American Handbook of Psychiatry

PSYCHOTHERAPY OF ADOLESCENCE

E. James Anthony

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PSYCHOTHERAPY OF ADOLESCENCE

Historical Introduction

For reasons that would strike a responsive chord in the minds of most practitioners, Freud included therapy among the three “impossible” professions, the other two being teaching and governing. The psychotherapy of adolescence may demand, at different times and for different adolescents, the exercise of all three, which might well make it the most impossible of the impossible professions and therefore the one most avoided in practice. Anthony has this to say about such evasiveness:

Psychotherapists, confronted by the adolescent, have put forward as many reasons and rationalizations as parents and adults in general for treating the adolescent with special care and caution or not treating him at all. They have argued cogently in favor of treatment but by other therapists and in other institutions. Many have concluded, on the basis of sound reason, that it is better to leave adolescents psychotherapeutically alone during adolescence because of their well-known proclivity to act out and drop out [and because] the vivid metaphors they have coined possess a strong deterrent quality. “One cannot analyze an adolescent in the middle phase,” says one prominent author; “it is like running next to an express train.” Another likens adolescence to “an active volcanic process with continuous

eruptions taking place, preventing the crust from solidifying." Once the psychotherapist gets it into his head that he has to deal with a bomb that might explode or a volcano that might erupt or an express train that will outpace him, he will approach the treatment situation with very mixed feelings. If one adds to this array of stereotypes the reputation that even the mildest adolescents have for resorting to slight delinquencies at the least provocation, then the psychotherapist's reason for bypassing adolescence is easier to understand if not to condone.

A major source for the difficulties arising in the treatment of this particular age group stems not only from fixed preconceptions of the adolescent as a patient but also from rigid insistences on treating him by a single method.

Flexibility is the hallmark of good treatment practice at this stage, and to discard this principle is to ask for trouble. As far back as 1904, Freud provided a balanced statement on this point: "There are many ways and means of practicing psychotherapy. All that lead to recovery are good. . . . [W]e have developed the technique of hypnotic suggestion, and psychotherapy by diversion of attention, by exercise, and by eliciting suitable affects. *I despise none of these methods and would use them all under proper conditions."*[1] If this is true for psychotherapy, it is even more so for adolescent psychotherapy. Later on, Freud did change to the exclusive practice of

analytic psychotherapy because, he said, it penetrated more deeply, carried furthest, brought about the most marked transformations, and offered a more meaningful and interesting experience to the therapist. He also had, naturally, a considerable investment in the practice of psychoanalysis. Though Freud never treated children, he had some experience in treating adolescents in both early and late stages and had developed considerable understanding of their psychopathology way back at the end of the last century. What follows is a contrasting account of a case of night terror as envisioned by Freud and by a contemporary psychiatrist (Debacker).

Case History

A thirteen-year-old boy in delicate health began to be apprehensive and dreamy. His sleep became disturbed and was interrupted almost once a week by severe attacks of anxiety accompanied by hallucinations. He always retained a very clear recollection of these dreams. He said that the Devil had shouted at him: “Now we’ve got you!” There was then a smell of pitch and brimstone and his skin was burnt by flames. He woke up from the dream in terror, and at first could not cry out. When he had found his voice he was clearly heard to say: “No, no, not me; I’ve not done anything!” Or “Please not! I won’t do it again!” Or sometimes: “Albert never did that!” Later, he refused to undress “because the flames only caught him when he was undressed.” While he was still having one of these devil dreams, which were a threat to his

health, he was sent into the country. There he recovered in the course of eighteen months, and once, when he was fifteen, he confessed: “I didn’t dare admit it; but I was continually having prickly feelings and overexcitement in my parts; in the end it got on my nerves so much that I often thought of jumping out of the dormitory window.”

Freud refers to Debacker’s conclusions as “an amusing instance of the way in which the blinkers of medical mythology can cause an observer to misunderstand a case.” The sad thing is that such medical mythologies still continue to flourish in the present day and age.

Some question has been raised as to whether Freud explored the period of childhood and adolescence with as much openness as he investigated the adult. Lack of investigation of the early periods of life prevented him from making further discoveries, and his work with the younger group bears all the characteristics of self-fulfilling prophesy. In the case of Little Hans, for example, he remarked: “Strictly speaking, I learnt nothing new from this analysis, nothing that I had not already been able to discover (though often less distinctly and more indirectly) from other patients analyzed at a more advanced age.” In 1900, he wrote to Fliess as follows: “The new case is an interesting one, a girl of thirteen whom I am supposed to cure at high speed and who for once displays on the surface the things I generally have to unearth from beneath superimposed layers. I do not need to tell you that it is

the usual thing.” There is a certain developmental logic in assuming that what occurs earlier is merely buried deeper and that the instinctual substratum is the same at all ages. Nevertheless, this point of view tended to overlook the fact that a thirteen-year-old girl is confronted with tasks specific to her phase of the life cycle and with which she deals in ways specific to her developmental status. For the same reasons, she needs to be regarded psychotherapeutically differently than in childhood or adulthood and to be treated technically in a different way. One has, however, to remember that this was in 1900 and that Freud was almost singlehandedly creating the discipline of psychotherapy. If one remembers this, one can better understand why he frequently extrapolated from one age to another, trying out a variety of techniques that he was in the process of developing systematically. In the same year, he wrote again to Fliess: “I have a new patient, a girl of eighteen; the case has opened smoothly to *my collection of picklocks.”* With Dora, he was to find his most generally applicable and powerful “picklock,” the transference analysis. He continued to experiment boldly with the psychotherapy of adolescence, and some of his methods can still be usefully applied today. A fourteen-year-old boy came to him for psychoanalytic treatment suffering from multiple tics, hysterical vomiting, and headaches. How to persuade an adolescent boy to communicate, much less associate, at the start of therapy is a difficult problem for any psychotherapist in any era, but Freud tackled it in his usual imaginative style.

