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Narcissistic Vulnerability in the Hyperaggressive Child: The Disregarded (Unloved, Uncared-for) Self

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Efforts to treat hyperaggressive children frequently break down in a manner which reinforces the feeling that these children are beyond the reach of psychotherapeutic intervention. This study was undertaken in an attempt to elucidate the essential nature of the psychopathology of these children in order to provide a better foundation for the therapeutic enterprise. One finding was that much of their violent behavior is related to underlying narcissistic vulnerability, one facet of which is here termed *the disregarded self.* Much of the child's aggressive, antisocial behavior can be understood as an attempt to cope with and defend against the hurt, the anger, and the anxiety associated with this aspect of self-structure. Origins of the disregarded self are considered from a psychodynamic perspective integrating child-rearing, sociocultural, and psychobiological factors. The implications of this concept for individual psychotherapy and milieu treatment are discussed.

INTRODUCTION

This report concerns a population of children whose violent, unmanageable behavior has earned them considerable notoriety in both educational and clinical milieus. Their expressive and defensive style, replete with loud threats and sudden, wildly destructive outbursts, typically leads to increasingly negative reputations in their communities, and at a young age they may already be well known to local authorities. Less well known is what to do about them, particularly how to really help them.

Over the years these children have been assigned a variety of diagnostic labels: maladjusted, predelinquent, latent delinquent, unsocialized aggressive reaction, antisocial character disorder, primary antisocial conduct disorder,

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primary behavior disorder, impulse ridden personality, tension discharge disorder, aggressive conduct disorder, etc. Less formally they have been referred to as "wayward youth" (Aichhorn, 1935) and "children who hate" (Redl & Wineman, 1951). They are sometimes considered psychopathic since it may appear as if they do not experience shame, anxiety, or guilt, and that they do not "learn from experience" (at least not the lessons society wants them to learn by the pedagogical and corrective methods usually employed). It is, however, important to differentiate "primary," "affectless," "true" psychopathy—a relatively rare condition—from the far more common "secondary" or "symptomatic" psychopathy, which appears in children who just act as if they had no conscience (Karpman, 1959). This latter term would fit some of the children being considered in this paper.

In a typical case, a hyperaggressive child might be suspended from school for fighting, swearing, throwing books at the teacher, overturning desks, smashing windows, running out of class, and generally defying all attempts to restrain his or her impulsive outbursts. At the school's insistence, parents might bring their child to a mental health facility for consultation. However, as Tooley (1974) has noted, "By any mode of assessing accessibility to psychotherapy these children would be judged the poorest of risks. They have little capacity for expressive or reflective verbalization [and] no evident capacity for dramatic, imaginative play" (p. 341). Unlike neurotic children, they do not have a variety of complex symbolic operations at their disposal for expressing, modulating, and defending against aggressive impulses. In psychotherapy they do not confine their warfare to the realm of puppets or toy soldiers. Instead, when they are upset (which is frequently) they are likely to smash anything they can get their hands on. They will make a shambles of their therapists' offices unless they can be restrained quickly—a feat that increases in difficulty in direct proportion to their size and age.

In view of the above, it is not difficult to understand why some professionals have come to believe that these children are simply "beyond the reach of education . . . below the grip of the psychiatric interview" (Redl & Wineman, 1951, p. 277).[1] Nor is it completely surprising to find studies indicating that of all such children referred for treatment, only a small fraction are actually offered it (Bahm, Chandler, & Eisenberg, 1961). Of those who are, it is said that few actually benefit from the individual therapies typically provided (Levitt, 1971). Even residential treatment facilities are reported to have little success in effecting long-term behavioral change with these children (Meltzoff & Kornreich, 1970; Teuber & Powers, 1953).

Thus, even if a hyperaggressive child is fortunate enough to be accepted into one of the few residential facilities with adequate treatment resources, it

[1]For Redl and Wineman, this viewpoint was not a counsel of despair, but rather the impetus for developing new modes of intervention.

is all too likely that sooner or later he or she will be deemed untreatable. This conclusion is frequently reached in a highly charged atmosphere where the staff feels as frustrated and angry as those who originally referred the child for treatment. Whether discharged home or transferred to another residential setting, this unproductive scenario is very likely to repeat itself. The child will either run away or be extruded once more. Increasing involvement in delinquent activities will eventually lead to incarceration in some nontherapeutic detention facility where antisocial tendencies will be refined and hardened.

For those striving to intervene and alter this otherwise grim "course of the illness," there is precious little in the clinical literature to enlighten and sustain them in their uphill, often lonely, struggle. The shortcomings of existing formulations have been underscored by many experts such as Berman (1964) who asserted that the "concepts which guide us in treatment are of no avail" (p. 24). He believed the field lacked the technical knowledge necessary for treating these disorders and that:

> Only a theoretical model of the dynamic processes which determine the behavior of these children will provide the vehicle for the application of those therapeutic principles necessary to orient us in the therapeutic process. (p. 29)

The aim of this current research project was to seek a more coherent theoretical understanding of these problematic children in the hope that it might provide a better framework for the therapeutic enterprise. This report discusses one of the central concepts that emerged from this study. The findings are based on a detailed review of several cases treated by the author and his colleagues[2] in a long-term inpatient setting, supplemented by a consideration of similar cases which have been reported in the literature.

NARCISSISTIC VULNERABILITY AND THE RANGE OF AGGRESSIVE BEHAVIOR DISORDERS

Some hyperaggressive children appear to be more intractably aggressive than others, raising the question of whether they should all be grouped in one diagnostic category. It is useful to think of a spectrum. At the less disturbed end, one would locate those children who flare up more or less frequently in response to the challenges, frustrations, and demands inherent in the activities of daily living. When not reacting to stress in their characteristically ex-

[2]I wish to express my appreciation to Thomas Horner, Ph.D., David Klein, Ph.D., Laura Levine, Ph.D., Michael McManus, M.D., and William Schafer, Ph.D. for sharing clinical material, and Kay Tooley, Ph.D. for her assistance and encouragement at all stages of this project.

plosive manner, they can relate warmly with others in a generally well-controlled, lively, engaging manner. Their proclivity to violence constitutes a relatively circumscribed area of psychopathology within an otherwise relatively normal, action-oriented personality.

At the other end of the spectrum are those children who seem to be acting up almost constantly. Even when they are not creating a disturbance, their caretakers still feel unable to relax their vigilance because they are liable to erupt at any moment, with little or no warning. They pose a constant management problem, challenging and draining their caretakers' emotional resources. Rather than being circumscribed, their pathology tends to dominate their personalities, pervading all areas of functioning.

