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The purpose of this chapter is to deal with issues of values, limit-setting, and confrontation as central aspects of psychotherapy with certain adolescent patients. Several authors (Symonds, 1963; Josselyn, 1968; Knobel, 1966; Godenne, 1965; Easson, 1966), in the course of reviewing the general concepts of psychotherapy with adolescents, make some mention of the need for limit-setting. Schonfeld (1968), for instance, lists "willingness to play ... a parent surrogate role" (p. 471) as one of several qualities required of therapists who work with adolescents. However, he seems to be restricting this to instances where an adolescent is behaving in ways that are dangerous to himself or to the community. This approach is somewhat narrow, in my estimation, as it limits the therapist's intervention to those situations where a physically dangerous action is taken by an adolescent patient. Furthermore, the emphasis in the literature (Brandes, 1968; Spiegal, 1958; Geleerd, 1961, 1964; Rubins, 1968) remains on the need to preserve the autonomy of adolescent patients.

New value systems combined with changing authority patterns within the family may be responsible for the differing requirements of therapy for a

growing group of adolescent patients. In the past the need for recognition of the adolescent's right to develop his or her own ways seemed paramount. The therapist often had to refer parents to a social worker or talk directly to them about the need to tolerate the development of the adolescent as an individual. Hence, the task for the parent of the adolescent patient was often viewed as acknowledging his need to take increasing responsibility for his own controls in social and personal spheres of life. The type of neurotic interaction in which the parents attempt to overcontrol and not permit the adolescent to develop independently is still a pattern encountered in psychiatric practice. However, this paper concerns itself with a different type of neurotic family interaction in which the problems faced by the adolescent are complicated by parental figures who have abandoned their position of authority and have even, on occasion, openly advocated their adolescent's indulgence in rebellious and self-destructive behavior or failed entirely to recognize the need to encourage an adolescent's positive adult strivings by setting limits in a variety of settings.

The material for this report is derived from psychotherapy of adolescent patients. It focuses upon the need for the psychotherapist to compensate for parental deficiencies in setting limits with these patients. While the parents in these cases might have been seen concomitantly and urged to resume their parental function, the actual cases involved situations where parental resistance to seeking therapy was formidable. In addition, in

all of these cases the patient, though adolescent, showed surprising degrees of maturity when confronted with a new value system. The parents' capacity to question their own value systems was judged to be considerably more impaired than that of the patients. Not only was it necessary for the therapist to take a stand on an issue of values, but it was often necessary to do so firmly while withstanding the angry protestations of the adolescent, which were often supported directly by his parents. This chapter will explore the clinical phenomena while placing basic emphasis upon the therapist's need to function as a firm, limit-setting, parental figure at crucial times in the treatment of these adolescent patients. The hypothesis is that, if a therapist fails to fulfill this role and remains, instead, detached and nonintervening, in the service of promoting so-called autonomy, the therapy may be preserved but the adolescent patient lost in the sense of his failing to refrain from acting-out behavior that would have permanent and damaging effects on his future. Furthermore, in each of these cases the limit-setting, value-promoting, confronting position of the therapist became a crucial part of the work done in the psychotherapy. It served as a fulcrum for moving the patient in the direction of healthy activity while serving as the basis for a therapeutic relationship in which other life problems could be explored. The style of intervention in all these cases definitely had elements of confrontation when this is defined as taking a position that is actively opposed by the patient's neurotic needs and persisting in this position in face of that opposition.

Three cases will be described in detail. Emphasis will be placed on aspects of the parental failure, including, when possible, the basis of parental encouragement of destructive acting out in their adolescent offspring. The nature of the therapist's intervention will be carefully examined in light of the adolescent's basic strengths and weaknesses as well as the clinical indications for parental limit-setting positions.

