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The Paranoid-Schizoid Position and Pathologic Regression in Early Adolescence

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The divergence of clinical psychoanalytic theory and metapsychology has been described by many authors and perhaps most elaborately by George Klein **(1976)**. This divergence is probably most extreme during the stage of development of early adolescence. Although there are a number of well-articulated psychoanalytic theories of adolescent development (**Bios, 1962a**; **Jacobson, 1964**; **Erikson, 1968**), there is certainly not a coherent clinical theory of psychoanalytic treatments at this stage. At best, technique is described in terms of modifications of the adult model of psychoanalysis.

In this paper I will be suggesting a model of analytic treatment of the early adolescent drawn from a formulation of development based on object relations theory. I will begin by describing the clinical presentation of two early adolescents who showed marked pathological regressions. A formulation of their pathology will be presented based on Melanie Klein's concept of the paranoidschizoid position. The implications of this formulation of these adolescents' treatments will be discussed. Finally, I will suggest ways in which this approach applies more generally to psychoanalytic treatment of the early adolescent.

The concept of a normative regression in early adolescence has been described from multiple vantage points: ego structure, drives, a second separation-individuation phase, a reworking of the oedipal complex, and object relations. (**Katan, 1951**; **A. Freud, 1958**; **Blos, 1962a**; **Jacobson, 1964**). Where the normal adolescent during

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the early phases of adolescence will show and continuous fluctuation in the degree and quality of regression, gratification, defense, and adaptation, there are those adolescents who find themselves in the grips of a regression beyond which they cannot develop. In the broadest sense, this is what is meant by a developmental breakdown. Whatever pathogenic stresses the adolescent may be facing, the stress of his or her own development is predominant.

Laufer and Laufer (**1984**, p. 23) have described a number of ways in which such breakdowns may manifest themselves symptomatically. These include withdrawal from peers, compulsive masturbation with perverse actions, attacks on parents, a new onset of school phobia, denial of the physical changes of puberty with an attempt to change the body, and self-harming or suicidal gestures. Where behaviors are overt and rebellious, as in the pseudoindependent disregard of restrictions which is so common, or in the pseudoheterosexual behaviors of early adolescence **(Blos, 1962a)**, the defensive functioning against the regressive instinct can be gleaned. In those adolescents, however, who manifest internalizing symptoms with overt behaviors of withdrawal and avoidance, the nature of their regressions may be less apparent and more entrenched than is initially apparent. The cases of two adolescents whom I will be presenting typify this class of problem.

Lisa was 15 when she was coerced into a psychiatric consultation. Towards the end of the ninth grade she had begun missing school and over the summer began to experience difficulty traveling without accompaniment. When I first saw her in the late fall, she had been unable to attend school entirely for several months.

She made it clear from the first consultation that she was uninterested in treatment. She was not disturbed by the school problem, mildly disturbed by the traveling problem, but most of all bothered by the shape of her nose. She was unable to look at her face's full reflection but with a small compact mirror would study her nose from every angle. During the summer she had been told that she was an Edie Sedgewick look-alike, Edie Sedgewick being a deceased model and avant-garde actress made famous by Andy Warhol. Her nose was the one feature which she feared distinguished her from Edie. Over that summer she had begun collecting information on Edie and read the recently published biography like a Bible. In fact, Lisa was often able to travel alone when she carried the biography or her scrapbook of Edie articles.

What was striking was her ability to recount to me almost every detail of Edie's life and almost nothing of her own. “Typical psychiatry questions” at best bored her. More often, she was at a complete loss of words in response to any question that touched on her thoughts or feelings about her phobias, body distortions, or relationships to family or friends. In fact Lisa decided to pursue treatment with me because I offered to purchase a copy of the biography “for the office.” The importance of this decision was highlighted by an incident during the second year of treatment. Lisa's agoraphobia and school phobia were generally improved but transiently recurring. Halfway to my office, traveling on her own, Lisa panicked. Rather than turn back, she was able to continue on knowing that a copy of the biography awaited her. This she borrowed in order to return home.

