

Treating Violent “Untreatable” Adolescents: Applications of Intrapsychic Humanism in a State-Funded Demonstration Project

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The dual aims of this paper are to describe and impart a concrete sense of an innovative state-sponsored residential treatment program that existed between 1974 and 1977, and to give an illustration of naturalistic research.* The program applied a new treatment approach based on the principles of intrapsychic humanism to severely emotionally disturbed, homicidally violent, poverty-level adolescents who were considered untreatable by any other method. Intrapsychic humanism is a recent, nonderivative, comprehensive depth psychology that represents a unified theory of child development, psychopathology, and treatment. This new psychology is comprehensively explicated in *Intrapsychic Humanism: An Introduction to a Comprehensive Psychology and Philosophy of Mind* (Pieper & Pieper, 1990). Since the theory is fully presented in that volume, this paper will address only those aspects of intrapsychic humanism that are most pertinent to an understanding of the treatment of violent adolescents.

In the tradition of Aristotle, but in contrast to Freud, the object relations theorists, Bowlby, Kohut, Stern and Alice Miller, intrapsychic humanism asserts that every baby is born with an innate motive for and capacity to experience the pleasure of a conflict-free caregiving relationship. Therefore, the term normal development acquires a specific and unique meaning. It refers to a caregiving process that brings about an attainable type of childhood and adulthood in which the subjective experience of personal existence consists of a consciously self-regulated and conflict-free

inner well-being. The psychic pain that other psychologists and philosophers take as unalterable normality, while typical, in fact represents a heretofore unrecognized form of (alterable) mental illness; conversely, true normality, while not typical, i.e., not widespread, is an attainable state of stable inner well-being that is neither associated with internalized conflicts nor vulnerable to the influence of external stresses and losses. Even more radically, intrapsychic humanism asserts that the unshakable well-being that characterizes true normality can be established as a result of intrapsychic treatment, which is the form of treatment based on the view of human nature and development explicated by intrapsychic humanism.

While intrapsychic humanism asserts that the psychic pain that Freud and others assume to be the inevitable unhappiness of everyday living not only can be treated, but can also be prevented, intrapsychic humanism is not utopian. It does not suggest that a structural improvement in the human condition can be attained by social reform or cognitive understanding

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*Editor's Note: See the Preface and Chapter 4 for a discussion of naturalistic research. See also the methodology section later in this paper for a discussion of the application of the principles of naturalistic research to this project.

alone (although clearly both are necessary, neither is sufficient). And, just as importantly, intrapsychic humanism neither ignores the individual's interaction with her/his environment, nor concludes that situational effects are insignificant.

After Freud abandoned his trauma theory of mental illness, he unswervingly promulgated a view of human nature that continues to be prevalent in our culture: that psychopathology is only an extension of endemic psychic pain, that is, that mental illness is an exaggerated but qualitatively unchanged state of the normal mind. From the perspective of intrapsychic humanism, however, the cause of mental illness is trauma. Conflicted human nature is not innately determined, but represents the developing human's attempt to maintain a viable sense of inner well-being in the face of unstable parenting. Our view that the etiology of psychopathology is trauma is reflected in the aim and action of intrapsychic treatment. The goal of intrapsychic treatment is not the completion of an incomplete developmental process that commenced in infancy, but rather the completion of a developmental intrapsychic process that commences within the therapeutic relationship. Other clinical theories mistake what Freud called the common unhappiness of every day life for essential human nature and assert that even the most successful treatment will leave the client with an intractable type of existential incompleteness. This is illustrated by the quote attributed to Freida Fromm-Reichmann which Hannah Green chose as emblematic of her treatment: "I Never Promised You a Rose Garden."

The therapeutic action in intrapsychic treatment is the caregiving act of nurturing the client's heretofore unengaged motives for the conflict-free pleasure of intrapsychic caregiving intimacy. Intrapsychic caregiving pleasure refers not to an affect, but to a meaning structure of effective self-regulatory agency nurtured by the act of regulating the caregiving relationship. Accordingly, the therapeutic action in intrapsychic treatment is not hermeneutic; it does not have the primary goal of conflict resolution (it does not rely on transference interpretations of dynamically unconscious psychosexual conflicts) (Freud, 1953-1974); it does not have the primary focus of constructing a coherent narrative of the client's life (Cohler, 1988); and it does not aim for the restoration of the self by means of strengthening compensatory sectors of the self through transmuting internalizations that retribute defects accrued from unavoidable lapses in parental

empathy (Kohut, 1971). Just as importantly, intrapsychic treatment does not advocate any type of unreflective caregiving, specifically, the practice of intrapsychic caregiving never entails indiscriminate transference gratification, nor does it represent a process of re-parenting (e.g., it is not a 'corrective emotional experience,' Soth, 1986). Also, it should be noted that intrapsychic caregiving does not depend on empathy, either as perception (vicarious introspection) or as the mode of therapeutic action. It is manifestly demonstrable that because of the solipsistic nature of introspection, empathy as vicarious introspection represents at best a figure of speech. That is, the act of introspection is not open to the knowing act of another; therefore empathy cannot reliably distinguish between delusion and actuality. In consequence, there are conceptual flaws in theories that posit empathy either as the basis of therapeutic action or as a mode of perception,* because there is no way to know when the therapist's experience of affective attunement represents her/his wish fulfillment or compliance with the client's wishes.

The mechanism of therapeutic change in intrapsychic humanism is not insight but the intrapsychic caregiving pleasure produced by the client's experience of effective self-regulatory agency with regard to being the regulating cause of the caregiving s/he receives from the therapist. Over time, the superiority of this type of relationship-based self-regulation causes the client to recognize that the type of self-regulation that depends on motives for pain which have the unconscious meaning of pleasure represents an unnecessary and unwanted loss. Because it does not rely on insight, intrapsychic humanism is an appropriate treatment for infants and psychotic and/or violent clients, as well as for the type of relatively mature and well functioning client who is considered most appropriate for traditional psychodynamic treatment.

THE PROJECT

In the middle 70's, a concatenation of circumstances affecting the Illinois Department of Child and Family Services, hereafter called DCFS, gave us the opportunity to use the principles of intrapsychic humanism to treat the Department's "most difficult," violent, anti-

*Editor's Note: For example, self-psychology (Kohut, 1959, 1971); see also Pecukonis, 1990.

social adolescents. The problem presented by DCFS's violent adolescents was and is a staggering one. In the State of Illinois, as in most other heavily urban states, there is a large number of homicidally violent and self-destructive adolescent state wards for whom there exist no treatment programs. In the past these adolescents were restrained and medicated in state mental hospitals. However, one result of the Civil Rights movement was a changed interpretation of the rights of children and the mentally ill, which resulted both in stringent restrictions on the commitment of adolescents to mental hospitals and also in the requirement that restriction of liberty for mental illness be accompanied by a corresponding right to treatment. As a result, in the late 1960s and early 1970s, DCFS suddenly found itself saddled with a group of adolescents for whom it was responsible but for whom it had no available resources or programs. Attempts to send these adolescents out of state to custodial and quasi-treatment institutions resulted in well-publicized disasters and law suits.

In February of 1974 we approached DCFS with a proposal to treat its "most difficult" adolescents.¹ DCFS funded our project and referred us those adolescents who, by DCFS' own determination, fit into the "most difficult" category. The numbers of these "most difficult" adolescents, the lack of resources for them, and the high per capita cost of the program (\$150-\$200 a day per adolescent—remember, this was the 1970s) insured that our Project was not being given adolescents who could be placed elsewhere.

RELEVANT CONSTRUCTS OF INTRAPSYCHIC HUMANISM

This brings us, then, to a brief description of the key principles and constructs of intrapsychic humanism and the specifics of how they informed our program. One central tenet of intrapsychic humanism is that within every human there are two distinct but interrelated and interacting forms of consciousness, interpersonal and intrapsychic. Interpersonal consciousness refers to the diverse motives and self-experiences that are immediately accessible by introspection. It corresponds both to the consciousness of cognitive psychology and also to the psychoanalytic topographic and structural constructs of conscious and unconscious consciousness. Interpersonal motives are cognitive (e.g., to learn), social (e.g., to make friends), and physiological (e.g., to eat). Motives to regulate the

choice and pursuit of interpersonal motives also exist in interpersonal consciousness.

