delinquent children met their criteria for psychomotor epilepsy.

In a paper by Robins (1970) findings indicate that childhood conduct disorders constitute a major risk factor for a broad range of adult psychopathology, not just adult criminality and alcohol abuse as expected. In their study they found data which supports a direct correlation between childhood conduct disorder and the internalizing adult disorders such as panic disorders, obsessive compulsive disorders, depression and schizophrenia.

Oppositional Defiant Disorder and Conduct Disorder

A considerable amount of research has been carried out in conceptualizing and establishing separate diagnostic criteria for oppositional defiant disorder and conduct disorder. There has been considerable disagreement about the nature and subclassification of these disorders since the introduction of separated diagnosis in DSM-III (American Psychiatric Association, 1980). Researchers and clinicians have debated the usefulness of such a distinction, with some favoring a

single diagnostic entity instead of two (Anderson J. C. et al., 1987).

In more recent research in preparation for the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), studies have supported the utility of viewing oppositional defiant disorder and conduct disorder as different disorders but also as developmentally related (Loeber, R. et al. 1991).

In Loeber's (1991) review of literature the following is concluded:

1. In terms of behavioral covariation, much of the literature suggests that most symptoms of conduct disorder and oppositional defiant disorder are distinct.
2. The mean age of onset for oppositional defiant disorder symptoms is earlier than for conduct disorder.
3. Developmentally, oppositional defiant disorder symptoms predict conduct disorder symptoms.
4. In general, the seriousness of disruptive child behaviors tends to increase with age, wherein oppositional defiant symptoms are viewed as less serious than conduct disorder symptoms.

Aggressive Conduct Disorder

Hewitt and Jenkins (1966) were the first to define aggressive conduct disorder in children. They applied correlational techniques to behavior problems recorded in the mental health charts of 500 children attending a child guidance clinic. Their findings revealed a cluster of symptoms which they named "unsocialized aggressive." It is defined broadly on basis of disobedience, starting fights with peers, quarrel-someness, meanness, and destructiveness.

Subsequently, Achenbach (1978) and Achenbach and Edelbrock (1979) have defined more specific dimensions, one of which consists of aggressive and noncompliant behaviors and is relatively free of antisocial behaviors such as lying and stealing.

Within the group of children with conduct disorders, two subtypes can be discerned: Aggressive-socialized and aggressive-nonsocialized (Wells and Forehand, in press). Aggressive-socialized children manifest some capacity for peer relationships, social attachments, guilt, shame, and remorse, whereas aggressive-nonsocialized children are characterized by overt antisocial behavior and an inability to understand rules or the feelings of others. According to Kernberg and Chazan et al. (1991), although the diagnostic manual of the American Psychiatric Association (1987) has deleted this distinction, the two categories refer to different clusters of disorders and require different interventions.

Willock (1990) points out that as psychoanalysis widened its scope to include the treatment of children, a number of investigators turned their attention to a particularly challenging group of patients who became known by a variety of terms: predelinquent, unsocialized aggressive reaction, antisocial character disorder, hyperaggressive, impulse-ridden personality, tension discharge disorder, and so forth.

Willock (1986,1987) discusses the hyperaggressive child's extremely sensitive core of narcissistic vulnerability. This vulnerability is typically masked by aggressive denial, externalization, projection and

related primitive defensive processes. The child's underlying belief is that no one really cares about him, that for some reason he is unable to engage the loving concern of care givers and sustain a bond of valued connectedness with them. The child also believes there is something grossly repugnant and unlovable about him that makes others turn away in disgust. Complex relationships may exist between these different aspects of self-structure. The child may, for example, embrace a devalued, negative identity (Erikson, 1959) in order to ward off the more painful feelings of emptiness associated with his sense of being fundamentally unloved.

Aggression, Frustration and Identification In Delinquency

Aggression is a topic that is not well understood because of the multiplicity of factors involved (Feshbach 1970). According to Nielson (1983) aggression should be viewed in terms of resolution, stress and the history of having frustrations relieved and demands met. The Frustration-Aggression Hypothesis (Dollard, et al. 1939) is one of the oldest and simplest explanations of aggression. This approach has much in common with the psychoanalytic view, while at the same time being a drive-reduction learning theory model. The Frustration-Aggression Hypothesis predicts that the natural result of frustration is aggression.

In discussing the psychodynamics of delinquency, Binder (1987) points out that delinquency can be viewed in terms of substitute sources of gratification for needs not satisfied in the family. When an individual is

frustrated in the family setting, he or she may turn to the delinquent gang or to other groups with criminal orientations for acceptance and recognition. Binder states that "The delinquent is an emotionally frustrated and perturbed individual who unconsciously seeks in his actions a resolution to his problems in the form of compensatory satisfactions which have been denied him in his familial relationships." (p.43). The goal is attainment of psychic balance.

There is a group of psychodynamic theorists who contend that delinquency occurs in social settings where individual social and economic success are highly prized but where opportunities are limited . Feldman (1969) reports that the gap between expectation and opportunity has the greatest psychological impact on those individuals who are least equipped psychically to undertake the unrewarding pursuit of success.

Stott (1980) posits two "psychic needs" of the growing child. The first is a need for self-realization, which means being effective in coping with reality and being valued by other members of one's group. The second is a need for care, affection, and devotion from an adult. Denial of either of these needs leads to discomfort and frantic efforts to resolve the frustration.

According to Kernberg and Chazan (1991) children with conduct disorders experience failures in coping with frustration and aggressive feelings. They state that an undue sense of frustration and failures of

attunement, consistency, and empathy have caused their aggression to take a deviant path and be counterproductive.

In his study of inner-city children of poverty Solnit (1966) found that their average expectable environment is characterized by aggressive interactions with significant others. He speculates that these aggressive interchanges contain the necessary and sufficient conditions for the establishment of a limited form of object constancy based upon aggression in contrast to libidinal ties. Solnit states that although this does not rule out the presence of libidinal strivings or gratifications, it does suggest that repeated and expected discharge of aggressive impulses can become a way of life that finds confirmation in the child's environment.

In Solnit's terms, the repetitious, provocative aggression of the child is not only representative of ingrained channels for discharging tensions but can be seen as a request for a particular type of relationship that constitutes a partial repetition of earlier experiences with significant adults. Solnit argues that this relationship is not only reflective of an identification with the aggressor in terms of mastery or control, but can be viewed as a manifestation of the child's identification with the parent. The raw aggression can also be viewed as an adaptation to the child's violent environment, as well as the precipitant of the lack of soothing libidinal experiences which are essential for fusing the aggressive drive.

Several investigators have utilized attachment theory (Ainsworth 1972 & Bowlby 1969) to inquire about the etiology of conduct disorders, and Bowlby (1979) found that the early childhoods of individuals with antisocial personality disorder were grossly disturbed by events resulting in disruption of attachment.

Alexander and Healy (1935) stressed the failure of the delinquent's family to provide healthy models for identification and suggested that these families often promote pathological identifications that encourage, rather than sublimate, the child's impulsivity, aggressiveness, and entitlement. Rinsley (1982) too has pointed to the delinquent's failure to achieve wholesome identifications. For example, a number of studies have found that mothers of clinic-referred children with conduct disorders is associated with increased prevalence of paternal antisocial personality disorder, criminal behavior, and substance abuse (Stewart & Leone 1978; Robins 1966).

In the preceding literature review, various aspects of conduct disordered youths were discussed. For many years researchers and clinicians have sought to develop theories and clinical approaches which can contribute to more effective treatment of children with this disorder.

Depression

An individual who describes his mood as "depressed" may be referring to normal sadness. But as Rutter (1972) points out, misery and unhappiness occur in childhood as does depression, but unhappiness

as a symptom and depressive illness are not synonymous. In more pathological depression there appears to be an intense, exaggerated form of sadness accompanied by anorexia, insomnia, fatigue, and other symptoms (Beck 1967). Beck pointed out that the key factor in diagnosing depression is change in the psychological systems- changes involving emotion, motivation, cognition, physiology, and behavior.

In Exner's (1982) review of some concepts about the predisposition of depression he notes that many of the psychoanalytic authors, beginning with Freud, have postulated that one component of depression is a hostility that is turned inward. However, this belief has been challenged by other authors indicating that depression is relatively independent of hostility (Klerman et al. 1974). Another long standing notion about depression is that guilt and shame constitute important precursors. Again, several investigators have found that significant proportions of depressed patients do not exhibit these features (Harrow and Amdur 1971 & Rosenthal and Gudeman 1967).

Another conceptual model suggests that significant life events such as separation and loss relate to the onset of depression (Paykel 1970). This view was challenged by Klerman (1974) who used Paykel's data and concluded that loss and / or separation are not universal in depressions and that not all people experiencing loss and/or separation will become depressed. He suggests that these incidents may only serve as a precipitant in some cases where there is an already existing

condition which is more latent.

Seligman and his colleagues (1974) have suggested that depression stems from a form of learned helplessness. In this framework, the individual's failure experiences have been generalized into a sense of helplessness, hopelessness, and powerlessness.

A number of attempts to understand depression have been based on concepts derived from conventional learning theory. The work of Lewinsohn et al. (1974) exemplifies this approach. The guiding assumption underlying the Lewinsohn work is that depression is a function of the degree to which an individual's behavior is maintained by positive reinforcements. In this view, depression is seen as a continuous variable ranging from profound states to mild occurrences, depending on the dynamic process of response-reinforcement.

In addressing themselves to the complex interface between social environmental factors and clinical depression, Brown and Harris (1978) have produced a wealth of data which they interpret as supporting an etiological role for social factors in the development of depression. Their central thesis is that clinical depression is an understandable response to adversity. In short, Brown and Harris focus on the etiological role of social influences, particularly the low self-esteem and hopelessness commonly associated with vulnerability factors, and the experience of actual or threatened loss among the provoking agents (such as losing a job, divorce or separation, or events without discrete beginnings such as

alcoholism).

Beck (1967) first began publishing a systematic theory of the origins of depression in the early 1960's. Beck's cognitive model draws upon three concepts to account for the psychological substrate of depression: cognitive triad, schemes, and cognitive errors (faulty information processing). The cognitive triad consists of three patterns of thought that account for much of the negativistic ideas and attitudes commonly observed in depressives (negative view of themselves, the world and the future).

Schemes, Beck's second major concept is somewhat akin to personality traits. These schemes represent stable, long-standing thought patterns. The depressive is viewed as responding to certain situations in fixed, negative ways. Cognitive Errors: This involves disordered thinking resulting in six basic errors: arbitrary inference, selective abstraction, over generalization, magnification and minimization, personalization and absolutistic, dichotomous thinking.

Childhood Depression

Depression in children and adolescents has received a great deal of attention over the years (Schulterbrant et al., 1977). Kashani et al. (1979) provides an overview on current perspectives on childhood depression. In their review of the literature on depression in children they note several competing viewpoints: 1) that depression in childhood is similar to depression in adults, 2) depression in childhood is masked and

is manifested as behavior problems, such as hyperactivity and acting out and 3) depression in children is rare. In their review on depression epidemiology, diagnostic criteria, classification, assessment and intervention studies they report that current literature suggests that depression as a clinical entity is observable in children.

Sources of depressive symptoms in children have included incidence of early separation from parents and other attachment problems (Bowlby, 1969), parental depression (Pozanski, 1983), biochemical problems (Cytryn et al., 1980; Puig-Antich et al., 1978), learned helplessness (Seligman, 1974), Life stress (Holmes and Rahe, 1967), cognitive distortion (Kovacs and Beck 1977), behavioral reinforcement (Lewinsohn, 1974), and sociological issues (Klerman, 1974).