I came to appreciate her inability to talk about her problematic thoughts and feelings as a symptom in itself. Although the external phobic symptoms were clear, the same process was at work in relation to her own thoughts and feelings. An incident 6 months into treatment demonstrated this. Entering the session, Lisa confessed that she had stopped up the toilet in the waiting room lavatory. While waiting, she had tried on her glasses for the first time in many months, was horrified by her complete facial reflection, broke her glasses into bits and flushed them away. This was the first I learned that Lisa even wore glasses. Although it was becoming safer for her to see, she had unfocused the world by her self-imposed myopia. Denial of this extreme has its counterpart in a psychic denial, hence her absolute inability to discuss thoughts and feelings in the usual way.

Kevin at 13 presented in a manner similar to Lisa. He had skirmishes with transient school phobia since the age of 9 with intermittent psychiatric treatment that proved frustrating both to him and the previous psychiatrist who “couldn't get him to talk about his feelings.” A new and overzealous school psychologist made some determined home visits, with the result that Kevin stopped attending school altogether. When he first saw me in consultation he had been home for some 8 months. His inarticulateness about the symptom was more severe even than Lisa's. When pushed to express himself, he became nearly apoplectically red in the face. Like Lisa, he too entered the first consultation with a book in hand. His interest was in comic books, superheroes, and horror movies. As mute as he was about his fears, he could talk at length about the super heroes. He knew, actually, nearly every

fact about every superhero in just about every described galaxy in the Marvel Comics universe. The superheroes and the latest horror movies served as the basis for our conversations.

Kevin, too, showed his version of Lisa's self-imposed myopia. Some 2 years into treatment, when Kevin was beginning to express an interest in girls, he reported that while walking down the street a good-looking girl had smiled at him and he went back into tunnel-vision. He was most surprised that I didn't know what he meant. On questioning, I learned that for at least the first year of treatment he was able to travel around only when he used tunnel vision, by which he meant focusing only on a thin straight line ahead of him and tuning all else out. At this point, tunnel vision was no longer generally needed. He also revealed that he had also navigated about with a system of mental maps that delineated safe and unsafe areas. In retrospect he was functioning in a state of generalized agoraphobia, as well as the school phobia, but his adaptation to the former had quickly become ego syntonic.

Treatment with Lisa and Kevin quickly fell into a routine. With Lisa, for many months we read together, each from his copy of the Edie Sedgewick biography. She'd tell me to look at page so and so, where we'd discuss an aspect of her life, or discuss how she appeared in a given photograph. As time went on, we shifted to a discussion of Lisa's looks, often discussing her appearance in photos of herself that she brought in. Although she did not give up her distortions of her own physical appearance for the longest time, the distortions lessened in reality to her. With Kevin, I began by asking him endless questions about the superheroes. This evolved into my giving him "superhero quizzes" on which he always got an "A+" and which soon had an effect on his fear of test-taking in school. When I had exhausted my repertoire of superhero questions, I suggested that he bring in comics that he owned doubles of, and we did oral readings together, dividing up the parts. Sessions might also begin with his straight-faced recitation of the gory details of the most recent horror movie.

Although the treatments went on for several years, both adolescents were back in school within 4 months after treatment started. Consolidation of this gain, of course, required a much longer period of time. An explanation of these gains lies both in the conceptualization of the pathology and of the treatment.

With no more history than what has been given, and it is obvious how difficult obtaining a personal history from these adolescents would be at this stage, one already has a great deal of

information. The subsequent clinical procedure will necessarily derive from the conception of analysis at this stage. If the model is essentially that of adult analysis with modification, one will proceed cautiously to identify conflictual themes in the material. For instance, there are aspects of the relationship to the hero which represent the ego-ideal, yet the relationship is dependent and the admired traits are passively acquired. With Edie, these traits involved grandiosely, if not magically, acquired fame and admiration. With the superheroes, these traits involved strength and overcoming threats of destruction. Another example of such a conflict is that of sexual identity. These figures allowed for a postponement of choice for the adolescent. Edie, although female, is thin, boyish, and androgynous. Among the female superheroes are many muscle-bound and angular women whose strength matches any man's. These conflicts clearly cannot be addressed as one would an adult with well-developed ego and cognitive capacities.