Intrapsychic consciousness, which is the new type of consciousness identified by intrapsychic humanism, is unlike interpersonal consciousness, in that it exclusively refers to a unitary motive—the motive to have an effective agent-self that stably regulates one's core well being. In development, the intrapsychic motive for effective self-regulatory agency is focused on the pleasure of being the regulating cause of the caregiving motives of the primary caregivers. One of the key discoveries of intrapsychic humanism is that the intrapsychic motive is the basis for the capacity for self-regulation: that is, what makes each of us human is truly defined not, as is usually thought, by the attributes that set us apart from other species, the cognition and language manifested in our capacity for sophisticated symbolic thinking, but rather by the need we share with many other species for caregiving intimacy. Further, we demonstrate (Pieper & Pieper, 1990) that cognitive and linguistic motives are under the hegemony of the intrapsychic motive.

A child will develop intrapsychic psychopathology when the parents' own conflicts about intimacy render them unable to respond to the child with stable caregiving pleasure. The experience of inconsistent caregiving causes the child to develop motives for a form of caregiving mutuality that an external observer would recognize as unstable, but which to the child represents an ideal (stable) type of caregetting pleasure. This motive for a pain-based mode of self regulation of core well-being is the defining characteristic of intrapsychic psychopathology. In addition, intrapsychic psychopathology prevents one's core well-being from ever becoming autonomously self-nurturing, but rather one's inner well-being remains fixated in its original state of vulnerability to the vicissitudes of interpersonal motive gratification. In the presence of intrapsychic psychopathology, intrapsychic motive gratification (pathological core well-being) can result either from the gratification of pathological interpersonal motives, such as motives for compulsive gambling, or from the gratification of interpersonal motives that are not pathological in themselves, such as making a new, positive friendship. To reiterate, optimally core (intrapsychic) self-esteem is unaffected by the events of everyday life. It becomes autonomously self-regulating only through the developmental gratification of intrapsychic motives for genuine caregetting pleasure. In contrast, the clinical hallmark of intrapsychic psy-

chopathology is that the individual's core self-esteem never becomes stable, but remains vulnerable to the ups and downs of everyday successes and failures, and, in addition, it can be generated by the gratification of motives for pain with the meaning of pleasure.

What differentiates the "most difficult" adolescents from individuals with intrapsychic psychopathology who manage to have successful careers and satisfying family lives is the degree to which their interpersonal consciousness is regulated by pathological motives, and, specifically, the degree to which their conscious sense of contentment derives from the gratification of motives for aggression toward others or themselves. Violence as a way of life can become an object of desire when intrapsychic psychopathology becomes interpersonally organized in a volatile combination of highly self-destructive and paranoid interpersonal identifications. In the case of the State wards, these identifications occurred within the corrosive socioeconomic privation of unrelieved poverty.

REGULATORY PRINCIPLES OF THE RESIDENTIAL MILIEU

The structural difference between intrapsychic and interpersonal forms of psychopathology was directly reflected in the structure of the program's milieu. While the intensive individual intrapsychic treatment, the part of our therapeutic program which aimed at effecting structural change in the nature of the adolescents' intrapsychic motive gratification process (core self-esteem), was essentially the same for the "most difficult" adolescents as for a well-functioning outpatient, the residential milieu was designed to respond therapeutically to the destructive interpersonal motives which were used as the ongoing fuel of the adolescents' pathological core self-esteem.

The challenge for the milieu was to make it possible for the residents to discover that nurturing, relationship-based ways of regulating themselves were superior to the destructive patterns of self-regulation which were deeply entrenched at the time they entered our program. Therefore, we tried never to leave any adolescent without a therapeutic relationship to turn to; all residents had 'round the clock one-to-one milieu staff called, fittingly, their 1-1's. This intensive interpersonal coverage had two aims: (1) to make it possible for the adolescents to experience their motives for violence in the context of a caregiving relationship, and (2) to enhance the adolescents'

abilities to recognize the superior pleasure of a self-esteem based on genuine intrapsychic relationship pleasure by providing abundant opportunities for interpersonal relationship pleasure (socializing with the workers, cooking good food, getting help with homework).

Because the pleasure of true caregiving intimacy is incompatible with the type of pain-based intimacy that is intrinsic to psychopathology, the residents periodically experienced the therapeutic relationship offered by the 1-1's as threatening (consequently, the 1-1's were in constant danger of being attacked). As a result, in carefully selected, critical instances, psychotropic medications and physical isolation were used to protect both the staff and resident. However, to facilitate the goal of helping the residents turn to the experience of caregiving intimacy rather than to destructive motives for soothing, when residents needed to be separated from other residents or staff, their 1-1's would stay with them. The Program Director would make a contract with the affected adolescent as to what behavior the adolescent needed help with controlling and what forms of control would be appropriate. Such a contract is entirely different from the contracts used in milieus organized by the principles of behaviorism, such as token economies (Agee, 1979; Edwards & Roundtree, 1981; Feindler, 1987; Kupfersmid, Mazzarins, & Benjamin, 1987). Our contract focused on preventing behaviors (such as hitting others) that endangered the resident's ability to continue in the program. Our contract was designed neither to induce or coerce compliance with specific programmatic aspects of the milieu therapy (e.g., attending a scheduled group meeting) nor to foster behaviors that were merely socially desirable (such as having good table manners or being polite, e.g. Burd-sal, Force, Klingsporn, 1989). When a resident was not able to maintain her/his agreement not to attack staff, the consequences (such as some time in the quiet room, or, later when the program was no longer located in a hospital site, a few days on an inpatient unit at the Illinois Department of Mental Health's Read Zone Center) were chosen only because they promised to allow the resident to continue in the program by protecting the staff and residents from the resident's lack of regulatory control. In intrapsychic humanism, therapeutic change is seen as a function of the intrapsychic caregetting pleasure generated within the client's therapeutic relationships, not of behavioral inducements.

While in most residential programs, the therapist makes or participates in many of the management decisions about her/his client (Piersma, 1985; Scavo & Buchanan, 1989; Soth, 1986), our program administrators were assigned total responsibility for decisions about the residents' daily lives, such as the granting of passes. Because the engine in intrapsychic therapy is intrapsychic caregiving pleasure, it is important for the therapist not to bear responsibility for the resident's interpersonal world, e.g., not to be associated with milieu decisions resulting in interpersonal losses, such as the decision that it would be dangerous to allow a resident a field trip. When the residents know that therapists do not make these decisions, they are free to turn to the therapeutic relationship with pain-regulated reactions of anger, hurt, and paranoia, thus furthering their dawning awareness of the superiority of the pleasure of therapeutic involvement over the soothing pleasure of pain relief based on meanings of self or other-directed rage.

It should be clear both that the child care workers were an integral and valued component of our program, and also that our approach to the milieu placed them under tremendous stress. In most programs, when residents break the rules or hurt staff or other residents, they are expelled from the program, so that although staff may occasionally feel themselves in danger, they know that if a resident erupts, s/he will be gone (Colson et al., 1991; Gentilin, 1987). We knew that the nature of the adolescents we had accepted meant that initially they were likely to become violent in response to facilitative staff responses as well as in reaction to staff errors and other externally imposed losses. In fact, in the course of this demonstration project there was much property damage, and the staff incurred many bruises, cuts requiring sutures, serious eye injuries, and, on one occasion, a broken nose. One psychotherapist required emergency room treatment as the result of the residents' actions. A focus of this paper concerns the principles for managing violent behavior in a residential setting, and, particularly, for helping staff work with violent adolescents without a loss of morale in a therapeutic program that does not permit total isolation or aversive or punitive measures. The programmatic issue of how to protect clinical staff from violent patients in ways that are not antitherapeutic is rarely addressed because therapeutic concerns tend to be submerged in the presence of violence (Allen et al., 1986; Colson et al., 1986; Colson & Coyne, 1978); the violent patient is typically

expelled from a program or responded to solely with the goals of enforced acceptable behavior, deterrence, or containment (Feindler, 1987; Gentilin, 1987; Scavo & Buchanan, 1989). In order to support the staff and help them understand the process of treating the teenagers, we provided them with a weekly, hour-long, supportive and educational inservice training session in which they discussed their interactions with residents.

