PSYCHOTHERAPEUTIC TECHNIQUES

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Psychotherapeutic Techniques

The therapy that will be described in this chapter is concerned in the main with the treatment of neurotic and characterological conditions and disorders of reality testing in children aged 6 to 12. These conditions impair the abilities needed for the development and organization, production, and maintenance of states of latency. Conversely, in the style of a vicious cycle, the absence of latency defenses intensifies the symptomatology of these pathologies. Learning disabilities and organic brain disease are not the targets of the treatment modalities to be described, although to some extent they may be useful in youngsters with these conditions in dealing with cognitive immaturity and social maladjustment, especially where states of calm are striven for but poorly mastered by the child.

It is essential to the maturation of any child as a social being that these states of calm be achieved. It is during such states that most social learning is acquired. The ego skills exercised in the development of the mental functions (e.g., fantasy formation) that are used in maintaining states of calm form the groundwork for the development of reality-oriented future planning as the child enters adolescence. Therapeutic attention is required for the states of disordered mood and behavior that mark failures in attempting to attain the latency state. Attention should also be directed to the deficiencies that result when the development of latency states fails.

Background

Childhood has a history all its own. It is the history of a minority too weak to defend itself and in constant need of advocates. As strikingly portrayed by De Mauss (1975), the history of human attitudes toward childhood is only now just beginning to touch the cultural horizon at which children are perceived as individuals with needs and personalities independent of parental goals, and as creatures to be understood rather than herded and manipulated. Child-oriented psychotherapy is a part of this history.

Only lately in the history of childhood has there come the discovery that there is a specific organization of the personality (latency) that imparts characteristics to the years 6 to 12. These

characteristics develop independently of ordinary physical growth and are subject to pathological alterations and influences. As such, they may be enhanced or modified by psychotherapeutic interventions.

Prior to 1900, awareness that a child's behavior is motivated and that children have an emotional inner life appears in the writings of the occasional intuitive observer. The Spanish mock epic of the late Middle Ages "Lazarillo of Tormes" depicts a boy who is capable of self-reflection and remorse. In the mid-nineteenth century, Felix Descuret (De Saussaure 1946) viewed troubled children with an understanding of their needs, and wrote of the resolution of jealousy and emotional discomfort, with insight into the psychological workings of the inner world of the child. A number of other sources could be quoted to demonstrate that an awareness of the emotional life of the child has long been available. Such an awareness was occasionally used by gifted people, independent of organizations and educational disciplines.

It was not until 1896 that Freud (1950) first detected distinguishing characteristics of the latency period that set childhood apart. At first all that was perceived was a relative paucity of recollections from this period during the psychoanalysis of adults. This was apparently sufficient to call attention to the period for further study. During the first quarter of the twentieth century, knowledge of the period grew until the latency period came to be viewed as a period of calm between the early infantile sexual life and the burgeoning sexuality of adolescence. The calm attained during this period was at first explained by the growth of mechanisms of defense. These mechanisms were capable of transforming the moral demands of society into patterns of internal control that kept the drives in check, and shaped the drives when the efflorescence of bodily growth and instinctual energies that marks adolescence began. This view of latency held sway until 1926, when Freud declared that in latency "the sexual urges diminish in strength" (1926c, p. 210). From that point on, this became the most widely accepted general principle for understanding the quiet behavior of latency-age children. This theory obviated the development of concepts related to cognitive and ego growth that could be used as the basis for developing a psychotherapeutic strategy for dealing with troubled latency-age youngsters. Fortunately, some workers continued to advance Freud's earlier ideas. Recently the concept of an ego structure of latency has been introduced, reflecting the view that latency calm is the product of the maturation of ego functions. This view is forced upon us by the observations that calm behavior is inconsistent in children, and that some

children experience no latency at all. This theoretical orientation provides the basis for a psychotherapy for latency-age children.

Failure to enter latency and marked breakdowns in latency calm become important target syndromes in the psychotherapy of latency-age children. The appearance of such behavior, though not necessarily discomforting to child or parent, has predictive value in relation to social adjustment in adolescence and adulthood (see Chapters 2 and 3). The adjustments in fantasy that help the latency-age child master humiliating situations are the forerunners of the future planning skills vital to individual adjustment in the older person "on his own." The skills in abstraction and delay required for adolescent and adult functioning are developed and practiced in the production of states of latency. Failure to develop or maintain appropriate states of latency may indicate that vital cognitive skills are unavailable or are being bypassed and given short shrift in the development of the child.

Among those clinicians who were aware of the discovery of latency, a growing body of knowledge about the psychology of childhood was organized. At first this had to do with reconstructions of the psychic life of children based on the analysis of adults (Freud 1905). Direct observation started as early as 1909 (Freud 1909). Papers began to appear that described interviews with children containing therapeutic interpretations based on psychoanalytic principles derived from earlier observations. Interestingly, in one such case (Ferenczi 1913a) a child was thought to have lost interest in pursuing a discussion of his wish to be a rooster when he ceased to talk about one in conversation and instead wanted to play with a toy rooster. The examiner was not trained to realize that the child was also communicating through his play.

Such blocks to the direct role of a trained therapist in work with a child were removed when psychoanalytically trained therapists who could work with children perceived that children of latency age symbolize their problems in their play, much in the way adults symbolize their problems in their dreams. Two prominent workers in this endeavor were Melanie Klein and Anna Freud. Their books *The Psychoanalysis of Children* (Klein 1932) and *The Psychoanalytic Treatment of Children* (A. Freud 1946) describe in great clinical detail their techniques that they found to be effective in reaching children of latency age who have adjustment problems. This psychoanalytic psychotherapy for the individual was developed and practiced in Europe and studied there by American psychiatrists. In 1935 Maxwell

Gitelson brought the technique to Chicago, where it was integrated into the individualized approach to troubled children introduced by William Healy some decades before. Thus was dynamically oriented psychotherapy for children introduced to the United States.

The Theory of Child Psychotherapy

The psychotherapeutic approach to the latency-age child is predicated on the theory that the appearance of emotional symptoms and signs is determined in large measure by psychological influences. The concept does not in any way exclude biochemical or genetic factors; it merely creates a context that provides for psychotherapeutic leverage. Such factors as social influences, cognitive development, maturation of the organization of ego defenses, and the vicissitudes of the instinctual drives can be applied to the treatment of adjustment and emotional problems in latency-age children through these theories.

As opposed to the therapy of adults, which deals with internalized conflict and social maladjustments within a context of a stable cognition, psychotherapy with children must be shaped to fit the fact that one is dealing with a growing child. What is acceptable and normal behavior changes with age. Symbolizing function and abstract cognition in the areas of comprehension and memory undergo marked changes during the latency age period. As a result, interpretations must be framed and phrased in the context of an approach that takes into account the child's age-appropriate capacity for comprehension and memory. Mechanisms of defense, such as projection, repression, and denial, serve a different function in latency than they ordinarily do in adolescence and adulthood. In addition, there is an organization of defenses, *the structure of latency,* that is unique to latency. It channels drive discharge into fantasy during the latency years, while in itself serving as the groundwork for the ego capacity of future planning, which in turn becomes the bulwark of emotional health in adolescence. In the psychotherapy of the latency-age child, the structure of latency must be encouraged at the same time that its products (fantasy) are analyzed (and devalued should they be the source of trouble) if one is to understand the drives and conflicts that the products represent.

Acceptable and Normal Behavior

During the latency age period, acceptable and normal behavior is defined differently at different ages. The young child in latency is expected to be close to his mother, with few interests outside the home. The late latency child is expected to show evidence of independence, with plans of his own, often derived from the influence of his peers. The early latency child opposes his parents' wishes with contentless negativism ("No, I won't!"), whereas the older latency child opposes his parents by championing positive suggestions, showing that he wants to do something on his own. Throughout latency, normal and acceptable behavior is defined in terms of appropriate obedience to parents and teachers and an ability to achieve states of calm, quiet and pliability where required. This readiness for calm is coupled with an ability to let go and vent energy in appropriate times and places, such as in the gym, at recess, and at parties. A child who is younger than the latency age cannot be relied upon to have well-differentiated responses to differing situations, for he has not yet developed skill in identifying and responding to the cues in a given situation that indicate appropriate behavior. The capacity to achieve behavioral constancy (the ability to behave consistently in given social settings), is not fully developed until the latency years begin.

As the child enters late latency, ages 9 to 12, behavior is influenced to a greater extent by peers. In essence, this phenomenon, commonly attributed to adolescence, has roots that stretch back into latency. It is appropriate for children in late latency to show evidences of a process of individuation from the parent on the ethical level. This *ethical individuation* phase of late latency is a reflection of the cognitive maturation that places more emphasis on outside influences, reality, and the environment than on internal, past, and family influences. The superego demands derived from internal, past, and family influences are usually linked with guilt and indeed actuated into influencing personal behavior through guilt. The acquisition of new contents is contested by these affects of doubt and guilt. There is conflict and guilt when new influences challenge the child to seek new ways of doing things. Guilt is stirred when old ways of doing things are challenged and forbidden activities are encouraged by new influences. In marked cases of conflict involving ethical individuation, paranoid states, tics, urticaria, and obsessional symptoms of severe but transient character appear. They point to the presence of *ethical individuation conflict*, which should be explored in these instances.

Coupled with the problems of ethical individuation is the problem of passivity, which may also be marked in late latency. This is a conflict between the wish of the child to be cared for and to remain a child, and resentment of the loss of independence that fulfillment of this desire brings. Moods, temper fits, withdrawal to rooms, and challenges of authority take center stage clinically when these conflictual areas are most intense. Ethical individuation, with its emphasis on seeking new ways of doing things and new things to do, intensifies the passivity problems of late latency.

The normal symbolizing function undergoes changes during the latency time period. Most striking are the changes in the symbols used for the production of fantasy. The prelatency child has very direct fantasy symbols ("When you die, Mommy, I'll marry Daddy"). The early latency-age child populates his fantasies with amorphous figures, especially of persecutors, who frighten him, especially when it is dark. At about 8 ½ there is a shift from amorphous figures to real figures, who populate fantasies that are mainly lived out in the imagination or played out in fantasy play. In adolescence, real people populate fantasies, which are forced upon reality and are lived out in reality. What began as normal in early latency comes to be seen as neurotic behavior when it is carried on into adolescence.

The symbols that play a primary role in the formation of latency states are a special symbolic form, called a psychoanalytic symbol. An ordinary symbol is an object, idea, or thing that in the process of memory represents in the awareness and communications of the person another object or thing. It is a kind of convenient shorthand through which a great deal of information can be represented by a signal or sign that requires little effort. In the formation of a psychoanalytic symbol, the message to be conveyed is usually tied in with anxiety or another uncomfortable affect. To permit the expression of the message while maintaining comfort for the individual, the connection between the symbol and the original information is repressed. In this way fantasies can be created that express and discharge the urges implied in the original (latent fantasy) information package without revealing its content to the child or the casual observer. This sort of symbol becomes a highly useful tool in the process of mastery of uncomfortable experiences and in the discharge of drive energies for which the immature physiology of the child provides no other outlets. The latency play fantasy formed from psychoanalytic symbols becomes a means of reducing emotional tensions, much in the way that masturbation, some categories of dreams, sexual relations, athletics, and adult sublimations are used.

In keeping with the preponderance of inward-turning mental events in the latency-age child, the psychoanalytic symbols of the child have the characteristic of not taking into account communicative potentials in relation to possible listeners and observers. The symbols serve primarily the role of a medium through which past experiences and memories can be evoked for the discharge of drives, independently of objects in reality. The play fantasies of children, which are constructed from these symbols, resemble the distortion-filled dreams seen in the treatment of adults. In child therapy the play fantasies of children serve a role similar to that of the dream in adult therapy. Because of the similarity of function, dreams are less frequently reported spontaneously in the psychotherapy of the latency-age child than by adults. With the exception of bed-wetters, latency-age children rarely report dreams during therapy, even though dreaming is not rare. The therapist must make a special point of encouraging dream reporting if this is desired.

The characteristic which should have the greatest impact on the tactics of the child therapist is the level of cognitive maturation of the child. Symbols, fantasies and the structure of latency contribute to the content of the therapy and shape the interpretations of the therapist. Although the comprehension, appreciation and memory for events and the therapist's interpretations of them are the key to success, verbal content is not the whole story. The therapist's approach, the patient's productions, and the very form of the therapist's interventions are determined by the level of cognitive maturation of the child. Typically, a major portion of the child's spontaneous recall of events is channeled through the intuitive masked and highly symbolized medium of fantasy play. Therefore, the therapist, in order to gain access to the child's preoccupations, must encourage fantasy play and pay close attention to it. When the time for interpretation and reconstruction arrives, a change of pace is required. The therapist should keep as a point of reference the concrete experiences of the child in the therapy session. Though the child can produce symbolic abstractions, he is weak in the comprehension of and memory for abstraction. The poor capacity for the recall of abstraction by the child in early latency militates against abstract phrasing in interpretations made to these children. Though the therapist may understand and theorize on an adult level of comprehension, cognition, and memory organization to his own satisfaction, molding of these insights into interpretations following adult patterns of phrasing and abstraction will fall on the child's awareness as on deaf ears.

In phrasing interpretations the therapist should consider two primary areas of cognition: the

organization of the understanding of events and the organization of the memory function. As Piaget (1945) has pointed out, children in the early latency years tend to understand the happenings about them in a magical, symbolic, and intuitive manner. It is only at about *7 ½* years of age that the child can use abstractions in the interpretation of concretely experienced and observed events. With a child younger than this, the therapist's interpretations should be concrete, and should be aimed at reconstructing true experiences that the child has distorted into distressing or even disorganizing fear fantasies. In the child older than *7 ½,* interpretations may be more general and abstract, relating seemingly disparate concrete elements. It is not until the child is at the very end of latency (12 ½) that one can expect universally to find abstract reductions of abstractions. These can be understood at this age, and logical conversations can be conducted without breaks of attention and distractions into play by the child. In essence, it is at this age that the interpretation typical of adult therapy comes consistently into use. Such interpretations of content are used when the aim of the therapist is to help the child understand current behavior.

No matter what it is that the child can understand of his current behavior as a result of the level of cognitive comprehension he has reached, it is only that which the child can carry with him and remember in the future that will have an impact. When the therapist feels that insight and the ability to recognize repeated patterns of behavior are indicated in the therapy, the nature of the ontogenesis of memory function must be kept in mind.

The ontogenesis of the memory function is extraordinarily complex when related to the psychotherapy of the latency-age child. Every element brought into the session by the child is, in whole or in part, a product of memory. Since at least three different memory organizations are at work creating the spontaneous recall that produces the contents of the therapy session, the therapist must be tuned in on at least three levels of communication.

The earliest formed and most primitive memory organization used by the child is the affectomotor memory organization, which dominates until 3 years of age and bears the burden of the memory function until well past 6 years of age. The components of this memory organization are sight, sensations, and feelings that re-create the total life experience of the child, including associated affects. In the absence of verbal components, early life experiences can be recalled through affectomotor memory in the form of

somatic sensations which are signifiers of the broader affectomotor imagery seeking representation in memory. Motor tone and posture, the selection of a broken toy that represents a recall of an old injury, angers, and sudden needs for toileting are all clinical manifestations that must be observed and interpreted to bring the totality of the child's experience into the psychotherapeutic field of view.

Fortunately for the therapist working with the latency-age child, the second form of memory organization, which is introduced at the end of the first year of life, begins to dominate the memory functions of the child at about age 6. This is the verbal conceptual memory organization. At this age, the child is able to reduce memory elements for holistic, nonlinear affectomotor total memory elements to efficient and logically organized concepts locked into verbal representations. To some extent, their scope is limiting. The limitations are traded off against the expanding usefulness of elements based on memory in the sphere of communications. Thus, the child can talk about or represent in verbal symbols that which he has experienced and must master. It is incumbent on the therapist to help the child to improve his verbal conceptual memory skills, and to help translate experience carried forward through affectomotor memory function into verbal concepts that can be shared, discussed, and mastered. While the child is in this phase (6 to 8), there is little value in converting observations into abstractions, for there is less likelihood that children will be able to carry forward abstractions than rote memory and verbally organized concepts in memory.

