

The Devalued (Unloved, Repugnant) Self – A Second Facet of Narcissistic Vulnerability in the Aggressive, Conduct-Disordered Child

Brent Willock, Ph.D.
C. M. Hincks Treatment Centre

The concept of the devalued self complements a previous presentation concerning another fundamental facet of narcissistic vulnerability that I termed the *disregarded self*. Whereas the disregarded self reflects the child's fear that others simply do not care about him, the devalued self reflects his belief that there is something grossly repugnant about him that makes people reject and abandon him in disgust. Much of the conduct-disordered child's antisocial behavior and character stance can be understood as an attempt to cope with and defend against the hurt, the anger, and the anxiety associated with these aspects of self-structure, these feelings of being unloved and unlovable. Manifestations of, and defenses against, the devalued self are discussed, primarily in terms of how they can be observed during the course of intensive treatment. Implications of the concept for individual psychotherapy and milieu treatment are discussed.

This is the second report from a clinical investigation into the nature of the psychopathology of hyperaggressive children. Notorious for being exceptionally difficult to treat, these children have led many to conclude that they are simply beyond the reach of psychotherapeutic intervention, at least until we have developed a better understanding of their disorder. The aim of this investigation was to increase our knowledge of these disturbances and to try to formulate any new insights which might emerge in such a way that they could be readily applied in clinical situations. The findings are based on a detailed review of several cases treated by me and my colleagues in a long-term, psychoanalytically oriented, residential treatment center. The results of this

investigation should also prove relevant to professionals working with similar, perhaps somewhat less disturbed youngsters in other settings.

A previous presentation (Willock, 1986) proposed that much of the violent behavior of hyperaggressive children can be understood in terms of narcissistic vulnerability. That article focussed on a facet of core vulnerability, which I called the *disregarded* (unloved, uncared for) *self*. The disregarded self reflects the child's feeling that no one really cares about him. It represents a profound disturbance in the fundamental sense of valued connectedness with important others, in the sense that it deeply matters to someone whether one comes or goes, lives or dies, thrives or perishes. Because of hypersensitivity in this area, the hyperaggressive child is constantly on the lookout for hints of not caring in those who are supposedly looking after him. If there is any ambiguity, he is likely to grossly misinterpret it as indicative of total noncaring, whereupon he reacts with instant alarm and aggression.

Beyond feeling unimportant, unappreciated, and unloved (i.e., disregarded) these children have also come to believe that there is something essentially unloveable about themselves. They fear that others will regard them not merely as worthless, but as utterly repulsive. It can be difficult to convey with abstract, experience-distant terms just how terribly these children feel about themselves. In the course of intensive treatment, however, the children themselves eventually reveal in graphically explicit terms the degree to which their self-images are debased.

Sam let a child care worker he had come to trust have a glimpse of how badly he felt about himself when he told him that his (Sam's) head was "lined with shit."

Deep down these children not only believe that they are worthless, but they are also convinced that they are full of, and even overflowing with, repugnant badness. On a basic level, they seem to feel that there is nothing right about themselves, that just about everything they do comes out wrong, that every expression of their inner nature is likely to be awful. This abysmally negative self-image, this feeling that there is something about them which makes people turn away in disgust, constitutes a second fundamental facet of narcissistic vulnerability. It is this aspect of their problem of self-regard that is referred to in this article as the *devalued self*.

This facet of self-structure is closely related to the previously described concern about not being able to engage and sustain the attention of significant others (the disregarded self). Sometimes the devalued self appears to be the less threatening component of narcissistic vulnerability in that the child may feel that he is at least in some kind of a relationship, even though it is an awful, devaluing one, or one in which he has considerable negative value. He may feel hated and abused, but this may be considered preferable to feeling that he is regarded with indifference, almost as if he does not exist, or as if his

existence does not matter. The distinction between these two aspects of narcissistic vulnerability is analogous to the adage that the opposite of love is indifference rather than hate. It also relates to the frequently described “paradox” that abused children often prefer to remain in their homes rather than be placed elsewhere, as if they believe that sticking with the bad relationship that they know and can be sure of is better than risking not being able to establish any substitutive relationship.

The language of hyperaggressive children is frequently profane. No attempt has been made in this presentation to lessen its extremity. The aim has been to present them as they are. Those who have worked in residential treatment centers will scarcely be shocked by the rawness of the words and images. For others, there may be some “culture shock.” If one tried to avoid such reactions, however (by merely saying the child had a poor self-concept, engaged in much cursing, etc.) the reader would not likely understand how these children really feel about themselves and their worlds. Such an approach would be as misleading as to simply describe them as aggressive, as if they were merely a variant of the ambitious, driven, Type A personality (Friedman & Rosenman, 1974) rather than making it clear that the term *aggressive*, when applied to these youngsters, means that in working with them one is in danger of being hit on the head with one’s dictaphone or anything else that can be hurled across a room and that one may frequently have to struggle to restrain an upset child — that is, a biting, spitting, hitting, kicking, scratching, hair-pulling child — lest he destroy everything in one’s office. Because forewarned is forearmed, it seems best to “tell it like it is.”

It might also be helpful to bear in mind that these children resort to crude language for several reasons. Most relevant to this presentation is the consideration that they have extremely devalued images of themselves, and the language that a child must use to articulate such a degraded self-concept is almost necessarily as crude, ugly, and repugnant as the self-image itself.

Detailed discussion of the origins of the devalued self would exceed the scope of this article. As there is some overlap with the variables contributing to the formation of the disregarded self, interested readers might consult the literature review in Willock (1986), which emphasized the importance of a multidimensional perspective.