Case Examples

Case One

Richard was sixteen years of age when he first sought treatment with complaints of intolerable feelings of hopelessness and depression. He was referred by a psychiatrist who had treated his older brother. His initial position was to project all his depression and unhappiness onto school, which he found intolerable. He complained bitterly of the excessive work demands of school and insisted that this caused his nervousness. He indirectly and then directly asked that I give him permission to retreat from these excessive school requirements, as his parents frequently did when they reassured him that he should not work so hard because "work led to breakdowns." The patient's problems were clearly not limited to school work. He related serious problems with alcohol; he had been drinking heavily and almost on a daily basis for a year prior to entering therapy. In fact, his desire for treatment was,

in part, precipitated by an episode of drinking so severe that he lost consciousness for an undetermined period of time. This frightened him and gave him the added impetus to seek psychotherapy.

The patient's parents were both troubled, despite a veneer of normalcy. Disorders in parental functioning soon became apparent. Father, a man in his mid-fifties, had at least one episode of psychosis several years prior to the patient's therapy. He was treated by E.S.T. and had rationalized his illness in terms of working too hard with little reward from his employer. There apparently was an earlier history of psychiatric disorder, which necessitated separation from the armed services on psychiatric grounds with a permanent disability. Mother, who was more central to the running of the family, had a neurasthenic disposition. She had been a nurse in World War II but also was separated from the service with a psychiatric disability. Neither parent was willing to talk of past psychiatric difficulties but always insisted to the patient that they had worked too hard and gotten ill as a result of this work. There were four children in the family, including the patient, a brother one year older, a brother two years younger, and a sister eight years younger. All four children showed some signs of maladjustment; the patient appeared, in many respects, to be the most reasonable of the four children. This was manifest by his greater cooperativeness and understanding of his parents. The patient, however, was consciously unaware that the parents turned to him to do all the chores around the house rather than confront either of his brothers, who

were overtly hostile to the parents and narcissistic in their orientation. What limits the parents bothered to set were only for Richard. This seemed to be related to his ability to comply with sensible limits. When his younger brother brought friends home for bouts of drinking or pot-smoking in the basement, the parents ignored these completely. When the patient informed his parents directly of what was going on, he was told to mind his own business and not tell tales on his brothers. They seemed to set limits in accordance with degree of resistance so that the older brother, who refused responsibility in many areas, was given in to in much greater degree than any of the other children.

Richard's initial motivation involved largely a quest for symptomatic relief and permission from the therapist to view himself as sick. In particular, he wanted the therapist to pronounce him unsuitable for military service and endorse his plan to drop out of school and travel around the country. The parents had agreed to this as a reasonable plan, only modifying it by weakly requesting that he complete high school. Since he was missing classes and doing no homework, a token completion of school was not something that he opposed strongly. I refused to second his plan as reasonable, stating that his obvious good intelligence showed through despite his depression and despair. Since therapy was initiated at the beginning of his senior year of high school, I pointed out to him that it would be advisable to apply to colleges. This was met with surprise and negativism on his part. I suggested that, since we were embarking on a year's therapy, we would not know how he would

feel at the end of that year and that, in my experience, many young patients did confuse the source of their depressed feelings. Richard agreed to this procedure, particularly when it was clarified that applying to college was in no way equated with his having to go unless he felt differently at the time. He had a conviction that, because his grades in high school were so poor, he could not possibly be accepted by any college. This also reflected his intense feelings of worthlessness related at the time to his guilt over drinking.

Work in the therapy depended largely on the patient's encounter with the therapist, who was willing to take stands in opposition to the patient's rationalizations and regressive positions. He was encouraged to express directly his feelings about the inequality of rewards among his siblings. Since his guilt had prevented him from asking his parents to consistently set limits with his brothers, his impressions of the deleterious effects of no limits at home were confirmed by me. Social isolation and retreat from heterosexuality were analyzed.