The third level of the memory organization involved in spontaneous recall is abstract conceptual memory. It may become available at about 8 years of age, but since it develops only with social and parental encouragement, it may be absent, depending on the home environment from which the child comes. Called the abstract conceptual memory organization, the third memory organization permits the child to recall spontaneously the intrinsic nature of things, rather than words.[1] As such, at this age, interpretations can be formed to take into account intrinsic relationships between related concrete experiences.

(The application of abstractions to abstractions must await very late latency.) It is possible for the therapist to encourage the child to achieve skills in abstract conceptual memory at 8, and even for the child to show spontaneous evidences of this function at 8. It is the common experience of therapist and parents, however, that not until age 10 is there a meaningful increase in the child's interest in current

events, abstractions, and short, clearly thought out conversations.

If the child has not reached a given level of memory organization, it is useless for the therapist to use its formal characteristics in the formation of his formulations and interpretations to the child, without first working to develop mature cognitions.

During latency, a number of mechanisms of defense undergo developmental vicissitudes. The pathology implied by their presence differs from that implied in a similar clinical manifestation in the adult. For instance, projection of transient persecutory fantasies serves an adaptive function in latency. Some defenses are less strong in latency than they are in adulthood. For instance, direct questions can often bring out repressed material in the latency-age child.

Repression is less strong during late latency. In dealing with an obsessional symptom or a paranoid episode, often all that is needed to bring forgotten events into consciousness is to ask some direct questions. As the return to consciousness occurs, the symptoms clear.

> A 12-year-old girl refused to go to school out of fear that she would be kidnapped by a group of men in a car that was following her. She had a complete remission of symptoms when she was able to reconstruct the situation in which the symptoms had begun. The therapist, aware of the problems in ethical individuation that occur at this age, asked the child whether her friends had wanted her to do something that her parents would disapprove of. "Steal," said the girl, without hesitation. She then described stealing some gum from a candy store at the prompting of her friends. Though she had returned the gum, she was haunted by guilt, which had been dissociated from the theft and then expressed through the persecutory delusion. When the episode of stealing was restored to consciousness, the fear symptom cleared.

Projection in adults has strong pathological implications, but in latency it is one of the mechanisms of the normal "fear fantasy" neuroses. With the passage into adolescence, projection pursues a number of vicissitudes which include participation in sublimations, use as a bridge in object finding, and the projective-introjective process that contributes to modification of the superego. If the projections of latency continue unaltered into adolescence, a pathological import may be inferred (Sarnoff 1976).

In early latency, the child's tendency to respond intuitively and to interpret the world and its events in terms of his own self-oriented view of things permits him to assume that what he wishes to see or not to see should be accepted by others as a true view of the world. Any attempts to shatter denials at this age are fraught with frustration, if not danger. The child may stare right through the therapist. If the

therapist brings too much pressure to bear, aggressions and even destructive behavior aimed at the therapist or the playroom may be expected. This is in marked contrast to the adult, for whom interpretations of denial usually produce new data.

The Structure of Latency

The two organizations of ego structure previously discussed, the mechanisms of restraint and the structure of latency, characterize latency and differentiate it from any other developmental period. Both are important because they are consistent in a given individual and are generally found in any youngster who is able to achieve states of calm. Both have dual functions: They help to produce and maintain states of latency and, in the post-latency period, form personality structures which are part of character. The mechanisms of restraint will give shape to the superego and the control of instincts, and the structure of latency will become the core of the ego skill of future planning.

In adolescence, humiliation gives rise to stress. Adaptation to the stress of humiliation may consist of fantasy formation, much as this process occurs in latency. Such adolescent fantasy, however, typically uses reality elements as symbols (i.e., "I'll drive a big car," "I'll do better in school," "I'll become a professional," "I'll be a sports [military] hero and when I return, there will be a parade and they'll know how good I am."). This type of fantasy serves more than the discharge function it did in the latency-age child. The action elements of the fantasies (going to school, joining a team, joining a uniformed service) are possible and even perhaps attainable. They become the inspiration or source for adaptive acts using a reality orientation. They provide more than a momentary fantasy response to a stress of the moment. They offer, in addition, a bridge to tomorrow. Since the child in adolescence is beginning to have the physical resources to make these truth-based dreams come true, there is the possibility that the bridge can be crossed. Thus is future planning born out of the structure of latency.

Since these personality structures serve to produce and maintain one developmental stage and also participate as character elements in subsequent stages, the child therapist is well advised to regard them with respect. The study of these structures will help to reveal psychopathology and clinical psychodynamics of the child, but strengthening them is sometimes a necessary goal of the therapy. This is especially so in those youngsters who show poor study skills, a short attention span, impulsivity, and

explosiveness in chronic situations of psychological overstimulation.

These organized structures of the ego are best described within the context of the psychodynamic theory of latency. This is the theory that explains the fluctuations between excited states and calm, malleable states in the latency-age child. The theory deals with the means of drive control during this age. The latency-age child has sexual and aggressive drives equal to those of the child in prelatency, although not as strong as those seen in adolescence. The drives are manifested in aggressive behavior, sexual excitement, and masturbatory equivalents. Such inner forces as powerful drives create a problem for the child in a society that considers acceptable behavior to be indicated by suppression of these activities. The situation is compounded by the fact that biologically the child is no match for his elders physically and has not yet been equipped with a mature genital organ capable of expressing the sexual drives in a realistic, object-oriented context. In essence the child must seek the resolution of his need to discharge his drives, utilizing predominantly his inner ego resources.

If one adds to this situation the frequent seductive stimulation of the child by adults, one sees that the inner life of the apparently calm latency-age child is more analogous to a sessile steam boiler sometimes pushed toward exploding, than to calm bays that invite one to meditation.

When one is confronted with distracting drive derivatives (e.g., sexual fantasies), states of goal directedness and calm can be threatened. In early latency, the most common fantasy that threatens goal-directed, reality-oriented behavior is the Oedipal fantasy. This fantasy is characterized by sexual impulses in regard to parents, associated with guilt and fear of retribution.

These fantasies are uncomfortable for children. Any situation that stirs them up creates affects and excitements that threaten the external appearance of calm and the availability of quiet moments, which can be harnessed by educators as times for the transmission of culture.

Disruptions of calm need not take place. As Freud was the first to note, children who have reached the phallic-oedipal level resolve the threats involved in oedipal fantasy, whether spontaneous or induced, by retiring from the advanced lines of battle to re-involve themselves in the conflicts of earlier ages. Usually this means that the child regresses to the anal-sadistic level. Oedipal sexual longings are replaced by more easily expressed urges to tease, to defy, to mess, and to smear. Such behavior is seen in

angry, excited youngsters. Rooms in which parties are given are often left in shreds by such youngsters. Mothers who drive car pools know well the back seat society to which all children belong. It is a club which has as its main activity and shibboleth scatology and anal references piled high one upon the other.

Although such behavior and sadistic teasing leak out from time to time, the majority of children express their anal regressions in a masked manner. This masked outcome is the product of maturity. The child has a stronger and more complex armamentarium of ego defenses for dealing with anal-sadistic urges than he had when first he encountered them at about age 2. Reaction formation, symbol and fantasy formation, repression, and obsessional defenses (e.g., collecting) all express the primitive drives and channel them into socially acceptable patterns. The aggression and messing urges are turned into calm and neatness as a result of reaction formation. Aggressive fantasies replace actions, and collecting takes up energies in collecting and valuing stones that might otherwise be thrown. These mechanisms are grouped under the rubric "the mechanisms of restraint." The patterns into which they shape the drives are guided by the expectations of parents and the demands of teachers and society. These patterns carry over into adolescence, where they influence strongly the attitudes of the child toward the burgeoning drives that threaten to overwhelm. This is the patterned shape of the prior experience that guides the child when pitted against the seductive demands of the adolescent peer group.

There are children who are unable to handle their drives on the anal-sadistic level. Excitements and humiliation call for comfort rather than responses of aggression. These youngsters regress further to the oral phase, where they can be seen to comfort themselves with dreamy television watching, thumb sucking, cuddling of pets, and eating to the point of obesity. Maternal prohibitions that block phallic and anal assertiveness leave as the only outlet the establishment of a pattern of defenses with an oral cast.

The child who is successful in using the mechanisms of restraint to transmute the potential tumult of his anal-sadistic urges into a period of calm is a child who is capable of producing states of latency. This product of the mechanisms of the ego opens the door to education and the absorption of culture.

The process of producing states of latency is dynamic. Overstimulation and seductive behavior, beatings and parental sarcasm can cause a flooding of the mechanism and a breakdown in the latency

state. Aggressive behavior and regressed symbols are clinical expressions of a failure in the latency. In contrast, in situations such as parties, recess, free play, and athletics, such behavior is encouraged. These are natural safety valves well recognized by the caretakers of children. The child also decreases the pressures of humiliation, stimulation, and seduction by the use of talking, complaining, and the seeking of allies on a verbal level. This verbal adjustment is important for the child therapist. Through it he establishes a rapport with the child, and if phrasing is simple, the therapist can help the child to reach verbal comprehension of his problems. The slightest deflection of the therapist's attention from the child —as may occur should the therapist, for example, answer the phone—turns the child to motor syntaxes and other symbolic ways for the expression of conflicts.

The dynamic process of latency has yet another safety valve useful in maintaining the state of latency. This is the structure of latency, succinctly paraphrased by Donnellan (1977) as a ". . . configuration of defenses in the latency child which allow the expression of impulses through fantasy" (p. 141). The oedipal drives, with the aid of the structure of latency, are expressed through fantasy. Their energies are discharged through fantasy, instead of being responded to by regression and adding to the burden of the mechanisms of restraint. This is accomplished in the following way: The oedipal fantasy, either in part or in whole, undergoes repression. The repressed fantasy is fragmented, and the fragments are in turn represented by elements that, as the result of displacement, are divorced from the original and not recognizable as related to them. This is the defensive role of psychoanalytic symbolization. The symbols are then drawn together into a coherent series of symbols, which make up the manifest fantasy of the structure of latency (e.g., the child who wants to kill his father, kills a king in fantasy instead). The coherency of the series is due to its patterning by the tales and myths belonging to the child's culture. This ability to adapt personal memories and fantasies (e.g., oedipal) to stories that have a social and cultural source becomes yet another conduit through which the potential for producing a state of latency can be used to enhance the socialization and acculturation of the child.

In children with impaired capacity for delay, displacement, abstraction, symbolization, or fantasy formation, the state of latency is unstable. Therapeutic goals take this into account. To bring a child into latency so as to produce states of calm and prepare for future planning in adolescence is an important goal in the therapy of a child with an impaired ability to produce states of latency.

In all children with a structure of latency at all operative, the fantasies produced and played out in the therapy sessions become an endless source of data. Like the dreams of adults, they provide the key to the complexes, sensitivities, and instigators of regression in the individual child. The following case vignette illustrates the use of fantasy play in acquiring data in a session.

> J.B. was 11 years old. He was a bright, handsome boy whose school performance fell far below expectations. At home his verbal abuse and provocations of his mother were severe enough to cause battles. He was brought for treatment because these matters had got out of hand.
>
> J.B. was highly verbal and quick to deny his responsibility for home problems. He also denied that these problems existed. He related calmly to the therapist, spending most of his therapy time drawing uninvolved individual figures, recounting gunslinger Westerns, and talking about the books he was reading. He could not participate in any discussion of his family or the problems that he denied existed. During the early phases of the treatment, changes and defects began mysteriously to appear in the therapist's office. Telephones were disconnected. Paper wads appeared in light sockets. Toilet paper disappeared by the roll. For months the patient denied responsibility for these events. To get him to accept the need to analyze his sadism, it had to be demonstrated to him that he could not hide his role as the source of difficulties for himself and others. This required a fantasy some of the elements of which could not be ascribed to an external source. Some newly acquired soft clay provided the opportunity. He made a white human figure. He shoved a pencil point into its stomach. "Take that, Lancelot," said he. He pulled the pencil out and rejoiced as he filled the hole with bright red clay. "Blood!" he exclaimed. The therapist asked about Lancelot. The child claimed the story as his own. He had never heard of Tennyson or Malory. He explained that he used the name Lancelot because the pencil was a lance. His pleasure in the gush of blood was interpreted to him and was related to his excitement in telling and playing out movie plots. He was able to connect his wishes to the story he had told of Lancelot. Although somewhat abashed, he was thenceforth able to talk about his role in the provocations of others.

Note how the use of a three-dimensional play figure permitted movement and the passage of time to be introduced into the play. Such a figure is better than a drawing in permitting the introduction of these elements of story-telling structure. In this way symbols can be manipulated, and, without words being used, fantasy with the mobility in space and time characteristics of that found in a dream can be encouraged in a psychotherapy session. One is best warned (as we will expand upon below) that such activities have much vitality and high cathexis, and that it is not unusual for an interpretation of an underlying hostility in the patient to trigger a shift of the hostility from an interaction within the story to an interaction between the patient and the therapist or the playroom. Thus are desks and ceilings marred.

The Application of Latency Theory to Therapy

As we have described, analytically derived psychotherapy with latency-age children can be

applied when there are problems of social adjustment, acceptance of self, and hypersensitive reactions to situations that induce feelings of humiliation. The child who has entered latency and manifests internalized conflicts in such a way that the same patterns of behavior are demonstrated in disparate situations (e.g., sibling rivalry, jealousy of peers, being picked on and teased) can be helped by therapy to direct his energies away from his fantasies and toward the resolution of reality problems. The overstimulated child can be helped by the therapy to place his relationship with adults into perspective, once the parents have been induced to stop the overstimulation. Children of parents who overemphasize needs for self-control and limit the rate of maturation of the child can be helped by therapy to bring their conflicts to the surface. This replaces battling within themselves to the accompaniment of guilt and doubt, which in turn alleviates the somatizations, paranoid symptoms, and tics that defend against the guilt and doubt.

Children who fail to enter latency can be helped by the therapist who understands the mechanisms involved in the psychodynamics of the establishment of states of latency. The therapist can construct a therapeutic strategy that will diminish the pressure on the child at the same time that weak ego mechanisms are strengthened.

In children with delayed cognitive growth, child psychotherapy can be applied with the aim of encouraging the establishment of more mature means of comprehending and remembering the abstractions necessary for school survival. Concurrently, improved cognition aids in the therapeutic process. A means is established by which interpretations can be enhanced to achieve lasting impact.

The technique of therapy entails the unravelling of the meanings of fantasies when direct verbal communication fails as a channel for bringing conflicts and memories to the arena of consciousness and communication.

In the following pages we consider specific procedures, activities and interventions which can be of therapeutic value. In essence, the process of cure will be explored through an investigation of the nature of its effective components.

The Hows and Whys of Equipping a Playroom

All therapies occur within a setting. For the therapist who wishes to work with the latency-age child, with the great emphasis on play and fantasy that occurs, the nature of the setting and objects in the room are crucial. Therapists offer settings of varying degrees of complexity and elaborateness. All have one thing in common. The equipment in the office is selected with an eye to its use by the latency-age child with the techniques he has available to use alternative media to express concepts and conflicts when words fail.

There are moments in therapy when words cannot be found to convey the concepts that the child wishes to express. There are times when the use of words conveys threatening concepts so directly that uncomfortable affects appear. In these circumstances, ego mechanisms related to the structure of latency are activated by the child to shift the concept into fantasies, graphic representations, three-dimensional figures, doll play, movement patterns, and somatic responses.

The therapist sets aside a drawer of his desk, a cabinet, a closet, a corner, or, best of all, a full room for the purpose of fantasy play, and equips it with the necessary devices. There is some difference of opinion over whether one should undertake the expense of having a separate playroom. Such a room is kept separate from the consultation room which has decorations that are more in keeping with the mature style required for treating adult patients. Some therapists claim that they do not need a separate playroom or play equipment because they have never worked with, or seen, a child who made messes, was sadistic, tore things, or became openly destructive in their office. These therapists imply that their skills surpass those of the ordinarily endowed therapist, who feels a need for a playroom.

I feel that the therapist without an independent playroom works under a limitation. He cannot encourage regression, follow fantasy undeterred, encourage the playing out of fantasy, or explore neurotic patterns that may be expressed through motor syntaxes. It is wise to have the playroom connected to one's consultation room so that the child can move freely between them. In this way, the child who is given a choice of rooms from the start can wander between the "talking room" and the "playing-and-talking room." His movements toward play are propelled by regressions, and the requirements of his need for ego distance from the latent content with which he is trying to cope.