TREATMENT

Defenses Against the Experience of the Devalued Self

When the importance of the aggressive child’s narcissistic vulnerability is recognized, much of his antisocial behavior and character stance can be understood as an attempt to ward off awareness of feelings of being unloved

and unloveable (disregarded and devalued). The aggressive, characterological defenses—such prominent features in the self-presentation of these children—make it difficult to tolerate, let alone care for them. Understanding that their conduct disorder is not simply thoughtless aggression against the world, but that it also represents a desperate attempt to avoid being in touch with the unbearably devalued self, can help one to maintain necessary empathic interest.

To cope with the hurt and angry belief that nobody really cares about them (the disregarded self) hyperaggressive children may communicate in word and deed that they do not care about anybody either. To stave off wounded feelings emanating from the conviction that others only see them in a negative light (the devalued self) they erect a thick wall of denial. They proclaim that they do not care what others think about them and act as if they themselves are not concerned about how they behave. Through their intolerable behavior they may act out a fantasy that reverses their intolerable feeling about themselves. For example, they may treat others in a grossly disrespectful, devaluing manner.

Their profanity can sometimes be understood in relation to these defensive needs. At rare moments, they may wax scatological in describing themselves, but more characteristically, they spew such vilification onto others, trying to make them feel like the degraded ones to reassure themselves that they are the abusers rather than the abused. Their profanity also reflects their commitment to defying adult rules and values, part and parcel of the “tough guy,” “I don’t care what you think” facade.

Sean liked to fantasize that he possessed “fart rays” which could destroy the world. His motive seemed to be the defensive wish to “turn a bad thing into a good one” by identifying with a powerful image of repulsive smelliness which he imagined drove people away from him. This way he could pretend he was willfully in control of his isolation, rather than feeling he was the helpless victim of others’ rejection.

Hyperaggressive children seem to feel it is better to be regarded as real “stinkers” (willfully bad) than to risk feeling that people reject them for being inherently “yucky” and undesirable. Believing their possibilities to be awfully limited, they may prefer to actively assume the role of the “asshole” who treats others “like shit” rather than having the passive experience of being rejected like unwanted excrement.

To protect themselves against their yearnings for adult approval, aggressive children may adopt negative identities (Erikson, 1959) reinforcing the solidity of these roles by joining forces with other alienated youngsters. The supreme value of the gang may be defiance of the traditional values of the respectable adult world (Redl & Wineman, 1951). They may flaunt their de-

linquent exploits in front of their therapists to demonstrate how little they care about their therapists' positive regard.

Tod informed his therapist of "how sweet it was" when he and another member of the "Junior Mafia" beat up a patient. What they found particularly offensive about the other boy was his "special relationship" with the teacher. At a less defensive moment, Tod explained that "getting a kid" or "kicking someone's ass" was just like beating them at pool. It is to show them that you are better than they are. Underlining the crucial significance that he attached to such defensive operations, he added that, "Kids have to keep proving how good they are in order to survive." Evidently, he felt that unless the debilitating impact of the devalued self was counteracted in a most aggressive manner, the very core of his psychological self would be destroyed.

The flaunting of "potent" delinquent identities relates to another defense that aggressive children sometimes use to deny low self-esteem, namely inflating their self-images with defensive grandiosity (Kohut, 1971) and parading them loudly.

When Brian, a feisty black child, was feeling badly about himself, he often marched around his white therapist in a vaguely menacing manner, proclaiming himself to the "Super Black." Sometimes he topped off this performance by putting his chair on top of the treatment room desk, challenging his therapist from what he referred to as his "throne."

Another defense used to avoid negative feelings and self-images associated with the devalued self is externalization.

With one patient whose mother was a prostitute, work on the devalued self began when he started cursing his therapist as "a no good, god-damn, son of a prostitute." The specificity of his insults made it relatively easy to begin dealing with them as externalizations of his despised self-image.

From the preceding account, it is apparent that we are dealing not just with a deficit in psychic structure but also the presence of a structure in the psyche that impels much of the pathological acting out. Treatment must address both sides of this problem. The therapeutic regimen must provide experiences that are not overwhelming and impossible to master but rather are self-affirming and structure building. Therapy must also concern itself with defense analysis, helping the child to face, understand, and ultimately transcend the devalued self, rather than continuing to manage it with denial, externalization, and acting out.

The facet of narcissistic vulnerability we are discussing reflects a primitive,

internalized, object relational paradigm – a grossly debased image of self in relation to a nonsupportive, unloving, devaluing object. The term *devalued self* seems to capture the essence of this phenomenon fairly well, conveying the idea that it is something within themselves and about themselves which these children bring to current relationships and tasks that leads to so much difficulty. The term also suggests that at some level, these children identify considerably with these devalued self-representations despite the fact that they struggle so vigorously against experiencing them. Indeed, the intensity of their repudiation of these self-representations bespeaks their underlying, conflictual identification with them. In this sense, the devalued self can also be said to reflect a primitive superego precursor phenomenon.

The theoretical underpinnings for the formulations in this article derive from three of the main streams currently prominent in psychoanalysis: traditional ego psychology (e.g., Jacobson, 1964; Redl & Wineman, 1951, 1952), self psychology (e.g., Kohut, 1971) and object relations theory (e.g., Fairbairn, 1954; Guntrip, 1961; Kernberg, 1975; Winnicott, 1958).

Countertransference and Technique in Relation to the Aggressive, Acting-Out Defenses Against the Devalued Self

The constant stream of obnoxious misbehavior designed to ward off the debilitating impact of the devalued self can stimulate extremely difficult countertransference reactions. Therapists can feel so unappreciated, devalued, discouraged, and angry that it becomes difficult to regard these youngsters as other than sources of grief. If the therapist perceives a devalued self through all the behavioral and affective turbulence, he is more likely to locate this construct in himself rather than within the patient. The therapist is likely to feel defeated, impotent, and demoralized, while the patient goes obliviously about his business, defying, destroying, and denying.

