Psychotherapeutic Strategies

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Psychotherapeutic Strategies

Adolescent psychotherapy patients differ from latency-age patients in that ludic symbols play no important part in their associations. This rather obvious difference dictates that play therapy is inappropriate for the adolescent age group.

As participants in psychotherapy, however, the difference between the early adolescent and the older adolescent is more subtle. The cognitively mature adolescent who willingly seeks therapy, who is verbal, and who is psychologically minded is likely to benefit from the free association-based interpretive process that works well in the form of psychoanalytically oriented psychotherapy for adults. Unfortunately, few early adolescents fit into this category.

For the most part, it is required that the psychotherapeutic strategy applied to early adolescents be adjusted to take into account certain characteristics of the early-adolescent life-stage. These include, in part, developmentally mandated requirements (e.g., immature thinking processes—thought disorders) and socially defined immaturities (e.g., lack of comprehension of the role of educated professionals in providing expert help in areas of need). Therefore, this chapter is devoted to those psychotherapeutic strategies and techniques derived from information about the psychology of psychotherapy, discussed previously in this book, which set the psychotherapeutic treatment of the early adolescent apart from the treatment protocols used for children of latency age and adults.

Initiating Therapy

More often than not, the early adolescent is brought to treatment against his will. Even if brought to therapy willingly, the idea of therapy—what is required, what should be done in therapy, what the act of therapy requires, and whether secrets can be told—is a source of bewilderment to the child. Furthermore, the symbol-surfaced mirror of fantasy play is unavailable to reflect, in the early sessions, the inner world of the troubled child. There are available to the therapist only speech and symbolic acts. Should the child refuse to speak, refuse to direct his thoughts to his trouble areas, or be unable to do so, progress will be very slow.

To motivate the unmotivated child one must interview, in the first sessions, with the aim in mind of discovering a discomfort the relief of which could become the goal of the therapy for the child while the therapist pursues the larger goals of extending insight and enabling progression. The object of the search should be easily recognized by both therapist and patient as a valid psychotherapeutic goal.

> At 14, the slightly overweight redheaded girl proclaimed in her very first interview that her life was a shambles because of her parents. "They don't let me do anything. They interfere with my life." She had been taken to see two therapists prior to this appointment by her parents. She had refused loudly to return to one and had run from the office of another because she did not like the questions she had been asked.
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> "The only reason I'm here today is that my parents say they won't take me to Florida for Christmas and won't buy me a car when I'm 18 if I don't come here," she said. "There is nothing wrong with me. I don't need a damned psychiatrist. You've got an hour. I'll answer your questions. NOTHING wrong!— Shoot," she shouted.
>
> As her story unfolded it became clear that she needed extra freedom and late hours in order to pursue drugs and sex, and that her school work was suffering. She related as poorly to peers as she did to her parents. Her approach was to shout and demand, to lie and expect to be believed and forgiven as easily as one could expect to remove soil from the hand by washing. Obviously her life was out of control. For her, words were things and people were things, and people and words could be interchanged. Everyone and everything could be moved about as the agents and objects of her will, like the symbols and situations of a fantasy.
>
> Even she could see that there was a problem in her functioning. Sometimes it didn't work. She didn't blame herself. She blamed the world for the selfishness that resulted in her failures.
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> When the session ended, she looked at me defiantly and barked, "O.K. I've told you about me. Can you find anything wrong with me?"
>
> "Yes," I said, "I think so. You can't control your parents. They can't control you. Your life is out of control. You don't know how to control people." I had selected from all the problems that I saw in her the deficit in the ego function of *the ability to influence people.* I chose it because of her felt need to control, which was manifest in her behavior toward me. It was the one criticism that could be ego-syntonic.
>
> She seemed stopped in her tracks. "You could help me with that?—When is the next session?" she said in response to my assent.

The early-adolescent child has a poor concept of the contextual relationship between current behavior and the future. This a part of the object-ground differentiation thought disorder, which is a maturational way station. This contributes to the fact that early-adolescent children can see no need for therapy. The impact of today's disorders of behavior on the quality of life in their mid-20s is beyond their spontaneous ken.

> A lad of 15, darkly handsome, anxious, and defiant proclaimed at our first meeting that there was nothing wrong with him. His school work suffered as the result of long hours out after curfew.

He often came home confused, with bloodshot eyes, listing as he walked, and calling out his parents' expected complaints before they had a chance to speak.

"I'm happy with myself and what I'm doing. Who needs school," he rationalized after receiving a mark of 40% on a hygiene and health education test. He did equally poorly in geology. He was sufficiently organized to have some friends and a life planned around the pleasures of the moment. His movements had form but, sadly, their guiding star was whimsy. All sessions seemed alike in their lack of purpose. The therapy appeared to me to be a string of initial sessions as goalless as was he.

I decided to try to lend him some self-reflective awareness and to help him create a superego-like goad that would push him to think of today in the context of the influence of his "now" on his "later." With the next session, I told him that I had heard that there was a 26-year-old man waiting for him on the road he planned to travel. I warned him to take care, for the man wanted to kill him because of the things he had done to him. He looked at me incredulously. "What?" he said, "Don't know anybody like that."

"He's here," I said. "You've ruined his life." He seemed to know almost at once that I had used a metaphor. It took two sessions for him fully to realize that the boy he was, the man he was destroying, and the ruined man in search of revenge that would take his life were all one man.

The early adolescent child is just coming out from under the hegemony of the parents. The passivity involved in sustained exposure to adult influence generates anger and exclusion of adults from the private thoughts and adventures of the child. The therapist does not at first stand apart from other adults in the mind's eye of the child. He is tarred with the same brush. Therefore, the therapist must expect slow acceptance into the secret world of the child. His confidence must be won. In the thinking of the child, the therapist may be an agent of the parents. "Does he repeat what I tell him to Mom and Dad?" "Can I trust him or is he a spy?" Extended sessions may have to be spent talking about films, singers, and news events attractive to the child while a relationship is established that will permit the interchange of information of therapeutic value.

Dealing with Parents

In dealing with parents, it is important to determine if the child is so mature that there are secrets to be kept. In that case, the parents must be told that after the first interview with the child, they will only be seen in the child's presence. Thus the child will know all that has been said to the parents by the therapist. As a result the child can be assured that he will be able to speak freely. It has been my impression that the most willing early-adolescent child will present a drift toward impersonal and surface topics if he suspects that his parents are privy to his thoughts through the therapist.

Since early-adolescent children are not willing to share freely, or even able to judge what is important to tell the therapist, some contact with the parents may be necessary. Telephone messages and letters from parent to therapist, as well as family sessions, fill the need nicely. The calls and letters should be reported to the child, in order to bring topics into the therapy. Parent information that is unknown to the child and is of a highly personal nature should be reported when appropriate, watched over by the twin guardians of tact and discretion.

"Interpreting" on the Predicate

It is not rare, before trust has been gained, to find that the therapist's questions about the patient will draw limited responses:

Q. "How are you?"

A. "Fine."

Q. "What did you do this weekend?"

A. "Hung out."

Q. "How are things in school?"

A. "Fine."

If no questions are proffered by the therapist, the early-adolescent child will in many cases offer only silence. This occurs in spite of the fact that at this age the child's experience is vast. There are many things of which to tell that are maturational, developmental, or social. Even if the child wanted his world to stand still, exciting and interesting events are being called forth by biology. There is a technical way around such withholding. It consists of active questioning which will not lead the content of the sessions away from the ideational content of the child. I like to call this technique *interpreting on the predicate.*

It should be recognized that whatever a relating child says must contain sentences consisting of a referent to himself or a past conversational element that is shared by both therapist and patient. In addition, most sentences contain new material in the predicate portion of the sentence (predicate nominative or predicate adjective), or in the object. One of the ordinary pathways pursued by free

association follows the predicate. Therefore, with the early-adolescent child who would be silent, a synthetic form of free association compounded of the patient's own ideas can be produced. One need only remember the predicates, storing them if too many appear, and in times of excessive silence make questions out of them.

Let us say, for example, that we are in a session with a silent early- adolescent child. A silent child plus a silent therapist means trouble at this age. I ask questions about such things as what the patient did last weekend, or will do next weekend. I ask about movies seen, relationships between people heard of in school, or favorite television shows. From the child's answers I gather predicates from which to fashion questions.

Which questions? One might be guided in selecting topics from the problem areas and topics to be found in the chapters before and after this one. Oedipally flavored situations, sibling rivalry, strivings for independence are important, as are references to growth and development. Remember that the early-adolescent child's major means of achieving repression is through the countercathectic direction of attention and energies to external events and experiences. For the child at this age people and their experiences are symbols. The child is most sensitive to those events that represent his own conflicts and preoccupations. Through actualization and displacement, he removes the responsibility from himself while he continues to enjoy discharge or master situations vicariously. For the adolescent, gossip is the equivalent of the fantasy of the child in the latency years. Therefore one should look for parallels to the child's conflicts in the distant mirror of a child's selective gossip or his thrice-told tales from the movies.

> A girl of 15, who had been sent for treatment by her parents because of a school phobia, went to school immediately after she had started treatment. That she had great problems with separation from her mother and feared growing up could easily be seen from her parents' report that she rejected dating requests from boys while arguing continually with her mother in a style that kept their hostile relationship primary. Through the latter, she kept her mother's control at a distance. At the same time, she forced her mother to be watchful of her. Her mother had to supervise her, for she refused to take any responsibility for herself. She would not clean her room or do her homework without prompting. She both rejected and invited parental intrusion. A prime matter of contention was her large breasts, which she attributed with a sense of blame to inheritance from her mother's family. Her mother could do no right. Yet the girl wanted to go shopping with her and be with her in preference to peers. At the same time, she was in competition with her mother over the mother's inability (in the eyes of the girl) to care for her father properly with respect to religiously mandated customs of the hearth which were especially important for her father, who was a member of the clergy. As far as she was concerned, she had no problems—there was nothing to talk about. She did not know why she was in treatment. The reason for treatment, if there had been one, was obviated by her return to school. There were no problems now. The issue was closed. The basic underlying conflict that led to the school phobia was seen as solved the moment its

derivative in action had been erased. How could one approach her conflict and her fear about growing up?

Direct statements and questions availed little. The associations that followed such interventions somehow always brought her back to her favorite topic for study and discussion, New Guinea. For weeks on end she returned to thoughts of this far country as though it were her own beleaguered domain. I searched through the events of the adolescent age and through the physiological prerogatives that seize upon the mind of a child and could find no link to her preoccupation. How could this very distant land be a mirror to her mind? No reconstruction was possible. It seemed as though her interest had proven false the rule that "in therapy, an adolescent's spoken interests contain a kernel of her fear or worry." Finally I gathered the predicates, and asked, "Why are you so concerned with New Guinea?"

She answered quite directly that New Guinea was wonderful as the virgin jungle it was, and that she thought it would be awful if they "caused it to develop too soon."

The Technical Polarization of Interventions in the Therapy of the Early-Adolescent Child

If a child speaks of problems directly, one need not "prime the pump" through such interventions as asking questions or pursuing predicates for their hidden meanings. Therapeutic problems arise when there is silence, or when the child's associations drift away from the self and into the world of counter-cathected things. Silence may be used as a defense at this age. A child mind can be set to dwell in worlds away from troubles. Interventions are needed to keep the child on the track. Unless there is current anxiety to hold the problem in the mind's attention, problems drift away when an early adolescent talks to an adult. The child did not bring himself for help for the dysfunction that only an adult can see in its inherent dangerousness. The child who did not seek help may not welcome it. Like the dog who bites the hand that helps, the early-adolescent child may turn his anger or disdain on the therapist who offers his skills, as though the therapist were an intruder. He may turn from the therapist to silence, or he may drift in his associations in a direction away from the expected tendency to go inward toward the self or backward in time.

