

A PSYCHOTHERAPEUTIC STUDY OF THE CHILD WITH
STRONG SOCIOPATHIC TENDENCIES

A Thesis presented to the Department of Psychology
of the University of Cape Town, in fulfilment of
the requirements for the degree of
Doctor of Philosophy

by

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To:

My Love, Hennie

and our children

Hanlie

Willem

Ismarie

Adriaan.

Thanks for being

and

being part of the fullness of my life.

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Perhaps these are other people's children, not yours or mine or even our neighbors . But the time has passed when we ignored their troubles. Just as we now know that smallpox in the slums constitute a danger to the homes in our garden districts, so do we also know that human failure, whether it be in high places or hovels affects us, our families, our communities and ultimately the nation.

Anna J.V. Levy 1958,

American Children's Court Judge.

ABSTRACT

This study investigates the effectiveness of psychotherapy with the child with strong sociopathic tendencies in the age group when the pathology is still in a developmental stage, namely six to thirteen years.

The main contributions of this study to the field of Psychology are the following:

1. The literature on the sociopathic child is very fragmented and no comprehensive text on the child with strong sociopathic tendencies seems to exist. One of the aims of this study therefore was to synthesize the fragmented literature on the child sociopath.
2. Individual psychotherapy with the sociopathic child has failed in most cases, but suggestions in the literature have pointed to the possibility that an integrated psychotherapeutic approach to the sociopathic child might bear positive results. There are no guidelines however on what modes of psychotherapy should be employed in such an approach. This study has as its main aim to test an integrated therapeutic approach, based on the principles of the Humanistic school of psychology, on these children. The therapeutic techniques used in a combination on these children were: play therapy, image therapy, the use of the transitional object, Gestalt therapy and verbal therapy. Moreover, each child of the Experimental group was placed in a group of normal children, constructed for the needs of the sociopathic child. This is a new concept in group therapy and scientifically evaluated here for the first time.

3. As no theory of Gestalt therapy with the child could be traced, one was worked out as part of the study and presented as such.
4. As this is a study of the practical application of therapy, a full description of the therapeutic process of the first child taken into therapy is given in the form of a full case study in order to reveal the psychodynamics of the therapeutic process itself, particularly for clinicians interested in employing this method.
5. The literature suggested a particular scatter pattern on the WISC and NSAIS for the sociopathic child, namely a higher Performance than Verbal score and indicated these certain sub-tests are sensitive to the sociopathic process resulting in a particular scatter pattern than can be very useful for diagnostic purposes. All the sociopathic children's I.Q. scores on the abovementioned tests were analysed. Their scatter patterns were found to be the same as those suggested in the literature, namely a higher Performance than Verbal I.Q. on both tests. On the NSAIS the sub-tests that seemed to be sensitive to sociopathy were: Vocabulary (significant below mean I.Q. scale) Problems (significant below mean I.Q. scale), Verbal Reasoning (raised) and Memory (raised). On the WISC the sensitive tests were: Information, Comprehension, Arithmetic (all significantly elevated above mean I.Q. score), Digits, Picture Completion, Picture Arrangement and Object Assembly (all significantly elevated above mean I.Q. score). For diagnostic purposes these findings were also compared with the scatter pattern of a group of 30 neurotic children and a significant difference was found in the scatter pattern of the two groups. This study established the usefulness of the WISC and the NSAIS for the diagnosis of the sociopathic child.

The subjects of the research project consisted of the Experimental group consisting of 10 children who received therapy as abovementioned, plus two control groups, namely a Passive Control Group and an Active Control Group. As sociopathic children are usually either left in the care of their parents, mostly without receiving therapy, or placed in an institution, the two control groups consisted of an Active Control Group of ten children who were in institutional care and a Passive Control Group of ten children who were left in the care of their parents without receiving any therapy at all. The three groups were matched for age, social background, I.Q. and their scores on the Jesness Inventory Asocial Index. The therapy for each of the ten children in the Experimental group lasted from eight to twelve months.

The results were presented in two parts. Firstly, a single in-depth, case study of the first child taken into therapy was described in full as mentioned above.

Secondly, a qualitative analysis of the Rorschach and a statistical analysis of the data obtained on the following apparatus is presented. The apparatus for Pre-and Post-Therapy consisted of the WISC, NSAIS, Rorschach, Jesness Inventory Asocial Index and a Behaviour Rating Scale for determining sociopathic behaviour devised by the author-ess. Scoring of the latter was done by independent raters, namely, a clinical psychologist, social worker, teacher of each child and the parents (real, foster or house parents as the case may be).

The results of the individual psychotherapy program indicate that children with strong sociopathic tendencies who received individual psychotherapy, according to the methods described in this study, improved

significantly as far as their anti-social behaviour was concerned ($P < 0,01$); that children in institutional care remained unchanged and that the group left in the care of their parents deteriorated significantly as far as their anti-social behaviour was concerned.

The same results were obtained on a two-year follow-up study. The trends in the three groups remained unaltered, suggesting the value and necessity of early psychotherapeutic intervention in the developing sociopathic condition. Children already in institutional care should also receive individual psychotherapy. As early detection by means of a clinical interview, the scatter analysis of the NSAIS or WISC and clinical diagnoses with the available psychological tools, such as the Jesness Inventory is possible, a possible new treatment program for the sociopathic child has been made available by this study.

A further follow-up study possibly ten years later may be of benefit to verify these findings. Some of the therapeutic techniques used in this study may be combined to determine the specific effect of each. This should be considered as a pioneer study in this field, opening the doors for further research in this area.

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CHAPTER I.

INTRODUCTION

According to statistics South Africa has one of the highest crime rates in the world (Midgley, 1977). Although only a small percentage of criminals are sociopaths, and not all sociopaths are criminals, those that are, are disruptive powers in families and communities wherever they operate. Here it needs to be mentioned that sociopathy and psychopathy are interchangeable terms.

Sociopathy often starts in early childhood, but is mostly not diagnosed before adolescence. Hare (1970) states that one can diagnose sociopathy in most cases as early as seven years of age. Roux (1970) found that most sociopaths had a record of uncontrollable behaviour of sociopathic nature before the age of ten. Most writers seem to acknowledge that one can already diagnose sociopathy very early but in practice it seems as if most clinicians are hesitant to diagnose them before they have clashed with the law. This practice has led them forbearing early treatment directed at their actual problem (Reid, 1978).

The entity of the child sociopath has already been described as early as 1855. In the journals of the New York Juvenile Asylum of that year, some problem children were identified as such and the term applied to them. In the literature today, one finds quite an extensive description of the child sociopath. The symptoms, except for anxiety, which is still very high in the child, are much the same as those of the adult sociopath.

In the literature, many possible causes of sociopathy are discussed. The authoress takes the view that the sociopathic personality is formed

in the dynamic subtle interaction between the genetic potential, the biological functioning of the individual and the environment in which he has to develop.

In this study it is preferred to call the child sociopath "a child with strong sociopathic tendencies", or the sociopathized child as the child and his pathology is still developing. He may or may not become an adult sociopath but he usually will already show some kind of personality defect or disorder.

Most writers, like L^{ourie} (1959), as will be seen in the literature survey, feels that strictly speaking there is no successful treatment for the psychopath. This seems to have become a self-fulfilling prophecy in as far as most therapists do not even attempt to do some kind of therapy with them. Bromberg (1954, p. 608) put it in these words: "*One wonders in relation to this complex problem, whether psychiatry has not been frightened by the sardonic smiling mask of the psychopath, behind which lies the frightened lonesome face of a neurotic character*". Lurie (op. cit.) qualifies his statement by saying that he considers it possible to treat the very young sociopathic child, but that he himself has not done any research on this. Rabbinowitch (1959) feels that treatment is only possible during the latency years. Bender (19⁴⁷) also states that as one of the main problems of the sociopathic child is that of object relations, therapy should take place while object relations are still being formed.

Different approaches to the matter of therapy with the sociopathic child has been tried namely:

i. Milieu Therapy

This treatment entails that the child is placed in an institution

and treated away from his home environment. In the ideal situation the new environment in itself forms a therapeutic means. In South Africa this is the treatment of preference although little research has been done to evaluate the outcome thereof. (One of the active control groups will be formed out of candidates from this set-up).

ii. Group Therapy

Mostly one finds that group therapy is a part of milieu therapy. In South Africa no groups, specially geared for the young sociopath, could be found outside institutions.

iii. Individual Psychotherapy

Shaw (1959), Backwin and Backwin (1971) and others feel that "psychotherapy is of little value" (Shaw, p. 243) for the sociopathic child. The problem is that not one of them has ever tried individual therapy with these children. They simply generalise from their experiences with adult sociopaths to the child sociopath. Only a few studies on individual psychotherapy with these children has been undertaken so far. Taubers and Powers (1951) have found no significant improvement in sociopathic children who have received individual treatment in comparison with those who have not. Unfortunately they do not state clearly what kind of psychotherapy they have done so that it is difficult to properly evaluate their findings.

In South Africa no study has as yet been undertaken on individual psychotherapy with these children. This study has taken as its aim to fill this gap and to establish whether individual psychotherapy, with methods specially selected for the complex problems of the child sociopath, in the age phase when the pathology is still

developing, (before thirteen years) has any positive influence on the behaviour of the child.

As no comprehensive text on the child with strong sociopathic tendencies could be found, this study has as its secondary aim a synthesis of the fragmented literature on child sociopathy. In order to do this the history of the concept of sociopathy in general will be traced. To ascertain whether child sociopathy could be classified historically as a separate diagnostic entity one had to trace the historic roots of this concept in detail.

The definitions of sociopathy are of importance as they contain the basic elements of the disorder. In this study literature research is first done on sociopathy in general and then more specifically on the child, so as to see whether the child already presents the same clinical entity as the adult sociopath.

To diagnose the sociopath one has to differentiate it from other entities. To this end one needs a comprehensive knowledge of the symptoms of sociopathy in general and more specifically as it presents itself in the child. For this purpose the "Differential diagnosis of Sociopathy" and the "Symptomatology of Sociopathy" will be discussed in detail.

Up to date it is not totally clear what causes sociopathy. To treat the sociopathic child however one needs to take the etiology into account and for this purpose the "Etiology of sociopathy" will be discussed in detail. There are different theories of etiology, which at times may seem conflicting, but which will be integrated at the end of the section.

To do psychotherapy with the sociopathic child one needs to understand his deeper psychodynamics. As the authoress is of the opinion that no one school in psychology presents a full explanation of this complex entity, the psychodynamics of the child sociopath will be reviewed from the view points of the different schools in psychology. As each school rests upon a definite philosophical basis, they will each be discussed separately without integrating them into one theory. The useable and applicable principles in each school will be taken into consideration for the planning of the therapy, but they will not be mixed indiscriminately.

To plan the therapy of the sociopathic child one will have to find out firstly what kind of therapeutic approaches had been tried with these children in the past and how much success was obtained with each method. From the overview of the therapies tried with these children, the conclusion will be drawn, that an integrated "battery of therapies" should be tried as the problems of the sociopathic child are so complex and deeply rooted that more than a single therapeutic approach is needed to reach them. Reid (1978) also came to this conclusion, although he never tried it out himself.

In the literature the term sociopathic child is interchanged with the term psychopathic child. The authoress feels that the above-mentioned terms are too definite for the child whose pathology is still in a developmental stage and therefore the terms "child with strong sociopathic tendencies" or "sociopathized child" is preferred.

In the next chapter an overview of the history of the concept of sociopathy will be discussed.

CHAPTER II.

DELINEATION OF THE CONCEPT OF PSYCHOPATHY AND SOCIOPATHY

The terms psychopathy and sociopathy form the centre of a controversy in psychology for which no satisfactory solution has yet been found. Since this thesis deals mainly with the condition as manifested in the child, it will not attempt to discuss all the points of contention in depth but merely delineate a number of important aspects.

Widely divergent viewpoints on the abovementioned terms are represented in the literature. Preu (1944) maintains that psychopathy is no separate nosological entity, but merely a term used to classify persons who would otherwise be nosologically unclassifiable. *"The term psychopathic personality is useless in psychiatric research. It is a diagnosis of convenience arrived at by process of exclusion. It does not refer to a specific behavioral entity. It serves as a scrap-basket to which is relegated a group of otherwise unclassified personality disorders and problems"* (p. 936). Rumke (1967) agrees with this view. He contents that psychopathy as a nosological concept should be replaced since it is not clearly definable as a clinical picture. Although he uses the term, he does so with reservations and expresses the hope that *"de term op en duur geheel uit onze nomenclatuur verdwijnt"* ("The term will eventually disappear completely from our nomenclature") (p. 175). Slater and Roth (1969) are convinced that no fundamental difference exists between the psychopathic and the neurotic personality and that the former term is as such useless.

An opposite viewpoint is held by Schneider (1928), Henderson (1939), Cleckley (1955) and McCord and McCord (1964), who delineate psychopathy as a clear clinical entity.

Cleckley (1955) calls the psychopath "the forgotten man of Psychiatry" (p. 33) and advocates the delineation of the condition as a separate form of pathology.

In other words, two strongly conflicting schools of thought have developed around the concepts of psychopathy and sociopathy. In order to establish whether delineation of the clinical picture is justified, the historical background of these concepts will have to be considered.

HISTORICAL BACKGROUND OF THE CONCEPTS OF PSYCHOPATHY AND SOCIOPATHY

Initially "psychopathy" was the only term used and the term "sociopathy" was not introduced until recently, as will be indicated. Historically, in other words, the two terms have generally been regarded as synonymous.

The first attempt at delineating psychopathy as a separate entity or clinical entity was the description "Manie sans d'elire" used by the French doctor Pinel (McCord et al., op. cit., p. 25).

In 1812 Rusch described a condition of which the main symptom was habitual lying (McCord et al., op. cit.).

Pritchard introduced the term "moral insanity" in 1836 (McCord et al., op. cit., p. 24). This term was widely used for a considerable period of time, but gave rise to strong legal and theological objections, on the grounds that it exempted the individual from personal responsibility.

Koch (1888) was the first person who used the term "psychopathic" in the context of "psychopathic inferiority" (Craft, 1965, p. 11).

Adolf Meyer used the actual word "psychopathy" for the first time in 1903 and delineated the concept as separate from the neuroses in 1912.

This distinction was not a nosological one, but merely an attempt to establish a psycho-biological differentiation between neurosis and psychopathy. Birnbaum supported this view in 1914, indicating that not necessarily all criminal conduct implied psychopathy (Gurwitz, 1951, p. 88-89).

From then on the concept was taken up by various fields in psychology and psychiatry in an attempt to investigate the etiology of the deviation. Under the influence of Bolsi, whose research established a connection between encephalitis and psychopathy in 1924, one group sought the cause in defective brain functioning (McCord et al., op. cit., p. 26-28), while the developing psycho-analysis tried to find the solution within its own framework. Individual solutions were later offered by each of the various schools of thought. These theories will be discussed in greater detail below.

In 1961 Overholser and Owens rejected the term "psychopathy", replacing it with "sociopathy" after studying the investigations of Davidson (1956). Davidson (op. cit.) put forward the term "oligothymia" since he felt that psychopathy could not be regarded as a simple clinical entity, but rather as a syndrome compounded of 16 different symptoms (Wolman, 1956, p. 1059). Overholser and Owens (op. cit.) gave preference to the term "sociopathy", maintaining that there was no such clearly definable nosological entity as psychopathy, but merely a description of a group of symptoms. They found support for their views in a conclusion by the A.P.A. in 1957 that "psychopathy" was increasingly regarded as "a poor and inexact term" (Wolman, op. cit., p. 1059).

Although Overson and Owens (op. cit.) preferred the term "sociopathy"

to that of "psychopathy", they did not in fact attempt to describe a separate condition, but merely suggested an alternative term for the previously described clinical picture of psychopathy.

Reid (1978) regards the sociopath as a person with a normal personality but deviant behaviour, whereas the psychopath exhibits a definite personality deviation.

Before the behavioral characteristics and symptoms of psychopathy/sociopathy can be discussed in greater detail, it will be necessary to delineate the condition as separate from other forms of psychopathology.

DELINEATION OF THE CONCEPTS OF PSYCHOPATHY AND SOCIOPATHY

As early as 1930 Patridge suggested that the term "sociopathy" should replace that of "psychopathy". However, he merely suggested a new name without in fact using it himself. Overholser and Owens (op. cit.) were the first to accept and actively use the term. Schmiddenberg (1961) and Wolman (op. cit.) agree with Chwast's view (1972) that *"the terms psychopathy and sociopathy are interchangeable, although the latter is preferred generally because it does not carry the connotation of constitutional irreversibility"* (p. 436). The most recent authors such as Reid (1978) and R.M. Suin (1971) also use the two terms synonymously.

In order to establish whether the two terms do in fact represent one concept or whether they should be differentiated, the definitions offered in the subject literature will have to be investigated.

1. Definition of the concepts of psychopathy and sociopathy.

There is as little agreement in the subject literature on a uniform definition of these concepts as there is on the terms to be used

to denominate them.

The first person who attempted to define psychopathy was the German Schneider in 1928 (East, 1949). He described the psychopath as a person who rejects the values and norms of his society on account of a personality deviation, without considering the consequences of his actions. Although still hardly an adequate definition, this description is at least an attempt at separating the concept from other conditions.

Davis Henderson, who made an intensive study of psychopathy, offered various definitions of the concept between the years 1939 and 1949, finally culminating in the following definition: "*Individuals who conform to certain intellectual standards, sometimes high, sometimes approaching the realm of defect but yet not amounting to it, who throughout their lives or from a comparatively early age, have exhibited disorders of conduct of an anti-social or asocial nature, usually of a recurrent or episodic type, which in many instances, have proved difficult to be influenced by methods of social, penal and medical care and treatment and for whom we have no adequate provision of a preventative or curative nature. The inadequacy or deviation or failure to adjust to ordinary social life is not a mere wilfulness or badness which can be threatened or thrashed out of the individual so involved, but constitutes a true illness for which we have no specific explanation*" (East, 1949, p. 138).

According to Robert Lindner (1944) the psychopath is a person who is in revolt against his environment, but is a "rebel without a cause". He describes the psychopath as follows: "*The psychopath is a rebel, a religious disobeyer of prevailing codes and standards. Moreover clinical experiences with such individuals make it appear that the*

psychopath is a rebel without a cause, an agitator without a slogan, a revolutionary without a program: in other words his rebelliousness is aimed to achieve goals satisfactory to him alone; he is incapable of exertions for the sake of others" (p. 2).

Carp (1948) regards psychopathy as a basically defective personality development which is due to a "predisposition" to the development of a psychopathic personality structure.

East (op. cit., p. 130) describes the psychopath as *"a person who, although not mentally defective, psychoneurotic or insane, is persistently unable to adapt himself to social requirements on account of abnormal peculiarities of impulse, temperament and character, which may require specialized medical and rehabilitative treatment, instead of, or in addition to, the ordinary methods of punishment, before his social reclamation is affected."*

According to Lipton (1950) psychopathy is a congenital defect and he defines it as such.

Thornton (1951), Maslow and Mittelman (1951) and Thompson (1953) see psychopathy mainly as a behavioral deviation and an inability in the patient to conform to social standards. Maslow and Mittelman (op. cit., p. 406) sum up these views in the following definition: *"conditions in which the main pathological manifestations are in the individual's actions and behaviour, and is based on his inability to experience certain interpersonal, social and moral values."*

Harvey Cleckley (1955) regards psychopathy as a selected defect which prevents the integration of ordinary experiences into the personality. This defect applies mainly to the affective components in social interaction. Important is his observation that the psychopath displays

no decay in thought and memory processes, so that he appears outwardly normal in all respects, while functioning pathologically in his inner dynamics. He sees the psychopath as a person who can no longer be regarded as fully human, but as a "subtly constructed reflex machine which can mimic the human personality perfectly" (p. 424). According to him, in other words, the psychopath goes through life with a "mask of sanity".

Terruwe (1958) describes the psychopath as a person who displays defective cognitive control over the emotional aspects of the personality.

The Mental Health Act (1959) of England and Wales defines psychopathy as follows: "*persistent disorders of mind - whether or not accompanied by subnormality of intelligence - which result in abnormally aggressive or seriously irresponsible conduct on the part of the patients, and require or are susceptible to medical treatment.*" (Batchelor, 1969, p. 307). This is hardly an exact definition, in view of the fact that aggressive and irresponsible conduct as such also occurs in other psychiatric conditions, such as schizophrenia. The definition by the American Psychiatric Association published in 1960 is considerably more comprehensive. Important in this definition is the differentiation made between two forms of psychopathy, termed "antisocial reaction" and "dyssocial reaction" respectively. The A.P.A. prefer the term "sociopathy" to "psychopathy". Their differentiation is based on the assumption that there are two basic forms of sociopathy, of which one group exhibit antisocial conduct due to a basic personality deviation, while a second group have failed to internalize the values of their society due to their social environment and have adopted the values of a negative

or antisocial sub-culture instead. The one form of sociopathy is described as a basically immature personality, while the other form allows adult bonds, but of a negative nature.

In 1968 the A.P.A. delineated additional forms of psychopathy, which they called "dysocial behaviour" (involving no basic personality disorder) and "antisocial personality", which they defined as follows: *"This term is reserved for the individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups or social values. They are grossly selfish, callous, irresponsible, impulsive and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior. A mere history of repeated legal or social offences is not sufficient to justify the diagnosis"* (Freedman and Kaplan, 1976, p. 1287).

Whereas the A.P.A.'s 1960 definition classified all conditions of addiction as well as sexual deviations under sociopathy, these conditions are grouped under the heading of "dysocial behaviour" in 1968, so that "antisocial personality" becomes a separate entity comprising those conditions which were previously known as "psychopathy" and "sociopathy".

After having investigated most of the existing definitions of psychopathy, Roux (1972) defines the psychopath who is constantly in conflict with the law as follows: *"Psychopathy is a deviation or defect in the personality and character structure (of a person) which leads to recurrent antisocial behaviour and misconduct from an early age (before or during puberty) and on which neither punishment nor conventional methods of treatment have any remedial or reformatory effect, with the*

result that these individuals repeatedly come into conflict with the norms of the society in which they live" (Roux, op. cit., p. 10).

He differentiates between two forms of psychopathy, viz: "primary psychopathy", which is determined mainly by constitutional disposition or neurological or organic factors - although environmental and dynamic factors may contribute, they are of secondary importance, in the sense that they are largely responsible for the degree or intensity of the psychopathic tendencies but not for their origin - and "secondary psychopathy", which is due to a process of psychopathizing caused mainly by environmental and psycho-dynamic factors. Constitutional disposition and neurological or organic factors are once again conditions of development, although not as dominant as in "primary psychopathy" (Roux, op. cit., p. 55).

The Mental Health Act, Section 1 (xxvi), defines "psychopathic disorder" as "a persistent mental disturbance or defect (whether or not accompanied by subnormal intelligence) which has been present in the patient since before the age of 18 years and which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient" (1973).

The problem with this definition is that it gives a very limited description of the concept and implies that psychopathy inevitably involves abnormal aggression. It also inevitably excludes those psychopaths who due to their high intelligence and well-developed manipulatory ability do not come into conflict with the law before 18 years of age.

It should be regarded as a legal rather than psychiatric definition. Justice and the law is concerned mainly with protecting the

individual and the norms of our society, and the legal definition is designed to enable certification and subsequent removal from society of the psychopath whose seriously irresponsible and aggressive conduct constitutes a hazard to the social order and the norms of our society. Psychiatry, on the other hand, is more concerned with the total symptomatology of the psychopath, the etiology of the condition and its treatment and prognosis, and would require all these various aspects to be dealt with in a psychiatric definition. Although the Mental Health Act (1973) refers to the psychopath as a "patient", its definition of psychopathy is merely a practical legal definition allowing courts to pronounce judgement on liability with regard to a crime. From a psychiatric point of view it does not offer a comprehensive description of the psychopath.

Summary and discussion

As indicated above, the concept of psychopathy/sociopathy went through several phases of development. Initially it was regarded as a general concept which did not differ greatly from other forms of psychopathology. Since the early nineteenth century authors have attempted to delineate psychopathy as a clearly separate nosological entity. The concept has been approached from various view-points, such as the social, medical and medical-legal frameworks. In time authors such as Hare (1970), the A.P.A. (1960) and Roux (op. cit.) arrived at the conclusion that the clinical entity involved was not a simple one. They saw psychopathy as a possible syndrome. The term "psychopathy" was discarded in favour of "sociopathy". While none of the authors differentiated between the two terms, all of them

preferred "sociopathy". In 1968 the A.P.A. rejected the possibility of psychopathy as a syndrome and defined it once again as a simple concept, using the term "antisocial personality".

The most comprehensive and acceptable definition seems to be that of Roux (op. cit.), since his description touches briefly on the possible etiology, symptoms, treatment and prognosis. He also recognizes the possibility of a syndrome. Roux's definition is more satisfactory than other recent definitions, such as that of the A.P.A. (1968), the majority of which merely describe a number of symptoms.

The authoress will offer her own definition, more specifically of sociopathy as it manifests itself in the child, at a later stage.

According to the existing definitions of the concepts of psychopathy and sociopathy, the two terms used are simply interchangeable deonominations for the same psychopathological condition - two names, in other words, for a single somewhat unclear clinical picture.

DELINEATION AND HISTORY OF THE CONCEPT OF SOCIOPTHY IN THE CHILD

In the delineation of the concepts of sociopathy and psychopathy it was shown that these concepts were interchangeable. When dealing with the condition as manifested in the child, preference will be given to the term "sociopathy". The reasons for this will become apparent at a later stage.

In the early nineteenth century the child with strong sociopathic tendencies was regarded as a child who functioned defectively in the normal sense of the word and who had inherited the "sinful inclinations" of his fathers (Whitetaker, 1973). According to Whitetaker (op. cit.), the first attempt at an objective investigation of the causes of the

condition in children was made by the staff of the New York Juvenile Asylum in 1855. Their Minutes describe these causes as follows: "*Far from seeing delinquency as an inherent evil, the Asylum felt that three main causes of delinquency were (1) parental training, (2) outside associations of childhood (street influences) and (3) the indifference of society towards depraved youth*" (Whitetaker, op. cit., p. 15).

The first recorded description of what would today be classified as child sociopathy was that by Brooks in 1865, even though he did not use the term as such: "*Offer to these children the most luxurious and inviting homes and place before them the best means of education and happiness and many of them will spurn the offer and quickly turn from you to pursue their lives of wandering, idleness and mischief. They are not as yet recklessly, but rather ignorantly vicious; they have a keen relish for excitement, change, new things and for unrestrained liberty. Under this culture their minds have become active, sharp, cunning and possessed with a quick understanding of men and things. Indeed they may be said to be truly smart*" (Minutes of the New York Asylum, 1865, p. 36).

In 1866 the Massachusetts Board of State Charities classified children with behavioral deviations into three groups, viz:

"i. The good boys of strong moral tendencies who gravitate naturally towards virtue. If surrounded by vicious associations they are contaminated for a time, but like precious stones they are easily made pure. Little Nells and David Copperfields are not merely characters of fancy.

ii. Those boys who are unhappily organized; their feeble moral sense leads them towards vice rather than virtue. They have high innate

activities of the animal propensities and are likely to grow up to be vicious and depraved.

iii. By far the largest class, these boys have general inherited unfavorable moral tendencies, but have not a very marked bias towards vice or virtue. We may count on recovering 90% of them" (Massachusetts Board of State Charities Minutes, 1866, p. LXX).

Even at this early stage a distinction was made between different types of juvenile delinquents and a group described which could today be classified as child sociopaths. It is notable that even then the causes for criminally deviative behaviour was sought in congenital hereditary as well as environmental factors.

Although neither the term "sociopathy" nor "psychopathy" was used as a diagnostic entity for children in the nineteenth century, it may be concluded from the descriptions given above that the clinical picture of sociopathy as manifested in the child was not only known at that stage, but was even then ascribed to environmental and hereditary factors.

In the beginning of the twentieth century the term "psychopathy" was not used in relation to children either. The first person to apply the term to children was a German paediatrician, Ziehehn, who in 1923 described a group of children who exhibited mental deviations which could not be classified under the ordinary mental disorders or mental deficiency, but bore a strong resemblance to the condition of adult psychopathy.

The next reference came in a booklet by Gevers Leven, "De Toekomst van den Jeugdigen Psychopaat", which was published in 1924 and offers the first clinical description of the youthful psychopath. Important

on defective interpersonal relationships and on the absence of affectionality, which is regarded as one of the principal symptoms of child sociopathy even today. This symptom is vividly described by Levy in the case of an eight year old girl who was brought in for treatment because she lied chronically. Her foster mother said, amongst other things, that "she would kiss you, but it would mean nothing" and "she chatters but it is all on the surface" (Shaw, op. cit., p. 235). She had friends who were attached to her, despite the fact that she did not care for them in any way. She did well at school, even though it was of little consequence to her (Shaw, op. cit., p. 235). The strong emphasis placed on early deprivation is understandable, since at this stage Spitz (1945) had only recently published his research findings, which traced most forms of pathology later in life back to the early childhood.

On the grounds of research undertaken in Vienna in 1935, Aichorn differentiates between two types of juvenile delinquents, viz:

- i. The child whose antisocial conduct is a symptomatic expression of an underlying neurotic tendency, and
- ii. a group which he calls "sociopathic children", who exhibit asocial conduct without an underlying neurosis. This group have usually experienced no love and have often been brutally abused.

Whereas Anna Freud (1949) tries to explain psychopathy purely psycho-analytically from a psycho-sexual, intra-psyche orientation, other psycho-analysts such as Szurek (1942 and 1949), Johnson (1949) and Eissler (1949) see pathological conduct in children as the realization of the unconscious impulses of their parents. Eissler (op. cit.) suggested that these children are punished for their conduct in order to satisfy both the unconscious hostile desires of the parents as

well as the demands of the parents' superego simultaneously. Johnson (op. cit.) alleged that the antisocial conduct of the child stems from unconscious parental initiation or incitement on account of defectively integrated forbidden impulses in the parents themselves. These impulses and the incitement to act them out are usually unconsciously transferred to the child.

According to Bender (1947) the clinical picture of sociopathy in the child does not differ essentially from the adult picture. She describes the sociopathic child as aggressive, impulsive, asocial, unable to experience any feelings of guilt and incapable of forming any meaningful permanent relationships. She indicates that the symptoms can be observed in very young children - even before the age of five years. Hippman (1951) supports her views and states that it is not by any means unusual to find children in child guidance clinics who exhibit exactly the same symptoms as adult psychopaths. These children usually have an unsatisfactory relationship with one or both of their parents and are particularly hostile towards the parent who has to maintain discipline. They also play truant, are aggressive towards their teachers and come into conflict with the law very early in life. He also observes that many of them display disorders in eating habits, enuresis and homosexual tendencies. This emphasis on the early signs of sexual disfunction can be explained by the fact that in 1947 most sexual deviations were still regarded as part of the symptoms of psychopathy.

According to Spitz (1950) the most notable characteristic of children who grow into adult psychopaths is their total lack of anxiety

even in situations conducive to anxiety. He also indicates that they possess no motivation whatever to undertake and fulfill any task. As toddlers, he says, they are often hyper-active. The problem with Spitz's findings is that he does not arrive at any sort of criterion for identifying future psychopaths. The symptoms which he describes could to a certain extent apply to the condition which is today known as the Minimal Brain Disfunction Syndrome.

Greenacre (1945) mentions that sociopathic children have a low pain tolerance level and their time conception appears to be disturbed. It is difficult to establish whether or not Spitz (op. cit.) and Greenacre (op. cit.) were in fact incorrectly describing children with minimal brain disfunction as psychopathic. Important, however, is the fact that according to the two authors these children later became adult psychopaths. It is, in other words, an open question to which extent these children could have been organically predisposed to antisocial conduct on account of some form of brain disfunction. However, both authors also stress the fact that the children developed in a disturbed social environment.

Lowrey (1945) comes to the conclusion that psychopathic reactions in children are complicated and recurrent. These reactions are self-destructive and are not modified by circumstances or experience. Such reactions cannot be adjusted to a social environment, due to the fact that, while conscious feelings of guilt and fear may occur, they are projected outwards instead of being integrated into the self. Because he sees psychopathic reactions in children as so highly complex, Lowrey feels that psychopathy does not occur as a fully developed clinical picture in the child, but already starts developing at the toddler stage.

Lowrey's main contribution is basically that he does not deny feelings of fear in the child sociopath, but suggests that the child's dynamic handling of these fears differs. The fact that he regards sociopathy as a developing pathology which starts at the toddler stage is of the utmost importance to this study, since the authoress maintains a similar view, which will be more fully discussed at a later stage.

During the period 1949 to 1951 the "American Orthopsychiatric Association" held three "round table" discussions in which the sociopathic child was thoroughly scrutinized. The controversial points in these discussions were mainly the viability of such a clinical picture in the child as well as its etiological factors. The constitutional factors in the sociopathic child on the one hand and the interpersonal relationship factors on the other were heavily debated. Louis Lurie (1949), for instance, who places strong emphasis on the constitutional interaction with the environmental factors, writes as follows: "*The psychopath is a psychopath primarily by virtue of his specific constitutional structure. The psychopathic state may remain dormant indefinitely. On the other hand various psychogenic or somatogenic factors may activate this condition or state and thereby give rise to the type of behaviour which characterizes the so-called psychopathic delinquent*" (Lurie, 1949, p. 226).

Although according to Lurie (op. cit.) a basic constitutional structure is a pre-condition for the development of sociopathy, the specific constitutional structure with which the child is born is not inevitably a predisposition to the development of sociopathy. It is only in interaction with a certain (as yet unknown) psychogenic as well as somatogenic environment that the basic inborn "constitution" can

develop into a sociopathic personality. In genetic terms his theory can almost be regarded as multifactorial. His contribution is a major one in view of the fact that he does not describe sociopathy simplistically.

On the other hand, Frederick Allen (in Kessler, 1966) writes as follows: *"A child by his negative behavior creates a chain reaction which feeds on itself and shrouds the early beginnings of such behavior in mystery. Explanations focus more and more on the individual containing within himself all the causes for his mounting difficulties, because he seems to have no feeling and remains untouched by efforts to modify his behavior"* (in Kessler, op. cit., p. 310).

According to Allen (1970), in other words, it is not in the first place the environment which influences the sociopathic child, but rather the child with a "pathological nucleus in his developing personality who influences his environment negatively. On account of this deeply rooted pathology in the child the environment, however positive it may be, is apparently incapable of any rehabilitative influence on the child. According to this model, in other words, any therapeutic intervention will be doomed to failure from the outset. Allen does, however, concede that the blame for the problem could possibly be projected onto the child by the parents initially and later on by the society.

In 1950 Levy differentiates between the "deprived psychopath" and the "indulgent psychopath": *"In terms of superego structure it is weak in the deprived psychopath because of a deficiency in the process of identification. It is weak in the indulgent psychopath because the identification is so strongly represented by the indulgent loving mother* The deprived psychopath is defective in the capacity to develop

standards. In the indulgent psychopath standards are well understood but taken lightly" (Levy, 1950, p. 252).

Levy (op. cit.) puts the psychogenic factors first and foremost. The sociopathic child, according to him, repeats throughout his life that conduct for which he was rewarded during infancy. The neglected child is not rewarded for good conduct, while the over-protected child does not learn to practise control because he is rewarded indiscriminately.

In support of Levy (op. cit.), Ben Karpman (1941) proposes that psychopathy develops during the first five years of a child's life and after that becomes such a firmly established behavioral pattern that it cannot be reversed by therapy.

Piaget (1951), however, maintains that, although the basis for the development of morals and norms - even for the superego - is established during the first six to seven years of a child's life, the true individualization of this development does not take place before early puberty. Karpman's allegation (op. cit.) that psychopathy is irreversibly established within the first five years is unacceptable to the authoress, as the superego and the cognitive functions only fully develop at puberty.

Bowlby (1951) studied child psychopathy intensively. On the strength of his research on mother deprivation, which he initially regards as the cause of most forms of child pathology, he states that child psychopathy is caused by:

- i. an inability to form a strong bond with the mother;
- ii. any form of mother deprivation during the first three years of life;
- and
- iii. a change of mother figure during the first three years of life.

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Basically, Bowlby (op. cit.) traces psychopathy back to a defective mother-child relationship. In his later research, however, he modifies his own initial conclusions placing less emphasis on the inevitable harmful effects of mother deprivation, and more on the role of the society in forming the sociopath.

Not one of the abovementioned authors differentiate between the psychopath and the sociopath. Backwin (1972) is the first person to attempt this. He does not, however, suggest two separate clinical entities, but two different forms of the same picture, which he defines as "persons who habitually commit antisocial acts, but are uncontrolled by pangs of conscience or feelings of guilt" (p. 599). He also differentiates between the constitutional child psychopath, the child sociopath and the child with a psychopathic personality which stems basically from both constitutional and social factors. Another notable observation is that psychopathy is present in the young child, but is usually not diagnosed before puberty, when the child comes into conflict with the law.

From the foregoing it becomes clear the psychopathy is one of the first pathological conditions to be delineated in relation to the child, possibly due to the unmanageable behavioral deviations involved. The sociopathic children of the nineteenth century also came into conflict with the law at an early age and were placed in institutions where their condition was more readily available for investigation than other forms of child pathology. Although the clinical picture of child sociopathy was tentatively described as early as the nineteenth century, it has not yet been fully investigated or delineated even today.

In the next section the symptomatology of sociopathy will be discussed, in the first place as it is manifested in the adult and

secondly in the child. Since the condition in the child is developing, it is not identical to adult psychopathy. Certain symptoms of the adult condition, however, already become apparent during childhood.

Summary and Discussion

Although both the terms "psychopathic child" and "sociopathic child" are used in the literature, the term "child with strong sociopathic tendencies" is preferred for the purposes of this study. The authoress feels that the condition as manifested in the child is a developing pathology and requires a more fluid descriptive terminology, which will allow for development. The term "child with strong sociopathic tendencies" or sociopathized child is merely a new description in preference to that of "psychopathic /sociopathic child". The child with sociopathic tendencies is a child who is involved in a process of psychopathizing or sociopathizing.

DIFFERENTIAL DIAGNOSIS OF SOCIOPATHY

Before the characteristic behavioral deviations and symptoms involved in sociopathy can be more comprehensively discussed, the clinical picture will have to be delineated as separate from other forms of psychopathology.

1. Sociopathy and the ordinary criminal

Although Arieti (1969) and Roux (op. cit.) feel that most criminals display psychopathic characteristics, they do differentiate between the two entities. The A.P.A. classification (1968) also tends to group the ordinary criminal under the heading "Dyssocial behavior".

The ordinary criminal plans his crimes for a specific purpose and

usually disposes of the spoils discriminately, while this rationalization is absent in the crimes committed by the psychopath. Even when planned, his actions invariably contain a strong impulsive element. Whereas the ordinary criminal usually displays strong loyalty to fellow-criminals, "the typical psychopath shows no loyalty to anything or anybody" (Arieti, op. cit., p. 574). Even in prison the sociopath is usually a lone wolf (Roux, op. cit.).

The ordinary criminal generally takes great care to evade the consequences of his deeds and does so persistently - the psychopath on the other hand is incapable of safeguarding himself persistently against the law. *"The psychopath is often ingenious and his lack of anxiety or feelings of guilt, as well as his appearance of absolute candor, often enable him to avoid detection. He is likely however, after many cleverly arranged thefts or swindles, to lose interest in safe-guarding himself and to carry out another act under circumstances where his detection is inevitable"* (Arieti, op. cit., p. 574).

Roux (op. cit.) maintains that, while all criminals display psychopathic features or characteristics to a certain extent, the fully developed pathological picture is not manifested in all criminals - almost a question of a difference in degree of psychopathy.

In practice, it is often exceedingly difficult to differentiate between the criminal delinquent and the psychopath in view of the fact, as stated by Roux (op. cit.), the the criminal displays definite symptoms of psychopathy. It would appear as if much of the mode of behaviour of the criminal is learned conduct, acquired to enable him to maintain himself in a criminal subculture.

2. Sociopathy and juvenile delinquency

Rosen and Fox (1972, p. 256) make the observation that, while not all youth delinquents become sociopaths, all sociopaths have been guilty of some sort of juvenile delinquency. They also maintain that all habitual juvenile delinquents are sociopathic, and differentiate between the congenitally sociopathic youth, which they call the "psychopath" or "antisocial sociopath", and the youth who becomes sociopathized through circumstances, the so-called "group juvenile delinquent" or "sociopath". According to them the ultimate clinical picture which emerges in adulthood is the same for both these categories, viz: sociopathy. Possibly the principal difference is the anxiety factor, which is still comparatively strong in the juvenile delinquent. They describe the juvenile delinquent in contrast to the antisocial sociopath as follows: *"The group delinquent emerges from an abnormal moral environment, identifies with criminal figures, models himself after them and then adheres to the values of a criminal or predatory group. He is capable of strong loyalty to such a group in contrast to the antisocial sociopath's loyalty to no-one. His sociopathy, in short, is an adaptation to a special environment His superego is deviant rather than weak. His behavior is controlled, but his goals are unacceptable to society. He does not lack in effective reactions to others, but his affection is distorted and dominated by hostility"* (Rosen and Fox, op. cit., p. 262).

3. Sociopathy and neurosis

The neurotic's actions remain basically rational even though he exhibits irrational fears, disturbed, obsessive thought processes or

unacceptable subjective symptoms. It could possibly be postulated that the principal symptom of neurosis is anxiety, and this is precisely the symptom which constitutes the greatest contrast to sociopathy, which is characterized by a notable lack of manifested anxiety. In comparison to the sociopath, the neurotic is generally over-sensitive to social norms.

Lykken (1957) describes a "neurotic sociopath" who displays a high anxiety level which is acted out in antisocial conduct instead of the normal defense mechanisms. He regards the sociopath's antisocial conduct as an attempt at controlling an over-developed superego. Lykken (op. cit.) concludes that even the primary sociopath possesses a strong conscience, which is, however, deeply repressed.

Saunders (1972) indicates that the sociopath often purposely invites punishment by concealing his actions so inadequately that he cannot escape detection. He comes to the following conclusion: *"An application of the hypothesis that sociopaths have an unconscious need to be punished is that sociopathy is ultimately a defense against neurosis. Were the sociopath to become conscious of his deeply repressed guilt and anxiety, he would feel overwhelmed. As a defense, he keeps all affective reactions in check"* (p. 267).

The abovementioned authors regard sociopathy as a neurotic reaction pattern, not to be differentiated from neurosis as such.

Hare (1970) disagrees strongly. He maintains that the personality structure, motives and life history of the neurotic differ greatly from that of the sociopath. He also states that the neurotic, in contrast to the sociopath, experiences and displays feelings of guilt and is capable of forming meaningful relationships with others, and then proceeds to

indicate that where antisocial conduct is manifested in the neurotic, it is motivated by neurotic conflict and tension.

Hare (op. cit., p.8) concedes that in relation to the child the description "neurotic personality disorder" would be preferable and puts forward the term "Sociosyntonic Personality Disorder" since he sees the condition in the child as a developing pathology. This view contrasts sharply with the earlier conclusions of McCord and McCord (op. cit.) who already differentiate between the psychopathic and neurotic child in child delinquency. According to them the "child psychopath has the embryonic personality traits of the adult psychopath" (McCord et al., op. cit., p. 99).

Although some of the abovementioned authors connect sociopathy and neurosis closely, it is symptomatically possible to differentiate between the two conditions and to delineate them as separate entities. The authoress sees the principal differences between the two clinical pictures as follows:

- i. Both are characterized by a long preliminary development, with some symptoms becoming apparent even in childhood.
- ii. The neurotic displays a high level of manifested anxiety, which is apparently absent in the sociopath.
- iii. The neurotic handles his reality mainly by means of defense mechanisms and the sociopath by manipulation.
- iv. In the neurotic the superego is over-developed and high dominant and punitive, while the sociopath's superego is under-developed.
- v. The ego in the neurotic is under-developed and extremely vulnerable. That of the sociopath is strongly but pathologically developed.

- vi. Whereas the neurotic generally represses his id-impulses, the sociopath exercises practically no control over his id-impulses.
- vii. The sociopath is apparently unable to form lasting social relationships, while the neurotic is capable of strong social bonds, even though these often lead to conflict.
- viii. Anti-social actions, which generally constitute a mode of living in the sociopath, are rare in the neurotic.
- ix. The neurotic often boasts a good employment record, while the sociopath is unable to persevere in an employment situation.

4. Sociopathy and psychosis

In most countries the diagnosis of sociopathy is not yet legally regarded as an extenuating circumstance (Arieti, op. cit., Vol. 1, p. 573). This means that the sociopath has to accept full responsibility for his actions, however perverse or deviative they may be.

In South Africa, the aggressive psychopath can be certified as mentally disturbed in terms of the Mental Health Act (1973). At present, however, South African courts tend to see this certification as an aggravating rather than extenuating circumstance (Lecture: Dr. Henning, University of Cape Town, March, 1977). The reason for this is the fact that a prisoner who is certified as a psychopath may be indefinitely detained in a prison hospital for psychopaths. In certain isolated cases the death penalty was actually imposed on the grounds that the accused was a psychopath (Lecture: Prof. Van Rooyen, Groote Schuur Hospital, May, 1978). The reason for this was that the accused was regarded as unrehabilitatable and as such constituted a serious hazard to society. In terms of the Act the young child or adolescent cannot be certified

directly, as in the case of other mental disturbances. The child is usually committed under the Childrens' Act and sent to a clinic school or reformatory without any consideration of his own specific and unique personality structure.

The psychotic person's acts are often irrational and dangerous to himself and others. At the root of his actions there is an elaborate delusional or hallucinatory system which feeds his bizarre behaviour patterns. In the psychopath delusions or hallucinations are absent. His thought processes display no disturbances of a psychotic nature and his contact with reality appears to be adequate. *"On the other hand we see the psychopath repeatedly carry out acts as self damaging, disastrous and inappropriate as many that are considered characteristics of schizophrenia without delusional or hallucinatory prompting"* (Arieti, op. cit., p. 573).

According to Millon (1969) the psychopath does not exhibit any apparent disturbances in thought processes, cognitive disfunction or brain function deterioration, neither can his irrational behaviour be explained in terms of manic excitement or depression. In fact it is notable that the psychopath expresses a very limited capacity for depressive feelings, even in cases where this is reasonably to be expected.

In conclusion it can be observed that psychopathy and the child with strong sociopathic tendencies are separate delineable entities, even though somewhat unclear each with its own symptomatology, which we will now proceed to discuss.

CHAPTER III

SYMPTOMATOLOGY OF SOCIOPATHY WITH SPECIAL REFERENCE
TO THE CHILD WITH STRONG SOCIOPATHIC TENDENCIES/
CHILD SOCIOPATH/CHILD PSYCHOPATH

According to Millon (op. cit.) sociopathy is one of those psychopathological conditions for which it is difficult to determine clearcut symptoms. He regards sociopathy as a behavioral deviation which differs from normal behaviour only in degree: *"There are no simple or clearcut signs such as phobias or obsessions, that emerge as distinctive features to contrast sharply with the more general and prosaic style of the patient's functioning. Rather, distinction in the sociopathic disorder lie in the exaggeration or accentuation of his less striking and everyday personality pattern. The symptom therefore is neither unusual nor bizarre, but an extention or intensification of what the patient habitually does or thinks"* (Millon, op. cit., p. 429).

As will be indicated shortly, most experts do not agree with Millon. Before discussing the symptoms displayed by the child with strong sociopathic tendencies, the symptoms of adult sociopathy will be briefly elucidated.

Cleckley (op. cit.) describes the following symptoms of sociopathy: unaccountable failure in all undertakings, adequate level of intelligence, absence of neurotic symptoms, recurrent and insufficiently motivated antisocial conduct, irresponsibility, inability to distinguish between truth and falsehood, inability to learn from experience, inability to love or to take any blame, disproportionate reaction to alcohol, lack of insight, superficial reaction to sexual experiences and suicide attempts which are rarely successfully carried out.

Schmiddenberg (1961) mentions the following as symptoms of sociopathy: *"The psychopath is unable to tolerate delay or frustration, has little sense of responsibility, lacks self-control and is antisocially orientated. He tries to use the other person because of his fear of being used by him"* (p. 734). He also indicates that the sociopath displays strong narcissistic inclinations as well as an underlying megalomania. He can neither handle nor tolerate anxiety because it could conceivably expose his human vulnerability. According to Schmiddenberg (op. cit.) the sociopath's conscience is blunted rather than non-existent - he immunizes himself against anxiety and guilt by his inability to socialize. Although he denies his emotions, he is unhappy, frustrated and lonely. His thought processes and reality orientation are disturbed, but not to a psychotic degree, "whilst he spends an inordinate amount of time creating complications, troubles and excuses" (Schmiddenberg, op. cit., p. 743).

Wolman (1966) regards sociopathy as a "hyperinstrumental character neurosis". According to him the sociopath is characterized principally by the trait of always wanting everything for nothing. *"They show no consideration for fellow men, nor even for their own parents, marital partners or children, they act convinced that the world owes them a living, but they don't owe anything to anyone in return"* (Wolman, op. cit., p. 53). Wolman (op. cit.) uses the vivid illustration that sociopaths use life as a bank which they can rob or an oil field to be exploited. They are selfish, callous and exploitive and think only of themselves. They easily feel sorry for themselves but show no mercy to others. They never accept blame, but invariably project it onto others. They also tend to regard themselves as weak but amiable,

surrounded by enemies who are both unjust and selfish. *"Hyperinstrumentalists are dishonest and disloyal. Yet they believe in their own innocence. They believe the world is hostile and they are resentful whenever others refuse to serve them"* (Wolman, op. cit., p. 53).

After an exhaustive study of the relevant literature, Rosen and Gregory (1965) summarize the major characteristics of the adult antisocial sociopath as follows: They are predominantly males who come from the lower socio-economic strata and who make their first psychiatric contact in their early adolescence. They manifest uninhibited indulgence of impulses and are unable to postpone gratification. Their superego is defective or absent and they display no feelings of guilt. They are immoral, irresponsible and unreliable and could be addicted to drugs or alcohol. If it suits them, they can act with cruelty and aggressiveness. The opinions of others leave them cold, unless such opinions thwart their aims. *"Confident and carefree, without long range plans, the sociopath uses his superficial charms and plausibility to manipulate others. Incapable of true affection, his sexual behaviour tends to be uninhibited and promiscuous"* (Chwast in Wolman, 1972, p. 436).

William Reid (1978, p. 3-5) offers more comprehensive criteria, which appear in the DSM III:

- "B. onset before age 15, as indicated by a history of two or more of the following:
1. Truancy (positive if at least five days per year for at least two years, not including the last year of school).
 2. Expulsion from school.
 3. Delinquency (arrested or referred to juvenile court because of behavior).

4. Running away from home overnight at least twice while living in a parental or parental surrogate home.
5. Persistent lying.
6. Unusually early or aggressive sexual behavior.
7. Unusually early drinking to excess.
8. Thefts.
9. Vandalism.
10. Required to repeat school grades, or grades markedly below those expected on the basis of estimated or known "IQ."
11. Chronic violations of rules at home and/or at school (rather than truancy).

C. at least three of the following since age 15:

1. Poor occupational performance over several years, as shown by either (a) frequent job changes (three or more jobs in five years not accounted for by nature of job or economic or seasonal fluctuation), (b) significant unemployment (six months or more in ten years when expected to work), or (c) serious absenteeism (average three or more days late or absent per month). N.B.: Poor academic performance for the last few years of school may substitute for this criterion in individuals who, by reason of their age or circumstance, have not had an opportunity to demonstrate occupational adjustment.
2. Three or more non-traffic arrests, or one felony conviction.
3. Two or more divorces or separations (whether married or not).
4. Repeated physical fights or assaults (not required by job or to defend someone).

5. Repeated thefts, whether caught or not.
6. Illegal occupation (e.g. prostitution, pimping, drug sales).
7. Repeated defaulting on debts or other major financial responsibilities (e.g., child support).
8. Traveling from place to place without a prearranged job or clear goal, or without a clear idea of when the travel will terminate.

D. no period of five years or more during which the individual behaved in a conforming manner, with the exception of time spent bedridden, confined to a hospital or penal institution, or under treatment.

E. does not meet established criteria for a diagnosis of Schizophrenia or severe Mental Retardation."

In addition, the following "essential features" of the antisocial personality disorder are described by the DSM III draft:

..... antisocial behavior in many areas beginning before the age of 15 and typically from earliest school years or before, and persisting into adulthood. As an adult there is invariably a markedly impaired capacity to sustain lasting, close, warm and responsible relationships with family, friends, or sexual partners, and a failure to sustain good job performance over a period of several years.

It would appear as if the abovementioned authors regard sociopathy as a psychopathological condition with a clearly recognizable symptomatology. However, Millon's observation (op. cit.) that the difference between the symptoms of sociopathy and normal behaviour is essentially one of degree is also valid, since most of the symptoms of sociopathy also occur to some extent in non-sociopaths. This difference of degree

is of considerable importance, although it is difficult to determine the degree or intensity at which the deviative behaviour is to be regarded as sociopathic. The culminative effect of the various behavioral symptoms, however, is of the utmost importance. The "normal" person displays certain sociopathic behaviour patterns at times, but generally not persistently. In other words, it is the intensity or persistence and totality of the deviant sociopathic behaviour patterns which determine a culminative diagnosis of sociopathy.

Since this study is mainly concerned with the child with strong sociopathic tendencies, the symptoms manifested in the child will be discussed primarily, with only occasional reference to the adult picture.

THE SYMPTOMS DISPLAYED BY THE CHILD WITH STRONG SOCIOPATHIC TENDENCIES

The description of the child with strong sociopathic tendencies is still based largely on the behavioral deviations and the lack of emotional warmth displayed. It must be stressed that, though the sociopathized child displays disturbances in his relationships with and feelings for others, this does not mean that he possesses no feelings at all. He decidedly experiences more basic emotions of fear, anger and hatred, but the subtler emotions such as love, sympathy, loneliness and longing elude him.

Shaw (1966, p. 24) says the following: "*The diagnosis of (child) psychopathy becomes, more than any other of the psychiatric disorders, a subjective one involving to a large extent the feelings which the examiner experiences in his contact with his patient.*" He also mentions that once the therapist gets to know the sociopathic child truly well, he will be able to identify him instantly. "*But once having known such*

a one, there is no mistaking a truly empty child" (op. cit., p. 242).

A brief summary of the principal characteristics of the adult sociopath according to authors such as Maslow and Mittelman (1951), Cleckley (op. cit.), McCord and McCord (1965), Craft (1966), Roux (1972) and Millon (1969) will now be given, followed by a discussion of the major symptoms by which sociopathy can be diagnosed in children, according to Redl (1957), Karpman et al. (1950), Kanner (1966), Verville (1967), Backwin and Backwin (1961), Keesom (1971), Rosen Fox (1972), Vetter (1972) and William Reid (1978).

1. Absence of notable psychotic or neurotic symptoms or mental deficiency

As indicated in the delineation of the condition, no neurotic or psychotic symptoms occur. An underlying psychotic process could exist together with the sociopathic condition, but is not imminently part of it.

2. Disregard for social norms

According to Millon (op. cit.) the principal symptom of psychopathy is a total disregard for any social norms. He points out that psychopaths act as if group values simply do not apply to them. This contempt of norms is manifested in asocial conduct or even overt aggression against the norms.

However, many mentally sound children also display a certain degree of antisocial conduct during the process of developing into adults. The antisocial modes of behaviour of the sociopathized child will therefore have to be investigated thoroughly in order to distinguish between sociopathic symptoms and "normal" rebellious behaviour displayed by ordinary youths in their quest for identity.

2.1. Unmanageability and disobedience

Disobedience is basically resistance to authority. Sometimes this resistance serves a purpose and particularly in the child a certain amount of resistance is necessary in order to achieve self-emancipation. In the normal family, however, this should not cause insurmountable problems. Kanner (op. cit., p. 688) states that disobedience only becomes problematic if a child is driven to rebellion by his parents. Complete unquestioning obedience, on the other hand, is equally pathological: *"Complete obedience is the expression of pathologic submissiveness resulting from suppression of spontaneity and initiative. The perfectly obedient child is one who has been crushed, whose tremendous sense of guilt has paralysed the natural drive for self-assertion."*

According to Perls (1963) resistance to authority occurs more persistently in sociopathized children than any other single symptom. He argues that they are basically incapable of coping with their reality, and try to handle it by rebelling against authority.

Freedman (1976) p. 550) puts it as follows: *"It is the fear to face reality, not the often repeated platitude of 'resistance to authority' which forms the most reasonable and therefore the hardest to overcome source of resistance."* He also points out that authority is that part of their reality which they handle with the greatest ease. More often than not the child with the strongest sociopathic tendencies appears to become the most hardened warder's best friend, only to carry on blithely with his criminal actions once he is released. The sociopath often proves to be a model prisoner.

The "normal" child displays varying degrees of disobedience, ranging

from passive resistance to overt and total rejection of authority, which results in unmanageability. Usually in the "normal" child this rebelliousness is merely a phase of development. Once adulthood is reached authority and the social norms are generally accepted and integrated.

The resistance displayed by the sociopathized child often falls well within the bounds of manageability, but equally often he refuses to recognize or submit to any authority whatever. The one and only form of authority he accepts is his own, and he rejects any other authority which attempts to control him. In the sociopathized child rebelliousness is not a temporary phase which resolves itself in adulthood. His resistance increases rather than diminishes and develops into a mode of living in adulthood.

2.2. Theft

The term "theft" only applies after the child has become aware of the fact that certain objects belong to others, in other words - in terms of Piaget (1969) - when object constancy together with object cathexis has been established. In the discussion of the dynamics of sociopathy the basic object cathexis disturbance which occurs in the sociopathized child will be investigated more fully. It may be concluded that for the sociopathized child theft means something entirely different than for another child who becomes guilty of theft due to some other psychological problem.

The very young child cannot be accused of theft since he is not yet aware of the concept of personal possession. From a psychological point of view theft is a complex concept and the reasons why children

steal are equally complex. Kanner (op. cit.), p. 697-705) indicates the following motives for theft by children:

2.2.1 Desire to possess

If a child's parents are over-indulgent and allow him everything under all circumstances, he can be led to appropriate for himself everything that he desires. On the other hand, if parents consistently deny their child everything, the temptation to possess what his friends have, may simply prove too strong to resist.

2.2.2 Loose social standards at home

"In many instances children's stealing develops naturally in a environment permeated with asocial or antisocial attitudes" (Kanner, op. cit., p. 698). If a child cannot internalize social norms from his immediate figures of authority or is confused because his parents do not conform to the same norms structure which they impose on him, rejection of these norms by the child may result. In the sociopathizing process the sociopathized child often transfers the asocial conduct of his parents to his own behavior patterns.

2.2.3 Need for recognition and prestige

The child who feels inferior or whose parents are unaware of the fact that he wishes to compete with his peers on an even footing, sometimes reverts to stealing to assert himself. *"These children do not steal deliberately but out of a grave emotional conflict. Unable to attain coveted affection, they help themselves to earthly goods which are within their reach"* (Kanner, op. cit., p. 703).

Since the sociopathized child is generally a "lone wolf" and apparently sets little store by the affection of others, this motive for theft obviously does not apply to him.

Amongst 44 child thieves Bowlby (1944) found 14 who could be classified as "a character type which has been christened affectionless." These children can be regarded as sociopathized children who have been subject to a negative process of socializing from a very early stage.

There are many reasons for theft amongst children. The principal difference between theft by the "normal" child and that by the sociopathized child is the fact that the "normal" child steals in an attempt to communicate some underlying problem to the adult, while in the sociopathized child theft is a primary purpose as such. The sociopathized child steals merely to gratify his own desires or to get what he wants. If he is caught, he displays no sense of guilt or remorse. He steals consistently over a long period of time and punishment has no effect whatever.

2.3. Arson

According to Verville (op. cit.) and Kanner (op. cit.) arson occurs mainly in two groups of children: children who have perfectionistic mothers and rejecting fathers on the one hand and sociopathic children on the other. In both cases aggression is the initiating factor, in the first instance directed mainly against the mother and in the second at society in general.

2.4. Truancy

Verville (op. cit.) ascribes truancy in the sociopathic child to his inability to persist with a given task, his aggressive conduct which brings him into conflict with authority, and the poor parental control which often characterizes the home situation. This symptom is one that varies greatly in sociopathized children. Some may attend school regularly

and even achieve satisfactorily while others show little progress because of absenteeism. Intelligence obviously does play a role, but not a conclusive one.

2.5. Sexual offences and drug abuse

In some sociopathized children sexual offences occur at a very early age. These offences are usually of a nature which cannot be ascribed to the ordinary curiosity of the developing child.

Many sociopathized children use drugs and alcohol. However, drug abuse as such cannot be regarded as a symptom of sociopathy, but rather as the outcome of the basically impulsive and uncontrolled personality structure of the sociopathized child.

2.6. Aggression

Most sociopathized children are guilty of deeds of aggression and destruction. A characteristic of these children is that they act destructively without apparent reason. They can display aggression with a smile. Redl (op. cit.) who has worked with sociopathized children for many years, describes their aggression and hatred as follows:

"They have to survive by aggression in a world of struggle. There is a great difference between the child who occasionally kicks back at frustration or expresses the negative side of an ambivalent feeling towards brother or sister and the child who has been reeling under the impact of cruelty and neglect to such a degree that the acid of counter-aggression has eaten itself by now into the very stomach linings of his adaptation system. There is also a great difference between the child who breaks into some minor aggressive rebellion from time to time and the child whose aggression seems to flow uninhibited, skipping even the in-between stages of fantasy, into direct action of reckless destruction into flare-ups of blind and murderous rage" (p. 22).

Redl (op. cit.) also points out that, while in some of these children aggression takes the form of a stream of uncontrolled aggressive deeds, others display their aggression more subtly or conceal it entirely behind a facade of affection and friendliness, which is maintained only for as long as it serves their purpose. Alternatively, they withdraw into an attitude of apathetic indifference to society in general. Behind this apparent cold front, however, they harbour unmitigated aggression, destructivity and hatred, which is their response to deeds of aggression and neglect committed against themselves. They are, in a manner of speaking, frozen into apathetic (im)mobility, but their repressed aggression can erupt without any warning into a volcanic of hatred which would shock even the most seasoned therapist if he is not yet familiar with such boundless youthful hatred.

The more aggressive antisocial actions of the sociopathized child will now be discussed briefly.

2.6.1 Destructivity

Just as a child cannot be accused of theft before he fully understands the concept of ownership, purposely destructive conduct cannot be regarded to occur before a child has developed a system of value. Nor does a child initially have the discriminative realization that things can break. It is through incidental experiences coupled with the approval or disapproval of his immediate figures of authority that a child learns to cope with his object world. As in the case of theft, the child can only handle his object world adequately once object constancy and object cathexis are properly stabilized.

After this stabilizing process the destructive conduct which occasionally occurs in the "normal" child is usually due to clumsiness,

haste, curiosity, robust games or sometimes even momentary aggression. In the sociopathized child, however, destructivity is not incidental, but forms part of his established behaviour patterns and attitude to life.

6.2.2 Cruelty

Although cruelty can be regarded as a form of destructive behaviour, it is the most objectionable and socially the most alarming form. Kanner (op. cit.) makes the following differentiation between incidental cruelty in the "normal" child and sociopathic cruelty. The sociopathized child is habitually cruel, enjoys his deeds of cruelty and displays no apparent sympathy with his victim. An impulsive element is often present in their actions. The "normal" child may react cruelly when angry or jealous, but his deed is usually connected with whatever happened to upset him, while the sociopathized child needs no specific provocation to prompt him to cruelty. "He derives pleasure from seeing others suffer. He lacks any trace of sympathy." (Kanner, op. cit., p. 711). Kanner (op. cit.) also points out that most sociopathized children were themselves subjected to cruelty from parents, often in the guise of discipline.

6.2.3 Murder

Bender (1959) established that most murders committed by children under 16 years of age were of a highly impulsive and mostly exceedingly cruel nature. He traced the causes of these murders back to every possible psychopathological condition, including sociopathy in the child.

The official report on a recent case presents a typical picture

of the sociopathic juvenile murderer: Two sociopathized boys, aged 10 and 12 years respectively, had tortured a five-year old boy slowly and cruelly and had then drowned him. They readily admitted having committed the deed and laughed about it. The following extract from the interrogation report illustrates their attitude to the murder:

"Both had the sultry, case-hardened air of cold brutality the commissioner had grown to associate with dockland thugs

'Why did you do it?' asked the commissioner quietly.

'Well', answered Wolfgang, 'we've drowned lots of things, but only cats and dogs and mice. We wanted to know what it feels like to kill a real, live person.'

'It feels nicer,' added Gunther. (Peter Bach, 1974, p. 51).

3. Pathological unreliability and untruthfulness

According to Roux (op. cit.) it appears that the adult psychopath cannot distinguish between truth and falsehood and often tells lies without apparent reason. In spite of being repeatedly confronted with his lies, he will object strongly if his word is questioned later on. Cleckley (op. cit., p. 386) points out that the clinical picture is further complicated by the fact that the psychopath does sometimes tell the truth, and is even capable of reliable work. Precisely this, according to Cleckley, is what makes him all the more unreliable.

Millon (op. cit., p. 430) regards lying as a conscious mechanism to handle and manipulate people: *"Untroubled by feelings of guilt and a sense of loyalty they often develop a pathological talent for lying. Unconstrained by matters of honesty and truth, they learn with great facility to weave an impressive picture of their superior competencies*

and reliability."

Conscious misrepresentation of the truth generally does not occur in toddlers, since their superego system is not yet developed. Unconscious misrepresentation, however, frequently occurs in pre-school children and is often incorrectly labelled as "lying". Before the age of three a child will lie purposely only by way of exception. According to Kanner (op. cit., p. 691) a lie can be defined as follows: "the two principal criteria of a lie are knowledge of the untruth, of the utterance and the goal of gaining advantages or avoiding unpleasantness." Verville (op. cit.) regards lying as normal in the pre-school child. The super-ego is not yet sufficiently developed at that stage to control the actions of the child. A sense of guilt about his lies is therefore rare in the young child. Lying in the true sense of the word does not appear until around six years of age. Verville also points out that the frequency and character of the lies must be considered in determining their pathological nature.

Kanner (op. cit.) distinguishes between various forms of lying in children:

3.1. Distortion or denial of the truth

This occurs when, for instance, a child merely denies having broken a plate or maintains that he could not do his homework because he had a headache.

3.2. Exaggeration

Because a child's reality testing is still so close to the world of fantasy he exaggerates easily, often without intentionally distorting the truth.

3.3. Creating his own fantasies

This happens when a child presents as facts things which he wishes would happen, in order to make him appear important in the eyes of others.