The setting may be only a corner or as much as a room without outside views or noises, small enough and so simple of shape that the child cannot use distance or alcoves as means to hide. Whether the setting be a corner or a room, the material required to furnish and equip it share certain characteristics. They call upon the child's resources and personality in a response context of spontaneity. Patterned and organized play material, such as games with rules and games of chance are less helpful than dolls, clay, and drawing material, which at every manipulation are reflections of the inner life of the child. The basic principle is to place at the child's disposal material that can be used to express that which cannot be expressed in words. Fantasy play can reveal much while masking. Games with fixed rules mask more than they reveal, if only by dint of the fact that the time that is taken up with their formal aspects could otherwise be used for the spinning of fantasy. The child's personality is the subject, not the personality of the designer of the game or the personality of the therapist.

By the same token, when the therapist enters the fantasy of the patient as a character, he may not intrude his own fantasy or personality; he must seek direction from the child as to his role. Otherwise the child would be led from his thoughts and drives to follow a path that may gratify the therapist and reinforces the therapist's theories about the patient at the expense of true insight for both. When mutual storytelling is done, the therapist should avoid introducing his own fantasies and characters. Instead the therapist should seek elaborations of the ideas of the child.

Sometimes it is necessary to use structured toys and board games when investigative therapy is to be avoided and the therapist's goal is to provide companionship or support for coping skills that are heavily loaded with obsessional mechanisms. I have a preference for storing such games in a special place so that they are not available to be used by youngsters as a defensive maneuver when inappropriate to the therapy.

Nonstructured therapy materials fall into two groups. These serve the two major regressive pathways observed in children. The first group serves regression along the line of cognitive skills. The second group serves regression along the line of psychosexual development. The former emphasizes the formal aspect of media used for the recall of memory elements, (i.e., paper, crayon, clay). The selection of the latter emphasizes symbolic content (i.e., soldiers, cars, guns, dolls).

Ontogenetically, memory elements are first expressed without media. They take the form of affects and body parts in motion. The memory function expands its recall horizon to media when music, rhythm, bodily motion, and form are expressed in pounding and shaping clay. Rhythm, motion, and shapes come to be recognized and can be used to express and master prior experience toward the end of the first year of life. Later, during latency, active shaping and clay play will reflect regression to this stage. A playroom is incomplete without clay.

The next step in development is the addition of the expression of memory (spontaneous recall) in the use of two dimensional lines (three to four years of age) when the child begins to draw pictures. Often, hundreds of drawings will be made over a period of years, to the amazement of parents. Parents are equally amazed when this productivity ceases, and the child who had been seen as a potential artistic prodigy reveals himself to have been only going through a stage. Indeed, drawing is an age-appropriate way of using media to master experiences that is later deemphasized when pictures give way to words. In short, a playroom needs pencil and paper.

By the time of mid-latency the telling of tales, experienced both actively (in telling) and passively (in listening), becomes the primary means of mastering events. Now symbols find expression in words, rather than in plastic form. Yet the transition to the use of words is incompletely reached throughout latency; clay forms and drawings persist. Repeatedly, the child is seen to require the participation of his whole body (body movements expressing his excitement), so that symbolized fantasy becomes fantasy play. The playroom needs space to move (minimally 10' x 12'). Obviously, latency is the time when play materials are of great value. Without them, the child is limited to words. Only part of the story that the child has to tell can be told. Only words as symbols will be available for translation into words as direct communication to the therapist. Affects and motor patterns expressible only in play will be deleted from the translating process and no one will be the wiser.

I have already described progress developmentally, in the area of media for memory, and spontaneous recall in the service of mastery has been portrayed. In reverse order, regressions along this developmental line traverse the following schema. What the child can say, he will say. What the child cannot say, he will put into action and fantasy play. What cannot be put into fantasy play, can be drawn. What cannot be drawn, can be molded in clay, or, more primitively, acted out directly in aggressive acts

and discharges of affect. Thus, if a child cannot tell a dream, he may be able to draw elements from it. If he cannot draw, then let him try to work in clay. If the child cannot tell about himself, then introduce ego distance by having the child tell the story through the use of dolls with assumed names.

The regressive pull in child therapy is in the direction of direct physical expression and organ language. Therefore the substitute expressions I have described present a potential danger that tempers their capacity to improve communication through placing the media with which the child is comfortable at his disposal. They can encourage too rapid regression in the borderline child. For this reason, for some children the play material is used to encourage the child to substitutions in the direction of less regressed activity. For example, there are times when the child has regressed to the point where he no longer expresses his latent contents through symbols and substitutes, but is actively involved in the expression of aggression through affective displays and discharge via motor syntaxes, using the therapist as object. This is a technical way of saying that sometimes the kid gets temper tantrums and starts punching out the therapist. At these times, substitutions should be upward, with the suggestion made that the child show the therapist what he has in mind using dolls or a punching balloon as a substitute object. Similarly, in children who have failed to develop verbal symbols of the psychoanalytic sort, it is necessary as a technique to encourage substitution upward through the creation of plastic elements, doll play, clay play, and drawing, as a means of expanding the child's media for expressing and mastering events, displacing and binding affects, and delaying responses.

A list of helpful play materials for the playroom includes clay, paper, pencil, watercolors, scissors, glue, a punching doll, plastic toy soldiers, a dollhouse with a doll family, and toy cars. Plastic clay that hardens is particularly useful because figures made from it may be used session after session as a basis for further elaborations of the fantasy or dream in which the figure first appeared. There should be a bathroom available. Often the regression to body and physical sensations takes the form of masturbatory activity or the need to use the bathroom. Water should be available. I prefer a pump-action sink with a self-contained cool water supply instead of a standard sink with hot and cold water and a head of pressure. Hot water can bum a child's hands, and a head of pressure can be most unfortunate if the child places his finger under the faucet and then places himself between the faucet handle and the therapist and directs a spray of water at the therapist.

The levels of regression that have to do with psychosexual development consist of a series of phases. The earliest is the oral phase. This finds reflection, in the latency years, in play in which bottles, care-taking of dolls, eating, and stories of dependency using dolls are pertinent. For this reason, dolls with bottles are useful in the playroom. Some therapists keep food around, recommending only small amounts. I find that the less that children eat, the more they talk about their need to eat, and so I do not recommend this practice.

The next phase is the anal phase. This finds reflection in the latency years in regressions to needs to smear and mess as well as sadistic and warlike fantasies. There are also fantasies of bombing, direct anal references, and projection. Clay and finger paints are most useful for expressing and letting off steam in this area. Toy soldiers are helpful for carrying out large scale fantasies of omnipotent power. The child needs both discharge in this area as well as analysis of content to help master prior experienced stresses. In addition, especially in dealing with the anal regression of the latency-age child, the mechanisms of restraint need strengthening. The most useful and most feasible strengthening maneuvers during child therapy sessions in this regard are techniques that encourage collecting and the obsessional patterning mechanisms that are used naturally by most children. An example of such a technique is the familiar game of "dots," in which lines connect dots to make boxes and each box completed belongs to the person who has completed it. Children may be encouraged to bring in pennies, baseball cards, and so on, and to organize them.

Doll play may be used to good advantage for the expression of anal phase material. It is important in this regard that the dollhouse be equipped with bathroom furniture. Clay should be available for the child to use to represent feces.

Next on the level of expression of psychosexual development are materials that can symbolize the elements of the phallic phase. Important among these elements are the Oedipus complex and sibling rivalry. Dolls of different ages and sexes and a dollhouse are invaluable in helping the child to portray the conflicts relating to this period. Guns are useful in helping children to express assertiveness, phallic penetrative urges, and oedipal aggression towards parents. Family dolls which represent parents and children to scale invite the child to express feelings in this area.

The important thing to keep in mind about the cognitive and psychosexual determinants of the material used in the playroom is the difference in goal inherent in the selection of material for the expression and study of each of these developmental lines. The materials used in the cognitive area are chosen with an eye to the form of the media needed for the expression on a symbolic level of latent memory elements. Motor syntaxes are learned at each phase for dealing with each medium (clay, paper and pencil, symbolic motor patterns, words). Such phase-related motor experiences and skills are retained in memory. They become the basis for building up a body of learning on which to base future functioning and development, or as a mechanism for the continued processing of trauma with an eye towards mastery. Regressions can activate them inappropriately.

The materials used to encourage play that will reflect information about the child's phases of psychosexual development are chosen with an eye towards their usefulness as symbols. They must be able to express latent, phase-appropriate memory content. The choice of material is based upon prior experience with symbols in the play of children and in the dreams of adults. Certain symbols have been found to be consistently used to express certain latent contents. Thus a doll with a bottle has oral connotations. Clay and feces, or finger paints and feces, have come to be equated symbolically. This is a convention which is constantly reinforced by the spontaneous clinical productions and associations of players and dreamers. A gun repeatedly appears in play and dreams as a phallic symbol.

There are some who challenge these symbolic equations and their use. Indeed, even the relationship of fantasy and latent thoughts to symptoms and behavior is challenged by some. If the child therapist takes such a negative stand, analytically derived child therapy becomes a therapy divested of much of its effectiveness. I recall from my college years a young man who openly challenged the theory that dream symbols could have an unconscious meaning. He challenged the class to analyze a dream he had had the night before. He started off at first to tell the dream in words. "I was hunting. I had a rifle. I went into this cave after a mountain lion. I raised my gun to shoot. Just as I was about to shoot, my gun went like this." At this point he ceased using a verbal mode for relating his dream and shifted to a symbolic motor pattern. He pointed his finger straight out as if aiming into the cave. Then, with the phrase "like this," his finger relaxed and hung limply from the knuckle. The class, which had maintained its demeanor up to this point, dissolved into laughter, while the dreamer only looked bewildered. A class of unsophisticated 18-year-olds apparently knew something of the secret of dreams, and put it to use that

day. Experiences like this contribute to my certainty that guns should be present in playrooms so that phallic symbolism may be expressed.

The playroom furnishings themselves have specific therapeutic value. There should be low shelves in which play material may be placed in a casual and accessible manner, though easily available to the child. A table should be provided as a work surface, preferably with a top of Formica, not wood. Within reach of the table should be a low chest for tools and equipment that can be brought out by the therapist as needed. A holder for paper, watercolors, pens, and pencils should be at hand. Many therapists have a couch on which the child can rest. A bin for each child is an excellent idea. File cabinets can be useful for this. In these bins, whatever the child works on consistently or has produced and wants to keep for the next session can be kept out of harm's way and out of the hands of other child patients with sibling rivalry problems. There should be an open, hard surface floor area on which the child can play by himself.

The treatment of walls is important. Children often want to write on walls. This cannot be permitted, if only because one child can fill one wall in one day. Yet, something is lost if the child is blocked in this. I've solved this by covering one wall with a dry marker board. Another wall, covered with cork, becomes a place where the child can proudly exhibit his achievements in drawing and design. In addition, the corkboard can be used to keep exposed and at hand pictorial symbolic products that might otherwise have been thrown away and that the therapist wants to keep in sight and available for future working-through.

The Qualities of the Therapist

Of all the elements in the playroom, perhaps the most important are the therapist's personality, knowledge and experience. The successful therapist must genuinely like children, not in the abstract but over prolonged periods of contact with individual children. If the impulse of the future therapist is to give his patient something to do while he reads, or if the potential therapist wishes to play games of chance with the child, or if the potential therapist finds himself dozing when assigned to the care of a child, the likelihood is that he should seek another profession. Gifted child caretakers and child observers may be insufficiently comfortable with children to be able to interact with them on a level that

permits psychotherapeutic insight and communication. This may well explain why so many well trained child therapists give up direct work with children to take on supervisory and administrative roles.

The personal attributes of importance in the child therapist are warmth, a quiet and relaxed manner, a voice capable of modulation, and a capacity to remain cool and to think in the face of sometimes destructive surprises. When these attributes are present, the child's needs in a therapist are satisfied, for a child can be comfortable in the presence of such a person. Of no less importance is the ability of the potential therapist to accept regressions that occur during the therapy sessions. He must be able to accept regression in the child and accept the stirring up of his own drives that this entails without the mobilization of defenses that could block communication or insight. He must be able to accept the child's behavior, think on the level that the child thinks, and still not regress himself to the level of playing and interacting with the child on a regressed level. Play and interaction that express the therapist's own infantile needs will intensify the child's regressions and problems. The troubled child needs an adult as a therapist, not as a best friend. A child of his own age would serve the latter purpose better.

In essence, then, the potential therapist should be comfortable with a child's regressed behavior. He should be capable of regressing cognitively to be able to appreciate the child's communications and to communicate in turn. Consonant with these controlled regressions he must not lose the sense of distance that permits reflection, free-floating attention, and awareness of the influence and needs of society in guiding behavior.

It is very helpful if the therapist can draw, or can model clay into a recognizable representation. This will support the use of figures as interpretations and in the passive introduction of symbols to children with poor symbolizing function.

Child therapy requires neither the use of medication nor the "laying on of hands." It is a field open to child-oriented people of many professional backgrounds. The experience of the physician equips him to deal with childhood psychopathology from the standpoint of differential diagnosis and physical or organic modalities of treatment. This does not bear a direct relationship to the therapy of the latency-age child as such. The experience of the physician in the treatment of the physical disorders of mankind creates in the therapist what may be called a "feel for tissue": this implies that to administer any therapy

one must be aware that the strongest forces for health lie in the natural recuperative and restorative processes of the body and personality. One must be able to put aside one's omnipotent fantasies and the search for hermetic magic in favor of choosing modalities of intervention that will not interfere with natural developmental and curative processes. One must accept limitations on rescue fantasies and feelings of omnipotence so that interventions can be tuned to the pace of needs of the patient, not the therapist. There is a great deal to be learned from any physicianly ministrations governed by the rule "first of all, not to harm" that can immediately be applied in the child therapy situation. Working with tissue on an intensive level, as physicians do, brings such skills into focus early in the career of the medically trained therapist. As seemingly distant an activity as learning to diagnose pathology slides has a bearing. There is an abdication of narcissism (jumping to conclusions) in favor of the verifiable and consistent observable facts revealed on the slide that is brought immediately to bear in child therapy. The theories and hypotheses of the therapist must take second place to the observable facts of the child's behavior.

Over time, anyone who works in child therapy can acquire the "feel for tissue." An awareness of this concept in the hands of therapists without medical experience may hurry the process.

Those who come to child therapy from backgrounds related to child caring have had access to an invaluable knowledge base. Child therapy requires that the troubles of the child at a given age be familiar ground to the therapist. Knowledge of the typical fantasies and reality problems of each age helps the therapist to know where to look for trouble and what to talk about and encourage in the therapeutic situation.

It is incumbent on the child therapist to fill in those areas in which background is insufficient as soon as is possible. It is of importance in seeking out a training program that it is designed to fill these needs rather than the needs of the institution on the level of research or earnings. A personal analysis is an invaluable source of knowledge into the unconscious. In addition, it helps the therapist deal with personal reactions, which would interfere with his capacity to participate in the therapeutic situation.

Effective Therapeutic Techniques

In child therapy, two areas, at least, are the focus of therapeutic attention. First, we focus on current stresses and humiliations that unsettle the child. Insulting and disappointing experiences trigger regressive behavior. Memory for the actual experiences may undergo repression. Defensive and regressive symptoms, as well as anxiety, appear in their stead. Personal insults are not the only current stresses that confront a child. Overwhelming of the ego by the drives, and developmental demands, also confound. Social pressures and the task of integrating newly acquired skills into peer accepted behavior can also unsettle a child. Psychotherapeutic activities must be aimed at helping the child deal with these difficult inputs and tasks, as well as resolving the use of defenses, when they are counterproductive or when their function produces symptoms.

The second group of problems consists of unresolved past humiliations and traumas that were not mastered when they first occurred. These are manifested in self-defeating patterns of defense mechanisms, and internalized fantasy structures, which dominate the child's behavior (such as sadomasochistic persecutory fantasies). They sensitize the child to turn current situations into insults.

Which of the usual activities that occur during child psychotherapeutic sessions are most effective in resolving these problems, both current and chronic? Of the many activities that take place during the child therapy sessions, only a small percentage are effective in helping a child to resolve repressions, master trauma, deal with humiliation, give up symptoms, and progress from regressive behavior.

