MEMORY & FANTASY IN THE PSYCHOTHERAPY OF THE LATENCY-AGE CHILD

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The main focus of this chapter will be on a search for an understanding of the psychopathogenetic role of past experience and memory in sensitizing a child to find affect stimulation in current situations. Experience is carried through memory into the present in a form, a pattern—*sensitizing latent fantasy*—that may be adapted to create misinterpretations of new situations and experiences. An attempt at mastery of past experience takes place through re-experiencing in the new reality. The process is a dynamic one, with its driving force coming from the pressure of unresolved traumatic events of the past. The forces of mastery and repetition seek the new experiences to serve as symbols for past traumas. The result is a distortion of reality, which takes the form of misunderstandings, manifest fantasies, or defensive (masking) fantasy play in children. The process may progress to such a degree that defensive energies are mobilized at the expense of neutral energies needed for the pursuit of healthy growth. Child therapy takes advantage of this process when the therapist recognizes that the play of the child contains a use of toys to express and master trauma.

The Role of Fantasy in the Psychic Life 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 who have a structure of latency that is 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 fantasies produced by the structure of latency are the highly symbolized, defensively constructed manifest fantasies that are played out in symbolic latency fantasy play. They mask latent fantasies, which are *not* merely passive unconscious symbol patterns, awaiting a cue to come forth and

give some shape to the manifest fantasies of play. Actually, their presence is part of an actively motivating system of psychical forces, which are ever at the ready to alter the child's behavior. They bring unresolved experiences and traumas from the child's past into action through distorted interpretations of new experiences, and overreactions in action as well as fantasy. Thus, the child whose latent fantasies are tied up with jealous feelings in regard to his parents quite likely will be stirred by seductive behavior to the point that the structure of latency is moved to produce an oedipal fantasy in play. Failing this, there may be a shift in a regressive direction. This portends aggressive behavior unless further mobilization of the mechanisms of restraint can bring the aggression under control.

The mechanisms of restraint deal primarily with regressions from oedipal fantasies. The latency defense of the structure of latency is less specific, since it is often called upon to deal with a multitude of possible complexes, sensitivities, and instigators of anger, overwhelming excitements, humiliations, and the many putdowns to which the psyches of our patients, as children, are prone—and heir.

Though there are times when the child can tell us what troubles him, it is not rare to find that the child has tucked away the memory of troubles and set out in pursuit of masking fantasy in their stead. Often one must derive the hidden content from the child's activities in the playroom.

Translation of a play fantasy into the recent trial or trouble that it represents requires an interpretive technique similar to dream interpretation. The recent trouble is like the day residue of a dream, in that it is the source of intensification of a sore spot in the child's sensitized psyche. The sore spot represents old unmastered experiences (for instance, infantile memories of deprivation or trauma) that provide a pattern—a sensitizing latent fantasy—which new traumas reawaken and into which new experience is forced, to produce a new synthesis in the form of a manifest fantasy. The process is dynamic. The forces of mastery and repetition seek new experiences to serve as symbols for past traumas; the events of today call forth memories, and the result is a distortion of reality that takes the form of misunderstandings and produces manifest fantasies and defensive (masking) fantasy play in children.

The child who talks directly of his current problems presents difficulty to the therapist only in gauging the level of cognition at which to aim a comment or interpretation. Content is focused by the child.

Recall through fantasy adds complexity. Because of the presence of sensitizing latent fantasies, current experiences tend to activate fantasy contents that lead the observer away from recent events and toward seemingly unrelated residues of past experience. The therapist must try to differentiate between the two sources of content and decide which one to pursue. The child who immerses his troubles in a sea of fantasy presents a problem to the therapist akin to a puzzle box to which a key must be found.

Phase-Specific Fantasies

For the child therapist, an understanding of the nature of the phase-specific, typical sensitizing latent fantasies of childhood is useful. It helps in alerting him to pertinent possibilities and in recognizing what may be troubling the child on a deeper level in cases where recent events dominate the manifest fantasy. Knowledge of latent sensitizing fantasies assists the therapist in identifying that which may be motivating manifest play elements in play therapy sessions.