In terms of defense, this outcome is consonant with the child's aims. Despite the fact that this defensive strategy is, in certain regards, highly effective, it simultaneously compounds the child's difficulties. Oppositional, anti-social behavior makes it hard for therapists and other members of the treatment team not to develop an increasingly negative view of these patients, frequently leading them to discharge these obstreperous youngsters from treatment in frustration, anger, and despair.

To avoid becoming totally enmeshed in such transference/countertransference binds, it is helpful to challenge the child's defensive defiance. For example, the child may be totally convincing in his loud insistence that he doesn't "give a damn" about some serious misdeed he has committed, to the point that the therapist may believe the remorseless child completely lacks the third component of psychic structure (superego). It is, nevertheless, better

for the therapist to assume otherwise and say, "You certainly seem to be trying to act like you don't care, but deep down I think you really do." The child will either not challenge this interpretation, or he will redouble his noisy denial of its validity. In the latter case, it behooves the therapist to stick to his or her guns: "I think you protest so loudly because you feel it would be losing face to admit you care." The therapist thereby shows that he perceives a better, more lovable aspect of self at the very moment when the child is showing his worst face and insisting that's all there is. The insistent denial is interpreted as a defense against underlying narcissistic vulnerability.

Such interpretations are important for creating a therapeutic alliance. In their absence, the child is left after these defiant, remorseless interactions with a more ingrained feeling that he really is just a hopeless, unlovable outlaw. Such confrontative, yet self-affirming interpretations are important not only for psychotherapists but also for teachers, child care workers, and others who are at least as vulnerable as therapists to becoming trapped in their countertransference reactions to these provocative youngsters.

In order to maintain a positive attitude towards the patient, it is important for therapists (and other members of the treatment team) to share the rare insights they gain into the meaning of the child's behavior. Self-reflection is not an area of ego strength in these patients. They are much more oriented to action than to introspective verbalization, and it is easy for staff to forget that these children have any such capacities unless they communicate regularly with each other, particularly about any soft signs they may detect in the otherwise seemingly impenetrable character armor. If Tod's therapist, for example, shared some of the dynamics underlying the bullying behavior of Tod's "Junior Mafia" (e.g., the devalued self envying other children's success or valued relations to adults) then the staff who worked with Tod and other members of the gang might have been able to better understand and empathize with their patients' underlying feelings. Otherwise, it is all too easy for staff to see these children in a one-dimensional, devalued manner, as nothing but despicable little hoodlums. When the therapist can help other staff see a more complex picture of the patient that includes some ordinary human reactions (e.g., jealousy, envy), staff can then identify more easily with the patient's psychological dilemma and focus on helping the child to learn better ways of dealing with emotional situations that are difficult for him. This is quite a different perspective from merely striving to manage difficult behavior. The alternative appears to be the not uncommon endpoint of seeing the child as an incorrigible psychopath who needs to be incarcerated and treated with harsh punishment, although there is not much ground for believing that even more negative reinforcement than has already been applied will have greater success in extinguishing undesirable behavior.

The psychoanalytically oriented psychotherapist, as consultant, leader, or simply member of the multidisciplinary treatment team, is in a particularly

advantageous position for acquiring and sharing insights into the dynamics, defenses, self-structure, and predictable countertransference reactions to aggressive, conduct-disordered children. Psychoanalytic theory helps one maintain perspective, an appropriate psychological distance, and, perhaps most important, helps one recover from inappropriate losses of distance (e.g., overwhelming countertransference reactions) provoked by the patient's acting out. Others may not have such well-developed theory to draw on and may, therefore, welcome the psychotherapists' sharing his or her perspective.

Theoretical insights can also be useful to team members to help them maintain interest in the child, his behavior, and his progress (with its inevitable ups and downs). Maintaining interest is not a trivial matter either, for waning interest is apt to stimulate the disregrated and devalued self and is, therefore, liable to be experienced by the child as abandonment or hostile rejection, thereby provoking increased acting out, increased negative counterreactions in staff, and so on, in a vicious circle that decreases the likelihood of a positive outcome.

More Open Manifestations of the Devalued Self During Intensive Treatment

Children may give hints of the despised self in beginning psychotherapy sessions during a brief "honeymoon" phase of relatively civil relatedness.

Sean drew a picture of a car during his first appointment. (After a few sessions, it was more characteristic of him to demolish things, curse, and spit at his therapist rather than to engage in such settled activity.) He claimed he did not like his product because it was skinny and long, and the way he wrote the letters on it was ugly. His therapist commented that Sean wanted to write and draw well and did not like it if his work was not good. Perhaps fearing that the therapist was in thorough agreement with his own negative assessment, Sean quickly retorted in a belligerent tone that he did not care what others said about his writing.

Sean's concern about what his therapist might think of him continued in the second session when he asked if his therapist liked fishing. The therapist wondered why this was important to him. Sean replied that if his therapist did not like fishing, then Sean wouldn't like him. When questioned about this reasoning, Sean clarified, "I wouldn't like you if you didn't like fishing. . . . No, only if you considered fishing gross, disgusting, and stupid." Sean evidently worried that if he revealed what was meaningful to him, important people would consider *him* to be gross, disgusting, and stupid, and would turn away with revulsion and contempt.

Even after the child has come to believe that at least some therapeutic personnel do care about him, at least to some extent, it is still difficult for him to relax his hypervigilant defensiveness and related hyper-offensiveness as would be necessary to progress. Even though his relationships with some staff may seem all right, he fears this is more appearance than reality. If they were not being paid to put up with him, he believes, they would probably wash their hands of him in an instant. The relationship does not feel like anything he can count on, and could probably never get any deeper. He is convinced that if he were to want something more, or if he let down his guard and revealed his true self, he would be rejected totally.