On a study of depressive Comorbidity in children and adolescents Angold et al. (1993) found that conduct or oppositional and anxiety disorders are more common in depressed than in nondepressed children and adolescents. In fact, he found that the presence of depression increases the likelihood of another disorder up to 100-fold; in most cases, the increase is of the order of 20-fold.

Psychodynamic Perspectives on Depression

Freud's paper "Mourning and Melancholia" (1917) has been the most influential contribution to the classical psychodynamic theory of depression. According to Becker (1977) Freud hypothesized that

depressives are orally fixated characters. Fixations result from extreme impulse gratification, frustration, or inconsistent handling during the early developmental process and can stem from interpersonal transaction, biological predisposition, or an interaction between the two.

Klein (1948) focused on the concepts of introjection, projection, and aggression. She theorized that if mothering is ineffective or the biological determinants of sadistic fantasy are exceptionally powerful, a lasting vulnerability to depressive doubts about one's capacity to love and be loved results.

Chodoff (1970) considers guilt and anger as secondary symptoms of depression, which reflect the disruptive effects of depression and reparative attempts to cope with such affects. Hostility is viewed as secondary to frustrated dependency needs, not as anger displaced toward an introject.

In reviewing historical perspectives on depression, Becker (1977) states that Jacobson (1971) is probably the most influential contemporary ego-analytic contributor to the psychodynamics of depression. Jacobson focuses primarily on the determinants of self-esteem regulation, which is increasingly considered as the most central psychological phenomenon in depression.

In summarizing the main points of the psychoanalytic theory of depression Brenner (1989) notes :1) inadequate mothering during the oral phase, ie., during the first 18 months of life; 2) depression, like

mourning, is a consequence of object loss; 3) object loss leads to identification with the loss object, which is both loved and hated; 4) as a result of this identification, hate or aggression becomes self-directed.

Blatt et al. (1990) advocates for the importance of distinguishing two subtypes of depression based on psychoanalytic theory. They note that clinical and research literature suggests that, phenomenologically, an important distinction can be made between one type of depression focused on intense dependency experienced in interpersonal relationships (anaclitic), and a second type, involving an excessive preoccupation with self-criticism and guilt (introjective) (Blatt, 1974). Such concepts as object relatedness, attachment and separation, and loss figure prominently in theorizing about personality development in general and depression in particular (Bowlby, 1969;1973).

Sullivan (1956) and other interpersonalists stress the role of environmental factors such as cultural, familial, and peer interactions in shaping personality. Observable patterns of interaction are emphasized more than intrapsychic dynamics, and the impact of experience beyond infancy and childhood in shaping personality is recognized.

Masked Depression

According to Gabrielle, et al. (1980), recent attempts to clarify the nosology of childhood depression have concentrated appropriately on distinguishing depression as a symptom from depression as a syndrome to depression as a disorder. These authors also point out that we need to

know not only what percentage of unhappy children are suffering primarily from an affective disorder but also the converse- what percentage of children who deny and have other symptoms are actually suffering from depressive disorder.

Kovacs and Beck (1977) noted that there are two basic viewpoints on the manifestation of childhood depression. One view holds that except for some developmental-specific modifications, childhood depressions resemble adult depressions. The alternative view essentially states that most children do not express depression directly and that it must be inferred from behaviors and symptoms "masking" the underlying depressive feelings. Many problems have been implicated as so-called depressive equivalents. Conduct disorders (hyperactivity, delinquency, aggressiveness, irritability), somatic complaints (especially headaches, stomach aches, and enuresis), and school problems (school phobia, poor school performance) are the most frequently cited. Since these problems account for most child psychiatric referrals, it is unlikely that depression is behind all of them.

In this paper Gabrielle et al. (1980) examined depressive symptoms and conduct problems in 102 systematically interviewed children between ages 7 to 17 to elucidate the category of so-called masked depression. Test results drew several conclusions: 1. It is possible to diagnose children over age 7 as having a major depressive disorder using adult research diagnostic criteria. 2. When children are

interviewed systematically about their symptoms, a much higher incidence of depressive disorder is found than by the usual evaluation procedure. In fact, the more traditional evaluation methods overlooked the diagnosis of depression in 60% of the cases. 3. Some children who meet criteria for depression also meet criteria for other disorders- most often attention deficit disorders (hyperactivity), conduct disorders, and anorexia nervosa. These are the problems that most often bring them to psychiatric attention and thus may divert attention away from the concomitant depression. The fact that the majority of missed depressions fell into the category of unsocialized aggressive reactions or adjustment reactions suggests that this is precisely what happened. They hypothesize that these children have what has been called "masked depression." Kovacs and Beck (1977), made similar observations after reviewing the literature. They noted that "masking behaviors" are often nothing more than presenting complaints. Not all children with behavior disorders or anorexia nervosa are depressed. There are two differences between the behavior problems of children who are simply depressed and those who have diagnoses of both depressive and behavior disorders. In children with depression, behavior problems were seen as less severe and postdated on the onset of depressive symptoms. In children with both diagnoses and in children with behavior disorders alone, the behavior problems were chronic and of greater magnitude.

Several conceptual models of depression were presented including psychoanalytic, cognitive and behavioral approaches. From reviewing this literature, it is clear that assessing, diagnosing and effectively treating depressed children continues to represent a major challenge to all those who work with this population.

In addition, the theoretical underpinnings of our understanding of three defense mechanisms, denial, projection and identification, including acting out and the role of aggression were reviewed. While it is clear that a great deal of theoretical work has been dedicated to the understanding and treatment of conduct disorders and depression in children and adolescents, there has been relatively little empirical testing of these concepts in their relation to the use of defense mechanisms. This study seeks to translate some of the theoretical constructs pertaining to these clinical populations into empirical data by examining the use of defense mechanisms among boys diagnosed as Conduct Disordered, Depressed and "Normal."

Hypotheses

Given the findings and issues raised in the literature, the following hypotheses will be tested:

1. Boys diagnosed as Conduct Disordered will rely primarily on the defense mechanism of denial as compared to those diagnosed as Depressed or "Normal."

2. Boys diagnosed as Depressed will depend primarily on the defense mechanism of projection as compared to those diagnosed as Conduct Disordered or "Normal."

3. Normal boys will depend primarily on the defense of identification as compared to boys diagnosed as Conduct Disordered or Depressed.

Definitions

1. **Acting Out:** Direct expression of an unconscious wish or impulse in order to avoid being conscious of the affect that accompanies it. It includes the use of motor behavior, delinquent or impulsive acts, and "tempers" to avoid being aware of one's feelings. (Vaillant 1977).

2. **Conduct Disorder:** Involves persistent patterns of rule breaking and violent behaviors. Is estimated to have a prevalence of 9% for boys and 2% for girls.

3. **Denial:** Ego-defense mechanism by means of which the individual protects himself or herself from unpleasant aspects of reality by refusing to acknowledge them. .

4. **Depression and Depressive Disorder:** Presence of both dysphoric mood and self-deprecatory ideation.

5. **Ego Defense Mechanism:** Type of reaction designed to maintain the individual's feelings of adequacy and worth rather than to cope directly with the stress situation usually unconscious

and reality distorting. (Coleman et al. 1980).

6. **Externalizing Behavior Problems:** Childhood behaviors marked by defiance, impulsivity, disruptiveness, aggression, antisocial features, and overactivity. (Achenbach & Edelbrock, 1978).

7. **Identification:** Ego defense mechanism in which the individual identifies himself or herself with some person or institution.

8. **Masked Depression:** When pervasive overt sadness or depression does not manifest itself in a clearly recognizable form but instead in a variety of emotional disorders, among them hyperactivity, aggressive behavior, psychosomatic illness, hypochondriasis, and delinquency. (Cytryn et al., 1980).

9. **Projection:** Ego-defense mechanism in which an individual attributes unacceptable desires and impulses to others.

CHAPTER III

METHODOLOGY

Subjects

Clinical subjects were boys who have been referred by their parents, schools or other local agencies to an out-patient mental health clinic. There were a total of 36 Hispanic and African-American boys who ranged from 12 to 16 years of age. All were of normal intelligence as indicated by their placement in regular grades, although some were referred for special education class placement because of emotional and conduct problems. They were given psychological examinations upon referral. The protocols of these examinations were used for this study.

These boys were divided into two groups, 19 who have received a DSM III-R diagnosis of conduct disorder and 17 who have received a DSM III-R diagnosis of depressive disorder. The files of the subjects consisted of a psychological evaluation, protocols and relevant background information. The diagnosis for depression and conduct disorder for each subject was based on the diagnosis reported by the psychologist who initially evaluated the subject. An advanced doctoral psychology student appointed as staff psychologist scored the defenses of denial, projection and identification on selected Thematic Apperception Test (TAT) stories supplied by the clinical and control group subjects.

The control group consisted of a total of 18 African-American and Hispanic boys matched in age and ethnic backgrounds with the clinical group. They were drawn from boys who attended a church-based after school program in the same urban inner-city community. See table 1.

Measures

The control group was given selected cards from the Thematic Apperception Test (TAT) and their parents asked to complete the Child Behavior Checklist (CBCL).

A. Thematic Apperception Test

The Thematic Apperception Test (TAT) was developed by H.A. Murray (Morgan & Murray, 1935) as a projective test employed to investigate information concerning specific thoughts, attitudes and imaginative productions of subjects which are projected within the fantasies stimulated by ambiguous situations pictured on 20 cards containing black and white pictures of people in vague situations. The respondent is asked to make up a story to fit each picture, telling what led up to the event shown in the picture, describing what is happening at the moment, what the characters are feeling and thinking, and what the outcome will be.

In interpreting the TAT stories, the examiner first determines who is the "hero," the character of either sex with whom the respondent has presumably identified herself or himself. The content of the stories is then analyzed principally in reference to Murray's list of "needs" and "press."

TABLE 1
Demographic and Social Characteristics

Ethnicity	Conduct Disorder (n=19)	Depressed (n=17)	Normals (n=18)
Hispanic	73.70%	76.50%	55.60%
African American	26.30%	23.50%	44.40%
Average Age	13.4	13.8	13.8

Examples of needs include achievement, affiliation, and aggression. Press refers to environmental forces that may facilitate or interfere with the satisfaction of the needs. Being attacked or criticized by another person, receiving affection, and being comforted are illustrations of press.

The TAT has been used extensively in personality research. A fair amount of normative information has been published regarding the most frequent response characteristics for each card, including the way each card is perceived, the themes developed, the roles ascribed to the characters, emotional tones expressed, speed of responses and length of stories (Atkinson, 1958; Henry, 1956; Murstein, 1972). Although these normative data provide a general framework for interpreting individual responses, most clinicians rely heavily on "subjective norms" built up through their own experience with the test.

B. Child Behavior Checklist / 4-18 (CBCL) (Appendix C)

The Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1991) for ages 4-18 was completed by the parents for all the boy's in the control group. The CBCL assesses children's internalizing and externalizing problems at home, as well as the child's overall social competence, as assessed by the mother. Achenbach and Edelbrock (1991) have analyzed CBCL data from many samples and have empirically derived several narrow-band factors as well as the two broad-band factors of internalizing and externalizing separately for boys and girls at three different age groups (4-5, 6-11, and 12-16 years of age).

The social competence measure is a composite score based on parental report about the child's recreational activities, social relationships, and school performance and functioning.