Defense analysis is a cornerstone of the classical approach. Here we see, first and foremost, denial in the visual symptoms. Denial is, of course, one of the earliest and most pathological of defenses. We also see projection, which is inherent in the phobic symptom. Along with this, there is a primitive splitting, seen in the elaboration of safe and unsafe areas, blatantly good and bad characters, and thinking that in general is dominated by these binary functions. Projective identification is also operative, most obviously in the attribute of the hero. Drawing the adolescent's attention to the pathology of his defenses is, however, impossible. We are not addressing an individual with generally more evolved defenses who has pockets of maladaptive pathological defenses. These defenses are dominating most of the adolescents' operations.

If, for the most part, the content of the conflict or the types of defense against it have been excluded from the analyst's comments in the clinical encounter, what then guides the clinical encounter? It is, I believe, the quality of the therapeutic relationship as it evolves, and the underlying, developmentally determined, capacity for relationship.

At the start of treatment, Lisa's and Kevin's primary and most involved relationship was with the hero. In the early years of treatment, Lisa usually had one best friend who was just like her, by her own description, but who quickly fell out of favor. Kevin, at this point, had withdrawn from peer relationships except for visits arranged by his mother. Their day-in and day-out concerns

with the hero. In the therapeutic relationship, I was allowed at first to observe this, approve of it, and share in it as time went on but not allowed to be curious about their feelings, thoughts, or wishes outside of their interest in the hero. They were each extremely reliable about coming to sessions. There was never any question about the importance of the treatment to them, but neither was there any expression of its importance.

The nature of this relationship can be understood as schizoid, that is, one in which there is an extreme of dependency as well as a denial of dependency. Because the dependency was experienced in relation to a fictive character, there was protection against the self-dissolution experienced in merging with another. This is akin to the phenomenon Anna Freud **(1958)** described as a state of primary identification in which the relief of the regression can be only short-lived because of the deeper anxiety of emotional surrender. Fairbairn **(1940)** described three features of schizoid phenomena: an attitude of omnipotence, an attitude of isolation and detachment, and a preoccupation with inner reality. The omnipotence is evident in the extreme control exerted both in the therapeutic relationship and in relationship to the hero. The detachment and isolation permeated actual relationships. The extent of the visual symptoms is indicative of the degree to which external reality was excluded. From Fairbairn, too, we learn that when there is an overinvest in internal reality, the act of giving leads to inner impoverishment, and hence there is a predominance of taking in relation to others. The inability of these adolescents to respond to the analyst's questions may be understood in this context. What they each wanted first was external approval and support of their inner fantasies. On one occasion when Lisa hazarded a dream, my attempts to pursue an interpretation were met with a rebuke: Couldn't I just appreciate her dream?

Melanie Klein **(1946)** expanded on the operations and etiology of schizoid states in her concept of the paranoid–schizoid position. This concept describes more broadly the psychology of the first object relationship. As originally delineated (see also **Segal, 1981**), this corresponded to the first 6 months of life. Developmentally, this relational position was followed by the depressive position **(Klein, 1935)**. Before I elaborate on these concepts as they relate to adolescent regressions, I wish to cite Ogden's reference to these positions as “distinctive states of being” that “constitute enduring, fundamental components of all subsequent psychological states” (**1986**, p. 5). More broadly, he sees the paranoid–schizoid position

as representing the transition "from the purely biological to psychological experience" and the depressive position as representing the transition "from the impersonal psychological to subjective experience." Understood in this way, regression to one of these positions will be taken to mean a regression to a more fundamental and primitive way of organizing experience and relationships, not literally a regression to the experience of a 6 month old.

A Kleinian position may be specified in terms of (1) the nature of the object relationship, (2) the nature of the defenses, (3) the nature of the dominant anxiety, and, related to this, (4) the attendant set of fantasies. In the paranoid–schizoid position, the object relationship is in essence schizoid as described by Fairbairn. The defenses, as previously described, are those considered the most primitive. A particular emphasis in the Kleinian concept of a relational position is the nature of the anxiety.

