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Adolescent Sexuality

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ABSTRACT: The reader is offered a contemporary view of adolescent sexuality, which has evolved into new forms of sexual behavior, in response to current shifts of values and societal realities. The current phenomena of excalating sexually transmitted diseases and teen-age pregnancy and parenthood are examined. The recent developments in clinicians views about homosexuality and heterosexuality are also offered. A case of more "optimal" adolescent heterosexual activity is presented, depicting the accompanying self questioning, uncertainties, passions and inner musings, regarding a male adolescent's sense of self and self object choices.

Introduction

Anna Freud noted that following the publication of "Three Essays on Sexuality" [S. Freud, 1905], and the observance of the existence of an infantile sex life, the significance of adolescence diminished. Prior to this publication ". . . . adolescence a derived major significance for its role as the beginning of sex life in the individual; after the discovery of an infantile sex life, the status of adolescence was reduced to that of a period of final transformation, a transition and bridge between the diffuse infantile and the genitally centered adult sexuality" [A. Freud, 1958, p. 256]. Understanding the contemporary teenager necessitates consideration of the existent social changes which have altered familial style, roles, parental work patterns and adolescent peer behavior and sexual patterns. Currently, we observe ever increasing numbers of children raised without consistent parenting. The increase of divorce has all but ended shared parenting. The lack of an available extended accessible family and inconsistent social ties are the inevitable results of increased social mobility. The high proportion of substance abuse and the resultant regression has made it

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difficult for many adolescents to tolerate frustration and to develop and sustain significant emotional attachments. These realities, the excessive dependence on music, peers, and drugs, have resulted in a paucity of tolerance for ambivalence and ambiguity. The extended period of financial dependence and academic preparation, combined with the expanded time period in pre-adult personality consolidation, has altered our concept of adolescence and the age-appropriate behaviours of this time of life. All of these realities have altered the teenagers approach to sexuality and intimacy. Today's adolescents have been affected by the sexual revolution and the new feminism, which many believe complicates the consolidation of late adolescence.

Patterns of heterosexuality have changed also. Teenage pregnancy is of epidemic proportion and increasing numbers of adolescents have rejected a heterosexual orientation in favor of a bisexual or homosexual lifestyle. For both gay and straight youth, sexually transmitted diseases are running rampant. Regardless of one's theoretical orientation, these phenomena must be recognized by clinicians working with the contemporary adolescent. Successful engagement and sustainment of the therapeutic relationship requires clinician's sensitivity, and when appropriate, openness to modify concepts or therapeutic postures that alienate young people who reflect vulnerability as they attempt to master a whole new set of demands and expectations that further threaten autonomy and self-esteem. Minimizing personal, social and cultural conflicts, and normalizing heretofore recognized pathology is a danger. Because specific behaviors are widely observed, they cannot be dismissed simply as "the youth culture." Indeed, the casualties of youth are on the increase.

Kaplan [1984] notes the current cult of immediacy with its emphasis on sensation, which saps the vitalities of the young and "incites their sexual passions to precocious consummation, stultifies their intellect, trivializes their imaginations" [p. 336]. Adolescence is ordinarily a period of significant upheaval and developmental stress. Now current sociocultural and technological phenomena have complicated earlier easier possible career choices. Additionally, familial breakdown, and lessened institutional support heighten problems of maturation for today's teenager. Rather than "blaming the victim," these interfamilial and cultural realities must be recognized as contributing to the accelerated modes of drive expression of today's youth. This is clear in the new forms of sexual behavior, as well as aggressive expression. The remainder of this paper will examine the

implications and outcomes of adolescents' sexual behavior in the context of changing values and realities.

Teenage Pregnancy & Parenthood

"Adolescent pregnancy in the United States is now the fourth highest in the world . . . " [Copeland, 1981, p. 245]. Fisher & Scharf [1980] in discussing teenage baby keeping, observed that 95% of lower-middle class and working class girls keep their babies. Abortion "had become a relatively accepted solution to the pregnancies of middle and upper-class American girls . . . and long-time observers believe that they are seeing a rise in adolescent abortions. . . . The different maternity rates may only reflect the greater push for abortion by the middle-class families and a greater number of alternative channels to displace the emptiness and psychological disturbance that can characterize all these girls, regardless of social class." [ibid p. 394-395].