Norms have been established for all scales of this widely used and highly valid and reliable measure from demographically matched clinical and non-referred samples. Subjects were precisely matched for ethnicity, SES, sex of the child, and age of the child. The CBCL was shown to not differ significantly in matched samples in ethnicity, age, SES, and sex. The significant effects of SES reflected higher competence scores and lower problem scores for higher SES children. That is, the higher SES parents described fewer problems presented by their children than did the lower SES parents. The inverse reporting of more problems and lower competence is one reason that Achenbach and Edelbrock (1991) recommended that SES be controlled in regression equations where the CBCL is the dependent variable.

Spanish speaking control group parents were provided a Spanish version of the CBCL. This Spanish version was provided by Achenbach & Edelbrock (1991) (Appendix D).

C. The Defense Mechanism Manual (DMM)

The Defense Mechanism Manual (DMM) by Cramer (1987) uses stories told about Thematic Apperception Test pictures to assess the presence of the defenses of denial, projection, and identification.

In developing the DMM, Cramer (1987) completed various empirical studies using the DMM to study the functioning of defense mechanisms in children, adolescents, college students, and in psychiatric patients. These included four studies that have investigated defenses in children. A fifth study compared adolescents' defenses with those of their parents. Two more studies looked at defenses in college students, and two other investigations were concerned with the defense mechanisms of psychiatric patients. Taken together, the various statistical studies provided strong support for the reliability and validity of the defense measures.

Among the studies noted (Avery, 1985) one provided information from 94 fourth-, fifth-, and sixth-graders of diverse SES backgrounds, on the relationship between DMM scores and several other personality measures. Sixty percent of the children in the study were from minority backgrounds (mostly African-American); there was an equal number of boys and girls at each grade level.

The results of this study supported the notion of a developmental hierarchy of defenses, even within the restricted age range studied. For example, According to Cramer (1991) when defense scores were correlated with Loevinger's (1966) ego development measure in this study, the results indicated that the use of the lower level defenses of denial and projection were unrelated to level of ego development ($r = -.14$ and $.07$, respectively), while use of the higher level defense of

identification was positively and significantly related to level of ego development ($r = .24$; $p < .02$).

Scoring Defenses (Appendix E)

For each defense, the components have been arranged by Cramer into seven scoring categories. In the Defense Mechanism Manual, numerous examples from various TAT cards are given. Also, specific rules for scoring or not scoring a category, and for differentiating between similar categories are provided. The DMM can also be used for scoring these specific defenses on the Children's Apperception Test (CAT). The DMM was devised to assess the use of denial, projection and identification in children, adolescents and adults.

The following are the seven scoring categories for denial, projection and identification:

Scoring Categories for Denial

1. Omission of major characters of objects
2. Misperception
3. Reversal
4. Negation
5. Denial of reality
6. Overly maximizing the positive or minimizing the negative
7. Unexpected goodness, optimism, positiveness, gentleness

Scoring Categories for Projection

- 1. Attribution of aggressive or hostile feelings, emotions, or intentions to a character or other feelings, emotions or intentions that are normatively unusual**
- 2. Additional or ominous people, ghosts, animals, objects, or qualities**
- 3. Magical or circumstantial thinking**
- 4. Concern for protection from external threat**
- 5. Apprehensiveness of death, injury, or assault**
- 6. Themes of pursuit, entrapment, and escape**
- 7. Bizarre or very unusual story or theme**

Scoring Categories for Identification

- 1. Emulation of skills**
- 2. Emulation of characteristics**
- 3. Regulation of motives or behavior**
- 4. Self-esteem through affiliation**
- 5. Work; delay of gratification**
- 6. Role differentiation**
- 7. Moralism**

The TAT's of children were scored according to these categories as defined by Cramer (1991).

Procedures

The initial psychological tests given to boys, ages 12 to 16, who were referred to the mental health clinic were used as the basis of this study. Records were chosen based on appropriate ages and diagnoses from charts collected during the preceding eight years. Only those who received a diagnosis of Conduct Disorder and Depressive disorder were included. Those who received other diagnoses, including the combination of conduct disorder and depressive disorder were excluded. The responses to seven TAT stories were used. These included responses to cards 1, 2, 3BM, 4, 5, 13B and 8BM. An advanced doctoral clinical psychology student appointed as staff psychologist scored the defenses of denial, projection and identification on TAT stories using the Defense Mechanism Manual (Cramer 1991). This rater was not familiar with the hypotheses and purpose of this study and was blind to the name, age and diagnosis of each subject.

Rater reliability for scoring the defenses for all subjects was established as follows: the author of this study supplied the rater with a copy of the DMM and several practice TAT stories unrelated to this study. Once the rater became familiarized with the DMM and gained experience in using the DMM for scoring the defenses of denial, projection and identification, this researcher and the scorer did several stories concomitantly. Inter rater reliability ranged from .80 to .90. Following this, the scorer scored all the TAT protocols.

The control group was 18 boys drawn from an after school

program located in the same neighborhood and with the same socioeconomical status of those referred to the mental health clinic. This after school group was a program in the local Catholic church, but included noncatholic children. The parents of this control group received parent consent forms in English (Appendix A) or Spanish (Appendix B), and Child Behavior Checklist (CBCL-Achenbach and Edelbrock, 1981) to be completed by them. The consent forms indicated the purpose of the study and that their son's participation in this study would be completely confidential. The boys selected for the control group were those who scored within the "Normal" range on the CBCL. On the CBCL, "Normal" range scores are T scores below 67 on competence, internalizing and externalizing problem scales. Boys who obtained T scores of 67 and above ("Borderline Clinical" and "Clinical" ranges) were not used for this study.

Once consent was obtained, this researcher met each participant at the after school program and administered the seven TAT cards. The subjects were asked to tell a story, including what was happening in the picture, what led up to it, the outcome, and what the character(s) were thinking and feeling. These stories were transcribed verbatim.

CHAPTER IV

RESULTS

As described in chapter 3, this study set out to clinically assess whether there were significant differences in the use of denial, projection and identification in adolescent boys diagnosed as Depressed, Conduct Disordered or Normal.

The following three hypotheses guided this study: 1. Boys diagnosed as Conduct Disordered will rely primarily on the defense mechanism of denial as compared to those diagnosed as Depressed or "Normal." 2. Boys diagnosed as Depressed will depend primarily on the defense mechanism of projection as compared to those diagnosed as Conduct Disordered or "Normal." 3. "Normal" boys will depend primarily on the defense of identification as compared to boys diagnosed as Conduct Disordered or Depressed.

The results presented in this section are based on analysis of the three defenses and their components. The findings for the overall defenses are the main emphasis. Due to the small sample size making definitive statements about the defense components is limited. Nevertheless, this study attempted to maximize the available data to understand the defensive behaviors of the subjects under study. For this reason the components and their respective elements are evaluated and presented.

Table 1 describes the demographic and social characteristics of

the sample. Table 2, 3, and 4 present the means standard deviations and P-values for the components of denial, projection and identification in accordance to Cramer's Defense Mechanism Manual (1991). Table 5 presents the total responses according to the diagnostic category of the boys on each of the overall scales of denial, projection and identification. Table 6 presents the bivariate correlation between all the components. Table 7 presents data on the correlation among the three defenses and age.

Means for demographic variables and defense mechanisms according to group membership (Conduct Disordered, Depressed and Normal subjects) are presented in table 1. A total of 54, 12 to 16 year old Hispanic and African American males were grouped according to psychological evaluations as Conduct Disordered, Depressed or Normal, with the three groups consisting of 19, 17 and 18 subjects, respectively. With respect to age, the three groups exhibited very similar mean ages: Conduct Disordered (mean age =13.4), Depressed (mean age =13.8) and the Normal group (mean age =13.8). There was 69% majority of Hispanic males (n=37) while African Americans represented 31% (n=17). Hispanic subjects made-up approximately three quarters of the depressed (76.5%) (n=13), and Conduct Disordered (73.7%) (n=14), and more than half of the Normal group (55.6%) (n=10). African American subjects represented approximately one quarter of the subjects for the Conduct Disordered (n=5) and Depressed groups (n=4) and more

than two-fifths of the Normal group ($n=8$). The variation across the three groups was not statistically significantly different.

In evaluating the mean differences for the use of denial, an analysis of variance was conducted and presented in table 2. Because of a significant difference in the use of Misperception (D2) among the three groups, Multiple Comparisons were conducted to evaluate the three means. It was found that Conduct Disordered subjects used Misperception (D2) significantly more than the Normal subjects (mean difference .3560, $p < .05$). While the ANOVA for Statements of Negation (D4) only approached significance, in evaluating the difference between the three groups conducting Multiple Comparisons, the Conduct Disordered subjects were statistically different from the Normals (mean difference - .6696, $p < .05$).

Omission (D1) was used more on average, but not statistically significantly more by Normals (means .94 vs .63 and .53) when the three groups were compared to each other. However, when grouping Conduct Disordered subjects with the Depressed and comparing them to the Normals there was a statistically significant difference (.58 vs .94, $p < .05$) in the use of Omission.

Conduct Disordered subjects tended to use Misrepresentation (D2) (means .47, vs .12 and .11), Denial of Reality (D5) (means .58, vs .29 and .28) and Overly Maximizing the Positive or Minimizing the Negative (D6) (means .16, vs .00 and .06) more on average than the

TABLE 2

Denial

Means, Standard Deviations and F-values for Denial Among all Subjects

Category of Denial			Conduct Disorder (n=19)	Depressed (n=17)	Normals (n=18)	P
D1	Omission	Mean	0.63	0.53	0.94	.076 NS
		SD	0.60	0.62	0.42	
D2	Mispreception	Mean	0.47	0.12	0.11	.052 *
		SD	0.61	0.33	0.32	
D3	Reversal	Mean	0.11	0.18	0.06	.536 NS
		SD	0.32	0.39	0.24	
D4	Statement of negation	Mean	0.95	0.94	0.28	.025 NS
		SD	1.03	1.14	0.46	
D5	Denial of Reality	Mean	0.58	0.29	0.28	.357 NS
		SD	0.90	0.60	0.57	
D6	Overly maximizing positive, minimizing negative	Mean	0.16	0.00	0.06	.191 NS
		SD	0.37	0.00	0.24	
D7	Unexpected goodness, optimism, positiveness	Mean	0.32	0.53	0.33	.754 NS
		SD	1.16	0.87	0.69	

*** = < .005

** = < .01

* = < .05

NS = Not Significant

other two groups. On the other hand, depressed subjects tended to use Reversal (D3) (means .18, vs .11 and .06) and Unexpected Goodness and Optimism (D7) (means .53, vs .32 and .33) more often than the other two groups. As far as of Negation (D4) , both Conduct Disordered and Depressed boys tended to use this defense equally (means .95 and .94 vs .27).

Overall, as a group Conduct Disordered boys used various components of denial more often than the other two groups, either at statistically significant levels or on average. However, Normal and Depressed boys also used several of the components at various levels. As a result, it's predictive value is limited. That is, while it appears that Conduct Disordered boys do utilize this defense more often than the other two groups, from a statistical viewpoint, it does not confirm the hypothesis that denial will be utilized primarily by the Conduct Disordered boys.

Table 3 represents mean differences for Conduct Disorder, Depressed and Normal subjects in their use of projection. A significant difference was indicated between Normal and Depressed subjects in the use of Attribution of Aggressive or Hostile Feelings, Emotions, or Intentions (P1). In this case, Normals relied on P1 more often than Depressed and Conduct Disordered (means 4.8, vs 3.0 and 4.0) subjects.