The adult weighs the emotional defect of the child in the balance against the impact of the defect on the future life of the child. The child adjusts for the moment; the parent seeks adjustment that will serve a lifetime. When the child is alone or with friends, troubles and depression loom over their thoughts, and they can talk endlessly of such matters with the assurance that they can be treated as passing things. Adults remind one, children let one go. With the therapist, an adult who reminds the child of the extended implications of a problem, silence tends to supervene. Many adolescents consider it more important to be free of adult influence than to be helped. For this reason, free association can be

compromised in the psychotherapy of adolescents. In the early-adolescent child, free association may tend to pull thoughts away from the self and toward the world.

The goal in adolescent therapies is the same as that of adult therapies: insight and change through interpretation, especially of the transference. Adolescents often demand special attention during the early phases of treatment and some adjustments during the mid-phase. The approach to termination is little altered, though. The technical adjustments required take into account the special conditions, expectations, attitudes, and cognition that mark adolescence, especially the closeness to drive awareness that is produced by the increase of hormone levels and the loss of masking ludic symbol skills. This demands a turning outward of the attention cathexes that scan for free associations, which produces a hyper-countercathexis of the environment as a means of drive suppression. Clinically this is manifested in therapy sessions as a tendency to respond to interpretive interventions by associating away from the self after an interpretation in which the self is mentioned. This tendency is intensified in situations of acute and chronic marijuana use, wherein patients will actually respond to interventions by providing extensive lists of things seen or experienced. The emphasis tends in all these situations to speak of things, not selves. Thus, a technical adjustment should be made to move interventions toward an interrogatory pole, which will keep the child's attention on himself.

We now digress to take note of the nature of the interventions in psychotherapy, in order to provide a foundation for explanations of the adjustment required.

There are six basic interventions used during verbally based psychotherapy:

Confrontation—conflicting pieces of information presented by the patient are placed side by side for his response ("You said, you would never marry, now you speak of becoming engaged.").

Construction—that which is currently happening to the patient is verbalized. Both affect and action may be constructed, resulting in two categories of construction, *affect construction* and *action construction* (e.g., "You are angry now.").

Reconstruction—what has happened to the patient in the past is verbalized. Both affect and action may be covered in a reconstruction; thus there are two categories of reconstruction, *affect reconstruction*

and *action reconstruction* (e.g., "You were angry then." "Your father threatened you, and you became afraid.").

Interpretation—an intervention is framed using similarities of psychic function of the individual drawn from the areas of real-life events, past experience, and transference. One expects from an interpretation not necessarily confirmation but rather extended associations, which become the source of new information and insight ("Isn't it striking that in your work, your dreams, and in your way of talking to me in the sessions, you fear to speak because you worry you will not be liked?").

Each of the six basic interventions can be presented in one of three ways: They can take the imperative form, as in "Call me if you plan to do something foolish." This form is rarely used. They can take the declarative form. This was illustrated in the above *reconstruction.* They can take the interrogatory, or questioning, mode. This was illustrated by the *interpretation* above.

In adult therapy, declarative modes are preferred. Undue pressure is not brought to bear. The adult patient spontaneously associates with himself as focus and backward in time. For the young adolescent, the lack of structure in the use of the declarative mode permits the associations to drift toward more superficial externals and away from the self. Therefore, the interrogatory mode provides a polarity toward which one can direct the posing of an intervention in such a way that it will enhance the development of therapy along a patient-oriented line.

Adjustments in the Mid-phase

Symptoms and characterological behavior require insight for therapeutic gain to be made in the adolescent. In this, adult therapy and adolescent therapy are alike. The point of departure that characterizes therapy in late latency-early adolescence is the fact that this phase is normally dominated by change and progression. Development, maturation, and unfolding cultural demands make *change* the watchword of the phase. Psychotherapy must be conducted with knowledge of the average, expectable changes that are taking place concurrently. Developmental gains must be differentiated from therapeutic gains. At times, the work of the therapist is not so much interpretation as it is the encouragement that enables maturational changes to produce developmental results.

In early latency and adulthood emphasis must be placed on holding firm an ego structure which will be able to handle extended periods of status quo. The late latency-early adolescent ego structure must change in accord with internal changes and in response to the ever-changing requirements of self, peers, and society. In addition to the gain of insight and the pedagogical transfers of information that occur when one lends ego, the therapist must aid and enable progress.

At this age progress has many aspects. One of the most important is the development of readiness to achieve removal. This is the transfer of libidinal cathexes from primary objects (parents) to peers. It is a necessary step. After all, parents will not always be around, and members of the new generation must find each other and found their own dynasties. The hope is that removal will be so complete that the drives will find new objects without carrying with them the trappings of neurotic fantasy. Removal may take many years. Its high point occurs in late adolescence. In some societies, in which the family remains intact, removal would be considered pathological. Removal is not linked biologically to the growth period of youth or the stage of adolescence. It is a culture element of societies in which children set up their own separate households.

Early adolescence is an age period in which removal is not a primary feature. Early adolescent psychotherapies deal with the prospective enablement of successful removal in late adolescence. Usually this revolves around an event that occurs in mid-adolescence and casts its shadow on early adolescence: the break involved in moving from home at 18, as happens when someone goes to live in a dormitory at college, or to work away from home after graduating from high school. Although the patient says that nothing is going on or that he cannot find the reason for anxiety or sadness, the therapist should be alert to anxiety that deals prospectively, at times years in advance, with the upcoming separation. Bursts of depression are not unusual. They represent prospective mourning. This is a form of working through of separation. It is better done if the object of the mourning is identified and the process can be discussed.

Sometimes the source of fear is the threat of new freedom. When away from home, the suzerainty of the parents threatens to be displaced by a hegemony of inner forces and drives. Away from home and with free unsupervised hours to “get into trouble,” new and fearedly profane experiences crowd those horizons of fantasy that invest the new life. Lunch hours for “quickies” (brief sexual episodes) are not as common in the lives of college students as they are in the fantasies of high school students. Their

presence opens for the child awareness of how inexperienced he is. Anxiety ensues. The child must know how to evaluate danger in new situations. If he has been sheltered or inexperienced, this ego skill may be quite faulty. Look for this especially with overprotective parents.

Another possible source of difficulty in family interaction that may be linked to the separation of ensuing college matriculation or its equivalents is the sense that between now (usually about 16 years of age) and then (usually about 18 years of age) there never will come to pass all of the things that the parents could not provide for, for which the child had hoped. These include clothes, vacations, entertainments, and expensive colleges. Since such resentments are considered to be reprehensible, the content is often suppressed, with the affect retained in consciousness as a resentful mood in search of a precipitant. Usually it is necessary to hear complaints about the precipitant for a while until the underlying material can be elicited.

An important step in maturation and development that rivets the prospective attention of the early adolescent is *sexual initiation.* The first exploratory moves toward sexuality are apt to strip latent insecurities of their defenses and to produce anxieties. It is quite difficult to encourage a teenager who fears his or her own sexuality to talk about sex or to approach a partner maturely without appearing to the child to be seductive. Questions about masturbation or about intercourse experiences are apt to cause children great discomfort. They may, in fact, appear to be near panic; there is little chance that they will tell the truth. It is better to wait until the child gives indications of interest in the topic than to compromise an extended therapeutic situation in its incipient stages by making the child feel seduced and raped by a new intrusive adult. When there is a male therapist and a female child patient in early adolescence, an additional problem exists if a sexual transference is developed in silence. The girls are likely to act out on the sexual transference with peers. Pregnancies can occur. In such situations, it is necessary to ask about dreams and sexual fantasies to achieve discharge through verbalization. Severe situations of the sort require transfer of the patient to a female therapist. Male adolescents with a tendency to feminine sexual identifications may develop homosexual panic as a manifestation of a sexualized transference. Transfer to a female therapist may also be indicated here.

Remedies for Slowed Removal

The most frequent warning signs of slowed "removal" in the making are temper flares and battles involving the members of the nuclear family over schedules and telephones. Parents must often be included in sessions in the early part of treatment if their behavior in this regard is dominated by a need to infantilize the child. In the sessions with the parents, it can be explained that their child will be completely on his own in college, or in the military, or in work life. Some risks will have to be taken if the child is to gain the experience first-hand that will result in a position of safety when confronted with new problems. It is important for parents to let go early enough for the child to prepare himself for life and its joys and dangers.

The parent-child battles in early adolescence may have the appearance of a struggle for independence. As often as not, the purpose is battle itself, not freedom. At its root is a close relationship whose binding glue is intense anger; it is the opposite of removal. Such early adolescents may fight and cry for independence, but rarely take the steps to insure it, such as getting a job so as not to have to ask for money in order to carry out a personal project or plan. At times, parental acquiescence results in loss of interest in a plan that has been fought for. The real excitement for the child lies in the battle with the parents, not with dating a passingly fancied peer. In the battle children tend to see progress if the parent agrees to surrender when demands are made. Winning fights is seen as progress. The parents, conversely, see progress in the breaking of the child's will and the cessation of demands. Actually such "progress" is merely a shift within a battling family between a polarity that consists of fighting on one end and passivity on the other. True progress in removal exists when new and independent life relationships develop with peers.

Remedies for Omnipotence

Many forms of pathological adult narcissism or omnipotence have roots in the unwillingness of the child to give up the latency-age tendency to use fantasy as a means of expressing, mastering, and gratifying drives. In essence, fantasy holds the attention of the cathexes of consciousness. This counters the contributions of maturation, which strip the personality of symbols from within (evocative) as objects for drive discharge and provide the child instead with an organ system for discharge that requires a real

object fitted with a partnering organ. Relatedness and compromise are required. If fantasy discharge persists instead, narcissism is reinforced; the object is recruited to help live out the fantasy, and the needs of fantasy usurp the place that would belong to the real world. Interventions, especially confrontations, can be used to enhance the shift to the testing of reality. I have found it possible to open the way to a modification of the force of omnipotence by introducing the concept of the reality one can feel, which must be differentiated from the reality one can touch. Thus one can view each new topic from the standpoint of its place either in reality that can be checked with others, or the felt reality that is informed by need, drive, and fantasy. Working through takes the form of repeated reviews of evidence.

> At 16 ½ though attractive, the shy but truculent tall blond girl had never been to a party. She was invited often, but feared to go. She held a newly received invitation in her hand and spoke with trembling lips of the fun she could have, but also of her fear that she would be seen as stupid and ugly.
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> "Why would they invite you if they thought that of you?" I asked.
>
> "The other ones," she said.
>
> "What is your reason for this thought," I asked. "What has been said or done?"
>
> "I just know," she replied. Then she said, "I want to go so badly. I know what I'll do—I'll go early and wait outside and listen to what they say about me. They'll look at my face and I'll hear them talk." She went to the party and did just that. Reality was kinder than her fears. The party was enjoyed.
>
> Some weeks later, she responded to one of my interventions with a groan, saying, "That is the stupidest comment I have ever heard." Then she said, "How can my parents hate me so to put me into a room with the ugliest man I've ever seen and make me stay here for hours?" Apparently her fear of insult was informed by the projection of her own wish to insult. She saw others as motivated as was she, and she feared herself in them.

Eventually, on a deeper level, the feeling of inadequacy that causes one to fear realistic communication with the world, and forces the child to control his contacts by clothing new objects in the trappings of old fantasies which can be controlled, must be analyzed to its roots.

Thinking Disorders

It is wise not to consider thinking disorders to be diagnostic of severe mental disorder during the latency years. Only flagrantly disordered use of predicate identification in hallucinations (see Despert 1948) and loosening of associations that inform disorganized behavior should be used diagnostically. Concrete thinking and even mediate associations, though suggestive (Bleuler 1905) of autism, should

only be indicators that further study is needed.