The explication of sensitizing fantasies is not difficult. They are not diffuse; they have a discernible pattern. There is a march of fantasies through the years, against which the latency defenses of the child are mobilized and from which their manifest fantasies are derived. Each fantasy in its turn is based upon the new and unfolding problems that a child is brought to ponder by the expanding awareness that accompanies cognitive and social maturation. Certain fantasies and types of fantasy activity are characteristically invoked to resolve the specific problems that are introduced with each specific phase of maturation. Their appearance denotes attempts to explain or resolve universally experienced phenomena. Persistence of these fantasies colors the fantasy life and sensitivities of individuals throughout life.

Preoedipal Fantasies. When the prelatency child is able to differentiate himself from the outside world and from his parents, and conceive of himself without his parents—and therefore alone—he is primed for emotional reactions that revolve about problems of aloneness, separation, and loss. When the child reaches the age of 3 he is able to differentiate sexes, and his thoughts thenceforth deal with sexual differences. When he reaches the age of toilet training, his thoughts become involved in bowel and urinary control. These relate to the already well-known and accepted timings of the pregenital stages of development. The presence of siblings introduces rivals and patterns of sibling rivalry that may last a

lifetime. Parental preferences for a child of another sex, or feelings of weakness in the face of drives which the child feels could be dealt with better if the genital apparatus of the opposite sex were present, can introduce womb or penis envy, which if unresolved contributes a warp to the character in later years.

Universal Fantasies in Latency

Early Latency: Oedipality and Guilt. Certain thought preoccupations and fantasies are processed during the latency age period as well. Awareness of their typical times of appearance primes the therapist to be alert for them as possible sources of difficulty that beset a child at a given age. At the beginning of the latency period (5 to 6 years of age), thought processes and fantasy preoccupation revolve about certain aspects of the Oedipus complex. As the child reaches 6, the capacity to experience guilt develops. Fantasies of taking the roles of either of the parents at this point often cease to be the source of pleasant musings and instead become associated with guilty discomfort. These fantasies (oedipal) give rise to fear situations when the child is dealt with seductively. They are defended against by fantasies of theft followed by imprisonment or ones in which a peasant leader kills the king in a galaxy long, long ago and far, far away. Such fantasies are the predominant fantasies of the latency period, but they may persist to populate the fantasy life of the individual thereafter.

Middle Latency: Loneliness and Separation. With the passing of years, additional fantasy contents appear. They are related to the problems of the child at the stage of latency-age development at which they emerge. Their pertinence to the immediate problems at hand pushes them into prominence, resulting in a de-emphasis of oedipal fantasy in the middle and late latency years. For instance, when a child begins to feel a sense of independence from the parents at about 7 or 8 years of age, he confronts himself with fear fantasies of being small, vulnerable, and all alone in the big world. This is reflected in a fear of being alone. A fear of monsters develops. The monsters are symbols of the impotence children fear, masked representations of their defensively mobilized aggression.

Late Middle Latency: Passivity. Beyond the age of 9 or 10, the problem of passivity becomes a major issue. The sense of independence has grown in these children to the point that they wish to break free of parental control. They object to the passive role that they have to take in relation to the decision-making parent. In many ways this is a recapitulation of the 2-year-old's demand to know, "Who's the boss of me."

These children—who, unlike Peter Pan, want to grow up— would like to be able to take over, and run, their own lives. They object to parental control and interference on an ever-widening horizon of activities. Eventually this trend becomes so intense in adolescence that there is little else to be seen.

Clear evidences of it are to be found in late latency. Children begin to defy parents, and confront them with a desire to make their own decisions. Often they angrily say, "Don't treat me like a baby!" When this happens, the child often finds himself threatened by the loss of the parent's love. The child feels, and the parents often concur, that the parents want the child to continue to behave like that healthy, happy youngster who did everything he was told to do in early latency. At this point, the child is readying himself in fantasy to confront his parents and to turn his adaptive energies from inward-turning fantasies, which solve problems through the manipulation of symbols, to demands and actions that will intrude on the world. The children become especially sensitive to situations in which their decisions are challenged or their immaturity emphasized.

Late Latency: Ethical Individuation. The child's sensitivity leads to feelings of humiliation and inferiority when faced with ethical conflicts with parents in reality. This may include activities as simple as crossing the street alone, and as ominous as peer pressure involving stealing, drugs, and sex.