TABLE 3

**Projection
Means, Standard Deviations and F-values for Projection Among all Subjects**

Category of Projection			Conduct Disorder (n=19)	Depressed (n=17)	Normals (n=18)	P
P1	Attribution of aggression or hostile feelings	Mean	4.05	3.00	4.78	.029 *
		SD	1.87	1.97	1.93	
P2	Addition of ominous people, ghosts, animals	Mean	1.21	1.41	0.67	.232 NS
		SD	1.18	1.58	1.19	
P3	Magical or circumstantial thinking	Mean	0.00	0.00	0.00	---
		SD	0.00	0.00	0.00	
P4	Concern for protection for external threat	Mean	3.05	2.24	1.67	.079 NS
		SD	1.65	1.92	1.94	
P5	Apprehensiveness of death, injury or assault	Mean	2.63	2.29	1.72	.293 NS
		SD	1.86	2.05	1.27	
P6	Themes of pursuit, entrapment and escape	Mean	0.16	0.18	0.17	.995 NS
		SD	0.50	0.39	0.71	
P7	Bizarre or very unusual story or theme	Mean	0.00	0.06	0.06	.583 NS
		SD	0.00	0.24	0.24	

*** = < .005

** = < .01

* = < .05

NS = Not Significant

Although not statistically significant, Conduct Disordered subjects tended to use Concern for Protection from External Threat (P4) (means 3.0, vs 2.2 and 1.7) and Apprehensiveness of Death, Injury, or Assault (P5) (means 2.7, vs 2.2 and 1.8) more than the other two groups. Depressed subjects tended to use Addition of Ominous People, Ghosts, Animals, Objects or Qualities (P2) (means 1.4, vs 1.2 and .67) and Themes of Pursuit, Entrapment and Escape (P6) (means .18, vs .16 and .17) more than the other other two groups. As far as Bizarre or Very Unusual Story or Theme (P7), both Depressed and Normals tended to use this defense equally (means .06 and .06 vs .00).

These results indicate that projection is not a good predictor of group membership. It was expected that Depressed boys would utilize this defense more often than the others. Instead, it was used at a significantly statistical level only once by Normals who relied primarily on the components P1, the Attribution of Aggressive or Hostile Feelings, Emotions, or Intentions.

Table 4 represents the mean differences for Conduct Disorder, Depressed and Normal subjects in their use of identification. Significant differences were indicated in the use of Regulation of Motives or Behavior (Id3) , Self-Esteem Through Affiliation (Id4) , and Work; Delay of Gratification (Id5) among the three groups. In all of these three cases, the Normals had significantly higher means than the other two groups in the use of these components. In addition, when grouping the Conduct

TABLE 4
Identification
Means, Standard Deviations and F-values for Identification Among all Subjects

Category of Identification			Conduct Disorder (n=19)	Depressed (n=17)	Normals (n=18)	P
I1	Emulation of skills	Mean	0.05	0.12	0.33	.164 NS
		SD	0.22	0.33	0.69	
I2	Emulation of characteristics	Mean	0.00	0.06	0.06	.583 NS
		SD	0.00	0.24	0.24	
I3	Regulation of motives or behavior	Mean	0.53	1.18	1.89	.014 *
		SD	0.77	1.13	1.94	
I4	Self-esteem through Affiliation	Mean	0.05	0.06	0.56	.004 ***
		SD	0.23	0.24	0.78	
I5	Work; Delay of gradification	Mean	0.16	0.47	1.67	.000 ****
		SD	0.37	0.80	1.41	
I6	Role differentiation	Mean	0.00	0.12	0.39	.109 NS
		SD	0.00	0.49	0.85	
I7	Moralism	Mean	0.79	0.47	0.22	.092 NS
		SD	0.92	0.80	0.55	

*** = < .005

** = < .01

* = < .05

NS = Not Significant

Disorder with Depressed subjects and comparing them to the Normals on Role Differentiation (Id6) there was a statistically significant difference (means .39, vs .00 and .12).

Although not statistically significant, Normal subjects tended to use Emulation of Skills (Id1) (means= .33, vs .05 and .12) more on average than the other two groups. As far as Emulation of Characteristics (Id2), both Depressed and Normals tended to use this defense equally (means .06 and .06 vs .00). Conduct Disordered subjects tended to use Moralism (Id7) (means= .79, vs .47 and .22) more on average than Depressed and Normal subjects.

These results indicate that identification is a good predictor of group membership. Normals used four out of the seven components of identification significantly higher than did both the Depressed and Conduct disordered boys, except for Moralism. The Moralism component of identification was the only one used by the Conduct Disordered boys, and they did so to a significantly greater extent than the other two groups. The Depressed boys used one identification component, Emulation of Characteristics, but at the same rate as did the Normals.

In table 5, three scales are presented. These scales are made up of the individual components (ie: D1 through D7; P1 through P7 and Id1 through Id7) for each of the three types of defense mechanisms under evaluation. The only scale that demonstrated statistically significant differences was the identification scale ($F=12.154$, $p<.000$). When

TABLE 5

Comparison of Defense Mechanisms by Category and Diagnosis

		Conduct Disorder (n=19)	Depressed (n=17)	Normal (n=18)	P
Denial	Mean	3.21	2.59	2.06	.063 NS
	SD	1.51	1.84	0.87	
Projection	Mean	11.11	9.18	9.06	.187 NS
	SD	3.81	2.74	4.47	
Identification	Mean	1.58	2.47	5.11	.000 ***
	SD	1.54	1.23	3.36	

*** = < .005

** = < .01

* = < .05

NS = Not Significant

looking at these differences using Multiple Comparisons it was established that the Normals were significantly different from the Depressed (mean difference 2.64, $p < .005$) and the Conduct Disordered (mean difference 3.53, $p < .001$).

Although not presented on the table, the frequency distributions for the three scales demonstrate the following: 1. that two Depressed subjects did not use any of the denial components; 2. Conduct Disordered subjects had a higher range than the other two groups with respect to denial; 3. Normals had a higher range in terms of projection and identification components than the other two groups.

The Alpha score for the three scales demonstrated low reliabilities. Reliability scores were: denial (-.37), projection (.13) and identification (.37).

Pearson correlations between all the components of denial, identification, and projection are presented in Table 6. There were sixteen significant moderate correlations, meaning that their absolute values ranged between .27 to .46: While the lowest correlations observed were between Omission of Major Characters of Objects (D1) and Regulation of Motives or Behavior (I3) and Overly Maximizing the Positive or Minimizing the negative (D6) and Moralism (I7). The highest correlation observed was between Emulation of Skills (Id1) and Regulation of Motives or Behavior (Id3). Overall, the highest correlations were between the Identification components (eg: Emulation of Skills

**TABLE 6
PEARSON CORRELATION MATRIX**

	DENIAL							PROJECTION							IDENTIFICATION										
	1	2	3	4	5	6	7	1	2	4	5	6	7	1	2	3	4	5	6	7					
DENIAL	1																								
	2	1.00																							
	3	-0.15	1.00																						
	4	0.19	0.20	1.00																					
	5	-0.26	-0.14	0.04	1.00																				
	6	-0.08	-0.23	-0.11	-0.09	1.00																			
	7	0.02	0.01	-0.10	0.01	-0.08	1.00																		
	7	-0.17	0.13	0.11	0.06	-0.15	0.27	1.00																	
PROJECTION	1							1.00																	
	2	0.01	0.11	-0.26	-0.08	-0.07	-0.03	0.00	-0.17	1.00															
	4	-0.19	-0.16	-0.11	0.06	0.32 ¹	-0.02	-0.26	0.07	-0.01	1.00														
	5	-0.15	0.10	-0.13	-0.07	-0.01	0.14	0.07	0.02	-0.15	0.31 ¹	1.00													
	6	-0.05	0.21	0.12	0.06	-0.33 ¹	0.09	-0.01	0.02	0.00	0.20	0.10	1.00												
	7	0.04	-0.16	-3.17	0.00	0.03	-0.09	-0.10	0.15	-0.01	-0.19	-0.19	-0.06	1.00											
	7	0.10	-0.10	-0.07	0.06	-0.11	0.32 ¹	0.02	0.15	-0.01	-0.19	-0.19	-0.06	1.00											
IDENTIFICATION	1												1.00												
	2	0.26	-0.19	-0.13	-0.15	-0.20	-0.10	-0.07	0.19	0.04	0.32 ¹	0.05	0.11	-0.07	1.00										
	3	-0.07	-0.10	-0.07	-0.15	-0.11	-0.08	-0.08	0.00	-0.09	0.07	-0.08	-0.08	-0.04	0.14	1.00									
	4	0.27 ¹	0.29 ¹	-0.07	-0.15	-0.14	0.01	-0.04	0.16	-0.06	0.05	-0.25	0.03	0.25	0.46 ³	0.36 ³	1.00								
	5	0.28 ¹	0.01	0.16	-0.13	-0.23	0.02	-0.10	0.01	-0.13	-0.02	-0.05	-0.13	0.10	0.23	0.10	0.24	1.00							
	6	0.24	-0.17	-0.24	-0.27	-0.16	-0.06	-0.14	-0.09	-0.10	-0.23	-0.07	-0.18	0.04	0.15	0.04	0.15	0.36 ³	1.00						
	7	0.15	-0.15	-0.10	-0.19	0.16	0.04	-0.13	-0.08	0.30 ¹	-0.26	-0.26 ¹	0.03	0.12	-0.11	-0.06	0.17	0.24	0.21	1.00					
	7	0.04	-0.06	0.30 ¹	0.26 ¹	0.02	0.27 ¹	-0.01	-0.20	-0.06	-0.05	0.04	0.02	0.12	-0.23	-0.12	-0.05	-0.04	-0.20	-0.15	1.00				

¹ < .05	D1 Omission	D5 Denial of Reality	P1 Attribution of aggression	P5 Apprehensiveness of death	I1 Emulation of skills	I6 Delay of graduation
² < .01	D2 Misperception	D6 Overtly Masking Positive	P2 Addition of ominous people	P6 Themes of pursuit, entrapment	I2 Emulation of characteristics	I6 Role differentiation
³ < .005	D3 Reversal	D7 Unexpected goodness	P3 Magical or circumstantial thinking	P7 Bizarre or very unusual story or theme	I3 Regulation of motives or behavior	I7 Meritism
	D4 Statement of negation		P4 Concern for protection for external threat		I4 Self-esteem through affiliation	

(Id1) and Regulation of Motives or Behavior (Id3); Emulation of Characteristics (Id2) and Regulation of Motives or Behavior (I3); and Self-esteem through Affiliation (I4) and Work; Delay of Gratification (Id5)). In addition, there were three negative correlations among the components. The negative correlations were: Misperception (D2) with Regulation of Motives or Behavior (Id3), Denial of Reality (D5) with Apprehensiveness of Death, Injury, or Assault (P5) and Apprehensiveness of Death, Injury or Assault (P5) with Role Differentiation (Id6). More than half of the significant correlations were between denial and the other items of the other two components, primarily identification ones. For example, the first significant correlation observed was between Denial of Reality (D5) and Addition of Ominous People, Ghosts, Animals, Objects, or Qualities (P2) which had a Pearson correlation of .32 and was statistically significant at the .05 level.

Overall, the correlations between the components of denial, projection and identification were very small. Some identification measures correlated strongly with each other. Otherwise, the correlations had weak values and their associations may have been randomly associated.

In table 7, correlations between the defense categories of denial, projection and identification and the demographic variable age are presented. Although age was not correlated with any of the three defense mechanisms, the correlation between identification and age approached

TABLE 7

**Correlation Coefficients between Defense Categories
and the Demographic Variable Age**

	Denial	Projection	Identification	Age (Years)
Denial	1.00			
Projection	-0.13	1.00		
Identification	-0.29*	-0.16	1.00	
Age (Years)	-0.03	0.03	0.27	1.00

*** = < .005

** = < .01

* = < .05

NS = Not Significant

significance (.27, $p=.051$). In terms of correlations between defense mechanisms, denial and identification were significantly inversely correlated ($-.29$, $p<.05$). This indicated that as subjects tended to emphasize the use of Denial they deemphasized the use of Identification, and vice-versa. The denial-projection and projection-identification associations were not significantly associated.