This frightening belief is poignantly illustrated by an incident from Sam's treatment. For several months Sam and his primary staff¹ had been building a positive relationship. In psychotherapy, Sam, like most hyperaggressive children, was not talkative. One day he blurted out, "Scumbag! Fucker!" When his therapist asked what this was about, Sam replied that this is what his primary calls him. The therapist expressed surprise. Sam conceded that his primary hadn't actually called him that, but only because he would get fired if he did. In this manner, Sam communicated the fantasy weighing on his mind, namely that the person he liked most, whose love and respect he most wanted, must regard him as worthless and disgusting.

Such fantasies of gross devaluation make it difficult for these children to dare to even want to establish trusting relationships, although Sam, for one, seemed to be using psychotherapy to begin working on these debilitating fantasies. Therapists must be ready to make the most of these references to the devalued self for they may be few and far between and more characteristically buried beneath a wall of denial, externalization, and acting out.

The devalued self and the defenses against it are readily evoked by any experience that touches on "abandonment." Just what constitutes a threat of rejection and abandonment might seem incredulous to anyone without an understanding of the narcissistic hypersensitivity of these children. An experience that might contain an element of loss or disappointment, and hence, might by stretching one's imagination seem like a minor slight, can evoke in these children a profound experience of rejection and devaluation. These abandonment reactions are similar to those discussed in connection with the disregarded self (Willock, 1986) though here the emphasis is on the child's perception that the adult turns away in disgust rather than indifference.

¹"Primary staff" means the child care worker responsible for Sam (and one other patient). For a description of this staffing system see Kutchinski (1977) and Nagera (1981).

In the latter part of Brian's treatment, when some cracks were beginning to appear in his hyperaggressive defensiveness, his mother brought him back late from a pass and interfered in other ways such that he missed two therapy sessions in a row. When Brian's therapist met him, Brian refused to go to the treatment room, barricading himself in the bathroom instead. He claimed he hated his therapist and never wanted to see him again. His therapist suggested that the missed sessions had led Brian to wonder whether his therapist liked him, and that this had caused him to feel badly about himself. Brian was finally able to stop his defensive barrage and reveal the extremely awful feelings about himself that had been stirred up. Typical of hyperaggressive children, he conveyed his experience in an action mode. Sitting on the toilet, he pulled a large trash bag over himself, then flushed the toilet a couple of times, dramatically portraying his image of himself as trash, fecal matter which people would want to flush down to the sewers where he was sure they felt he belonged. This vignette also brings home the point that terms like *low self-esteem* and *poor self-concept* scarcely suggest how narcissistically vulnerable and grossly debased the self-images of these children actually are.

Other concerns besides abandonment can also evoke the degraded self-image and the need to externalize it.

Sean asked his therapist if he had checked into getting a model from the lady in charge of ordering toys. When his therapist replied that he had not done so yet, Sean told him that he (the therapist) was "ugly like a dog" and also a "fucker." Later he called him "shit." At first glance, one might simply regard these insults as expressions of angry frustration. They can, however, also be seen to refer to Sean's despised self-image and to his fantasy that his therapist had not tried to get him a model because he saw him as too repulsive a child to do anything nice for. Sean's play subsequent to these remarks (and the ego state that it reflected) supports this interpretation of the self-referent nature of his grossly derogatory comments. As he tried to construct a truck, it kept falling apart, leading him to describe his effort as "shit on display," which everyone could smell. His comments about his truck point to a corresponding image of himself as one who can only make a mess and is basically a smelly mess that repulses everyone. Far from getting a new model for such a child, people would not even be inclined to give him the time of day.

Further Aspects of Therapeutic Technique

Although the aggressive child's attempts to externalize negative self-representations are frequently transparent and can scarcely be denied by the

child when pointed out, the proximity to consciousness should not be seen as indicative of ability to tolerate such awareness. The therapist should phrase interpretations in such a way that the patient has no grounds for distorting the communication to support his fear that the therapist agrees with his negative self-evaluation.

Tod called his therapist a “damn bum” and commented on how fortunate he was not to have had sessions the previous week when his therapist was out of town. The therapist reflected that it was hard for Tod to say that he missed him. This interpretation led Tod to cease his externalization attempts and he began cursing himself as a damn bum. He added that he also farts like a dirty pig and continued calling himself a “low bum,” emphasizing that he didn’t just think this was so—he knew it was. The failure of his flimsy attempt at externalizing his debased sense of himself, which apparently had been evoked by the therapist’s absence during the previous week, soon led to increasingly aggressive acting out because Tod was unable to tolerate the painful awareness of such a degraded sense of himself. He pounded the window screen, threw things, stomped on an ashtray, then bolted from the room, flailing frantically at a member of the staff who tried to restrain and settle him.

Knowing that the severity of the aggressive conduct disorder is more or less proportional to the severity of the underlying images of the devalued (and disregarded) self, one might have proceeded a little differently. Realizing that feelings of abandonment are likely to arouse the devalued self and that this dreaded experience is beyond the child’s capacity to bear, the therapist might have interpreted less directly. Knowing that anger, externalization, abuse, and devaluation of others constitute desperate attempts to maintain ego cohesion in the face of the threat of the debilitating impact of the devalued self, the therapist might have focussed more on how angry the child was at the therapist (narcissistic rage), proceeding to suggest he might be angry at the therapist for having missed two sessions, and that he may have felt the therapist’s going away reflected a nasty, self-centered, uncaring attitude. Only after such preliminary, desensitizing dialogue respecting the child’s defensive needs, would the therapist begin to broach the more sensitive issues of the child missing the therapist, fearing perhaps the therapist did not like him, in fact, feeling certain he dislikes him intensely, and finding all this hard to talk about.