One finding that emerged from this investigation was that much of the violent behavior of these children is related to underlying narcissistic vulnerability. The extent and nature of this vulnerability is related to the severity of the behavior disorder. For children at the less disturbed end of the spectrum, narcissistic vulnerability, like their explosiveness, is relatively circumscribed, whereas for those at the more disturbed end, the vulnerability tends to be more pervasive and primitive.

Another finding was that this core of narcissistic vulnerability has more than one facet. Although it is somewhat artificial to discuss one facet in isolation from the others, such an approach seems warranted for purposes of conceptual clarity. The focus of this presentation is therefore restricted to one fundamental aspect of narcissistic vulnerability here termed *the disregarded self*. A second major facet (the devalued self) will be discussed in a subsequent paper.

THE DISREGARDED SELF

Narcissistic vulnerability may not be the first concept to come to mind when thinking of hyperaggressive children. Therapists (and other professionals) may be more likely to recall the many times they have had to dodge rocks and ashtrays, or fend off punches and kicks while working with these obstreperous youngsters. However, if one can see beyond these highly charged memories and perceptions, one discovers that behind the defiant, "tough guy" facade, these are angrily alienated children who feel basically unwanted, unappreciated, and unloved. Uncertainty about their caretakers' regard gives them profound doubts about their self-worth and constitutes a fundamental source of narcissistic vulnerability. They may fear that they lack whatever it is that one needs to engage and sustain the genuine interest of significant others. This type of vulnerability is related to self-esteem. It concerns the most basic sense of valued connectedness with important others, the sense

that it deeply matters to someone in this world whether one comes or goes, lives or dies, thrives or perishes.

Lacking a secure sense that someone cares and is looking out for them, they are prone to feeling frighteningly alone and threatened, and that they must therefore constantly be ready to fend for themselves. In the faces and actions of their caretakers they tend to perceive or imagine, at best, disinterest, and they tend to generalize this expectation to the world at large. One troubled youngster in an inner-city school bluntly expressed the anger and hurt associated with his feeling that he mattered to no one: "I don't see why I should give anybody in this room any respect . . . 'cause they ain't going to give a damn about me!" (Emanuel, 1977). It is this sense of self in relation to an uncaring world which I refer to as the disregarded self.

The disregarded self can be thought of as a major component of a primitive ego state consisting of an image of the self in relation to an uncaring object (person). The intense emotional charge associated with this object relational paradigm is extremely upsetting and much of the child's antisocial behavior and character stance can be understood as an attempt to ward off awareness of this feeling of being unloved. To cope with the hurt, angry, frightening belief that no one really cares about them, they act as if they do not care about anybody either. By their intolerable behavior, their flagrant contempt for the social constraints of everyday life, and their blatant disregard and defiance of adult rules and values, they act out a fantasy aimed at reversing their intolerable conviction about themselves, (i.e., they disregard others and treat them as if they merited no serious consideration).

With such a core feeling of being unloved and uncared for, these children constantly expect anyone they become involved with to immediately or eventually treat them in accordance with this image they have of themselves in relation to others; that is, they expect to be rejected and abandoned. This expectation hangs over their heads like a sword of Damocles. In order to terminate this tension they may strive to bring down on themselves what they see as inevitable, often going out of their way to make everyone furious at them. This strategy also fills the craving to feel somehow attended to, but it simultaneously alienates them even further from the type of loving concern they really want and need.

There is currently much interest and controversy in psychoanalytic circles concerning self psychology (Kohut, 1971, 1977) and object relations theory (e.g., Kernberg, 1975). From the preceding discussion it is clear that the aspect of narcissistic vulnerability under discussion reflects a fairly primitive, internalized object relational paradigm. I have chosen the term, *disregarded self,* because of its readily understood meaning and to emphasize that it is something within themselves and about themselves which these children bring to current relationships and tasks which leads to so much difficulty.

ORIGINS OF THE DISREGARDED SELF: A REVIEW OF SOME RELEVANT LITERATURE

A complete review of all literature pertaining to the origins of the disregarded self is beyond the scope of this paper. This section therefore has the more restricted aim of bringing together certain findings from some rather diverse realms of investigation. Childrearing, sociocultural, and psychobiological variables are considered in terms of their impact upon the development of the disregarded self.

The Parent-Child Relationship

Judging from children we have seen, and others reported in the literature, it seems that most hyperaggressive children have experienced some degree of emotional or physical neglect or abuse. In many cases the child may have been rejected before he was even born (Field, 1940; Lander, 1941). Field studied parents of 25 children with primary behavior disorders and found that in 16 cases one or both parents did not want the child born. There were four attempts at abortion and only five of the infants were breast fed for a normal length of time. Redl and Wineman (1951) described the characteristic relationship between "children who hate" and their parents in terms of there being little or no relationship at all. The parents seemed to have no difficulty "abandoning" their children to the treatment project. They showed little interest in maintaining contact. Under such circumstances it would be hard to imagine a child failing to develop a disregarded self.

While Redl and Wineman's patients (and their families) typify the more disturbed end of the hyperaggressive continuum, familial circumstances at the other end of the spectrum tend to be similar, though less extreme. Bandura and Walters (1958) studied aggressive, delinquent children who were still living with their families and concluded that there was "little doubt that the boys' distrust and lack of security in all dependency relationships had originated in their parents' failure to provide a warm, acceptant, nurturant family atmosphere" (p. 16). The sense that one is not accepted and loved, that parents do not treat one in a warm, nurturant manner, is characteristic of the affect associated with the disregarded self.

There has been some question as to the relative importance of maternal versus paternal deprivation in the genesis of aggressive personality disorders. Bandura and Walters (1958) found that the aggressive children they studied differed little from a control group in terms of the amount of warmth and esteem they showed for their mothers, although they differed significantly in this regard in relation to their fathers. Bandura and Walters characterized the fathers' relationships with their sons as distant and cold. However, the children's consciously positive attitudes towards their mothers cannot simply be

taken at face value. Other studies indicate that many aggressive, impulse-disordered children utilize massive defensive operations in order to maintain a good image of their mothers:

> conflicts, related primarily to the original object, the mother, are expressed in displaced form. It is as though a positive image of the mother, misted over with denial, must be preserved at all costs, even at the cost of destroying the rest of the world. "Don't you dare talk about my mother," is the most popular refrain we heard in our patients' defensive theme songs. (Kitchener, Sweet, & Citrin, 1961, p. 349)

That such defensiveness might pertain to Bandura and Walter's delinquents is suggested by their responses when asked which parent they would prefer to live with should their parents separate. Both the controls and the delinquents frequently refused to register a preference, although for very different reasons. Whereas the controls were attached to both parents, for the aggressive children it was a case of double avoidance. As one of them put it, "If I had to live with one or the other, I wouldn't live with any of them."