In addition to helping staff cope with their reactions to client violence, we faced what was often the equally difficult challenge of helping staff to keep their positive feelings for the clients within therapeutic bounds. One regulatory principle of the clinical theory of intrapsychic humanism is the importance of distinguishing between personal and caregiving motives. The etiology of psychopathology as we define it is that the parents' psychic pain prevents them from giving the child the stable well-being that arises from the experience of being the ongoing regulating cause of the parents' caregiving motives. By definition, the individual with intrapsychic pain uses interpersonal experience for intrapsychic well-being. Unstable parenting itself falls into this category, so that, in spite of their best efforts to give their child optimal parenting, parents with intrapsychic pain use their child to gratify personal as well as caregiving motives. A relatively benign example of this phenomenon is the parent who encourages a child to excel at something in order to gratify the parent's needs. A more psychotoxic example is the parent who creates and fosters conflict with the child in order to satisfy a personal need for conflicted relationships.

Thus, central to both intrapsychic treatment and also to milieu treatment regulated by the principles of intrapsychic humanism is the therapist's and child care worker's capacities to be free from the need to use the client for the gratification of personal motives, which include the need to feel helpful, to be liked, etc. Much of our inservice training was devoted to helping the staff distinguish between positive impulses toward residents based on personal motives (such as to take a resident home) and positive impulses based on caregiving, professional motives.

THE DIAGNOSTIC PROCESS IN INTRAPSYCHIC HUMANISM

Intrapsychic humanism takes a unique approach to diagnosis. Whereas other treatment modalities use static categorizations (Grellong, 1987; Lochman, 1984;

Meeks, 1985; Place, Framrose, & Willson, 1985a; Reis & Resnick, 1984) which often overlap and do not lead straightforwardly to therapeutic interventions, the only nosological categories in intrapsychic humanism are treatable and untreatable. The explanation is that the foundational, determining type of all psychopathology, intrapsychic psychopathology, is unitary, in that it represents the use of interpersonal motive gratification (including the gratification of motives for interpersonal pain) to produce a delusional type of core (intrapsychic) well-being. There is only one criterion for treatability in intrapsychic humanism: the conscious motive to become less regulated by psychic pain through a commitment to a treatment relationship. The sole criterion for admission into our program was that the adolescent make at least a one-time expression of the motive to be helped in the program (if she or he disavowed this motive soon after or steadily for the next three years, this did not disqualify her or him).

METHODOLOGY

The Choice of a Naturalistic Research Methodology

The most compelling of the several reasons for choosing a naturalistic method of data collection over an interventionist methodology was that, since the therapeutic action of a treatment process informed by the psychology of intrapsychic humanism depends on the therapist's ability to subordinate personal motives to caregiving motives, and since research-determined interventions are driven by personal motives, research-determined interventions are by definition iatrogenic and contraindicated in intrapsychic treatment. Randomization of subjects was out of the question, since it would have interfered with one of the program's objectives—to treat adolescents who were carefully selected by DCFS as their "most difficult." While it was also not possible to establish a control group (without treatment these adolescents would have been even more dangerous to themselves and others), we did have a standard of comparison already available since each adolescent came to us with a long baseline history of being untreatable by any other method and in any other setting. The behavior problems of all the adolescents referred to us had been chronic since an early age and had been steadily worsening in spite of

the efforts of those programs which had tried and failed to treat these teens.

The Dependent Variables

Although there were no research-determined interventions in our project, a full anamnestic record was kept by all therapists for supervisory purposes and by all child care staff for purposes both of communicating with other shifts and also of bringing to inservice training sessions.² From this very full record, the variables that were chosen to indicate client change were the very behaviors that had made these adolescents untreatable by any other method, namely violence toward themselves and others. In assessing the effectiveness of the treatment process for helping these teenagers to gain self-regulatory control over their violent behavior, we chose two types of events as markers: the nature of the teens' aversive reactions to pleasure, and the nature of their response to losses. Examples of losses are therapist and 1-1 vacations, and caregiving lapses by staff.

The *aversive reaction to pleasure* is a key construct in intrapsychic humanism. The aversive reaction to pleasure represents the reactive peremption of an individual's motives for genuine, self-caretaking pleasure by nurture-induced motives for pain, which have the unconscious meaning to the subject of (delusional) self-caretaking pleasure.³ Aversive reactions to pleasure are not limited to the therapeutic relationship, but characterize all psychopathology, which, you will remember, we define more broadly than any other theory, to include the common unhappiness of everyday life. An example of a relatively benign aversive reaction to pleasure is the otherwise successful individual who feels unaccountably depressed or dissatisfied after achieving a sought-for recognition. Although never before recognized, the phenomenon of the aversive reaction to pleasure is pervasive. Further, clinicians' failure to understand their clients' aversive reactions to pleasure is probably the most unseen and common source of clinicians' dissatisfaction with their work.

The advantage of using violent behavior as the dependent variable is that arguments over whether or not intrapsychic change occurred can be avoided—either an adolescent hits someone or swallows glass or s/he does not. Without exception, in the initial stage of treatment each resident's aversive reactions to plea-

sure and reactions to externally imposed loss involved violence directed at others and/or themselves.

The dependent variable was studied at certain recurring times: 1) before and after the occurrence of major stresses (losses), such as therapist and child care worker vacations, program relocations, caregiving lapses by program staff, provocative or hostile acts by family members, and all significant events of chance (death, serious illness) and 2) at those times when an aversive reaction could be anticipated. In addition, any time that there was an unanticipated episode of violent behavior, an effort was made to ascertain whether the primary stimulus was a loss or an aversive reaction to pleasure.

CLINICAL RESULTS

Due to limitations of space, we cannot give the milieu process the same attention as the psychotherapy process will receive. The following example is meant to illustrate the important function served by the child care workers. This milieu process involved a resident we will call Carol. Carol came to us with the dual diagnosis of brain damage associated with mental retardation and schizophrenic reaction. She related to the world as an aggressively unsocialized, retarded individual. Carol had been severely abused by her mother, who was diagnosed as both schizophrenic and as a substance abuser. The mother beat the children, and did not feed them regularly, so that Carol reported that they were forced to eat roaches, suck on plaster, and borrow, beg or steal money and food. The mother would also take Carol and her siblings far from home and drop them off like dogs to be gotten rid of.

Carol's 1-1 worker, Adrian, mentioned during an inservice meeting that she had been worried by Carol's behavior the day before. What confused and concerned Adrian was that Carol, who had been reacting to beginning psychotherapy, had approached her insisting that she (Carol) was Carol's sister and that Carol was at home. As Carol described the sister's characteristics, they were all positive and sociable. Carol said she was going to get Carol, left and then came back as Carol, which meant she came back with a lot of negative and aggressive feelings. Adrian wanted to know how to help Carol recover from what she understood to be a delusional state. She was also concerned that Carol might have a multiple personality disorder. The inservice leader suggested that it was

more helpful to see Carol's behavior as representing the beneficial effects of her treatment—that it was a communication to staff that she was starting to feel there was another Carol who she had never known was there, who was an unretarded beautiful person. Carol could not feel yet that she owned this sense of self, so she experienced it as an attribute of a sibling, and was trying it out experimentally with the staff. She was soliciting positive feedback from her 1-1 about the good feelings that were emerging from her psychotherapy. This incident also provides a contrast with the prevailing approach to aggressive impulsive adolescents (Agee, 1979; Davis & Raffe, 1985; Edwards & Roundtree, 1981; Feindler, 1987; Scavo & Buchanan, 1989), which is to discourage fantasy and to focus on helping the adolescent become more in touch with "reality." In other modalities (Davis & Raffe, 1985; Feindler, 1987; Grellong, 1987; Lochman, 1984), Carol's statement about being her own sister would have been seen as a process of ego regression or fragmentation of the self. In intrapsychic humanism, regression is defined very differently—as the client's movement away from the use of the therapeutic relationship for genuine self-esteem. By this definition, Carol's sharing of her fantasy was the opposite of regression—it was an attempt to try on a new, more positive self identity in the context of the caretaking intimacy with her 1-1. Adrian was able to apply her newfound understanding of Carol's fantasy the next day, when Carol once again asserted that she was her own sister. Adrian reported that she felt very comfortable making positive responses to Carol's description of the "good sister," and that Carol seemed very pleased with their interchange.