Comparison of Interpretations by Freud and Debacker

Interpretation (Freud, 1899)	Interpretation (Debacker, 1881)
1. One would infer that the boy masturbated when younger, that he probably denied it, and had been threatened with severe punishment for his bad habit.	1. The influence of puberty on a boy in delicate health can lead to a condition of great weakness and can result in a considerable degree of cerebral anemia.
2. The onset of puberty and the tickling feelings in his genitals had probably revived the temptation to masturbate.	2. Cerebral anemia produces character changes, demonomanic hallucinations, and very violent nocturnal and perhaps diurnal anxiety states.
3. There was a struggle to repress these emergent feelings and impulses as a result of which a suppression of libido took place and transformed it into anxiety; this anxiety had then taken over the role of punishment with which he had been threatened at an earlier age.	3. The demonomania and self-reproaches are attributable to his religious education.
	4. Recovery took place as a result of physical exercise and the regaining of strength at the passing of puberty.
	5. The predispositions to this brain condition are probably genetic and congenital (past syphilitic infection in the father).
	6. They have classified this case among the apyretic deliria of inanition arising from cerebral ischaemia.

I began the treatment by assuring him that if he shut his eyes, he would see pictures or have ideas, which he was then to communicate to me. He replied in pictures. His last impression before coming to me was revived visually in his memory. He had been playing at draughts with his uncle and saw the board in front of him. He thought of various positions, favorable or

unfavorable, and of moves that one must not make. He then saw a dagger lying on the board—an object that belonged to his father but which his imagination placed on the board. Then there was a sickle lying on the board and next a scythe. And there now appeared a picture of an old peasant mowing the grass in front of the patient's distant home with a scythe.

With this set of visual associations available to him, Freud was able to uncover the psychopathology related to a most unhappy family situation, demonstrating that it was the boy's suppressed rage against his father that had stimulated the apparently meaningless set of pictures and that represented the masturbation and castration moves in the operation of a serious oedipal conflict.

The so-called false connection, or transference discovery, of Freud was adapted superbly by Aichhorn in his treatment of wayward adolescents, which he carried out extensively during the 1920s and 1930s. The transference relationship was not analyzed in the systematic way of psychoanalysis, but the pressure of transference was used to force action into specific channels and maintain it there. Aichhorn, as Freud pointed out, intuitively and sympathetically practiced his own brand of therapy with delinquent adolescents, and psychoanalysis did little more than provide him with a theoretical framework. Since Freud himself was then of the opinion that wayward youth could not be analyzed because the analytic situation

could not be set up, he was appreciative of the value of this analytically oriented influencing technique. This, in fact, was what it was, and it was, therefore, understandable that Aichhorn should compare his approach to high-powered salesmanship. Salesmen, like psychotherapists, pursued a definite goal with their clients, and the client needed to be softened up before he could be persuaded. In order to do this, the salesman sets up a situation of dependency in which he plays the role of superior, knowledgeable adult, at the same time reducing the client to the position of a helpless child who has surrendered himself to someone's will. The salesman becomes cathected by libido and is transformed into a transference figure. For Aichhorn, a number of "shopping situations" existed in the treatment of adolescents, and his method of "planned influencing" including the parents, who also needed to be kept in a state of dependence.

In a very modern sense, Aichhorn was extremely conscious of the transference network surrounding the treatment of the patient, which helped to modulate the parental response to the child's antisocial acting out during therapy. The resilience of the parent to be criticized, to be critical of herself or himself, and to be influential in the treatment, is gradually strengthened. Toward termination, the transference relationship is resolved, the parent is made an equal partner in the situation, and the libido displaced onto the therapist is returned to the child.

The therapeutic work with the parent can parallel the therapy of the adolescent child, and the family crisis with which treatment frequently began is gradually replaced by ongoing psychotherapy. The alternation of passive and active phases can surprise the patient into making profound changes. An empathic understanding of the parental superego can help such changes to be made and consolidated. Aichhorn’s “shock” techniques and active-passive alternations, if used skillfully, can undoubtedly bring about dramatic changes in the life style of the adolescent patient. To use it successfully, the incorruptibility of the therapist has to be above question. When Aichhorn counsels the therapist to agree with whatever the delinquent says, share his views, and side with him against other people in order to win him over, there is an appreciable danger in becoming, or seeming to become, an adult delinquent in the process. Where the “juvenile impostor” is concerned, the approach can be startling. The therapist could plan a criminal project in detail with the young delinquent, drawing his attention to various ways of improving his methods of stealing. The various disconcerting maneuvers—taking the loot from him, planning a robbery with him, and finally, giving him money for his needs—are designed to leave the young person in a state of tension until the next session. Aichhorn was very successful with this “timely use of the factor of surprise” that allows the therapist to keep a step ahead of his patient. The method aimed at creating a dependency relationship and overcoming the initial and inevitable feelings of mistrustfulness. Much of this

can perhaps be best understood as a preparation for bringing apparently unreachable and untreatable adolescents into treatment.