The portal to obtaining mastery of the facts of progress in child therapy lies in the area of understanding the functioning of the ego structures of the latency-age child. When the child's defenses do not permit him to talk of adjustment problems directly, the alerted therapist is aware that the ego structures of the child still may permit communication through fantasy play. The alerted therapist encourages fantasy play since it can also serve as a means of discharge and vicarious coping with precipitating stresses.

Superficial Use of Play and Fantasy

The encouragement of fantasy and fantasy play is a therapeutic maneuver with multiple potentials.

Coping, discharge, working-through, and communication of information are all possible through fantasy play. Therefore, fantasy play may be a means of helping the child to discharge and resolve in conflict areas, at the same time that it becomes a source of information for the working-through of chronic problems of early origin. Strengthening the capacity to fantasize also strengthens the capacity of the child to enter states of latency, with the attendant calm cooperativeness and pliability that permits the child to be taught and to learn. This is done by encouraging the use of symbols and requiring delayed responses. If a child speaks of events haltingly, and with little spontaneity, one may ask if there are any "make believes" that the child has in regard to it. Play objects in the playroom encourage this. Just letting the child play in fantasy, and develop the fantasy, helps the child to work through problems.

One can tell if this technique is working if the fantasies as told, gradually change. For instance, the child who starts off with fantasies that deal with fear of injury and loss of body parts, who goes on to fantasies of penetration and heroism, and the child who moves through fantasies of sadism towards siblings, to fantasies of the acquisition of objects to be used in adult occupations, are heading in the right direction. Often, little in the way of intervention is necessary on the part of the therapist. However, an occasional interpretation or discussion of a fear, coupled with reassurances, may hurry the child on his way to health. All the child apparently needs in order to progress is place enough and time to pursue his fantasies undisturbed. The effectiveness of this technique can be further checked simply by viewing the child's behavior outside the sessions. Maturation of fantasy content (defined in terms of less regressed symbols, situations, and reactions) and improved behavior at home, coupled with appropriate states of latency, are indicators that the therapy is effective.

In many cases discharge through fantasy leads to improved behavior very quickly. Parents tend to remove children from treatment at this point. It is well to forewarn the parents of this course of events. In this way, one is permitted to work through the child's problems more fully. In addition, one is saved the problem of patients who drop out and then return to find no place in a busy practice.

Direct discussion of surface problems, and indirect confrontation of problems through fantasy play, are the most important of the effective technical activities in Latency Age Psychotherapy. Progress clinically with discharge through fantasy is often sufficient to produce improved states of functioning. It cannot be depended upon to produce lasting results. The child who improves using play therapy alone

cannot be depended upon to hold his gains. Remissions are common. For this reason, interpretive interventions, improved communication, and sympathetic discussion are important factors in securing gains.

Supportive Therapy Techniques

Selected therapeutically supportive activities are used in child therapy sessions. We deal here not with the technique of cure, but with the activities which are the building blocks from which cure is constructed.

Coping Skills. Coping skills are here defined as those aspects of the personality which may be used in confronting and dealing with day to day issues on a moment to moment basis. They are practical steps and manipulations used to handle pressures brought to bear by others, and to deal with tendencies within the child's own group of disorganizing defensive reactions. The child psychotherapist's role in regard to coping skills is, in essence, what one does while waiting for insight to arrive.

The emphasis on coping skills early on is one of the characteristics of child therapy which differentiates it from child analysis itself. In child analysis, manipulation through discussing coping skills is deemphasized. In child analysis, the dynamic interpretation of the internalized cognitive, defensive, and fantasy structures, that form and sometimes deform the patterns of a life, are the dominant activity. Such interpretations are also frequently used in child therapy, where they are paired with the techniques, especially nonverbal, described here. Dynamic interpretation becomes the basis for working through fantasies.

Other effective psychotherapeutic maneuvers similar to the development of coping skills (e.g., fantasy play as discharge, encouragement of defenses, reassurance, and pedagogy) are emphasized in dynamic psychotherapy but dominate in supportive psychotherapy. When a child's problems are the result of internalized structures and fantasies, child analysis or dynamic psychotherapy is the treatment of choice. Where reality situations, family problems, and insufficient training, or ego fragility are the issues, the therapy will require more and more noninterpretive procedures. Primary emphasis on the latter techniques in therapy is the basis for supportive psychotherapy.

Impaired coping skills are often in evidence in youngsters referred to child therapists. As the result either of chronic pressure from the disordered behavior of the child, or as the result of preexisting disorders of adjustment, the parents themselves often display poor coping skills. Thus, the children have poor models from whom to derive their own techniques. For this reason, there are times when the management of coping skills entails direct work with the parent as well as with the child. The parent who responds to stress by running and panic introduces the child to these techniques. If the parent is not worked with along with the child, the parent may undermine gains made in the treatment as a result of his continuing inappropriate behavior.

A sign in the office of a successful personnel manager read "When in danger, fear and doubt, run in circles, scream and shout." This epitomizes a typical behavior element of a person with poor coping mechanisms. Avoidance as reflected in withdrawal from sports and from contact with aggressive peers is another.

When working with a child who uses avoidance, the therapist should look for a parent who quiets his own inner anxiety by limiting the activities of the child. The parent who drives the child to school when the child could walk or ride the bus limits the child's future capacity to cope with situations requiring independent judgment, and his ability to evaluate and respond to potential danger in new situations.

Working with coping skills usually requires direct intervention. It makes up a good deal of the pedagogical aspect of child therapy. For example, the child who has trouble doing his homework may be invited to do his homework in the therapy session. Direct tutoring help is obviously not the object of the therapist. Rather, an appraisal is made of the child's formal approach to the work. For instance, a child who repeatedly "forgets all I know," when taking tests for which he had "studied hard" was found to have studied only to the point where he could recognize the material required. He had no ability to recall the material spontaneously. No amount of interpretation of motivation could have helped him to utilize his memory skills in a manner that was, until then, beyond his ken. Helping a child to set up schedules and to organize his approach to homework is useful in youngsters who tend to panic when they bunch all their work up to be done at one time.

The youngster who is constantly teased and picked on will find that therapy will eventually help him cease to seek out the group of children whose level of sadomasochistic aggressive energies propel them continually into constant situations in which they are teasing or being teased. They will leave this group when the conflicts (i.e., castration anxiety) that have initiated their regressions are worked through using dynamic interpretation. Early in the process, it is helpful to help the child to cope by helping him to identify those aspects of his own behavior that exaggerate or call forth repetition and intensification of teasing. The therapist may explain that provocations ("What did I do, I only stuck him with a pencil by accident!" "All I did was curse at him, why did he hit me?" "The teacher punished *me* for kicking *him* when *he* started it by moving my paper!") and hypersensitivity ("I can't help crying when they tease me," "They sometimes bring friends along to see how upset I get. It's like I'm a show.") are explained to the child as activities which intensify the amount of teasing received.

Two things happen when this is done. The child implements his new knowledge, so that the teasing decreases. The child is able to gain some distance from the situation, sees his active role in the process, and becomes more available for exploration into his unconscious motivation.

Direct intervention of this sort makes up a large part of the work on coping skills in child therapy sessions. A not inconsiderable contribution, though often inadvertent, is the stance and behavior of the therapist.

> A 10-year-old boy, known for his temper tantrums as well as his tendency to respond to his teacher's questions in the classroom situation using expertly imitated French, German, or Spanish accents, came into a session in a furor. He railed against his soccer coach, who had criticized him that day. I sat quietly and listened. At one point he seized a towel rack and actually pulled it out of the wall. I interpreted his displaced anger. He responded with, "How can you sit there calmly?" "If I yelled back, there would only be a fight, and we would have learned nothing of what happened, and then we wouldn't be able to understand anything," said I. He seemed impressed by the use of calm in dealing with an angry person. This impression was confirmed by his mother, who reported that, within the week, he had used calm to deal with her. Upon returning home one afternoon she found that he had left some dirty socks on the floor of his room. She called him from watching television and began to scream her displeasure at him. Instead of his usual raised-voice response, he calmly waited out the storm and then commented to her on the value of discussion rather than yelling. She was doubly taken aback, once because of his new approach, and once because, in spite of his new leaf, he still had not picked up his socks.

In working with children who react to stress or frustration with temper tantrums, the therapist should alert himself to the antecedents and stresses that precipitate the regression, and be ready to offer

the child substitute activities. Should the regression begin, the therapist could help the child to replace aggressive, disorganized regressive responses with organized motor syntaxes, which will then be converted to verbal equivalents, so that verbalization and reason can take the place of destructive rages, and interpretive work can be done.

> For example, a child of 6, whenever confronted with a toy that he could not operate or a break in an object he was making out of Playdough, began to scream, shout obscenities, throw chairs, and make a mess. During these periods he was not verbally communicative and tended to set toys poised to break on the edge of shelves and performed exaggerated movements such as the opening and closing of window-curtains. He did the latter with such force and alternating rapidity that I feared they would be broken. I noticed that he had set a superhero doll behind the curtain and then opened and closed it. Sensing that he was creating a quasi-stage for a character he sees on television, I placed a Victorian toy stage that stood on a nearby table at his disposal, showing him how to operate the curtains. He immediately abandoned the window-curtains and placed the doll figure on the stage. He added a second figure and had them play out a tale of attack and trickery in which one character hid beneath the stage while the other sought to find and kill him. When asked, he told me the story and discussed what the characters were doing. Thus was his rage effectively contained through the "socialization" of a gross motor syntax in which he had made global use of the room to express a half-formed fantasy. A bop-bag, clay, or even handing a child a toy gun might have served as well as the stage which was fortuitously at hand that day.

Encouraging Obsessional Defenses. One of the mainstays of the mechanisms of restraint that produce the calm of latency states in the face of anal sadistic drive regressions is obsessional defenses. In states of latency, the clinical manifestations of these defenses consist of controlled patterns of behavior which bind much energy. These include collecting stones, coins, baseball cards, and toy cars, as well as playing board games built around complex rules, drawing pictures based on patterns of geometric forms, and setting up dominoes with great and meticulous care so that they can fall in a row. These activities help to maintain for the child the state of calm which is part of an age-appropriate adjustment pattern.

When such behavior appears in the session it should not be directly discouraged, nor interpreted sui generis. Rather, discussion should proceed parallel to its appearance, with the therapist's awareness, at least in part, directed to the fact that the child is actively struggling to control regressive sadistic urges. The underlying problems may be dealt with without discouraging behavior within the therapy that has the therapeutic effect of strengthening the child's capacity to deal with intrusive regressive trends.

In children who have failed to enter latency, and who show hyperactive, excited, and at times destructive behavior in therapy sessions, or difficulty in achieving states of calm at home or in school, the introduction of games and activities with structure, such as checkers, board games, counting, watching

the clock tick away minutes, or penny collecting, provides defenses that help the child achieve a component of the ego organization that is necessary for achieving latency calm. This in turn permits the child to make progress in the work of maturing that must be done during the latency age period. This must be accomplished if the child is to be ready to negotiate the difficulties of adolescence and adulthood.

Interpretation

The two therapeutic activities described consist of strengthening ego function by changing defenses through encouragement or identification. They are prime representations of nonverbal activities which are psychotherapeutically effective. Now we focus on the role of verbalization and insight in the psychotherapeutic process. The emphasis turns from what to do to what to say.

The Interpretation of "Repeating in Action". Aggressive actions directed toward the therapist, such as silence, teasing, or striking, usually reflect or repeat an event of the day in which the child was the victim. In effect, the behavior of the child reflects an identification with (i.e., internalization of) a person who has behaved in an aggressive manner towards the child. The actions in the sessions serve to help the child to master the recent humiliation. The gain, though of importance, does not have much of an effect beyond the immediate session or relieving the immediate momentary distress. The child is only minimally aware that something is being mastered through the aggressions being brought to bear on the therapist. Through interpretation that causes a verbalization of the process, consciousness, consisting of verbal concepts, is widened to include an awareness of the defensive process.

Often, if the therapist interprets an attack against him with a question such as, "Who hit you like this today?" or "Who teased you like this today?" the child will stop, think, look surprised, and then explore the half-forgotten humiliation which had returned with such force in masked form just moments before. As the child begins to talk of the experience, there is no longer a need to relive it in action. Once the complex of events has been made expressible in verbal form, a kind of world-picture painted in words begins to appear on the canvas provided by the therapeutic situation. Unlike the spontaneous and seemingly random revelations in the playing out of fantasies, a descriptive process that uses words can be directed and expanded so that it can explore with few limits. It can even open doors through the use of verbal deductive reasoning that could only be reached through arduous work, using actions and

fantasies brought to the therapy through associations in the nonverbal sphere.

The moment that the child's experience is translated from the world of affect and action to the world of words, there is a change in the quality of the therapy. Reflection, deduction, expanded detail, and manageable abstractions of extended events enrich the potential of the psychotherapeutic situation. Verbal insight becomes possible. Verbal memory becomes a therapeutic tool. Patterns of behavior are recognized. Conflicting, often self-defeating, activities can be considered simultaneously and recognized for what they are. Sources of anxiety in the child's own behavior, potentially under his control, are brought into focus. As a result, motivation for change may be introduced. The child who can see the origins of inappropriate behavior during sessions in misfortunes that befell him in the day just past, may have learned to look for causes in unexpected places and may be induced to use such thinking in other situations. Therefore, working-through (recognizing complexes and reactions and correcting them in all the places that they occur) may be introduced into child therapy, as it can in adult therapy.

Encouraging Verbalization

One is not always confronted with a child who takes out his humiliating experiences on the therapist. The therapeutic activity of getting a child to move his recollection of his experiences into the realm of words, does not always fall so easily "into one's lap." (There are exceptions to this in the form of quite verbal children.) It therefore becomes necessary at times to encourage verbalization in other ways. The most common such procedure is to question the child about his experiences, feelings, and fantasies in such a way that he must put them into words, thus invoking a verbal mode of communication. Questions that can be answered with "Fine," "Good," "All right," and "No" are counterproductive. A much more useful technique is to pick up the part of a child's sentences or activities that contain new elements, and ask for elaboration.

One should be on the alert for sudden changes of topics or a switch from verbalization to fantasy play. This may indicate that material has been reached with which the child cannot deal. These "switch moments" are often the hinges on which therapeutic progress turns. Two possibilities are the most common causes of "switch moments." In the first, the child may have hit material that is too affect laden to face. In the second, the child's cognition has not matured to the point that he has reached the level of

abstraction required to understand the therapist's recent adult-oriented interpretations and to remember them. In the latter case, the level of thought process needed to master the material on a verbal level is beyond the cognitive powers of the child.

There are two technical psychotherapeutic procedures to be followed in this situation. If the cognitive potential is available, the development of the child should be encouraged toward a level at which comprehension, memory, and insight can be maintained at a sufficient level for sustained behavioral changes to occur. Where this is not possible, greater emphasis must be placed on working-through in fantasy. A brief description of these psychotherapeutic processes follows.

Helping to Achieve Cognitive Maturation. The mere act of verbalizing in a situation in which the child is a center of attention for a sustained period of time has a strong influence in making a child become more verbal. Pointing out connections is an important part of this activity. Showing the child the assembly of whole pictures out of smaller units such as lines, circles, and dots, with accompanying verbalization is a useful exercise. For example, draw a few lines which vaguely indicate an animal. Explain to the child that with each new line he will be more able to recognize the image that is slowly being revealed. Add lines until the child links words to the concept of the animal conveyed in the simplest abstract reduction of its form. When a child speaks of a dream, or plays out a story, bring the nonverbal components into the realm of shared memory by having the child mold or draw the image. Then ask about details to foster verbalization. Retain the plastic form of the concept, and return to it again and again. Introduce it when concepts it represents are apparent in the associations of the patient. Concurrently, it behooves the therapist to avoid depending upon or using these communications which improve cognition as dynamic interpretations if they are well beyond the understanding and memory capacity of the child. They need not serve as therapeutic tools over and above their role in encouraging cognitive maturation. Therefore, when the job of cognitive maturation has been achieved, one must return to them if interpretive content is to be conveyed.

Working-Through through Fantasy Play

Fantasy Play as a Therapeutic Activity. Playing out fantasies even in the absence of communicative verbalizations that involve the therapist, and insight, can be of benefit in helping the

child to abreact traumas and to work through fixations in psychosexual development.

> This was brought home to me strikingly by an 11-year-old girl who had come to analysis some years before, dominated by the wish to be a boy. She refused to wear girls' clothes, was very athletic, and avoided dolls and such. Toward the end of her treatment she insisted on extended periods of doll play. When I asked her the reason for this, she said that it expressed and fulfilled her need to play out being a mother. This was something she had denied herself before.