The clinical results from the psychotherapy process will be the focus of the remainder of this paper. To return to Carol, the following psychotherapy interview represents Carol's aversive reaction to pleasure and the therapist's facilitative response.

Initially, Carol had tremendous outbreaks of hostility in which she hit staff and destroyed property. Carol's treatment had been complicated by the fact that her first therapist left the program after another resident hit her with a chair, opening up a gash in her leg that required 100 stitches to close. Over the course of a year Carol made dramatic progress with her new therapist, to the point that it became obvious that she was not in fact retarded. When this interview occurred, Carol had just transferred to a school for children with normal intelligence.

When the therapist arrived, Carol was waiting at the door.

Carol: I got my glasses and went to school.

Therapist: You look marvelous.

Carol: Thanks. She drew a picture and talked about what happened at school and how much she liked it.

Therapist: That's great, I'm so happy you have a school that is just right for you.

Carol: Yes, I'm proud of myself. Proud of you too.

Therapist: Yes, I'm proud of us too—we've done good work.

Carol: I'm glad to have you. She drew a chicken.

This was the first aversive reaction to pleasure. The therapist remained attentive but silent. Then Carol asked the therapist if she had seen the news, that there was a three year old baby who had been beaten severely by her father. The baby didn't die, but everyone said she was retarded. They thought the father had done it, but he was crazy. To this second aversive reaction to pleasure, the therapist responded,

Therapist: He must have been crazy to do that. It must have been terrible for the baby.

Carol: Yes. And my mother died of a drug overdose.

Therapist: You are telling me your parents weren't able to care for you the way you deserved.

Carol: Yes. I took care of me and them, cooked, cleaned, gave all the money I earned to them.

She had a look of great pain and was silent for a moment. Then, assertively,

Carol: I love my parents, we did a lot of things together.

Therapist: I can hear you have a lot of different feelings about them.

Carol: Draw a picture of me before you go.

As you can see from this process, Carol's aversive reaction to the dual pleasures of possessing a conscious experience of core well being that was apart from the identity of being retarded, and of being helped to achieve this through the therapeutic relationship, took the form of bringing to her therapist feelings of love for the parents who had been so abusive towards her. This expression was thoroughly constructive, in that though the need for the experience of self-rage was overriding, in stark contrast to her established pattern

of destructive acting out, this time Carol was able to gratify her motive for self-rage within the safety of the caregiving mutuality with the therapist.

This process illustrates that the aversive reaction to pleasure represents a singular opportunity for deepening the therapeutic caregiving mutuality (which is yet another way in which this construct is categorically different from the psychoanalytic notion of negative therapeutic reaction). The aversive reaction to pleasure advances the therapeutic process by bringing to the surface, that is, to the caregiving mutuality, previously invisible manifestations of the pathogenic intrapsychic process in which the significance of caregiving love is attached to experience that objectively represents pain.

AN EXTENDED EXAMPLE OF INTRAPSYCHIC TREATMENT

The focus on the process of one client—Andrew—will be used to concentrate not only on identifying change (outcome) but also on the principles and techniques associated with that change (process). Our dual aims are to describe how change is brought about, and also to indicate that positive change in fact occurred.

The large file that DCFS had on Andrew revealed that in the first 10 years of his life Andrew was in the care of five sets of people. Both his parents were addicted to drugs and alcohol. At age three Andrew's father described his affect storms as "demonic." Andrew was abused by his parents and siblings. For example, one of the parents' disciplinary methods was to make him eat garbage. From his 10th year, he was placed in and expelled from a long series of foster homes and Illinois institutions. When no other Illinois program could be found to accept him, he was sent to an out-of-state institution.

As had happened in each of his in-state failed placements, following a honeymoon period in which the out-of-state institution began to feel that it was getting somewhere with Andrew, he became unmanageably aggressive. Notwithstanding the various types of restraints, including psychotropic medications, administered by the institution, Andrew began to attack, bite and bruise staff members. He also swallowed objects, such as paper clips, straight pins, and buttons. As a result, he had to have abdominal surgery, which the institution took as the opportunity to perform a punitive sterilization. The institution never informed Andrew about the nature of the surgery.

After the surgery, Andrew's attacks on staff continued, and the institution expelled him. He was transferred to a residential treatment center in Illinois, where the familiar pattern of a calm period followed by aggression and expulsion repeated itself. At first, his new therapist noted that Andrew was developing a positive paternal transference to him and that he was trying to provide Andrew with the warm early developmental experiences he had lacked. Two weeks later, when this therapist told Andrew to stop writing on a wall, Andrew picked up a knife and grabbed him. He held the knife at his throat and threatened to kill him. Andrew then made the worker get down on his knees and beg. He hit him in the face, threw him against a chair, and ran out of the room.

Andrew was transferred to a private hospital where a senior child psychiatrist with broad expertise in treating regressed antisocial adolescents advised the Court that he was unable to keep him even in a specialized hospital setting and that he knew of no program anywhere in the United States that would accept him. The psychiatrist said that Andrew was constantly either suicidal or homicidal and that he no longer had any motive to engage positively with anyone. DCFS chose Andrew as one of the "most difficult" adolescents being referred to the intrapsychic humanism project.

Andrew was to remain in his current inpatient unit until mid May, when he was to transfer to our program. However, in late April, Dr. L, the therapist who was to have begun therapy with Andrew, manifested a health problem that required surgery. That fact plus the therapist's impending vacation in August suggested that it would be better to delay Andrew's therapy until September. However, the waiting period he was already undergoing was beginning to unhinge the little self-regulation Andrew could muster, and he began seriously to decompensate. He told our program director that he had rabies and verbalized other manifestations of psychotic soothing, and it was decided that the gain of offering him an immediate therapeutic relationship experience outweighed the loss he would experience from the two premature interruptions.

The first interview went as follows:

Andrew walked down the hall rolling his eyes wildly and singing in a loud, aggressive voice. He had a wild disorganized look, and was barely relating through a dissociative haze.

Andrew: Can I bring some of those toys in from the playroom?

Dr. L: Sure. (Andrew made no move to do so)

Andrew: What do you want to know?

Dr. L: Whatever you feel like telling me.

Andrew: (very defensively) I don't know anything about myself. (Pause) Well, what do you want to know?

Dr. L: Whatever you feel comfortable telling me.

Andrew: I don't have anything to say.

Dr. L: Sometimes you will feel like just being silent in here. I know it is difficult to begin because we are just beginning to get to know each other. And I don't need to know anything at all. I just want to be of help to you.

Andrew: I know all about you.

Dr. L: What do you mean?

Andrew: You are going to be my psycho. . . (he got stuck)

Dr. L: Psychotherapist. Yes. (Explained he would see him twice a week, and what the times were.)

Andrew then related how he liked to play with soldiers, especially Green Beret dolls. Suddenly, he said, "They" did an operation on me.

Dr. L: They did?

