Brit. J. Psychiat. (1964), **110**, 406–410

Observations on Adolescents in Psycho-Analytic Treatment*

By ILSE HELLMAN

This contribution is based on observations made in the course of the psycho-analytic treatment of thirty-six adolescents, 24 boys and 12 girls. These are partly cases I have treated and supervised myself; but to a greater extent relate to material brought together over the past three years by many colleagues and students co-operating in the study of adolescents in treatment at the Hampstead Child Therapy Clinic. The study includes young people between puberty and late adolescence with neurotic or borderline psychotic disturbances. Cases are not included which presented a clear picture of delinquent personalities from the outset, though this does not mean that in the course of treatment such features have not appeared. The appearance of impulsive and delinquent features in clinical pictures where we would not expect them in other age groups belongs to the typical experiences and problems of treatment during this phase.

In daily life with adolescents, as in their treatment, we have difficulties in keeping in touch with their inner world and with the repercussions which developmental changes bring about in their relations to the world around them. Our present great need to study and discuss problems of adolescent treatment arises partly from this fact. What adolescents need and what we offer them in treatment are not as closely related as in work with adults and younger children. What adolescents communicate to us about themselves—if they have decided to do so at all—does not consistently enable us to anticipate their next move, to intervene in order to reduce their anxiety in time to forestall the panic which can lead to a breakdown, or to prevent their putting into action the very things they are struggling against. With many adolescents analysis is deprived, to a great extent, of the means of access to the unconscious, on which we rely most in treating children and adults: play is no longer used to convey the continuous stream of phantasies, and free association is resisted until the late stages of adolescence. Communication remains restricted to behaviour and often to carefully censored talk; we become aware that large sections of thought, feelings and daily events have been consistently left outside the treatment, and we may subsequently be faced with considerable surprises.

Such surprises may be due to the fact that we have not yet studied adolescents sufficiently; but a more important reason lies in the nature of the adolescent process itself. Rapidly changing relations between impulses and internal controlling forces and the external world can lead to contradictory behaviour and divergent clinical pictures in rapid succession. Our problem lies in keeping pace with these rapid changes without having been given full insight into the unconscious phantasies and anxieties which have brought them about.

Wide differences exist within the age range we refer to as adolescent patients. The way in which they enter into, make use of and leave treatment differs not only with the nature of their disturbance, but according to the point at which they find themselves in the process of getting acquainted with and winning control over their new bodily sensations and the phantasies deriving from them. In addition, their attempts to detach themselves from their parents and from their internalized aspects have important repercussions in the treatment.

It is helpful to distinguish on the one hand between patients whose disturbance has been

* Paper read at a meeting of the Psychotherapy and Social Psychiatry Section of the R.M.P.A., Autumn, 1961. This study was financed by the Psychoanalytic Research and Development Fund.

https://doi.org/10.1192/bjp.110.466.406 Published online by Cambridge University Press

firmly established from childhood, where the picture in adolescence does not present strikingly unexpected features in spite of intensification of the symptomatology, and on the other hand patients in whom there was no well-defined neurosis in childhood. These latter have dealt with their anxieties in a variety of ways that have enabled them to go through latency apparently without much trouble, but some time between puberty and adulthood there is an upheaval, unpredictable in form because of the variety of defensive measures which are adopted, discarded again and exchanged for others. While the first group does not present us with specific problems in treatment, at least until they have been freed to enter into the struggle for adolescent independence proper, those whose disturbances appear to be in a state of flux can show rapid changes (e.g. from neurotic to delinquent behaviour, or through a phase of perverse activity into serious withdrawal) which present us with a variety of technical problems.* It is, I think, about the latter group we mostly talk in discussions of technical problems.