Given the recent disssemination of birth control information, and no apparent diminution of pregnancies, rather in fact a rise, we must recognize that prevention, education and intervention has little impact on the dominating psychological factors. One such factor appears to be a "peculiarly tenacious quality of symbiosis within the maternal line, . . . and this dimension of character is most unresponsive to [educational] intervention" [ibid. p. 395]. Few adolescents desired marriage despite pregnancy, and there is a high degree of marital failure in the teenage groups who actually marry.

Biologic factors associated with adolescent pregnancy are numerous, and Copeland [1981] points to an elevated mortality rate, toxemia, anemia, prematurity, and the repeated finding that the babies of young mothers are considered as being at risk. Many adolescents consider precocious sexual activity and pregnancy as avenues for emancipation and independence. However these behaviours commonly are, in fact, evidence of conscious or unconscious compliance with the symbiotic mother, [Fisher & Scharf, 1980] and in reality cause greater dependency on the mother [Copeland, 1981] who most always cares for her adolescent daughter and her infant. Copeland [1974] notes that adolescent repeat pregnancies arise out of an incomplete sense of identity and poor self-esteem; other authors [Douvan & Adelson 1966; Bandura & Walters, 1963] observe early closure in personal development and overidentification with mothers who themselves were teenage mothers. Teenage maternity limits life

choices and personality development, and restricts these young girls from educational, vocational, social and emotional growth. Pregnancy and subsequent maternity seem to interfere with the completion of developmental tasks of adolescence [Copeland, 1981].

Fraiberg [1982] states that the more disturbed teen mothers, with emotional problems of attachment and detachment, were mirrored in severe disorders of attachment in the babies, and in fact were "the most severely impaired children in our case load" [ibid, p. 81]. "Failure to thrive" babies are joyless, listless, inconsolable, and often retarded in physical and emotional development. Depressed young mothers frequently become neglectful and severely abusive, particularly when they and their infants are living in poverty, and miss support from family, extended kinship network, and/or community. They have an incapacity to parent.

The treatment focus that Fraiberg describes is a form of undoing the past, by way of examination of the intense internalized rage of teenagers towards their own abusive, neglectful parents. Unsatisfied longings, hopes for mothering, the baby of fantasy who will offer rebirth, or fill the sense of emptiness, must be articulated. Helping teen mothers identify with their own early selves rather than with their abusive aggressor parents facilitates maturation, separation and individuation, as the adolescent mother surrenders symbiotic ties to her mother in the safety of the therapeutic relationship. The goal is to help the overwhelmed young mothers empathize with their babies, via an empathic identification with themselves in their early years.

Effective programs provide educational and career facilities for teen mothers, and outreach and involvement of teen fathers whenever possible. Most necessary is the need for long term services and "client contact beyond the separation-individuation phase of the child" [Fisher & Scharf, 1980, p. 397]. This is a crucial period for these mothers, in that they have not effected separation and individuation in their own lives. The most vulnerable period occurs as the babies begin to talk and walk. The mothers will hopefully have begun employment. They feel fragile, explosive, overwhelmed and depressed, tempted by ideas of placement. They regress and display poor impulse control, leading potentially to neglect, physical abuse, and/or a new pregnancy.

Some programs, with follow-up studies showing impressive results, offer various levels of therapeutic intervention, based on an assessment of those at minimal, moderate, and high risk.

> Mothers of infants consistently placed at high risk presented serious characterological and borderline characteristics. They appeared to feel negative and unconcerned about their babies or see them as a burden. Becoming pregnant was a form of acting out. Their babies were at very high risk diagnosed as 'failure to thrive' during the first year, and, as abused and neglected during their second year. Family backgrounds were chaotic with no role models for these [young] mothers to emulate. Their own mothers were in some cases having more children and had little time or love to give these adolescent daughters [Salguero et al., 1980, p. 419].

Optimal services for these unwed adolescents are comprehensive health services by obstetricians, pediatricians, nurses, dentists, nutritionists, child psychiatrists, psychologists, social workers and special education teachers in a community health facility.