Andrew: Yes. They sterilized me. I can't ever have children not ever. (He told the story. How he had swallowed coins at the out-of-state institution, and was told that the surgery he had was merely to remove them. He hadn't known until he got back to Chicago and was examined at another hospital what they had actually done.)

Dr. L: That's criminal and shocking.

Andrew: What they did to me was important.

Dr. L: Very important.

Andrew: My father was really mad—but I am madder—they did it to me. They were trying to suicide me. I know it—I was the only one who was sterilized. How much time do we have?

Dr. L: Andrew, we have to stop for today. I'll see you Friday at 9:30.

Andrew: Goodbye. It's been nice talking to you.

Dr. L: Goodbye.

In the second interview Andrew was very frustrated at not finding toys he liked and he requested a soldier doll, which the therapist said he would provide. He then sang a song which included the words, "I have a Doctor Feelgood." Shortly after this interview, Dr. L decided that he must tell Andrew both that he had to have minor surgery in the near future and also that he would be taking some vacation time in August. Andrew

was extremely distressed by the impending operation and convinced that Dr. L's experience with the medical profession would be similar to his.

In the month and a half before Dr. L's surgery, Andrew was very edgy. He continued to relate Dr. L's upcoming surgery to his own experience, and he tried to kill a pigeon that sat on the window sill. However, he was also able to express concern for his therapist and to recognize that he was going to miss him.

During the time Dr. L was in the hospital, Andrew went on a destructive rampage: he hit another therapist with a chair, kicked in a glass door, and in general was totally out of control. Beginning the first postoperative day, Dr. L called Andrew daily.

Upon his return, Dr. L found Andrew angry, regressed, and regulating his sense of self almost entirely through destructive and self-destructive forms of pain relief. He became upset easily and met every frustration by hitting someone. Over the next few days, Andrew broke the nose of one worker and sent two others to the hospital with eye injuries so severe they could not return to work for a month. Our staff at this point refused to have anything to do with Andrew, and our only hope of keeping him in the program was to put him in a quiet room. His 1-1's remained with him at all times. Dr. L assented to Andrew's request that the frequency of therapy times be increased to every other day. Andrew talked about being lonely and scared and manifestly leaned on Dr. L for help.

In the middle of July, the program director took a five day vacation and Andrew swallowed coins and had to have his stomach pumped at a general hospital. The radiologist said his colon looked "like a junk shop."

The days before Dr. L's vacation were spent trying to work with the staff around letting Andrew out of the quiet room. For the first time Andrew was able to reduce the tension he experienced between therapy interviews by bringing his discomfort to the therapeutic mutuality. For example, when he became upset about something that had happened on the unit, Andrew sat down and wrote Dr. L a note telling him about it. In one interview, he told Dr. L he didn't want to see him anymore, and when Dr. L suggested that those feelings stemmed from his imminent vacation, Andrew broke down and sobbed. The day Dr. L left, Andrew arranged a party for him.

In September, Andrew found the reunion with Dr. L very difficult and brought a friend to many therapy sessions as a way of regulating his tension. There was a

tumultuous period when it seemed that two different Andrews were deadlocked in a fierce battle for control, but occasionally he was able to regulate his violent impulses in a new way as the following interview indicates.

Dr. L was meeting with the program director just before therapy time, when Andrew stormed upstairs and began hitting Dr. L, saying that he would teach him to go away.

Dr. L: I can understand your feeling that way, but you don't have to hit me for me to hear you.

Andrew: (Then began hitting the program director. After a minute it became clear that part of the problem was that his friend had asked Andrew to go somewhere with him at a time that would conflict with Andrew's therapy.)

Dr. L: That's a real problem being pulled in two different directions by divided loyalties—I bet we can get a staff person to take your friend where he wants to go and you can meet him after therapy is over.

Andrew: I need to be in the quiet room.

Dr. L: O.K.

Andrew: No. (He looked very sad. Suddenly he took a huge desk and turned it upside down on himself so he couldn't move, creating his own external restraints.)

The staff did transport Andrew's friend, and when it was time for the actual therapy to begin, Andrew studied his baseball cards contentedly for the duration of the session. While the episode began with violence, Andrew also managed to convey the problem to his therapist—his fear of missing his therapy time—thus exhibiting trust that the program would solve that problem for him.

At the end of September, Andrew was subjected to an acute, unexpected loss when the hospital administration abruptly reclaimed our unit. Andrew alternated between fury and desperate closeness. When he first heard the news, he slapped Dr. L hard a number of times, then in a menacing manner vowed to keep him imprisoned in the therapy room. Dr. L made no move to force Andrew to let him out, and in time Andrew relented and told the staff he had hit his therapist. He then spent the rest of the session expressing regret for what he had done. Dr. L said, "Both of us wish we could be locked in in the sense of being able to continue to have therapy here."

In the last interview in the hospital unit, Andrew sang a song about there being "a thin line between love and hate." He asked Dr. L to write something to him on his mattress which he was using like a yearbook, asking people to inscribe notes to him on it. Dr. L wrote, "To Andrew: For all we have done together in the past and can do together in the future."

Andrew was very pleased and thanked him. But as the end of the therapy time neared, and the magnitude of the loss sank in, Andrew began hitting Dr. L very hard. Dr. L reminded him of what he had sung, that there was a thin line between love and hate. Andrew allowed Dr. L to leave the therapy room, but then lunged at him again. Dr. L knew he appeared upset. Later Dr. L was in his office on the unit and Andrew came in and hugged him and said he was very sorry.

Andrew: You're upset.

Dr. L: Yes, it's a sad day.

Andrew: Because I hit you?

Dr. L: No, because we have to leave here before we are ready.

Andrew initially had a difficult time adjusting to the group home to which we relocated. He would beg Dr. L not to leave at the end of the session, and hit him a number of times. At this point, at Andrew's request, Dr. L was seeing him seven days a week and calling him every night. In the middle of October, a staff member failed to get Andrew back in time for his therapy hour, and that night Andrew hit the staff person and broke his glasses. Andrew called Dr. L, who said he knew he was upset about missing therapy and that everyone still wanted him there. Andrew ran out the door and around the block, and, with his child care worker chasing him, he raced back in the door and went to sleep. When Dr. L came in the next day, Andrew was waiting at the door for him with some poems he had written. Andrew said one of them was about his resolution not to hit people anymore, but to try to talk to them. This was an example of the fact that Andrew's motives to feel better through inflicting pain were becoming consciously unattractive to him, even though he couldn't always control them.

In the interviews immediately following, Andrew was elusive and unpredictable, and clearly having an aversive reaction both to the closeness he had felt and to his new wish to control his aggressiveness. In the grip of an aversive reaction to pleasure, clients unknowingly attach the meaning of loss (pain) to each

experience of care-getting pleasure with the therapist, because conscious caregetting pleasure interferes with their unconscious use of internalized relationship unpleasure for delusional inner well-being. As a result, the client consciously experiences the therapist as a source of pain and trouble rather than as a recognized and available ally. Swept up in this dynamic, two days later Andrew slapped Dr. L hard enough that the next day the program director told Andrew that he would only be seeing Dr. L with someone else in the room. Andrew looked very depressed and promised he would never hurt Dr. L again and that, if he ever did, then Dr. L could always have someone else sit in on the therapy. The program director assented to his plea. The next two days he maintained regulatory control, but then, in the face of staff errors, he blew up, hit two staff, and ran off. The staff called the police, who found Andrew and took him to a hospital emergency room. The program director and Dr. L spent the night with him there, making arrangements for him to go to the State adolescent inpatient unit because our staff adamantly refused to have him back. Dr. L continued the treatment at the hospital during the interval needed to help the group home staff accept him back.

