CASE STUDY

Short-Term Psychoanalytic Psychotherapy with Obsessive Preadolescents

CHARALAMBOS S. IERODIAKONOU, M.D.*
IOANNA IERODIAKONOU-BENOU, M.D.**

The phenomenological and psychodynamic differences between obsessive preadolescents and obsessive adults are pointed out. Case material shows how an effective therapeutic alliance on psychoanalytic lines can be established quite early with preadolescents. The therapy can be shortened mainly by opening up sexual subjects connected with the onset of puberty, and by working through the guilt engendered by the ambivalent relations this age group has with its parents.

The special problems of dealing with the obsessive personality traits, particularly those of preadolescents and early adolescents, have great clinical significance, both from a therapeutic and a preventive aspect. When youngsters of that age use obsessive mechanisms, they suffer and are prevented from being effective or enjoying that period in life. They are confronted with various ambiguities, while their healthy psychosexual development into adolescence is obstructed. There is imminent danger that the obsessive mechanisms will be permanently established and the individual may become a chronic psychoneurotic in adulthood. The task, therefore, is to find the most effective therapeutic method for removal of symptoms, as well as of the underlying obsessive processes, thereby preventing the psychoneurosis from taking root.

Various psychotherapeutic techniques have been used and are being continuously developed in an effort to solve that problem, resulting in different outcomes.[1–3] Our position is that a psychoanalytically oriented

* Professor of Psychiatry, AHEPA General Hospital, University of Thessaloniki. ***Mailing address:*** 4 Aristotle Square, Thessaloniki 546 23, Greece.
**Psychiatrist, Hippocratio General Hospital, Thessaloniki.

treatment is the most promising approach for solving the conflicts that lead to obsessive manifestations. It opens, at least, the possibility for a change of the mechanisms with which problems will be dealt in the future. The question remains, however, how much can be achieved, especially during the process of short-term psychotherapy.

For a more informed answer, it is useful at this point to look into the similarities and differences between cases of obsessive adults (for whom there are more data regarding defense mechanisms and therapeutic handling [4,5]) and those of obsessive preadolescents. One should also search for the special characteristics of preadolescence—a period that may offer certain advantages for intervention, as we will try to illustrate through our cases.

PHENOMENOLOGICAL ASPECTS

Comparing psychotherapy in preadolescence with that in adulthood, two favorable aspects can be observed on a phenomenological level: First, the fact that preadolescents continuously relate their symptomatology to one of the parents, sometimes to such a degree that they force the parent to replicate their obsessive ideas, makes possible a more extensive and deep analysis of the ambivalent relationship during therapy. Dealing with an ongoing situation facilitates interpretations and the development of a transference relationship, as we will further discuss.

Second, obsessive manifestations in preadolescence are mainly disturbing *ideas* and rarely compulsive *acts*. Tormenting, continuous washing of hands, so frequent in older adolescents and adults, is not usually present. It may appear at ages 16 to 19, but even then more than 20% of adolescents will only show obsessive thoughts with no associated compulsive behavior.[6] The existence of obsessive ideas rather than rituals makes a psychoanalytic approach clearly the treatment of choice, because it allows for verbal communication as means of solving problematic inner thoughts.

It is well known that obsessive ideas in adults are symbolically expressing instinctual tendencies with an aggressive or sexual content.[7,8] The aggressive content is manifested usually by a continuous doubt of the individual "whether he/she may hurt somebody unwillingly," though the patient admits that no harm could actually derive for the reported actions, e.g., "a letter of mine to my father will upset him and he may die"; " the food I gave my colleague was not fresh and he may be poisoned." Mechanisms of ambivalence and omnipotence are here at work, based on anal-sadistic fixations. The aggressive, murderous wish is frequently inverted and formulated into an obsessive idea of guilt and consequent self-punishment,

such as, "I am afraid I may throw myself out of the balcony"; "If I pass by a hospital I may get cancer"; etc. Similar morbid ideas are observed also in preadolescence and adolescence.

During the first interview with preadolescents, ideas of sexual content often escape the attention of the clinician. Even in subsequent sessions, the youngster may be embarrassed or ashamed to report them. They are, of course, of vital importance, being part of the nucleus of the conflicts and increase the sense of guilt. Sometimes the sexual ideas are incestuous or homosexual. In other cases, sexual and aggressive components exist together.