Hypotheses

Table 5 summarized the findings concerning the hypotheses. Hypothesis 1 stated that boys diagnosed as Conduct Disordered will rely primarily on the defense mechanism of denial as compared to those diagnosed as Depressed or Normal. This hypothesis was not sustained.

Hypothesis 2 stated that boys diagnosed as Depressed will depend primarily on the defense mechanism of projection as compared to those diagnosed as Conduct Disordered or Normal. This hypothesis was not sustained.

Hypothesis 3 stated that Normal boys will depend primarily on the defense mechanism of identification as compared to boys diagnosed as Conduct Disordered and Depressed. This hypothesis was sustained.

CHAPTER V

DISCUSSION OF RESULTS

This study sought to examine how often boys diagnosed as Conduct Disordered and Depressed used various defense mechanisms. Questions about the relation between the use of defense mechanisms and the manner in which children with disruptive and affective disorders coped with stress and anxiety was the impetus for conducting this study. One basic question was: would there be a specific configuration or pattern of defense which characterized youths clinically diagnosed as Conduct Disordered versus those diagnosed as Depressed? In working with these clinical populations it seemed clinically apparent that both relied heavily on the use of denial and projection. However, it was not clear that empirically in a controlled situation whether this "choice" of defense could be demonstrated. In addition to examining how these two clinical groups related to each other on the use of these "primitive" or less mature defenses, a "Normal" group was included to assess if boys who live in similar environments, but who are not considered "troubled", utilized developmentally higher order defenses, such as identification. According to the literature, the defense of identification is thought to contribute to their greater adaptability.

The defenses of denial, projection and identification were scored using Cramer's Defense Mechanism Manual (1991) on selected TAT stories of normal boys and those diagnosed as Conduct Disordered and

Depressed. Cramer's Defense Mechanism Manual provided a tool for scoring the three defenses and their seven components or sub-categories.

Overall, the results of this study supported the hypothesis that identification is used more often by Normal boys. Conduct Disordered boys tended to use denial more on average than Normal and Depressed boys. Those diagnosed as Depressed fell somewhere in the middle. That is, Depressed boys did not rely primarily on projection as was hypothesized. Instead, they used various components of the three defenses and in doing so, they could not be described as using any one particular defense system.

These results are consistent with the findings of several investigators such as Noam et al. (1994), Lerner and Lerner, (1980), Loevinger, (1976) and Vaillant (1971, 1977, 1994) who found that the use of different levels of defense relate to different levels of psychopathology or adjustment. In this study, normal boys who were considered the "best" adjusted, used the defense mechanism identification which is considered a mature defense compared to denial and projection. On the other hand, the conduct disordered boys whose externalizing behavior problems are associated with delays in ego development, used denial more often than the normal and depressed, albeit not at a statistically significant level (P-value .063).

While studies have reported that affective disorders such as depression are associated with the developmentally more mature, "internalizing" states of ego development (Noam et al. (1994) , the depressed boys in this study did not utilize projection or identification more than denial. This may have distinguished them from the conduct disordered and normal subjects from a developmental viewpoint. Nonetheless, regardless of the diagnostic type, correlations between denial and identification indicated that as subjects tended to emphasize the use of denial they deemphasized the use of identification.

In addition to comparing the overall defense mechanism categories, the seven components of denial, projection and identification were evaluated. This was useful because it provided a closer inspection of the three defenses and their association to group membership. The following is a discussion of the significant findings among the components of denial, projection and identification.

Denial

One finding was that Conduct Disordered boys used Misperception significantly more often than Normal boys. According to Cramer (1991), Misperception is a means for dealing with upsetting perceptions of reality by changing the percept into something it is not, something that is less threatening. This result is not surprising given that Conduct Disordered children and adolescents typically misinterpret things, make mistakes in reality testing and often react to problem

situations, claiming that they were unaware or "not knowing."

Results also indicated that Statements of Negation were used more often by Conduct Disordered boys than by Normal boys. Similar to Misperception, this component of denial is considered "primitive" in so far that an event may be perceived but accepted in a negated form, as in "It didn't happen that way." It is rather common for Conduct Disordered youths to change things around, to turn the truth to the untruth when they are caught doing something wrong or blamed for something.

An interesting and unexpected finding revealed that Omission was used significantly more by Normal boys when Conduct Disordered and Depressed boys were grouped together. Omission represents a failure to see what exists in reality. Cramer (1991) states that this "not seeing" can occur through a total withdrawal of attention from the event, or through a "negative hallucination." In attempting to understand why Normal boys scored higher on this defense compared to the clinical group one may speculate that selective attention and blocking-out may well be one protective way of surviving in hostile and threatening environments like that of this sample. With this sample, Omission seems to be functional for maintaining "normal" functioning. On the other hand, boys in the clinical groups who may have already been subjected to threatening influences and are more vulnerable to future injury have learned to be more vigilant and cannot use Omission or "not seeing" to survive.

Projection

Attribution of Aggression or Hostile Feelings, Emotions, or Intentions to a Character, or Other Feelings, Emotions, or Intentions that are Normatively Unusual was used significantly more often by the Normal boys than by Conduct Disordered and Depressed boys. This is an unexpected finding given that projection of aggressive and hostile feelings is usually associated with troubled youths who get involved in fights and other forms of aggressive confrontations with others. One way of explaining this result is that projections of aggression and hostility do not necessarily lead to physical aggression and violence. For the "normal" boys in this sample, the propensity to act out may be quelled or balanced-out by the availability of higher order defenses such as identification and other ego mechanisms.

Identification

Identification had the best variability across components and was most predictive of membership in the Normal group. In all, four components were statistically significant. These represent identifications, ideals and values which Normal boys have internalized. These include the internalization of rules, codes or mores which were originally derived from parents or other authority figures; enhancement of self-esteem that comes about as a result of being part of a group, or association with a peer or an extrafamilial adult; recognition of the value of work and acknowledgement that one must delay gratification to attain rewards and

success ; and recognition of the differences among people in the world outside of the family which reflects an individual's capacity to differentiate between self and others. Unlike the Normal boys, those in the clinical groups in general, and the Conduct Disordered boys in particular, made fewer references of the aforementioned identification components and did not demonstrate the capacities noted. Socially, they constantly challenge authority figures and are resentful when they are forced to comply to established rules and demands. While they speak of friends they are often alone and experience considerable difficulties maintaining healthy relationships. They struggle with school work and have little motivation and interest in working, often falling to the temptation of making quick and "easy" money.

The use of these defenses among the Normal boys may be understood in terms of available models or internal representations where Identification served either to protect or to enhance their self-esteem and to develop mature relationships with others (Horner, 1983; Menaker, 1979).

One other interesting finding was that Conduct Disordered boys used Moralism more often on average than the Normal and Depressed groups. Furthermore, when compared to Normal and Depressed boys, Conduct Disordered Boys used Moralism statistically significantly more. One explanation for this result is that youngsters who are disruptive, break rules and challenge authority are frequently lectured and

punished by teachers, parents and other adults. These youngsters tend to exaggerate moralism in identifying with others and even though they are aware of how wrongdoing will be punished, their poor judgment and impulse control leads to repeated acting out. The use of Moralism with Conduct Disordered boys may also be viewed as representing a component of *defensive* identification (Cramer 1991), which occurs as a way of avoiding anxiety, maintaining self-esteem and controlling unacceptable impulses. According to Cramer this is seen as a regressive phenomenon reflecting anxiety caused by loss, or anticipated loss. This is compared to a *developmental* identification, in which the child modifies his own ego, on the basis of experience, to become increasingly independent, individuated and autonomous from significant others.

Limitations of Study

The limitations of this study can be summarized as follows:

A larger sample size would have allowed for better comparisons.

Defenses were measured according to Cramer's Defense Mechanism Manual (DMM) (1991). While it has demonstrated good reliability, validity and success in assessing the use of defense mechanisms in a number of areas (ie., developmental differences, the effects of psychological interventions, the relationship between psychopathological symptoms and defense in psychiatric patients) this approach has not been widely used with adolescents and clinical populations.

Another limitation of this study is that boys in the clinical groups, unlike those from the control group, were not interviewed and evaluated directly by the author of this study. Instead, files were used which consisted of psychological evaluations, protocols and relevant background information. The diagnosis for depression and conduct disorder for each subject was based on the diagnosis reported by the examiner who initially tested the subjects. Consequently, the criteria used for diagnosing the clinical subjects were not known and may have been based on subjective clinical judgment or other means which were not consistent for all subjects.

Finally, subjects who participated in this study were of Hispanic and African-American descent only. This limits the ability to generalize the findings of this study to white populations.

Suggestions for Future Research

A larger study population would have allowed for better comparisons of subjects at the younger, middle and older age ranges and would have provided a greater opportunity to examine the developmental differences in the use of defenses in these clinical groups.

It may have been more useful in furthering our understanding of the use of defense mechanisms in Depressed and Conduct Disordered boys by assessing a larger sample of defenses, on one hand, and by sampling other behaviors in addition to the TAT.

Summary and Conclusions

Thirty-six adolescent boys from the same inner-city minority community were examined and diagnosed as Conduct Disordered or Depressed. They were matched by nineteen "Normal" boys from the same backgrounds. The study was performed to determine if theoretical constructs concerning these diagnoses and uses of "primitive" or more mature defenses could be empirically confirmed by test data. The defenses of denial, projection and identification were chosen and Cramer's Defense Mechanism Manual (1991) was used to explore how often clinical and normal boys used these defenses. Based on this study and its limitations, the following conclusions are tenable:

1. It was confirmed that there were differences in the way Conduct Disordered, Depressed and Normal boys respond to a test of defense style. These differences are consistent with predictions concerning developmental level of the defenses and the pathology of diagnoses.

2. "Normals" were different from the clinical groups in their greater use of identification, the most sophisticated of the defense groups studied.

3. There was a sufficient difference in how often Conduct Disordered boys used Denial compared to how often Denial was used by the Depressed and Normal boys to indicate concurrence between this use of this most "primitive" defense selectively more by the boys in this

most "primitive" of the diagnostic categories.

APPENDIX A: PARENT CONSENT FORM

THE CITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
NEW YORK, N. Y. 10031

81

CLINICAL PSYCHOLOGY
DOCTORAL PROGRAM
DEPARTMENT OF PSYCHOLOGY
NAC Bldg., 8th Floor 8/107

(212) 650-5674

Dear Parent,

We are asking for your consent for your son to contribute to our study of children's management of social and school tasks in relation to their overall sense of well being. This study is part of a doctoral dissertation in psychology. We expect that it will improve understanding of ways to help children cope with expectations.

We will simply give participants a series of seven pictures and ask them to make up stories about them. There is no right or wrong to these responses and no grades.

Whether or not your son is a part of the study will have no effect on his marks or standing in school. The study will be completely confidential . No responses will be identified with any particular child.

If you agree, we are asking you to fill out the attached form about him. A self-addressed stamped envelope is also attached for your convenience in returning the form.

We would appreciate your valued cooperation. Please sign below to indicate that you agree to have your son participate in this study.

Date

William Hernandez, M.S.

Vera S. Paster, Ph. D.
Professor, C.U.N.Y.
Doctoral Program in
Clinical Psychology

I consent to my son _____, to participate in the study of boy's management of social and school demands.