One day after he returned Andrew told Dr. L he had gotten a girl pregnant and showed him lots of pictures of pregnant women. He told Dr. L he liked him a lot, and then had an immediate aversive reaction and took a tack, put it in his mouth and claimed to have swallowed it. Dr. L told him that there were better ways to help himself feel better, expressed his concern for him, and declared that Andrew would have to go to the emergency room. After ten minutes of listening to Dr. L's concerns, Andrew confessed that he hadn't swallowed the tack. Dr. L realized Andrew was telling him the truth, and praised him for having shared the pain of the need to hurt himself and just as importantly, for the self-restraint it took to keep his self-rage on the level of fantasy instead of actually swallowing something harmful. For the duration of Andrew's stay in the program, there were only two further episodes of acting out the need to hurt himself, and in neither instance did he have to go to the emergency room. Increasingly, his need for self-rage was gratified solely on the level of fantasy, to the point where motives that at one time resulted in physical self-abuse now presented as a form of banter. He would tell his therapist or the staff that he had harmed himself, would listen to their concerned response, and then would laugh and say the story was untrue.

It took Andrew a longer time to gain regulatory control over his aggression toward others. During Andrew's therapy hour a week or two later a terrific fight erupted in the group home and one of the other adolescents put his hand through a window and had to go to the hospital. Andrew was very upset by this and declared that he was leaving the house. He turned on Dr. L and began seriously strangling him, saying he was going to kill him. He relented to the point of being able to call the program director to announce that he was hitting his therapist. Hanging up, he said with clenched teeth that if Dr. L made a sound Andrew would break his nose, then finish him off before anyone could rescue him. He talked about wanting to stab Dr. L in the groin. He said he had never actually killed anyone, but that maybe he would tonight. He called another staff member and told him that he was hitting Dr. L. He kept telling Dr. L to stay silent. He turned out the lights and said he was going to kill Dr. L in the dark. After what seemed to Dr. L like an endless time, Andrew said he was sorry. He let go of Dr. L and walked him downstairs. Then he burst into tears and again told Dr. L how important he was to him. Dr. L told him he would stick with him. He helped Dr. L on with his coat. (From this interview on, Dr. L was never again alone with Andrew—Andrew's one-to-one staff person and sometimes a third person sat in on every therapy hour.)

The subsequent therapy sessions were very difficult for Andrew both because he was faced with the self-imposed loss that he would never again be able to see Dr. L alone, and also because the presence of the third person interfered with Andrew's delusional belief that he was capable of controlling his violent outbursts. In a representative hour, Andrew saw Dr. L coming and ran into the bathroom saying he was going to jump out the window. Then he started hitting at Dr. L. His primary 1-1, Bert, held him.

Dr. L: Talk to me, don't hit me.

Andrew: I can't talk to you with Bert there.

Dr. L: It's necessary, Andrew.

Andrew: You're afraid of me.

Dr. L: Yes.

Andrew: Hit me back.

Dr. L: That won't help—I can't help you by hitting back.

(Andrew began talking about how he was going to kill Dr. L. He was getting so agitated that Dr. L felt he

should leave, that at any moment he might break away from Bert.)

Dr. L: Can I say two things?

Andrew: Go ahead.

Dr. L: I know that part of you feels very angry, given the betrayals you experienced with people in your past. . .

Andrew: (screaming) I know what you are talking about don't ever say "past" to me again.

Dr. L: The other thing is that in terms of your saying you don't want me for a therapist, I have to be fair to all parts of you and they aren't all talking, so I am going to keep coming.

Andrew: (consumed by the murderous rage) GET OUT!

With child care workers holding him Andrew would recite lists of ways in which he was going to murder Dr. L. He said he never wanted Dr. L to come back, and he demanded that he leave. Dr. L would stay as long as he felt the child care workers could tolerate the strain of restraining Andrew, and he kept saying to Andrew that he had to be fair to all parts of him. Over the next week and a half, Andrew came to accept the reality of the third person(s) and thus began to relinquish his own delusions of having regulatory control over his violent impulses. At the end of this time he brought a problem to Dr. L about a friend of his, and when Dr. L helped him find a solution, he hugged Dr. L and told him he valued him and that he would never really kill him.

A week later, after a fight broke out between two residents, Andrew blew up, grabbed a kitchen knife and hit one of the staff. However, when the staff indicated that they were afraid to wrestle him for the knife, Andrew ran out the door and two blocks directly to the fire station, where he allowed the firemen to take the knife away and call the police, who arranged his commitment to Read Zone Center, where he remained for three days.

A scheduled physical examination provided the stimulus for Andrew's beginning the process of mourning the punitive sterilization he had undergone at the out of state institution. On the day he was to see his physician, he talked seriously about killing himself. When Dr. L made the connection between his suicidal feelings, the visit to the doctor, and his operation, he broke down and sobbed in terrible pain. The next interview he ran into the kitchen and got a knife, saying he was going to kill Dr. L because he was the

only reason he ever felt upset. As the child care workers held Andrew, Dr. L repeated over and over that the pain did not originate with him, but was inside Andrew. (This pattern in which the pain of Andrew's aversive reaction to the pleasure of turning to Dr. L for help was first manifested as negative feelings about himself, and then was reorganized in a paranoid shift in which Andrew externalized the source of his painful feelings onto Dr. L, continued for the next two months. However, the duration of his regulation by paranoid rage progressively shortened until finally he would permit himself to have a reunion with Dr. L in the same interview.)

Although he never actually needed to go to Read Zone Center again, in the following months, Andrew began saying he wanted to go there whenever he was upset to the point that he feared losing control. He also began to realize that when he was upset he would hit out at anyone to reduce his tension.

In December 1974 the therapy process afforded evidence of a beginning change in Andrew's capacity for self-regulation. Dr. L told Andrew of his plan to take a week's vacation. Andrew became very angry, but, in contrast to the previous summer, he did not pursue a soothing based on the pain produced by harmful acting out. Instead, his motive to pursue core well-being through the pleasure of the therapeutic caregiving relationship remained hegemonious, even though Dr. L's motives were the source of a significant loss. In one session, he ran into the kitchen and grabbed a knife, but he was able to put it down himself without needing to go to the firehouse, and then he returned to go back to playing cards with a staff member.

After Dr. L's Christmas vacation, some things began coming together for Andrew. He was able to go to his physician without being paralyzed by pain, and, most importantly, he was able to start school. Andrew had been diagnosed as retarded, but the staff had no question that Andrew possessed above average intelligence. However, Andrew's reactive pride in response to his relentless experience of self-denigration had always prevented him from admitting that he was not up to grade level. In fact, he was such a talented story teller that he could fake reading, making up stories as he recognized a word or two, and it was a long time before the staff and Dr. L realized that he could only read at a first grade level. His increasing reflectiveness made it possible for him to recognize both that the therapeutic relationship could help him with his anxi-

eties about going to school, and also that he could regulate that relationship to make it even more facilitative. Accordingly, he worked with Dr. L to rearrange the times of the therapy so that he could leave for school immediately afterward, drawing on the caregiving relationship to enable him to stay in balance until school was to begin.

At the beginning of March, Dr. L had to change the time of a therapy hour. The next day when Dr. L went in, Andrew was very angry. He called his father and said he had a terrible therapist. His father obviously told him to hit Dr. L, because Andrew's reply was "That wouldn't work because he would just tell me to stop hitting him." Andrew hung up, ran down the stairs and out the door and, grabbing a brick from the alley, smashed in the windshield of Dr. L's car. Later, he was very apologetic and Dr. L told Andrew he knew that part of him had felt very betrayed when the time was changed.

As Andrew became more consciously positive about his therapeutic relationships, he decreasingly needed to turn to his parents as a source of pain with the meaning of pleasure. But his aversive reactions to relinquishing this source of self-rage meant that he was constantly on edge and the slightest loss from the milieu was more than he could bear. One day, his 1-1, Bert, failed to come in. Andrew called Bert and stayed on the phone for 3/4 of the therapy time, using his relationship with him for regulatory control. While he was on the phone he was quite friendly to Dr. L, but the moment the call ended, he threw the phone at him. Andrew said he was sorry and that he had promised Bert he wouldn't hurt Dr. L. He said Dr. L could sit down, that he would be O.K. Dr. L did sit down because Andrew had recently demonstrated a newly won capacity for a self-regulation that enabled him to keep this sort of short-term promise. A moment later Andrew hurled a plastic case at Dr. L, blackening his eye.