Needless to say, both mother and father can contribute to the development of a child's sense of being unloved. Consideration of the particular combination of maternal and paternal disregard helps explain some of the variations in the population of hyperaggressive children. In terms of origins, however, it appears that the disregarded self usually has its roots in the earliest stages of identity formation, when the child's relationship with the mother is most important. Experience in subsequent developmental stages—when children begin turning to their fathers to acquire a sense of what they can expect from relationships outside of mother-bound existence—may reinforce this sense of self.

In some cases the disregarded self appears to emanate not so much from experience with a characterologically neglectful parent (e.g., a pathologically narcissistic mother with an impaired capacity for empathy and giving) but rather from experience with a caregiver who became overwhelmed and depressed by stressful life circumstances combined with a lack of emotional support (poor marital relationship or none at all, lack of extended family, etc.). In response to the mother's emotional unavailability, her children may feel uncared for and abandoned.

Tooley (1974, 1976) observed a particular form of nonresponsiveness in mothers of a broad range of aggressive children. She described these women sitting in an impassive, impenetrable manner, gazing into the middle distance while their children clamored for attention, protection, information, permission, food, or whatever. Tooley distinguished this behavior from depressive apathy (and in a footnote cited Waites' opinion that such withdrawal is the only form of vacation these overburdened mothers ever get).

The concept of a "good enough" mother–child relationship becoming not good enough is central in Winnicott's (1958b) theory of the antisocial tendency. Disruptions in the mother–child relationship can be precipitated by the stress accompanying marital deterioration, major moves, the birth of more children, and so forth. The clinical picture that a family ultimately presents may represent the outcome of a long-standing pattern of deteriorating parent–child interaction, a vicious cycle that has culminated either in the angry desire to extrude the child from the family or in a distant, unrelated form of familial noninteraction. In some cases it is possible to restore and improve upon a previously healthier state of affairs, while in other instances the elastic limit of familial resilience may already have been exceeded such that a new home must be found for the child. This latter outcome is more likely with adopted children (Lewis, Balla, Lewis, & Gore, 1975).

Some variations in the clinical pictures of hyperaggressive children can be understood in terms of the timing, intensity, and duration of maternal emotional unavailability. With regard to the more severe forms of maternal neglect, it is interesting to note that Pavenstedt et al. (1967) found that even in some of the most severely disorganized, impoverished, multiproblem families in which maternal deprivation went back many generations, when the mothers' emotional and other reality needs were met so that they felt less overwhelmed and better about themselves, they were able to shift from being emotionally absent to being bright and genuinely warm with their children. Similarly, when circumstances are less stressful, these mothers may be more accessible to therapeutic interventions than one might otherwise expect.

Patterns of Family Interaction

In studying families with delinquent children, Minuchin and his coworkers (Minuchin, Montalvo, Guerney, Roseman, & Schumer, 1967) observed a frequent mode of interaction characterized by an alternation between enmeshment and disengagement. Enmeshed life typically is mother-centered and consists of frequent, intense contacts around nurturance and aggression. The tempo of interpersonal exchange is rapid. Tensions are resolved by action and there is little in the way of mediating processes to delay the flow between impulse and activity. Mother serves as the pathway through which most transactions are conducted and she attempts to regulate the stream of behavior like a traffic cop. Her style of control emphasizes *don'ts* rather than *shoulds,* and there is a paucity of verbal explanation and guidance. This method of family management does not foster the development and internalization of rules. It thus perpetuates a situation in which the children require continuous parental participation in order to regulate their behavior.

The struggle to manage the family by constant "presence control" tends to drive the mother into a state of exhaustion and despair. Her solution is disengagement. This may consist of a psychological tuning out, or it may be

carried to greater extremes: abandoning the family, extruding a particularly burdensome child, or "acting out" via promiscuity, alcoholism, psychosomatic illness, and so forth. Thus, at the very point where family stress is greatest and the children are most in need of good parenting, the mother, in order to protect her own sanity, is liable to disregard her children most. One can easily imagine how such an alternating pattern of enmeshment and disengagement could contribute to the development of a character structure in which the abandoned, uncared for (disengaged, disregarded) state would be chronically feared.

Even within the enmeshed phase itself, there is frequently a serious dissociation between parental presence control and remote lack of control. Mother and child may feel a complete lack of connection when they are not interacting directly. Parents may feel no responsibility for their children's delinquencies simply because they were not present when they occurred. "The teacher says he did it, but I don't know because I wasn't there" (Minuchin et al., 1967). Parents tend not to manifest much interest in the details of how their children are faring when they are out of sight or beyond earshot (e.g., at school). Compared to how the child feels in the enmeshed home, in many extrafamilial situations he might feel disengaged and disregarded. To ward off these disquieting feelings, he might attempt to induce, or frantically provoke, intense, action-oriented relationships with the environment (Hamblin, Buckholdt, Ferritor, Kozloff, & Blackwell, 1971; Minuchin et al., 1967).

Although one might think that the enmeshed mother's close scrutiny of the children would make them feel well attended, this is not necessarily so. Minuchin et al. make the point that while these mothers are very invested in the identify of "being a mother," they are not necessarily child-centered. Particularly when they are feeling stressed (which may be almost always) their focus may be upon their own emotional equilibrium. Their constant commands to their children may then be couched in terms of how difficult they are making their mother's life, how they are making her sick, nervous, etc. Thus, even as she is addressing her children, she may be disregarding their individual needs, conveying the message that she regards them mostly as an irritation and would prefer, at least for the moment, to be able to totally disregard them.

The children seem to learn the coping strategy of disengagement such that in a disengaged family all members appear to be oblivious to the effects of their actions on one another. Monologues, parallel play, and a variety of maneuvers of psychological and physical abandonment characterize their *modus vivendi*. Minuchin et al. (1967) described how one girl shared a painful school experience in response to a specific question from the family therapist.

> Immediately after finishing, she initiated another activity, as though once she had performed the requested act the interaction ended. She did not think her communicative behavior would have any effect on the rest of her family or that

> it could prompt a response. Her assumption was complemented by the behavior of the mother and the siblings, who showed no signs of involvement in or response to her verbalization. (p. 202)

Everyone in the family seems to take it for granted that they will be disregarded. The disengagement process seems to anesthetize them from the feelings they might otherwise have under such circumstances.