One defense is to generate fantasies through the structure of latency. Thoughts about being movie stars or champion athletes, or owning motorbikes take center stage in these fantasies. Some children who have conflicts about such confrontations with their parents deflect the challenge into fantasies of defiance. These often take the form of fantasies of theft and crime, which are at times acted out. Often a sense of pre-experienced guilt imbues them with a feeling of permission. Others accompany the fantasies of defiance with doubt and guilt, and this often blocks the ability to manifest the fantasy in play, thought, or action. As a compromise to resolve the conflict, children may shift into symptom formation. Urticaria, paranoid ideation, and obsessional symptomatology are common in this circumstance. In the presence of these symptoms in a late latency child, it is wise to look for conflicts with the parents in reality or with the parents as they appear in the child's mind's eye over such issues as passivity, stealing, sexual play, greater freedom of movement, and smoking. As the child masters the problem of independence from parents and can accept individuation from parents in the ethical sphere, the symptoms usually clear.

The late-latency child, who is struggling for independence, usually deals with a harsh, limiting, and condemning parent in his fantasies, as well as with the real parent. This fantasy of the hostile parent places limitations on the child's activities, which in turn evoke hostility in the child. The hostility so evoked causes the child to further distort the real parent, usually the mother, into a stick-wielding disciplinarian (the phallic mother). Parents respond with hostility in return. Escalating anger and a deteriorating situation ensue. Therapeutic leverage is in the hands of the therapist who is aware of the potential of fantasy to distort the relationship between parent and child at this age, and who is ready to help child and family recognize and work through the problem.

Late Latency-Early Adolescence: Sexual Identity Crises. There are other characteristic fantasies which mark the latency age period. These have to do with the awakening concern about sexual identity, which intensifies at the point that children begin a growth spurt, at about 9 years of age. Body changes, though too slight to be detected by a casual observer, alert the child to the sexual dimorphism that defines the adult sexual assignment. Evidences of such sexual dimorphism create concern in the child who has not fully decided to be comfortable with the sex to which he has been assigned biologically. Children begin to develop concerns about sexual identity, and to worry about what they'll look like as adults. They ask whether they are really boys or girls; boys wonder if they can turn into girls, and girls wonder if they can turn into boys. These are often well-defined fantasies, which cause the children concern, stir up other fantasies and castration fears, and are detectable in interviews with children in late latency.

Therapeutic Strategies

What should be the approach of the therapist in dealing with the fantasy life of latency-age children? The therapist may help the child to elaborate and play out the fantasies. This helps when the child is experiencing the fantasy as a means of repetition, or mastery and discharge. It is also useful when manifest fantasy deals with disorganizing experiences and disquieting new awarenesses or thoughts. The therapist may help the child to verbalize his concerns, to clarify his ideas. Reassurance may be given that the situations that concern the child will come into the province of the child's ability to cope as he grows and matures, and the child may be helped by the therapist's strengthening in him the mechanisms of defense that are appropriate for his age.

The fantasies described so far are universal in latency-age children. They relate to universal experiences associated with common growth phenomena, such as the shared maturations of cognition, which bring potentials into view and ready the child for independent functioning. The structure of latency when brought to bear on these stresses produces the fantasies described above.

Fantasies to Manage Trauma. Therapy with children in the latency years would be incomplete if therapeutic interventions were limited to common or universal situations and the reactive fantasies associated with them. There are experiences that are relatively unique in individual children. These too are defensively processed into fantasy by children. To identify these, the therapist does not have such guidelines as the brief outline presented above for the common fantasy-provoking situations of latency. Unique psychopathogenetic past events and situations must be detected and reconstructed as the result of continuous attention and interpretation. Generalizations are not possible. There follow clinical vignettes to illustrate some of these.

It is well to keep in mind the following rules for recognizing that manifest fantasy play is being used to process a unique experience or is related to some item of aberrant past behavior. The older the child, the more is he apt to act out the fantasy without recourse to verbal representations. Anger, shame, guilt, and sexual excitement in a fantasy play situation indicate that the child is dealing with a strategic memory based upon a traumatic experience. Memory is selective in these matters: events selected for retention, recall, and working through are by their very nature attractive to the sexual and aggressive drives. For the small child, these drives find little in the way of realizable outlet. Stimulating these drives forces the child into an untenable position. The child becomes "overcharged," with no place for release save recourse to discharge in fantasy.