Name of Parent

Date

Witness

AN EQUAL OPPORTUNITY EMPLOYER

**APPENDIX B: PARENTAL CONSENT FORM
(SPANISH)**

THE CITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
NEW YORK, N. Y. 10031

83

CLINICAL PSYCHOLOGY
DOCTORAL PROGRAM
DEPARTMENT OF PSYCHOLOGY
NAC Bldg., 8th Floor 8/107

(212) 650-5674

Estimado Padre,

Estamos pidiendo su permiso para que su hijo participe en nuestro estudio. Este se trata de como los niños manejan tareas sociales y escolares en relación a como se sienten acerca de ellos mismos. Este estudio es parte de una tesis doctoral en psicología. Esperamos que eso nos ayude a entender mejor las maneras de ayudar a los niños a bregar con expectativas.

Simplemente le mostraremos una serie de siete láminas a los participantes y le pedimos que hagan cuentos acerca de las mismas. No hay respuestas correctas o incorrectas y tampoco se le da nota. El que su hijo participe o no en el estudio no afectará sus notas en la escuela. El estudio será completamente confidencial. Ninguna respuesta se va a identificar con ningún niño.

Si usted está de acuerdo, por favor llene el cuestionario que le estamos enviando. Le estamos incluyendo un sobre con sello para su conveniencia.

Agradecemos toda su cooperación. Por favor, firme para indicar que está de acuerdo con que el niño participe en este estudio.

Fecha

William Hernandez, M.S.

Vera S. Paster, Ph.D.
Profesora, C.U.N.Y.
Programa
Doctoral en la Psicología Clínica

Doy permiso para que mi hijo _____, participe en el estudio.

Nombre de Padre

Fecha

Testigo

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**APPENDIX C: CHILD BEHAVIOR CHECK LIST
(CBCL)**

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For items use only 1-5

CHILD'S NAME _____			PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific—for example, auto mechanic, high school teacher, homemaker, teacher, auto operator, steel welder, army sergeant.)		
SEX <input type="checkbox"/> Boy <input type="checkbox"/> Girl	AGE _____	ETHNIC GROUP OR RACE _____	FATHER'S TYPE OF WORK _____		
TODAY'S DATE Mo. _____ Day _____ Yr. _____		CHILD'S BIRTHDATE Mo. _____ Day _____ Yr. _____		MOTHER'S TYPE OF WORK _____	
GRADE IN SCHOOL _____	Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.		THIS FORM FILLED OUT BY: <input type="checkbox"/> Mother (name) _____ <input type="checkbox"/> Father (name) _____ <input type="checkbox"/> Other—name & relationship to child: _____		
NOT ATTENDING SCHOOL <input type="checkbox"/>					

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, plans, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None

	Don't Know	Less Active	Average	More Active
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None

	Don't Know	Below Average	Average	Above Average
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- V. 1. About how many close friends does your child have? None 1 2 or 3 4 or more
 (Do not include brothers & sisters)
2. About how many times a week does your child do things with any friends outside of regular school hours?
 (Do not include brothers & sisters) Less than 1 1 or 2 3 or more

- VI. Compared to others of his/her age, how well does your child:
- | | Worse | About Average | Better | |
|---|--------------------------|--------------------------|--------------------------|---|
| a. Get along with his/her brothers & sisters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Behave with his/her parents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Play and work by himself/herself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

VII. 1. For ages 6 and older—performance in academic subjects. If child is not being taught, please give reason _____

	Failing	Below average	Average	Above average
a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., etc.				
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Is your child in a special class or special school? No Yes—what kind of class or school?

3. Has your child repeated a grade? No Yes—grade and reason

4. Has your child had any academic or other problems in school? No Yes—please describe

When did these problems start?

Have these problems ended? No Yes—when?

Does your child have any illness, physical disability, or mental handicap? No Yes—please describe

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1.	Acts too young for his/her age	0	1	2	31.	Fears he/she might think or do something bad
0	1	2	2.	Allergy (describe: _____)	0	1	2	32.	Feels he/she has to be perfect
					0	1	2	33.	Feels or complains that no one loves him/her
0	1	2	3.	Argues a lot	0	1	2	34.	Feels others are out to get him/her
0	1	2	4.	Asthma	0	1	2	35.	Feels worthless or inferior
0	1	2	5.	Behaves like opposite sex	0	1	2	36.	Gets hurt a lot, accident-prone
0	1	2	6.	Bowel movements outside toilet	0	1	2	37.	Gets in many fights
0	1	2	7.	Bragging, boasting	0	1	2	38.	Gets teased a lot
0	1	2	8.	Can't concentrate, can't pay attention for long	0	1	2	39.	Hangs around with others who get in trouble
0	1	2	9.	Can't get his/her mind off certain thoughts/ obsessions (describe: _____)	0	1	2	40.	Hears sounds or voices that aren't there (describe: _____)
0	1	2	10.	Can't sit still, restless, or hyperactive	0	1	2	41.	Impulsive or acts without thinking
0	1	2	11.	Clings to adults or too dependent	0	1	2	42.	Would rather be alone than with others
0	1	2	12.	Complains of loneliness	0	1	2	43.	Lying or cheating
0	1	2	13.	Confused or seems to be in a fog	0	1	2	44.	Bites fingernails
0	1	2	14.	Cries a lot	0	1	2	45.	Nervous, high-strung, or tense
0	1	2	15.	Cruel to animals	0	1	2	46.	Nervous movements or twitching (describe: _____)
0	1	2	16.	Cruelty, bullying, or meanness to others	0	1	2	47.	Nightmares
0	1	2	17.	Day-dreams or gets lost in his/her thoughts	0	1	2	48.	Not liked by other kids
0	1	2	18.	Deliberately harms self or attempts suicide	0	1	2	49.	Constipated, doesn't move bowels
0	1	2	19.	Demands a lot of attention	0	1	2	50.	Too fearful or anxious
0	1	2	20.	Destroys his/her own things	0	1	2	51.	Feels dizzy
0	1	2	21.	Destroys things belonging to his/her family or others	0	1	2	52.	Feels too guilty
0	1	2	22.	Disobedient at home	0	1	2	53.	Overeating
0	1	2	23.	Disobedient at school	0	1	2	54.	Overtired
0	1	2	24.	Doesn't eat well	0	1	2	55.	Overweight
0	1	2	25.	Doesn't get along with other kids	0	1	2	56.	Physical problems without known medical cause:
0	1	2	25.	Doesn't seem to feel guilty after misbehaving	0	1	2	a.	Aches or pains (not headaches)
0	1	2	27.	Easily jealous	0	1	2	b.	Headaches
0	1	2	28.	Eats or drinks things that are not food - don't include sweets (describe: _____)	0	1	2	c.	Nausea, feels sick
					0	1	2	d.	Problems with eyes (describe: _____)
0	1	2	29.	Fears certain animals, situations, or places, other than school (describe: _____)	0	1	2	e.	Rashes or other skin problems
					0	1	2	f.	Stomachaches or cramps
0	1	2	30.	Fears going to school	0	1	2	g.	Vomiting, throwing up
					0	1	2	h.	Other (describe: _____)

page 3

Please see other side

0 = Not True (as far as you know)			1 = Somewhat or Sometimes True			2 = Very True or Often True			
0	1	2	57.	Physically attacks people	0	1	2	84.	Strange behavior (describe): _____
0	1	2	58.	Picks nose, skin, or other parts of body (describe): _____	0	1	2	85.	Strange ideas (describe): _____
0	1	2	59.	Plays with own sex parts in public	0	1	2	86.	Stubborn, sullen, or irritable
0	1	2	60.	Plays with own sex parts too much	0	1	2	87.	Sudden changes in mood or feelings
0	1	2	61.	Poor school work	0	1	2	88.	Sulks a lot
0	1	2	62.	Poorly coordinated or clumsy	0	1	2	89.	Suspicious
0	1	2	63.	Prefers being with older kids	0	1	2	90.	Swearing or obscene language
0	1	2	64.	Prefers being with younger kids	0	1	2	91.	Talks about killing self
0	1	2	65.	Refuses to talk	0	1	2	92.	Talks or walks in sleep (describe): _____
0	1	2	66.	Repeats certain acts over and over; compulsions (describe): _____	0	1	2	93.	Talks too much
0	1	2	67.	Runs away from home	0	1	2	94.	Teases a lot
0	1	2	68.	Screams a lot	0	1	2	95.	Temper tantrums or hot temper
0	1	2	69.	Secretive, keeps things to self	0	1	2	96.	Thinks about sex too much
0	1	2	70.	Sees things that aren't there (describe): _____	0	1	2	97.	Threatens people
0	1	2	71.	Self-conscious or easily embarrassed	0	1	2	98.	Thumb-sucking
0	1	2	72.	Sets fires	0	1	2	99.	Too concerned with neatness or cleanliness
0	1	2	73.	Sexual problems (describe): _____	0	1	2	100.	Trouble sleeping (describe): _____
0	1	2	74.	Showing off or clowning	0	1	2	101.	Truancy, skips school
0	1	2	75.	Shy or timid	0	1	2	102.	Underactive, slow moving, or lacks energy
0	1	2	76.	Sleeps less than most kids	0	1	2	103.	Unhappy, sad, or depressed
0	1	2	77.	Sleeps more than most kids during day and/or night (describe): _____	0	1	2	104.	Unusually loud
0	1	2	78.	Smears or plays with bowel movements	0	1	2	105.	Uses alcohol or drugs for nonmedical purposes (describe): _____
0	1	2	79.	Speech problem (describe): _____	0	1	2	106.	Vandalism
0	1	2	80.	Stares blankly	0	1	2	107.	Wets self during the day
0	1	2	81.	Steals at home	0	1	2	108.	Wets the bed
0	1	2	82.	Steals outside the home	0	1	2	109.	Whining
0	1	2	83.	Stores up things he/she doesn't need (describe): _____	0	1	2	110.	Wishes to be of opposite sex
					0	1	2	111.	Withdrawn, doesn't get involved with others
					0	1	2	112.	Worries
								113.	Please write in any problems your child has that were not listed above:
					0	1	2		_____
					0	1	2		_____
					0	1	2		_____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

PAGE 2

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

**APPENDIX D: CHILD BEHAVIOR CHECKLIST
(CBLC)
(SPANISH)**

*** GENERIC SPANISH VERSION ***
CUESTIONARIO SOBRE EL COMPORTAMIENTO DE NIÑOS (EADAES 4-18 AÑOS)

NOMBRE	ID#	
SEXO ___ Masculino ___ Femenino	EDAD _____	Ocupación de los Padres. (Por favor sea específico, por ejemplo: Mecánico de autos, maestro de escuela superior, ama de casa, etc.)
FECHA DE HOY Mes _____ Día _____ Año _____		Ocupación de padre: _____
FECHA DE NACIMIENTO DEL NIÑO(A) Mes _____ Día _____ Año _____		Ocupación de madre: _____

Por favor llene esta forma con su opinión sobre la conducta del niño (a), aunque otras personas no concuerden con Ud. Si desea hacer comentarios adicionales o alguna pregunta, hágalo junto a ésta o en el espacio indicado en la página 3.