We can further clarify our understanding of what goes on in terms of both the revival of infantile (pre-genital) drive activity and of new emergent urges and experiences. Both have to be integrated into the existing system, and a new equilibrium has to be established. And at this same time, that these far-reaching readjustments have to be made and the conflicts and anxieties deriving from them have to be dealt with, there has to be a loosening of the attachments to the very people around whom their phantasies and intense feelings of love and hate are centering. Attachment to and dependency on the parents must gradually give way till a point is reached which makes it possible for the adolescent to establish his own identity, and to find new love objects. These must neither be based too extensively on repetition of the early attachments nor be too diametrically opposed to them in hostility and rejection, in order to make favourable adult life possible. This can be achieved only after much upheaval and experimenting.

We get the full repercussions of these simultaneous re-adjustments in the transference. While in content this is not too different from what we experience in adult analysis, there is a difference because of the relative weakness of the adolescent ego; the existing real dependency on the parents and the intensity of longing to return to or remain in the earlier position represent a far greater threat for adolescents than for adults.

It is essentially from the aspect of this process of detachment from their infantile love objects and its repercussions in the transference that I shall now approach some technical problems:

We can assess the adolescent patient's capacity to enter into and remain in treatment from the point of view of his capacity to feel and admit that the conflicts which disturb him are located within him, and that he needs help to solve an inner struggle. Such insight, whether it exists when we first meet him, or has to be brought about in an introductory phase of his treatment, can carry him through the analytic work; but it may give way before our aim is achieved, according to the nature of his object relationships on entering treatment and the solutions he now tries to find in freeing himself from the bond to his parents. The defensive methods by which various adolescents deal with the anxiety aroused by these bonds and their need to break them in the struggle for their own identity can threaten the relationship to the analyst as well. Heightened anxiety and guilt make massive defensive measures necessary, and an important aspect of our work with adolescents centres on following these successive attempts and failures which produce frequent and rapid changes of behaviour in relation to the analyst.

This makes itself felt already in our first contacts. We constantly meet boys and girls in a state of defiance, who reject their parents and all they stand for. Therefore, they refuse to enter treatment to which their parents try to introduce them. If we succeed in getting them to attend, treatment may be successful at first, often on the basis of their phantasy that they have found an ally against their parents, whereby in their minds they make us entirely good and their parents entirely bad. When this is pointed out, the defiance can quickly turn

* See K. Eissler, *Psycho-analytic Study of the Child.*

https://doi.org/10.1192/bjp.110.466.406 Published online by Cambridge University Press

against the analyst. Technically one should be able to deal with it, as one does when this occurs in patients of other ages; but all one's capacity and skill may be useless, simply because the patient breaks off treatment at this point. Such adolescent boys and girls attempt to find freedom from the internalized and from the external parents by turning love into hate, or dependence into revolt. The freedom resulting from this does not go far; they remain in fact closely attached and soon experience guilt and suffering which lead to further increase in defensive measures.

Where projection is used extensively, the parents and the analyst may turn into persecutors. Suspiciousness in the transference, as a passing phase, can easily turn, with increased projections, into paranoid behaviour; and again the problem, difficult as it may be, can be successfully dealt with only if the patient is able to come and face the dreaded analyst at all. But this is exactly what seems too difficult for many of them.

There is another type of adolescent patient, often around the middle years, who makes us feel at first that he has fewer problems and is likely to benefit from treatment. He seems eager to come, he asks for help, and he shows a good measure of insight into his disturbance. He comes punctually on the appointed day and five days a week, he talks about his troubles and phantasies, his daily life, his ideas about the world and his hopes for the future. He behaves towards the analyst as to a friend he has long waited for and found at last. But this initial rosy picture tends to change as soon as the analyst does his job and analyses, and does not conform in reality to the role that has been attributed to him in phantasy.

Analysis of the transference nature of their feelings and of defensive elements in them, and especially of the infantile aspects underlying them, quickly brings clouds into the picture. Much depends on the existing ego strength of the moment whether in spite of frustrations in the transference the patient will stay on and co-operate or will, at least temporarily, relinquish the tie to the analyst which was built on such insecure ground.