Strengthening the Symbolizing Function

At times a child has an absence of the ability to symbolize defensively. This interferes with fantasy play. Such children tend to have latency calm interspersed with episodes of marked anxiety, as opposed to excited behavior. Usually it is active symbolization that is missing. The child can passively use the symbols of others in the form of stories and TV dramas, for hours on end. He cannot, however, produce symbols on his own. Typically, such children fall into silence when they come upon material that is difficult to verbalize. This is in contradistinction to the shift into fantasy play that one normally sees in latency-age children. It is therapeutically useful to help these children to create unique personal symbols so that they can develop fantasy play for use in therapy and life for the mastery of conflicts, humiliations, and fixations. How is this done? One technique is to introduce clay figures, doll figures or drawings to represent the situation being described by the child at the moment he became silent. The next step is to ask the child what happens next, or even to suggest what may happen, using doll figures to illustrate the suggestion. As with most work which deals with cognitive growth in children, the symbolic potential of these children exceeds their functional capacity. This can be harnessed for therapeutic gain.

Fantasy as a Data Source

Fantasy, like dreams, can serve as a source for information and insights. This is even more true in child therapy than it is in the therapy with adults. Childhood fantasies often reflect the stressful events that have confronted the child prior to his coming to the session. The child who beats a punching bop-bag for refusing to eat may be telling the therapist of his own recent experiences with his parents at the dinner table. A repeated play theme of punishment for refusal to obey brings into focus the character trait of stubbornness in a child. The theme, oft repeated, of protecting oneself from having a leg cut off reflects castration fears. Stories of thefts, captures, and imprisonments can serve as signals, like buoys in a bay,

that something lies just beneath the surface. In this case, most likely guilt.

Not only recent events but also chronic stresses, fixations, and unresolved conflicts are the precipitates around which the fantasy of the child crystallizes. A current stress that evokes a fantasy defense in latency is usually related in content and form to the pre-existing fantasy that it activates. New fantasy themes are rare. New fantasy content elements, however, are not. Repeated patterns of fantasies that are evoked in a child are usually related to unresolved antecedents and parental attitudes. Thus, the child who fantasizes that he is a hero in the face of being called a name that day may be expected to be chronically sensitive to being called a name because of a parental preoccupation with defects and inadequacies which had been part of his early life. As a result he is ever on the alert to conceal defects, and oversensitive to fault finding. The analysis of fantasy during psychotherapy is a topic that could fill an endless volume. Other examples of it will be found in succeeding chapters.

Judging Therapeutic Progress

There is little in the way of formal psychological testing for progress in therapy in the latency-age child that differs from the standard available psychological tests. In situations in which the behavioral problems of the child are manifestations of a poor symbolizing function, and the usually associated inadequate latency, the progress of the child's improving symbolizing function with therapy can be followed with a test recently devised by Donnellon (1977) that detects the quality of a latency-age child's symbolizing function.

Clinical indicators are reliable and easily detected. Improvement in function is the primary goal of therapy. Improvement is defined in terms of the following key elements. The child should be able to maintain states of sustained calm, quiet, pliability, and educability in appropriate social settings. By the end of therapy, the latency-age child should be capable of symbolization, and resolution of situations of stress, through fantasy play discharge. This should be strongly differentiated in the mind of the therapist from fantasy activity that seeks only to escape from reality. The eventual outcome of latency fantasy as defense is the assumption of primacy by its trial action component. Fantasy as compensatory trial action normally becomes reality-oriented future planning in adolescence. The symbols and situations of late latency play fantasies should be strongly colored by appropriate tendencies toward realistic elements

rather than improbable creatures.

The child should be free of the symptoms which brought him to therapy. There should be good relations with peers, including acceptance of the child by other well-functioning children. Often the progress of a child in latency-age therapy can be traced best by following the changing nature and number of his friends. The march toward health is accompanied by an increase in the number of healthy friends, with troubled and provocative children diminishing as companions the further down the road to health the child goes.

Children Who Destroy the Playroom

A most trying situation for the psychotherapist, especially the beginner, occurs when a child reacts to approaches to insight with attempts to destroy the playroom. As often as not information to be gained from a child's behavior is both buried in the chaos produced in the room and reduced by the therapist's need to devote his attention efforts and energy to self-defense.

To introduce the situation in its most virulent form, let us watch it through the eyes and experience of a neophyte therapist. The following is taken from a supervisory session, which occurred immediately after the session in question.

> The resident who presented was involved in his first experience in working with latency-age children. Jimmy was 8 years old. He came into the session with a rather negative attitude. There was a clinic rule which required that sessions be held during the Christmas vacation. The child insisted that this week was his vacation week. He could see no reason to be at the session. He was there only because his mother had said he had to be there. He claimed that he had no need for therapy.
>
> The child's history revealed repeated difficulties. In school he broke things belonging to other children. He was known to have broken a window. Once, while at summer camp, he stole the keys to a counselor's car, started the car and, with a group of other children in tow, drove the car a distance of two blocks. The voyage ended when he smashed the car into a nearby tree. He told the other children, who had somehow miraculously escaped unscathed, that if they told the counselors or the head of the camp about his stealing the car, he would kill them. The children were victimized and brutalized by the patient for three or four days. Finally one of the children went to the camp director and told him of the incident and of his fear for his own life.
>
> Jimmy was a particularly handsome youngster, with a winning smile. He knew well that he was in therapy because his behavior was out of control. He was on the brink of being transferred from public to private school because he couldn't be managed. Still he lost sight of his problems and of the goal of the therapy. Instead he came to see the therapist primarily as someone with whom to play, to use as a foil for teasing, and as an object for acting on his sadistic fantasies.

Severe family problems were apparent. The parents had little interest in each other. They were occupied most of the time in highly complex, multiple extramarital affairs. The father was known to have punched a hole into the wall of the living room when he felt that his job was endangered.

A psychotherapeutic approach involving individual therapy for the child was chosen to augment counseling of the parents. The primary reason for this was the observation that the youngster's behavior was not merely attributable to a tension-discharge disorder (impulsive type). There was seen evidence of pattern to his behavior. Internalization of fantasy was present.

A fantasy-driven neurotic pattern informed his behavior. He had repeated dreams in which overt castrative elements appeared. He was diagnosed dynamically as a person with marked internalized conflicts manifesting castration anxiety, which was defended against by counterphobic aggressive behavior. His behavior in the individual sessions in no way contradicted this.

He was filled with bravado, braggadocio, and flaunting of powers. When his fears and bodily vulnerability fantasies were explored or approached, he became doubly upset and angry and he doubled his sadistic activities towards the therapist.

Play therapy in which these fantasies were played out in the therapy room were accompanied by a diminution in the amount of aggressive, sadistic, counterphobic behavior in home and in school. He played out Superman-type fantasies in which he would rescue the world from dangerous attackers.

The main problem presented to the supervisor therapist was containing the energies of the child. They were being diverted away from fantasy play, which, when permitted to progress, led to insight and mastery. Unfortunately, though, the child's energies were usually diverted into aggressive, sadistic, and sometimes physically destructive behavior aimed at the contents of the playroom, as well as at the therapist himself.

For example, during the Christmas session, the child had unexpectedly stopped his play and begun to punch the therapist. This was followed by throwing a container filled with colored felt markers on the floor. He then screamed at the therapist, telling him to pick up the markers or else he would kill the therapist. He then took a wastebasket and threw it up at the ceiling, breaking one of the acoustical ceiling tiles.

Interpretations of his aggression as a defense against castration fears only stirred the child to greater anger and brought his attention toward the therapist, whom he began to pummel with his fists. When the therapist held the child at a distance to prevent himself from being further punched, the child began to kick him in the shins. The child could not be restrained. However, he kept close watch on the clock. He stopped punching the therapist to take time out to break a small metal car with a hammer. Precisely at the end of the session the child walked out.

At the beginning of the following session the child came in somewhat apprehensively. He was obviously concerned with the impact of what he had done on the therapist. He displayed immediate relief when he saw the therapist had provided a punching bag, which, the therapist explained to him, could be used for the deflection of his aggression should that be necessary in this session. The child did not show insight at that point. He was more concerned with punishment. If there were no punishment then he didn't particularly care to pursue what had happened further, even though he was asked to do so by the therapist. At one time he stated, "My Mommie pays the clinic for the sessions and you have to stay here and let me do these things." Insight was not his goal.

A regressed externalized superego marked the moment of shame that he had shown when walking into the

playroom (see Chapter 14). When the therapist did not respond by taking the role of the punishing superego, the child was able to retire his superego-motivating affects. He then began to look around the room to see what he could do or use for play.

The supervisor asked for descriptions of any prior episode which could have provided some warning to the therapist, had he been on the lookout. The supervisor pointed out that in the very initial stages of any therapy with latency-age children—especially the younger ones—there should be a phase of exploration to see the propensity that the child has for such regressions.

There are two distinct categories of children with regressive potentials.

First, the purely neurotic child has regressive potentials in the area of psychosexual development. He may go from phallically- to anally-informed fantasy activity. Fantasy and fantasy play continue to be operative during such regressions. Destructive action is not available. In response to interpretation, the neurotic child tends to change his associations in the direction of making the unconscious conscious and utilization of energies formerly used for repression in the service of healthier defenses.

Second, the child who has a potential to destroy the playroom has regressive potentials in the area of ego function and impulse control. In the face of stress he may shift from destructive fantasy to destructive action. The existence of this potential should be determined before interpretations of unconscious content are offered. In response to interpretation, the impulsive, motor-oriented child will transmute the uncovered unconscious impulses into action.

There are, of course, mixed pictures of regression, which are described in Chapter 6.

How does the therapist determine early on that such potentials exist? When working with a child whose relationships are characterized by teasing and being teased, bullying and being bullied, the therapist should be on the alert for overt physical aggression against himself or the playroom. A history of impulsive behavior also indicates such potential.

A limited ability to use words, symbols, and play is also an important clue. Be on the alert for physical aggression, too, when working with the child who prefers to work through and express himself with three-dimensional objects used in an only slightly symbolized manner. The child who would rather make swords and have duels is more apt to tear the office apart than the child who is content to sit and talk about his problems, or to spin fantasies. The following material, based on a supervisory session,

illustrates the ease with which aggression assumes physical expression in such youngsters.

> The therapist confirmed the fact that his patient's history and therapy behavior contained many examples of impulsive motor acting out of impulses. The therapist told of an attempt on his part to help the child to bind his energies and to slow down his responses. The therapist introduced origami, a Japanese paper-folding technique. (This gains the child's interest and deflects energy into a constructive channel.)
>
> Upon entering the room the child insisted that he wanted to play ball. There was no ball present. The child still insisted. The therapist, who was skilled in origami, pulled out an instruction book. He soon showed the youngster that the office was not as ill-equipped as the child had thought. It would be possible to make a ball out of a piece of paper. Each took a piece of paper and began to make an origami ball.
>
> Certainly it would have been better to have searched through interpretation for that against which the aggressive behavior defended. The problem was that the child at that moment required ego building. The antennae for receiving insight had been withdrawn and had been replaced by provocation. The youngster became fascinated by the paper-folding process. He was able to slow down his activities and his impulsive movements. There was a jocular interchange. The youngster had to have a number of corrections. He insisted upon exchanging model balls, or pieces of paper, with every mistake that he made. Camaraderie developed. The therapist began to let down his guard, relaxing and regressing away from an adult and therapeutic distance. He could now play with the youngster, losing his somewhat distant but clearly differentiating psychotherapeutic stance. The balls were completed. The first ball was completed by the child, with the therapist's help. Then the therapist lightheartedly completed his own ball.
>
> At that point the therapist picked up the ball—very light and made of paper—and tossed it at the child, hitting him on the forehead. The youngster became enraged, humiliated, and began to grab the ball, threw it on the floor, stepped on it, and began to punch at the therapist and to throw everything on the table to the floor.
>
> In supervision, the therapist added, "I know and understand what happened there. I had aggravated his castration fears by throwing something at him when he hadn't expected it and hitting him in the forehead. The boy felt humiliated. I had become so comfortable with what we were doing that I forgot his propensity for destructiveness and his vulnerability and sensitivity." (The myths of childhood innocence and of the bland drives of latency are easily evoked. They are icebergs in the psychotherapeutic sea, set to endanger the unwary.) "But I don't quite understand what happened in the most recent session when he almost tore the place apart."

The supervisor suggested that they go over the therapy session in detail to see what could have happened.

"To begin with," noted the supervisor, "the youngster was very angry when he came into the session. In dealing with any youngster who has a tendency to regress to physically expressed impulsivity, anger upon entering the playroom signals danger that the room or therapist could be attacked.

There are techniques, both long-term and short-term, for minimizing the potential for patient

violence during child psychotherapy sessions. One short-term technique would be to help the youngster to structure the session. Ordering the child to behave might work, but is fraught with a potential that the child as a result of admonition will see his aggression and anger as a potent expression of sadistic drives that can "get to" the therapist. This will only increase the possibility of aggressive action aimed at the therapist.

Structuring is best achieved through befriending the child. This can be done by introducing games and play material that require mutual interaction and some structuring rules. The introduction of origami is an example. One must remember not to lose distance just because the child has gained some. In introducing a game, the child's potential for action is limited to the parameters of the game. This is not insight-oriented activity, nor should it be. Interpretations that would expand access to unconscious, material, and free energies, and modify fantasies are more apt to stir up more rage and pathological defenses when directed towards an enraged child. The angry child is not receptive to insight. He must be prepared for insight, through being made calm and sufficiently distant from himself to be able to accept and make observations about his behavior.

When a child with a potential for violence comes into the session angry, one is confronted by a non-therapeutic situation. The therapy session is not set within the matrix of calm which will enable self-reflection and the pursuit of insight. Whereas adults comment that they are aware of how upset they are and wish to understand it, the child is very often immersed in his upsetness and struggling only to free himself of the discomfort. Like the dog who has been hurt, he is apt to bite the person who extends the helping hand of friendship.

Once the child is calmed enough to listen, the therapist may direct the child's activity into verbalization, for instance storytelling. Careful questioning about what has happened and what the child's plans are can reintroduce the therapist as ally and friend. The therapist should try to get the child to verbalize the reasons for his discontent. Has he been misled? Does he feel tricked? Is there a way to prevent the difficulty in the future?

Although there are what appear to be discussion topics in these questions, in each case the primary purpose is not to obtain information. It is to bring the child out of the affectomotor world of anger into the

world of interactive communicative speech. Through delay and symbolization, the world of representation will provide a buffer against the world of feeling and acting. The technique is just the opposite of that used with the obsessional adult neurotic. It is also opposite in intent to the technique ordinarily used in helping a youngster find a way to communicate something that has been strongly repressed, or something for which the child has never found words.

With a child who is capable of regression to physical shows of violence it is necessary to avoid play activities which consist of three-dimensional expressions of memory. These include working with clay, and acting or living out dueling, wrestling, or fighting with the therapist. It is all right if the child fights with a bop-bag. It is all right if toy figures fight. It is courting danger, however, to permit the child to take on the therapist in hand to hand combat. It is especially necessary, during times of upset, to step aside and let the child's aggression and anger bypass the therapist.

> Mansur, aged 10, decided to build swords out of cardboard with which to play out with the therapist a fantasy of swordsmen. The youngster particularly liked to play a game in which he was almost defeated and then, rising like a phoenix from the ashes of defeat, he destroyed the person who had been defeating him. This eventually was traced by the child and the therapist to a feeling of being overwhelmed by the angry yelling of his father, who apparently lost control as much as the child did. At one point during the dueling play the child let his guard down and the stereotyped striking of a raised sword which was an agreed-upon maneuver in the fantasy was not achieved. The therapist's sword fell lightly upon the youngster's arm.
>
> The child had come into the session angry and tense. Through controlled play he was mastering these feelings. He was at the edge of experiencing and actively mastering recent painful events. Touching his unguarded arm unexpectedly in a situation which was not under his control revealed to him the passivity imposed by his age and size. Shorn of his defenses and too close to the physical as a mode for the expression of his drives, he lost control. This gave rise to tears, rage, screaming, punching, and trying to involve the therapist in a fist fight. This replaced what had been a good-natured exploration of his fantasy life, a turn of events that could be measured within the blink of an eye.
>
> The therapist pointed out to the youngster that he was so upset that he would probably start a fight at home. The child projected responsibility for his rage onto the therapist, saying, "and it will be your fault." Thus he indicated a total loss of the prior insight. Although this particular situation was somewhat devastating and disastrous it was used in subsequent sessions to point out to the youngster the displacement derived from the interactions that he was having with his parents.