Andrew: (immediately) I'm really sorry.

Dr. L: That pain is inside you, Andrew, it stays with you; it's not left behind by hitting me.

From that day forward, Andrew was not allowed to bring hard objects into his therapy.

In early April, 1975, Andrew was faced with another tragic event when an older sister died in a car accident. Andrew was able to get through this wrenching experience without destructive acting out by draw-

ing on his caregiving relationship with the staff and Dr. L to help shore up his capacity for self-regulation. He was able to ask Dr. L not only to come to the funeral, but also to come with him to his father's house before the service, which Dr. L did.

The structural shift in Andrew toward a pain-free type of self regulatory agency continued so that increasingly he was regulated by the ideal of anchoring his sense of core well-being in the caregiving relationship rather than in the gratification of pain-regulated motives. When Andrew missed a therapy hour, instead of hitting someone or swallowing something, he would go to bed. If Dr. L had to change a therapy hour, Andrew asked him to bring him some candy rather than breaking his windshield or blackening his eye. Increasingly, Andrew's aversive reactions occurred in the form of fantasies and associations. One day, Dr. L brought him a toy racing car he had asked for, and he reacted with manifest pleasure, showing it to everyone in the house, and thanking Dr. L profusely. He said he wanted to take a picture of the racing car with Dr. L and his 1-1. Then he immediately began to sing "On shaky ground."

Andrew: You know what Bert told me? Bert told me about this paranoid schizophrenic girl who wanted Nelly (a child care worker) to take her out to the Y and when her request was granted, she became totally paranoid and said she hadn't wanted to go and demanded that she be returned home immediately or she would attack the 1-1.

Andrew's story of the girl who reacted negatively to getting what she wanted was an aversive reaction to the pleasure of Dr. L's responsiveness to his request, but it occurred in the form of associations conveyed within the intimacy of the therapeutic relationship and indicated that he was beginning to recognize that he could be angry in reaction to feelings of closeness.

Andrew developed a new resilience to caregiving lapses by the staff and to the losses caused by other residents' aggressiveness. In an incident that directly paralleled the earlier time when he had strangled Dr. L, a fight broke out in the house and one of the residents started hitting one of the staff. Andrew intervened and shepherded the boy into the staff room and talked to him until he calmed down.

Instead of getting angry at Dr. L for purposes of pain relief whenever he felt badly, he began to turn to

the therapeutic caregiving relationship and specifically, would ask Dr. L to help him understand his discomfort. The following interview also illustrates the helpful role the milieu staff played vis a vis the psychotherapy. Near the end of the therapy session, Andrew told his 1-1 that he had had a good dream the night before. He and his sister-in-law had been stuck in an elevator together and they were laughing and smoking marijuana. He asked Bert curiously why he would dream about being stuck in an elevator when that had never happened to him.

Bert: Ask Dr. L.

Andrew: Why would I Dr. L?

Dr. L: You can dream about anything you have ever known or could imagine or that has ever happened to you.

Andrew: My sister in law died three years ago—she was stuck in an elevator once (silence).

Dr. L: I have a hunch that in your sleep last night you were dreaming about your sister.

Andrew: (angry) If I wanted to dream about her I would dream about her.

Andrew: (suddenly very soft) I was thinking a lot about her last night. I miss her so much. Remember when you went to tell me she was dead, and I already knew. It's just not the same without her. I don't like my family so much any more. We used to crack up and joke and play. It's not as much fun. What's wrong with you, Dr. L?

Dr. L: It's just so sad about your sister.

Andrew: I want to go to the cemetery and bring some flowers to her grave, O.K. Bert?

Bert: Yes.

Dr. L: I'm sorry, but I have to leave for today.

Andrew: I won't be here tomorrow—I'm going to my friend's house and I'm not coming back for therapy (an aversive reaction that he shared within the therapeutic relationship).

Dr. L: I'll be here, though and I'll hope to see you. Bye.

Andrew: Bye.

Andrew began to have sustained times of enjoyment without dysfunctional types of aversive reactions. For the first time he would call Dr. L and tell him he had had a good day and relate his activities.

The balance between Andrew's motives had shifted to the point that he would manifestly worry about

slipping back to a reliance on the old, destructive forms of soothing, and he used Dr. L as an ally to try to help him decide how to take care of himself.

Dr. L's second summer vacation came and went, and Andrew did not become violent toward himself or others. One of the most significant changes Andrew manifested was his increasing willingness to allow Dr. L to enhance his self-awareness of forms of his pain that were invisible to him, and his capacity to avoid destructive aversive reactions to this potent type of therapeutic pleasure. Whereas in the beginning of therapy Andrew consistently soothed himself every time he felt badly by blaming Dr. L for his dysphoria and becoming enraged if Dr. L mentioned motives he was not feeling at the moment, now he often welcomed Dr. L's comments and worked hard to understand them. The day after Dr. L returned from vacation, the following interview occurred.

Andrew spent a long time saying he was going to kill himself, drink dye, swallow aspirins, run out in the street and get hit by a car, etc. After about fifteen minutes of this Dr. L said that he thought that some of this pain was coming from the interruption caused by his vacation, from the fact that they hadn't seen each other for so long.

Andrew's mood seemed to change after Dr. L said this and he played cards.

Andrew was fine the rest of that day and evening.

Andrew was also increasingly receptive to hearing about his aversive reactions to pleasure. This interview took place ten days after the one just mentioned.

Andrew called Dr. L from his father's house before therapy and said he wasn't coming and hung up.

Dr. L: (Called him back). I think I can help you with what is happening, if you could listen to me for a minute.

Andrew: O.K.

Dr. L: You are really learning to be good to yourself—for weeks you have been taking fantastic care of yourself, but the old part of you that tried to feel better by not being good to yourself is really reacting to that good care.

Andrew: (very sadly) I sent the 1-1 back—I can't make therapy now.

Dr. L: He should have waited anyway as Bert would have, but he's new.

The next day Andrew was clearly struggling to understand the pain-motivated part of himself, which

was becoming more and more alien. He puzzled: "You know, I don't understand something. There's this lake near where my father lives where children are always drowning when they try to skate on it, but they still go back and skate and drown."

Even when Dr. L had to cancel a therapy hour, which was a stimulus that had led to disaster in the past, Andrew was able to keep his anger on the level of fantasy, and to use both the 1-1 sitting in on therapy and Dr. L to bolster his desire to keep the relationship pleasure intact.

Andrew occasionally became violent after this, though he never caused any significant injury, and his aggressive behavior only occurred in response to chaos caused by other residents or significant caregiving lapses by staff. He himself wondered at the change. In March, 1976, on the anniversary of his sister's death, a time he would normally have become violent, he said, "You know what? I haven't broken any windows in a long time." His 1-1 said, "Yes. You are really learning there are better ways to deal with the pain." Andrew had an aversive reaction and said, "but I am today," but immediately added, "No I'm not. I don't feel like breaking windows." On days that were difficult for him, he began to report having dreams of hitting people, but would remain calm during his waking hours.

His attitude toward school continued to undergo a metamorphosis. Whereas initially his shame made him hide his inadequacies, he was now able to spend thirty minutes of sustained work doing difficult multiplication problems and asking for help when he got stuck. Within a few months he was reading at a seventh grade level.

Another important aspect of Andrew's progress was his sustained effort to mourn his punitive sterilization—that is, to respond to his pain about it by turning to the therapeutic relationship rather than by becoming violent or self-destructive. In an interview that occurred in March of 1976, Andrew appeared wearing a new pair of pants and a shirt and feeling pleased about how he looked. The compliments he received stimulated him to think about his loss. Characteristically, he began by denying the fact of the loss.

Andrew: I went to the doctor and he told me my sterilization was reversed.

Dr. L: Wow.