The period of late latency-early adolescence represents a time of emergence during which maturing cognition usually causes the intuitive thought styles of latency to give way to properly ordered thinking. There is a period of years during which certain thinking disorders persist during the transition. They represent remnants of the earlier thought patterns of the latency years. Their persistence into adult life has severe pathological implications.

Early adolescence is a time at which much can be done to resolve and treat thought disorders. Even those associated with process schizophrenias seem to give way. Therapeutic progress during this period is difficult to differentiate from maturational processes. During early adolescence, thought disorders, if identifiable, should be treated through: (1) challenge, (2) ego lending to set examples of correct thinking patterns, and (3) attempts to minimize anxiety, which causes thought disorders to intensify and fix. Since omnipotence is served by disordered thought, thought disorder can be treated through the resolution of omnipotence.

One type of thinking disorder normally colors behavior during the stage of adolescence, and one must be aware of its strength and appearance while doing treatment. It is *inadequate capacity for object-ground differentiation.* It is manifested in a tendency to understand present behavior as justified by affects and drive needs. Life contexts are ignored. (Mis)behavior occurs in a vacuum. Punishment for antisocial or antifamily behavior is not understood as being appropriate or connected and often stirs anger instead of contrition.

Using this form of thinking, one is justified in doing something if one "feels like it." Often the child's poor object-ground differentiation is encouraged by the persistence of this kind of thinking in the parent. A parent with poor object-ground differentiation may prevent a child from going to visit a friend because it makes him or her anxious, not because there is real danger. This does not support the development of reality testing or the process of removal.

During latency, immature (inadequate) object-ground differentiation was necessary. It supports fantasy as a drive outlet and as a technique for the mastery of the past. Even in healthy adults, it continues to work in dreams, with the effect that the outside world is excluded, giving free rein to a secret

place for discharge of tensions through fantasy and symbols. In adolescence, its persistence applied to the contexts in which real people as manifest symbols of the inner fantasy life are set, can wreak havoc. It permits the child to live for today without reflecting on the effect of current behavior on the rest of his life or the real lives of the people who currently surround him. (See the preceding section on the therapeutic approach to omnipotence.)

> At 11 years of age, the towheaded boy became aware that the cursing, kicking, hitting behavior that he carried on in the classroom, though it gave him momentary power and release, was the true cause of his placement in a hospital school. He had thought that the teachers were mean and intolerant and sent him to be with ill-mannered children as a result of their prejudiced opinion of him. His behavior had been a response to his passions. He had thought that others behaved this way, too. In his therapy, it was seen that he could be calm if his hands and eyes could be kept busy with structured activities. He was given puzzles to do while talking. During these calm periods it was possible to engage him in discussions of causes, motivations, and affects. He could carry this over into other areas of his life and bring experiences into the sessions and analyze them from the standpoint of the web of causality that related in his case to needs in classrooms for discipline. He came to see as the result of a construction ("If you behave, and only if you behave, will you be acceptable in a regular class. The teacher is not the cause of your transfers. You are.") that his behavior, not teachers' affects, were damaging his education and the outcome of his life. Note here that behavioral constancy came late and as a product of therapeutic work.

Once object-ground differentiation is an active force in the mental life of a child, affect- and drive-informed behavior can be differentiated from behavior motivated by the web of realistic and verifiable reality. Once it can be seen that anger is a thing with a source or a potentiator, instead of only a justified cause for behavior, it is possible to place it among those things that can be analyzed and, through knowledge, controlled. Parental moods then come to be seen as something to be coped with rather than responded to in kind.

Clinical Instances: A Primer for the Beginner

This section of the chapter is devoted to information of particular interest to the beginning child therapist. It deals with the nature of psychotherapy and its special characteristics during late latency-early adolescence.

Psychotherapy is a verbal technique for overcoming human discomforts of psychogenic origin. By *psychogenic* is usually meant experiential causal factors with roots in memories of experiences in the past. In working with people in late latency-early adolescence, it is necessary to add to psychogenic factors such age-specific psychological phenomena as delayed or neglected cognitive development, social

expectations, and residual defenses that contribute to the production of psychogenic symptoms (e.g., depression and phobia). The complexity of the psychology of the situation makes the techniques of psychotherapy more varied than those ordinarily called into use in dealing with adults.

In standard circumstances, in dealing with adults, psychotherapy has as its primary goals such tasks as making the unconscious conscious, replacing primary process thinking with secondary process thinking (i.e., replacing reliance on the sense of what *feels* real with an awareness of that which can be *tested* and *validated* to form the reality one can touch), replacing id with ego, and developing the ability to love and to work to its highest individual potential. This is achieved in dynamic psychotherapy through bringing into consciousness repressed memory elements that in potentially psychopathogenetic states tend to draw energy away from useful functioning in the world. Instead of being available for the resolution of reality problems, emotional time, energy, and attention are locked into service as caretakers and guards for past affects and memories that are feared, actively forgotten, or proscribed from within or without. Euripides described this state of mind when he wrote,

> "You who sit there in utter misery, look up and show your friend your face. There is no darkness bears a cloak so black as could conceal your suffering. Why wave your hand to warn me of the taint of blood? For fear your words pollute me? I am not afraid to share your deep affliction with you. . . ." (Euripides 423 b.c.)

For some, the source of suffering has simply been concealed. For them, sharing and exploring forbidden thoughts in search of insight is a simple act of will involving the mere uncovering of that which had been willfully withheld. For instance, telling of that of which one is ashamed requires an act of will. The rewards of telling are mastery, organizing one's thoughts, discharge of tension, hope of good advice, and the possibility of gaining insight. In the *Tale of Genji* Lady Murasaki came close to an explication of this when she wrote, in the year 1008, that ". . . even those who wander in the darkness of their own black thoughts can gain by converse a momentary beam to guide their steps" (Chapter 1, p. 12). Such supportive tasks as giving comfort, and permitting relief of tension through ventilation in the form of repeated telling about traumas in the service of mastery through repetition, help to deal with much stressful material once it has been shared.

There are times and situations in which the source of anxiety and pain is unknown or repressed and therefore excluded from consciousness. Simple communication is not enough. In these situations,

special techniques based upon special understandings are required. Such techniques are the distinguishing characteristics of dynamic psychotherapy; they serve to unlock the unconscious and bring it to the surface, where its contents can be defined, discussed, and resolved. Such unconscious content, which contributes to anxiety, fear, depression, and symptoms, is rockbound away from consciousness in the adolescent and adult. The repression is less well concealed the earlier in late latency a child's development can be placed. The older the child, the more difficult is the task of retrieving the unconscious. It eventually requires an understanding that surpasses reassurance and kindliness. The key to uncovering of this magnitude lies in understanding the following: that which is in the unconscious, but is so actively on the mind that it serves as a potential source of affect and discomfort, is actually quite capable of distorting the concurrent conscious activities and thoughts of the child. If one speaks or acts in a way that might influence the child's thinking, the unconscious influence might be lessened. If one remains silent or avoids intrusion into the thought stream of the child, the persistency of the influence of unconscious elements is sustained. The symbols, interests, and play of the child can then serve to carry active bits of the contents of the system unconscious into manifest play and talks.

S. Freud (1909) was the first to observe this in a child; he had already studied the process extensively in adults. He noted that all thoughts and actions are to some extent *psychically determined* by unconscious elements. As a result, any sequence of thoughts and actions should not be seen as random, even though they are seemingly disconnected: there is an unconscious connection between any series of thoughts. Sequences of thoughts serve to bring the unconscious to the surface. The process can be encouraged. The less one interferes and the more isolated the patient is, the greater is the *unconscious motivation* that is represented by the activity or verbal associations of the child. This gives rise to the therapeutic principle that one does not introduce one's own ideas during therapy sessions, and that one directs the early adolescent (postludic demise) patient to "say what comes to mind to

the best of his ability" or one directs the late-latency (preludic demise) patient to do anything in the playroom he wishes so long as it does not hurt self, therapist, or the room and its equipment. Once this has been done, the therapist takes the position of observer. His task is to figure out from the persistence of manifest (conscious) ideas and themes those distressful experiences and affects in the unconscious that influence the daily life of the child. With the younger ludic child, the use of toys and symbols in play gives the clue. With the late adolescent, subtleties of action and ideas expressed in the verbal associations

of the child must be searched for hidden themes.

Let us take some examples. In each case, what is repressed is related to rejection and the child's response to it.

Late Latency (Preludic Demise) Fantasy Play

> At the age of 9, she was still tiny. There was no sign of physical development. She spent her sessions quietly drawing pictures of kittens, rainbows, and stars. She answered questions with short and undetailed answers. Little if any personal information could be elicited directly. She had effectively established a countercathectic boundary between herself and the preoccupations that lay beneath the surface of her smug and proud retreat from communication with the therapist. Then one day the therapist asked her to make a series of pictures about the life of the kitten. With a gleam in her eye she began to draw cartoon after cartoon. A story began to unfold. A cat was hit by a car. She was badly hurt and therefore had to be taken to the hospital in an ambulance. Once in the hospital, she recovered quickly. The doctor took an interest in her. He was a fine tall cat with a long, somewhat bushy tail. He took her home from the hospital still on crutches. They married. A baby cat was soon born. The baby cat was very smart. In each class she was swiftly promoted to the next. In this way she grew up quickly. It wasn't long before she became a grownup teenager. One day while out walking, she was hit by a car. She had to be taken to the hospital, where she both healed quickly and met a handsome doctor cat. She didn't bother to draw more, pointing out to the therapist that since the story repeated through cat and kitten endlessly, all that the therapist had to do was to read the cartoon again and again from beginning to end.

One would be hard-pressed to guess that this immature child had so much in her mind about glamorous romances. She did not watch television "soap-operas." Yet the theme of the story was more than a story about cats. It could be used as the basis for exploring her ideas about babies. In addition, erotic transference wishes toward the doctor- therapist could be inferred.

Transitional, Shifting between Play and Talk.
(Rarely Fully Reality Oriented)

> He was 11 years old and in the second year of therapy for uncontrolled behavior in school, which included bullying other children and cursing out loud in the classroom. On this day he came storming into the room holding tightly to his bag of little metal airplanes.
>
> "Did you buy more airplanes?" . . . "You didn't? Why not? I need lots for my game!"
>
> He unpacked his planes and lined them up on the desk.
>
> "How much would you spend for a car? ... I mean the most," he said.
>
> "What do you have in mind?" responded the therapist.
>
> "The Mercedes Benz is a good car. Don't you want people to think you are a success?" . . . "How old are you?" . . . "You're old enough to have a nicer car than you have."

He began to fly the planes around. He crashed them into each other and into the walls. He ate a cookie his mother had given him and then dropped the cookie bag on the floor. The therapist made no move.

"I need some of your planes." He went over to where the therapist was sitting and began to move the wastepaper basket away from the tray that holds cars and planes. He suddenly lifted up the basket and spilled the contents all over the therapist.

Said the therapist, "What was that for?"

"I'm trying to see what will get to you."

Notice, the first attempt at provocative defiance was the throwing of the bag on the floor. Failing to elicit a response he escalates the attack. When that fails, he tries a verbal approach. Curiosity about an adult's response to defiance mounts in him. "What would your wife do if you raped her?"

The therapist said, "What does that mean?" The patient knows of rape as a sexual and offensive act. His sophistication does not permit more subtle questioning.

"What would you do if you saw someone raping your wife?" The therapist said, "Call the police. That is what they are for." Still unable to provoke an expression of rage from the therapist, he changed the question to "If you meet him after he gets out of prison, what would you do?" Concurrently he spilled a box of rubber stamps on the floor.

The therapist said, "You'll have to pick that up."

With a haughty expression he said, "What if I won't?"

The therapist said, "It's not a question of won't. I'm asking you to act like a gentleman. You didn't mean to spill that, so it isn't one of your games in the therapy." Notice the sharing of therapeutic distance and self-observing awareness that the therapist has offered.