The borderline and psychotic adolescent was for a long time excluded from the psychotherapeutic situation, until Sechehaye described a method of “symbolic realization” whereby the therapist would enter into contact with his patient at the exact level of his regression, however archaic this might be. Thus, a patient at a preverbal stage could be reached better by physical care than by words. For instance, a gift of an apple could be made a symbol of gratification and could thereby ensure the continuity of communication and contact.

The Preconditions for Psychotherapy

The psychotherapeutic treatment of adolescence demands a working knowledge of normal adolescence as well as the characteristic psychopathology of the period.

Normal Adolescence

Many normal adolescents are recipients of psychotherapy because clinicians who deal with them are not altogether familiar with the wide range of healthy reactions that occur at this stage. What would be designated, in terms of intensity, as a clinical disturbance in other parts of the life cycle is no

more than an expectable disequilibrium at adolescence. The line of demarcation between mental health and illness is never sharp at any age, but it tends to be especially fuzzy during this transitional period from childhood to adult life. Transitional phenomena are characterized by rapid change, and previous and subsequent balances and compromises between internal and external forces and circumstances give place to unpredictable oscillations of feelings and behavior. Adolescence constitutes the most revolutionary step in human development. The revolutions involve massive physical and psychological changes that affect appearance, the mode of thinking, and the phase of reacting and inter-reacting. The revolution may be so sweeping that, as Anna Freud remarked: "The picture of the former child becomes wholly submerged in the newly emerging image of the adolescent." The pregenital reactivations of preadolescence are replaced by the genital impulses of early puberty, and the new urges carry new dangers with respect to incestuous wishes and feelings. The need to keep these under control requires a constant deployment of defenses, but the emerging drives are sometimes so strong that a breakthrough from time to time is almost inevitable.

The whole situation is in a constant state of flux, so that we rarely meet the same adolescent twice. He is always in a state of shifting defensiveness, changing defenses, or releasing drives. In the interpersonal sphere, he moves forward to the accompaniment of a constant rearguard action against his parents. He both wants to be rid of them and to keep them tied to his needs

and gratifications. He fluctuates between independence and helplessness, between progression and regression, between idealization and disparagement of the parent, between love, hate, and studied indifference. In his efforts to break the tie, he turns to his peers, treating the group as a whole as a surrogate to which he transfers his drives and identifications, receiving in turn its support and solace in his adolescent predicament.

The pains of this period can be so intense that adults in general suppress their memories of it. Adolescence, according to Anna Freud, is quintessentially an interruption of peaceful growth, and therefore a steady equilibrium during this phase is by definition abnormal. It is important for the diagnostician to bear in mind that abnormality is the major characteristic of normality at this time. A Group for the Advancement of Psychiatry report, dealing with the same issue, pointed to the recurrent alternation of episodes of disturbed behavior with periods of relative quiescence stemming from experiments in submission and rebellion, in control and free expression. The report emphasized that an alternation of this nature is frequently nothing more than "a temporary and essentially normal outburst of a more primitive behavior." Under ordinary conditions, the drives are once again brought under control, and the ego gains additional strength through the mastery of the new experience.

If one can speak of the normal abnormality of adolescence, one can

surely describe a normal psychopathology of adolescence. To some extent, Deutsch did this with respect to the female, and Erikson depicted, in his epigenetic chart, the stage of role confusion that forms the negative pole to an integrated ego identity. The normal adolescent girl remains, said Deutsch, "completely childish" in her deepest being for a long period during puberty. She is frightened of her new self-confidence and her new responsibilities and, at the same time, is becoming increasingly aware of some of her frailties.

The watchful adolescent psychotherapist is alert to the increase of narcissism and its importance in the process of maturation and in the strengthening of the ego. The adolescent becomes acutely aware of the "I am I," and though this narcissistic force works toward a unification of the personality and an increase in self-confidence, a little excess of it leads to the "arrogant megalomania" that can make interpersonal relationships (and these include those with the therapist) at times exasperating. This narcissistic ego of adolescence is extremely sensitive to frustration, especially love frustrations, to the breaking of promises, to disappointment in the expectation of admiration, and to criticism, especially on the part of parents.

The second trait typical of the adolescent girl is her masochism, which Deutsch regarded as an "elemental power in feminine mental life." The association between pain and pleasure derives from the genital trauma aggravated by the onset of menstruation, both combining to produce the

female castration complex. One type of masochism originates in an infantile tie to the mother and the other from an over-attachment to the father, with a concomitant masculinity complex. The third central attribute of adolescent femininity is passivity, which is in part a further consequence of the genital trauma but also has constitutional and evolutionary antecedents. It is as though the little girl is awaiting true development into adolescence, "for something to happen to her," and unless this occurs, she remains unawakened and predisposed to frigidity. Her greater passivity makes her more prone to identification, more inclined to fantasy, more governed by subjective impressions and inner perceptions, and more apt to intuitive judgments. All in all, she has a lesser "reality potential" than the adolescent boy.

The psychotherapist, therefore, must be prepared for all three elements to enter into the therapeutic relationship. He will be constantly confronted by the girl's expectation that something will happen to her, that something will be given to her, and that in due time, the deficiencies in her developmental experience and endowment will be made up to her. The nuclear fantasies associated with these trends are narcissistic-exhibitionistic ones, involving fame in some form, the adoration and admiration of many, and masturbatory dreams in which she is the cynosure of these fantasies. The passive-masochistic fantasies involve the idea of violent seduction and rape in which a female figure forces the girl to submit to painful sexual acts performed by

men. In dreams, terrifying male persecutors with knives in hand are breaking in at the window for the purpose of stealing valuable objects.