If we try to see the point in the course of the process of detachment from his parents at which we have entered the adolescent's life, we may find that he had just arrived at a measure of freedom from them by shifting the positive feelings from them to us. The shift, so well known in the form of the "crush" on the teacher or youth leader, has reached the analyst. Idealization, the wish for closeness to a new object, the need for identification and admiration are all to be found in these first positive moves. In daily life during this phase, when the admired adult falls short of the hopes set on him, the relationship is broken and the feelings moved to a new person. The repercussion of this *need to exchange love objects*, which in itself is a normal phase, can present a subtle technical problem during treatment: the attachment to the analyst may not prove sufficiently strong to carry the patient through the frustrations of analysing the infantile and defensive elements of his feelings—and he leaves.

Yet another problem we have encountered is the following. Where analysis proceeds satisfactorily, we come to a point when intense infantile feelings are re-experienced in the transference. As the patient's dependence on the analyst grows, and he regresses, we may find, especially in the early and middle years of adolescence, a strong reaction against experiencing regression, whereby the further emergence of infantile feelings is evaded. Eruptive aggressive behaviour against the analyst, or acting out and asserting "grown-upness" by sexual experiences with yet another boy or girl, may appear at the very time when babylike separation anxiety, the need to be taken care of and tender feelings are beginning to be felt towards the analyst. Such a regressive phase is painful at all ages, but a favourable therapeutic outcome depends on it. Once he reaches it, the adolescent who may have been progressing well in his treatment, may now be compelled to muster all his defences so as to counteract *the fear of ego regression*. the fear of losing his intellectual and creative achievements and losing touch with reality. The threat of losing what independence and separateness he has achieved seems more intense where the patient finds himself only just on the threshold of establishing his identity.

https://doi.org/10.1192/bjp.110.466.406 Published online by Cambridge University Press

Boys who have been fixated to their mothers long beyond the normal time, and have experienced direct bodily care and satisfaction from them through latency and into puberty, present a special problem. Their demanding, dependent relationship is quickly transferred to the analyst; but forward movement into more advanced stages of object relationship is established in them only with great difficulty. I see two main reasons for this: genital urges and phantasies are especially frightening when the mother has remained so close to their bodily experience and where her actual behaviour is seductive towards the adolescent boy rather than restrictive. Clinging to baby ways in relation to her, to her food, and her care in illness, with aggression expressed in infantile ways, is maintained or reverted to as a safeguard against emerging masculine sexual and aggressive wishes.

A move forward and to a new object runs up against another difficulty in these cases. There is a *fear of the mother's depression or of her breakdown or of her vengeance* on the boy's turning away. The fear of such responses by the mother has a certain basis in reality, powerfully reinforced by past and present hostile wishes against her. Where this manifests itself in the transference, *clinging to the analyst*, in passivity and oral dependency, reappears again and again, and in these cases the decisive moves are made only in late adolescence and after very long analyses, when the mothers also have been helped to find a solution for their problems in relinquishing the tie to their sons.

Patients who either start their treatment or later arrive at the point where the analyst becomes the centre of hetero- or homo-sexual feelings experience serious difficulties, especially where the actual person of the analyst is not too remote in age and sex from the most intense wishes of the moment. The *anxiety caused by experiencing sexual feelings in the sessions*, the fear of having erections and losing control are at the back of many silences, apparent boredom and absenteeism. Again the problem itself is well known to us, but the intensity of the fear of losing control and the increased narcissism which makes rejection and frustration so especially difficult to stand in adolescence can create a more serious impasse here.

The question of termination of adolescent treatment can be clarified if also approached from the angle of growing detachment and separateness. The *wish to feel free from the analyst* often appears well before we feel safe about the patient's capacity to make this step. It seems important to differentiate here between a state which looks like resistance, but which—at this stage—may contain important elements of normality and health. Where this is recognized we have found that successful work, where integration had been almost reached, has made it possible for adolescents to return to their analyst later, of their own accord, either to continue work which they felt to have been incomplete, or to report on their good experiences and let their analyst share in them. From such adolescents who return as young adults we can learn a great deal, especially about the problems which they have been compelled to keep outside the analysis earlier on, and about the reasons for it.