Andrew: I can be a father (pause). Can't I?

Dr. L: Any baby you care for and love becomes yours.

Andrew: But I don't want someone else to go through all the work of having it and giving it up, that isn't right.

Dr. L: If they can't take care of it and give it to someone who can, whoever loves and cares for a baby is the father or mother.

Andrew: But I can have my own. (pause deadly serious) Can they reverse it? (pause) Can they?

Dr. L: Probably not, Andrew.

Andrew: Why not?

Dr. L: Because it is difficult under the best circumstances and your surgery was done badly, which makes it even harder.

Andrew: If they can. . . I'm going to stop talking about it (he left the room but came back in minutes). Can't they fix it?

Dr. L: No, they should be able to, but they probably can't.

Andrew: But they can transplant hearts.

Dr. L: I know.

Andrew: By the time they figure it out, I'll be dead.

As time went on, Andrew was able to call the out-of-state institution himself and ask them why they had done this to him, and, even, to make an appointment to see our medical consultant to have him explain the exact nature of the surgery he had undergone. A few months later, Andrew made an appointment with someone at a local adoption agency to discuss the possibility of adopting a baby in the future.

Andrew's relationship with Dr. L continued to evolve into a stable and conscious source of pleasure. After the program director had told him he could never be alone with Dr. L again, he had a sustained aversive reaction to the pleasure of being prevented from following his motives to harm the therapeutic relationship, and he would either studiously ignore Dr. L, or he would try to attack him. While the 3rd person held him back, Andrew would describe in detail all the sadistic things he intended to do to Dr. L when he got the chance.

Subsequently, he would talk to his 1-1 about private and important things knowing Dr. L was listening. However, because the 1-1's lack of training often meant that his responses were inadequate, Andrew would leave the room, allow Dr. L to tell the 1-1 what to say, then return, listen to the 1-1, and calm down, knowing full well where the response had originated. Finally, he was able not only to address questions to

Dr. L directly, but also to turn to him as a source of superior caregiving when the 1-1 let him down in some way.

The worst and, ultimately, insuperable problem Andrew (and all of us) faced was DCFS's abrupt insistence on rewriting its contract with the program and reducing the per diem it was paying for the adolescents, which in effect meant closing the program. When we first agreed to accept these "most difficult" clients, we set only one condition—that as long as things went well, the state would leave the residential component of the program intact for a minimum of five years. We explained that the clients' symptoms would be much improved after a year or two, but that the clients would continue to need the same level of support they had been receiving for some time after their symptoms improved or many of the gains that had been made would be lost. DCFS accepted our conditions, but two years later, when the residents had improved demonstrably, it concluded that either the adolescents had not been as ill as it had thought, or, alternatively, that they were so much better they did not require the same level of support. The nature of the clients' personal histories and relations with DCFS was so chaotic that they were all represented by the public defenders' office, and the public defender, an ally of the program, managed to use the courts to stave off the State's desire to cut back the clients' treatment services from January until October 1976. At that point, DCFS forced the program to move out of the home in which it had been located. One of the adolescents reacted by stealing money and running away. Shortly thereafter, Andrew hit one of the staff in the face, sending him to the hospital. It was clear that, although for a year he had been able to tolerate staff and therapist vacations, caregiving lapses from the milieu staff, the constant violence in his family, chaos in the residential setting, and aversive reactions without seriously hurting anyone or himself or needing hospitalization, the threat of the program ending overwhelmed his newly won capacity for self-regulatory control.

Andrew chose to live with his father rather than to accept temporary quarters in another program. When this arrangement predictably failed, Andrew was very reflective and said that Dr. L had been right, that it hadn't worked out at his father's.

Dr. L: There are some things you can only really find out by going through.

Andrew: Well next time I'll listen.

Dr. L: But if you can listen next time, it will be because you went through it this time.

Andrew: (somerly and prophetically) I'll tell you what I do know now. I know that the day will come when I will be well enough to live on my own, but that I have to take my time and not rush it.

Dr. L: That's exactly right.

Unfortunately, this story does not have the happy ending that Andrew was reaching for with increasing stability and determination. In spite of heroic efforts on the part of the public defenders' office, DCFS managed to reduce the residents' per diem to the point that, in spite of our assiduous private fund raising efforts, our program was forced to close altogether. Although DCFS was convinced that the adolescents would continue to improve as outpatients, it was clear to us that this was not true. We knew that the residents still needed a milieu that could support their newfound capacities for self-regulation, especially given their intense aversive reactions to the pleasure of their progress. In our judgment, if the residents were confronted with a milieu that was both less supportive and also exposed them to new losses, they would not continue to improve and would be unable to maintain the gains they had made. The only question in our minds was the extent to which they would return to violence as a source of self-soothing. As the program directors emphatically told DCFS, in Andrew's case, at least, we were convinced that he would not be alive in two years if his treatment were prematurely terminated.

Dr. L said goodbye to Andrew with great sorrow and regret. We knew that Andrew had not reached the point at which it would be safe for him to be seen as an outpatient, although it was equally clear that that day would have come if DCFS had not prematurely ended the residential component of the program. Dr. L never saw Andrew again after the program closed, although Andrew called him occasionally. From his calls, Dr. L knew that Andrew was in and out of foster homes and was hospitalized a number of times at a state facility.

Though foreseen, it was still a terrible shock to all of us when eighteen months after we were forced to close, a call came from the public defender telling us that Andrew had died playing "chicken" on a motorcycle.

CONCLUSION

Since space considerations preclude a full discussion of the clinical implications of our program, we will focus on the question most readers may have, namely, given the numbers of troubled, acting out adolescents, what is the real significance of a treatment approach that is so expensive and necessitates such high staffing patterns? The answer is twofold. First, it is meaningful to know that even the "most difficult" adolescents are not beyond help—that if these adolescents do not receive treatment, it is because a decision has been made about the allocation of scarce resources, not because they are incorrigibly feral. Second, many adolescents—who are not driven to enact this degree of interpersonal violence and who could be treated in a less intensive setting—currently are pronounced hopeless or handled with repressive measures unlikely to result in lasting change because of the failure to understand their true dynamics (Gilliland-Mallo & Judd, 1986; Grellong, 1987; Grey & Dermody, 1972; York, York & Wachtel, 1983). To give but one example, a recognition of the existence of aversive reactions to pleasure can help mental health professionals treating troubled adolescents to maintain their commitment and effectiveness in the face of behavior that otherwise appears to signify the adolescents' imperviousness to dedicated therapeutic caregiving.

Notes

1. Not only were there no therapeutic programs that could either contain or help these teens, but, more fundamentally, there was no other theory that led straightforwardly to treating them (Cornsweet, 1990; Place, Framrose, & Willson, 1985b; Rinsley, 1990). The theories that were available for treating aggressive or self-destructive teenagers were developed and implemented with teens who were much less disturbed and violent than this population (Aichorn [1965] worked with adolescents who were "lazy" or involved in petty thievery; Redl and Wineman [1957] worked with latency age children in residential care; others implemented behavioral programs with incarcerated teens). Further, we were very uncomfortable with the authoritarian and intrusive nature of many of the behavioral approaches, such as the token economies that were being used with less aggressive populations (for recent examples of behavioral approaches, see Kupfersmid, Mazzarins, & Benjamin, 1987; a similarly authoritarian model is the 'tough love' approach, e.g. Newton, 1985).

2. In order to protect the confidentiality of the patient and family in conformity with statutory law and the social

work code of ethics, we have disguised both identifying information and the specifics of the case process.

3. Freud's notion of negative therapeutic reaction and our construct of aversive reaction to pleasure differ in cause, scope, and perceived significance. Freud posited that the neg-

ative therapeutic reaction occurred only in treatment, and he ascribed it to his construct of the death instinct, which he advanced as an incorrigible instinctual drive derivative that aims for self-defeat and destruction (Freud, S., 1953-1974 *The Ego and the Id, Standard Edition, vol. 19, pp. 49-50*).