Passivity and masochism are less prominent in male adolescents, but the bisexual conflicts, the guilty reactions to masturbation, the anxieties over the changing body image and worrying incestuous dreams occur as frequently.

On the cognitive side, psychotherapy is enhanced by a new capacity for abstract thinking, for dealing with thoughts instead of things, for chains of free associations, and for a capacity to integrate and systematize large collections of ideas. The adolescent patient becomes able to look at himself, to examine the processes of his mind, and to construct theories about his feelings, particularly when he is defensively prone to intellectualization. In addition, his newly integrated identity furnishes him with a sense of continuity and a perspective of past, present, and future, making him free to roam in thought and fantasy over wide sections of time and space. He has transcended the period of latency in which the child is incarcerated within the confines of the present and the concrete. For the first time, the individual at this stage of his development can see himself in perspective, can examine his life both internally and externally, and can formulate plans and programs for the future.

Diagnosis and Treatment Planning

Having acquired a good working knowledge of the normal range of adolescent responses, the adolescent psychotherapist must further orient himself to clinical diagnosis within the context of adolescence. He will then come to realize that the disorders of this period fall roughly into four categories: (1) those that begin in childhood and terminate in adolescence (many cases of enuresis, asthma, and epilepsy); (2) those that begin in childhood and continue through adolescence into adult life (personality disorders of various types); (3) those that begin in adolescence and terminate in adolescence as phase-specific disorders (situational maladjustment, identity confusion, and some cases of obesity and anorexia nervosa); and (4) those that begin in adolescence and continue into adult life (schizophrenia and a few manic-depressive psychoses). The classical psychoneuroses may fall into any of the four categories, but a careful anamnesis will generally disclose antecedents in a forgotten infantile neurosis.

All syndromes, except the massive inhibitions and the schizoid character disorders, acquire an additional adolescent flavor of mood swings, episodic changes in behavior, acting out, identity problems, intellectual and ascetic defenses, masturbatory and bisexual conflicts, and a general coating of narcissism and egocentrism. These adolescent elements superimposed on the basic psychopathology generate a quality of crisis characterized by more

available affects, more fluid defenses, and freer communications. It is not surprising that many therapists, in practice, begin their treatment of an adolescent disorder by the technique of crisis intervention and subsequently proceed with the usual psychotherapeutic procedure. Nevertheless, it is at this stage that the neuroses of later life take on their characteristic configuration. Jacobson has drawn attention to patients suffering from protracted adolescent problems who may still, at age thirty or more, show a typical adolescent fluidity both in their moods and in their symptoms, so that their clinical manifestations may oscillate from neurotic to delinquent, perverse or borderline.

Adolescent depression is frequently phase specific and reminiscent of mourning and unhappy love affairs. Jacobson described adolescence as "life between a saddening farewell to childhood—i.e., to the self and the objects of the past" and the as yet unknown country of adulthood. There is a general feeling among those who care for adolescents that too much is asked of them within Western cultural life and that this is what provokes the violent crises of affect, the painful depressions and despair, the severe guilt and shame and self- consciousness, the hypochondriacal preoccupations, and the constant fluctuations between convictions and doubts, all enmeshed in feelings of isolation and loneliness. Within a short period of time, the adolescent has to make renunciations of the past, undergo mental and physical revolutions in the present, face painful initiations into the future, and, at the same time,

make binding decisions about careers. During this clash between progressive and regressive forces, there would seem to be a pressing need for a moratorium, and psychotherapy may help to provide this.

The treatment planning must be done in conjunction with the adolescent and take into close account the realities of his external circumstances. In assessing his response to therapy, one has to evaluate the positive and negative, the therapeutic and antitherapeutic forces at work in the environment. What goes on in the other twenty-three hours may be crucial to the outcome of treatment. In assessing capacity for psychotherapy, one is concerned with basic attitudes of mind, such as introspectiveness, psychological mindedness, proneness to aggression, transference potential, ability to form a therapeutic alliance, tolerance for anxiety and frustration, and sufficient skills for conceptualization and communication. Negative indications for psychotherapy would be an adolescent with a weak ego and superego, suffering from a longstanding, severe disorder, with a basic difficulty in looking within, conceptualizing, and communicating, and whose symptoms offer a high degree of secondary gain. Unfortunately, because of disadvantageous upbringing, a large number of adolescents fall into this category of poor potential. In these cases, a long period of preparation for psychotherapy or psychotherapeutic "management," in Winnicott's term, may help to increase the quota of treatable patients. Good treatment planning, as outlined by the Group for the Advancement of Psychiatry entails

consideration of intrapsychic modification, alteration of intra-familial functioning, changes of peer- group interaction, modification of school or community setting, and possibly removal of the child to an altogether different environment for a period of time. The more internalized the syndrome, the more focused is the treatment on the psychotherapeutic situation; the more externalized the syndrome, the greater need to bring about concomitant shifts in the familial and extrafamilial environments.