Sexually Transmitted Diseases

Infections spread by sexual contact need to be understood by adolescents and all personnel engaged with them in professional work. AIDS, Acquired Immune Deficiency Syndrome, once considered the gay plague, only affecting homosexuals and intravenous drug users, now is the number one public-health menace, threatening ever increasing groups of individuals. "No one has been known to recover. Once infected, a person is infected and infectious for the rest of his life" [Clark et al., 1985, p. 20]. This disease is no longer solely passed on by drug users or between men, but now has struck women, children of parents carrying or with AIDS, patients receiving blood transfusions, and hemophiliacs. AIDS symptoms include Kaposi's sarcome, i.e. skin cancer, swollen lymph glands, fatigue, fever, night sweats, diarrhea and gradual loss of weight. Because of the virus's invading brain cells, mental and neurological problems are noted, such as impaired speech, seizures and tremors. Bodily fluids and blood transmit the disease, e.g., sexual activity, intravenous drug use and blood transfusion.

Quick diagnosis and immediate intervention reduce the risk of serious complications with other diseases transmitted by oral sex and even kissing, as well as sexual intercourse. Gonorrhea is easily diagnosed in males from the puslike discharge from the penis and painful frequent urination. In females, when the symptoms do occur (vaginal discharge, burning with urination, and abnormal menstrual patterns), they are often mild and overlooked. This is indeed serious because, untreated, this disease can cause permanent sterility. Treatment is large dosages of penicillin, with almost 100% cure.

Syphilis, less common today, affects males more often than females. A painless sore appears on the genitals or near the anus, but also, on a finger, the lips or inside the mouth. Untreated this sore heals in a matter of weeks, creating the false impression that the infection has gone away. However, the infection moves into what is known as secondary syphilis and may not be apparent for six months. "A latent stage occurs where the infection invades tissues such as the spinal cord and brain; in the most devastating stage of late syphilis, serious heart problems, eye problems and brain damage can occur. It is effectively treated (best in the earlier stages) with penicillin" [Kolodny et al., 1984, pp. 85–86].

Herpes virus type 1 occurs above the waist and herpes virus 2, below the waist. We hear about herpes on radio, TV, the newspapers and feature magazine articles. Cold sores, mononucleosis, chick pox and shingles are caused by herpes virus. The real increase in the herpes virus family has been in genital or venereal herpes, which undoubtedly spread because of more casual liaisons, minus conventional contraception, abandoned because of the development of the contraceptive pill. The psychological impact has been enormous on those that have the disease and on those who fear contracting it. The fear relates to the incurable nature of the disease and the serious consequences, particularly for women and infants. Herpes is passed on by kissing or sexual intercourse, genital to genital, or lovemaking, mouth to genital, rectal to genital, and mouth to rectum.

Genital herpes infection is no different in incidence, severity, and management in the homosexual community. "There is, however, another lesser known herpes virus which is causing severe problems which are largely confined to the gay population" [Langston, 1983, pp. 158–159] Cystomegalovirus [CMV] appears to interfere with the body's ability to fight infection, and the development of a particular form of cancer known as sarcoma. If diagnosed promptly it may respond to early x-ray therapy.

Laskin [1982] has written about the Herpes Syndrome, the sense of being impaired, damaged, anguished and in isolation. Support groups, psychotherapy, group therapy, hypnosis and relaxation techniques are noted as successful avenues to explore to regain self-esteem and self-confidence. Herpes is only as devastating as a patient allows it to be. This disease is profoundly dependent on mood and emotion, and thus once a patient is more emotionally stable, many outbreaks are tamed, managed and diminished.

Homosexuality

Homosexual oriented activities and fantasies are common in male and female latency children, when object choice is normatively narcissistic. Blos [1962] posits a similar later normal homosexual stage lasting into early and middle adolescence, of positive value because it contributes to the evolution and maturation of the ego ideal. Traditional psychoanalytic theory suggests that when there is not an ultimate heterosexual orientation it is due to a pathologic deficit or arrest, due to the adolescent's having experienced early trauma, sexually, often due to molestation or overstimulation, or, unresolved problems in the parent-child relationship.

Other clinicians assert that homosexuality is "a normal variation in both sexual orientation and sexual behavior." [Marten, 1982, p. 52]. Still others disavow engagement in discussion about the health or pathology of homosexuality versus heterosexuality, but maintain the position "that in the absence of developmental interference, preferential adult heterosexuality is the species, as well as the mammalian norm" [Gadpaille, 1978, p. 139].