Paranoid, or persecutory anxiety, refers to the anxiety of destruction or annihilation. It is felt more powerfully as an overwhelmingly dreadful force and is qualitatively distinct from other anxieties. For Klein, it exists in conjunction with the operation of a set of fantasies involving the wish to destroy the frustrating object, the projection of retaliation, and the weakening inherent in complete surrender to the satisfying object. Whether this set of fantasies is repressed, as with Lisa, or displaced, as with Kevin, any discussion of the fantasies in direct relation to the adolescent is to reify them. Their subjective experience, however, can be seen to be dominated by this overwhelming emotion. They were hounded at every turn by their fears. An appreciation of this quality of anxiety must inform every intervention. For Freud the situations which give rise to anxiety were specified, and the quantity of anxiety was specified, but there was little attention to the quality of anxiety. The full extent of the generalized phobic withdrawals shown by Lisa and Kevin could not be appreciated for some time because they refrained or were unable to discuss their symptoms and because they rapidly incorporated many of their symptoms in an ego-syntonic manner. Some prior conception, therefore, is needed which elucidates the quality and extent of the anxiety by which one can surmise the subjective experience which is essentially unspeakable. The descriptions of persecutory anxiety provide this.

The concept of the paranoid–schizoid position offers a unified approach to the phenomena. From pathological defenses, one may assume the presence of persecutory anxiety and schizoid relatedness.

From more evident schizoid detachment, one may similarly assume the presence of the other elements. When one then considers the nature of treatment that will unfold, the concept of a relational position will attune the analyst to how it is possible to relate to the individual. An individual is in the given "position." He must be encountered in this "position." One must speak the language of the "position." The analyst's automatic questions—How do you feel? What were you thinking when … ?—translate without empathic connotation but with intrusion, threat, and violence. The adolescent who cannot use a real morror is in no position to use the "therapeutic mirror."

As can be seen, my use of object relations theory to illuminate these early adolescent regressions concerns the structure, not the content, of the relational regression. Almost all theories of adolescent development describe a shift in object relations. The decathexis of the primary object relationships in order to make nonincestuous libidinal attachments in adolescence was first described by Freud **(1905)** in "Three Essays on Sexuality." Katan **(1951)** made this shift explicit in a process she termed object removal. Other writers (**A. Freud, 1958**; **Blos, 1962a**; **Jacobson, 1964**) have contributed to an understanding of this process. A formulation of these regressions in terms of the paranoid–schizoid position, however, emphasizes the nature of the relationship that is possible at this stage. Since all psychoanalysis proceeds through the therapeutic relationship, it can be seen that the structure of the relational regression must guide treatment.

Returning to the treatments of Lisa and Kevin, the program of the sessions changed little for over a year. Although the joint readings gave way to broader discussions of their heroes, these were never self-reflective in any way. As can be seen the adolescents exerted extensive control over the sessions. This might be said to mirror the more primitive grandiosity of control of the primary object, but since the adolescents had virtually withdrawn from the world of relationships, it was a necessary precondition for a reentry into actual and viable relationships. The control exerted in the relationship to the fictive hero was gradually extended to the figure of the analyst. The act of joint reading allowed for an extensive, but symbolic, regression reminiscent of bedtime story reading. This was followed with the more active reading by the adolescent. The entire process, however, remained under the control of the adolescent who had, of course, chosen the story.

The formulation of the paranoid–schizoid position informs us,

too, that the nature of the phobia is not what might first assume to be reflecting separation anxiety as many writers have described in relation to school phobia (**Johnson et al., 1941**; **Coolidge et al., 1957**; **Eisenberg, 1958**; **Sperling, 1967**). Separation anxiety assumes a relatively complete internal object representation and would be understood in Kleinian terms as pathology related to the depressive position. With these adolescents, the fear was not one of being away from someone, but rather one of being out in the world. In this sense, the hero can be understood to be what might be termed an identity symbol. Thus, there is not only the relationship to the hero, but the adolescent is the hero who is successfully out in the world. In his story, the adolescent sees his own personal conflicts impersonally. Yet it can also be said that the adolescent creates the identity symbol. To disregard the identity symbol is to disregard the adolescent. It is the only way he can speak about himself and his wish to be back in the world. Attention then to the identity symbol serves to usher the adolescent back into a relationship and back into the world. In his extended, regressed control of the analyst, the adolescent transfers his "primary identification" with the hero to the analyst and thereby defuses it. In terms of aggressive drives, the rebuffed personal question the imperfect analyst must now and then hazard is experienced as a violating intrusion. But it also serves to subtly challenge the split between the ideal and the persecuting, and this leads to a differentiation between interpersonal assertiveness and the more virulent forms of feared aggression.