Implicit in the preceding discussion is the idea that some types of families that produce aggressive, antisocial children are poorly equipped for dealing with separation reactions. Pavenstedt et al. (1967) reported that children in day care settings from impoverished multiproblem families take leave of their mothers without either party uttering a word. The mothers' own histories of traumatic separations prevent them from acknowledging such emotional reality. They cannot help their children deal with separation feelings, other than by modeling coping styles based on denial and other defensive maneuvers. As a result, while they are at nursery school the children manifest a striking absence of questions about their mothers or when they will be returning home. In the unspoken gap between parting and reuniting, there is much room for a sense of being disregarded to flourish. To the extent that it is unacknowledged, it probably remains mostly unconscious.

Socioeconomic and Sociocultural Factors

Oppressive socioeconomic conditions can influence the development of the disregarded self throughout the life cycle. Parents who belong to an impoverished or otherwise disadvantaged minority group may feel left out, uncared for, and abandoned by the socially dominant majority. Their sense of being disregarded by society may influence their attitudes towards their children and their hopes for their development, sapping them of the energy necessary for good child rearing.

Inadequate financial resources can also exacerbate marital discord, further impairing the parents' capacity to invest themselves in raising their children. Parents who are frustrated, burdened with stress, and living in overcrowded, substandard housing are likely to be irritable. Their discipline may be related more to the vicissitudes of their own narcissistic equibria than to any actual variations in child behavior. They may strike a child who happens to be nearby rather than punishing the more distant one who misbehaved, disregarding the individuality of the children (Minuchin et al., 1967; Pavenstedt, 1965, 1967). Fathers, if present, frequently do not participate much in child rearing, considering such involvement a threat to their masculine role (Scheflen, 1970). They may be particularly prone to this belief because their feeling of masculinity has already been reduced by their position at the bottom of the social hierarchy. The aloof, seemingly cold, uninterested father

may serve as a prototype for the child's view of the social world beyond mother as a nonresponsive, uninviting milieu (Forest, 1967). Thus, in myriad ways oppressive socioeconomic factors exert a powerful influence upon the child (initially mediated by the parents), which increases the likelihood that he will develop a disregarded self.

As the disadvantaged child grows up, he is likely to have more direct experiences at school and in the community that will convey to him the message that he was somehow marked at birth as one who would be less than equally regarded in terms of the distribution of social resources and opportunities. Teachers in middle-class schools are often quite sensitive to emotional pressures that might be operating on a child at home or at school whereas in the slums the problems of social adaptation are so massive that professional sensitivities are blunted (Deutsch, 1964). Shortcomings in parental child rearing practices are frequently repeated in the classroom. For example, teachers in ghetto schools may resort to "partial withdrawal," ignoring the extreme acting out of the majority as if nothing were happening (Emanuel, 1977; Henry, 1966)—a phenomenon reminiscent of the parental disengagement practices described by Tooley (1976) and Minuchin et al. (1967). The cumulative impact of the failures of the adult world to recognize and address the needs of these children is such that while socioeconomically disadvantaged children are often cute, affectionate, and curious when they begin school, by fifth grade they are frequently alienated, withdrawn, angry, apathetic troublemakers (Deutsch, 1964).

Based on his experience teaching in a "problem school" for lower-class blacks, Herndon (1965) vividly portrayed the problems encountered by these junior high school students and their teachers who were trying to socialize them to accept an orderly position in a social structure which basically did not accept them. Particularly pertinent to our discussion is one epithet created by these students seemingly designed to strike directly upon that area of sensitivitiy which I call the disregarded self.

> "Forget you!", one kid would say to another as if he really wished to insult him badly. It was almost as bad as calling him black. "Forget you!", when they said it, it was a threat and, like a magical word or curse, a prediction—a prediction of possibilities for tomorrow, next period, next month, when it just might happen that they were going to finally forget *you*. (p. 70)

These students could scarcely have chosen a phrase that could have more aptly expressed the mutually known dread of the unloved, abandoned, uncared for self.

While more of the patients we have seen have been white than black, membership in a disadvantaged minority can undoubtedly contribute to and reinforce a sense of being disregarded. The presence of the disregarded self in the

social character[3] of Afro-Americans was strikingly evident during the Civil Rights Movement when blacks began to feel sufficiently strong to protest their disregarded state, standing up en masse to assert to themselves and the world: "I am somebody!" Moynihan's (1965) recommendation that the government should treat blacks with "benign neglect" was, understandably, not well received. It must have sounded much like the same old, unbenign, "Forget you!" The theme of the disregarded self has also figured prominently in Afro-American literature, as is suggested in the title of Ellison's (1947) book, *Invisible Man* and Gordone's (1969) play, *No Place to Be Somebody*.

Psychobiological Factors

Another body of research points to various congenital traits within the child that can influence and exacerbate the impact of the preceding external factors (e.g., Bell, 1968; Berman & Siegal, 1976; Eysenck, 1952, 1964; Franks, 1956; Fries & Wolf, 1953; Glover, 1960; Graham, Rutter, & George, 1973; Hare, 1968; Mednick & Hutchings, 1978; Michaels, 1955; Quay, 1965; Reitsman-Street, Offord, Finch, & Dummitt, 1984; Rutter, Korn, & Birch, 1963; Thomas, Chess, & Birch, 1967, 1968). For example, Stott, Marston, and Neill (1975) argued that one crucial factor distinguishing aggressive, antisocial children from others is a strong *overreacting* temperament. This *inhibitional impairment* manifests itself developmentally in a variety of behaviors that are likely to influence parents to punitively attack and/or distance themselves from (disregard) the tiresome youngster. The child will then frequently react by becoming angrily alienated from his parents.

Soddy (1960) noted that the restlessness of the extremely active, outturning baby makes it difficult for him to settle down to steady, efficient sucking. This can undermine the mother's confidence in her ability to handle her infant and lead her to withdraw (especially if she were already in an unstable or depressed state). The baby will have less feeding satisfaction to enhance his relationship with his mother – a factor that could interfere with the development of positive object relations (a contented, loved self in relation to a caring, gratifying mother/world) which might otherwise serve to counteract the development and influence of a disregarded self.