The traditional view holds that problems in child-parent relationships can predispose a child towards a permanent homosexual orientation [S. Freud, 1905; A. Freud 1958, Looney 1973, Swanson et al. 1972, etc.]. Originally homosexuality was explained in terms of drive theory with emphasis on the unresolved oedipal conflict and intense castration anxiety it caused by the interplay of a child's and/or parent's inability to surrender the erotically charged oedipal relationship. In the situation where a parent has died, or is inordinately weak, absent, cold, hostile or frightening, the child, will not identify with this absent or negative parental figure. Ego psychology and object relations theory note that some children, e.g. borderline youth, never effect genuine separation and individuation, but remain symbiotically bound to the original object, the mother. Staller [1974] notes that when a boy baby remains tied to mother, this will lead him to feeling like a woman, and cause the male adolescent to seek love and intimacy with other males. "However, even if he does not identify with her, . . . his wishes to remain faithful to her cause him to give up other women permanently. On the other hand, an overly close relationship between a boy and his father can lead to powerful love feelings for father and a male object choice for sexual activity even though the identification is masculine" [Robinson, 1980, pp. 424-425]. Female homosexuality may be caused by an overly strong attach-

ment to the father and a need to reject other males, or by the fearful reaction to mother's envy over the daughter's bond with father. Some female children reject the feminine role out of distaste for their mother's submissive role in which they have been dominated or abused by the father. Other clinicians note that 'feminine' girls homosexual stance emanate out of parental rejection and disapproval of the girls' oedipal strivings; fear of paternal rejection, and/or fear of mother's envy and disapproval.

Homosexuality more currently is explained as due to pre-oedipal arrests and deficits. For example, an incomplete early symbiosis with the mother can cause female offspring to seek maternal nurturance in their subsequent object choices. Family violence, increase in substance abuse, and subsequent loss of drive regulation has created many child victims, particularly when children are raised in nonintact families in which parents' lovers and series of partners are not restrained by incest taboos. Trauma can occur when a child witnesses or overhears parents engaged in intercourse.

Robinson [1980] notes nonsexual determinants. Proclamation by gay liberation groups that "homosexuality is a normal, even superior, alternate lifestyle" has attracted many older adolescents. Defries [1976] has described what he terms "pseudohomosexuality" in female college students. When adolescents are struggling to make attachments and resolve identity conflicts, many have combined ideological and political feminist issues with sexual identity issues.

Some researchers distinguish between gender identification and object choice. Individuals who choose a homosexual love object may not have gender identity problems but individuals with gender identity confusion are prone to a homosexual adaptation [Whitman, 1977]. Gadpaille [1978] takes issue with the perspective that sexual identity and object choice, i.e. sexual orientation, remain fluid and modifiable through adolescence. Current childrearing practices, in this researcher's view, are causing lack of "heterosexual readiness." Gadpaille notes Western middle-class constraints on early childhood sexuality, in contrast to the "remarkable infrequency of either sexual deviations or sexual dysfunctions in cultures permissive of childhood homoerotic sex play and curiosity" [ibid., p. 151].

Cultural permissiveness is also addressed by Josselyn [1974] in her discussion of the changes in sexual mores among adolescents. She observes extreme points of view—from open homosexual gratification as indicative of superego lacunae to considering guiltless sexual behavior as evidence of healthy achievement of freedom from repres-

sion. She sees, alternatively, a pseudosexuality, a pseudoheterosexual activity, whereby many teenagers use sexual behavior to express reactivated immature needs because of the failure of culture and family to provide constructive sublimation of the adolescent sexual drive. Reconciling these perspectives entails the notion of greater permissiveness in early childhood and increased limit setting during puberty and adolescence.

The traditional psychodynamic position has regarded homosexuality as a problem that requires either "the beneficial passage of time to allow for maturational processes" [Winnicott, 1965]; the postponement of analysis of homosexual tendencies, until the adolescent has achieved his sex-appropriate orientation, to avoid intensification of the self-doubts and identity conflict [Fraiberg, 1961; Blos, 1953]; or immediate intervention. The notion that self-motivation is immaterial and that guilt and anxiety must be generated is shared by many other psychoanalysts.