The Adolescent as Patient

The adolescent is an unpredictable patient for whom it is difficult to plan a complete course of treatment. Since dropouts are so frequent as to be characteristic of adolescent psychotherapy, it is possible that wide fluctuations in resistance and accessibility exist and that it might be good practice to carry out psychotherapy intermittently. It would seem better to do this as part of the general plan than to have it occur at less desirable phases of the treatment. Experience has shown that the adolescent in the early phase has many of the characteristics of the child in late latency, such as heightened resistances, outer-directedness, increased activity and aggressiveness, decreased tolerance for one-to-one situations, and poor communicativeness. These factors tend to make psychotherapy short and difficult during these two phases. In the mid-phase of adolescence, the patient develops some of the typical fluidity of the era and talks a great deal without saying too much or

making too many meaningful connections. Communication is used as abreaction, and insight and understanding are resisted. In the late phase, treatment already takes on qualities of adult therapy, and the patient can be treated as a young adult who is accepting of interpretations and is developing a taste for insightful communications. In general, therefore, the ease with which the adolescent assumes the patient role varies with the phase of adolescence.

The adolescent is not only a patient in the psychotherapeutic situation, but generally carries his role into his external environment, where he is likely to talk to his friends about his therapeutic experiences, dramatize the interchanges with his therapist, and act out when the transference resistances mount up. His friends may hear his dreams before his therapist, and he may come armed with their interpretations. He may also maintain a reserve therapist in the form of a good friend to whom he may go in times of crisis when his own therapist is not too easily available.

The adolescent is not the patient for routine psychotherapy. Fluctuations, reversals, sudden progressions and regressions generally mark the course of his treatment. The defenses are never quite the same from week to week, and the range is between early infantile types, such as projection, denial, and isolation, to repression, intellectualization, and asceticism.

With many adolescent girls, the effects are forever “bubbling,” as though instinctual impulses were constantly threatening to break through. In such cases, and in contrast to adolescent boys, the wish is maintained on the safe side of activity, so that masturbatory fantasies and latent homosexual crushes are more likely to be activated by treatment than masturbation and homosexual activity. The incestuous impulse in blatant form is also much more likely to invade the consciousness in the therapeutic situation than would be the case with boys.

With both sexes, the treatment environment is regarded simultaneously or alternately as dangerous and safe, and the adolescent, after an episode of courageous revelation, is likely to take flight. For both sexes, also, seductiveness, both sexual and intellectual, is often a primary weapon to keep the therapist under control. The unwary therapist who allows himself to respond too positively to such a maneuver may find himself treated as a seducer, to the temporary detriment of his therapeutic function.

In addition to the kaleidoscope of bubbling affects, varied defenses, florid dreams and fantasies, the instinctual danger also tends to stimulate creativity, so that entrancing flights of fancy and rich chains of associations may occur. This fluid interplay between primary and secondary process tends to make the adolescent a most interesting patient. However, with the settling down of the instinctual upheaval characteristic of this period, there is also a

recession in this creative and artistic elaboration brought into play in the therapeutic situation. Many therapists have experienced a sense of disappointment when the adolescent returns as an adult patient and, in contrast, appears dull and down to earth.

Techniques of Individual Psychotherapy with Adolescents

As Geleerd pointed out, the adolescent is biologically as well as psychologically a very different individual in the three phases of adolescence, reacting differently to treatment in each phase. She felt that the therapeutic approach had to vary accordingly. Although she was speaking of psychoanalysis, this is equally true of psychotherapy. Psychoanalysis with adolescents, like psychoanalysis in general, focuses on transference, the analysis of defenses, and the interpretation of unconscious, repressed material. Geleerd felt that the analysis of adolescents differs from that of the adult patient in several ways: A greater effort has to be made to increase the tolerance of the ego to pathogenic conflicts; more help is needed in learning to test reality; less consistent and systematic analysis of defense mechanisms is possible or even desirable; and working through is only feasible to a limited extent. She also thought that the analyst fulfills a parent role, but in a more neutral way than in child analysis, and that the management of transference is different.

The analysis of the first-phase adolescent is extremely hard, and the unconscious life of the child seems almost nonexistent. The analyst is rejected along with parents and other adult figures, and the sessions are mainly filled with battle accounts from the home front. The same long preparation is needed as with children in late latency.

In the mid-phase analysis, unconscious fantasies are more available, thus the treatment seems to move faster against a background of greater fluidity. Geleerd warned that the analyst may have to guard against creating chaotic conditions. During this phase, the patient may develop a crush on his analyst, superimposed on the underlying transference relationship. The transference neurosis is now seen in intimate form, and the patient may from time to time prefer to lie on the couch.

The analysis of the late-phase adolescent is more similar to that of the adult. Geleerd suggested that the patient may require explanations and encouragement to accept sexuality or aggression, but such educational measures are generally self-defeating as well as undermining to the analytic process. Contact with the family is generally avoided except in emergencies. It is generally agreed, however, that in contrast to adult analysis, the person of the analyst plays a greater role in adolescent analysis, and many adolescent analysts have adopted the intermediate posture of allowing the adolescent to lie on the couch but facing the analyst. By opening and closing the eyes, the

adolescent can then control to some extent the impingement of the analysis on his reality and fantasy.

The adolescent also strives to keep the distance from his parents under control, but even when he reports them as remote figures, a simultaneous analysis of parent and adolescent soon discloses the considerable extent to which the child is influenced by the parent in his imitations, identifications, acting out, and unconscious wishes. The adolescent often seems to recapitulate the adolescent struggles of the parent. The confusion of personal identity with parental identity thus becomes a real menace to further development, especially as the adolescent is involved in the task of disengaging primary objects and the giving up of infantile ego states, referred to by Bios as the second individuation.

Individual psychotherapy with the adolescent is essentially ego therapy, and the goal may be anything from symptomatic relief to the furnishing of insight into relative unconscious determinants of the manifest conflict. Generally speaking, however, the treatment deals only with conscious and preconscious material, and only occasionally does the therapist interpret unconscious content. The ego is strengthened through suggestion and support, which help to break down resistance and develop self-confidence, and through the abreaction of tensions. Confrontation and clarification are two important change-producing mechanisms.