The preceding considerations are not meant to suggest that if only therapists of aggressive children were perfectly empathic masters of impeccable technique, then psychotherapy would proceed smoothly, without horrendous outbursts. Conversely, the presence of explosive tantrums should not be taken as an obvious sign of therapeutic incompetence, or as an indication that therapy is not going well. Violent outbursts are not just a sign of decom-

pensation, a breakdown product, but also reflect a preferred mode of defense against what would otherwise be felt as a more dangerous submission to the destructive impact of the devalued self. Violent acting out is a tried and true coping device in the repertoire of these patients and one can expect that it will be brought into therapy.

On the other hand, one would not want to underestimate the importance of the therapist seeking supervision or engaging in ongoing self-supervision, submitting all such crucial sessions to a critique aimed at understanding the meaning of the material and considering how there might have been empathic or technical "failures" on the part of the therapist. The therapist is then in a position in following sessions to carefully bring the matter up, perhaps acknowledging possible errors on his part, endeavoring to learn more about the patient's vulnerabilities through this exploration. Such exploration needs to be done tactfully, respecting the patient's exquisite vulnerability. Otherwise, at the mere mention of the previous session, the child may storm out of the room.

One might describe this as "uncovering" psychotherapy insofar as the child would strongly prefer to bury that previous session under a thick layer of avoidance, denial, and other defensive processes. The therapist challenges, indeed threatens, the child's preferred defenses, and the child will fear that he is going to be left wide open to further trauma. The child will, therefore, need much ego support. Otherwise, he will feel he is being sadistically attacked (e.g., "You just want to get me all upset again! You damn therapists just love to ruin kids' days!"). While "attacking" the child's defenses, the therapist must provide empathic support to help contain the child's anxiety and counteract his paranoid fears of the therapist's intent.

The therapist encourages the child to lay down his aggressive defenses, to engage in an exploration of new psychic terrain. If the child can, he will ultimately be able to exchange his defensive weapons for new psychological skills and functions that will have an overall ego strengthening effect. At this stage, there is no aim to uncover infantile origins of current manifestations of psychopathology. There is more than enough for therapist and patient to work at on the more "superficial," here and now level of day-to-day ego functioning. On the other hand, no attempt is made by the therapist to cover up underlying ego weakness. Much needs to be accomplished at this ego challenging/ego strengthening level before the child will have sufficient trust and motivation to be willing to look beyond current sources of distress and start to consider how events in his past may have influenced his feelings about himself and the world.

In light of these considerations, let us consider how a therapist might attempt to explore an upsetting incident from a previous session with a patient. After establishing some rapport, perhaps by discussing some nonconflictual area of interest to the child, the therapist might ask if the child is feeling okay

and mention that he had been quite upset in the previous session. Depending on the child's reaction, the therapist might then be able to say, "I can understand if you'd rather not talk about that upsetting session, but would you mind if I asked one question (or said one thing) about it?" Even if the child refuses, the possibility of dialogue has been advanced. Later the therapist might say, "Perhaps I will ask you again tomorrow if we can talk a bit about what happened last session. I think we could learn some important things and I don't believe it would be so terribly upsetting to talk, even though I have a hunch you think just discussing it would make all those horrid feelings come right back. Would that be okay if I asked you next time?"

This may sound like a slow way to proceed. It is. One should not, however, lose sight of the fact that significant interpretations are nonetheless being made, even though the patient has not yet given permission to begin discussing the matter. The therapist has communicated that the incident was not trivial, that it should not be handled with collusive denial, and that he understands some of the patient's anxieties about discussing the incident, which are based partly on compelling but erroneous notions of concretistic word magic – the fear that talking about something will inevitably make it happen again. Thus, even at this early phase, there has probably been some empathy, respect, interpretation, and desensitization experienced by a child who is, in a sense, word phobic. Quite a lot has been accomplished despite the fact that at first glance it might have seemed as if therapist and patient were getting nowhere. Furthermore, the very capacity of the relationship to have survived and even in some ways to have benefited from what otherwise might merely have been experienced as yet another disastrous episode is important in keeping alive and developing the therapeutic alliance.

The Wish to be Valued

Despite vigorous denials, the hyperaggressive child's underlying longing to be appreciated and loved by a caregiving adult does not disappear. In treatment one can observe them daring to test out, in small ways at first, the trustworthiness of adults in this regard. Sometimes one sees indications of this longing in beginning sessions, along with worried hints of the unappreciated, devalued self.

In an early session, Sam shared his belief that he was not very good at drawing or singing. He also mentioned that his music teacher said he played the saxophone quite well. He wondered if his therapist could come hear him play in the band, even though he expected she had more important things to do.

Although therapists would not want to gratify all such wishes, there are times when it would not be inappropriate to occasionally do something like

Sam was requesting, particularly with some of the more severely disturbed members of this severely disturbed population.

Andy, a profoundly disturbed, hyperaggressive child, could not get along with anybody. Alienating everyone, he undoubtedly felt alienated himself. He resisted therapy to an extreme degree. When the patients put on a Christmas concert, Andy's parents were unable to attend. Despite his poor relationship with his therapist, which seemed to consist mostly of hatred, dread, and the need to oppose, it seemed very important to Andy that his therapist was able to be at the concert. After his group had performed their number, Andy could not resist dashing to the back of the auditorium where his therapist was sitting in order to make eye contact, receive a "well done" signal, then dash off.