Case 1

A., 14 years old, repeated in his mind the word "cousin" many times, imagining her being half-naked with him. Then he could neither restrain himself from uttering or thinking indecent words nor could he shut out tormenting ideas about "the death of the cousin's fiance." A.'s other symptoms also pointed clearly to sadomasochistic elements; "I am afraid I may kill somebody by mistake," and then, turning the aggression into self-punishment: "I am continuously worrying I may die of cancer."

PSYCHODYNAMIC ASPECTS

On a psychodynamic level the obsessive mechanisms in preadolescence and early adolescence are similar to those of adults, but because of the lower age, there are differences that facilitate the psychotherapeutic process. Intrapsychic conflicts have a direct relation to anal, sadomasochistic fixations, which create insecurity and doubts in individuals about their ability to control themselves. With such difficulties in a pregenital stage, aggressive and demanding attitudes remain unaffected, without much possibility for them to be changed during the Oedipal stage; even less so, since the parental figures of obsessive patients do not as a rule allow for a helpful, affectionate relationship.

Obsessives often come from an environment where parents stress self-discipline and self-control. The mother is usually rigid, pedantic, insecure, anxious, and possibly full of prejudices. The father is very formal, emotionally distant and adheres to strict rules.[9] Being naughty or noisy is considered a serious infraction. In many cases, toilet training had been hasty and coercive. No expression of any type of aggression or even indignation had been allowed to the child, and spontaneity is generally inhibited. Emphasis is put on knowledge and scholastic achievement rather than on emotional relations.

Restrictions and prohibitions tend to produce a strict and relentless

superego in the child. Preadolescents who present with obsessive symptoms almost always continue to live in the same family atmosphere that had led to the symptom formation. This currently experienced reality can be discussed within the psychotherapy process and can immediately be dealt with. This constitutes a good therapeutic and prognostic opportunity. Quarrels and disputes with the parents come more easily to the surface during a psychoanalytically oriented therapy and so new and healthier attitudes can be established. It is not, as in the treatment of adults, where past parental commands have been totally incorporated in a solid superego.

As a result of the rivalries and controversies dominating the parental environment, aggressive drives remain particularly strong and manifest themselves with sudden and cruel actions against others (sadistic) but, because of prohibitions of the superego, are also directed toward oneself (masochistic).

Case 2

R., an exceptionally clever 11-year-old boy, was persistently preoccupied with ideas about God, the existence of man, "what might have been in the space if the space and the universe did not exist"; various questions about stars, and other questions that perplexed him. His father, a high-school teacher, distant and easily vexed, had many pecularities and "grumbled like a little child," according to the mother. She was an active but insecure woman, who admired R.'s intelligence. She found it was always difficult "to get the whole family (i.e., father and an older son) together, without a fight between them." Aggression of a sadistic intensity was apparent in R.'s cold and hostile comments about his schoolmates and his father. It also emerged in connection with other subjects. For instance, he wondered why other children were sympathetic to a little mouse if a cat chased it, since he "considered it just and right that the cat, being stronger, would eat up the little one." He also did not approve when seeing a cartoon that a small bird (Tweety) escapes and is not swallowed by the big cat (Sylvester). R. would bring to the therapist a school newspaper, which he prepared by himself, being the sole proprietor, editor, reporter, director, feature writer, and artist. He drew only monsters, which he discussed with the therapist at the beginning of the session. In later sessions connections between the monsters and his parents emerged.

The case illustrates one of the aims short analytic psychotherapy of obsessive preadolescents should focus on: the lessening of aggressive drives

through the transference relationship, always in reference to the parent-preadolescent relationship.

The tremendous tension caused by the repressed and unexpressed aggressivity creates—through multiple defenses—a sense of guilt. Since the repetitive thoughts, which are a kind of self-punishment, do not succeed in relieving the guilt feeling, it becomes a treatment target. During a short analytic psychotherapy, the therapist should focus on guilt, since such a move at the right phase is comforting for the patients and promotes positive transference.

Theoretically, a very significant conflict that may produce ambivalence and guilt takes place during the anal phase, when the child faces the dilemma whether or not to satisfy the mother who insists on cleanliness and obedience. Guilt may also to a great extent derive from conflicts with the parental figures during the oedipal phase.[10,11] In obsessive patients, oedipal themes regress to anal fixation points—a process that explains the sadistic intensity of the interpersonal relations.