The child picked up the stamps and replaced them with care.

The airplane race began in earnest. For about fifteen minutes, planes took off and landed and raced about. There was a collision of planes. The therapist asked what happened. This is appropriate, because it will add data and certainty to his observations and conclusions. It also checks to see whether the child is using the evocative or communicative mode in the use of symbols. The child went into detail in explaining the accident that had occurred.

Then the patient sat on the couch next to the therapist and told him they were involved in a race and that he was the pilot. They are being delayed for takeoff by the "umpires." "Don't you just hate officials? Give them the finger."

The activity of this child seems chaotic. Yet there are scenarios and themes driving the content from within the unconscious. He had been criticized for his rough behavior during a school game that day. However, the session content was not unusual for him and could not be related to that incident alone. His

trouble with others was more the product of his difficulties with aggression control and sexual preoccupations. He wondered how people handle anger. The anger that he had in mind was aggression interpreted with a sexual cast as seen from the viewpoint of a young boy. He was not telling the story of an air race alone. He was expressing anger, defiance, and sexual excitement. His anger as experienced in the session reached such proportions that he attempted to displace it to the therapist. He tried to do this by attempting to provoke the therapist in hopes that he could actualize his own anger in another. He would then attribute the anger to the therapist, while his provocations could be forgotten and as a result, his own aggressions seemingly mastered.

Early Adolescent (Postludic Demise), Primarily Fantasy-Dominated Verbalizations. The final step during psychotherapy in the transition from late latency to early adolescence is the move from the playroom to the consultation room. The child simply feels out of place among the toys and tools for drawing, and may actually initiate the move through a request. If the playroom has two doors, one to the waiting room and one to the consultation room, it is possible to choose direct entry into the playroom from the waiting room or to choose to walk through the consultation room each day on the way to the playroom. If the latter course is chosen during the transition period, the child will find himself confronted with the option of choosing the "talking room" over the "playing and talking room" each session. This eases the process of moving into the consultation room. The child who chooses the consultation room consistently is quite verbal and ready to speak. In fact this is a sign that he has changed his mode of drive expression from play to speech. The timing of the transition varies markedly from child to child. It is usually encompassed by the years 1214 to 14. The shift away from toys toward talk does not mean that now children will speak of their problems directly. Spontaneous introspection into the problems of separation, sexuality, passivity, and mortality will not be shared by the average child for two or three more years at the least. At first speech is used to report on recent events, countercathexes, and reality problems for which an attempt to enlist the therapist's prestige is made.

One should keep in mind that the first task of therapy, which is the uncovering of disquieting unconscious content to be confronted and worked through, runs directly contrary to the primary psychological task of the age period. Shorn of the structure of latency and its tool, ludic play, the early-adolescent personality is busy establishing a new, more adaptive structure for the selective repression of drives and derivatives—*selective,* because some of the drives and their derivatives are prohibited in the

adult world, while others are encouraged by social custom and the possibility of finding objects for the discharge of drives in reality. The effect of therapy at this age could be an undermining of the establishment of personality functions that are important elements in support of superego demands, culture, and defense. One must therefore be wise, and be careful to avoid attempts to puncture defenses in a way that would bring stress contents from the system unconscious into consciousness. Telling the child that by saying what comes to mind we can unlock his secrets and uncover the repressed may be counterproductive in a youngster whose developmental goal and current dearest wish is to put and keep his most troublesome thoughts in repression. One should avoid interventions that would interpret and undo defenses in such a global fashion that the development of the mature personality will be impaired; permit the child to associate at his own rate; formulate questions about the stories the child tells at an ego distance congruent with the distance through displacement that the child has chosen.

For instance, should a child be playing out a battle between soldiers, it is possible for the therapist to enter the game as a newspaper reporter whose questions can elicit details and associations that would not be available through direct questions. Direct interpretation of the child's responsibility for the displaced anger and the unconscious wishes that its presence represents should await one's sensing that the child has already come close enough to the material to be able to come to the conclusion by himself without undue stress. It helps little to bring material to a level of awareness at which it could be confronted or worked through if concurrently there is mobilization of so much anger and affect that it would impair communication or muffle reason.

> Age 13 seemed a bit late for a child to elect to start his treatment in the playroom. This was especially so for this tall, pleasant- appearing, and slightly overweight young fellow. He seemed to be too big for the room. Toys were dwarfed by his hands. He wanted to draw.
>
> His parents spoke of his problems of sexual identity, his shyness and lonely pattern of existence, particularly emphasizing his "addiction" to television. He was the frequent butt of jokes in school and was teased repeatedly. He had trouble sleeping at night because of his fear of intruders, robbers, and thieves. In the initial sessions he gave brief, unelaborated, positive answers to questions about that which his parents had reported. Within a few days of the beginning of the sessions, he described the rapid disappearance of all symptoms and troubles. In answer to all direct personal questions about himself and his problems, he thenceforth responded with variations on "Good," "Fine" and "O.K." This response covered even those questions which dealt with the normal process of sexual development. His words hid his real feelings. The mere mention of sex caused him to become riled, upset, and apt to call the therapist a pervert or dirty- minded person. He often brought in quotes from friends to reinforce his point of view. In spite of this, his activities in the playroom consisted primarily of the production of television dramas of extended duration which contained multiple references to sexuality, which were accompanied by a knowing look or leer. He drew the pictures of each new character and then

handed the therapist the sheet from which to cut out the characters. This help speeded up the process. The characters were then pinned in affinity and marital groups to a cork wall. As the story of multiple affairs, much sadism, few children, murders, divorces, surgery for brain tumors, illegitimate pregnancies, and a few sex change operations unfolded, it was clear that he had watched his television well and had more than the interest of an "actively rejecting prude" in matters sexual. He willingly spun out his stories. However, he refused to see any connection between them and the content of his unconscious mind, or with his problems. After all, they were distant events with no possible relationship to himself. The summer break came and went. With his return, he opted for the consultation room where we could "sit and talk." Occasionally, he drew a picture. There was no attempt made to identify the picture or to connect pictures to make up a tale. The therapist supported this de-emphasis on verbalization woven around the pictures in order to encourage verbalization woven around mental constructs. The content of the sessions changed little at first. He was able to talk about a lessening of teasing in school.

"Why do they pick on me? I don't bother them," he would say repeatedly.

"Why are you with people who tease in the first place?" asked the therapist.

"A lot of people are in the lunch room. I mind my own business and don't bother anyone," said he. Then he remembered that he had had a dream the night before, but somehow could recall nothing of it. "I know you psychiatrists need dreams, but I'm sorry I can't tell you about it," was his comment.

He recounted his visit to a movie with his mother where he saw the movie "Superman." The superhero had been teased because of mildness born of forbearance. The session had come to the end of its time. I told him this and bade him good-bye. As he left the room, and with the door half open, he said, "Now I remember the dream." As he spoke these parting words, the gleeful, knowing leer of old returned to his face. He held out the dream as though he had food to offer to a hungry animal. He was teasing as he said, "I could tell it now, but I don't have the time.

Next time." By next time, the dream was forgotten. His provocative way of handling the dream remained with the therapist. Through teasing he invited an attack on himself. The therapist recalled the French expression, "le pécheur péché" which conveys the meaning that it is the sinner who is sinned against, and that the fisherman alone who drops a hook for the fish to bite runs the risk of being pulled into the sea by his quarry. In the sessions, his repeated gestures of secretiveness, withholding, momentary offers of surrender, and then withholding again were bordered round with hardly concealed excitement. The patient's similar excited teasing of aggressors in the school had, in a not so subtle way, set for him a reaping of the wild wind he had so secretly sown.

The therapeutic task required that his behavior be demonstrated to him, and that the concealed hostility that drove it be brought to consciousness and analyzed to its source. This could not be simple in light of the indirect way that he yielded up his secrets to the therapeutic process.

In the next case, a child went to the playroom after starting in the consultation room.

He had come to therapy because of bullying of his sister, being the butt of teasing in school, and massive temper outbursts at home. At first this wiry 11-year-old chose the talking mode in an attempt to be grown up. Even after he moved to the playroom, he did not use toys or drawings as more than things to handle out of curiosity. He did not develop stories or organize the toy material. Instead, he used the playroom's space and permissible freedom of movement as a place in which he could throw a ball up and down and in general release physical tension. This is a physical equivalent of the ordinary teenage use of paradoxically calming, strongly plangent, raucous music. The tension release so achieved permitted him to converse about his problems with

the therapist much in the way that loud music helps teenagers to study, or sound-makers, fans, or air-conditioners help them to sleep.

Theoretically, these activities and sounds can be viewed as projection, actualization, or externalization of internal, potentially disruptive masturbatory excitements.

This case and the next illustrate techniques for bringing topics into sessions when the early adolescent, who is using communicative speech and tertiary elaboration to discuss social issues, sports, and entertainment, chooses to avoid a spontaneous self-reflective exploration of manifest problems. The technique is to ask questions or pick up on topics related to the reasons for which the child has been brought to sessions, and also information about ordinary ongoing events in the child's life. One should ask about school progress, report cards, weekend activities (before and after) if the child does not bring up these topics spontaneously. Parental letters or telephone calls should, within the limits of tact, be brought to the attention of the child, with emphasis on events that reflect the child's problems.

The boy came clattering into the playroom encased in the 11- year-old's full regalia, including helmet, face mask, and mouth guard, of a football player ready to play. "I have to go right from here to the game."

The therapist evinced great interest in the sport, asking how long the youngster usually is in the game.

"I'm usually in for three quarters," said he. "Trouble is, I may be cut because my marks aren't good."

A discussion of the trouble he was having in school ensued. Then he fell into silence while he played with a ball. Undoubtedly he was comforting himself with something he could do well after revealing his deficiencies. After an appropriate time to let him heal his wounds in this way, the therapist brought up the topic of a call left on his answering machine by the child's mother. He suddenly became angry and had a temper fit for which the mother could find no cause. "He ran out of the house and we couldn't find him for hours. No one knew where he was hiding. We finally found him. He had climbed a tree. He was hidden by the leaves. All the time we were looking for him, he was watching us."

The therapist chose to enter this topic with a parsimonious question that would permit the child free rein in avoiding the topic as well as freedom to expand on it without being forced into a digressive and therapy-blocking defense should the mother have seen events differently from the child. Note the use of the interrogatory form of intervention. The therapist wanted to force an answer. In this way he would focus the child's attention on recognition of the recent unpleasantness as his own (the child's) problem. A question that could be avoided because of insufficient recall for the experience during latency cannot be so easily deflected during early adolescence. In early adolescence, one may expect that the

child will remember important events as contrasted to the child in full latency, for whom fantasy defense provides countercathectic repressive forces that result in a dropping from conscious awareness of important experiences.

"What happened on Sunday?" asked the therapist.

"Did my Mom call?" answered the patient.

"Yes," said the therapist.

"It wasn't as bad as she said," demurred the patient in advance of the therapist's information.

"What?" said the therapist.

"I wasn't so angry," the patient replied.

"The tree?" asked the therapist.

"I got angry 'cause I wanted to go with my mother, and she wouldn't wait for me till I was done with the TV," said the boy. "No one listens to me. My sister got a new bike and clothes and stuff and all I got was a book. I ran and went up the tree to calm myself."

"How else do you calm yourself?" asked the therapist.

"I listen to music you wouldn't like. I don't like to go to my room. I get away from people."

"How does that solve the problem?" asked the therapist.

"It doesn't, but I get calmed down," the youngster rejoined.

The therapist then pointed out, "Have you thought of talking to your parents directly about how you feel? Calming things stop anger, but the problems are still there the next day."

The youngster complained in response, "It won't make a difference. They won't listen. They don't care a s—t about me."