3.4. Confabulation

Confabulation is used to supplement those aspects of reality which a child cannot account for.

3.5. False accusation

Children sometimes accuse others of offences which they did not commit. Accusations, for instance, that they have been assaulted by others are not uncommon amongst sociopathic adolescents.

Although the lies told by sociopathized children contain elements of the abovementioned, the psychopathological element is dominant in their lying. Hayly (in Kanner, op. cit., p. 693) defines pathological lying in the sociopathized child as follows: "*Pathological lying is falsification entirely disproportionate to any discernible end in view, engaged in by a person who, at the time of observation, cannot definitely be declared insane, feeble-minded or epileptic. Such lying rarely, if ever, centers about a single event; it manifests itself more frequently over a considerable period of years, or even a life-time. Various charges against others, or even self-accusations are sometimes indulged in, which may prove troublesome matters in courts of law.*" Kanner (op. cit.) points out that this process is highly complicated in the pathological liar and rarely occurs in the normal child. If it does occur, he regards it as an indication of an underlying process of sociopathizing.

Verville (op. cit.) contends that the child who lies pathologically is basically unsure of himself and is constantly trying to escape from

his threatened reality into fantasy. This description agrees with the picture of the sociopathized child who, in fact, exists by virtue of that which threatens him.

Of considerable importance here is the fact that the sociopathized child eventually grows to believe his own falsehoods, and even when detected and confronted with his lies, still displays no sense of guilt or remorse.

4. Inability or unwillingness to adapt after punishment or to learn from past experience

Although adult sociopaths generally possess average or above-average intellectual faculties and are capable of clear and logical reasoning, they are manifestly lacking in self-insight and the ability to anticipate the consequences of their actions. Millon (op. cit., p. 430) observes that, even though they have the cognitive ability to understand why their conduct should be modified, they are simply not capable of modifying their behaviour in order to reverse their social misconduct.

Maslow and Mittelman (op. cit.) support this view and point out that punitive measures have no modifying influence on the sociopath's conduct. Punishment, in other words, has no positive effect whatever on the sociopath, for the simple reason that he is incapable of effectively learning from past experience.

The sociopathized child displays the same inability to react constructively to ordinary punitive measures. He may commit the same offence time and again, and merely shrug or laugh it off. Keesom (op. cit.) attempts to explain this characteristic of the sociopathized child on the grounds of his impulsiveness. The sociopathized child lives for the moment, and will react only to immediate stimuli. He is incapable

of transferring experiences from one occurrence to the next.

Keesom (op. cit.) also indicates that the sociopathized child is extremely egotistically inclined, with the result that he cannot realise the consequences which his actions may have for others, and is thus unable to experience any feelings of guilt which could have an inhibiting effect.

5. Lack of emotional depth

The sociopath displays an inability to experience and integrate deeper emotions on a personal level. However, this does not mean that he experiences no emotions at all. On the contrary: sociopaths are often notably adept at expressing emotions verbally, but are apparently incapable of experiences at a deeper emotional level (Roux, op. cit. p. 10).

Millon (op. cit.) goes even further in stating that the sociopath not only lacks all depth of feeling, but even derives pleasure from the pain of others. In other words, the sociopath is apparently unable to experience any true empathy with or love for others, and will even go as far as intentionally injuring others with apparent enjoyment.

"To achieve these malevolent ends, they often go out of their way to exploit others, enjoying not only the tangible fruits of their cunning and deceit, but the distress and pain they leave in its wake" (Millon, op. cit., p. 430).

Terruwe (1958, p. 30) ascribes the vicissitudes of the sociopath's emotional experiences to his inability to exercise cognitive control over his emotions. He regards the sociopath as cognitively bound to the concrete and accordingly impulsive, without the ability to progress to finer abstract emotional experiences.

The question arises how any person can be capable of such strong negative emotions and yet be totally incapable of the opposite, i.e. experiencing positive emotions. As yet the literature offers no solution.

The lack of feeling manifested in his actions more than any other single symptom is diagnostic of the sociopathized child's psychopathology. The psychotic child also displays emotional blunting, but never of quite such a coldly calculated nature as the sociopathized child. At times it appears as if these children derive a sadistic pleasure from their emotional blunting. They do not display any feeling whatever towards those who are injured by their actions. Even their parents are callously exploited to their advantage. Shaw (op. cit.) points out, however, that although sociopathized children display no feelings for other people, this does not mean that they do not experience any feeling at all. The more basic emotions, such as fear, anger and pleasure are decidedly experienced by them, but the more truly human emotions, such as love, joy, sympathy, loneliness and longing elude them. He also states that the diagnosis of child sociopathy is made principally on the basis of this inability to form relationships. "It involves a lack of feeling, an awareness that nothing personal exists between patient and examiner, there is no warmth, no human spark" (Shaw, op. cit., p. 241).

6. Impulsive hedonism

Cornyak (1940) describes the adult sociopath as a person who has no control over his id impulses. Millon (op. cit.) regards him as someone in whom pleasure-hunting and immediate gratification of desires run rampant. Sociopaths are easily bored and cannot direct their full

attention to one particular task in order to complete it satisfactorily. *"Quite characteristic is a proneness to taking chances and seeking thrills, acting as if they were immune from danger. Others jump from one excitement and momentarily gratifying escapade to another, with little or no care for potentially detrimental consequences"* (Millon, op. cit., p. 430).

This impulsiveness is manifested in most of the actions of this personality type and it appears as if lack of cognitive control over their actions is one of their principal problems. This means that they seldom plan their actions in advance and mostly react to a momentary impact. They are opportunistically inclined and often retain an astonishing optimism in situations in which a normal person would display well-founded worry.

All sociopathized children are impulsive. This is apparent in their conduct and speech and it often leads to antisocial actions. It would appear as if these children have a control defect. This aspect will be discussed more fully under the dynamics of the sociopathized child. It must be pointed out that other forms of psychopathology, such as brain damage and minimal brain disfunction also involve serious impulsiveness, but that the other symptoms of sociopathy are usually not present in these other conditions.

Shulman (1957, p. 80) expresses the view that this impulsiveness stems from the sociopathized child's inability to cope with anxiety. He describes these children as "grossly intolerant of anxiety or for that matter of any ego-dystonic feelings" and maintains that, in order to cope with tension, they react impulsively, aggressively and with total disregard for the values and feelings of others.

7. Apparent lack of anxiety

A certain amount of anxiety is necessary to motivate man and to prevent intentional violation of norms. This function is apparently absent in the sociopath. This does not mean that psychopaths never experience anxiety, but it does appear as if anxiety does not occur or function to the same extent as in the average person (Roux, op. cit., p. 12).

Saunders (1972, p. 66) differentiates between two types of psychopaths, viz, the primary psychopath, who apparently experiences no anxiety, and the neurotic sociopath, "who has a high anxiety level which is acted out antisocially." He also describes psychopathy as primarily a defense against anxiety.

Whereas the adult sociopath is described as largely free from anxiety, a high level of anxiety is manifested in some sociopathized children.

The "normal" child's anxiety falls within manageable limits and he copes with it by means of fantasy, day dreams, delusions of grandeur and play. The sociopathized child's world is so unpredictable and overwhelmingly threatening that he is totally unable to cope with it. According to Redl (op. cit., p. 81) sociopathized children resort to the following means of handling their anxiety: either they totally avoid any potentially pleasurable activity if it presents even the most insignificant element of anxiety, or they react with diffuse aggression against any person or object which happens to be in their vicinity.

8. Manipulation of others for own purposes

On account of his egocentricity the adult sociopath is constantly

manipulating other people to his own advantage. The facade which he presents to the world at large often invokes sympathy and enables him to use and exploit other people adroitly without them being aware of the fact.

Even though sociopathized children appear to be basically feelingless, they possess a remarkable ability to gauge a social situation and exploit it to their advantage. Therapists are often amazed at the way in which even young children manage to manipulate others. These children have obviously had to maintain themselves from a very early age and have accordingly developed a refined manipulatory ability.

Keesom (op. cit., p. 116) indicates that the sociopathized child often appears to be a "prachtkerel" (great guy), but misleads and manipulates other people through his verbal dexterity.

In spite of their disregard for the rights of others, both the adult and child sociopath present a facade of sincerity, humanity and maturity. With this "mask of sanity" they often succeed in winning the confidence of other people initially. Generally they are eventually exposed and leave their victims aghast at the way in which they have allowed themselves to be misled.

9. Low level of frustration tolerance

Henderson (1969, p. 307) indicates that, although the adult sociopath is grown-up in years, he reacts like a child, due to his extremely low frustration tolerance level. Roux (op. cit.) agrees with this view and points out that the sociopath usually handles frustration negatively by means of violence or other forms of uncontrolled aggressive conduct.

The child sociopath also displays an extremely infantile and low

frustration tolerance level, and is consequently unable to function successfully under stress.

10. Inability to form intimate meaningful interpersonal relationships

The sociopath is incapable of affectional involvement with other people and consequently forms only superficial relationships with others. These superficial bonds occur both in the child and adult sociopath. The child's bond with his parents is often extremely superficial and relatively meaningless.

Cleckley (op. cit., p. 369) feels that the only binding emotion which the sociopath experiences in interpersonal relationships are those of self-love. From this it becomes clear that for the sociopath a relationship is only meaningful in as far as he can benefit from it, and he will consequently break off any relationship as soon as the needs of the other party intrude.

Frankenstein (1959, p. 12) regards the sociopath's relationships as pseudo-relationships, because *"the psychopath does not feel with the other on the basis of genuine self-to-self relationship but only understands the mask the other wears, the role he plays in his own eyes and for his environment."* He wears a "mask of sanity" himself and therefore only understands the mask which the other presents to the world.

The basis of all therapeutic work is the relationship which exists between the therapist and the patient. It is obvious that with a sociopath such a relationship is extremely difficult to build up. To the therapist of the sociopathized child this "defect" presents a considerable obstacle in the development of a relationship of trust.

11. Absence of feelings of guilt

The mentally sound person whose conscience functions have developed normally usually displays guilt, shame and remorse if he has committed an offence. In the adult sociopath this faculty is absent. He lacks all adult values systems and moral standards, and is capable of committing any offence or antisocial act without the least indication of feelings of guilt, remorse or shame (Roux, op. cit., p. 11). Millon's view (op. cit., p. 430) supports this: "They are devoid of guilt and remorse as a consequence of their malicious acts."

In psycho-analytical terms the function of the superego is to control man through feelings of guilt when the introjected norms of society are contravened. From this it would appear as if sociopathy involves a defectively functioning and possibly under-developed superego, an aspect which will be discussed in greater detail at a later stage.

Since the child is still in a process of development, feelings of guilt do not emerge strongly before adolescence. In the sociopathized child this symptom is accordingly of less importance than in the adult sociopath.

Since the child's superego has not yet been fully established, the symptoms discussed under points 12 to 15 are equally of less importance in relation to the sociopathized child. They are, however, mentioned briefly for the sake of completeness.

12. Pathological egocentricity

Wilson and Prescott (in Cornyak, op. cit., p. 1328) and Henderson (op. cit.) regard sociopaths as grown-up children who do not learn to

handle their primitive impulses in an adult way. They remain children who think that "the world is made for their pleasure and exploitation" (Cornyak, op. cit., p. 1328) They live as if they form the centre of the universe, and the egocentricity in all their thoughts and actions assume pathological proportions.

13. Lack of perseverance

The psychopath's actions are conspicuously lacking in any form of advance planning or long term objectives, which means that he does not live according to any plan or purpose. (Roux, op. cit., p. 14), Henderson (op. cit.) and Arieti (op. cit.) point out that, although the sociopath is capable of excellent work for a limited period, he cannot persevere long enough to work out a life plan. This changeability in the sociopath occurs in all walks of life and prompts him to favour short term above long term objectives. Considering the sociopath's basic impulsivity, hedonism and egocentricity, this characteristic is understandable. Only that which appeals to him directly and reaps instant benefits is of any importance to him.

14. Irresponsibility

The sociopath is neither able nor prepared to accept responsibility for his actions. *"Perhaps such people mean for the moment to do what they promise so convincingly, but the resolution passes almost as the words are spoken"* (Arieti, op. cit., p. 572).

Sociopaths may function successfully for a period of time and even show real talent in a certain field, but they almost inevitably wreck their own chances irresponsibly and without proper cause. It is this characteristic which influences their work record so unfavourably.

15. Lack of insight

Although the sociopath's reality orientation is adequate and his thought processes rational, he displays a notable lack of insight into his own conduct. Through rationalization he blames anyone and everyone except himself for his deeds.

According to Cleckley (op. cit., p. 400) the sociopath is totally incapable of seeing himself as others see him. In other words, his self-image and self-view appear to be distorted, and this lies at the core of his lack of insight into the consequences of his own actions.

SUMMARY

According to the literature the characteristics or symptoms discussed in the foregoing are the principal features of the sociopath. Although all these symptoms form part of the clinical picture of sociopathy, they seldom occur simultaneously in any one person who is diagnosed as sociopathic.

Looking at the literature, one cannot help wondering whether the lack of feeling in these children might indicate a basic neurological disorder, possible in the reticular or mid-brain system, which could prevent more positive feelings. Much research will still have to be done in this field if a satisfactory solution is to be found.

The possibility of a cognitive control defect, causing the impulsivity of the sociopath seems much more acceptable to the authoress. It also fits in better with the possibility of a mid-brain defect, an assumption which is as yet merely based on the knowledge of brain function and has not been proved.

The authoress is of the opinion that the sociopathized child does

in fact experience anxiety, but that due to being exposed to excessive anxiety, his reactions are not one of retreat or attack, which would have been normal, but of freezing into feelinglessness, so that by the time he has grown into an adult sociopath, his anxiety is no longer apparent.

Sociopathy is a complex condition, but notwithstanding this complexity it constitutes an entity which can be delineated as separate from other forms of psychopathology.

The child with strong sociopathic tendencies usually displays most of the symptoms which occur in the adult sociopath, but the fully-developed picture is not yet manifested. The sociopathized child generally still exhibits a high level of anxiety, which can be used positively as a motivating factor in his therapy. His affectivity is usually not yet altogether blunted, but is mostly of a negative nature, leading to destructive aggressiveness. In other words, the clinical picture of the sociopathized child is one of a developing pathology. It is for this reason that the term "sociopathized child" or "child with strong sociopathic tendencies" is preferred to that of "sociopathic" or "psychopathic child", since the latter descriptions imply a fully developed clinical picture, which seldom occurs in the child.

CHAPTER IV.

THE ETIOLOGY OF SOCIOPATHY AND THE DYNAMICS OF THE CHILD
WITH STRONG SOCIOPATHIC TENDENCIES

In the description of the concepts of sociopathy and psychopathy no differentiation could be made between the two clinical pictures. However, the question arises whether a more accurate delineation would not become possible through the etiology. The etiology of the conditions will now be discussed briefly.

GENERAL ETIOLOGY OF SOCIOPATHY/PSYCHOPATHY

Since Adolf Mayer delineated psychopathy as separate from the neuroses in 1912 several theories have been formulated in an attempt to gauge the etiology of psychopathy. On the strength of Bolsi's research (Roux op. cit.) on the connection between encephalitis and psychopathy, one group of researchers tried to trace the cause of the condition back to pathological brain cells, while the developing school of psycho-analysis sought the solution within its own framework. More recently other schools of thought, such as behaviorism, have also put forward their theories on the causes of psychopathy. From all these, two schools of thought in particular have emerged, viz, that which ascribes the condition of the psychopath to his unique genetic-constitutional individuality and another group which finds the causes in the influence of the social environment. Both approaches will be discussed in order to indicate that they do not necessarily represent conflicting or contradictory viewpoints.

1. Genetic and constitutional factors

1.1. Typological theories

Hippocrates already established a connection between physical constitution

and personality. He described four basic body fluids which he claimed to influence the personality directly. Galen elaborated on this theory in the second century A.C. and described nine different personality types which were supposedly caused by combinations of body fluids. One of these personality types was the criminal (Wolman, 1965).

In 1902 Lombroso made the allegation that criminals belonged to a certain type of persons "who were biologically defective or inferior" (Voss et al., 1971, p. 6). Hooten (op. cit.), who undertook an anthropological study of criminals, supports this view and describes the criminal as physically-anthropologically deviative.

Although Kretchmer and Sheldon (1940) devised a typological classification of people according to physical build by which criminals and more particularly psychopaths could be classified, they did not describe these groups as separate types. Sheldon claims that "major components must be determined by constitutional factors" (Wolman, op. cit., p. 292). In other words, his conclusion is that most forms of behaviour, including criminal behaviour, are determined constitutionally and for each person uniquely.

1.2. Neurological theories

Henderson (1939), Bender (1947) and Silverman (1943) observe that personality changes in patients frequently occur after brain trauma or infection, and certain researchers have attempted to find the solution for the etiology of sociopathy in this. Thomson (1953) and Kanner (1966) point out that sociopathic tendencies frequently occur after brain damage and encephalitis, particularly in children. Stafford Clarck (1951)

indicate that 54% of the sociopaths examined by them displayed a clinical history of brain damage and epilepsy.

Thomson (1955) established that only 6.4% of a group of criminals examined by him did not display any neurological disorder, compared to 74.43% of a control group of non-criminals. The main objection to these investigations is that the authors treat sociopathy and delinquency as synonymous.

Reid (op. cit.) maintains that, although various researchers have attempted to prove a connection between sociopathy and epilepsy, particularly temporal lobe epilepsy, in his opinion none of them have succeeded. Grunberg and Pond (1957) also question the connection between epilepsy and sociopathy and point out that only 9% of all epileptic children display serious behavioral deviations.

Harrington and Letemedia (1958) question the possibility of a connection between brain trauma and sociopathy and maintain that the consequences *"are more related to the pre-traumatic personality, and persistent adverse environmental factors continuing after the accident, than on severity or site of brain injuries"* (In Craft, 1965, p. 20).

It would appear, in other words, as if no clear proof exists that brain damage can initiate sociopathic conduct or that all sociopaths display signs of brain damage (Puntigan, 1950, and Essen-Müller, 1956).

Infection and brain diseases have also been indicated as causes of sociopathy. Although Henderson (op. cit.) recognizes other causative factors, he places considerable emphasis on encephalitis as cause of sociopathy. Reid (op. cit.) points out that in one third of all children who recover from encephalitis lethargica complications occur in the form

of serious psychological deviations of which sociopathy is only one possibility. However, in contrast to this Puntigan (op. cit.) and Essen Möller (op. cit.) could find no evidence of sociopathic deviations in persons who had suffered from meningitis or encephalitis in childhood, and consequently reject the theory that these diseases cause sociopathy.

Thomson (op. cit. , p. 37) disagrees strongly with the abovementioned authors. According to him, sociopathy always involves some form of underlying brain damage: "It is hypothecated that the syndrome of psychopathic personality develops upon the basis of psychogenic factors working upon a previously injured brain."

It is clearly not possible to prove a specific connection between brain damage and psychopathy although most authors agree that it possibly plays a role. A great deal of research will be required, however, before the exact nature of the possible connection can be established.

1.3. E.E.G. deviations

Electrical potential deviations of the brain are determined in vivo by means of Electro-Encephalographical Examination (E.E.G.). In 1942 Hill and Waterson examined the brain rhythms of 104 sociopaths by means of EEG and found abnormal brain rhythms in 65% of these, compared to only 15% of the normal control group. This confirms the research findings of, amongst others, Silverman (1944), Ostrow et al. (1946), Gottlieb et al. (1946) and Erlich and Koch (1956). Following up the research done by Stafford-Clark in 1951, Gibbens et al. established in 1955 that 47% of the sociopaths examined by them displayed abnormal EEG's, indicating immaturity of the cortex.

In his later research findings in 1959 Stafford-Clark (op. cit.) points out that 10% to 15% of the "normal" population also display EEG abnormalities. Levy and Kenhard (1953) and McCord and McCord (op. cit.) established that between 27% and 30% of sociopaths display abnormal records, which is considerably higher than the 10% to 15% of the "normal" population indicated by Stafford-Clark (op. cit.).

Ulman and Krasmer (1969) point out that the mere occurrence of an abnormal EEG record is meaningless in itself, since EEG deviations also occur in other forms of psychopathology. They place more emphasis on the locality and nature of the deviation, namely slow theta rhythms (4-7 Hz), bilateral paroxysmal slow waves which occur mainly in the anterior temporal and frontal areas. These findings are confirmed by Craft et al. (1962), Arthurs et al. (1964) and Monroe (1970). Erlich et al. (op. cit.) and Stafford-Clark (op. cit.) conclude from this that the sociopath displays a delayed maturation process of the cerebral cortex. Monroe (op. cit.) in fact indicates that normal children display slow theta waves (4-7 Hz), but that this deviation diminishes with maturation. This is supported by the findings of Gibbens et al. (1955), Robins (1976) and Reid (op. cit.) that the behavioral deviations in the sociopath diminish with age as from the median age of 35 years. Hare (1970) confirms that delayed cerebral maturation occurs in sociopaths. However, he points out that this hardly explains why retarded cortical maturation should cause sociopathy.

Roux (op. cit., p. 223-224) found the following after an intensive study of the EEG record of sociopaths: The most wide-spread EEG deviation in both psychopathic and non-psychopathic delinquents is distributed delayed activity (particularly theta rhythm) which could indicate the

possibility of delayed cortical maturation as etiological or causative factor in both groups. Contrary to the view generally maintained in the literature, it is not only an important abnormality in outright psychopaths, but also in non-psychopathic delinquents. Roux ascribes this contradiction to the fact that psychopathy occurs in degrees and that non-psychopathic delinquents may also display psychopathic tendencies. The important point in his opinion remains the fact that psychopaths display a higher number of abnormal EEG records (particularly theta and delta abnormalities) than the normal population.

Hare (1970) connects the abnormal spike waves in the temporal brain area and the slow alpha and theta rhythms found by Kurkland et al. (1963) in 40% of sociopaths and by Hughes et al. (1965) in between 20% and 40% of persons with serious behavioral deviations, with a malfunction of the limbic system. According to him the limbic system regulates the ability to learn responses through avoidance of fear. From his research, Hare (op. cit., p. 34) concludes the following: *"We may hypothesize that temporal slow-wave activity frequently observed in the EEG records of psychopaths reflects a malfunction of some limbic inhibitory mechanism and that this malfunction makes it difficult to learn to inhibit behaviour that is likely to lead to punishment."*

Hare (op. cit.) also points out that the malfunctioning of the limbic system may be caused by illness or brain damage, genetic factors or a biochemical disorder. According to him the malfunctioning of the limbic system prevents inhibitory reaction by the system to external stimuli. This could cause the psychopath's impulsiveness.

Roux (op. cit., p. 228) was unable to confirm that positive spike waves of temporal origin occur more frequently in psychopaths than in

his control group. EEG records as such can accordingly not be regarded as diagnostic criterion in relation to psychopaths who come into conflict with the law. However, it must be pointed out that Roux's control group also included persons with behavioral deviations. The results may have been different if the psychopaths had been compared to a control group from the normal population.

Two main theories have emerged from the investigation of EEG as causative factor of sociopathy: One group of authors finds the cause of the condition in delayed maturation of the cerebral cortex which displays spontaneous remission with age. A second group ascribes the condition to a malfunction of some inhibitory mechanism in the limbic system of the brain. Hare (op. cit.) points out that the malfunctioning of the limbic system prevents effective learning from punishment or experience.

Direct localized brain examinations have also been undertaken to throw more light on the condition. Fransen and Meyers (1972) observe that damage to the pre-frontal and antero-temporal cortex causes deviations in the social reaction patterns to environmental stimuli. Persons with brain damage of this nature display diminished social bonding, although social interaction still occurs normally. This observation supports the research done by Radinsky (1969), who says that "the importance of the prefrontal lobes to the regulation of social behaviour is just beginning to be realized" (Fransen et al., op cit., p. 155).

It would appear as if there may be enough reason to assume that sociopathy has an underlying organic basis as revealed by EEG records and studies of direct brain damage. Why these deviations are not observed in all psychopaths remains an open question. It has to be taken into

account, however, that the EEG is a very crude measuring instrument which mainly registers the electrical activity of the cortex and seldom that of the deeper brain structures.

1.4. Genetic factors

For many years it was assumed that sociopathy resulted from hereditary factors. (Pritchard (1835), Koch (1888), Kreapelin (1909) and Patridge (1929)). McCord et al. (1964, p. 71) as well as Arieti (op. cit., p. 583) point out that although the abovementioned early investigators undertook extensive statistical studies in order to confirm their research on heredity, their diagnosis of sociopathy was not always based on entirely accurate diagnostic criteria.

Initially it was attempted to isolate genetic factors from twin studies. Thompson (op. cit.) made an exhaustive study of all the known twin studies in connection with sociopathy and summarized his findings in the following table:

CRIMINAL-SOCIOPATHIC TENDENCIES IN TWINS

(According to Thomson (op. cit.))

Monozygotic (identical twins)				Dizygotic (non-identical twins)			
Criminal conduct in both		in one		Criminal conduct in both		in one	
Number of cases	%	Number of cases	%	Number of cases	%	Number of cases	%
72	69,9	31	30,1	37	33,0	75	67,0

This table shows clearly that criminally deviant conduct occurs more concordantly in monozygotic than in dizygotic twins. According to Thompson (op. cit.) this could be an indication of the presence of

an underlying hereditary factor, and he connects sociopathically deviant conduct of a criminal nature with heredity.

Salter (1953) is of the opinion that hereditary factors play a role, but that the conclusive factor in criminally sociopathic conduct rests in the environment. In his studies he found more non-identical twins than identical twins of which both members were sociopathic. In the same year, Essen-Möller (1953) found exactly the opposite; a concordance of 66% in criminal sociopathic conduct in identical twins, compared to 32% in non-identical twins. In other words, he once more emphasizes the possibility that sociopathy may have an underlying hereditary basis.

Roux (op. cit.) and Reid (op. cit.) point out that the major objection against these twin studies is the selection criteria for identical and non-identical twins. Lange (1930) indicates that the environmental factor can never be isolated completely and constantly influences the child's behaviour. He also emphasizes the fact that monozygotic twins are subject to a more homogeneous environmental variable than dizygotic twins (Lange in Craft, 1965, p. 17).

Studies on parents and relatives of sociopaths were also undertaken in an attempt to isolate the genetic variable. Kallman (1930), for instance, found a higher incidence of sociopathy in parents of sociopaths than in those of the control group. Terruwe (op. cit.) and Craft (op. cit.) established that the parents of a considerable number of sociopaths had been admitted to a mental institute at some stage or another. According to them, two to three times as many instances of schizophrenia and manic-depressive psychosis occurred in the families of sociopaths as in the normal population. From this, Craft (op. cit., p. 107) makes the following

observation: "The review of studies of genetic endowment suggested that while there was no evidence as to direct genetic endowment of offsprings with psychopathic traits by their parents, it was possible that traits were transmitted causing children to react in this way to a later adverse environmental influences." In other words, he also recognizes the fact that although genetic factors may play a role, the environment also contributes towards the development of the sociopath.

Twin and family studies have not proved conclusively that sociopathy is determined genetically. At the most they indicate that genetic heredity does play a role, but that the environment in which the genetic endowment develops also leaves its mark in the development of the sociopathic personality.

In addition to attempts at more accurate analyses of chromosomes in order to determine genetic deviations, fresh research has been undertaken recently into the connection between genetics and sociopathy. The earliest studies mainly involved the XYY karyotype person. Griffiths and Zareba (1967), Brown et al. (1968) and Nielsen and Tsuboi (1970) established that there was a high incidence of the extra Y chromosome amongst hospitalized criminals. It was also established that many of these patients were guilty of offences of an aggressive nature. Brown (1967 in Kesler and Mooss, 1970) states that the correlation between XYY karyotype and delinquency is the most important discovery ever made in human cytogenetics, but that even so this disorder is insufficient in itself to explain the pathology. He once again points out the unique interaction between the hereditary endowment and the environment: "To ascribe to a single chromosome specific behavioral effects fails to take account of a broad range of pertinent environmental

factors and ignores the fact that the phenotype is the result of the total integrative properties of the genome interacting with the environment" (p. 167).

Roux (op. cit.) observed none of these chromosome deviations during his investigations. He comes to the conclusion that to date no definite correlation between antisocial conduct or delinquency and the extra Y or male chromosome has been established (Roux, p. 231).

Roux's research was mainly concerned with the presence of the extra Y chromosome in his testees. The XYY karyotype person is not very commonly found. Kesler and Moos (1970), for instance, mention that between 1965 and the publication of their book only approximately 100 of these patients could be traced. This does not mean to say that other forms of chromosome deviations do not exist in the sociopath. They could quite conceivably be determined in future by means of more refined chromosome analysis techniques.

Research by Nielsen et al. (1973) and Scott et al. (1968) indicates that the IQ of the XYY karyotype person falls within the limits of the normal and average. They ascribe the high incidence of XYY karyotype found amongst mentally retarded person by Brittain and McClemont (1965) and Casey et al. (1966) to the fact that this type of mentally retarded person constitutes a higher criminal risk than other retarded persons, and consequently come to the attention of examiners more readily.

Johannes Nielsen et al. (1973) made a comprehensive longitudinal study of 22 XYY karyotype boys and concluded the following: Learning problems occurred in 81% of the XYY boys, irrespective of IQ, as compared to only 29% of the control group. These problems stemmed largely from behavioral deviations, such as truancy. Criminal conduct at an

early age was found in 52% of the group, compared to 19% of the control group. ($P < \text{than } 0,01$). Impulsiveness as well as an incapacity to form meaningful relationships with others occurred considerably more often in the experimental group. These two aspects are subsequently connected to their susceptibility to developing a mental disorder, more particularly of a sociopathic nature. From his research, Nielsen (op. cit., p.24) concludes the following: *"With respect to personality development and risk of mental disorder and criminality the present study indicates that boys with the XYY syndrome represent a relatively higher risk of encountering difficulties at school, playing truant and manifesting behavioral disorders with impulsivity and ensuing aggressive behavior. Moreover the risk of difficulties in establishing contacts with others, criminality and of entering psychiatric hospitals is also relatively higher in such boys."* A much more comprehensive study will be required to establish a more definite connection between the XYY karyotype and sociopathy.

At present it would appear as if the XYY karyotype cannot be regarded as a cause of sociopathy, but rather that sociopathy may be a symptomalogical consequence of the basic XYY personality. In other words, it is not so much a question of sociopathy having a genetic base as of persons with genetic deviations displaying a pre-disposition to behavioral deviations including sociopathy.

The newer, more refined chromosome analysis techniques, particularly the Giemsa band colouring technique, have made more accurate chromosome studies possible. By means of this technique the chromosomes are coloured, forming transverse bands of lighter and darker shades across the chromosomes. Each pair of chromosomes forms its own specific

identifiable colour bands and this facilitates the study of certain chromosomes and particularly translocation studies considerably. By means of the Giemsa band colouring technique J, Escobar (1976) made chromosome analyses of 30 children with behavioral deviations and found balanced translocations of the 13/14 chromosome in two unrelated children. In addition he found abnormal EEG records of "poorly developed background rhythmic theta activity in the frontal and temporal areas" in these children (1976, p. 121). The estimated translocation ratio for these cases would be 1.7 per 1,000 births, and this makes Escobar's findings statistically highly significant.

The abovementioned study seems very promising, but can at this stage not be regarded as more than an isolated research study which will have to be followed up and verified by further research.

Summary

At present there is still some doubt as to whether or not genetic factors play a role in the etiology of sociopathy. Eysenck (1965, p. 96) feels that heredity always plays a role in all human behaviour in as far as it determines the biological basis of reactivity. There is always a subtle interaction between the biological endowment and the environment. According to Eysenck (op. cit.), an underlying biological basis for sociopathy does exist. Exhaustive genetical studies by T. Reich et al. (1975) also lead to the conclusion that the cause of sociopathy is multifactorial. They regard genetic transmission as polygenetic and recognize the fact that the social environment in interaction with the genetic endowment plays a conclusive role.

Most of the abovementioned authors agree that there may be a genetic

basis to the behaviour of any person, but that the genetic endowment is always influenced and formed by the environment in which it has to develop.

2. Environmental Factors

In the abovementioned studies attempting to delineate the etiology of sociopathy it becomes abundantly clear that, although biological, neurological and genetic factors may play a role in the etiology of sociopathy, environmental factors are also highly significant in the development of the condition.

The earliest investigations on the role of the environment in the development of criminality were concerned mainly with parent rejection, particularly with the separation of mother and child.

In the thirteenth century an early attempt was made by King Frederick II to establish whether language developed spontaneously in children and thus he initiated one of the first known experiments on deprivation, even though it was not intended as such. These children were physically well cared for, but were never spoken to or caressed. Unfortunately all the children used in the experiment died of affective neglect.

Hertzer (1927) and Patridge (1928) were amongst the earliest investigators of mother deprivation. Patridge attempted to prove a direct connection between mother rejection and criminality. In 1928 he carried out case studies of twelve sociopathic boys and came to the conclusion that in all the cases parental rejection played a role in the development of the sociopathic behaviour.

Bowlby (1944) indicated that 14 out of 44 youthful thieves, 12 of which had been separated from their mothers in early childhood, were

cold and apathetic. In 1952 he elaborated on this observation in a World Health Organization report: "*Separation of a child from his mother (or mother substitute) during the first five years of life, stands foremost among the causes of delinquent character development*" (p. 34). The case histories of the children examined by Bowlby indicate a highly traumatic background of affectional neglect and include a number of foster placings, which means that his results can hardly be ascribed only to separation from the mother, although this is what Bowlby maintained.

Goldfarb (1943-1945) indicates that mother deprivation causes intellectual problems. He also points out that deprived children display defective ego and superego functioning, aggressive antisocial conduct and a low frustration tolerance level. Follow-up research by Beres and Ofers (1950) and Bowlby (1965) indicates that personality damage can not necessarily be ascribed to early separation from the mother alone. They conclude that, although personality development may appear outwardly normal in these children, they always display an underdeveloped ego and defective superego functioning in relation to value systems. Sociopathic behaviour patterns occur to a significant extent in these children.

Hilgard (op. cit.) supports these findings, but points out that the degree of vulnerability of a child who is subjected to a separation trauma of this nature can only be measured in adulthood. He also maintains that, even though personality development may appear normal, deprivation in childhood always leaves scars which may open up again at a later stage.

In 1954 Bowlby carried out his major investigation into the consequences of mother deprivation and institutionalization in children. He postulates radically that these children remain scarred in their

adult lives and points out that a considerable number of them become youth delinquents. However, Bowlby does not take sufficient account of those factors which may have played a significant role in the development of the child's personality before separation. He ascribes all deviations to mother deprivation and institutionalization alone. He undertook no long-term studies to follow up his findings and is inclined to excessive generalization in relating childhood experiences to adult life.

More recent follow-up studies investigating the family histories of the children examined by him strongly question the existence of the connection between mother deprivation and subsequent personality pathology. He also appears to have overlooked or underrated man's capacity for recuperation and his ability to cope with trauma (van der Berg, 1970).

A number of examiners have given considerable attention not only to separation but also to the interaction between parent and child at home.

Spitz and Wolf (1946) made a study of the child after replacement with its mother and concluded that the quality of the mother-child relationship before separation was an important variable factor. The child who has had an unsatisfactory relationship with its mother before separation displays a less disturbed behaviour pattern than one who has had a positive mother relationship, because the latter has lost a true love object and mourns this. These children experience problems in developing renewed object cathexis later in life, they become cold and withdrawn and may eventually tend towards delinquency.

Glueck (1950) regards the causes of delinquency as multidimensional,

but emphasizes the fact that rejection by and hostility from the parents, together with inconsistent discipline may lead to criminal behaviour.

Cleckley (1955) points out that some parents who ostensibly accept their children in fact subtly reject them. They maintain a pseudo-relationship of love and care, while in actual fact rejecting the child. This causes feelings of frustration and aggression in the child. *"More prominent than gross difficulties in the surroundings are the indications of beautifully and mercifully veiled sorts of invisible rejection or pathologic stimulation of unspoken but powerfully communicated appeals that evoke efforts resulting in frustration"* (Cleckley, op. cit., p. 483).

Although Craft (op. cit.) recognizes the role of genetic factors in the development of sociopathy, he points out that behaviour patterns are intensified by the example of the parents, which makes it extremely difficult to determine the part played in the development of the condition by learning experiences on the one hand and heredity on the other. However, he reaches the significant conclusion that the parents of 95% of the children examined were either detached or inconsistently hostile towards their subsequently sociopathic children.

Resistance against the absent father in particular is postulated as a cause of sociopathy by Siegman (1966). He contends that the absence of the father forces the son to substitute the mother as identification model. The son rebels against this situation and takes revenge on his society, which he holds responsible for the state of affairs. Siegman bases his investigations on the research by Wilkens (1961), who ascribed the increasing delinquency after World War II to the fact that the war children had been deprived of their fathers. Although this may have been

a contributory factor, the other tension factors connected with the war situation were not sufficiently taken into account. Andry (1966), who undertook a comparative study, disagrees with the abovementioned authors and points out that it is not so much the absence of the father as the unsatisfactory father-son relationship which influences delinquency. In other words, it is the mental rather than the physical absence of the father which is significant. However, this aspect has not been sufficiently investigated to reach any definite conclusion.

The research on cerebrally handicapped children undertaken by Bobath in 1967 brought to light that the earlier the child is diagnosed and treated, the fewer physiological symptoms he display later on. Lourie (1971) concludes from this that during the period from birth to eighteen months the child is at its most pliable and the brain most capable of accommodation and adaptation. During this period pathology is still largely remediable. According to Lourie (op. cit.) the child's brain is still involved in a phylogenetic development process at this stage. He quotes Negara (1969), who sees the development directly after birth as follows: The genetic potential in terms of the development of the anatomic structures of the brain is not yet fully realized at birth. *"The blue-print of that genetic potential - determined by the chromosomes and genes - is such that in order to be unfolded at its fullest, organic anatomical-maturational processes of the brain structure must continue after birth."* This development is not determined solely by the internal embryonic maturational processes, but the full potential is only realized in interaction with external stimuli.

Lourie (op. cit.) also elaborates on the theory of "critical learning periods." He points out that, even though a child may have the potential

to learn a certain behaviour pattern, if he is prevented to do so by environmental deprivation during the critical period, he will be incapable of it at a later stage. He concludes that even the brain structures of a child may be influenced by his environment. If social learning does not take place during the critical period, criminal conduct may result because the personality is not co-ordinated and a defective ego function develops.

Although unquestionable evidence of the influence of the environment on the development of criminal conduct exists, some authors maintain that this influence is over-emphaised. Thompson (1953), for instance, maintains that environmental factors may cause delinquency, but never sociopathy. "A perfectly endowed and integrated nervous system can probably stand any environmental stress without psychopathic or other type of breakdown" (p. 39).

Wootton (1966), Andry (1966) and others reject the possibility that mother separation and parent deprivation may lead to delinquency. They find no evidence of such consequences in their research.

The literature shows clearly that authors and researchers are unable to reach agreement on the role of environmental factors in the development of sociopathy. It is evident that these factors do play a role, but the extent of environmental influence has not been determined as yet.

Millon sums it up as follows: "*Environmental influences are vital, and after conception they gain co-equality with those arising from heredity. However only within the limits set by the genetic constitution of the organism can external factors have an effect on the dynamics of physiological functions and interactions. Beyond these limits, no power plant exists for generating behavioral potentials*" (p. 38).

In the development of sociopathy, in other words, there is a subtle interaction between the hereditary and the environmental endowment, which interact continuously and dynamically to form the unique individual into either a normal or sociopathic person. The deeper dynamics which cause this pathological development will be more fully discussed from various theoretical viewpoints at a later stage.

Summary

Two etiological theories for one individual pathological condition emerge from the foregoing: One group of authors treats the condition as a basically biological pathology, whereas a second group, while not denying the biological factor, places more emphasis on the consequences of a negative socializing process. It is postulated that during the process of development of sociopathy, that is during childhood, one of two factors, namely either the organic or the dynamic sociological factor, plays a dominant role. The authoress feels that there is always an interaction between the two, and that it is difficult to determine which of the two is dominant at any particular stage.

THE MULTI-PROBLEM FAMILY AS ETIOLOGICAL FACTOR

According to Rosen Fox (1972), Schmiddenberg (1961) and others the sociopathized child is largely the product of the lower socio-economic multi-problem family. Charles Melone (1967) mentions that the sociopathized child displays deviations of a sociopathic nature as early as the toddler stage.

The dynamic interaction in the multi-problem family is different from that in the normal family, since it is a heavily conflict laden interaction. Socializing consequently does not take place normally either.

We will now proceed to discuss the factors which cause the pathological development of the socializing process in this type of family and which may eventually produce sociopathized children.

The following social and psychical factors characterize the multi-problem family and exert a continuous negative influence on the child:

1. Maternal deprivation

Bowlby (1951) points out that no child's physical, mental or cognitive development can be normal without the influence of a "mental organizer" (mother) during certain critical periods.

In the multi-problem family the mother is usually mentally and physically over-burdened and simply incapable of giving sufficient attention to each child. Pavenstedt (1965) puts forward that the mother's own unsatisfied needs are so overwhelming that she does not have any extra emotional reserve for involvement with her children. These children are left alone in their cots for hours on end, they are not held while bottle-fed and are seldom cuddled or caressed. The less attention a child demands and the quieter it is, the more acceptable it is to the mother.

Pavenstedt (op. cit.) also points out that these children are alternatively rejected and over-protected. Weaning from the bottle usually does not take place before three years of age and very little effort is made to train the child in the basics of hygiene. The mother is also highly inconsistent in her provision of affection. She will smother a child with affection if in need of it herself, only to reject him the next moment if he wants to satisfy his own affectional needs. Thus these children are subject to ambivalent stimulation, sometimes overwhelming and at other times totally

inadequate. In consequence they do not acquire the constant pattern of affection gratification alternating with healthy deprivation, required to build up their frustration tolerance threshold, with the result that they lack what Kris (1955) calls "initiative for independence."

Provence and Lipton (1962) point out that the sociopathized child derives his security from objects rather than from a constant mother figure. Thus object constancy, the first manifestation of which should be related to the mother (Werner, op. cit.), develops negatively and this influences all other relationships which a child tries to build up later in life. These children are seldom successful in their relationships with others and remain bogged down in a world of "things" because the world of people provides no security. But the "things" also fail to satisfy their needs and are rejected in their turn. This leads to a negative object cathexis of their world. They are quick to learn that indiscriminate friendliness to all gives them power over adults and this forms the early basis of manipulation of others to their own advantage and without emotional involvement.

2. Devaluation

In the multi-problem family a strong sense of inferiority is evident. The children in this type of family grow up in an atmosphere of defeat and develop an inability to do anything about their own destiny. Woltse (1962) observes that these families constantly experience contempt from other people and that even the welfare aid on which they are dependent acts as a daily confirmation of their own inferiority. This situation leads to a strongly negative

self-valuation in the parents, which is transmitted to the children. Rank (1963, p. 78) puts it as follows: *"What is most evident to me is not that the mothers were detached and not there, but rather that the mother's relations to the child fluctuated with the degree of her own self-esteem, that she thus transmitted her own worthlessness to her child."*

In view of the financial destitution in these families the children often possess no clothes of their own and clothes are worn communally. The same applies to the few toys they own. In consequence the child is never in the position to learn to value his own or other people's possessions. In this climate theft ceases to be a crime and merely becomes part of a process of taking what one needs as and when you need it. Thus a singular norm is established in the value system of these children.

As a result of the devaluation process, these people not only lack self-esteem, but the ego fails to build an ideal "self-image" to maintain, and the ego function is consequently characterized by impuseiveness and immediate gratification of desires.

3. Actual physical danger

The under-privileged environment in which many sociopathized children grow up presents actual physical danger situation which simply do not exist in the well-protected world of the ordinary child. The means to provide for their most basic needs are often lacking and discomforts such as cold and hunger are a reality with which they become familiar at an early age. The street is their play-ground and they have to learn to live with its hazards. The parent, who should be the one to protect, is often the one who

threatens or physically assaults them.

Malone (1966) points out that this threatening reality mobilizes very early self-preservation tendencies in children from under-privileged environments. They are forced to assert themselves and fight for their existence at an early age.

According to Blos (1963) these children learn to discern the preferences and dislikes of adults at the toddler stage, and thus learn to manipulate their environment in self-preservation.

Perceptually certain modalities develop hyper-sensitively, while others are blunted. Silberman (1964) and Deutsch (1964) have established, for instance, that these children display defective auditory discrimination, which they need to learn to read, but at the same time are hypersensitive to the sound of an approaching car. They explain this as follows: the noise level in the homes of these children is considerably higher than in a normal home, and the children quickly learn to block out the sound of the human voice, whereas it is necessary for their self-preservation to register the sound of an approaching car.

Anna Freud (1946) established that children who are forced to develop systems of defence against physical danger, use the same defence mechanisms against intra-psychic dangers. Malone (op. cit.) supports her view, and puts forward that these children defend themselves through non-recognition and non-perception of danger instead of actively reacting with visual acuity.

From his experiences in his environment the child from the under-privileged home thus develops a particular ego function which is characterized by continuous self-assertion and a strongly

omnipotent and manipulatory attitude to his world, with a total lack of consideration for other people, due to the threat to himself which he constantly anticipates.

4. Psychic factors in the multi-problem family

The abovementioned environmental factors give rise to certain psychic influence factors which precipitate the sociopathizing process in the child, viz:

4.1. Escape into fantasy

When his reality becomes too threatening for the "normal" child, he develops psychosomatic symptoms, clings to reality or retreats into fantasy and play. The sociopathized child, whose ego system is characterized by an over-developed instinct of self-preservation, retreats into fantasy to the extent that his lies become absolute reality to him.

4.2. Identification

In the sociopathized child internalization of the identification figure is replaced with imitation identification, due to the threatening nature of the identification figure. Hartsman (1962) defines internalization as follows: "regulations that have taken place in interaction with the outside world are replaced by inner regulations" (p. 73). Ritvo and Solnit (1958, p. 73) elaborate as follows: "*Internalization is a term used to describe the process by which the ego forms inner or psychic representations of object persons to whom the child is attached that originally and still influences the child from without. The process is a continuum from perceptions to imitations, to taking over a characteristic of an object in ego identification. The more developed the internalization process, the more subtly and intimately blended is the attitude*

or characteristic as part of the ego."

Hendricks (1951) and Saunders (op. cit.) assume that internalization and identification can only take place under normal external conditions.

Since the sociopathized child is incapable of strong identification with significant figures in his life, the internalization process cannot take place. He progresses no further than imitation, which he uses selectively at a later stage.

4.3. Learning problems

In view of their environmental deprivation the verbal potential of children from multi-problem families is usually handicapped although some of them develop very strongly verbally. (Redl., op. cit.). According to Saunders (op. cit.) their thought processes retain a magical infantile omnipotent character.

Summary

In the sociopathized child the normal socializing process needed for the development of a system of norms and the internalization of identification figures does not take place. Object cathexis - the relation and affectional attachment of the ego to people - is disturbed and the young ego is forced to assert itself in a threatening climate without undergoing any development of sound mental abilities. The result is the sociopathized child with his insensibility, his hatred and aggression against everyone and everything and his calculated manipulatory attitude, which is the only way in which he can manage to maintain himself in the wilderness of the multi-problem family. In other words, what we see is a little man who answers his world in the same terms in which his world spoke to him.

PSYCHODYNAMICS OF CHILD SOCIOPATHY

1. The Psycho-analytical view

Redl and Wineman (1941) call the sociopathized child an "ego-disturbed child". This view was also maintained at the "Round Table" conference on the sociopathized child held in America in 1950. The congress report reads as follows: *"All participants agreed that the pathology lies with the ego development, which can only mean that instinct is nearly at its prestine level; the ego, still a part of the id, is grossly but not culturally developed with a corresponding lessening of the superego development and functioning. There is inability to relate, no opportunity for identification (which becomes lost or distorted), with consequent failure of developing anxiety and guilt because these children do not appreciate threat to object relationships. There is a poorly defined ego concept, and no superego awareness. Rather than being merely hostile in its aggression, the behavior is impulsive and diffulse patterned. Fantasy is shallow, conceptual thinking is defective, there is no motivation to future goals. There is difficulty in language development; projection reaction is prominent"* (Karpman, 1950, p. 224).

From a psycho-analytical point of view the sociopathic child's ego is developing pathologically. To differentiate it from the normal ego one has first to look at the functions of the normal ego.

Heinz Hartman (1950) worked out the concept of the ego. Whereas Freud saw the ego together with the superego as originating from the id, Hartman (op. cit.) as ego-psychologist, sees all three as originating from a mutual core in the genetic "Anlage". According to him the id does not only represent the primitive urges of man, but can also become a positive action-stimulating force in life.

The major purpose of the ego, according to Hartman (op. cit.), is reality contact. In order to maintain this contact, the ego possesses certain functions:

1.1. Functions of the "Normal" Ego

1.1.1 Cognitive function

The basic function of the ego is to maintain contact with the world. It does this by means of perceptual observation and cognitive assimilation of external stimuli into familiar experiences.

This function of the ego becomes possible through its cognitive assimilation of the outside world. In the development of object constancy it is only when the ego comes to recognize itself as separate from its world that it can successfully cope with its outside or object world.

However, the ego should also be aware of what is happening in its internal reality. In other words, the ego must know and recognize its id urges.

In addition the ego must be capable of evaluating its own superego and be sensitively integrated into the value systems of the superego. In other words, there must not be an imbalance between the urges of the id and the superego. These two should be kept in contact and in harmony through the subtle control of the ego.

1.1.2 The power function of the ego

The ego should possess the control function in the personality. In order to maintain contact with reality and to bring the conduct of the person into agreement with this reality, the ego needs energy power. *"We have to assume, for any usable conception of the ego, that it somewhere*

has access to a power system and then can use whatever energies it has at its disposal to enforce the dictates of its insights upon our pleasure-greedy impulse system" (Redl, 1957, p. 64). The term "ego power" implies the strength of the power with which the ego is able to control the personality.

1.1.3 The selective function of the ego

If a person is confronted with conflict situations or threats from his environment it is the task of the ego to select a mode of action. "The old idea that all the ego has to do is to decide whether an impulse can be afforded or not, is over-simplification which needed debunking long ago. Even in the most flash like and simple situation, where the ego resorts to ready-made stereotyped reflex-like "defence mechanisms" it still has to select one from quite a number" (Redl., op. cit., p. 65).

The selective function of the ego is generally discussed under the reality testing ability. In relation to the sociopathized child a distinction is made between the testing of that reality to which the child has to adapt and the testing of the adaptation techniques by means of which the child tries to adapt and their reality context.

1.1.4 The synthetic function of the ego

Numberg (1931) first relegated this function to the ego. In simplified terms it means that the ego determines the role of a particular part of the personality in a particular situation. In other words, it is the function of the ego to determine which part of the personality will be dominantly influenced by the demands of the external reality, the demands of the impulse system and the demands of the norms of the superego system. Psychopathology may develop from an imbalance or

dominance of any of the systems. In the sociopathized child, for instance, the ego throws its weight in with the id impulses, resulting in a criminally inclined superego.

1.2. Pathological ego functioning in the sociopathized child

The ego functions in the sociopathized child start to develop negatively somewhere in the development process and are, in fact, in a process of pathological development during childhood. Consequently, the child's ego cannot develop according to the standards normally expected at his age level. In his book "Controls from within" Redl (1952) discusses this pathological functioning of the ego. The outlines of the ego dynamics of the sociopathic child as drawn by Redl will now be discussed and elaborated by the authoress.

1.2.1 Coping with frustration

Mainly two modes of functioning are involved here, the first of which is a rapid break-through of the impulses, in other words the impulses of the sociopathized child are simply too strong for the controlling power of the ego. Consequently the child reacts impulsively and is unable to exercise adequate control over his impulses. The organic theory formulated by Hare (op. cit.), who puts forward the possibility of a control defect in the limbic system of the brain, supports this. The second mode of functioning is a low frustration tolerance threshold. The sociopathized child is often incapable of tolerating even insignificant frustrations because the ego has never learnt to postpone or control gratification of desires or impulses to the benefit of himself and others.

In both the abovementioned situations the ego displays an inability

to function constructively. In the first instance the ego is powerless against the eruption of the impulses and in the second place it is powerless against the frustration of desire gratification. The consequences in the conduct of the child, however, are the same in both instances - an uncontrolled eruption of emotions and passions.

Therapeutically these dynamics offer certain points of contact. Egoremedial therapy can be applied to help the sociopathized child to acquire self-control, provided this takes place during the period when the ego is still in a development stage, that is before puberty.

1.2.2 Absence of object cathexis

Without object cathexis in relation to people or things no person can possibly relate to or cope with his world in a meaningful way. The principal disturbance manifested in the sociopathized child is that of object cathexis. "Hun problematiek schijnt hoofdzakelijk te liggen in een gestoorde dialoog met het milieu." (A disturbed dialogue with the environment seems to be their main problem) (Keesom, 1971, p. 115).

The child's first known object is the mother, and it is through the ego's perception of her that the child not only evaluates himself but also relates to his object world. The mother is the first person in relation to whom object constancy is manifested, and as such is of vital importance to the child's subsequent object cathexis. (Sylvia Bell, 1970). The sociopathized child is frequently rejected by the mother, which leads to a negative cathexis in the child both to her and his object world. Objects consequently lose their value to the child and this is what causes his destructivity. To the child objects are symbolical of the people in his world. If these people lose their value, so

does his world of things and vice versa. In other words the ego functions without basic object cathexis relationships and remains detached, cold and apathetic towards its world of reality. The child is incapable of any true reality testing, since no real relationship with reality has ever been established.

1.2.3 Coping with insecurity, anxiety and fear

Every person, including the mentally sound child, has to cope with anxiety and fear daily. His ego handles these fears in various ways indicated by the psychological literature as defence mechanisms.

Since early childhood some of the sociopathized children's egos have been bombarded with threatening situations, without ever receiving support from an adult, so that he has never been provided with a safe, protected environment in which to learn to cope with his anxiety and fears. In self-defence he resorts to drastic means of coping with anxiety, usually in one of two forms: either he retreats totally by avoiding confrontation with situations containing even the most insignificant element of fear or anxiety, or he resorts to uncontrolled attacks on or indiscriminate destruction of any object or person that happens to be in his vicinity. These extreme reactions occur so directly that there is no time to develop any consciousness of the experience of insecurity, anxiety or fear.

Whereas the normal child handles his fears by means of sublimated fantasies, the sociopathized child can only do this through wild, uncontrolled outbursts. Furthermore, these children sometimes do not react to the original anxiety situation itself, but to the direct experience of it.

1.2.4 Coping with temptation

The normal ego is capable of exercising control when the id impulses emerge in conflict with the expectation of the superego and the ego is made aware of a potential danger situation which could lead to feelings of guilt. The ego utilizes its energy power for this control. However, there are times when even the normal ego is incapable of control and then the impulses break through. This may become possible in conditions of clouded consciousness, intoxication, illness or extreme physical and mental fatigue.

In the process of becoming sociopathized the sociopathized child fails to develop this control function since his world generally sanctions uncontrolled acting out of impulses.

This inability to control impulses also applies when they experience temptation, even if their needs are relatively small. For instance, the sociopathized child would steal money even though he hardly needs it, simply because the opportunity for theft presents itself. It would appear as if the ego reacts to all impulses which are evoked in the child's perceptual field without any consideration of the consequences of such a reaction.

1.2.5 Coping with excitation

The normal child may at times work himself into a state of excitation which his ego is unable to handle. The sociopathized child's reaction is often impulsively excited without any proper cause for this excitation. It appears almost as if the excitation wells up spontaneously from inside.

Another form of excitation which occurs in these children is group

excitation. Redl (op. cit., p. 89) calls this "group psychological intoxication" and describes it as follows: "*Beginning with some minor freefloating contagion of the one or the other more excited youngsters the whole group sometimes breaks into stages of impulsive wildness which surpasses anything that we usually would expect of it.*"

Under this group assault it appears as if the individual ego disintegrates totally and loses all control. The here-and-now gratification of all desires runs rampant and the controlling aspect of reality testing is simply non-existent. Whereas the normal ego is capable of a reasonable degree of resistance against the assault of the group, this controlling or discriminatory function of the ego is evidently absent in the sociopathized child. If a group of sociopathized children is brought together, it takes very little to create total chaos around them. It is because of this extreme susceptibility to group reaction that most authors regard these children as unsuitable for group therapy. The power of youth delinquent gangs also rests on this "group infection". The adult sociopath, on the other hand, as has been indicated, becomes progressively more isolated and group influence is apparently much less powerful than in the sociopathized child.

1.2.6 Inability to sublimate

Around the age of six the ego of the normally developing child should be capable of adequately postponing or sublimating desires until the time or opportunity for gratification arises. This level of ego development is necessary for the child to function in the school situation. The ability to sublimate also involves the ability to

relate an object to the required situation. A normal child would, for instance, see in a tennis racquet an object with which to hit a ball, while the sociopathized child might conceivably break it over another child's head. Once again the object cathexis disturbance in these children emerges strongly. In other words, these children react directly to impulses without any sublimatory consideration of the situation. Various authors (to be discussed under the heading "Therapy") have observed that if the sociopathized child were to be exposed to a sublimating social environment, spontaneous recovery would take place. However, these authors do not take into account that the ego of such children no longer functions normally in their perception of reality, and that environmental manipulation alone cannot have the desired effect because their ego defects render these children incapable of sublimating their desires.

This aspect of their conduct often becomes apparent when they are playing with animals. They will pet the animal affectionately one moment, only to treat it sadistically the next. Towards younger children they often display a similar behaviour pattern.

1.2.7 Resistance to change

Perl (1971) states that sociopathized children show a tremendous resistance to any attempt at changing them or placing them in a new situation. In an effort to cope with repeated onslaughts of rejection and pain the ego has withdrawn into an attitude of apathy towards the approaches of other people. Any approach directly evokes a stress reaction because it may involve the possibility of feeling and affectional reaction, with the inevitable risk of experiencing pain. In a situation

of this kind they may disintegrate altogether and react with uncontrolled aggression. This reaction complicates therapy considerably and is regarded as initial "treatment shock" by some authors (Redl. op. cit.).

1.2.8 Time cathexis disturbance

Redl. (op. cit.) and Stott (in Herbert, 1975) mention that the traumatic experiences of the past are brought into perspective in relation to the present by the reality orientation function of the ego. Where the ego cannot cope with these experiences neurotic symptoms often develop. In the sociopathized child it is the total past which becomes unmanageable to the ego, because of its pathological nature. The past is never repressed or handled neurotically: it constantly operates actively on the present. At times it appears as if the ego is totally submerged by the past. Whereas in neuroses the unconscious is too strongly controlled by the superego, the superego in these children appears to have developed no controlling function whatever with regard to the past. This conscious and continuous bombardment by traumatic experiences blunts the emotional reaction to these experiences and at the same time causes a total blunting of emotional experience in general.

In other words, it appears as if a total time cathexis disturbance is manifested in the sociopathized child.

1.2.9 Inability to cope with feelings of guilt

A sense of guilt must be present in any person in order to socialize. In this way the child develops an inner censor for his actions, which enables him to adapt to his social "Umwelt". The presence of feelings

of guilt form an indication that the superego is functioning. Excessive guilt feelings exist in the neurotic and indicate an over-developed control function of the superego. (Bull, 1969). The sociopathic child displays an inadequate sense of guilt, or, an under-developed or defective control function of the superego. If slight feelings of guilt are evoked in these children, they are totally incapable of coping with them and usually react with overt aggression. Other reactions which may occur if feelings of guilt are evoked during the process of therapy are: refusal to speak, resentment and hatred towards the person who succeeded in evoking these feelings, irritation, resistance and eventually overt aggression against the person on whom he wants to revenge his feelings of impotence in handling the situation.

1.2.10 Internalization of ego control

The normal child still depends on external control of his conduct, which he finds in his immediate figures of authority. Fromm (1947) states that the child's very existence depends on his figures of authority and that he incorporates them into his ego system to function as superego. In other words, the child tries to avoid conflict with and rejection by his figures of authority by means of introjection. At some stage in the process of development the child must begin to assume responsibility for his actions, and it is around the age of six that the authority-imposed conscience is gradually replaced by his own judgement. The authoritarian voice of the parent is superseded by the voice of his own conscience and his true self. *"The must of the child becomes the ought of the adult External controls yield to internal controls; fear yields to self-respect, must to ought; obedience*

to external discipline yields to self-discipline" (Bull, op. cit., p. 97).

However, in the sociopathized child it appears as if the ego simply cannot develop the ability to accept responsibility for his own actions. Redl. (op. cit.) observes that even after prolonged therapeutic build-up and ego-support, these children, when left on their own, still cannot exercise conscience control and remain dependent on the adult for external control.

1.2.11 Manipulation as a result of basic narcissism

In the reality testing process of the ego, these children have learnt in self-defence to develop a refined ability to gauge social situations and to manipulate them to their advantage. Wolman (1966, p. 53) explains this as follows: *"His libido is self-hypercathected; he has never outgrown the primary narcissism of an infant and is in love with himself. He has no true object love for others; whatever object relations he has are on an exploitive, primitive-instrumental, oral-cannibalistic level. He uses people and is inclined to destroy them for his own use. His friends are to be used and not helped; those who resent being used must be 'liquidated' as enemies."*

The sociopathized child becomes fixated in the oral phase, and thus remains the "taking" narcissist for whom everything revolves around the self.

1.2.12 Defective cognitive control

One of the principal functions of the ego is to acquire cognitive control of the environment from learning experiences. (This facet is a possible point of contact between learning theorists and ego psychologists). On the one hand the sociopathized child has learnt the lesson

of trauma through rejection overly well, on the other hand there are vast areas in which they have simply been unable to learn from experience. On the one hand they over-react to situations which evoke their past and on the other the slightest reminder of their past is so threatening that they block it out altogether. It appears as if the ego directs all its energies into defence and attack strategies in order to protect the child in its present against its terrifying past and future, and thus attempts to wipe out the traumatic past.

It is also part of the function of the ego to place its total reality into context in order to control it cognitively. Cognitive inference very seldom occurs in the sociopathized child - this is one of the factors which makes ego-building therapy so exceedingly difficult in these children. They also fail to learn from other people's experiences. Not only do they reject these as irrelevant to themselves, but apparently they are unable to acquire the insight that the experiences of the "non-self" are valuable to the "own self".

1.2.13 Coping with failure and success

Even the mentally sound ego often finds it difficult to cope with failure or success. Failure subdues the energy power of the ego or leads to the use of various compensatory defence mechanisms. Success, on the other hand, may give rise to a sense of superiority or over-optimism, which often leads to exploitive conduct in children. Most sociopathized children are so fatalistically afraid of failure that they do not even attempt to achieve success. If they do succeed, however, they almost inevitably exploit this success to their own maximum advantage.

1.2.14 Inability to anticipate the consequences of their actions

If a very young child bumps into a table he will blame the table for his pain in consequence of his animalistic thought patterns. (Piaget, op. cit.). These thought patterns disappear when the child attains object constancy because he has then reached the stage where he can distinguish between the living and the inanimate world and where his thought processes become logical and deductive. This occurs around the age of seven years (Piaget, (1945)). At this stage the child gradually begins to anticipate the consequences of his actions and accept responsibility for them. Although the sociopathized child has passed this stage, it appears as if they have developed no insight into their contribution to the chain of cause and effect. In other words, deductive, logical reasoning about their share in any particular matter seems to be problematic to them. Consequently, it is, for instance, not only merely an excuse if they claim to have forgotten things in order to escape punishment. The sociopathized child may, for instance, accuse another child of having hit him, actually "forgetting" that he swore at the other child first. These children develop a marked ability to "forget" actions which they have in fact committed. Admittedly they often use lies merely to avoid trouble, but it may be safely assumed that a total dissociation from their own motives, feelings, thoughts and actions also play an important role.

Redl (op. cit., p. 110) maintains that this aspect makes socio-pathized children totally unsuitable for periodic therapy and he strongly advocates institutionalization and constant daily therapy. *"In fact it is the existence of this very ego disturbance, it is this unusual fast evaporation rate of self-contributed behaviour, which makes the*

usual 'Monday afternoon' or 'twice a week' style of interview technique unusable with these children. The proximity of the therapist to the daily behavioral scene is essential so that he may catch up with the speed of events and counteract the fast evaporation rate of such incidents through special strategy."

Summary

The ego of the "normal" child develops gradually with the support and protection of adult egos. It is a very slow process which cannot be accelerated without adverse effects on the child. This process depends on the prior development of object relations and object cathexis. It is only when the child attains object constancy that he can form object relations.

The supplementary powers which support the basic developing ego, such as control, value systems, emotions and object cathexis to other people and things, develop together with it. Initially these supporting powers are externalized in the form of adult egos which guide and direct the young ego. Gradually, however, the ego internalizes these powers in itself and starts to exercise control within itself.

Most sociopathized children are deprived of the supporting powers of adult egos at a very early stage and are consequently forced into self-maintenance before they are ready for this. The ego is forced to develop rapidly in self-preservation, but the supporting powers of the ego do not develop accordingly, which results in an extremely strong but pathologic ego. This is what causes the sense of omnipotence which is often prevalent in these children. The ego is disturbed in its reality concept and cannot judge its own power or value.

It is clear from this that ordinary therapy would not produce much success and that a complete ego-reconstructive therapy involving the child's total "Gestalt" may be needed.

Basically, the sociopathized child is indeed in Redl's terms (op. cit.) an "ego-disturbed child" with particularly disturbed object relations, and is therefore unable to form any affective bonds either with his world or with people. He is literally the small rebel, but neither without cause nor without purpose, since this is his way of procuring a corner for himself in a big, hostile world - to us a pathological way, but to himself the only way he knows.

2. The social theories

In 1925 Cyril Burt described the causes of sociopathic conduct as multifactorial, with the social aspect forming only one part. In direct contrast are the findings of Loretta Bender (1948) who made an intensive study of the youthful sociopath. She concludes that *"it is not a heredity or constitutional defect. It is caused by early emotional and social deprivation, due either to early institutional or other neglectful care, or to critical breaks in the continuity of relationships to mother and mother-substitutes any period of deprivation under five years, may be sufficient to produce this defect"* (p. 39). Lourie supported this view in his lecture at the "Round Table Conference" in 1956: *"There may be other causes but thus far they have not been established; behavior in these cases stems from failure of inhibition of instinctual hostile impulses, the source of inhibition being gratification in mothering"* (p. 234-235).

Deprivation is regarded as one of the principal sociological factors

which contribute towards the development of sociopathy. Silverman (op. cit.) investigated the family histories of thirty-five criminal sociopaths and established that a quarter of these had been rejected by their parents, one third had had a highly insecure childhood and another third displayed unresolved Oedipus complexes.