For the analyst, engagement in a relationship that is predominantly schizoid is intermittently, but necessarily, boring. His curiosity must be curtailed and his sense of improvisation guarded. The boredom is an essential aspect of the experience and must be welcomed. In time, the adolescent's own experience of boredom will allow him to begin to challenge his own phobically circumscribed limitations.

Having admonished a requisite curtailment of one's usual analytic curiosity, I have thus postponed presenting any description of the developmental hazards experienced by Lisa and Kevin which probably gave rise to the massive regressions in early adolescence. Between the ages of 3 and 4, Lisa's parents separated. Although they had been rather dedicated parents previously and were so subsequently, for this period of time Lisa was virtually abandoned by them and left with a series of friends and caretakers. Although there were no reported regressions in language or

self-care behaviors, descriptions of her at the time suggest a depression. Around the age of 7 she experienced mild separation anxiety and recurrent nightmares. For Kevin, the nature of his relationship with his father posed a developmental hazard. His father was an unusually unemotional and distant figure whose main interaction with his son at home was to criticize anything that disrupted his routine or interfered with the orderliness he required. Their one "fun" activity, from a very early age on, was to go shooting together.

There is, of course, much more to say about each of their developmental histories, but I give this information to show how irrelevant these facts are to the clinical process. Lisa's terrifying separations in the past were of course inherent in the present fears. Similarly with Kevin, the overstimulation of aggression with his father in the past was inherent in the present clashing of the superheroes or in the compulsive watching of horror movies. The fears are so overwhelming, however, that no extraneous elements can be introduced. The defenses are operative to contain the emergency in the present. The phobic symptoms which separate the safe from the unsafe for the adolescent carve out for him a livable niche.

Transference does not exist discretely. To describe the transferences as part-object transferences is of course correct, but this suggests that the parts of the object in the transference may be delineated. Splitting describes the defensive operation which, like the overt phobic symptom, attempts to separate safe from unsafe, good from bad. However, the unsafe and the bad cannot be tangled with. They are cast out. Repression has usually failed, to be supplanted by denial. These adolescents do not challenge or criticize the analyst. Instead, they fix him in a position that is rather distantly aligned with the good and safe projections. In this position he is kept from eliciting the terrifying anxiety that is almost always rampant. His goodness and safeness is of an impersonal nature, that is, it exists via the goodness he has allowed to be ascribed to him.

The splitting that is usually described in the borderline patient is different from this process. Borderline splitting is probably closer to vacillations of idealization and denigrations which assume a more coherent self which can feel disappointment and a more coherent view of the object as one capable of carrying out an idealized function. When denigration and disappointment become manifest in the clinical interaction, a more advanced stage of

object relations has been reached. In Kleinian terminology, these experiences are part of the depressive position. At this point, the analyst approaches being viewed as a more complete object, however distorted, and he may now attempt to interpretatively describe the distortions, the clinical interactions, and affects or ideas out of the patient's immediate consciousness. At this point, too, seemingly paradoxically, the adolescent becomes not so good a patient, more frequently missing sessions, coming late, wanting to change times.

Because interpretation assumes a higher level of self and object integration, as well as more involved cognitive and emotional functioning, interpretation is not a useful therapeutic mode for the patient predominantly in the paranoid–schizoid position. In fact, the analyst oriented solely toward interpretation may impede the adolescent's recovery. Rather the emphasis must remain on the adolescent's experience in a relationship in which he is given extreme control and whose forays into a relationship are met with cautious appreciation. A formulation of the type of regression manifested by Lisa and Kevin in terms of the paranoid–schizoid position emphasizes the nature of the anxiety, the primitive defensive operations, and the quality of object relations. It should be pointed out, however, that the therapeutic approach I have suggested is at variance with Klein's **(1932)** recommendations regarding adolescent analysis. She allowed for few technical modifications at this stage.