In this exchange was revealed the underlying complex of sibling rivalry and feeling of rejection that gave rise to the seemingly cryptic anger reported by the mother. Thus, it was brought to the surface to be worked on. This kind of data should alert the therapist to poor parent- child communication. The youngster had improved markedly from the very beginning of the therapy. This was less the result of therapy than the product of a sense of importance in that his parents now thought enough of him to give him therapy. There was obtained thereby a reversal of the lack of parental attention that he had felt

existed.

The following case focuses on the approach to the patient's associations that makes it possible for both therapist and child to bring into awareness trends that are unconscious and that shape the child's life avoidances and sensitivities.

> Hilda was 15, frail and thin, with a firm belief that her parents should take no part in her life.
>
> She limped into the session, threw herself into a chair, gave a sigh of relief, and stared at the floor. After four or five minutes of musing while studying the rug, she began an almost imperceptible humming. She tilted her head till she could see me with one eye, while the other eye squinted tightly.

If you object to a patient who starts a psychotherapy session in this way, stay with the treatment of adults. A high tolerance for aberrant behavior is needed in work with early adolescents. They need such behavior to set the session off (isolation) from the rest of their lives, to create a mood, to proclaim their equality, and to gather together their energies for the difficult work of facing themselves.

> She opened her associations with "I'm grounded again. My folks finally figured something out. I told them I wanted to spend the night with Jane after the church social last Saturday night. They told me to get home by two. How can I tell George I have a curfew? They figured I'd be with him all night. They said so. I got so mad. What is it their business? How are you supposed to get laid? When I got to Jane's house I got so mad I started breaking things. I kicked the thing in the fireplace. How do you know if your toe is broken? Do you think I need an X-ray?" Looking at her foot. "I couldn't enjoy anything. George was mad. I finally got home at 5:30 in the morning. Can you imagine? They were waiting up for me. The chauffeur was up. The maid was making them coffee. They were eating cake. (Pause) Can you imagine,—They were having a party. When the h—1 do they get laid? They grounded me. The worst thing is that now I'm going to be in more trouble, 'cause they haven't got over this and already I got something else to worry about."
>
> Up to this point the therapist sat quietly. The child had by this age acquired much experience in extremes of anger at her parents, and could tolerate it without fear of loss of the relationship with them or danger that unfamiliar levels of anger would activate either the internalization of anger (depression) or the projection of anger (paranoia). However, he should have given second thoughts to the self-injury that the anger produced when she kicked the andiron. The therapist waited out the storm and permitted the patient to discharge affect until she could calm down. When her thought content switched from past concerns to apprehension about the future and she began to slow down her affects, he asked "What's the something else?"
>
> She thought for a moment and began to sift through her concerns. Report cards were due to be sent home shortly. She was due to fail in chemistry. "My average is 85. But the nutty teacher is going to give me an F because I didn't get the lab reports in on time."
>
> There is now enough information for the therapist to recognize and share with the patient through interpretation one of the sensitivities that arouse such rage in her. She becomes angry and defiant when she is forced to match her time schedule to the demands of others. Note the content of the above associations. They follow closely fifteen unbroken minutes of free association during early adolescent psychotherapy. They begin

with a period of silence during which she waits to begin the therapy at a time of her own choosing. Then she tells of her rage at her parent's intrusion on her all-night social schedule. Finally, she speaks of school failure as a result of a defiance of academic deadlines. One such incident could be an accident. Two could be a unique and accidental confluence of similarities. Three such associations, including one which was acted in during the therapy call for a therapist to pursue the possibility that there is an unconscious pattern in action. When the therapist pointed out the similarities of theme to the patient, she became quite muted, seemed to think for a moment, and said, "You say whah!" The therapist remained silent. The patient began to talk of her next weekend schedule.

Note how much the patient is involved in the present moment and her affects. In the overall picture, this represents her wish to grant priority to her own schedule. She just cannot see time and responsibility from the perspective of adults. It is not unusual for youngsters to be so involved in current troubles that they miss telling about important events. It is necessary, therefore, that the therapist ask about events of the past weekend that have been ignored or of the next weekend that loom in the near future and are important. The perspective of young teenagers is skewed in that their capacity to place proper emphasis is not weighted as is the capacity of adults. Their object-ground differentiation tends to idiosyncratic personalizations of what is important.

Questions about the child's current affairs and scheduled events often must be asked by the therapist in order to keep himself informed to a level adequate for the responsible conduct of a therapy. In asking such questions, one should be aware that one may be trespassing on the child's priorities and that transference anger may be generated. If the child is angered at such questions, interpretations that refer the anger to its source in the child's preoccupation with control over her own schedule would have been prepared for, in the case of the present patient, by the explaining that she had become angry at being forced to match first the time schedules and then the contents of the session to the presumptive priorities of others.

The complex psychology of late latency-early adolescence is characterized by an underlying developmental theme. This is a period of transition to those cognitive skills that emphasize realistic evaluations of observed phenomena, as opposed to intuitive and self-oriented interpretations. During this period, the needs of others gradually come to influence the planning and decision-making of the child. Concordantly, social demands guide the superego, and the schedules of others come to be respected. As a result of these developmental characteristics, the techniques of psychotherapy must be more varied and pedagogic in aim than those typically used when dealing with adults with settled, adult

ego functions. Early adolescents often have to be reminded of social demands that in adults have been internalized. As we have said, the social contexts within which people coordinate their lives through conventions of time and the use of schedules become the topics of interpretations. Age-specific psychological phenomena, such as delayed or neglected cognitive development, must be monitored and interpreted. Often, the behavior of the therapist becomes the pattern upon which the patient bases his identification with social uses and accepted customs.

> This 17-year-old was short, thin, and frightened when first seen by the therapist in the disturbed ward of the county mental hospital. He had been admitted the night before. He had lost control of his anger at home and expressed it by smashing the tiles in the bathroom of his mother's home. The police had been called and had brought him directly to the hospital. His affect was appropriate and there was no thinking disorder. He spoke of his life at home with his mother and sister. His father was rarely home, and remained a shadowy figure throughout the treatment. His mother was constantly controlling. No attempt at adaptation to the environment for the children had been made by the mother. School attendance had been spotty. He had never worn a belt or a tie. The main source of his argument with his mother had been his refusal to finish his dinner of *baby food.* His mother served mainly strained food to the children. His sister, who was 12 years old, had never eaten anything but baby food. He had eaten more age-appropriate food on occasion when taken out by a concerned uncle. There was no identifiable mental illness. His uncle arranged for him to be in therapy after his discharge from the hospital. In addition, he obtained for the boy a job soldering connections on prototypes of electronic weapons. He was quite conscientious. He saved his money. He was a messy but accurate solderer. In the therapy he spoke of his rage at the extreme passivity that dominated his position in the home in relation to his mother. He hoped someday to move out and to provide help for his sister. One day, he appeared particularly apprehensive upon entering the consultation room of the therapist. He stared at the therapist's tie. When asked about this, he revealed the following: "The boss on the job has invited me to dinner. I keep looking at you to find out how to dress and what clothes to wear. Looking won't help my problem. Please teach me how to tie a tie. How do you use a fork when you eat?"
>
> Sometimes we take for granted that children know more than they do.
>
> Let us return to the case of Hilda.
>
> She was so taken up with her own needs that she could not consider the needs of others in the organization of time, or their concerns for her whereabouts, safety, or mores. This came to a head during family preparations for a summer vacation. She wished to go on a teen tour. Her family did not object to this. However, they were perplexed by the fact that the tour she had chosen conflicted in time with the wedding of a cousin. They wanted her with them at that time. They suggested that she take a slightly different tour that would fit in with their schedule. Her response to this was "S—t no. I refuse. Why can't they leave me alone?"
>
> "Do you want to go to the wedding?" asked the therapist.
>
> "Sure, but I don't want to give in," she answered.
>
> Her parents eventually hit on a solution. Since the teen tour passed near the distant city at which the wedding was to take place, they offered to arrange to have her leave the teen tour for a

few days in order to attend the wedding. "You know," she said,

"I have to admit they're being fair to me—to you—but I'll never admit it to them. They worked it out so I won't really lose anything. How did they do that?"

"It's called love. Keeps families together. You've got to give to get," said the therapist neatly summarizing the concept that love means taking the needs of the loved one into account before one's wishes reach the planning stage.

She used this information in a somewhat self-serving way, which gave evidence, however, that she had absorbed the concept. She began with an awareness that she had a right to be treated by her boyfriend in a ". . . loving way. I see him. We have sex. Then I do a slow burn. He leaves me alone for the rest of the day while he gives his pals rides on his motorcycle." She told him good-bye. Then she began a relationship with a boy who "calls every day," builds his free-time schedule around her, and pays attention to her whenever they are together.

The Interpretation of Dreams in Early-Adolescent Psychotherapy

Spontaneous dream reporting is rare in the psychotherapy of latency- age children. The same material that could find its way into therapy sessions through dream (oneiric) symbols can be expressed in the near- at-hand medium of ludic symbols. Fantasy play serves a function so similar to dreaming that insights into one of these fantasy forms can help in understanding the functions of the other. The early adolescent, having lost the functional capacity of ludic symbols to communicate or to evoke inner moods, must turn to dreams and fantasies, in which reality is manipulated to a form in which it will be able to carry the message of the unconscious into therapy.

Dreams are not so much different at these different ages. Their use, primacy, and effectiveness as discharge or communicative psychological instruments undergo a transition during the period of cognitive changes of late latency-early adolescence. This transition contributes a perceptible difference to the psychotherapeutic interpretation of dreams during early adolescence. In working with latency-age children, dream interpretation yields little if it is based on waiting for the child to associate to individual symbols. If a symbol can be made into a cardboard figure and introduced as a play-toy, the fantasies built about the cardboard figure can be seen as dream associations.

In working with adults, dream interpreters in dynamic psychotherapy use one or more of four techniques. First, there is the technique of asking the patient to look for elements in the events of recent days that the dream reminds them of. This produces links between the dream and unprocessed, stressful

events that require more effort for mastery. Second, there is the request that the patient respond to each dream symbol by saying what comes into his head in association to the symbol. Third, there is the technique of avoiding focus on the dream while the therapist seeks enlightenment by considering the content of the *entire session* to the associations to the dream. Fourth, there is the study of the secondary elaboration of the dream as a source of information or confirmation about the core fantasies that identify the sensitivity and predilections of the patient in his current life. *(Secondary elaboration* refers to the organization of the disorganized mélange formed by the dream symbols into a coordinated tale with sense in its relationship of one element to another. It can be differentiated from tertiary elaboration in that the latter creates order for a listener, while the secondary creates order for oneself.)

In early adolescence, it is possible to ask about day residues and to pursue the use of the session as an association to the dream, as is done with adults. Because of the limitation on abstractions during early adolescence, free association to dream symbols is not particularly productive. On the other hand, the pursuit of secondary elaboration (themes that tie together content) can be very useful in giving clues to problem areas and defining goals for the therapy.

> A young man of 19 had never lived away from home. He was greatly attached to his mother, and tried his best to substitute for his father as the man of the house. His father and mother were estranged, and the parents had lived apart for years. During a period of expectation prior to his father's return to the home and his parents' reconciliation, he had the following dream:
>
> He was in Russia . . . with his mother . . . and two brothers .. . they ran as they were being pursued . . . his mother fell a couple of times . . . each time, he picked her up.
>
> Each individual unit of the dream was inquired about. There were no associations other than those that expressed wonderment at the flimsy relationship that the units had to him. The family was originally from France. Although the dream consisted of symbols selected from realistic representations, it was fantastic in content when considered in the context of the patient's life. No day residue could be uncovered. If viewed as a symbolic representation of an oedipally involved young man, one can see parallels to his current life situation and problems. He escapes to a strange land with his mother. Someone pursues (guilt—the father?). Her falls represent her ambivalence as conceived by the boy. He reinforces their flight by helping her up. What has been done by the dream interpreter is to guess at the core fantasy that predicts and shapes the boy's fate. The oedipal fantasy is chosen from the usual currency of fantasies active at this age in young men who have failed to achieve removal, because of the similarity of elements between the manifest dream and the oedipal fantasy (i.e., the child is allied with the mother against a pursuing father). There is no certainty that this is the operative fantasy; however, in the absence of associations to the dream, the oedipal fantasy can be used as the basis for theories and interpretations. Should this tack steer the patient's thought toward confirmatory associations and unlocked memories, the guess will be worth the risk of losing time.