Studying precursors of ego in neonates, Aleksandrowicz and Aleksandrowicz (1976) found that *arousal* or *excitability* correlated negatively with *consolability* and at times with a factor labeled "relaxation" (including cuddliness, self-quieting ability, smiling, hand-mouth facility, and consolability). An active, excitable child who could not be readily consoled by his

[3]Social character, according to Fromm (1965), is that aspect of character structure which is common to a group and which is attributable to the group's relationship to the mode of economic production.

parents and could not easily soothe himself might develop a pattern of relieving tensions by restless motility or aggressive discharge. Thus, this combination of excitability and nonconsolability could interfere with the growth of intimate dependency bonds between parent and child (bonds that would mitigate against the development of disregarded self) and in extreme cases could contribute to the development of a "tension discharge disorder," a label sometimes applied to some hyperaggressive children. This combination of congenital traits characterized Eddie (Makkay & Schwaab, 1962). He had always been very active, never wanting to sit in his mother's lap. If she held him, he became restless and struggled to get down. When he learned to walk, he began wandering away from home. If he fell or was hurt by someone, he might approach his mother, but he would ask her for money rather than sympathy or protection. Such counterdependency (masked dependency) is common in aggressive, antisocial children and it is interesting to consider its possible origins in the interaction between constitutional and interpersonal factors.

SOME MANIFESTATIONS OF THE DISREGARDED SELF IN THE THERAPEUTIC MILIEU

The combination of narcissistic vulnerability with an aggressive, acting out defensive style creates a highly unstable, potentially explosive personality. Constantly fearing rejection, abandonment, and other forms of disregard, hyperaggressive children maintain hypervigilance for any hint of it. If there is the slightest ambiguity in a situation, they will make the worst of it. To illustrate, Tod, after many weeks of inpatient treatment, had finally begun to settle down in school. However, when a substitute informed the class that their regular teacher was ill, Tod suddenly began to have a horrendous time. He became extremely disruptive and had to be physically restrained. Evidently he did not believe for a minute that his teacher's absence was simply due to sickness. To him it was an uncaring or hateful abandonment. If she was sick, it could only mean that she was sick and tired of him[4].

On another occasion, Tod's nurse told him that she had to go to a meeting but would return in half an hour. When she was still not back after an hour and a half, Tod began to act up in a highly aggressive, oppositional manner –

[4]In "A Project to Teach Learning Skills to Disturbed, Delinquent Children," Minuchin, Chamberlain, and Grauband (1971) made some related observations. They found that the primary way these children saw things happen in school was in terms of whether or not the teacher liked them. If they got a good mark on a spelling test, it was because their teacher liked them. If they were suspended, it was because she did not like them.

his way of protesting, retaliating, and defending against the feelings of the disregarded self.

It is important for child care workers (and other mental health professionals) to be aware that these children are so prone to these gross misinterpretations. This knowledge can help them to understand and address the child's true worries, rather than having to restrict themselves to managing aggressive behavior. Because these children are not given to lengthy verbalization, and would usually rather throw chairs than talk, it can be very difficult for child care staff to understand what these children are really so upset about. In the absence of verbal clues from the child, they may be led to believe that the child is exploding, as he insists, simply because he was asked to wash his hands before dinner, or to pick up his clothes, or whatever the seemingly innocuous matter was that appeared to have triggered his explosion. An awareness of the types of situations that are likely to touch upon their hypersensitivity can help staff to anticipate, prevent, or resolve such extreme reactions.

Many staff members might be surprised to learn how precariously balanced and vulnerable these self-styled "tough guys" actually are. They are often fairly convincing in their swaggering presentations of themselves as not "giving a damn" about others, especially adults, and so the staff may fail to realize that they are, in fact, extremely concerned about the staff's investment in them – so much so that the slightest hint of possible not caring shakes them to the core. Sam provides a good illustration of this aspect of narcissistic vulnerability. On his way to bed one night, he passed the nursing station mumbling, "Good night." Absorbed in writing her notes, the nurse did not immediately hear, or respond. "You hate me!" snarled Sam (no longer mumbling). Beyond expressing his fear and hypersensitivity, Sam's heated accusation may also have served a defensive function, warding off an even greater anxiety, namely his worry that the nurse might simply be coolly indifferent to him.

Krug, Haward, and Crumpacker (1951) reported the case of a 9-year-old girl with an aggressive behavior disorder. When this child's worker turned her attention to another child for a few seconds, the girl began to act out wildly. Her verbalizations while her worker tried to restrain her aggressive outburst clearly revealed that she had experienced the momentary loss of her worker's attention as tantamount to an expression of total disregard. Such hypersensitivity places heavy demands on staff to be hyperattuned to the state of the child's narcissistic equilibrium and to the potential impact of their actions upon the child. Needless to say this can be very taxing and is not always possible to achieve.

The preceding discussion and the accompanying vignettes demonstrate how rather small, everyday frustrations, ambiguities, and disappointments tend to be perceived by these children as major slights, as ominous indica-

tions of underlying, totally uncaring, rejecting attitudes. Hypersensitive to perceived or imagined neglect, they tend to interpret any possible hint of it as hostile disregard, then respond with enormous quantities of anxiety and aggression. Whatever smooth ego functioning they might otherwise be capable of enjoying is swept away. The goodness and solidity of their sense of themselves in relation to others is insufficient to serve as a stable basis for self-esteem regulation and impulse control. This narcissistic hypersensitivity is a key factor underlying the phenomenon which Redl and Wineman (1951) described as "the disorganization and breakdown of behavioral controls."

MANIFESTATIONS OF THE DISREGARDED SELF DURING THE COURSE OF INDIVIDUAL PSYCHOTHERAPY

Although this section focuses upon the behavior of hyperaggressive children in psychotherapy, it is nonetheless relevant to anyone working with these children in any capacity. During the course of treatment, all members of the therapeutic team must deal with many of the same issues and problems. The relationship concerns that are central to the psychopathology of these children lead to highly disruptive behavior in all areas of the milieu, as we have seen. Thus, even the most behaviorally oriented staff member must be alert to the crucial significance of his relationship with the child. Likewise, the most psychoanalytically oriented psychotherapist must devote considerable attention to issues of behavior management when working with these children.

Most of the clinical illustrations have been taken from the treatment of children who are chronologically in late latency or preadolescence. As Sontag (1959) noted, predelinquents less than 7-years-old usually show emotional discomfort and anxiety because their defenses do not fully ward off their dependency needs. Their need for warmth and acceptance gives therapeutic personnel greater opportunity for a relationship which, once established, allows for limit-setting. Bearing such qualifications in mind, it seems valid to say that these findings about narcissistic vulnerability are germane to both younger and older patients.