At that point in therapy, it would have been impossible for Andy in the context of their regular sessions to acknowledge any positive feelings towards his therapist or any wishes for contact and approval. The type of group situation that the concert represented, however, made it acceptable, even irresistible, for him to permit this gratification and to see his therapist for a few moments in a manner far different from the usual, one dimensionally negative one. Such moments, although not analytic in any usual meaning of the term, can make more usual psychotherapy possible. They can counteract some of the intensity of an extremely negative, possibly unworkable transference, reducing it to a more containable level, gradually leading to a more viable therapeutic alliance.

With Sam, who could reveal his wish that his therapist come see him play the saxophone, actually doing so would probably be less significant than for the more disturbed Andy. Sam was much more verbal, more open to dialogue, in touch with his wish to be admired, and more trusting of his therapist. His longing and his fear of being disappointed could probably be handled on a verbal level or in some other way within the therapy session.

As therapy progresses, the longing to be valued and the fear of being devalued may be seen to pick up steam simultaneously.

This process was highlighted dramatically in Sean's treatment when, after a couple of months of therapy, he arrived with a model he had built. "How do you like my model boat?" he asked. "It's nice!" his therapist replied. "Is it a cargo or a war ship?" "Fuck you! Does it look like a cargo ship?" snarled Sean. The therapist was quick to assure Sean that he had not intended to be insulting, but for such a child such reassurance carries little weight. Stirred into a state of fight/flight arousal, he threatened to throw his model at the therapist. Ultimately, he smashed it against the wall, trashed the office, and stormed off. The ship, which had been his pride, lay shattered on the floor.

This incident illustrates the child's wish to be appreciated and also how hypersensitive and vulnerable his self-esteem is when he dares to seek some confirmation in the eyes of an esteemed person. Although longing to be valued, his overriding expectation is that he will be insulted. Hypervigilant for any hint that the person might not appreciate him or his works, if he finds any possible evidence of such devaluation, he immediately considers it a certainty, and reacts accordingly. Though Sean was ostensibly putting his model-building ability on the line, his narcissistic vulnerability was so great that the imagined negative evaluation of his ship spread instantly to a feeling of total self-worthlessness, as if the therapist had said the model was just more "shit on display" (see p. 228) and, for that matter, so was Sean. Given such a gross misinterpretation, Sean's outburst of narcissistic rage is understandable.

With such extremely sensitive self-esteem, such profound narcissistic vulnerability, the course of therapy for an aggressive child like Sean is likely to be long and rocky. When he begins to consider giving up his negative identity based on such grandiose, omnipotent fantasies as having fart rays that can destroy the world, desiring instead to be admired for producing a product requiring far more complex, real world, ego functioning, he enters into uncertain terrain where he feels terribly vulnerable. Somewhere in the past he has picked up the belief that significant others will consider him and his interests "gross, disgusting, and stupid." Unconsciously, he hopes that he has finally arrived in a better, less devaluing milieu where his defensive character armour will not be so necessary, where he can at last get some much needed aliment for his battered self. However, like a soldier just returning from the trauma of war, he cannot readily relax. He remains hypervigilant. Though he has laid down his weapons, they are nearby, just in case. Always fearing an attack, he is prone to seeing one where it does not exist, in the shadowy ambiguity of emotional responses that are not 110% clear. For Sean it was as if the therapist, in failing to say immediately, "Wow! What a fantastic warship!" was instead firing one of Sean's world destructive fart rays at him, threatening to annihilate his budding, new self. Instantly, to protect his exposed, vulnerable self, he grabbed his trusty armaments, transforming himself into an anal expulsive weapon of destruction. Nothing else mattered. The ship ceased to be a receptacle for admiring eyes and comments, and an extension of his admirable self. It became, instead, a bomb. If the therapist thought his ship was just more "shit on display," then he would display it on his therapist's face or wall. Once more the therapist's office looked like a battlefield, its period of existence as a showcase for the remarkable new achievements of an admirable new self having been all too brief.

Much skillful intervention and understanding will be necessary before a child like Sean will be willing to present not just a model ship but more model behavior, surrendering his characteristic battleship stance, his readiness to

fire missiles around the room and at his therapist, in exchange for more pleasant, trusting interaction with an adult who, he knows, likes and respects him. Gradually, however, as incidents like the cargo ship affair are worked through, the open wound of narcissistic vulnerability begins to heal and the explosive irritability decreases correspondingly. The therapist helps the child understand his feelings about himself in relation to others – his fears, his defenses – and he attempts to link this up with an historical understanding of how the child came to be so vulnerable and so angrily alienated. (More detailed exploration of this process would exceed the scope of this article but will be the subject of a future presentation.)

Role of the Therapeutic Milieu

For children whose degree of disturbance necessitates residential treatment, the residential milieu plays a crucial role in altering the child's devalued sense of self. Consistent, long-term relationships with child care workers and other members of the treatment team gradually challenge and undermine the child's conviction that no one can stand him for long. Sam, for example, who feared his primary staff secretly regarded him as a "scumbag," may not even have been aware prior to treatment that he harbored such a deep-seated conviction about himself, such certainty that important others would inevitably feel the same way about him. For Sam to become aware of his devalued self and to begin to share and explore these fears with his therapist, all within the context of a relationship with his primary staff and others that not only lasted but became increasingly significant, trustworthy, supportive, and rewarding, was a radically new, transforming experience. Conversely, in the many cases that end in premature discharge of the patient by a totally frustrated staff, the child's negative sense of himself in relation to others is unfortunately reinforced.

It is, of course, essential for staff, even when feeling frustrated and enraged, to refrain from totalizing, countertransference-based judgements (e.g., "You rotten, ungrateful little _____. You'll never amount to anything!"). Such forceful "confrontations" are sometimes felt to be just what the child needs to shape him up. However, if that were true, the child would already be in great shape from the many lectures and tirades he received prior to coming for treatment. Behind his obstreperous facade, the child already feels rotten and is convinced that he has no future. He does not need to have the message pounded into his head.