With this model for the handling of the early-adolescent dream in mind, let us examine the dream

of a 15-year-old girl.

> The vital facts of her life at the time of the dream were that she was sexually inexperienced and thought of sex as repulsive. Still, she was excited by boys and attracted to them, and was being courted by her first boyfriend. She lived with her mother and half-sister. Her mother often referred to sex as an unnecessary burden. Her father, to whom she had been close as a companion and confidante, had been divorced by her mother when she was 10. He had moved to Europe two years before the dream. Her mother had recently remarried. Her stepfather paid little attention to her; she stated that he only ". . . takes me out or talks to me as part of being with my mother."
>
> She started the session with the statement, "I don't want to see my boyfriend anymore and I don't think he wants to see me. What a nerd. That goofball. Can you imagine—he wanted me to unzip his pants! In the movies yet. What does he think—I'd know what to do? I don't know nothing. I never did nothing. He keeps nagging, nagging. If I even think about it I get antsy. I get this sandy feeling in my mouth and my throat gets all up and full and feeling funny. What does that mean?" (pause) "Oh God! don't say that!"
>
> "What," said the therapist.
>
> "You know . . . (slight pause) . . . Oh, I could throw up! You know, and if you don't know I'm not gonna tell you. (Note the typical softness of repression that marks the transition period from latency to adolescence. Bereft of repression-supporting fantasy symbols and not yet fully protected by the countercathectic defenses of adolescence, the contents of the repressed unconscious come to consciousness spontaneously as well as at the behest of interpretive psychotherapeutic work.) "Why does there have to be boys? The whole d—n thing is disgusting. You like dreams. I had two last night. I only remember one," she said.

She then recounted the dream that follows. The dream, though quite long as presented here, has been edited. One of the characteristics of the typical early-adolescent 15-year-old's dream is its immense detail and length. This is a characteristic that is shared with the latency-age child's dream during treatment. Often the entire session is occupied by the dream recital. This characteristic shapes the potential for dream interpretation at this age. Focus on individual dream elements is difficult. A search for a day residue becomes like a search for a needle in a haystack. In broad overview, secondary elaboration includes the influence of all the dream elements it has been forced to provide for in the synthesis of a story that can make the dream as a whole seem related, internally consistent, and relevant. Note that the softness of repression that characterizes the period of transition between late latency and early adolescence also makes confirmation of interpretation and subsequent working through more accessible than is customary with adults.

> The dream resolves into three segments—
>
> *Segment one:* "I was walking alone near the train station. I went into the station to get a drink of coffee. I saw my father there. I went over to him and said 'Hello.' He gave me a hug. I told him to come back to the house.

He said he couldn't. He stayed with me at the train station."

Segment two: "We were talking. He was holding my hand. Some foreign looking men came over to us. One of them gave the sign. You know it? They tickle your palm with their finger. It means I want to lay you. Imagine with my father right there. He didn't make a difference."

Segment three: "Then I was in a car. My father wasn't there. I was driving. I couldn't drive. I went from one side of the road to the other. I almost went over the side a couple of times. Then I woke up."

The theme of the dream that ties it together is the presence or absence of her father. Each segment of the dream is distinct in content from the other. The child calls attention in each segment to the presence and the absence of the father. With or without him she is alone and unprotected in the world, either from her own uncontrolled drives, as in driving the car, or from the approaches of men.

Questions about the individual dream elements were met with blank responses. The total context of the session during the time preceding the dream dealt with some of the problems reflected in the dream, such as controlling the drives. However, the total status of her mental adjustment, which included depression, feelings of loss, and a sense of desertion by her father—which were available from her life history—was introduced into the session through the symbols of the dream.

The therapist said, "You feel your father left you to deal with life alone."

She became angry and tearful. She felt ". . . so alone. I want a boyfriend 'cause there is no one to be with at home. I used to have girlfriends. But they have boyfriends. If my father was here, he'd take me out like he used to. I got this boy. He's kind. But he wants what I don't know to do. I think my father is there and telling me to be a good girl. It don't help. Dating isn't the funnest thing when that happens. I'm so ugly. I won't get another boy. I know. Life sucks. Why live when everybody is unhappylike. I don't want to live. I feel terrible." She spoke about her feelings of being deserted by her father. The depression that lay beneath her earlier manic-like excited associations could no longer yield to the pressure of denial. She became aware of her anger at her father and verbalized her fear of establishing close relationships with boys in which she could be hurt again. She began to withdraw into a defensive nihilistic denial of the value of life. If all were valueless, then the hurt in comparison would be of no importance. At the end of the session, as she went toward the door, she began to take out a cigarette and said, "What's the use of living, if it's so hard and you're only going to die anyhow?"

The therapist pointed at her hand and said, "Why enjoy a cigarette now if it's going to be all burned up, useless, and thrown away in a few minutes?"

"You got a point there," she said.

Transference in Early Adolescent Psychotherapy

Transference as used in psychotherapy refers to an expansion of a psychoanalytic concept. In psychoanalytic theory, transference describes the recall of a past experience through a reliving of its content or a derivative memory which in the here and now takes the form of an action or fantasy that involves the person of the therapist. The recall can be expressed through events that are part of a

psychoanalytic situation. Should the action or fantasy be modified by defenses to produce a symptom, the resultant syndrome is called a *transference neurosis.*

In psychotherapy, there are a number of phenomena considered to be transference also. The form, shape, and usefulness of these phenomena during late latency-early adolescence differ according to the nature of the past experience relived and the level of maturation of the cognitive structures that both shape the manifestations of transference and provide the capacity to achieve insight and understanding.

All transference manifestations have in common the psychotherapeutically useful characteristic that the therapist can use the patient's transference experience during the session as an incontrovertible example of a character trait of the patient. In the presence of cognitive maturity that will make insight possible, such examples can be used to anchor verbal interventions to recent experiences. When the therapist links the mutually observed transference experience of the patient with related and similar experiences reported by the patient during present or previous information-gathering therapy sessions, a psychotherapeutic intervention called an *interpretation* can be produced. One expects the patient to respond to interpretation with recollection of information that can be used in the therapy to understand many aspects of the patient's current behavior. The latter process is called *working through.*

It is possible that while a patient reviews and reports pertinent events in his life, he may gain intellectual insight into his idiosyncratic patterns of behavior. This provides only moderate therapeutically induced leverage in the direction of mastery of these patterns. Fantasy play contributes mastery through discharge and also, to a small degree, through increased awareness of such patterns. Insight involving drives and the resolution of neurotic conflict depends upon the appearance of new data during free association that follows a transference interpretation. Once this activity affords the patient experience of the origins of today's behavior patterns in drive-impelled memory traces from the formative years of life, it becomes possible to turn the exploration of current psychopathogenic patterns of behavior into therapeutically effective working through of problem areas. Note that the same verbalizations on the part of a patient can be either conversation or psychotherapeutic working through. What makes for psychotherapeutic working through is the existence of awareness that the behavior in question is a repetition, on the time plane of the present, of patterns whose potential for causing difficulties has been seen both in the transference and in recall of early years. Essentially, one shows the

patient during working through that a single episode of a given behavior does not serve the rationalization to which it is assigned by the patient. Rather, the rationalization (i.e., secondary gain) is an afterthought that hides the now demonstrated fact that the behavior serves an internal and secret scenario which in turn mediates the needs of drives from ways and days that once were lost in the tomb of time.

The Fantasy Components of Early Adolescent Transference. The fantasy components of transference in early adolescence are derived from past experiences. These past experiences consist of:

> Early maternal care—the child is primed to relate to the kindly ministrations of the therapist by past experience of being able to turn to mother and have injuries soothed. The prior experience could be called the "band-aid" stage. This contributes to "positive transference." This produces a state of expectant cooperation. Its existence should not be pointed out to the early adolescent unless it interferes with the treatment.

A 16-year-old girl with an acute phobic reaction found that she could travel anywhere as long as she had with her a pill which her therapist had given her. "It's like you are there with me," she would say.

> Traumatic experiences—These are such as occur when the therapist is identified with a hostile relative.
>
> Early infantile wishes that have never been fulfilled—These are exemplified by wishes for tender caresses, that have been thwarted either by an emotionally distant parent or by the establishment of internal prohibitions in the child to the expression of these needs as a result of inhibiting and drive- expression-limiting behavior on the part of early caretakers of the child. This is the only manifestation of early experience that can occur during the psychoanalytic situation that can properly be called transference. Rarely can this be seen in psychotherapy. This rarity gives rise to the broadening of the concept of transference to include most reliving of any early experience in the psychotherapeutic situation. Infantile wishes that have not yet come to the surface—The child has not yet reached a stage in which it would be appropriate that they appear. These include phallic-stage wishes in an anal-stage child. The therapist is the first or primary object to which drive derivatives are directed simply because of the circumstance of being present at the time the drive manifests itself. Such transference is not a characteristic of early-adolescent psychotherapy.
>
> Phase-appropriate wishes, both pregenital and genital— These are wishes (e.g., oedipal wishes) that have broken free of the fantasy defenses of latency, and following the shift of symbols away from fantastic referents and from the primary love objects (the parents), settle for a moment on the therapist while on their way to peer objects and lasting relationships. This phenomenon is primarily a characteristic of the psychotherapy of early adolescence. It can be viewed as a phase in the process of removal (Katan 1937). *Removal transference* touches the therapist as it brushes by on the way from the parents to a peer. There is a remarkable similarity here to the "transitional object in statu nascendi" described by Winnicott (1953). A growing need comes from the increasing pressure of the drives as the result of weakening of symbol-based defenses and stronger hormonal influences. The therapist's role as the armature around which transferences are formed makes him the perfect target for removal transferences. These transferences are particularly perilous events in early-adolescent psychotherapy. The peril arises from the fact that the transferences serve as formative testing

grounds for ensuing real-life experiences. Erotically tinged removal transferences can usher in sexual acting out with peers. In addition, libidinal energies needed for the therapy may be withdrawn from the therapist when an erotically cathected peer appears. This could result in the decathexis of the therapist and a premature termination of the patient-therapist relationship.

The Structural Immaturities that Produce Early Adolescent Pseudo-transference. Because of structural immaturities, there are psychotherapy situations involving the therapist that appear to be transference. The patient appears to be making fun of the therapist in what seems to be a transference. In actuality they are not the recreation of prior experience; instead, they are the products of the misunderstanding of the use of verbal communication. This is likely to happen when the child feels that he can claim that something is a likeness of something else, when actually it is not in any way a likeness. A prime example of this is the use of words as though they were capable of producing realities at the moment they are spoken.

Ptah was 11 years of age. Strong of face and lean of limb, he actively voiced his preference for the playroom because "I feel more comfortable here." Yet he did not play out tales with the toys. Rather he threw a ball or kicked a sack. In his mind he played out competitive ball games with peers or showed off to me his peerless skills. He was willing to talk freely about his problems with aggression control, which made life difficult for parents, neighbors, and schoolmates. His concomitant fear of thieves who might come at night (projection of aggression) was amply documented by his parents. When they were brought up, he discussed them freely. This resulted in a resolution of his fears, since he was able to confront his anger as his own and thus master the need to project anger. There was marked improvement in his persecutory fantasies; they dwindled to a minor element in his symptom configuration. Soon he ceased to speak of his aggressive behavior. Therapy sessions threatened to become part of a fitness program for him. Then his mother called to tell me that he had broken a window. When his mother's report was mentioned to him, he flushed and said, "She told you that. Damn! She told you that. Why did she have to tell you that. What a fool. If she tells you that how can you believe me? Now you know that, I have to stay here longer. How long do I have to stay here now?"