Because one of the child's main conflicts centers around his fear that he cannot engage and sustain an adult's attention, in the beginning of treatment, particularly in the case of a younger child, the child's main concern may simply be in holding the therapist's interest. Even the young child is likely, however, to be highly defended against any open acknowledgement of such a preoccupation. Eight-year-old Eddie (Makkay & Schwaab, 1962) tried to appear casually unconcerned, but was actually hypervigilant for any hint that his therapist might be the least bit bored. As they played, Eddie furtively glanced

at his therapist to gauge his level of interest. The therapist often sensed he was being observed, but whenever he looked up, Eddie was simply playing with a smile of complete unconcern. However, Eddie's increased activity and renewed interest in his play, together with his pseudononchalant whistling, provided ample evidence that his disinterested facade concealed extremely keen interest in his therapist's attention.

This hypersensitivity to the therapist's perceived or imagined disinterest may be associated with considerable aggression readiness. This phenomenon may be more evident in older children whose hyperaggressivity is more characterologically consolidated. Eleven-year-old Janet was playing in the sand while her therapist looked on. When he decided to sit down to make himself more comfortable, he was startled to find handfuls of sand flying towards his face. Janet was apparently reacting to a feeling that her therapist was "sitting down on the job," that he was too concerned about his own comfort and needs to devote his attention sufficiently (i.e., completely) to her. For apparently similar reasons, when another therapist casually rested his foot on a table in order to be more comfortable—a gesture of informality which he thought might be welcomed by his patient—his patient instead snapped, "What are you so damn concerned about your foot for?!" Any time these children experience a shift in attention away from themselves, they feel threatened and frequently respond with an outburst of aggression.

Despite their heightened aggressivity, even the older children frequently reveal something of their concern about how interested their therapists are in them during an initial "honeymoon period," a phase of treatment where the child is still familiarizing himself with his new environment, refraining from the violence that his reputation would have led staff to expect. In the brief period before he began refusing to attend therapy, Sean asked his therapist, "How come you don't ask me how my day was? Everyone else asked." Clearly he was worried that his therapist's not inquiring might be indicative of a profound lack of concern. On anything resembling a "blank screen," these children expect to see reruns of the dreaded interactions between the disinterested parent and the disregarded self.

Another chronic worry, indeed expectation of these children, is that someone else will suddenly replace whatever importance they held in their therapist's eyes, leaving them totally out in the cold. It is hard for them to imagine that anyone could be seriously interested in and committed to them. As early as the first session they may ask whether their therapists see other patients or have children of their own. They jump to conclusions on the basis of the most minimal information. For example, when Tod spied some testing materials on his therapist's desk, he immediately asked if his therapist had been testing someone recently and, more crucially, whether he would be taking that person on in treatment. Their instant conclusions are felt to be more than enough basis for action, usually in the form of aggressive outbursts. After

seeing his therapist in the elevator with another child, Sean refused to attend his session later that day. There seemed to be no doubt in his mind that his therapist had shifted his interest to that other child which meant that there was, or would soon be, none left for him. (It is worth noting that Sean's avoidance was a sign of progress. Earlier in treatment he would have felt fully justified in trashing his therapist's office and, if possible, destroying possessions of other children who, he was certain, received so much more from the therapist.)

Oftentimes the child's rival is not a spouse or sibling figure, but an adult's interest in a hobby, book, career, and so forth. However, whether the child imagines that he is not considered interesting because he is not a girl, a baby, a sexual partner, or whatever, the crucial factor is his belief that he does not have, and never could have, what it takes to secure the adult's interest. The patient of Krug et al. (1951) who erupted when her worker momentarily shifted her attention to another child did so after some conversation in which she had accused her worker of preferring boys. While pummeling her worker, the girl insisted that her worker had grown tired of her like some animals who love their babies but get rid of them when they get big. Thus, in a single episode she revealed two fantasies concerning two factors (sex and age) which she believed with certainty eliminated all hope of engaging and sustaining her caretaker's attention.

Such fantasies are by no means unique to this population. What distinguishes these children is that they take them as absolute truths. In contradistinction to working with neurotic patients, one does not have to meticulously uncover intricate defensive layers to reveal such fantasies. They are usually right near the surface and are not felt to be fantasies at all, but rather straightforward perceptions of how it is, or how you are. Feeling so convinced that their supposed caretakers are treating them with such gross disregard, they feel more than justified in exploding in vengeful attack.

The belief that the therapist is eager to shift his attention to more significant pursuits can often be seen in reactions to ending sessions. Winnicott (1958a) suggested that analysts express hate every time they end sessions. Although I cannot vouch for the generality of this assertion, at times therapists of aggressive children certainly are tremendously relieved to be rid of their infuriating patients. On the other hand, if a session has been relatively enjoyable, the child may interpret the ending as indicative of the therapist's hateful, depriving, uncaring attitude. He may accuse the therapist of trying to get rid of him, or he may refuse to leave, indulging in a destructive rampage instead. When there are major difficulties ending sessions, it sometimes helps to make announcements such as: "In 10 minutes we will have to stop. . . . Now there are only 5 minutes left. We'd better begin winding up." The therapist may then be able to help the child deal with his disappointment or anger, or with his denial of any separation reaction. Sometimes it is helpful to have a

significant staff member pick the child up at the end of the session so that the child can feel that he is leaving his therapist to go on to some other activity with someone who wants to be with him, rather than feeling he is simply being dismissed by someone who is no longer interested in him.

Another important way in which hyperaggressive children reveal their fearful expectation that significant others will find them too uninteresting for sustained investment is through extreme attempts to externalize this unwanted aspect of their self-image. In order to reverse their experience, they may strive to make their therapists feel that they do not have anything to offer that would make anyone want to be with them. For example, Brian frequently berated his therapist for being no good. He claimed he did not want him for a doctor and declared that he could get himself another therapist. Most extremely, in terms of externalizing his fear of being disregarded and decathected, he would tell his doctor that he was not his therapist, and that (Brian) didn't even know who he was! Such a barrage might occur if his doctor was a few minutes late, an event that would be sufficient to make hypersensitive Brian feel cruelly disregarded unless he shifted quickly into defensive high gear in order to turn the tables on his therapist and try to make *him* feel totally disregarded instead.

When therapy has progressed to the point where these children are no longer so terrified of being disregarded and hence no longer need to rely so heavily upon such explosive outbursts and such aggressive externalization and denial, then these children sometimes poignantly express their belief that they do not have much that would engage and sustain another's attention. After many months of treatment, Sean was able to share that he thought his therapist must find their sessions boring. He wondered if his therapist would rather not attend. At a similar stage of treatment, Tod fantasized that a (toy) pistol belonged to a therapist who, having grown tired of his patient, shot him.