It is understandable that staff might fail to realize the nature of the child's intrapsychic situation because rather than telling them how awful he feels and how worried he is about their opinion of him, he is more likely to act in a manner that would suggest he does not care about anyone or anything. Nor is the caveat against devaluing judgements meant to imply that stern lectures

have no place in the treatment of destructive children. It may be quite appropriate to express one's concern and outrage about something the child has done (cf. Bettelheim, 1950). The point is to differentiate between the undesirable acts of the child and the total child—a distinction that the child's parents (and others) may not have made and that staff may repeat if they do not understand the nature of the child's psychopathology, self-structure, defenses, and character style.

Special education and activity therapy also play important roles in modifying the child's devalued sense of self. Because of their self-esteem problems, hyperaggressive children are unable to handle academic frustrations. Prior to treatment, they have typically acquired negative reputations in their schools. Overburdened teachers may have communicated in no uncertain terms that they were not and never would be welcome in their classrooms. These factors, combined with their aggressive, externalizing, defensive styles, typically lead them to hate school. In a small class in an intensive residential treatment program with a well-trained, sensitive teacher, their sense of themselves as learners can be turned around. Children who are convinced they are hopelessly "retarded" dummies can gradually become enthusiastic about school and about themselves as learners.

Tyrone, who used to inflate his devalued self-image with defensive grandiosity to boast of (imaginary) advanced academic feats, after long treatment took genuine pride in his new ability to operate a computer and to teach these skills to younger children in the hospital's school.

Similarly in recreation, their self-esteem problems, with the related low frustration tolerance and aggressive defensive style, often make them poor losers and poor team members. A skillful recreational therapist can do much to prevent and resolve play disruptions, helping the child gain a new sense of self in activities that have natural appeal for action-oriented children. From being feared and unwanted because of their explosive tempers, they can become athletically competent, admired team members. Pride in a new identity as part of an esteemed team is a vast improvement over previous gratifications derived from participation in violent, antisocial gangs, like Tod's "Junior Mafia" or Brian's periodic performance as the grandiose, vaguely menacing "Super Black."

Recall Tod's assertion that beating a kid up was just like beating a child at pool. Both activities showed Tod that he was the better person. Given Tod's equation, it would not be surprising to learn that children were not eager to play pool, or any other game, with him. Given his philosophy that "kids have to keep proving how good they are in order to survive," it would not be surprising to find him to be a fierce competitor, a horrendous loser who saw games more as a matter of life and death than as mere social fun.

A good recreational therapist can help a child contain his anxiety and ag-

gression and develop new attitudes towards group games, thereby helping him to sustain beneficial, modulated involvement in group activities. When this is supplemented by the psychotherapist (and others) helping the child feel less threatened by the underlying devalued self such that he does not have to be battling constantly against everyone or anything that might stimulate this pathological structure, then major progress can be made towards enabling the child to participate in a more relaxed, mutually gratifying manner. Recreation can become a vehicle for enhancing self-esteem, not just for warding off and triumphing over the devalued self and its projected representations.

When the child has progressed from viewing himself as a dummy and a poor team player to feeling he can succeed academically and be a highly regarded member of an esteemed team or other social group, a significant shift has occurred in the balance of valued versus devalued self-representations. The trouble the child used to encounter so frequently in these areas was due largely to the interference of the devalued self. Narcissistic injury in these important spheres of everyday functioning readily stimulated this powerful structure and the associated defenses. The child's new sense of a competent, likeable, even admirable self achieved through corrective emotional experiences in the therapeutic milieu helps counteract the influence of the core devalued self.

There is a mutually beneficial relationship between the progress achieved through working on the core devalued self in psychotherapy and the gains made in other areas, like special education or recreational therapy. Progress in any area facilitates progress in all others, largely through its positive impact on the balance between valued and devalued self-representations.

There is a similarly important relationship between all members of the treatment team. The child needs to know that each member values and supports the work of all others. There are times when the child devalues, abuses, or resists one member or activity when he needs to be confronted by other staff members. This may involve talking, imposing consequences, or interpreting. Such teamwork at critical points in treatment often enables the child to resume attending and benefitting from therapy, school, or whatever area he was avoiding. The team acts as parents ideally would, supporting each other as well as maintaining interest in their child's activities beyond their direct sphere of influence and supporting those adults responsible for their child in those areas. Such close cooperation between the significant adults in the child's life usually did not occur in the child's past.

The Transition Back to the Community

After the child has made substantial progress within the therapeutic milieu, he will need assistance to begin the transition back to the community. If he has become able to play team sports without explosive play disruptions, then

he may be ready to join, for example, a community baseball team. (Sports that encourage violent contact may be counterproductive, undermining recently acquired control of aggressive impulses.) If the child has developed some capacity for sublimatory pursuits, like building models without smashing them in frustration, then he might benefit from a model club at a community center like the Y, or from other organizations like the Boy Scouts.

Because the child now performs at a level so much higher than before, the treatment team may fail to realize that he still needs much support. Looking ahead optimistically, they may forget how much effort was required to enable the child to inch forward to this new level of functioning. They may prefer not to remember how many disappointing setbacks there were along the path of progress. They may also be encouraged not to "drag out" treatment in the face of institutional, ideological, or financially based goals of providing less lengthy, less intensive treatment.