During a year of psychotherapy on a once-weekly basis, Richard was able to stop drinking and start attending school regularly. When he complained of the sterility of the work at his local high school, he was encouraged to read on his own, which, to his amazement, he found enjoyable and stimulating. A particular area of interest was psychology. He also found some teachers who were willing to be more flexible with him than he had

anticipated possible. He was accepted at college in April, reporting at the same time his pleasure at the acceptance and his growing conviction that he could manage college in a reasonable way. He continued in treatment through September when he left for college. Although he had done a considerable amount of work, he felt it would be useful to continue to consult periodically, which the location of his college permitted on about a once-monthly basis. Despite the fact that he had chosen a rather strict school, he managed to adjust to difficult, stressful situations. His view of himself was much more as an individual who could cope with unpleasant situations in life. He still had fantasies of impulsively dropping out and going on the road for a life of wandering with no obligations. His attitudes, however, changed somewhat when his work at school was rewarded with excellent grades. On last follow-up, Richard had completed his junior year, was doing excellent work, and had plans for graduate school that seemed realistic. He consulted me after the break-up of an intense, yet not totally satisfying, relationship with a young woman. The break-up of this relationship had resulted in some symptoms of anxiety and depression again. We decided that a brief period of treatment at his college would be most helpful.

Richard's parents' reaction to his changes was of great interest. They were markedly disappointed in his decision to go to college but focused on the financial aspect of this and indicated to him directly that it would be better for them economically if he did not go to college. This did not reflect an

actual economic necessity for them since he did attend a tuition-free college, and their circumstances were not marginal. They were increasingly dismayed by his ability to function and his requests that the home function less chaotically. They never responded to suggestions, which were made early in the treatment, that they might benefit from consultation themselves. The degree to which their much more narcissistic elder son was preferred was striking and never changed during the course of the treatment.

Case Two

Ann sought psychiatric consultation on her own at age sixteen. Her chief complaints were depression and a crippling inarticulateness that made her feel completely out of place at her exclusive private school where outspokenness, drug usage, and sexual freedom were highly regarded by her peer group. She regarded her suffering from two contradictory points of view. On the one hand, she felt that school made her depressed and that the solution lay in changing her environment by dropping out and traveling around the country much in the same fashion that an older brother had done. On the other hand, she seemed to recognize that there were many pressures that influenced her adversely.

Her family history was complicated. Her parents had been divorced when she was eight. Despite the divorce and her father's subsequent

remarriage, the family pattern remained basically unchanged. Her father still regarded himself as master of both households and put this into action by continuing to insist on his role as father and husband in his first household. Her parents continued to have strong disagreements about standards for the children. Mother openly embraced the values of the "counter-culture," feeling that drugs, sexual freedom, and goalless living in general represented the wave of the future. Father, as if by creation of some novelist's imagination, embraced the antithetical position of each of her mother's stands. Hence, he was highly moralistic, insistent on formality in human relations, and appalled by even casual drug usage. Both parents continually presented their standards as absolutely correct without any regard for their children's particular personalities or life situations. The patient's mother encouraged her to attend the same exclusive private school from which her brother had dropped out to become a migratory drug-user. Father openly denounced the school as too permissive and responsible for his son's downfall but continued to finance the patient's education at this institution.

The patient initially felt that her depression made it impossible for her to work, and it was pointed out to her that her depression and guilt might be related to some of her sexual promiscuity and drug-taking. She responded with some disbelief that these things could be detrimental to her sense of well-being without being judged from a moralistic point of view. She was surprised to find the therapist willing to take a stand between her mother's

fervent endorsement of her peer group's standards and her father's moralistic denunciation. She acknowledged that her own inclination was to feel comfortable with a more conservative approach to life, but she had found no one else who supported such a position. Although she felt some symptomatic improvement on controlling her acting-out behavior, she was still left feeling unable to have any interest in learning. On close examination it appeared that she had been thoroughly conditioned with the idea that learning could occur only if one enjoyed every moment of the learning process. The idea of work as requiring energy, even against wishes for more passive pleasure, was a foreign one to her. The idea of learning as a pure pleasure was markedly enforced by her school and mother. The antithetical notions presented by her father were so rigid as to merely reinforce her acceptance of this idea. Furthermore, her school work was so unstructured and her teachers placed such heavy emphasis on freedom and so thoroughly denounced conformity and actual work that she felt quite justified in doing almost nothing.