By contrast, Szasz [1965] stressed the inadvisability of forcing treatment aimed at a heterosexual adaptation on unwilling homosexuals. Many homosexual adolescents and adults seek treatment for depression and academic difficulty and do not acknowledge conflict about their homosexuality. This is no longer viewed by all clinicians as a form of denial, but instead, a potent preference. The therapist's values and assumptions, and fit or misfit with those of their patients, will influence the therapeutic process. Self psychology has amplified therapeutic positions such as those exemplified by Szasz. Kohut [1966 and 1971] questions therapists' foisting their Judeo-Christian ethic of heterosexual object love onto patients. Different aims and goals are articulated by Self Psychologists who follow the patient's concerns solely in the process of therapy.

Newer programs "provide gay adolescents with the opportunity to have social [and clinical] environments in which they can develop their personal and social skills free from fear of exposure and censure" [Martin, 1982, p. 63]. Such settings provide therapeutic assistance in a self-identification as a homosexual. Professionally trained gay staff may provide gay adult role models. Concerns about the successive acts of deception, social isolation, hiding, stigma and discrimination has stimulated the development of special programs for homosexual youth.

A number of practice principles are offered for professionals working with a homosexual client population, adolescent and/or adult. Clark [1977, p. 149] says: "the gay person has learned to feel differ-

ent . . . has learned to distrust his or her own feelings, often has decreased awareness of feelings, often suffers various degrees of depression and immobility for which misuse of drugs and alcohol frequently occurs." Help can be offered, but not forced. The primary objective is to help the person become more truly himself or herself. All effective clinical work requires the therapist's sensitivity to counter-transference phenomena, in this case one's own homophobic or anti-gay feelings. Breach of confidentiality, by divulging facts about a client's gay identity "is an absolute violation of trust as well as an ethical violation of confidentiality" [Clark, 1977, p. 150]. This includes sharing information with parents, police, an employer or a spouse.

Prejudice inevitably results in stigma, myths, false generalizations, and varying degrees of discrimination. A study by Bell and Weinberg [1978] of the Institute for Sex Research builds on a plan conceived by Dr. Kinsey some 30 years ago. These authors emphasize variables such as race, sex, age, education and occupation and various patterns in relationships which demonstrate as many "homosexualities as there are heterosexualities, each involving a variety of different interrelated dimensions" [Bell & Weinberg, 1978, p. 219] to comprehend the full diversity of the homosexual orientation. Straight therapists might be surprised by one of the major findings of the Bell and Weinberg study.

> It would appear that homosexual adults who have come to terms with their homosexuality, who do not regret their orientation, and who can function effectively sexually and socially, are no more distressed psychologically than are heterosexual men and women. Clearly, the therapist who continues to believe that it is his or her job to change a homosexual client's sexual orientation is ignorant of the true issues involved [Bell & Weinberg, 1978, p. 216].

Other decisions beyond homosexual or heterosexual choce are crucial in adolescence.

> The central dynamic issues, then, are not whether the adolescent makes a homosexual or a heterosexual adjustment, but how he/she arrives at that adjustment and the relative balance between self-love and the capacity to love others. Is the person able to commit herself (himself) to lasting love relationships? Are the relationships dominated by the narcissistic longing to see mirrored in the other what one wishes to be oneself? Does the person have the sexual and moral capacity to be caregiver and lawgiver to the next generation? As we have seen, het-

> erosexuality is no guarantee of sexual and moral maturity. Social conventions make it possible for a heterosexual adult to hide his or her less-than-adequate solutions in a social role. Unless they are pressured into a role of deviant by social conventions, homosexuals also have available to themselves a variety of successful or failed solutions to the incest taboo [Kaplan, 1984, p. 164].

Heterosexuality

Adolescence is viewed as a second chance. The irreversible and final farewell to early passionate attachments to parents invokes anxiety, depression, and profound sadness. For some adolescents, the pain is so intense that they hurriedly cast about, seeking substitute incestuous objects; others preoccupy themselves with daydreams and fantasies that may be lengthy, detailed stories and hopes of love.

Genital masturbation is a phase-specific positive adolescent activity. Some clinicians [Lauffer, 1968; Eissler, 1958; etc.] suggest that its absence connotes psychological immaturity, arrest, or significant disturbance. Submitting to parental prohibitions often results in a subsequent disapproval of pleasurable sexuality and coitus.