This case illustrates how quickly a youngster can shift from three-dimensional, whole-body, direct combatant play into angry fighting and destructiveness. It is much more difficult to go into this state from playing with two cardboard figures which are fighting each other on a tabletop while the therapist sits on the other side of the room, observing.

The ordinary pattern of cognitive steps used in helping a child to express that to which he doesn't have ready access requires one to follow the following rules. If a child cannot tell about it, have the child draw it. If the child cannot draw it, have the child work in clay. Notice that one goes from verbalization to two-dimensional figures (e.g. drawings) and thence to three-dimensional figures (e.g. work in clay or motor syntaxes involving aggressive, whole-body movement). Knowledge of this pattern is highly useful. It is more fully described below (Chapter 10). Working with three-dimensional units is very close to slipping into whole-body participation as a combatant in destructive behavior. When one approaches this type of activity or interaction with a youngster who has a tendency towards destructiveness, one is walking on rather thin ice. In the area of three-dimensional activities or three-dimensional story-telling, the more involved in fantasy the story-telling is, the better the outcome and the safer one is. The more direct and concrete the representation is, the more one is apt to light up destructiveness in the playroom.

The therapist at this point interrupted the supervisor to say, "What you're describing here are rather general concepts which can help in heading off destructive outbursts. They guide through the use of certain principles. They help the therapist who is afraid of the child's anger during the course of therapy. What if the therapist wants to face the anger and analyze it? Isn't it possible that the child will take advantage of a therapist who consistently avoids anger in this way? The therapist could be completely cowed. Isn't there a point at which such behavior on the part of the therapist will interfere with and even limit some of the potential of psychotherapy to help the child to mobilize information and bring it to the surface? I would think that there is a limit to the extent that it can be followed. If one decides not to follow these principles with a vulnerable child, but rather one does proceed to explore for hidden and repressed material, and the child does begin to go over the edge, what techniques do you advise to head off further destruction?" The supervisor responded by describing what he considered the most important step. "The most important thing you can do is to *distract* the child. Fortunately, for the circumstance, these youngsters are rather immature and easily distracted. At least this combination exists in children who are easily raised to anger. There are many elements of immaturity here which have parallels in youngsters with immature central nervous systems and neurological disorders.

One of the most useful distractions is a bop-bag. The very aggressive youngster will be apt to take the simple plastic one and throw it around and punch it and even tear into it until he causes the sand to pour out. More endurance can be obtained by using a sturdy cylindrical cloth punching bag on which

drawings can be made in chalk. This is presented to the child when the child feels he wants to hit or punch something. Drawings in chalk can be utilized for helping the child to mobilize the fantasies which are often involved in this kind of behavior.

There is always the last resort, which is asking the child to leave the session and explain to the mother that the child is not in control. I've never actually gotten to the point where this had to be done, but have been amazed at how quickly children quiet down when the mere mention of the possibility of terminating the session is made."

"How therapeutic is this?" asked the therapist.

The supervisor answered, "Setting limits and helping the child to displace or restrict himself to cognitive patterns requiring self-restraint and verbalization when handling problems and excitements has therapeutic value in and of itself. The ego is strengthened by the experience. There are times in therapy sessions when children who are capable of destructive behavior force one into the position of helping the child to preserve his self-esteem. This is achieved through aiding the child to preserve his sense of his ability to control his own aggression, and avoid humiliation as a result of loss of control. Ego regressions and associated ego anxiety often occur in response to being overwhelmed by one's drives. It's a major humiliation for many of these children to lose control. Many are ashamed to come back. There are times in psychotherapy when long-term therapeutic goals become less important than the preservation of the child's pride of self as well as preservation of the therapist's own physical integrity and office property. Incidentally, I cushion the child for this from the start. I say to the children when therapy begins in a playroom, 'you can do anything you want here as long as it doesn't hurt the equipment, you or me.' "

The therapist then stated, "You know, I don't actually have a playroom, and it makes me very nervous and tense in working with these children. I think in the future I'm not going to work with any child who has this potential. I'll try to rule it out as soon as possible and then discharge him, because I don't think I want the cost of a playroom."

The supervisor then asked, "What kind of a setup do you have for children?"

The therapist then stated, “I have a corner of the room with a little table in it and some things to draw on and some clay and things to play with. But I have to put the table away in a closet and clean up before my next patient comes in.”

The supervisor said, "There’s no question about the fact that a playroom would be necessary if you were to consider working with children who have this propensity. The mere fact that you are tense will be picked up by them and will be used by them. You are becoming the target of their sadism. It’s hard to be a good therapist when you’re afraid that a child’s going to break your favorite picture frame, destroy a chair, or cut up a couch that’s to be used by the next patient. It’s hard enough for a child to differentiate forbearance from weakness. It makes things harder for the child when he can really make you frightened.”

The therapist asked, “Is it possible for mixed pictures to appear? Are there neurotic youngsters who have this potential? What are the typical dynamics of such neurotic youngsters?”

Answered the supervisor, “Well, I’m glad you asked that question because it points toward certain psychotherapeutic strategies to be used in working with them. There are, indeed, mixed pictures. There are two types of neurotic youngsters who behave in this way.

“*First,* there are those who have much fear of their fantasies. They have a primitive symbolizing function that makes their fantasies almost as disorganizing and frightening as raw drive energy. They become very fearful when any kind of aggressive feelings occur. Very often these youngsters will claim to hear a voice that tells them to misbehave and throw things. On the surface it looks spontaneous and impulsive. They appear to have isolated and encapsulated expressions of aggression.”

> I remember working with one youngster, the prettiest little 6-year-old girl who was most refined in her manner and attitude. In the middle of sessions and quite unexpectedly when something made her angry, she threw a pencil across the room. When asked, she blandly spoke of the voices that commanded her. When it was explained to her that the voices were really her rejected angry feelings and she was encouraged to verbalize her anger or to find play symbols through which to express anger through fantasy, the voices (externalization of anger) ceased.

“With such youngsters it is necessary to help with the development of the symbolizing function by substituting more and more symbols which are more and more displaced so as to help them develop a

symbolizing function. This is extensively illustrated by Sarnoff (1976, Case 1).

"*Second* there are those who are well able to form symbols and to develop a rich fantasy life. These symbols and fantasies might well have been able to be used defensively to enter into latency had the child the requisite calm and lack of overstimulation in the home. These youngsters are usually very strongly stimulated by the parents, and the only way to deal with them is to counsel the parents to see that such things as wrestling with the children, bathing with the children in the nude, taking the children into bed with them, beatings, screaming and yelling, and appearing drunk before the children come to an end.

"The most frequent, immediate dynamic family problems that I have detected, especially with these aggressive children, is a pathological fathering, which consists of an overconcern with the child's sexuality in the girls, and a lack of time and attention on a one-to-one basis by the fathers with both girls and boys. In regard to the latter, the fathers come home, take naps, and watch TV. They don't spend time with the children. The children's rage is, to a large extent, derived from the sense of being deserted by the parent for whom they very often wait. Often the child will not tell you about this, and it has to be asked for, when interviewing. Look for great anger at omissions. For instance, look for the situation in which the child feels that he has been promised that he will go out with his father and then the promise which has been made is not kept. Often parents will attempt to substitute buying gifts in toy stores for the relationship that the child needs. Although the child likes getting the presents, the sharp contrast between the ready purchase of any present wanted and the lack of interest that follows creates an even greater sense of disappointment." These potentially harmful outbursts are more commonly seen in youngsters before the age of 8 or 9. In the later years, it usually takes the form of the child getting up and stamping out of the room, or of a child smashing nails into pieces of wood with a hammer, or cutting up all of your chalk with a scissor. It's therefore a good idea to be especially on the lookout for such behavior in the youngster younger than 9.

Interferences with the Therapeutic Process

Parental Attitudes

One of the most common intrusions on the child therapy situation consist of actions by parents whose other obligations or wishes cause them to interfere with or cancel sessions. This is often an indication that the motivations and aspirations of the parents and the therapist may be quite at odds. The following clinical vignette illustrates the way in which therapist and parent may have ideas in relation to psychotherapy and its purpose that clash and create interferences with therapy.

> The parents of a child who was making progress in therapy requested a meeting with the therapist in order to discuss the future career goals of their child. They were somewhat distressed by the thought that the child wanted to be a musician. They felt that this was not a sufficiently dependable or responsible a job. The reason that the parents brought the child to therapy was the mother's preoccupation with the thought that the child might grow up to be a homosexual. She voiced no concern for her child's diffuse inability to function in all areas —school, home, friends—that became apparent in the initial diagnostic evaluation of the child. In prior discussions, the mother had said that she would like to see the youngster become a physician. By this point in his therapy, the youngster had achieved a certain amount of skill in his academic work. The therapist attempted to help the parents to realize that, since the child was 10 years of age, there was still a great deal of time before career decisions had to be made. He tried to bring them to talk of the child's current problems, but the parents pressed forward with their discussion.
>
> "I would like him to be a professional," said the mother.
>
> "What kind of professional?" asked the father.
>
> "Well, you know what we talked about before," the mother replied.
>
> "You mean a lawyer!" exclaimed the father. "That's what I am. It takes a real man. That's not for him. I think he'd be better doing what you do, doctor. That's more in keeping with his personality. What do you think?" The father completely missed the implications and irony involved in the father's request that the therapist join him in the identification of psychotherapists as passive and nonmasculine.
>
> Parental attitudes led to numerous interferences with the psychotherapy schedule. At one time during the therapy, the father's attitude informed a request that a session be cancelled because the child's masculinity needed to be strengthened and this could best be done by having the youngster go to see a world series baseball game. This, in the father's estimation, was the best way to create masculinity. The father had very little sympathy with the psychotherapeutic goal or method for achieving it. He would not have accepted as a successful resolution of the child's sexual identity confusion the achieving of the role of teacher, or psychotherapist for his son. The therapist would have considered his work well done had the patient been able to achieve the academic, social, and personality skills required for the relatedness necessary for any of those roles. A pursuit of the unconscious was beyond the father's ken. He sought instead identification with sports figures as a means of strengthening his child's masculinity at the expense of regular attendance at therapy sessions.

It was clear that the father was not particularly involved in the therapy, except to challenge it. It was the mother's wish to have the child in therapy that kept him there, even though her reasons were not the same as those recognized by the therapist as that which required therapy. It was the mother with whom the therapist needed to maintain a therapeutically supporting relationship in order to continue the therapy. The therapy of a latency-age child can function only if the parent is willing to bring the child and to support the therapy.

It is not unusual for the parent to destroy the therapeutic situation simply by engaging in intensive fights with the child on the trip to the doctor's office. It is necessary to instruct the parents of children who tend to establish sadomasochistic relationships not to engage in this pattern.

It is also advisable to tell parents to keep the therapy out of fights and family battles. It is best to keep the therapy from becoming a bone of contention. It is especially wise not to threaten the child with the loss of the therapy. Therapy should not be used as a means for getting the child to behave. The therapist should be portrayed by the parent to the child as a colleague, a guide and a helper—never as a punisher. In no way should the parent make an unwarranted assertion that information that has become available to him has come from the therapist. This will only support and intensify the common fantasies that children have at the beginning of therapy that the parent is using the therapist as a spy, colleague and agent for the assertion of the parent's wishes.

A parent became angry at his enuretic child, and told him that if he wet his pants again he would not be permitted to see his psychiatrist. The child, who had appeared on the surface to be quite confused, turned to his father and, with very clear logic said, "But isn't that why I'm going there?"

Parental Wealth

Sometimes a patient's wealth presents problems.

A man in his late forties entered his therapy session making a whistling sound, closed the door, sat down and said, "Wow, that's really something."

"What's really something?" asked the therapist.

"That car. You know the mother who just left here with that girl?" said the patient. "She was driving a Cadillac Eldorado. She only takes it sometimes. Most of the time she's got a little Mercedes Benz to scoot around in. Doesn't it just make you jealous?"

The therapist, who had no children himself, gazed at the patient with an intense feeling of awe which was in no way related to the jealousy that was imputed to him by the patient. Rather, his thoughts dwelled upon the fact

that this man had a son who was a graduate of a fine college, an achievement from which he derived little in the way of pride. He related to money as power and was in awe of it.

The man's observation was—though faulty in particulars— valid in general. The girl's parents' money created problems for the therapist. However they were not problems of envy. They were problems in the child's adjustment, that he had to work with. The patient herself, aged 10 years, devoted extensive periods of therapy time to playing games involving multitudes of small dolls which lived in a big house near which lived a very poor family. The content of one therapy session after another dealt with fear that the poorer family would do something to the wealthy family out of jealousy. Once the child assigned the therapist the task of making a house for one set of dolls, while she made one for another. She kept criticizing the therapist for his lack of foresight in leaving out the swimming pool, the extra garage, the room for the giant-screen television set—all of which she felt were the sine qua non for an average home. She was led from these presentations to a discussion of her attitudes which held those people who did not have this to be disgusting and lazy and dangerous.

Homes of great wealth can make the giving of gifts meager gestures. Those who treat wealthy youngsters must be aware of the impairments to ego strengths and reality testing that occur when wealth facilitates the ability of fantasy, wish, and reality to fuse with much ease. Extra time should be spent in detecting and treating impairments in reality testing. Envy should be dealt with in oneself. On the other side of the spectrum, one must beware the aggression and patronizing countertransference-like behavior that is involved in dealing with youngsters from a poor background who are seen in clinics. Their material needs may be so great that one may lose sight of the intrapsychic. Therapy may be interfered with by the therapist's desire to provide the child with toys. With affect-starved children, this may give rise to hostility in the child when giving does not continue unabated. The therapist should be ever on the alert to recognize his own unconscious impulse to show up the parents. Children will defend against any activity that is seen as showing up the father. Latency-age children become angry and find an excuse or a reason to justify their parents' way of living.

The Child Seeks an Ally

Even though their interferences are blatant, and their discipline severe, direct criticisms of parents by the therapist are much to be avoided when talking to the child. One should speak to the parents directly, when the child seeks to get the therapist as an ally against the parent in situations as the following.

A 10-year-old child reported that the other children her age were permitted by their parents to go to see a movie that she was not permitted to see. It contained explicit sex. Her parents disapproved of such movies. The child felt very much put upon. She complained, began to yell and misbehave. The parents restricted the

child from going out at all and added to this a six-month restriction on watching television. Cries of "Tell them to change. I'm right. They're wrong." filled the therapy session.

In such instances it should be explained to the parents privately that this sort of punishment is too severe. The child will soon forget his misdeed, but will remain angry at the punishment itself. Thus the ground will be laid for new provocations by the child. The duration of a punishment should not exceed the child's ability to remember the original incident of misbehavior. With latency-age children, punishment should be immediate, short, and directly related to the misdeed at hand.

The child, however, will turn to the therapist often and say, "Were my parents wrong? Look at how unhappy that made me, I can't watch television, what am I going to do? Call them up and tell them to let me watch television." The therapist should define his role, telling the child that his work and the child's work are not aimed at change in the parents. Rather, there are sessions in order to help the child to understand what the parents are doing and to comprehend what influence the parents' behavior is having on the child's patterns of behavior and will have on the child's way of behaving in the future, when they meet other people who behave as their parents do with them. Sometimes it is useful to refer to the moods of parents rather than their actions. Actions vary in content. There are fewer variations of mood. Mood can be asked about and returned to in later sessions.

Third-Party Payment

One of the most difficult situations in dealing with parents has to do with the parent of the child who is being seen in the clinic in which the treatment is paid for by a government program that does not require payment for missed sessions. Where there is no payment for missed sessions to reimburse the clinic, there is pressure on the therapist from the clinic. There is no financial pressure on the parent to bring the child to treatment when there is no charge for missed sessions. Other activities are given priority, especially those that entail an expense.

A therapist reported a multitude of misses during the treatment of an 8-year-old boy. When the family bothered to offer a reason, forgetting, other activities, inability to obtain transportation were foremost. The child behaved in a most verbal and cooperative manner whenever he did come to sessions; but he came to sessions rarely. The clinic had a rule that if there were three sessions in a row missed, therapy would be dropped. At no time did the family reach this limit.