Even though his mother wished the aggression to be brought into treatment, the child felt that if I were to say he was better, he would be "better" and could stop treatment without the bother of working through his aggressive behavior. "My mother says that when you say I'm done, I'll be all better." He interpreted this in the light of his own attitude toward words. He felt that my word would be accepted as truth just as he expected his words to be accepted as truth. He had no conspiracy with his mother. Yet he depended on her for silence in support of his manipulative use of words to render his cause plausible.

It was explained to the boy that words cannot create reality, they can only reflect it. "When you say something, I don't listen for your words. I listen to what you are trying to tell me. It has to fit in your whole world, or I know it isn't true. Your world has your mother in it. What she says helps me to see the whole picture. You wouldn't be here if she wanted to help you fool me. If you could make up real things just by saying them, you would be very powerful. People who think they can do that get into trouble because they make up their own rules. Lots of times there is no room for such people. Then they get picked on and disliked."

While the therapist was alternately "naying" and weighing the introduction of the proverb "If wishes were horses, beggars would ride" to a child whose thinking had not reached the level of abstract operations, the boy

> blurted out, "I used to think I came from another planet. I was so sure, that I must have asked my mother if I was adopted a hundred times. That's why I always wanted to play 'Star Wars' when all the other kids wanted to play cops and robbers. I was waiting for my family to come and get me."

In the session, the therapeutic activity is twofold: First, it serves to modify the omnipotent use of words as magic instruments with an existence independent of the reality that all people test and share. In a second and larger sense, one of the processes that support the hyper- cathexis of fantasy in preference to reality is being confronted and undermined. Early adolescent reactive narcissism is being undermined.

In the course of a session, the child is being led through a recapitulation of the cultural evolution of man's use of words from the use of words as things to the use of words as representations of things and concepts in memory (Sarnoff 1987a). The therapist must have sufficient cultural background to appreciate the role of culture in developing cognition. With this background, he will be able to recognize as normal those developmental levels in late latency-early adolescence that represent pathology when found in adults. This patient, for instance, is using a cognitive thought pattern that would be markedly pathological in the daily thinking of an adult. In the latency-age child, the ability to use words as realities strengthens the fantasy-forming defenses (the structure of latency). These defenses depend on the creation of fantasies that have sufficient sense of reality to permit drive discharge. Once the child begins to enter the object-related world of drive discharge that marks early adolescence, such styles of thinking must leave the area of personal life. They may persist in the passive experience of political, religious, and ethnic myths. Persistence in the child's personal life leads to strong fear fantasies and may presage omnipotent thinking in adolescence and adulthood. Such use of words as things and the creation of personal realities unaffected by the presence and needs of others must be attended to if the child is to become capable of relating to others and falling in love as an adult.

In Western culture, the capacity to create matter, situations, or truths through the use of words is limited in attribution to deities, or those who have been deified. In ancient Egypt, before there was Nephthis, before there were Osiris and Seth, there was a god who made all the things of the earth by speaking their name. The Bible says in the Gospels, "In the beginning was the word." In children, such belief in one's own speech is a warning of a spillover of the normal narcissism of latency into adolescence. In adults, when "one regards as a likeness what is not a likeness" (p. 297) (i.e., the equation of words and

reality), it is a sign of mental illness (Aristotle, circa 340 B.C., 451 A 10).

The therapist's experience of normal thinking in adults becomes, unfortunately, the model for comparison in his observations of children. As a result, pathological deviations in adult thinking become for the therapist the only recognizable childhood deviations in thought. Because children are evolving adult thinking patterns, there are to be diagnosed in addition maturational lags in thinking, whose origins are to be found in styles of cognition that precede modern thought. The labyrinths of the human psyche extend beyond the perigrinations of a single human experience during a single lifetime. Modern cognition is the product of eons of insights and codifications, and integrations of these insights into socialized patterns of thought. These in turn become the basis for the maintenance and continuity of social institutions. The thinking of children contains elements of outworn ways of thought that are normally challenged by the precept and example of parents, peers, and teachers. In this way the path is cleared for the potential for more effective and acceptable forms of thought to mature. Nowhere is this more sharply in evidence than in the organizations of memory and in definitions of truth.

Quite accurately, the therapist was able to tell that the patient's creation of an image of himself solely for the therapist was neither a "cute" saying by a child, worth repeating to others, or a transference based on libidinally charged memories in search of expression. His knowledge of the evolution of thought forms caused him to diagnose instead a cognitive developmental lag or fixation. The works of many thinkers (Cicero, Aristotle, Piaget, Freud, the *Ad Herrenium,* quoted in Yates 1966) contributed to this understanding. The therapist was aware that what his patient told him was an anamnesis rather than a history or memory. If we define history as the story of what has happened as reported by many observers, we recognize the possibility of reality testing the recall of past events. If we define memory as all that the patient is capable of retaining of an experience, we recognize that under even the best of circumstances the whole truth is not available to the patient. And if we define anamnesis as a recollection which is an ". . . excogitation of true things, or things similar to truth to render one's cause plausible ..." (Cicero, p. 8, quoted in Yates 1966), we shall recognize that anamnesis can be a conflation of memory elements with the primitive thought process that creates truths out of words. This produces the immature cognition of the patient.

A therapist who is equipped with such knowledge about cognition and thought is removed from

involvement in conversation in therapeutic sessions. In addition, he is able to recognize that situations that involve the therapist are not automatically transference when one is dealing with children in late latency-early adolescence. Instead he is able to view from a distance the processes of thought of the patient, recognize deviations, and devise therapeutic strategies with which to confront them.

Recruitment and Metamorphosis through Transference

Because *removal transference* (defined on p. 206) is an early step in the establishment of object relations during late latency-early adolescence, the therapist is often in a position to make therapeutic inroads into the patient's personality through his behavior and thought style rather than through interpretation and insight.

> She was tall and willowy, winsome and wily, and wise beyond her 16 years in the ways that women sway men. Her father, who was fascinated with her, could easily be made "to see the light" when she became flirtatious. She had been sent to therapy because of an unexplained drop in grades that was directly relatable to clouding of thinking following marijuana use. A pout had crossed her face when she was told that the therapist would not call her parents to tell them that it was all right for her to sleep over at her girl friend's house the following weekend. As she got up at the end of the session, the pout turned into a sweet smile. She advanced toward the therapist. He moved back slightly and offered a handshake. "I only wanted to give you a hug and kiss good-by," she said.
>
> "Kisses and hugs are parts of a different kind of situation. Therapy has to do with thinking. Let's talk about it more next time," said the therapist.

She had tried to recruit her therapist into the interpersonal interactions of her fantasy world, but had received from him a pattern upon which to base a character metamorphosis.

> At the age of 10, it had already become clear that the gracile young lad who spent hours in the playroom playing out brutal combats with toy soldiers felt no need to work diligently in school. His low marks had placed him in a remedial classroom where he was separated from friends whose level of intelligence and perspicacity he shared. He met with them after school. He felt left out of their school talk and was beginning to suspect that they were talking about these matters as a mean way of leaving him out of things. He had come to therapy because of the disruption of the household that resulted from his constant provocations and fights with his mother. His mother contributed to the problem, for she had difficulty in containing herself when he refused to clean up after his dog, left clothing on the bathroom floor, or left his socks and toe pickings on the living room cocktail table on the evening of a party she was giving for socially prominent people she had hoped to impress. As often as not, he reported that he was unable to do his homework because the fights with his mother upset him so that he could not settle down to study. He spent his time in the sessions playing out robberies and war games using toy soldiers. He spoke often with the therapist; however, psychotherapeutically effective communication was shied from by immersion in play. The therapist equated the games with fights with his mother. The child made no verbal response. He just played on. The therapist began to think that he was a very nice boy with a nagging mother and no internalized tendency to become a partner in sadomasochistic

wrangling. There was marked improvement in his behavior at home. This could be attributed to discharge of tension through displaced playing out of battles in the playroom.

Concurrently, something strange was happening in the office. Not always, but often, the toilet paper in the bathroom became tied up in a knot. Sand deformed the soap. Emergency lighting fixtures became disconnected. Other children, taking heed of the events, began to engage in similar pursuits, so that identifying the culprit was difficult. It's hard to place blame on a child for a type of destructiveness when there is someone who already has admitted responsibility for a similar disruptive pattern. One day, no other suspect had come to the office, and a telephone had been disconnected and a wad of paper placed in a light fixture, incapacitating the bulb. At the next session the therapist described the problem and asked if the patient "knew anything about it."

The patient repeated the description of the misdeeds and then said, "That's mean."

The therapist remained calm through the session. He checked the office before and after the child's visits. It became clear that he was the source of the problem, but not the only culprit. The therapist mentioned each damage to equipment and explained how he knew the child was at fault. "Gee!" said the child, "you don't get angry like my m (his words dwindled to a hum)."

"It's not something to be argued about. It's something to be settled."

After that the patient's contribution to disorganization of the office disappeared. Concurrently, he began to work on his lessons in the professed hope that he could regain his academic position and rejoin his friends.

One can construct the theory that he was in the process of transferring his internalized sadomasochistic patterns of discharging his drives from the family to peers and school. In the process of moving his conflicts from home to the world, he included the therapist. Through provocations that disrupted the therapist's reality and set examples for other young patients to follow, he recruited the therapist into a relationship in which his removal transference could be expressed. Instead of finding a partner in this life expression for the battles of the toy soldiers, he found a calm model who both diverted his energies toward useful interactions and provided him with a pattern for the handling of provocations that might come his way.

His foray into sadism had resulted in the attempt to recruit the therapist into a mutual acting out of the transference. The resulting interaction provided for a model that could produce a metamorphosis of behavior in the direction of the exploration of new realities in place of the persistence of old patterns for drive discharge.

One of the most important differentiating characteristics of psychotherapy during late latency-early adolescence is the chance to get at therapeutic targets early in the life of the patient. Often the patient is

seen just as new styles of thought are being introduced or are just beginning to dominate. During early adolescence, libidinal and aggressive drives are transferred onto the therapist on the way to the world. One might say the therapist catches them on the way. All such transferences and the patterns upon which they are based still have the potential for transience. Secondary gain has not yet had a chance to lock a pathological pattern into place. As a result, therapy during the transition has great potential for producing change. It might be better to say "Shape the personality to start with." This chance to influence is based on the fact that during adolescence the child's personality is first hatching out of the shell that had been provided by the inward turning and narcissistic cathexes of latency. Since one can observe during therapy the initial experiencing of self-world confrontations without parents and without the structure of latency, one is in a position to guide, interpret, and set examples while the structure of the personality is still flexible and more open to influence than when locked into place by an interdependence of defenses and secondary gains. In this regard, one should be especially watchful of the vicissitudes of anger during therapy in these years.

The First Experience of Anger Free of the Structure of Latency in Early Adolescent Psychotherapy

During the period of transition between latency and adolescence, the organizations of defense that have supported latency fall away. The mechanisms that supported them are organized into new systems which focus away from the egotism of latency and toward the altruisms of adult life. Anger, which had been siphoned off into displaced fantasy elements through the mediation of the structure of latency, is now present. The buffer of symbols is weak during the transition. Later, displacements, sublimations, even fantasy and symptoms will be available to be interposed between the self of the child and the people of his world. During the transition, raw anger begins to stir and—for the first time for many of those who have been called by their parents "The best-behaved child I have ever known"—rage begins to disturb their adjustment. Depression, projected anger, anxiety, unrest, and irritability in the face of passivity mark the period. They are signs of attempts to forge a piece of the personality that can be used to modulate the impact of an affect that had been well contained during a healthy latency and now bursts forth into a state of exposure to the elements that cries for emergency relief and the development of a long-term personality structure to deal with it.