Some sexual fantasies create shame and fear, because they, and day and night dreams, are "of having relations with someone of the same sex, of having sex with a close relative or friend, of having sex in unusual or hurtful ways, or of watching secretly while others make love" [Greenberg, 1982, p. 54]. Such fantasies use current people in a teenagers' life, as the day residue, or substitute characters, to mask experiences, people and events from early childhood. Lauffer [1968] states that in normal adolescence, in general a heterosexual fantasy predominates. Problems like phobias, compulsions, impotence and frigidity, when actual sexual activity begins, require therapeutic intervention. They are significant when they create protracted repeated problems. Sexual problems are not necessarily revealed in performance difficulty. Early adolescent heterosexuality is regarded as being primarily motivated by defensive counter-oedipal maneuvers and struggles against strong homosexual strivings [Deutsch, 1967; Blos, 1961].

First crushes and love relations are of lifelong significance. This first bond is a test for how important and desirable the boy or girl is, and the course of the relationship frequently "leaves an indelible impression that may fester in the psyche well into adulthood" [Giovacchini, 1981 p. 141]. Youth live together today in co-ed dorms and apartments, at college, and following graduation, and engage in

social, political and athletic activities relating as asexual platonic friends. The ultimate romantic pairing varies according to the individual's background, maturity, and situation. Sexual fondling is common during early and middle adolescence. "At the beginning of adolescence girls are usually more interested in dating than boys are [and in fact] early dating has more social than sexual significance." [Schowalter & Anyan; 1979 pp. 52-53].

The early falling-in-love experience of adolescence is accompanied by erotic arousal and physical intimacy. This experience is commonly characterized by the narcissistic quality of the attachment, with its absorption, ecstasy, and maintenance of a state of absolute perfection. Kaplan [1984] suggests that despite the frequent devastating aftermath, "it is an honest outpouring and genuine expression of the stream that links the love-hates of the past with the future and the present living in the world" [Kaplan, 1984, pp. 219-220]. The lover often has been selected to represent early adored significant objects, i.e. parents or siblings. First love relationships may continue for a period, or be short-lived, followed by a subsequent intense exclusive attachment.

The exclusive relationships of early and middle adolescence, are replaced by less, rather than more, commitment in the late adolescent phase. Nonexclusive dating patterns, and later, trial cohabitation minus future plans for marriage have characterized the '60's, '70's, and '80's. However, currently the consistent postponement of marriage, commitment and parenthood seems to be abating. We are witnessing a return to the 1950 mores which emphasized marriage and parenthood. The freedoms that followed the widespread use of the pill and other modes of "safe" contraception altered all the so-called prior established rules. Now the epidemic proportions of varied sexually transmitted diseases is creating new viewpoints. Group sex and open relationships are on the wane, with a statistically visible return to the safety of monogomy. Mutual masturbatory relationships, i.e. gratification of the biologically genital level of sexuality, minus a genuine relationship, are increasingly renounced. Unquestionably, health factors have forced adolescents and young adults to examine heretofore casual and transitory relationships. Some researchers contend that they did not find evidence of rampant promiscuity and the sexual revolution in groups they studied in the '60's and '70's. Offer and Offer [1977] studied a very special group of normal, healthy adolescent males, white, from upper-middle class background. They report that juniors in high school disapproved of sexual intercourse

for teenagers, out of fear of impregnation, developing a bad reputation, contracting a disease, or worry about handling sexual intimacy. A follow-up study showed that half the sample group engaged in sexual intercourse by the third year out of high school. The cautions and fears of this well educated group may herald a new era of constraint across socioeconomic, racial, and class lines.

Case of Ben

Ben, was self referred three months shy of his 18th birthday. He was interested in having a therapist with whom to sort things out with, as he was becoming increasingly anxious about beginning college in the next six months. He had been awarded "early admission" to a highly desirable East coast college. Ben is a very attractive, tall, Jewish upper middle class adolescent, enrolled at a prestigious private school in a large metropolitan community. He is a twin and suffers considerable guilt about the fact that he is the more successful brother, achieving excellent grades in contrast to his brother's more average academic achievement. His social adjustment also surpasses his twin, and this has been the case throughout high school. Ben's twin suffered a birth injury with a resultant mild, but discernable, neurological impairment and learning disability. At the time that Ben began therapy, his brother also entered treatment, agitated over his lack of college admission and "wait list" status at several colleges.