In regard to this problem, the therapist actively presented to her the notion that work was not always pleasurable but often required an input of energy. When Ann insisted that she could find no areas of interest in her work, she was encouraged to pursue areas outside of her school's curriculum. Since she was in her senior year of high school, the issue of college became a prominent one. Both her parents failed to encourage her serious

consideration of a college education. Her mother's failure seemed to be related to a sincere belief that all such education was no longer helpful to the individual. Her father's position was largely one of indifference toward specifics of what his children undertook in life. Surprisingly, her private high school also encouraged many students not to continue their education but to take time out to "develop themselves." The patient was surprised when I stressed the need to think of college and to make plans, again as a way of feeling better and leading a more productive life. Through direct encouragement, she had pursued a tutoring program for underprivileged children and found, to her surprise, that professional workers approved of her work. Despite her reluctance to see college as a useful endeavor, she agreed that it made sense to apply to colleges in case she felt well enough to attend one after her senior year. However, she insisted on restricting her applications and applied to only one school, which represented an educational philosophy and type of student radically different from her high school.

During the first year of treatment, the therapy concentrated on the patient's understanding of herself in relationship to her family. She was able to recognize the neurotic quality of her parents' continual bickering. Awareness of her father as a narcissistic man enabled her to lessen her pains from his persistent tendency to ignore her real needs and wishes. For instance, despite the obvious improvement in her depression in the first year

of treatment, he continued to maintain that therapy was worthless and that she should stop it as soon as possible. He would complain to her bitterly about the expense of therapy, although the cost of once-a-week psychotherapy was meaningless to the family. The rigidity of her father's narcissism emerged during the course of the treatment. Sharing with her the recognition of these qualities in him was considerably important and enabled her to understand overt slights and peculiar actions on her father's part. With understanding, her usual reaction of depression turned into one of recognizing the problems of dealing with a difficult parent. Mother's heavy use of alcohol was also recognized as a problem; during such periods she would make grandiose and confusing statements that could be taken less seriously. She also saw that both of her parents denied that her brother's way of life was severely disturbed.

After eight months of treatment the patient went on a prolonged summer vacation and joined a group dedicated to the rediscovery of outdoor living. Characteristically, when this group suggested to her that she drop out of school the next year and live in the out-of-doors for the next winter, both of her parents easily gave their consent with ample indication that they did not see it as important that her school plans not be interrupted. Although the patient presented herself as determined to act on these plans with her parents' consent, she seemed relieved when the therapist questioned the wisdom of such a move and indicated that he shared none of her confusion as

to which would be a more constructive activity. With this supportive definition of limits, she proceeded to attend college. Despite many complaints about the dullness and lack of relevancy of her work, she did face squarely that sometimes one had to work despite lack of enjoyment. At mid-semester she informed the therapist of having received straight A's in her course work. She also came to the conclusion on her own that a more challenging academic situation would be better for her. She proceeded to apply to several more challenging colleges and had by this time evolved an identity of her own that involved plans for the future, including work with children, probably in the area of child development. Despite the dramatic changes in this patient's life, father still continued to wonder why she was in psychotherapy and what use it could possibly be. When he complained of this to the therapist, the patient remarked that at least he was beginning to complain to the right party rather than making her justify the reasons for her treatment.

A third case is presented in brief to illustrate the fact that failure of a therapeutic intervention to deal with issues of values and set limits can have long-standing effects on the patient's life that still may be modified by a later therapeutic intervention that does not neglect these issues.

Case Three

This twenty-three-year-old patient, who was chronologically beyond

adolescence, sought treatment on her own initiative. She had just returned from a five-year sojourn on the West Coast. In that time she had lived a life marked by gross disorganization, communal living, and physical neglect. She revealed that she had been an extremely bright student through her freshman year in college when, despite excellent achievement, she decided to leave school for economic reasons. She was convinced that formal education was not important and that, furthermore, her parents could really not afford to continue to support her education. On the West Coast she lived a chaotic life, in spite of her being in psychotherapy. Her parents, who were professional people, visited her and, despite their seeing first-hand the state in which she lived, in no way questioned its appropriateness for someone of her background. An immediate characteristic that became clear to the therapist was her exquisite sensitivity to rejection and intense need for approval. She responded precipitously and strongly to signs of disapproval from those surrounding her. Many of her friends and her parents had values that made success, in terms of achievement, quite unacceptable to her. She had difficulty accepting that the therapist felt she had misused her talents and was indeed "letting herself go." She could state directly her belief that to be successful and middle-class was unacceptable. With support and clarification of her right to success, she embarked upon an ambitious academic program that enabled her to complete college within two years and gain entry into a first-rate medical school. Her depression and destructive acting out disappeared within

the first year of treatment. She was able to articulate the fact that encountering a value system that permitted work and success enabled her to express her talents in a positive fashion.