Weinberg (1952) summarizes the major social aspects as follows:

"The psychopath develops within a matrix of distant and impersonal parent-child relationships, and especially amidst changing and emotionally depriving parent figures" (in Rosen and Fox, op. cit., p. 264).

This statement is experimentally confirmed by Bandura and Walters (1959). In a study comparing a group of sociopathic youths to well-adjusted adolescents they established that the most notable difference was that in the case of the sociopathic group both parents were less affectional than those of the control group. They ascribe the sociopathic conduct of these boys to the frustration of their dependency needs, which leads to a sense of rejection, critical reaction to the parents and consequently aggressive behaviour.

Research on sociopathic adolescents from the higher socio-economic group undertaken by Herskovitz, Levine and Spivak (1959) produced results exactly similar to the findings of Bandura and Walters (op. cit.). Rosen and Fox (op. cit.) concludes from this that "apparently the emotional deprivation sustained when the child's dependency needs are frustrated produces antisocial aggression in upper as well as lower socio-economic levels" (p. 264).

According to Gregory (1959) and Glueck and Glueck (1950) deprivation is further aggravated by the loss of one or both parents. However, Gregory (op. cit.) points out that a considerable number of sociopathic

children come from homes which may be physically intact but provide an unsatisfactory emotional climate. O'Neal (1962) describes the dynamics in these homes as follows: *"The parents may reject the child and make it impossible for him to develop the identification needed for close human relationships. If he is not rewarded for desirable behaviour, he may accept the values of a delinquent peer group. On the other hand parents may over-indulge in the child, and because he is permitted to express his aggressive and other needs without inhibition, he may develop a very lax superego and become psychopathic"* (p. 11). He also established a more pronounced correlation of inadequate supervision and discipline in sociopathic children than in children with other psychiatric disturbances. His findings appear to support the view held by Finichel (1945) that inconsistency in parental attitudes is the main cause of the condition of sociopathy.

Rosen and Fox (op. cit.) see a combination of a rigid, detached father and light-hearted mother in the family unit as a possible cause of sociopathy in children. The child finds it difficult to identify with the emotionally distant father and rebels against him and his moral standards. He assumes his mother's light-hearted attitude towards his own failures and either rationalizes or finds excuses for them. In other words, he does develop a superego but a very weak and inadequate one. The whole family unit presents a facade of "being good" to the outside world. *"The contradiction between facade and internal family conflicts contributes to the shallowness of the child's affective development and to his perception of the world as a place where one must try to get away with as much as possible"* (Rosen and Fox, op. cit., p. 265).

Another possible theory is the hypothesis made by Johnson (1959)

that the parents sanction the child's undesirable conduct because it gratifies their own undesirable impulses. He points out that the parents of the sociopathized child sometimes derive a certain pleasure from their child's repeated failure through antisocial conduct, since their own aggressive feelings towards the child are gratified by this.

These observations find support in the research by Kiernan and Porter (1963), who indicate that sociopathic children frequently display behavioral deviations identical to those displayed by their parents in childhood.

From these theories it would appear that some sociopathic children act out the unconscious desires of their parents in their own actions. Although clearly possible, this cannot be regarded as more than a contributory factor which would only apply in some cases.

According to Gough (1949) the sociopath has never learnt to socialize adequately and is consequently incapable of playing his roles successfully. *"The deficiency in role playing means the incapacity to look upon one's self as an object, or to identify with another's point of view. The psychopath is unable to foresee the consequences of his own acts, especially their social implications because he does not know how to judge his own behaviour from another's standpoint. What might be called social emotions and gregariousness (group identification) are not experienced by the psychopath"* (p. 346).

Maslow and Mittelman (op. cit.) approach the dynamics from three vantage points:

1. Due to rejection by the parents the child fails to build up identification models or to form close emotional bonds with other significant figures in his life.

- ii. The over-indulgent parents fail to set adequate limits to the child, who then becomes unmanageable, with the result that the parents react by over-controlling. The child rebels against this and consequently cannot identify with them.
- iii. The sociopath experiences both strong feelings of guilt, which he represses, as well as an unrecognized need for acceptance.

Summary

Although most social theorists regard the parent-child relationship as the principal cause of the sociopathizing process, others, such as Gough (op. cit.) and Maslow and Mittelman (op. cit.) regard it as a defect in socializing in the wider sense.

Possibly Cyril Burt (op. cit.) comes nearest to the truth when he describes sociopathy as a condition caused multifactorially, with the social factors playing only a partial role. The basic personality and hereditary endowment are not sufficiently taken into consideration by the social theorists. After all, any form of pathology involves a basic core of heredity which finds unique expression in a specific environment. This is also the case with the sociopathized child. It could be postulated that only part of the child's personality is accessible to therapy, and that therapy could possibly be of a socializing nature only and may fail to modify the basic personality.

3. Learning theories

Initially behaviorists connected sociopathy with the level of intelligence. Hill and Hartman (1936 and 1950), for instance, postulated that sociopathized children had a higher level of intelligence than other members of their age group. In direct contrast Frank (1931), Glueck (1955)

and Shulman (1950) stated that sociopathized children had a lower than average intelligence and were consequently unable to learn from experience. Merrill (1947) and Woodward (1955), on the other hand, tried to prove that intelligence played no role whatsoever in the sociopathizing process.

As the sociopath seems to have difficulty in learning socially accepted behavior patterns the conditions under which a person learns is of importance here as some of the more recently behaviorists tend to find the basis of this pathology in a personality dimension.

3.1. Weak conditioning capacity theory - classical conditioning

Pavlov's experiments on neurotic animals (1927 , 1928 and 1941) indicate that hysterical animals display increased inhibition processes. He calls this "passive inhibition", which means that the animals do not react to the stimuli, basically do nothing and consequently learn to do nothing - the animal can learn not to fight simply by not fighting. He also established that dogs which conditioned readily displayed an increased cortical excitation, while those which conditioned poorly displayed an increase in cortical inhibition. Rimm and Masters (1947) conclude from this that hysterical patients are less susceptible to conditioning, while neurotic patients should be easy to condition. Franks (1955 and 1956) states that extroverts are less susceptible to conditioning than introverts. He also established that the extroversion-introversion factor plays a role in all conditioning. These findings suggest a causality in the personality dimension of introversion-extroversion, as seen in the cortical excitation and inhibition of Pavlov.

Franks (op. cit.) proceeds to define sociopathy in the behavioral framework as follows: "*By psychopathic personality we mean that*

extroverted neurotic, who has a life-long history of maladjustment and antisocial or asocial acts Since it has been shown that psychopaths condition very poorly, then such behaviour traits as these may be described in terms of an inability or difficulty in developing, retaining and generalizing conditioning responses" (in Quay, 1968, p. 78-79). It can be assumed that, since the sociopath is unable to develop, retain and generalize conditioning responses, he is also unable to learn the basic rules of socializing. Because he cannot generalize conditioning responses he is also unable to learn from experience or to identify himself with the feelings of others.

Eysenck (1964 and 1971) took this research a step further and established a clear connection between inhibition/excitation and extroversion/introversion. He describes the typical extrovert as someone who likes social occasions, always requires other people around him and is not fond of studying or reading. He is constantly in search of excitement, is impulsive and acts on the spur of the moment, is optimistic, likes to move around and angers easily. The introvert is retiring, shy and quiet, orientated more to things than to people. He plans his life meticulously and has strong preference for a well-ordered life. He is subject to rigid self-control, is generally more reliable than the extrovert and values ethical norms highly. According to Eysenck (op. cit.) the extrovert displays cortical inhibition, which obstructs learning, while the introvert displays greater cortical excitation, which stimulates learning. Only the processes of inhibition and excitation need to be considered here. Pavlov (op. cit.) already indicated that both processes were to be regarded as positive processes. He pointed out that inhibition

could never be seen as the absence of excitation, but that the two processes supplemented and regulated one another.

Eysenck (1971) regards the sociopathized child as a person with an incapacity to learn avoidance responses as a result of excessive cortical inhibition, which in its turn obstructs social learning. Hare (op. cit.) supports this view when he puts forward that the sociopath is unable to develop "anticipatory anxiety", and also connects this with excessive cortical inhibition. Both Hare (op. cit.) and Eysenck (op. cit.) thus assume a strong constitutional element in the development of sociopathy which influences conditioning capacity.

More recently behaviorists have undertaken research into the question of what and to which extent the sociopath can learn. Fairweather (1954) found that, in contrast to normal persons, sociopaths learn better if they are uncertain of what their reward will be. Vetter (1972, p. 248) concludes the following: "*The often stated belief that the psychopath does not learn from experience may require qualification in terms of motivating conditions or to an enhanced arousal due to the variability of stimulation induced by the uncertainty.*"

A normal inhibitor of antisocial conduct is anxiety. The greater the anxiety, the smaller the possibility of reacting to an antisocial impulse. Lykken (op. cit.) indicates that sociopaths display an incapacity for developing affective social anxiety, which could act as inhibitor to antisocial conduct.

Painting (1961) and Lykken (op. cit.) both undertook research to determine whether positive or negative reinforcement made any difference to responses in the sociopath. No significant differences

were established, but it became apparent that, in contrast to the normal person, the sociopath persistently maintained rigid behaviour patterns.

Hare (1965) attempted to determine experimentally whether direct or delayed reinforcement made any notable difference to the learning capacity of the sociopath. He failed to establish any difference but concluded that "the clinical observation that the psychopathic person is relatively unaffected by threat of punishment, receives laboratory support from this research" (Vetter, op. cit., p. 253).

Following up the research by Schachter and Singer (1964) Schachter and Latene postulated in 1964 that an emotion was a condition of psychological arousal and of cognitive orientation to a condition of physical arousal. Any person will thus react emotionally only to the extent to which he has been aroused physiologically. They concluded that, if the sympathetic nervous system could be activated or inhibited, criminal impulses could be controlled. For this purpose they administered the drug epinephrin. The drug had an adverse effect on normal persons but in sociopaths it appeared to increase the conditioning capacity and accordingly also their learning ability. An increase in general autonomic reactivity, blood pressure and pulse rate, was also observed in these psychopaths.

Duffy (1962) failed to establish any improvement in his sociopathic patients after use of the drug, and strongly opposes its use.

Summary

Research on the conditioning in-capacity in sociopaths indicates the following:

- i. The sociopath tends to learn more readily in a situation where the reward is uncertain.

- ii. The reaction to aversion therapy is poor. This means that punishment has no positive effect on the sociopath.
- iii. The sociopath develops rigid response patterns where the learning situation requires a degree of adaptability. It appears as if the sociopath is inflexible and unable to adapt to new situations.
- iv. Poor time-perspective with regard to both positive and negative reinforcement occurs.
- v. Signs of manifested anxiety are seldom apparent.

In this section more emphasis is placed on the organic factor of cortical reactivity in interaction with the environment as a basis for learning. As pointed out by Eysenck (op. cit.), the sociopath apparently displays a poor ability for learning or conditioning. Without learning and conditioning no adequate socializing is possible. However this aspect, as the previous one, must be seen only as a single factor in a complex problem and not as the total answer.

3.2. Operant conditioning

Johns and Quay (1962) undertook a study comparing neurotics with sociopaths and found that sociopaths were less susceptible to verbal social conditioning than neurotics. Their findings met with strong criticism, amongst others from Persons and Persons (1965), who pointed out that their test for sociopathy was not valid. Their investigations are based on the work by Cleckley (1964), who postulated that the basic characteristic of the anti-social sociopath was the absence of normal affectional components in his experience. He places particular emphasis on the sociopath's

inability to react appropriately to words and phrases which evoke emotional response in the average person.

Following up the research of Johns and Quay (op. cit.), Bryan and Kapche (1967) established that the sociopath does occasionally react to positive social reinforcement - a finding which is in direct conflict with all previous findings in this field. An experiment by Accord (1967) in which verbal positive reinforcement (like praise) was coupled with monetary reward and negative reinforcement with shock, indicated no difference in reaction or learning capacity between sociopaths and non-sociopaths. The sociopath thus seemed to react in the same way as normal people on reinforcement. Accord postulates from this that if verbal positive reinforcement coupled with concrete rewards were to be used in the therapy situation, the sociopathic conduct could possibly be modified, provided that only positive reinforcement is applied, as they reacted negatively on negative reinforcement.

Vetter (op. cit.) criticizes these findings and points out that the selection criteria for the term "sociopath" are still difficult to find and that Accord's findings (op. cit.) could possibly be influenced by this. He emphasizes, however, that Accord's study is the most comprehensive yet undertaken using verbal operant conditioning on the sociopath, and that his findings have definite implications for therapy and as such justify further investigation.

Summary

It would appear that, while the sociopath conditions differently from normal persons, he is not altogether incapable of conditioning, as thought previously. It is probable that he may be able to learn socially accepted behavior and consequently to socialize to

an extent, but possibly in some other way than merely by verbal social rewarding. A more substantial concrete reward may be needed as an incentive for socializing.

3.3. Other learning theoretical approaches

Behaviorists mostly assume that child sociopathy has an underlying constitutional basis. Bender (op. cit.) maintains this very strongly. The assumption is based on twin studies by Rosanoff et al. (1941) and Kallman in Slater (1969) which indicate that heredity plays a role in the development of sociopathy.

Thus Kraulis (1931) mentions that hysteria and sociopathy are closely related conditions and frequently occur in the same families. These findings are confirmed by Roth (1952), Kennedy (1954 and 1955) and particularly by Robert Cloninger, Reich and Guze (1975). They observe that it appears as if women tend to develop a hysterical condition while the men tend more towards the sociopathic condition, but that both conditions are developed by the same process. "Specifically analysis indicates that hysteria in women is a more prevalent and less deviant manifestation of the same process that causes sociopathy in men" (Cloninger et al., op. cit., p. 23). They also indicate that girls who display sociopathic conduct in childhood generally develop hysterical personalities in adulthood, while the boys frequently grow into fully-developed adult sociopaths. In more recent research Cloninger et al. (1975) indicate that the hysterical mother and the mother with sociopathic tendencies are the most detrimental to their child's development. They claim a significant connection between this pathology in the mother and sociopathy in the child according to the multifactorial model.

This model envisages that there exists a single dimensional quantity "s" called liability which determines the probability of an individual succumbing to either sociopathy or hysteria. The s-values may be determined jointly by genes and by the environment and may be the concentration of some biochemical product of metabolism. According to this model individuals whose liability is greater than the threshold value, which Cloninger has worked out according to a formula, manifest the disease, whereas those whose liability is lower do not. A person whose liability is just above normal will develop hysteria and those whose liability is more than 20% higher than normal will develop sociopathy.

The conduct of the sociopathized child is characterized by a marked incapacity for socializing. He has failed to learn desirable behaviour patterns. In terms of conditioning it can be said that the sociopathized child has an incapacity to learn conditioned responses which are expected by society in order to function satisfactorily.

Franks (1968) differentiates between the sociopath, who displays an incapacity for conditioning, and the dystemic personality who, according to him, conditions well but in whom the conditioning responses are difficult to erase. The models according to which the dystemic personality conditions, are negative and he consequently acquires a negative social conduct pattern, which is difficult to erase. Franks describes the two forms as two types of the same condition and not as two separate forms of pathology. He also observes that the sociopath who he thinks conditions well comes from a very poor social environment, whereas the one who conditions poorly may come from any social background.

Mercus (1955) found both introverts and extroverts amongst the children examined by him, but he points out that, while the introvert child sociopaths invariably came from poor homes, the background of the extroverts was not necessarily poor. He calls the latter the "true sociopathic children".

Summary

A search of the literature for a single cause of sociopathy inevitably leads to one conclusion only: that no single cause exists. The condition is a complex one, in which the learning process obviously plays a role but does not present a full and final solution.

The absence of anxiety obstructs learning through the instrumental conditioning method. Aversion methods used in the conditioning of the sociopathy have as yet proved unsuccessful. Weak cortical excitation with strong inhibiting forces are postulated as physiological causes.

However, promising new therapeutic dimensions have recently emerged from the findings of behaviorists. Their positive reaction towards reward certainty holds possibilities of conditioning in sociopaths. The possibility also exists that verbal operant conditioning coupled with concrete reward effect small modifications in behaviour.

4. Ecological approach

The most recent development in the social sciences is to study man in his ecological environment. Although the study of human ecology is a relatively young science, it has its roots in the work of Darwin (1981). As Morris (1957, p. 41) puts it: "*The importance of Darwinism in the late nineteenth century can hardly be overestimated. Evolution and natural selection were concepts adopted and adapted wholesale in almost every field*

of intellectual inquiry from biology to sociology." Darwin's research led to the concept of man as a physical entity similar to the animal kingdom, only on a different evolutionary level.

Lombroso's theory in his "L'uomo delinquente" (Delinquent man) (1876) that the delinquent is born criminal is based on Darwin's work. According to him the physical characteristics of the delinquent were those of primitive man: *"While these stigmata identify the criminal type of man's remote evolutionary ancestors, they do not cause crime, but as indicators of degeneracy identified the person predisposed to criminal behaviour"* (Voss et al., op. cit., p. 6). Lombroso's basic theory was maintained in both America and Europe for a considerable period of time. *"It may be that the theory of the born criminal offered a convenient rationalization of the failure of preventative effort and an escape from the implications of the dangerous doctrine that crime is an essential product of our social organization"* (Lindesmith and Levine, 1937, p. 670).

However, Darwin himself strongly emphasized the interaction between species and environment. He mentions certain "limiting and constraining effects of environment" (Voss, op. cit., p. 9), in which he included all the influences outside the organism.

One of Darwin's followers, Ernst Haeckel, became the first man to use the term "ecology" in 1868, but only in relation to plants. It was only in 1921 that the term "human ecology" was first used by Park and Burgess (p. 161-2-6). In 1925 Park defines the term as follows: "The study of processes operative in urban communities which result in orderly typical grouping of its population and institutions" (op. cit., p. 1). According to Quin (1964) ecology is the study of the interaction of the individual in his group with his environment.

Parks (1936) elaborates on this and points out that human society

functions on two levels: the symbiotic level, based on the co-operative and competitive element, and the cultural level, based on inter-personal communication.

The first ecological study on juvenile delinquency was undertaken in 1921 by Shaw in Chicago. He established a significant connection between the occurrence of delinquency and certain city areas. This was followed by a considerable number of studies on juvenile delinquency including, amongst others, that by Shaw and McKay (1931). However, very little research has been done with the sociopathic juvenile delinquent as subject. The first major investigation in this field was undertaken by Landers (1954) in Baltimore. He established a correlation between sociopathy in the child and immigration and early school leaving of the parents. He interprets his own findings as follows: *"When the group norms are no longer binding or valid in an area or for a population subgroup, in so far as individual behavior likely to lead to deviant behavior. Delinquency is a function of the stability and acceptance of the group norms with legal sanctions and the consequent effectiveness of the social controls in securing conforming juvenile behavior"* (op. cit., p. 76).

Cohen (1955) points out that sociopathized children often come from the lower socio-economic strata, which maintain different standards from those of the middle-class child. They sometimes attend the same school and, according to Cohen, this leads to status frustration and a loss of self-esteem, with the result that these children group themselves together into a subculture. In this subculture the values of the middle-class are rejected and it is from this group that the sociopathized child emerges.

Scarpitti et al. (1960) observe that not necessarily all children from lower socio-economic areas become sociopathized. They maintain that those children who do not become sociopathized have stable family

relationships and positive relationships with their teachers. Even in the pre-adolescent stage they possess a strongly developed self-image and a sense of superiority over their environment, thus negative identification with their environment takes place and accordingly rejection of the negative norms of their environment and positive acceptance of the norms of the wider society occur.

An ecological aspect which emerges from the study of Carter and Jepson (1952-1954) on a British mining community is the nature of the family as a conclusive factor. They established that children who came from streets with a low crime rate took pride in their homes and reputations, that they were strictly controlled and that their parents valued education and up-bringing highly. The sociopathized children, on the other hand, generally came from streets where they were constantly exposed to domestic violence, brawling, drunkenness and promiscuity. These children were subjected to adults who rejected the norms of society in their conduct and who put their own advantage above the rights of others. Carter and Jepson come to the following conclusion: "It would seem that the family within the community is more important than the community itself in the causation of antisocial behavior" (Rosen and Fox, op cit., p. 268).

More recent research by, amongst others, Palmer (1967) and Hathaway and Moachesi (1963) indicates that progressively more children from higher socio-economic classes are being diagnosed as sociopathized. However, Gordon (1967) maintains that, although there is a trend towards more sociopathy in children from the higher socio-economic strata, most of the truly sociopathized children still come from the lower socio-economic group.

In a cross-cultural study undertaken in 1963, Bacon, Child and Barry found a considerable difference between aggressive and non-aggressive sociopaths. They indicate that aggressive sociopaths are found mostly in

communities where the mother and children live separated from the father, or in a matriarchal family structure.

From a psycho-analytical point of view they explain criminality in men as a manifestation of their struggle to escape from female dominance and identification.

CONCLUSION

It seems as if Erikson's theory (1950) that every society creates a unique personality which is forced to function and maintain itself within its particular community, and is thus enabled to cope with the tension, may also prove to be true of the sociopathized child. Possibly the sociopathized mode of behaviour is the only means by which he can maintain and preserve himself in a "deviant" subculture.

Sociopathy is a concept which has been defined in a wide variety of terms. It has progressed from Pinel's early description (op. cit.) and Prithchard's "moral insanity" (op. cit.) to a clearly delineated clinical picture.

The descriptions of the dynamics and etiological factors are equally divergent, ranging from a purely biological orientated theory to the more recent ecological approach.

Each of the various schools of thought in psychology puts forward its own views. Psycho-analysts tend to regard sociopathy mainly as an ego disfunction. They offer a highly comprehensive exposition of the defective ego functioning which leads to inadequate self-control and reality contact. Learning theorists regard it as a defective conditioning capacity either as a result of conditioning inability or negative conditioning through a negative modelling figure.

The more recent ecological approach sees the problem as one of

interaction between the child and his environment and regards it as a mode of living representing the only possible form of existence in a "deviant" environment.

However, no final or fully satisfactory solution has as yet been reached in regard to the etiology and dynamics of sociopathy. The sociopathized child remains an enigma in the science of psychology.

Although the condition in the child was already described in the previous century, very little significant research has as yet been done on sociopathy as manifested in the child. According to the available literature the sociopathized child can be described as follows: The sociopathized child displays pathological behaviour in his development process of persistent antisocial conduct without any apparent sense of guilt occurring together with blunted emotionality. Ordinary punitive measures have little or no effect on his conduct and he is constantly in conflict with the norms of his society. The condition appears to be the result of a neurologically or organically determined constitutional disposition in interaction with the environment, which plays a conclusive role in the development of a negative socializing process. Although a considerable number of children with strong sociopathic tendencies eventually grow into adult sociopaths, this does not necessarily apply to all sociopathized children, because the child is still involved in a developmental process.

The next chapter will deal with the therapeutic techniques used in the treatment of sociopathy with particular reference to the methods applied in the treatment of sociopathic children.

CHAPTER V

THE THERAPY OF THE SOCIOPATHIZED CHILD

Authors such as Shaw (op. cit.), Vetter (op. cit.), Turnley (1962) and others feel that "strictly speaking there is no treatment for the psychopath" (Shaw, op. cit., p. 243). Vetter (op. cit.) maintains that the attitude of psychiatry to sociopathy is largely self-fulfilling in that most therapists simply assume that the sociopath is untreatable, without attempting to disprove this (Vetter, op. cit., p. 248-259). According to Bromberg (1954, p. 608) *"one wonders in relation to this complex problem, whether psychiatry has not been frightened by the sardonic smiling mask of the psychopath, behind which lies the frightened lonesome face of a neurotic character."*

Lourie (1959) states that the diagnosed adult sociopath who responds to treatment is no sociopath in the true sense of the word, but that changes are possible in child sociopaths in whom the condition is not yet fully developed. "Even the most dramatic picture of psychopathic behaviour in young children is better described as psychopathic like, particularly as most of the them are reversible" (Lourie, op. cit., p. 136). Rabbinoitch (1959, p.58) agrees with this view and points out that the sociopathized child is most susceptible to therapy during the latent years. He bases his observations on Bender's theory (1953) that, although the sociopathized child is unable to form object relations, he does develop normal handling of symbols, so that socializing through imitation is still possible.

A wide variety of therapeutic techniques have been applied to the sociopath with varying degrees of success. Since this study deals mainly with the sociopathized child, those techniques which are relevant to the child will be discussed briefly.

MILIEU THERAPY

The earliest evidence of treatment of the sociopathized child is found in the records of the New York Juvenile Asylum in 1862, which indicate that the vast majority of children in the care of the asylum failed to respond to treatment of any kind. The importance of empathy and understanding is emphasized for the first time in the 1865 report, when Superintendent Brooks pointed out that staff members who worked with the "sick young brain must know what there is in the heart and feelings of a child from his standpoint and just how to reach it" (New York Juvenile Asylum Report, 1862, p. 37).

Whittaker (op. cit.) mentions that an attempt made in Germany to rehabilitate sociopathized children through farm work had little success. Most of these boys grew into hardened criminals. In 1848 a school for youth delinquents was opened in Westborough, Massachusetts. Initially this reform school also seemed doomed to failure, but the situation improved greatly as more emphasis was placed on understanding and measures were introduced which would today be labelled as positive conditioning. The institution functioned according to a homes system and discipline and order was maintained to a large extent by the children themselves. This institution can be regarded as one of the first known therapeutic communities. A vital observation which repeatedly appears in their reports is that the children were more susceptible to therapy before puberty than after. The children's sense of self-esteem was built up through work for which they were rewarded. The reports also mention that the the Board of Directors soon realized that the children needed "the tender and healing influence of a woman" as a substitute for mother love. This approach is today regarded as one of the first successful forms of milieu therapy, although no statistically based outcome is given.

Whittaker (op. cit.) mentions an interesting experiment conducted in 1897 by a certain Mr. George. He does not however give a detailed report of the outcome of the study. Mr. George not only isolated youthful sociopaths in an institution on a farm, but required them to be totally self-supporting. Vitally important was the fact that they were placed in situations which continually posed a challenge. George was convinced that characteristics such as pluck and stubbornness could and should be positively used in the rehabilitation process. In so doing, George utilized the sociopath's constant need for new challenges and stimuli. Even today this aspect deserves more emphasis in the rehabilitation programme.

Whittaker (op. cit.) comes to the conclusion that during the 19th century the majority of American institutes for sociopathic children were excessively hard and rigid and showed little understanding of the problems of the children entrusted to their care. However, even then there were exceptions where sincere attempts were made to arrive at the core of the problem through understanding. According to Whittaker the recent emphasis on environmental therapy as opposed to individual therapy is a historical consequence of this time when this form of therapy was the only possible for of corrective treatment for the sociopathized child.

Suiin (1970) maintains that milieu therapy is based on the assumption that the entire community with which the sociopathized child comes into contact is therapeutically motivated. The child does not have a personal or private therapist to himself alone, but each member of the staff acts according to a pre-determined therapeutic programme under all circumstances.

Freedman and Kaplan (1976, p. 2175) formulate the main aim of milieu therapy as follows: "The personnel try through the experience of group living, to give the child new and corrective growth opportunities" by breaking the ties with the destructive home background. They do not describe what exactly was done in the institutions.

Aichorn (1935), Jones et al. (1953) and Redl and Wineman (1957) all undertook extensive studies and developed milieu therapy programmes. Redl (op. cit.) in particular achieved considerable success in the sense that most of the children treated by him became normal citizens. He regards the following as the main requirements for a therapeutic milieu:

- i. Each child must be fully safe-guarded against repetition of parental extreme punitive problems. The personnel must be strictly selected and trained in this respect.
- ii. Each individual child must be assured of unconditional love and acceptance in spite of his actions. Love may never be given as reward or withheld as punishment.
- iii. Symptom tolerance and a chance for the child to regress is regarded as vitally important.
- iv. The institution should not be totally different to the child's home environment and socializing should take place gradually.

Although never formally organized, individual psychotherapy was undertaken by Redl and his staff, and the question arises as to how much of his success may have been due to this.

In South Africa the sociopathized child is at present either admitted to a clinic school or, if he has repeatedly come into conflict with the law, to a reform school. As yet no distinction is made in these institutions between the various types of juvenile delinquency, of which the sociopathized child represents only one facet. The therapy applied here is mostly group and milieu therapy. Individual therapy occurs only occasionally.

Under the auspices of the Roman Catholic Church a number of convent schools, the so-called "Boys and Girls Towns" have been established with

the specific purpose of rehabilitating the sociopathized child from a sociological/religious point of view.

Milieu therapy seems to be the treatment generally preferred in South Africa, but very little scientific information is available as yet on the degree of success achieved in practice.

GROUP THERAPY

Apart from milieu therapy, group therapy seems to be the generally preferred treatment for young sociopathized children.

According to Vetter (op. cit., p. 260) the most important advantage of group therapy is the fact that it serves to "unfreeze the psychopath's defensive character structure" as he is accepted as part of the group.

Bromberg (op. cit.) is of the opinion that the therapist can only establish contact with the child sociopath through the group. According to him the group leader should adopt a very firm approach but at the same time should remain passive and in the background as far as possible. In the group the youthful sociopath is allowed to act "as if society accepts his hostilities and aggression without actually having to give up his protective structure" (Bromberg, op. cit., p. 606). Bromberg regards it as vitally important that the child should be enabled to experience his emotions fully and to recognize them as truly his own in a group in which he feels secure and protected and is not condemned. In this way, according to Bromberg (op. cit.), his cold, defensive apathy "unfreezes" and he learns to cope with his emotions instead of retreating from them. He puts it as follows: "For the psychopath group therapy is essentially a method of mastering anxiety-provoking situations by re-enacting them" (Bromberg, op. cit., p. 607). Baslow and Kendal (1965, p. 26) maintain that the group therapist should focus his attention on the sociopaths'

"distorted perceptions, feelings and attitudes and the part these distortions play in developing their anti-social behavior patterns. Manipulative behavior and unconscious motivations are also attacked in group therapy."

Tyler and Brown (1967) achieved a considerable degree of success in their treatment of pre-adolescent sociopathized children by means of what they call the "time-out" method. If a child exhibits any form of antisocial or aggressive behaviour in the group, he is directly removed from the group and placed in isolation without any stimuli. This therapy is based on the theory that the child should never receive any positive reinforcement of his conduct by directing even the slightest attention of other group members to himself. From the research of Burchard and Tyler (1965), Tyler and Brown (1968) and Bostow and Baily (1969) it appears that better results are achieved when "time-out" treatment is coupled with positive reinforcement in the form of reward and verbal commendation of any acceptable conduct in front of the group. The period of removal from the group should be kept as brief as possible.

Martin Herbert (1975) maintains that not even group therapy can achieve any permanent improvement in the conduct of the sociopathized child since *"therapy in order to be effective requires of the patient the wish to change. The psychopath does not really believe that he is out of step with society, society is out of step with him"* (Herbert, op. cit., p. 328). However, he also states that, even though the child sociopath fails to react positively to therapy, he can never be written off as irremediable. The onus still rests on the therapist to continue investigating methods through which the sociopathized child can be successfully treated.

Although the literature offers evidence of successful treatment of

sociopathized children through group therapy, very little unconditional success has been recorded with the use of group therapy as sole method.

INDIVIDUAL PSYCHOTHERAPY

Levy (1837), Shaw (op. cit.), Hare (op. cit.), Backwin and Backwin (op. cit.) and others seem to feel that "psychotherapy is of little value" (Shaw, op. cit., p. 243) to the sociopathized child. However, very few studies have been undertaken in which different forms of psychotherapy were applied to these children. Most of the abovementioned authors base their statements on the results achieved in therapy with adult sociopaths. Although Rabbinowitch (op. cit.) states categorically that psychotherapy can achieve success in the sociopathized child if applied intensively in the latent years, he never investigated this personally. Millon (op. cit.) points out that psychotherapy after puberty has no significant effect on the sociopathized child, but does not discount the possibility of success before puberty.

The most comprehensive investigation yet undertaken on individual psychotherapy with the sociopathized child is that by Taubers and Powers (1951). In 1948 they divided a number of sociopathized boys between the age of six and ten into two groups, one of which received individual psychotherapy while the other was used as a control group. They describe their therapy as ranging from a friendly father-son relationship to formal interviews. No mention is made of any play therapy. A follow-up study undertaken by McCord in 1958 revealed that after ten years those boys who had received individual therapy had committed as many offences as the control group.

Levine and Bronstein (1972) conducted a follow-up investigation on a group of 325 juvenile psychopaths and a control group of child psychopaths.

The experimental group had received psycho-analytically orientated or client-centred individual therapy at the Cambridge-Somerville Youth Study in 1951 (Powers, 1951). The control group had received no form of therapy at all. After ten years there was no significant difference in the number of criminal offences committed by both groups.

The Judges Baker Guidance Centre in America claim to treat their sociopathized children successfully by means of prescribed activities and individual psychotherapy. They do not give a detailed description of the forms of psychotherapy applied, but it is clear that they preferably treat the child before puberty.

At the Henderson Hospital in Sutton, Surrey, Dr. Steward Whitely (in Macy, 1977) achieved considerable success with his intensive programme on adult sociopaths who were regarded as irremediable. Of importance to this study is his therapeutic technique which combined group therapy with individual therapy. *"The technique is to take the patient back into a child-like state so that they can learn lessons they ought to have learned as children, but for some reason failed to"* (C. Macy, 1977, p. 32). It can be deduced from this that, if a child in the sociopathizing process could be enabled to experience his emotions intensively and accept them as his own (as with the existential methods), it could have a therapeutic effect in the same way as regression works therapeutically in the adult.

Summary

The literature does not offer a very encouraging picture in regard to the therapy of the sociopathized child. At present milieu therapy seems to be widely preferred as the most successful treatment. However, this form of treatment is not always feasible or practicable and other therapeutic approaches will have to be investigated. As Backwin (op. cit.,

p. 538) puts it: *"The fact that psychotherapy as currently practised has been found ineffective does not mean that some other psychotherapeutic approach might not be effective."*

This study aims to investigate a new form of therapy of the young sociopathized child. It is based on the statement by Fox (1961, p. 476) who feels that the therapist who deals with the sociopathized child "must attempt something unusual, unorthodox and unexpected in order to reach this type." He even suggests that the therapist should adopt such unorthodox approaches as to help the young sociopath plan to kill his mother. The therapist should enter into the world of the sociopathized child, meet him at his own level and gradually lead him back to the normative world.

Reid (op. cit.) strongly propagates an integrated approach of different therapeutic methods! "Treatment demands an interactional approach" (p. 54). He also points out that "early intervention and continued research may help prevent this continuity of outcome" (p. 55). Reid (op. cit.) does not describe which therapies he includes in his integrated approach, but only advocates such an approach. It is this integrated method advocated by Reid which is applied in this study. In the next chapter the methodology will be discussed.

CHAPTER V.

METHODOLOGY

AIM OF THE STUDY

In the previous chapter it became clear that individual therapy with the sociopathic child is considered by many to be of little success. The fact is that none of the writers, e.g. Shaw (op. cit.) Backwin and Backwin (op. cit.), has ever tried individual therapy with these children. They simply generalise from their experience with adult sociopaths to the child sociopath. As we have seen, only a few studies on individual psychotherapy with these children, have been undertaken and then with little success.

It is a study so designed to fit in with the postulation set out by Reid (op. cit.), that an integrated method of different individual therapeutic methods, with the young child before puberty, ought to yield positive results. The aim then is to establish whether or not individual psychotherapy, with methods specially selected for the complex problems of the child with strong sociopathic tendencies, in the age phase when the pathology is still developing, has any positive influence on the behavior of the child. (The psychotherapeutic techniques used, will be discussed in more detail below).

Although an integrated approach of psychotherapy was used in this study it needs to be mentioned that the methods used were all applied according to the principles of the Humanistic school of Psychotherapy.

"The humanistic psychotherapies are not bound by common techniques nor are they a unified school of psychotherapies. Rather they represent a general approach to understanding human beings. All are outgrowths of

a similar philosophical view of the nature of man" (Watson, 1977, p. 162).

All humanistic therapists have two basic beliefs. Firstly that the therapist must have a fundamental respect for his patients as active agents capable of change. Secondly he must see each patient as an individual with whom he must have an interpersonal relationship, conceptualized in terms of the individual patient and not in terms of any preconceived idea of any particular system. All the humanistic therapies emphasize that the patients must be helped to get "in touch" with their feelings, so as to acknowledge, accept and experience them. The "here and now" is of primary importance. If a patient starts crying he is not only regressing to the stage of a baby but is experiencing the real emotions of a baby, and has become a baby at that moment in the here and now.

When symbols are being presented they have no preconceived meaning but the therapist accepts without questioning the patient's interpretation of his symbols.

Even when terms like "ego states" as in Transactional Analysis are being used they do not have a Psychoanalytic meaning, but are present time interpretations of the basic psychoanalytic concepts.

In this study it was accepted that the sociopathic child was an ego disturbed child and that ego reconstruction was needed. The therapeutic reconstruction of the ego however will not take place by making the unconscious conscious as is the aim of psychoanalytic therapy, but the ego and super ego will be built by experiences in the here and now through interpersonal interaction.

Another aspect of importance for this study is that in the

humanistic therapies it is accepted that what one experiences in fantasy is one's reality. If a patient thus can handle a problem in fantasy, it is expected that he will eventually be able to handle it in reality also.

SUBJECTS

1. Three groups, each consisting of ten White children with strong sociopathic tendencies, were selected on the basis of the Jesness Inventory Asocial Index. (This test will later be described in the section "APPARATUS"). To make sure that only children with clear sociopathic trends were included in the study, a score of 60 was taken for the lower cut off point in selection. Jesness considered a score of above 55 as a valid diagnosis for sociopathy.
- 1.1. Age: Lourie (1959), Rabinowitch (op. cit.), Millon (op. cit.) and Reid (op. cit.) all feel that it might be possible to reach the sociopath with psychotherapy in the formative years up to about the age of 14 years. This was taken into consideration in the selection of the subjects. The children were selected between the ages of seven and thirteen. Seven was taken as the lowest age level, because ego controls can only be considered effective as from six years of age, according to Piaget (1965). Between the ages of five to six years the child ought to have become sufficiently socialized to enable him to conform to the norms of society. All asocial behaviour which might be the result of a sociopathic process, can only be identified as such, after this age.

1.2. Intelligence

Only children with a total I.Q. of 90 plus, as obtained on the NSAIS and WISC, were selected as subjects. The inter-test scatter pattern was studied and significant aspects thereof are discussed in the section on the RESULTS.

1.3 Screening procedures

The children selected on the Jesness Inventory Asocial Index score and social background. They were divided for social background into one of Hollingsheads' (1958) five social class groups. He used area of residence, occupation and education to determine his five class positions.

Twenty of the children (Experimental Group and Passive Control Group) were referred to the Munitoria Child Guidance Clinic, Pretoria, for conduct disorders. They were all seen by a psychiatrist and an EEG was performed on them. Any subject with an abnormal EEG or any signs of CNS impairment was excluded. They were then seen by the therapist who tested them for screening purposes on the Jesness Inventory Asocial Index. They were then tested on the WISC and NSAIS. They were matched and randomly assigned to the two groups. The children included in the Active Control Group were screened and matched in the same way with the previous two groups but this group consisted of children who were already in an institution. The groups were matched for ~~social class, I.Q., age and~~ the score on the Jesness Inv. The groups were as follows:

1.3.1 Experimental group

This group consisted of ten sociopathic children who were given

individual psychotherapy by the researcher the nature of which is fully described in the section on the "Therapeutic Methods". To obtain a workable size group children both in care of their own parents and in foster care had to be included, in the first two groups. Five of the children were in the care of their own parents and five were in the care of foster parents, for more than two years already, at the time of treatment. They had to be in foster care for more than two years so as to exclude the affect this placement might have on therapy.

1.3.2. Control Group 1. (Passive Control Group)

This group consisted of ten sociopathic children of whom five were in the care of their parent and five were in foster care for more than two years. They were put on a waiting list and remained in the care of their parents or foster parents without receiving individual psychotherapy. Care was taken not to counsel the parents on the handling of these children.

1.3.3. Control Group 2. (Active Control Group)

Ten sociopathic children, who had been placed in an institution, were tested and rated within the first three months after admittance. These children were under the influence of milieu therapy, the accepted kind of therapy for the sociopathic child in South Africa. They were in a children's home where the home system was functioning e.g. ten to twenty children are placed with one pair of houseparents that became their substitute father and mother figures. The children were actively included in the discipline and a system of a court run by the children was in operation. They had to earn privileges by good conduct and were punished by being denied privileges. There was no therapist in the

institution and none of them received individual psychotherapy.

1.3.4. Control Group 3.

This is a control group that was selected to compare the I.Q. scatter and the Behavior rating scale's ratings (see APPARATUS) of the sociopathic children with that of neurotic children. A group of the first thirty children that were seen at the indicated Psychiatric clinic for any problem of a neurotic nature excluding behavioral problems of a sociopathic nature and learning problems were selected with the Jesness Inventory's Associal Index with a score of below 50 in order to exclude sociopathy.

THE ASSESSMENT PROCESS

1. INTRODUCTION

The sociopathized child is diagnosed mainly in terms of behavioral criteria as discussed in a previous chapter. However in order to assess the unique functioning of each individual child, a complete diagnostic evaluation is necessary. Palmer (1970, p.3) puts it as follows: "*Psychological assessment is the use of scientific knowledge and methods in order to study the behavioral problems of an individual child.*" Even though the sociopathized child can be classified under one broad pathological picture, each child nonetheless remains a unique individual who must be assessed and treated as such during therapy. The value and validity of psychological testing and diagnosis are often doubted and should thus be discussed before one can look at the apparatus used for testing.

It is scientifically necessary that all phenomena must be defined

and described before they can be investigated. It follows that in psychology it is often accepted in principle that a clear-cut diagnostic model is required before research can be done on any psychological condition. This pre-supposition is based mainly on the medical-psychiatric model of which Kreapelin was the founder in psychology, since he was the first to attempt to establish a nosological index based mainly on the description of a condition as such. In later years he also incorporated the etiological grounds and modified his categorization accordingly.

Today psychologists question this model strongly (Ash, 1949; Cattell, 1957; Eysenck, 1952; Foulds, 1955; Harrower, 1950; Hoch and Zubin, 1953; King, 1954; Leary and Coffey, 1955; Mehlman, 1952; Menninger, 1955; Rogers, 1951 and others).

In direct reaction to the purely medical model, Szasz (1961) wrote his "Myth of Mental Illness" and recorded his main objection against the model as follows: "*One principle component of the medical model is the disease or illness concept of abnormal behavior*" (Szasz in Zax and Stricker, 1971). Dr. Szasz sees all psychiatric conduct as deviations from the social, ethical or legal codes of society, which lead to "*problems in living*" in certain unfortunate individuals. He is convinced that "*mental illness is a name for problems of living*" (Szasz, op. cit., p.4).

In support of Szasz, Mowrer (1960) postulates that "*personality disorders, therefore, can be most fruitfully conceptualized as products of moral conflict, confusion and aberration psychiatric symptoms are primarily reflective of unacknowledged sin, and that individuals manifesting these symptoms are responsible for and deserve their suffer-*

ing, both because of their original transgressions and because they refuse to avow and expiate guilt" (Mowrer, op. cit., p.301, 304).

David Auseble (1971) maintains that, if the Szasz-Mowrer model should be accepted, it would set psychology back several centuries. According to Auseble (op. cit.) Szasz and Mowrer operate from the assumption that no diagnosis needs to be made and that all psychiatric phenomena are to be regarded as problems of daily living.

Bindura (1951 in Mahler, 1973) rejects diagnosis on the grounds of dynamics and suggests a behavioral analysis according to which behaviorally modifying therapy can be applied.

In recent years the value of psychological assessment has been widely criticized. Moral objections against the so-called violation of the basic rights of man were raised by Gross (1962). From within psychological circles the most significant criticism comes from Meehl (1959) and Zubin et al (1965), who regard diagnostic testing procedures as invalid and thus valueless.

The purpose of psychological evaluation is twofold: firstly to establish a diagnosis according to a nosological index and secondly to obtain a description of the dynamic functioning of the person in question.

Buss (1966), Cole and Magnussen (1966) and Zubin (op. cit.) are of the opinion that psychological diagnosis can be regarded as useless because it does not conform to the three basic criteria for medical diagnosis, i.e. to determine: i) an etiology, ii) the prognostic indications and iii) the nature of treatment required.

With regard to dynamics Affleck and Strider (1971) state that it has greater value in itself than nosological diagnosis, but that

patients never remain static, with the result that the dynamics must be constantly re-assessed. In direct contrast to this view Cole and Magnussen (op. cit.) postulate that there is no scientific basis to the clinician's "speculations" about the patient. The reliability and validity of psychological evaluation has been investigated and criticized by a considerable number of authors, such as Meehl (1959), Little and Scheidman (1959, Golden (1964) and Zubin et al (op. cit.).

Meehl (op. cit.), for instance, established that only 17% of all clinicians regarded previous diagnosis as significant to their therapy.

However Breger (1968) comes out strongly in support of dynamic assessment of the patient and maintains that it serves a dual purpose: in the first instance it enables the therapist to understand and treat his patient as unique and secondly it can contribute considerably to research in this field.

Larry Beuter (1972, p.304) summarizes the value of all assessment as follows: "*Description of itself has little value as separate from the treatment to be offered to the patient. Thus the value of psychological assessment is ultimately in its ability to positively affect the type and course of treatment.*" He also advocates the assessment not only of the patient, but of the therapist as well, in order to determine the degree of compatibility between the two, since not all therapists attain the same degree of effectivity with all types of patients. This aspect is one which does not as yet enjoy the attention it deserves in practice. Each therapist should at the very least have the self-knowledge to judge which patients he is capable of treating most effectively.

The most recent research in this field seems to emphasize the dynamic description of the patient with a view to therapy instead of a

specific diagnosis. This is the viewpoint entertained in this study with regard to the assessment of the child.

2. ASSESSMENT

In order to assess a child fully, the therapist needs to build up a positive relationship with the child. Hurried testing can never be regarded as valid in a child and the assessment process generally requires several sessions. The assessment is based on observation of the child's conduct and play and on testing. There are many psychological tests for this purpose, but only those which have been used in the relevant research will be reviewed here. The different procedures will be discussed individually. However it must be pointed out that the procedures applied in the evaluation of a child can hardly be classified into clear-cut compartments being, as they are, closely interwoven and overlapping.

2.1. Observation of children

Man exists in the world in his totality as a person. The expression of the unique existence of each individual person takes place via the body, which enters into the known world of others by means of words, deeds, actions and attitudes. The therapist must be capable of understanding and interpreting the invisible communications of the patient to him (Fast, op. cit.).

He must also understand the communication symbols. In any communication process the idea (conscious or unconscious) must be coded into a symbol (word, action, attitude, etc.), which is then transmitted to the recipient, who decodes and interprets it. Problems can arise at any of the points of transmission, with the result that the idea finally re-

ceived is not the original one. Consequently it is vitally important for the therapist to assure that the symbols which he decodes and interprets are the carriers of the original idea (Werner, 1963).

To achieve this, it is imperative that the patient is observed against the background of his total world of experience (internal and external). Fidgeting, for instance, could indicate tension in a child, whereas the same symptom would have a totally different meaning in a child with brain damage.

An observation can never be regarded as complete unless the child has been observed in as many different situations as possible. Since this is not always feasible in practice, a sample of his conduct as displayed in the playroom is taken. However account must always be taken of the fact that this kind of test is merely a sample, that it cannot even be called representative and that its reliability cannot be determined in any way. This does not necessarily mean that the data acquired in this way must be disregarded as useless, but the therapist must take the limitations of the test into account at all times. Furthermore it is a known fact that children bring their total world of reality into the playroom with them, so that it can safely be assumed that, even though this observation can never be complete, it can at least reveal a part of that reality. This part can be seen as a sample image of the whole.

2.2. Objectivity

People in general, and the therapist who works with children in particular, usually approach children with sympathy and empathy. The therapist's empathy may unconsciously differ from child to child. This empathy is a prerequisite for therapy, but could form an obstruction in

the observation phase, since objectivity is essential for effective observation.

The observer must dissociate himself from any note of feeling towards the child and must record his observations as accurately and objectively as possible. A position of detachment to the child's conduct must be assumed and he must be observed purely on individual merit against his individual milieu. In this regard it is important that the therapist should take particular care not to allow counter-transference to intrude into his interpretation of the child's conduct.

2.3. Accuracy

The therapist can never satisfy himself with general, superficial impressions, but will have to make more penetrating and differentiated observations.

Care must also be taken not to make premature interpretations on the basis of first impressions. Initially observation should merely be descriptive. It is only in combination with all the data that it can be integrated into a unified diagnosis in accurate terminology.

APPARATUS

The tests are used mainly to assess the functioning of each child individually, but also serve to determine the collective functioning Pre and Post Therapy of the Experimental Group as a whole.

Although various projection tests for children, such as the C.A.T. Columbus, Michigan, and others are known, a fully comprehensive thematic projective test covering all aspects of the child's life adequately is yet to be found. The mother-son relationship, for instance, has never

been covered satisfactorily. A considerable number of these tests have been conducted on the sociopathic children, but, although all based on the rationale of projection, each test dictates its own interpretation methods, so that, with the exception of the single case study, the protocols are not included in the research. The Rorschach test, which is much more standardized, was used in this research and analyzed according to a fixed system, which will be discussed at a later stage.

1. The Rorschach inkblot test

Since the Rorschach test was applied only to children in this case, only those aspects which are directly relevant to children will be discussed.

The same basic principles apply to the analysis of both the adult and child Rorschach, but the child's level of development must be taken into account. No fully developed theoretical rationale for the child Rorschach exists as yet. A psycho-analytical approach is generally adopted. However Authoress is of the considered opinion that a more organismic and phenomenological approach should apply. An organismic approach will take into consideration the developmental aspects of Piage (op. cit.) and Werner (op. cit.). By phenomenological approach one understands that what the child gives in his reality is accepted as he gives it in the here and now without distorting it by what the interpreter thinks he might be giving. Such an approach offers a deeper insight into the child's structuring of Rorschach projection and enables his perceptual dimensions to be considered holistically.

The ontogenetic development principle formulated by Werner (1971), for instance, must be taken into account. The child attains his equili-

brium through various developmental stages. Between stages a state of imbalance prevails, and when the child reaches a next stage his balance is better than between the two stages. This aspect is of considerable importance in the analysis of the child Rorschach, since certain traits could be ascribed only to this imbalance. The adolescent, for instance, often gives a pseudo-psychotic Rorschach.

1.1. Analysis

A more phenomenological analysis is essential in the child's test. The child's development into a person through identification, for instance, must be observed in the Rorschach. The process of internalization through which individualization and identification develops, can only be indicated by phenomenological analysis (Schachtel, 1944).

In this study the scoring of the Rorschach will be done according to accepted norms. A short analysis of the scoring used will however be included in the Appendix 3.

The qualitative analysis as used in this study is as follows.

1.2. Qualitative analysis of the protocols

For the sake of brevity only a brief content analysis will be given of each individual protocol (in the Experimental Group) and at a later stage of the collective protocols of each group, according to the following framework:

1.2.1. Coping with reality

Card I is regarded by Alcock (1973), Allen (1966), Aronow (1976) and others as the "reality card". According to them this is also the card which indicates the testee's reaction to a new situation.

Card V is analyzed together with Card I and is regarded as the "reality card" by Brown (1953 and 1960).

1.2.2. Self-image

Aronow (1976) and Klopfer II (op. cit.) regard Card II as the testee's self-image or his perception of himself in relation to his reality. In other words, this card represents the person in his world.

1.2.3. Interpersonal Relations

Allen (1966), Aronow (op. cit.) and others regard Card III as the representation of the testee's experience of, and reaction to his human or interpersonal world. Whether or not he can perceive people in his projections is also significant.

1.2.4. Relation to male authority - father figure

Aronow (op. cit.) and others call Card IV the "father card". Alcock (1966) relates this card directly to the Oedipus phase. In this study Card IV will be approached more phenomenologically and will be interpreted as the child's direct reactions to the father figure.

1.2.5. Relation to the mother

According to Aronow (op. cit.) and other investigators, particularly Schachtel (op. cit.), two cards are used to indicate the testee's reaction to the mother figure. On Card VII the more affectional relation to the mother is projected, whereas Card IX, with its delicate images and soft colours, represents the emotional relation to the mother.

(See p.515 for meaning of affectional and emosional)

1.2.6. Emotionality

In considering the projection of the child's emotionality the entire protocol is taken into account, but Cards VIII and X are considered

more specifically (Alcock, op. cit; Allen, op. cit; Aronow, op. cit.). However most children find Card VIII easier to cope with and to integrate than Card X.

Although the above-mentioned analysis technique is strongly criticized by authors such as Zelin and Sechrest (1963), who feel that the projection material is totally unstructured, the majority of clinicians do not agree with this view. Aronow (op. cit., p.263) formulates it in clear terms:

"It is clear from all the findings that the Rorschach blots cannot be considered totally unstructured stimuli to which the subject contributes structure; each of the ten blots has distinct stimulus characteristics which influence responses." He maintains that a much simpler and more accurate analysis can be made if specific reaction values are assigned to each Card, as has been proved empirically to a large extent. Aronow (op. cit.) also points out that such an analysis can have considerable research value, particularly if protocols are compared. However he emphasizes that caution must be taken in ordinary clinical work to follow a wider perspective in qualitative interpretation, since sexual pathology, for instance, can be represented over the entire protocol. Such cases require considerable clinical skill.

As this is a research study, the interpretation of all protocols will be done strictly according to the framework discussed above for the sake of homogeneity. With regard to the interpretation of content as such, the phenomenological approach is adopted.

1.2.7. Quantitative interpretation

Since this is a research study, only the spontaneous responses of

the children themselves are considered (performance proper). Inquiries, such as are permissible in the clinical application of the Rorschach were not used. The determinants used are Klopfer's (II, 1970).

Three additional assessment scales, viz. Elizeur's Scales of Anxiety and Aggressiveness and Holz's Scale of Primary Processes were used. These scales will now be discussed somewhat more fully:

1.3.1. Elizur's Aggressiveness and Anxiety Scale for the interpretation of Rorschach data

Elizur (1949) drew up a scoring system for the assessment of hostility and anxiety on the Rorschach.

Elizur (op. cit.) uses the term "hostility" to refer to *"feelings of resentment and enmity, which are often repressed in our culture but almost inevitably show up in the individual's distorted attitudes toward people, either being too antagonistic or too submissive"* (p.248).

In the assignment of scores on the two scales only the content of the Rorschach is taken into account.

1.3.2. Aggressiveness or hostility scores

The symbol H or h is assigned and later converted into a quantitative score, viz.: H=2; h=1.

H - is assigned in the following cases:

where hostility or aggressiveness is explicit in the conduct of the projected figure;

where emotions or attitudes reflect such conduct;

where an object of aggression, such as a bomb, is mentioned.

h - is used in cases:

where feelings of hostility are only implied;

where an object is not aggressive as such, but can be used aggressively, such as a pair of scissors;

where symbolic aggression occurs;

where both anxiety and aggression are contained in a single response.

1.3.3. Anxiety scores

The symbols A or a are assigned and quantified to A=2; a=1.

A - applies to the following instances:

where anxiety is exhibited in the conduct of the projected figure;

where emotions or attitudes of anxiety are clearly projected;

where an object, such as a nuclear bomb, which clearly provokes anxiety, is indicated.

a - applies to the following:

where anxiety is merely implied in conduct, attitude or emotion;

where the projected object provokes fear rather than anxiety;

for symbolic anxiety;

where both anxiety and aggression are contained in a single response.

For a more detailed discussion see "Rorschach Handbook of Clinical and Research Applications" by M.R. Goldfield, G. Stricker and I.B. Werner, 1971, p.89-140).

These two scales are applied to the Rorschach protocols of the sociopathized children before and after therapy, and processed statistically.

1.4. Holtz Scale of Primary and Secondary Aggression

Holtz (in Aronow, op. cit., p.144) drew up a scale on which different basic urges can be scaled according to the psycho-analytical model on two levels, Scale 1 and Scale 2. Scale 1 represents the basic uncontrolled, primitive level of the urge or emotion, while Scale 2 represents the more controlled, adult level of the basic emotions and urges.

For the purposes of this study only the Aggression Scale was used and applied according to Holtz's formula, as follows:

A.1 is assigned to aggressive images, such as demons dismembering a woman (Subject).

Sacrificial images, i.e. sadism, dead images, i.e. a limb about to be chopped off, etc (Object).

Result of aggression, i.e. burnt body, rotting flesh, etc (Effect).

A.2 is assigned as follows:

Subject, i.e. fighting men, charging bulls, pirates, etc.

Object, i.e. terrified women, children being beaten, etc.

Effect, i.e. blood, broken bones or flowers, artificial limbs, etc.

As can be seen, "*Level 1 applies to the more primitive id-oriented, blatantly unsocialized responses, whereas Level 2 is designated for those precepts that are more controlled and responsive to socialization factors*" (Aronow, op. cit. p.144).

A1 responses, in other words, could reasonably be expected to diminish and to become modified to A2 responses with socialization. In the sociopathized child both responses should diminish if therapy is achieving any effect whatever, and A1 responses should be modified to

A2 responses.

"In my experience Rorschach with children has proved a valuable key to understanding, a diagnostic tool both flexible and rewarding. It must, like all tools, be used with intelligence and care. So used, it can light the way to much that would remain dark without it" (Francis-Williams, 1968, p.160). Authoress agrees whole-heartedly with this view and from personal experience regards Rorschach as the most useful projection instrument in the hands of the qualified clinician in the assessment of both children and adults.

1.5. The use of projection tests in research

In research which does not require exact scoring but involves deeper human interaction, projection tests are acceptable. For the purposes of this study in particular, which aims to assess the functioning of the child, his perception of his world and his reactions to it, this method is eminently suitable.

According to Lindsay (1952) the main advantages of projection tests are the following:

- i. They are sensitive to latent personality aspects.
- ii. They evoke multiple responses, which are rich in variety.
- iii. The responses are multi-dimensional.
- iv. There is little awareness in the testee of what he is relinquishing.
- v. The responses lend themselves to analysis of the total personality.

Much of the criticism against projection tests stems from the fact that the limitations of the test are not sufficiently taken into account. Clinicians apply the projection tests to achieve results which these

tests were never designed to give, or without sufficiently understanding the theory behind the test. It would, for instance, be illogical to attempt to determine the extent of brain damage by means of Rorschach, while several more accurate tests exist.

If projection tests are to be minutely scrutinized as to their reliability in research, the concept of reliability in relation to these tests will have to be more clearly defined.

1.5.1. Content reliability

In her book, "Mental Testing" (1949), Goodenough states that the protocol in projection tests is comparable to the content reliability test in ordinary research in that the conduct of the testee is always measured in terms of a sample of his behaviour or functioning. This sample could provide certain indications which could reveal personality traits. However these remain no more than traits until the sample is generalized to the population (that is the total conduct of the person) and proved true.

As in any research, it could, for instance, be possible that at the 1% reliability level the particular sample may fall within the 1% rejection level, although it is accepted as true, or vice versa.

The fault does not lie in the reliability of the tests but in its inadequate application.

It is essential to delineate and define the aspect to be tested as well as the scoring method clearly. It is this aspect which often gives rise to problems, since many psychological concepts are open to different interpretation by different people.

The internal reliability of a test must be known. How reliable,

for instance, is the Rorschach in determining schizophrenia at the 1% reliability level? Meehl and Rosen (1955) investigated this aspect, but they failed to assign specific scores. This is a factor which must be taken into account.

1.5.2. The problem of overlapping

Projection tests should be analyzed in the context of the testee's total functioning. Blind analyses usually miss the essence of his functional dynamics. As pointed out by Purcell (1958), if Dollard and Miller's avoidance-approach theory (op. cit.) is ignored, it is possible that only the testee's aggressiveness could be perceived while his withdrawal tendencies and his anxiety about his aggressiveness are ignored. The observation of significant aspects can be obstructed because projection tests sometimes inherently obscure certain data. This basic flaw can only be overcome by determining the possibility of a certain form of conduct by considering how frequently it occurs as well as how soon it appears in the protocol. At the same time, according to Purcell (op. cit.), the latent inhibiting forces of conduct may never be ignored.

Wallace (1966) points out that every protocol is merely an indication of the person's conduct. Just as in purely experimental research, it can be postulated that the conduct represented in the projection tests is merely a sample of the testee's total conduct. However when the testee idiosyncratically reconstructs his world on the strength of the projection stimulus, his total functioning is involved. This makes the projection a representative sample of his conduct and experience.

1.5.3. Discussion

From the ranks of academic experimental psychology the validity of the use of projection material in research is increasingly being questioned. The principal objections against this method are that it is unscientific, time-consuming and subjectively dependant on the competence and skill of the investigator.

If these objections are to be countered, accurate account will have to be given of the exact aim and purpose of the research and of the aspect to be tested. In a study such as this the functioning of an individual person can never be represented merely in terms of a figure, just as man in all his complexity can never be reduced to a single numeral or his value represented numerically.

Projection may sometimes be a more refined measuring instrument in that it not only tests and assesses the testee's conduct as such, but also uncovers the unconscious processes and motivation underlying his conduct. According to Rappaport (op. cit.) projective test responses reflect the nature and structure of the thought processes.

The projective test situation allows the testee to represent his own individual world perception to the examiner.

The objection that the interpretation depends solely on the clinician's skill is equally invalid, since all research contains an element of subjectivity. Even in the most purely empirical research interpretation via a subjective investigator is still inevitable. Many of the projective tests also have an objective scoring system like the Rorschach and Kahn.

In the research under discussion it is assumed that the unique world which a child reconstructs with his unique aperceptive abilities

during the test is his world of reality. Although exact scores cannot be obtained by means of this technique, differences in degree in his experience can be brought forward if the phenomenological method is applied. It can be verified by objective scoring as in the case of the Rorschach.

The Rorschach projection test was chosen because, as a moderately structured test it lends itself to a relatively undisturbed representation of the child's own experience of his reality.

2. Wechsler Intelligence Scale for Children (WISC)

The WISC is the standard American intelligence test for children. It was re-standardized in 1973 and made available in 1976. For the purposes of this study the old test was used, since the re-standardized version was not yet available in South Africa at the outset of the research.

As in the case of the NSAIS, the WISC consists of a Verbal and a Performance Scale. The Verbal Scale comprises six sub-tests: Vocabulary, Information, Comprehension, Similarities, Arithmetic, and Digit Repetition. The Performance Scale comprises: Picture Completion, Picture Arrangement, Object Assembly, Coding, Mazes and Blocks.

In this study the Vocabulary test was not applied since it is too strongly culture-bound, and the Mazes test, which is a substitute test for Coding, was also omitted.

Each sub-test covers a considerable number of factors, but only those which are directly relevant to this study will be discussed.

2.1. Scoring of Scatter pattern symbols

The scatter pattern symbols are scored in the following way according to Glasser (op. cit.). The same system will be used in the analysis of the NSAIS.

Deviances are calculated from the total IQ of each child as follows for each sub-test.

- 0 = 0-9 points more or less than the total IQ. This is considered as "not significant".
- (+) or (-) = 10-14 points more or less than the total IQ. This is considered as "indicative".
- + or - = 15+ points more or less than the total IQ. This is considered as "significant".

2.2. Information

In order to perceive and absorb his world adequately, the child must be capable of detaching himself from his mother and of perceiving himself as an object separate from the mother and his world as objects separate from himself (Werner, op. cit.). If the child is unable to detach himself from the mother or remains introverted, he will develop an inadequate perception of his world or fail to absorb sufficient information from it. That information which he does absorb from his world will accordingly also be deficient. The sociopathized child may come from an exceedingly poor world - a culturally deprived world - which failed to draw him out of himself, or he may be so egocentrically self-orientated that he is unable to move out into his world.

In other words, according to Glasser et al (1967), a low score in this test indicates:

- i. poor social background

ii. egocentricity.

2.3. Comprehension

This test involves mainly sound judgement (Griffin, 1958), but also covers social skills. Since the test is heavily loaded in regard to moral standards, it pre-supposes a certain knowledge of accepted social behaviour patterns. As the sociopathic child lacks an ability to accept norms he might perform low on this test. He however may have a very good social insight which might be a compensating factor.

2.4. Arithmetic

Apart from purely arithmetical ability, this test also measures the testee's concentration capacity and his ability to function under stress (Glasser et al, op. cit.).

The scoring in this test is generally low in sociopathized children since they are apparently incapable of adequate functioning under stress (Wittenborn et al, 1951).

2.5. Digit Repitition

Anxiety plays a considerable role in a child's ability to give undivided attention and accordingly this test can be regarded as sensitive to the presence of anxiety (Cohen, 1959).

In view of the fact that sociopathized children are generally assumed to be relatively free from anxiety, a positive score in this test would seem a logical deduction. However Glasser (op. cit.) established that sociopathized children obtained scores ranging from minus to positive.

2.6. Similarities

This test measures the child's capacity for abstraction as well as his ability to perceive the connection between relevant objects and occurrences (Madge, op. cit.).

A low score in this test, according to Wittenborn (op. cit.), is indicative of sociopathy. It appears as if the sociopathized child is unable to see the connections because he remains impulsive even in his thought processes, so that he is not readily capable of drawing connections between similar concepts.

2.7. Picture Completion

Glasser et al (op. cit.) point out that this test does not measure a single element, but several. Madge (op. cit.) states that the test pre-supposes a certain social insight and social intelligence and will therefore show a positive score in the sociopathized child.

2.8. Picture Arrangement

Apart from projecting visual sequence, this test involves a refined ability to gauge social situations and use them to personal advantage, in other words, a manipulatory ability (Glasser et al, op. cit.).

It should consequently show a positive score in the sociopathized child.

2.9. Blocks

This is mainly a visual-motoric test based on spatial insight, which required perceptual organization on a high level (Cohen, op. cit.).

According to Altus (1949), Foster (1959) and Franklin (1945) this test shows negative outfall in the sociopathized child.

2.10. Coding

Visual-motoric skill is measured in this test (Glasser, op. cit.).

3. New South African Individual Scale (NSAIS)

The NSAIS is at present the only standardized test in South Africa for determining intelligence in children. This test was used in conjunction with the Wechsler Intelligence Scale for Children (WISC) not only to determine intelligence, but also so that the intertest distribution could be analyzed diagnostically.

The NSAIS was drawn up from various other intelligence scales. Binet designed the first measurement scale for mental potential in 1908. From this scale Stern developed the mental age/chronological age concept, which he called Intelligence Quotient, abbreviated to IQ.