Ben presented closeness, love and admiration for his idealized parents. His parents' lifelong active involvement in politics and varied altruistic endeavors were things Ben professed great respect for and he shared their value system and commitments. He indicated that family communication was open and mutually respectful, with conflict arising only in regard to his peer activities, involving drug experimentation in conjunction with his enthusiastic attendance at endless "Grateful Dead" concerts. Mother was described as more "hysterical" about drugs than father, who keeps his "cool" and is able to discuss all more calmly. Ben began with use of pot in the 8th grade and has used mushrooms and LSD. His parents are only aware of the use of hashish and liquor. Though he is sure he is not addicted, Ben admits he is probably using pot too frequently. He states he is careful never to substance abuse in conjunction with driving. Ben is an inexperienced, hesitant driver and mediocre athlete and these activities often appear to be metaphors for his sexual hesitancies and uncertainties. He is nervous about drug usage and the possibility that he will become more involved at college, where drugs are very prevalent. In his college orientation, this reality was frankly acknowledged by the college, and the institutional attempts at handling these phenomena were spelled out to parents and incoming freshmen. Ben has questions about which college dorm to select and stated that he wanted to avoid the "straight preppie" one and opted for one housing what he called a more interesting and varied mix of kids who are "artsy, gay, politically aware and creative." The greater drug use in this dorm seem to be an attraction and repellant.

Ben was very open about a general sense of apprehension about college and recollected older friends literal terror the year before—when they were leaving home. "If I was going to a West coast school—I'd still want to come home over and beyond Xmas and Spring break—maybe 10–12 times during the year." Ben considered not going to college and requesting instead a deferred admission. He predicted parental opposition to such a plan since he had no constructive or worthwhile alternative programs in mind. Additional to his own hesitancies and questions about readiness for college, it appeared that he was loath to possibly move ahead of his brother. The theme of his brother falling behind has been a life long issue, despite parental efforts that he not feel guilty, responsible, or act as the "older caretaker" brother. To further separation and individuation the twin brothers were enrolled in different high schools.

Ben questioned his own maturity and social readiness for college. He reminisced about his struggle at making friends when he entered high school, having transferred in from another school. The parents had become concerned about the administrative changes and highly permissive environments at his initial school. Ben and his parents attribute his initiation into drug experimentation as an adolescent phenomena exacerbated by his effort to connect, conform, make friends and be accepted in a new milieu.

Subsequently, in the course of treatment, Ben blurted out his dissatisfaction and self-consciousness about his sexual and physical development and appearance. Although Ben is actually most attractive, he feels self-conscious and embarrassed, since he's far from what he idealizes and values. He yearns to look older, more worldly and experienced than he does, and he confesses that this is strongly tied to sexual uncertainties. He has entered into a flurry of sexual experimentation during his senior year in high school . . . as though to accelerate his sense of cohesion, competence, and confidence. Drug use was recognized as linked in part to feeling insecure and desperately wanting to relax and stabilize his emotional and sexual regulation. He wants to gain experience with girls and treat them honorably and in a fashion that furthers respect for his companions, self respect and self assurance. Pot and some excessive drinking seems to be used for self medication to stimulate a sense of cohesion, steady nerves and "cool."

Traditional developmental theory suggests that adolescence recapitulates earlier stages, particularly separation and individuation. Alternative perspectives suggest unresolved issues and deficits from earlier phases, requiring different parental responses. Ben believes that mother particularly has not moved beyond her intense upset over pot voiced in early adolescence as he increasingly directed his energies towards his peer group. This seems to be one of several reasons that, as he faces departure from home, he reached out most eagerly for connection with a female therapist and other significant heterosexual attachments to substitute for the original Oedipal object.