There's an ethical conflict about discontinuing therapy with a motivated child. If neither child nor

parent is motivated, one might as well drop the therapy. However, something is gained by the motivated child. When it is the parent who is interfering, it seems unfair to the child to drop him from treatment without making a strong attempt to explain to the parent what's happening. When the fee or a part of it is covered by patients, missed sessions are fewer and arbitrary misses are a matter of parental concern. Sessions for which parents are not financially responsible often create unavoidable complications.

> For instance, a child entered the therapy session after a missed session. No mention of the missed session was made. There had been no phone call from the parent. The therapist commented, "I noticed that you missed the last session."
>
> The child responded, "I had to get a new suit. Didn't my mother call you?"
>
> "No," said the therapist.
>
> "Well, I went to get a new suit with my mother," said the boy.
>
> "I asked my mother, 'Shouldn't we go see the doctor,' but— weren't you on vacation last week? I think that's what my mother said."
>
> "No."
>
> "Oh, wait a second, I remember, I asked my mother to call and my mother promised to call you. Didn't my mother call you?"
>
> If the therapist is to answer this question honestly, he, in effect, exposes the mother as a liar. On the other hand, the child may be lying, and if the therapist says that the mother called, then the therapist is the liar. It's important to avoid revealing the parent as a liar, however, and the therapist was eager to avoid such a revelation.
>
> While the therapist was trying to think of something to say, the child said, "Why, didn't *you* call?"
>
> Under this pressure, the therapist told the child that he did not call and that the mother did not call. He stated that directly. Implied was the fact that the mother had lied to him.
>
> The supervisor suggested to the therapist that in the future, should such a situation come up, he should not put himself in a situation where he is opposed to the parent. State the situation positively. For instance, one could say, "I will call your mother to tell her I feel the appointments are important." The interest in the child is reinforced. The possibility is kept open for the mother to cooperate without a polarization being created in which the mother is seen as behaving in a certain way that is wrong, and the therapist is all good.

Making Announcements

Ironically, it was necessary in the above case for the therapist to bring up in the same session the

fact that the clinic was to run a summer camp. The therapist had the responsibility to ask the youngster whether or not he wanted to attend. Since they were fast approaching summer and the child was seen once a week, it was necessary to ask him as soon as possible. He might well miss the next few sessions and be unable to be informed in time.

When should the topic be broached: at the beginning of a session, with such a phrase as "Before we begin, I'd like to tell you there's a summer camp run by the clinic. Would you be interested in going?"; at the end of a session, with such phrases as "We have to stop now, and, by the way, we have a summer camp for people in the clinic; I'd like you to think about it and tell me whether you want to go, when you come back."; in the middle of the session, preferred by many, saying "There's a summer camp run by the clinic. Would you be interested?"?

It's important to make an announcement to parents first so that they are informed and can let you know whether what you wish to offer is possible or impossible. If the parents are absolutely against it, there's no use bringing these things up with a child. You may only end up pitting the child against the parent. Gifts should be approved by parents. This helps avoid a situation in which the parents reject.

Making an announcement when the therapy session starts may interfere with the patient's ability to bring in important new information. An end announcement leaves the child without any chance to associate or let you know how he feels. It's like homework.

If one is to use the initial part of the session for an announcement, one does not interfere with ongoing associations, and it is possible to follow the person's associations and responses to the announcement throughout the session. I prefer this timing for this reason.

If possible, one should provide at least two sessions of leeway in advance of an announcement. This gives one the chance to wait for an appropriate time to make an announcement. If it's at all possible to present it appropriately during the middle of the session, so as not to interfere with associations, then of course this should be done.

Countertransference

Countertransference refers to reactions on the part of a therapist to a patient's behavior or to therapeutic situations, either of which recreate for the therapist reflections of early life experiences. The therapist's behavior is obligatory, repetitive, and distracting from the primary work of the therapy. The most common situations that evoke such countertransferences are those associated with ordinary breaks in schedule. These include absences, misses, late payments, and announcements of future missed sessions. The introduction of a scheduled vacation announcement in the middle of a session, though preferred by many, tends to interfere with ongoing associations and gives more play for countertransference than either end or beginning announcements.

Let us turn to some examples of the way in which countertransference can interfere with associations and result in announcements that interrupt the flow of free association.

In the case of the youngster whose mother repeatedly missed sessions with the child:

> The child had busied himself after the interchange with the therapist about why he was absent and who was responsible for his absence; the youngster began looking around the room and found some racing cars. He announced that he was going to play a story about two brothers in racing cars. The two brothers were involved in a race to see who could go faster. At this point the therapist intervened with the announcement that the clinic-related summer camp was available, and this put an immediate end to further associations having to do with the rivalry between the two brothers.

It is only conjecture that the fact that the therapist had a brother may have influenced his intercession at this time. There is less conjecture in the nature of the countertransference in the next case.

A 30-year-old fellow in child psychiatry, a single woman, known for her sturdy shoes, makeup-free face, and sensible clothing, presented the case of a 14-year-old girl with an elevator phobia.

> The girl worked as a candy-striper in a nearby hospital affiliated with the clinic in which the fellow was working. She had discussed with the therapist her fear of elevators, her fear of going up in the elevator, her fear of being caught in the elevator. Claustrophobic problems had been talked about and worked through. Separation-individuation and imagery relating the elevator to the womb had been dealt with. The child was now able to ride the hospital elevators instead of walking up and down stairs. During a session in which she spoke of the increased ease with which she was able to carry out her tasks in the hospital, the girl reported the following experience.
>
> "I got all scared again the other day in the elevator. I was riding—I got on the second floor and I pushed the button to go up to the third floor and the elevator went down to the first floor instead of going to the third floor

> first, and a surgery resident [who was blond, and blue-eyed with broad shoulders and a chummy manner] got in. I got a big lump in my throat and I hoped I wouldn't get scared. The elevator got stuck between the second and third floors and people came running. The doctor pushed the alarm and people yelled at us, 'We'll have you out of there in about twenty minutes.'"
>
> She said, "I began to get all nervous all over, and I began to have all kinds of funny, excited feelings in my vagina."

At this point the fellow saw fit to make her first intervention of the session. She simply stated, "In four and a half weeks, I'm going on my vacation."

We can surmise that the therapist had expressed her own discomfort and lack of ease in dealing with topics relating to attractiveness and sexually exciting situations in a distracting thrust of irrelevant material into the session. In this way the therapist could present a well rationalized reason for interfering with problems in the life of the patient, that the therapist had not mastered in her own life.

Termination in Child Psychotherapy

As in other respects of psychotherapy with the latency-age child, termination of psychotherapy has characteristics contributed by the structure of latency.[2] There is a propensity for the use of fantasy as an escape from, and expression of, problems. Fantasies can express termination reactions which might otherwise have entered treatment through acting out, verbalization, or description of inner experiences and sensations.

Since, in the latency-age child, fantasy formation often takes precedence over verbalization, it can serve as a conduit through which otherwise unobtainable material relating to termination enters the therapeutic situation. At times the defensive, masking aspect of such fantasy formation will override its communicative aspect and interfere with the working through of termination. Fortunately, there are certain characteristic fantasies that occur in latency state children during periods of termination that represent termination reactions. Familiarity with the nature of these fantasies equips the therapist to recognize them as such. Thus termination reactions can be dealt with more quickly and effectively.

Children have less control over terminations than do adults in psychotherapy, and there are more frequent separations during child therapy. Children's dependence on parents in such matters as

mobility, place of domicile, and payment for treatment creates more possibilities for separations, interruptions, and terminations in the psychotherapy of children. The lives of children are thus shaped by the movements, emotional reactions, and decisions of adults. Parents may have to move for occupational reasons. Parents may lose interest in therapy. Parents may feel physically overwhelmed by the task of bringing a child to therapy. Parental vacations may cause interruptions in treatment. Parents may develop negative transferences that cannot be worked through. These elements create a multitude of interruptions in psychotherapy which are beyond the child's control, and may produce psychological responses in him.

There are other causes of interruptions in child therapy, such as illnesses, departures for summer camp, special school trips, and school holidays. Interruptions and "mini-terminations" during summer camp, vacations, and parental travel stir separation feelings in child therapy situations long before the actual termination phase of the psychotherapy. This occurs to a far greater extent than is seen in psychotherapies with adults. Furthermore, children can sense interruptions of therapy on the basis of parental behavior long before the separation has been announced by the parent to the therapist. A child's play may contain the first clue for the therapist of an upcoming interruption of treatment.

Latency-age children have termination experiences that parallel the classical termination phenomena seen during the termination phases of adult psychotherapy. Their specific manifest forms are often influenced by the ego structure of latency. Therefore, they must be sought in the fantasy life of the child as well as in overt emotional reactions and behavior. In separation situations in the psychotherapies of childhood, there are two interwoven areas of response: reactions to object loss and reactions to the unmasking of strong libidinal feelings in response to the expectation of separation.

Reactions to Object Loss

Reactions to object loss include fantasy activity reflecting any or all of the following: mobilization of aggression, feelings of rejection, incorporation of the therapist or of symbols of the therapist, and identifications with the therapist. In addition, a process of object replacement occurs in the real life of the child through the seeking of new friends. Ties to these friends replace the object tie to the soon-to-be-lost therapist. Such object replacement is a common indication of a strong, often positive, relationship

between therapist and patient. The nature of the new objects sought can be used as an indicator of the long-range outcome of the therapy to an even greater degree than is possible in adult therapies.

In adult psychotherapies, object replacement usually takes the form of an intensification and modification of ties to individuals with whom the patient is already involved in a relationship of intimacy. Changes in friends and love objects as treatment progresses are usually seen in the young or in those who began treatment with limited capacities for object ties. As a rule, a child has greater freedom in the acquisition of close new friends than has an adult. In the evaluation of the new relationships that the child establishes during the termination phase, the detection of specific characteristics can be useful in evaluating the effectiveness of the psychotherapy. The nature of the people who are sought out by the child and who accept the child as a friend is an indicator of the nature of the child himself.

> Take the example of a child of 10 whose few friends, in pretreatment history, devalued school performance and were continually involved in classroom disruptions. His presenting problem was related to this behavior. As treatment progressed the youngster became more concerned with his school performance and began to relate to classmates who were similarly involved with achievement. Termination was determined on the basis of cessation of disruptive behavior in school. As termination approached, the boy developed a close friendship with a mature, achievement-oriented peer. The restructuring of the patient's personality was thus reflected not only in the level of insight he had attained in therapy but also in the type of peer who accepted him after the treatment.

Libidinal Response to Termination

Reactions to the unmasking of strong libidinal feelings in response to the expectation of separation are manifested in uncomfortable feelings and overt rejection of associated ideas more often than they are expressed in fantasy. These reactions are most commonly seen in children who have concern about passivity, and problems of sexual identity. Often these children respond to such feelings with panic reactions. In essence, the child who fears that he is homosexual becomes acutely uncomfortable when he perceives love and warm feelings for a person of the same sex. It is necessary to point out to such a child that the feelings he has for the departing therapist are the expected products of working comfortably with another person over a prolonged period of time. The feelings of love can be likened to that between father and son. The homoerotic implications of the feelings are thus defused. However, such a strong reaction predisposes the child to stress in similar situations which could arise subsequent to the end of therapy. The child who reacts with such discomfort is not ready for termination. His overwhelming

reactions to homoerotic feelings should be worked through. In children, such reactions are tied to fear of subjection and situations of passivity. Cognates to these reactions on a deeper level consist of fear of castration and fusion.

Since the nature of childhood entails a passive, subjugated role in society, this role and the child's response to it should be addressed in the therapy of every child. Strikingly, the children who are most in need of such intervention are those least capable of cooperating in treatment. They are less able to talk about and investigate their reactions than to feel them and act on them. Phobic children and children with persecutory fantasies are most prominent among those who have such underlying complexes. This important aspect of the psychology of the latency-age child may be brought into focus by termination techniques which permit the child, especially the child in late latency, to join in the decision to terminate and in the selection of the termination date. The child's reactions and manipulations in the actual termination situation can be brought to his attention and discussed.

Most separations during the course of therapy occur as the result of decisions by either the therapist or the parents. Rarely does the child have any role in the decision-making process. Termination of treatment is the one area in which the child's will and psychic processes within him are primary in determining the timing of a separation. It is worthwhile to harness this reality. The inner events of the child's psychic life should contribute more to the decision-making process when it comes to termination than do the child's wishes. In the termination situation, it is possible for the child to learn to differentiate between the act of bowing to the will of another and the act of planning based on the limits set by reality. In this situation the reality involved relates to his own progress.

The Termination Decision

One evaluates a multitude of elements in a child's progress toward termination. For an accurate appraisal, parents, teachers, siblings, and the therapist as well as the child should be considered to be sources of data. The requirements of termination in child therapy are:

1. The presenting problem has been solved.

2. Access of fantasy to motor activity and action is within acceptable bounds.

3. The child's academic and social activities reflect success.

4. Verbal and abstract conceptual thinking is being used in the processing and solution of stressful inputs, to the extent that the child can understand his responses in terms of genetic antecedents in the parent-child interaction.

5. The child's developmental progress reflects a stage and rate commensurate with his peers.

6. The child's current friends reflect the level of healthy adjustment that he himself appears to have attained.

7. Further therapeutic work will only produce progress that age-appropriate natural development could provide as well.

It must be borne in mind that fantasy, which is a product of the structure of latency, persists as a defensive structure of the ego throughout the latency-age period. Therefore fantasy as a defense can normally be expected to persist on into the termination phase in the therapy of a latency child. The persistence of fantasy as defense is not considered to be pathological during the latency age. In evaluating a child for readiness for termination, however, the nature of the fantasies should be reviewed for pathological aberrations in the fantasizing function. For instance, excessively omnipotential fantasies manifested in hyper-cathexis of fantasy which produces withdrawal, or fantasy based on action outside of the play situation, are unacceptable. The presence of phantasmagoric symbols or symbols which are highly charged for the child (e.g., persecutory fantasies; see Chapters 4 and 8) are likewise evidences of a pathological symbolizing function during the latency-age period. This is especially true when there occurs a failure to achieve a shift to fantasies based on symbols derived from the environment and contacts in reality. When this failure occurs, the expected developmental trend toward the establishing of future planning suffers. A fantasizing function with impaired characteristics is an indication for continued treatment.

Once it has been determined through conference between the parents and the therapist that the goals originally set are fulfilled or near fulfillment and the requirements for termination mentioned above have been fulfilled, it is time to think about termination. At this point the child is told that this is the case. He joins in the decision-making process. He is asked if there are still any areas or problems for which he feels he needs help. The child is not asked to give an immediate answer; he is told to think

about the important question of ending therapy and to respond as soon as he can. Usually the period of self-searching lasts a few weeks. During this time the child and the therapist discuss the child's thoughts on the matter. They establish the date on which they will talk specifically about whether or not they are ready for termination. On that date, the child, in concert with the therapist, sets a termination date or decides to put off termination for a while. Often the termination date is put off repeatedly as a result of the child's heightened awareness of his problems. The fact that he is soon to lose the skilled help of his therapist adds to his diligence. One problem after another is brought into sharper focus. One youngster, who repeatedly devalued the therapist and insisted that his sports activities should be given priority over his treatment sessions, came to one of the decision-making sessions with a concerned look. He had reviewed all of his areas of progress and had found little wanting. Yet he seemed apprehensive. Said he, "I think I'm okay now. Do you think we have taken care of all the problems?"

The time of preparation for termination is not one of passive waiting for the therapist. Rather, an intensification of therapeutic activity marks the period. Increased transference feelings energize fantasies and reactions that may be usefully mined to therapeutic advantage.

Reactions to Passivity

Primary among the reactions that may be worked with psychotherapeutically during the termination period is the negative reaction to situations of passivity. Passivity may especially be activated as a problem when a child is involved in responding to, handling, and dealing with natural processes. A child can become frustrated when dealing with the intrinsic time sequences of natural processes. He is engulfed in a sense of passivity because his desire to control the world is frustrated. The child who has problems in dealing with passivity will often be unable to agree with any date that has been set by the therapist. No matter what date the therapist may have suggested, the child will insist on an alternative. When it is decided by the child and the therapist that a termination date should be set in earnest, any date beyond two weeks from the date of the decision can be used as a termination date. Latency-age children have an emotional time awareness of about two weeks. Events more than two weeks off have less import on them. Typically, the child with passivity problems will choose a date which differs from any first agreed upon by the therapist. For instance:

> One youngster, in a session in late September which was set aside for deciding on a termination in October, suggested October 10 as the termination date. The therapist readily concurred. The child immediately changed the date to October 12. Again the therapist agreed. Again, the child changed. This time the therapist asked what was happening. The child replied, "I want to decide. I don't want you to have anything to do about it."