Discussion

While Gitelson (1948) stressed the role of the therapist in promoting character synthesis in the adolescent patient, there is little in the literature that deals extensively with such factors as group pressures on the adolescent patient, parental failure to provide reasonable standards or set limits, and the therapist's need to fill the gap and present to his patient a viable code of standards. There are indeed strong opinions expressed against the approach presented here. The presentation of a value system to the adolescent patient has been viewed as a countertransference problem. To quote Spiegal (1958),

> Countertransference problems may interfere significantly with the analysis of adolescents, particularly certain expectations of the analyst.... In a society which stresses conformity the pressure within the analyst towards having his adolescent patient adjust and succeed is probably very strong and it may be more difficult for him to refrain from imposing his philosophy and hopes on his adolescent patients than on his adult ones. (p. 300)

To view the role of the therapist in these three cases (and many others with similar characteristics) in proper perspective it is necessary to consider certain changes in cultural forces brought to bear on modern adolescents. The

adolescent today is subjected to forces from outside that differ radically from those of past decades. While the tasks of adolescence may have remained unchanged, whether these be viewed from a biological-analytic point of view or from a sociological-identity formation point of view, the external forces impinging on the adolescent have changed. For the sophisticated adolescent, the "counterculture" standards are a reality. Drug-taking, sexual promiscuity, and dropping out are there not only as fantasy temptations but as concrete examples in friends and close acquaintances. Not only are these values prevalent at the high school level, but they are also presented with great skill and force by popular authors, such as Paul Goodman, R. D. Laing, and Charles Reich. The views of these individuals have been widely disseminated and indeed have affected values of parents and adolescents alike. Laing's image of society as a destructive force, causing the elaboration of false selves, calls for a revolt against the essence of this society; namely, concentration on achievement and expression of self through work. Although the parents of a particular adolescent, as in the first case, might never have heard of, much less read, any of these authors' ideologies, they may either be psychologically tuned in to these aspects of revolt or disarmed by these arguments when they are presented by their more interested adolescent offspring. When an adolescent patient begins to rationalize his lack of effort in scholastic areas by pointing out our society's participation in a corrupt war, then it is necessary for the therapist to point out that the extension from our participation in a

corrupt war to the total corruption of society is not a proven fact and that it is being used to rationalize. In the area of sexual activity the therapist may also take a stand against promiscuity while making it very clear that he views sexual activity as a natural and healthy part of life. He may have to point out to the adolescent patient the symptomatic unhappiness resulting from casual sexual activity while making it very clear that he is not being puritanical in his standards. The sexual unreadiness of many adolescents that has been found by Dr. Helene Deutsch (1967) can indeed be confirmed in talking with adolescent patients. The adolescent, in his natural need to detach from the family, may fall prey to group standards that are incompatible with achievement and responsibility. The so-called permissiveness of the new freedom may involve actions that, although attractive and instinctually gratifying, may be at variance with the consciences of numerous adolescent patients.

Parents may abdicate their role as providers of reasonable standards for adolescents for a number of reasons. First, as indicated above, they are subject themselves to changing standards. Second, the widespread dissemination of so-called analytic ideas about adolescence has led many parents to take an anything-goes approach to their adolescent offspring. Since the word on adolescence is that it is a period of intensely disturbed behavior for most adolescents, the parents may misinterpret this as meaning, more or less, that anything goes. Third, parents may be so overwhelmed by personal

problems, either acute or chronic, that they are unavailable to expend energy on their adolescent children. In the detailed cases presented earlier, parents condoned acting-out behavior on their children's part that was close to areas in their own lives where actions and fantasies had actually occurred. In the case of Richard both of his parents resented work as an activity in their lives and both yearned for excessive passivity. In Ann's case, the father's large inherited wealth enabled him to indulge in certain narcissistic positions that would have been impossible under other economic circumstances. He had indeed never depended upon his work for earning a living and may well have been encouraging in his children a similar position because, in fact, inheritance would make work unnecessary for them in later life.