ESTA FORMA FUE COMPLETADA POR:

- ___ Madre
 ___ Padre
 ___ Otro _____

Grado escolar: _____ **No va a la escuela:** _____

<p>I. ¿En qué deportes le gusta más a su niño(a) participar? Por ejemplo: natación, béisbol, patinar, montar bicicleta, baloncesto, pescar, etc.</p> <p>___ Ninguno</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>En comparación con otros niños(as) de su edad, ¿cuánto tiempo le dedica a cada uno de estos deportes?</p> <p>No lo sé ¿Menos que los demás? ¿Igual que los demás? ¿Más que los demás?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>En comparación con otros niños(as) de su edad, ¿cuán bueno(a) es en cada uno de estos deportes?</p> <p>No lo sé ¿Menos bueno que los demás? ¿Igual que los demás? ¿Mejor que los demás?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>II. ¿Cuáles son las actividades, juegos o pasatiempos favoritos de su niño(a), aparte de los deportes? Por ejemplo: colección de estampillas, muñecas, libros, piano, artesanías, mecánica, cantar, etc. (No incluya escuchar Radio ó T.V.).</p> <p>___ Ninguno</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>En comparación con otros niños(as) de su edad, ¿cuánto tiempo dedica a cada una de esas actividades?</p> <p>No lo sé ¿Menos que los demás? ¿Igual que los demás? ¿Más que los demás?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>En comparación con otros niños(as) de su edad, ¿cuán bueno(a) es en cada actividad?</p> <p>No lo sé ¿Menos bueno que los demás? ¿Igual que los demás? ¿Mejor que los demás?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

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 Translation by: The Dellcrest Children's Centre & Earlscourt Child & Family Centre-Toronto, Canada

<p>III. ¿A qué organizaciones, equipos, clubes o cualquier otro grupo pertenece su niño(a)?</p> <p>___ Ninguno</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>En comparación con otros niños(as) de su edad, ¿cuánto tiempo dedica a cada grupo?</p> <table border="0"> <thead> <tr> <th>No lo sé</th> <th>¿Menos que los demás?</th> <th>¿Igual que los demás?</th> <th>¿Más que los demás?</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	No lo sé	¿Menos que los demás?	¿Igual que los demás?	¿Más que los demás?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
No lo sé	¿Menos que los demás?	¿Igual que los demás?	¿Más que los demás?																		
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
<p>IV. ¿Qué tareas o trabajos tiene que hacer su niño(a)? Por ejemplo tender la cama, cuidar niños, repartir periódicos, etc. (Sean pagados o no).</p> <p>___ Ninguno</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>En comparación con otros niños(as) de su edad, ¿cuán bien hace cada tarea o trabajo?</p> <table border="0"> <thead> <tr> <th>No lo sé</th> <th>¿Peor que los demás?</th> <th>¿Igual que los demás?</th> <th>¿Mejor que los demás?</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	No lo sé	¿Peor que los demás?	¿Igual que los demás?	¿Mejor que los demás?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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<p>V. 1. ¿Cuántos amigos(as) íntimos(as) tiene su niño(a)? [sin incluir a hermanos(as)]</p> <p>2. Sin contar las horas en que está en la escuela, ¿con qué frecuencia se envuelve en actividades con sus amigos?</p>	<table border="0"> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Ninguno</td> <td>Uno</td> <td>2 ó 3</td> <td>4 ó más</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Menos de una vez por semana</td> <td>1 ó 2 veces por semana</td> <td>4 ó más</td> <td></td> </tr> </tbody> </table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ninguno	Uno	2 ó 3	4 ó más	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Menos de una vez por semana	1 ó 2 veces por semana	4 ó más					
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Ninguno	Uno	2 ó 3	4 ó más																		
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Menos de una vez por semana	1 ó 2 veces por semana	4 ó más																			
<p>VI. En comparación con otros niños(as) de la misma edad, cómo..</p> <p>a. se lleva con sus hermanos y hermanas?</p> <p>b. se lleva con otros niños(as)?</p> <p>c. se comporta con papá y mamá?</p> <p>d. puede jugar y hacer sus tareas por sí solo?</p>	<table border="0"> <thead> <tr> <th>¿Peor que los demás?</th> <th>¿Igual que los demás?</th> <th>¿Mejor que los demás?</th> <th>No tiene hermanos ó hermanas</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table>	¿Peor que los demás?	¿Igual que los demás?	¿Mejor que los demás?	No tiene hermanos ó hermanas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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VII.1. Para niños de 6 años o más- Rendimiento escolar. Si no está en la escuela, diga la razón.

	¿Fracasando?	¿Bajo Promedio?	¿Promedio?	¿Sobre Promedio?
a. Lectura, Inglés o literatura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Historia o Estudios Sociales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Matemáticas ó Aritmética	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Ciencias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otras materias como por ejemplo: Idiomas, computación, comercio, etc. No incluya clases tales como: educación física, artes industriales, etc.				
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. ¿Su hijo(a) está en una clase o escuela especial? No Sí
 ¿En qué tipo de clase o escuela especial está (ESPECIFIQUE) _____

3. ¿Alguna vez ha repetido un grado? No Sí
 ¿Qué grado o grados ha repetido? _____
 ¿Por qué repitió ese(esos) grado(s)? _____

4. ¿Su hijo(a) ha tenido algún problema académico u otros problemas en la escuela? No Sí
 ¿Qué tipo de problemas? (DESCRIBA): _____
 ¿Cuándo empezaron estos problemas? _____
 ¿Han terminado? No Sí ¿Cuándo terminaron? _____

5. ¿Padece el niño de alguna enfermedad, problema físico o mental? No Sí
 Describa: _____

En el siguiente espacio explique qué es lo que más le preocupa acerca de su niño:

Describe que es lo mejor que tiene su niño:

Instrucciones: A continuación hay una lista de comportamientos o de sentimientos que se observan en los niños. Si alguno de ellos describe a su hijo(a) durante los últimos seis meses, haga un círculo alrededor del número 2 si ocurre frecuentemente o si es bien cierto, y un círculo alrededor del número 1 si le aplica a su hijo(a) solamente algunas veces. Si según usted puede apreciar que no es cierto o no se ha observado nunca durante los últimos seis meses, haga un círculo alrededor del 0. Por favor conteste todas las frases lo mejor que Ud. pueda, aunque algunas frases parezcan no relacionadas a su niño(a).

0 = Falso(hasta donde ud. sabe) 1 = De alguna manera ó algunas veces es verdad 2 = Muy cierto ó a menudo cierto

0	1	2	1.	Actúa como un niño menor de su edad.	0	1	2	30.	Le da miedo ir a la escuela.
0	1	2	2.	Padece de alergias (diga a qué): _____	0	1	2	31.	Tiene miedo de que pueda pensar o hacer algo malo.
0	1	2	3.	Discute mucho.	0	1	2	32.	Siente que tiene que ser perfecto.
0	1	2	4.	Padece de asma.	0	1	2	33.	Siente o se queja de que nadie lo quiere.
0	1	2	5.	Se comporta como si fuera del sexo opuesto.	0	1	2	34.	Siente que los demás le quieren perjudicar o fastidiar.
0	1	2	6.	Se hace pupu o caca fuera del baño.	0	1	2	35.	Se siente inferior y como que no vale nada.
0	1	2	7.	Es jactancioso, engreído.	0	1	2	36.	Se da golpes a menudo, tiene muchos accidentes.
0	1	2	8.	No se puede concentrar o prestar atención por mucho rato.	0	1	2	37.	Se mete mucho en peleas.
0	1	2	9.	No puede quitarse de la mente ciertos pensamientos: está obsesionado (DESCRIBA): _____	0	1	2	38.	Los demás lo fastidian o se burlan de él a menudo.
0	1	2	10.	No se puede estar quieto es inquieto o hiperactivo.	0	1	2	39.	Se junta con niños/muchachos(as) que se meten en problemas.
0	1	2	11.	Es demasiado dependiente o apegado a los adultos.	0	1	2	40.	Oye cosas que no existen. (DESCRIBA): _____
0	1	2	12.	Se queja de que se siente solo.	0	1	2	41.	Es impulsivo o actúa sin pensar.
0	1	2	13.	Confuso, como en las nubes.	0	1	2	42.	Le gusta estar solo.
0	1	2	14.	Llora mucho.	0	1	2	43.	Dice mentiras o hace trampas.
0	1	2	15.	Es cruel con los animales.	0	1	2	44.	Se muerde las uñas.
0	1	2	16.	Es abusador, cruel o malo con los demás.	0	1	2	45.	Es nervioso, tenso.
0	1	2	17.	Sueña despierto, se pierde en sus propios pensamientos.	0	1	2	46.	Tiene movimientos nerviosos, tics, (DESCRIBA): _____
0	1	2	18.	Se hace daño a sí mismo deliberadamente o intenta suicidarse.	0	1	2	47.	Le dan pesadillas.
0	1	2	19.	Exige mucha atención.	0	1	2	48.	No le cae bien a otros niños/muchachos(as).
0	1	2	20.	Destruye sus propias cosas.	0	1	2	49.	Padece de estreñimiento.
0	1	2	21.	Destroza las pertenencias de sus familiares o las de otros niños.	0	1	2	50.	Es demasiado ansioso o le da mucho miedo.
0	1	2	22.	Desobedece en la casa.	0	1	2	51.	Se siente mareado.
0	1	2	23.	Desobedece en la escuela.	0	1	2	52.	Se siente culpable por cualquier cosa.
0	1	2	24.	No come bien.	0	1	2	53.	Come demasiado.
0	1	2	25.	Le se lleva bien con otros niños/ muchachos(as).	0	1	2	54.	Se cansa demasiado.
0	1	2	26.	No parece sentirse culpable después de portarse mal.	0	1	2	55.	Exceso de peso.
0	1	2	27.	Se pone celoso fácilmente.	0	1	2	56.	Problemas físicos sin causa médica conocida:
0	1	2	28.	Come o bebe cosas que no son comida (diga qué): (no incluya golosinas) _____	0	1	2	a.	Dolores o molestias.
0	1	2	29.	Tiene miedo a ciertos animales, situaciones, o lugares (NO INCLUYA LA ESCUELA) (DESCRIBA): _____	0	1	2	b.	Dolores de cabeza.
					0	1	2	c.	Ganas de vomitar, náusea.
					0	1	2	d.	Problemas con sus ojos (Describe)
					0	1	2	e.	Urticaria o erupciones de la piel
					0	1	2	f.	Dolores de estómago o retortijones.
					0	1	2	g.	Vómito.
					0	1	2	h.	Otros (Describe): _____

0 = Falso(hasta donde ud. sabe) 1 = De alguna manera ó algunas veces es verdad 2 = Muy cierto ó a menudo cierto