The first intelligence test in South Africa was drawn up by M. Moll and C. Leipoldt from the scales of Binet, Knox, Goddead and Healy. However no evidence can be found that this test was ever standardized.

The first comprehensive test in Afrikaans was the Eybers Scale (1924), which was based on the Binet-Terman Scale. In 1930 the K.P.I. was drawn up by Cruse and Malherbe.

In 1939 the Eybers Scale was revised and an Individual Scale brought out by the Bureau of Educational Research. This scale was used until 1955, when the National Bureau of Educational and Social Research instructed the National Council for Social Research to compile a new scale. The NSAIS stems from this.

According to Mienie (1966, p.16) the following requirements were stipulated:

- i. The NSAIS had to be a point scale, that is, items of homogenous

- content had to be grouped together into different group tests.
- ii. The standard deviation method had to replace the age method by which IQ was determined by comparing the test scoring of the testee with that of his age group.
 - iii. The same test had to apply to all ages.
 - iv. The battery had to be practical and serviceable in that: the apparatus involved had to be manageable; the age limits had to include all children; it should not be time-consuming; it had to be capable of holding the testee's attention, and it had to be applicable to both Afrikaans and English children with common, standard norms for both language groups.

The standardization of the test took place during the period 1959 to 1962, and the final standardization in 1962 involved 1402 pupils. From this standardization the following sub-tests were finally selected and a global test compiled:

Verbal Scale

Vocabulary

Coprehension

Verbal reasoning

Problems

Memory

Performance Scale

Pattern completion

Blocks

Absurdities

Form board

It must be pointed out that neither the verbal nor the Performance scale in NSAIS can necessarily be assumed to measure exactly the same elements as that of the WISC, and that the diagnostic conclusions will not necessarily be identical either.

Mienie (op. cit.) assessed the reliability of the NSAIS according to the test-retest method as follows:

Verbal - extremely high

Non-verbal - adequate

The form-board gives a very low reliability correlation ($r = ,473$).

(The exact scores were not given).

The validity of the verbal sub-tests is very high, but that of the Performance tests is low. The validity of the test as a whole can be regarded as satisfactory.

According to Madge (1971), certain tests in the NSAIS can be regarded as sensitive to sociopathy, viz.:

- a. a higher Performance than Verbal score;
- b. positive score on Verbal Reasoning;
- c. minus score on Vocabulary, Problems and Blocks.

The positive and minus scores will be discussed in the Results.

Verbal Scale

3.1. Vocabulary

The ability to learn words and their meaning is clearly related to the child's social environment.

In the sociopathic child it will thus depend on his background what his scoring on this test will be.

3.2. Comprehension

This test is based on the idea that the child absorbs social and moral behaviour in his daily contact with people. This test correlates with the Comprehension test on the WISC. The sociopathic child seems to lack the ability to integrate social norms but has a very good social insight. So both of these factors will determine their

scores on this test.

3.3. Verbal Reasoning

This tests the same aspects as the Similarity sub-test on the WISC.

3.4. Problems

This test tests the same aspects as the Arithmetic sub-test on the WISC.

3.5. Memory

This test correlates with the Digit sub-test on the WISC.

3.6. Pattern Completion

This test has as its basis the ability to reason and analyse. It is also a test of visual perception. Sociopathic children, because of their impulsiveness might perform in the normal or minus outfall range.

3.7. Blocks

This test correlates with the Blocks test on the WISC.

3.8. Absurdities

This test correlates with the Picture completion test on the WISC.

3.9. Form Board

This is a test of the ability to synthesize concrete visual perception. Madge (op. cit.) has also found this a test of creativity. She mentioned that the impulsive child scores low on this test. This aspect may cause the sociopathic child to give a minus score. His

creative ability however, might compensate for his impulsiveness.

Summary of WISC and NSAIS scatter patterns

The following combined distribution table of the sub-tests in the NSAIS and WISC can be deduced from the above:

SCORING ON NSAIS AND WISC IN SOCIOPATHIZED CHILDREN

(Tests which measure more or less the same elements are placed alongside)

<u>NSAIS</u>	<u>SCORE</u>	<u>WISC</u>	<u>SCORE</u>
Vocabulary	0 to -	Vocabulary	0 to -
Comprehension	0 to +	Comprehension	0 to +
<u>Verbal reasoning</u>	+	Similarities	- to 0
<u>Problems</u>	-	Arithmetic	- to 0
<u>Memory</u>	+		
Pattern Completion	0 to -		
<u>Blocks</u>	-	Blocks	-
<u>Absurdities</u>	+	<u>Picture completion</u>	+
Form Board	- to 0		
		Information	- to 0 to +
		Digit Repitition	- to 0 to +
		<u>Picture Arrangement</u>	+
		<u>Object Assembly</u>	+ to 0
		Coding	0 to +
		Mazes	0 to +
Performance IQ always higher than Verbal IQ.		Performance IQ always higher than Verbal IQ.	

(The underlined tests are highly sensitive to the presence of sociopathic behaviour patterns).

Reid (op. cit.) feels that the WISC and NSAIS are still the best diagnostic tools available for diagnosing sociopathy both in the child and adult.

4. Jesness Inventory

This test was developed as part of a five year research program on delinquency in California in 1966 with the aim of differentiating between ordinary disturbed children and those with psychopathic tendencies. It has provided us with "*a single index of tendencies predictive of social and personality problems*" (Jesness Manuel 1972, p.3).

The inventory consists of 155 True-False items designed to measure the reactions of young people on a wide range of content. From this 11 personality characteristics clustered into seven scales were statistically derived.

In this research only the Asocial Index thereof was used. This index is accepted by the American Children's Courts as a means to predict and diagnose sociopathy in children (Jesness op. cit.). Jesness himself found that normal children usually have an Asocial Index score of well below 50 and that children who have mild personality problems never score above 55. A score above 55 is considered valid for the diagnosis of sociopathy. To make sure that only children with clear sociopathic trends are included in this study a score of 60 is taken as the lower cutoff point for selection.

As a means of testing change in the behaviour this index should go down if the sociopathic behaviour and tendencies of the child changed positively.

Although the Jesness Inventory was not validated for South-African conditions, it was used as a research instrument because no validated tests, for testing sociopathy in South-Africa are available. This test however was validated on a population with very much the same social background as those of the subjects used in this study.

4.1. Statistical Considerations of this test

The test was standardized on 970 delinquents with psychopathic tendencies and 1075 non-delinquents during 1961 to 1962 in public schools in North California.

Reliability was tested with odd-even items and was significant at the ,05 level.

The ability to cheat on the test was also tested under different conditions and found that the asocial index was not affected by any of these conditions favourable for faking.

Jesness (op. cit.) has found that *"the majority of delinquents can be correctly classified with greater than two-to-one odds of correct designation. Using a raw score - asocial index of 22(64) for example 74% of the delinquents are identified with a probability of ,65 for a true positive and ,35 for a false positive"*. (Jesness op. cit.), p.24).

Jesness stresses the main use of the inventory as that of discriminating between ordinary delinquents and those who will become psychopathic if not given intervention or treatment. This is where this test is so important in the selection of the subjects and to determine the effects of therapy on sociopathic behaviour in this study.

5. The Behaviour Rating Scale

This scale was devised by the authoress to rate the behaviour of the sociopathic child objectively by observation of his behaviour. It was constituted on the basis of behaviour indices of the sociopathic

child as found in the literature.

It covers different areas namely the child's attitude and behaviour towards norms, school discipline, parents, peers, animals, his identity and direct sociopathic behaviour (See table 1).

It is a seven point rating scale with one taken as positive non sociopathic behaviour and seven as total sociopathic behaviour. Four was rated as Normal behaviour. It is a scale between totally non sociopathic behaviour (scaled at 1) and totally sociopathic behaviour (scaled at 7). As mentioned in the literature no "normal" child under all circumstances has totally non sociopathic behaviour. Rather normal children seem to exhibit some non conforming behaviour at times. Thus 4 was rated as normal behaviour.

It needs to be mentioned that this is an apparatus where clinical judgement is used and should be evaluated in this light (See table 1.1 for the Behaviour Rating scale).

The criteria for rating each item are in Table 1.

Table 1

Guideline for Scoring the Behaviour Rating scale

<u>Total Non-Sociopathic Behaviour</u>	<u>Normal Behaviour</u>	<u>Total Sociopathic Behaviour</u>
<u>RATING OF 1</u>	<u>Rating of 4</u>	<u>Rating of 7</u>
<u>Obedient</u> Responds every time	Responds most of the time	<u>Disobedient</u> Never responds
<u>Honest</u> Always totally honest	Honest most of the time	<u>Dishonest</u> Dishonest most of the time
<u>Does not steal</u> Never steals anything	Occasionally steals	<u>Steals</u> Steals more than three times a week.
<u>Stays at Home</u> Home most of the time	Away from home three afternoons a week	<u>Does not stay at home</u> Away every afternoon of the week
<u>Never tells lies</u> Never tells a lie	Lies approximately twice a week	<u>Tells lies</u> Lies more than five times a week
<u>Likes School</u> Enthusiastic about school	Some days does not like school	<u>Hates school</u> Hates school

Regular school attendance

Always at school

Absent not more than
5 days per term

Truancy

Absent more than 10
days per term without
a reason

Does well at school

70% plus

60%

Underperforms at school

Under 60%

Does his homework

Homework done every day

Forgets once in two
weeks

Does not do his home-
work

Never does his home-
work

Never fights

Never fights with other

Fights once per week

Fights

Fights every day

Controlable

Always controlable

Uncontrolable once
a week

Uncontrolable

Totally uncontrolable

Concerned about parents

Very concerned

Indifferent at times

Unconcerned

Totally unconcerned
about parents

Calm relations with
parents

Calm relationship

Stubborn once a day

Anxious relations with
parents

In opposition with
parents mostly

Warm relationship with
parents

Open and close to parents

Has some secrets

Cold relations with
parents

Cold distant relations
with parents

Loves parents

Openly expresses his love
for his parents

Lots of friends

More than six friends

Popular

Children invite him to
their homes more than
three times a week

Leader

Has been selected or nom-
inated for a leadership
position more than three
times

Loves animals

Never hurts an animal
Caring towards them

Loving

Very affectionate towards
most people

Thinks before he acts

Always considers the con-
sequences before he acts

Hates parents

Openly hates parents

No friends

No friends at all

Unpopular

Never invited

Follower

Never selected or nom-
inated

Cruel to animals

Nearly always cruel
to animals

Hateful

Negative towards most
people

Impulsive

Impulsive more than
six times a day

Expresses his love
at least once a week

More than three
friends

Invited at least
once a week

Selected or nominated
twice

Occasionally will
hurt an animal

Affectionate towards
people he knows

Impulsive once a day

Anxious

Very timid and anxious

Timid and anxious
in new situations

Bravado attitude

Never timid. Acts with
bravado

Not easily angered

Never loses his temper

Loses his temper
once a day

Easily angered

Loses his temper more
than five times a day

Responsible

Can depend on him always

Acts irresponsibly
once a day

Irresponsible

Acts irresponsibly
more than three times
a day

Sexually normal

Very little sexual
interest

Has normal sexual
interest as he has
in other things as
well

Sexually abnormal

Preoccupied with sex
or abnormal sexual
acts

Strong sexual identity

Strongly aware of his
sexual identity

Normally aware. Takes
it for granted that
he is a boy or a
girl

Poor sexual identity

Poor negative identity.
Not sure if he wants
to be a boy or a girl

5.1 Raters

The subjects of the Experimental Group were rated on this scale by four raters Pre and Post Therapy. The Passive Control Group and the Active Control Group were also rated by four raters on this scale at the beginning of the research study and again for the second time eight to twelve months after their first rating as this was the period specified for completion of therapy in the Experimental Group. All three groups were again rated by four raters two years after therapy at the follow up study.

The subjects were rated on this scale according to the observation of their behaviour, interviews with the child and play sessions with the child. Each rater could spend as much time as she or he needed with the child to evaluate him.

The Pre and Post Therapy raters were as follow:

Clinical Psychologist. The psychologist who did the therapy rated subjects on the behaviour rating scale after she had completed the evaluation process and testing procedures. She knew who had received therapy.

Social Worker. The social worker who had to write the social report on the child and thus had to obtain a full background history from any source she needed, was asked to rate the children. She was told that the information was needed for the treatment of the child. She did not know that it was a research project or which of the children received therapy.

Teacher of the child. Each child was also rated by his school teacher who was told that it was information needed for assessing the child. She did not know whether the child had received therapy or not.

Parents. The parents or foster parents of the child were asked to rate

their children but they were not told that it was a research project. They were told that it was part of the evaluation program for every child. The children in the institution were rated by the houseparents instead of their own parents.

At the follow up study two years later the raters consisted of the following people, none of whom knew which children had received therapy: a clinical psychologist, a social worker, the children's teachers and their parents, foster parents or houseparents. To motivate the psychologist and social worker to do the follow up study they had to be told that it was a research project, but it was explained to them that the nature of the study could not be disclosed to them. This might have had an effect on their ratings but as they did not know the nature of the research nor which children had received therapy the effect would have been minimal. The results of the Behaviour rating scale was also compared with the results of the Jesness Inventory Associal Index, which is a more objective test.

The clinical psychologist who rated subjects, first completed the Jesness Inventory with them. She then spent as much time as she needed to know the child with each child in the playroom, observing his behaviour and talking and playing with him.

The social worker visited the home, spent time with the child and could contact whoever she felt necessary to obtain a full picture of the child before she rated him.

The teachers were asked to rate the child as an evaluation of him was being made by the clinic. She did not know whether he had received therapy or not nor did she know that it was a research project.

The parents were told that the child was re-evaluated and were

requested to help by filling in the Behaviour Rating Scale together as far as possible. They did not know that it was a research project.

TABLE 1.1

THE BEHAVIOUR RATING SCALE

<u>Total Positive Behaviour</u>	<u>Normal Behaviour</u>	<u>Total Negative Behaviour</u>
1 2 3	4	5 6 7
Obedient		Disobedient
Honest		Dishonest
Does not steal		Steals
Stays at home		Does not stay at home
Never tells lies		Always tells lies
Likes school		Hates school
Regular school attendance		Truancy
Does well at school		Underperforms at school
Does his home-work		Does not do his homework
Never fights		Always fights
Controlable		Uncontrolable
Concerned about parents		Unconcerned
Calm relation parents		Anxious relation
Warm relation iwth parents		Cold relation
Loves parents		Hates parents

	1	2	3	4	5	6	7	
Lots of friends								No friends
Popular								Unpopular
Leader								Follower
Loves animals								Cruel to animals
Loving								Hateful
Thinks before he acts								Impulsive
Anxious								Bravado attitude
Not easily angered								Easily angered
Responsible								Irresponsible
Sexually normal								Sexually abnormal
Strong sex- ual identity								Poor sexual identity

EXPERIMENTAL PROCEDURES

- 1.1. The subjects were selected according to the Jesness Inventory's Asocial Index.
- 1.2. Each child was tested on the apparatus, namely the WISC, NSAIS and Rorschach, where only the performance proper was taken into consideration (no leading questions, as usually done in clinical situations, were asked).
- 1.3. Each subject was rated on the Behaviour rating scale by the four raters.
- 1.4. The subjects of the Experimental Group were given individual psychotherapy by the authoress, consisting of 20 to 25 individual sessions

and followed by eight to ten group sessions in a period from eight to twelve months in order to control developmental variables as far as possible.

- 1.5. After two years all the sociopathic children were again tested on the Jesness Inventory and rated by four raters on the Behaviour Rating Scale.

As already stated the authoress agrees with Reid (op. cit.) that the sociopathic child needs an integrated method of different therapeutic methods or techniques used in connection with each other. The different psychotherapeutic techniques are only instruments in the hands of the therapist, to select and use for the specific problems of a specific patient (Truax. op. cit.). No one method is a cure all, just as no one pill is used for all illnesses. At the same time however, it is dangerous to move in a so-called eclectic manner from one school of thought to the other. Thus although different kinds or methods of therapy were combined in this study they were all performed according to the Humanistic psychological school of thought.

The sociopathic child has such a complex pathology, that one method or technique of therapy, as tried up to now, seems inadequate to really help the child to become fully functioning as is the aim of existential therapy. In this study the basic pathology and symptomatology of the sociopathic child in general was analysed and specific kinds of Humanistic therapy selected for the main areas of disfunction.

That one of the techniques could be more effective than the other might be true, but up to now no one technique alone has proved to be successful. In a follow up study different combinations of the techni-

ques could possibly be tested. The aim of this study is restricted to test whether a battery of different techniques have a positive change effect on the behaviour of the sociopathic child. This hypothesis has so far never been tested previously.

Before one can look at the techniques used one has to examine the therapist as an outcome variable in therapy.

THE THERAPIST AS VARIABLE

In any therapy the personality of the therapist is to a certain degree an uncontrollable variable and for this reason it is of great importance to consider the requirements for the child therapist.

According to Rutter (1975) therapeutic methods are merely an instrument in the hands of the therapist. It follows that the personality of the therapist, and particularly the child therapist, is of the utmost importance. Rutter (op. cit.) points out that the personality of the child psychologist is one of the most significant variables in the success or failure of the therapy. According to him "*the therapist's faith, interest and optimism are important factors in leading to improvement*" (Rutter, op. cit., p.305). Warren (1969) and Palmer (1971) observe that the personality of the therapist working with the sociopathized child is of the utmost importance. Before therapeutic methods can be discussed individually, the child therapist and the requirements he or she must fulfill will have to be considered.

THE CHILD THERAPIST

In the development of child psychology many and diverse views on the child have been expressed through the centuries. La Bruyere regard-

ed the child as "already a man". He and many other psychologists before Freud either maintained the highly pessimistic view that the child exhibited all the negative traits of the adult, or, like Rousseau over-idealized the child. Freud (1905) was one of the first persons to point out that the child was different, that he was not a small adult but functioned on an entirely different level - a level which had become unconscious in the adult, was no longer understood, and therefore rejected.

Today psychologists understand the psyche of the child sufficiently to realize that Freud (op. cit.) was correct. According to Rabinowitch (1959), Rutter (o. cit.) and others it is thus obvious that disturbances in the child will not follow the pattern of adult pathology. Accordingly child therapy will of necessity differ from adult therapy and the characteristics required in the child therapist will differ to a certain degree from those of the adult therapist. However this does not necessarily mean that the child therapist will be unsuitable for adult therapy.

The basic personality requirements of the adult therapist, as determined by Truax and Carkuff (1967), also apply to the child therapist, but according to Wolman (1973), Palmer (1972), Mook (1962), Rutter (op. cit.) and others, he must fulfill additional requirements, which will now be more fully discussed.

1. Knowledge of the development of the child

It is only on the basis of a thorough knowledge of the normal child's developmental process that the child therapist is able to distinguish pathology. He must possess sufficient sensitivity to determine

when normal conduct in the child crosses the threshold of abnormality or when it merely coincides with a specific development phase. He must be able to distinguish between developmental disturbance and deeper pathology (Johnson, 1971 in Rutter op. cit.). By knowing and understanding the normal child he learns to know the abnormal.

The child therapist must also be fully aware of the individual differences in the development of individual children (Berger, 1973, and Richard and Bernal, 1974).

2. Knowledge of the techniques of child therapy based on a developmental rationale

In the therapy of the child account has to be taken at all times of the child's way of thinking, his cognitive abilities, fantasy world. According to Anna Freud (1966) this is a world strange to the adult, but the child therapist must be capable of entering it. In order to do this, he must retain a link with his own childhood world (Mook, op. cit.). He must actively exercise himself in ways and means of evoking and experiencing his own childhood, sensations and perceptions, and must continually ask himself the question, "*What was I like as a child? What were my sensations? What did I feel?*". A written self-analysis in which childhood memories are relived and recorded could be of considerable value to the child therapist. It is, after all, through self-analysis that Freud discovered child sexuality.

3. Love of children

The child therapist must have a sincere love of children and must be capable of spontaneous contact with them. He must possess a natural attraction for children and must be able to communicate with them

effortlessly. He can never be intellectually detached from the child and must be prepared to descend to the level of the child. He must speak the child's language, be prepared to touch the child and be touched in return. It may be necessary to caress the child affectionately, to hold him close and make him aware of the fact that the therapist truly cares (Palmer, op. cit., Warren, op. cit., and Reisman, 1973).

4. Perceptiveness

In child therapy observation is more significant than anything else (Vetter, op. cit.). In the images of his play the child communicates with more than words. "Play provides a mode of communication" (Rutter, op. cit., p.308). The therapist must observe, perceive and understand this non-verbal communication. Questions must be kept to a minimum in child therapy. The therapist must obtain his knowledge of the child principally through observation. According to Kounin (1970, p.305), the person who communicates most effectively with the child is *"on the ball and able to appreciate accurately what is happening"*.

5. Flexibility and adaptability

Although therapy can be planned in broad outline, each session contains a moment of surprise. In essence child therapy always remains unpredictable. This means that the therapist must be flexible and adaptable in his approach and must allow himself to be led by the child (Reisman, op. cit.). This requires resourcefulness in the therapist and the ability to improvise on the spur of the moment.

6. Animation

According to Werner (op. cit.) the child is essentially in movement in his world. The child whose conduct does not have a basically dynamic character is usually handicapped in some way, mentally or physically. The therapist is required to move with the child, if necessary to crawl over the floor with him in order to share his world with him at his own level. There is simply no room for a static desk relationship in child therapy.

7. Confidentiality

The child therapist must be able to maintain the same confidentiality in regard to the child as to an adult. Nothing which a child tells him in confidence may ever be repeated without the child's knowledge or permission to any other person, not even to the parents. The therapist must be capable of persuading the child that he, unlike other adults, will respect his confidences because he listens to and regards the child's experiences with sincere earnestness and respect.

To be a child therapist means becoming a child for the sake of the child - living and moving in his world. Child therapy, more than any other form of therapy, is a learned art.

The following quotation aptly sums up the requirements of the child therapist: *"In conclusion it seems clear that the interpersonal approach to child therapy is most demanding in the resources of the therapist. He must be personally present, know and account to both the child and the child's family. He must be capable of intimately sharing feelings with a wide range of ages and character structures, and with the sexes of children he treats, being at ease with laughter, tears, anxiety, fears, irritation, anger, envy, jealousy, frustration*

and rage. He must also guide, instruct, inform, set limits, design therapeutic strategies and programs for the family as well as for the child. And above all he must be accepting of his own limitations, so that he can be more simply human with his patients and their worried, anxious, searching parents" (Maurice Green in Woman 1972, p.563).

The therapist as variable in the outcome of therapy research can thus be controlled to a degree by selection of the therapist, training in the skills of therapy and child development and by the experience gained through working with children.

THERAPEUTIC PROCEDURES

The sociopathic children were taken into individual therapy for eight to twelve months consisting of 20 to 25 sessions each and then put in group therapy for eight to ten sessions. All the patients were seen on an outpatient basis of once per week. The techniques used will be discussed in detail in the next section. In the beginning the children were allowed to play freely in a non-directive way, without any interpretation of their play from the therapist. The main aim during this stage was to try and build a strong relationship between the therapist and the child. As soon as he started trusting the therapist, the transitional object was introduced. After this, image therapy was started, which was done mainly through the medium of paint, clay or meloh doh (kind of papier mache).

Whenever the child was reluctant to produce images, either because he needed time to work on problems or when he was not ready to move on, image therapy was interchanged with play therapy. Slowly direct communication was introduced to help the child to understand

and handle his images and his play. Once he started to give any problem direct attention, gestalt therapy was employed to help him experience his aggression and his emotions and to accept these as part of himself as seen in the existential model. In this phase of the therapy the child was mainly helped to accept his chaotic world (not necessarily his physical world) as his own.

He was supported to accept his chaotic world of rebellion against everything and everybody and afterwards led to build an inner world of order and control for himself.

After this a few image and play sessions followed, with the view to greater personality integration. Hereafter the Experimental group were put into group-therapy so as to experience interaction without having to use manipulative or sociopathic behaviour. Each one was placed in a separate group.

Although different kinds of therapeutic techniques were used, the whole setting of therapy was one of play therapy which was done in a playroom.

After 20 to 24 individual therapeutic sessions followed by 8 to 10 group-therapy sessions each patient was again tested with the Rorschach, WISC and NSAIS and Jesness Inventory and rated by the same four raters on the Behaviour scale in order to get a Pre therapy and Post therapy picture.

After two years they were again tested on the Jesness Inventory and rated by different raters on the Behaviour scale.

RATIONALE FOR THE THERAPEUTIC TECHNIQUES

As most of the therapy with the child is done through play or in

a playful setting it is of importance to look at the meanings play has for the child.

PLAY AS THERAPEUTIC METHOD IN CHILD THERAPY

In the young child communication during therapy generally takes place through play, hence the term "play therapy". However, "*play itself does not constitute therapy. Rather the play provides a mode of communication*" (Rutter, op. cit., p.308).

In order to fully appreciate the significance of play in communication with the child, the meaning of play for the child has to be more fully considered.

1. The meaning of play for the child

Play is the child's natural, spontaneous "work" (Mook, op. cit.). However, whereas work is purposeful and makes specific demands of the worker, play is free and undemanding - unrestricted and spontaneous.

The world challenges and entices the child out of himself and it is through play that he gets to know his world and learns to cope with it. Through play the child develops a relationship with his world and learns to step out into it with confidence.

The healthy child must be able to play. It is his mode of expression.

As the child develops, his play becomes more purposeful and more socially orientated.

The developmental phases of play, according to Piaget (op. cit.), are the following:

1.1 Before two years of age

At this stage the child's world is still relatively new and unfamiliar, and objectification and object constancy still have to develop. His thought processes, his perception of things and his means of coping with them - and consequently his play as well - are concrete. Fantasy or true play are not yet possible.

1.2 Two to six years

This is the period of magical thinking and therefore of fantasy play. The child is still intuitive and irrational in his thinking and consequently also in his play. His world is an animated one and he feels dynamically part of it. A sense of omnipotence emerges strongly and in his play he is capable of virtually impossible feats. At this stage play is detached from reality and steeped in fantasy. It is during this period that fixation on a particular object - the transitional object - occurs, and it is the absence of this fixation rather than its presence which should arouse suspicion of pathology in later years.

1.3 Six to ten years

This is the stage of socializing and play is generally group-orientated. Play becomes rule-bound and also grows into a means of communication. A certain detachment between the two sexes starts developing. Imitative sex role play is a valuable aid in the identification process and could provide an indication of the level of development reached by the child in this process.

Competition is all-important in this age group and competitive team games are generally preferred to individual competition.

1.4 From ten years upwards

The group, and consequently group play, now becomes progressively more important. The two sex groups gradually start playing together and play takes the form of organized sport or entertainment.

Since play is such an important mode of expression in the child, it is one of the most significant sources of information on the child.

2. Psycho-analytical view of play

Anna Freud (1946) was the first person to attempt to analyze child's play. On the basis of the pleasure principle, she assumes that conduct is determined by the degree of enjoyment or pain it causes. Human conduct is further motivated by the individual's wishes in his dreams, fantasies and play.

With the use of play objects from his world of reality the child creates a pleasant world of fantasy around himself. In this way he attains the authority of the adult over his play world and play and creativity become an extension of his day-dreams.

The child's development takes place in specific psycho-analytical phases. In any of these phases his libidinal energy can be fixated and projected in his play world. In play the child can cope with his repressed urges through substitution of toys. In this way the conflict and urges in any stage of development are symbolized in the child's play. If the anxiety factor becomes improporionate, big, all play is inhibited.

In 1955 Anna Freud made use of Fechter's concept of energy conservation to explain why children incorporate unpleasant incidents in

their play. This concept involves the principle that the organism strives to maintain its nerve energy on an optimal level. Unpleasant incidents are repeated in play because repetition lowers the unpleasant energy level evoked.

Tingerberg (1951) and Hinde (1958) regard play as instinctive, but this theory is not generally favoured in psychology.

Melanie Klein (1961) sees play primarily as free association. According to her, every play situation has a symbolic meaning within the psycho-analytical framework.

Erikson (1943) regards play as the medium through which a child can develop autonomy and independence in an atmosphere of security.

Peller (1954) describes play as "the assimilation of anxiety", which takes place independently from the source of anxiety. According to him, play provides the child with the means for catharsis and synthesis within himself.

Whereas the adult communicates by means of words and language, play is the language of the child, according to Brody (1961).

Sally Province (1972) maintains that play and toys are essential to enable the child to detach himself from his mother and to attain object cathexis. Without adequate opportunity for contact with desirable objects, the child remains locked in a symbiosis with his mother.

The analysis of child's play by Max Goldblatt (1972) is still strongly psycho-analytically orientated and he places considerable emphasis on the symbolic significance of play. He regards sensopathic play with water, sand and clay as sublimating and indicative of anal and uretal preoccupation. Destructive play, according to him, is not only an expression of aggressiveness, but reveals the child's curiosity about his

own sexuality. Trains and other moving, colliding objects symbolizes the child's perception in regard to the sexual life of his parents. Heavily loaded objects, such as trucks, etc., are connected with his perception of pregnancy. Goldblatt points out that the principal pleasure symbol in the child's play must be identified and analysed.

Although as a sexual being the child is unquestionably preoccupied with his sexuality, this is only one aspect of his world, and while the sexual symbolism must obviously be taken into account, emphasizing it to the exclusion of other symbolism in the child's play would severely impede the therapist's understanding of the child's total world. The child's world is much more extensive and more dynamic, and a penetrating insight into his play world is essential in child therapy.

3. Behavioristic view of play

Most behaviorists maintain that play as such does not exist. Schlossberg (1948) states that play is a useless concept in a complex behavioral pattern. According to him, play is a learning process by which the child acquires the correct behaviour patterns through trial and error. In one of his more recent theories, Schlossberg (op. cit.) explains play as a lowering of the reaction threshold in resting organisms to stimuli which would otherwise be too weak to induce response.

Guthrie (1935) maintains that reward improves achievement, not because it stimulates activity, but because it precipitates the end of activity. According to him, play falls into this reward category.

Hull (in Dollard and Millar, 1941) regards unrewarded play as a secondary incentive, initiated by the organism itself. According to him, play can only occur when the primary needs have been satisfied.

Olds and Milner (1934) as well as Fisher and Maddi (1961) established that play could stem purely from the urge for activity and the impetus to overcome boredom.

Berlyne's research (1960) indicates that action occurs when the stimulus contains a surprise element. This element activates the energy action mechanism and the organism starts striving for an optimal level of stimulation through play.

The Behaviorists, in other words, regard play merely within the framework of stimulus and response and fail to perceive the deeper dynamics of the child's venture into his world. It follows that this school of thought rejects the concept of child play therapy.

4. Gestalt and field theory view of play

Koffka (1924) applied the Gestalt principles to child development. He says, amongst other things, that a response is evoked as soon as perception takes place, since both belong to the same configuration. Seeing a ball and throwing it forms one pattern configuration. The impulse, according to him, always evokes reaction since the action forms part of the total pattern.

Imitative play occurs because the child's world is less differentiated than that of the adult. Whether or not a toy totally represents the adult world is of little consequence to the child, provided that it represents one element. Koffka (op. cit.) maintains that the child does not in fact animate his world, but is simply not yet able to differentiate between animate and inanimate objects. The child's perceptions are undifferentiated and that is why his conduct often appears inappropriate to the adult.

Kurt Lewin (1935) expanded the Gestalt theory to include dependency on the total field. The response evoked in the child, according to him, depends both on the child himself and all the factors of his total environment. He maintains that the so-called inexplicable part of the child's play is the result of a blending of his wishes and reality. Objects still have a fluid meaning for the child and it is for this reason that he will treasure an object one moment and destroy it the next.

The Gestalt view of play contributed considerably towards a more comprehensive and integrated approach to play, but does not yet involve the child's total world of experience. This only became possible in the existential school.

5. Organismic view of play according to Piaget

According to Piaget (1951), play is the as yet unattained equilibrium between thought and action. He postulates two processes as basic and fundamental to development, viz. assimilation and accommodation. Assimilation is that process by which the individual absorbs and integrates new experiences and schemes into his behaviour pattern and which modifies his conduct and thinking. Accommodation is the adaptation to his world which the individual must make before he can assimilate. It is also the process through which previously absorbed schemes are changed. Intellectual adaptation takes place when the two processes are in equilibrium. When assimilation - the intake of previous impressions according to the needs of the individual - takes place, play occurs.

In Piaget's opinion, play and imagination form an integral part

of intelligence and involve the same developmental stages:

0 to 1½ years:	sensoric motoric phase
2 to 7/8 years:	representative phase
11/12 years:	concrete operational phase
14 years plus:	final operative phase.

In each stage concepts are formed through the integration and equilibrium of assimilation and accommodation activities. Each phase has built-in limitations, mainly due to maturation defects of the nervous system and inadequate social experience. Play in the sensoric-motoric phase stems from "reproductive assimilation", which means that the child carries on doing what he has already been doing. After feeding, for instance, a baby continues to suck, and sucking becomes a form of play.

Piaget (op. cit.) sees no need for recognizing an impulse to play, since he regards play as assimilation, that is, repetition of conduct in order to consolidate it into the total pattern. An action which is learnt in this way will be repeated. "Pleasure as being a cause" stems from the repetition of actions after the child has attained control over them. Even coincidental results will be ritually repeated.

Fantasy play occurs between two and seven years of age. The child's whole world is animated at this stage and a stick or a rag can easily become a doll to him. Behaviour which is appropriate to one object is indiscriminately transferred to the next. According to Piaget (op. cit.), images stem from physical adaptation to an object in the body space. Initially the internalized actions take the form of concrete symbols representing the object. Somewhat later they

become signs which indicate the object. Symbolic and fantasy play, in other words, are purely assimilation in the form of consistent repetition into organized thinking in terms of known images and symbols.

Any significant incident is represented in play. That which occurred in reality is repeated in play in distorted form, since no adaptation to reality is possible in play. This characteristic distortion of reality in play stems from the child's thought processes at this stage, which involves an egocentric and highly individual use of images and symbols.

As the child's thought processes become more logical and objective (around eight to eleven years), his play becomes more reality-bound and free from individual symbols. Play is now controlled by group discipline and certain rules apply.

Piaget (op. cit.) sees in play a biological function of active repetition and experimenting with schematized new experiences and situations. His theories on the thought processes of the child determine his analysis of the child's play. Many of Piaget's theories have been proved correct in more recent research, while others are questioned. His most significant contribution in this field is his view of child's play as work activity which stems from cognitive maturation.

6. Existentialistic view on play

As the Existential view on play is used as a working model in this study, it will be discussed in detail.

In the dynamics of child's play, Buitendijk(1964) finds the characteristics of playful dynamics. According to him play is no more than movement in some form or another. Vermeer (1968) rejects this view and

points out that play is much more than mere movement, since the movement is characterized by dedication and intensity of facial expression.

Langeveld (1968) sees play as the most essential aspect of the secure, protected child. Play stems from the child's explorative relation to his world. This world invites the child to open communication. The open world is the antithesis of exploration. Exploration is the child's dynamic ability to detach himself from his safe, secure world. This exploration is differentiated into rationalization and acquisition of knowledge on the one hand, and play on the other. In play the child's world reacts incompletely to him, but will occasionally reveal its secrets unexpectedly. This means that the child plays with the unknown, unexpected world and the world consistently responds. The world must reveal its secrets to the child, but must keep the moment of revelation shrouded in mystery. The world always retains something mystical and mysterious, without which play would not be possible. Play is free only without a fixed purpose, otherwise it becomes work. Nevertheless, child's play is loaded with intentionality because he purposefully applies himself to his exploration of the world.

Vermeer (op. cit.) analysed play phenomenologically. She maintains that a child should be "spelend-in-de-wereld" (at play in the world) and that the way in which the child plays is the most important aspect of all. Not what he plays but how he plays must be investigated by the therapist. The therapist cannot merely be spectator, but actively and emphatically forms part of the world which the child creates together with him in the process of play. Nor can he ever be completely non-directive, because he is the one who must intervene in problem areas and guide the child out of these.

Even though the boundaries of the play world are wider than those of the everyday world, it does have boundaries which the child must recognize and respect. Not only the knowledge of these boundaries but also their penetration requires guidance. The responsibility for this cannot be placed on the child alone, since the therapist functions as mirror and sound-board for his conduct in the therapy situation. In other words, the play leader has a two-fold task: he must venture into the world of play together with the child, but at the same time maintain sufficient detachment to function as observer.

Play, according to Vermeer (op. cit.) means something different from non-play. There is, for instance, a significant difference between played and non-played aggression. In fully developed child's play the child forms a relationship with his world and creates a new world out of this. The manner in which the child forms this relationship, the way in which he approaches the play world forms the basis for analysis of child's play. In play, interaction between world and child always takes place. The child plays with the world, which attracts him, and the world responds in reciprocal play with the child, who responds in turn, and it is through this dialogue that the child becomes familiarized with his world.

Fantasy is an essential part of play. This aspect was first emphasized by Buitendijk (op. cit.). However, play must always be firmly anchored to reality and contain no more than elements of fantasy. Pure fantasy has no connection with reality and is free-floating and unproductive. Only play as such is productive. Fantasy can only be productive if it is incorporated into play. For the child the most direct representation of reality is the image (Werner's things-of-action).

It is from the child's images that his symbols develop, which are activity-loaded and find expression as language. The richer the child's symbolic world, the richer will be his language and verbal play. Play stems from the interaction with reality via the child's images, in order to anchor him to reality.

Vermeer (op. cit.) analyses play as follows:

6.1. Fully developed or illusional play

In illusional play, the everyday world is transformed. Objects are taken from their fixed and valid context and approached in a sphere of intimacy. The child has an agreement with the things and they become whatever he wants them to be. A crust of bread, for instance, becomes a car or a boat or whatever the child makes of it. His images overstep all boundaries of the world of reality and open up a new world of limitless possibilities.

From the rigidity of reality, his images entice him into a world of mystery and mysticism. In the play world the possibilities are limitless, while in the real world these same possibilities are impossible. However, the child never entirely deserts his real world and regularly reverts back to it. The normal child knows that he is playing. It is an active decision of his will. In the pathological child, however, this discrimination has become obscured and he can no longer distinguish the boundaries between his play world and the world of reality.

The child whose world of reality is too threatening does not have the necessary confidence to leave his reality and venture into the play world. The child who is unable to play has either been

confronted with reality too soon or too intensively. Anxiety or rigid discipline can also keep him imprisoned in reality.

The worlds of reality and play meet in unalterable borders which the mentally sound child soon learns to recognize. The world of reality can break through the borders of the child's play world when, for instance, his toys are broken. This intrusion of the real world, can be traumatic to the child if the adult fails to understand and respect the ambiguity of the play world. If the log which has become a doll to the child is burnt, for instance, she can experience it as an act of murder.

If the reality underlying play no longer exists, it is no longer play in the true existentialist sense of the word. Then it is no longer imagery but imagination. *"Play may have the imaginative character of a dream and the practical features of reality"* (Wolff in Vermeer, op. cit.).

6.2. Aesthetic play

In aesthetic play the child uses the objects of his world to create freely and without forethought or planning. It always contains an element of surprise to the child. This form of activity is improvisation in which the imminent intentionality and existential togetherness of play become apparent. The repeated switch-over to a relation of playing-with-something tends to obscure the playful character of aesthetic play. It may have the appearance of a bordered-play situation. However, this is misleading, because, even though this form of play develops unintentionally, it can be regarded as fully-fledged play. The only difference is that the images are created in the reality.

To the disturbed child, illustional play with its free, dissolute character is too threatening to approach, while aesthetic play provides him with the concrete security and order which he needs. Consequently this form of play can be successfully used in therapy.

6.3. Handling play

This form of play involves the handling or arrangement and use of objects and toys in their reality. In children who are locked in their problematic reality, play remains fixed at this stage and does not proceed to illusional play.

6.4. Diagnostic significance of play

In an assessment of the child's play the following aspects must be taken into account:

6.4.1 The level of play

It must be established whether the child is capable of detaching himself from his familiar world and venturing into the attractive unknown world of play. Can he proceed to full illusional play of his own accord or does he remain fixed in handling play?

6.4.2 Does he use play constructively as a means to attain control over his world or as a means to retreat from reality? Some pathological children, for instance, want to do nothing but play constantly. In them play tends to take the form of fantasy and becomes a means of escaping from reality.

6.4.3 Does the play have a regressive character? For instance, does the child revert to sensopathic play in an anxiety-provoking situation

or does he continue to play with his teddy after ten years in order to satisfy his need for security?

6.4.4 Does the play have an obsessive character?

6.4.5 Is the child capable of objectivity in his play or is he unable to perceive the borders between his play world and his own body, as is the case with autistic or psychotic children?

6.4.6 Is there any forethought or planning in the child's play or is it a totally disordered activity which mirrors his chaotic existence?

PLAY THERAPY

In play therapy the means of communication between the child and the therapist is the play itself?

In the humanistic school two main stream of child therapy exist, namely that of Axline (1947) as a non-directive child therapist and that of Moustakas (1969) who, as existential therapist, uses the phenomenological method. In this study the orientation of Axline will be taken as a working model in the beginning of therapy until a relationship with the child is formed. As soon as possible however the principles laid down by Moustakas, who feels that therapy should be closely connected to real life situations and that limits must be set explicitly in the therapeutic process will be followed. For this purpose these two models of play therapy will be discussed in detail. The other models of play therapy will be discussed shortly.

1. Pedotherapy

The pedagogue sees the child in terms of a pedagogic situation.

The therapist is not so much therapist in the strictly psychological sense of the word, but rather a responsible, guiding adult who handles the child normatively in a pedagogic sphere on his road to adulthood. Behavioral disturbances are regarded primarily as a pedagogic problem which must be remedied pedagogically. For the pedotherapist norms play a major role. The existing or even lacking norms of the parental home must be integrated into the child's form of play. Varying degrees of norms structures, which are determined according to the needs of the child, always apply to some extent in this form of therapy.

Vermeer (op. cit.) clearly states that the play situation can change into a pedagogic situation at any moment and that the therapist must be prepared for this.

Although in strictly psychologic play therapy, the emphasis falls strongly on the free development of the inner forces of the child, the psychologist is sometimes placed in a position of having to give pedagogic guidance as well. In the seriously disturbed child, however, this is impossible, and he must be allowed to play freely. In the less disturbed child, as well as the sociopathized child, the therapist is forced to intervene pedagogically at times.

In adult therapy norms are generally not involved at all. In child therapy, however, it may be necessary for the therapist to reinforce the norms of the parental home, since the child's play world can never conflict totally with his everyday world. From his play world the child must inevitably move back to his everyday world and the two worlds may never be in conflict to the extent that the child's confusion and resultant fear and anxiety are aggravated.

2. Psycho-analytically orientated play therapy

Melanie Klein (1932, 1961 and 1975) was the first psycho-analyst to use play as form of therapy with the child. She recognized the fact that the child uses play to symbolize his inner conflicts, fears and anxiety. She found that children are normally incapable of free association, but that play becomes a form of free association to the child and as such can be utilized as an analytic instrument.

Her techniques differed somewhat from the techniques used by psycho-analysts today. Each child, for instance, received his own box of toys with his name on it. The toys were small so that they could be handled without difficulty. In addition to a considerable variety of toys, the box also contained paper, pencils, glue etc. The purpose of the toys was to provide the child with as much opportunity as possible to act out his fantasy and unconscious fears.

The room had to be fitted out so as to allow the child to act out his aggression to a certain degree and a couch had to be readily available so that the child could lie down at any time for spontaneous free association.

In her opinion, the therapist remained the adult in control of the child at all times and his main task was the interpretation of the child's projections through play.

Modern child psycho-analysts have basically retained Klein's method, with slight modifications here and there. The child is allowed more freedom in his choice of toys and play but the interpretation of his symbols still remains the main purpose of therapy.

Hanna Segal (1972) maintains that, unlike the adult therapist, the

child therapist must actively take part in the child's play up to a certain point. However, the therapist must not form part of the child's play unless his participation is absolutely essential to help the child recognize and communicate his inner inhibitions and repressions. His main task remains to help the child by interpreting his play.

The authoress is of the considered opinion that the child learns through experience and not through insight alone, and that for this reason, if applied in isolation, this form of play therapy has many disadvantages.

3. Non-directive play therapy

Virginia Axline (1947) gave a comprehensive exposition of this form of play therapy in her book, "The inner dynamics of childhood". In the same way as the adult is enabled to speak out his problems, the child is offered the opportunity to play out his problems. She calls her technique "a method of helping problem children help themselves" (op. cit., p. 9).

In directive child therapy, the therapist assumes all responsibility and control. In non-directive therapy the direction and responsibility is left to the child himself.

The theoretical framework on which non-directive therapy is based is briefly the following: Each person possesses the inner motivating power to attain maturity, self-actualization and self-realization. To attain maturity, he needs freedom and development space. In this freedom he must be allowed to accept himself, since the therapist can only accept him as he presents himself to the therapist.

The individual is continually involved in a dynamic development

process. According to Werner (op. cit.), this development is spiraldic, that is, everything is relative and constantly unfolds to the individual. It is also constantly changing in its degree of significance to the individual in view of the reorganization and integration of his attitudes and feelings. This implies that the individual is constantly dynamically changing his relations to himself and his environment. The individual must recognize that he exercises control over the interaction with the changing internal and external forces. It is only when he becomes aware of this controlling role that he can attain direction and meaning in his life.

Non-directive therapy, is based on the assumption that each person possesses not only the power of self-recovery but the impulse and motivation for maturation. Non-directive therapy allows the individual the freedom to be himself, to accept his true self without evaluation of that self. It also offers the possibility to allow that self to grow if he so desires.

Non-directive play therapy can be described as a method by means of which the child is allowed to experience full growth and development in a situation of optimal acceptance. Through play his development repressions are spontaneously brought to the surface and he learns to cope with and control them. As he becomes more relaxed during this process, he learns to accept himself as a person in his own right and to allow himself to develop to an emotionally mature level.

The non-directive child therapist must be a sensitive, friendly, accepting person who will allow the child to take the lead in the playroom and to become the most important person in that room. She

reflects back to the child the feelings and expressions which he communicates to her. However, she must never fail to respect the child as the person who is best able to explore his inner life and to learn to know it and control it.

Axline (op. cit.) regards maladjustment as the result of obstruction of the child's self-actualization urge. There is an aggressive determination in the child to be himself and a strong resistance against any obstruction of his self-expression.

During therapy the child is free to test himself and to allow his personality to develop, and he is moreover required to assume responsibility for himself during the whole process.

Diagnosis is never made, since the child is approached in his development process, and he is allowed to develop as far as he chooses.

The principles of non-directive play therapy are basically the same as for all non-directive therapy. Axline (op. cit.) regards the following as the most important principles:

The therapist accepts the child unconditionally.

The therapist allows the child to express his feelings freely by assuming an accommodating attitude.

Through an attitude of warmth and friendliness, the therapist builds up a sincere relationship with the child.

The therapist receives and reflects the feelings and attitudes of the child.

The therapy situation merely provides the child with an opportunity to solve his own problems - the therapist never does this for him.

The child takes the lead during therapy and the therapist follows.

Therapy is a time-consuming process and can never be hurried by the therapist.

The therapist handles the resistance, anxiety and dependence in the child and guides him back to coping with reality.

The child approaches the first therapy session fearfully, enthusiastically or cautiously, just as he would normally approach any new situation. It is during this first contact that structuring through the relationship which the therapist builds up should be established. Structuring in this instance implies the gradual guidance of the child into a unique new situation of self-expression by means of a relationship built on certain principles.

The disturbed child normally approaches the relationship with hostility and mostly with strong distrust of the adult, and it is the therapist's task to penetrate his barricades and establish contact with him. It is through contact with, and confidence in the therapist, that the child becomes capable of growth.

The child is free to direct the therapy session as he chooses. The therapist may arrange toys beforehand up to a point or, in the case of milieu deprived children, explain the toys to the child, but, true to the non-directive principles according to Axline (op. cit.) the therapist may only offer the child security, never support.

Direct questions from the child must be answered honestly, but must not be encouraged.

The therapist's main task remains reflecting and interpreting the child's symbolic communication. The interpretation principles laid down by Sullivan (op. cit.) apply here as well, viz. that the therapist may only interpret under the following circumstances:

if no hypothesis of any other possibility exists;

if the patient is ready and prepared to receive and accept it.

If modifications in the behaviour patterns are to be of a permanent nature, they must, within this framework, grow from the insight obtained by the patient himself. In other words, by placing the responsibility in the hands of the child, the therapist centres therapy on the child himself. He does this by guiding the child to recognition of responsibility but never puts any pressure on the child. The therapist never praises the child, never helps him, never makes any suggestions, but merely provides the space for growth. To the child the therapist is thus a totally unique person, different from everybody else. He is no surrogate teacher or parent, but a soundboard against which the child can act out his personality.

The child lives in a world in which he is constantly pressed and time limits demanded of him. During therapy he must be allowed to develop at his own tempo and reveal himself at his own good time. Often nothing at all happens during a therapy session, but even then the therapist must have understanding and patience with the child. It is usually precisely this session which has a consolidating effect on the child. During this period he often prepares himself to arrive at self-expression during a later session.

In this kind of therapy limitations and prohibitions are kept to an absolute minimum and usually only apply in the case of wilful destruction of toys or attacks on the therapist. The time factor is an obvious and unavoidable limitation.

To the child, non-directive therapy is an experience of growth

during which he is offered the opportunity to get rid of his tensions and to purify the air of feelings with which he cannot cope. In this way he attains insight into himself and, through this insight, control over himself. In the playroom he discovers himself in a new way and learns new behaviour patterns of interaction with others. Thus he develops into a more fully-fledged adult person. This is an excellent form of therapy, particularly for the neurotically disturbed child. In the therapy of the sociopathized child, it is primarily the existentialist method of play therapy which is used, although it is alternated with non-directive therapy.

4. Existentialistic play therapy

The living relationship between therapist and child is the essence of therapy here as elsewhere.

Clarck Moustakas (1969 and 1973) states the following as conditions for existentialist child therapy:

Each person, and the child in particular, needs another person who is significant to him. During therapy such a relationship is established. One of the meanings of the original Greek version of the word "therapy" is to serve, to be of service, in other words, the therapist must be of service in so far as the child requires this.

Each child must be respected as an individual with his own integrity. The therapist does not set objectives but actively participates in the child's self-realization process. In other words, the therapist must bring about a deepening in the development and life processes of the child.

The therapist approaches the child at his own emotional level and

thus perceives his direct feelings rather than his symptoms and problems. According to Moustakas (op. cit.), the child is in search of someone who will allow him to discover himself free from his parent identification, without interference or domination, someone who cannot be fooled, who is strong enough not to fight back.

The therapist is at the child's disposal and aids his development process by orientating himself to the child's world of experience, which is of direct significance. Sometimes it may be necessary to allow the child to regress to an earlier level where he can find his true self and then to build him up to a creative experience of his new self. To the child the therapist is symbolic of his new relationship with his world, and through his relationship with the therapist, the child recovers his inherent strength and finds confirmation of his true self.

The therapist must at all times listen with empathy and without attempting to identify causes. The therapist merely creates the situation in which the child can creatively discover his true self and realize his potential in responsibility to himself.

Although explanations and interpretations are sometimes used, the recovery takes place through the relationship between the therapist and the child.

It is not so much what the child does as the fact that he is allowed the freedom to be himself that leads to growth and recovery. The child who has experienced this freedom also becomes emotionally free to share himself with another person.

Existentially the basis of a child's pathology is his denial of himself as unique person. He feels rejected by others and therefore rejects himself and fails to attain self-realization.

During therapy the child must be persuaded to make peace with himself, to discover and accept his true self with his limitations and possibilities. Through the therapist's unvarying and unconditional recognition of him as a unique person, his self-esteem increases and he becomes capable of releasing his life forces in order to enable full functioning.

Any direct attempt to change the child is experienced by him as rejection and is therefore resisted. It is only when he can express his hatred that he can attain inner tranquility; it is only when he can act out and verbalize his fears that he can begin to feel secure and unafraid; it is only when he can talk about his cowardice and incompetence that he can begin to realize that he is free to make his own choices and valid meaning can be obtained through his own perception of reality.

With the friendly, loving and accepting therapist, he feels secure enough to reveal his negative side as well. From her he learns that he is allowed to hate, but her empathy elicits his love - both part and parcel of human emotionality. Because he is led to self-acceptance, he attains self-expression and self-realization. In the process he builds up a system of inner values which is not in conflict with his true self but stems from it and lends it direction.

The playroom must provide the child with the necessary security within which he can attain self-knowledge. Sufficient structured and unstructured material must be available. In the playroom he builds up a relationship with his object world in the first place, and therefore the room must remain familiar in order to ensure stability for the child. Through this relationship and harmony with his world of

inanimate things he moves into the human world. Here the relationship with the therapist provides him with the necessary practical example.

Unlike in non-directive therapy, definite limits are laid down to the child, since therapy in the existentialist framework may never be totally unfamiliar to the child's everyday life. There has to be integration and order in life if individuals are to realize their potential. During therapy the limitations provide the structure within which development can take place. These limitations cannot be conclusively determined beforehand, since every experience and every situation is unique. Every meeting between child and therapist also remains unique. The therapist, even though he is a person of power and substance, is nonetheless also a person in development. He can also grow during the therapy. This means, in short, that the limitations in each therapy situation depend on the life situation, which varies from child to child and therapy session to therapy session.

If these limitations are broken, the child must never be punished. Instead the therapist must offer his help so that a solution can be found together. Sometimes less formidable limitations may have to be laid down and the demands made of the child increased only as development becomes apparent.

The therapeutic process generally starts when the child is placed into the situation filled with anxiety. Gradually his anxiety is identified and he learns to recognize his fears. This leads to diffuse aggression which ultimately changes into confidence and trust in the therapist.

The disturbed child sees himself as an inferior person, loved by no-one, inadequate and afraid of the consequences of his deeds and urges.

He feels himself threatened by criticism and punishment, which aggravate his sense of inadequacy and insecurity. Reward and praise are experienced as equally threatening, since he regards it as an attempt to change him. Moustakas (op. cit.) maintains that, however inadequate a child may feel, he will still struggle to keep his self-image intact. The therapist is not motivated by any wish to change the child by means of punishment or reward. He approaches the child with honesty and with faith in the recuperative power of the child himself. He respects not only the positive aspects of the child, but also his fears, hatred and aggression. He helps the child to feel experience and express his perception of his total world in words. In this unique relationship, which differs totally from all his previous relationships, the child is free to develop true self-knowledge and self-acceptance. This is equally true in the case of the sociopathized child, and this form of therapy is an eminently suitable means of obtaining entry into his disturbed world.

THE TRANSITIONAL OBJECT

Winnecott (1953) describes the transitional object as a mode of experience through which the child establishes relations between his object world and his inner reality. Paul Horton (1974, p. 292) puts it as follows: *"The transitional phenomenon is a mode of experience and relatedness in which the internal reality of wishes, desires or convictions is blended with external physical reality in the contemplation of an object."*

In the course of his work, Horton (op. cit.) observed by chance that, in contrast to other psychopathological deviations, personality

disorders were unable to remember a transitional object. He then undertook a research study in which he compared three groups, consisting of alcoholics, schizophrenics and personality disorders, with regard to their ability to remember and represent a transitional object. Whereas 93% of the schizophrenics were capable of describing a transitional object, 84% of the personality disorders had no recall whatever of such an object. In other words, he established a high negative correlation between the ability to relate a transitional object and personality deviation.

He also points out that the absence of a transitional object in the child may in itself be indicative of pathological personality development, since such an object serves as medium through which the child establishes further relations to his world. *"The ability to personalize and to internalize and thus possess at least part of an object, does much to relieve the separatedness of inner states and of impersonal external reality"* (Horton, op. cit., p. 292). He also found that those personality disorders who had had a transitional object were most accessible to individual and milieu therapy than those without, in whom the prognosis was extremely poor. Accordingly he postulates that the transitional object can be applied as prognostic test.

This research supports what has already been indicated in the discussion of the dynamics of the sociopathized child, viz. that his major problem is one of object cathexis.

In 1976, Horton published further research findings indicating that considerable success had been achieved in therapy with sociopaths merely by concentrating on the transitional object. As a first step he goes through the patient's childhood with them specifically in search

of a transitional object. Then he brings the patient into contact with other people and their transitional objects and explains the importance of such an object to the patient. A transitional object is then purposely given to the person and he is helped to develop a relationship with this object. Horton comes to the high significant conclusion that this form of therapy holds great promise of positive possibilities for all forms of personality disorders and particularly for sociopathy. Another important aspect is that, according to him, the development of this relationship is apparently not subject to any critical period, as is the case in, for instance, language development.

In this study a transitional object was purposely given to the sociopathized children and they were encouraged both by the therapist and the parents to form a relationship with it. The transitional object initially took the form of a cuddly toy which they were expected to take to bed with them. More or less around the start of group therapy, the object was extended to a live pet for which the child had to assume full responsibility.

IMAGE THERAPY

Early in 1937, John Buck of the Lydenburg State College, Virginia, tried to establish contact with a disturbed nine year old girl. She flatly refused to speak to him at all until one day, in sheer desperation, he gave her a pencil and paper. She immediately started drawing and when he questioned her about her drawings, she was entirely willing to start speaking. Gradually he began applying this technique to his other young patients as well, and was surprised at their positive responses. He never personally applied the technique therapeutically,

but developed the so-called "House-tree "person" diagnostic test.

Deeper conflict in the child's life is often better revealed in drawings than in any other way. Wyatt (1947) states that "in drawings deeper, more primary and less differentiated levels of experience are tapped." Both Bellak (1953) and Symonds (1953) are entirely in agreement with this and add that drawing uncover deeper personality functioning in the child than any other projective method. Hammer (1969) points out that the image obtained from drawings is a deeper but less differentiated image and cannot reveal the finer nuances which are picked up by other projective tests.

Stern (1952) explains the claim that drawings represent a deeper picture of the personality as follows: the image is a more direct representation and consequently on a lower level of development than language. It is accordingly more accessible to the consciousness than the more structured language symbols, which require greater cognitive control.

Lubbers (1971) maintains that, in order to understand the child's being, the adult must become child himself once again, with the child's helpless attachment to the parents. Langeveld (1955) points out that the child is totally dependent on the parents for experiences of love and security. This security is a process of mutual growth and togetherness of parent and child in a sphere which allows undisturbed development.

Without this security the child stumbles around in a world of confrontation with threats. Because he is required to face these threats alone and to flee from them, he never learns to experience freedom of anxiety. In this process, he moves steadily further away

from his parents. At this stage, the parent is no longer able to reach or help him. The child is by now so overwhelmed with anxiety that he no longer can or wishes to communicate to them the desperate cry for help which rises from his innermost being. Only rebonding with his parents can prevent the child from retreating in anxiety and fear for his existence and so totally withdraw from the threatening contact existing between himself and his parents. At the same time, he will also withdraw from all other adults.

Lubbers (op. cit.) also points out that any other threat, such as illness or death, attacks the child's security and places him into a confidence conflict. If the child can bring himself to turn to the parent, this conflict can be resolved and he can be released from his anxiety. Because parents so often strongly appear as the symbol of norms, they evoke feelings of guilt and so cause further conflict which drives the child to retreat even further instead of turning to the parent.

Communication disturbances occur in all disturbed children. The child's language and conduct become strange and illegible to those around him, so that he can no longer use the normal communication symbols. Even his parents cannot communicate with him in the normal way, because all his actions remain obscured.

Piaget (op. cit.) points out that collective communication, that is language, is an inadequate means of expression of the total reality of any person. Another means, closely related to language, must initially be found to act as symbolic mediator.

In the therapeutic contact with the child, this symbolic mediator can take various forms. In play therapy the means of communication

is play; in art therapy it is modelling, drawing and painting; in psychodrama it is interpretation through role-playing. Image therapy is closely related to art therapy, but is an altogether separate medium which offers deeper and more communication possibilities. It is no art practice in the true sense of the word, but, as Lubbers (op. cit.) puts it, it concerns the perception rather than the creation of the image or end product. Langeveld (1955) was the first to use the word "image therapy" instead of "art therapy". According to him, the product created by a person in action must be regarded as an image rather than a work of art. It stems from the creative urge which is present in all people. Image therapy is rich in all forms of creativity represented in the action of a person - language, posture, mimicry, etc. all form part of the creative image which he builds up. Buytendijk (1965) and Vermeer (op. cit.) see in the image the ability to perceive the world in its emotional ("patische") character.

In image therapy the child represents his world by means of shapeless symbols or integrated images. By means of his symbols, but even more by his images, he allows admission into his personal world. In this way he makes himself more accessible to the therapist than he could have done in any other way.

The purpose of image therapy is to lead the child back into a truly human, secure and communicative world. This is possible because all therapy situations are fed from the daily existence of the child.

1. Expression media in image therapy

The child sees art and creativity as part of play (Lubbers, op. cit.). The media are merely playthings to him. Image therapy is a

child activity rather than true play and alternates between purely aesthetical play and image-projecting stories (Vermeer, op. cit.). This means that the therapist cannot apply the expression media at random, but must select them carefully according to the needs of each individual child. Sensopathic play with clay, sand and water, for instance, is used for regression, while clay is regarded as an excellent medium for the anxious child. The selection of the media must be based on sensitivity and empathy between the child and the therapist.

2. Symmorphosis during image therapy

Lubbers (op. cit.) uses the word "summorphosis" for the joint process of image-forming by therapist and child. It is based on the sense of security which stems from the relationship with the therapist. In the child who has no security the search for security is the motivating force in image-forming. In image therapy the child designs an image of his world while playing and working. This image allows him to form part of his world in play, and yet to distantiate himself from his world (Vermeer, op. cit.). In this way he reduces his world to a known entity and attains security. In the normal child this is a natural, spontaneous process, but in the disturbed child it must be brought about artificially in the therapy situation.

During therapy the child learns to feel free in the vicinity of a protective adult and he is able to express his projections freely. If the child reacts to images, the therapist must interpret his reactions. If he displays aggression towards the image, the therapist can act protectively towards the image or he can allow the child to destroy the image, which to the child is the representation of whatever

is provoking his anxiety. The child must, however, eventually learn to find realistic solutions to his problems, together with the therapist.

3. Full projection through image therapy

Full projection of the inner being requires perseverance as well as involvement of the total person. The therapist must help the child attain full projection. He must select the media, arrange the therapy room and, if necessary, join the child in image-forming. He must also intervene and exercise control if the child handles the media wastefully.

The therapist must determine the child's level of self-identification, emotion and disposition with the utmost sensitivity in each session. He must aim at increasing the level of image-forming at each session.

The therapist must eventually also enable the child to convert his images into verbal images. The child does not necessarily recognize his own situation in his images of his own accord. He must be taught to accept these images before he can recognize them.

The therapist must ultimately always guide the child back to reality via his images. The child with sexual problems, for instance, who represents the genitals as excessively large, must be helped to restore the correct proportions with the sympathetic intervention of the therapist..

The highest level of image-forming is attained when the child reaches the point of full image play together with the therapist. He creates his own world in which the problems of the real world are reduced to manageable proportions and are observed and accepted together with the therapist.

The materials must be displayed invitingly, so that they attract the child and stimulate him to image-forming. The therapeutic room must be equally attractive and inviting to the child.

The disturbed child is incapable of free image-forming, just as he is incapable of free play, because he is constantly protecting himself against imminent danger. He can only again find security with adults and must be enabled by them to express his fears in images.

4. Stages in image therapy

As can be deduced from the above, it is difficult for the adult to understand the child with behavioral deviations. The child himself becomes hopelessly entangled in his contact with adults and is unable to find solutions to his problems. In other words, he finds himself in what can be described as an emotional no-man's land in which he wants to call for help but does not know how, and becomes hopelessly lost in the known avenues of contact.

It is the adult's duty to find and reach the child, and the image provides an invaluable means of contact.

Image therapy brings the child into contact with his problem area and allows him to attain self-expression in this area. His images help him to digest his problems and to adapt accordingly. They also form a mutual area of contact between himself and the therapist about which they can later communicate verbally.

The four phases of image therapy, according to Lubbers (op. cit.), are the following:

4.1. Establishing contact

The therapist plays an extremely important role in establishing

contact by creating a suitable atmosphere for image-forming. Initially the images themselves are also determined jointly by the therapist and the patient.

4.2. Help in image-forming

The therapist provides guidance in the representation of the child's problems in images, and therefore has to identify himself with the world of each individual child. He must assist the child with the details of his images until they approach reality. If the child moves too quickly, the therapist must responsibly and protectively curb him. Once the child has formed an image, he often feels insecure and needs the support of the therapist. The underlying meaning of the image must always be identified.

4.3. Image dialogue

Up to this point the therapist has been following the child's lead in his images. Where possible, he must now help the child give meaning to his world by bringing his images into correspondence with reality. The witch, for instance, becomes the child's mother. The therapist can suggest modifications which bring the image into correspondence with reality. Solutions must be found. At this stage the child is generally ready to reveal his deeper problem area, and the therapist must be both exceedingly finely tuned to the child and capable of communicating with him in the language of his images.

Eventually the images are gradually replaced by verbal communication.

4.4. Verbal dialogue

Through his images the child has now found new access to the adult. He has learnt to talk about his life and his problems and can now begin to verbalize without a mediator. At this stage the therapist must help him relay his problems into words so that language regains new meaning for him.

Image therapy can open the veiled doors of the child's mind and become for therapist and child together an experience of reality acceptance and open communication.

5. Image therapy with the Sociopathic child

The sociopathic child lives in a splintered world. In image therapy the child learns to communicate with the adult through an image. Gestalt therapy takes him a step further, namely to actively learn to feel, to will and to accept his emotions as his own. It is sometimes closely linked with image therapy, but is much more an active expression of his emotions and not only a representation thereof. This method is a very effective way of dealing with the sociopathic child, as it deals directly with his affectional problem, which is one of his main problem areas. Gestalt therapy with children is in practice to a greater degree loaded with action than with the adult, which suits the action inclined sociopathic child excellently. The theory of Gestalt therapy with the child has not been worked out in the literature and had to be done by the author.

6. The meaning of the use of colours

Although the use of colours must always be interpreted with extreme caution, colour can be significant in the analysis of the child's images.

In the analysis of the single-case study the following colour interpretation by Isaac Jelles (1969) will be used:

Black: generally indicates depression and anxiety, particularly in combination with clouds and smoke;

Blue: the need to exercise control;

Blue-black: schizo-affective reaction;

Blue-green: need of control in order to maintain security;

Brown: immature reactions to emotional impulses and defensiveness;

Green: attempt at creating a sense of security; avoidance of threat;

Orange: combination of sensuality and aggressiveness if used excessively; ambivalence;

Purple: need for authority;

Red: sensuality; need for warmth in environment;

Reddish or ambivalence in regard to love object from whom love is wanted;

Pink: repressed affectionality;

Yellow: hostility;

Lime green: repressed hostility;

White: antisocial feelings. (Jolles, 1969, p. 11-15).