The continuous doubts of obsessive persons whether or not to undertake forbidden actions, their dilemma between obeying orders passively or imposing their wishes (a conflict reflecting on their symptomatology) are actually a struggle with their superego to see whether they will be considered " a guilty or a good child." Our argument here is that, in spite of the oedipal phase having passed, obsessive preadolescents are still continuing the struggle with their parents—not with parental representations—thereby affording further opportunities for reformation of the superego. This is, therefore, an area that can be addressed directly and openly, even in short analytic psychotherapy. Our experience shows that it can lead to a fairly rapid improvement in young patients before a rigid, oppressive moral conscience is ingrained.

In addition, we should mention some psychodynamic aspects of preadolescence that prove helpful during psychotherapy. In preadolescents, mechanisms of intellectualization, isolation of emotions, or introspection have not been as firmly established as in adult obsessives. Preadolescents or early adolescents continue to search for their emotional relationships, both in their families and, by displacement, among their peers. The same will happen in the transference situation, through which they will learn how to gradually discharge their aggression and how to accept a partial gratification, instead of the characteristic obsessive attitude of "all or nothing." They will thus understand that their interpersonal relations can survive in spite of their fears.

PSYCHOTHERAPEUTIC ISSUES

As discussed above, obsessive preadolescents can be much more easily approached than adults, and psychoanalytic psychotherapy provides many channels for their improvement. On a phenomenological level, the symptomatology connected with the continuing interrelation with the parents, the existence of obsessive ideas rather than compulsive actions, and the presence of not only aggressive but also sexual thoughts are indications for a therapeutic method based on psychoanalysis. On a psychodynamic level, the sadomasochistic fixation and the dramatic, ongoing struggle with the parents need psychoanalytic working through to reconstruct the superego. Guilt feelings, emotional engagement, and a low level of intellectualization facilitate focussing on selected subjects and strengthen the effectiveness of even short-term psychotherapy.

During the initial phase of treatment, these elements promote the therapeutic relationship. Children do not usually have the resistances, dogmatism, and theoretical ways of thinking of adult obsessives, so that more emotional investment is present from the very beginning. Even aggressive drives are not shown through various mechanisms but are expressed directly against the parents, siblings or schoolmates. The oppressive home atmosphere, at an age when preadolescents or early adolescents are searching for more autonomy, push them to a therapeutic alliance in which they can speak openly and sometimes ask for the therapist's intervention.

Initial resistances may appear if the youngsters are coerced by the parents to enter therapy. They will, however, cooperate as soon as they understand that the therapist will remain impartial. The tormenting symptoms and the need for relief from guilt feelings create an inner pressure that hastens the development of a therapeutic alliance.

Preadolescents may show resistance to therapy (or even refuse to attend) if the therapist does not give them a chance to refer to obsessive thoughts of a sexual content, their appearance, their sexual identity—thoughts about which they may feel ashamed.

Case 3

M., a 13-year-old girl, presented with obsessive ideas and doubts, such as, "Is the earth round or is it not?", as well as fears that "something might happen to her." Consequently, she had been avoiding going out by herself during the previous year. No other symptoms were reported. The parents only pointed out that "she never was jealous of her brothers." When M. stayed alone with the therapist, she referred to her parents' fights. She also

mentioned that she was haunted by thoughts that "Christ was not pure and saintly," and that "a porno scene from a TV show comes constantly to my mind." She also "made a confession" that she considered herself "ugly, short, with a big mole on the cheek." A little later in the session, she said, "Ah, I keep thinking of a schoolboy. . .," and then she blushed.

Case 4

R., an 11-year-old girl, was obsessed with fear that if she passed by a place with garbage, she might stumble on syringes of drug addicts and get infected. Her mother admitted that she insisted that R. clean the toilet meticulously. She also was pressuring R. to bring top grades from school. R.'s ambivalence toward her mother was obvious. On the one hand, because she was afraid "she might die in her sleep," R. insisted on sleeping with her mother. Yet, she complained to her father that "mother never loved me." During the second session, R. said about her younger brother of whom she was very jealous: "He beats me, and I. . .hold his hands," and then immediately added: "I don't like the girls in my school." In the same session, she was given the opportunity to refer to her body image. Her bosom was not developed, but she wanted to become slimmer; she had not yet menstruated and she was afraid that if she did, "she would not grow taller." Then she stated: "I never before realized how shy I am about sex."

Case 5

P., a 12-year-old boy from a cattle-raising family in a secluded, distant area was tormented by his urge to repeatedly use dirty words about saints. He was unable to stay long in church. His father, a simple and naive man, said during history taking: " I thought he already knows about those (sexual relations) from the animals, doctor!"