In summary then, this approach to the analytic treatment of the severely regressed adolescent suggests treating the adolescent, at least initially, as one would a schizoid character. Features of this approach include (1) the importance of the adolescent's control of the therapeutic relationship; (2) the fragility of relationships and the degree of withdrawal from relationships; (3) the adolescent's creation of an identity symbol which represents some aspect of the idealized self functioning in the world, the adolescent's attempt to reengage in real relationships, and comprises as well his regressed relationship to a primary object; (4) the requisite curtailment of the analyst's curiosity with the attendant counter-transference response of boredom; and (5) the relative contraindication of an interpretative approach until evidence of phenomena of the depressive position are manifest. Above all, it is important to conceptualize the clinical process as derived from, and specific for, this set of psychological operations, not as deviations from an analytic process specific for more mature psychological operations

or as preparation for future analytic work which, I believe, guarentees a poor attunement between analyst and adolescent.

Thus far, I have been discussing a formulation and treatment pertaining to two adolescents who manifested extreme developmental, although not psychotic, regressions. I would like to raise the question whether this particular formulation of their regression has relevance to the normative regression of this developmental stage, and if, correspondingly, this model of treatment is applicable more generally to other disorders arising at this stage.

The concept of a normative regression in early adolescence is well established (**A. Freud, 1958**; **Blos, 1962a**; **Jacobson, 1964**). This regression has been described in terms of an increase in pregenital drives and in terms of the relative weakness of the ego in relation to the emerging drives. This necessarily involves a regression to more primitive mechanisms of defense which has been noted as an essential aspect of the paranoid–schizoid position.

The second important aspect of the paranoid–schizoid position entails the nature of the object relations described as schizoid. Is there evidence for this in the normally developing adolescent? The importance of the group to the early adolescent is manifestly evident **(Group for the Advancement of Psychiatry, 1968)**. Among the reasons for this have been included the need to replace the family allegiance. Group identification also involves relatively impersonal and less intimate relationships. Individual choice, decision making, and preference are suspended and supplanted by a conformity that allows for any individual to substitute for another. This can be seen as reflecting a basically schizoid manner of relating. As one 14-year-old boy with a mild conduct disturbance put it when I asked him if he ever remembered his dreams: “I don't tell my dreams to anybody. In fact, you'll never catch me telling anything personal to anybody.”

Although she does not use the term schizoid to describe the early adolescent's object relations, Geleerd **(1961)** has detailed the normative process in adolescence as a partial regressive to the undifferentiated phase of object relations. This concept is developed in terms of degree of dependence on the love objects and the fusion of inner and outer experience and can be seen to be directly related to the concept of the paranoid–schizoid position.

Finally there is the particular nature of the anxiety manifest in this position which has been described as persecutory. Clearly, most adolescents do not manifest the quantity nor quality of the

anxiety experienced by Lisa and Kevin. An emotion, however, that is universal at this stage is self-consciousness. Is there an adolescent who at some point has not cringed at his own reflection or felt the eyes of the whole class sneering at him as he entered late? Self-consciousness is, I believe, the normal manifestation of persecutory anxiety. The experience of a normative and usually transient regression to the paranoid–schizoid position is also captured in Blos's discussion of adolescent acting out: "The outside world appears to the adolescent, at least in certain aspects, as the mirror image of his internal reality, with its conflicts, threats, and comforts; his inner world is thus summarily experienced as external. Every adolescent is brushed—even if for brief moments—by paranoid ideation" (**1962a**, p. 268). This is, in essence, a phobic process which can only occur with extensive projection and omnipotent denial.

Other writers have reflected their recognition of this process. Katan **(1951)** described the process of object removal in adolescents whereby an individual irreversibly breaks the primary object ties to the parents in order to make nonincestuous attachments. What is often overlooked in this much quoted paper is that in her description of the process of object removal she compares a 14-year-old girl's flight from treatment during her first love relationship (when the process of object removal was being realized) with a 41-year-old woman's agoraphobia which had been present since the age of 14. Although object removal is the normative process and agoraphobia the pathologic, both entail a phobic process and at least transient schizoid object relations. For Katan, this phobic process is ubiquitous. In the same essay (p. **50**) she writes: "Slight agoraphobia as an acute symptom seems to constitute a normal transitory stage in young girls." It is in such observations that one can detect a normative return to the paranoid–schizoid position. Although Katan does not comment on the nature of the object relations accompanying this phobic process, Segal **(1954)** has expanded on schizoid mechanisms underlying phobia formation.