VERBAL THERAPY WITH THE CHILD

In child therapy, as in adult therapy, the ultimate objective is direct communication by means of language. The therapist communicates with the child via the child's images and ultimately leads him to full verbal therapy. The child is also guided in play to verbalize his problems.

In the child, pure verbal therapy without a mediating means seldom occurs. However, verbal therapy is never totally excluded in child therapy - it merely takes a different form from adult verbal therapy in that it takes place on the level of the child and in his idiom or image.

GESTALT THERAPY

Jaspers (1923, 1963) was one of the first psychologists to see mental health as the degree of consciousness of the person. The fully functioning person is the one with the highest possible degree of awareness. He approaches his environment with active participation. Whatever he experiences, feels, perceives and chooses in full awareness is recognized as his own. The mentally sound person, in other words, is someone who consciously experiences, recognizes and integrates his experiences and environment as his own. Even the negative reaction patterns must penetrate to the consciousness and be recognized as part of the personality. The individual must develop sufficient ego strength to accept and integrate his negative emotions as part of himself.

"In the Gestalt point of view the healthy organism-in-its environment is constantly attending to matters of importance to its maintenance or survival" (Fagan, 1970, p. 107). All people constantly focus their attention selectively on incidents in themselves or their environment which are important to their self-maintenance. This "attention" is not always conscious. If the impulses are new or of a great impact to the individual, he not only directs his attention to them, but essentially becomes aware of their quality, character and demands

on him. The awareness leads to maximum functioning of the person, which in turn motivates him to cope with his environment with the highest possible degree of effectivity.

According to Fagen (op. cit.), pathology occurs when this awareness does not develop due to an obstruction of some kind. Enright (1970) takes the concept of malfunctioning as obstruction of awareness a step further and describes the following four forms of obstruction:

Projection

The patient projects his own negative characteristics onto others and becomes hypersensitive to outside criticism.

Retroflection

Impulses and ideas rest mainly on organismic, senso-motoric tension, which is partially determined by inner impulses and is directed to environmental situations. Retroflection is the process by which the impulse tension is negated, detained or balanced. It involves repression and inhibition as over manifestations of the concept. The total person is brought to arrestment of movement. It is important to understand that the person uses energy in order to maintain the tension between impulse and resistance, but that this "balance" is totally strange to the self. An extreme example of this is depression.

Desensitization

Over-bombardment by impulses results in closure, so that, for instance, a person hears certain sounds but does not register them. Sensoric blunting and frigidity occur.

Introjection

This occurs when the developing individual integrates the behaviour patterns of other significant people in his life without assimilating them or recognizing them as part of the true self. This results in conflict between the ideal self and the true self.

When any person blocks out contact with awareness by means of the above-mentioned mechanisms, pathology exists. The primary purpose of therapy in the Gestalt framework is to help the patient resolve this blockage of consciousness in the immediate here and now.

Unlike in other existential therapies, a diagnosis or "patterning", as Fagan (op. cit.) describes it, is made in Gestalt therapy. By means of this, the therapist forms an understanding of the patient's interaction with the incidents and systems which lead to his unique life-style and support his symptomatology.

The therapist also assumes co-operative control of the therapy. On the one hand, he builds up the patient's autonomy, but on the other hand he remains in control of the therapy with the patient's permission. The patient is free to object to the therapist's procedure, provided that he can give reasons for his objections.

At the outset of therapy the patient is expected to communicate his problems verbally to the therapist and to state what he hopes to achieve by therapy. He is then invited to an experiment and must place himself in the hands of the therapist. It is clearly explained to him that growth is always a disruptive process. The patient must consciously explore the therapeutic process and also consciously venture into it.

Since this technique was applied to children during this study,

Gestalt child therapy will now be more fully discussed:

1. Gestalt child therapy

Although isolated cases of the application of the technique to children are described in the literature, no fully developed framework for Gestalt therapy as applied to children could be found. Fagan (op. cit.) agrees that the technique can be successfully applied to children, but did not describe its actual technical application.

The child is continually in movement and his emotions are still strongly experienced through the total physical and psychical "Gestalt". Blocking of conscious experience of emotions is more traumatic to the child than to the adult. The adult, for instance, can control his tears, whereas for the child this is practically impossible, and if he is forced to do so, the results are much more far-reaching. Somatization in the child often stems from his inability to overtly handle aggression, anxiety or despair. According to the literature, Gestalt therapy has achieved considerable success in such cases.

The child, much more than the adult, experiences his world through his body, and physical contact with his world remains of the utmost importance. For this reason, the child must be allowed to touch the therapist and be touched by the therapist. Even his aggression, which he would normally not dare to express to an adult, can be acted out in the play situation. Hand puppet games have been found to be successful for this purpose. The therapist, for instance, takes the part of one character and the child that of another person who displays considerable aggression towards the first character in the child's world. The therapist could be the witch and the child the good fairy

who attacks and conquers the witch. In this form of play the child must be allowed to attack the witch physically and even injure her. In this way, the child learns to cope with his emotions in a secure, symbolic world. His symbols are not only observed, but after the game the child is encouraged to tell the therapist who, for instance, he thinks the witch is. If he is not yet ready to make his own interpretation, the matter is dropped and a similar play situation repeated at a later stage until he is able to experience and perceive his images consciously - until, for instance, the witch becomes "Mummy" and the good fairy is given his own name. A sense of guilt about his aggression is always present.

It is generally a tremendous relief to the child to realize that an adult can understand his negative feelings towards, for instance, his mother, without condemning him.

In play the roles are later reversed and the good fairy must do as the witch wishes. The child must also be led to a perception of and a degree of insight into the problems of the witch.

To be able to actually cry is sometimes essential to the child, and Gestalt therapy is eminently suitable for this. Crying is the primary symbolic expression of pain and suffering and, if repressed, could lead to a prolonged period of suffering and mourning called depression. Gestalt therapy in the child is always incorporated into his play and differs from adult therapy in this respect. Whereas the adult takes his own decision to venture into the exercise of consciousness and either to grow - with the help of the therapist - or not to grow, it is the child's therapist, as the responsible person, who takes the decision for the child and the Gestalt therapy is spontaneously incorporated into the play situation.

For the child the borders between fantasy and reality are not yet clearly demarked. The child therapist must be capable not only of accompanying the child into his mystical world, but of experiencing it as reality together with the child. In childhood fears and phobias this is a highly important aspect to be taken into account. Once again the child must first be allowed to experience his fear in its full horror, then helped to represent this experience in images and finally to verbalize it. He must learn to recognize that it is his fear and that only he can cope with it.

The most significant contribution of the Gestalt approach to child therapy is that it offers the child the opportunity for an integrated, intense experience. In this way, he already learns in childhood not to fear his emotions, but to experience and accept them as part of himself, and consequently he is able to develop the responsibility to use his emotions to his own development and not to his destruction.

No other form of child therapy makes such taxing demands on the therapist as Gestalt therapy. It is an exhausting experience because both therapist and child are constantly in movement physically and mentally. At the same time, however, few other forms of child therapy offer more adventurous possibilities. For the child the here-and-now is his reality and he invariably experiences it much more intensely than the past or the future. Even his past only has significance in as far as it appeals to him here and now. This is another aspect which makes Gestalt therapy eminently suitable for the child.

The sociopathized child is caught up in a process of alienation from his emotions. His hatred, for instance, has an intensity which

frightens other people but which escapes his consciousness. This separation between overt emotions and their conscious experience lends itself eminently to Gestalt therapy. The sociopathized child must consciously learn to experience and accept what others are doing to him. He must be guided to full experience and acceptance of the pain of his own hatred and aggression, be brought to realize that he is entrenching himself against further feeling and persuaded to rid himself of the fear of feeling. In the therapy of the sociopathized child, this process is inevitably a painful experience, both for the child and the therapist, but it reaps rich rewards when the child succeeds in escaping from his cocoon of apathy and self-pity and starts to move into freedom of emotional experience.

GROUP THERAPY WITH CHILDREN

In 1921 Freud already published the first theoretical framework for groups in his "Group Psychology and the Analysis of the Ego." He felt that the individual had to be seen in relation to others. In a certain sense he sees all psychology as group psychology. This aspect of Freud's work is not always fully appreciated. Freud (op. cit.) pointed out that a number of persons who have come together incidentally do not necessarily constitute a group, because, before a group in the true sense of the word can be formed, there has to be a leader. He also differentiated between permanent and temporary groups and heterogeneous and homogeneous groups. He mentions that identification with the leader and empathy between the members of the group are beneficial to the development of the individual egos, and also maintains that neurosis decreases where there is strong group

forming. Freud does not proceed beyond a mere analysis of the group, but the logical conclusion of the last statement would have been group therapy.

Today group therapy is extensively used in a wide variety of fields. This study does not allow a full exposition of the development and techniques of adult group therapy. Only group therapy as applied to children will be discussed.

Slavson (1934) was the first to apply formal child group therapy. His groups were called "activity groups for latent phase juveniles." Before him, as early as in 1896, Witmer treated disturbed children in groups, but his therapy was in no way scientifically founded. In 1937 Bender reports that he successfully treated children in groups in hospital wards. Glatzer and Durkin started to apply what they called "relationship therapy" to children in 1944. Play and verbalization were used by them as medium in groups.

In the various psychological schools of thought, different forms of child group therapy developed and gradually changed with the years.

The child's activity is a means by which he reveals his inner life. He is often unwilling to share his personal fantasies with other children, because he fears rejection and ridicule. In individual therapy he learns to express himself to the adult, but very often the disturbed child does not have the courage to reveal himself to his fellow group members. The security of the group therapy situation could become a practice field for such communication.

Group forming is a spontaneous human process and the normal, natural grouping according to age must be taken into account in the

formation of child groups. Kraft (1968) and Soble and Geller (1964) classify children into the following age groups:

four to six years;
six to nine years;
nine to eleven years;
twelve to thirteen years;
thirteen to fourteen years;
fifteen to sixteen years;
seventeen years upwards.

Another variable which must decidedly be taken into account is the sex of the members. Gratoon (1966) maintains that separate groups are justified in the latent phase, but that mixed groups are preferable in puberty. Other authors, such as Axelrod, Gabriel, McCormic, etc., who all published during the forties and fifties, reject mixed groups under all circumstances. Ackerman (1955) admits that mixed groups are more disruptive, but maintains that the positive growth potential offered in such groups outweighs the negative aspects. The Commission on Group Psychotherapy of the World Federation for Mental Health (1952) found that mixed groups resulted in more emotional reaction and "acting-out" behaviour, and also that more physical illness, such as colds and flu occurred in these groups. Although fear of sexual misconduct was voiced by several group workers, Rosenbaum (1971), Schulman (1959), Becker (1964) and Fried and Godenne (1965) state that no such misconduct arises in mixed groups, provided that they consist of different personality types, including, amongst others, members with over-developed superegos. They also suggest that mixed

groups should always be managed by more than one therapist. Teicher (1966), who has had extensive experience with young sex delinquents, maintains that mixed groups are definitely too stimulating and therefore not therapeutically advisable. However, Teicher is inclined to generalize too strongly from the juvenile sex delinquent to the ordinary disturbed youth.

The literature offers no conclusive evidence on the advantages of separate boys' and girls' groups above mixed groups. The nature of the pathology in the child must be taken into account in this regard. Certain deviations, such as sociopathy, lend themselves to successful therapy in separate groups, while identity problems, for instance, are decidedly better handled in mixed group interaction.

The therapist must decide for himself how to constitute his group on the basis of his knowledge of the functioning of each group of children.

This leads to the next question in regard to the selection of the group: the diagnostic criteria. There is no easy solution to this problem. Most authors, such as Schulman (op. cit.), Rosenbaum (op. cit.) and others, are of the opinion that homogeneity in the group, also in regard to diagnosis, is of the utmost importance. Authors, such as Schudlinger and Rauch (in Wolman, op. cit.) maintain that the sociopathized child is too disruptive to be included in a group. Kraft (in Kaplan, op. cit.) points out that the therapist has a responsibility towards the other members of his group and can therefore never include strongly sociopathized children in groups with other forms of pathology. In the literature, it is practically only the child with strong aggressive or sociopathic tendencies who is singled out on

diagnostic grounds as unsuitable for inclusion in the ordinary group. Kraft (op. cit.) puts forward that the most important selection criterion is the ego strength of the group members.

Boenheim (1957) accepted only homogeneous groups with interpersonal problems for group therapy. Kraft (op. cit.), Ackerman (op. cit.), Schulman (op. cit.) and others agree that the strongly sociopathic child, in view of his deviative perception, should preferably not be placed in a group together with neurotic children.

Ginnot (1961) categorically states that, in view of the irreversibility of his condition, the sociopathized child cannot receive group therapy. However, he does make provision for the possibility that, in cases where the sociopathizing process is not too far advanced, group therapy might provide the obvious solution.

In their research on 280 child guidance institutions, Peck and Steward (1964) came to the following conclusion in regard to group work: 28% of the organizations had play therapy groups. All of them applied age and sex selection. Less important but nevertheless significant selection criteria were religion, race, socio-economic status and intelligence. They also established that in 79% of the groups, heterogeneity was regarded as essential for effective functioning. Children with serious psychotic or sociopathic tendencies were purposely excluded from groups.

Before ten years of age, groups generally include six to ten members. However, the authoress has found that with sociopathized children, who make more taxing demands on the therapist, groups should preferably be limited to four or five children. According to Kraft (1977), adolescent groups generally comprise of 15 members, basically

because only half of the members regularly attend.

The following age groups are involved in children's groups:

1. Toddler and young juvenile groups (up to eight years)

Therapy in these groups usually takes the form of free play or specific structured activity determined by the therapist. Interaction in this group still takes place via the toys or play objects and not directly with each other. By means of the play objects the children succeed in communicating with one another and catharsis can be brought about in this way. The therapist interprets their conduct to each other and thus they learn through the group situation.

Ginott (in Freedman, 1969) says that the play group can bring about modifications in the child's intra-psychical equilibrium through relation catharsis, insight, reality testing and sublimation. The group provides the child with the opportunity to identify both with the therapist and the group, and so develop a sense of belonging. The child remains the focal point at this stage and the development of group cohesion is of secondary importance. Slavson (op. cit.) advises the use of these groups principally for neurotically disturbed children.

2. Latent group (nine to twelve years)

In this group, elements of play, activity and discussion can be combined. It differs from adult groups in that the therapist still actively interprets the child's conduct and attitudes to himself and the group. The children are now also encouraged to verbalize their problems and to talk about, for instance, their dreams and fantasies.

3. Puberty groups (thirteen to fourteen years)

The same activities as for the previous group apply in this group.

In view of the fact that the "Sturm-und-Drang" period is beginning to develop at this stage, these children need more support from the therapist. The group members themselves now also start playing a supporting role.

Slavson (op. cit.) regards the group, which he calls an "activity psychotherapy group", as a substitute family, in which the therapist must remain passive and neutral in order to function as a surrogate for the parents. The children use the expression materials under the control of the therapist to attain self-expression. They must gradually begin to transfer their energy from the material to interaction with one another. Within the group, the therapist remains to each child a catalyst to acquire new behaviour patterns.

4. Adolescent groups (from fourteen years upwards)

In this period the therapist's main task is to support the developing egos, which are gradually attaining self-identification. Ego-building therapeutic techniques are accordingly imperative. Particular emphasis must be placed on the alleviation of anxiety through discussions on sexuality and role-taking. Interpretation becomes much more cautious at this stage and groups members are encouraged to make their own interpretations. Reality must be increasingly emphasized. Subjects for discussion are still determined jointly by the therapist and the group.

5. Groups with sociopathized children

Although, as has already been indicated, most authors regard these children as unsuitable for group therapy in view of their disruptive influence on the rest of the group, research has been undertaken in

which a certain degree of success has been achieved with group therapy. In spite of the fact that Kassoff (1958) felt that "the tremendous emotional demands of such boys are really too great for the therapist", he nonetheless successfully placed them in groups.

Shellow (1958) strongly feels that the most important aspect of therapy with the sociopathized child is laying down limits which must be rigidly adhered to under all circumstances. Thorpe and Smith (1952) challenge this view, pointing out that the greatest need of these children is identification with a warm, accepting person, who for them symbolizes non-identification with authority. Head (1962) agrees, adding that the most notable characteristic of the sociopathized child is his resistance against all attempts to change him. This "changing" represents adult authority in his mind.

The purpose of most forms of therapy is to bring about a change of conduct, which in itself is utterly unacceptable to the sociopathized child. Schulman (1957) contends that the major objective of group therapy with these children should be the re-establishment of an authority dependency relation which is totally different from anything the child has known up to this stage.

Perls (op. cit.) uses fantasy experiences in the group to reach the children. He makes use of psychodrama in which socially acceptable conduct is represented heroically.

Stranahan (1957) reports that he has achieved considerable success with activity groups for sociopathized children.

Adler and Berman (1960) suggest that in groups of sociopathized children, two therapists should be involved, one of which represents the authoritative figure while the other represents the tolerant approach.

"We believe that dual leadership, which combines authoritative and non-authoritative representatives, is the key factor in our project. By dividing the adult figure into two representatives - one representing the authoritative and denying aspect of the adult, the other representing an effort to understand and to make interpersonal contact - the problem of ambivalence is temporarily bypassed" (Adler and Berman, op. cit., p. 67).

All the above-mentioned therapists agree that the basis of group therapy with the sociopathized child should be mainly ego-organizing and integrating, in view of the fact that children in this analytical framework represent mainly ego-malfunctioning pathology.

Whereas in other disturbances group therapy can often be successfully applied as the only form of therapy, this is never the case with sociopathized children. In their case, group therapy should always form part of an intensive treatment programme which may even require a full institutionalization programme after puberty. Nonetheless, group therapy remains an important aspect of their treatment in view of the fact that their pathology is basically also a disturbance of contact, firstly with themselves and their own feelings and secondly, with their fellow-men, against whom they are constantly in resistance.

The sociopathic child, as we have seen, is usually unable to form stable interpersonal relations. He is constantly either in conflict with his siblings and peers or withdrawn from them. Some kind of relationship problem mostly exists.

In this study, after the individual therapy has been completed, each of the children from the experimental group were placed in a group consisting of four or five normal children from the same age group as

the sociopathic child concerned. These children could be considered relatively normal in the sense that none of these children showed any behaviour problems. Because they had no behaviour problems, they could serve as models for the sociopathic child. This group was primarily constituted for the benefit of the one sociopathic child in the group and not for the sake of the other children in the group. This is a new concept in the way a group is used, as it is usually constituted with the benefit of the whole group in view. In this method the "normal" group members had become unknowingly co-therapists. After each group session, the group-interaction and his own behaviour was discussed by the therapist with the sociopathic child and he was helped to plan more appropriate behaviour. The group sessions lasted about an hour and each child was in eight to ten group sessions.

For each sociopathic child, a new group was constituted to be of the same age and sex as he was.

SUMMARY

In the therapy of the sociopathized child with his unique problem field, a number of different techniques are required in order to cover the complexity of his problem. Each therapeutic method described above is applicable to a certain facet of his problem, but none of them are comprehensive enough to cover his total problem field and consequently a variety of different techniques becomes imperative. The authoress fully agrees with Snyders (1961) in his belief that *"the most mature approach to psychotherapy constitutes a systematic integration of what is good in a number of different schools of therapy."*

STATISTICAL ANALYSIS OF THE RESULTS

The statistical analysis of the data obtained on the different tests were processed as follows:

RORSCHACH

The Rorschach was used to determine any change in the intra psychic orientation of these children Pre- and Post-therapy. The protocols of the Experimental group were qualitatively analysed according to the method described previously under apparatus when the Rorschach was discussed.

The Rorschach protocols of the different groups were statistically analysed to compare the direction of change pre and post therapy. As these data were obtained from ratings that might be subjectively affected and are on an ordinal scale, a non-parametric test was chosen. As matched pairs of a small sample were used and only the direction of change was needed, the Sign test was used as suggested for this kind of calculation by Siegel (op. cit., p. 68).

NSAIS AND WISC

According to Glazer (op. cit.), Madge (op. cit.) and other writers, there is a definite diagnostic scatter pattern on the NSAIS and WISC protocols of the sociopathic children. Reid (op. cit.) feels that the WISC scatter pattern is the most important diagnostic tool for sociopathy in the child. This aspect was investigated by the following scatter pattern symbol analysis.

The scatter pattern symbols are scored in the following way according to Glasser (op. cit.). The same system will be used in the analysis

of the WISC and the NSAIS.

Deviances were calculated from the total mean IQ of the group of 30 sociopathic children as follows for each subtest.

<u>Symbol used</u>	<u>Meaning of symbols</u>
o	= o - 9 points less or more than the total mean IQ. This is considered as of "not significant".
(+) or (-)	= 10 - 14 points more or less than the total mean IQ. This is considered as "indicative".
+ or -	= 15 points more or less than the mean IQ. This is considered as "significant".

The scatter pattern analysis is only used in practice for diagnostic purposes.

The IQs of the different groups of sociopathic children were compared to see if there was any difference between the three groups, so as to determine whether they were drawn from the same population, i.e. sociopathic children. Here the Kruskal Wallis one-way analysis of variance was used, as this test is a good means of establishing whether different groups of small samples were from the same or different populations according to Siegel (op. cit.).

The correlation and intercorrelation between the different items on the WISC and NSAIS were calculated using the Spearman Rank Correlation. As the item ratings were strictly speaking, of an Ordinal nature, this non-parametric measure of correlation was used as suggested by Siegel (op. cit.).

JESNESS INVENTORY ASOCIAL INDEX

This test was used to determine whether the sociopathic children's inclinations changed from a basic sociopathic attitude to a more socially accepted attitude from Pre- to Post-therapy and whether the change, if any, was still present at the two year follow-up study.

For this a multivariate analysis was used as Allan Wilson (1975) states that "*the potential gain for a multivariate approach to treatment evaluation far exceeds any disadvantages*" (p. 407). He also states that this is a good method "*to determine the relative effectiveness of several treatment regimes*" (p. 404) which fits this study very well, as more than one therapeutic technique was used.

BEHAVIOUR RATING SCALE

This scale was used to determine whether there was any significant behavioral change between the groups from Pre- to Post-therapy and again after two years. If there was a significant change in the Experimental group, an item analysis would be done to determine the main areas of change according to the Behaviour rating scale that took place.

As independent raters were used, their inter-reliability had first to be determined. Siegel (op. cit.) suggests three basic tests for determining inter-reliability of raters for the behavioral scientist, namely the Wilcoxon sign rank test, the Friedman two way analysis of variance and the Kendall Coefficient of concordance. The Wilcoxon is used to determine the relative magnitude as well as the direction of the differences between the raters. The Friedman test is used on ordinal matched scales and is very useful to determine whether there are any differences between independent raters. Siegel further states

that he still considers the Kendall coefficient of Concordance as the best means of establishing whether there was significant concordance between the raters to accept their inter-reliability. All three of these tests were done.

To determine the effects of therapy on the three groups, an analysis of variance was used. A one tail test, which predicts the direction of change and gives one a method of determining therapy effects, was used, by subtracting the Post-therapy ratings from the Pre-therapy ratings; the after two years' ratings from the Pre-therapy ratings and the after two years' ratings from Post-therapy ratings. According to Allen Wilson (op. cit.), this is the best method to determine therapy outcome on rating scales.

The data are presented in two parts:

A full case description of the first therapy case is given to analyse the therapeutic process in depth dynamically. To do this, the therapy was recorded on video tape, and reported in a shortened format. This is important for clinicians who want to apply these methods themselves.

Secondly, the rest of the data were statistically analysed and presented as described above.

CHAPTER VII

RESULTS - THE SINGLE CASE STUDY

INTRODUCTION

The research data will be presented in two parts. Firstly a full single case study will be presented. Secondly a quantitative analysis of the research data of the experimental group, compared with that of the control groups will be given. Thirdly the data of the experimental group will also be analysed statistically and qualitatively before and after therapy.

THE SINGLE CASE STUDY

The first case taken into therapy was recorded on videotape. After each therapy session the therapist recorded the therapy in a workable format from the tape.

The boy's T.A.T. protocol is included in this case study although it was not used as part of the research. It is done to give an idea of this child's total chaotic life when he entered therapy.

1. VALIDITY OF SINGLE CASE STUDIES

Davidson (1969) sees the task of the psychologist as one that only a trained clinical psychologist can perform. As the task of the psychologist, he includes finding ways and means in the literature and research of helping patients but also that he must contribute towards research and the literature from his experience in his daily work. He must describe and evaluate his therapy on a day to day basis. For this he sees the single case study as of great importance.

Single case studies are considered just as valid as detailed studies according to Payne (1953), Jones (1956), Bartlett (1956) and Chassen (1967) and may in certain cases of research be the method of choice. "Investigations of this kind make as much demand for originality and precision of thinking as does the best fundamental research. In fact this kind of work is a form of research and perhaps the most appropriate name for it is clinical research" (Davidson, 1969, p.19).

The aim of the single case study is the following:

- i) To obtain data about the way in which already proven and standardized techniques and procedures in the clinical field are applied practically.
- ii) To establish the workability of a method of research whereby the patient becomes his own control and where the aim of the method is the successful treatment of the patient and his readjustment.
- iii) To propose new hypotheses.

Most studies in psychology are of extensive nature, as they use more than one subject for their sample. This method has great value for clinical psychology but the time has arrived for the clinician to also put his work under the microscope and evaluate it. Dustin (1969) feels that therapy and the deeper dynamics involved in the therapeutic process can only be evaluated in the person to person relationship and thus recommends one-case descriptive studies to form the basis of all future extensive research.

Chassen (1967) agrees when he states that a series of single case studies are of more importance to the clinical field than the most extensive studies done.

In contrast to the academic psychologist, research is only really

relevant to the clinician if he can apply his results to his patients and not if he can only prove a hypothesis.

Davidson (op. cit.) feels that even the statistics can be more meaningful than in the case of an extensive study. Variables can be kept more constant than in any other research. The parameters in an extensive study are vague because the variables are never totally controllable in even the smallest sample.

"Thus the argument against generalization to other patients from the results of a single case intensive study can actually be applied in a more realistic and devastating manner against the value of inferences which are customarily drawn from studies in which extensive rather than intensive degrees of freedom are used - that is where it is based on the number of patients rather than on the number of observations of a single patient. This is particularly true when one seeks to apply the results of a study to a treatment program" (Davidson, op. cit., p. 36).

In this study the main emphasis will be on the therapeutic process and thus a single case study together with a more extensive study is included.

SINGLE CASE - FULL DESCRIPTION

HISTORY OF JOHNY (7 years 11 months old)

This history was compiled from information gained from his foster parents, the social worker and his teacher.

1. PRESENTING PROBLEMS

Johny was very aggressive and destructive at home and at school. He had failed sub.A because of his behaviour and due to truancy. He was constantly telling lies and was stealing from others, the school, and

his foster parents. He already had two police contacts for shoplifting and breaking into the neighbour's house. He took on a non-caring attitude when confronted with these incidents. He could be very charming and manipulative when he wanted something or was in a difficult situation. Mostly however, he was cold and without positive emotions towards other people and his peers. He had no friends and even the contact with his own brother was very poor. He had, on more than one occasion, molested animals sexually. On one occasion he stuck a stick into the vagina of a cat and hurt it so badly that the cat had to be put down. His father described "a sadistic laughing" as he was doing it. He was also very seductive towards his stepmother. He used to get on her lap and then wanted to fondle her breasts or touch her genitals. When she refused he became very aggressive.

Most of these problems were already present when he was placed into foster care, more than two years ago but has become progressively worse to the extent that he was not even fearful of police action. The foster parents were at their wits end with him and could not handle or control him at all.

His older brother, who was placed with him in the foster care of Mr. and Mrs. X, showed no problems, although he had the same background history as Johny,

2. PERSONALITY DESCRIPTION BY THE FOSTER PARENTS

Mr. X described Johny as: "a cold criminal that hates and destroys everyone and everything he comes into contact with."

Mrs. X described him as a sadistic pervert that has no feeling for anyone except a very deep hate for all people.

He was further described as very impulsive. Although he may at times seem to be an introvert who withdraws from other people he easily loses control over himself and then reacts uncontrollably destructively and aggressively.

He was preoccupied by stories of aggression and making money and could spend hours alone working out how to make money or how to be destructive in some way.

3. BACKGROUND HISTORY OF JOHNY

The marriage of his real parents was very unstable. Both of his parents had numerous extramarital relations and at one stage there was a query of prostitution being practised by the mother.

The mother very often left the children locked in their room for a whole day and only returned in the evenings. Very often there was no food in the house. They only had a few pieces of furniture and the three children had to sleep on a blanket on the floor. The children and the mother begged for food and she sent the children out on their own to beg. On more than one occasion she had asked the welfare to remove the children for they were only a nuisance to her. The possibility exists that she abused the children sexually.

The father is an alcoholic criminal who had received an undetermined sentence. Very little was known of his contact with the children.

The two older children attended school very haphazardly. They were very dirty and unkempt and the other children used to laugh at them.

One day the mother just left the children in a garage that was their home at that time. For five days they had to fend for themselves.

Johnny was only five years old at this stage. The children were found in need of care and Johnny and his elder brother were placed in the foster care of Mr. and Mrs. X.

Mr. X is a 40 year old clerk. He felt it very strongly as his Christian duty to help Johnny and his brother and really tried to be a father to them. He seemed to be an emotionally balanced person without any obvious pathology.

Mrs. X is a 42 year old receptionist to a doctor. She is a highly strung nervous person with very high social norms. She had had five miscarriages and thus applied to have children adopted but it was refused as she was being treated for depression. The two children were however placed in her foster care. She related very well to the older boy and had a good relationship with him but felt that she could not reach Johnny no matter how hard she tried.

They were both determined to succeed in their foster care, but were at their wits end with Johnny and tried psychotherapy as a last resort before having him committed into an industrial school or clinic school.

The marriage relationship of the foster parents is at the moment stable but did go through a problem stage when Mrs. X received psychiatric treatment for her depression.

Both the foster parents tried to be involved in what the children were doing. They played with them and helped them with their homework. The family could be considered as a reasonable normal family.

They disciplined the children by talking to them as they felt that they had already been punished too much by their own parents.

Discipline had no effect on Johnny. The couple had a good relationship with their neighbours.

4. MEDICAL HISTORY OF JOHNNY

Johnny was the youngest of three children with an age gap of two years between each one of them.

His birth and ante-natal history was normal.

His milestones were within the normal range.

From the age of two he was a very aggressive child and it seems as if his antisocial behaviour started from about four years of age.

He had had no serious illnesses.

His E.E.G. was normal.

OBSERVATION FOR DIAGNOSTIC EVALUATION 1.

Johnny was very withdrawn and reacted only by nodding his head. His voice was nearly inaudible and he did not take much notice of the therapist. He looked at her in a defiant manner but did not show any overt aggression.

He was given a clean piece of paper and asked to draw. At first he just looked at it, then grabbed it and started to draw. It seemed as if he lost himself in it once he started to draw.

Free Drawing (see plate 1).

He started by drawing, what he called the new house with a father and mother with their hands stretched out. At the new house was everything that a child could long for. A garage with a motor car, another small motor in which the father took them for rides and a lawn on which he could play. There was also a tree and a servant girl who did all

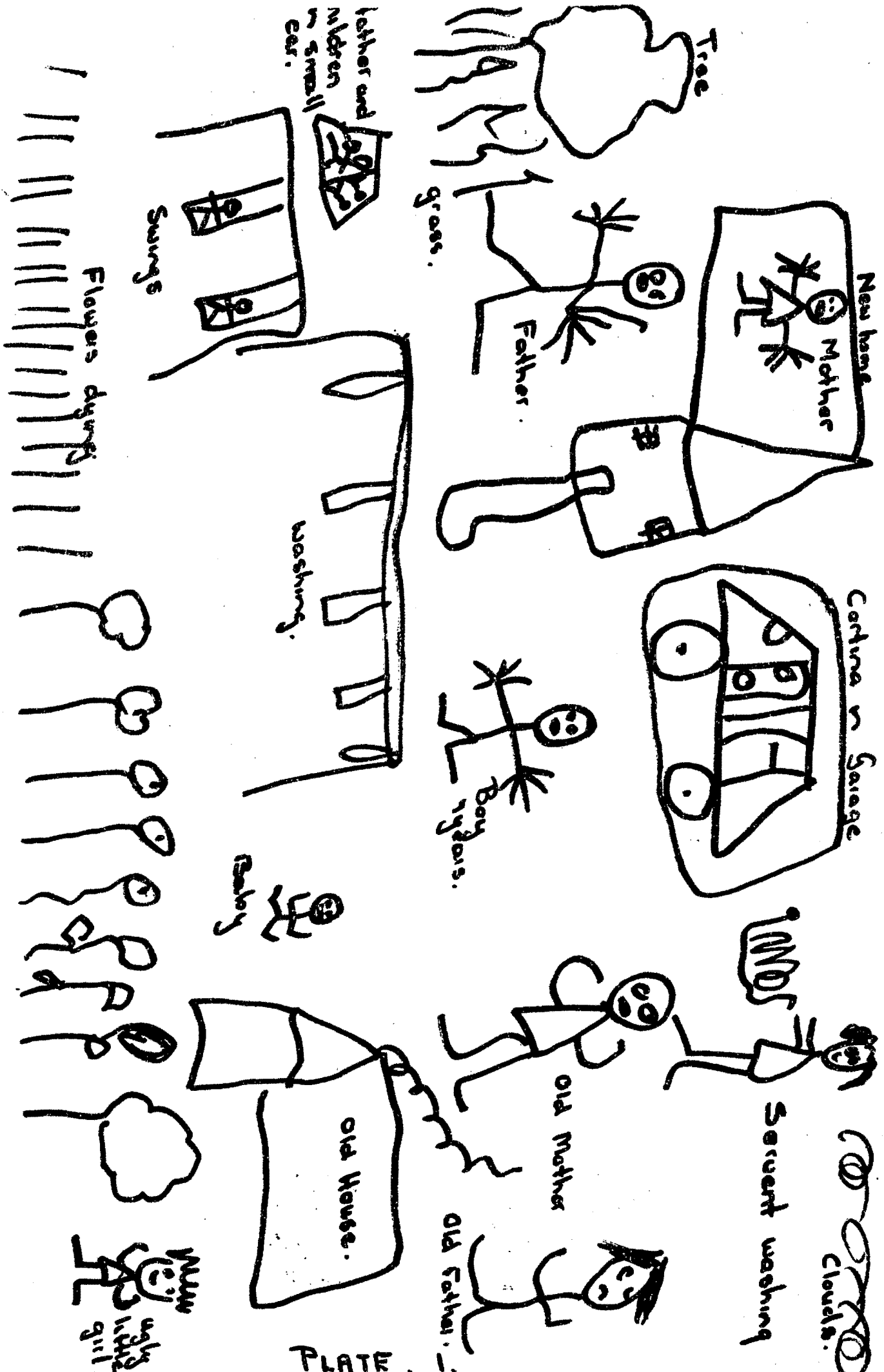


PLATE . 1 .
JOHNNY'S FIRST FREE DRAWING.

the work. Near the house is a playpark where children could play.

He then drew the old house with a mother and father with hands folded back. Everything here according to him is ugly. Here is an ugly naughty little servant girl and a dirty baby. All that is still beautiful here are the flowers but half of them have already died and the rest of them are in the process of dying.

Between the two houses stands a little boy with the name of Johny. His hands are outstretched to both houses. He is caught between two worlds.

After he had completed his first drawing and told the story of his drawing he was asked to draw a person. He drew a very small insignificant little figure.

The house tree person test was then performed.

At the end of the session Johny was talking free to the therapist but on a very superficial level. No real deep contact could be made with him.

Discussion

Johny did not trust the therapist and to make contact and overcome his resistance she uses a free expression medium. He accepts this and gives more of himself than was expected. In this open communication she proceeds to start with some of the tests, which he does without resistance. Although at this stage the therapist thought she had made reasonable good contact with him, it later proved to be of a very superficial nature.

DIAGNOSTIC EVALUATION 2.

Johny came into the observation room totally at ease. He started

talking as if he was in control of the situation but what was very obvious was that he avoided all eye contact. He looked and touched the toys selected but did not start to play with them spontaneously. The therapist assured him that he could play with any of the toys in any manner he liked.

He immediately took the cowboys and Indians and started to play with them. He got totally absorbed in his play, but did not include the therapist. He played the one story after the other, verbalising what he was doing. All his play stories had the same theme. All the people were killed in the most brutal fashion except one person whom he called the hero who could then do whatever he liked or wanted to do. A mother and her child were then found and protected by the hero for the child was a special child whom they all wanted to kill. But when everyone was killed, the hero also brutally killed the child and the mother. As Johny killed the child and the mother he laughed sadistically and then repeated the story.

This boy was able to play at an illusive level but his play was exceedingly destructive. Strong aggression and even sadistic tendencies were noted in his play.

He ended his play and left the room smilingly.

DIAGNOSTIC EVALUATION 3.

The therapist explained to Johny that they were going to play a different game that day. She would show him pictures and he had to tell her stories about the pictures. His story had to be his own story and not one he had heard. He had to tell what had happened on the picture, what will happen afterwards and how the people felt. The instructions

were repeated and then he was asked to repeat in his own words what he had to do.

Johny was immediately very involved with the pictures and lost himself in his own stories which he told with animation. He nearly lost contact with reality and became totally absorbed in his own world, ignoring the therapist almost completely.

After he had completed the projection cards, he was told that they would be playing another game with other cards. The cards he was going to look at now, looked different to every other person. He had to tell the therapist what they looked like to him or what they reminded him of. There were no right or wrong answers. Here again he gave good responses but was more in contact with reality.

(Although the Thematic Projective Tests were not used in the research per sé, they were included in Johny's case to give one an idea of his total chaotic world at the time when he entered therapy. The protocols will however not be interpreted as they speak for themselves. The projective cards that were used comes from the following projective tests: The Columbus (CO) and the C.A.T.).

CO.6.

There lies a father and there sits a mother and another uncle. The child got up and sat on the mother's box. They all shouted and the father is cross and hits the child with a whip five times and the blood flows out of a very small hole. Then came a snake and mother hits father over the head with an axe, and then he died. And a snake killed the father. No he only walked on dad. Then father is drunk, and when mom did not make food he hit her on her mouth. Mother throws

a knife at him. Father throws an axe. The child throws the father with a hammer. Then mom told the snake to spit at dad.

CO. 20.

There is a mother and a father. Mother sees dad has a sore leg. Then they got into the car and bumped into another car. And they lie in hospital. The whole car is broken. It lies in pieces. There lies a piece. Dad pays R 500. Then mom has to travel with the broken car and mom says "I will hit you with an axe and you will stay in jail." Dad was drunk again so he made another accident. Dad's windows lie like this. The speedy says "You will have to buy the mother a new car. You and your children will go to jail for 300 months. You are going to pay all your R 200 in the bank. You cannot bump into cars for ten times." Then they hit him so that his teeth went in all directions, and the children did not know what to do. Then came the ghost and said "Who is there?" Then came a man and said "Where is your dad?"

CAT. 4.

This is a small boy who is following a woman. He pushes the woman to fall on the ground. He steps on her and tramps on her and grabs the baby. Tramps also on the baby who cries. And the police catch him and ask him why he did it. Then he has a stick and break off all the spokes of the wheels and one wheel is on fire. He hits the child so that the police throws him against the van. The balloon burst in his eye so that he is blind. Then the police threw him into jail.

CAT. 2.

Two no three children tugging at a rope. One alone and two on the other end. Then the small boy fell on the sand and cried but they did not hear him. Then the girl's foot slipped and she also fell and then they all fell on each other. Then a bird and a cow came and eat them up and the bird flew away. Then the cow died, bitten on his neck and the blood runs down. Then they got up and ran away but the cow eat them again.

In the forest were two lions, four horses and one pig. Then the horse kicked them all and the cow eat them all.

CAT. 8.

There is a child and a mother and another mother - two or three mothers. Sit on the bed and drink coffee. The other mother tells the boy to go and play. One woman talks to the boy. The round thing shows a ghost. They go and the boy plays and sees a big black snake and he throws the snake with sand. Then the snake spits at him. He then starts to cry and throws sand at the snake. Then the boy bit the snake and his mother looks for him for only ten minutes and they all feel very heart-broken because he is dead.

CAT. 24.

Then the child blew like this and the mother fell in the bath. Then the mother said "I am going to eat you and kill you." He went to sleep and his mother hit him on his head. Then mother went to sleep and he bit her on her ear but she did not see or hear him. Then he broke a window and went to sleep in a very small house where his

mother could not find him. Only he had the keys and he said "That one on the bed can die I do not worry."

Later he unlocked the door and mother wolf says "Why are you so big?" and he said "In the night I did not bite your leg off, I did not feel well." Mother said "I long to see you, I have done everything for you." But the boy did not tell her what he had done. He had stepped on two toads until they were dead and the blood spattered all over the place. "Here is the keys, "Voetsek," get away. I am very rich now and can look after myself." He threw the keys down and took a knife and made a big hole in the roof. He then hid himself and then the mother fell down.

CO. 5.

Here is a bird that flies with a child and everybody looks at them. He takes them to his nest with his children. He flies away with his babies. And he said "How am I ever going to get out of this tree? Nobody will look after me." The nest is of straw. Then he wanted to sleep because he wanted a house. And then he went to a toadstool and lay down under it. And a pig smelled at him and bit him and ate the stool. He cried and said "Piggy will you take me home?" and he said "No I will not." He then went to the bird and climbed up to the bird and said "Will you take me home?, you have brought me here." And it was dark and the bird was fast asleep, so he climbed higher. He dreamed but fell off the branch and was hurt. Then he said "Where am I now? I am going home. But where is my right home?" He again went to the bird and said "Take me home." He gave him a small piece of food. The mother thought "Where is he?"

He is gone. Who has taken him? I am now cross."

Then the bird did take him home and they knocked three times, but nobody opened. Then he said "Take me to a little hole in the mountain, then I will stay there and go on looking for a house for myself where I can be happy."

RORSCHACH (BEFORE THERAPY)

Card	Response	L.	S.	C.	Holtz	H	A
1	There is a leaf in a tree I do not see the tree	dr	Fo	Nat			
111	That is a window Face with cheek	W/S	Fo	Obj			
		D.	Fv	H Obj			
111	Face	W/S	Fo	H Obj			
IV	Fly, This is a toy fly	W	Fo	A			
V	Real fly. He can fly with his wings	W	FM	A.P.			
V1	Looks like a crocodile	W	F-	A	A2	h	a.
V11	Like rabbits	D	F	A			
V111	Lions	D	F	A		h	a.
	Camel face	dr	F	Ad			
	Man that sits	d	M	H			

RORSCHACH (BEFORE THERAPY) (Cont.)

Card	Response	L.	S.	C.	Holtz	H	A
1X	Lamb	D	Fv	H			
	Baboon	dr	Fv	A			a.
	Feet with long nails	dr	Fo	H det.		H	a.
X	Fly	D	F	A			
	Star	D	F	Star			
	Buck, it walks	d	FM	A			
	Slingshot that you						
	shoot with like this	D	F	Obj	A2	H	a.
	The sun, the sun is red	D	FC	Nat			
	Green leaves	D	CF	Plant			
	Looks like a snake						
	spitting	D	FM	A	A1	h	a.
	Looks like yellow,						
	what is yellow, some-						
	one's cheeks	d	CF	H det			
						7	6

RORSCHACH ANALYSIS BEFORE THERAPY (JOHNY)

Handling of Reality:

His reality testing is intact but he sees his reality very fragmented and cannot integrate it into a meaningful whole. Only the parts are there, the whole is still missing.

Self image:

His self image is not very clearly differentiated and he feels

as if he is looking through a shield. He is not very sure of himself.

Interpersonal relations:

He does not project much in this area. To him it is indiscriminate and superficial contact but he does not describe much about the kind of contact he has with people.

Relationship towards father:

His relation is somewhat unrealistic to him. He makes it unthreatening but also unreal - it is only a toy fly.

Relationship towards mother:

This relation is given at a very infantile level but when he is confronted with the emotional feelings towards the mother he does project aggression.

Sexuality:

Here again he does not project much of himself except that he gives an aggressive object that does indicate sexuality mixed with aggression.

Emotionality:

No affectional responses are given. He does however show strong emotions coupled with aggression which he feels are coming from his environment, but also with which he is acting on his environment.

THERAPY SESSION 1.

Johnny entered the play room very quickly and looked around as if he was totally at home in the new situation. He was told that he

could play with whatever he wanted to. He looked around undecidingly. The therapist moved to the sandpit and sat next to it playing with the sand. Johny also moved to the sandpit and started to play excluding the therapist totally.

For a while he only handled the toys and could not come to real play. He suddenly started telling the therapist of his holiday at the sea but in a way as if he was the only person who went there. Upon being asked, he said that the rest of the family did go but that none of them could do the things he did so they are not very important.

He asked the therapist as he was playing with an animal, whether she knew what kind of animal he wanted to be. He then proceeded to say that he wanted to be a very special kind of animal.

In front he wanted to be an elephant and his back must be a lion for then he would be the strongest animal in the world, who could hurt others without them being able to hurt him.

Suddenly he gave her a crocodile and said that she was the crocodile and that he was the horse in his stable and that the crocodile had to try to kill the horse. The therapist as the crocodile, tried to get into the stable but each time the horse kicked the crocodile and killed him. Johny repeated the game a few times and enjoyed it very much laughing as he killed the crocodile.

He changed the scene and made a pigsty in which there was a mother pig, a father pig and a baby pig. He was now able to come to full play, again almost forgetting about the therapist but talking the whole time as he played. The mother and father pig left the home

and locked the baby pig in. The baby got very cross and started eating right through his house and went out to look for his mother. He could not find her anywhere and went on looking until he came to a hippopotamus who looked nearly like his mother. He stayed with her and took her as his mother but was not very happy and cried and cried. Suddenly he laughed and said that he enjoyed it when the small pig cried because he liked it when people were hurt. He continued his play. The small pig found his mother and went with her, trying to sleep with her but there was no place for him.

As this was his first session, the therapist did not interpret anything and just allowed him to play freely, but it was obvious that he enjoyed the plight of the little pig nearly sadistically.

The therapist then moved over to the table with paper and paint and he immediately started painting. He drew in darker colours. He drew a man and a woman and a baby in a carriage. He identified the woman as the therapist and called himself the baby in the carriage. The motor car was in his picture again. At the bottom he drew a ghost. He did not verbalize much about his drawing. (See plate 2).

When he was told that the time was up, he became stubborn and did not want to leave the room. The therapist handled him firmly but assured him that he was coming again the next week. She also told him that he had an hour every week in which the playroom belonged to him and that he could then do whatever he liked except break things on purpose.

He left sticking out his tongue at her.

Plate 2.

The image of the Ghost.



DISCUSSION

Johnny entered the therapy session very easily because he had already had contact with the therapist in the diagnostic sessions and a very flimsy relationship did exist. He however did not trust her completely as he does not trust any adults who had shocked him in his trusting relationship in the past. This is also the reason why his play was very reality orientated at the start.

He only handled the toys as if he wanted to get security from the concreteness in his environment. He further handled his inner insecurity by making himself omnipotent. This is a sociopathic way of handling a stressful-reality.

In his play with the horse and crocodile he again tried to

establish his authority over the therapist and in this way tried to cope with the relationship that is growing between them. He feared involvement, but at the same time desperately needed it. Thus his need for control and his attempt at destroying the bond that he feels can destroy him. She was a crocodile but at the same time he invited her into his world, but he could only tolerate her if he was in control. The reason for this he gave in his next symbolic play. His father and mother had deserted him and he did not trust his new parents.

Then suddenly he moves emotionally, very quickly and quite unexpectedly. In his drawing he told her that he was prepared to enter into a new relationship but only if she would nurture him as a small baby. Subconsciously he seemed to know that he can only really learn to relate if he again developed from a baby emotionally.

This can be seen as a very successful session as on symbolic level an agreement was reached between Johny and the therapist to enter into the search of building trust and an emotional bond between them, that can become the bridge to normal emotions, feelings and norms between him and his world.

THERAPY SESSION 2.

For the first time Johny looked very unsure upon entering the playroom. He just looked aimlessly around.

T: "How would you like to play with something different today?"

Johny remained disinterested and only pulled up his shoulders.

T: "Come and see what I have in this big bucket. It is something with which you can play very nicely."

He moved towards her as she took some "Meloh doh" from the bucket and handed it to him. He took it and pressed it through his fingers. His face immediately lit up.

J: "Oh it is nearly like clay only it is cold and sticky, but I like it."

T: "Don't you want to play a special game with me today? You take this stuff and make something with it - a kind of story and then tell me the story."

Johny suddenly became very unsure and only pressed the stuff through his fingers.

J: "Ag, I never know what to make. I cannot make anything nice."

T: "It really sometimes feels as if one can do nothing right hay?"

J: "Yes, it will be ugly. Everything I do is ugly and I like it."

T: "Okay let's not try to make something nice, but let's try something totally different. Let's try making something as we feel. We try to let the clay speak for us. If we feel ugly, we make something ugly and enjoy it. We make whatever we like."

J: "Well that I can do."

For quite a while Johny only rolled the "meloh doh" in small pieces thinking deeply without saying anything.

J: "Ah, now I know, I am going to do it."

He started building a block like form and smiled the whole time while doing it. Time and again he let the "meloh doh" pass through his fingers just enjoying the sensation of it.

T: "Oh I wonder if I will ever guess what you are making? Or are you going to tell me. I think I am really too dumb to know what it is."

J: "This is a magic window. A very beautiful dream magic window. If you can move through him all your wishes will come true. He is in all the colours of the rainbow."

T: "Do you want to paint him so that he really looks like he is in your dreams?"

J: "Yes bring me all the colours."

Johny started by painting the window first red and then green but suddenly took the black and covered his window in black. In front of the window the ground is black but at the back it started to get green with yellow spots. (See plate 3).

T: "Yes you say this is a magic window that can make all your dreams come true. Let us try. Here my one hand is through now my next hand, my body and my legs. I am at the other side. It is beautiful. Don't you want to come and join me?"

J: "No, I cannot."

T: "Why not?"

J: "The darkness and the ghost are holding me."

T: "Give me your hand then I will help you."

J: "No your hand cannot reach me. I am alone and can never reach the other side."

T: "Come it is beautiful. Just try."

J: "No, no, I cannot."

T: "But do you want to come?"

J: "Yes but I cannot."

T: "Will you come one day Johnny?"

J: "I don't know, I cannot."

T: "Must I come and fetch you?"

J: "You cannot, nobody can. I have slipped too far."

T: "I will wait for you here until you are able to come."

J: "No I'll never be able to come."

T: "O.K. I will wait for you here, take your time for I know that one day you will be able to climb through to me. May we try next time?"

J: "I do not know."

T: "Oh Johnny, I know you will. I will wait for you."

Johnny just sat for a while then got up and kicked some of the toys and

sat down just handling some toys until the end of the session.

Plate 3.

The Magic Window



DISCUSSION

The "meloh doh" provided an outlet for Johnny's need for sensopathic play and at the beginning of the session he used the medium only in this way.

His basic need for a new life style is being projected in his image but he is realistic enough to know that he cannot easily obtain this new way of living. This is a very positive prognostic sign.

The therapist tried to lead him into fantasy so as to handle a new world. This is in line with the concept of Lubbers (op. cit.) that what is lived through in fantasy has a direct positive reaction

on the behaviour of the child. He is not able to follow her at this stage. It might be that he still does not trust her enough or that his real world is still so filled with anxiety and stress that he cannot leave it and enter into a world of fantasy.

The therapist is moving too fast for him and should have returned to him immediately. She is standing on the unknown sector of his life (van der Berg, 1970) and is trying to help him to explore it but he is not ready for it yet.

Johny is still upset and unsure, even after being assured that he will be able to handle a new reality in the future and that is why the therapist allows him to vent his aggression on the toys without moving to him.

The fact that he himself knows that there is another way of handling his reality and that there is a longing for it at this stage is very positive and shows that emotionally Johny is moving in therapy.

THERAPY SESSION 3.

Johny was much more relaxed upon entering the playroom but again stood aimlessly in the door. Upon asking what he was going to play with that day he shrugged his shoulders. He noticed the window that he had made the previous time and moved towards it. He looked at it and said in a proud voice.

J: "It is a nice thing hi, more beautiful than anything any other child has ever made here."

T: "It might be, but can you still remember the game we played with it last time?"

J: "Of course I know it is the magic window. Do you think I am stupid?"

He suddenly turned from the window and took a car, playing with it aimlessly. For a while he stood undecided and then moved to the doll's house. He rearranged the doll's house by placing all the furniture in one room only. When the therapist approached him he told her that it is a garage-house. The people that stayed here were very rich "for look at all their furniture."

He then took two child-dolls and placed them in the house. Then he looked in a superior manner to the therapist and commanded her:

"Woman, you stay home while I go and steal for you and the children."

With screeching brakes he left and arrived at a bank where he convinced the banker in a very manipulative way to hand over money to him. Outside the bank he laughed saying: "Ha, this one is too clever for any policeman to ever catch."

Arriving at the doll's house he threw the money at the therapist saying: "Woman, here are the money. Stop nagging me, otherwise I will chop you up with an axe."

T: "But my dear, where did you get so much money?"

J: "At the bank, where else? Remember you are talking to a very important man. Never forget that or you might be sorry."

T: "But what if the police catch you?"

J: "Ha, they can try but if they get near to me, I will shoot them all and then you will only see blood - a whole bath full."

T: "And if they catch you after that?"

J: "Oh you know today's jails are not very strong. Zip and I am out."

T: "But don't you feel sorry for the people whose money you have taken?"

J: "Never, if they have money in the bank they must be rich. I say: help yourself. Nobody else will help you. It is there for the taking."

T: "You feel one can take whatever he wants even if it belongs to somebody else?"

J: "Yes. Just be careful not to be caught. That's bad."

T: "Johnny do you think all people feel as you do about other people's property?"

J: "How should I know, I don't know all the people in the world."

T: "What kind of people do you know?"

J: "Only people that I hate because they can hurt me."

T: "Johnny you feel that people don't protect you, that they don't provide for your needs. That you are all alone?"

J: "Hm.."

At that stage Johnny looked at the floor and was beginning to withdraw and the therapist realized that the situation was becoming too threatening for him and left it at that. He got up, went to the sandpit and let the sand just slip through his fingers again.

The therapist sat at the side of the sandpit watching him. He got

up and stood very close to her and suddenly laughed. "Ha I had you fooled and worried. You thought I could really steal money. It is only a joke, man. Don't take it seriously."

T: "You are afraid that I will see you in a bad light."

J: "Perhaps ... but it does not really matter."

T: "Johnny it is not really true, is it? You do care what I think as deep down you do care what others think and feel about you. Let's make an agreement, we can even sign it. We promise to always try and tell each other what we really feel."

J: "My, that is a strange kind of game. How must I ever know how I feel?"

T: "But I think you can learn to know. How about by starting to tell me when you really get cross."

J: "I'll try. I can get very cross. Like a lion. Would you like to see that."

T: "Yes even that. I want to see and hear how you really feel."

He just laughed and was again reluctant to leave the playroom trying to manipulate the therapist in letting him stay.

DISCUSSION

Upon entering the playroom Johnny was looking for support and acceptance from the therapist. When the magic window, the symbol of

his deepest needs, was touched he withdrew as he was not able to work with it at that moment. His deprived background was projected in the way in which he arranged the doll's house. He again became very manipulative and made the therapist dependent upon him in his play because he was still very much afraid of becoming dependent upon her.

His total lack of social norms, as well as his strong aggression against society, was very eminent in his play.

When the core of his problem was touched and he realized that he already had revealed too much of himself he regressed to sensopathic play to find security. It seemed as if he wanted to get a grip on his reality through the contact with the sand. In the sand he had contact with his basic primitive needs.

It is clear that he had moved emotionally toward a relationship with the therapist, from his concern of what she thought of him. The fact that he did not want to leave the playroom was an indication that he did find security in the situation but that he still needed to revert to sociopathic manipulative means to get what he wanted.

Although Johnny still rejected nearly all social norms at that stage, the therapist did not go deeper into this as therapy was still at the stage where she was allowing him total free expression of his feelings and anxieties.

THERAPY SESSION 4.

Johnny entered the playroom with enthusiasm but again stood undecidedly once he was in the room. He looked at the therapist and sighed. After a few minutes he moved to the paint and started

mixing the paint himself. He refused any help. He then started to draw very slowly and deeply in thought.

He began by drawing the clouds and then a house with a sun. He said that it was Sunday afternoon. Everybody in the house was fast asleep. He himself was lying on a bed in one of the rooms. While he was asleep his stepmother entered and wanted to listen to the radio. There was no radio only a piano. So for a while she played on the piano, but did not like it. So she looked around and saw Johnny on his bed and turned him into a radio and then enjoyed listening to it.

Outside there were fruit on the trees but the windghost came and blew everything away. The father was outside and rode away in his motor car. (See plate 4).

Upon finishing his drawing Johnny stood back and looked at it perplexed.

T: "Johnny do you feel that grownups can do to children whatever they want to?"

J: "What do you mean. I don't know or I think you are right.

That is precisely what I think."

T: "Like turning children into radios for their own needs."

J: "Laughingly ... if they are very strong, yes."

T: "In other words you feel that they are very strong and you can do nothing against them."

J: "Perhaps."

T: " That they can push you around as they want to.

J: "They have done it."

T: "I know Johny and I feel you have a right to feel very angry with big people for they have hurt you very deeply."

He did not reply to this. He just kept looking at his drawing.

T: "And the ghost?"

J: "It is the same ghost that wanted to grab the baby."

T: "Oh, I see and what do the nasty thing wants to do today?"

J: "I don't know. He is just always there. Part of it."

T: "Just a ghost without a name."

J: "No Windghost, big fat Windghost."

T: "I think we will have to deal with him one day too."

J: "Oh, I don't know."

T: "I hope that one day you and I together will catch him and put him into a cage.

Johny only remarked on how fast the time had passed but left the therapy-room without objecting.

Plate 4.

A chaotic Sunday afternoon.



DISCUSSION

In his images he revealed his threatened world. A world full of clouds (anxiety) and ghosts that threatened him from the outside. Also in his house he experienced no security but felt himself at the mercy of adults that can do to him whatever they wanted to. Even the construction of his drawing reflected on his chaotic life. He himself did not see at that stage any solution to his problems.

When Johny left the playroom, the social worker was outside waiting for him and reported to the therapist that Johny was very naughty. He took a knife and cut his stepmother's new dining-room chairs upholstery into small pieces. The therapist tried to handle it but Johny immediately ran off swearing and cursing them all.

THERAPY SESSION 5.

Johnny entered the playroom without greeting the therapist and looked at her defiantly, without saying a word. The therapist could see that he was aggressive. She greeted him in a friendly way, but he ignored it and went to the "meloh doh" and took a piece out of the bucket. The therapist sat down at the table next to him without saying a word. For a long while he only rolled the "meloh doh" and played with it in a purposeless way.

The therapist started mixing the paint and put it, together with a clean piece of paper, on the table in front of him. She gave him all the colours but purposely did not give him a brush.

Johnny started to model a house out of the "meloh doh" and placed it on the paper and for the first time looked up at the therapist who only smiled at him without saying a word. He then modelled a man, whom he placed next to the house. Although he did not say a word, he was watching the therapist with side glances.

Suddenly he said very aggressively.

J: "It is not me and not my house. Just a child you know, just any child and any house."

T: "Why?"

J: "Because it is ugly. Nothing is beautiful. Not the house, not the child. This place is ugly too. Nothing do you hear me. Nothing."

T: "Johnny you are very cross with everybody today."

J: "Yes I hate all people."

T: "Including me?"

J: "Yes including you. You are a person too."

T: "If I may ask, why?"

He gave no answer, but banged his hand against the table. The therapist looked at him for a while then put her finger into the paint and started to colour in his picture. He followed her, starting with light blue colours followed by purple, brown and red. As with his first contact with the "meloh doh" it was evident that he enjoyed the sensopathic aspect of the finger painting. He proceeded to colour in the whole painting and seemed to enjoy it.

Suddenly he dipped his hands in the paint and started to sprinkle it over the therapist.

T: "Johnny you know I don't like it if you sprinkle the paint on me."

He carried on laughingly, upon which the therapist took his hands firmly in hers saying:

T: "Johnny one does not do unto other people things that you would not like them to do unto you. So stop this immediately."

He withdrew from her screaming:

J: "You are very ugly and I hate you. You are like all the other people."

T: "Johny I can understand that you are very cross with me. But I know that it is not really pleasant for you to hurt me, so I am going to help you not to hurt me or to hurt yourself in the process."

Johny stared at the therapist and it was evident that he was very cross. He suddenly grabbed his drawing, pulled the man and house from the paper and threw it at the therapist. He then dipped his hands in the paint and smeared it on the paper while screaming: (See plate 5).

J: "You nasty bastards. I hate you all. You say I am naughty. I will show you."

It seemed as if at this stage he lost complete control and started to throw the paint against the walls as he was screaming and swearing at the therapist. The therapist moved towards him, put her hands protectively around him and held him against her breast. For a moment it seemed as if he wanted to yield to her embrace, but the next moment he pushed her away and ran out of the room. The therapist did not follow him. A few minutes later he was standing against the social worker's car as if nothing had happened at all. The therapist requested of the social worker to ignore the incident and not mention it to Johny at all.

Plate 5.

Total loss of Control.



DISCUSSION

This session was an illustration of the total disorganized world of this little boy. He entered the therapy with reservation but also with a need to project his images.

Up to now Johny had started to build a relationship with the therapist, which may have been too threatening to him. Thus, not to get too deeply emotionally involved, he had to reject the therapist. It may also be that at this stage he had enough trust in the therapist to test their relationship. He may also have asked himself the question whether the therapist was really different from other adults in his life and was now testing this question before he could allow himself to become deeper involved with her.

When the therapist set limits, he became very aggressive and lost total control over himself and acted in a very impulsive way, showing his low frustration tolerance. When the therapist took him into her arms in a protective way instead of scolding or reprimanding him, it totally confused him and he had to flee from this close encounter with an accepting and even loving adult, which was too threatening to him.

The therapist allowed him to escape, as all people had always seemed to follow him when he had misbehaved in the past. She allowed him the freedom of choice to move out of the threatening situation, but also the possibility to move back into it, when he could handle it. In the playroom, the limits were set in a constructive loving and accepting way and as this was totally foreign to him it had to be very threatening. This was in line with the principles laid down by Moustakkas (op. cit.).

The fact that the social worker said at the end of the previous session that Johnny was naughty in his presence, may have caused this outburst. This may have been his way of asking the therapist whether she agreed with the opinion all others had had of him.

For the therapist herself this session was very taxing and exhaustive, as she had to meet total rejection and aggression with acceptance and love. At the end of this session she asked herself the question whether this child was really reachable by therapy.

THERAPY SESSION 6.

Upon calling his name, he spontaneously moved towards the therapist

and for the first time, put his hand into hers as they moved towards the playroom. Upon entering the playroom, he again stood looking around as if he could not decide what to do.

T: "What are we going to do today?"

The therapist ignored his reaction of the previous session and accepted him as he entered the room that day. He ignored her question and went to the "meloh doh" and took out a piece. It seemed as if "meloh doh" had a tremendous sensopathic value for this child. Although he was still unable to acknowledge it, this medium represented a strong desire for nurturing and mothering, which he had never really experienced.

As he was kneading the clay, the therapist started to mix the paint and placed a clean piece of paper in front of him. For quite a while he palyed aimlessly with the "meloh doh." Suddenly he asked:

J: "Can I really make whatever I like?"

T: "Yes, Johny, anything you want to make, you can."

J: "Even a very ugly little house?"

T: "Yes, if you feel like making a very ugly house today, you may."

J: "And if I feel like it can I break it in little pieces again?"

T: "Johny do you feel that I am cross with you for doing just that last time?"

J: "I don't really know. Everybody is always cross with me."

T: "Do you think I was cross with you last time?"

J: "I don't no you held me very close and did not hit me."

T: "How did you feel when I held you?"

J: "I don't know. Afraid, very much afraid. I could feel you were holding me differently. Not as if you wanted to hit me. That made me very much afraid. I am afraid if somebody holds me like that."

T: "And that was the reason why you had to run away?"

J: "Yes and you did not follow me to give me a hiding."

T: "Johny, do you know why you are coming here to the clinic every week?"

J: "Because they say I am naughty."

T: "And why do you yourself think you are coming here?"

J: "I don't know and I don't care."

T: "If we do things that others call naughty, do you think we are actually naughty?"

J: "How must I know man. Everybody always says I am naughty."

T: "But you don't agree with them. You feel very cross and angry with the people that call you naughty, hay?"

J: "Himm."

T: "There are a lot of things that you do that are very upsetting to others and to yourself, but it does not mean that you are actually naughty. Together we are going to try and find out why you do these things and then we are going to catch them and tie them like thieves so they can no longer bother you."

J: "You talk so strange. How can one catch naughtiness? One is naughty you just do naughty things."

T: "Yes I know, but in a play-play way we are going to catch them and deal with them."

J: "Oh like the cowboys catches the crooks and put them into jail and kills them all?"

T: "Yes, but my, today you are making a really nice little house. Who is the little boy standing next to the house?"

J: "(Laughingly) "It is me, can't you see and it is my very own house."

He coloured in the house with pastel colours. The sun was shining and blue birds were flying high in the air. (See plate 6).

J: "Oh, I forgot to make something."

T: "I wonder what it can be?"

He proceeded by drawing a woman next to the house.

J: "That's you. This is our very special house where we are going to live together."

T: "It really is a beautiful house. Next time we are going to enter the house and see what goes on inside. What do you say?"

J: "Yes, but I don't want to go now."

T: "I know you don't want to go, that you want to stay with me in our lovely house and I would really have liked to have you here longer, but we have agreed upon the time, and your time is up. But next time I will be here, waiting for you. But I have got something very special for you."

The therapist got up and took out a little soft monkey.

T: "Johnny, I have a very special friend for you here. You must give him a name. He can become your friend to whom you can tell whatever your feelings are, cross or happy or sad, You can even hit him when you are cross or kiss him when you feel like it. But you must promise me one thing. You must take him to bed every night and tell him what has happened to you during the day. He is your special friend when I am not there."

Johnny looked very perplexed but took the monkey. It seemed that for once Johnny did not know what to say. He greeted and went out of the therapy room, clutching the monkey.

Plate 6.

The beginning of a New Relationship.



DISCUSSION

Although the previous session had ended very dramatically, Johny approached the therapist this time as if nothing had happened. In contrast, he took her hand as if to show his willingness to co-operate. He showed her that he can co-operate but only if the initiative for co-operation proceeded from him.