The beginning of treatment with adolescents invariably requires special handling by the therapist both in analysis and in psychotherapy. An introductory phase has been recommended for both forms of treatment during which the initial negative reactions are gently resolved, the strangeness of the situation made more familiar, and the complex phenomenon of feeling at home gradually inculcated.

The so-called normal paranoia of adolescence is exacerbated by the peculiar conditions of therapy. The therapist is perceived as threatening, his technique as intrusive, the situation as dangerous, the confidentiality as suspect, and the complete circumstances as a trap. For the patient, the immediate implications are that he is crazy and that the differences he is experiencing in his mind and body are indications of brain degeneration. The compulsively disobedient adolescent will feel impelled to attack the authority figure of the therapist immediately, and the uncompromising adolescent will refuse to budge from his prepared position, which would preclude his becoming a patient.

Many have felt that Aichhorn’s method of taking a patient’s part in order to win his confidence and bring him into a positive transference is essential at the beginning of psychotherapy with the adolescent. The patient must become convinced that he is not the focus of an adult conspiracy and that his therapist is not in league with his parents to bring him to heel. For this

reason, many psychotherapists accord the adolescent full adult patient privileges, contracting with him regarding time and money, and refusing to see the parents at the beginning without the adolescent being present to hear the discussion. They continue with this principle during treatment when crises arise and parents are interviewed, but only in the presence of the patient. No phone calls are made or letters written without the concurrent knowledge of the adolescent. Whereas Aichhorn felt that it is necessary to avoid becoming identified with the parents or seeming to side with them, Ella Sharpe felt that these initial resistances are inevitable and respond to direct interpretation. The therapist should not fall over backwards in this sensitive situation but try and confront it head on. Treating the adolescent with velvet gloves may only increase his suspiciousness.

All therapists agree that the negativism of puberty is a formidable resistance to overcome and is a primitive defense against emotional surrender, or complete submission to the therapist and a sacrifice of identity. Even in the most rebellious cases, surrender is always around the corner.

The major elements that are potent in overcoming the initial negativism and mistrustfulness of the adolescent in treatment are the unruffled equanimity of the therapist, his steady regard for his patient, his concern for the patient's welfare, his intense preoccupation with the patient's productions, and his unconditional acceptance of all aspects of the patient.

Erikson pointed to the inferiority engendered in the adolescent patient when his negative identity is brought into contact and, therefore, comparison with the positive, well- integrated identity of the therapist. The patient is well aware of his poor identity and is equally anxious not to have it submerged or destroyed by the curative process. In cases of identity confusion, Erikson stated that it is sometimes necessary to reach rock bottom, “letting the ego die,” before healthy reintegration can take place. In addition to being a conspiracy, a trap, and a means to enforce surrender, treatment may also be conceived as a punishment, especially when sadomasochistic tendencies are uppermost. If the negative feelings, however, are dealt with as soon as they arise in therapy, or are even anticipated by the therapist, confidence in the therapist and his treatment is established, allowing for the development of a working therapeutic alliance. A further measure of confidence is attained during the course of treatment when the therapist demonstrates his continued equanimity in the face of violent affective fluctuations and persistent negativism. In the case of girls, the therapist has not only to allow for the usual fluidity of the period but must also familiarize himself with the shifts in fantasy that occur during the menstrual cycle, as shown by Benedek.

Some Specific Technical Considerations

The acting-out adolescent, as is apparent from Aichhorn’s management of this problem, can tax the patience and ingenuity of even dedicated

psychotherapists, who may come to feel the same sense of helplessness and resentment generated in the parents of such patients. The therapist is torn between his ideal of therapeutic tolerance and acceptance and the pragmatic necessity for imposing restrictions; as a result, his treatment posture may become inconsistent and, at times, even incoherent.

Bergen strongly advocated the use of limits. In her experience, the adolescent who acts out may look upon even severe restrictions as an indication of a basically friendly approach, and many therapists have experienced (with some alleviation of guilt) the diminution in anxiety when limits are firmly set. Bergen felt that the conflict with authority cannot be handed over to the administration; it needs to be treated and worked through in relation to the therapist's authority. The patient with a weak ego cannot be expected to handle his own controls and may respond with some relief to controls from the outside as a temporary measure. Permissiveness in this case could create feelings of omnipotence with terrifying consequences for the patient. Working patiently within limits may gradually bring about an internalization of controls in a regular sequence. Because of results ensuing from his wayward behavior, the patient is driven to seeking help; he is well received by the therapist who respects his wish to cooperate in the establishment of controls; the restrictions are found reassuring, and even attempts at rebelliousness carry elements of cooperation. The struggle follows the early developmental pattern of internalizing controls and needs to

be taken step by step because, as Bergen said, the patient “needs to feel his struggle.”

Theory can sometimes help to support the therapist in the difficult management of such cases. Acting out can come to mean something much more than just obnoxious behavior indulged in by the adolescent in order to provoke his environment. The therapist may come to regard such behavior as a desperate attempt to draw attention to the patient’s predicament, as a cry for help. The therapist may also think of acting out as the equivalent to remembering, and since the recovery of memories plays a considerable part in the intensive psychotherapies, such as psychoanalysis, a serious degree of acting out may render the patient untreatable by these methods.