When children in this state (the struggle can contribute to discomfort and psychopathology from 11

years of age to the early 20s) come to psychotherapy, the problem is not how to get them "in touch with their feelings." Rather, it is to help them to deal with their feelings and how to handle or avoid levels of anger that they have never experienced before. The therapist is not protected by the presence in the patient of years of experience in dealing with such feelings in financially successful and independent adults. The children who are introduced to such unguarded anger for the first times cannot be depended upon after they have left the session to activate defenses which will result in "resetting" of the personality and a placing of anger on "hold" until the next session. The inadequately defended anger persists, mounts in fury, gives rise to fulminating rage and obsessing about remembered hurts and slights of childhood at the hands of parents and siblings, and draws vitally needed attention and energies from studies and work. Often the anger spills over into raging fights with parents, withdrawal from parents, and even suicide attempts.

> "I feel a dread within me. It comes over me from time to time. I feel depressed and frightened. I love my parents so that I can't stand coming here. Why are you emphasizing my mother so much? Why are you making me hate her?" This was said by a 17- year-old girl whose fear of leaving the house with her friends had started when her friends began talking about going away to college, and her parents told her that she would have no choice but to go to the college they had chosen for her. Her father, an attorney, had sufficient funds to send her to any college, and their choice of a college of their religious denomination seemed arbitrary in light of their lack of involvement in religious affairs. "They want me to marry a boy of the same religion, I think," she said wistfully in the early sessions. As she said this, it seemed to be more of an observation than a pivotal source of anger at passivity in the hands of overcontrolling parents.
>
> In the early sessions, she reported fears of leaving the house because of feelings that she would become upset and not be able to handle the feelings if her mother were not with her to comfort her. This gave the therapist a clue. Such a longed for, comforting companion is often at the center of the conflict as a symbol or source of the repressed problem.
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> "What are the feelings that you have that you fear?" asked the therapist.
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> "I get sad. I feel alone. I'm afraid I'm going to die. It's awful. Sometimes I feel I want to kill myself—I mean, go to sleep for a long time so I don't have to have these feelings for a while," she replied.
>
> "The feelings are present always?" the therapist asked.
>
> "No, only now and then. Most of the time I'm afraid they will come on and that's bad too," she stated. "I can hardly study. I spend so much time listening to records about lonely people. Gee, I wish I had a boy friend." This is another clue to the therapist. Removal was not sufficiently far advanced for the patient to have disengaged her conflictual energies from her parents. He knew that he should look for the source of the conflict in the relationships at home. He noted that questions about a boy friend led to answers that dwindled quickly.
>
> In one session she came in reporting that she was depressed. "Depression is anger turned on the self," stated the therapist. "When did the depression start?"

"On Saturday afternoon."

"What happened on Saturday?" the therapist asked.

"I had a fight with my mother," answered the girl. "I wanted to go out and I couldn't get my makeup. She spends three hours in the bathroom when she has to go and nobody is allowed in there. Why did she have to use the one with my makeup? She sometimes isn't thoughtful. When I told her I wanted to go out, you'd think she would be happy. I wanted to go out and I *wasn't* scared. She wouldn't let me go 'cause she was going out to the library and she wanted me to stay home to make dinner for my father."

She began to feel angry at her mother and spoke of the angry feelings, which were new to her. As is so typical in these situations and at this age, the child was able to feel forbidden feelings of disappointment because of failures of the parents to offer material, financial, or educational advantages that had led to unspoken envy of peers throughout the latency years. Each new session or two brought a new episode of depression, which in turn when analyzed brought into focus another situation in which her self-bound angry reaction, through its lack of expression, had encouraged the mother to take advantage of the child's apparent passivity. It wasn't long before the child could ". . . identify the start of the anger that starts the depression.

Now when I get depressed I try to figure out what makes me angry and then I tell whoever is pushing me around to stop it. Only I use a lot tougher language." "Sometimes it's my brother. . . . Sometimes it's my parents. ... I get scared when I get angry at them. I'm going away. I'm going to need them and miss them, but I can't control getting angry."

Then, one day when the defiance of her mother reached a level that "sounded as loud and bad as when my parents fight," she experienced an urge "to pick up a knife and stab her, or was it me." Now we have come to a turning point in the treatment. An intervention was needed in order to set a course that would permit the resolution of the emotional family situation without interfering with therapeutic progress. To go on with the therapy could relieve the depression and free her from the close and sadomasochistic relationship with her parents, which would surely sap the emotional energies that would make it possible for her to have a boy friend. To stop would leave these problems untouched and leave the relationship with the parents in a sorrier state than when she had started the therapy. To continue the therapy without change could intensify the situation to the point that a severe and dangerous acting out could occur. Suicide attempts and termination of college careers are not unusual in these situations. It was then that she said "I feel a dread within me. It comes over me from time to time. I feel depressed and frightened. I love my parents so that I can't stand coming here. Why are you emphasizing my mother so much? Why are you making me hate her?"

Said the therapist, "I do not choose the topics. I follow your associations and sometimes ask you to expand on them. The feelings that come up here are not brought up for you to act on them or revenge old wrongs. They are brought into focus so you can understand where your fears and angers come from and free yourself from them." These became the guiding principles of the therapy. It then became possible to see that the fights drew her closer to her mother and were being used to counter the feelings of distance and loss that her ensuing departure from mother and home for college promised.

The first experience of anger after the passing of latency has been our topic in this section. Mentioned, but not emphasized, is the strong role of passivity that is both superimposed by the parents and sought out defensively by the child who is frightened of a world of other peers whose sole role in the life of the child is to serve as recruits to play out roles that parallel the neurotic interactions learned from

the parents. Often a child is afraid of sexual and other new life situations because of expectations to know more than he or she can ever know, and from fear of attacks by potential partners for lack of sophistication. "What will I do? . . . What does he (or she) expect of me? ... If I say no, will he be angry?" The projection of anger into a situation that is seen as indicating humiliating passivity is great in a child with little experience of expressing anger. The reactive anger the child fears is brutal. For the therapist, it is wise, rather than to explore the source of the anger alone, to add supportive comments that will permit the child to understand that there is no need to remain in any relationship that is so uncomfortable. After all, peers are not parents. One is not bound to a person with whom the shared history goes back a few weeks. The reality that others cannot expect any more from them than that for which they are ready can sometimes be conveyed by the reassurance that "sophistication is a cumulative thing and that people who would reject one cruelly for its lack are better done without."

During the transition phase there is a strong push toward object- relatedness. The world arena for the discharge of the drives presents a hitherto open field within the boundaries of which the child can explore. Except for those who project their hostilities into the world newly found, this is a time of great excitement. The transitional child either greets the new world in an object-related, reality-oriented way or enters through the bridge of projection into a world that is known through assigning it the role of persecutor in areas with which the child has had some experience. The most angry and troubled children turn their energies away from the object world. Their energies become involved in their own bodies. They distort their body image, as in anorexia nervosa or become, in rare cases for this age, hypochondriacal. These develop delusional fantasies about their body parts or organs. Intensifications of symptoms come in times of increased anger and feelings of passivity. They reflect feelings of dread at things that could give rise to bodily disintegration, which is the ultimate paradigm of passivity. The problem of passivity and aggression can be addressed directly only after the body delusion has been decathected. Directing attention to the problems of passivity and aggression— similar to that pursued in the case of the girl with the new-found rage at her mother—sometimes works. Most often, the patient becomes infuriated at the failure of the therapist to join in the preoccupation with the patient's body. At that point, the only possible course is to treat each somatic complaint as though it were an element in a dream.

In essence, one agrees that the patient's sense of reality makes the symptoms seem real. However, by

following them back to their roots, their origins can be found beyond the boundaries of reality and they can be devalued. Once they are established as semi-delusional and, as such, derived from memory sources with roots in early experience, it becomes possible to seek out the situations and affects that are being avoided and unmastered as a result of the countercathectic function of overemphasis of body parts and their disordered function. The following case is one of therapeutic handling of an example of passivity directly.

Passivity in Early Adolescence

One of the primary sources of angry defiance in early adolescence is the experience of passivity at the hands of others who, either by attitude or position in life, take charge of one's life or give orders.

> A girl of 13, who limped because of an incapacitating bone pain for which no physical cause could be identified, reported a "hysterically funny" time at a big family party the Saturday night before her early Monday morning therapy session. The most fun came when the children began to ". . . cheer wildly at the grandparents. They get so uncomfortable and embarrassed when we do that."
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> The therapist sensed that here was a role reversal, frequently seen at this age, and of importance psychotherapeutically. He said, "You turned the tables."
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> "Most of the time you can't kid them," she answered.
>
> "You are taught democracy, but when it comes down to it in your home, you get upset when you see how small your vote is," said the therapist.
>
> She became heated in her discussion as she added, "My mother says, 'clean up your room.' I say 'Why?' She says, ' 'Cause I'm the adult.' Then I say, 'But Mom, it's not fair.' Before you know it we are having a small fight and I'm calling my friend to tell her what my mother is doing."
>
> In this way a discussion of the patient's reactions to passivity is developed.

This interchange is perhaps the key to the conflict of generations that occurs in Western culture with its democratic tradition. In societies in which more authoritarian theories govern the relationship between children, family, and the state (such as the traditional Chinese, Greek Catholic, and some early primitive societies), conflicted early adolescence with its defiance and rebellion is not so much in evidence. In Western cultures, democracy is so honored that even totalitarian countries call themselves "people's democracies." Our children are taught to revere the principle of equality among men. When they are old enough to think that they can function independently, they demand a vote in their daily

destinies. Unfortunately for them, they find themselves confronted by "the tyranny of a gerontocracy, of old men who initiate the young men and forcibly impose the tradition of the tribe" (Harrison 1921, p. xxxvii). Our children, raised in the tradition of democracy, discover that living in a family does not permit the development of an organization consisting of presidents alone. Some must lead. Others must follow. The therapist would do well to be ever alert for signs of conflict reflecting this strain in the associations of our patients.

This interchange between a father and son indicates the proper handling of this area of strain between the generations:

> The son was 9 years old, wiry and with a will of his own. That day, his father had decided against a trip to the city to attend a baseball game, in spite of the pleadings of his son.
>
> In response to this, the boy said: "The trouble around here is that every time I want something, maybe I get it, maybe I don't. Every time you want something you get it."
>
> The father said, "That's right. It's because I'm older; I'm in charge; I'm the father."
>
> "It's not fair," said the boy.
>
> "Who said things are fair?" said the father. "The fact is that I'm older, I work for the money. I've been around longer than you. So, I know more about what is important and how to make decisions. . . . But don't fret. Soon, when you grow up, you'll be the daddy; you'll be working; and then you'll make all the decisions. It's just a matter of time."

It is helpful to point out to the child that there is a progression of the generations and an orderly transfer of power to be traversed, all to his benefit. Sometimes children who have taken high school biology enjoy hearing that they and their parents have the same genes. The current situation comes from the fact that the parents got them first. Soon enough the children will get to use them on their own.

Summary

Most adolescent problems can be dealt with using a therapy closely akin to that which is used with adults. Late Latency Early Adolescence comprises a distinct phase of transition between the ego structure of latency and the adultiform ego organizations of adolescence. During Late Latency Early Adolescence, there are transitional characteristics to the child's experiences which require special handling. These experiences include removal, thought disorders, omnipotence, the involvement of parents, and the

persistence of evocative polarities in symbolic usages. The latter is of special concern since it limits free association. Such impairments of the therapeutic usages of free association are dealt with separately in Chapter 10.