In the playroom he took control by selecting his own medium. In his images, he came to his behaviour the previous session by himself. He tried to communicate to the therapist his fears that she was also going to reject him. He needed verbal assurance from her that she was totally and unconditionally accepting him. The therapist reacted to this unconscious need of him. She subtly led him to understand her

reaction in the previous session. He then told her in his actions that he was not yet ready for a close emotional binding with her as it was still too threatening for him.

The therapist then confronted him with the question of why he was coming for therapy. This question is usually dealt with very early in therapy, but in this case a relationship had to be built before it could be discussed. Johnny acknowledged that he was aware of his basic problems but at the same time distanced himself from it.

In this session the therapist contracted with him to enter therapy. Until then their interaction had been organized by others, but from then on it would be a therapeutic association.

Immediately after that contracting, he acknowledged his images as his own. The subject became himself and the place his own house. He even proceeded a step further by including the therapist in his world.

His house was now rich and full of life, but the windows told a story of a growing dependency.

The use of light pastel colours indicated that he was trying to gain emotional control over his reality. Even the blue birds were symbolic of the amount of control that was necessary to integrate his life into a meaningful oneness. Only the therapist was drawn in bright red colour symbolizing the need for affection from her that was unconsciously growing in him.

Also in his drawing of a tree, he was fighting for control over his feelings of omnipotence.

At the end of the session he again tried to manipulate the situation. The therapist reminded him of their agreement and gave him a symbol of their relationship. This transitional object had to be used

from then on by him as a mediator between him and his other relations. He accepted it without commentary and left the room without objecting. It was an object of trust and a symbol of their relationship.

This was one of the most significant sessions up till then as the therapist and Johnny have constructed their relationship verbally.

THERAPY SESSION 7.

Johnny was waiting in front of the playroom door and immediately came in when the therapist opened the door. He greeted her very friendly and was more at home than in any of the previous sessions. He immediately went to the doll's house and started arranging it.

In a previous session he had only used one room whereas he was now using the whole doll's house but the arrangement of his furniture was still in a very unorganized way.

He placed two boys and two mothers in the doll's house. It was evening and they were asleep. The moon was shining but suddenly disappeared behind a cloud. The youngest of the two boys got up and wanted to show his mother the big snake that was sleeping with him in his bed. When he reached his mother's bed, he noticed that his snake was shining in the moonlight. His mother allowed him to get into bed with her, with his snake. They slept for a while, but when the boy woke up his mother was gone. In the other room he found the other mother and showed her his snake. She got very cross and killed his snake in a bloodthirsty way. The boy screamed and scolded her, telling her it was a tame snake, and that it was his very own snake that she had killed.

The boy went outside and climbed into a tree with a big stone in his hands waiting, until morning. When the mother came out of the house he killed her with the stone. Her blood ran in a stream down the road. He was then very happy because his mother, who had killed the snake, was dead. He then went into the home and baked a big cake that he ate all by himself.

Johny played, verbalizing the whole time as if the therapist was non-existent. It seemed as if he was in a world of his own. While he was busy eating the cake in his play-world, the therapist entered requesting a piece for herself.

J: "Oh, it is you young lady. Come and join me. Outside my house you will find a nasty old lady that has killed my snake, and now she is dead."

T: "Your snake, what was its name?"

J: "Oh, just Snake, but he was my friend, and I don't allow anybody to kill my friends."

T: "What did this snake do?"

J: "It seems to me you are stupid, man. What does a snake usually do?"

T: "It's just that I don't know your snake."

J: "Oh, but I can't describe him to you now."

T: "Never mind, I will meet him one day. But what about the dead woman? The police may arrive any moment. One cannot go about killing people."

J: "But she killed first and then you are allowed to kill also. You can do whatever you like to people if they are nasty to you."

T: "What do you mean Johnny?"

J: "I can't explain, you know man."

T: "You feel that they have taken something from you that meant a lot to you?"

J: "Hmmm."

T: "And you feel that your mother who knew that it was important to you, has also deserted you?"

J: "She did, she never wanted me, and auntie X says I am naughty. She does not want me either. I hate her."

T: "What kind of naughty things does she say you do?"

J: "She says I play nasty with little girls."

T: "Do you agree with her?"

J: "I don't know."

T: "Is it possible that it might be your snake she is trying to take away from you?"

J: "Man I told you I don't know. Will you stop it or I am going to hit you."

T: "You are not going to hit me Johnny but I can see it is upsetting

for you to talk about these things so we shall leave it for today."

J: "You are also nasty and ugly and I want to kill you as well."

T: "You feel very cross with me for I want to know too much about you."

J: "Remember if I get cross I get very cross."

T: "And then you scare everybody away and upset them in this way. But here you are allowed to get very cross. I am not going to be upset by you, nor am I going to scold you for getting very cross."

J: "Ag, I am tired I want to go."

T: "O.K. Johnny you may go, the coice is yours. I'll be seeing you next week."

He jumped up, threw the doll he still had in his hands against the wall, stormed out of the room and slammed the door.

DISCUSSION

Johnny was very relaxed when he entered the playroom. He again immediately took control of the situation and started playing with the doll's house. He became so involved in his playworld that he became nearly unaware of the therapist. She allowed him to play freely and observed and listened to his verbalizations.

In his play he for the first time represented in psycho-analytic terms, his sexual problems. His own mother allowed him sexual play with her - accepting his snake -, but his new mother refused it - killing his snake. He is aggressive against both mother figures for

both have rejected him in some way. He allowed his aggression to come out freely and killed his mother in a bloodthirsty, nearly sadistic way. No guilt feeling was present.

When the therapist entered his play-world he accepted her without questioning and used her as part of his play.

He was however not yet able to handle his symbols. This was the reason for his aggression when the therapist moved too quickly for him. He immediately tried to gain control of the situation by letting the therapist know that up to now he was able to handle any threat with aggression and was going to try it now again. The therapist put it to him clearly that she was not going to react like the adults he had known till then. She was not threatened by his aggression and was not going to be manipulated by it. Although he objected to her behaviour he did not lose control and acted aggressively like in the past. He rather opted out of the situation which in this case was a more positive way of handling the stress. It is still a negative way of reacting but far more positive than any behavioral reaction of him in a stressful situation in the past.

There was growth in the therapy as Johnny at that stage was dealing more directly with his problems in his play-world. In his images he had started to relay his problems to the therapist, but was still unable to work with them or to handle them.

The therapy demanded a great amount of observation and contact with the child from the therapist in order to enable her to move with Johnny and not faster than what he was capable of handling.

THERAPY SESSION 8.

Johny was not in the waiting room when the therapist called him. She found him outside on the jungle-gym. She went to him and called him, but he looked at her in a defiant manner and went on swinging. She went up to him, touched him and said:

"Johny, I am going to the playroom. You have the choice to stay here as long as you want but I shall only be in the playroom for the hour upon which we have agreed. The time you spend here will be subtracted from the time available to you."

She went to the playroom and Johny proceeded playing as if he did not hear her. After a quarter of an hour he came into the playroom as if nothing had happened. Upon entering he said:

J: "Man, have you not mixed the paint yet?"

T: "No, I first wanted to see what a little boy with the name Johny was going to do."

J: "Ag, you knew I would come. So make the paint immediately."

T: "It seems to me as if you are cross with me again."

J: "Hmm, yes, of course. I can get cross with whomever and whenever I like."

T: "Even if the other person has done nothing to provoke you?"

J: "Yes, man. But will you mix the paint now?"

T: "But I think you are capable of doing it yourself."

J: "I will get very cross with you again and hit you."

T: "No Johnny, you are not going to do such a thing. You know it is not a solution and by the way I repeat I am not going to get cross with you or get upset when you get cross."

At this stage it was clear that Johnny was going to lose control. He was looking around him for something to attack the therapist with. He grabbed a bow and started lashing out at her. She took the bow firmly from him and held him against her. He screamed and fought her, but she held him gently but firmly until he slowly relaxed and allowed her to caress him. One could see that he was fighting against himself because this close bodily contact was threatening to him. He did not want to show the therapist how he was experiencing this close body-communication. He got up and stared at her.

She went to the paint and put the powder in the buckets and called at him to mix it. For a while he looked defiantly at her, then suddenly took the powder and mixed it.

He again first drew a house in yellow and then a boy whom he identified as himself. On the other side was an auntie, whom he identified as his foster-mother. He said that he likes his new house but enjoyed it more when he was alone in the house.

Again he drew the blue birds and himself wrote Johnny above the one figure and "auntie" above the others. (See plate 7).

He himself greeted the therapist upon finishing his drawing and left the room as if nothing had ever happened.

Plate 7.

Johny and his foster mother.



DISCUSSION

Johny still had a need to demonstrate to the therapist his autonomy and even power to control a situation. He went on playing after being called. The therapist acknowledged his right to choose to enter therapy but stood very firm in setting the limits of time. She will be available to him but only within the set agreement between them.

Upon entering the playroom he again tried to control her by dictating to her to try and prove his power over her. When she opposed him, he again lost control and acted out his aggression and frustration in a very impulsive way. He channelled it directly at the therapist who was acting as control for his still immature and unstructured ego.

He calmed down with direct physical comforting, but did not show any positive emotional reaction towards her. He wanted to continue his fight against her but suddenly submitted and mixed the paint.

In contrast to the neurotic child, who would have been unable to project freely after such a confrontation, he started drawing as if nothing had happened. This is typical of the unpredictable behaviour of the sociopathic child. Uncontrollable impulsive rage may break forth under the slightest provocation, to change suddenly into a don't-care attitude or to act as if nothing had happened at all. The intensity of Johnny's emotional experiences at this stage was high, although the content was still negative. It seemed as if he could not react positively, even on very strong positive emotions demonstrated towards him.

In looking at his image, one could see from the yellow of his house that symbolically he still saw his environment as threatening and that he had strong feeling that he needed to cover up his life and his deeds against any critical onslaught from outside. Also the step-mother that, was drawn in yellow, was symbolic of his strong aggressive feelings that he still had against her. Drawing himself in pink, symbolised his need for control over the aggressive feelings he had. The whole drawing is still very expansive and projected Johnny's feelings of omnipotence that was present. At the same time he was conscious that the adult world had a controlling influence, for the aunty was at least the same size as he was. High above all reigned the blue birds as symbols of his control over everything.

He identified very strongly with his images. Previously he had

said emphatically that he was not the boy in the drawings, but now he so strongly identified with him, that he wrote his name above the boy. This was his way of showing his willingness to work in his images with his problems.

Although the session could be considered full of aggression, Johnny did submit himself willingly to the limits set by the therapist. This was a total new experience for him and thus growth stimulating. To him it might still have meant that he could gain control by submission. Inner ego-control did not exist yet, thus the therapist had to act as a controlling ego from the outside for him. She still had to do it in the most direct way, with bodily communication, for he was still unreachable at emotional level. She, in other words, let him to regress to a sensopathic experience with a mother figure. It seemed as if, even at that stage, that basic communication was still disturbing to him. From now on she would allow him to grow in emotional experiences until he might be able to handle and experience the most subtle positive emotions.

THERAPY SESSION 9.

Johnny was waiting at the door of the waiting-room and promptly greeted the therapist in a very friendly manner. He talked about school, reporting that he was doing much better in his arithmetic.

In the playroom he immediately started to mix the paint. He took some paper for himself, stating that he wanted to draw on red paper that day. For a few minutes he looked hesitatingly at the paint and then shook his head saying that it would never work to use paint on a

red paper. He himself then went and fetched the pastels.

He drew different coloured block with a man, a woman and a little boy in the lower corner of the paper. They were holding hands but the little boy was still cut off from them by a separating white line. He volunteered the following story without prompting. The black was the ghosts that wanted to catch the little boy. (It was the first time that he himself had used the term "little boy".) The yellow was the house, to which the boy could run, but it did not have doors everywhere. The blue was the good fairy who wanted to protect the boy from the black ghosts. The good fairy also assisted the mother and the father to hold onto the boy as to prevent the ghost from grabbing him. (See plate 8).

Johny enjoyed this session tremendously to the extent that the therapist felt that no interpretation was needed as the living through of the experience in his fantasy and images was enough for that session. He left the playroom without any resistance.

Plate 8.

Fairies and Ghosts.



DISCUSSION

In his drawing Johnny depicted more than ever his chaotic world - a world in which the destructive forces intermingled with the positive counteracting forces. He, as child, is forced into a small corner, from where he could only clutch unto adults. For the first time he acknowledged his dependence upon adults and by doing that, denounced his feeling of omnipotence. He is now in the process of symbol-formation in his relationships. Only by becoming the small dependent child first of a few months old, could he get into contact with his basic symbolic relations. This was not regression but a handling of his reality in the here and now. This was existential play therapy and not psycho-analytic play therapy. However, by becoming dependent and small, his world became overwhelming. The house, in which he had to stay, was drawn in yellow, symbolizing the threatening aspect thereof. Also, he was not yet sure that the doors were always open to him. The good fairy was blue, symbolizing his strong need for emotional and inner control. It seemed as if he was becoming more and more aware of his need for emotional control, and realizing that this was one of his basic problems. In control over himself he was seeing his only hope. It seemed as if he was moving slowly away from the sociopathic omnipotent control over his environment, to a need for inner control, signifying the acceptance and integration of social norms into his growing personality. The black destructive ghost was still present, but the softer blue controlling forces were gaining ground. Intermingled for the first time, was green, symbolizing his need for security. What was of note, was that the green culminated in the father figure, whom he also drew in green.

There was still no direct contact with the father figure, but Johnny drew himself smaller than the father, signifying thereby his dependence upon him. For the first time there was direct contact with the mother figure, although still through a barrier. Strong animation of his world still existed, depicting that he was functioning at a lower emotional level than his chronological age.

The overflow of colours over his total life-space (the page) symbolized his present uncontrollable emotional reactivity to his environment. The red life space depicted his strong need for a warm accepting environment in which he could attain control over himself.

Although he first chose paint and afterwards pastels, it was allowed by the therapist, as this was not purposeful waste of material but part of Johnny's impulsiveness.

INTERVIEW WITH FOSTER MOTHER

The day before the next therapy session, his stepmother made an appointment to come and see the therapist. She mentioned that Johnny's parents saw him during the week-end and had caused him to react in a total uncontrollable way. He had on two occasions assaulted his stepmother and even threatened her with a knife the day before. He was swearing and screaming and breaking things and had refused to attend school. On being questioned, his stepmother mentioned that he did not constantly behave in such a manner. He usually played quietly by himself but would react violently if he did not get what he wanted in the least. She was totally at her wits end and felt as if she could now reject him completely. The therapist supported her but also tried to

encourage her to give more affection to Johnny. She again stressed that discipline of an accepting nature was very necessary for him.

The stepmother also mentioned that at times there was a positive improvement but that he was utterly unpredictable, and impulsive.

Upon being asked she replied that he was sleeping with his monkey and that she herself has heard him speaking to it at night. He did not allow anybody to touch it and put it into his bed during the day. So it seemed as if he was slowly building a relationship with the transitional object.

THERAPY SESSION 10.

While walking to the waiting room the therapist heard a boy screaming and was told that Johnny had lashed out at a little boy for no reason at all. He was not in the waiting room and she was told that he had run outside. She went to the playroom and waited for him inside, leaving the door open as a sign that he could come in himself if he wanted to. After about a quarter of an hour he came running in slamming the door behind him. He stood against the door looking defiantly at her. She greeted him and then waited for him to act. He first went to the toys and handled them aimlessly as if he was fighting very hard to get control over himself. He turned his back towards the therapist and started to throw a ball in the air and catch it again. Then for quite a time, he held the ball in his hand as if he was deep in thought. He then suddenly turned around, threw down the ball and went to the paint and paper. He selected a blue paper and some colouring pens. He placed the paper on the table next to the therapist and sat down starting indecisively as if he was trying to get a clear picture in

his mind of what he wanted to draw.

He first drew a house with a little boy next to it. Next to the boy he drew a windswept tree and an overwhelming large man with a whip in his hand. He then drew small little stripes around the tree and the boy. (See plate 9).

At this stage the therapist moved towards him and sat down next to him asking:

T: "It seems to me as if you are trying to tell me something today.

Do you want to talk about it?"

For a few minutes he stared at his own drawing as if he himself was trying to comprehend what he had given in his images.

J: "It is a story. Remember just a story. There is no truth in it.

It was night and it was very cold. The wind blew and it rained and rained. There was a big bad father who drank and drank. And the mother was gallivanting on the streets and the little boy was all alone in the house. And the wind blew harder and harder and the whole place was full of rain. It was very, very cold. The little boy was freezing and asked the father to close the door, but the father grabbed him and swore at him and threw him out of the door into the cold. He had to sleep all alone in the freezing cold outside. And the wind got stronger and then it rained more and more and it was getting colder and colder, and very, very dark and the little boy had to sleep in all that. But the boy was not afraid, for one day he would be bigger and stronger than all the fathers and then he would kill all fathers and allow them

to freeze to death and he was laughing and laughing, thinking how nice it would be to kill the father."

T: "Wow, Johnny, I think it must be a bad and nasty father that does a thing like that to a little boy. Do you think all fathers are like that?"

J: "All drunkards of fathers yes but I don't know."

T: "When your father was nasty to you, did you ever feel like killing him?"

He looked up surprised but when he saw that the therapist looked at him unshocked and accepting, he answered without much feeling.

J: "Yes, I hate him. He hates me and I hate him. One day I'll kill him."

T: "Johnny, I know that you have seen your father again last week-end. Don't you want to tell me what happened at home when you visited them?"

J: "I'll tell you but only you, do you hear? My father hit me again like he always does and he and my mother fought the whole night and I had to sleep on the stoep."

T: "How did that make you feel inside?"

J: "Cross, very cross. I hate him! I hate him!"

T: "Have you ever felt sorry for him?"

J: "No I hate him. I never want to see him again. He is ugly and nasty."

T: "I understand Johnny. He has hurt you deeply and very badly but you will do the same if you have so much hatred in your small heart."

J: "I don't care. I want to hate. I will hate and hurt other people as they have hurt me. I like to hate."

T: "Johnny, do you remember that we agreed that together we were going to catch the ugly things that cause unhappiness in you? One of them is hatred. But I cannot catch your hatred alone. You must help me."

J: "I don't know. I tell you, I don't know. Don't go for me now. Leave me. I want to hate right now."

T: "I understand, but later together we will catch him. Do you agree?"

J: "Hmmm...."

For a time he sat scribbling on the paper, deep in thought. When he was told that the time was up he left the playroom without saying goodbye.

Plate 9.

Alone in the Storm.



DISCUSSION

Johnny was still very aggressive upon coming to therapy, demonstrating it by bullying the children in the playroom. He withdrew however from an immediate confrontation with the therapist. Again the therapist gave him the choice of entering therapy or leaving it. The open door as well as the fact that she was sitting in the playroom, doing nothing, assured him that she was giving him the freedom to come into therapy once he was ready for it.

He entered the therapy session with the expectation of being scolded, but instead was greeted in a friendly way by the therapist. This unguarded him and he had to regain control of the situation as he was used to control his environment by aggression and he met by

counter aggression from his environment. The game with the ball symbolized his inner struggle with himself. In this confrontation with himself he cut out the therapist completely, by turning his back on her.

He voluntarily entered into projection of his image. The choice of the blue life space, indicated his struggle for inward and outward control as he had just experienced it. Even his house was blue, showing his unconscious need of control over his total life sphere, which he no longer could get successfully by using aggression. He felt very small in that situation and was the prey of overwhelming destructive forces around him. It seemed as if, when he controlled (the blue) his aggression, he became very small and vulnerable. The storm however became overwhelming and he had to answer with the only defence he knew, aggression, and hate.

He, to a certain extent, was willing to accept his images and identify with them, but to handle and work with his aggression was still too threatening to him. For, if at this stage he had to deny his aggression, he would have had no other defence.

What was very meaningful was the fact that although, for the whole week he was overtly aggressive, he was able to handle his aggression in a symbolic and therapeutic way in the playroom and not lose control like in the past. Here in the safe supportive situation, he was beginning to be able to exert control over his aggression. He rather left the situation, than to compromise or lose his control.

THERAPY SESSION 11.

Johny entered the room promptly and greeted the therapist in a friendly manner. He told her how they had to rush to the clinic to

be on time and that he had enjoyed it very much. He said that he wanted to make a very big and more beautiful picture than all that of the other children that day.

He chose a yellow paper. He took the colouring pens and started to draw very slowly and in deep concentration. He again started by drawing the house but it was done in a bright red colour. There was a road leading to the house but the house itself still had no door. Next to the house he drew a mother with red hair and a green dress. On the one side was a big bloodthirsty wolf with a small black house behind him. Right in front he drew a little boy, which he later changed into a girl, who was picking flowers. He told the following story:

"A little girl went out to pick flowers for her mother. But on her way she met a big bad bloodthirsty wolf who wanted to catch her and she was very much afraid. But she could not go to her house for the old house was very far and black and dark. The new house had no door. The wolf laughed at her and showed her his teeth and she was very much afraid of him." (See plate 10).

T: "How on earth will she escape the big bad wolf?"

J: "Oh, that I don't know. Wolf is very strong and he will catch her and eat her."

T: "Can nobody go to her help? Perhaps if she screams real hard somebody will go and help her. Let her scream for help."

J: "Help, the big bad wolf is here and wants to catch me. Help, help!"

T: "I will help you."

J: "Who are you? Do you perhaps think that you are stronger than the big bad wolf?"

T: "No, I am not stronger, but if you come to me the wolf will not be able to grab you away again. Come to my home."

J: "But who are you?"

T: "I am your mother. I want to protect you."

J: "My new mother? But I don't have a mother. I am alone, left in the forest all alone."

T: "No Johnny, I am going to be your mother. Come here, I will protect you."

J: "I don't know. I still fear you too. How do I know that you also, will not throw me away again and leave me for the wolf to have a nice breakfast on?"

T: "No, I will not. Come to me."

J: "But your house has got no door. How do you think we are going to get in?"

T: "O.K. Johnny, do you see the tree near your house? Get into the tree and wait there until I have had time to put a door on the house."

J: "O.K. Here I go. And from the tree I'll watch until your house has

got a door so we can enter and get safely away from the big bad wolf."

T: "I agree. Next week we may go and have a look inside the house if you would like it."

J: "O.K....."

Johny left the playroom without protest, but returned immediately, looked around the door and said: "I'll be good", and then slammed the door close.

Plate 10.

The Big Bad Wolf.



DISCUSSION

Johnny entered the therapy in a much more co-operative fashion than before. He was beginning to show that he wanted the attention of the therapist for him alone by indicating to her that he was going to make a better picture than all the other children. This was an indication of positive growth, as it indicated that a small spark of affection was developing. For him it was the start of concern over another -person's feelings towards him. It is a relationship in the here and now. A situation where he can test to give and accept love.

For the first time he drew his house in a warm red, indicating thereby his need for warmth and affection in his environment. But the house was still inaccessible, closed. Only the need for affection was depicted, the satisfaction of this need was still for him unobtainable. The road led to it but the entrance to the satisfaction of this need was still closed.

The mother figure was also drawn with red hair and was wearing a green dress, symbolizing his need for security and the absence of anxiety.

He was starting to look for security and warmth from other people, but by doing this, he had become very small and insignificant and nearly lost his identity in a world full of destructive forces.

His omnipotent feelings had disappeared and this made him defenceless. In Auseble's terms, he now had to find a satellising figure in order to reconstruct his already badly damaged ego. Unconsciously he knew this and from this realization stemmed his drawing of that mother figure. Flowers, that died at his old house, were beginning to grow as a symbol of hopefulness.

The therapist tried to lead him to the mother figure in his own image-language, but he was still so threatened of affectional binding, that he could not move freely towards her. It was the adult-world that had shocked him into a cold feelingless world, and now he was waiting for an adult to find him and lead him slowly back to accepting and experiencing feelings without anxiety (Lubbers op. cit.). He was slowly starting to acknowledge his need for affection but was very cautious in accepting it before he was sure that what he was offered, was not a serogate for real love and acceptance.

One could clearly see that his ego was growing and that reconstruction thereof was taking place. He was losing his omnipotence and was focussing on the more subtle parts of affection. His control was also much better in the playroom.

THERAPY SESSION 12.

Johny entered the playroom in a friendly manner. The mistrust and defiant way in which he used to look at the therapist had changed into a playful manner.

He asked to look at his pictures. He looked at them one by one without saying anything until he came to the picture that he had smeared when he lost total control. He suddenly asked:

J: "Do you think this one is nice?"

T: "No Johny I don't think so. I think it is an ugly picture. As ugly as you felt that day. Very cross and afraid of everything."

J: "Hmm... That's right. You know, I know now that you don't tell

lies to me. At school when I make something ugly on purpose and ask my teacher about it, she says it's beautiful. Auntie also tells me that things are nice when it isn't. I know they lie to me."

T: "You were afraid that I would do the same. That I would also lie to you?"

J: "Yes I think so, but now I know that you would not lie to me."

T: "And now you know I will not lie about all the other things we have already discussed."

J: "You are very clever. You always know what I want to ask."

T: "You feel that I understand you."

J: "In the beginning I thought you are going to be cross with me and would punish me."

T: "And now?"

J: "No man, now I know. I don't know how to put it. I just know."

He put his drawing away, mixed the paint and started drawing as if he had already thought out what to draw. He again started with the house, which he drew in green. On the one side he drew a man in yellow and a woman in blue. Above was his birds again, but this time in yellow. In front of the house all the flowers had died. He made small stripes on the man's head, indicating his hair. Suddenly he stood back and said: (See plate 11).

J: "This is my Dad. Look he looks like a kaffir. He is a kaffir."

For a moment it was as if his own words shocked him and he looked at the therapist as if he was expecting a rebuke from her.

J: "But.....my father....cannot be a kaffir."

T: "Johnny your father is a kaffir, or rather like a very bad man."

J: "Yes, but...don't you think I am swearing?"

T: "No Johnny, but tell me what your father had done to you that makes you feel he is a kaffir."

J: "I don't know."

T: "Come Johnny, let's go and look."

Johnny became very anxious but the therapist continued as it was the first time that Johnny reacted with a different emotion than anger.

J: "Man, I really don't know. It is so many things."

T: "Like hitting you when he was drunk?"

J: "Yes, he chased me out of the house and called me a curse. He doesn't want me. He never wanted me. I eat the money he needs for wine. He hates me. He hates me."

T: "And that is the reason you call him a kaffir. A very nasty ugly man who did not deserve to have a beautiful little boy like you. I would have felt the same as you do, if he was my father."

With these words the therapist placed her hands on his shoulders. He started to shake and screamed: "He is cruel and nasty. I hate him. I hate him." Suddenly he turned around and threw himself into the therapist's arms, crying. The therapist held him and cuddled him on her lap while he kept on crying. She did not say a word. She just held him and stroked his head. For a very long time after he had stopped crying, he sat quietly on her lap. When he had completely calmed down she cleaned his face for him and accompanied him to the waiting room. He only looked at her and smiled.

Plate 11.

Father and Mother.



DISCUSSION

The relationship between the therapist and child had grown to such an extent, that he could test her. For him it was very important to know that he could absolutely trust her and he tested her in a very subtle manner. He asked her to evaluate something he himself rejected. She could easily have fallen into a trap if she thought he was questioning her acceptance of him by giving him an untruthful answer. He now accepted her honesty and was thus able to trust her with his deeper problems, and to give into her hands the reasons why he in the first place made such a chaotic drawing.

He was projecting his own parents. He tried to create a secure and stable home in green. The mother was depicted in blue, for unconsciously he was aware that it took the utmost of emotional control to draw her. The father was drawn in yellow, because he was able to openly show his aggression towards him, as he was not emotionally as near to him as to the mother. Thus he felt more safe to start with the father. His bird also was not blue any more which indicated control but had now changed into an openly aggressive yellow.

For the first time Johnny was able to give more than hatred and aggressive feeling towards his father. He now felt a raw tearing pain because of the rejection he had received from his father. He was overwhelmed by the feelings he had and again lost control but not in the negativistic way he was used to when he reacted with omnipotent rage. Instead he threw himself into the arms of his pseudo-mother figure, the therapist. The therapist allowed him to experience his emotions in the secure supporting environment of her arms. At that moment he was a baby and from there he could now slowly grow

emotionally. The therapist allowed him to feel the closeness and security of a mother's arms and waited until he had completely gained control before she dried his tears for him. From here he had to move to his real world, where he had to start to put into practice his new-found ability for affectional responsiveness.

THERAPY SESSION 13.

Johny was standing in the waiting-room door waiting for the therapist and immediately approached her when he saw her. Upon entering the playroom he took out a peach and handed it to the therapist. She took it and thanked him for it. He mentioned that he had selected this peach specially for her and allowed it to ripen on the tree telling everybody that nobody was allowed to pick it. The therapist thanked him again and told him that she thought it was very nice of him to keep such a beautiful peach for somebody else.

He again mixed the paint himself and selected a white sheet of paper. He drew a very large red man that nearly filled the whole page and then started making black dots all over the page. As he was doing this his whole body became defiant and full of aggression. He became so lost in his activity that the therapist did not intervene for quite a while. Every time he made a few black dots he stood back and laughed in a nearly sadistic way again. After a while the therapist asked him: (See plate 12).

T: "Johny, today I really do not know what you are doing. Do you mind to tell me?"

J: "I am killing my father."

T: "Killing your father?"

J: "Yes, my Kaffir father. I am throwing stones at him till he is dead, dead, dead!"

T: "You don't want him as a father any more?"

J: "No, he must be dead, dead, dead!"

T: "Why do you want to kill him Johnny?"

J: "Because he still comes and hurts me."

T: "Johnny, do you actually never want to see your father again?"

J: "Yes, I never want him again."

T: "How do you think we can really get him out of the way?"

J: "I don't know, perhaps go and kill him in his sleep."

T: "Don't you think we should rather ask the social worker to tell him never to come to you again?"

J: "Do you think you can do it?"

T: "I'll try, but I cannot promise you. I think we must both ask her."

J: "Yes, and if I don't see him any more, he will be dead."

T: "If that is how you see it, then I agree with you."

J: "O.K, Then you are dead, dead, dead! Dead as a rat."

While he was saying this, he threw more paint stones at his father. What was very surprising, was that the fanatic aggression of the past was lacking. He was more accepting of a very difficult situation. He was now out of free will, denying the father who in the past had rejected him, and against whom he had constantly to defend himself emotionally.

Johny himself took his painting and put it into his holder. For the first time he himself cleaned and washed the paint dishes. He left in a very friendly mood.

Plate 12.

Killing Father.



DISCUSSION

In his peach, Johnny symbolically presented the therapist with his new-found affection. He, to whom everything in his world had circled around himself now included another person whom he presented with a prized possession, e.g. the first ripe fruit of the season. Satellization, in Auseble's terms, had started to develop with his pseudo-parental figures.

He goes further and excluded the negativistic rejecting father freely from his reality. Only by voluntarily giving up this negative identification figure could he now start to build a new relationship with his new reality.

The way in which he performed this death rite, was a mixture of both growth and reliving his previous state of emotional coldness, hate and rejection. When the pain became too great, he could only break down into not feeling. In the previous session he worked through his feelings of being rejected on a deep emotional plane, but in this session it was much more on a rational level, looking for answers. Herein the therapist helped him in finding a more rational and reality orientated answer. She did not make any promises but only promised to be with him in his seeking for answers.

Johnny showed that he was totally open to work with her in obtaining answers and demonstrated his willing co-operation in his clearing of the paint trays. This was a session in which Gestalt therapy was used with great success.

THERAPEUTIC SESSION 14.

Johny immediately entered the playroom, but once inside he stood a while undecidedly. He first went to the doll's house, touched the dolls but left it at that. He then went to the other toys but again only handled them, without really moving into play. The whole time he was looking at the paint and it was as if he was not sure whether to start working through his images or not. The therapist talked about ordinary things but she was aware that Johny was shying away from something. It seemed as if he was wrestling with himself about what to do. He stopped suddenly, stared at the paint and then moved quickly towards it as if he was afraid that he might change his mind again. He mixed the paint very slowly and also selected the paper very slowly. He took three pieces out, looked at them and placed them back before taking the fourth paper. He was also not satisfied with the way in which the drawing board was standing and changed it. He then started to project slower than ever before.

First he drew a big woman in green. Beside her was a woman in red and between them a little boy in yellow. The little boy was hanging in the air and was held by both the women. He told the following story:

"Once there was an auntie who got a small boy. She sometimes loved the boy and at other times did not like him. Sometimes she gave him food and sometimes not. One night she left him in the cold outside and he cried a lot. Another lady arrived and picked him up, but to her he was also too ugly, so she went and gave him to another auntie. This auntie also did not like him and kicked him. She also thought he was very ugly. But when he became clean from being bathed

every day she started to like and love him and cared for him. She also always gave him food. One day they were walking in the street and the mother saw her son with the auntie and saw he was clean and thought:

"I can go and brag with him. I must steal him back." The little boy heard it and got afraid for he did not want to go and stay with the dirty, nasty mother again. He also did not know what his new mother was going to do. Was she going to give him back. He then said to her: "My nasty mother wants to grab me."

Both pulled at the little boy and nearly ripped him in two. Then the good fairy appeared and killed the mother and they lived happily ever after."

Upon saying that, he drew a line through the green lady. Johnny told the story with feeling but without any emotional outburst.

(See plate 13).

T: "Johnny do you know who the little boy is that the two ladies were fighting about?"

J: "Hmm... But you know also."

T: "And do I hear correctly that the little boy rather wants to stay with his new mother forever?"

J: "Yes she does not hit me any more."

T: "Johnny, who is your new mother?"

J: "Auntie X. She told me she will never throw me away."

T: "And now you rather do not want to see your old mother?"

J: "Yes, like my father."

T: "We can talk about this to the social welfare. But what if your mother says she wants to see you?"

J: "She does not and must not be allowed to."

T: "You rather only want one mother, hai?"

J: "Yes."

With this he got up and started to clean the paint tray. He greeted friendly and left the room.

Plate 13.

The Struggle.



DISCUSSION

The mother and the handling and working through of his emotions around her, was to Johnny the most threatening aspect. This was the reason why he could not move directly and smoothly into projecting. In himself he fought a battle, trying to avoid this confrontation. At the same time he knew that he had to tackle this problem. The painstaking way in which he prepared the projecting situation, was depicting his involvement in this aspect of his life.

He tried to portray the mother, as security figure, in green but a stronger emotional figure in red, entered his life. She represented somebody that approached him with affection but at times also with rejection. Between the two he felt himself cornered in a choice that was too difficult for him to make. A power from outside, the fairy had to do it for him. The mother figure is cancelled out and by doing this he can give his loyalty and a new emotional bonding to his new mother figure.

What is surprising is that he does not allow very deep emotional involvement in the making of these images. Perhaps this aspect was still so full of deep down hurt that he could not become emotionally really involved without losing control. In Piages terms he was accommodating new schemes and with it integrating new affect. The child in a feelingless cocoon must first enter into new positive interpersonal relationships before he can build up new schemes in which affect and love are accommodated and integrated. For this Gestalt therapy, combined with image therapy as illustrated in this session, can be of tremendous help.

INTERVIEW WITH MR. AND MRS. X.

The foster parents felt that Johnny was much more in control of himself. The sexual problems still presented at times.

Destructive behaviour they felt at present only resulted from contact with his own parents. He still at times could become very destructive after he had seen his parents like, breaking windows, and gutters, cutting a bedspread with a scissors, scratching photos, sticking a knife into a chair etc. He then will not listen to his step-mother and will swear at her.

The therapist told her that she had already discussed the situation with the social worker and that in future he will only see his parents if it was absolutely necessary.

The foster parents felt that Johnny was beginning to accept them as his parents, something he had rebelled against before therapy.

They were trying to give him as much security as possible and were following the guidelines of positive reinforcement for constructive behaviour, that the therapist had given them.

THERAPY SESSION 15.

Before Johnny entered the room the therapist had arranged the puppets so that he had to notice them. Upon entering, he stood still for a few moments, after having greeted. The therapist asked him whether he would like to play a different game that day. He immediately reacted with enthusiasm. She showed him the puppets and said that he could make a story and decide who the main characters were going to be. He first examined each doll and then tried to fit them onto his hands. He then selected a jackal and a monkey puppet. He himself

became the jackal and the therapist had to be the mother-monkey. He moved to the sandpit and made a zoo. He ordered the mother-monkey to go to sleep in one cage. He then started to play in a fully developed illusive play, playing with total involvement and in an animated way.

It was in the middle of the night and the mother-monkey was sleeping while her jackal son was running around outside. He tried to enter her cage when he had become cold, but she snored so loudly that he could not wake her up. He then said:

"Because my mother let me sleep in the cold and does not hear when I call her, I am going to become bad and cross, real bad and really cross. I am going to kill all the animals."

He then went from one cage to the other and with sadistic pleasure killed one animal after the other. Every time after he had killed an animal he went back to his mother's cage to see if she would open the door for him. After he had killed all the animals, he again returned to his mother's cage and found a small hole through which he could enter. He then actively attacked the mother-monkey with his jackal puppet, swore at her and told her how bad she was. He became so involved in his play, that he actually attacked the therapist and lost all control over himself. When she restrained him by holding him, he started to cry and clung to her. After a while he turned his back towards the therapist, grabbed the monkey and chucked it into the corner. He then went to the puppets and took a bunny and a sheep. He himself put the bunny on his hand and gave the sheep to the therapist. He called her to the doll-house and told her how happy they were living together. His mother looks after him, baked cakes for him and the door of her house was always open.

Because Johnny so intensively experienced this session and his play, the therapist did not interpret or reflected the material but just allowed Johnny to experience and come to terms with the distressing feelings about his mother in himself.

Johnny did not want to leave the playroom immediately, but not in a manipulative way. He came to the therapist, took her hand and rested his head against her without saying anything. He then greeted her and left.

DISCUSSION

Johnny's aggression against everything and everybody came to the fore in this session because his mother had not fulfilled his basic needs. He experienced his aggression against her so intensively that his play left reality. He actively attacked the therapist, who at that moment represented his mother. He wanted to destroy her in reality as he had destroyed her in fantasy. When the therapist controlled him with affection, he immediately regressed but was willing to accept the security and comfort she was offering him. It no longer was too overwhelming and threatening to him because he himself was learning to feel and to love. Puppets were used here in Gestalt way to help Johnny express his feelings more deeply.

For the first time he was able to move forward spontaneously from this security. He tackled his problem by himself and went a step further with it. He realistically accepted the new mother and his new situation. Where he had accepted his new mother cognitively in the previous session, he now also did so on an emotional plane.

It is noticeable that he tackled his problem with the father first on an emotional level and then . . . cognitively whereas he did the opposite with the mother figure, probably because his feelings around the mother were much more threatening to him.

A tremendous amount of growth had already taken place at that stage. Johnny's emotional control was at times still weak, but he was already able to substitute positive affect for aggression.

THERAPY SESSION 16.

Johnny again was waiting in front of the playroom and greeted the therapist in a friendly way. He immediately told the therapist that he and his stepmother went to town alone the previous day and had cake and cold drinks in a cafe. He was very excited about the outing as it had been the first time that he went out with her alone and was treated in this way. He asked to look again at his drawings. When he came to the drawing that he had smeared black he said: (See plate 5).

J: "I was very angry and cross when I drew this. It is very ugly but I will not draw such an ugly thing today."

T: "Yes, my boy, you were very upset when you made this."

J: "Whew, a person must be black inside to make a thing like this."

T: "And now Johnny? Are there still black things that must come out?"

For the first time Johnny dropped his head ashamed and said in a very timid little voice:

J: "No auntie, that's the old Johnny. I am going to be a new Johnny."

The auntie (his stepmother) also said that I am a new Johny. I am her very own little boy."

T: "Oh I am so happy to hear this. Did we not agree to catch the ugly nasty things, which other people call naughtiness? We have caught a few, but I know that all little boys must be naughty sometimes."

J: (Laughingly) "Yes....but the nasty black we have caught I am sure I will never be able to draw so ugly again. But wait, I want to show you how beautiful I really can draw. It is going to be a very special drawing."

He closed his folder by himself and put it away. He mixed the paint carefully and placed a white sheet of paper in the drawing-board. He started by drawing a sun that was shining. Then he drew a boat on the sea with a woman in it. In the big sea was a small little boy that she was pulling from the waves. He told the following story:

One day there was a small boy, whose father and mother went to a far away land. He went to look for them everywhere but could not find them. Everywhere he met only with bad people who did not want to give him food. And he went on and on, looking for somebody to care for him but he could find no one. Then it became dark and the boy walked and walked until he came to the sea. He wanted to swim through the sea to find his mother's house but did not know that the waves were very big and very strong. He was beginning to drown and sink and started to scream but all the people laughed and said he was just naughty. He screamed louder but nobody took notice. Then one auntie jumped in a boat and grabbed him out of the water. She gave him food and covered

him in a blanket and allowed him to rest. Then she took him to his new mother where he stayed forever and ever, very happily. (See plate 14).

T: "Johny, can you already tell me who the little boy of your story is?"

J: "Yes, now I know I am the little boy. I used to stay in the cold and all the people said I was very naughty."

T: "I know. And how did the little boy get out of the water?"

J: " (Very shy) "You are the auntie in the boat."

T: "You feel that I have helped you to come to your new mother?"

J: "Yes, and also not to get so many hidings. My auntie said I am not so very naughty any more."

T: "Yes, but you have helped me. You were the one who had to paddle the boat to the beach and for doing that I am very proud of you."

J: "This drawing you must put in your home. I have specially made it for you. You must not keep it here. It is yours. Take it."

He took the painting from the drawing board and gave it to the therapist who thanked him for it. He cleaned the paint dishes before he left.

Plate 14.

The Rescuer.



DISCUSSION

It seemed as if a turning point was reached in this session. Johnny himself asked to evaluate his progress. At his first real outburst he stopped because it seemed that during that catastrophic session he had made his first progress. In his image (plate 14) he typified the therapeutic progress with an unbelievable clarity. He also acknowledged the therapist's part, but had already grown from the safe relationship with her to a new realistic relationship with his new mother. He sees the therapist with right only as the mediating factor to his new relationship. His childlike thankfulness he showed her by giving her that precious picture which carried so much of his symbolic pain and growth.

Here one sees a child that has grown from total egocentrism to a great deal of altruism. Other people have become of importance to him and he was now able to admit and recognize his dependence upon them. He is even thankful towards other people. This is the germ development of a conscience or superego, depending upon a particular frame of reference. The sociopathic process had already been arrested to a great extent and was being annulled by the process of ego-reconstruction.

THERAPY SESSION 17.

Johny was waiting calmly in the waiting-room. What was of note was that he was now able to await his turn while paging through a book, something that was impossible for him to do at the beginning of therapy. He came immediately when called and walked silently to the playroom.

He took a car and played with it, but was absent-minded. He then saw the bow and arrow that he attacked the therapist with during a previous session and asked her to join him shooting with it. He shot at a ring but missed the mark every time. Where such an incident would previously have caused him to become very aggressive, he then just said "Johny pumpkin head. You must practise more."

The therapist took the bow and showed him how to aim. He went on until he could hit the mark. He enjoyed it extremely and continued to play with the bow and arrow for the whole session.

DISCUSSION

Although it may seem as if nothing really important happened during this session, it did show Johny's greater control over himself. He needed this more calmer session for consolidation after the previous

period of immensely rapid growth. In this session he had to find himself in a calm accepting situation. He exhibited that he had the possibility of constructive boys' play in satisfying conditions.

THERAPY SESSION 18.

Upon entering the playroom Johnny sat down on one of the chairs and said:

J: "Today I really feel like doing nothing."

T: "O.K. Then we do nothing."

Johnny sat talking about his school without really talking about anything important. Suddenly he asked if he could again see the Columbus projection picture with the little child on the bird which was used in the beginning in his projection tests. He looked at it for a while and then said that he wanted to draw the story of the picture.

He drew a big tree with a small nest and a bird flying above the nest. In the nest was a small boy and curled around the tree-trunk was a big snake. He told the following story:

"There was a little boy who was stolen from his mother by a bird. And they flew very far and the bird dropped the boy in his nest and only gave him a little bit of food. The boy had a small snake in his pocket to whom he always used to give some of his food. The boy again gave some of his food to the snake and because of this did not have food for himself some days and was also given a hiding by the bird for doing so.

One morning when the boy woke up the snake had become too big

for him to handle. So big that he got afraid of it and threw it away from him. The bird then said to him: "I told you that a snake is a very dangerous thing. Why did you keep on playing with your snake? Look how big and dangerous he had become. One day he will overwhelm us all." (See plate 15).

T: "This seems to be a different story you are telling today. Let's together try and find the meaning of it."

J: "The boy must surely again be me. But the snake and the bird I do not know."

T: "Or it may be that you are still afraid to know who they are."

J: "I don't know. It may be that the snake is some of the naughty things I have done. But I really don't know."

T: "Do you remember that you have always played with your Willie and at times have hurt the cat? It might be that this is the snake that is now so big."

Johny became very anxious and started to deny it by repeating: "I don't know."

T: "O.K. Johny let's leave it for today. How about a game of bow and arrow again?"

He got up immediately and fetched the bow and arrow and he and the therapist played for a while. Slowly he relaxed again. When he left he was once more totally calm.

Plate 15.

The Snake.



DISCUSSION

One big problem area remained for Johny to still tackle and that was the area of his sexual problems. He already entered this field in his images but it was still too threatening to handle it on a conscious level. Even in his symbolization through his images, he could not directly work on it. He had to use a mediator, the projection card to handle this very stressful material. He again revealed his own life problems but the separation from the mother did not carry so much weight any more. The snake as a symbol of his sexuality, had now grown and become unmanageable. He acknowledged that he himself had nurtured his snake but that at that moment he could not handle

it himself any more. He also realized that other people knew about his problems with his snake and were accusing him of misusing it. In this he was starting to show a sensitivity for the opinion of others which again is a growth step away from the sociopathic process. It still was very problematic and threatening to him to verbalize about his sexual problems, although he could communicate them in images to the therapist showing his willingness to start working on them. The therapist caught on to his anxiety and was allowing him to move at his own pace, thus she led him to sublimatory play. She played with him until he was calm enough to leave the playroom. Here the symbol he used was accepted as his problem area and would be handled in the here and now as a symbol of an immediate problem and not of a suppressed problem.

THERAPY SESSION 19.

Johny came late for this session because the social worker who had to bring him, was late. Consequently the therapist could only see him for a short while. He was very upset because he was late and blamed the social worker for not caring enough about him to have him on time. The therapist explained to him that things sometimes happen that we have no control over like a flat tyre and that no one was to blame for his coming late. Although he was very upset the therapist was surprised to see how much control he had acquired over his negative feelings.

The therapist helped him to mix the paint as he said he quickly still wanted to paint even though he only had a short time. He drew a large black boy with a large red snake around him. On the one side

he drew a small yellow house and on the other side a small black house. He said that the boy was the same one that had thrown the snake out of the tree. The bird had thrown the boy out of the tree because of the snake and now the snake came and curled around him. His one house was very dark and all the windows and doors were closed and he could never again return there. The new house was very far and he could never reach it before the snake might possibly kill him. He feared the snake was going to swallow him. But suddenly he awoke. It was only a dream. "So-so, my story ends." (See plate 16).

The last words he said smilingly as if to let the therapist know that he was not willing to talk about it any more that day. As time was short, the therapist helped him to clean up and he left smilingly.

Plate 16.

Fighting the Snake.



DISCUSSION

It was clear that Johnny's emotional control had grown tremendously. Previously he would have reacted with uncontrollable aggression against the social worker for bringing him late. He was in a hurry to draw as if he wanted to work through his problems with an urgency. At the same time he felt as if he was caught in the grip of his problems and that he could expect no help from his old home or from his new home. He only stated the problem that he felt unable to handle it and was at that moment working with it, but at the same time he was not yet willing to go deeper into it. This was the reason for ending his story with "So so my story ends."

The therapist let him go because she knew that he himself had to be willing and ready to work with this very sensitive problem. Noticeable at that moment was that he no longer showed any sexual problems in his behaviour but at an unconscious level it was still a problem to him. This again was an indication that his superego was growing.

THERAPY SESSION 20.

Upon opening the playroom door Johnny was noticed already waiting and he told the therapist that he was early that day as he had the social worker promise him that she would not be late again.

He again talked about all things in a very superficial way. Upon asking whether he wanted to play with the toys he declined. He went to the holders with drawings and took out his own. He asked for the last two drawings and said that he was drawing a serial.

He studied the two previous drawings carefully before he started

to draw again. He drew a small brown house with a little door. In front of it was a boy with a big stone in his hand and a snake at his feet. He said that this little boy saw that nobody could help him, he himself would have to help himself. He himself would have to kill his snake which first he had liked but later became wild. So he took the stone and killed his snake. As he said this he drew a cross over the snake. When the boy killed the snake he felt big and strong for he himself had killed the snake without any help. His mother was very proud and all the other people were very happy, for he had done it on his own. And he went to his mother and lived in their new house. He never again feared any snakes. (See plate 17).

T: "This really is a beautiful story. I am also happy that the boy killed the snake all by himself."

J: "Yes the boy was also happy."

T: "Yes but who is the little boy of your story?"

J: "Me!"

T: "Then it is you who have killed the nasty big old snake."

J: "Yes all by myself."

T: "If I may ask, do you know now what the snake was?"

J: "(Shyly) "Must be the nasty naughty things."

T: "Yes, that's true. But now they are gone and Johnny lives with his new mother who loves him."

J: "And Johnny loves her too."

T: "This is fantastic and now I know that in future you will know how to kill the snakes that come your way."

Johnny just laughed but it was clear that he felt very proud of himself. He cleaned up with great care. For a moment, before he opened the door, he turned around and looked the therapist full in the eyes, smiling and then left.

Plate 17.

The Killing.



DISCUSSION

Johnny had an urgency to work through the problems he had been struggling with for the past weeks. He realized that his stories were

connected to that problem. For the first time he handled a problem on his own and solved it by himself. He himself killed his snake, for only he could solve the inward turmoil around a problem which outwardly no longer occurred. The knowledge that he could do it, brought about an inward calmness and an outward self-assurance that did not exist before. Right in the beginning he used to look at the therapist in a defiant hateful way, but he now could look at her in a calm and accepting way. For the first time he verbalized a positive emotion when he said that he loved his mother. Initially he could only scream: "I hate", but in this session could say: "I love." One of the greatest signs that this little boy had grown from negativistic coldness to deep affectionate feelings.

THERAPY SESSION 21.

Johny was sitting quietly in a corner in the waiting room waiting to be called and only then got up. He was very calm, restful and friendly. Upon entering the playroom he immediately moved to the paint and started to mix it. He took a white sheet of paper and started to draw. He first drew a tree full of fruit. Next to the tree was a ladder with a black man on it picking fruit. On the ground was a little boy and further another boy in a motor car, playing.

(See plate 18).

J: "This is me and my brother at our home. There are many ripe fruit on the trees and the Boy picks us as many fruit as we want. Our new Daddy has made a go cart with which we play."

T: "Johny, it is clear to me that you like your new home very much now."

J: "Yes my uncle-daddy play a lot with us and he has made us all kinds of toys. He does not hit us."

T: "And what about your Auntie? Your new mommy?"

J: "It is also nice to stay with her. She baked some cake and has even made some jam for us."

T: "From all the fruit?"

J: "Yes.... Can I look at my drawings again please?"

Johny looked at each of his drawings without saying anything. When he came to the black one he paged over it very quickly. He cleaned the paint trays and asked if they could play bow and arrow again. Johny could shoot much better then and enjoyed getting higher marks than the therapist. He also talked about the nearing exams and said that he was studying very hard, for he did not want to fail again. When the therapist told him that his time was up, he said that he would have liked to stay longer but that he knew other children were coming. He greeted without protest and left the room.



Plate 18.

Satisfaction.

DISCUSSION

In this session Johny symbolized the richness and fullness that was part of his life now. He no longer was the lonely boy fighting for himself against everything and everybody - a rebel with a cause - for he now had other people, including his brother, with him.

His life had become full with nurturance which he symbolized in his image of the ripe fruit tree.

THERAPY SESSION 22.

Johny was again waiting in front of the playroom and seemed restless and upset. He however greeted the therapist very friendly. Inside the playroom he again stood looking aimlessly around, then took a small car and pushed it along without really playing. It was clear that something was again bothering Johny, for he did not want to communicate. She, however, left him in his aimless play to give him time to find a way to communicate to her what was bothering him. He went to the sand-pit but here he also only handled the toys by arranging them and then throwing them over again. He then slowly moved to the paint and started mixing it very slowly. The therapist moved towards him and helped him in mixing the paint. He drew a tree without fruit and yellow butterflies around it with a little yellow boy having his hands on his hips. (See plate 19).

J: "This is a big peach tree that had lovely peaches on it. Every day I give it water. When the peaches were big, ripe and red, nasty

butterflies came and ate them all up. Another naughty boy came along and laughed at me for having lost all my peaches."

T: "This is a total different story. What do you think the story wants to tell us?"

J: "I don't know, it is just a story."

T: "Ah no, have we not agreed that all the stories that we tell here also tells us a real story?"

J: "Hmm...."

T: "Come let's go and try to find the nasty butterflies so we can kill them. Tell me did something happen that upset you or have made you very sad?"

J: "Ag, just something. My daddy says I am naughty if I fight about it."

T: "But it still hurts you."

J: "Yes."

T: "Now, don't you in any case want to tell me what it is?"

J: "My brother got a prize for good progress at school and I did not get one although I also did my best."

T: "And you feel you ought to have got one too?"

J: "Yes, and my brother laughed at me and teased me."

T: "I don't think that was nice of him. I know that you have worked very hard, but sometimes it happens that one does not get what he worked for or what he wants very much. It is not always easy, but I know and you know that you have progressed very nicely although you did not get a certificate for it."

At this stage the therapist decided to do something unconventional in therapy. She asked Johnny to go and call the social worker. Johnny looked at her questioningly but nevertheless went out to do it. She then took a colouring book and crayons and wrote in the book: "To Johnny, for exceptional progress made in personal growth" and signed it.

When he and the social worker entered, she handed it to him while reading the inscription. He first looked at her in surprise but the next moment he threw his arms around her neck and started to cry. It however was not the the painful cry of the previous sessions. He now was crying with joy. He let her go and went out of the room with the social worker beaming with pride.

Plate 19.

The Moths.



DISCUSSION

In Johny's shunning mannerisms it was clear to the therapist that he was struggling with a problem again and that he did not know how to communicate it to her. His world, that was so full in the previous session, had now crumbled. From this, it was clear that this little boy's emotions were still so fragile that they could be disturbed by the smallest crisis. Even his personal security was still unstable. Butterflies, that seemed harmless, were able to upset his whole world and his brother could still very easily become his enemy. He still had to grow in his trust of other people.

The therapist proceeded to hand him the drawing-book with a double aim in view. Firstly, it was given as a way of reinforcing his security and as a positive reinforcer for his constructive behavioral change and emotional growth. Johny acted with positive gratitude and abundant joy.

TELEPHONIC INTERVIEW WITH JOHNY'S TEACHER

She said that Johny's behaviour in class as well as his school work was very good . He however still had problems with interaction with the other children. Where in the past he was very aggressive and manipulative in his handling and interaction with his peers, he had now moved away from them. He did not interact with them at all. She had found him during playtime hiding in the classroom. Where in the past he was able to handle other children with aggression, it seemed as if he now was afraid of them. The therapist told her that she would in the very near future place him in group therapy. The teacher promised her full co-operation.

THERAPY SESSION 23.

Johnny waited calmly to be called. He took the therapist's hand and walked hand in hand to the playroom. He immediately told her that he had passed his exams and that the teacher had said that he had progressed very well. The therapist congratulated him and he laughed heartily. He went to the paint, mixed it and took a white sheet of paper. He drew very carefully and with concentration.

He drew a little boy that was lying on a bed. Next to the bed was a mother reading him stories from a book. He drew a radio and a window. Under the bed he made a urine pot.

J: "The little boy stays in a comfortable warm house and he does not even have to go far when he wants to wee-wee. His mother is sitting next to him reading him a beautiful story. They have a brand new radio and when his mother goes out he listens to the radio. And this, this is my magic window. (See plate 20).

T: "This is a very beautiful story."

J: "It is."

T: "And who is the little boy on the bed?"

J: "Man, you know."

T: "But I want you to tell me his name."

J: "Mr. Johnny."

T: "That's right and is Johnny now happy?"

J: "It surely looks like it."

T: "Yes it surely does. He now has a mother and everything that he wants."

J: "And a radio."

T: "And this is our magic window of the beginning."

J: "Hmmm."

T: "What did you say will happen when you climb through this window?"

J: "All your wishes will come true."

T: "On which side of the window are you now, Johnny?"

J: "On the inside."

T: "I like this picture so much that I am going to put it on the board where everybody can see it."

Johnny was very excited about this and helped to pin the picture on the board. He cleared up and greeted to go although the time was not yet up.

Plate 20.

On the other side of the Magic Window.



DISCUSSION

In his images Johny showed that he knew that most of his problems were now solved. He was now in his bed of security and nurture, he had a radio, and his life was ordered. This was in strong contrast to the chaotic life situation of therapy session 4. The adults no longer used him for their own purposes and he could relate to them in a secure way. His wishes were largely fulfilled. He was inside the magic window and his sexual problems have been worked through and his sexuality healthily integrated - the potty was under the bed where it should be.

The fact that he left before the time was up was an indication that he was separating himself from the therapist. It was as if he

himself was starting to realize that he no longer really needed her support.

THERAPY SESSION 24.

Johny again waited calmly until his name was called. In the playroom he immediately started to draw.

He drew a tree that stood securely in the earth, full of fruit. Next to it was a house with smoke coming from its chimney. Next to the house was a mother with a red handbag and a little boy on her hand. Above the sun was shining.

J: "There once was a small boy that was lost in a big jungle all alone and very cold. He looked everywhere for a mother but could not find her anywhere. Then he met a woman and asked her: "Are you my mommy?" and she said: "No, but I will help you to find her." And she brought him to a mother but for a very long time the mother looked strange and talked a strange language and he could not understand her. But then the auntie taught him his new mother's language and they could then understand each other. And then the mother learnt to love the boy and he also loved her. And one day he said to his mother that he wanted to take her to a shop. At the shop he bought a red handbag for her and she was very happy. And they went home and lived happily ever after. So - so my story ends." (See plate 21).

T: "We know now whose lovely story you have told."

J: "Yes, it is my story. I do have a new mother now and I love her."

T: "And you have a lot of fruit and everything you want at home."

J: "Yes bags full."

T: "I wonder what the red bag that you gave her might be."

J: "Jis, I don't know."

T: "Let's try."

J: "Well, I am well behaved"

T: "Yes, but let's look deeper. What do you call her now?"

J: (Shyly) "Mamma."

T: "And don't you think she is very happy about that?"

J: "Yes, she said so and kissed me."

T: "I think it is the most beautiful red handbag you could have given her."

Johny only laughed.

T: "Johny, for a long time you have come here and played with me.

But for a while I also want you to come and play here with some other boys. You do stay in your new house with your new mother on the inside of the magic window, but you still have to learn to play with other boys."

Johny first objected but after sitting quietly for a while he agreed and asked whether he knew the other children. The therapist said no,

but that she will help him to get to know them and help him to learn to play with them.

Plate 21.

Home at last.



DISCUSSION

Johnny actually terminated his own therapy with this image of his. He symbolized his new world and told the therapist that actually he did not really need her any more, for she had taught him the language of love through which he now could communicate with his mother.. He thus did not object to the termination of his individual therapy but was weary of the prospect of being placed into a group with other children. The therapist however assured him that she will support him also in that new group experience.

GROUP THERAPY SESSION 1.

The group was formed with Johnny and four other children from a children's home, who had no overt psychological problems.

They were all brought together in the playroom and introduced to each other.

To them it was said that they could play with whatever they liked but that there was only one rule, namely, that whatever they played they had to do it together. They did not know immediately what to do and stood around in the playroom looking at the toys. One of them then moved to the sandpit and suggested that they build a town. All of them immediately selected cars and houses and started to build. Johnny, who up to now had not said anything, just stared at them. Upon the therapist suggesting that he join them, he bit his lip and moved towards them but did not join them.

The children played and enjoyed it, but for the whole session Johnny just stood on the side and watched. When they left the therapist saw Johnny for a short session.

T: "You did not actually want to play with them."

J: "Hmm... I don't know."

T: "You still felt a bit awkward and do not like to play with other children."

J: "No, I don't like them all. Children always fight with me."

T: "I do know that it is still very difficult for you to play with other children, but this is still one of the problems we must handle as

we have done with all the others."

J: "I don't like other children."

T: "You feel that other children ignore you and don't want to play with you."

J: "Yes, we always fight."

T: "Johnny, are you afraid that you might fight with these children also?"

J: "All the children always fight with me."

T: "Let's play a game. We play that these children that come here like you a lot. So next time will you try to think in that way?"

J: "And if they do fight with me?"

T: "Then they are naughty. But let's wait and see what will happen."

J: "O.K. we will see what will happen. I am not so sure but I will come next time."

Johnny was unsure of himself when he greeted but still smiled at the therapist.

DISCUSSION

Johnny was placed in a group of "normal" children who had plus minus the same background as he had but without his behaviour problems. The group consisted mainly for Johnny's sake. In a group of children who had problems themselves it would have been impossible for Johnny to function. He was seen alone for a few minutes after the group to

help him to understand his group interaction.

Johnny still felt very unsure of himself and was unable to become part of the group at all. He remained an onlooker, as the situation was too threatening for him. With the support of the therapist he was however willing to try and handle it in the future.

GROUP THERAPY SESSION 2.

Johnny entered the room with the group, but stood in a corner while the others told the therapist about their week's experiences. Upon the therapist's direct questioning of what he had done, Johnny only shook his head.

The therapist suggested that they play some games that day and they agreed. In that way she could involve Johnny as well. He took part, but without much enthusiasm. The other children were really enjoying themselves while Johnny remained quiet. When he lost the game, he became very cross and knocked the board from the table. One of the children teased him and Johnny tried to hit him but the boy ran away. Johnny got crosser. The therapist did not intervene, so as to see how Johnny was going to handle the situation. He then started to cry and one of the children tried to comfort him but he got pushed away. The therapist said that she wanted them to stop, for at the beginning they had agreed to play together and at the moment they were not doing it. Next week they could try again.

They greeted but all looked at Johnny accusingly. He just stood there staring in front of him.

T: "My, my what has happened again?"

J: "Keep quiet, man."

T: "You are cross with yourself and now you are cross with me as well."

J: "And at them. I told you all other children are nasty brats."

T: "Let's look why they were nasty. Can you tell me who turned the board over?"

J: "Yes, but they first crooked me."

T: "Are you very sure, Johnny?"

J: "They bumped the table and that was why I lost."

T: "Johnny, are you sure it is their fault?"

Johnny remained quiet looking at the floor.

T: "You know that very often things happen for which we are the cause ourselves, but because we don't like it we very easily blame other people. It is very difficult to admit when we are wrong."

J: "I don't know."

T: "Like when we see we are losing and don't like it, then we don't want other children to enjoy the game so we turn the board over."

J: "Hmmm."

T: "Perhaps we should try and look to see if it might not be that you make other children cross with you and that they then don't want to play with you."

Johnny stood looking at the floor for a few minutes, then bit his lip and said:

J: "O.K. I'll try to play with them next time."

DISCUSSION:

The therapist assumed a more directive role in order to get Johnny involved in the group. When he lost the game he could not assert himself and lost control by acting aggressively - the only defence he knew. It is however clear that he had much more control than at the beginning of therapy.

The therapist interpreted his behaviour to him and tried to give him insight in his part of the behaviour of others towards him. It seemed as if he, to some extent, accepted it as he agreed to try again the next time.

GROUP THERAPY SESSION 3.

The therapist gave them some "meloh doh" and said that they could make whatever they liked as long as they made it together. For a while they made different suggestions. Johnny was standing next to them although he did not partake in their discussions. They decided to make a castle and everyone started on a part of it. For quite a while Johnny was only rolling the "meloh doh" without taking part in the project. He was however looking at what they were doing. One of the group suddenly said: "Johnny, you must make the wall so that the enemy cannot enter from the outside." He still stood undecidedly for a while and then suddenly started to build along with them. He still did not

partake in their conversation but was working with them.

At the end the therapist said they could leave the castle and play with it next time if they would like to.

Johnny left with the group as if to say that he did not want to discuss anything that day. The therapist allowed him the freedom of choice and allowed him to go.

DISCUSSION

Although Johnny did not spontaneously interact with the group, he was standing near them as if to imply his willingness to co-operate. He still seemed to lack enough assertiveness to plan together with the group or to take part spontaneously in their activities. Only when he was invited by the group, did he participate in their activities.

GROUP THERAPY SESSION 4.

The group moved to the castle right from the start and took out the soldiers. Suddenly Johnny suggested that they should first paint the castle, upon which the others reacted with enthusiasm. Johnny beamed when they accepted his suggestion and he started to mix the paint for them. He took out the brushes himself and gave one to each member of the group. They painted the castle in detail, chatting about ordinary things. Johnny joined in although he was still quiet at times. He suggested that next time they could again play with the castle as it would still be there.

Johnny remained behind when the others left without the therapist having had to call him.

T: "Did you enjoy it today?"

J: "Yes, today we played very nicely."

T: "Do you still think all children want to fight with you?"

J: "I don't know, some still do fight with me."

T: "But those that are here?"

J: "No, I am starting to like them."

T: "O.K. my boy, next time we will enjoy the play again."

DISCUSSION

For the first time Johnny was able to act spontaneously in the group and when his suggestion was accepted, he even moved into a leadership role. This to him was a great forward step in his interaction and socializing process.

GROUP THERAPY SESSION 5.

The group immediately started with their game around the castle and divided into two groups. One group had to attack the castle while the other group had to defend it.

Johnny first objected that he did not want to defend the castle but wanted to attack it. He however submitted to their decision when they made him the leader of the group that was defending the castle. In his play it was evident that a certain element of aggression was still more visible in his play compared with the rest of the group. He even broke a part from the wall of the castle, to which the other

children objected. He only answered them: "It is war and in war man can do whatever he likes." They played and Johnny really enjoyed himself. It still seemed at times as if Johnny was playing more on his own than really as part of the group.

DISCUSSION WITH JOHNNY AFTERWARDS

T: "It seemed to me you really enjoyed today's game."

J: "Yes, we beat them."

T: "Do you think so?"

J: "But of course. I am stronger than all of them."

T: "You feel as if you alone had won the war."

J: "Yes."

T: "And what about all the others?"

J: "Ag man, they only fought behind me."

T: "But they also helped you."