Trauma-Based Mastery Fantasy

> An 11-year-old kept coming home drunk. He had come to treatment for depression, which occurred only in winter. The experience of getting drunk was eventually related to his mother's reaction to the death of her father, who had died on a winter's day. She had become drunk during the wake and had lost control of herself and the situation. In drinking, he was acting out the fantasy that he could handle the situation better than his mother had. His grandfather had died at home after a series of acute situations of near-death, which the youngster had witnessed, sometimes as the only one present. He was able to describe his feelings of terror at those times, and of fear for his life. With the working through of this material, the depression present at that time cleared. It did not occur during subsequent winters.

A 6-year-old child was brought to the clinic for evaluation of an apparent absence of conscience. His mother presented as a point of history of great importance to her the fact that when he was 4, she had left him and his less than 2-year-old sibling alone in the bathtub while she ran out to buy some cigarettes. When she returned he announced that the baby wasn't moving. She rushed to the bathroom and saw that the younger child had drowned. In the direct interview with the child, the youngster conveyed no verbal recall for the incident. I did not ask him directly about his brother. About the middle of the interview, the child asked me for a piece of paper because he wanted to draw a picture of a favorite uncle. He drew the uncle in a swimming pool. The uncle was described by the child as "drowning a boy."

Treatment Approach to Trauma Based Fantasy

Jimmy[1] was 8 years old. He was brought to treatment because of provocations on his part in home and at school. His mother brought him for treatment out of a sense of guilt, at the time of a separation from her multiply unfaithful husband, who had left the family home to take up residence with his mother. The child's situation had been unique in the following regard. His mother would beat him and only scold his younger brother when she was angry. She took out on him her anger, rage, despair, and spite for his identification with her husband's family. This was no fault of his. His father's family identified him as one of their own, while losing sight of the role of the mother in his birth. The mother had suffered toxemia at his birth and had remained in the hospital for a few weeks after his discharge to his paternal grandmother. The father's mother prepared the religious naming ceremony, which was celebrated on the very day that the child's mother left the hospital. In an oversight considered by the mother to be reflective of the attitude of the parental family, the mother was not invited. She learned of the ceremony after the fact from her own outraged mother. Thus the child came to be identified with the father's family in the mind of the mother. As a result, he became the proper target of her wrath. (Such attitudes are not unique. Another patient once reported the story of a visit to her mother-in-law. The dining room table was noted to be set with three extra plates instead of the four indicated for her family. When her husband asked about the absent plate, his mother regarded his wife with disdain, saying "Why should I cook for strangers?")

Clinically, the child appeared to be depressed. He refused to talk about his problems or concerns. At the end of the sessions, he put on an expression that was interpreted by the therapist as pride that he had held out and not talked as requested. He was not silent. He loved to play. He would sit at one side of the table with the therapist on the opposite side. A short wooden building block was given to the therapist. The boy took a long one. The edges of the table were the goals, and the blocks were the playing paddles in a game that used a mother doll from a family doll group as the ball. Points were won if the mother doll could be hit in such a way that it was forced over the edge of the table. The child, who admires wrestlers who fly into their opponents, called out a lengthy play-by-play description of the battles involved in the game.

Attempts at intervention other than cooperating in the game were futile. Such techniques as interviewing the mother doll or the players during halftime were brushed aside. This represented an attempt to get the child to discuss his problem at a removed level. The objective is to distance one's comments as far into fantasy as the ego of the child has removed himself, and removed his area of concern. Usually one can judge the nature of the original nonremoved concern by listening to the topic of conversation in which the child was involved at the time he stopped talking and began fantasy play. Since this child had refused to talk, recourse to another source of ideas was necessary. Here the topic about which he was to be asked was indicated by the game and the history that had been given by the mother. Obviously, the child was dealing with anger at his mother and an identification with her aggression and her hitting him when he was younger. The mother doll could have been asked if she had had any prior experience at being hit or hitting someone else. ("Did anyone hit you like this before?" "Did you ever hit anyone like you are being hit?") The child rejected all communication, save the hitting game. In spite of this failure to achieve verbalization, on either a direct or removed level, there was

consistent improvement in behavior at home and at school.