These undefended expressions of the sadly disregarded self may occur in the transference relationship, as in the previous two examples, or in more open admissions of how the child feels in relation to others, especially parents. Nanette, a child from a severely disorganized, multiproblem family, began to realize that whether or not her family came to visit her for Christmas, it was not going to be the warm festive, family time she longed for. Becoming very despondent, she shared with her therapist her feeling that she was not even a person. She felt more like a chair—dumb and rotten. (In contrast, when her externalizing defenses were more in command, Nanette could assume the role of the disregarding parent, telling her therapist in the deep gruff, intimidating voice of her alcoholic father, "You do not exist! I do not hear you!")

CONCLUDING REMARKS ON TREATMENT

Conceptualizing the pathology of hyperaggressive children in terms of underlying narcissistic vulnerability has implications for treatment. Some of these have been discussed in the preceding sections. At this point I touch upon a few general considerations.

The first requirement for treating these children is related to their fear that they cannot engage and sustain the loving attention of those who are supposed to be looking after them. To help them feel that they are not unwanted, unloved, and uncared for, they need a therapeutic milieu that can meet their basic emotional needs in a way that did not happen in their earlier development. In such a "good enough holding environment" (Winnicott, 1965) the child may gradually begin to feel that he belongs and that he will not be dropped in disinterest, disgust, or despair. Such a milieu is by no means easy to provide. The hyperaggressive child identifies with the power of his impulses and will direct their full, raw force at his new milieu and caretakers. His explosive manner of coping and defending constitutes his basic security and he will not readily abandon it. The therapeutic holding environment must be prepared to contain impulsive rampages and help channel them into more acceptable, adaptive modes (e.g., talking versus hitting).

The individual psychotherapist contributes to the healing of this early narcissistic wound by demonstrating serious concern for the patient, by being highly regular and reliable, by maintaining objectivity such that he does not respond to provocations with any form of retaliation, by keenly observing verbal and behavioral expressions and reflecting their meaning back to the patient in a sensitive manner which informs the patient that he is empathically unders' ɔd (often despite his vigorous attempts to the contrary), and that he is regarded as a basically worthwhile person. Thus, while the patient may be raining blows upon his therapist, the latter may interpret to the child that he is worried about his teacher being off sick and that he is afraid his therapist will also abandon him. Besides setting safe limits, the therapist consistently detects something understandable and natural in the child's behavior, no matter how chaotic or destructive it might be. Such factors as regularity and reliability are, of course, important with all patients, but they are especially important with these children who are so slow to form the idea that their therapist is genuinely interested in them, and so quick to discard it.

Sometimes child care workers dismiss children on the grounds that they are "merely seeking attention," especially if they are being bothersome and demanding. For hyperaggressive children, maintaining a sufficient and reliable supply of adult attention is, as we have seen, no "mere" matter. It feels as necessary as food and the two are sometimes experienced as interchangeable.

The terror of feeling that they do not matter is an overwhelming threat to the self which impels much of their pathology. They must reassure themselves that they do exist, that they are important. A child care worker's exasperation may be understandable, but it is necessary to transcend that reaction and ask why the child always seeks attention so persistently, or why he is after it so much on a particular day, week, or month. Although it may be desirable to teach the hyperaggressive child more acceptable ways of soliciting attention, attempting to extinguish such behavior by simply disregarding it is likely to be countertherapeutic. "Benign neglect" is liable to be misinterpreted as not caring, or as hostile disregard.

A closely communicating, multidisciplinary, residential treatment team approach can be an effective means for engaging and sustaining the child's investment in the treatment process. When, for example, the child enters a phase of intensely negative transference and resistance in his relationship with his psychotherapist, he may continue to have a strongly positive, relatively conflict-free relationship with his nurse or care worker. These other team members, united in their commitment to the importance of all facets of the total treatment plan, can use their influence to keep the child attending therapy, counteracting his devaluations, and challenging his avoidance, externalizations, and so on.

The preceding discussion of treatment has concentrated upon matters pertaining to the disregarded self. Crucial as these issues are, they do not, of course, constitute all that is important for treating hyperaggressive children. In a forthcoming paper I will discuss a second major facet of narcissistic vulnerability which will permit a more comprehensive discussion of therapeutic issues.

REFERENCES

Aichhorn, A. (1935). *Wayward youth.* New York: Viking.

Aleksandrowicz, M. K., & Aleksandrowicz, D. R. (1976). Precursors of ego in neonates: Factor analysis of Brazeleton Scale data. *Journal of the American Academy of Child Psychiatry, 15*(2), 257–268.

Bahn, A. K., Chandler, C. A., & Eisenberg, L. (1961, March). *Patient characteristics related to services in psychiatric clinics for children.* Paper presented at the 38th Annual Convention of the American Orthopsychiatric Association.

Bandura, A., & Walters, R. H. (1958). Dependency conflicts in aggressive delinquents. *Journal of Social Issues, 14,* 52–65.

Bell, R. Q. (1968). A reinterpretation of the direction of effects in studies of socialization. *Psychological Review, 75,* 81–95.

Berman, A., & Siegal, A. (1976). A neuropsychological approach to the aetiology, prevention, and treatment of juvenile delinquency. In A. Davids (Ed.), *Child personality and psychopathology: Current topics* (Vol. 3, pp. 259–294). New York: Wiley.

Berman, S. (1964). Techniques of treatment of a form of juvenile delinquency, the antisocial character disorder. *Journal of the American Academy of Child Psychiatry, 3,* 24–52.

Deutsch, M. P. (1964). The disadvantaged child and the learning process. In F. Reissman, J. Cohen, & A. Pearl (Eds.), *Mental health of the poor* (pp. 172–187). New York: The Free Press.

Ellison, R. (1947). *Invisibile man.* New York: Random House.

Emanuel, J. (1977). Student-teacher interaction in an urban school. In M. C. Nelson (Ed.), *The narcissistic condition: A fact of our lives and times* (pp. 66–73). New York: Human Sciences Press.

Eysenck, H. J. (1952). *The scientific study of personality.* London: Routledge & Kegan Paul.

Eysenck, H. J. (1964). *Crime and personality.* Boston: Houghton Mifflin.

Field, M. (1940). Maternal attitudes found in 25 cases of children with primary behavior disorders. *American Journal of Orthopsychiatry, 10,* 293–311.

Forest, T. (1967). The paternal roots of character development. *Psychoanalytic Review, 54,* 81–99.

Franks, C. M. (1956). Recidivism, psychopathy and personality. *British Journal of Delinquency, 6*(3), 192–201.