0	1	2	57. Ataca físicamente a otras personas.	0	1	2	84. Se comporta de una manera extraña. (DESCRIBA): _____
0	1	2	58. Se mete los dedos en la nariz, se raspa la piel u otras partes del cuerpo con las uñas. (DESCRIBA): _____	0	1	2	85. Tiene ideas raras. (DESCRIBA): _____
0	1	2	59. Juega con sus partes sexuales (genitales) en público.	0	1	2	86. Testarudo, malhumorado, de mal genio o irritable.
0	1	2	60. Juega demasiado con sus partes sexuales.	0	1	2	87. Su estado de ánimo o sentimientos cambia rápidamente.
0	1	2	61. Rendimiento escolar bajo.	0	1	2	88. Refunfuña mucho.
0	1	2	62. Es torpe, poco coordinado.	0	1	2	89. Desconfiado, receloso.
0	1	2	63. Prefiere jugar con niños(as)/muchachos(as) mayores que él(ella).	0	1	2	90. Blasfema o dice malas palabras.
0	1	2	64. Prefiere jugar con niños(as)/muchachos(as) menores que él(ella).	0	1	2	91. Habla de quererse matar.
0	1	2	65. Refusa hablar.	0	1	2	92. Habla o camina cuando está dormido. (DESCRIBA): _____
0	1	2	66. Repite ciertas acciones una y otra vez; compulsiones. (DESCRIBA): _____	0	1	2	93. Habla demasiado.
0	1	2	67. Se fuga de su casa.	0	1	2	94. Se burla mucho de los demás.
0	1	2	68. Grita mucho.	0	1	2	95. Le dan rabietas o tiene mal genio.
0	1	2	69. Es reservado; mantiene sus cosas en secreto.	0	1	2	96. Piensa demasiado sobre temas sexuales.
0	1	2	70. Ve cosas que no están. (DESCRIBA): _____	0	1	2	97. Amenaza a otros.
0	1	2	71. Muy vergonzoso, se avergüenza con facilidad.	0	1	2	98. Se chupa el dedo.
0	1	2	72. Prende fuegos. (DESCRIBA): _____	0	1	2	99. Se preocupa demasiado por la limpieza y el orden.
0	1	2	73. Problemas sexuales. (DESCRIBA): _____	0	1	2	100. No duerme bien. (DESCRIBA): _____
0	1	2	74. Le gusta lucirse, llamar la atención o hacerse el gracioso.	0	1	2	101. Falta a la escuela sin motivo.
0	1	2	75. Tímido.	0	1	2	102. Poco activo, lento o falto de energía.
0	1	2	76. Duerme menos que la mayoría de los niños(as)/muchachos(as).	0	1	2	103. Infeliz, triste o deprimido.
0	1	2	77. Quiere más que la mayoría de los niños(as)/muchachos(as) durante el día y/o la noche. (DESCRIBA): _____	0	1	2	104. Ruidoso o "bocón".
0	1	2	78. Embarra ó juega con excremento (caca).	0	1	2	105. Toma alcohol; usa drogas. (DESCRIBA): _____
0	1	2	79. Tiene problemas para hablar o de pronunciación. (DESCRIBA): _____	0	1	2	106. Vandalismo como destruir ventanas, carros u otras cosas.
0	1	2	80. Se queda mirando al vacío.	0	1	2	107. Se orina encima durante el día.
0	1	2	81. Roba en la casa.	0	1	2	108. Se orina en la cama.
0	1	2	82. Roba fuera de la casa.	0	1	2	109. Se queja o lamenta mucho.
0	1	2	83. Almacena o guarda cosas que no necesita. (DESCRIBA): _____	0	1	2	110. Desearía ser del sexo opuesto.
				0	1	2	111. Ensimismado, retraído, no se relaciona con los demás.
				0	1	2	112. Se preocupa demasiado por todo.
				0	1	2	113. Dígame cualquier otro problema que su hijo(a) tenga y que no ha sido mencionado.
				0	1	2	_____
				0	1	2	_____
				0	1	2	_____

**APPENDIX E: SEVEN SCORING CATEGORIES FOR DENIAL
PROJECTION AND IDENTIFICATION**

Seven Scoring Categories for Denial, Projection and Identification

Scoring Categories for Denial

D1. *Omission of major characters or objects:* This category represents the most primitive component of denial- the failure to perceive what is there to be seen. For example, in TAT 1, the omission of either the boy or the violin.

D2. *Misperception:* This also represents a primitive component of denial. This represents a way of “not knowing” the meaning of an object by changing the object into something it is not. It is scored for any unusual or distorted perception of a figure, object , or action in the TAT picture that is without sufficient support for the observation.

D3. *Reversal.* As a component of denial, reversal modifies the disturbing aspects of reality by changing them into their opposite.

D4. *Negation.* Although negation is sometimes considered to be a separate defense, it can be considered a component of denial as well, for it changes the real to the not-real, the truth to the untruth. Negation is accomplished by assigning a negative value, a minus sign, to an experience that if acknowledged would produce pain.

D5. *Denial of Reality.* This category includes two of the components of denial- avoidance of a situation and daydreaming. They are grouped together because they share a characteristic of denial through the *avoidance* of reality, rather than through rejection (omission), distortion, or change.

D6. *Overly maximizing the positive or minimizing the negative.* This category represents one of the components of pollyannish denial. It may occur as an aspect of idealization and may be accompanied by a note of unfounded optimism.

D7. *Unexpected goodness, optimism, positiveness, gentleness.* This also is part of pollyannish denial. It represents the continuing need to see the world as only a positive, pleasure-giving place despite evidence to the contrary.

Scoring Categories for Projection

P1. *Attribution of aggressive or hostile feelings, emotions, or intentions to a character or other feelings, emotions or intentions that are normatively unusual.* This category includes instances in which negative feelings are attributed by the storyteller to a character in the story, as well as instances in which one character in the story attributes negative feelings or intentions to another character.

P2. *Addition of ominous people, ghosts, animals, objects, or qualities.* As a special subgroup of this category, references to people, animals, or objects as being decrepit, falling apart, or deteriorating is scored here.

P3. *Magical or circumstantial thinking.* This relates to the projection of responsibility onto causes external to oneself. By maintaining that events occur as a result of magical, illogical, and uncontrollable external forces, the individual is absolved from any personal responsibility, and therefore from experiencing shame or guilt.

P4. *Concern for protection against external threat.* A projective stance indicated by an attitude of suspiciousness, of being on the lookout for expected danger, or of expected persecution.

P5. *Apprehensiveness of death, injury, or assault.* It relates to the preceding category, "Concerns for protection against external threat", but in this category events involving death, physical attack, or injury must actually occur, or have occurred in the story.

P6. *Themes of pursuit, entrapment, and escape.* Included here are themes involving one character being pursued by another, or mention of being trapped or kidnapped or being put in prison without legal justification.

P7. Bizarre or very unusual story or theme. This category depends heavily on the subjective judgment of the scorer, who must determine the limits of bizarreness. It includes negative themes that occur very rarely, especially if they have a peculiar twist.

Scoring Categories for Identification

Id1. Emulation of skills. This includes references to one character imitating, taking over, or otherwise acquiring a skill or talent of another character, or trying to do so. This is often seen in a younger character trying to be like an older one.

Id2. Emulation of characteristics. This category includes references to one character imitating, taking over, or otherwise acquiring a characteristic, quality, or attitude of another character, or trying to do so. It also includes examples of "identification with the aggressor."

Id3. Regulation of motives or behavior. The rationale underlying this category is based on the storyteller's having internalized certain rules, codes, or mores governing behavior. Within the context of the storytelling task, these regulatory mechanisms are expressed by assigning them to one of the characters in the story; a second character may then be regulated or influenced by these demands or prohibitions, or may rebel against the constraints.

Id4. Self-esteem through affiliation. This category includes instances of success or satisfaction that come about as a result of a character's association with peers or extrafamilial adults, as well as references to the *need* for this kind of affiliation.

Id5. Work; Delay of gratification. In this category, there is a recognition that the acquisition of skills is a slow process that requires considerable expenditure of effort. Examples of this category are seen in references to a character working, or in implications that a character is about to work or has been working, where this is not clearly suggested by the picture.

Id6. Role differentiation. This category is meant to reflect the individual's capacity to differentiate *among others*, a capacity that follows on the

capacity to differentiate between self and others. In the TAT, this is seen in mention of characters occupying specific adult roles other than parents or relatives.

Id7. Moralism. Included in this category are stories that have a moralistic outcome, in which goodness begets goodness, or good conquers evil, or a moral lesson is learned.

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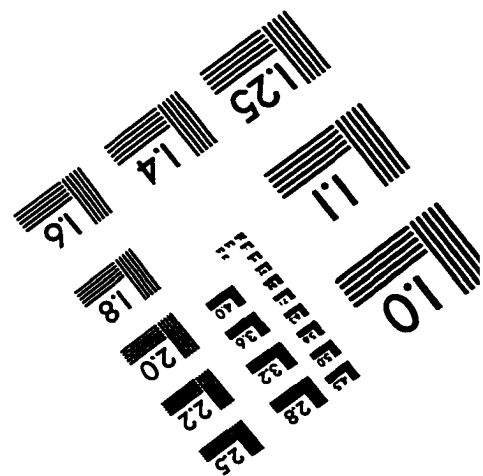
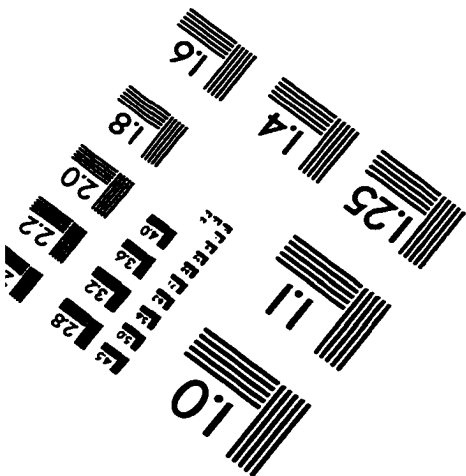
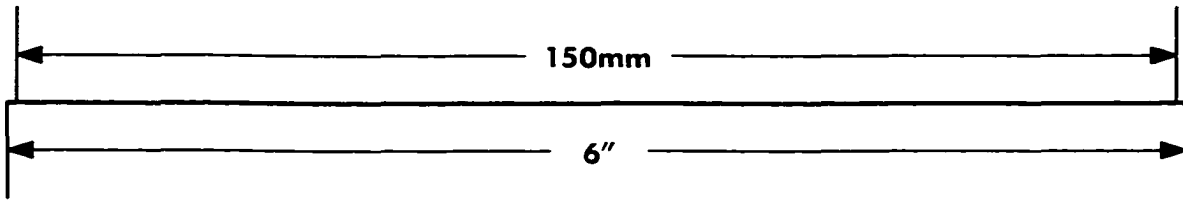
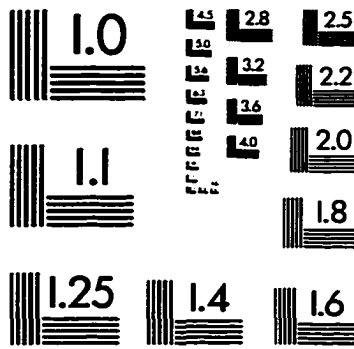
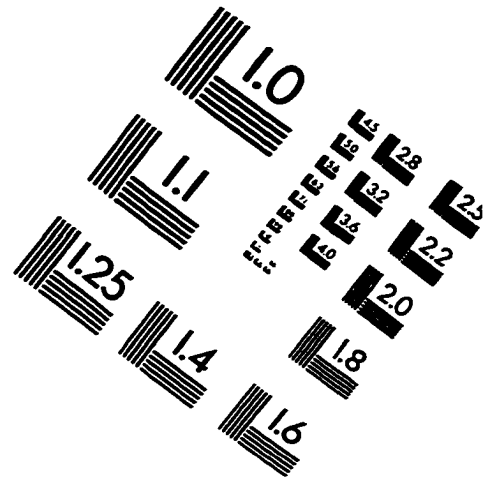
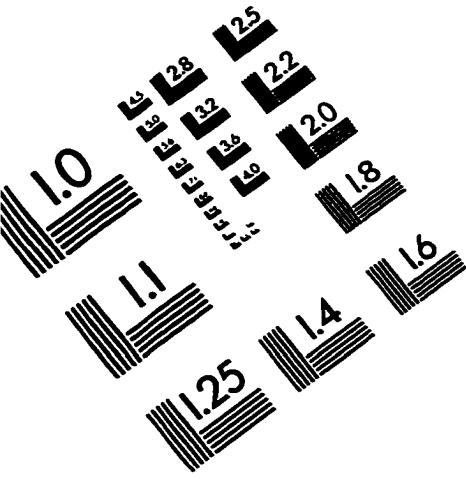
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IMAGE EVALUATION TEST TARGET (QA-3)



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