At the next meeting the therapist opened the subject, upon which P. immediately referred to his ignorance and anxieties about sex, particularly masturbating, and asked for more detailed information. At the third meeting he reported that the dirty words no longer occupied his thoughts, and psychotherapy proceeded in the usual way.

The therapist should not hesitate to discuss sexual subjects, such as masturbation and the consequent guilt feelings, which are of special concern to preadolescents. Sex should be brought up by the therapist at first indirectly but, if necessary, a more direct approach is recommended. That will greatly shorten the treatment and many conflicts and ambivalence will come to the fore more easily and quickly.

Psychotherapeutic experience shows that in preadolescence and early

adolescence, youngsters are looking for discussion and enlightenment about masturbation, about which they feel guilty. But they also complain that their parents never instructed them about it. A direct and proper approach by the therapist will enable patients to bring the subject out into the open, talk about it, and feel (maybe for the first time) that they can relax their extreme self-control. In a few cases, it may be necessary to choose a therapist of the same sex in order to facilitate discussion and free association to such subjects.

We have found that conflicts of a sexual nature with consequent guilt in preadolescents are at the bottom of "indecent," "dirty" obsessive ideas, which, as a result of fear of damnation, are frequently related to religious themes. Very often obsessive preadolescents are tormented by thoughts like, "Mary was not a virgin," "Christ had an affair with Magdalen," etc. Such ideas are basically questioning the parental and social commands in a morbid way, adding more guilt and making them feel "like being a sinner." This is particularly true in rural areas where sexual education by parents is still taboo.[12] The therapy is, therefore, shortened when the therapist and patient work through the displacement of personal sexual problems to religious ones. Sometimes, a surprisingly quick relief from such preoccupations is obtained when the sexual subjects are brought in the open; a cure, however, requires more time. Finding a treatment focus is generally accepted to be a helpful technique in short-term psychotherapy of both adolescents and adults.[13,14]

Case 6

E., an 11-year-old girl, with excellent marks at school, started to neglect her studies. Some days, she would sit alone without saying anything and sometimes she would burst into tears, full of anguish. In psychotherapy, it was revealed that during those moments she had "wicked" thoughts. E. had to repeat in her mind that her "bottom was turned on"; to utter insults against the Holy Mother; or to think again and again about scandalous erotic scenes she had watched on TV. E. was afraid, she would bring death to her family and so she avoided going out. She no longer wanted to sit on her father's knees, and she began to be interested in her mother's underwear. She asked her mother about "the affairs between the two sexes," getting no answers since her mother "felt lost" with such subjects!

A vivid transference situation can be established quite frequently with preadolescent patients, because of nonintegration of the personality at that

age and of the continuing struggle with the parents—factors that make the youngster compare the therapist's attitude with those of the parents.

Resistances are more prominent when the patient projects negative aspects of the parents. The therapist should be prepared for those resistances, so he/she can avoid countertransference mistakes. A common cause for resistance at this age is the preadolescents' desire for freedom, which the therapist can handle in a better way than the parents. In cases where patients "forget" their appointments, a probable defense against the emergence of erotic phantasies toward the therapist must always be considered, especially if the therapist is of the opposite sex. The increase of physical sexual desires at this age leads every now and then to flirting or to covert rivalries with the therapist (in the same way many boys seemingly reject girls and vice versa).

A positive transference relationship, in spite of the intensity of aggressive drives, is not difficult to be established in cases of obsessive youngsters. One must not forget that such patients have been deprived of emotional contact and understanding, which they now seek from the therapist. Among the many narratives of everyday happenings related by these youngsters—sibling rivalries, "gossip" by and about schoolmates, family fights, etc.—the therapist will find opportunities to strengthen the therapeutic alliance and help preadolescents to form their sexual identities and more accessible ego ideals.

Case 7

L., a 13-year-old girl, had been "afraid she might contract cancer" while she was still in elementary school. For the last year she had also been afraid of various graphic signs, such as an upside-down cross, or a number (666 being an anti-Christ symbol). She had to sing several Psalms, so she "wouldn't go to Hell."

Early in psychotherapy, L. started to dwell on two subjects: (1) animosity toward her mother (a fearful and pedantic woman) who always gave L. instructions on everything, usually "ending with a should or a must"; (2) interminable stories about the boys and girls in her class, showing obvious aggressive intentions, which she covered up with laughter.

When the therapist assisted in introducing the subject of the relation between the sexes, L. gave a lot of details about love affairs between schoolmates. She voiced her fears of being ugly and suddenly mentioned how, a couple of years ago, she had been "in love with a boy and felt guilty." On that occasion, she also made a lapsus linguae (in Greek), which may be

translated: " The other girls are relaxed and audacious when they want to get laid," immediately laughing and correcting, "to lie, I meant."