Returning to Fairbairn, who pioneered the exploration of the psychology of schizoid phenomena, we find a reference to the relevance of schizoid operations to adolescent psychopathology. He described several categories where overt schizoid conditions may be found. Among these is "the schizoid state, or transient schizoid episode—a category under which, in my opinion, a considerable proportion of adolescent 'nervous breakdowns' fall" (**1940**, p. **4**).

Thus there are many indications that the concept of the paranoid–schizoid position is more generally applicable to the normative experience of the early adolescent. Reviewing in this light some of the discussion of analytic technique in early adolescence, the disparate recommendations of various writers can be seen to reflect a more unified approach.

Geleerd states: "The ego of the [early] adolescent is already so threatened by the increased id drives that a very little over eagerness on the analyst's part may be too overwhelming" (**1957**, p. **273**). This corresponds to what I have described as the requisite curtailment of curiosity on the part of the analyst.

Laufer and Laufer **(1984)** have cautioned against interpreting the preadolescent past until the adolescent breakdown, in its own terms, has been understood. An understanding of the present must be constructed before any reconstruction of early childhood is possible. To judge from their numerous examples, this inevitably waits until, at the earliest, the late adolescent years. This corresponds, as I have suggested, to the relative contraindication of an interpretative approach. Furthermore, Blos (1962) has described the psychological task of late adolescence as one of character consolidation at which time the infantile conflicts are rendered specific and become centered within the self-representation. At this point, more traditional analytic work can proceed.

Geleerd **(1957)** has also noted that a consistent analysis of defense mechanisms is not desirable, and often contraindicated, in adolescence. Among other differences between adolescent and adult analysis, she also commented that the working-through process is limited, that transference is handled in a way to allow for a real relationship, and that there is a greater role in helping with reality-testing with the analyst acting at times as a parent substitute. All of these recommendations imply an approach that is not principally interpretative and that attempts to pace the relational shifts and integrative capacities in a particular adolescent. Anna Freud is quoted as saying, "One cannot analyze in adolescence. It is like running next to an express train" (Geleerd, **1957**, p. **266**). If analysis during the early phases of adolescence were formulated according to the specifies of the developmental phase, it might be seen that, in the "run next to the express train," analytic work was being accomplished in terms of a renegotiation of the paranoid–schizoid position. Thus when Geleerd states, "With this age group the emphasis is predominantly on the problems of daily life …. There appears to be a general poverty of

material … and little communication of fantasy life" (**1957**, p. **264**). She is addressing, I believe, a relationship organized along schizoid themes. The aim of the therapeutic relationship is not to facilitate a special intimacy, but rather to facilitate a relationship in which distance is accepted. Support of defenses does not lie in well-articulated statements of support but in the context and structure of a relationship that can accommodate the developmentally limited capacity for relationship.

It has been suggested **(Harley, 1970)** that the limitations of psychoanalytic technique for the adolescent probably reflect a limitation of knowledge about the nature of adolescent psychopathology. A study of the more extreme manifestations of developmental psychopathology may serve to illuminate the processes of normal development. In the two cases which I briefly presented, the psychopathology was extreme, and the required psychotherapeutic technique was an exaggeration of what may be required for the less deviant adolescent. In formulating the early adolescent regression in terms of the Kleinian concept of the paranoid–schizoid position, I have emphasized the structure of experience and the capacity for relatedness which have direct bearing on the specific relationship in which psychotherapy will be elaborated. I believe that this consideration takes precedence over the specific conflictual themes associated with the various phases of adolescence **(Blos, 1962b)**, the usefulness of which assumes a more-or-less insistently interpretative analytic approach. Content cannot be divorced from structure and the capacity for relatedness.

The less deviant adolescent will not show as fixed a regression as did the two adolescents I presented. His experience will shift between the earlier organization of the paranoid–schizoid position and the progressive depressive position of greater self and object stability. A radically different analytic approach is required in each of these early relational positions. The analyst who is aware of such differences will proceed with a greater clarity of therapeutic aim.

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