J: "Hmm."

T: "That means that together you have won the war."

J: "But actually it was only me."

T: "You feel that you are stronger than they are."

J: "They fight like pumpkins. Only I know how to fight."

T: "It still seems to me as if you still enjoy it very much to fight."

J: "Only if they make me."

T: "And otherwise?"

J: "Ag man, you know I don't fight any more."

T: "I know, but I only wanted to make sure how you felt."

J: "All right, we won the war together."

T: "Do you say it because you think that is what I want to hear or because you really believe it?"

J: "No man, I only made a joke."

T: "You only wanted to impress me with how strong you were."

J: "Hmm."

T: "But I know it."

J: (Laughingly) "I know."

DISCUSSION

When the play did not proceed as he wanted it, Johnny still objected. He had however grown enough to accommodate for the group's decision but also to be self-assured enough to take what he wanted. A degree of socialization but also of self-assertiveness had developed.

In his play, stigmata of his old sociopathic tendencies surfaced again. He still felt omnipotent but his ego's reality-testing

had developed to the extent that he could adapt to it's cue's under guidance of a trusted outsider.

Johny had succeeded in becoming a member of the group but was still reserved and inclined to withdraw into fantasy and in that way not really handled the demands made upon him by the group.

GROUP THERAPY SESSION 6.

One of the group members requested to play games again and the therapist asked the group how they felt. They all agreed but Johny did not answer. He however joined in and enjoyed it. He now and then made a remark. When he lost again he was on the verge of becoming aggressive but verbally told the others that he thought they were cheating. The group disagreed with him and it was clear that he was fighting for control over himself. He sat quietly looking at his hand, biting his lower lip for a while. Then he looked at the therapist pleadingly as if he was asking for her help and support. She smiled at him and moved towards him placing her hand on his shoulders. The others started to play again handing him the dice as if nothing had happened. He seemed undecided for a moment then joined in again, but was very quiet for the rest of the session.

INTERVIEW WITH JOHNY

T: "Today you played nicely with the other children." Johny smiled.

T: "It was difficult for you not to lose your temper?"

J: "I was very cross, but I did not fight."

T: "Yes Johnny, but I think you have seen that one can get cross without making the people around you cross also."

J: "Yes...hmm."

T: "We all get cross at times but it is not right to place our cross-ness on other people or blame them for it."

J: "Hmm. I'll try."

T: "Still Johnny, I am very proud of you, for I know that it was not easy for you not to fight today. You are becoming a big man now."

He smiled and nodded.

DISCUSSION

Johnny agreed with the group's decision and joined in an activity that had previously caused him to lose control over himself, and thus was a potential threat to his integration. In this session he became more part of the group. When the previously frustrating situation repeated itself, he verbally expressed his aggression although he had to exercise tremendous control not to come to an aggressive outbreak again. When he felt he was going to lose control, he asked for help from the therapist which she gave to him.

The therapist gave him positive feedback for his behaviour, thereby reinforcing it.

GROUP THERAPY SESSION 7.

The group was initially undecided about what they wanted to do,

but finally agreed to hold a concert. All of them were very enthusiastic about it, but Johnny refused to do anything. The others all performed and got applauded. They all did something again. Suddenly Johnny got up and said a recitation very quickly. The others clapped hands and he enjoyed it very much. They asked him to do something else, as he had had only one turn. He was hesitant but recited again and was again applauded. He laughed with more self-assurance.

In her discussion with Johnny afterwards, the therapist gave him very strong positive feedback for his participation in the group.

DISCUSSION

Johnny still initially lacked the self-assurance to perform in front of the group. He seemed to doubt whether he was acceptable to them. He tested their attitude towards him and when they did accept him, he felt more self-assured and experienced gratification.

GROUP THERAPY SESSION 8.

The group asked whether they could again play with their castle and Johnny eagerly agreed. They again played the war game. Johnny's play was still of a more aggressive kind than his groupmates but he was much more integrated into the group and did not withdraw into his own fantasy so much as in the previous play session. He also interacted much more on verbal level with the group members and at one time gave the orders. Two of the other members started to fight, but Johnny intervened and called the therapist explaining to her that one of the two had played roughly with the other one. The two again started to argue about what Johnny had said but the other members of the group

agreed with Johnny's version of the story. This was to Johnny very meaningful and one could detect his self-esteem rising.

When they went home, Johnny did not come to the therapist but went to the boy whom he had accused and talked to him. After a while the therapist saw the two of them playing outside.

DISCUSSION

Johnny was feeling much more a part of the group and was already planning with them. He also did not flee from group interaction into fantasy so much, but was participating cohesively in the group activity. Surprisingly, when a problem in the group arose, he acted as mediator and leader. What was very meaningful was that he insisted upon justice. This was an indication of how far this child, who had entered therapy totally without social integrated norms, had already developed in this area. Socialization had also developed very far and further growth was now dependent on the maturation process, practice and time. Therapy had done its part and this child should now be allowed to develop further in the school of life where he could learn to handle and practise his newly learnt skills himself.

GROUP THERAPY SESSION 9.

Johnny was talking to one of the members of the group when they entered and was much more relaxed than at the beginning of therapy. Johnny suggested that they draw something. The therapist agreed on the condition that they do it together. They discussed it and decided to draw the castle that they had made. Johnny started to mix the paint, but allowed the others to help. When one of the boys spilled paint on

Johny, he became cross, but instead of hitting him, he yelled: "You stupid, can't you look out? Look what you have done!" The boy stood back apologising. For a moment Johny still stared at him, then he stood back and said: "All right man, but you must look what you do. If you should do it again, I will throw all my paint on your head." It was evident that Johny meant every word that he said.

At the end of the session, the therapist told them that they had played nicely together here for the past weeks, but that this was their last session here.

Next week she was going to take them to the zoo as a farewell party. They were all very excited about this.

When the others left, Johny stood quiet for a moment as if he was deciding what to do. Then he looked the therapist full in the eyes, smiled, greeted and left. With this he said to her that he did not need her any more, neither for support in his social interaction. He was now on his own. He still had problems, but he had to handle them himself. If they did become too big, he knew he could return.

DISCUSSION

Johny was now spontaneously part of the group. He even took the lead in suggesting what they should do. He allowed the rest of the group to do the preparations with him.

When a crisis did occur, he handled it very positively. He did acknowledge his emotions but handled it verbally. However, he stated that he could not handle too much pressure on his control system or he would lose control and react aggressively.

When the therapist announced the termination of therapy, he did not object. He even condoned it when he left without discussing the session with her.

From his school report it was learnt that Johnny had started to make friends and was much more a part of the normal playground setting.

RE-EVALUATION OF JOHNNY THREE MONTHS AFTER TERMINATION OF THERAPY

Three months after termination, Johnny was seen for three sessions to repeat his tests.

Johnny was happy to see the therapist, but assured her that he had no problems and had two very close friends at that time.

The Projection test and Roschach were done in the first session and the Intelligent tests in the second session.

The Jessness Inventory and the Behaviour Scale were done in the third session.

RORSCHACH : FOLLOW UP 3 MONTHS AFTER THERAPY OF JOHNY

					H	A
l	Looks like clouds	W	KF	Clouds		A
	Looks like the wings of					
	a bird	W	F	Ad		
	Looks like holes	S	F	Obj.	h	
ll	Looks like blood	Al	D	CF	Blood	H A
	Here is a cat	D	F	A		
lll	Looks like a horse	D	F	A		
	Looks like a red bird	D	CF	A		
	Looks like a cat in a					
	tree. The tree is very					
	rough	D	F,CF	Plant		
lV	Looks like a skin of wool	W	cF	A.Obj.		
V	Two legs	D	F	Hd		
	Bird	W	F	A.P		
VI	Looks like a swallow					
	with wings	D	Fc	A		
Vll	Clouds	W	KF	Clouds		A
Vlll	Looks like a tiger or					
	lion climbing	D	FM	A.P	h	a
	Looks like a sheep's					
	bones when he is killed	Al	D	F	A det	H

RORSCHACH (Cont.)

					H	A
LX	A horse's teeth	d	Fc	A det	h	a
	The hair on the horse's back stands up	D	Fc	A det		
	People arriving	D	M	H		
	Pig	D	F	A		
X	Sheep's leg	D	F	A		
	Sun that shines with yellow rays	D	FC,cF	Nat		
	Worm	D	F	A,P		
	Piece of green grass	D	CF	Plant		
	The Moon	D	F	Nat		
	A catty	A2	D	F	Obj	H
					9	8

QUALITATIVE INTERPRETATION OF JOHNY'S RORSCHACH AFTER THERAPY

HANDLING OF REALITY

Although his reality testing was intact, there still seemed to be a very strong affectional anxiety reaction on a new situation. Although at the moment he seemed to be experiencing more anxiety, he also was more realistic in contact with his reality.

There was also still the awareness that his reality was not totally complete, but that certain things were still lacking.

SELF IMAGE

A very strong uncontrolled emotion is projected in connection with his self image, but at the same time there is stronger integration. It may be meaningful that he sees a cat here as his initial sexual aggression was towards a cat.

INTERPERSONAL RELATIONS

Although he still does not see human figures, there are now a greater wholistic integration. He can see the whole tree now, and even included an affectional and emotional element. If it is taken into account that the child first sees animals in his projections that later may become human, one can assume that Johnny is still relating at an infantile level to other people.

He has only begun to really make interpersonal contact.

RELATIONS TOWARDS THE FATHER

Very strong affectional needs are projected in this area, which in Johnny's case could be considered as positive.

RELATIONS TOWARDS THE MOTHER

In his relationship towards the mother, strong affectional anxiety, as well as very strong affectional needs, are still projected. There was however an awareness of interaction on a personal level. He was however still ambivalent in the image he had of the mother figure.

SEXUALITY

Strong affectionality have developed in this area and he was indeed like a swallow that had got its freedom.

EMOTIONALITY

The greatest growth has occurred in the affectional area. He primarily has affectional need and affectional anxiety, but to a child who had only negative feelings, this was a great positive growth sign away from the sociopathic process. There still were elements of aggressiveness and uncontrolled emotions present. His whole protocol was however more controlled and he was willing to project much more of himself. Inner consolidation and growth were still needed to come about in time.

JOHNY'S PROJECTION TESTING AFTER THERAPY ON THE COLUMBUS

14

This little boy used to sleep alone in the cold and his heart was cold. Now he has a home and sleeps and dreams of his mother.

6

There sits the uncle and the auntie. They were always alone. Then

they picked up two boys in the cold. Now they are sitting in front of the fire and the little boys are sleeping.

9

The boy is going to climb up the ladder and build a playhouse where he is going to enjoy himself.

2

This boy got up during the night and is now walking down the stairs. He is going to whee-whee and then he is going back to bed.

24

This is the magic window. Inside are people. They are happy. They sleep together and live together.

5

There is a boy on a dove above the sea and the houses. They are going to fly over the sea to their house. The wind will blow, but they will go into their house and it will be warm.

The other people on the sea will drown but they will be warm and happy.

DISCUSSION

If one looks at this projection in comparison with the one before therapy, it is clear that Johnny's world is now more integrated.

He got his house and no longer has a hole in the mountain to look for. He is inside his magic window with his father and his mother and they are happy. The blood no longer flows in streams because of their fighting. He is secure and happy for he knows that even if the

storms should come, he would be safe.

This protocol, in comparison with the previous one, gives the picture of a child that has grown from a total lack of security to a feeling of being secure and nurtured. The road to the adult has been restored to him. He is free and no longer has to answer his world with sociopathic behaviour in order to survive.

CHAPTER VIII

RESULTS

In this part, firstly, the qualitative interpretation and comparison of the projective material of the experimental group will be presented. Secondly, the research data of the different groups will then be statistically compared on the Rorschach, WISC and SNAIS, Jessness Inventory, Asocial Index and on the Behaviour Rating Scale.

INTEGRATED QUALITATIVE INTERPRETATIONS OF RORSCHACH PROTOCOLS
OF EXPERIMENTAL GROUP PRE THERAPY

The protocols of the experimental group and the individual interpretation of each protocol is in Appendix 2.

1. HANDLING OF REALITY

All the members of this group's reality testing was intact. Some of them, however, did have the feeling that something was wrong with their reality. (20 %)

There was a very close scrutinising awareness and perception of their reality, e.g. "Funny cunning eyes to watch everything" (Robert). At times their manipulation of their reality was clear. "One of those beetles angry one with a leaf over it, so one cannot see the damage it is doing" (Janica). Strong aggression against their environment and felt coming from their environment, was present in most cases. Omnipotent feelings and feelings of controlling their environment were also present. "I have made this picture myself" (Ashley).

2. SELF-IMAGE

Their self-image was an aggressive one, e.g. a wolf, a robber,

Dracula, Vampire, bomb, etc. A self-centred, egocentric approach was mostly on the foreground. They were aware that they could hurt and even destroy others but did not care about this. "The bee stings. It hurt people when it stings. People don't like this bee, but it can make honey in a beehive for himself if he wants to" (Robert).

They also were pretending to be what they were not. "A poisonous snake mascarding as a leaf" (Janica). Strong uncontrolled emotions towards the environment were present, represented in the overwhelming "blood" responses.

On the other hand, they were aware of the pain and self-destruction which their uncontrolled reaction on their environment had on themselves. They, however, seemed helpless to do anything in counteracting this process.

3. INTERPERSONAL RELATIONS

50% of them could project interpersonal relations in that they gave human movement response, but 80% of the interactions was of an aggressive nature. "Two robbers fighting over a bag of money" (Kiewiet) or otherwise it was defiant. "A man that got an olden day tie on, sticking his tongue out" (Robert) or they dehumanised the human figures. "A monster out of a horror film, with blood dripping down its sides."

There were one or two who did not project any problems in this area, but their responses were coupled with uncontrolled emotional outbursts. An element of trying to manipulate while they are being threatened was also present. "Two men trying to catch a sly crab."

4. RELATIONS TOWARDS THE FATHER

The father was 60% seen as overwhelming and aggressive with no positive interaction between them and their fathers. On the other hand 20% of them saw the father as a weakling and thus rejected him. "Half frog, half pelican" (Janica) or just a "thing." In one case, affectional anxiety towards the father was projected "a black night thunder cloud" (Marius), but mostly the interaction was of a cold detached nature.

5. RELATIONS TOWARDS THE MOTHER

80% of them gave a mixed picture of affectional anxiety mixed with strong feelings of aggression against the mother. "Now this looks like the inside of a volcano, where fire erupts" (Ashley). 40% of them had a strong need for communication with the mother, but felt helpless to bring it about. "Two bunnies turning right round to talk to each other and still unable to hear each other" (Janica). Strong feelings of being on an equal plane with the mother were present, but were always mixed with aggressive feelings towards the mother. "Small daughters yelling at each other" (Maria). "Two monkeys shouting at each other, biting and fighting two snarling animals" (Wayne). "An angry black devil that swears" (Marius). There is also an intellectual approach towards mother. "Head without a body" instead of an affectional need that seemed to be present but being suppressed "woman's eye-lashes and woman's dress" (Gustaf).

6. SEXUALITY

As most of the subjects were in the latent phase, no strong sexually coloured responses were expected. This was the case for 80% of them.

An element of sexuality mixed with aggression was present where sexual problems were present. "A torn cat. He has been ripped open and blood is streaming from his neck. One can see his ribs sticking out."

7. EMOTIONALITY

Strong aggression was projected as the main emotional content. Many responses of skeletons, teeth, decaying and blood that were flowing were present.

Uncontrolled emotions of explosive nature were present. It seemed that 60% of them were however aware of the fact that their own aggression caused them to lose control over their emotions. "The skeleton has broken the coat of arms" (Ashley).

Affectional needs are projected only as affectional anxiety, but even then they reacted upon this need with aggression as if they could not allow themselves to acknowledge a need for affection. "A colourful atombomb explosion, the picture of the child looks like it" (Marius).

INTEGRATED QUALITATIVE INTERPRETATIONS OF RORSCHACH PROTOCOLS
OF EXPERIMENTAL GROUP POST THERAPY

1. HANDLING OF REALITY

90% of them handled their reality with a much more positive approach and a greater openness for positive interaction than Pre therapy. "A butterfly with outstretched wings ready to fly" (Janica). There also seems to be a feeling of being supported in their approach to and handling of their world. "A father and a mother and a little boy whom they are holding in their hands" (Gustaf).

Underlying there still at times were sociopathic stigmata of being on the outlook to use their reality to their advantage. "A flying bat ready to make a catch" (Robert).

There seemed to be greater control over the destructive forces in their reality, but an element of threat was still present. "A monster with a chain through his nose held by a big lock."

2. SELF-IMAGE

They seemed to have a much more positive self-image in their interaction with their environment, but elements of aggression and manipulation were still present.

"A bee on a flower making honey" (Robert)

"A sly fox" (Kiewiet)

"A snarling dog, but it will not bite. Just a warning dog" (Wayne).

Feelings of being the one that can cause aggression are still present but in a much more controlled way. "A vampire - not very scary. A make believe one."

70% of them had the feeling that they had changed, but were still not quite sure of their new self-image. "A butterfly creeping out of a cocoon. It's got lovely wings that it must still test" (Janica). They have the feeling that the support of others can make them stronger in their new found freedom in themselves. "A bird that flies above two people holding their hands together." But at the same time they are aware that they have been injured in their self-image by their past. "Their paws have been hurt."

3. INTERPERSONAL RELATIONS

What is striking is the many "dancing" responses found on their

interpersonal cards. This causes one to ask whether, although they seemed to be more positive in their interaction with others, in reality they are not interacting at a superficial nearly hysterical way. Aggression was still present, but in a much more controlled manner "wardance", "wardance at a festival."

To a great extent their interaction seemed split up as if they still found it difficult to integrate their interpersonal relations successfully with the rest of their personality functioning. Interpersonal relations awoke strong feeling in them even of anxiety "dancing in the dark around a fire."

4. RELATIONSHIP TOWARDS THE FATHER

It seemed as if the least changes have occurred in their relationships with their fathers. In a (2) cases the relationship was more positive, but an element of threat was still present. "A big strong man, but he looks as if he may be cross."

Mostly the father was still seen as remote, inadequate and unstable. "It's an old man with torn clothes hanging in bags around him. It's shoes are broken" (Robert). (80%)

Feelings of degrading the father were present. "A puppet on a string trying to dance, but everybody is laughing at him" (Janica). Mixed feelings of empathy for the father sometimes seemed to surface. "A very sad man" (Wayne). Strong affectional needs towards the father were projected. "White sheepskins, sheared with the wool" (Gustaf). "Gorilla, it's got a hairy skin like a gorilla" (Andre). "A big blanket. My granny has one. It is made from sheepskins. Nearly like wool." One totally excluded the father from his life. "A dead elephant (Ashley).

5. RELATIONSHIP TOWARDS THE MOTHER

There now seemed to be a much more guarded approach towards the mother. "Two people looking guarded at each other" (Kiewiet). The threatening elements are still there, but it seemed that although they realise that the mother has not basically changed, her behaviour towards them has changed. "A spider web, where his children stays" (Janica). Anxiety and insecurity still mingled with their new binding with the mother. "Clouds something like clouds that is half dark and half light. Just after a storm" (Ashley). Emotionality towards the mother evoked anxiety. "Clouds with the colours of the sun in between" (Ashley). They seemed to interact more spontaneously and to a greater extent with the mother, but in their interaction, elements of manipulation and feelings of equality are still present. "Two monkeys playing and fighting with each other." "Two people playing a game, watching each other very carefully. They are also teasing each other" (Wayne). "Two little girls pulling their noses up at each other" (Marius).

Very strong affectional needs from the mother are projected, but they seemed to doubt if she was able to fulfill their needs constantly. "It's wool from a sheep. Can make a fur coat with it. Can make you warm if it wants to" (Robert).

6. SEXUALITY

A much more positive approach intermingled with affectionality and anxiety was projected.

"This is a snake. His skin is full of scales (Andre).

"Cat here, it's got a long black pelt" (Kiewiet).

They still seemed to approach sexuality in a very guarded way. "Two people trying to hold hands with their backs to each other." An element of sexuality being a new unexplored field was present. "A strange sort of cat" (Robert). The last two elements are part of the normal sexual development.

With one there was still an element of underlying aggression mixed with sexuality.

7. EMOTIONALITY

Their control over emotional outbursts have developed extensively. This seemed to have evoked feelings of anxiety in them which often occurs in therapy. They have the feeling that they still need the help of external power to control their aggression and fear that without it they might lose control again. As Robert puts it in a nutshell "A coat of arms of a skeleton."

Underlying aggression is still present "showing his teeth" (Janica), but it does not break out uncontrollably any more.

In this area the greatest growth seemed to have occurred. Affectionality as a need, is overwhelmingly present in their projections. Where it was mostly absent previously it seemed as if they have suddenly realised what they have missed. "Torn out coloured wool", wool from a sheep", "long fur and hairy whiskers", etc. In a normal child the extent of their affectional responses would have been of pathological degree but in these children, who had no deep feelings, this is a positive transitional stage. But their strong need for affection and emotional closeness leads to feelings of affectional anxiety. "Clouds at sunset full of colour" for they are still unable to handle so much feeling without being overwhelmed by it.

STATISTICAL ANALYSIS OF THE RORSCHACH DATA

1. Results of the Elizur's Hostility and Anxiety scores and the Holtz Aggression scores

Table 2.1 gives the Raw data as obtained from the Rorschach.

Table 2.2 indicates the following.

The Experimental Group showed significant decrease in anxiety, Hostility and Aggression on the Rorschach at the $P < 0.1$ level. The Active Control Group in care of the Institution showed no significant decrease in their anxiety, hostility or aggression according to the Rorschach.

The Passive Control Group in the care of their parents also did not show any significant change in their anxiety, hostility or aggression according to the Rorschach.

Raw scores in table 2.1 of both the Passive Control Group and the Active Control Group show that there was an increase in their hostility, anxiety and Primary aggression on the Rorschach although not of significant amount.

Table 2.1

Summary of raw scores obtained from the Elizur's Hostility scores; Elizur's Anxiety scores; and the Holtz Aggression scores as scored on the Rorschach data

	<u>Groups:</u>					
	<u>Experimental</u>		<u>Passive Control</u>		<u>Active Control</u>	
	<u>Pre Ther.</u>	<u>Post Ther.</u>	<u>Pre Ther.</u>	<u>Post Ther.</u>	<u>Pre Ther.</u>	<u>Post Ther.</u>
Elizur's Hostility	118	39	124	132	105	109
Elizur's Anxiety	90	36	101	107	99	103
Holtz Primary Aggression	38	5	45	51	41	44
Holtz Secondary Aggression	8	8	11	13	9	8

Table 2.2

Statistical Analysis of the Rorschach data shown in Table 2.1

	<u>Groups:</u>					
	<u>Experimental</u>		<u>Passive Control</u>		<u>Active Control</u>	
	<u>Sign test</u>	<u>P</u>	<u>Sign test</u>	<u>P</u>	<u>Sign test</u>	<u>P</u>
Elizur's Hostility	M = 0	*** 0,001	M = 4	0,377	M = 8	0,989
Elizur's Anxiety	M = 0	*** 0,001	M = 5	0,623	M = 6	0,828
Holtz Primary Aggression	M = 0	*** 0,001	M = 4	0,377	M = 9	0,999
Holtz Secondary Aggression	M = 0	*** 0,001	M = 5	0,623	M = 7	0,945

N = 10 for each group.

*** Significant at P<0,01

** Significant at P<0,05

STATISTICAL ANALYSIS OF THE WISC AND NSAIS DATA

1. Comparison of the IQ's of the Experimental Group, Passive Control Group and Active Control Group to determine whether there were any differences Pre-therapy

To use the IQ scatter in any meaningful way one has first to ascertain that the IQ's of the sociopathic children were the same for all three groups pre-therapy.

Table 3.1 gives the mean IQ scales statistically analysed in table 3.2 which shows that there is no significant differences between the three groups as far as IQ is concerned. One can thus accept that the three groups were homogenous as far as IQ was concerned.

Table 3.1

Summary of the Mean scores of all three groups of Sociopathic children combined on the WISC and NSAIS

n = 30

<u>NSAIS</u>	<u>Mean</u>	<u>S.D.</u>	<u>WISC</u>	<u>Mean</u>	<u>S.D.</u>
Vocabulary	85,99	15,45	Information	85,67	15,47
Comprehension	98,99	17,49	Comprehension	99,33	22,43
Verbal Reasoning	117,33	13,63	Arithmetic	97,67	14,31
Problems	91,99	11,26	Digits	128,99	17,10
Memory	127,33	12,58	Similarities	116,33	16,30
Verbal I.Q.	100,59	7,14	Verbal I.Q.	102,23	7,03
Pattern Completion	111,99	13,24	Picture Completion	121,67	15,56
Blocks	100,33	10,98	Picture Arrangement	154,67	19,95
Absurdities	138,67	16,97	Blocks	101,67	11,17
Form board	119,99	9,09	Coding	106,67	9,59
Performance I.Q.	110,27	7,46	Object Assembly	141,33	16,13
Total I.Q.	105,03	7,61	Performance I.Q.	118,03	8,66
			Total I.Q.	111,03	8,20

Table 3.2

Summary of the Results obtained on the NSAIS and WISC to determine whether there was any differences in the IQ's of the three groups Pre-therapy on the Kruskal-Wallis ANOVA

	<u>ANOVA</u>	<u>P</u>
NSAIS Verbal IQ	2,51384	0,2845
NSAIS Performance IQ	2,41838	0,2984
NSAIS Total IQ	2,00856	0,3663

Table 3.2 continued

	ANOVA	P
WISC Verbal IQ	0,98657	0,6106
WISC Performance IQ	1,22500	0,5420
WISC Total IQ	0,8124	0,6662

2. Comparison between the WISC and NSAIS IQ scores of the 30 Sociopathic children

The NSAIS is the accepted standardized IQ test in South Africa whereas the WISC is not. The WISC however seems to be, according to the literature, a better diagnostic test for sociopathy. To ascertain whether there were significant differences between the scores obtained on the standardized NSAIS and the WISC the two tests were correlated (see Tables 4.1 to 4.3), and the following results were obtained.

There was no significant correlation between the Verbal IQ's and Performance IQ's on either the WISC or the NSAIS indicating a difference between the Sociopathic children's Verbal IQ's and their Performance IQ's.

There is a significant correlation ($P < 0,001$) between the WISC Verbal IQ and the NSAIS Verbal IQ indicating that they both test the same aspects of intelligence.

There was no significant correlation between the NSAIS Performance IQ and the WISC Performance IQ. As we have postulated in the literature study these two Performance scales seem to test different aspects of Intellectual Performance functions and one can thus expect that they will not correlate as has been found here.

The Total IQ's on the WISC and NSAIS showed a significant correlation ($P < 0,001$).

Table 4.1

Summary of the Correlations on the Spearman test between the WISC IQ scores of the 30 sociopathic children Pre-therapy

	Total IQ	Performance IQ	Verbal IQ
Total IQ	0,00		
Performance IQ	0,7809 ^{***}	0,00	
Verbal IQ	0,7093 ^{***}	0,2948 ^{**}	0,00

*** = $P < 0,01$

** = $P < 0,05$

Table 4.2

Summary of the Correlations on the Spearman test between the NSAIS IQ scores of the 30 sociopathic children Pre-therapy

	Verbal IQ	Performance IQ	Total IQ
Verbal IQ	0,00		
Performance IQ	0,2935 ^{**}	0,00	
Total IQ	0,6650 ^{***}	0,8505 ^{***}	0,00

*** = $P < 0,01$

** = $P < 0,05$

Table 4.3

Summary of the Correlations on the Spearman test between the NSAIS and WISC IQ scores of the 30 Sociopathic children Pre-therapy

<u>NSAIS IQ</u>	<u>WISC IQ</u>		
	Verbal	Performance	Total
Verbal	0,7635 ***	0,2448	0,6175***
Performance	0,6903	0,2318 ***	0,4740 ***
Total	0,5274 ***	0,5841 ***	0,6627 ***

*** = P<0,01

** = P<0,05

3. Scatter analysis of the NSAIS of the 30 Sociopathic children Pre Therapy

As seen in the literature study Human Research Council (HSRC) has found a definite scatter pattern on the NSAIS for Sociopathic children. To verify their findings an analysis of the 30 Sociopathic children's NSAIS was done (see section on Statistical Analysis of Results for scatter pattern symbol scoring).

In table 5.1 the mean IQ's of the 30 sociopathic children were scored for scatter symbols as set out above and the following results were obtained on the NSAIS.

There was a significant difference between Verbal IQ and Performance IQ, with Performance IQ higher by 10 points.

A significant positive outfall was present on Memory, Absurdities

and Form board.

A significant negative outfall was present on Vocabulary.

The four tests mentioned above, namely Absurdities, Memory, Form board and Vocabulary can thus be considered as sensitive to a sociopathic process according to this study.

Table 5.2 presents a Comparison between this study and the one done by HSRC with the following results.

Both studies found a higher Performance IQ than a Verbal IQ.

The only two tests that differ in their scatter pattern analysis were Form board and Blocks.

According to Madge (op. cit.) Absurdities and Memory could be considered as sensitive to sociopathy as also found in this study.

She did not however, found a positive outfall on Form board. If one takes into consideration that Form board tests creativity (Madge, op. cit.) it is understandable that the sociopathic child with his manipulative creativity might score high on this test.

Madge (op. cit.) also found a negative outfall on Vocabulary as in this study. She also found an indicative positive outfall on Verbal Reasoning and an indicative negative outfall on Problems.

One can thus conclude that the children tested on the NSAIS were sociopathic children as their scatter pattern correlated with the one found by HSRC for sociopathic children.

As the children were already screened to be sociopathic one can also conclude that the scatter analysis of the NSAIS together with behaviour analysis can form a basis for diagnosing sociopathy in the child.

Table 5.1

Summary of Mean scatter pattern of 30 Sociopathic children on the NSAIS
with scatter symbol analysis

<u>Item</u>	<u>Mean</u>	<u>Scatter Symbol</u>
Verbal IQ	100,6	
Performance IQ	110,2	
Total IQ	105,3	
Vocabulary	86,0	-
Comprehension	99,0	0
Verbal Reasoning	117,3	(+)
Problems	92,0	(-)
Memory	127,3	+
Pattern Completion	122,0	0
Blocks	100,0	0
Absurdities	138,6	+
Form board	120,0	+

Table 5.2

Summary of the comparison of scatter pattern symbol analysis of the NSAIS between the results of this study and the one done by HSRC (Madge, op. cit.)

<u>Item</u>	<u>This study</u>	<u>HSRC</u>
Vocabulary	-	-
Comprehension	0	0
Verbal Reasoning	(+)	+
Problems	(-)	-
Memory	+	+
Pattern Completion	0	0
Blocks	0	-
Absurdities	+	+
Form board	+	-

4. Scatter analysis of the WISC of the 30 Sociopathic children Pre Therapy

As seen in the literature study a definite scatter pattern has been found on the WISC for Sociopathic children. To verify this an analysis of the scatter pattern of the Sociopathic children tested in this study was done.

The scatter pattern symbols were scored in the same way as for the NSAIS (see Statistical Analysis section). In table 6.1 the mean IQ's of the 30 sociopathic children were scored for scatter symbols as set out above and the following results were obtained.

Performance IQ was significantly higher than Verbal IQ. Glasser (op. cit.) found the same

Significant positive outfall (meaning more than 15 points deviance from mean) on the following tests.

Digits Picture Arrangement, Object Assembly. This scatter is in line with the research done by Glaces (op. cit.), and Altus (op. cit.). They found that Digits sometimes was not elevated - in some cases it was lowered.

Significant negative outfall was present on: Information and Arithmetic. This is in line with the research of Altus (op. cit.).

Indicative Positive outfall (meaning 10 points more than the mean IQ) was present on Picture Completion. Altus (op.cit.) found it at the significant level.

Indicative Negative outfall (10 points lower than mean) was found on Comprehension.

Griffiths (op. cit.) found an indicative positive outfall on this test. He mentioned that this test, tested social skills. When one analyses the content of the Comprehension subtest it becomes clear that social norms constitute the greater part of the test content. When this is taken into consideration one can expect the sociopathic child to have a negative outfall on this test (10-15 lower than mean IQ).

In table 5.2 the results of this study is compared with the results found in the literature and it was found that they were the same except for Comprehension which was discussed above.

Table 6.1

Summary of Mean scatter pattern of 30 Sociopathic children on the WISC with scatter symbol analysis

<u>Item</u>	<u>Mean</u>	<u>Scatter symbol</u>
Information	85,6	-
Comprehension	99,3	(-)
Arithmetic	87,7	-
Digits	129,0	+
Similarities	116,3	0
Picture Completion	121,7	(+)
Picture Arrangement	154,7	+
Blocks	101,7	0
Coding	106,7	0
Object Assembly	141,3	+
Verbal IQ (V.IQ)	102,2	
Performance IQ (P.IQ)	118,0	
Total IQ (T.IQ)	111,0	

Table 6.2

Summary of the comparison of scatter pattern symbol analysis of the WISC between the results of this study and a combined scatter pattern as found in the literature (in Madge, op.cit. and Glacer, op. cit.)

<u>Item</u>	<u>This study</u>	<u>Literature</u>
Information	-	-

Table 6.2 continued

<u>Item</u>	<u>This study</u>	<u>Literature</u>
Comprehension	(-)	0 → +
Arithmetic	-	- → 0
Digits	+	- → +
Similarities	0	0
Picture Completion	(+)	+
Picture Arrangement	+	+
Blocks	0	- → 0
Coding	0	0
Object Assembly	+	+

5. Combination of the scatter pattern analysis on the WISC and NSAIS as found in this study

In the literature survey certain tests of the WISC correlated with tests on the NSAIS as far as content was concerned. In table 7 a summary was made of the subtests on the NSAIS and WISC that were found to be sensitive to sociopathy in this study. The tests that correlated with each other as far as content was concerned were placed next to each other, e.g. Absurdities on the NSAIS and Picture Arrangement on the WISC that both test elements of social insight, were placed next to each other. If one looks at table 7 the following conclusions can be made according to the literature study as described under Apparatus.

On both the NSAIS and the WISC the Performance IQ was higher than the Verbal IQ, indicating a possible aspect of impulsive acting out behaviour among the group tested.

Very good social insight seems to be present according to the positive outfall on Absurdities, Picture Arrangement and Picture Completion.

Very little anxiety was overtly manifested as seen by the positive outfall on Memory and Digits.

A good self image seems to be present as manifested in the high positive outfall on Object Assembly.

The negative outfall on Information may indicate egocentric tendencies.

The negative outfall on Vocabulary and Information may be an indication of a poor social background.

An inability to function successfully under stress seems to be present as indicated by negative outfall on Problems and Arithmetic.

They seem to lack good "common sense", judgement and did not seem to integrate social norm as is indicated by the negative outfall on Comprehension.

The results obtained above on the NSAIS and WISC combined fits the definition of the child with strong sociopathic tendencies. These two tests may thus be used with behaviour criteria to help diagnose the sociopathic child.

Table 7

Summary of IQ scatter pattern of tests that seemed sensitive for socio-
pathy both on the WISC and the NSAIS as found in this study

<u>NSAIS</u>		<u>WISC</u>	
<u>Sub. Test</u>	<u>Scatter Symb.</u>	<u>Sub. Test</u>	<u>Scatter Symb.</u>
Absurdities	+	Picture Arrangement	+
Memory	+	Digits	+
Form board	+	Object Assembly	+
Verbal Reasoning	(++)	Picture Completion	(+)
Vocabulary	-	Information	-
Problems	-	Arithmetic	-
		Comprehension	(-)
Performance IQ > Verbal IQ		Performance IQ > Verbal IQ	

6. Comparison between IQ scatter patterns on the NSAIS and WISC of the 30
Sociopathic children and the Neurotic children (Control Group III)

If the NSAIS and WISC are sensitive tools to help diagnose socio-
pathy in the child it should give a different scatter pattern for the
sociopathic child in comparison with the scatter pattern of the neurotic
child. To ascertain if this is true the IQ scatter of both the WISC
and the NSAIS of the two groups were compared and analyzed. The stat-
istical results are summarized in table 8.2 and table 8.1 contains the
mean scales and the scatter deviances from each group's mean

The results obtained on the above-mentioned two table are as
follows.

Total IQ's. On both the NSAIS and the WISC the total mean IQ's of the sociopathic children are higher than that of the neurotic children but only significantly so ($P < .00$) on the WISC.

Verbal IQ's. The Verbal IQ's of the Sociopathic children are significantly lower on the NSAIS ($P < .04$) and the WISC ($P < .04$) than that of the Neurotic children

Performance IQ's. The Performance IQ's of the sociopathic children are significantly higher ($P < .001$) on both tests, than that of the neurotic children.

Scatter Analysis. On the NSAIS and the WISC the following subtests are significantly higher than those of the neurotic children (table 7.2).

<u>NSAIS</u>		<u>WISC</u>	
Memory	($P < .001$)	Digits	($P < .001$)
Absurdities	($P < .001$)	Picture Completion	($P < .001$)
Form board	($P < .001$)	Picture Arrangement	($P < .001$)
		Object Assembly	($P < .001$)

The following subtests are significantly lower for the sociopathic children than those of the neurotic children (table 8.2).

<u>NSAIS</u>		<u>WISC</u>	
Vocabulary	($P < .001$)	Comprehension	($P < .001$)
Comprehension	($P < .001$)	Similarities	($P < .001$)
Verbal Reasoning	($P < .001$)	Arithmetic	($P < .04$)
Problems	($P < .04$)		

The subtest that thus differs significantly from those of the neurotic children both on table 8.2 and on table 8.1 is:

<u>NSAIS</u>		<u>WISC</u>	
<u>Subtest.</u>	<u>scatter symb.</u>	<u>Subtest.</u>	<u>scatter symb.</u>
Memory	+	Digits	+
Absurdities	+	Picture Completion	+
Form board	+	Picture Arrangement	+
		Object Assembly	+
Vocabulary	-		
Verbal Reasoning	-	Arithmetic	-

This is in line with the findings of this study and those of Madge (op. cit.) and Glacer (op. cit.) except that the Verbal Reasoning here is lower than that of the neurotic children, whereas in the literature it was higher. As this subtest also tests social norms it may be that the neurotic constricted child will adhere strictly to the social norms and thus test much higher than the sociopathic child who rejects norms.

The abovementioned subtests can be seen as very sensitive to sociopathic functioning in the child.

It seems as if both the NSAIS and the WISC are able to distinguish between the scatter pattern of the neurotic and sociopathic child.

Table 8.1

Summary of mean IQ scores of sociopathic children (Experimental Group, Passive Control Group, Active Control Group) and Neurotic Children (Control Group III) Pre Therapy

Variable	Sociopathic Children			Neurotic Children Control Group III		
	mean	a	b	mean	a	b
<u>NSAIS</u>						
Total IQ	105			102		
Verbal IQ	100			105		
Performance IQ	110			99		
Vocabulary	86	-	-	110		(+)
Comprehension	99			117	+	+
Problems	92	-		103		
Verbal Reasoning	117	(+)	+	134	+	+
Memory	127	+	+	93		(-)
Pattern Comprehension	112		(+)	101		
Absurdities	139		+	97		
Block	100			108		
Form board	120		+	103		
<u>WISC</u>						
Total IQ	111			103		
Verbal IQ	102			108		
Performance IQ	118			98		
Information	86	-	-	109		
Comprehension	99	(-)		119	+	+

Table 8.1 continues on next page

Table 8.1 continued

<u>WISC</u>	Sociopathic Children			Neurotic Children		
	mean	a	b	mean	a	b
Arithmetic	88	-	(-)	100		
Digits	129	+	+	86	-	-
Similarities	116		+	142	+	+
Picture Completion	122	(+)	+	99		
Picture Arrangement	155	+	+	96		
Object Assembly	141	+	+	88	-	(-)
Blocks	102			108		
Coding	107			100		

a = Deviation from group mean IQ

b = Deviation from IQ = 100 (Normal IQ).

Table 8.2

Summary of Statistic Analysis of the Comparison between the IQ scores of the Sociopathic and Neurotic children

Variable	Analysis of Variance		Welch		Brown Forsythe		Sig-nificance
	F Value	Tail P	F Value	Tail P	F Value	Tail P	
<u>NSAIS</u>							
Total IQ	1,4635	0,2371	1,2695	0,2888	1,4635	0,2377	
Verbal IQ	3,4520	0,0361	2,7120	0,0750	3,4520	0,0367	* ->
Performance IQ	21,2051	0,000	16,6553	0,000	21,2051	0,000	**
Vocabulary	12,9962	0,000	10,7255	0,0001	12,9963	0,000	**
Comprehension	9,2330	0,0002	7,6250	0,0012	9,2330	0,0002	**
Verbal Reasoning	10,7143	0,0001	8,1967	0,0007	10,7143	0,0001	**
Problems	4,8253	0,0103	3,4114	0,0401	4,8253	0,0111	*
Memory	29,9743	0,000	21,6638	0,000	29,9744	0,000	**
Pattern Completion	3,6540	0,0299	2,3843	0,1018	3,6540	0,0322	* ->
Absurdities	46,4285	0,000	41,4146	0,000	46,4285	0,000	**
Blocks	1,9029	0,1553	1,2597	0,2919	1,9029	0,1592	
Form board	20,6346	0,000	14,7923	0,000	20,6347	0,000	**
<u>WISC</u>							
Total IQ	9,4656	0,0002	9,3924	0,0003	9,4656	0,0002	**
Verbal IQ	4,0978	0,0199	3,4409	0,0388	4,0974	0,0202	*
Performance IQ	55,3559	0,000	54,5357	0,000	55,3559	0,000	**
Information	9,8965	0,0001	6,6068	0,0027	9,8965	0,0002	**
Comprehension	9,2927	0,0002	9,6518	0,0002	9,2927	0,0002	**
Arithmetic	3,8833	0,0242	3,4141	0,0398	3,8833	0,0248	*

Table 8.2 continued

Variable	Analysis of Variance			Welch			Brown Forsythe			Sig-nifi-cance
	F Value	Tail	P	F Value	Tail	P	F Value	Tail	P	
Digits	36,0142	0,000		28,9837	0,000		36,0142	0,000		**
Similarities	18,2038	0,000		14,5331	0,000		18,2038	0,000		**
Picture Comprehension	20,7499	0,000		17,0600	0,000		20,7499	0,000		**
Picture Arrangement	93,0216	0,000		99,7910	0,000		93,0716	0,000		**
Blocks	1,3070	0,2759		1,2564	0,2926		1,3070	0,2773		
Object Assembly	93,5451	0,000		75,5308	0,000		93,5451	0,000		**
Coding	1,8494	0,1635		1,3874	0,2586		1,8494	0,1699		

P = ,01 **

P = ,05 *

-> Not on all tests

Statistical Analysis of the Jesness Inventory's Asocial Index Pre-to
Post-Therapy and after 2 years

1. Explanation and Interpretation of results

In the two-way ANOVA summary Table (Table 9) calculated from data in Table 8, it is seen that Factor A (The Group) and B (The Stages), are very highly significant ($P < 0,001$). Interaction (Factor A,B) is however also very significant ($P < 0,01$).

When significant interaction (AB) is found, the main effect (A and B) cannot be independently interpreted. One has to examine the particular effect of each factor (A and B) at the specific levels of the other factor. Simple main effects (Table 9,2) and Turkey's pairwise comparison enables one to do this.

In Table 9,2 3 simple main effects are found to be highly significant, namely A at B_2 , A at P_3 and B at A_3 . A Turkey pairwise comparison was computed on these, using the original cell means. The results of these are what one is interested in.

2. Findings

From Table 9,2 the following conclusions can be made.

- 2.1. There are no significant differences between the three groups (Experimental, Pass Control and Act Control) before treatment (A at B_1).
- 2.2. There are no significant changes from Pre-therapy to 2 years after therapy in the Active Control Group and the Passive Control Group. Thus the two control groups do not change significantly over time.

2.3. There is a significant change ($P < 0,01$) from Pre-therapy to Post-therapy in the Experimental Group (Group I). This change is still present after two years. Note however that on the Experimental group the change between Post-therapy and after two years is not significant. Thus subjects improve Post-therapy and although the improvement is sustained for 2 years, they do not improve significantly farther.

2.4. Groups II and III (Passive and Active Controls) show no significant change from Pre-therapy to Post-therapy or from Pre-therapy to two years after therapy, or from after therapy to two years after therapy.

2.5. Significant results were found for A at B_2 and A at B_3 . In both of these cases it is found that the Experimental group differs from the two control groups ($P < 0,01$) but that the control groups do not differ from each other. This means that the Experimental group improved Post-therapy but the two control groups do not.

3. Overall Interpretation of Results on the Jesness Asocial Index

3.1. There is a significant change ($P < 0,01$) in the Experimental Group from Pre-therapy to Post-therapy. Their final means score was within normal range (49,8). See Table 8,2.

3.2. The change does still exist after 2 years ($P < 0,01$). There is however no significant change from Post-therapy to two years after therapy.

3.3. The Sociopathic children in the Experimental group thus have improved according to the Jesness Inventory's Asocial Index during

therapy and the improvement was still present after two years follow up.

The Sociopathic children in the Passive Control Group, who remained in the care of their parents, deteriorated slightly but not significantly over the period.

The Active Control Group in the care of the institution showed no change over the period.

Table 9.

Summary of Mean Scores of the Jesness Inventory Asocial Index for the
Experimental Group, Passive Control Group, Active Control Group at
Pre-therapy, Post-therapy and after two years.

Factor B.

Factor A	Pre-therapy		Post-therapy		After two years	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Experimental Group	80,3	8,19	54,5	11,62	49,8	10,56
Passive Control Group	80,1	8,49	83,6	7,11	84,0	5,40
Active Control Group	80,3	7,12	81,6	6,59	79,6	5,80

Table 9.1

Split plot design of Anova table

<u>Source</u>	<u>ss</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>P</u>
<u>Between Subjects</u>					
A Type of Group	8064,07	2	4032,04	25,79	***
Subj. W.G.	4220,32	27	156,31		
<u>Within Subjects</u>					
B (Stages)	136,20	2	681,10	34,89	***
A.B.	4143,73	4	1035,93	53,07	**
B x S. W.G.	1054,08	54	19,52		

Total

P <0,001 ***

P <0,01 **

P <0,05 *

Table 9.2

Summary of Simple Main effects

<u>Source</u>	<u>ss</u>	<u>df</u>	<u>MS</u>	<u>F rate</u>
A at B ₁ (Pre testing)	0,27	2	0,13	0,002 ^{***}
A at B ₂ (Post testing)	5284,07	2	2642,03	40,57 ^{***}
A at B ₃ (After Two years)	6923,46	2	3461,73	53,16
W cell	5274,45	81	65,12	
B at A ₁ (Experimental)	5393,27	2	2696,63	138,15 ^{***}
B at A ₂ (Passive Control)	92,07	2	46,03	2,36
B at A ₃ (Active Control)	20,60	2	10,30	0,53
B x S.W.G.	1054,08	54	19,52	

P *** Significant(P <0,001)

A Turkey was worked out with the following results.

At Pre Testing

There was no difference between the three groups.

At Post Testing

Significant difference (P 0,001) between Experimental Group and Passive Control Group with the Experimental Group lower on the Jesness Inventory Asocial Index.

Significant difference (P <0,001) between Experimental Group and Active Control Group with the Experimental Group lower on the Jesness Inventory Asocial Index.

No difference between the Passive Control Group and Active Control Group.

At Follow Up

Significant difference ($P < 0,001$) between Experimental Group and Passive Control Group with Experimental Group lower on Jesness Inventory Asocial Index. Significant difference ($P < 0,001$) between the Experimental Group and Active Control Group with Experimental Group lower on Jesness Inventory Asocial Index.

No significant difference between Passive Control Group and Active Control Group.

Statistical Analysis of the Behaviour Rating Scale

1. Interreliability of Raters

The Kendall Coefficient of Concordance can give sufficient evidence of the interreliability of the raters. However, an extra test was calculated to ensure the interreliability of the raters. The results of the Kendall are of the only real importance for the parametric tests that follow.

1.2. Friedman two way analysis of variance to establish variance between the Raters.

On the Behaviour Rating Scale the probability of variance between the raters on Table 10.2 shows that there was no significant variance between them ($P < 0,28$).

The interreliability of the raters is thus accepted.

1.3. Kendall Coefficient of Concordance

This test was worked out on a computered program and shows a mean concordance of 0,04189 ($P < 0,05$) between the raters (Table 10.2). As this test is considered by Siegel (op. cit.) as the best method of establishing interreliability of raters, one can thus accept the interreliability of the raters on the Behaviour Rating Scale.

Table 10.1

Summary of the Mean scores of raters on the Behaviour Rating Scale
for the three groups of Sociopathic Children

<u>Rater</u>	<u>Mean</u>	<u>St.D.</u>
Therapist	4,4477	8,9
Social Worker	4,4866	8,0
Teacher	4,5322	10,2
Parents	4,4899	9,5

Table 10.2

Summary of the Friedman Two-way analysis of variance test results
on the inter-ratings of the raters on the Behaviour Rating Scale

<u>Variable</u>	<u>Sum Rank</u>
Therapist	68,5
Social Worker	75,5
Teacher	86,0
Parent	70,0

Friedman test statistic 3,769.78

P = 0,2874 with 3 DF

Kendall Coefficient of Concordance:

P = 0,04189.

2. The effect of therapy at Pre- and Post-therapy and after two years ratings on the Behaviour Rating Scale.

To establish if therapy had any effect on the Experimental group in comparison with the control groups, the pre-therapy ratings on the Behaviour Rating Scale were statistically compared with that of the Post-therapy ratings.

To establish further whether the changes, if any, brought about by therapy were still present after two years, the follow-up rating was also compared with those of the Pre and Post Therapy ratings on the Behaviour Rating Scale.

The following results were obtained.

2.1. In Table 11,1 and 11,2 one finds a summary of the analysis of variances of the different conditions, e.g. Before vs. After (11,1), Before vs. After two years (11,2) and After vs. After two years (11,3) scored on the rating scale.

In each condition the second rating value has been subtracted from the first to form a one tail test.

The results obtained are summarized in Table 11,2 namely,

2.2. The Experimental group improved from Pre-to Post-therapy significantly and this improvement was still present after 2 years.

2.3. The group in care of their parent (Passive Control Group) deteriorated significantly and this deterioration continued at the follow-up study.

2.4. The group in the institution stayed the same from Pre- to Post-therapy and from After therapy to after two years. (Active Control Group).

2.5. From the above results the following conclusions can be made

2.5.1 It seems as if individual psychotherapy performed according to the rationale of this study did have a positive influence upon the behaviour of the sociopathic children according to the Behaviour Rating Scale.

2.5.2 Institutional care seems to stop the sociopathic process, but did not seem to change it for the better according to the Behaviour Rating Scale.

2.5.3 Parents seem to exercise a negative influence upon the behaviour of the sociopathic child according to the Behaviour Rating Scale.

To establish in which areas the sociopathic children have improved, an item analysis of ratings on the Behaviour Rating Scale was calculated

3. Item Analysis of Behaviour Rating Scale to assess areas of change in the Experimental group

In Table 12 a summary of the statistical results of the areas of change for the Experimental group Pre-versus Post-therapy are given. From this the following conclusions were drawn.

3.1. The sociopathic children have improved in individual therapy in the following areas: Obedience, honesty, interest in school, school attendance, school marks, doing their homework, fought less, adherence to discipline, love towards animals, cruelty.

3.2. They showed no significant change in the following areas: Closeness to parents, relationship with parents, love towards their parents,

popularity with peers and leadership abilities, sexuality and identity.

3.3. In the following aspects the teacher and parent only saw a significant change. As the parent and teacher are more closely in contact with the child, they will be the people to first notice any change in his behaviour: Relationship to parents, impulsivity, not easily angered, and responsibility.

3.4. It thus seems as if the children mainly socialized but did not change in their very close interpersonal relations (feeling aspect) or in their basic personality (e.g. impulsivity).

The sociopathic child seems thus to keep his basic personality, but seems to be able to socialize in individual therapy changing his behaviour to a more socially accepted form.

Table 11

Summary of global ratings of mean scores on the Behaviour Rating Scale

Pre, Post Therapy and after two years for each item

Items of Behaviour Rating Scale	Experimental Group (n = 10)			Pas
	Pre-Therapy	Post-Therapy	After two years	Pre-Therapy
a	6,08	4,39	4.22	5,75
b	5,00	3,85	3,80	5,50
c	5,67	3,68	3,68	5,50
d	5,32	4,06	4,00	6,00
e	6,04	4,30	4,28	5,25
f	5,53	3,95	3,86	5,00
g	5,34	3,02	3,02	4,75
h	5,40	3,67	3,68	5,00
i	5,65	3,48	3,42	5,75
j	6,17	4,69	4,65	5,75
k	6,14	4,33	4,30	5,00
l	4,33	3,37	3,38	4,00
m	5,57	4,30	4,25	5,25
n	4,75	3,92	3,93	4,00
o	4,08	3,52	3,50	4,00
p	5,12	4,39	4,40	4,75
q	4,80	4,22	4,24	3,75
r	4,73	4,32	4,23	4,00
s	5,18	3,63	3,60	5,25
t	5,98	4,23	3,80	5,50
u	5,87	4,95	4,79	6,00
v	6,20	5,34	5,32	6,00
w	6,14	5,23	5,20	6,25
x	5,90	4,63	4,59	5,75
y	3,88	2,86	2,81	5,00
z	3,70	2,65	2,63	3,50

These are Mean scales.

Table 11 continued

sive Control Group (n = 10)		Active Control Group (n = 10)		
Post-Therapy	After two years	Pre-Therapy	Post-Therapy	After two years
6,25	6,73	5,75	5,50	5,75
5,50	5,65	5,75	5,50	5,65
5,50	5,82	5,75	5,50	5,65
5,75	5,75	4,25	4,00	5,13
5,75	5,80	5,50	5,50	5,38
5,75	6,02	5,25	5,25	5,13
5,25	6,12	4,00	4,00	4,38
6,25	6,32	4,00	4,50	4,50
6,50	6,83	4,50	4,50	5,13
5,75	5,92	5,75	6,25	5,75
6,25	6,80	6,00	6,00	5,50
5,25	5,35	6,00	3,00	5,00
5,20	5,65	5,50	4,75	5,38
5,00	5,12	5,50	4,00	4,75
4,25	4,76	4,50	3,75	4,25
4,00	4,32	4,25	4,00	4,50
3,75	4,01	3,50	3,75	4,00
3,75	4,00	3,25	5,00	3,75
3,75	3,82	3,75	5,75	5,25
5,50	5,68	6,50	6,00	5,65
6,25	6,55	5,50	7,00	6,25
6,75	6,78	5,70	6,75	6,25
5,75	6,00	5,50	6,00	5,97
6,25	6,35	5,25	4,75	5,65
5,00	5,22	4,25	4,00	5,13
3,50	3,56	3,50	3,25	3,80

Table 11.1

Summary of Means and Standard Deviation of Differences between Stages

		<u>Groups</u>		
		<u>Experimental</u>	<u>Passive Control</u>	<u>Active Control</u>
Pre - Post	X	1,292	-0,238	0,027
	S.D.	0,514	0,639	0,990
<hr/>				
Pre - After	X	1,346	-0,488	-0,176
two years	S.D.	0,538	0,690	0,578
<hr/>				
Post - After	X	0,054	-0,249	-0,203
two years	S.D.	0,090	0,199	0,694
<hr/>				

Table 11.2

Summary of the Interaction between the Groups on the Behaviour Rating

Scale

	<u>Groups</u>			
	Experimental	Passive Control	Active Control	
Pre vs. Post	*** 1,292	N -0,238	N 0,027	Exp. > Pas. > Act. ***
Pre vs. After two years	*** 1,346	** -0,488	N -0,176	Exp. > Pas. > Act. ***
Post vs. After two years	*** 0,054	*** -0,249	* -0,203	Exp. > Pas. > Act. *
	P < 0,001	***		
	P < 0,01	**		
	P < 0,05	*		
	N > 0,05	=	N.	

Table 12

Summary of Test Statistics of the Pearsons Chi² on the Ratings of the Behaviour Rating Scale of the Different Raters to assess the areas of change Post-Therapy in the Experimental Group

Variable		Therapist	Social Worker	Teacher	Parent
Obedient	F	12,5**	13,1**	16,3***	20,0***
	D.F.	2	2	2	3
Honesty	F	9,0**	12,0**	14,2**	14,2**
	D.F.	2	3	3	3
School Interest	F	12,9***	10,1***	5,59	16,0***
	D.F.	2	2	2	3
Stay at home	F	4,5	7,3*	1,3	11,1**
	D.F.	2	2	2	3
Lies	F	8,3*	8,2*	16,5***	15,2***
	D.F.	3	3	3	3
Likes School	F	13,1**	11,2**	11,7**	10,7**
	D.F.	3	3	3	3
Truancy	F	16,3***	13,3**	20,0***	8,5*
	D.F.	2	3	3	3
School marks	F	14,0**	8,1*	16,5***	10,4**
	D.F.	3	2	3	3
Homework	F	14,00**	12,0***	20,0***	16,3***
	D.F.	3	3	3	2

Table 12 continued

Variable		Therapist	Social Worker	Teacher	Parent
Fighting	F	8,5 [*]	7,7 ^{**}	16,6 ^{***}	13,4 ^{**}
	D.F.	3	3	3	3
Discipline	F	8,4 [*]	8,9 [*]	10,4 [*]	14,6 ^{**}
	D.F.	3	3	3	3
Close to parents	F	2,6	2,2	1,2	5,0 [*]
	D.F.	2	2	1	1
Calm relation	F	8,1 [*]	4,0	8,6 [*]	7,7 [*]
	D.F.	3	3	2	3
Warm relation	F	2,2	3,6 [*]	0,0	4,1
	D.F.	2	2	1	2
Love parents	F	3,0	3,0	0,0	1,5
	D.F.	2	2	2	2
Friends	F	5,3	1,9	2,6	3,2
	D.F.	3	2	3	2
Popular	F	4,0	0,0	5,5 [*]	2,3
	D.F.	2	2	2	2
Leader	F	0,2	1,1	1,1	2,2
	D.F.	2	2	2	2
Love animals	F	16,5 ^{***}	14,0 ^{**}	16,4 ^{***}	10,4 ^{**}
	D.F.	2	3	2	2
Cruelty	F	11,0 ^{**}	12,5 ^{**}	14,1 ^{**}	14,0 ^{**}
	D.F.	3	3	3	3

Table 12 continued

Variable		Therapist	Social Worker	Teacher	Parent
Impulsive	F	5,0	1,1	7,2*	9,5*
	D.F.	2	2	2	3
Anxious	F	8,6*	4,4	10,0**	11,2**
	D.F.	3	2	3	3
Anger	F	6,0	1,5	11,2**	8,6*
	D.F.	3	2	3	3
Responsi-	F	3,7	3,6	11,0*	8,8*
bility	D.F.	3	3	3	3
Sex	F	2,2	2,9	5,0*	4,1
	D.F.	1	2	2	2
Identifi-	F	No sign	1,0	No sign	No sign
cation	D.F.	differences	1	differences	differences

F = Statistical Value of the Pearsons Chi².

P < 0,001 ***

P < 0,01 **

P < 0,05 *

CHAPTER IX

DISCUSSION

As seen in the literature Sociopathy still today seems to be a problem to psychology. The treatment programmes mostly seem to be doomed to failure. It also seems true that by ignoring the problem in a self-excusing way by saying that no treatment exists, is self-fulfilling and a mask behind which the therapist hides to excuse himself for not trying to really tackle the problem.

The sociopathic child is difficult and often very taxing to work with. It takes a lot of perseverance from the therapist to do therapy with them. Only by having a philosophical background of believing in the ability of the person to change and the will in every person for self-actualization as set out in the Humanistic model, will the therapist be able to persevere in the therapy of the child so filled with hate, anger and destruction that he wants to destroy even the one who wants to help him.

This study was a pioneer study in the field of therapy performed according to the humanistic model on the child with strong sociopathic tendencies. As can be expected, it has many shortcomings but at the same time has shown that the young child in the formative years of the pathology is still accessible to therapy and has the ability to socialize.

The results show that, according to Rorschach, the Experimental Group's anxiety aggression and hostility diminished significantly during therapy while that of the two control groups have remained the same. (Table 2). It seems thus as if intra-psychic rebellion has diminished.

The Rorschach which taps intra-psychic functioning is a sensitive test to what really is happening in the subconscious of the child and gives us thus a picture of not only his behaviour but also of his deeper unconscious feelings.

As the sociopathic child seems to be overwhelmed by aggression, hostility and suppressed anxiety, a diminishing herein indicates a basic change in orientation towards the world.

In the qualitative interpretations of their Rorschach protocols, one finds the following changes in the Experimental group which further indicates their change during therapy. Most of them were able to handle their reality in a more open and positive way. It seemed as if they were more aware of support from their environment and that they now felt more in control over the destructive forces in their environment.

An element of guardedness was still present indicating that they still had elements of the basic sociopathic elements in their reaction towards their environment. This means that one cannot be sure whether some elements of sociopathy was not still present in their personalities.

Although their self-images have improved from one ruled by an aggressive need to control to one of better control over themselves, they seemed to be unsure of how to present themselves in their new self awareness. In this area elements of manipulation were still present.

In their interpersonal relations, they seemed to interact on a more positive but on a superficial level. Interpersonal relations still seemed to be the one area where they still experienced feelings of anxiety. One can understand this as it was one of the main problematic areas for them to work through.

Their relations to the father seemed the one area in which little change has occurred. Most of them however were able to handle the negative feelings they had towards the father figure in a more positive way. This reaction towards their father is understandable if one takes into consideration that most of the fathers were either criminals themselves or unable to basically change or move closer to the child.

Their relations towards the mother seemed to be one that evoked affectional anxiety which may be viewed in the case of the sociopathic child as positive. At least they have become aware of their basic need for affection from the mother, something they have repressed or denied before.

An element of guarded playful manipulation of the mother was present indicating an ability to move closer towards the mother.

The mother figure thus seemed to be handled better by the children Post-therapy than the father figure which seemed to remain a problem.

Sexuality was integrated much more positively and in a normal way than Pre-therapy. Although not all of the children had sexual problems Pre-therapy, those that had seemed to have integrated their sexual aggression in a positive way during therapy. They all had a much greater control over emotional outbursts of impulsive nature.

Some of them projected a need for external support in controlling their emotions. This could be seen in a very positive light as it indicated that the omnipotent feelings of the sociopathic child have grown to his ability to accept the adult as a controlling external support system for his own weak developing ego-system.

They were mostly still aware of their impulsive urges but were able to control these urges more. In this area the greatest growth

seemed to have taken place.

Strong need for affection was present indicating a move away from the feelingless coldness of sociopathy. The child that has a need for affection and who is aware of it, will fight to secure it. Basically the problem with the sociopathic child is that he is not in contact with this need of his and fights against all efforts to reach him with affection. Once he has become aware of it however and acknowledges it, he has started to move away from the sociopathic mode of handling feelings.

Overall on the Rorschach it thus seems as if the Experimental group has changed intra-psychically from a basic sociopathic way of functioning to a more positive growth orientated way of reacting towards the stimuli from their environment.

To verify this change one has to look at the more objective tests used in this study, namely the Jesness Inventory Asocial Index and the Behavioral Rating Scale.

The Jesness Asocial Index is a standardize apparatus in which the child gives his own evaluation on a conscious and subconscious level of his orientation and acceptance towards social norms. The higher the Asocial Index, the more indication thus of rejecting the norms in a sociopathic way.

The Behaviour Rating Scale on the other hand is not a standardized tool but one developed specially for this study to have a tool on which to rate the behaviour of the sociopathic child as clinically observed by different people.

As different raters were used who could have biases, it was important to first establish the interrators' reliability which was calculated

and accepted. The Behaviour Rating Scale still has shortcomings in that some of the items may be overlapping, such as "obedience" and "controllability", although when one analyzes it more carefully, one has a subtle difference between the items.

As the other tests, namely the Rorschach and Jesness Inventory Asocial Index are standardized tests, the Behaviour Rating Scale was used in connection with these and the results obtained were not taken on their own but were evaluated in the light of the results obtained on the other two tests.

On both the Jesness Inventory Asocial Index and the Behaviour Rating Scale, the following results were obtained, namely: (See Tables 8,2 and 11,2).

The Experimental group who received therapy improved significantly. The Passive Control Group in care of their parents deteriorated significantly. The Active Control Group in care of the Institution showed no change.

These results show that individual psychotherapy, as conducted in this study, does have a positive effect on the behaviour of the child with strong sociopathic tendencies, that institutional care seems to stop the pathological process but not revert it, but when no treatment was given, it was detrimental to these children.

Item Analysis on the Behaviour Rating Scale (Table 12) showed that the sociopathic children who had received individual therapy seemed to have socialized and showed improvement in social behaviour. Their interpersonal problems as far as relationships with parents and peers were concerned, as well as their basic impulsivity did not improve however. It thus seems that what they themselves experienced as a

problem area on the Rorschach, namely their interpersonal relations was verified by the objective observation of the raters of their behaviour in these areas. They themselves felt that they had more inner control over their basic impulsive emotional outbreaks, although objectively it seemed as if they still were impulsive.

It appeared as if the sociopathic children had socialized during therapy, but still had certain sociopathic traits in their personalities. Although the tendencies in all three groups, also the improvement in the Experimental group, were still present at a two year follow up study, only a longer follow-up study will be able to verify whether they have changed from a sociopathic way of handling their reality to a more positive socially accepted way.

Where the literature is very negative as to the effect of individual psychotherapy with these children, this study seems to prove that the hypothesis postulated by Reed (op. cit.) that an integrated method of psychotherapy might bear fruit is true. The integrated method tried here was performed according to the Humanistic school. This is just one approach experimented with. There might be others just as effective that still has to be experimented with.

The institution seems to stop the process but not revert it. In reality this means that the basic sociopathic process is arrested but still present. In the rigid control system of the institution the sociopathic child seems not to deteriorate further, but basically he remains a child with strong sociopathic tendencies and will leave the institution as such. It seems of utmost importance that the child in the institution should also receive individual psychotherapy.

The literature has placed the parent as a strong etiological factor in the development of sociopathy. This seems true when one looks at the results of this study showing a definite detrimental effect executed by the parent on the children that remained in their care.

This raises the question whether the sociopathic child should not be removed from the parents. This study however has also shown that if the child with strong sociopathic tendencies receive individual psychotherapy while in the care of the parents, this might not be needed. If we were able to supply more facilities for individual psychotherapy for young children with strong sociopathic tendencies, less children might later be found in need of care and sent to an institution. This finding has far-reaching consequences for the future planning of psychiatric services for the young child with strong sociopathic tendencies. It also involves a willingness to accept sociopathy in the young so-called "innocent" child. By diagnosing the child, even tentatively - one gives him the change of treatment. By waiting till later after puberty, one might deny him his only chance to change. For those unwilling to label the child as a sociopath, the terms "child with strong sociopathic tendencies" or "Sociopathized child" offers alternatives indicating a more fluid changing process.