L. came only once a week, but a transference relationship was soon established. In the seventh session, for example, she said: "Let me show you the blouse I bought," or, "Oh, how sweet you are when talking." She continued to delve on similar subjects and obsessive thoughts, which, at other sessions, she said that she "had forgotten." So she again applied herself to her studies.

In the twelfth session, L. presented a better insight: "Yes, perhaps I am jealous; I don't know how to kiss with the tongue as a friend (girl) does. May be I am afraid of such distasteful things." At the same time L. admitted that she liked the way a pianist had been looking at her lately.

A gradual easing of the strict tendencies of the superego is feasible in such a therapeutic relationship, frequently without the need for interpretations of past events, but by working through current emotions and everyday events. When questions and ambiguities of preadolescence (e.g., about self-image, parents, schoolmates, the opposite sex) are resolved and ambivalence decreases, patients proceed to the next developmental stages without a morbid escape into obsessive symptomatology.

During psychoanalytic psychotherapy, obsessive preadolescent patients may pass through various phases of optimism and despair, of pleasant phantasies and self-deprecation. Nevertheless, at the end, therapy will usually enable the youngsters to achieve the step-by-step integration of their personalities.

SUMMARY

Obsessive preadolescents have a lot in common with adult obsessives, but there are differences—explored in this paper—that give the therapist opportunities to achieve results more expeditiously. Conflicts are current—not only past—realities in preadolescence and, therefore, situations and emotions are not yet deeply repressed. Everyday experiences, especially the ongoing close and ambivalent relations with the parents, are more open to effective analytic interpretations. The intense child-parent relationship leads to a vivid transference climate even during short-term individual analytic psychotherapy. That is shown by the youngsters' erotic tendencies toward the therapist. It is also demonstrated by a displacement of aggression (e.g., toward schoolmates) or, more often, by persisting resistances due to underlying sadistic drives. The problems connected with the imminent sexuality of puberty, especially masturbation, produce very strong conflicts

and consequent guilt feeling with relevant obsessive thoughts. Such subjects, if brought up in time and worked through, can shorten the duration of analytic therapy.

REFERENCES

1. March, J.S., Mulle, K., & Herbel, B. (1994). Behavioral psychotherapy for children and adolescents with obsessive-compulsive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 333–341.
2. Salzman, L. (1966). Therapy of obsessional states. *American Journal of Psychiatry, 122*, 1139–1146.
3. Kendall, P.C. (1991). *Child and adolescent therapy: Cognitive-behavioral procedures*. New York: Guilford Press
4. Swedo, S.E., Rapaport, J.L., Leonard, H., et al. (1989) Obsessive-compulsive disorder in children and adolescents: Clinical phenomenology of 70 consecutive cases. *Archives of General Psychiatry, 46*,335–341.
5. Freud, A. (1954). *The ego and the mechanisms of defence*. London: Hogarth Press.
6. Toro, J., Cervera, M., Osejo, E., & Salamero, M. (1992). Obsessive-compulsive disorder in childhood and adolescence: A clinical study. *The Journal of Child Psychology and Psychiatry, 33*,1025–1037.
7. Freud, S. (1895). Obsessions and phobias. In *Standard edition*, vol. 3 London: Hogarth Press.
8. Freud, S. (1909). Notes upon a case of obsessional neurosis. In *Standard edition*, vol. 10. London: Hogarth Press.
9. Ehiobuche, I. (1989) Obsessive-compulsive neurosis in relation to parental child rearing patterns amongst the Greek, Italians and Anglo-Australian subjects. *Acta Psychiatrica Scandinavica (suppl.)*, 115–120.
10. Winnicott, D.W. (1958). Psychoanalysis and the sense of guilt. In *The maturational processes and the facilitating environment,* chap.1.London: Hogarth Press.
11. Adams, P.L. (1973) *Obsessive children: A sociopsychiatric study*. London: Butterworth.
12. Ierodiakonou, C.S. (1988). Adolescents' mental health and the Greek family: Preventive aspects. *Journal of Adolescence, 11*, 11–19.
13. Swift, W.J. (1993). Brief psychotherapy with adolescents: Individual and family approaches. *American Journal of Psychotherapy, 47*, 373–386.
14. Balint, M., Ornstein, P., & Balint, E. (1972). *Focal psychotherapy*. London: Tavistock.