The Theory of Therapy. In dealing with such a child in need of therapy, two levels of help are possible. One can either help the child by encouraging him to play out his fantasy (evocative play) or one can lead the child to talk about his problem at its traumatic root (communicative play).

Evocative play. The continuation and encouragement of evocative play provides through the therapy a controlled and guided outlet for tensions and a theatre for the cathartic discharge of tensions associated with traumatic memories. Such play can be introduced and encouraged in a context that is nonthreatening to both the child and the therapist if a playroom is used and the child is told that he can do anything that does not hurt himself, the therapist, or the equipment. The lowering of tension thus achieved will often discharge tensions to the level that the child can produce periods of latency calm. In these latency states there is produced a new behavioral niche in the social ecological system of the child. If the mother has changed, as the result of experience, education, or maturation, there is opened a door to the learning of a new style of relationship between parent and child. Often, concurrent interviews with the parent succeed in encouraging and directing the parent to behavior that welcomes and shapes the newly revealed potentials of the child. At times, interpretations during play do not result in direct communication about problems, but rather, as good interpretations do, in changes in the content of the fantasy play which expands the area and content of the catharsis; and sometimes control and limitation of behavior in sessions suggest, or strengthen, defenses that provide for stronger latency states outside of the therapy situation.

Communicative play. Communicative play uses the child's play fantasies as a tool for discharge as well. However, if the child will cooperate, then questions may be asked that will take the child back to the roots of the problem. Actual trauma can be discussed and misinterpretations clarified and corrected. In this way, there is conscious mastery, and dissipation of the trauma that is sensitizing the child to a current experience.

> A child played out a situation in which she was the master and the therapist a slave. She would scold him furiously. In response to the question "Did anyone ever treat you like a slave and scold you?" the girl, aged 8, reported that her mother was hiring a new housekeeper, who was to arrive at work that week. The girl was very anxious, because once they had had a maid who hit her while her parents were out, and forced her to go to bed very early so that she (the maid) would be free to read; she threatened the children with death if they described her actions to the parents. The child came to realize that this was her present concern, or at least

contributed to it. She was able to discuss this with her mother, clear the air, and plan with her mother steps to reassure herself that such a situation would not arise again.

Summary

The treatment of latency-age children revolves primarily about manifest fantasies derived from drives that have been stirred but cannot be discharged. These fantasies are universal and typical. They are the products of masking modifications of latent fantasies evoked by universal situations and experiences, which could not be resolved at their inception and are carried as extra baggage in memory. They are brought out on every possible occasion in an attempt to master and resolve them. The manifest fantasies of latency have origins in the child's early fantasy interpretations of the events, experiences, and mysteries of early childhood.

However, treatment of the latency-age child is not limited to work with universal latent fantasies (e.g., drive-influenced distortions) or the phases of unfolding awareness that occur during the latency years. There are facets to latency-age fantasy life that are best understood if the origin of the fantasy is recognized to be an actual trauma.

Latency may be seen as a phase organized into coherent developmental substages. It has a structure of its own and work to accomplish if the child is to reach emotional adolescence. Emotional health is aided if problems of adjustment to these subphases are recognized in their masked reflections in the mirror of fantasy.

Analytically derived psychotherapy with latency-age children can be applied to 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 so as to have the same patterns of behavior in disparate situations (i.e., sibling rivalry, jealousy of peers, being picked on and teased) can be helped to direct energies away from fantasies and toward the resolution of reality problems. The overstimulated or traumatized child can be helped to place his relationship with adults into perspective after the parents have been induced to stop the overstimulation. Children of parents who overemphasize needs for control and limit the rate of maturation of the child can be helped in bringing their conflicts to the surface instead of battling within themselves to the accompaniment of guilt

and doubt. This in turn alleviates somatizations, paranoid symptoms, and tics, which defend against the guilt and doubt.

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

In children whose failure to enter latency is associated with delay in the maturation of the cognition required to establish a state of latency, child therapy may be applied with the aim of encouraging the establishment of more mature means of comprehending and remembering the abstractions necessary for survival in school. Concurrently, improvement in cognition aids the therapeutic process. There is established a means to enhance interpretations, in terms of improving the child's level of understanding, in order to achieve a lasting effect.

Notes

1 I am grateful to Margaret Moxness, M.D. for calling this case to my attention.