Still other therapists view this form of behavior in the context of the transference relationship and the resistance to its analysis. Such therapists would tend to control acting out by means of interpretation rather than restriction, but they may also find that their interpretations are often not heard nor heeded.

Delinquent acting out raises additional problems for the psychotherapist who may find himself, to his dismay, involved in time-consuming administrative and legal situations. Eissler suggested that the delinquent, unlike the neurotic, needs to be treated in two phases, the first of

which is preparatory for the second. According to him, there are three indispensable steps in the treatment of delinquents. First, in keeping with Aichhorn's approach, the therapist must work actively at establishing a positive transference relationship, something that happens automatically in the treatment of neurosis. Interpretation plays only a minor role during this initial phase and is given only if it serves the goal of preparing for the second phase. The abatement of delinquent symptoms occurs when a working relationship is established between the therapist and the patient, which itself is predicated on the patient's experience of the therapist as an omnipotent but benign being who will use his power for the patient's benefit but never to his detriment. In the next step, the therapist relinquishes this role and assumes his habitually more neutral position, and as a consequence the delinquent condition is neuroticized, with the aggression being gradually replaced by anxiety. Aichhorn claimed that he could carry a delinquent patient through both treatment phases, but the technical skills required are so different that a relay of therapists is generally preferable. The method can backfire and lead to an increase in acting out or exploitation of the therapist. Cautious optimism is a prerequisite in the treatment of all adolescents but particularly with the delinquent type.

Anthony discussed the difficulties of treating the clinical depression of adolescents, which he regards as an extension of the normal and expectable sadness of young people caught up in the adolescent predicament,

imprisoned, as it were, within a disturbing developmental phase with often a curious pessimism with regard to getting through it. He describes two different forms of the illness. (1) The type x depression tends to show a cyclical development related to variations in self-esteem brought about by approval or disapproval by an idealized parent figure. In one part of the cycle, self-esteem is high, the mood is elated, and the patient eats well; following a narcissistic injury, there is a swing into a second phase characterized by low self-esteem, self-hate, and feelings of extreme helplessness. The psychopathology is mainly preoedipal and based on a marked symbiotic tie to the omnipotent mother. Shame, humiliation, inferiority, inadequacy, and weakness are the pervading affects, and narcissism and egocentrism are extreme. The mother is seen as sadistic, disparaging, and reproachful. (2) The type 2 depression is more oedipal in nature, with a great deal of guilt and moral masochism associated with a punitive superego. The feelings of self-disgust often begin in late latency, precipitated by disappointment at the breakdown of parental idealization, and this leads eventually to the aggression turned against the self in which both self and hated incorporate objects are annihilated. The management of the type 1 depression is a function of the therapist’s sensitivity to the cycle of self-esteem and of his understanding that the two parts of the cycle reflect two parts of the total psychopathological picture. He therefore works carefully at the self-depreciating tendencies during the low phase and with the abundance of

good feelings and their significance during the high phase. The acceptance of the patient throughout the cycle operates significantly to break up this phasic development and dispel the patient's magical conviction that good will inevitably follow bad and bad, good. The crises of self-esteem are tactfully and gently interpreted and any apparent reproachfulness on the part of the therapist brought into the open. In the type 2 depression, the ambivalent dependency on the therapist may be extreme, so that even routine separations at weekends may become catastrophic in their impact. As times goes on and continuity in treatment is maintained, the therapist becomes a stable internal figure that eventually allows the patient to retain an equilibrium in his absence. With both types of depression termination may occasion a resuscitation of hopeless and helpless feelings and a demand for prolongation of therapy.

The schizoid adolescent may come to psychotherapy in adolescence with a long childhood history of distant and remote feelings with regard to people. The problem posed is not unlike that of the delinquent and, for the same reasons, requires a period of preparation during which a therapeutic alliance can be established. The technical difficulty of making contact with the inner life of the patient is considerable, since the more one presses forward, the more he retreats, and the pursuit itself becomes unreal.

Anthony described an approach making use of primitive memories in

the form of sensations that he termed “screen sensations,” since they cover deep, nonverbal experiences of a sensory or kinesthetic type. The treatment of such patients is often punctuated by the emergence of peculiar and unusual sensations, vividly experienced and vividly described, that seem to haunt the patient for a while as if resonating with some distant remote past. The screen sensations lead back to other experiences in latency, the preschool years, and finally to infancy, when the re-experience in the therapeutic situation is an almost ecstatic Nirvana experience of timelessness and spacelessness, with the disappearance of the ever- constant fear of submersion and annihilation. In the preparatory phase, the therapist permits the development of an intense symbiotic relationship, and after the emergence of the screen sensations, he initiates the process of separation that generates a more treatable neurotic disturbance.

There are limits to the therapeutic development of such withdrawn individuals where even the establishment of the initial relationship is quite an achievement. In this context, Anna Freud remarked: “There are many cases where the analyst would be wise to be content with this partial success without urging further treatment. A further, and deeper, involvement in the transference may well arouse all the anxieties described above and, again, lead to abrupt termination of the analysis due to the adolescent’s flight reaction.”

Bryt discussed the perennial problem of dropout from psychotherapy of adolescent patients. In the lower socioeconomic stratum, the dropout rate has been exceeding 50 percent. The factors may include selecting patients with little "psychological literacy" (in Slav- son's terms), inflexibility of the treatment procedures, unrealistic therapeutic goals, linguistic and semantic incompatibility between therapist and patient (as Hunt emphasized), and finally pessimism on the part of the therapist. According to Bryt, a meaningful semantic framework is a prerequisite to the talking treatment of psychotherapy.