Fries, M., & Wolf, P. (1953). Some hypotheses on the role of the congenital activity type in personality development. *Psychoanalytic Study of the Child, 8,* 48–62.

Fromm, E. (1965). The application of humanistic psychoanalysis to Marx's theory. In *Socialist humanism: An international symposium* (pp. 207–222). Garden City, NY: Doubleday.

Glover, E. (1960). *The roots of crime* (Selected Papers on Psychoanalysis, Vol. 2). New York: International Universities Press.

Gordone, C. (1969). *No place to be somebody: A black, black comedy in three acts.* Indianapolis: Bobbs-Merrill.

Graham, P., Rutter, M., & George, S. (1973). Temperamental characteristics as predictors of behavior disorders in children. *American Journal of Orthopsychiatry, 43*(9), 328–339.

Hamblin, R. L., Buckholdt, D, Ferritor, D., Kozloff, M., & Blackwell, L. (1971). *The humanization processes: A social, behavioral analysis of children's problems.* New York: Wiley.

Hare, R. D. (1968). Psychopathic behavior: A bibliography. *Excerpta Criminologica, 1,* 365–386.

Henry, J. (1966). White people's time, colored people's time. In J. L. Frost & G. R. Hawkes (Eds.), *The disadvantage child: Issues and innovations* (pp. 394–99). Boston: Houghton Mifflin.

Herndon, J. (1965). *The way it spozed to be.* New York: Simon and Schuster.

Karpman, B. (Ed.). (1959). *Symposia on Child and Juvenile Delinquency: Presented at the American Orthopsychiatric Association.* Washington: Psychodynamic Monograph Series.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Aronson.

Kitchener, H., Sweet, B., & Citrin, E. (1961). Problems in the treatment of impulse disorder in children in a residential setting. *Psychiatry, 24,* 347–354.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* New York: International Universities Press.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Krug, O., Haward, H., & Crumpacker, B. (1951). Intensive residential treatment of a nine year old girl with an aggressive behavior disorder, petit mal epilepsy and enuresis. In G. E. Gardner (Ed.) *Case studies in childhood emotional disabilities* (Vol. 1, pp. 155–177). New York: American Orthopsychiatric Association.

Lander, J. (1941). Traumatic factors in the background of 116 delinquent boys. *American Journal of Orthopsychiatry, 11,* 150–156.

Levitt, E. E. (1971). Research on psychotherapy with children. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 474–494). New York: Wiley.

Lewis, D. O., Balla, D., Lewis, M., & Gore, R. (1975). The treatment of adopted versus neglected delinquent children in court: A problem of reciprocal attachment? *American Journal of Psychiatry, 132*(2), 142–145.

Makkay, E. S., & Schwaab, E. H. (1962). Some problems in the differential diagnosis of antisocial character disorders in early latency. *Journal of the American Academy of Child Psychiatry, 1,* 414–430.

Mednick, S. A., & Hutchings, B. (1978). Genetic and psychophysiological factors in asocial behavior. *Journal of the American Academy of Child Psychiatry, 17*(2), 209–223.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy.* New York: Atherton Press.

Michaels, J. J. (1955). *Disorders of character: Persistent enuresis, juvenile delinquency, and psychopathic personality.* Springfield, IL: Thomas.

Minuchin, S., Montalvo, B., Guerney, B., Jr., Roseman, B., & Schumer, F. (1967). *Families of the slums: An exploration of their structure and treatment.* New York: Basic Books.

Minuchin, S., Chamberlain, P., & Grauband, P. (1971). A project to teach learning skills to disturbed, delinquent children. In E. M. Bower (Ed.), *Orthopsychiatry and education* (pp. 257–271). Detroit: Wayne State University Press.

Moynihan, D. P. (1965). *The Negro family: The case for national action* (L1.2:N31/3). Washington, DC: U.S. Government Printing Office.

Pavenstedt, E. (1965). A comparison of the child-rearing environment of upper-lower and very low-lower class families. *American Journal of Orthopsychiatry, 35,* 89–98.

Pavenstedt, E. (Ed.). (1967). *The drifters: Children of disorganized lower-class families.* Boston: Little, Brown.

Quay, H. C. (1965). Psychopathic personality as pathological stimulation-seeking. *American Journal of Psychiatry, 122,* 180–183.

Redl, F., & Wineman, D. (1951). *Children who hate: The disorganization and breakdown of behavior controls.* New York: Free Press.

Reitsman-Street, M., Offord, D., Finch, I., & Dummitt, G. (1984). *Comparison of antisocial youth and their non-antisocial siblings.* Unpublished manuscript.

Rutter, M., Korn, S., & Birch, H. (1963). Genetic and environmental factors in the development of "primary reaction patterns." *British Journal of Social and Clinical Psychology, 2,* 161–173.

Scheflen, A. E. (1970). Living space in an urban ghetto. *Family Process, 10*(4), 429–450.

Soddy, K. (1960). *Clinical child psychiatry.* London: Bailliere, Tindall, and Cox.

Sontag, L. W. (1959). Defenses in delinquent behavior. In B. Karpman (Ed.), *Symposia on child and juvenile delinquency* (pp. 233–239). Presented at the American Orthopsychiatric Association. Washington: Psychodynamic Monograph Series.

Stott, D. H., Marston, N. C., & Neill, S. J. (1975). *Taxonomy of behavior disturbance.* London: University of London Press.

Teuber, H. L., & Powers, E. (1953). Evaluating therapy in a delinquency prevention program. *Psychiatric Treatment, 21,* 138–147.

Thomas, A., Chess, S., & Birch, H. G. (1967). Findings of an anterospective study. *Journal of the American Academy of Child Psychiatry, 6,* 321–332.

Thomas, A., Chess, S., & Birch H. G. (1968). *Temperament and behavior disorders in children.* New York University Press.

Tooley, K. (1974). Words, actions and 'acting out': Their role in the pathology of violent children. *International Review of Psychoanalysis, 1* 341–351.

Tooley, K. (1976). Antisocial behavior and social alienation post divorce: The "man of the house" and his mother. *American Journal of Orthopsychiatry, 46*(1), 33–42.

Winnicott, D. W. (1958a). Hate in the counter-transference. In *Collected papers: Through paediatrics to psychoanalysis.* New York: Basic Books (Originally published, 1947)

Winnicott, D. W. (1958b). The antisocial tendency. In *Collected papers: Through paediatrics to psychoanalysis.* New York: Basic Books, (Original work published 1956)

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment.* London: Hogarth.