In each of the case examples there were indications that the patients would be able to use a tactful confrontation from the therapist. They had been extremely active, for adolescents, in seeking psychotherapy almost on their own. None of them was sent by irate or worried parents. A tendency to view the therapist in a realistic fashion as a helpful physician with special knowledge was marked. Although there was a confrontation over values as expressed in action, this was not done in an angry or dictatorial fashion. Care was taken to remind the patients that they were free to reject my different interpretations of their actions but that I would not agree with them to avoid conflict.

None of these patients was absolute in a commitment to a regressed mode of living, as is often the case in adolescents who have been acting out extensively by dropping out of constructive activities, taking large amounts of drugs, and living in casual, shifting, and gratifying sexual relationships. They often are sent to a psychiatrist by their parents or school authority. In my experience they are often resistant to any constructive goals in psychotherapy and find my mention of values repellent. In these instances the style of approach described in this paper is not applicable. Here a therapist may need to accept that the main goal of treatment is to keep the patient coming, in hope that the manifest regression is related to some hidden stress or conflict in the patient's life.

Conclusion

The perils of adolescence as a developmental stage have been increased during the past decade. The adolescent is faced with the task of being active in working out a future that includes satisfying human relationships and work activities. Since it is a time of uncertainty and biological stress, regression becomes a possible solution. The seductiveness of ideas concocted by adults (and perhaps representing the product of their repressed and suppressed passive yearnings) is particularly great. Drug usage, sexual freedom, states of intense closeness, and an anti-work ethic have been vigorously promoted by the media. The result is a group of adolescent patients who have not been

able to navigate between the Scylla of excessive rigidity and the Charybdis of passive gratification. For them effective psychotherapy requires a therapist who is willing to help them develop skills in navigation by recognizing the dangers from both sides. Currently, for certain adolescents, the pulls of passivity and the pleasure principle create the most danger. When parents are unable or unwilling to challenge extreme, irrational values, it becomes, in my opinion, essential that the psychiatrist be willing to step in and fill the gap. Taking such a position may seem anti-analytic and a bit mundane. Furthermore, many therapists may feel uncomfortable with interacting in such a direct way with adolescent patients. Josselyn (1957), who has written extensively about private outpatient psychotherapy of adolescents, calls attention to this problem:

> Probably one reason there is so little in the current literature in regard to general concepts of therapy with adolescents is because of the self-consciousness of the therapist.... So often the most successful therapeutic results with this age group either are attained inexplicably by seemingly unorthodox therapy, or by means scarcely justifying the dignity inherent in the concept of psychotherapeutic methods. At other times they have been accomplished too easily to warrant credit to the therapist. In contrast, so often nothing has been achieved in those cases in which the therapist was most convinced that he understood the case and was using the right therapeutic approach. In the author's experience, practically every successfully treated case of an adolescent warrants the criticism from colleagues either that the case was not "analyzed," an attack against which a psychoanalyst has no answer, or that the so-called treatment was just an example of common sense or relationship therapy, an attack against which no psychiatrist has a defense, (p. 28)

Indebted as any psychiatrist need be to psychoanalytic concepts, there are times when certain so-called psychoanalytic techniques have been misinterpreted and/or misapplied to psychotherapy. The idea of analytic neutrality and regard for the autonomy and independence of the patient is a case in point. While crude directives are certainly to be avoided in the treatment of adolescents, there is no doubt that patients are subjected to such authoritative directives from other sources in their lives. The therapist may have to stand firm against such influence with adolescent patients. He may have to do so with vigor and force when the adolescent's inner life is enforced by authority figures who define autonomy in passive regressive fashions, and he must do so despite accusations from within and without of being old-fashioned and rigid.

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