In a psychology course in school he was introduced to some of Freud's work, and was particularly fascinated and embarrassed by the concept of slips following several incidents of calling his most favorite girl friend "mother." He acknowledged shame and rationalizations, e.g. how "mothering" and "organizing" is Ellen, in her interactions often with him and his friends. Ellen has been an object of erotic arousal, and first love, shame, betrayal,

disillusionment when she connects with other male peers. Ellen is Ben's idealized best friend, and a stabilizing sex object. He often recognizes that his is fearful, passive and inhibited in being assertive with Ellen, out of fear of losing his connection with her. The closest male friends are described as often impatient with him over the recurrent obsessiveness and sense of tension and frustration he experiences in numerous transactions with Ellen as they oscillate frequently, between an erotic and platonic contact. Other girls have been turned to for some dates, camping weekends, and sexual intimacy and Ben worries about not being exclusively committed, following sexual intimacy. He does not want to manipulate or use anyone, be used, or become promiscuous. He ponders the dilemma of physical intimacy minus real emotional attachment and commitment, something which is sometimes impossible to forge, as he's so young and just about to embark on the expanded social and sexual "open market" at college. Because he and Ellen are about to enter the same college, he is fearful about his emotional freedom to make other genuine connections, and he is alarmed at the prospect of having to witness the same on her part.

It seems Ben is struggling with incomplete separation and individuation from parents and his twin brother. Twinship relationships traditionally delay and interfere with genuine separation and autonomy. Ben's superior achievements, as compared to his handicapped brother, are a significant added dimension, as his freedom to move on also connotes to him abandoning his less competent brother. He does not demonstrate the usual degree of egocentrism and narcissism so universal in adolescence. Ben is attempting to self regulate and modulate affective intensities and, too frequently, he turns to substance abuse to promote self cohesion. The age appropriate sexual uncertainties are difficult for Ben to endure as he struggles with his grandiosity and perfectionistic strivings in the search for a cohesive self. He is facile with his studies and somewhat uncomfortable and guilty to be giving only last minute attention to his courses—resorting to short cuts and superficial handling of academics in the final months of high school since college admission is settled. He feels he is behaving like an imposter in regard to his studies and his heterosexual exchanges with various new girls he's been meeting. Ben would prefer that any and all experiences afford him the experiences of feeling worthwhile and self-respecting. He confesses a sense of shame as he skims, rushes, and offers scant investment in his studies and senior service projects at shelters for the homeless. "I hate my obsession with tallying up the requisite hours and not really letting myself react to those suffering lost souls." Ben aspires to the lofty idealism and genuine dedication to altruistic causes, that so direct his parents lives. He fears never being able to attain the degree of self respect that would correspond to his pride and admiration of his parents. Ben's idealization of his parents embraces his view of them individually as a superbly happy married couple, who lead lives of value and significance. He becomes agitated if he notes the mildest sign of imperfection in them or in himself and recognizes that this is "THE FOCUS" of his therapy. He wants a more even sense of self-esteem and well-being and plans to continue his therapy even after his departure to college, via phone appointments and office sessions as frequently as possible.

Summary

Ben started treatment in the spring of his senior year of high school, prior to his departure for summer employment out of town and college in the fall. Treatment offered something of a rehearsal for the future [Ekstein, 1983] as Ben struggles to make a final emotional separation from his parents and bid farewell to childhood [Laufer, 1966]. "Adolescent individuation. . . . involves the reconciliation of genitality with morality" [L. J. Kaplan, 1984, p. 95] and is not simply a recapitulation of the original separation-individuation process. In this process of adolescent individuation, Ben used the therapist as a "transitional parent" [Ekstein, 1983] an affirming admiring self-object, as he realized that he could no longer solely rely on parents to affirm and confirm his value and worth. Sexual and caring relationships were also sought to provide closeness and a sense of affirmation. Ben was instinctively wise enough not to throw himself into an all consuming substitute love relationship, to defend him from the anxiety, sadness, and depression at moving away from his parents. As Ben struggled with middle adolescence and better consolidation of varied narcissistic selves [Kohut, 1972] he entered into normal heterosexual connections. The struggle for cohesion and competence entailed some substance abuse as Ben struggles to achieve a more even, consistent sense of self esteem. Because of Ben's amvibalence and discomfort about substance abuse, hopefully, in the near future, this defense will be surrendered.

Ben's parents were seen once together and mother was seen once individually at the onset of Ben's therapy. They acknowledge their pride and delight in their son as well as distress of the last several months as they struggle to let go and to contend with Ben's ambivalence of holding on versus emancipating. They demonstrated sensitive awareness to Ben's activities and responses to his burgeoning sexuality, which "seems to be exploding out of him recently." The parents intuitively divined the extent of Ben's passions and longings as a passage to free him from "the confining safety of childhood" [Kaplan, 1984 p. 348].

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