There are grave dangers here. For the child to progress to community activities is not a simple step. For him there are many challenges and dangers out there. He has not forgotten the traumatic experiences he had in such activities in the community prior to treatment. Despite his enthusiasm to try his new wings and succeed, he is terrified he will fail. The situation is similar to when Sean took the big step of bringing his model to show his therapist, though hopefully, it is now less of a hair trigger situation, more modulated than in the past, due to the cumulative, structure building effects of long-term treatment. Nonetheless, though it may take a little longer, perhaps a few games or a few weeks in public school, the situation could still degenerate to a similar extent if the team does not provide the necessary support to enable the child to expand outward from his new, secure base to achieve more success experiences, and to consolidate his new sense of self, simultaneously distancing himself from the grip of the old devalued self with its aggressive, acting-out defenses.

The treatment team can help the child make the transition in many ways. Elements of enthusiastic grandiosity can cloud the child's judgment such that he would choose activities so beyond his current level of ego skills and controls that it would be a prescription for disaster. The team can help him to avoid such an outcome by assisting him to select more appropriate activities. In the process of guiding the child, important work can be accomplished, strengthening such ego functions as the capacity to tolerate delay and frustration. The child's observing ego will also be strengthened as well as his capacity for accurate self-assessment, and sound judgment.

A trusted member of the staff may accompany the child to his activity, lending support by their interest and presence. If staff cannot actually be in the area of the activity, they can be nearby. If the child encounters difficulty that exceeds his adaptive resources, rather than resort to old, acting-out de-

fenses, he can excuse himself to go speak to the staff person to obtain the support needed to settle down and carry on. In time, the child will require decreasing amounts of this support as he gradually internalizes these functions and develops confidence in his new sense of self and his increasingly sophisticated level of ego functioning. If there are family members who can be involved in this transitional process, so much the better.

The particular facility where the children described in this article were treated had a music therapy program for all inpatient children. It was frequently astounding to see extremely aggressive children learning in a matter of months how to read music and play instruments well enough to become members of the jazz band. The children and their families were equally amazed and proud of these achievements. After discharge, when the children returned to public school, their new music skills often provided them with an area in which they were actually more advanced than their peers, an experience which was usually unprecedented for these children, boosting their self-esteem and helping them to maintain a more positive attitude towards the overall academic experience.

Activities therapy, special education, and community liaison work are important aspects of residential treatment with all child patients. However, with these children who have such a devalued sense of self, who feel there is nothing likeable, competent, admirable, or praiseworthy about themselves, and whose ego functioning is consequently severely impaired, these components of the total treatment plan are absolutely crucial.

CONCLUSION

Although the treatment of hyperaggressive children is a long and difficult process, a comprehensive milieu treatment program in combination with individual psychotherapy can have impressive results. Knowledge of the devalued self, the defenses against it, and related countertransference reactions can increase the likelihood of a positive outcome. These are not the only issues a therapist needs to know about conduct-disordered children (see, e.g., Willock, 1986), but they are amongst the most crucial.

Initially these children deny with all their aggressive defenses that they feel badly about themselves, but gradually, in a suitably facilitating environment (Winnicott, 1965) they begin communicating how abysmally low their self-esteem really is. Ultimately, they can emerge from those depths and begin feeling more positively about themselves.

After almost a year of treatment, Sam (who used to feel that even his head was "lined with shit") no longer felt so badly about himself. He then had to face the harsh fact that his mother and stepfather did not

want him back in their home. In one session during this critical period, Sam seemed on the verge of tears. His therapist suggested that some people might start feeling badly about themselves when something like this happened. Sam quickly corrected her, saying that he no longer felt that way about himself. He insisted that now, in contrast, "I know I'm good!"

Sam's treatment was by no means complete, but his ability to discuss such difficult issues and feelings without resorting to previously habitual types of destructive behavior suggested that the devalued self no longer had such a tenacious grip on his sense of himself. He seemed to be developing an increasingly positive sense of self—one that could help him to maintain his balance in the face of life's frustrations and insults.

Such moments, where the child's hard won gains are so strikingly manifested, can help therapists to feel that despite whatever doubts they may have had along the way, the difficult therapeutic endeavor to which they have committed themselves can be both effective and worthwhile.

ACKNOWLEDGMENT

I am grateful to Thomas Horner, Ph.D., David Klein, Ph.D., Laura Levine, Ph.D., Michael McManus, M.D., William Schafer, Ph.D., and Kay Tooley, Ph.D. for sharing clinical material and contributing in other ways that made our experience together both stimulating and rewarding.

REFERENCES

- Bettelheim, B. (1950). *Truants from life*. Glencoe, IL: Free Press.
- Erikson, E. H. (1959). Identity and the life cycle. *Psychological Issues, 1*. New York: International Universities Press.
- Fairbairn, W. R. D. (1954). *An object relations theory of the personality*. New York: Basic Books.
- Friedman, M., & Rosenman, R. H. (1974). *Type "A" behaviour and your heart*. Greenwich, CT: Fawcett.
- Guntrip, H. (1961). *Personality structure and human interaction*. New York: International Universities Press.
- Jacobson, E. (1964). *The self and the object world*. New York: International Universities Press.
- Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.
- Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.
- Kutchinski, W. (1977). Milieu therapy under the primary caretaker system at the University of Michigan's Children's Psychiatric Hospital. *Child Psychiatry and Human Development, 8*(1), 31-42.

- Nagera, H. (1981). *The developmental approach to childhood psychopathology*. New York: Aronson.
- Redl, F., & Wineman, D. (1951). *Children who hate: The disorganization and breakdown of behaviour controls*. New York: Free Press.
- Redl, F., & Wineman, D. (1952). *Controls from within: Techniques for the treatment of the aggressive child*. New York: Free Press.
- Willock, B. (1986). Narcissistic vulnerability in the hyperaggressive child: The disregarded (unloved, uncared for) self. *Psychoanalytic Psychology*, 3, 59-80.
- Winnicott, D. W. (1958). *Collected papers: Through paediatrics to psychoanalysis*. New York: Basic Books.
- Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. London: Hogarth.