The combination of the different therapies used may sound to some like a shotgun approach which it may well be. As the aim of this study was primarily to establish whether change through individual therapy was possible in the child with strong sociopathic tendencies, it is recommended that the methods used be compared in their effectiveness

in another study. It may well be that some of the methods are less usefull, but this has to be proven in a later study.

The orientation of the humanistic model with its emphasis on the here and now and the experience of emotions proved very valuable for these children and it is felt that the value of the therapy lies not so much in the methods used as in the orientation in which they were used.

Including a full case study opens the research to criticism but as this is a Clinical study, the process of therapy is of great importance to the student and for this reason, the therapeutic methods used are illustrated by the full case study.

Looking back at the research, a process analysis of the therapy might have been of value, but submitting the subjects to intermittent re-testing during the therapy, would have had a detrimental effect on the Experimental group and might have had a therapeutic effect on the other two groups. Thus although it is a better method of research in therapeutic research, one is never sure of its detrimental effects as well.

As has been discussed under Apparatus, one is always aware of the influence of the personality of the therapist as to a certain extent an uncontrollable variable. In a follow-up study, different therapists using the same methods could be experimented with.

As one had a group of Sociopathic children at one's disposal, the scatter analysis of their NSAIS and WISC scores were compared with those found in the literature. This scatter with other instruments can be of great use in the diagnosis of the sociopathic child and for this reason was included in this study. Only the Pre-testing scores of the sociopathic

children was used to exclude the influence of therapy on the scatter pattern, as the scatter pattern is mainly used for diagnostic purposes.

It was found that on both the NSAIS and the WISC, the Performance I.Q. was higher than the Verbal I.Q., indicating a possible aspect of impulsive acting-out behaviour as postulated by Glasser (op. cit.) and Madge (op. cit.). Very good social insight seems to be present according to the positive outfall on Absurdities, Picture Arrangement and Picture Completion. (Table 8,1).

Very little anxiety was overtly manifested as seen by the positive outfall on Memory and Digits.

A good self-image seems to be present as manifested in the high positive outfall on Object Assembly.

The Negative outfall on Information may indicate egocentric tendencies. The Negative outfall on Vocabulary and Information may be an indication of a poor social background or an inability to absorb the norms from his background.

An inability to function successfully under stress seems to be present as indicated by a negative outfall on Problems and Arithmetic.

The children seemed to lack good "common sense" judgment and did not seem to integrate social norms as is indicated by the negative outfall on Comprehension.

The results obtained above on the NSAIS and WISC combined, fits the definition of the child with strong sociopathic tendencies. These two tests may thus be used with behaviour criteria to help diagnose the sociopathic child, as was postulated by Reid (op. cit.) that the WISC and the WAIS are still the best diagnostic tests for Sociopathy. This study seems to agree with this.

It is hoped that this study will encourage the clinician to undertake therapy with the child with strong sociopathic tendencies and that it will initiate further research in this area.

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APPENDIX 1

BACKGROUND HISTORIES OF THE EXPERIMENTAL GROUP

A very short background history of those children included in the experimental group, will be given here.

Kiewiet: 11 years 4 months.

He was the youngest of four children who was all found to be in need of care. His three older brothers had all been placed in Industrial Schools but later on his older brother was transferred to a reformatory. He was already three years in foster-care with a family who had no children of their own, when therapy was started.

His own family could be classified as the typical multi-problem family. The father had been in jail a few times and at the time of therapy, worked only sporadically. He was extremely aggressive towards his family and had had numerous extramarital affairs.

The mother seemed to be totally overwhelmed by her situation and could in no way assert herself against her husband. She worked as an assistant nurse in order to provide for them. They lived in a servant's room in the backyard of a suburban home.

Kiewiet, even though he was in foster-care, was constantly playing truant and was one of a gang of young boys who were caught for breaking into houses and stealing. He was not sent away because evidence against him was insufficient. He constantly told lies and was the bully of the neighbourhood, forcing younger children to do as he ordered them. The main complaint was however one of sexual deviancy. He had molested young girls to the extent that one of them had to receive medical treatment. The parent of this child did not lay an official charge but requested that he should receive treatment.

His foster-parents were at their wits end with him but were willing to give their full co-operation in his treatment. His teacher and social worker also promised their full co-operation.

His therapy progressed very slowly and although his behaviour improved, he still sporadically told lies and played truant.

His sexual deviant behaviour was curbed only perhaps because he sublimated it into masturbation.

His school work improved a lot but one remained with the feeling that contact with him was superficial.

His ultimate projected image at the end of therapy was of special significance. He made a young boy who was sleeping on a bed, with a big chest full of gold next to the bed. At the window was a robber with a knife and above the bed was a big clock. This he said was not a real clock but a time-bomb. When the bomb was on the verge of exploding, the boy would get up and leave with the robber, taking the gold with themselves. After being asked what animal he would like to be, he modelled a wolf with blood dripping from its teeth. It is also significant that he saw a "sly fox" on his self-image projecting card on the Rorschach.

It was evident that this boy had socialized in his behaviour but that his basic sociopathic behaviour had not changed.

After two years a follow-up study revealed that his behaviour was well controlled and that he was attending school regularly. Only time will show what really will be the strongest.

Robert: 8 years 10 months.

Robert was the middle child from a family consisting of an elder sister and a younger brother. The father and mother were divorced and Robert was in his father's care. His father was living with a woman who was in the process of divorcing her own husband. The family that Robert formed part of thus consisted of himself, his brother and his stepmother's three daughters. His own sister was in his mother's care. All the other children seemed to have adjusted well and showed no overt problems.

Robert's father was a very successful businessman with extensive business concerns. He travelled a lot and was away from home on overseas trips for the greater part of the year. His contact with Robert was superficial and he discussed him in the same manner as he would any business transaction.

Robert's own mother was a dependent and inadequate person with a much lower developmental level than his father. She had had numerous psychiatric treatments with a diagnosis of either an inadequate personality or of a histrionic personality. She was very inconsequential in her handling of Robert. Whilst he was still in her care, she was more dependent on his affection than being able to provide his needs.

His stepmother was a professional person, who could not form a relationship with him. Initially she felt that he was a threat to their marital relationship. She was however prepared to be involved in the therapy and to try to provide him with a more stable interaction. She acknowledged

that she found it very difficult to have any feelings for him, mainly because of his own coldness and shunning of any affection from anybody.

The presenting problems were: difficulty to communicate with him, lies, shoplifting and aggressive outbursts. He had also started with truancy and at one stage had drifted through the streets for more than two weeks before he was found. During this time he fended for himself by stealing from shops. He had two contacts with the police, one for shoplifting and one for breaking into the neighbour's house and stealing money. Only his father's influence stopped further steps from being taken.

A court inquest for a child in need of care was opened but because of the father's status, it was stalled to allow him to receive treatment.

Robert was able to make contact very easily with therapist but only on a superficial level. It was however difficult to really reach him as a person and to illicit any real feelings from him. His superficial contact changed after a while into aggressive outbursts against the therapist. These outbursts also increased at home to the extent that his father felt they could not deal with it any more. Slowly rapport with him was established and he started to talk about his problems. But even image therapy was initially extremely difficult for this boy to communicate in.

At the termination of therapy, most of his antisocial behaviour did not exist any more but he was still emotionally cold and remote in his contact with people. At times he would however break out in an impulsive burst of affection towards therapist or his stepmother but on the whole, one had the feeling that contact with him was on a very superficial level.

His schoolwork had improved tremendously and he did not play truant any more. The relationship with his father improved and they had more contact with each other.

Ashley: 11 years 4 months.

Ashley was the youngest of two brothers. His eldest brother was twelve years older than himself. His father was already 45 years old and his mother 43 years old when he was born.

The father was the artistic type who had numerous jobs, although he was a qualified architect. Early in his career he was struck from the register because of some kind of fraud. They moved often, even to different countries, because of the father's impulsivity and restless nature. When Ashley was taken into therapy, the father was a traveller for a wholesale firm and was often absent from home.

He abused alcohol sporadically and then became aggressive towards his

wife and Ashley. His mother had an immature and histrionic personality who could not give Ashley constant secure handling. One day she would refuse him to leave home but on the next day she would chase him out of the home. When he was taken into therapy, he and his mother were sharing a room while his father had his own room.

The presenting problems were as follows: Ashley was aggressive and cruel towards animals. He used to catch dogs and then carve out pictures with a blade on them. At one time he put a cat on a hot stove plate and baked one alive in a hot oven. He had started to be cruel to young children when he was brought in for treatment. He was constantly telling lies, playing truant and had been shoplifting. He was abusing alcohol and dagga, which he did not even deny, but told it to the therapist in a defiant manner.

It was difficult to establish contact with him. For more than two months the therapist only played darts with him twice a week, without being able to involve him in any other activity. During this time he tested the therapist by telling her about real or perhaps fantasized acts of aggression that he had performed to see if she would keep it confidential as she had promised. He returned to school but was placed in a new one as he had a lot of aggression against his old school.

Both parents were receiving marital therapy from a different therapist at that time.

Slowly he started to trust the therapist and opened up to her. His school work improved but sporadic lies and one case of theft at school occurred which he acknowledged and took the money back. His cruelty towards animals and children diminished until it did not occur any more at all but he remained very aggressive generally and could still very easily be provoked.

In this case the transitional object was very important. He accepted a monkey as his friend and used to talk to him for long periods at night. He even took him with as a companion when he was moved to his own room. As he grew emotionally, he slowly used the soft toy less and less. At the end of therapy his father bought him a real squirrel monkey which he cared for and cuddled. He never showed any cruelty towards this animal.

Gustaf: 7 years 11 months.

Gustaf was the eldest of three children. This child came from an upper middle class home. Both his parents are university graduates. His

father is at present senior lecturer at a university and his mother is a well known actress.

The mother brought the boy for therapy after she had received complaints from the school that he was telling constant lies, taking things from the other children and from the teachers' cases and that he seemed to be cold without any feeling for anybody.

After questioning, his mother halfheartedly told of two incidents where he had tried to harm other children physically. On one occasion he attacked his younger sister with an axe and said that he wanted to kill her. He also took the three year old daughter of the neighbours to the garage where he bound her hands and then took his tie and tied it around her neck. He stood laughingly watching her. Only the intervention of the garden boy saved the little girl who was already unconscious when he found her. He said he wanted to see how somebody died.

The mother as well as the father were seldom at home and the children were mostly cared for by their granny. She could not control Gustaf at all. Inconsistent discipline was used by both the parents and the grandmother.

The parent's marriage relationship seemed to be stable. The father was a warm person who said he just did not have the time to devote to Gustaf. The mother in contrast was over-dramatic with hysterical tendencies. She was defensive and tried to blame the father for everything.

The teacher at one stage felt Gustaf was becoming a danger to the other children and threatened to have him expelled from her class.

Gustaf's father was at one stage drawn into the therapy when he was taught in the playroom how to play with his son.

The aggressive behaviour diminished but the lies and stealing continued for quite a while until it slowly started to disappear. At the end of therapy he seemed to be totally adjusted in his family and school although one still had the feeling of coldness and aloofness when dealing with him.

Wayne: 9 years 3 months.

Wayne was the fourth of six children. Two of his older brothers were committed to a reformatory and his one sister was in an Industrial School. He and a younger brother had been in foster-care for the last four years.

The father was serving an undetermined sentence in prison. Although Wayne had not seen his father for more than five years, he was still identifying with him very closely when therapy started. The mother was of

borderline intelligence and had an inadequate personality. Discipline in his own home was non-existent.

Wayne himself had had numerous police contact for theft. He was very aggressive and told lies continuously. He even bragged about his behaviour to his friends. At the start of therapy he was attending school very sporadically. His foster-parents were at times over-indulgent and at other times rejected him completely. It seemed as if they had taken the children into foster-care more for the sake of the grant than out of real concern for them.

In therapy he was defiant and aggressive. He talked with bravado and even spat on the therapist. In the beginning of therapy he scorned her and tried to degrade her in any way he could. Slowly however she managed to build up a rapport with him. For quite a while however he did not trust her and one always had the feeling that you could not really reach his feelings. His antisocial behaviour diminished although at the end of therapy he still resorted to telling lies when it suited him. One also had the feeling that deep down this child was still very cold and callous although at times a flicker of genuine concern and positive feeling did come out that was not present at all in the beginning of therapy.

At the end of therapy he was attending school regularly and was much more in control of his aggression. At the time of the follow-up study he was selling papers and handed part of his pay over to his own mother for her needs. Although this was very positive one still had the feeling of coldness and aloofness in his emotional interaction.

Janica: 11 years 5 months.

Janica was the only child of parents from an upper middle class family. Her father was a businessman who never wanted to have anything to do with the therapy. He was abusing alcohol but was trying to keep it a secret for people outside the home. He was financially a successful businessman. He was a loner and mostly went out on his own. He even took his holidays on his own and quite often had his meals with business associates. He was aggressive towards Janica and had abused her at times. Twice she had to receive medical treatment for injuries received from him. The mother was so afraid of him that she never told anybody about it. It only came out during one of the therapy sessions.

The mother worked full-time as a typiste and mostly provided for her and Janica's needs from her salary, as she was too afraid to ask the father

for money. She was an immature person and depended upon Janica to make the decisions. Her approach to Janica was very ambivalent. At times she was affectionate towards her but at times she rejected her or demanded attention for herself from Janica. She in any case always treated Janica as her equal and not as her daughter.

Janica was an intelligent girl who did well at school initially, but started to lose all interest in her schoolwork. As she was very aggressive towards other children, she had no friends. Her school marks had dropped to failing level and at the same time she became aggressive and defiant towards her teachers. She would swear at them and even kicked one of them, and slapped another through the face. She was stealing whenever she had the chance to and had a don't care attitude when caught. She was also telling lies. The main thing however that disturbed the mother was her cruelty to animals. Her mother related that she would systematically torture an animal and watch it as it was writhing in pain.

Janica herself was very small of build for her age. At the beginning she was aggressive, abusive and refused to have any contact with the therapist. Therapy with her was, initially, extremely difficult. One never knew whether she trusted you or not. When eventually her trust was gained she started to have anxiety provoking dreams and nightmares. At that stage the therapist handed her a soft woolly cat to take to bed with her as her transitional object. She first laughed and scorned it saying it was childish. At home however she did put the toy in her bed and continued to do so for the whole period of therapy.

On the therapist's suggestion, she started to ice-skate and showed a lot of talent in that direction. At the end of the therapy she came second in the Provincial championships.

Her schoolwork improved although she still was not functioning at her optimum level. She became less aggressive although she remained aggressive towards her father. She could not be brought to accept his alcoholism or to have an understanding of it. Her relationship with her mother improved and she was relating much more on an affectional basis to her. Her antisocial behaviour stopped. At the end of therapy she had two Siamese cats to whom she was very attached and cared for diligently. Her cruelty towards other animals totally disappeared.

Although a great amount of growth did occur, the fact that her father remained distant and uninvolved proved to be a very sensitive and heart-breaking experience to this child. In no ways would he be involved in the therapy.

André: 9 years 2 months.

André was the youngest of four children, who was found in need of care. One of his elder brothers was in prison and the other two were in a clinic school. He was in foster-care with an elderly couple whose own children were already out of the house.

His father was an alcoholic who only worked sporadically. He could be classified as a work-shy immature personality. The mother used to practise as a prostitute. Discipline was irregular and inconsistent.

Uncontrolled aggressive behaviour occurred at home and at school. He had already been asked to leave two schools because of this behaviour. He used to get money through all kinds of illegal means. At one time he stole a collection list from the church and filled in his own dates. He collected quite a lot of money in this way. He also used to steal motor car wheel-caps and resold them. He never stole money directly but always goods which he then sold afterwards. He was also able to pick-pocket people and at one stage demonstrated to the therapist how he did it. He also acknowledged during therapy that he had on more than one occasion broken into houses. He had never been caught, mainly because he always entered through open windows and only took single items that he could easily sell. He could tell lies with a smoothness that often made it difficult to know whether he was telling the truth or not. He was however caught when he broke into the headmaster's office and took a tape recorder and the curtains. He was caught by the watchman and brought to the clinic by the headmaster instead of taking him to the police.

In the beginning of therapy he confused the therapist with the role of the social worker. This caused him to be very weary of her and hindered the relationship for quite a while. He also was very aggressive towards her at times. After he realized that she was really different to the social worker and that she had nothing to do with his removal from his home, he slowly started to trust her and the therapy began to progress.

He had no friends and those that at times tried to play with him he met with aggression. He was especially aggressive towards younger children.

In therapy he came to accept his parents as being sick and the choice was put to him of never seeing them again or having any contact with them. He chose the latter and became less aggressive towards them. During therapy he grew emotionally and socialized to the extent that no antisocial behaviour was still present. He however at times could still become very aggressive.

Marius: 8 years 3 months.

Marius was the youngest of five children of a family who was found in need of care. He was already two and a half years in foster-care when the therapy started. His behaviour had deteriorated so much that the foster-parents wanted the social worker to take him back. She however persuaded them to keep him a while longer and give him a chance in therapy, which they did.

His own father was in prison after being declared a habitual criminal. His mother was in a rehabilitation centre for alcoholics. His foster-parents could be considered as a good choice as they were stable, well adjusted people, who were able to give emotional warmth to him.

Marius used to steal increasingly more from other people and had started shoplifting. He was constantly telling lies. His schoolwork was deteriorating because of truancy. He was very aggressive towards children and animals and had started fires at two different times.

He was very aggressive towards the neighbour's son who was his own age. Just before therapy he had attacked him with a hammer and hurt him so badly that he landed in hospital. This initiated his therapy.

At the start of therapy the relationship with his foster-parents was very shaky and they had to receive instructions of how to handle him and a lot of support to keep him in their care.

His play in therapy was totally destructive and he did not allow the therapist to participate in his play or to reach him as a person. He was totally closed and defensive against her. He was so destructive that at one stage the therapist considered him totally unfit for therapy and nearly discontinued his therapy had he not been included in the research.

Slowly however he started to incorporate the therapist in his play. He started by making her the object of his aggression. When she did not react back with aggression, he slowly became more positive towards her and started to trust her, but still on a conditional basis.

This was a very eventful and aggressive therapy but it could be considered as successful as far as his readaptation to society and its norms are considered. He had more control over his aggression but still could be provoked easily. He was however less impulsive.

Maria: 11 years 3 months.

Maria was the only child of unstable parents. The father had

assaulted the mother on more than one occasion. The parents were both immature and used to use Maria as a pawn in their fights. The mother had had numerous extramarital affairs. She was an aggressive person who used to abuse Maria as a baby. When Maria was two, she was admitted to hospital with a fracture over the temporal area inflicted by her mother. For this reason an E.E.G. was done which was found to be normal.

Maria was brought by the social worker for therapy after having been picked up by the vice squad in the streets when she was picking up men for alleged prostitution. She would approach men and offer them sex for R1. She already had three police contacts for housebreaking and shoplifting. She was totally uncontrollable and defiant towards any authority. The mother was mostly alarmed by her total lack of feeling and her aggression.

Her school record was fluctuative in spite of her high intelligence. She played truant and was defiant about this towards the school authorities.

She sporadically had friends but never had any lasting relationships. Most of her friends that she mixed with were much older than herself.

This girl was a candidate for the Industrial School and plans had already been made to send her there when the social worker heard of the research project and brought her in for therapy.

She was a cold distant child without any real feelings. She had a defiant don't care attitude. During the first few sessions she used to stare at the therapist refusing to do anything. Slowly she was drawn out and reacted with very strong negative and aggressive emotions.

Even at the end of therapy only a few positive emotions could be elicited. She remained a cold callous child although her antisocial behaviour completely disappeared.

This girl eventually socialized, but one was constantly aware of strong underlying sociopathic trends that were still present in her personality make-up.

APPENDIX 2.

RORSCHACH WITH INTERPRETATIONS OF EXPERIMENTAL GROUP

KIEWIET BEFORE THERAPY

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
I.					
Vlermuis met stukkende vlerke.	W	F	A	H	A1
II.					
'n Rower se gesig.	W	M	H	H	A1
Hy lyk kwaai en wreed en sal kan moer.	W	F	A	h a	
'n Wolf se gesig.					
III.					
Twee rowers wat om 'n sak met geld baklei.	W	M	H	H	A2
IV.					
'n Rower wat aangestorm kom. Hy is baie kwaai en sterk.	W	M	H	H A	A2
V.					
'n Vlermuis.	W	F	A		
VI.					
'n Verskeurde kat. Hy is oopgeskeur en die bloed spuit by sy nek uit. Mens kan sy ribbes sien uitsteek.	W	F A C,m FK	Bloed	H A	A1
VII.					
Donder wolke voor 'n storm.	W	FK	Wolke	a	
VIII.					
'n Platgeryste kat. Sy derms en bloed lê oorals. Mens kan ook sy geraamte binne sien.	W	F,C FK	A	H	A1
IX.					
Die geraamte van 'n verrottende dier.	W	Fm	A	H A	A1

KIEWIET BEFORE THERAPY

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
X.					
Goggas wat 'n leeu-kop opeet.	W	F	A	H	A1
Hy is verskeur deur iets.				H a	
				<hr/>	
				19	9

KIEWIET AFTER

Vlêrmuis wat vlieg	W	FM	A		
II.					
'n Skêlm jakkals	W	F	A	h	
III.					
Twee ou meide om 'n vuur wat 'n oorlogs dans dans.	W	M,CF	H, vuur	h A	A2
IV.					
'n Groot sterk man					
Hy lyk of hy kwaad is.	W	F	H	h a	A2
V.					
Vlêrmuis	W	F	A		
VI.					
'n Kat hier is sy snorbaard en hy het 'n lang swart pels	D	Fe,FC	A		
VII.					
Twee mense wat versigtig kyk hmmm na mekaar.	W	M	H		
VIII.					
Twee verkleurmannelies wat teen 'n veelkleurige boom baie versigtig opklim	W	FM,FC	A		
IX.					
Wolke met sulke kleure van die son daarin.	W	KF,CF	Wolke		
X.					
Allerhande goggas.					
Hulle het elkeen 'n ander kleur.	W	FC	A		
				<hr/>	
				3	3

KIEWIET - QUALITATIVE ANALYSIS OF RORSCHACH BEFORE THERAPY

Handling of Reality

His reality is intact but he has the feeling that something is missing from his reality to make it meaningful.

Self-image

He identified with a robber who was full of aggression and able to destroy other people. Also the image of wolf furthers this image.

Interpersonal Relations

Although he is able to see human movement and thus identify with others, the interaction he projected was full of aggression and the people he saw were robbers with money.

Relationship towards Father

The father is also seen as a robber. He sees him in an aggressive light and able to do almost the impossible. No positive interaction with the father is projected.

Relationship with the Mother

On the one hand he felt affectional anxiety and tension towards the mother but on the other hand he reacted with strong aggression and destruction towards her on an emotional basis.

Sexuality

Aggression and sexuality are mixed to the degree that it nearly implies a sadistic element.

Emotionality

It seems as if his emotional responsiveness are literally destroyed by his aggressiveness. The only emotion projected throughout the protocol was one of aggression. It was a destructive aggression over which he seemed to have no control.

No affectionality was projected, except in the form of a need that is in affectional anxiety towards the mother, but even against this he had to defend with aggression.

KIEWIET - QUALITATIVE ANALYSIS OF RORSCHACH AFTER THERAPY

Handling of Reality

His reality testing was positive and intact.

Self-image

The fact that he sees himself as a sly fox was a disturbing sign as it indicated a slyness and cunningness in his approach and handling of his reality.

Interpersonal Relationships

Although he sees people in interaction the interaction was still of an aggressive kind. What was of note was that the aggression was of a much more controlled nature.

Relationship towards Father

He now sees the father as an identification figure, strong and somebody to look up to, but at the same time he had the feeling that the father was not satisfied and was cross.

Relationship towards the Mother

There seemed to be a guarded approach towards the mother although some interaction with her was possible. Any feelings of strong emotions towards her however still led to feelings of insecurity.

Sexuality

More positive responses were now given in connection with his sexuality although it seemed as if it also brought on an element of anxiety in this area.

Emotionality

Although he gave more controlled emotionality as well as some affectional responses his approach to his emotional world seemed to be nearly sly and manipulative in nature.

ROBERT BEFORE

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
I.					
It a butterfly					
It's got torn wings	W	F	A	H	Al
It has got funny, cunning eyes.					
II.					
What's this ?					
Is it a bee?					
The bee stings					
It hurts people when it stings	W	FM	A	H a	Al
People don't like this bee					
But it can make honey in a beehive for himself if he wants to.					
III.					
A man that got an olden day tie on sticking his tongue out.	W	M	H	H	
IV.					
It's a man that fell in a thorn bush. The thorns hurt. It's shoes are broken	W	M	H	H	Al
It got flappety hands.					
I don't like him.					
V.					
A bat, flies in the dark					
It eats mice	W	FM	A	a	
It's got very good eyes to watch everything.					
VI.					
It's a cat that's holding his head up. Got four legs. It's ears are'nt nice. Its tail is behind its back.	W	FM	A		

ROBERT BEFORE (Cont.)

Rorschach

Elizur

Holtz

VII.

What is this!

..... I don't know.

VIII.

It's a skeleton. It's got bones

White ones

You can see it's teeth

W

F

Geraamte

H

A

Al

It has not got eyes

FC'

Skeletons are scarry.

IX.

Inside of an elephant

They use it in the circus to

make people scarry.

W

KF

A

h

A

Al

You can see through them they

are'nt nice.

X.

It is a fox that has been killed

on the beach

F

A

H

Al

Crabs are biting it

W

FM

H

Al

They are eating his flesh

Foxes kill people because they

H

A

can't get meat.

17

7

ROBERT AFTER

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
I.					
It's a butterfly flying.	W	FM	A		
II.					
It's a bee on a flower making honey	W	FM	A		
III.					
Two old men dancing around a flaming fire.	W	M CF	H		
IV.					
It's an old man with torn clothes hanging in bags around him. His shoes are broken.	W	F	H		
V.					
A flying bat ready to make a catch.	W	FM	A	h	
VI.					
It's a cat with very long fur and hairy whiskers. A strange sort of cat.	W	Fc	A		
VII.					
It's wool from a sheep. Can make a fur coat with it. Can make you warm if it wants to.	W	Fc	A obj.		
VIII.					
Hmm Sort of difficult. A coat of arms or a skeleton.	W	F	coat of arms skeleton	h	A Al

ROBERT AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
IX.			
Torn out coloured wool.			
From a torn jersey	W	FC	Obj. h
X.			
A beautiful coloured flower			
opening. You can see the	W	FC	Nat.
stem, the petals and the		m	
inside.			<hr/> 3 2

ROBERT - QUALITATIVE RORSCHACH ANALYSIS BEFORE THERAPY

Handling of Reality

Although his reality testing was intact he had a feeling that all was not totally right in his reality. There seemed to be a sly manipulative approach to his reality in the darkness, not in the light.

Self-image

He gave a very realistic view of his self-images. He was aware that he could cause damage to other people and that this was the reason why they did not like him but he did not care for he was contented in himself. He can look after himself and provide in his own needs even at the cost of others.

Interpersonal Relations

He was able to see people but his interaction with them was on a distant base and defiant in nature.

Relationship towards Father

He saw the father as somebody who could cause himself harm. He sees him as a weak person and rejected and despised him for it.

Relationship towards Mother

Initially the mother figure provoked so much anxiety that he was unable to respond to the card. Then he saw her as threatening and without the ability to make any contact with him.

Sexuality

Although he was aware of his sexuality he wanted to ignore and cover it up. He did not want to hear about it although he did not deny it altogether.

Emotionality

The main emotional tone was one of aggression and threat. He became so overwhelmed with his aggressive feelings that he seemed unable to project any other emotional or affectional feelings.

ROBERT - QUALITATIVE RORSCHACH INTERPRETATION AFTER THERAPY

Handling of Reality

He saw his reality in a much more positive light and was more animated although an element of self gain in interaction with his environment was still present.

Self-image

He saw himself much more positively active without the strong underlying aggression against everybody as before therapy.

Interpersonal Relations

Much more positive conceptualization and interaction in his interpersonal relations were now present. An element of distancing himself from people however was still present.

Relations towards Father

The father was still seen in a distant relationship. He still saw him as unable to fulfill his needs. He further saw him as unstable and thus somebody whom he could not trust.

Relations towards the Mother

Very strong affectional needs mixed with emotional needs were projected towards the mother. He knew that she could fulfil his emotional needs but seemed unsure whether she was able to do so on a constant basis. That was the reason why his emotional reaction towards her was still ambivalent.

Sexuality

He was able to integrate sexuality with affectionality as that was still a foreign aspect to him.

Emotionality

Although he still seemed confused in this aspect, he felt that his emotional world was unfolding like a flower. He still needed external control and he felt aggressive about this. This also made it difficult for him to integrate his emotions smoothly into his personality make-up. Affectionality and especially the need for it was projected very strongly.

ROBERT BEFORE

Rorschach Elizur Holtz

I.

Well, I have made this picture
myself. It's a scary old mons-
ter with a few tics and flies
on him. He scares other people
but I laugh at him.

W M (H) H A A1

II.

Blobs are very big.
Dracula who has just killed
someone. Blood all over,
dripping from its teeth.
A mat with a hole in it.

W F Blobs
W M,C (H) H A A1
 m Blood
W F Obj. h

III.

Two men trying to catch
a sly crab.
Got bitten
Seahorses swimming
upside down
Seapigs
Vampire

W M H h a A2
 H
D FM A
D F A
D F (A) H a A1

IV.

An elephant skin
Two tusks and ears
Ends worn down.

W F A obj.
D F A obj.

V.

Bat
Two horses or goats coming
to each other
Going to ram each other.

W FM A H A2

ASHLEY BEFORE (Cont.)

	Rorschach		Elizur	Holtz
VI.				
Two pigs being tied up by their hind legs. One leg has been torn off.	W	m	A	H a Al
Two swans putting their necks up.	W	FM	A	
Reflection in the water.	D	cF	Reflection	A
VII.				
Now this looks like inside a volcano Crator where fire erupts. Down inside is water.	W	KF	Volcano	H A
VIII.				
Another dracula type of picture.	W	F	(H)	H Al
Coat of arms with two bears sticking out the side, with the skeleton of a monster next to it. The skeleton has broken the coat of arms.	W	F,m	Coat of arms Skeleton	A H Al
IX.				
More Blood	D	C	Blood	H A Al
Two monsters with their noses on fire ram into each other.	W	M,CF	(H) Fire	H A
X.				
Two seahorses	D	F	A	
Little seafish deap down	D	F	A	
Lobsters	D	F	A	a
Other fish.	D	F	A	

ASHLEY AFTER

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
I. A monster with a chain through his nose held by a big lock	W	F	(H) h a A1
II. A Vampire not very scarry A make belief one	W	F	(A) h a A2
III. O, now I see Two women dancing a, o no men dancing a war dance at a festival.	W	M	H h
IV. A dead elephant.	W	F	A a A1
V. Bat	W	F	A
VI. Two people trying to hold hands with their backs to each other.	W	M	H
VII. Clouds, something like clouds that is half dark and half light Just after a storm.	W	KF C'F	Clouds A
VIII. Coat of arms with all colours and two animals Perhaps I like it.	W	F,FC	Coat of arms

ASHLEY AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
IX.			
Clouds at sunset full of colours.	W	KF CF	Clouds a
X.			
Underwater Fish, plant etc.	W	F	A
			<hr/>
			3 6

ASHLEY - QUALITATIVE RORSCHACH INTERPRETATIONS BEFORE THERAPY

Handling of Reality

A strong feeling of control over his reality - feelings of omnipotence - was projected here. He was in control and could make his reality whatever he wanted it to be. Thus it became a reality full of threatening things to other people but to him it was a source of entertainment.

Self-image

Initially he gave an undifferentiated response as if he could not project himself immediately into his world. He however gained control very easily and then became the one that destroys, the aggressive one that will destroy his world with uncontrollable emotions. No wonder that something seemed missing from the wholeness of his world.

Interpersonal Relations

To him his interaction with people was one of cunningly misleading people while they tried to catch him. He was the "slycrab" that could escape people over and over again. His interpersonal world was an upside down, unreal world full of threatening things.

Relationship with the Father

Although he seemed to look for affection from the father, he met only with hard aggression which seemed to have little effect on him. He had the need to be heard and to communicate with his father.

Relationship with the Mother

Very strong emotional stress and uncontrolled outbursts of emotions were perceived in his relations with his mother. This to him seemed to be the source of his own inability to control his emotions.

Stress and conflict in this interaction seemed to be the rule. It was an unsatisfying, threatening relationship that was affecting him in a destructive manner.

Sexuality

Anxiety as well as the feeling of being harmed in this area were present.

Emotionality

Strong uncontrolled emotions were present. Explosive emotions that could totally destroy him were perceived. He himself felt that aggression was the cause of destruction in his emotional control "the skeleton has broken the coat of arms." No affectionality was projected.

ASHLEY - QUALITATIVE RORSCHACH INTERPRETATIONS AFTER THERAPY

Handling of Reality

He was still aware of destructive forces in his reality but they were controlled so that he could handle them. In comparison with his previous protocol, he now seemed to have more control over the destructive forces in his environment.

Self-image

An element of being the one that threatens his environment, was still present but he himself put it as a facade in making it "a make belief one."

Interpersonal Relations

He was now able to see positive interpersonal relations but still with an element of aggression present. He tried to handle this and make the aggression ineffective by turning it into a festival. This element of diminishing aggression or threat was repeated throughout the protocol.

Relationship with his Father

The father to him has become literally dead. No feelings or interaction towards him were projected any more.

Relationship with Mother

Affectional anxiety towards the mother was still present but it now had flickers of light in it. The storm had passed and the clouds now represented the anxiety that went with the rebinding with the mother. But even in his emotional reactions and relations towards her he still had feelings of insecurity and affectional anxiety. At least he was now showing positive feelings.

Emotionality

He had gained control over his previously uncontrolled emotions and he seemed to enjoy that new found control although he still needed external control to help him.

No affectional responses were given.

ANDRÉ BEFORE

Rorschach Elizur Holtz

I.

Lyk soos 'n wolf se gesig W F A H A
(Die vorm) h a

II.

Lyk na 'n ek het die
naam nou vergeet. Die ding wat
'n vuurpyl vashou en hom laat W F,m Obj. h
opstyg. Hier trek hulle hom,
dan as hulle hom los, weg is
die vuurpyl.

Lyk soos 'n bom wat in die
water ontplof. As hy in die W KF,m Bom H A Al
water val gee dit rook af ontplof

en skiet dan uit.

III.

Twee mense roer 'n pot W M H
Rooi bloedspetsels D C Bloed h A

IV.

'n Grot. (Die grot kom
so in dis die muur en hier W KF Grot A
gaan mens in)
'n Ding met 'n stert met
lang voete. W F (A)

V.

'n Vlêrmuis wat vlieg. W FM A a

VI.

Hierdie gedeelte is 'n
afgeskeurde slang ('n slang
moet rond wees en dis nie D F A H a Al
meer rond nie).

ANDRÉ BEFORE (Cont.)

	Rorschach	Elizur	Holtz
VII.			
'n Knyptang			
(Hy staan so oop)	W	Fm	Obj. h a
VIII.			
Lyk soos tiere wat iets onder wil bespring.	D	FM	A h a A2
Die bloed van hulle prooi			
Die rooi	D	C	Bloed H A Al
IX.			
Lyk soos 'n stofstorm want die draai in sulke kolke.	W	KF m	stof-storm A
Olifantjie met 'n rooi broekie en blou hempie aan.	W	F,FC	A
X.			
Twee leeus wat lê	D	FM	A H a
'n Rooi wurm.	D	C,F	A

ANDRÉ AFTER

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
I.				H	A
Vlêrmuis	W	F	A		a
II.					
Twee narre wat dans	W	M	H		
III.					
Twee meide wat in 'n pot roer. Hulle sing terwyl hulle dit doen.	W	M	H		
IV.					
'n Rooi skoenlapper	D	CF	A		
'n Gorilla (Hy is groot en sy vel is so harig soos 'n gorilla s'n)	W	Fc	A		a
V.					
'n Vlêrmuis wat vlieg.	W	FM	A		a
VI.					
Hierdie is 'n slang (sy vel is so vol skubbe)	D	Fc	A	h	a
'n Skaapvel (Lyk soos wol)	W	Fc	A obj.		
VII.					
Twee ballerina danseresse wat op hul tone staan en hul een been oplik.	W	M	H		
VIII.					
Lyk soos tiere hulle gaan iets bespring.	D	FM	A	h	a
Hierdie is 'n rooi en oranje skoenlapper.	D	CF	A		A2

ANDRE AFTER (Cont.)

.....
Rorschach

Elizur

Holtz

IX.

Dis weer die speelgoed olifantjie

met sy groen broek, ag hemp, en W F FC A
oranje broek.

X.

Krappe wat hul pote so lig D FM A

Watte lekkers

(Dis so sponserig en sag) D cF Obj.

'n Wensbeentjie D F Obj.

2 5

ANDRÉ - QUALITATIVE RORSCHACH INTERPRETATION BEFORE THERAPY

Handling of Reality

His reality testing was intact but his experience of reality was one of contact with an aggressive animal.

Self-image

His experience of himself in his world is one of explosive uncontrolled emotions. He had the realization of having impulses in him that could become totally destructive and this caused anxiety in him. He projected an element of having had external control but realized that this control was not sufficient to control him completely.

Interpersonal Relations

He seemed able to interact with people but it caused him to react with uncontrolled emotionality.

Relationship with Father

The relationship with the father was to him basically on a distant plane and to a certain extent foreign. He degraded the father image to a thing although he did acknowledge his male identify.

Relations towards Mother

A feeling of being constricted by the mother was projected. Affectual anxiety was projected mixed with positive feelings at an infantile level.

Sexuality

He had the feeling that something was wrong with his sexuality.

Emotionality

Strong emotions of an explosive nature seemed to be present which at times he seemed able to control, but in general his control over his emotions was very weak.

No affectional responses were given except in the form of affectional anxiety.

ANDRE - QUALITATIVE RORSCHACH INTERPRETATIONS AFTER THERAPY

Handling of Reality

Positive popularly experienced reality was projected.

Self-image

A much more positive experience of him in his world was given, but an element of superficiality, playing an insincere role was also present.

Interpersonal Relations

Good interpersonal relations with positive emotional involvement was projected.

Relations towards the Father

The father was still seen as an overwhelming figure but he had a much more positive and emotional interaction with the father.

Relations towards the Mother

There seemed to be a greater openness to interact with each other even if they had to "stand on their toes" to do so. There was a mutual involvement between mother and child. Controlled emotionality was still present but now without the affectional anxiety.

Sexuality

Sexuality was seen positively.

Emotionality

Emotionality was experienced in a controlled fashion. Affectionality was strongly present as a need as well as an experience.

GUSTAF BEFORE

6 jaar 9 maande

	<u>Rorschach</u>			<u>Elizur</u>	<u>Holtz</u>
I.					
Skoenlapper	W	F	A		
II.					
Skoenlapper	W	F	A		
Iets soos 'n mens, ek weet nie wat nie.	W	F	(H)	a	
III.					
Mens se lyf met 'n strikkie op sy kaal bors.	W	F	H		
IV.					
Ek weet nie					
V.					
Nek van sy kop afgeskeur	W	F	H det.	H a	Al
VI.					
Mens se lyf	W	F	H det.		
VII.					
Kop sonder 'n lyf	W	F	H det.	H a	Al
VIII.					
Dierasie	W	F	A	a	
IX.					
Vrou se ooghare	D	F	H det.		
X.					
Vrou se rok	D	F	H obj.		
Vrou se rok wat so oopgaan.	W	F,m	H obj.		

GUSTAF AFTER

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
I.			
Vlinder	W	F	A
Pappa en Mamma en 'n seuntjie wat hulle sy hande vashou	W	M	H
II.			
Vöel wat vlieg	W	FM	A
Twee mense wat hande teen mekaar sit	W	M	H
III.			
Een deel van 'n kewer	D	F	A h
Sy pote lyf en tande	D	F	A
Varkie se poot			
Vrou se skoer	D	F	H obj.
IV.			
Wit velle van skape wat so geskeer is so met die wol.	W	FC' Fc	A obj.
V.			
Vlinder se lyf	W	F	A
Vlermuis	W	F	A
VI.			
Tier se nek en kop (Snorbaarde en snoet)	D	F	A a
Skaap se vel (Wol)	W	Fc	A
VII.			
Dogtertjie of sy op haar kop staan	D	M	H
VIII.			
Twee diere - cheetas	D	F	A a
Wrak van 'n boot	D	F	Obj. h

GUSTAF AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>	
IX.				
As daai groen was (pienk) lyk				
dit soos 'n boom	D	F → C	Nat.	
Pienk soos 'n wurm	D	CF	A	
X.				
Knyptang	W	F	A	h A
				<hr/>
				3 4

GUSTAF - QUALITATIVE RORSCHACH INTERPRETATIONS BEFORE THERAPY

Handling of Reality

His reality testing was intact but his concept of his reality was one full of aggression.

Self-image

Initially he had a positive self-image but it changed into a near human concept of someone he did not really know. Gustaf was very young and this may be the reason why his self-concept was still so defuse.

Interpersonal Relations

He was able to see people but not able to perceive any human interaction. They are presented without any affection and with only a slight indication of emotionality to which he was unable to react to.

Relationship towards Father

The relationship towards the father was so threatening that he could not respond at all.

Relations towards Mother

He had a strong need for affectional mothering but all he received from her was a cold intellectual approach without the physical closeness that he was looking for.

Sexuality

To him sexuality was still only an anatomy function and he projected it as such.

Emotionality

No emotionality was projected which is unusual for a child of this age and indicates a pathological facet in the area of his emotional development.

GUSTAF - QUALITATIVE RORSCHACH INTERPRETATION AFTER THERAPY

Handling of Reality

His handling of his reality was much more positive than before therapy. He did not see himself as alone in the world any more. His reality now comprised of a "mother and a father and a small boy holding hands."

Self-image

He felt much more free in his world for he had found someone to hold his hands supportively.

Interpersonal Relations

His interaction with people still seemed disconnected to him and that caused underlying feelings of aggression towards people. He still had to integrate many pieces in his interaction before that part of his life would be an integrated wholeness.

Relationship towards Father

Strong affectional feelings towards the father was now present.

Relationship towards the Mother

He was still unsure about his relationship towards his mother. Things in this relationship was still not ordered and in an upside down condition. He was even unsure about the kind of emotions which he felt towards her.

Sexuality

Sexuality to him was still strongly mixed with affection but it also contained an element of anxiety.

Emotionality

Strong affectional and emotional elements were present in his protocol, but he still felt a pressure of not really knowing how to integrate those new feeling elements in his personality.

WAYNE BEFORE

	<u>Rorschach</u>			<u>Elizur</u>		<u>Holtz</u>
I.						
Kind of an Insect	W	F	A			
Two animals growling at each other	W	FM	A	H	a	A1
II.						
Looks like a dog's face, his eyes and mouth are bleeding - red blood dripping.	W	F C m	A Blood	H	A	A1
III.						
Two natives hitting a drum						
There is a fire around them	W	{M CF	H Fire		A	
Two women cooking.	W	M	H			
IV.						
Torn grasshopper's face	W	F	A obj.	H		
Two birds sitting against two bags.	W	FM	A			
V.						
Butterfly	W	F	A			
VI.						
Cat on the top lying down. (Form)	D	FM	A			
VII.						
Two monkeys shouting at each other	D	FM	A	H		A2
Biting and fighting.						
VIII.						
Two mountain lions.						
Inside is the body of a man ripped open by the lions.	W	{F FM	A H obj.	H	a	A1

WAYNE BEFORE (Cont.)

	<u>Rorschach</u>			<u>Elizur</u>		<u>Holtz</u>
IX.						
Two snarling animal faces	D	FM	A	H	a	A2
Two grown ups.	D	F	H			
X.						
Cat with a beard	D	F	A			
Two insects arguing	D	FM	A	H		A1
Two funny spiders.	D	F	A		a	
				<hr/>		
				14	8	

WAYNE AFTER

I.						
Wolf face with its teeth showing	W	F	A	H	a	A2
II.						
Snarling dog but it will not bite. Just a warning dog.	W	FM	A	h	A	A2
III.						
Two women dancing happily around a fire. The red.	W	M	H		A	
		CF	Fire			
IV.						
A very sad man with torn clothes. You can see it hanging around him.	W	F	H	h	a	
V.						
Butterfly.	W	F	A			

WAYNE AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
VI. Cat with long whiskers.	W	F	A
VII. Two monkey fighting and playing with each other.	W	FM	A h A2
VIII. Two lions climbing a tree	W	FM	A a
IX. Two people playing a game smiling and watching each other very carefully. They are also teasing each other.	W	M	H
X. A lot of insects in a bush living together and sometimes killing each other for food.	W	FM	A H A2 <hr/> 7 7

WAYNE - QUALITATIVE RORSCHACH INTERPRETATION BEFORE THERAPY

Handling of Reality

His reality testing was intact but he experienced his reality as being one filled with aggression and strife.

Self-image

He sees himself animated but wounded by his environment. Strong uncontrolled emotions were experienced in connection with his environment.

Interpersonal Relations

He saw interpersonal relations in a positive light although interaction provoked in him very strong uninhibited emotional feelings.

Relationship towards Father

The father was seen by him as being inadequate, having been injured by his environment and tending to be a dependent person.

Relationship towards Mother

He felt himself on equal plane with the mother but at the same time in constant conflict and competition with her. This could be seen as a very stormy relationship.

Sexuality

Passively experienced sexuality was projected, which is normal for this age group.

Emotionality

Strong aggression against his environment was projected. The possibility of uncontrolled emotional outbursts was present. There was only a suggestion that he might be looking for affection from his environment but was suppressing it at the same time.

WAYNE - QUALITATIVE RORSCHACH INTERPRETATION AFTER THERAPY

Handling of Reality

He still seemed to have a guarded, defensive approach to his reality.

Self-image

The basic aggressiveness in his personality was still present, but was now bridled, being able to control it. He was however constantly on his guard and warned that he had only marginal control over his emotions and he might again lose this under stress.

Interpersonal Relations

He projected a positive warm human interaction in this area.

Relations towards the Father

There seemed to be some empathy with the father for whom he now even experienced affectional feelings. No positive interaction with the father was however projected.

Relationship with the Mother

Although he still projected an amount of competition and anxiety in this relation he diminished it by making it more into a playful situation. The possibility of manipulation of each other cannot be ruled out.

Sexuality

Affectionality was now coupled with his sexuality which on the whole was still passive.

Emotionality

Much more controlled emotions were now projected especially as far as aggression was concerned, although underlying strong aggressive impulses were still present.

A bit of affection was also projected.

JANICA BEFORE (Cont.)

	Rorschach	Elizur	Holtz
VIII.			
Two animals climbing up a straight rocky fence.	D	FM	A
On the top is a big head rotting away.	D	F	A obj. h a
IX.			
Spider's face. Lots of green fungus growing on him.	D	F,CF	A a
X.			
A bear's face.	D	F	A a
			8 9

JANICA AFTER

I.			
A butterfly with outstretched wings ready to fly.	W	FM	A
II.			
A butterfly creeping out of a cocoon. It's got lovely wings that it must still test.	W	FM	A
III.			
Two natives dancing in the dark around a fire (The red)	W	M C'F CF	H Fire
IV.			
Ag A puppet on a string trying to dance but everybody is laughing at him.	W	M	(H)
V.			
Butterfly.	W	F	A

JANICA AFTER (Cont.)

Rorschach

Elizur Holtz

VI.

Skin of a lion made into
a carpet.

W Fc A obj.

VII.

Two girls holding hands and
talking.

W M H

VIII.

Two cameleons climbing up a
tree
(It got the colours of
the tree)

W FM A
FC

IX.

A spider's web where his
children stay.

W F A obj.

X.

A laughing man's face.

W M H

JANICA - QUALITATIVE RORSCHACH ANALYSIS BEFORE THERAPY

Handling of Reality

Her reality testing was intact. She saw herself in relation to her reality as angry towards her reality and in conflict with it, but she does her destructive work in an underhand way. Something of a slyness was suggested here. The possibility that acting in this way might cause anxiety in her could not be ruled out.

Self-image

She tried to hold up the image of having a positive self-image but knew that underneath she was not what she was trying to let people believe she was. Aggression against her environment was present but she acted on these impulses in a very sly and manipulative way.

Interpersonal Relations

Interpersonal relations seemed to be full of anxiety provoking dehumanised interactions which caused her to react with anxiety.

Relationship towards the Father

She seemed to be aware of the father's maleness. She however felt very ambivalent towards him. On the other hand she saw him as strong and proud but also as weak and insignificant. She knew that both elements were part of his personality.

Relationship towards the Mother

There seemed to be an extreme effort to communicate between mother and child, but somehow they do not succeed in communicating or really understanding each other. She also saw the mother as threatening, but nevertheless she was emotionally bound to her.

Sexuality

Strong emotional conflict was elicited by the sexual element. An element of aggression was also present in this area.

Emotionality

Aggression, uncontrolled emotions and manipulation of her environment were present. No positively softer affectional emotions were projected.

JANICA - QUALITATIVE RORSCHACH INTERPRETATION AFTER THERAPY

Handling of Reality

She now had a very positive handling of her reality. There now seemed to be an openness towards her world and an eagerness to handle and explore her reality.

Self-image

She seemed to have a deep realisation that something happened that changed her. She felt totally changed and saw herself in a different light, but still felt unsure about her new image that had to be tested out.

Interpersonal Relations

Although she now had a much more positive interaction with people she still felt anxious in interpersonal interaction.

Relations towards Father

She still saw the father in a very negative light. His weaker points were now much more to the foreground, and she reacted upon this very strongly. She saw him as a puppet doing what others wanted him to do. A great deal of disgust with the father figure was present.

Relationship towards Mother

A much more positive relationship between her and her mother was now projected although she still saw herself as her mother's equal. Although the threatening element was still present it was not a fearful element any more as the threatening thing (spider) was also the one that cared and nurtured now. One may postulate that she does not see her mother as basically different but that in her deeds she was a changed person.

Sexuality

She now gave a much more positive sexual response although it was still passive.

Emotionality

In her emotional responsiveness towards her environment an element

of insincerity was still present. (The cameleon). Her emotions were however much more controlled and a small element of affectionality was beginning to develop.

MARIUS BEFORE

	Rorschach			Elizur		Holtz
I.				H	A	
'n Aasvoël wat met sy bek 'n vrou se kop afbyt.	W	FM	A	H	a	Al
II.						
Bloed wat uit 'n oop seerplek spuit.	W	CF,m	Bloed	H	A	Al
III.						
Twee meide wat om 'n rooi vuur dans.	W	M,CF	H/duur		A	
IV.						
Swart nag donderwolk.	W	C'F,KF	Wolk	h	A	
V.						
'n Vlermuis.	W	F	A		a	
VI.						
'n Hoender wat nekomgedraai is (Hier is sy gorrel en daar spat sy bloed).	W	Fm, CF	A/Bloed	H	A	Al
VII.						
'n Kwaai swart duiwel wat vloek.	D	M,C'F	(H)	h	A	Al
VIII.						
Katte, rooikatte, wat opklim na 'n groen verskeurde sprinkaan	D	FM,CF	A P	H		
IX.						
'n Veelkleurige atoom- bom ontploffing. (Die prentjies van die wolk lyk so).	W	CF,m	Ontploff- fing	h	A	

MARIUS BEFORE (Cont.)

Rorschach Elizur Holtz

X.

Kleure wat oor die hele
blad sy gespat is. Dit lyk
soos verf wat so met 'n
tandeborsel gespat is.

W CF Kleur

MARIUS AFTER

I.

'n Vlieënde voël

W FM A H A

II.

Twæbeertjies wat soen
Hul pootjies het seer-
gekry (die bloed).

W FM,CF A/Bloed h A

III.

Twee meide wat om 'n pappot
dans. Hulle lig hul boude
so op.

W M H

IV.

'n Groot kombers (My ouma
het een en hy is van skaap-
velle gemaak
Omdat hy amper soos wol is)

W Fc Obj.

V.

'n Vlêrmuis wat vlieg.

W FM A a

VI.

'n Springbokkie se vel
(Hier loop sy streep en sy
hare staan so)

W Fc A/obj.

MARIUS AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
VII. Twee dogtertjies wat hul neusies vir mekaar optrek.	D	M	H h
VIII. Dis rooi katte wat op 'n berg klim.	D	FM,FC	A
IX. Lyk soos 'n blom (Die geel van die bo en die blare is groen)	W	CF	Pl.
X. Twee kinders wat koel drank uit 'n strooitjie drink Gekreukelde blare (dis opgekrul)	D	M cF	H Pl.
			<hr/> 2 3

MARIUS - QUALITATIVE RORSCHACH ANALYSIS BEFORE THERAPY

Handling of Reality

His reality testing was intact but he was overwhelmed by aggression against his environment.

Self-image

Strong, uncontrolled emotions, with the realisation that it caused pain to others, were present in his self-image.

Interpersonal Relations

He saw his interpersonal world in a positive light.

Relations towards Father

Strong affectional anxiety mixed with disphoric feeling was projected in connection with the father figure.

Relations towards the Mother

"An angry black devil that swears" was his experience of his mother, thus threatening him but also causing depressive feelings in him.

In his relationship towards her strong uncontrolled emotions were present mixed with affectional anxiety.

Sexuality

He again projected strong aggressive feelings mixed with uncontrolled emotions.

Emotionality

The main theme of his protocol was one of explosive uncontrolled emotions and aggression. Affectional anxiety was also projected.

MARIUS -- QUALITATIVE RORSCHACH ANALYSIS AFTER THERAPY

Handling of Reality

His reality testing was intact and positive. No anxiety was present.

Self-image

Affectionality in his self-image was given. He however had the realisation that he was injured in his self-image and still had strong emotional feelings in this connection.

Interpersonal Relations

Positive interpersonal relationships were projected.

Relations towards Father

He now had a strong need for affectional caring and protecting from the father but was at the same time unsure whether the father was going to provide in this need of his.

Relations towards the Mother

Integrated well controlled emotions were present towards the mother. There seemed to be a playful interaction between them but at least some interaction was now present.

Sexuality

Very good and positive sexual development seemed to have taken place.

Emotionality

This protocol was one of good integrated affectionality and controlled emotionality. Three "c" responses might look high for a child of his age but it shows a deep realisation of the affectional element which in this case can be seen as positive.

MARIA BEFORE

	Rorschach		Elizur	Holtz
I.				
Lyk soos 'n spinnekop (Omdat dit so lyk)	W	F	A	H A h a
II.				
Soos 'n kwaai spinnekop wat bloed suig. (Die rooi is die bloed).	W	FM,CF	A/Bloed	h A Al
III.				
'n Krap (Dis sy pote die)	W	F	A	a
IV.				
Skoene, die hakke (Dis soos die vorm van skoene)	D	F	Obj.	
V.				
Vlêrmuis wat vlieg.	W	FM	A	a
VI.				
Lyk soos 'n hoender wat se kop afgekap is. (Want sy bloed loop hier uit)	W	CF,m	A/Bloed	H A Al
VII.				
Klein dogtertjies wat vir mekaar skêl.	D	M	H	H
VIII.				
Goggatjies op die boom (Hulle is net daar. Die boom lyk groen).	D	F,CF	A/Pl.	

MARIA BEFORE (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
IX.			
Krap			
(Dit lyk soos die voelers van 'n krap).	W	Fo	A a
X.			
Onder die see. Al die diere en visse is vol kleure.	W	CF	A
			<hr/> 6 8

MARIA AFTER

I.			H	A
Vlêrmuis	W	Fo	A	a
II.				
Twee dansende mannetjies	W	M	H	
III.				
Twee meide wat 'n pot optel.	W	M	H	
IV.				
'n Skaapvel (Dis wollerig)	W	Fo	A obj.	
V.				
Skoenlapper wat vlieg	W	FM	A.P.	
VI.				
Weer 'n wol skaapvel	W	Fo	A obj.	

MARIA AFTER (Cont.)

	<u>Rorschach</u>	<u>Elizur</u>	<u>Holtz</u>
VII. Twee dogtertjies wat se hare so opstaan en mekaar roep.	D	M,m	H
VIII. Twee rooi goggas wat aan 'n groen boom eet.	D	FM,FC	A/Pl. a
IX. Twee narre wat met hul vingers wys.	D	M	H h
X. 'n Veelkleurige blom.	D	CF	Pl.

MARIA - QUALITATIVE RORSCHACH INTERPRETATIONS BEFORE THERAPY

Handling of Reality

Her reality testing was intact but contained an element of threat.

Self-image

She projected herself in an aggressive manner in her interaction with her world. Aggressive emotionality was also implied in this.

Interpersonal Relations

She felt cold and distanced from people and had to protect herself against them. She seemed to particularly have problems in this area.

Relations towards Father

Contact with the father seemed weak and undifferentiated. Only basic contact with him was experienced. No affectionality or emotionality was projected in this superficial relationship.

Relations towards the Mother

She sees the mother on an infantile equal basis with her and in competition with her. Interaction is of an aggressive nature. No affectional or emotional feelings were projected; instead she gave a cold callous approach to the mother.

Sexuality

Strong aggressive emotions were projected in connection with sexuality.

Emotionality

Strong uncontrolled emotional responses with an aggressive element were present. No softer or affectional responses were given.

MARIA - QUALITATIVE RORSCHACH INTERPRETATIONS AFTER THERAPY

Handling of Reality

Good integrated handling of her reality was projected.

Self-image

She had a much more positive, animated, happy seeing of herself in interaction with her world.

Interpersonal Relations

She had a positive experience of interpersonal relations now.

Relations towards the Father

Affectionality in relation to the father was given and it seemed that she saw it more as a fulfilment than a need.

Relations towards the Mother

She still saw the relationship on an equal infantile basis but now had much more positive interaction with the mother.

Although no expressive emotional interaction between her and the mother was projected, it seemed as if she still felt some emotional tension in their interaction. An element of affectional feelings towards the mother was present.

Sexuality

Good integrated affectionality are given in connection with sexuality.

Emotionality

No uncontrolled emotionality was present any more. Instead a controlled reactivity to her environment was projected. It also seemed as if her affectional needs have been met.

APPENDIX 3.

SCORING OF THE RORSCHACH

1. Tendencies in the child Rorschach

According to F. Williams (1968) and Ames et al. (1952) the following tendencies can be discerned in the child Rorschach:

- i. The number of responses increases with age.
- ii. The area use increases with age.
- iii. Determinants gradually increase.
- iv. Determinants change in relation to one another:
up to the age of seven to eight years FM is higher than M
up to fourteen years M is higher than FM

2. Colour responses

Initially, up to the age of seven years, the CF responses are extremely high and after that FC increases gradually. Before five years of age pure C responses are still normal (Williams, op. cit., and Ames, op. cit.).

3. Shading

This occurs from the age of ten, but can appear at an earlier age in affectionally sensitive or emotionally unstable children.

Differentiation is made between C' and Clob in the child. C' is indicated for the use of dark colours by the child without any fear relation. Clob indicates a more negative response and incorporates a fear and anxiety component. "Darkness is the primary quality of Clob, and almost invariably the content is unpleasant" (Ames, op. cit., p. 85). Loosli-Ustert (1949) first made this differentiation on the basis of Piotrowski's quantitative analysis of dark shading in the child (1945). It is a highly relevant distinction in the child test.

4. Content

In the child the content of the responses initially consists of animals, objects and plants. Gradually people (H) are introduced and the content expands with age (William, op. cit., and Ames, op. cit.).

5. Area

5.1 W

W is high in the young child. At the age of three only whole responses occur, which gradually decrease and become differentiated. Ames (op. cit.) gives the following rating of localization from two to ten years:

W	-	53%			
D	-	38%	=	W : D : Dd	
Dd	-	9%		5 : 4 : 1	

5.2 D

To distinguish D (or detail) requires experience and discrimination. Dd occurs only when perception becomes even more acute. At the age of seven to eight children are highly analytically inclined, so that Dd is the rule rather than the exception, and it is its absence rather than its presence which is significant.

5.3 S

Space responses are fairly general in children, since their perception of figure-background has not yet been fully stabilized. Nonetheless, if it occurs excessively, it could indicate a perceptual disturbance of figure-foreground-background.

Klopfer (op. cit., Vol. II) maintains that nothing can be deduced from the localization as such. He does not go beyond a cognitive analysis :

2-3 years: Global perseverant perception - W response.

3-5 years: Confabulatory elements occur and are applied to the whole chart by the child.

4-6 years: Confabulated combinations now occur. The child is capable of identifying certain elements, but continues to confabulate. At this age the child is perceptually differentiated, but not yet reality-bound.

5.4 Determinants

5.5 Form - F

Between the ages of two and ten half of all determinants are F, in other words: F% = 50 plus.

At two years of age the child attains object constancy and form plays an important role. At this age, in other words, practically only F responses occur (F% = 90). The F responses diminish gradually up to the age of seven years and then start increasing once more.

The F responses in the child are not based on the same rationale as in adults. The child's F responses incorporate the elements of the other responses which must still be realized through growth and differentiation. Language in the child is not an accurate representation of his symbols. His world is furnished with "things of action" and consequently his action elements are incorporated in his F responses, even if they are not directly expressed. His F responses, , are loaded with M, FM and C (Werner, op. cit.).

Nonetheless, it must be assumed that F responses in the child already indicate a degree of cognitive control over his environment.

5.6 Movement

Before the age of four the child's self-image is extremely diffuse, with the result that he is incapable of M projection. Animal movement occurs first, followed by human movement. Between six and seven years of age the child should be capable of representing at least one M response. If M responses are abnormally high in number and poor in quality they are indicative of pathology. However, if the quality and form level are satisfactory, it is a positive indication. M responses seldom occur before seven years of age and if more than one M response occurs between seven and ten years, it could indicate that the child is overwhelmed by unmanageable forces in his environment and is living in a threatening world.

5.7 Colour

Colour responses in children develop from C to CF to FC as the child attains cognitive control over the onslaught of the environment on his emotions.

According to Williams (op. cit.) and Ames (op. cit.) the following tendencies with regard to colour occur in the child:

2½ to 4 years: The child is still highly impulsive and prompted by his reactivity, so that only C and CF responses occur.

4 to 10 years: CF responses still occur, but FC responses gradually increase as the child attains control over himself and his environment.

From 2 to 10 years Sum C is higher than M.

From 10 years to puberty M is higher than Sum C.

5.8 Shading

Shading requires a degree of sensitivity in the child before he can react to it. This generally does not occur to any significant extent before puberty. If it occurs excessively before puberty, it could be indicative of pathology in the affectional area.

5.9 Content

This reflects the extent and nature of the child's interest.

The development tendencies in regard to content are the following:

2½ to 4½ years: Animals, plants and architecture are prevalent.

At this stage the child identifies with primitive life forms and represents this in his projections.

4 to 6 years: People, objects and explosions occur frequently.

Identification and symbolization are becoming more complex.

From 6 years upwards: A decrease in primitive life forms becomes apparent.

6. Popular responses

The same popular responses as in adults apply, but Forhouse (in Williams, op. cit.) puts forward the following additional popular responses in children under seven years of age:

Chart I	W - Animal
Chart II	W - Tree
Chart III	W - Four-footed animal/birds
Chart IV	W - Tree
Chart VII	Dd (below centre) - House
Chart VIII	W - Tree
Chart IX	W - Flower
Chart X	W - Tree.

Validity and Reliability of the Rorschach.

It was pointed out in the chapter on the use of projection tests in research (p. 150) that to validate any projective test is a difficult task.

The Rorschach test is one of the most disputed measuring instruments in psychology, but has nevertheless generated over 3,000 publications on its use in research. (Goldfried *opcit*).

Goldfried describes the outcome of all these studies as follows:

"Despite all this research, or perhaps because of it, most psychologists seem to remain in one of two camps : believers or nonbelievers. We purposely use the term believers and nonbelievers because they can note strong personal convictions rather than logical evaluations in the light of research data. These convictions may have evolved either through the success or failure of personal experiences with the Rorschach or through the simple acceptance of attitudes communicated by role models in graduate school." (*opcit* p. 1).

In evaluating the Rorschach one has to differentiate between the clinician who uses it as a diagnostic instrument and the academic who uses it for pursuing problems of basic research.

Levy and Orr (1959) studied the literature on the Rorschach in order to verify the interaction which occurs between the acceptance and orientation variables in Rorschach validity research. The three variables they investigated were :

- a) The type of institutional setting in which the study was conducted (academic vs. nonacademic).
- b) Type of validity study (theoretical i.e. construct validity vs. criterion i.e. predictive and concurrent validity).
- c) The outcome of the study (for or against the validity of the Rorschach).

Their findings are summarised in the following table.

	<u>Academic</u>		<u>Nonacademic</u>	
	<u>Construct</u>	<u>Criterion</u>	<u>Construct</u>	<u>Criterion</u>
Favourable	51	12	14	19
Unfavourable	22	23	14	13

They also found an interesting interaction between what they described as orientation to and acceptance of the Rorschach. Their results indicate that research done in academic settings was more than twice as likely to yield positive results than the study was of the construct type and almost twice as likely to yield results unfavourable to the validity of the Rorschach than when the study was of criterion type.

Thus it seems according to this study that the validity of the Rorschach test depends upon both the type of study and the institutional affiliation of the researcher.

Goldfried (op cit) also indicates that the way in which the Rorschach is interpreted plays a role in the validation thereof. If a clear rationale is set for interpretation, the validity is raised. If an idiosyncratic interpretation is used the validity becomes less and less. For this reason the interpretation of the Rorschach in this study was done strictly according to the indicated scheme of interpretation.

The criteria for validating all projective tests in research as set out on p. 150 should also be considered together with the above information when validating the Rorschach.

Finally one can only agree with Goldfried who concluded that in spite of more than 3,000 studies on the Rorschach one still gets what he calls the believers and nonbelievers in the Rorschach and that each group uses research to prove their point of view.

"Consequently, since few psychologists shift their view of the Rorschach, the validity research seems to continue largely on a functional autonomous basis."

The Meaning of the term "Affectional" and "Emotional" in the Rorschach.

The testee may react to the Rorschach stimuli with inward feelings and these are termed affectional reaction. In the Rorschach protocols these are the reactions one gets to shading stimuli.

On the other hand a person may react with strong outward emotion. This is termed emotional reaction which is evoked by colour on the Rorschach.