These examples may have shown among other things that *adolescent patients can, in fact, rarely fulfil the basic requirements of psychoanalytic treatment for any length of time*. Regular daily attendance, communication of thoughts, feelings and daily events in words, without conscious withholding, the capacity to maintain the relationship with the analyst through its changing and frustrating experiences are the basic elements on which psychoanalysis rests. But they are also the very elements which, at some time or other, if not throughout adolescence, are diametrically opposed to what adolescents want and can tolerate.

The part played by the adolescent's parents during treatment, and our role in relation to them, should be referred to. As we see the main goal of adolescence as the achievement of independence based on the subject finding his own identity and the capacity for heterosexual love and creativity, it is clear that treatment which aims at helping him towards this goal must be his own. He must feel that his analyst and his treatment is *his* concern. For many, the thought of their parents' part in it destroys the very hopes they have set on the treatment. This does not mean, however, that parents of adolescent patients do not need help. On the

https://doi.org/10.1192/bjp.110.466.406 Published online by Cambridge University Press

contrary, it seems more true to say that most parents of adolescents go through a phase when they need some guidance or support. Parents of a child who is ill enough to need treatment are likely to be people who react to some or all manifestations of the child's leaving them with a revival of their own conflicts, and this is bound to affect the process of detachment. The analysis of mothers and fathers of children during this phase shows us constantly the variety of feelings which are evoked in them. To enumerate only a few we have met, there is first the mother's feeling of loss, as a response to her child's wish to free himself, and with that the whole range of depressive, hopeless or angry feelings according to what loss has meant to her early on and throughout life. Or she may cling to the child, make him feel guilty and anxious and thereby interfere with his first tentative attempts to move out of the close bond. Or there may be a need to prevent, to share in, or compete in the first love relationships; an ambition to push the adolescent into a life which the parent has failed to make a success of; or on the contrary, envy of his achievements and destructive interference each time the child has achieved success that was out of the parents' reach. The subtle shades of interplay during this time, by which the adolescent's struggle can be helped or hindered, are seen especially clearly where we have the opportunity to look into the analysis of parent and child simultaneously.

It is, of course, the task of the adolescent's own therapist to deal with his reactions to the parents. We know, however, that where parents are severely pathological, and especially in this vulnerable phase, persistent onslaughts against the tenuous, growing feelings towards an independent self or the over-taxing of the weak capacity to control overwhelming impulses, may be such that the struggle is given up, and massive pathological defences establish themselves at a point when the way out of illness seems within reach.

To deal with the parents' need for help in practice mostly requires someone other than the adolescent's analyst, and where possible, a place other than the adolescent's clinic. In a later stage of a successful analysis, adolescent patients are able to differentiate between their own and their parents' problems more clearly and it is at this stage that I have met with a boy's and a girl's well-founded and well-received suggestion to their mothers that the ultimate success could be reached more safely if the mother sought help for herself.

A brief contribution to a topic of great complexity is bound to raise more problems than it can answer. It may, however, achieve the aim of highlighting some of them and of characterizing the special ways in which we attempt to find solutions.

Conclusion

The great variety of problems met with in the psychoanalytic treatment of patients in the years between puberty and adulthood has been discussed. They have been related to the main developmental changes which occur in this phase; the re-arrangement of the equilibrium between impulses and controlling forces, as well as the changing relations to the adult world, bring about temporary disturbances which make the analyst's intervention more threatening than at earlier or later stages.

The capacity to enter into the adolescent patient's world, to respond to his changing needs and to retain his trust is a pre-requisite for successful treatment at this stage. The number of analysts who feel able to deal with patients in this age group remains comparatively small.

Those whose interest in these special problems and whose gifts have enabled them to gather experience find that the value of psychoanalytic work with young patients is great. It lies not only in the therapeutic possibilities, but in the preventive role analysis can play at this stage, forestalling the establishment of sexual deviations and of a choice of partner made on the basis of the adolescent's psychopathology. It also plays a part in preventing entry into a career chosen for neurotic reasons.

Ilse Hellman, Ph.D. (Vienna), *25 Wellington Square, London, S.W.3*

https://doi.org/10.1192/bjp.110.466.406 Published online by Cambridge University Press