The Role of the Psychotherapist

More than at any other stage, the adolescent shows extreme awareness and sensitivity to the person of the therapist and, despite his characteristic self-absorption, may evince an avid curiosity about the therapist's background; age, sex, personality, and ethnic origins may assume vital positions in the progress of psychotherapy. Liking and being liked by the psychotherapist are also important prerequisites that may affect the dropout rate. The major factor is probably that of the sex of the therapist. For various reasons, some male psychotherapists are extremely uncomfortable with female adolescent patients, and some male adolescent patients are extremely disturbed and threatened by female psychotherapists. Geleerd warned of the dangers of unconscious seductiveness on the part of the psychotherapist, and

the situation can be made even more perilous when he misconstrues his approach as therapeutic. There is no doubt that countertransference is a major hazard in the psychotherapy of adolescents, and Anthony discussed its various forms.

Psychotherapists, like parents, may develop stereotypic reactions to adolescent patients in addition to the classical countertransference. In a more interpersonal way, therapists may dislike their adolescent patients as individuals, as well as particular aspects of them. Stereotypes might take various forms. The psychotherapist may view the adolescent as dangerous and avoid him, or as endangered and overprotect him. In the course of treatment, the countertransference feelings may become erotic and disturbing, especially when the situation is a heterosexual one. Once again, the need to get close may be translated into physical closeness. The patient may further confuse the issue. When, for example, he treats the adolescent girl in a way that he reserves for his child patients, she may react disconcertingly like a mature woman, so that his innocent maneuvers take on the guise of seduction; when he treats her like an adult patient at an appropriate distance, she suddenly "melts away leaving behind a little girl who cannot understand why she may not be loved in the old way." The therapist may also find himself getting fully involved in the sexual life of his adolescent patients and probe for unnecessary details for "therapeutic" reasons. The blatant homosexuality of some adolescents under conditions of

treatment may also evoke strong rejecting responses in the therapist and an increase in his severity and seriousness.

Again, the therapist, like the parent, may find it difficult to fit himself and the adolescent into the same therapeutic situation and may become disturbed at the marked fluctuations in the adolescent's moods and object relationships. He may react at finding himself treated as a transitional object to be taken up and put down at the whim of his patient. With the younger adolescent, he may become disgruntled at the patient's obvious boredom and restlessness, his open yawning, his lack of communicativeness, and his monotonous reporting of external events. Once, however, the psychotherapist has accepted the fluctuating and erratic reactions of his adolescent patients as part of the therapeutic situation, he may be able to settle down more easily and comfortably to incorporating such problems into his technical approach, even to the extent of regularizing breaks from treatment.

The therapist, like the parent, may also envy the youthfulness, the youthful activities, and the youthful loves of his patients and may find himself responding with resentment and reproachfulness to the "good things" happening to the young adolescent. At the close of therapy, he may find himself clinging unnecessarily to his patient and prolonging the termination phase. In the treatment of depression, Anthony described the almost contagious development of depression in the psychotherapist, sometimes

followed by a counter-depression of exaggerated professional good humor. The psychotherapist can also respond to the patient's narcissism; treatment then becomes an endless source of gratification and little more. The masochistic trends concomitant with the depression may provoke small exhibitions of sadism that may build up and assume monolithic proportions in the patient's mind so that the treatment situation becomes a torture chamber. Anthony also described the type of countertransference generated in the male therapist when treating a female adolescent patient with a type 2 depression. In the up phase, the male therapist is likely to envisage the inner space actually furnished with good objects of all kinds to be both admired and envied. In the down phase, these good things are drained from the female patient, and the psychotherapist becomes suddenly conscious of her deficiencies, her ungivingness, and her castrated state. The inner space, as Erikson put it, is "the center of despair in the woman," and its emptiness is apt to affect the man who is treating her.

Conclusion

The relative weakness of the adolescent ego has led to many doubts about treatability. There are some who feel that the adolescent is best left to treat himself and find his own solutions with some support from the therapist. There are others who feel that treatment itself is a sort of moratorium to the adolescent in which the habitual reviews of his life history,

as well as the regular sequential development of a therapeutic session, can improve his time sense and give him the feeling of continuity that he needs. Gitelson was against analysis and recommended what he called character synthesis, the putting together of the fragmentary experiences and feelings of the adolescent. Zachry felt that adolescence was a good time to institute treatment because this was when the growing-up child became introspective and aware of internal conflict. Others have stressed the need to adapt psychotherapy to the adolescent rather than the other way around. Above all, it is important for the psychotherapist to recognize the normal abnormalities of adolescents and not to rush in to treating them. What is normal for an adolescent has never been better stated than by Anna Freud:

> I take it that it is normal for an adolescent to behave for a considerable length of time in an inconsistent and unpredictable manner; to fight his impulses and to accept them; to ward them off successfully and to be overrun by them; to love his parents and to hate them; to revolt against them and to be dependent on them; to be deeply ashamed to acknowledge his mother before others and, unexpectedly, to desire heart-to-heart talks with her; to thrive on imitation of and identification with others while searching unceasingly for his own identity; to be more idealistic, artistic, generous and unselfish than he will ever be again, but also the opposite: self-centered, egoistic, calculating. Such fluctuations between extreme opposites would be deemed highly abnormal at any other time of life. At this time they may

signify no more than that an adult structure of personality takes a long time to emerge, that the ego of the individual in question does not cease to experiment and is in no hurry to close down on possibilities.

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Notes

1 Italics mine.—E.J.A.