An inability to accept guidance should be explored with the child. If a problem in dealing with passivity is deemed to be present, then the final date of termination should be put off until the child is capable of shared decision making. The child's difficulties in this area can be interpreted to him in terms of associations and fantasies which are developed from the child's attempt to process and master the problem of accepting natural and parental influences on his behavior, plans, and decisions.

Fantasy Related to Termination

Now we turn to the role of fantasy formation in the evaluation and detection of conflicts associated with separations, interruptions, and terminations in latency-age psychotherapy. The psychological responses of the latency state child to termination and separations can rarely be elicited by direct questioning. If one listens to the child's fantasies, however, one is often able to detect the presence of conflict laden material. Such fantasies point to therapeutic approaches and suggest areas of conflict that might not otherwise be considered. The fantasies produced immediately prior to any interruption in treatment convey information about the child's reaction to the upcoming separation. These fantasies prepare the therapist for dealing with the related intense responses of the child at the time that an actual termination date has been set and is being approached.

Fantasy as defense which is free of impairing characteristics is an acceptable ego mechanism in latency, and an important precursor of mechanisms in later life that will contribute to creativity, future planning, and the enjoyment of culture. It is not the purpose of psychotherapy to interfere with this important step in the maturation of the child's ego. A successful therapy leaves the child's fantasizing function intact; in many cases it must strengthen it. Much of the emotional reaction to termination in latency remains detectable through the child's fantasy productions.

The following case histories illustrate the use of fantasy and fantasy play as tools for detecting underlying emotional reactions to interruptions, separations, and terminations in latency age

psychotherapy.

Ellen was a 9-year-old brought to treatment because of depressed moods ever since the traumatic loss of her father the year before. She was able to work in school and had a few friends. Yet her days were joyless, and her eyes constantly filled with tears. She was repeatedly overcome with the desire to run from the house and go in search of her father. At night she would dream that he came to awaken her or that she heard his voice. She would search the house for him to no avail. She sometimes believed that he was dead, and then spoke of killing herself to join him.

Ellen's mother was an attractive woman in her late thirties, herself quite depressed. As she described her daughter's behavior there were no tears, but she lacked the spontaneity one would expect of a person emerging from mourning a year after suffering a personal loss. She had often hit her daughter to control her behavior. When she realized that this technique had no effect, she brought the child for treatment.

The story of the father's disappearance was told in separate versions by the child and the mother. According to the child, the father had taken her and her sister on an outing one Saturday in October. Mother had stayed home to study. They had intended to visit an aunt, have lunch, and then spend an afternoon watching a puppet show in a local park. While at lunch, they met a friend of the father who was also going to the puppet show. The father turned his children over to him, explaining that he wanted to get home to watch a football game on TV. This was unusual for him, since he usually spent his Saturdays on family outings. (The child emphasized this to illustrate her closeness to her father.)

When they were dropped off at home, Ellen and her sister both noticed that their parents were very quiet with one another, "like after they have a fight." The following Thursday her father awakened her very early in the morning by kissing her on the cheek. She did not show that she was awake because she was frightened by a strange wetness on his face. She fell back to sleep. Later in the morning she awakened to her mother's calls for her father. She kept calling his name. There was no answer. Her mother seemed upset, but not surprised.

The child stayed home from school and watched her mother call her father's office, relatives, friends, and hangouts. Each negative answer and each passing hour tightened the noose that strangles hope. At the end of the day the mother announced to the children with a tone of certainty that their father had disappeared forever.

The mother's story paralleled that of the daughter. She added details which explained the certainty and final tone of her pronouncement. The father had, in fact, returned home early from the outing. Upon entering the house he went directly to his bedroom where he found his wife in flagrante delicto with the gardener. The gardener left the house without confrontation.

When Ellen's mother turned to her husband, he responded to everything that she said with a quiet "I understand." She waited the hours through in expectation of an outburst. Days passed and still she waited for some response, perhaps a smile or some break in the grim silence. That Thursday morning, when she awakened, he was gone. He had spent the four days liquidating his assets, and when he disappeared the family was left without means or reserves. One friend reported that he had said he doubted the children were his.

In the therapy, the child was encouraged to verbalize her feelings. Her difficulty in expressing her anger in general had blunted her capacity to express feelings about her father's desertion. In her play fantasies of a family which she played out, she cast me in the role of the father. At times she struck out at me. She was often preoccupied with sexual fantasies, and liked to tell "dirty jokes." Although her sexual preoccupations suggested that she knew of her mother's encounters, at no time did I find any corroboration of this, direct or indirect. Her

excitement was directly traceable to her mother's constant discussion, of information couched in scientific terms related to emunctory functions and reproduction.

The patient felt guilty about wanting to love a man other than her father. In part she used her preoccupation with her father as a way of avoiding her budding sexual feelings for boys. As she became more aware of the reasons for involving herself exclusively in the fantasies about her father, she became less tearful and more able to involve herself with peers.

With the emotional reactions that had necessitated psychotherapy resolved, it was time to introduce the idea of termination. Because a separation problem was primary here, the idea of termination was introduced. At the thought of termination, the child became emotionally brittle and angry in response to any comment or suggestion related to the subject.

When I asked her to set a general termination date, she suggested a date a year and a half in the future. In the next session she was sullen and silent. While in school she had heard my voice again and again, saying, "There are other things." I pointed out her difficulty in letting me go. She carried me with her in fantasy. I related this to her difficulty in letting go of her father. Gradually she began to have fantasies, limited in content to reality possibilities. She fantasized that I would attend a piano recital in which she was to participate and that she would introduce me as her father. Sometimes she would see a man on a street corner and develop the fantasy that she could not be sure if it were I or her father. We spoke of the potential that a young person has to find someone new to take the place of a father companion. She became more content, and began to tell more jokes about boys and girls. Her interest now turned to her sexual development. She was free of symptomatology when she left psychotherapy.

In this case, the fantasies involving the therapist gave a clear picture of the motivations that dominated her response to her father's disappearance. Most of the work in depth with this child dealt with reactions of which she became aware as the result of reliving, in transference fantasy, separation reactions during the termination phase. In this case the fantasies lacked subtlety.

In the next case, the reaction to separation was subtly conveyed in fantasy, and was unexpected. It is a prime example of a termination reaction that is solely detected through fantasy.

Arnold was 7 years old and very handsome. He had dark hair and features that were strong and manly for a little boy. Arnold engaged in disruptive behavior in the classroom. He also developed acute episodes of loss of temper and anger at his parents. This was manifested in destructive behavior, including dropping and breaking a lamp on the kitchen floor. The child was brought to a clinic where I was a fellow in child psychiatry. While I did not understand the nature of latency at the time, in retrospect it is possible to see that this was a youngster with a good structure of latency who had been overstimulated by a family situation.

The father had given up his role of authority by default. The child was in very close contact with his mother, who overstimulated him in her own search for emotional support and companionship. The father's presence interrupted the child's relationship with his mother and mobilized his aggression. It was soon seen in the therapy that Arnold's acting out was based on an oedipal hostility that had been displaced from his father.

Direct hostility to the father would have been too dangerous for him.

The child played out fantasies in plenty. He established a positive relationship with me once he discovered that aggression directed toward me was not destructive. He established a non-sadomasochistic relationship with me. Very little insight-oriented

therapy was done. Most of his gains involved achieving a balance in his relationships with men and women. Since I provided a male object to whom he could relate, the amount of object libido directed to his all-too-willing mother diminished. This lessened his guilt, his excitement, and his hostility.

After seven months of our work together, I had come to the end of my training at that hospital, and military commitments forced my relocation to another part of the country. It was necessary, therefore, for him to be assigned to a new therapist who was a year behind me in the training program. Little working-through of termination was advised because the new therapist was available immediately. During our last session, which followed a meeting with the new therapist, Arnold thanked me for my help and said he hoped his new doctor would be more comfortable to be with once he got to know him. I interpreted this attitude as a manifestation of his anxiety at being assigned to a new therapist, but he ignored my remark.

He placed a chair on a low table, and put a carton in front of the chair. He sat down and pretended to drive. When I questioned him about his fantasy, again I received no response. I noticed that from time to time he pulled the imaginary steering device toward him and then pushed it away. I asked him if he were flying an airplane. He did not respond directly, but now began to make low, humming, airplane-like noises. In order to enter the game I held an imaginary microphone to my mouth and said, "This is the airport contacting Arnold's plane. Please answer; I want to give flight instructions." He immediately picked up his own imaginary microphone and responded, "This is Arnie, what do you want?" As so often happens in these situations, after the child responded I didn't really know what I could say that would avoid possible contamination of his fantasy. I asked where he was going, and fortunately got an answer. He said, "I'm going to California. I'm flying there." I asked him, "Where in California? If I want to send a letter to you, how would I reach you?" He responded, "That's easy. Just write to me care of the orphan's home."

The session was near an end. The explanations of the necessity for my going into military service at the end of my training had had no impact on this youngster. He saw himself as rejected and became subtly aggressive through his fantasy, in which he actively left, excluding me. I communicated information on the nature of his attitude to his next therapist. It was possible for the new therapist to handle this material or relate to the child who rejected him. The child refused to continue treatment with this therapist and dropped out of treatment after three months. With the cessation of treatment, the child returned to his old behavior patterns.

This case illustrated a number of points: fantasy can carry the attitudes of a latency-age patient; the technique of changing therapists in training centers is fraught with difficulty; more attention should be paid to the impact of such changes on a child.

Children do not respond strongly to separations and terminations until about two weeks prior to actual separation. Usually a child knows that he is going to go to camp or away for summer vacation on the day that he starts treatment. This does not become a pertinent element in the treatment situation until about two weeks before the termination or separation actually occurs. This is not an irrelevant

point. At time, therapists discuss termination or separation with a , child from four to six weeks in advance. They handle the immediate response and assume that everything has been taken care of. Even a few weeks before the separation, when the event is pressing, the child will not verbalize any difficulties. He's busy processing them into fantasies. It is only through observation of the fantasies and through heightened awareness during the two weeks before the actual event that it is possible to see through the fantasies to the fact that the child is troubled. The following case will illustrate.

> Betsy was 8 years old when she came to analysis because of a shyness which caused the parents great concern. She had almost no friends. She was quite explosive at home, and had difficulty in separating from her mother. As her treatment progressed, it became very clear that her mother also had difficulty in separating from her.
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> While telling me about her phobias the child began to dwell on a recollection of a camp to which she had been sent a few summers before and to which she was to return the following summer. There was a large stand of dark trees in the camp; it was right behind her bunk. When she first came to treatment, she was sure it contained all kinds of monsters and demons that would barge in on her. As she grew older, these turned into robbers and kidnappers. At the time of the sessions presented here, Betsy was more able to accept the prospect of going to camp for the following summer. In part she could consider camp because of the supportive nature of our relationship; she felt she could come to me if she became troubled and that I could help her to understand the reality of the situation and the inner origin of her fears. She appeared to have the camp situation well in control.
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> Approximately a week and a half before the interruption of sessions for her summer vacation, she began to tell stories of a hunter dressed in buckskin who carried a large knife and went into the woods in search of Indians. It seemed clear that she was attempting here to take an active role in fantasy and to master the fear of the fantasy people in the woods behind her bunk. I began to approach the fantasy from this aspect. She provided me with an imaginary satchel to carry and told me that I was her assistant who would help her with the hunt for the Indians. She found their camp, but no Indians were there. She was jumped on by the Indians. She fought the Indians off. Finally, she trapped an Indian and, uncharacteristically for her, told me that she was going to eat the Indian and that I should eat my own food. She then proceeded to kill the Indian and to prepare him to be cooked.
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> At this point I was alerted to the possible meaning of this fantasy by a previous fantasy in her treatment. I shall go back to the session in which the earlier fantasy took place, for a brief digression. In that session, the child, who had a food fad in which she refused to eat fish, had taken a wooden sculpture which had a mild resemblance to a phallic symbol and, calling it a fish that her father had caught, devoured it in fantasy. At that point I interpreted to her the confusion she had between her father (the fisherman) and the fish. Her desire to devour her father made her uncomfortable about eating fish. She developed a feeling of nausea in the session. She mastered this by gobbling down the wooden figure again. She then turned to me and said that she didn't think she'd have trouble eating fish any more. Her mother reported to me that the food fad had ceased after that session. I therefore was prepared to see the devouring of the Indian as a kind of active fantasy in which she played out her cannibalistic wishes toward her father.
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> With this thought in mind, we now return to the pre-separation session. I turned to her and asked what part of the Indian's body she was going to eat. I entertained the thought that she might be made more aware of her wishes to devour the father's penis. However, her response did not relate to any part of the fantasy figure which had undisplaced phallic associations. She said, "I

would like to eat his brains." It should be noted that in the hunting fantasy I had been assigned the role of a rather dull helper. It could have been easy to rule myself out as the latent content of the Indian symbol on this superficial basis. However, the role assignment in a fantasy of a given character, whether it be therapist, patient, or parent, does not negate his role as the latent content of another character. I could have been the latent content of the Indian. Since this was a session that occurred in a pre-separation period, I was especially on the alert for incorporative fantasies, such as the fantasy of incorporation and devouring that is so typical a human response to separation. I therefore asked Betsy whether the Indian represented myself. She said that she wished that she could take some of my brains with her when she goes to camp, because she was still frightened of certain things and would have liked very much to be able to talk about these things with me when she was frightened about them.

The recognition of fantasies of devouring brains as a possible incorporative fantasy opened the way to a specific focus in our psychotherapeutic work. By making this connection, it was possible to get her to verbalize her feelings. I then asked what she was worried about. She talked about walking to the camp bathroom at night, the dark woods, insects, and girls who might not like her. She especially feared that one of the children in the camp would begin to cry during the first days. This was especially threatening to her because of her feeling that if somebody else cried, her own wish to cry would break through. I pointed out to her that although she could not take my brains with her, it would be possible for her to discuss these problems and the origins of fears involved with them before she went away. She shifted from fantasy at that point to the direct discussion of problems that she was concerned with, although from time to time, when she became blocked in talking about what troubled her she turned to fantasy as a means of elaborating her problems.

Summary

The psychotherapist who works with the latency-age child requires special training because of the unique nature of the executive apparatus of the ego in this age group. This ego function, when operating well, can often mask problems that should be solved lest they menace adolescent adjustment. It is important to approach latency children as individuals, rather than to succumb to the use of modalities that put all children into one category, and create a buffer between the patient's needs and the therapist's response. This situation can be produced by the use of such disparate modalities as drug therapy or dynamically oriented therapy in which the source of interpretations are abstract theories rather than the associations and fantasy play elements of the child. Individual children should not be forced into the molds of a preconceived notion, constructed from the latest therapeutic fad.

In child therapy, the associations of the child should be the measure of all things. This is not meant to criticize the substance of current theories. What is criticized here are therapists who would use any single theory to explain the processes in many different children. Advances in theory should expand, not limit, the number of psychotherapeutic possibilities and strategies. Latency-age children should especially be protected from theory-boundedness. They cannot defend themselves. Unfortunately,

therapists with the least training, who are most apt to fall back on ready-made interpretations, are frequently assigned to work with children. This is a product of the myth that latency-age children are little adults, with little ego psychological development and diminished drives. Therapists of latency-age children should be specially trained to understand latency ego development.

In this chapter I have dealt with the technical strategies required for a psychotherapeutic approach to children in the latency-age period. Attention has been given to the effect of the state of latency on the ability of the child to cooperate in treatment. There is yet another aspect to the age of latency: the developmental process that marks this period influences the manifestations of certain clinical phenomena, producing characteristics that require special approaches in diagnostic and therapeutic situations. These are discussed in the following chapters.

Notes

1 This should be differentiated from *recognition* recall of similarities and intrinsic characteristics, which is present in the second year of life. Such recall is demonstrated by the child who can tell dogs from cats in a picture book.

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